



Alternatives to Suicide Research Project:

Exploring the experiences and impacts of a peer-based approach to responding to suicidal distress

RESEARCH REPORT

**NATALIA JERZMANOWSKA, SCARLETT FRANKS, EMMA TSERIS &
CHARLOTTE FINLAYSON**

**SOCIAL WORK AND POLICY STUDIES
UNIVERSITY OF SYDNEY**

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Executive Summary

'Community. A sense of belonging. A sense of connection, purpose, love... I think often that's the antidote to distress.'

Despite significant investment in suicide prevention in Australia, no consistent reduction has been achieved. In light of the limitations of biomedical interventions, this study builds upon a small body of emerging literature examining peer-led approaches to suicidal distress. Alternatives to Suicide (Alt2Su) is a peer-led model emphasising mutual sharing in an environment where open discussion of suicide can take place without the threat of involuntary intervention by the mainstream mental health system. This report presents the findings and implications of interviews and focus groups with 19 people who have attended and/or facilitated Alt2Su groups in New South Wales. The majority of participants described positive experiences and outcomes, strongly contrasting Alt2Su with their experiences of mainstream services as well as peer-led approaches premised on biomedical models of suicide.

Methodology

The study aimed to explore the experiences and impacts of Alternatives to Suicide, a model designed and facilitated by and for people with lived experience of suicidal distress. Co-design principles were embedded at every stage of the project, with Alt2Su participants informing the research design and two peer researchers conducting interviews and focus groups with all but one of the participants. The peer researchers, Natalia and Scarlett, brought experiential expertise to the project through their lived experience of attending and facilitating Alt2Su groups. The research was guided by the conceptual frameworks offered by critical mental health and Mad Studies, privileging the direct experiences of people with suicidal thoughts and feelings over diagnostic or 'mental illness' models of conceptualising suicide. The research team conducted thematic analysis of the data, identifying five key findings as outlined below.

Key findings

1. Alt2Su groups offer a safe space in which people can share their experiences, hopes, and fears around suicidal thoughts and feelings, in an environment free from diagnostic gate-keeping, compulsory psychiatric intervention, or the pressure to follow a manualised protocol for 'recovery'. Instead, the emphasis on curiosity, mutual sharing, and deep listening allows participants to share openly about taboo topics, be witnessed in both their suffering and their resilience, and to allow different narratives about the meaning of their experiences to arise in the absence of diagnostic explanations. Participants found Alt2Su groups to be safe and valuable places to sit with and explore their distress, in contrast to mainstream mental healthcare and some other peer-based approaches.
2. The values of Alt2Su, which seek to normalise and humanise experiences of suicidal thoughts and feelings, provide opportunities for group participants to discover and explore de-medicalised understandings of their distress. Participants found that without the imposition of a biomedical framework upon their experiences, the social contexts and meanings of their distress could be explored. Rather than endorsing a view of suicide as a symptom of 'mental illness', participants valued the way Alt2Su offered the chance for people to politicise their distress, connecting it with interpersonal and broader societal injustices and making space to discuss the need for collective, whole-of-society responses.
3. Attending Alt2Su supported participants to develop new ways of understanding and responding to their distress, reducing fear around suicidal thoughts and feelings and increasing people's capacity to respond with curiosity and self-compassion. Through conversations and connections with others in the groups, many participants made new meaning of experiences that had been labelled as illness or disorder by mainstream services, instead connecting their experiences to personal histories, adverse experiences and circumstances, and social contexts. In many cases this led them to a changed, more compassionate understanding of themselves. Participants described learning new ways to approach difficult feelings and experiences from one another, in ways that felt empowering rather than imposed.
4. Harmful experiences in mainstream mental health services were described by nearly all participants, who avoided contact with the system, sometimes at great personal risk in the absence of alternatives. With its focus on conducting risk-assessments and allocating care resources accordingly, many people described having to 'compete' for medical or psychiatric attention. Forced to manage the presentation of their distress so as to not appear 'too ill'

nor 'too well', some participants found themselves in potentially life-threatening situations in which they were denied care unless they expressed their distress through the 'Goldilocks' degree of self-harm. Alt2Su groups, by contrast, were valued for their novel orientation to 'risk', wherein group members are responsible *to* one another rather than *for* anyone's safety.

5. Alt2Su affords opportunities for group members to heal in relationship. The sense of community and belonging, as well as the contextualisation of distress in the broader picture of interpersonal, institutional, and/or societal oppression and betrayal, helped combat participants' deeply held shame. Participants shared how shame about the traumatic or otherwise disempowering experiences often underlying suicidal distress was compounded by the stigma and silencing in mainstream approaches to suicide, leading to a feedback loop of isolation and distress. In Alt2Su groups, sharing, listening, and bearing witness to one another's experiences helped to alleviate shame and isolation.

Implications and Recommendations

- Funding for Alternatives to Suicide should occur in order to expand its accessibility and ensure the long-term sustainability of the groups.
- Other peer-led models in the same vein as Alternatives to Suicide, such as the 'Suicide Narratives' approach (Ball & Ritchie, 2020), 'Suicide Cafes', etc., should receive attention, study, and pilot funding to proliferate the development of non-clinical approaches.
- To further develop and knowledge and practice, peer-led research on suicidal distress should receive greater investment and attention.
- Suicide prevention efforts, whether by governments or third sector organisations, should recognise the social contexts that contribute to a life worth living and address social injustices such as poverty and housing instability, abuse and neglect, and discrimination.
- Mainstream mental health services should recognise the limitations and harms of the biomedical understanding of suicide and in particular, review the impacts of coercive and compulsory interventions for suicidal distress. While services should focus foremost on structural and cultural changes, individual practitioners, too, should be supported to understand non-clinical approaches and their underpinning principles in order to pass the knowledge on to people experiencing suicidal distress. Social justice, peer-led, and trauma-

informed approaches are worthy of exploration to transform harmful practices and make alternatives available.

1 Introduction

This report is an account of a qualitative study (involving interviews and focus groups) undertaken to explore the experiences of people who have attended Alternatives to Suicide groups in NSW. Current approaches to addressing suicidal distress focus on attempting to predict suicidal actions ('risk assessments') and responding to suicidal distress within the framework of 'mental health' or 'psychopathology' (Kessler et al., 2020). Responses to suicide have largely been the purview of the fields of psychiatry and psychology. These fields operate on the premise that suicide is an expression of psychopathology or 'mental illness' (Cohen, 2017). In addition, the medical model is underpinned by an assumption that people who think about suicide are 'irrational' or incapable of decision-making (Callaghan et al., 2013; Kumbhare, 2020). Alternatives to Suicide (Alt2Su) arose from criticisms of the traditional models of service delivery, modelled on the Hearing Voices Network approach. Alt2Su offers a peer-led, community-based approach to responding to experiences of suicidal distress, through groups of mutual support. The framework was developed in 2008 by Wildflower Alliance (formerly known as Western Mass Recovery Learning Community).

The concept of 'risk'/'safety' is pervasive throughout legislative, institutional and response frameworks about suicide. Protection from 'harming oneself' is accepted in law as a justification for involuntary treatment. Many 'risk assessment' tools claim to measure the *likelihood* of a person taking their own life (Kessler et al., 2020), however the evidence for the efficacy of risk assessments is limited (Chung et al., 2019; Large et al., 2011). Indeed, the focus of mainstream approaches to suicide on risk assessment may reduce opportunities for people to seek help and to share openly and honestly about their distress and their needs, due to the adverse effects of involuntary treatment or hospitalisation (Nyttingnes et al, 2016). The lack of consistent reduction in the rate of suicide has led to calls to adopt a different approach. This has included acknowledging that the phenomena of suicide and suicidal distress cannot be reduced to psychological factors alone and are linked to broader social factors (Bastiampillai et al., 2020) including discrimination, socio-economic location, social isolation, exclusion, and intergenerational trauma (Fitzpatrick et al., 2019).

Alt2Su groups are designed, organised, and facilitated solely by people with lived experiences of suicidal distress. They do not incorporate risk assessments, nor do they 'gate keep' participation, they are voluntary and free for anyone to attend. The approach is grounded in a consideration that suicidal thoughts and feelings can occur as a response to various and intersecting factors (including trauma, structural inequalities and systemic injustice); it also considers contemplation of death a valid human experience that does not necessarily need to be 'cured'. The approach seeks to challenge pathologizing assumptions of suicidality being a symptom of 'mental illness' and invites making meaning of individual experiences through story sharing and listening. Sera Davidow and Caroline Mazel-Carlton (2020), Directors of Training for Wildflower Alliance, further elaborate on Alternatives to Suicide's characteristics, including:

- Focus on responsibility *to* (being with one another through dark times) instead of responsibility *for* (keeping others alive),
- Contesting the immovable 'fixer' or 'fixee' roles, which makes space for facilitators to participate in the groups, even if they themselves are struggling.
- An emphasis on curiosity, honesty and mutual exploration, as well as looking for opportunities to build connections with the community.
- Groups intentionally run in non-clinical environments and independently of mainstream organisations.
- The framework underpinning Alternatives to Suicide groups is outlined within the Alternatives to Suicide Group Charter.

