Curtin University

Clarifying the Alternatives to Suicide Approach: An Evaluation of the Theory, Values, Purpose and Practice

Acknowledgement of Country

The research team pay our respects to the Aboriginal and Torres Strait Islander members of our community by acknowledging the traditional owners of the land on which the Curtin University Bentley Campus is located, the Wadjuk people of the Nyungar Nation.

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Report prepared by Leo Rhodanthe, Emery Wishart, Lynelle Watts and David Hodgson

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Contents

Executive Summary

Suicide is of significant public concern, with approximately nine people dying by suicide in Australia each day. Globally, suicide is the leading cause of death in young people, and twice as many men than women will die by suicide.

Alternatives to Suicide (Alt2Su) has emerged in response to people with lived experience of suicidal distress expressing concerns about the way clinical mental health services and systems respond to suicide. The research literature also demonstrates several weaknesses and problems with a medical and clinical approach towards suicide. These include limitations in psychopharmacological treatment; lack of reliability of risk indicators and risk assessments; and further distress and disempowerment from hospitalisation as primary interventions for people experiencing suicidal distress.

Alt2Su is a peer support approach that involves groups of people who have had or are currently experiencing thoughts of suicide or wanting to end their life, coming together to speak freely about their experiences, without the threat of unwanted coercive or clinical interventions. Group facilitation prioritises peer support, dialogue, relationship building and meaning making, and is guided by a comprehensive charter outlining the important values, practices, and intentions for groups. Alt2Su is grounded in principles of social justice, drawing together participants lived experience to create spaces for self-determination in meaning making and building supportive relationships with peers. Alt2Su has many parallels with The Hearing Voices Approach.

Alt2Su was developed in 2008 by the Wildflower Alliance in Western Massachusetts, USA. It has expanded into other regions of the USA, as well as Canada and Australia. In 2017, an Alt2Su Steering Group was created with the purpose of bringing Alt2Su to Western Australia (WA). The first Australian Alt2Su group, DISCHARGED, was specifically for trans and gender diverse people and is supported by TransFolk of WA.

ConnectGroups in WA received funding from LotteryWest, and, with the support of a Steering Committee, has sought to expand Alt2Su in WA through facilitator training and the establishment of Alt2Su groups under the auspice of ConnectGroups. As there is limited empirical research into Alt2Su groups specifically, researchers from Curtin University have been subcontracted by ConnectGroups to undertake research and evaluation on the Alt2Su approach. This research utilised a lived experience co-design approach from project conceptualisation to final completion of the study. Alt2Su trainers and facilitators Leo Rhodanthe and Emery Wishart have collaborated with David Hodgson and Lynelle Watts from Curtin University to co-design and develop this study.

The research used a clarifying model for program evaluation, which is concerned to describe the thinking and practices of novel and emerging programs to help make them more explicit to stakeholders. In following this approach, four key research objectives were defined as follows:

1. Describe and articulate the theoretical, ethical and other principles that underpin the Alt2Su approach.
2. Explain and conceptualise the Alt2Su program logic, rationale and purpose.
3. Describe and articulate the Alt2Su intervention and practice.

4. Identify any modifications or improvements that would support the work of Alt2Su.

Data were collected by way of semi-structured interviews. A purposive sampling method was used to select participants who were knowledgeable about Alt2Su. The sample included advocates of Alt2Su, Alt2Su trainers and facilitators. Interview questions were derived from the study objectives, and focused on the Alt2Su theory, values, purpose, practice, how Alt2Su emerged, what Alt2Su means for the broader community, and what Alt2Su needs to flourish and grow as an approach. Interviews were audio-recorded and transcribed and analysed using a reflexive deductive approach. Eighteen people were interviewed for this research, including 10 advocates, three trainers and five facilitators.

Results show that Alt2Su has a clearly articulated theoretical and ethical foundation that translates into its peer group practice. Theoretically, Alt2Su has similarities to the Hearing Voices approach, particularly its non-clinical and lived experience emphasis on creating meaning and understanding from participants experiences of suicidal distress. Alt2Su values include freedom, respect, social justice, human rights, humility, curiosity, and connection. Other values include trust, belonging, being non-judgemental, consent and choice, learning, curiosity, safety, and solidarity.

The rationale for Alt2Su reflects the literature, in that many peoples lived experience of the mental health system has been ineffective and at times harmful. It was also found that people in suicidal distress have experienced stigma and discrimination from mental health services and were therefore seeking alternatives to it. Alt2Su peer-led support groups work to build social connection, solidarity, and exploration of the experience of suicidal distress and peoples' life circumstances. Alt2Su groups provide genuine alternatives to the mental health system, and they focus on existential meaning, belonging, and connection.

It was also clear from the data that Alt2Su group practices involved peer-to-peer co-facilitation that were very sensitive to power sharing, emphasised deep listening, and can be seen as exemplars of genuine reflective dialogue between participants.

Results further show that Alt2Su is vitally needed as a legitimate alternative to the standard response to suicide. However, participants were clear that Alt2Su needs resourcing and support, but it should not be subsumed into the clinical mental health system. Participants were clear that Alt2Su requires ongoing financial investment to ensure facilitators are adequately paid for their work and expertise. Results also underscore the importance of maintaining program fidelity, which refers to the extent to which Alt2Su is developed and delivered in accordance with the principles, values and methods that underpin its design and intent.

Alt2Su has emerged in contemporary social conditions, which have seen an increase in social inequality that contributes to social isolation, disconnection, stigma and discrimination. Neoliberal ideology has seen an increase in individualised and economic policies and practices that have permeated contemporary health and mental health services. Contemporary mental health approaches for people experiencing suicidal distress often involve such individualised clinical treatment, including pharmacotherapy and psychotherapy. Alt2Su was initiated by people with lived experience of individualised treatment who instead sought to establish a non-clinical, non-interventionist approach for people experiencing suicidal distress.

Alt2Su is a community based, mutual aid groupwork approach, through which people can come together to process suicidal distress using small group processes.

- Group are facilitated by trained peer facilitators and peer led facilitation is critical to preserving the mutuality of the process *within* Alt2Su groups. Facilitators require significant levels of training for effective dialogical communication that characterises Alt2Su group processes.
- Groups incorporate an ethic of equality and power-sharing amongst participants.
- Group processes utilise a dialogical communication method to engage in deep listening and reflection. This process is effective for building social connection, community through belonging.
- Dialogical communication is effective for exploring participants meaning-making and purpose in collaboration with others.
- Alt2Su groups are ideally initiated in response to community need.

Alt2Su groups may arise within the auspice of formal organisations, which are governed by established risk governance practices and this has the potential to create tension. Such tensions may be resolved by ensuring role clarity and relationship building are embedded into organisational practices. Alt2Su groups do require auspice and resources within the contemporary Australian social services sector.

Auspice organisations offer the following to Alt2Su groups:

- Resources.
- Training.
- Support for facilitators.
- Built infrastructure.
- Connection to service system.
- Protection from service system.

Alt2Su groups offer the following to the service system:

- Relational goods such as connection, belonging and social solidarity.
- Opportunity for citizens to process suicidal distress and build resilience through connection.
- Expertise by experience from the incorporation of lived experience within the knowledge and practices of organisations.

Auspice organisations should support Alt2Su groups to operate semi-autonomously to preserve the non-clinical, non-interventionist mutual aid component of the group. Auspice organisations supply the resources and infrastructure for training and supporting peer facilitators. Peer lived experience involvement in governance should be prioritised by auspice organisations as this offers alignment with the empowerment and self-determination values that underpin Alt2Su.

Auspice organisations will need to establish processes and practices for communication between semi-autonomous Alt2Su groups and the organisational auspice. There are key roles that have a crucial bridging function between mutual aid Alt2Su groups and the service system or auspice organisation. Peer facilitators and coordinators within auspice

organisations are key to addressing tensions between the different ways of working. Both roles need a clear understanding of the part each play in the Alt2Su approach. Relationships between peer facilitators and workers from the auspice organisation are therefore critical trust connections. Indeed, trust relationships are part of the relational goods that Alt2Su contributes to the service system in general, however, the integrity of the mutual aid approach needs careful protection.

The report concludes by recommending an emphasis on developing relations of trust in communities and organisations that interact with or have an interest in Alt2Su, and in establishing an approach that brings about genuine lived experience leadership in the development of Alt2Su. This may include working to ensure that Alt2Su operates with independence from the pressure to adhere to clinical guidelines or protocols that may intersect with the establishment and operation of Alt2Su groups.

Establishing Alt2Su groups would require genuine investment in grassroots community co-designed processes. However, as more and more Alt2Su groups develop, there will no doubt be problems with inconsistency between facilitators/groups. Appropriate support, training, peer supervision and co-reflection, debriefing and learning needs to be ‘designed in’ to the Alt2Su approach to help maintain program fidelity as groups are adapted to different local contexts.

For Alt2Su to develop as an approach, appropriate funding and resourcing for trainers and facilitators is needed, but resources are also needed to support the development of lived experience leadership. Such an approach would also help Alt2Su groups benefit from a continual emphasis on its non-clinical model, and delivery and promotion in non-clinical community settings and contexts.

Background and context

Approximately nine people die by suicide in Australia each day, representing 12 per 100,000 people (Australian Institute of Health and Welfare, 2022b). In 2020, Western Australia recorded an average of one suicide every day, the majority of whom were men (LifeLine, 2022). Suicide disproportionately affects Aboriginal and Torres Strait Islander populations (Australian Institute of Health and Welfare, 2022a) and transgender people (Bretherton et al., 2021). Globally, suicide is the leading cause of death in young people, but it is typically higher for older people. Twice as many men than women will die by suicide (Ritchie, Roser, & Ortiz-Ospina, 2022). While there has been no reported increase in suicide due to the COVID-19 pandemic, there has been an increase in demand on mental health services (Australian Institute of Health and Welfare, 2022b).

In response to the significant number of people with lived experience expressing concern about service delivery and clinical system responses, peer approaches have emerged. One such approach is the Alt2Su approach. It involves groups of people who have had or are currently experiencing thoughts of suicide or wanting to end their life, coming together to speak freely about their experiences, without the threat of unwanted coercive or clinical responses. The practice primarily consists of weekly 90-minute mutual support groups that provide a non-judgemental space for discussing, sitting with and exploring understanding of suicidal thoughts without providing any clinical intervention. Groups are facilitated by peers trained in the Alt2Su approach who steer away from clinical, risk driven and potentially coercive responses to suicidal distress. Instead, group facilitation prioritises peer support, dialogue, relationship building and meaning making and is guided by a comprehensive charter outlining the important values, practices and intentions for groups. The Alt2Su Charter can also be used as a framework for having curious and non-clinical conversations in other environments about suicidal distress and wanting to die.

Origins of Alternatives to Suicide

Alt2Su was developed in 2008 by the Wildflower Alliance in Western Massachusetts, USA. Their community had raised the need for a place to be able to openly talk about suicide without fear of receiving a coercive and harmful intervention response from mental health services. Drawing from their expertise in running Hearing Voices groups, the approach shares many similar principles and practices. As an innovative peer led alternative response to suicide, Alt2Su has expanded into other regions of the USA, as well as Canada and Australia.

In 2015, Alt2Su was featured at an international mental health conference and caught the attention of WA based mental health systems advocate, Joe Calleja. This led to the creation of a WA Alt2Su Steering Group in 2017, whose purpose was to bring Alt2Su to WA. The group comprised of local not-for-profit organisations and people with lived experience, including MercyCare, Recovery Matters, ConnectGroups, Consumers of Mental Health WA, and HelpingMinds.

Under the management of the Steering Group, Wildflower Alliance flew to Australia in 2018 and delivered an Alt2Su group facilitator training in Perth. Alt2Su advocacy group, Alternatives Melbourne also came together to utilise the presence of Wildflower Alliance trainers by rallying funding to host another facilitator training in Victoria. From this, the first

Australian Alt2Su group, DISCHARGED, emerged. The DISCHARGED group was specifically for trans and gender diverse people, was volunteer run, and supported by TransFolk of WA. The founders of DISCHARGED were pivotal to the establishment of the different Alt2Su projects across Australia. However, these projects have not emerged as a single program. Alt2Su is being seeded in silos across Australia and leaders in each state currently establishing groups have formed relationships of mutual support through community of practice channels.

