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THE LIVED EXPERIENCE OF SUPPORT STAFF WORKING WITH HOMICIDE SURVIVORS

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Abstract: Social service workers with lived experience can be valuable assets to those experiencing the loss of a loved one to homicide. Researchers examined interview data gathered from a Chicago homicide survivor service agency evaluation and found workers who had previously experienced the homicide of a loved one brought many benefits to helping clients. However, the data also showed providing services to this population put the workers at high risk for burnout and vicarious trauma.

Introduction

In the aftermath of a homicide, friends and family members of the victim (often referred to as co-victims or survivors) may experience prolonged grief, mental disorders (e.g., anxiety, depression, post-traumatic stress disorder [PTSD]), impaired family functioning, financial problems, and isolation.[1] Some use alcohol or drugs to cope and become at increased risk of developing a substance use disorder.[2] Certain survivors may be asked to assist with the police investigation of the homicide, which can continue to traumatize. Many survivors may not understand the criminal justice process or how to get information on the status of an investigation. This can leave survivors frustrated and overwhelmed by the criminal legal system.[3]

New programs have been developed to address the wide-ranging and unique needs of homicide survivors. These programs offer counseling, case management, criminal justice advocacy, funeral assistance, youth support, and financial services. Some homicide survivor programs employ persons with personal or lived experience of violence to deliver these services. These staff draw upon their own experiences with recovery as they deliver services and may or may not be professionally trained.

Much of the extant literature on staff applying lived experience has focused on the fields of mental health, substance use, and domestic violence; less is known about services provided by those with lived experience of surviving the loss of a loved one to homicide.[4] This study aimed to learn more about this population with the following research questions:

- What is the experience of staff with lived experience at a homicide survivor service agency?
- To what extent is lived experience beneficial or challenging?
- To what extent do staff with lived experience care for their own well-being?
- How can homicide survivor service agencies hire and support staff with lived experience?
- How do clients perceive homicide survivor service agency staff members with lived experience?

Literature Review

Research has found recovery from psychological distress, such as that caused by the sudden death of a loved one, involves multiple elements—renewed hope, involvement in meaningful activity, overcoming stigma, managing symptoms, and feeling empowered.[5] Although recovery is ultimately person-driven, holistic recovery services are important for addressing many individuals' extensive needs, which can include physical and mental healthcare, stable employment and housing, transportation, and social fulfillment.[6]

Staff who share their personal experiences with recovery from trauma can complement and enhance recovery services.[7] Some staff may have professional or clinical training, while others are employed solely as peer supporters who draw on their own experiences.[8] In general, research on employing staff with lived experience of violence is relatively scarce. More studies are needed that distinguish between the types of lived experience staff, such as a comparison of non-clinical to clinical staff who also have lived experience, and their effectiveness on various outcomes.

Benefits of Employing Staff with Lived Experience

Social service staff whose experiences are reflective of their clients can help navigate, and sometimes circumvent, barriers to and within social services. This assistance can be especially valuable for individuals who have felt mistreated or misunderstood by traditional caregivers.[9] Although clinical knowledge is important, lived experience may help humanize systems of care.[10] Diversity in staff experiences due to socioeconomic status, mental health, and upbringing, as well as gender, race, sexual orientation, and disability can assist organizations develop recognition and understanding of the unique obstacles clients encounter.[11] These staff can describe the complexities and needs of clients based on their own experiences, rather than through academic knowledge, as well as role model recovery for fellow staff and clients to witness.[12]

Gillard and Holley (2014) summarized literature on staff with lived experience in mental health fields and found the bonds these staff formed with clients reduced clients' feelings of isolation and enhanced their qualities of life and independence.[13] They also noted that individuals who perceive a sense of equality with staff may have increased receptivity to services. Bellamy et al. (2017) conducted a meta-review of research on peer services for serious mental illness and found peer services can reduce inpatient service use and crisis emergency services and improve client levels of hope and empowerment.[14] However, the authors noted future studies should identify how lived experience can contribute to recovery-oriented outcomes and that more research is still needed on the various models of peer support.