The Alternatives to Suicide approach was introduced to Australia in 2017 when the organisations Mercy Care and Helping Minds (WA) invited Wildflower Alliance directors and trainers, Sera Davidow and Caroline Mazel-Carlton, to run the first Alt2Su Facilitator Training in Perth. In 2018 the trainers returned to Australia to run facilitator trainings in Perth and Melbourne. They also participated in a community forum in Sydney organised by inside out and associates australia and Being NSW. By the end of 2018 the first NSW-based group was established in Sydney, NSW by a peer-led volunteer association Off The Wall, whose founding members had completed the Melbourne facilitator training. The group launched with the support of the Inner West Council Community Small Grant. In 2019 the group gained the interest of the NSW Ministry of Health, who at the time were rolling out the Towards Zero Suicides initiatives and were interested in supporting a peer-run program. Funded by the NSW Ministry of Health and operating under the auspices of Inside Out and Associates, several face to face and online Alternatives to Suicide groups have been piloted in NSW.

Despite Alternatives to Suicide successfully operating in North America for close to fifteen years, little academic research has been conducted to explore the experiences of people attending Alternatives to Suicide and the impact the groups have had. We hope that the dissemination of the findings of the research will contribute to a greater visibility of and the support for the Alternatives of Suicide Model in the community and within the mainstream 'mental health' system in Australia. We believe this project will supplement the growing body of research demonstrating the positive impact that non-clinical, peer-led support initiatives have on individual and communal wellbeing and will foster change in how suicidal distress is thought about, and the responses that are offered.

1.1 A Note on Language

We acknowledge that terminology within mental health research is highly contested. In this report, we avoid using terms such as 'mental illness' or the names of psychiatric diagnoses (unless used by research participants themselves), as such terms reflect a biomedical framing of distress as evidence of a brain-based 'dysfunction' while ignoring an array of other models and paradigms about the meanings and origins of emotional suffering (Read & Dillon, 2013). Instead, we use terms such as 'distress' and 'suicidal thoughts' to move away from rigid, medicalised understandings. We also use both 'Alternatives to Suicide' as well as the abbreviated term, 'Alt2Su', interchangeably in the report, as many people who attend Alternatives to Suicide groups prefer the shortened term.

2 Literature Review

Suicide and suicidal distress continue to impact the lives of many people. The overall rate of suicide in Australia in 2020 was 3,139 or 12.1 deaths per 100,000 population, decreasing from 3,318 deaths in 2019 (Australian Bureau of Statistics, 2021), with suicide being the 15th highest cause of death in Australia in 2020 (Australian Bureau of Statistics, 2021). Additional research suggests that certain groups are more likely to experience suicidal distress than others. Overall, men are over-represented within the suicide data. However, it is also well-known that women are more likely than men to report suicidal distress and suicidal behaviours (Vijayakumar, 2015). Young people and Aboriginal and Torres Strait Islander peoples also have a higher rate of suicide as a reason for death in comparison to other population groups (Australian Bureau of Statistics, 2021). People who live in rural and remote areas (Fitzpatrick et al., 2019), young people who have experienced childhood adversity and abuse (Madge et al., 2011), particularly those placed in Out of Home care after the age of 3 (Segal et al., 2021), and women who experience gendered violence including intimate partner violence, rape, and stalking are significantly more likely to experience suicidal

distress (Guggisberg, 2006; Rees et al., 2011), as are people who are homeless (Arnautovska et al., 2014; Ayano et al., 2019) and people who use substances (Rontziokos & Deane, 2019). However, it is worth noting that there is a large overlap between people who have experienced traumatic life events and people who use substances (Mills et al., 2006), thus it is possible some of the increase in risk due to substance use may be due to adverse life events. Previous literature reviews have indicated that same-sex attracted people, as well as non-binary and transgender people, may be more likely to experience suicidal distress, however, there are limitations in the available data, due to a lack of clarity regarding gender identity and sexual orientation on death registers (Skerrett et al., 2015).

Self-reported data from 2007 indicates that more than 2.1 million Australians have had suicidal thoughts at some point in their lives and more than 500,000 people have made an attempt (Department of Health, 2009). There are difficulties in reporting suicide-related deaths, due to limitations in data reporting. Changes to reporting procedures over time may make it more challenging to compare suicide rates across eras in Australia (Australian Institute of Health and Welfare, 2021), however the data indicates that the suicide rates ‘spike’ around periods of increased economic and social distress (Australian Institute of Health and Welfare, 2021). Despite the introduction of an array of suicide prevention policies in Australia, there has been no consistent reduction in suicide over time, even when measured over a 100 year period (Jorm, 2019; Shahtahmasebi & Omar, 2020).

2.1 Biomedical Paradigm

There are many proposed theoretical models for suicide, which have influenced common understandings of suicidal distress as well as approaches within healthcare in responding to suicidality. These models have largely been informed by the fields of medicine, psychology, genetics and neuroscience, which adopt a biomedical understanding of the suicidal experience. Researchers have examined genetic factors, brain functioning and predisposing personality traits - all of which, it is argued, lead one person to consider suicide whereas another may not. Some common approaches are summarised in the table below:

Approach	Summary
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Neuropsychological (van Heeringen & Bijttebier, 2016)	Differences in attention and perception, sleep patterns, memory, problem-solving, mental flexibility and decision making contribute to increased risks of suicidal distress.
Integrated Motivational-Volitional Model of Suicidal Behaviour (O'Connor et al., 2016)	Differentiates between the act of self-injury with intent to end one's own life and thoughts about suicide, attempts to explain how individuals transition between pre-motivational, motivational and volitional phases.
The Interpersonal-Psychological Theory of suicide (Chu et al., 2017)	Individuals will attempt to take their own life if they experience simultaneous thwarted belongingness, high levels of perceived burdensomeness and acquired capacity to self-harm.
Schneidman's Psychache theory (Montemaranano et al., 2018)	Psychache, the experience of intense psychological pain/anguish combined with depression and hopelessness, are required in order for a person to attempt to take their own life.
Beck's Hopelessness theory (Beck, 1986)	The extent to which a person experiences hopelessness is a predictor of how likely they are to attempt to end their own life. It is argued this is likely due to unhelpful patterns of thinking or 'thinking errors' associated with experiencing hopelessness.
Suicide as escape from the self (Baumeister, 1990)	Suicide arises when six steps are taken in order; a person feels they have fallen below a certain expectation/standard, they internalise the fault of this failing in themselves, they become aware of their own failing, they become distressed or low in mood due to this perceived failing, they attempt to avoid their negative cognitions without success, they become disinhibited and suicide becomes an option to escape this experience.

Biomedical approaches such as these are problematic on three fronts: firstly, they distract from the social oppressions that often underpin and precipitate suicidal distress (Fitzpatrick et al, 2019). Secondly, although many contemporary theories claim to be moving away from attempting to explain suicide through a strict diagnostic category (Chung et al., 2019), the biomedical paradigm

continues to assume that there must be an inherent 'dysfunction' within the individual that has led them to consider suicide, which ignores that suicidal distress is a relatively common human experience. Thirdly, the pathologisation of suicide positions suicidality as 'irrational' and is extremely paternalistic and coercive, by removing the rights of people experiencing suicidal distress from participating as equals within service and treatment models. This argument has been critiqued by Callaghan et al. (2013), due to the internal inconsistency between legislation that upholds the right of any person to decline medical treatment, and the simultaneous argument that suicidal distress should be treated involuntarily.

Critical perspectives on suicidal distress argue that suicidal distress can be logical and is often connected to experiences of suffering due to systemic injustice (Davidow & Mazel-Carlton, 2020). When suicidal distress is approached this way, it provides permission to sit with the distress and explore reasons for it. This non-pathologizing approach can inform a different response to suicidal distress that moves away from deficit-focussed, medicalised models focussed on responding to 'crisis' in people's lives, towards a model of mutual respect, two-way support that is ongoing and focussed on acknowledging, and potentially addressing, social inequality, in contrast to an individual 'illness' paradigm (Davidow & Mazel-Carlton, 2020; Shahtahmasebi & Omar, 2020).

2.2 Risk Assessments

Many risk assessment tools claim to measure the likelihood of a person taking their own life (Kessler et al., 2020) however risk assessments yield a high number of false positives and false negatives (Chung et al., 2019; Large et al., 2017). Several meta-analyses have demonstrated that risk assessments are yet to be able to provide any significant indications or predictions regarding suicide (Chung et al., 2019; Large et al., 2011). One meta-analysis found that 60% of patients who ended their own life after a hospital admission were categorised as 'low risk' (Large et al., 2017). No single characteristic has been found to be able to predict that a person will end their own life.

Mental health workers themselves report that risk-focussed service environments shift the focus away from client needs to a process of continual risk assessment. They discuss their fears that failure to successfully identify risk of suicide will result in either themselves or their organisation being blamed for the death of any person connected to the service, turning the focus away from supporting clients to averting blame (Green, 2007; Sawyer, 2008). Mental health workers are compelled to prioritise clients based on risk, leading to gate-keeping and clients being turned away because they are considered either too 'risky' or 'not risky enough' (National Suicide Prevention

Taskforce, 2020). Many clinicians are not aware that there is little evidence supporting the validity of risk prediction tools, which can lead to a sense of hopelessness and despair partly due to a lack of knowledge about meaningful alternatives (Grant et al., 2021). Despite this, risk assessments continue to be ratified in law and health policy guidelines with scant attention given to alternative approaches.

2.3 Coercive Interventions

Many countries throughout the world have legislation that enables involuntary mental health treatment (Callaghan et al., 2013). Such coercion occurs when a 'risk threshold' is reached and persons are deemed to be too 'at risk' of harm to themselves or others. For example, in New South Wales, Australia the *NSW Mental Health Act* provides grounds for involuntary treatment if a person is deemed a 'significant risk' of harm to themselves or others. Involuntary treatment may occur both in community contexts (such as non-consensual police 'welfare' checks and Community Treatment Orders) and hospitals, including involuntary medication, restraint, seclusion and involuntary admissions (Guzmán et al., 2020).

