BEHAVIORAL HEALTH NEWS

How My Suicide Attempts Made Me a Better Crisis Peer Specialist

Carl Alan Blumenthal, MS, MA, NYCPS, Jan 13, 2025

Trigger Alert: If you or someone you know is disturbed by the descriptions of suicide (attempts) in this article, please consult a behavioral health provider or contact the 988 Suicide and Crisis Lifeline.

Past is Prologue for Premature Life and Death

Car crash, asphyxiation, throat slash, frostbite, overdose, electrocution, hunger strike. These are the seven "lucky" ways I tried to kill myself between 1974 and 2006. "Lucky" because my dramatic but half-hearted attempts left me alive with only one scar (on my neck). Had I stuck with one of these methods and perfected it, I wouldn't be here today at age 73.

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However, my younger brother, Hank, who experienced anorexia as a young adult, starved himself to death at 66 in a nursing home 2 ½ years ago, after several attempts to do himself in by swallowing a tube's worth of toothpaste and a lot of the Adderall he used for his OCD.

The 988 Suicide and Crisis Lifeline lists eight risk factors for suicide. Although neither of us misused substances and we both had plenty of behavioral health care, we shared prior suicide attempts, mood disorders, access to lethal means, knowing someone who died by suicide, and chronic disease.

A key difference is that I was married and had many friends, whereas my brother lived alone without social support and depended first on our mother and, after she died, on me, who took care of him for the last four years of his life.

As for protective factors, Hank's behavioral health care wasn't effective in the long run, in part due to multiple diagnoses. It takes two to tango, and he wasn't always a therapeutic dance partner. My attempts to support him using my peer specialist skills tended to make him dig deeper into a hole. When I finally removed the wall that he had built around himself by hoarding, he became more defensive.

Hank's self-esteem depended on his ability to get the best deals for himself—by haggling with merchants, scalping concert tickets, winning insurance injury claims, and gambling on the stock market.

At his best, he was adventurous and put people at ease by acting as a clown because he relished his status as an outsider.

But, when he didn't get what he wanted from people emotionally, he often turned against them. His perhaps unconscious purpose in life was to use his brilliant mind to follow (hopelessly) in the footsteps of our brilliant father. Because our Jewish parents died before him, any religious belief against suicide was buried with them.

If I sound hard on Hank, it's because our lives mirrored each other's, beginning with us both doing time at the Yale Child Study Center for acting out. He spent a total of two years on psychiatric inpatient units; for me, it was only four months. I am the oldest of four, and while our two sisters had their problems, they did not become manifest until later in life. Plus, they both had children; neither Hank nor I did.

The roles that race, ethnicity, class, gender, etc. play in the risk/protective factor assessment are hotly debated. Being a middle-class, well-educated Jewish straight male seemed to help me, but not Hank. His failures in those regards made him feel like the odd man out in our family.

As the third child, Hank might have been overlooked, except his premature birth led to a "separation anxiety" so intense that our mother had little time for the rest of us. His cries for attention substituted for his inability to speak until the age of five.

Is it possible that this one adverse childhood experience (ACE) could wreak such havoc on me? Somehow, I and my two sisters lived up to the expectations of our father, who graduated from Yale University at age 19 and became a successful businessman. While my mania fueled overachievement, when depression didn't sideline me, Hank's multiple diagnoses crippled him ultimately.

Our mother was no slouch either. A graduate of Brooklyn College, she became a grammar school teacher and social worker after raising us. As president of our community mental health center, she persuaded me to become a peer specialist. The sad irony is that neither of us could save Hank from himself, parts of whom were embedded in her and me. Mom's parting words were: "Take care of each other!" To me, that meant assuming her lifelong guilt. Ouch!

Back to the Future (Of Suicide Prevention Practice and Policy) at NYC Well

Little did I know that these experiences would prepare me to work for Vibrant Emotional Health's NYC Well and VNS Health's Brooklyn Mobile Crisis Team (BMCT). After 27 years as a community organizer, urban planner, and journalist, I became a peer specialist in 2002.

But it wasn't until the Covid pandemic that I came out of retirement, at age 69, to serve the needs of peers in crisis. At first, I failed to become a Covid contact tracer, and the Samaritans rejected me as a hotline volunteer, apparently because they believed my prior suicide attempts would trigger me.

However, Vibrant viewed my lived experience as an asset and hired me. There, I only worked the noon-to-8 PM shift on Mondays, Wednesdays, and Fridays because responding to a couple dozen calls, chats, and texts a day was enough to burn out the coolest peer support specialist.