Benefits of peer support may apply beyond clients and to staff themselves. Johnson et al. (2014) found persons with lived experience who began working as service staff felt increased confidence and improved perceptions of their own recovery.[15] However, research indicates without ample training and support, these staff may not always be well-equipped to handle the traumatic life events of others.[16] Bartone et al. (2018) suggested only those who have successfully recovered themselves should be hired in these positions.[17]

Challenges for Staff with Lived Experience

While their work benefits clients, service providers with lived experience face challenges. Advocates say sharing a personal story can be draining and that doing so requires one to set aside the need for privacy.[18] Fair compensation and benefits may also be lacking for service providers with lived experience, leaving them to feel tokenized and devalued.[19]

Compassion Fatigue

Compassion fatigue refers to a service provider's reduced capacity for empathy after excessive exposure to the trauma of others.[20] Staff on the front lines are at risk for compassion fatigue. In one study of hospice nurses, Abendroth and Flannery (2006) found 78% were at moderate to high risk for compassion fatigue, with 26% in the high-risk category.[21] They noted that excessive empathy, anxiety, life stressors, and trauma were the key determinants of this risk. Although some researchers use the terms compassion fatigue, vicarious trauma, and burnout interchangeably, others note that these are overlapping but distinct phenomena.[22]

Vicarious Trauma

Vicarious trauma, first conceptualized by McCann and Pearlman (1990), is defined as a negative change in a person's view of themselves and the world from close association with another person's traumatic memories.[23] Symptoms of vicarious trauma overlap with PTSD and include

intrusive thoughts and images, avoidance of trauma reminders, and an inability to empathetically listen to repeated stories of trauma.[24] Those with vicarious trauma may experience isolation, loss of hope or faith in humanity, and difficulty trusting their own beliefs.[25] Vicarious trauma is listed as a potential exposure for causing PTSD in the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5).[26] This distinction was added in the latest edition of the DSM and was the first time that DSM criteria have included the harmful effects of repeatedly witnessing or hearing stories in the aftermath of trauma.[27] The inclusion of this exposure means that some of those who experience vicarious trauma may also be diagnosed with PTSD. This inclusion may help to legitimize the severity of trauma service providers' reactions, as some research shows nearly 15-20% develop PTSD from hearing the stories of survivors.[28]

Burnout

Burnout refers to negative psychological symptoms stemming from chronic workplace stressors. The workplace component is what distinguishes burnout from vicarious trauma, which is not necessarily connected with the workplace.[29] Burnout is recognized as a common occupational hazard for workers in people-oriented service professions (e.g., social work, nursing).[30] Risk for burnout is particularly evident for those whose work entails exposure to traumatic situations.[31] Research shows the COVID-19 pandemic amplified burnout complications among care providers due to increased workload, fear of infection, and other pandemic-related issues.[32]

Employee Division

Traditional professionals in the field may stigmatize or speak in clinical jargon about staff with lived experience, which can feel dehumanizing.[33] Staff with lived experience have noted feeling a part of the work team but of lower standing than their professional counterparts.[34] Staff without lived experience may encounter challenges forming collegiate relationships with staff who have lived experience, perceiving them as patients, interns, or pseudo-staff, and may not fully value the contribution of their perspectives.[35] In some cases, professional staff may have treated or cared for those with lived experience prior to their hiring, leading to a power differential.[36]

Support for Staff with Lived Experience

Employer Care

Employers can contribute to a healthy working environment by addressing the challenges staff with lived experience may face. Supportive efforts for staff with lived experience may include:

- Training on effective service delivery.
- Educational opportunities throughout employment.
- Consistent positive reinforcement and feedback.
- Opportunities for staff to share with supervisors how to offer constructive criticism, given a potential heightened sensitivity to feedback.[37]

When service providers with lived experience take on supervisory roles, staff may be more comfortable sharing the difficulties they encounter related to their lived experience.[38]