Literature reviews on the practice of coercive treatment indicate that there is little evidence for the efficacy of coercive treatment and that coercive treatment in fact poses multiple potential harms (Ward-Ciesielski & Rizvi, 2021). This includes trauma, corrosion of therapeutic rapport, and an understandable reduced trust in formal treatment options (Guzmán-Parra et al., 2019). The experiences in involuntary treatment settings equate to a removal of choice and control over a person's life (O'Hagan, 2006). Involuntary treatment can disrupt employment and finances, social connections, and housing stability (Ward-Ciesielski & Rizvi, 2021). Concerningly, the experience of coercive treatment and the fear of experiencing involuntary treatment have been shown to deter help-seeking for suicidal distress (Hom et al., 2015). Indeed, there has been a small but significant causal relationship found between perceived coercion during admission and suicide after discharge (Jordan & McNiel, 2020). Even in the context of Emergency Departments, the lack of control and clinical environment has been shown to increase distress (Guzmán et al., 2020).

2.4 Towards Zero Suicides

In NSW a total of \$87 million has been committed over three years 2019-22 with an aim to reduce the state's suicide rate by 20% by 2023 (Mental Health Commission of New South Wales, 2018). This approach is a multi-level whole-of-system reform which aims to address seven key elements of suicide prevention.

1. Leadership that is committed to the zero suicides target and creates a safety-oriented culture, including the inclusion of peer workers in planning/leadership roles.
2. Suicide-specific training across healthcare settings, as well as in relevant non-government and private mental health settings.
3. Identify people who are at an increased risk of suicide across any/all care settings.
4. Engage with the client in collaborative safety planning and 'restriction to means' counselling in a timely manner that meets the client's needs.
5. Treat the person's distress using evidence-based suicide-specific interventions.
6. Transition clients well, especially when exiting high acuity settings, through continuous contact.
7. Improve services constantly through data-driven, whole system changes with client outcomes as a key indicator of success (Turner et al., 2021, p. 243).

Many of the goals in the Towards Zero Suicides initiative are echoed within the NSW Strategic Framework for Suicide Prevention 2018-2023, which expresses a state-level commitment to implementing a suite of new programs and approaches to address suicidal distress (Mental Health Commission of New South Wales, 2018). Furthermore, the Australian Commonwealth Government committed \$2.3 billion toward improving overall mental health care, including enacting advice from the National Suicide Prevention Adviser.

Despite significant optimism about this approach, Turner et al. (2020) argue that the current approach to patient safety prioritises compliance with policies and protocols, including risk assessments. Instead, there is a need for a shift toward a 'restorative justice culture' that acknowledges the need for adaptive and responsive work practices. In addition, there is a need for healthcare systems to develop self-awareness about the potential trauma and iatrogenic harms of the current fear-driven and punitive responses to suicidal distress and move toward a compassion-focussed response (National Suicide Prevention Taskforce, 2020; Smith et al., 2015). More recent changes to NSW Health policies and models of care, and enhanced training for staff, aim to promote service leadership that embeds a just and restorative culture. Some details may be found in the [NSW Suicide Prevention Framework – Shifting the Landscape](#) (Mental Health Commission of NSW, 2022).

Although the Towards Zero Suicides approach claims to incorporate peer-led approaches through co-design principles (NSW Health, 2020), it is unclear to what extent this will be possible. Meaningful engagement with lived experience should include having lived experience incorporated

into every organizational level. For example, the overall lack of people with lived experience in leadership positions throughout mental health organizations is concerning. Although the NSW government has put in significant resources to roll out 'peer-led' programs such as the Safe Havens, there is little consistency in management roles, meaning some Safe Havens continue to be managed by clinical staff.

2.5 Peer-Led Approaches

Due to the lack of evidence that involuntary treatment options are effective at addressing suicidal distress, the potential for physical, psychological, social, financial and emotional harm and the association with increased rates of suicide post-discharge, there have been calls for change (Callaghan et al., 2013; O'Hagan, 2006; Ward-Ciesielski & Rizvi, 2021). One potential for change is the use of peer-led services. Peer-led services have been shown to be less distressing and better able to meet the needs of people experiencing distress than acute hospital settings (O'Hagan, 2006, p. 12).

Models of understanding and preventing suicide developed by people with lived experiences of suicidal distress are receiving increased attention from governments and stakeholders in mainstream mental health systems. An Australian Government report by the National Suicide Prevention Taskforce (2020) advised that an 'overwhelming' number of respondents called for non-medical spaces 'where suicide could be freely discussed' and relationships cultivated without the threat of 'crisis driven intervention'. Programs of this style, such as Safe Havens and Alternatives to Suicide, have recently received pilot funding from state government health departments.

Research on the efficacy of peer-led approaches to addressing suicidal distress is in its early stages. Qualitative research on the benefits of lived experience workers particularly in the 'suicide prevention' context demonstrate that peer workers have an ability to build an understanding of suicidal distress that exceeds the possibilities offered by clinical perspectives (Huisman & van Bergen, 2019). Writers from a lived experience perspective argue that what many clinicians construe as 'empathy' (e.g. acknowledgement of pain and requests to elaborate) are often thinly veiled ways of conveying to people in distress how incomprehensible their situation is to those who have not lived it (Ellis & Bryan, 2020). In contrast, peer workers are able to connect with people through experiential knowledge which helps to build a supportive emotional bond (Huisman & van Bergen, 2019). The quality of this bond is different from that of clinicians, who are often focussed

on preventing harm, including protecting themselves from litigation (Sawyer, 2008). In contrast, peer workers aim to educate, build hope, and advocate for a better system (NSW Mental Health Commission, 2015; Stratford et al., 2019). Peer-based approaches offer an opportunity to walk alongside people experiencing distress, not to 'fix' or 'save' them from their suicidal thoughts but to be with them (Ellis & Bryan, 2020; Jervert, 2022). For example, the Suicide Narratives approach, developed by the Humane Clinic in South Australia, emphasises the value of making space to collaboratively explore the potential meanings of suicidal thoughts and feelings, in contrast to the approaches of mainstream health services in merely aiming to eliminate distress (Ball & Ritchie, 2020).

A recent scoping review on peer-led approaches to suicidal distress indicated that few studies currently exist (Schlichthorst et al., 2020). There remains an emphasis on peer workers working alongside mental health teams and/or clinicians, meaning they continue to operate within the 'risk' paradigm (Huisman & van Bergen, 2019; Pfeiffer et al., 2019). This indicates not only a need for further research in this area, but also consideration of models that have been developed outside of the mainstream health system.

2.6 Alternatives to Suicide Approach: Current Evidence

The Alternatives to Suicide approach is an entirely peer-led program, developed and implemented by peers from the very beginning (Stratford et al., 2019) and provides a genuine alternative to the risk-oriented model, where people are able to talk openly about their suicidal distress with assurance that disclosing suicidal distress will not result in contacting emergency services or attempting to immediately problem solve. The Alternatives to Suicide model was developed by people with living experience of suicidal distress at the Western Massachusetts Recovery Learning Centre (RLC), as a response to the 'counter-productive' assumptions underpinning suicide prevention efforts (Davidow & Mazel-Carlton, 2020, p. 182), namely, that it is possible to analyse and predict the likelihood of a person's suicide, and that such risk-assessments justify a range of coercive interventions to contain the suicidal individual. In what was to become the first principle of the Alternatives to Suicide Charter of Values, the pilot program aimed to avoid responsibility 'for' keeping people alive and instead focus on responsibility 'to' others by 'being with one another through dark times...without the looming threat of...unwanted intervention' (Davidow & Mazel-Carlton, 2020, pp. 180-182). In contrast to the risk paradigm, it is accepted that

suicidal thoughts may never entirely go away (Jervert, 2022). The question then becomes how to live a meaningful life even in the presence of suicidal distress (Stritzke & Page, 2020).

While Alternatives to Suicide groups lack formal procedures as seen in other peer-support models such as 12 Step Meetings, co-facilitators are guided by a charter of values and a 'basic formula for how to be present and offer support' to fellow members (Wildflower Alliance, 2021). Groups open with an informal ritual where co-facilitators emphasise the importance of consent and choice, belonging and community, and the validation of systemic and interpersonal oppression. Co-facilitators are then guided by the 'basic formula' for connection, known as 'VCVC': 'Validation, Curiosity, Vulnerability, and Community'. Co-facilitators are expected to challenge traditional hierarchical group paradigms and share their own personal, contemporaneous experiences of distress and meaning-making. This shared vulnerability among participants helps cultivate a sense of community.

Participant feedback surveys conducted by the Western Massachusetts RLC in 2018 indicate positive outcomes. Over 85% of attendees reported improvement in at least one area of their lives, with 95% citing an 'increased sense of connection to community' (Davidow & Mazel-Carlton, 2020, p. 195). Over 90% of people said they found the groups helpful because they 'could talk openly about suicide', while others cited the importance of being able to 'listen to how others were making meaning or moving through their distress' (Davidow & Mazel-Carlton, 2020, p. 195). In 2018, the peer-led organisation *Discharged* was founded in Western Australia and began to offer an Alternatives to Suicide group specifically for members of the trans and gender-diverse community, as a strategy to address both the disproportionate rates of suicide and disproportionate incidence of discrimination in healthcare settings experienced by trans people. In collaboration with Curtin University in 2019, *Discharged* conducted a study examining the experiences of people attending their Alternatives to Suicide groups. Participants described the value of a place where they could 'talk openly' about suicidal distress without having to self-censor to avoid coercive intervention, and the sense of safety and connection experienced with peer facilitators fostered a sense of belonging (Rhodanthe, Wishart & Martin, 2019). Outcomes included: feeling less vulnerable to impulsively attempting suicide, increased capacity to sit with and move through suicidal distress, and improved capacity to negotiate meaningful support from family and friends (Rhodanthe, Wishart & Martin, 2019).