A second group also emerged in Sydney run by Off the Wall. In 2020, the COVID-19 pandemic forced support groups to move online, which created the unexpected outcome of a more connected and collaborative national Alt2Su network. In 2021, Wildflower Alliance delivered an online training to certify a small number of Australian facilitators to be able to train more people as Alt2Su facilitators. This was a significant step in increasing the sustainability and scalability of Alt2Su in Australia.

In response to the increased mental health needs of the community following the COVID pandemic, Alt2Su was seen as a leader in the peer response and in 2021 received funding to expand the reach and capacity of Alt2Su groups. In WA, ConnectGroups received funding from Lotterywest, and, with the support of a Steering Committee, sought to expand Alt2Su through facilitator training and the establishment of Alt2Su groups under the auspice of ConnectGroups. In NSW, Inside Out received funding from the Ministry of Health to for a similar separate project, establishing Alt2Su groups in NSW and delivering community forums.

With much planning and advocacy, the Lived Experience Leadership and Advocacy Network (LELAN) received funding in 2022 to create an Alt2Su presence in South Australia. Further facilitators have been trained by the Australian qualified trainers, and groups have emerged in both metropolitan and regional areas in South Australia, alongside online groups. LELAN continued their contribution to the sustainability of Alt2Su in Australia by funding an online training facilitated by Wildflower Alliance to train Australians to deliver ‘When Conversations Turn to Suicide’ training. This is a community and systems change training, geared toward supporting the everyday person to have curious and open conversations about suicide that do not revolve around safety planning or crisis intervention. The training also provides opportunities for clinicians or peer workers within the mental health system wanting to shift risk averse practices to learn how to use the Alt2Su approach to advocate for change.

Limitations of the clinical approach to suicide

Mental health services are not immune from the neoliberalism of the last four decades. Indeed, Fisher (2007) argues that neoliberalism has transformed citizens into consumers and ushered in a cultural logic and trend towards privatisation and market driven approaches to mental health services. In terms of suicide prevention, neoliberal ideologies use economic terms to describe *disability adjusted life years*, or *productivity loss* from suicide, and this serves to recast individual suffering into economic terms (Cosgrove & Karter, 2018). This provides an economic logic for state intervention strategies.

Australia has a National Suicide Prevention Strategy (NSPS) underpinned by a whole-of-government, multi-level, intersectoral approach, which includes education, at-risk screening, clinical treatment, restricting access to lethal means, and crisis intervention (Fitzpatrick,

2022). The NSPS is dominated in large part by the fields of psychiatry, psychology, and epidemiology. This dominance has contributed to the objectification of people experiencing suicidal distress as their experience is often described in clinical language “ill-suited for capturing the chaos, ambiguity, and confusion of the suicidal crisis and the myriad of challenges faced by persons after a suicide attempt” (Fitzpatrick, 2016, p. 3).

Critique of the dominance of clinical language and treatment is at the heart of the psychiatric survivor and lived experience social movements (Faulkner, 2017). Fundamental to the Alt2Su approach is the paradigm shift away from clinical mental health responses (Davidow & Mazel-Carlton, 2020a). Alt2Su positions itself as an alternative to the current approach that routinely utilises mental health trained clinicians and practitioners, a medicalised view of mental health, risk assessments, various mental health assessment and diagnostic tools, restraint, seclusion, pharmacotherapies, and psychotherapies as standard practice. Although the mental health system in Australia does reflect a largely biomedical view of mental health, the efficacy of the collection of practices that comprise this view has significant critique in the literature. When considering psychopharmacological treatment, risk assessments, and hospitalisation as primary interventions for people experiencing suicidal distress, research has shown limited positive outcomes.

For example, a cross comparison of 191 countries mental health systems (Rajkumar, Brinda, Duba, Thangadurai, & Jacob, 2013) found that countries with more advanced mental health systems had higher suicide rates. This may be attributed to higher investment in “curative psychiatric systems”, which the authors argue may sometimes be beneficial at the level of individuals, but do not necessarily translate to a net health benefit across broader populations. In contrast, greater emphasis on public health and social welfare are important to positive gains in population health and mental health. Ghaffari and colleagues (2020) conducted a systematic umbrella review of the available evidence of drug therapies for depression, the mental illness which many people with thoughts of suicide are diagnosed with. They argue that the evidence for the chemical imbalance theory of depression is weak. A more recent systematic review of the evidence (Moncrieff et al., 2022) found that “the serotonin theory of depression is not empirically substantiated” (p. 12), and that studies that showed any link between serotonin and depression were likely the result of samples exclusively comprised of participants taking antidepressants. The evidence the authors found for psychopharmacological treatment of depression were often of low quality or influenced by bias. Likewise, an umbrella review (Leichsenring, Steinert, Rabung, & Ioannidis, 2022) of recent meta-analyses of all Randomised Control Trials into the evidence for current mental health treatment approaches (psychotherapies and pharmacotherapies) noted that the effect size of such treatment was limited, and seemed to be capped. The authors suggest that for any progress to be made in mental health treatment, a paradigm shift is required. Despite the ongoing and increasing fiscal investment in such treatments, there does not appear to be corresponding increase in therapeutic gains. In short, pharmacotherapeutic treatment as suicide prevention has known limitations.

Another set of tools utilised under suicide prevention draw on risk assessment protocols. These tools are said to determine suicide risk factors and predict the probabilities of suicide in specific individuals and population groups. However, the evidence for the effectiveness of a risk assessment approach is also weak. Ryan and Large (2013) examined the research on the efficacy of risk assessments for predicting suicide risk. They concluded that “it is simply not possible to predict suicide in an individual patient, and any attempt to subdivide patients

into high-risk and low-risk categories is at best unhelpful and at worst will prevent provision of useful and needed psychiatric care" (p. 462). Franklin et al. (2017) reviewed 50 years of evidence into the efficacy of suicide risk factors, noting that their predictive power was no better than chance. Despite the limited accuracy of risk factors and assessment, the clinical mental health system continues to hold tightly to risk assessment protocols to determine where to apply suicide prevention strategies.

The primary crisis intervention strategy utilised by suicide prevention initiatives—hospitalisation, whether voluntary or forced—also has well documented limitations. In many cases, the evidence is suggesting that hospitalisation is associated with *increased* suicide risk, instead of reductions. An early study looking at Danish longitudinal data found that "suicide risk peaks in periods immediately after [hospital] admission and discharge" (Qin & Nordentoft, 2005, p. 427). Chung and colleagues (2017) found a similar result in a more recent meta-analysis. In a review of 100 studies, they determined the suicide rate after psychiatric hospital discharge was 100 times that of the international rate of suicide, and that this elevated rate lasts for many years. Interestingly, it wasn't just discharged inpatients who were admitted for suicidal behaviours or distress that had this elevated rate, but all inpatients discharged from psychiatric hospitals. These results were then replicated in a later study (D. Chung et al., 2019). Seemingly, suicide risk is not being decreased by psychiatric hospitalisation, but instead, increases both during and after admission.

Jordan and McNiel (2020) also explored this relationship by examining whether perceived coercion during hospitalisation increases risk for post-discharge suicide attempts. Drawing on a sample of 905 participants, they found that "patients who perceived coercion during hospitalization admission were more likely to make a suicide attempt after discharge than those who did not" (p. 180). The relationship between suicide risk and coercion remained significant, even after the authors controlled for a variety of other variables like diagnosis or recent self-injury. This is the first study to make a link between coercion and suicide risk, but it is supported by qualitative findings. Inpatient participants in Wood and Pistrang's (2004) interview study reported frequent non-consensual treatment, which significantly interrupts the ability to feel safe in hospital. Overall, treatment in acute mental health wards elicited feelings of "vulnerability and helplessness" (p. 16). Furthermore, focus group research with consumers found that seclusion and restraint practices were unnecessarily overused, and that inpatient experiences were times of marked trauma, isolation, and dehumanisation. These experiences within psychiatric care *worsened* the conditions of people's mental health and created a reluctance to access clinical services again (Brophy, Roper, Hamilton, Tellez, & McSherry, 2016). What the literature demonstrates here is that hospitalisation is not addressing suicide risk or distress. Whilst suicide prevention efforts may control someone for a moment in time, these strategies ultimately elevate suicide distress for many individuals.

Towards peer approaches in suicide support

The critiques in the literature above underscore the intent by Alt2Su to move away from a clinical and medical response to suicide, towards a social and relational perspective that is sensitive to power and context (Davidow & Mazel-Carlton, 2020a). In an interview with Wildflowers Alliance's Director of Training (Noorani, 2019), Alt2Su is highlighted as distinctly different from suicide prevention efforts. The approach offers an alternative to the clinical focus on risk assessment, pathology, and coercive practices by shifting from problematising the suicide itself, to instead recognising the conditions that create this distress. With the

focus away from reducing, eradicating, or assessing suicide within individuals, Alt2Su opens up new avenues for speaking about, sitting with, or moving through suicidal thoughts.

The Wildflower Alliance (2021) has created a charter for Alternative to Suicide, which outlines the values, practices and principles for running an Alt2Su group. The charter outlines the key principles of *responsibility to—and not for or over; consent and choice; responses to injustice; and healing in communities* (Wildflower Alliance, 2021). Alt2Su groups emphasise "connection (relationship building) and exploration (putting our suicidal thoughts in context and discerning our unique paths forward)" (Davidow & Mazel-Carlton, 2020b, p. 116). Instead of following a rigid script or group format, Alt2Su groups are guided by a framework referred to as VCVC, which stands for "Validation + Curiosity + Vulnerability + Community" (Davidow & Mazel-Carlton, 2020a, p. 189).

Similar to Alt2Su, the Power Threat Meaning Framework (PTMF) (Johnstone et al., 2018) replaces the question at the heart of medicalisation, 'What is wrong with you?', to instead explore people's life experiences, how it affected them, the meaning-making from such experiences, and what people needed to consequently do. In this sense, the PTMF thoroughly unpacks myths such as the biology of mental illness and problems of medicalisation, adopting instead a social framework of understanding. Suicide often occurs when people are disproportionately impacted by social inequality (Hochhauser, Rao, England-Kennedy, & Roy, 2020), and studies show that suicidal thoughts are higher in poorer communities with lower social capital (Choi et al., 2020). Because Alt2Su is grounded in principles of social justice, questions of inequality become vital considerations in thinking about suicide and making meaning from people's life experiences.

There is emerging evidence of the effectiveness of peer approaches in suicide support. A study by Pfeiffer et al., (2019) in the United States developed a peer specialist intervention (PREVAIL) to reduce suicide risk, incorporating components of motivational interviewing and psychotherapies targeting suicide risk into recovery-based peer support. They used a randomized controlled pilot study to assess the acceptability, feasibility, and fidelity of the intervention. A total of 70 adult psychiatric inpatients at high risk for suicide were included. Participants' qualitative responses were highly positive regarding peer specialists' ability to relate, listen, and advise, and to provide support specifically during discussions about suicide. Research into Hearing Voices groups (Hornstein, Branitsky, & Robinson Putnam, 2022) found that participants valued the space for self-determination in meaning making and an approach that fostered "egalitarian collaboration and genuine relationships among members seen as experts by experience" (p. 46). Other research into the benefits of hearing voices peer groups have yielded similar results (Beavan, de Jager, & dos Santos, 2017; Dillon & Hornstein, 2013).

The Hearing Voices approach has many parallels with Alt2Su. Hearing Voices groups are described in respect to style and content as follows:

> style of interaction (non-judgmental, curious, reciprocal and unstructured dialogue among people regarded as equals, in a shared community); and in the content of meetings (welcoming multiple perspectives and exploring coping strategies in non-prescriptive ways, with a focus on expertise by experience). (Hornstein, Robinson Putnam, & Branitsky, 2020, p. 201)

Although Alt2Su resembles many aspects of the Hearing Voices approach, there is limited empirical research into Alt2Su groups specifically. An Australian evaluation study explored the impact of Alt2Su peer support groups on group attendees (Rhodanthe, Wishart, & Martin, 2019). They used a qualitative participatory methodology of co-design and an insider/ outsider stance for the lived experience researchers. The study found that:

> participants have become empowered to navigate their thoughts, prolonging the time between thoughts of suicide and a suicide attempt, if there is any attempt at all. They appear to be gaining a greater sense of control, meaning they are less likely to act without thinking about the feelings and what they represent. (p. 4)

It was also found that there was considerable value of a peer approach for people in suicidal distress, supporting participants through a journey of healing, meaning making and belonging. Key aspects highlighted by participants in this evaluation were the crucial role of the peer support and facilitation, the opportunity for mutuality in the groups and the role this played in transforming participant relationships to their suicidal thoughts (Rhodanthe et al., 2019).