Psychological or Pharmacological Treatment

Staff with lived experience who work in a field that comes with repeated trauma exposure may benefit from psychological or pharmacological treatment. Therapy is generally recommended to

those affected by vicarious trauma. A therapist can provide an opportunity for individuals dealing with vicarious trauma to discuss the impact the experiences have on them and to learn coping skills to ease symptoms of vicarious trauma.[39] Certain medications have also been found to be effective for treating PTSD and trauma-related symptoms.[40]

Self-Care

Self-care has varying definitions, but it is generally encompassed by any physical, spiritual, mental, or professional activities that improve one's subjective well-being.[41] To effectively engage in self-care, individuals need unbiased self-awareness of their own experiences and emotional self-management.[42] Research has shown that in addition to employer care and professional treatment, self-care is critical for health care staff, although less research has investigated this specifically for staff with lived experience. Sanso et al. (2015) suggested that for palliative care staff who care for dying patients, practicing self-care not only improved their quality of life, but also improved their caregiving abilities.[43] Kearney et al. (2009) concluded self-care is essential to those providing therapeutic services and without it, caregivers may suffer from burnout, psychiatric symptoms (e.g., anxiety, sleep disturbances), and a sense of low personal accomplishment.[44]

Methods

The purpose of this study was to connect with staff who had experienced violence to learn how those experiences affected perceptions of their work. We also set out to identify the unique challenges these staff face and the benefits they bring to service delivery. The data collection used for this study was approved by the ICJIA Institutional Review Board. Qualitative data for this study was originally collected as part of an evaluation of Chicago Survivors, an agency providing services to the family members of homicide victims in Chicago. These services include crisis response; supportive, non-clinical counseling; funeral assistance and case management; criminal justice advocacy; and long-term support groups and memorial events.

Participants

Staff Member Sample

As part of the evaluation, semi-structured interviews were conducted with the following staff:

- Executive Director (n = 1): An administrator who oversees the organization, manages operations, and maintains external partnerships.
- Crisis Responders (n = 2): Frontline workers who arrive at the homicide scene and provide immediate support to survivors. They may act as liaisons with the police or medical personnel.
- Crisis Response Manager (n = 1): Supervisor of the crisis responders.
- Family Support Specialists (n = 3): Non-clinical staff who meet with survivors approximately every other week. They provide information on PTSD and coping strategies and refer survivors to other services (e.g., clinical therapy, furniture or food banks, social services).
- Youth Clinical Counselors (n = 2): Licensed clinicians who work with children survivors to address emotional needs and teach coping skills.
- Youth Program Manager (n = 1): Supervisor of the youth clinical counselors.

- Criminal Justice Advocate (n = 1): A staff person who accompanies survivors to court hearings and acts as a liaison with other agencies in the justice system (e.g., state's attorney's office, police department).

Most staff sampled were female under the age of 45 with education beyond college (Table 1). The staff's age range was 28 to 64 years old with an average age of 45 (SD = 13.9). Sampled staff had worked in the organization for a minimum of three months and maximum of 5 years with an average of 2.7 years (SD = 28.6).

Table 1

Demographics of Staff Sample

	n	*%*
Age		
25-35	3	27.3
36-45	3	27.3
46-55	1	9.1
56+	4	36.4
Gender		
Female	7	63.6
Male	4	36.4
Race/ ethnicity		
Black	5	45.5
Latinx	4	36.4
White	2	18.2
Highest level of education		
Some college	2	18.2
Bachelor's degree	2	18.2
Some Master's	3	27.3
Master's degree	4	36.4
Position in agency		
Directors, managers	3	27.3
Direct service staff	8	72.7
Licenses or certifications		
CPR (cardiopulmonary resuscitation)	1	9.1
Certified police officer	1	9.1
Licensed clinical professional counselor (LCPC)	1	9.1
Licensed clinical social worker (LCSW)	2	18.2
None	5	45.5

Note. Sample size was 11. Percentages may not equal 100% due to rounding. Direct service staff may include crisis responders, advocates, specialists, and counselors.

Client Sample

We conducted interviews with Chicago Survivors' clients (n = 11). Table 2 displays demographics of interviewed clients. All clients were women, and most were Black in their late 40s or early 50s.