Despite the promising findings described by *Discharged* and the Western Mass RLC, research on Alternatives to Suicide remains largely internal and informal (Schlichthorst et al., 2020).

Given the limitations of current approaches to suicidal distress that have been identified within the scholarly literature, and the contemporary focus on the need to expand peer work and lived experience expertise in mental health, a more comprehensive understanding of the impacts that Alt2Su groups have is urgently required.

3 Methodology

3.1 Conceptual Framework

The research was guided by the conceptual frameworks offered by critical mental health theory and Mad Studies. In contrast to the biomedical paradigm, we did not seek to position distress as 'symptoms' of an 'illness'. Rather, we sought to privilege the experiential expertise of people with direct experiences of suicidal thoughts and feelings in order to challenge the power imbalance between professionals and people with lived experiences of distress (Beresford, 2016; Sweeney, 2016). Diagnostic language was not included in the interview guide, but when participants referred to diagnoses, this was respected. Suicidal distress was positioned as a meaningful human experience, and principles of choice, consent and non-coercion were embedded into the research project.

3.2 Research Design

As the aim of the study was to explore the experiences and impacts of Alternatives to Suicide, the project employed qualitative methods, in order to generate rich and detailed understandings. The study was informed by co-design processes with people who have attended and/or facilitated Alt2Su groups. This approach aimed to challenge mainstream mental health research methods, wherein studies are constructed by people in professional or academic roles, who do not have direct relevant experiences or a personal stake in the issues that are being researched. A series of workshops with people with lived experience of the Alternatives to Suicide approach was facilitated in order to consider the study's methodology. Workshop participants discussed the importance of peer researchers (people with direct experiences of Alt2Su) in the project. In the first workshop, it was decided that the best methods for the project would be in-depth, semi-structured interviews and focus groups, with participants having a choice about their preferred form of participation. It was also agreed that two peer researchers would be employed, and that they would be the primary contact for potential participants, conducting the majority of interviews and focus groups, and deeply involved in the analysis and writing processes, in collaboration with the university-based researcher. In the second workshop, the interview/focus

group questions were discussed, and a set of interview questions was collaboratively developed. Based on the workshop discussions, the university-based researcher wrote the ethics application to be submitted to the University of Sydney ethics committee. The ethics application was sent out for peer review to three workshop participants, and edited to ensure that it aligned with the decisions made in the workshop.

3.3 Ethical Considerations

All participants received a Participant Information Statement and signed a consent form prior to participation. The interviews and focus groups were recorded, but names and identifying details have not been included in the publication of the findings, to ensure confidentiality. At the conclusion of interviews and focus groups, participants received a \$45 gift voucher or direct bank deposit as an acknowledgement of the time and the knowledge that they shared.

Ethics approval for the project was received through the University of Sydney in October, 2021. Obtaining ethics approval for the project took some time, as university ethics committees are framed by biomedical paradigms and risk aversion (Martino & Schormans, 2018), which differ significantly from the principles and values that underpin the Alt2Su approach. For example, the ethics committee considered that people experiencing suicidal distress are a 'vulnerable' population and requested that a risk assessment be made with a mental health clinician, prior to allowing participants to take part in an interview or focus group. In response, the research team emphasised that such an approach would lead to significant barriers to participation, exposing participants to mental health assessment processes that may be re-traumatising, impacting significantly on the quality of the research and on the diversity of people who would be able to participate in the research. The research team instead proposed a collaborative and supportive pre-research conversation with participants, facilitated by the peer researchers. Within this discussion, participants were provided with detailed information about what was involved in the study, prior to providing written consent.

At the conclusion of the interviews and focus groups, participants were provided with the option to stay for a debriefing conversation, to discuss the experience of participating in the research and to have a collaborative conversation with the researcher about experiences of distress, if needed. In this process, it was important to the research team that responses were not imposed onto participants, and that participants' existing supports or strategies were prioritised, rather than suggesting new or unfamiliar ideas. It is important to note that the vast majority of

participants did not request support or debriefing, instead reporting that their participation in the study was positive and that they appreciated the opportunity to contribute to the project.

3.4 Participants and Recruitment

People who have attended a NSW Alternatives to Suicide group on one or more occasions were invited to take part in an interview or focus group (according to their preference). Participants were recruited primarily through the Alt2Su NSW email newsletter. Alt2Su facilitators also advised people attending Alt2u groups about the opportunity to participate in the project. People who were interested to participate were invited to contact the peer researchers by email.

3.5 Data Collection

Interviews and focus groups were facilitated online via videoconferencing, due to high Covid-19 case numbers at the time of the study. As all Alt2Su groups were all taking place online when the research was conducted, participants were confident with the use of online meetings. The interviews and focus groups lasted for 60-90 minutes and were semi-structured, with the interview schedule being used as a guide, but with the flexibility to explore areas of importance to the participants. Choice was embedded into the project, with no question being compulsory, and with researchers attempting to focus on the areas of most interest and relevance to each participant. Interview questions included: Was there anything in particular that attracted you to the idea of coming to Alt2Su? What was your experience like when you first came to a group? What is different about this group compared to other groups you have attended or services that you have received? What has been anything that's challenging or difficult about coming to Alt2Su? What impact have other members of the group/relationships within the group had on your experiences?

In total, there were 19 participants in the research study. 14 participants took part in an individual interview, and two focus groups were facilitated (n=3, n=2). The peer researchers (Natalia and Scarlett) facilitated the vast majority of interviews and focus groups. The university-based researcher (Emma) co-facilitated one of the focus groups alongside a peer researcher, and facilitated one interview (at the participant's request). As the peer researchers have their own experience of attending and facilitating Alt2Su groups, they were able to connect with participants on the basis of shared experiences and to draw upon their experiential expertise to develop a warm, safe, and affirming research approach.

3.6 Data Analysis

The focus group and individual interviews were analysed concurrently, using Braun and Clarke’s (2006) thematic analysis approach:

1. Familiarising yourself with your data.
2. Generating initial codes.
3. Searching for themes.
4. Reviewing themes.
5. Defining and naming themes.
6. Producing the report.

Interview transcripts were initially coded and annotated by the researcher who had conducted the interview. The two peer researchers each took on one focus group transcript for coding and annotation. Questions guiding the analysis included: What are the experiences and impacts of attending Alternatives to Suicide groups? How do Alternatives to Suicide groups compare to other supports participants have received relating to suicidal distress? What are possible future directions for Alternatives to Suicide groups? The coded transcripts were then shared among the whole team, to allow for comparison and review. The research team held meetings to discuss the preliminary analysis, and to collaboratively discuss the emerging themes.

Five key themes are outlined in the following section of the report. In line with the study’s conceptual framework, the research findings are reported alongside direct quotations from the focus group and interview transcripts, in order to ensure that the perspectives of people with lived experiences of Alternatives to Suicide are centred and privileged in the project.

4 Findings

In total, 19 participants took part in either an in-depth individual interview or one of the two focus groups. A key intention of this project was to offer a narrative and non-prescriptive approach to interviewing that was flexible and participant-led, in alignment with the values of Alt2Su. The co-design workshops at the commencement of the study discussed the importance of offering a different process to a structured psychiatric assessment approach. Consequently, demographic information was not specifically collected in the study, however, some details about the participants are summarised below.

Participant	Number of times/length of time attended	Place of residence	How they have learnt about Alt2Su
1.	Since June 2021	VIC	Word of mouth/neighbour

2.	Since Feb 2020	Sydney	Meetup group (peer)
3.	One month	VIC	Peer network (Big Feels Club)
4.	Since early 2018	Sydney	The Sydney Alt2Su launch 2017
5.	Once	Sydney	Peer Service (Safe Haven)
6.	Two months, twice a week	Rural VIC	Peer network (Big Feels Club)
7.	A few months	Melbourne, VIC	Alt2Su community forum/peer work
8.	Two years	Not stated	Psychologist
9.	Once	Melbourne	Peer leadership circles
10.	Three times	Melbourne	Alt2Su Facilitator Training 2017
12.	Six months, twice a week	Qld	Alt2Su community forum
13.	Three times	Sydney	Social Worker
14.	August - December 2021	Victoria	Word of mouth
15.	Since February 2021	ACT	Peer network (Big Feels Club)
16.	Since mid 2021	Sydney	Peer service (Safe Haven)
17.	Since mid 2021	Sydney	Word of mouth (introduced by a friend attending)
18.	Since September 2021	Victoria	Alt2Su Community Forum
19.	Since November 2018	Sydney	Google; wanted a non-crisis service to discuss distress

Participants shared overwhelmingly positive experiences about their experiences of attending Alt2Su groups and the impacts of Alt2Su in their lives:

It was the first time I'd shared [about suicidal distress] actually, and I was really grateful that I was able to do that... it saved my life.

Well, I haven't had a hospital admission since I started attending Alt2Su... In the last five years I don't think there's been a full year where I haven't had any hospital admissions, so even that in itself says something... I definitely think that it's contributed to me doing a lot better.

The peer-led approach offered by Alt2Su was described by participants as a paradigm shift, in contrast to mainstream approaches:

It's been incredibly positive for me; right from the very beginning it was a really positive experience, and I really feel that lived experience and peer support is the way forward with supporting people who are working on their mental health.