Background to this evaluation research

With the ongoing growth of Alt2Su across Australia, there is a need for research and evaluation into the Alt2Su approach. As reported in a recent scoping review into lived experience peer support groups for suicide prevention, further research is needed to address gaps in evidence, particularly to conduct studies that include meaningful involvement with people with lived experience (Schlichthorst, Ozols, Reifels, & Morgan, 2020). Researchers from Curtin University have been subcontracted by ConnectGroups to undertake research and evaluation on the Alt2Su approach. This research builds on earlier work by Rhodanthe et al (2019). Alt2Su trainers and facilitators Leo Rhodanthe and Emery Wishart have collaborated with David Hodgson and Lynelle Watts from Curtin University to co-design and develop this evaluation study. The collaboration began towards the end of 2019, and involved co-designing the evaluation methodology, collaboratively working on data collection, analysis and write up of this report. Further details are below, under methodology.

Methodology

Nested within an action research framework, the methodology adopted a clarifying form of research and evaluation as described by Owen and Rogers (1999). A clarifying evaluation “takes place early in the delivery of a program. The purpose is to provide knowledge that identifies and documents the essential dimensions of a program to make them explicit to stakeholders” (Owen & Rogers, 1999, p. 9). Given that Alt2Su is a new and developing innovation within Australia, this approach to research inquiry is suitable as a way of making the approach explicit to stakeholders. A clarifying evaluation can assist in defining clearly the program rationale and purpose; producing insight into how the program is being developed; define its theoretical, ethical or other guiding principles; define the program’s intended outcomes; make clear what aspects of the program may need modification; and, lay the groundwork for future evaluations concerned with impact and outcomes (Owen & Rogers, 1999).

Novel and innovative programs—like Alt2Su—benefit from detailed analysis and articulation of their fundamental and informing theoretical, ethical, and guiding principles. This helps program developers and sponsors become more cognisant of what, why and how a program is developing, so that it can become more explicit and clearly articulated. Such an approach can usefully feed into action research reflective cycles, so that improvements and modifications can be made to the program development, and further evidence in the literature can be incorporated into program design and delivery. Furthermore, clear articulation of program fundamentals can assist program developers and sponsors to articulate and advocate for its public value.

Objectives

In following a clarifying evaluation methodology, four key objectives were defined as follows:

1. Describe and articulate the theoretical, ethical and other principles that underpin the Alt2Su approach.
2. Explain and conceptualise the Alt2Su program logic, rationale and purpose.
3. Describe and articulate the Alt2Su intervention and practice.
4. Identify any modifications or improvements that would support the work of Alt2Su.

Lived experience co-design and co-research

In clarifying evaluations, key program stakeholders are typically involved in the co-design of the study, and often carry out the evaluation themselves. This researched utilised a lived experience co-design approach from project conceptualisation to final completion of the study. The research team included two Alt2Su trainers and facilitators, Rhodanthe and Wishart, as co-researchers. Rhodanthe and Wishart were involved in co-designing the research methodology and ethics protocol, as well as defining the sample, co-designing the interview tool, recruiting participants, interviews, data collection and analysis, and co-authoring this report.

Significance

A key assumption in clarifying evaluations is that a “program rationale and design needs to be laid out” and that it is vital to make an intervention “explicit” (Owen & Rogers, 1999, p. 15). This approach moves from tacit to explicit understanding of an innovation or program. According to Owen and Rogers, typical issues to address in this form of evaluation are to identify intended outcomes, methods used to achieve outcomes, underlying program rationale, aspects amenable to modification, aspects amenable to an impact or outcome evaluation (p. 17). Owen and Rogers (1999) state that clarifying new, novel or developing programs can support “better policy and program planning and explicit program designs” and can help situate and strongly ground programs within a social science theory of action using data from several sources (e.g., data from the program evaluation and social science theory and literature). A clear program delineation can assist the development of public legitimacy and support, help attain a more concrete and explicit account of the kind of public value (Moore, 2007) that such programs generate, and create spaces for reflective learning over the conditions that are needed to adequately support, develop and administer Alt2Su programs elsewhere, and into the future.

Methods

Sampling method

A purposive sampling method was used to select participants who were knowledgeable about Alternatives to Suicide, such as the founders of Alt2Su approach (Wildflower Alliance), advocates of Alt2Su, Alt2Su trainers and facilitators. Three different sample groups were identified and defined (see Table 1), and these definitions were used to recruit participants.

Table 1: Sample Descriptions

Relationship to Alt2Su	Description
Advocate	Participants who are interviewed primarily based on their role in developing, sponsoring or advocating for the Alt2Su approach. Many advocates have also been involved in training, group facilitation, facilitator coordination, and more.
Trainer	Participants who were interviewed primarily based on their expertise and role in training Alt2Su group facilitators. All trainers also act as advocates and have experience facilitating groups.
Group Facilitator	Participants who were interviewed primarily based on their expertise and role in facilitating Alt2Su groups. Some group facilitators also act as advocates.

Recruitment

Members of the research team recruited participants directly via email and invited them to be interviewed. The recruitment email provided a brief overview on the project and information on who to contact if they chose to participate in the study. A participant information statement and consent form (see Appendices 1 and 2) was attached to the email and participants were given the opportunity to ask questions about the research and their involvement.

Data collection

Data were collected by way of semi-structured interviews. The purpose of interviews was to gather participants' knowledge of Alt2Su. The questions did not explore personal experiences of suicidal thoughts. Interview questions were derived from the study objectives, and focused on the Alt2Su theory, values, purpose, practice, how Alt2Su emerged, what Alt2Su means for the broader community, what Alt2Su needs to flourish and grow as an approach (see Appendix 3). Most of the interviews took place via Microsoft Teams video conferencing.

Data analysis

Interviews were audio-recorded using Microsoft Teams and transcribed for analysis. Analysis of the data utilised a reflexive methodological approach (Alvesson & Sköldberg, 2009) that incorporates thematic analysis (Braun & Clarke, 2006). The main concepts in the research objectives were defined and used to guide the analysis (i.e., key concepts in the objectives were highlighted and then defined, see Table 2).

1. Describe and articulate the **theoretical**, **ethical** and other **principles** that underpin Alt2Su.
2. Explain and conceptualise the Alt2Su **program logic**, **rationale** and **purpose**.
3. Describe and articulate the Alt2Su **intervention** and **practice**.
4. Identify any **modifications** or **improvements** that would **support the work** of Alt2Su.

Table 2: Concept Definitions for Data Analysis

Construct	Meaning
Theoretical (conceptual)	Concepts used to describe Alt2Su. Why something works, an explanation for, and argument for.
Values	Value statements, moral principles, matters that are seen as good, right, proper, important, necessary, valuable, needed.
Rationale	The why of, the reason for, a justification for Alt2Su, the necessary grounds for.
Purpose	A means to an end, desired states, an ideal situation, a goal, or end point.
Practice	What is done, how it is done, what is 'not' done, why it is done in particular ways.
Improvements, recommendations	What needs to change (why, how)? In group/ community/ systems/ society.

Transcripts were then analysed using a deductive method, to identify statements that reflected the definitions of the constructs in Table 2. Data were coded to the constructs, and relevant excerpts of the transcripts identified as illustrative evidence. In all, 16 tables of analysis were created (one per transcript), and then all the data codes were combined into a single document (see Appendix 5). In following, the combined codes were then used to generate several themes, organised under the following headings:

1. Theoretical and conceptual dimensions of Alternatives to Suicide
2. Values and ethical principles
3. Rationale
4. Purpose
5. Practices
6. Improvements and recommendations

Themes under each heading were defined further and illustrated with excerpts from the data (see below, under Results). A program logic model was then created from the data analysis (see Appendix 4).

Ethics

The research followed the requirements of the *National Statement on Ethical Conduct in Human Research*[1]. Principles of informed consent, voluntary participation, avoidance of harm, and privacy and confidentially were followed (see Appendices 1 and 2). Participants were advised that they do not need to answer questions that makes them feel uncomfortable. Participants were also informed that they can stop the interview at any time and that the researchers are available to debrief and provide support after the interview, or

[1] https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018#toc__95

at a time of their choosing. Consent to participate in this research was given in writing via a signed consent form (see Appendix 2). The research presented minimal risk to participants and there were no adverse events because of this research. Ethics approval and monitoring of ethical practice was obtained from *Curtin University Human Research Ethics Committee* (approval HRE2021-0499). All data is stored on Curtin's secure network, accessible only to the Curtin research team, and in line with legal requirements for data storage and retention.

Results

Eighteen people were interviewed for this research, including 10 advocatess, three trainers and five facilitators (see Table 3, Participant Sample).

Table 3: Participant Sample

Relationship to Alt2Su	Description	Transcripts	Participants
Advocate	Participants who are interviewed primarily based on their role in developing, sponsoring or advocating for the Alt2Su approach. Many advocates have also been involved in training, group facilitation, facilitator coordination, and more	N=9	N=10
Trainer	Participants who were interviewed primarily based on their expertise and role in training Alt2Su group facilitators. All trainers also act as advocates and have experience facilitating groups.	N=2	N=3
Group Facilitator	Participants who were interviewed primarily based on their expertise and role in facilitating Alt2Su groups. Some group facilitators also act as advocates	N=5	N=5
TOTAL		**N=16**	**18**

The results presented below are organised thematically under the main headings that guide the study objectives (See Figure 1, Data Organisation). Themes are described with examples, and quotes from transcripts are used to illustrate key points in the thematic organisation of the findings.

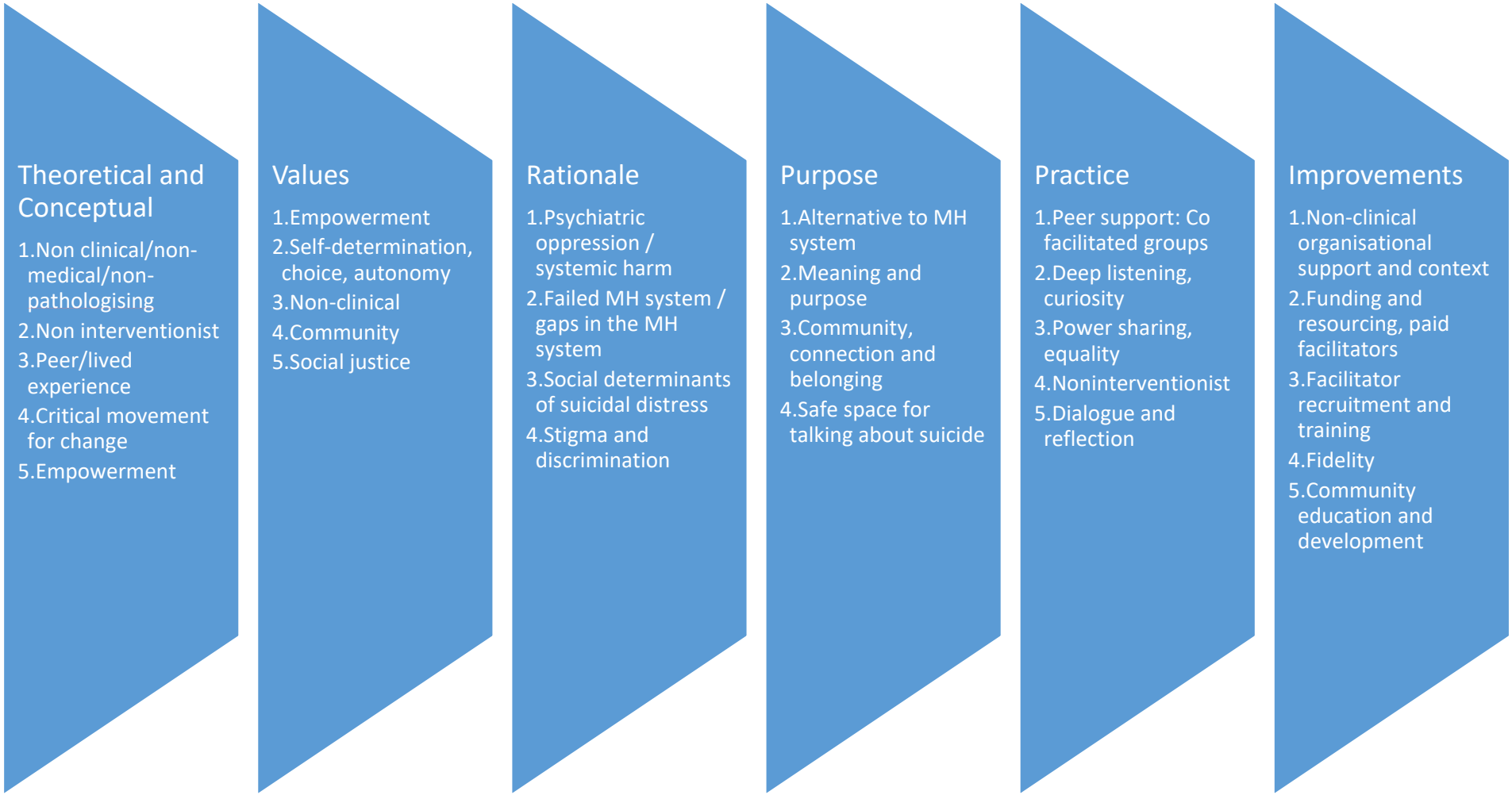


Figure 1: Data Organisation

Theoretical and Conceptual Dimensions of Alternatives to Suicide

Theoretical and conceptual notions of Alt2Su point to descriptions of what participants understand it to mean, how they explain it, what Alt2Su is doing, and for what theoretical purpose. Alt2Su has similarities to the Hearing Voices approach, particularly its lived experience emphasis on meaning and understanding.