I'll never forget my first day of work when I discovered so much suicidal and homicidal rage in visitors to the hotline that I could have written the script for a horror movie. Fortunately, my supervisor talked me down from the ledge of quitting.

Over the next two years, I became so adept at supporting peers in crisis that I could handle two suicidal texters or chatters at a time, even one in French and another in English, from as far away as Montreal and Mumbai. Of the thousands of interactions during that time, I was triggered by only a few peers

whose self-absorption reminded me of my brother. Nor did the past suicides of extended family members, friends, and other peers inhibit my work.

Because I was as old as the grandparents of tweens and teens, I developed a special rapport with them when the isolation of remote learning during Covid worsened tensions between them and their parents.

That I survived multiple suicide attempts was usually the basis of building trust with suicidal visitors. My safeTALK (Tell, Ask, Listen, and KeepSafe) training gave me the confidence to be supportive as well as safety conscious.

Even when a peer contacted me in the middle of a suicide attempt, the ambivalence that I had experienced during my own attempts was the key to their survival. In conversations that lasted up to 90 minutes, I would reinforce the positive, usually unacknowledged, aspects of their lives while validating the pain of their present existence. In other words, I accentuated protective factors to compensate for risks. Then, we would plan a way forward.

Among the several hundred with suicidal thoughts whom I successfully supported, I got one young man to lock his gun in a safe and a young woman to untie the noose around her neck. (Follow-up by crisis counselors confirmed their survival.)

However, my support for suicidal peers ended in April 2022 when Vibrant instituted the Columbia-Suicide Severity Rating Scale (Columbia-SSRS) for screening peers in crisis. Although the six-question scale is an easy-to-use tool, peer specialists were instructed to transfer the interaction to a crisis counselor if the person in need answered “yes” to one of the first two questions: 1) Have you wished you were dead or wished you could go to sleep and never wake up? and 2) Have you actually had any thoughts about killing yourself?

The reason for this change in protocol was liability. Peer specialists are only certified, whereas crisis counselors are licensed clinicians. Unfortunately, it deprived me of my raison d’etre as a peer specialist supporting suicidal peers. That is why I became a member of VNS Health’s Brooklyn Mobile Crisis Team and eventually resigned from NYC Well in October 2023, after it transitioned to NYC 988.

According to Vibrant, “All crisis counselors within NYC 988 come from diverse backgrounds, including those with lived experiences. Their role is to adhere to the 988 Lifeline’s safety assessment guidelines, the imminent risk policy, and other clinical standards while utilizing the least invasive interventions necessary to support the individuals in crisis. In addition, NYC 988 provides access to an internal Peer Support Warmline, a call-only referral service.

We acknowledge that peer support is vital within the crisis continuum of care. When a help seeker contacts NYC 988 and speaks with a crisis counselor, they are assessed for suicidality and imminent risk. If there is no presenting risk, the caller can be connected to the Peer Support Warmline either by requesting to speak with a peer support specialist or, after further assessment, the crisis counselor suggests it as one of the next steps.”

For all the operational sense this procedure makes, peer specialists have not only been further excluded from supporting suicidal peers directly but are also prohibited from text and chat interactions. Because Vibrant oversees the national 988 system and NYC 988 is the flagship local call center, this sends a discouraging message to other centers.

Although not well documented, it’s possible that some local 988 centers use peer specialists to support suicidal peers, as implied in “Peer Support Services Across the Crisis Spectrum” by Amy Brinkley and Justin Volpe of the National Association of State Mental Health Directors, for SAMHSA in 2024. SAMHSA’s other guidance on this subject is inconsistent. Sometimes, the agency only refers to “crisis

counselors;" sometimes, it mentions "people with lived experience" and even volunteers as potential workers. However, SAMHSA is silent about whether peer specialists can support suicidal peers. (Prior to 988, the National Suicide Prevention Lifeline prohibited employment of peer specialists due to the focus on suicide.)

But don't take my word for the importance of peer support in suicide prevention. Here's what the National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force reported in "The Way Forward: Pathways to Hope, Recovery, and Wellness With Insights From Lived Experience," 2014: "Peer support workers—specifically peers who are survivors of a suicide attempt and/or survivors of suicide loss [both true in my case]…can offer understanding, compassion, and awareness of the possible range of thoughts and emotions the person in crisis is likely feeling and thinking. The person with prior lived experience will also have an understanding and knowledge of what worked for them in their own moment of crisis, which can help quickly build trust and connection with the person in crisis…. The peer support worker can also model self-care practices and provide a unique and powerful contribution to another person's recovery."