It was alternative, it was transformative in the sense it was very different to anything I'd accessed in the past.

Participants described their enthusiasm and strong motivations for participating in the research, given the dearth of scholarly literature or community awareness about peer-led responses to suicidal distress:

I like talking about this stuff because it changes policies and it changes the services that are available, and makes better services.

There was a broad consensus that the research was important in order to develop evidence for alternative approaches, beyond the constraints of medicalised paradigms:

[Alt2Su should] be a resource that psychologists and peer support workers and people know about ... that people can direct people to. This is an incredible resource.

The interviews and focus groups produced rich and detailed accounts of participants' experiences of attending Alt2Su groups. Five key themes were identified within the analysis.

4.1 Theme 1: A Safe Space

Participants spoke in detail about the welcoming practices offered by Alt2Su groups, which created a safe and inclusive environment. A sense of welcome and safety quickly alleviated the uncertainties that many people felt when attending a group for the first time:

I felt safe. The first group, I felt welcomed and safe and inspired and relaxed and interested.

Many participants spoke about how they had noticed that their experience of being welcomed into Alt2Su groups was underpinned by social justice values:

Our introductions of the pronoun that we're going to use and [the Aboriginal Country on which] we're living – the respect that that has for everybody in the group is really, really beautiful. It was just such a beautiful thing to think, 'Look, of course we belong'. We're introducing ourselves every single week and I feel it's so important.

A key element of the safe space offered by Alt2Su was the opportunity to speak openly about suicidal distress, without judgement, which is often not available either within mainstream mental health services or the general community:

If I'm feeling suicidal, then that's where I'd like to go and talk about that and just to relieve the secret burden.

Participants described the immense relief that they experienced through finding a space where it is possible to talk freely and without censorship:

[Alt2Su has] a massive effect, because it's this ability to talk about the most taboo subject, the hardest subject to talk about in society; we still have a massive taboo around it. And you're just welcome to talk about this thing that scares people silent everywhere... It relieves the stigma because you know that these people aren't going to be fearful or medicalise you immediately for having said these things. You're allowed to say this stuff and it's not going to involve the ambulance, the police, the system. It's just going to involve people hearing you and saying, 'Yes, that's a lot, what you're going through, and we understand that you're feeling this way and you've got these hard feelings'.

It was also a relief for many participants to be given permission to sit with and explore distress, rather than to feel pressure to present a linear or sanitised narrative of 'recovery':

I went to... a meetup group once, which was a group of people who suffer from anxiety and depression. And I got nothing from it, because what they wanted to do was to share lovely, happy stories... I didn't want a group like that.

Meeting with other people with similar experiences was a positive and validating experience, which was not usually possible within mainstream mental health services that focus predominantly on 1:1 support, where the professional does not disclose from their lived experience:

It's very rare to be able to [sit] in distress with other people that potentially are experiencing similar distress.

The power of listening and being heard offered a counterpoint to coercive and medicalised responses to distress:

The realisation that there's something better than the medical model, and that's listening. And that that is what I need 90% of the time. I've been in psych wards, I've been in seclusion, I've been in high dependency and low dependency, and I used to think that that sort of thing was what I needed to be safe from myself. But now I realise, often what I just need is somebody to hear me and hear that I'm in distress and go, 'Yes, we hear you, we see you. The experiences that you're having are really horrible, and it's understandable that you feel suicidal because you're going through so much.'

The willingness to 'sit with' distress rather than applying a 'fix it' approach differed from common responses found within both mental health services and the general community:

If you're going to a Alt2Suicide group, you're just going there to listen and be listened to. So, it's a totally different dynamic; it's totally different. You're just going there to hear other people who are feeling like this, and to see them and acknowledge them and hear their distress, and for them to see and hear and acknowledge your own distress.

Participants described their experiences of feeling valued and respected for their contributions, in contrast to professionals who tried to eliminate distress or who were unwilling to talk about the details of suicidal distress:

There's a gentle kindness about the place... people saying, 'Welcome here', 'I'm pleased to see you', and 'Thanks for sharing', and 'I'm so moved by what you just told me, what you shared', and 'My heart goes out to you.'

Finally, Alt2Su groups offered a space to discuss a variety of topics, and the focus of the groups was not wholly on distress or suicide, demonstrating that Alt2Su provides a flexible and participant-led approach, which is attuned to the current circumstances of those attending, rather than a single, prescriptive focus:

Surprisingly, the number of groups we get through where no one actually talks about suicide. Not they can't, it's just that it's surprising that sometimes it doesn't come up at all.

4.2 Theme 2: De-Medicalising Distress

Common responses to questions about the impact of Alternatives to Suicide groups identified them as providing opportunities to explore the meanings and social contexts of suicidal distress, beyond the biomedical approach. While some participants presented to Alt2Su with already developed critiques of the dominant model, others were able to question the limitations of the messages that they had heard from mainstream practitioners for the first time:

(I realised) we don't have to go down the medical narrative; that we don't have to just accept it. We don't have to accept what psychiatrists are saying to us as being the truth, our own truth.

Re-thinking the 'mental illness' narrative of understanding emotional and suicidal distress and being able to explore the role of the assigned psychiatric labels in their lives and to practice not using labels in relation to their experiences was framed as an important aspect of being in Alt2Su spaces:

I think the role of the illness label had seemed like such a crutch or safety net and it continued to be so because there was nowhere where I could talk about what was actually going on which was at odds with the label anyway. So, having the space where it was actually OK to question it and to talk about it without the presumption of it fitting into a label, fairly quickly I found I didn't need the crutch and it wasn't a crutch at all. It was just hindering me in understanding my experience.

Several people offered alternative frameworks of understanding distress, including seeing it as a mental difference rather than an illness, a divergent way of being in the world, or a symptom of a

larger societal problem. Many appreciated the rare opportunity the framework of the groups provides to politicise distress and raise consciousness around the need for structural changes within the society to address it:

There's no political discourse or analysis, particularly in Australia around mental health. It's very uncritical. It's very [clinicised] ... So I think again, this is a space that can kind of revolt and hopefully provide a bit more political discourse around the need for alternatives at a structural level.

An appreciation for a space that is fully facilitated by peers and valuing of lived experience expertise was expressed by most of the participants; they found being able to talk to peers liberating and shame-reducing:

I think sort of idea of peer support is like something I hold as like an ideal, being able to connect with companions and people who walk alongside, pick up on that sort of sentiment that you shared before about, yeah, feeling a sense of camaraderie and companionship and, yeah, (...) you know, it's ideal I should say and in the sense that I feel like to some extent it mitigates a need to go and see a therapist.

The lack of an intrusive assessment process to be able to access the groups was named as a welcome departure from the clinical protocols by a couple of participants. Participants also specifically mentioned not having to retell their past stories:

I liked that I didn't have to tell them about [my whole story] or anything like that, I didn't have to explain myself. It was about right here, right now. Today, I'm struggling with this. Today, I feel unsafe. You don't have to go to your past, you don't have to tell anything. There's no explaining. Life gets so [difficult] explaining everything over and over again.

Many participants were consistent in valuing the non-directive approach of Alt2Su. It was often juxtaposed with clinical approaches, some of which lean heavily on solution seeking and skill development. Several participants appreciated the privileging of sharing stories over offering advice:

Nobody is saying, 'You should use this drug,' or, 'You should see this doctor,' or, 'You should try this medicine.' Nobody is saying any of that. They're just sharing experiences. They're just sharing their thoughts and feelings. That's it. They're not saying, 'Try this medication.' They're not saying, 'Try this doctor, try this herb,' none of them are saying anything like that. It's sitting together and sharing life and it's working really, really well.

Several participants made comments about their appreciation of a non-hierarchical approach to roles within the group and how it allowed for different, more generative conversations to take place. A participant, who is a group facilitator, mentioned being able to share their experiences and step into the role of a support-seeker alongside other peers from time to time:

I did share and I said, at the end, 'Thanks everyone for making space for me as well,' and someone spoke up and said, 'Actually, it's really nice to hear that you're here and we're all in the same boat.' They appreciated that I'd stepped down and not tried to be this facilitator that was not ever sharing anything personal. So, it really made me think, 'I might actually be making [the] group richer if I did allow that a bit more.'

Another facilitator shared how the non-hierarchical structure allowed for nuanced reflections on power and practices of de-centring oneself in the space:

I'm always very aware that I have the ability to exert control over the conversation and that sometimes people expect it. And even the expectation creates a power imbalance. So, I'm constantly thinking... It's an ongoing thing.

During discussions about the importance of accessibility, many participants offered their appreciation about the groups being available whenever it is useful, for as long as one needs them and regardless of whether one is in current distress:

It was nice to think that this is something I could do twice a week or simply whenever... if I was in that state.

Many participants value the unstructured character of the Alt2Su meetings; they specifically spoke to the permission to stay silent or not say much:

I really liked as well how sometimes there was not this like need to talk or like there wasn't pressure to talk. I found that really nice, because – I mean, yeah, like [a mainstream helpline service] or whatever it is, other than these groups, I find that there is this need to say almost that you're not well – like you have to say you're not well in order to actually get some real help.

When speaking about their preferred group format, the participants offered mixed opinions. While many expressed their wish for more face-to-face groups being available across NSW and interstate, others appreciated the accessibility of Zoom groups. The consensus appeared to be that accessibility is important and a hybrid model (a mix of face-to-face and online groups) works best to meet various needs. There was also a uniform request for more groups being offered at different times of day:

There needs to be at least one online group continuing permanently as long as there are groups. Because some of the people who've joined have been so isolated and this was the only way they would come to a group. So, I think it's really valuable that it's there online. But, if there's the option of going in an in-person group as well, then that's obviously going to apply to another range of people who wouldn't go to the online group maybe and would only go to the in-person group. So, they're both really important.