Non-clinical/non-medical/non-pathologising

Overwhelmingly, participants would conceptualise Alt2Su by what it is *not*. It is non-clinical, non-interventionist, non-biomedical and non-risk adverse driven:

> *"The problem with risk assessments is once they start using the risk assessment they stop listening"*

This marks it out from other approaches to distress and suicide, which have a strong emphasis on expert clinical knowledge and risk assessment, an interventionist approach to prevention and response. Such responses are largely the purview of clinical services and systems (e.g., clinics, hospitals, etc) and they have a long and institutionally entrenched history. By contrast, Alt2Su is influenced by movements in critical psychiatry, social justice, an anti-oppressive theory, and a social determinants of health perspective on human health and wellbeing.

Non-interventionist

Regarding a non-interventionist approach, Alt2Su has a standpoint position of not escalating people's experiences of distress into the mental health system.[2] It takes seriously the idea that '*suicide is not the problem'*. Furthermore, as it is not predicated on a clinical model, there are no protocols regarding risk assessment and response, nor are there clinical workers involved in groups, either directly or indirectly. Suicide is an indication of a problem that can be discovered with genuine curiosity. Theoretically, then, Alt2Su addresses participants meaning making around their lives and experiences as formative in the experience of suicidal distress, and therefore is responsive to contexts, histories and lived experience, not as a response to the manifestation of suicide itself.

Peer/lived experience

The peer support element was particularly emphasised. Peer support, lived experience, community, and solidarity with others was argued by participants as being a theoretical necessity for Alt2Su:

> *"…the value of peer support is gold; it will provide a means of allowing the power of choice to individuals to really fulfill and exceed their own limiting beliefs and expectations and that there is a supportive community out there…"*

[2] Violence or medical emergencies may be exceptions that require a police or ambulance response.

Critical movement for change

Alt2Su represents a critical movement for change in how suicide is thought about, talked about and particularly how it is addressed and responded to within the mental health system. There is a focus on community building, on fostering the conditions for self-determination, and a decolonising and critical stance towards the dominance of the biomedical model. Alt2Su was described by participants as enacting a form of liberation, connecting with, and building on survivors' movements, the consumer movement, and working to establish safe and alternative spaces away from the systemic experiences of discrimination, stigma and marginalisation that often manifest in the clinical mental health system.

Empowerment

While empowerment is discussed below as a value, participants evoked this word to denote the work of Alt2Su as being a practice towards empowerment, central to the achievement of self-determination, choice, and autonomy. The reason this is theoretically important is because Alt2Su aims to *increase* people's autonomy, not undermine it. As an alternative to other sections of the mental health system, Alt2Su was said to provide choices for people who may appreciate a non-clinical setting where they can discuss their experiences of suicidal distress.

Values and Ethical Principles

Value statements include moral principles, matters that are seen as good, right, proper, important, valuable, and necessary. Participants were very clear about certain values pertaining to Alt2Su. These might be values that have deep origins in philosophical ethics (e.g., freedom, respect, social justice, human rights), or simply statements that indicated the moral good that Alt2Su provides to the community (e.g., humility, curiosity, connection). Regarding the former, values were clearly couched in a humanistic position associated with Kantian respect for persons, the Rogerian idea of unconditional positive regard, and a more recent critical conceptualisation of human rights, such as valuing diversity and difference as fundamental to the human condition. Other values included trust, belonging, being non-judgemental, consent and choice, learning, curiosity, safety, and solidarity.

Empowerment

Although empowerment was conceptualised as a theoretical condition for choice and autonomy (see below), it is also a highly valued aspect of the Alt2Su approach. Whilst participants did not define empowerment, it was clear that its value was enacted through processes that attempt to give group members as much choice as possible in their decisions to attend Atl2Su, what they share, when, under what conditions, and to also have choices in how meaning and interpretation of experience is constructed:

> *"there's something liberating about hearing other people have the same sort of feeling maybe, or the same situation, but a very different interpretation and response. And then that helps me and I think it helps others. It helps me because I think, "Oh, well, I thought I figured it out. And it was definitely bad but evidently, there's other ways to look at it.""*

Self-determination, choice, autonomy

Participants argued strongly for the centrality of self-determination, choice, and autonomy. The phrase “responsibility to, not responsibility over” was invoked to illustrate this idea. This value was critical because many people’s experiences in the mental health system were quite the opposite of this (e.g., involuntary treatment). Such experiences of having choices removed tended to exacerbate or cause more trauma, undermined a sense of personal agency, and led to further feelings of disconnection. As noted by participants, these experiences heighten distress, rather than alleviate it.

Non-clinical

By far one of the strongest themes in the data was the repeated insistence that a key valuable aspect of Alt2Su is its non-clinical focus. This means that the experience and meaning of suicidal distress is not reduced into a biomedical frame of understanding, and that mental health more broadly is conceptualised in its social, historical, and political contexts. Furthermore, the practice itself does not adhere to clinical modes of working—there are no formally sanctioned mental health clinicians (e.g., social workers, mental health nurses, occupational therapists) involved in running Alt2Su groups, where such involvement would constitute an organisationally sanctioned role with necessary clinical practice delegations. Accordingly, Alt2Su does not deploy risk assessments, triage, or referral to other services, and it does not invoke emergency (e.g., welfare checks, police or ambulance callouts) as part of its practice.

Community

What Alt2su does do, according to participants, is build a community of social connection and belonging. This is seen as a valuable condition for people being heard, recognised, understood, included, and connected with others with shared lived experience:

> *There are so many flow-on effects from someone going to an [Alt2Su] support group…feeling like they’re not alone. Feeling like they don’t have to be ashamed feeling like they’ve got some kind of understanding and support.*

Social justice

Social justice is an ethical principle but also denotes individual and collective attempts to bring about justice along cultural, political, sexual, gendered, social, ecological or economic lines. Theoretically, Alt2Su takes an ethical and practical position to name, identify, and address problems such as discrimination and inequality, by appealing to principles of inclusion, anti-discrimination, and equality.

Rationale

Rationale concerns participants views on why Alt2Su has come about, reasons for it, a justification for Alt2Su, and arguments for its necessity. The main themes in the data are that the mental health system is seen as ineffective at best, and at worse, harmful to people in suicidal distress. The rationale for Alt2Su is on recognition that stigma and discrimination surrounding suicide is replete in society generally, but also, people in suicidal distress have

experienced stigma and discrimination through accessing services, be they voluntary or otherwise.

Psychiatric oppression / systemic harm

> *"…people that have been utilising those mental health services and mental health systems have found that sense of dehumanisation…the services there do not contribute to any form of recovery…it didn't resolve or support or give them a better quality of life. It actually added to their distress"*

It was clear that a key reason for Alt2Su was in response to people's experiences of psychiatric oppression and further distress they have faced after accessing services within the clinical mental health system. Participants noted that in some cases, the mental health system has been a source of harm itself and that some experiences have been dehumanising and traumatising. Participants spoke of not being understood or listened to, feeling stigmatised, discriminated against, and treated poorly. Alt2Su is a response to this oppression—it creates an alternative space that does not further perpetuate the alienation and loss of autonomy sanctioned under some aspects of the mental health system response to suicide.

Failed mental health system / gaps in the mental health system

Participants contended that the mental health system isn't working as an adequate response to suicide, and that there are not enough non-clinical options in the system. There were many comments stating that the system isn't working, that people experience a loss of personal power in clinical systems, there are gaps in services leading to unmet needs, and that services operate on a "limited tick box clinical approach", which results in disillusion with risk assessments/hospital/ambulances/welfare checks, etc:

> *"… I've seen in the past people have been suicidal. They had drugs on them. Police came and checked, took him to the hospital to be to be watched over, and then the following day charged them with possession of drugs… That just…ruins someone's mental health not only were they in psychosis or some sort of mental health distress and suicidal ideation now they have to go and appear in front of a court of law to you know to face these drugs charges and that just further person pushes someone to the brink of just saying, you know what enough's enough."*

As such, Alt2Su is seen as a logical response to both the deficiencies in the system, as well as providing genuine alternatives for people who do not want to access a medical or psychiatric service, or where such services may be inaccessible. This was particularly the case for people who have had traumatising experiences in the clinical system but are seeking safe spaces to connect with others over their experiences (e.g., of distress, suicidality, trauma, etc).

Social determinants of suicidal distress

It was noted that a key rationale for Alt2Su was to acknowledge and be responsive to the social and contextual dimensions of people's experiences. This draws on a social determinants of health perspective, appreciating the way that health and mental health have

historical and contextual origins, including past illnesses or injuries, lack of access to safe affordable housing, food insecurity, interpersonal violence, and so on. The important point here is that health is the function of an interaction between person and context. For example, social disconnection was mentioned as being a cultural and social phenomenon:

> *"…a lot of us are walking around feeling lonely and isolated. And unable to make sense because [we are] social beings, the way we make sense is in connection, but our whole way of being in this this current civilization is to drive disconnection"*

Stigma and discrimination

A contextual reason for Alt2Su is to work against social stigma and discrimination that gets attached to the phenomenon of suicide:

> *"…suicidal people are treated very, very poorly, both in the medical system and in community, as well. There's lots of really harsh stereotypes about suicidal people, always like mistrusted, as well, even in hospitals, like not just having no self-determination, and no real sense of autonomy and having all of that stuff taken away by the current model and the current approaches, you know, like, with sectioning and forced treatment, and force medicating and all that kind of stuff. It's like, I think that alternatives to suicide is kind of taking us a step towards the emancipation of from those things"*

From the data, it can be noted that this stigma and discrimination are systemic and have their own ecology. First, there is stigma and discrimination that is attached to distress and particularly some diagnoses. This manifests in discourses around mental health broadly. Second, stigma and discrimination occur in experiences of accessing services. In other words, certain attitudes, and behaviours from workers in mental health services can act as cyphers for social stigma, particularly in relation to suicide. Third, stigma and discrimination impact particular social groups (e.g., LGBTIQA+, Indigenous). The intersectional nature of stigma and discrimination has a compounding effect on people's experiences, whereas Alt2Su is said to exist precisely as an antidote to this, creating spaces that are respectful, non-judgemental, inclusive and with an intersectional awareness.

Purpose

While participants could readily state what Alt2Su is not, and clearly articulated what problems exist in society broadly—and in mental health services specifically—there were also clear answers to what Alt2Su is, and what it is aiming to achieve. Purpose here refers to a means to an end, a desired state, an ideal situation, a goal or end point. Alt2su purpose is not couched specifically in uniformly defined objectives like many social programs are, and nor was the purpose specifically tied to a quantifiable reduction in suicide (although, it should be stated that a reduction in suicide a side-effect of groups building social connection, solidarity and exploring one's experience of suicidal distress/life circumstances). Thus, purpose was most strongly conceptualised as providing alternatives to the mental health system, and couched in the language of existential meaning, belonging, and connection:

"I feel like something like Alt2Su, it's a spirit. It's a commitment. It's a human way of being together that, I don't know—organisations just think differently."