Due to the shortage of 988 crisis counselors nationally and their high burnout rate, SAMHSA should devise a way to balance liability and the benefit of support by peer specialists during suicidal crises.

Back to the Future II: VNS Health's Brooklyn Mobile Crisis Team (BMCT) for Adults

VNS Health solved the liability problem by pairing me with an experienced licensed social worker or nurse practitioner on visits to adult peers' homes. BMCT for adults is one of six MCTs VNS Health runs in Brooklyn, Queens, and the Bronx for peers of all ages. Approximately 20% of the 4,325 individuals referred annually by 988 to VNS Heath have exhibited some risk of suicide. Of those served, 60% are under the age of 21. Some drug overdoses may be suicide attempts, but these are decided case by case.

BMCT's clinical staff for adults was so caring, efficient, and effective in their practice (as were all the crisis counselors at NYC Well with whom I worked) that, at first, I had difficulty defining my role.

And, because the referrals are almost always from third parties, such as doctors, family, friends, and neighbors, the peers we encountered were free to refuse our services if they were even at home. Therefore, only during responses to peers who were suicidal did my experience at NYC Well kick in. Safety is the ultimate concern for mobile crisis teams. However, I found that I could differ with my partner clinician about whether, how, and when a person required transport to an emergency room.

In our most memorable response to a peer threatening suicide by subway, even though he was alone at home, we first meditated together to reduce his anxiety about returning to a hospital that he felt had mistreated him in the past. Then, before giving him time to pack, I advocated with my partner to allow the peer to pay his rent that would be due during his time away. These validations of his autonomy were key to his acceptance of transport by EMS to the hospital.

According to Deirdre DeLeo, VNS Health's Director of Behavioral Health Programs, "Data collected by NYC DOHMH [show] 5 to 10% of individuals seen by a mobile crisis team required transport to an emergency room for assessment for admission, which is a positive sign that the program is effective in managing cases safely."

She also described the clinician-peer specialist partnership this way: "I often compare the cooperation in MCT to dancing, where each partner has their own steps, but the true beauty is when the steps come together. This collaborative approach allows each person to play their role during an assessment…. Peers play a unique role in modeling resiliency and recovery in action. Discussing suicidal feelings and thoughts can be very difficult and scary. Peers may share their own journey and experiences…, which

can be a relief and a confidence builder for our clients." DeLeo described one interaction in which a peer specialist convinced a skeptical young immigrant to accept treatment based on the peer specialist's own positive outcomes.

VNS Health has pioneered MCTs since 1987 and incorporates SAFE-T in the Columbia-CSSRS screening tool. SAFE-T is a five-step plan that involves identifying risk factors and protective factors, conducting a suicide inquiry, determining risk levels and interventions, and documenting a treatment plan. And safety planning, whether for suicide prevention or other concerns, is an important part of VNS Health's MCT practices.

Even with 20 MCTs for adults and five for children, NYC's capacity falls short of the need because New Yorkers still mostly rely on 911 to summon assistance for themselves and others during behavioral health crises. New York City is experimenting with a combination of EMTs and social workers who respond to 911 calls from 20% of precincts. The number of people served is small, and the teams don't utilize peer specialists.

In other words, we need to advertise 988 more fully as an alternative to 911, promote the NYC model of MCTs throughout the city and state with a full partnership of clinicians and peer specialists, plus adequately fund the system.

Conclusion: The Future is Now

I left my part-time position at VNS Health in October 2023 for a full-time one at NYU Langone's Brooklyn clinic for peers experiencing altered states of consciousness (aka "psychosis"). Now, I work as a peer specialist in Fountain House's Medicaid-funded community-oriented recovery and empowerment (CORE) program. Why am I still so passionate about the role peer specialists can play in suicide prevention?

Without glamorizing the misery of feeling and acting suicidal, I contend that the philosopher Friedrich Nietzsche was right when he stated, "What doesn't kill you, makes you stronger." I have learned how to harness my manic energy without risking a depressive blackout.

Raised as a Conservative, middle-of-the-road Jew, I became a member of the Protestant Religious Society of Friends (Quakers), in part because my numerous recoveries from depression and suicide attempts felt like resurrections. The 40 years my brother lived independent of institutions was his form of rebirth. Hank's inability to sustain that independence is a cautionary tale that guides my practice as a peer specialist.

Now that I'm thriving after 50 years of living with bipolar disorder, every day is a new beginning. We don't have to go to the moon to declare that one small step by any of us is a giant leap for all of us.

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