4.3 Theme 3: A Changed Relationship to Distress

There was a consensus among almost all of the participants that attending Alternatives to Suicide groups supported them to develop new ways of understanding and responding to their individual experiences of suicidal and emotional distress. Many began the process of making meaning of their (previously pathologised) experiences, by connecting them to their life trajectories, circumstances, past adverse experiences and social contexts:

I try really hard to use non-clinical language then as well, which is quite tricky sometimes because people are so used to saying, 'I'm depressed, I'm anxious, I have BPD.' It's been really interesting

challenging that a bit, for myself but also in work roles, being like, 'What does that actually mean for you?' Yeah, so it's been interesting personally and also professionally.

Several participants came to understand their experiences of trauma and social injustice as significant contributors to their distress:

We are human and often the distress is done to us... It's not like illness. It's like something that happened in our lives.... We have been silenced forever... it's about the injustice.

Several participants remarked that alongside the changed relationships to their distress, they also developed new understandings of themselves as a person. Coming to a realization that experiencing distress and even contemplating ending one's life is a common part of the human experience was an important learning for several people:

It's made me feel like I'm not alone. I look around at other people and I can see them in a different way, I think. I see the pain in other people, or I imagine, but that's in a good way; it's not like it's made the world more depressing. It's actually – again, it's made me feel less alone and I'm not the only person who struggles in the world.

Only one participant described that their preference is to engage in a more linear, structured approach to recovery, as found within mainstream mental health services that emphasise the elimination of distress. For all other participants, sitting with suicidal feelings in a stance of curiosity and honouring the information that they may carry, rather than trying to eliminate suicidal thoughts and feelings, was commended as unique to the Alt2Su approach:

Because it's the first time that I've spoken to people who don't want to just change it and stop it; 'Right, we've got to stop it right now; we've got to make it better'. So, nobody comes in and tries to make it better; they just go with it.

As a result of this more accepting approach, some participants noted a shift in the way they respond to or manage their suicidal distress. A few people specifically discussed being less afraid of their suicidal thoughts than previously:

Going to Alternatives to Suicide group is – is that it provides a space where not only is it okay to share in that space but there's a residual feeling afterwards of like oh, this is like part of my daily life and I don't have to deny it and I don't have to isolate myself as much as what am I otherwise. That sense of not being alone I guess is kind of a feeling which empowers me to own the difficult thoughts that I might be having and the difficult experiences that might come from them.

Several participants reported that they were able to transfer these new knowledges and approaches to distress to their lives outside the group. This happened for them in different ways, including isolating less, being able to regulate intense emotions with more ease and using newly learned information to navigate their NDIS package:

[Alternatives to Suicide] provides a space where not only is it okay to share in that space, but there's a residual feeling afterwards of... I don't have to deny [suicidal distress] and I don't have to isolate myself as much.

The availability of alternative modes of learning in the Alt2Su spaces was frequently remarked upon. While ideas/strategies of managing distress are at times shared by members of the group, they tend to be multiple, specific to people's circumstances or contexts (vs manualised) and are offered as suggestions, rather than imposed:

And just to have it normalised and people saying, 'What do you do when you feel like that, and how do you cope with that?' And there are different ideas. Some people go for walks, some people listen to podcasts, some people sit with it and see what happens.

Some participants highlighted that in Alt2Su groups all people are learners; they learn from other peers rather than from experts:

And the other important thing is there's an opportunity to learn off others' experiences. So I also listen, personally I listen intently to what others have to say because I might actually learn something about their struggles and how they coped, and hey, maybe that's something that I could try.

Realising that their contributions in the groups could resonate with or help other peers during hard moments was named as an affirming and empowering experience by some participants. It moved them away from a passive 'patient' role and allowed them to value their own non-professional capacity:

So, I think what I'm trying to say is that every now and then the idea that I might have a way of thinking about it or dealing with it that might fit a gap in someone else's search is a really wonderful thought. (...) Just every now and then I get the feeling that something I've said has been useful. And that's a good feeling.

4.4 Theme 4: The Harms of Mainstream Approaches

Participants described a paradoxical increase in their suicidal distress as a result of the focus of mainstream services on conducting risk assessments that then dictate a protocol of interventions, sometimes imposed upon the person against their will. The experiences cited by participants as the most harmful involved involuntary or coerced intervention, such as being medicated, secluded, restrained, or hospitalised involuntarily. Alt2Su groups were described as a welcome contrast with mainstream services, which many participants actively avoided. One participant described his terror and desperation after someone called the local acute mental health team to report that he may be at risk of suicide:

I'm waiting for the train at Town Hall and I get a phone call from the critical care team at [the local hospital], and I could have just stepped in front of the train. That was absolutely a disaster. ... As soon as they called up and they said where they were from, I hung up, I hung up. And it's like, do I jump in front of the train? Are they going to come and pick me up? Are they waiting for me? Am I going to be admitted? So there was that fear of what is going to happen to me now?

And yet, participants shared that when they did pursue support from mainstream mental health services, the focus on risk assessments meant they were put in the position of competing for care. As one participant described:

So, if you're the loudest, most aggressive person, you get the [hospital] bed. So, there were times when I became the loudest, most aggressive person, and I couldn't hurt anybody else, so I started hurting myself. And it got to the point where I'm very capable of doing quite serious damage to myself so that I would get the bed. ... And it was like competing against the other psychiatric patients, going, 'I want to be the worst patient on the night, so that I get the bed, so that I'm safe from myself', which is a stupid system, because the quiet ones get sent home and they kill themselves.

In both hospital and community mental health settings, participants described the frustration of navigating risk-assessments to avoid being deemed 'too unwell' on the one hand, eliciting a cascade of unwanted intervention, or, on the other hand, being regarded as 'too well' to receive care:

Professionals get stymied by the system. If they hear the word suicide, then they need to put their medical hats on and risk assess you and then make a plan with you, and it all has to be medicalised suddenly. And they stop listening and stop really hearing you at that point. And it becomes more about proving that you're suicidal, to the system... If you're not the most suicidal or the most extreme case, you won't get the bed, you won't get the help.

In contrast, participants described Alt2Su groups as having a novel orientation to risk in which all members are responsible to one another, rather than *for* any member of the group:

I think the reactions to people talking about suicide in [Alt2Su groups] are so different to what you would normally get from a doctor, or a mental health nurse, or something like that. ... There have been a few times where I've showed up and said, 'I've been thinking that I just don't want to do this anymore,' and rather than people being like, 'Are you safe? Have you been thinking about how you would do it?' [they are] just completely focusing on what I've just said.

A majority of participants said Alt2Su appealed to them precisely because of its contrasting risk orientation compared with mainstream approaches:

So for me [Alt2Su is] a space accessible which is like non-judgemental and particularly welcomes people who might be having experiences which would otherwise be considered like 'high risk' and

allows myself to be able to express [myself]... in a way where there [aren't] consequences which might lead to hospitalisation.

The diagnosis-oriented approach in mainstream mental healthcare was contrasted by participants with the humanising, politically conscious approach of Alt2Su groups. The former was frequently described by participants as being a source of increased distress, particularly when attention was paid to diagnoses to the exclusion of personal histories that people connected to their distress and suffering:

Psychiatry just didn't ever spend more than 20 seconds talking about the fact that I was grieving. [In Alt2Su groups], it [the grief] was just validated as being impactful and as an experience that was going to be tough.

In addition to ignoring or dismissing the personal history and meaning accompanying a person's understanding of their distress, participants described how the crisis-focused intervention in mainstream mental healthcare often failed to pay attention to the chronicity and idiosyncrasy of suicidal thoughts and feelings:

All of the interventions that are actually in place, all the tools that are made available to medical professionals, are in a context of that acute side of suicidality, and when you do that, you actually completely ignore the chronic side of it.

Of particular interest to the authors was the contrast participants illustrated between Alt2Su and other peer-based approaches to distress. Many participants described their disappointment and frustration with the rigid, prescriptive approach to distress and recovery of other peer-support style groups they had attended:

I went to a [12-step inspired peer support group], which was supposed to be about mental health and it was supposed to be like Alcoholics Anonymous, but for mental health. I think that was the idea behind it. But ... it felt really judgemental. It didn't feel like a place where I could really express myself; and being suicidal was still very taboo.

The manualised, highly structured sessions offered in other peer-based groups were contrasted unfavourably with the conversational style of Alt2Su groups:

And Alt2Su is very different that way. There is no structure, you just rock up and share, and that is just so much nicer. There are no expectations.

In other peer-support style groups, ongoing contact or social relationships among members were strongly discouraged or in some cases contractually prohibited. In contrast, Alt2Su groups not only allowed but valued connections and friendships that arose within and beyond the group, trusting that adults can set boundaries and manage relationships as they see fit:

It feels like we get to all get to know each other, and it feels like it's a really supportive community, and with other groups there's this expectation that you're not allowed to make friends.

4.5 Theme 5: Healing in Relationship

Shame was described as both a key contributor to and consequence of suicidal distress, engendering a feedback cycle of isolation, shame, and suicidal thoughts and feelings. Recognising that abuse, trauma, grief, and injustice more broadly are situated within relationships involving betrayal, Alt2Su groups cultivate relationships involving bearing witness to one another's experiences, counteracting isolation and shame:

Community. A sense of belonging. A sense of connection, purpose, love, which many of us don't get in our families. So I think often that's the antidote to distress ... Because there's often a lot of shame wrapped up in our distress.