Table 2
Demographics of Chicago Survivors Client Sample

	n	*%*
Age		
25-35	0	0.0
36-45	2	18.2
46-55	6	54.5
56+	3	27.3
Gender		
Female	11	100.0
Race/ ethnicity		
Black	10	90.9
Latinx	1	9.1

Note. Sample size was 11. Percentages may not equal 100% due to rounding. Race was self-identified.

Materials

Staff interviews included 39 questions and covered staff demographics (7 questions), agency roles (5 questions), staff training (3 questions), questions regarding their clients (12 questions), and agency operations (12 questions). The interviews ranged from 42 to 127 minutes with a mean length of 71 minutes (*SD* = 28.6).

The client interview protocol contained 42 questions on demographics (6 questions), prior experience with or knowledge of Chicago Survivors services (3 questions), details surrounding the homicide of their loved one and experience with Chicago Survivors' crisis services (5 questions), use of Chicago Survivors' other services (15 questions), experience with the criminal justice system (5 questions), clients' perceived achievement of short-term goals (3 questions), and closing questions (5 questions). Clients were asked if staff shared their lived experience and whether that impacted their services.

Procedure

Interviews were audio-recorded with permission and transcribed by project staff into Microsoft Word. Staff completed coding and qualitative analysis in QSR NVivo 9, using the same codes for all sets of interviews. Two researchers independently coded a small sample of interviews. After discussion, the two sets were combined. Once the final set of codes were decided, researchers separately coded interviews. New codes were added as needed and communicated among the research team. Separate coding with agreement among a set of coders is a recognized practice to gain inter-rater reliability of narratives or transcripts.[45] Themes included experiences with crisis response, family support, the Chicago Police Department, and agency challenges. Within this report, we used pseudonyms for direct quotes from staff and clients.

Study Limitations

This evaluation had a few limitations. First, we were only able to interview existing staff of Chicago Survivors. We were unable to interview former staff, potentially creating selection bias. Second, we cannot confirm the percentage of staff with lived experience of violence at Chicago

Survivors. To limit re-traumatization, we did not explicitly ask staff to identify their previous experiences with violence or homicide, although staff were able to share these experiences in response to the interview questions (e.g., "What made you want to work for Chicago Survivors?"). Therefore, some staff with lived experience of homicide may not have shared their experiences. We also cannot say whether the shared experiences were applicable to all program staff. Staff who were comfortable sharing their experiences may have been further along in the recovery process than others who did not disclose. Most staff in this study also had additional professional training or education, therefore these findings may not apply to agencies using peer supporters in a less trained capacity. Finally, client perspectives in this study come primarily from the viewpoints of older Black women; their experiences may not be reflective of all Chicago Survivors clients.

Findings

The following are the collective summary of findings from interviews with Chicago Survivors staff and clients.

Use of Lived Experience in Service Delivery

Chicago Survivors staff reported their lived experiences were an important part of service delivery to clients. Staff highlighted the importance of having a similar race and/or ethnicity to clients, as well as of living in the same Chicago communities. As explained by staff member Gabriel:

> *"Most of my coworkers are either Black or Latino. And . . . I do think that is important because the vast majority of people who died because of violence in this city are Black and/or Latino. So, I think that if you either don't live in a mostly minority community, or you haven't had to deal with violence on a personal basis or a community basis . . . however well-meaning you can be, there's always gonna be somewhat of a disconnect."*

Clients of the agency echoed that sentiment, noting the benefit of working with staff whose race or ethnicity are reflected in the community. Michelle stated:

> *"You know, it helps a lot that [the family support specialist] lives in the community and he's been through what I've been through . . . because, you know, when people are not in the community and they offer you help, it's just, it helps, but it's not, you know what I'm saying? You don't feel like they really taking care."*

Another client, Kelly, who lost a child to homicide, noted:

> *"[The family support specialist] was telling me . . . about his brother's death near my kid age . . . that's how my kids open up to him. 'Cause it's like, they like, wow, he's talking and knows what's going on."*

Staff with lived experience were perceived to be genuine supporters who understood community struggles. Some staff noted that discussing their shared experiences with law enforcement with survivors was especially bonding. Clients noted that family members who were more hesitant to open up and speak with other professionals were more likely to speak and listen to the staff who shared their own experiences.