Alternative to the mental health system

A purpose of Alt2Su is to change the mental health system, or better put, to fill a gap in that system by creating more options and choices for people in suicidal distress. However, there is also a claim that Alt2Su is connecting with a long history in the consumer movement towards social and political change in how we think about and act in relation to mental health more generally. There were mentions of being part of a social movement, or paradigm shift in mental health. In moving away from the dominant biomedical model of mental health, Alt2Su presents itself not just a practical alternative, but a theoretical and ethical one too.

Meaning and purpose

"It's to create circumstances where people's lives are worth living or meaningful, with or without distress... it's not so much about preventing the acts you know of, of suicide"

Participants contended that Alt2su functions to help create a sense of purpose, meaning in one's life and experience, consciousness raising, and building the conditions for life worth living. They argued that a sense of purpose, the cultivation of understanding and meaning, and thinking about hope and healing are important to Alt2Su and as a response to suicidal distress.

Community, connection and belonging

A critical purpose of Alt2Su is to create spaces in the community that foster belonging:

"It's about connection between humans and the …recognition of sameness, the authenticity of being present, being vulnerable and connecting to other people empathically…being curious about other people's experiences and their meaning making…"

Given some of the issues identified earlier to include isolation and disconnection, belonging was explained by participants as being an important and worthy endeavour. This includes building and prioritising community, creating opportunities for people to experience genuine, safe, and trusting connections with others, expressing and demonstrating mutual care towards others, ensuring people are heard, understood, and validated, and creating moments for friendships to flourish.

Safe space for talking about suicide

Finally, participants expressed that an important purpose for Alt2Su was to create an authentic safe space for people to come and talk about suicide, without the fear of being shamed, judged, invalidated, or having their experienced medicalised and escalated into formal services and systems:

"In a clinical model there would be lots of like, trigger warnings, there would be risk assessments, there would be, 'oh, you can't talk about that

here'. And there would be a 'listen, we're really worried about you. So we've called an ambulance', whatever. There would be a lot of like case notes afterwards. That's horrifying thought, oh, my gosh. Yeah, that that that is so not what I want."

This was clearly identified as a gap in the mental health system, and Alt2su is considered as a safe space for meeting different needs, bringing together stories and lived experience from peoples complex but different worlds, being heard, sharing experiences, and otherwise working towards connection, emancipation and consciousness raising.

Practices

Practices concerns what is done within an Alt2Su approach—and within the groups specifically—how it is done, what is 'not' done, and why groups function in particular ways. Given that most of the participant sample were Alt2su trainers and/or facilitators, this necessarily generated substantial data. Overall, it was clear that practices involved peer-to-peer co-facilitated groups, that were very sensitive to power sharing, emphasised deep listening, and can be seen as an example of spaces for genuine reflective dialogue:

"When people are sharing really vulnerably, really honestly, about things, maybe they'd not have shared before or things they wouldn't dare speak otherwise, and we kind of feel it. We know it. And to me that's the core of Alt2Su, that's how I know that we are doing Alt2Su"

Peer support: Co-facilitated groups

Fundamental to the Alt2Su approach is its model of peer-led, co-facilitated groups that take place either online or in community settings. Facilitators have lived experience and are trained in the Alt2Su values and methods. Like all groups, there is some set-up and preparation, and facilitators engage in reflective practice via debriefing and support towards each other. The co-facilitation approach requires substantial self-awareness and reflection, to ensure that the Alt2Su approach is followed faithfully (i.e., does not become a space of advice giving, lecturing or intervention over others). Again, the phrase *responsibility to, not over*, was quoted as emblematic of this ethic. Likewise, an approach that is non-judgemental and curious involves a "light touch" method of facilitation to include shared responsibility and mutuality, which helps the practice stay true to Alt2Su in values by modelling validation, emotional safety, sharing power and self-awareness.

Deep listening, curiosity

It was clear from participants that fundamental to the Alt2Su approach is what can be called deep listening. This extends well beyond typical tropes of listening as communication but includes a much broader ethical quality and stance towards group participants. For example, concepts such as yarning, allowing space for the expression of big feelings, being able to reconceptualise experiences and exploring diverse and alternate understandings of distress in a context of uncertainty were noted:

"We need to trust in the power of our community, not just our systems. We need to trust in our own humanity that we have incredible power when we start to listen and be vulnerable with one another. I think we just need to

find the faith again in, you know, the power of a group of human beings sitting in a circle as they've done for thousands of years and sharing their stories"

Likewise, facilitating with open-ended questions any topic that arises with empathy, reflection, humility, vulnerability, curiosity, and intimacy were noted. This approach to deep listening was contrasted with other practices that emphasise risk assessment, adherence to safety protocols, rescuing, asserting dominance, the deployment of expert authority, attention to procedure, scripted conversations, and models of practice that categorise others into diagnostic groups were seen as antithetical to deep listening. The practice of deep listening includes at times being non-directive, with a focus on exploration, deconstruction, open meaning making, encouraging reflection, co-reflection, and creating the time and space for group participants to deeply explore their experiences.

Power sharing, equality

The peer and lived experience approach to deep listening requires attention to the use of power in groups. Participants spoke of the need to ensure that groups operated on a principle of equality (in which there is no hierarchy of knowledge or expertise), what could be termed epistemological equality. All experiences are valid and valued, and the job of facilitators is to reflexively keep in check their positionality as facilitators so that power sharing emerges as a key ethical practice in Alt2su groups.

Non-interventionist

A striking theme in the data was the very clear and strongly articulated view that Alt2Su is non-interventionist. This theme is discussed above, but worth recounting here. By non-interventionist it means facilitators do not operate from a prescribed agenda and there is no attempt to try to control others. Groups do not operate from a position of fear or risk management and there is no diagnosing, assessment, treatment planning, referral to other services or supports, nor are there predetermined outcomes associated with recovery.

Dialogue and reflection

An important quality about Alt2Su groups that we discuss further below (see discussion) is that groups are spaces for dialogue, reflection, and co-reflection. This is the method that underpins deep listening and is also a way to generate discussions around meaning, the interpretation of experience, wider conversations about being in the world, including struggle, pain, trauma, but also joy, hope and connection:

"Alternatives to suicide is a slowed down approach. We do a lot of talking, a lot of reflecting and yeah, I think to hold the integrity we continue in those ideals of slowing down and really taking the time to think about what does this mean, what does this mean to me, and what does this mean to the community"

Dialogue and reflection were mentioned in relation to mutual learning from experience and sharing of knowledge. Instead of groups being mechanisms for conveying expert knowledge from clinicians to clients (or patients), all participants, facilitators, and others, engage in

dialogue and reflection that is mutually transformative. In this sense, groups are dialogical, not didactic.

Improvements and recommendations

Interviews explored participants views about what is needed going forward for Alt2Su groups and the approach overall to grow and flourish. This concerns changes or improvements at different levels: in Alt2Su groups specifically; in the broader community; in mental health and other service systems; and, in society at large. An important point raised is that Alt2Su is vitally needed as a genuine and legitimate alternative to the standard response to suicide, summed up by this statement:

> *"…if you always do what you've always done, you'll always get what you've always got…"*

Overall views expressed by participants were that Alt2Su does need resourcing and support, but it should not be subsumed into the clinical mental health system.

Non-clinical organisational support and context

Participants argued that Alt2Su would benefit from organisational support, governance, and institutional and political backing, but that this should not get caught up into a medical risk adverse model of practice. They noted that this requires very careful balancing of competing organisational priorities, as some services are deeply rooted in procedural compliance and oversight responsibilities of their services, which could present a measure of conflict between that and the non-clinical, non-interventionist and peer led approach to Alt2Su:

> *"I've certainly seen that ugly side of how an organisation views Alt2Su and what actions it's prepared to take to shut it down. And shut out employees that have any association with it."*

Participants argued that Alt2Su should not develop in clinical settings (e.g., in-patient hospital or mental health clinics) mainly because it would be difficult to reconcile the governance obligations of such settings vis a vis the Alt2Su approach. Moreover, such settings would physically present barriers to would-be participants, who are attempting to avoid any connection or association with clinical settings often due to previous negative or traumatic experiences in such environments. Furthermore, there was a sense that the lived experience integrity could be threatened by the impersonal nature of organisational systems, and thus Alt2Su should remain in community contexts, rather than being embedded in organisational structures and systems:

> *"Organizations are often too big to be interpersonally accountable. So, if one person, like often there'll be a person in the organization that's deeply committed to the approach, and then they move on, or they just move to a different role and then the organization replaces them with a different person, and to me that means you've no idea if that person's committed."*

Trust is needed is at all levels, including lived experience leadership, in community strength and capacity, and investment in community development:

"I think what it [Alt2Su] needs to flourish is a deep trust. A deep faith in the human capacity to endure and change if we're given the right support, a deep trust, and the fact that even in our darkest moments, there's a spark inside us that knows the way forward and what we need from other human beings is a reflection of that spark. Someone to kind of like through validation, through care, to kind of blow on that spark that's within us"

Funding and resourcing, paid facilitators

Participants were clear that Alt2Su requires ongoing financial investment and resourcing, particularly to ensure facilitators are adequately paid for their work and expertise:

"it definitely needs some kind of structural support, that supports administration, the development of facilitators, the availability of supports, supports for facilitators and all of that stuff...needs to develop otherwise, I kind of fear that it will wither"

Facilitation requires skills and knowledge in the Alt2Su approach, and as indicated above, the practice of running an Alt2Su groups demands the development and refinement of very good facilitator and groupwork skills, attention to values and ethics, self-reflection, and reflexivity. Such skills and knowledge would ordinarily be remunerated for trained clinicians, and it was argued that this compensation for time, skills and expertise is important for trainers and facilitators too.

Facilitator recruitment and training

Given the skills and knowledge required to deliver Alt2Su groups, participants considered that the ongoing recruitment and training of facilitators is essential for the growth and development of Alt2Su. This includes a rigorous approach to facilitators learning from experience, sharing knowledge, and receiving ongoing support, training, and skills development. Data indicated that facilitation can be an onerous task, and facilitators require appropriate support if Alt2Su is to be sustainable.

Fidelity

An important point noted throughout the interviews was that Alt2Su must maintain its fidelity. Program fidelity denotes the extent to which programs are delivered in accordance with the methods and protocols that underpin their design. This is particularly important where programs may be delivered across multiple locations, at different times, and without a centralised overarching governance structure:

"…there's always the threat of co-optation or somebody trying to adopt the approach, but stripping it of the radical kind of content"

"I've been hearing that there is not always consistency across the board and how the groups are facilitated. So, I don't know whether that's to do with training or not enough training or obviously people have different individual flavours and it's not about personality, but there's certain people, facilitators who have never acknowledged country"

This situation reflects the growth of Alt2Su, which is developing in various locations under the auspice of diverse organisational contexts. Maintaining program fidelity was important to participants, which means that Alt2Su groups should follow the Charter, values, and methods faithfully. The main mechanism to manage program fidelity is through the facilitator training processes, which may also include follow up training, peer supervision or co-reflection, and sharing of facilitator expertise in the Alt2Su approach.

Community education and development

Finally, participants contended that Alt2Su has an important role to play in education and engagement in the broader community, through community education about suicide, (e.g., community forums and training on using Alt2Su in non-group contexts). This may take the form of addressing misunderstandings needed to transform the community approach to suicide through conversations about the Alt2Su approach, and various media and messaging strategies about Alt2Su:

> *"I feel like there's quite a lot of mythmaking that gets passed off as certainty and knowledge."*

There was also some mention of Alt2Su groups responding to specific lived experiences or demographics (e.g., older men, victims of FDV) although it is noted that Alt2Su's original intent is for mixed demographic open groups, which supports the intent for reflective dialogue across different contexts and experiences.

Discussion

Alt2Su has emerged as a response to contemporary social conditions that have, by and large, medicalised distress. This discussion will begin by locating the Alt2Su approach within current responses to suicidal distress. It will examine what it is that Alt2Su does that makes it a unique approach to processing and understanding suicidal distress for community members in contemporary Australian society. The aim of this evaluation was to clarify the approach by outlining the purpose, rationale, theoretical underpinnings of the Alt2Su model of practice as it has been translated into the community within Australia.