Rather than framing distress as endogenous and healing as requiring individual effort, conversations in Alt2Su groups validated people's responses to injustices as normal and understandable, requiring a community response. This helped participants let go of internalised shame about being 'broken' or at fault for their distress:

Yeah, I think it felt like it was normalised. To feel distress was okay. Like there was no need to escape from what I was feeling or – yeah, I think that has changed over time where I feel like I could just be myself and feel normal. Whatever that means. Yeah. Or that there's nothing wrong with me, ultimately. That it's normal to be feeling all these things.

When the group held space for distress, it was not only the person in distress who benefited:

There was one particular member that was quite acutely distressed in the group. And I felt like everyone really wrapped around this person and shared their own experiences and were really just trying to be each other's peer supporters. And I haven't had that experience before.

To be [a] witness of other people in the group supporting that person was really beautiful.

In a space where any topic of discussion is welcome, some participants found that humour arose as a way to throw off the constraints of social taboos and connect with one another more deeply:

We do a lot more laughing in the groups than anyone expects. Even last night, someone made a really, really dark joke. It was morbid gallows humour, but at least half of us were, like, 'That's exactly it, yeah. That's how my soul feels tonight.' Just this very, very bleak sense of humour that – there was something liberating about it.

The principle of responsibility towards rather than for one another allowed traumatic topics to be explored while making space for people to better understand their own boundaries and needs in relationship with others:

I think the biggest challenge is that I think it's an inherently traumatic topic. And being 100% empathetic and vulnerable is potentially really too vulnerable. ... So, for me it's been challenging to sort of figure out how empathetically open I can be. Which is usually quite a lot, as long as I know that I'm sort of watching it and – Well, if they think it's gone too far upsetting I'll just step out of the conversation and just try to tune out a little bit... It's like – when I empathise too much, I'm not even listening to them anymore when I respond to the emotions. [It's] more of an art than a skill.

Key to the relational healing in Alt2Su groups was the shared approach to leadership. Participants valued the vulnerability facilitators offered and found this helped cut through a sense of isolation experienced in mainstream mental healthcare:

With Alt2Su the facilitators have a lived experience as well. So, knowing that I'm not just talking to someone that's had some mental health training but maybe has no idea what it feels like.

Facilitators described trying to strike a balance between open and vulnerable enough to connect with others in the group, without monopolising conversation or neglecting their role:

I think, for me, it's a tricky balance to make sure, if I'm sharing, that I am still doing the job of making sure that other people have space and that there's some curious questions being asked, and that sort of thing. I'm really aware of someone saying something and me being like, 'Oh yeah, I can relate to that, I've had a really bad week,' and then just jumping into my stuff and not giving them the space that they actually needed.

Facilitators and other group members alike often took on leadership roles fostering pluralism and managing conflict:

And it didn't matter if we were having different experiences and talking about it together, because we weren't – It was the nature of the group, and the conversation was not presuming that we were going to have to agree and come away with the same interpretation and the same experience.

Participants described how interpersonal connection among group members was reflected in an increased sense of intrapersonal harmony and cooperation. One participant described how different parts of herself which had become partitioned off from one another in adaptation to severe child sexual abuse came to work together, with the help of acceptance and witnessing in the group:

It's just a good thing for all of us. I've gone on there and I've said, 'I've got a DID diagnosis, so when I talk about myself as a 'we', don't be surprised by that', and people have just gone with it. They haven't been too alarmed or anything; they've just met me where I was at that point and listened to

me and accepted me. And I've got other alters who like more risky behaviours, and their limitations for what is acceptable and what is not acceptable aren't the same as mine, but I'm the host and I keep us all in a healthy space because we've got a daughter and we've got to provide for her; we've got to provide a healthy emotional space for her. And the only way to do that is to work together. So, we work together.

By offering a witnessing space and a sense of community, some participants described tangible outcomes from attending Alt2Su groups:

Well, I haven't had a hospital admission since I started attending Alt2Su; I actually hadn't realised that until just then. I'm pretty sure that's right, yeah. So, that's a big thing. It's a little bit embarrassing for me to admit, but that means it's been a little bit under a year since I first went to an Alt2Su group, and that was several weeks after I'd had a suicide attempt, pretty much. In the last five years I don't think there's been a full year where I haven't had any hospital admissions, so even that in itself says something.

Shame, isolation, and distress were contrasted by participants with the relational healing afforded in the group.

People need love and care and kindness... And I think that's what the values within [Alternatives to Suicide] are really about.

5 Discussion

This project contributes to the currently limited scholarship on peer-led responses to suicidal distress. The existing literature contains an over-emphasis on diagnostic, medicalised, and risk averse perspectives in mental health, despite the well-known limitations of the biomedical paradigm (Fitzpatrick et al, 2019). This study therefore offers a much-needed exploration of the value of lived experience expertise in responding to suicidal distress. The majority of participants expressed a strong motivation for participating in the study, due to their overwhelmingly positive experiences of Alternatives to Suicide, and their hopes that the Alt2Su approach could become more well-known. In line with the existing literature on Alternatives to Suicide (Davidow & Mazel-

Carlton, 2020; Rhodanthe, Wishart & Martin, 2019), participants described the immense benefits of connecting with people with similar experiences and the opportunity to talk openly about suicide within Alt2Su groups. This differed from participants' experiences of mainstream mental health settings, which do not make space for detailed explorations of distress, due to a focus on diagnosis and risk assessment. It also differed from participants' experiences with friends and family, where in-depth discussions were often not possible, due to ongoing societal taboos, stigma, and silencing.

Participants provided detailed examples of the significant impacts of Alt2Su on how they understood, talked about, and related to their distress. Through taking away a goal of eliminating distress, participants experienced an approach that valued warmth and openness, rather than an unrealistic 'pressure to recover'. This enabled participants to spend time considering the possible meanings of their distress, outside the constraints of the medical model. The space that was provided within the groups to explore suicidal distress was described by several participants as a core benefit of Alt2Su, which differed from the diagnostic and assessment processes of mainstream mental health services, where suicidal distress is merely understood as a 'symptom' of an 'illness'. The safe, exploratory space in Alt2Su groups had profound impacts, including a reduced fear of suicidal thoughts and feelings, leading to new possibilities for how participants could make sense of and respond to suicidal thoughts and feelings within their everyday lives. This finding is significant, as participants conveyed the benefits of the *style of connection* offered within Alt2Su groups, in contrast to a 'step-by-step' or pre-determined approach for how participants should navigate distress. This is aligned with other literature that has advocated for a shift away from a 'fixing' approach, toward a collaborative meaning-making stance (Ball & Ritchie, 2020; Ellis & Bryan, 2020; Jervert, 2022). The benefits of attending Alternatives to Suicide groups often extended well beyond the time spent in discussion during a group, with participants describing positive and ongoing implications.

The study also concurs with existing critical scholarship regarding the need to address the limitations of mainstream mental health services through offering a non-clinical approach to understanding suicidal distress (Huisman & van Bergen, 2019). The vast majority of participants clearly expressed that they would not attend Alt2Su if it replicated the characteristics of the biomedical paradigm, including:

- A focus on psychiatric diagnosis and illness-based understandings of suicidal distress;

- A reliance on coercion and unwanted mental health treatment as a response to suicidal thoughts and feelings;
- An emphasis on professional rather than lived experience expertise.

Indeed, prior to attending Alternatives to Suicide, many participants had sought help within traditional mental health services and made a decision to not engage with such services in the future, due to experiences of harm during unwanted mental health treatment and the limited explanations offered by medical paradigms of emotional suffering (Ward-Ciesielski & Rizvi, 2021; Guzman-Parra et al, 2019; O’Hagan, 2006). The research therefore demonstrates that Alt2Su provided support to people who had made an active decision to avoid mainstream services or support when experiencing suicidal distress. This is a pertinent finding, demonstrating the urgent need to provide ongoing funding to peer-led options, including Alt2Su, rather than a sole emphasis on medicalised approaches, in order to ensure that meaningful options are available to a greater diversity of people experiencing suicidal distress. It is important that sustainable and long-term resources are provided to non-clinical supports, rather than funds only being allocated to a narrow suite of biomedical services, which a significant proportion of the population do not find relevant or helpful. Without such resourcing, it seems unlikely that the ambitious aspirations contained within contemporary suicide prevention policies, including *Towards Zero Suicides*, will be met.

In addition to identifying the value of Alternatives to Suicide, the findings elucidate the harms and limitations of mainstream approaches to responding to distress, including fears related to coercive interventions, compulsory hospitalisation, and medicalised assessments that did not attend to the meanings and social contexts of distress. Participants spoke at length about the traumatising impacts of unwanted treatment, which occurred when they sought help from mainstream services and crisis helplines. Several participants outlined in detail the betrayal that they experienced when confronted by systems that use force and coercion as a primary response to suicidal distress. These findings reflect existing scholarship that has outlined the harms of coercive treatment (Guzman-Parra et al, 2019), but the study adds to the existing literature through demonstrating the possibilities offered by a paradigm shift away from medical paternalism. Participants noted the sharp contrast with the Alt2Su paradigm, which was based on mutual sharing, curiosity, meaning-making, and deep listening. Importantly, another reason that participants valued the lack of assessments conducted by Alt2Su was that they were very welcome to attend a group outside of a crisis and receive support for suicidal feelings, which would

otherwise be dismissed within mainstream services as not ‘acute’ enough to justify support. These findings resonate with the existing literature that has identified the gaps created by systems that rely too heavily on coercive interventions, while also denying services to people deemed ‘not risky enough’ (National Suicide Prevention Taskforce, 2020).