Challenges Experienced by Staff with Lived Experience

Most staff reported various aspects of their work led them to place an increased importance on self-care practices. Some staff shared the toll the emotionally intense nature of the work takes on their mental well-being, in addition to causing burnout, increasing feelings of isolation and stigma, and experiencing vicarious trauma.

Mental Well-Being

Chicago Survivors' staff described how their work often impacted their mental well-being. Some staff reported experiencing PTSD when carrying high client caseloads. Others saw that the exposure to homicide and violence weighed on the emotions of their colleagues. This was especially true of new colleagues not yet used to the work. Linda stated:

> *"It is a serious psychological drag to come into work every day to work with people who are in crisis . . . and they just drain all of your positive energy out of you because they just need it so badly."*

Christopher noted:

> *"Everybody has [their] problems outside of work. And we're still able to balance the problems of others and process their issues . . . but we don't get a lot of healthy time as a staff."*

Compassion Fatigue, Vicarious Trauma, and Burnout

Often due to high caseloads and repeated exposure to homicide and violence, many staff reported experiencing compassion fatigue, vicarious trauma, and burnout, and some reported fear of becoming withdrawn or desensitized. Staff described the aspects of their work that may lead to burnout, including working 13-hour shifts. "*I do have more cases than I should be having*," said staff member Tiffany.

Richard reported experiencing sleep deprivation due to a high caseload:

> *"14 [homicide cases] in one weekend man . . . that was probably the first time that I knowingly experienced PTSD. It was sleep deprivation, man . . . 'cause my shift is 5p.m. to 5a.m."*

Three different staff members described their work as "overwhelming." Others described it as "draining," "difficult," and "highly stressful." Richard also reported not ever wanting to become insensitive to families seeking services. In response to a question on caseload manageability, Christopher replied that even though his caseload has dropped since he first started, he still thought it was too high:

> *"I remember when I first came and we were doing 50 cases. 50! And they just kept coming and kept coming and kept coming and kept coming. And now, let's say we already at 35, something like that, that still feels like 50. It don't feel no different is the thing. It's like, wow, that's a significant drop, that's still, it's still high… even talking about it, I just felt this little pang go into my left arm, like ooh talking 'bout the caseload stress. I feel it, that's all."*

One staff member, Linda, specifically mentioned vicarious trauma and elements of compassion fatigue:

"This work is really hard, is really draining, what are you doing for self-care? What are you doing for burnout? I think a piece of vicarious trauma is conflict . . . and therefore, a piece of addressing vicarious trauma is conflict management. And since we aren't going to lash out at the people we are trying to serve . . . we're going to take it home and be nasty to our spouse or our dog or whatever. Or we're going to take it back into work and blame other people for what is going on or we're not going to like getting supervised."

Stigma in the Workplace

Staff reported feelings of stigma from colleagues in their work. Linda indicated misunderstandings between professional clinicians and support staff that may lead staff to feel stigmatized:

"Part of tension that I feel in the program is between people who think of themselves as line staff and people who think of themselves as professionals. And the professionals blaming the line staff and the line staff thinking the professionals are snotty. It's not a battle all the time, it's just that they don't understand each other."

In response to changes that Chicago Survivors can make, Richard replied:

"All of us could bring . . . certain, amount of knowledge and creativity and uniqueness to the table, where we could share our input."

Their thoughts indicate a need for a higher degree of organizational inclusion among both those with lived experience and those with professional experience.

Isolation

Another staff member, Christopher, reported feelings of isolation from people in his personal life due to his family not understanding the work he does:

"I'm still trying to process that my dad, my grandmother, my mom, my brother, and everybody don't have a clue what I do. Like they know, but they really don't. They don't know. They've never really, they don't wanna know. They don't wanna know. If they really wanted to know, they would ask. It's been three years, they don't ask. They don't go into details. 'Cause they don't, I mean I wouldn't wanna traumatize them anyway."