The Alt2Su model was developed in the United States and has been translated to the Australian context. Australia and the United States share some common economic and social conditions. Both societies have widely adopted neoliberal ideologies that emphasises free market competition in which individuals are encouraged "to strive for self-actualization, personal growth, and happiness" (Becker, Hartwich, & Haslam, 2021, p. 947). Both societies have become markedly more unequal in the 70 years since the adoption of these widespread neoliberal economic policy, processes and practices (Watts & Hodgson, 2019). These policies also serve to undermine connection, belonging and social solidarity because "disparities [between individuals] are seen as accurate reflections of differences in hard work and deservingness" (Becker et al., 2021, p. 947). As Cosgrove and Karter (2018, p. 670) contend, for neoliberalism the market is not just about the allocation of resources, it is also "an epistemological machine that produces new modes of subjectivity". Therefore, individuals in contemporary society find themselves subject to power relations that set them up as entrepreneurial subjects who must manage themselves (Scharff, 2015). In fact, this very set up makes this kind of self-management natural, and when people fail to meet the

demands, they are often pathologized. Fisher (2007, cited in Scharff, 2015, p. 671) notes that “at the very moment that neoliberal policies transfer responsibility to individuals to provide for themselves, there is a simultaneous increase in the monitoring of their action”.

Fisher (2007, p. 4) offers the term *medical neoliberalism,* which refers to neoliberal ideology as “a cultural sensibility toward the commodification of health and wellness”. This results in recasting human suffering in economic terms, thus altering our very conceptions of the human condition and of psychological life. People and their experiences become commodified. Cosgrove and Karter (2018, p. 672) suggest that the global mental health movement (GMH) has seen depression argued as “leading cause of disability worldwide”. As an example of medical neoliberalism *par excellence,* the “GMH framework risks de-politicizing distress by accepting an understanding of affective life as being unmoored from social context” (Cosgrove & Karter, 2018, p. 672). Thus, the very inequalities that characterise contemporary society and affect people profoundly—poverty, racism, stigma, discrimination, mis-recognition, violence, sexism, ageism, and assaults on worth (Lamont, 2018; Young, 1990)—become obscured within a biomedical language that severs the connection between emotional suffering and social conditions.

The result of this kind of ideology leads treatment to focus narrowly on intrapsychic factors, leading logically to the creation of tools, programs and practices for detecting and assessing depression and suicide risk. Such tools, practices and programs become extensions of the state, as they are legitimated through the complex moral and political economy surrounding and governing the health and mental health of the population (Fitzpatrick, 2022). Prevention of suicide is considered to be a “just and legitimate function of the state and its institutions” (Fitzpatrick, 2022). As discussed earlier, Alt2Su arose in resistance to many of the practices and limitations of the clinical approach to suicidal distress, which commonly involves mental health clinicians’ assessment, and can involve restraint, seclusion, pharmacotherapies and psychotherapies for people experiencing suicidal distress. We turn now to consider what this evaluation has clarified about the operation of the Alt2Su program as it is situated within the complex social, moral and political economy surrounding suicide prevention in Australia.

The Australian mental health system is a complex assemblage (Rose & Miller, 1992) of State actors, organisations, bureaucracies and not-for-profit organisations that offer a range of services aimed at a coordinated approach from prevention to tertiary intervention for individuals experiencing distress. As Fitzpatrick (2022, p. 114) comments, these policies and practices “are dynamic, and involve opposing…at times contradictory logics, values and actions that entail…care and control, marketisation and government reform, and depoliticization…”. Suicide is still at the centre of many “normalising judgements and interventionist practices” (Fitzpatrick, 2022, p. 117) and this tension between care and control was clearly outlined in the participants’ accounts, which clarified the central notion of Alt2Su as a non-interventionist approach.

Thus, within the mental health system, Alt2Su represents a mutual aid approach through which ordinary folks can come together to process suicidal distress using small group processes. This makes Alt2Su a community approach and it therefore works in opposition to the neoliberal ideology discussed earlier, concerned instead with bringing people together to build solidarity across differences and in common cause (Westoby & Dowling, 2013).

What is mutual aid from a community development perspective? Kelly and Westoby (2018, p. 17) suggest that it is "the humble contribution of ordinary people taking responsibility for their well-being and learning and doing it together." This mutual aid approach is often contrasted with the dominant service logics of the wider system, but as Kelly and Westoby point out, with increasing complexities in contemporary life people need a wide array of services to address human need. For this reason, and in recognition of the need for auspice within the contemporary mental health system, Alt2Su requires the auspice of the service system, something we discuss below in more detail. For our purposes Kelly and Westoby (2018) neatly illustrate the differences between what they term participatory work—that is mutual aid—and traditional models of service delivery across a range of dimensions:

Table 4: Distinguishing Service Delivery from Mutual Aid[3]

Point of distinction	**Participatory work**	**Service work**
Relationship	Mutual	Role-based
Authority base	Bottom-up	Top-down
Democratic style	Inclusive	Representative
Engagement	Working with	Working for
Value base	Equality-driven	Eligibility-driven
Outcome focus	Process goals	Programme goals
Universality	Exploratory	Replicable

Alt2Su clearly operates according to the logic of participatory work and mutual aid, providing an alternative to the logic of service delivery more broadly associated with clinical models of mental health and risk assessment. Participants in this evaluation have described in detail the way in which Alt2Su offers opportunities for participants to build connection, belonging, empowerment and social solidarity through sharing experience and stories. This evaluation has clarified that the emphasis on mutuality via deep listening, reflective peer-led facilitation is key to the *internal* processes of Alt2Su groups. These key factors of an Alt2Su group are represented in Figure 2 below:

[3] Adapted from Kelly & Westoby, 2018, p. 16.

Figure 2: Key Elements of Alt2Su Groups

Peer led facilitation is critical to preserving the mutuality of the process within Alt2Su groups. Being able to facilitate groups towards deep reflective listening requires highly developed skills, needing appropriate training and support. Thus, the service infrastructure to ensure fidelity for the communicative practices of Alt2Su group process will be an important investment in the success of the approach. Communicative practices refers to the dialogical nature this kind of group, characterised by I-Thou recognition of the other as described by philosopher Martin Buber (1947, cited in Kelly & Westoby, 2018, pp. 68-76). This deep recognition of others was well described by participants in their discussion of what happens in the Alt2Su groups.

Another key aspect is how these groups and their facilitators interact with the wider health system as it is currently configured. The external relationships between Alt2Su groups and and service delivery might work together in support of this approach to suicidal distress in Auspice organisations constitute a crucial element in how the different logics of mutual aid the community. This is captured in Figure 3 below:

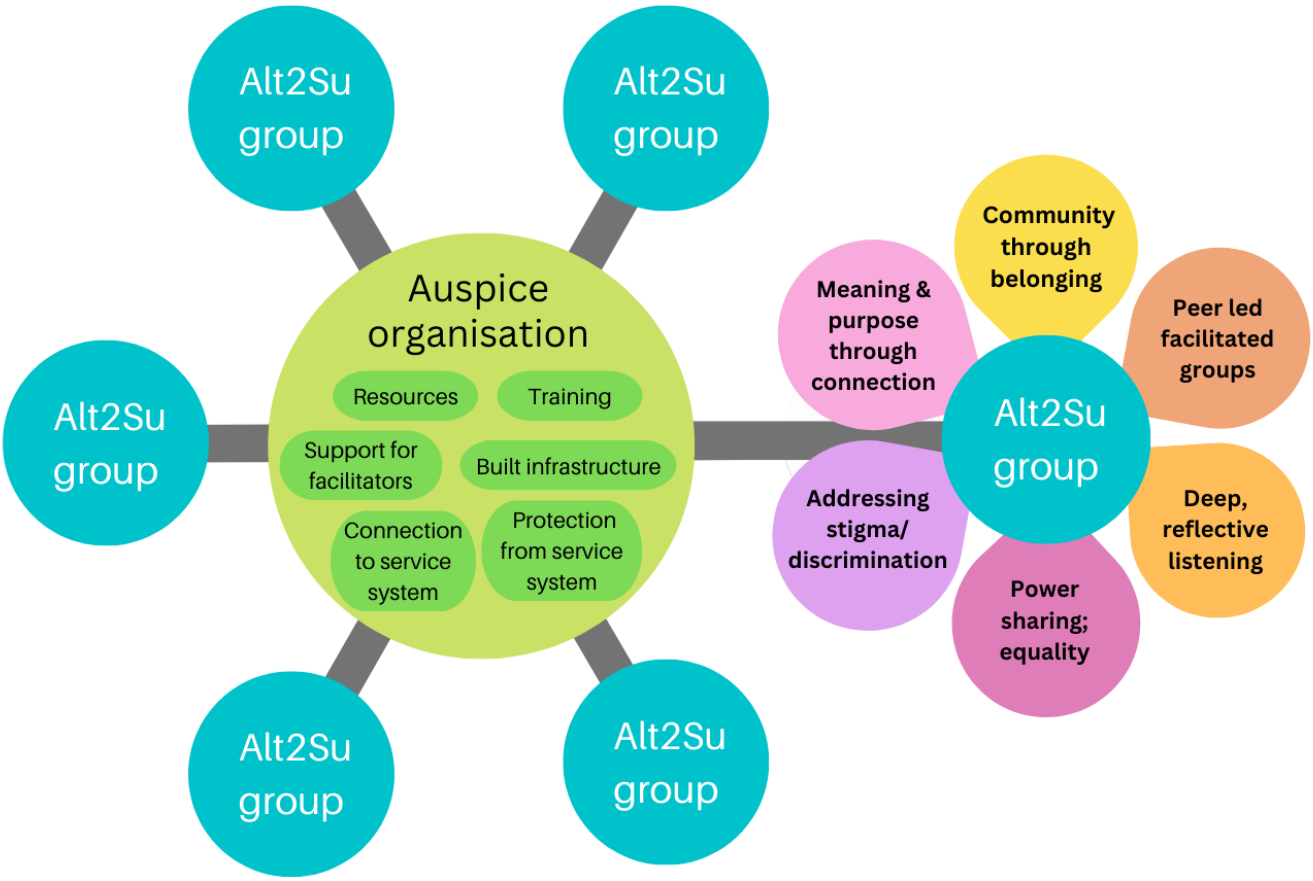


Figure 3: Alt2Su and Auspice Organisational Arrangements

The auspice organisation will, by its nature, operate according to a service delivery logic. Auspice organisations provide infrastructure, training, resources, protection from, and connection to, the mental health system. In some instances, infrastructure might be place-based, or it may be digital. The auspice organisation may also offer important normative infrastructure for consistency and fidelity, with some caveats: there needs to be alignment between the auspice organisation's mission and that of the Alt2Su approach, particularly at the level of values on empowerment, social justice, self-determination, and respect for lived experience. A tension for auspice organisations may be found in adoption of an ethic of non-intervention. This ethic is crucial to the dialogical-relational communicative practices of Alt2Su groups because an emphasis on non-clinical approaches to suicide are part of the Alt2Su critique of the mental health system for perpetrating psychiatric oppression and harm.

Ideally, groups would form from need identified by the community, rather than being imposed as a system driven response. This may mean that the Alt2Su groups emerge for different needs depending on different community contexts. What would make their operations recognisably an Alt2Su group is the adoption of internal processes that incorporate the Alt2Su focus on non-interventionist, peer-led facilitation and dialogical communicative practices (deep reflective listening and engagement), an emphasis on power-sharing and equality of relations. Working with others in groups has a long history in addressing different

experiences of stigma and discrimination (Kenny & Connors, 2017). This means auspice organisations should ideally have infrastructure that prioritises the inclusion of lived experience leadership within the agency remit, as this offers the best possible alignment to the bottom-up aspect of mutual aid.

There are a number of key roles within this configuration that serve as a crucial bridging function between the mutual aid Alt2Su groups and the service system more broadly. These involve the representatives within the auspice organisation and the peer facilitators leading Alt2Su groups. Both roles need a clear understanding of the part each play in the approach. Relationships between peer facilitators and workers from the auspice organisation are therefore critical trust connections. Indeed, trust relationships are part of the relational goods that Alt2Su contributes to the service system. Relational goods are conceptualised as social relations that arise from interaction with others and they have an emergent quality (Donati & Archer, 2015) that contributes to civil society across a range of practical and theoretical dimensions. Donati and Archer (2015) distinguish between primary relational goods and secondary. Primary relational goods have an intersubjective nature—we can see these in relationships that are deeply reciprocal such as friendship and families. They are also present in small groups utilising dialogue, of which Alt2Su is a good example. Primary relational goods are predicated on I-Thou relationships discussed earlier. In contrast, secondary relational goods are generated via impersonal relations such as service provision and engagement in voluntary associations (Donati & Archer, 2015) and equally have their place in contemporary society. Building and maintaining relationships across these boundaries should be seen as a crucial part of the process of establishing, growing and maintaining Alt2Su groups.