The research therefore indicates the need for a more nuanced understanding of ‘risk’ and ‘safety’ than is currently applied by mainstream mental health services. Currently, people experiencing suicidal distress are deemed ‘at risk’, with services claiming to provide ‘safety’, often through removing the rights of people experiencing suicidal distress (Hom et al, 2015). In contrast, participants in this study highlighted the risks involved in approaching mainstream services, due to the likelihood of coercive treatment, which could actually increase their distress and leave them without opportunities for connection and validation about their suicidal thoughts and feelings, due to a narrow, medicalised approach. In addition, participants described Alternatives to Suicide groups as a ‘safe space’, where they experienced openness relating to discussions about suicide. In this way, participants re-defined risk as caused by overly medicalised and coercive paradigms of distress, and re-conceptualised safety not as the elimination of suicidal distress, but as a community where experiences could be shared without the need for censorship or unwanted interventions.

A significant theme drawn from the interviews and focus groups therefore relates to the importance of human connection and community for healing, staying alive and living a meaningful life. All participants shared their appreciation of the Alt2Su groups being spaces where building connections and friendships among the group participants is actively encouraged. Many referred to Alt2Su as a *community* of mutual support, which inspires a sense of belonging and camaraderie. The participants frequently validated their peers as people they admire for their humility, wisdom, kindness, and ability to continue surviving against very difficult and ongoing circumstances. They emphasised both the learning and the healing power of shared experiences that occur in this peer space. The participants juxtaposed this with their other experiences of having been advised not to talk about suicidal distress with anyone except their mental health clinician or doctor. They also referred to the common practice in the mainstream system of disallowing group participants from making connections outside the group based on paternalistic assumptions of people being ‘too unwell’ to be able to support one another. This study clearly highlights the limitations of both one-on-one supports and supports which don’t connect people to each other, while demonstrating that people can have capacities to hold and support others in distress without professional training.

The study concurs with the scholarship reviewed in the literature review related to peer-led services having been shown to be less distressing and better able to meet the needs of people experiencing distress than acute hospital settings (O'Hagan, 2006, p. 12). At the same time, our findings demonstrate a clear difference between Alternatives to Suicide and other forms of peer support. The participants described their experiences of attending other peer-based groups as over-structured, focussed on eliciting specific outcomes, as well as promoting linear and proscribed narratives of recovery, which did not meet the participants' needs. Moreover, the participants who encountered peer support groups attached to mainstream mental health organisations and continuing to operate within 'risk-averse' paradigms, described experiencing a disjunct between the promised sense of peer camaraderie and safety and a threat of intervention, should one decide to share 'too much'. These findings complement existing research that highlights the limitations of peer work taking place within traditional medical model service agencies and upholding the 'mental illness' models of distress (Penney & Prescott, 2016). This calls to mind the examples of peer worker positions that are created in workplaces with little planning or understanding of peer support, resulting in peer workers being treated as unskilled labour (Davidson, 2015; NSW Mental Health Commission, 2015); peers being managed and supervised by non-peer clinicians, or peer workers being expected to perform the same roles as clinicians however with significantly less pay (Stratford et al., 2019). In contrast, the participants labelled Alt2Su as a unique offering in the peer space, distinguished by being peer-led (with peers involved in each phase of the project in leadership positions) and by existing outside of the mainstream mental health services. This finding indicates not only a need for further research in peer-led services, but also strong support for models that have been developed outside of the mainstream health system. Many participants shared that the criteria-based conditions of entry to many of the mainstream supports (one needing to demonstrate and fit within a required level of 'unwellness') have had a harmful impact, by creating hierarchies of 'deservingness', leading to people either exaggerating their experiences to access support or deciding not to seek support at all.

In contrast with these practices, Alt2Su offers truly inclusive access. The service is available to anyone who has had a personal experience of suicidal thoughts or actions, is 18 or older, and who would like to be there, the latter emphasizing voluntary and consensual aspect of participation. The absence of an intrusive assessment process when joining the group for the first time increased the participants' sense of safety and trust. Having the permission to use their own words to make rich descriptions of their state of (well)being rather than relying on manualised risk

assessments allowed the participants to regain a sense of themselves as ‘knowers’ of their own experience and thus experience an increased sense of agency. On the back of the existing scholarship which critiques the use of ‘risk assessments’ as having both limited efficacy (Chung et al., 2019; Large et al., 2011) and moving away the focus from listening to and supporting people who are distressed to averting liability (Green, 2007; Sawyer, 2008), this study’s findings demonstrate the importance of flexible supports both in terms of the conditions of access and the mode of participation.

In addition, the participants clearly indicated that they value Alt2Su groups being available to attend without the requirement of being in crisis or even distress, whenever it is useful and without limitations on the number of sessions or length of time one could attend. This finding is important, as it supports a new understanding of suicidality as a spectrum of experiences of varying intensity occurring in time, rather than always linked to a sense of ‘crisis’. It also points towards the importance of services that are based around community building and available whenever one needs them, as opposed to clinical, crisis-based and time-limited mainstream supports.

The study highlighted the importance of different kinds of access to Alt2Su groups. Initially the groups in NSW were offered face-to-face and were moved to the online format during the pandemic. Many participants appreciated the Zoom online format for its financial viability, easy access and being conducive to preserving confidentiality and privacy. Others expressed that face to face was their preferred mode of participation, as it facilitated increased social connectedness and community building. The consensus was clear that offering both options is the best model to accommodate diverse accessibility needs and styles of connection. The participants’ stories also demonstrate a clear need for an increased number of groups offered at different times of day and for more face-to-face groups being offered in rural areas of NSW.

Existing literature argues for the importance of survivor/peer-led research for the development of knowledge and practice, stating that research that centres the experiences and perspectives of people who have experienced distress and/or the mainstream system has the potential to represent new discourses, challenge the biomedical approach and can be transferable between contexts (Beresford, 2016; Sweeney, 2016). In line with this scholarship, our study demonstrates the benefits of a peer-led approach to research. All but one participant opted to be interviewed by a peer researcher. Several participants disclosed that their decision to participate in this project was heavily influenced by their knowledge of it being a peer-led project. Many

participants remarked that the presence of a peer researcher allowed them to feel more comfortable and safer to share more openly.

Finally, as well as illuminating the need for more resources and attention to peer-led approaches including Alternatives to Suicide, the findings reveal possibilities for significant shifts within mainstream mental health services, in terms of how mental and suicidal distress are understood. The gaps and limitations described by the participants in this study indicate the urgent need to critique and move away from pathologising and risk-oriented approaches to service provision. The principles and values of Alternatives to Suicide, including social justice, trauma-informed, and peer-led perspectives, are relevant and worthy of exploration to challenge and transform current responses to suicidal distress. This is fundamentally *not* about merely transplanting Alternatives to Suicide into mainstream settings, as this would dilute its non-clinical approach. Nevertheless, our study clearly demonstrates that there is a need for anyone working in suicide prevention to engage with approaches to care that challenge biomedical dominance and risk averse practices.

5.1 Limitations

The study is limited by its relatively small sample size, which means that the full range of experiences and perceptions of people attending Alternatives to Suicide are unlikely to be represented in the findings. Barriers to participation, including a lack of time and competing commitments, may have precluded some potential participants from taking part in an interview. Connecting with participants online may have hindered rapport-building and impacted upon the level of detail that was shared by some participants. Although many participants described the significant impacts of Alt2Su on reducing the distress associated with suicidal thoughts or feelings and increasing their repertoire of skills in responding to suicidal distress, it was not the purpose of the study to measure or quantify the effects of participation in Alternatives to Suicide.

It is relevant to note that this study focused upon Alternatives to Suicide groups that are open to anyone aged 18 years and over. Some participants indicated that, despite the sense of community and belonging they experienced in the groups, some topics could only be discussed in groups dedicated to specific communities, for example, Australia's first Alt2Su groups that were established by and for members of the trans and gender-diverse community, or a group specific for women, where experiences of male violence and relational trauma could be discussed. Future

research could explore interest in and the potential value of community-specific Alt2Su groups, in addition to those for all to attend.

Despite these limitations, the study makes a significant contribution to better understanding peer-led responses to suicidal distress, demonstrating highly promising qualitative evidence about the relevance of non-clinical understandings and approaches. Through privileging experiential expertise in the study's methodology, including the central role played by peer researchers in the design, data collection, and analysis phases of the research, lived experience knowledge was embedded across all phases of the project.

6 Conclusion

I go to the group specifically just to be heard and to be listened to, to be seen, to be acknowledged, to have my feelings respected.

In this study, the voices of 19 people who have attended the Alternatives to Suicide groups in NSW were heard. Their stories demonstrate the importance, if not necessity, of offering peer-led spaces where people can freely and safely explore the meanings of their emotional and suicidal distress without the threat of psychiatric or coercive interventions. Privileging humanistic and nuanced narratives of how suicidal distress can arise and be lived with over narrow, reductionistic notions of 'mental illness', Alt2Su's philosophy and practices indicate a paradigm shift in how suicidal distress can be understood and responded to.

Considering the dearth of research investigating the impact of the Alt2Su approach and peer-based approaches to suicidal distress more broadly, this study offers a much-needed significant contribution to the body of knowledge demonstrating the positive impact non-clinical, peer-led support initiatives have on individual and communal wellbeing. We argue that the Alternatives to Suicide approach (among other non-clinical peer offerings) deserves greater recognition and visibility, as well as sustainable and long-term resources to ensure its continuation and growth in Australia. This includes funds supporting further research in this currently under-researched area.

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