Employer Care

Some staff discussed actions that the agency took to care for their employees. However, some agency actions, such as their annual, two-day retreats providing training on trauma and burnout, were not perceived by some staff as the most beneficial for protecting against adverse effects. Denise shared:

"I don't wanna receive training, because we do that during the year every so often, we get all these trainings. I believe the retreats should be about the staff members…you know, self-care, it should be focused around us."

Another staff person, Patricia, disclosed that although the agency had provided a guidebook with helpful tips for staff, she wished that the agency would offer more current approaches to handling difficult situations that occurred in her work.

Self-Care Practices

Most staff reported various aspects of their work led them to place an increased importance on self-care practices. For example, Jennifer indicated the importance of practicing self-care due to the nature of her work:

> *"You just need to be careful of the burnout. Because if you're very connected to this . . . work that we do, not only professionally but personally, there's even more self-care that you have to do."*

Creativity, Laughter, and Joy

Staff members reported practicing self-care through creative outlets, such as being a playwright and working on stage productions, writing, reading, cooking, and listening to classical music. Staff also indicated ways in which they incorporated laughter and joy into their lives as a form of self-care. Richard said:

> *"I'm a firm believer that laughter is a medicine. So, man, every day, I'm laughing about something."*

Five staff indicated experiencing laughter and joy from their faith, spending time with friends and family, vacations and travel, going to the movies, and socializing.

Physical Health

Many staff members shared the importance of prioritizing their physical health to care for themselves. One staff member, Richard, used his physical health as an indicator of the success of his self-care practices. Six staff shared other ways that they prioritize their physical health, such as eating healthy, practicing yoga, working out, getting massages, and receiving spa treatments. Linda shared how she wishes she prioritized her physical health more, but her work often consumes her entire day, and she ends up with little time left over.

Work-Life Balance

Staff members at Chicago Survivors reported how they prioritize a work-life balance as a form of self-care. Richard shared that he tries not to take the job home with him. Linda and Richard shared that they make time to be in positive spaces in their personal lives that compensate for the negative parts of their jobs. Martin said that he can compartmentalize when needed and that he tries to maintain a good balance between his personal and professional life. Monica and Tiffany said that they set boundaries around their time and respect their calendars. Gabriel said that he is cautious of talking to colleagues outside of work to respect both his and his colleague's need for personal time away from their work. Amanda shared that she always takes her lunch hour as personal time.

Mindfulness and Therapy

A few staff members highlighted the importance of mindfulness, mediation, and awareness as practices of self-care. Martin shared:

> *"I'm always doing a constant self-assessment. Of, you know, what's driving me . . . what is motivating me. Or why I do what I do. Why I feel what I feel. You know. So, I always try to maintain that awareness so that if I do feel burnout . . . I'll take a minute."*

Seven staff reported receiving therapy or, at the very least, talking to someone else about what they were experiencing at work. Gabriel, Monica, and Amanda shared that they were receiving private therapy services at the time of the interviews or that they had in the past. Tiffany said:

> *"I have mentors who are in my life, and I enjoy talking with them; it's almost like my own therapy."*

Four staff shared that having someone to talk to who understood their work and was not a licensed therapist was helpful, such as a manager or a colleague who understands the field.

Many staff discussed the psychiatrist available via contract with Chicago Survivors. Staff who saw the psychiatrist often reported the services were helpful for debriefing about their cases and that they liked having an objective, neutral party to provide feedback on their work and personal lives. However, Amanda shared that she would prefer that Chicago Survivors offered unaffiliated, external counseling to address her concerns.

Discussion and Conclusion

This study resulted in several recommendations which could assist organizations who provide assistance to homicide survivors.