This evaluation has clarified the core ingredients of the Alt2Su approach within the context of its translation from the United States into the Australian context. The approach utilises dialogical mutual aid groupwork process that are deeply humanist and democratic. Deep listening and reflection are fostered by peer facilitators for the purpose of building belonging and connection amongst people experiencing suicidal distress. The approach is non-interventionist and non-clinical. Alt2Su groups may arise within the auspice of organisations that are governed by established risk governance practices and this has the potential to create tension. Such tensions may be resolved by ensuring role clarity and relationship building, which are embedded into organisational practices.

Recommendations

The results and analysis of this research are suggestive of some future directions that would support the Atl2Su approach. Future funding arrangements must seek to satisfy the following criteria:

1. ***Trust*:** Because the use and misuse of power has had such deleterious effects on people's lives, deep work to build and maintain trust at all levels (in communities and organisations that interact with or have an interest in Alt2Su), is a crucial ethic to be established. This ethic should be demonstrated towards those in distress, towards facilitators and trainers, and towards bringing about genuine lived experience leadership in the Alt2Su approach's development and delivery in the community. This

involves role clarity and the establishment of relational goods as core to organisational practices that may auspice Alt2Su groups.

2. ***Sovereignty*****:** Work to ensure that Alt2Su operates with a measure of independence from the pressure to adhere to clinical guidelines or protocols that may interfere intersect with the establishment and operation of Alt2Su groups. This will involve work to bring into alignment organisational values of empowerment, social justice, self-determination, and respect for lived experience into the auspices of Alt2Su groups.

3. ***Community*****:** Genuine investment in grassroots community co-designed Alt2Su groups, as opposed to top-down establishment of groups (see Table 4 in the discussion).

4. ***Fidelity*****:** As more and more Alt2Su groups develop, there will no doubt be problems with inconsistency between facilitators/groups if the workload on facilitators is not off-set with appropriate support, training, peer supervision and co-reflection, debriefing and learning that needs to be 'designed in' to the Alt2Su approach. This, plus continual documentation, research, and dissemination of the Alt2Su approach (e.g., charter, literature, resources, and training materials) will help maintain program fidelity as groups are adapted to different local contexts.

5. ***Lived experience leadership*****:** The process of expansion and rollout of further Alt2Su groups should be lived experience led. This may necessitate organisational support and backing, but with an approach that preserves the relative autonomy of Alt2Su groups, and both connects Alt2Su to the mental health service system as well as offering protection from it.

6. ***Resourcing*****:** Appropriate funding and resourcing is vitally necessary for trainers and facilitators, but funding should also account for lived experience leadership and governance, time for co-reflection, debriefing and learning, time and resources for documenting and researching the Alt2Su approach, for public communication and engagement such as community forums on Alt2Su.

7. ***Non-clinical setting*****:** The developing and delivery of Alt2Su groups would benefit from a continual emphasis on its non-clinical model, and delivery and promotion in non-clinical, community settings and contexts.

8. ***Funding arrangements*****:** Key to these recommendations is consideration to resourcing Alt2Su groups as a valued component of the wider mental health system. However, the conditions by which Alt2Su groups are funded and supported will require a paradigm shift approach. Funding from mental health systems is needed to support Alt2Su so long as independence from these very systems is clearly maintained. Future funding models should make resources available for lived experience leadership, training and infrastructure, but without the usual compliance for risk management and strict adherence to clinical governance protocols. Funders need to be open to negotiating risk management, governance, and evaluation practices so that the integrity of Alt2Su is maintained. To be clear, this means Alt2Su groups should maintain their sovereignty (self-determination) as a condition for ensuring their integrity (internal consistency).

Appendix 1: Participant Information Statement

HREC Project Number	HRE2021-0499
Project Title	Alt2Su Research and Evaluation
Chief Investigator	Dr David Hodgson
Co-Investigators	Emery Wishart; Leo Rhodanthe Darcee Schulze; Dr Lynelle Watts
Version Number	2
Version Date	26 June 2022

What is the project about?

This project aims to contribute to the evidence base of Alternatives to Suicide (Alt2Su). With the new LotteryWest funded project to expand Alt2Su groups across Western Australia (WA), researchers from Curtin University, have been subcontracted by ConnectGroups to undertake research with the hopes of evaluating the Alt2Su approach. This evaluation is not an outcomes evaluation, but a *clarifying evaluation*. This means the goals of the research are to understand and define what Alt2Su is, and how it works, rather than what impacts it has on group attendees.

The research and evaluation aims to:

- Describe and articulate the theoretical, ethical and other principles that underpin Alt2Su.
- Explain and conceptualise the Alt2Su program logic, rationale and purpose.
- Describe and articulate the Alt2Su intervention and practice.
- Identify any modifications or improvements that would support the work of Alt2Su.

This study involves researchers speaking to key stakeholders most knowledgeable about the Alt2Su approach through individual and/or group interviews. Key stakeholders include:

- Alt2Su founders from Wildflower Alliance
- Alt2Su trainers and facilitators
- Alternatives to Suicide Western Australia Alliance Group Members and other key stakeholders

Who is doing the research?

Researchers from Curtin School of Allied Health have been contracted by ConnectGroups to undertake this project. This research is lived-experience led, meaning that the interviews will be conducted by Leo Rhodanthe and Emery Wishart from DISCHARGED in WA. However, if

you would feel more comfortable being interviewed by a third party, our Chief Investigator Dr David Hodgson or co-researcher Dr Lynelle Watts will be able to conduct the interviews.

Why am I being asked to take part and what will I have to do?

We are inviting key stakeholders most knowledgeable about Alt2Su to participate in this research and would like to speak to you through a group interview and/or individual interview.

In the interview/s, we will ask questions about Alt2Su, particularly regarding its history, growth and values, in order to create a picture of the approach. You only have to contribute what you feel comfortable sharing, and are not obligated to contribute to this research. The interviews will not involve questions about your personal experiences, unless it pertains to understanding the Alt2Su approach.

If you would like to be involved in a group interview, these will likely be no more than four (4) individuals who have been selected and grouped according to their context. For instance, if you are a stakeholder from the U.S. you will be in a group interview with other stakeholders from the U.S. However, if you are a stakeholder within the Alt2Su Alliance in WA, you will be in a group interview with other Alt2Su Alliance WA members. You do not have to participate in a group interview, but if you would like both a group and individual interview, please inform the research team.

The interview will take up to two hours, be audio-recorded and take place via video-conference, or face-to-face at Curtin University Bentley campus. After the interview, we will make a full written copy of the recording. You will be able to review this transcript and approve it before it is analysed if you would like. There will be no cost to you for taking part in this research.

At all times, researchers will adhere to Western Australian Government restrictions and University advice regarding COVID-19.

Are there any benefits to being in the research project?

There may be no direct benefit to you from participating in this research. However, your contribution may become part of the global understanding of the Alt2Su approach, and may support the growing body of literature around the Alt2Su approach.

Are there any risks, side-effects, discomforts or inconveniences from being in the research project?

There is minimal risk to you for participating in this study. The interview questions we ask will not involve questions about your personal experiences, unless it pertains to understanding the Alt2Su approach. You only have to contribute what you feel comfortable sharing, and are not obligated to answer any question that you do not want to answer. You can also stop the interview at any time. If you need support, the researchers are available to debrief and provide support immediately after the interview, or at a time of your choosing. We are able to provide support over the phone, via email or direct message.

Who will have access to my information? What will be done with the information I provide?

Any information we collect will be treated as confidential and used only in this project unless otherwise specified. Confidentiality will be discussed in the group interviews to encourage people not to share information with others outside the group. However, it is possible that what is discussed in the group interview may be shared with someone outside the group. The people who will have access to the information we collect in this research include:

- The research team, and
- In the event of an audit or investigation - staff from the Curtin University Office of Research and Development.

To provide anonymity, we will remove identifying information from the data collected and replace it with a pseudonym (fake name) or code when we analyse the data.

We acknowledge that some people might wish their name to be included in the final report so that their historical and ongoing contribution to the Alt2Su approach is formally recognised. This is optional and subject to your consent. If you wish to have your name included in the final report, please let the research team know.

Electronic data will be password-protected and stored on Curtin's secure network (i.e. RDrive). The hard copy data will be in locked storage at Curtin University. The information we collect in this study will be kept under secure conditions at Curtin University for 7 years and then it will be destroyed.

The results of this research may be presented at conferences or published in professional journals. You will not be identified in any results that are published or presented.

Do I have to take part in the research project?

Taking part in a research project is voluntary. It is your choice to take part or not. You do not have to agree if you do not want to.

If you decide to take part and then change your mind, that is okay, you can withdraw from the project. You do not have to give us a reason for withdrawing.

If you decide not to participate or change your mind and withdraw from the project, it will not affect your relationship with Curtin, the researchers or ConnectGroups.

If you choose to leave the study, we will ask you if we can use any information you have shared.

What happens next and who can I contact about the research?

If you would like to participate, or have any questions, please contact one or both of the following researchers below.

Leo Rhodanthe (they/them) at leo.rhodanthe@curtin.edu.au

Emery Wishart (he/they) at emery.wishart@curtin.edu.au

You can also contact Dr David Hodgson (he/him) with your questions at david.hodgson1@curtin.edu.au or Dr Lynelle Watts (she/her) at lynelle.watts@curtin.edu.au.

If you decide to take part in this research we will ask you to provide consent by signing the consent form or by giving verbal consent on the audio recording. By providing consent, you are telling us that you understand what you have read and what has been discussed. Giving consent indicates that you agree to be in the research project.

Please take your time and ask any questions you have before you decide what to do.

You will be given a copy of this information and the consent form to keep.

Curtin University Human Research Ethics Committee (HREC) has approved this study (HREC number HRE2021-0499*). Should you wish to discuss the study with someone not directly involved, in particular, any matters concerning the conduct of the study or your rights as a participant, or you wish to make a confidential complaint, you may contact the Ethics Officer on (08) 9266 9223 or the Manager, Research Integrity on (08) 9266 7093 or email hrec@curtin.edu.au*

Appendix 2: Participant Consent Form

HREC Project Number	HRE2021-0499
Project Title	Alt2Su Research and Evaluation
Chief Investigator	Dr David Hodgson
Co-Investigators	Emery Wishart; Leo Rhodanthe Darcee Schulze; Dr Lynelle Watts
Version Number	3
Version Date	26 June 2022

By giving consent, I agree to the following:

- I have read the information statement version provided and I understand its contents.
- I believe I understand the purpose, extent and possible risks of my involvement in this project.
- I voluntarily consent to take part in this research project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I understand that this project has been approved by Curtin University's Human Research Ethics Committee and will be carried out in line with the National Statement on Ethical Conduct in Human Research (2007).
- I understand I will receive a copy of the Information Statement and Consent Form.

☐ yes	☐ no	I give consent to being audio-recorded.
☐ yes	☐ no	I give consent to the researchers using any data I provide before withdrawing from the study, if relevant.
☐ yes	☐ no	I give consent to the researchers using my real name in the final report and other publications and presentations.
☐ yes	☐ no	I give consent for the researchers to contact me about other related studies.
☐ yes	☐ no	I give consent to the use of my information in future ethically-approved research projects related to this project.

Participant Name	
Participant Signature	
Date	

Declaration by researcher: I have supplied the Participant Information Statement and Consent Form to the participant who has signed above.