Hiring Staff with Lived Experiences

Although primarily utilized in the mental health profession, employing persons with lived experience is a method of service delivery that has rapidly grown throughout several fields.[46] We explored the benefits and challenges of staff who had lived experience of violence and worked with clients of a homicide survivor program. Through interviews, staff explained the importance of sharing lived experiences of interpersonal or community violence with their clients. They felt sharing their experiences was critical to service delivery, in addition to sharing similar race, ethnicity, and socioeconomic demographics with their clients. In return, clients acknowledged and appreciated staff sharing their lived experiences. Other studies support the notion that when staff share demographics with their clients, they receive a deeper appreciation of client perspectives and increased openness from the client.[47]

Research suggests that having a diverse staff trained in cultural responsivity is fundamental to providing quality services that promote client strengths, dignity, and self-reliance.[48] Cultural responsivity refers to a set of congruent behaviors, attitudes, and policies that enable an agency to work effectively in multicultural environments. It is an ongoing and dynamic process that requires changing organizational structures and components as the demographics and needs of those served change. Cultural responsivity promotes relationships based upon understanding of how one's own cultural beliefs and values influence their perceptions, feelings, and experiences and incorporating this understanding into the helping process of one's job.[49] Culturally responsive services often provide a greater sense of safety from the client's perspective and offer clients an opportunity to explore the impact of culture, discrimination, and bias on their well-being.[50] Social service agencies seeking to incorporate culturally responsive practices may refer to Substance Abuse and Mental Health Services Administration's treatment improvement protocol on improving culture competency.

Ensuring Health and Wellbeing of Staff

Staff with lived experience may be at increased risk for experiencing vicarious trauma and/or burnout.[51] As indicated in staff interviews, their work can take an emotional toll on their mental well-being, producing feelings of isolation, stigma, and vicarious trauma. Their responses were generally supported by other research.[52]

Staff with lived experience shared how they mitigate adverse impacts of their work through self-care. Although staff development training and knowledge of burnout and trauma was noted as important, staff shared they personally undergo self-care practices. Staff practiced self-care through creativity, incorporating time for laughter, maintaining physical health, prioritizing a work-life balance, practicing mindfulness, and therapy. Other self-care practices included meditating, connecting with nature, and journaling. These are some strategies that can be encouraged to reduce signs and symptoms associated with burnout and vicarious trauma.[53] However, some may need additional services, such as psychological or pharmacological treatment for vicarious trauma.

Receiving Support from Employers

Although self-care is important, organizations should take considerable responsibility for staff care and retention. For example, Bell et al. (2003) advocated for staff to receive, when possible, diverse caseloads that are considerate of the risk of vicarious trauma that different clients may bring to staff.[54] They also noted the value of social change activities—such as advocating for policy change or engaging in community outreach and education—for empowering staff and lessening the effects of client trauma.

Lettau and Mathews (2012) suggested that employers of staff with lived experience adopt trauma-informed approaches and develop an organizational wellness plan to sustain staff wellness.[55] Welford et al. (2021) suggested employers of staff with lived experience should keep in mind that not everyone with lived experiences will want to take on frontline support roles. They also recommended that employers of staff with lived experience provide these staff with opportunities to develop skills and experience for career advancement. Additionally, Welford et al. (2021) recommended that employers of staff with lived experience provide adequate occupational health support, including the option for flexible working hours and leave and access to feedback from supervisors or debrief sessions.[56]

Employer Resources

The following resources may offer additional guidance to agencies that want to incorporate persons with lived experience into their programs:

- What are Peer Recovery Support Services? from the U.S. Department of Health and Human Services
- Who are Peer Workers? from the Substance Abuse and Mental Health Services Administration (SAMHSA)
- Supervision of Peer Workers from Bringing Recovery Supports to Scale Technical Assistance Center Strategy
- "Practical Guidance for Employers" section of How to Take Your Lived Experience to Work by Peter Bates
- The Vicarious Trauma Toolkit from the Office for Victims of Crime

Future Research

More research should be conducted on best practices for persons with lived experience as they integrate their knowledge and expertise with clinical or professional care.[57] Future studies also should further examine how leadership with lived experience may be impactful for line staff in gaining support and navigating boundary questions.[58] Increased knowledge in these areas may provide more evidence for the use of staff with lived experiences to improve client service delivery in both mental health and violence-related fields.

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