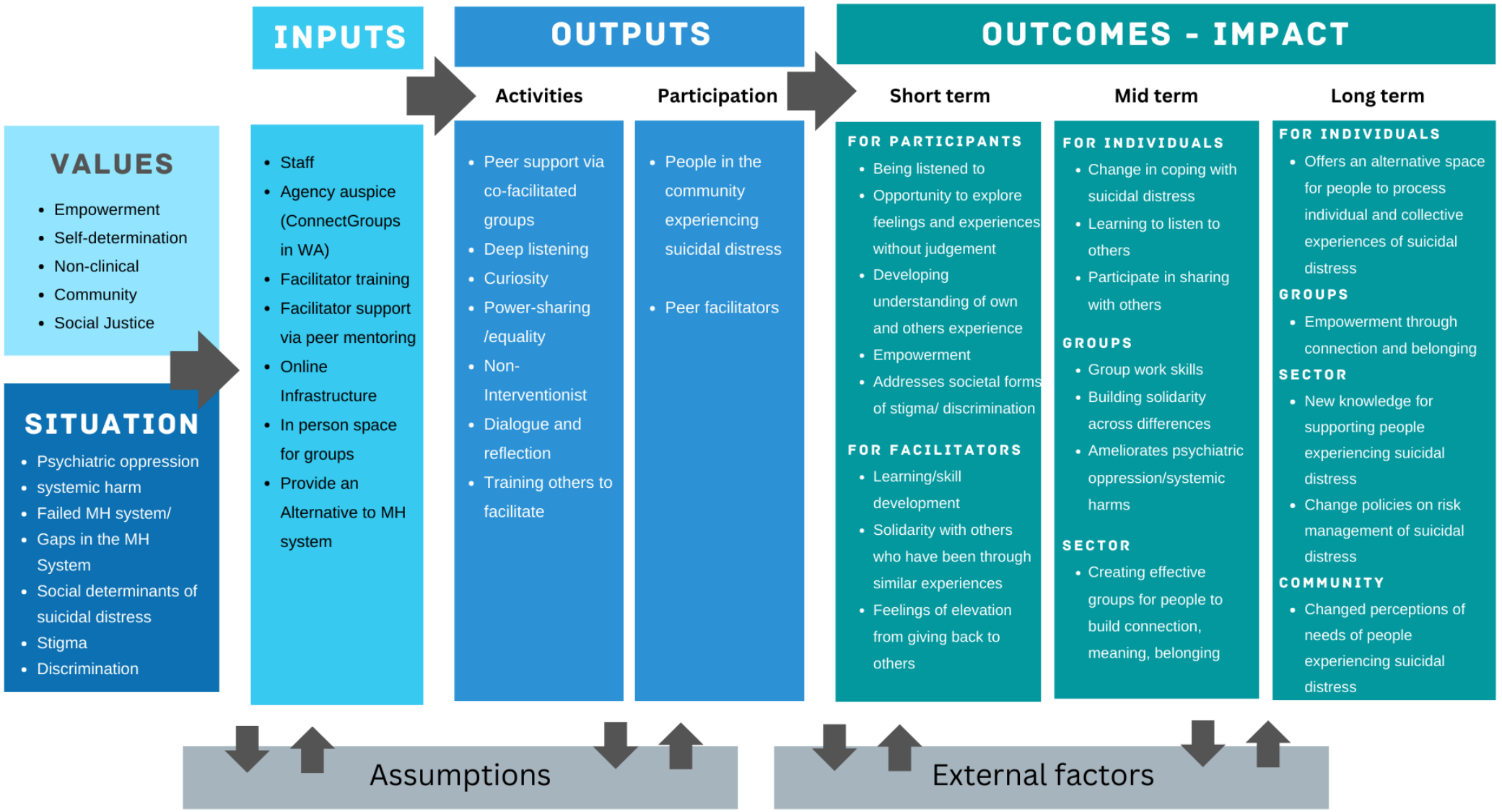
Researcher Name	
Researcher Signature	
Date	

Appendix 3: Interview Tool

1. Can you tell us about what your personal involvement in Alt2Su has looked like?
    a. What were your personal motivations for being involved in Alt2Su?
2. How would you define Alt2Su?
    a. What values are an essential part of Alt2Su?
    b. What are the purposes of the Alt2Su approach?
    c. How does Alt2Su incorporate social justice into practice?
    d. What does Alt2Su represent?
    e. What are the goals of Alt2Su?
3. Can you tell us why you think Alt2Su emerged?
    a. How did Alt2Su emerge?
    b. Where did Alt2Su come from?
    c. Why is Alt2Su important?
    d. What does Alt2Su mean for the broader community?
    e. Why is Alt2Su gaining popularity?
4. How is Alt2Su different from other frameworks or models?
    a. If Alt2Su were similar to any other approaches what would those approaches be? What do they look like?
5. What does facilitating an Alt2Su group look like?
    a. What does setting up an Alt2Su group look like?
6. How do you know that you're using the Alt2Su approach?
    a. How do you know if you're no longer "doing" Alt2Su?
    b. To an observer, what would it look like to move away from the Alt2Su approach (in conversation/group/practice)?
7. What are some things that prevent the practice of Alt2Su?
8. What has been the process for establishing Alt2Su as an alternative response to suicidal distress?
    a. At a system level?
    b. In the community?
    c. At a personal level?

9. Can you describe what the growth of Alt2Su has looked like over the years?
10. Have there been any barriers for the Alt2Su approach?
    a. How have the barriers been navigated?
    b. When faced with a barrier, how have you overcome it to maintain integrity to Alt2Su?
11. What are some of the common beliefs about Alt2Su? From internal (i.e. attendees)/external (i.e. broader community, policy makers, etc.) sources.
12. What is the common feedback about Alt2Su?
    a. How does Alt2Su respond to feedback that suggests the approach be changed?
    b. How is it determined if Alt2Su needs to be changed/improved?
    c. Who determines if Alt2Su needs to be changed/improved?
13. Has Alt2Su changed over the years?
    a. How has Alt2Su integrity been maintained over the years?
14. . Can you tell us a bit about the outcomes of Alt2Su (if any)?
    a. Are there times when Alt2Su has not been able to meet these outcomes?
    b. What prevented the outcomes from being met?
    c. Are there any unintended outcomes of Alt2Su? What are they?
15. What are some of the limitations of the Alt2Su approach?
    a. If Alt2Su could be improved, what might that look like?
16. What does Alt2Su need to flourish as an approach?
    a. What enables Alt2Su's success?
    b. What do you see as the future for Alt2Su?
17. What do you think would help more people understand and recognise the Alt2Su approach?
18. Is there anything else you would like to share about Alt2Su?

Appendix 4: Program Logic Model



Appendix 5: Data Codes

Theoretical and Conceptual Dimensions of Alternatives to Suicide

Similar to the Hearing Voices approach. Non-clinical (no risk assessments), peer support (lived experience led), Peer to peer, lived experience, non-clinical, Lived experience, peer led, non-clinical, non-risk assessment, alternative practice/model, Critical psychiatry, radical, social change, Community development, Movement building, Logical response(?)t, Non-intervention, Antidote to shame, Community owned, Belonging, recognition, meaning, listening, human need, distress, self-acceptance, healing, support, recognition, identity, harm reduction, unlearning, anti-capitalism, social justice, self-determination, decolonisation, spirituality, Harm reduction, Hearing voices approach, Adaptable, community owned, grassroots, deeply human, Hearing voices approach, non-pathologising, non-clinical, no welfare checks/risk assessments, meaning making, Peer support, lived experience, community, Lived experience, solidarity with others, Community, consciousness raising, sovereignty, counters narratives, Liberation, egalitarian, Non pathology, non-risk averse, survivors movement, peer consumer movement, hearing voices movement, safe spaces, suicide not the problem is solution, Non-medical, non-pathologising, empowerment, meaning of experience, suicide is not the problem, the problem is the problem, emancipation, anti-oppressive, anti-stigma, inclusion.

Values and Ethical Principles

Non-judgemental, non-clinical, respect, voluntary, hope, Belonging, normalising experience, non-judgemental, safe, empowerment, choice, Hold space, Myth of chemical imbalance, Social justice, No assumption of illness, Challenge social norm, Peer led, Outside the system, Lived experience driven, Community led, Responsibility to, not for or over, Dialogue, Non-clinical, Suicide as a human response, Suicide as a rational response, Non-intervention, Determination, generosity, commitment, freedom, integrity, Consent, choice, more options, own decisions, liberty, human rights, authentic selves, suicide not the problem – is solution (what are the conditions of?), Community, whole selves, being vulnerable, VCVC, paradigm shift (no force/coercion, no pathology, no risk aversion), collective responsibility, liveable world, asking why, being curious, supportive community, non-clinical, empowering, learning, exploring, genuine, unlearning (the clinical model), respect, removing helper/helped (or sick/well) binary, collective vulnerability, self-determination, decolonisation, Unlearning (the clinical model), Dialogue, Humility, service, local, Humaneness, connection, solidarity, authenticity, genuineness, valuing others, Anonymity, confidentiality, safety, autonomy and choice, honesty, transparency, Non-judgemental, non-stigmatising, Lived experience, beyond biomedical model, peer led, human, curiosity, friendship, Personal experts, meaning making, openness, curiosity, non-clinical, self-determination, humility, respect, honesty, Diversity, identity, community, autonomy, rights, empowerment, community, choice, self-determination, Valuing humanity, respect, trust, rights.

Rationale

Non clinical suicide response, Psychiatric oppression, dehumanisation, distress (from clinical model), Gap in services, System is causing harm, Nowhere to talk about suicide, Filling a gap, system isn't working, Community wants peer-led options, Listening to lived experience, Something new, avoiding interventionism, silencing, othering, 'indoctrination', paternalism, choice, Problems (contrast) with clinical model, failure of risk assessments, unable to talk about suicide, medicalisation of distress, lack of choice in clinical system, harm from clinical system, suicide = medical problem (pharma), social determinants of distress, blaming individual, negative consequence of talking about suicide, clinical approach creates barriers, System isn't working, Loss of personal power in clinical system, Gap in services, unmet needs, simple, misunderstanding, isolation, services, holding space, Tick box clinical approach limited, disillusions with risk assessments/hospital/ambulances / welfare checks (harm), Suicide problem not being resolved, problem of the clinical interventive model, Safe space, community, belonging, Beyond biomedical model, rebellion, stronger communities, freedom, unmet needs, unsafety, autonomy, consequences, Stigma, unheard, healing, clinical, paternalism, growth, norms, othering, online groups, intervention, High suicide rates in specific groups, racism, sexism, discrimination, gap in the system/sector, failure of clinical model, trauma, disempowerment, Injustice, loss of control, oppression, gap in the system, disconnection.

Purpose

Change the system, fill a gap in the system, Belonging, safe spaces, lived experience voice, sense of purpose, A movements for change, A place to talk about thoughts of suicide, As proof peer initiatives work, Empowering people to move through their own distress, Create choice, Alternative to suicide prevention, support without strings attached, presence, connection, unlearning, Social movement/social change, paradigm shift, creating community, authenticity, speaking freely, connection, belonging, talking (conditions of life/living), being heard and understood, advocacy (change, systems), consciousness raising, building more options and choices, harm reduction, isolation reduction, healing, unlearning, community building, individual and interpersonal transformation, empowerment, decolonisation, Talk without consequence, Social movement, Collectivism, Community, connection, healing, being seen, valued and understood, Belonging, building and prioritising community, life worth living, connection, contextualisation, mutual care, meeting needs, being heard, friendship, Healing, learning, exploration, meeting different needs, merging complex individual worlds, being heard, sharing/shared experiences, Connection, emancipation, poor treatment of suicidal people, consciousness raising, not a ‘fixit’, Connection (with self and others).

Practices

Peer support. Building trust. Listening. Strategic development (policy advocacy), networking, alliance building, promotion, Share stories, share experience, equal participation, lived experience expertise, listening, Support group, co-facilitation, community connection, yarning circles, Increasing involvement, Group practices: honest, transparent and present; responsibility to and not for over; attendance fully self-determined; Space for big feelings, No risk assessments, No clinical supervision, No escalation, No Fixing or rescuing. Meaning making, Reconceptualisation of experiences; Profound; Exploring alternate understandings of distress; Life changing. Facilitation: Burdensome, Uncomfortable, Fear, takes commitment, VCVC – validation, curiosity, vulnerability, community, Guiding others, Debriefing, Reflection, Co-reflection, Sacrifice, Problems if shifts away from Charter. Coordination: Amorphous, Supporting facilitators, Logistical support, High drop off rate of facilitators. Roadblocks: Problem solving, Infuriating, Burnout, Unreliable facilitators, Supportive management, embedding the approach, Community development, Community mobilisation, Community forums, need allies, Relationships with funding bodies, Systems advocacy, Clinical governance exemptions, Higher risk tolerance, paying facilitators, Charter as advocacy tool, Parallel processes, Layers of support, staying true to the approach, Supervision, learning from experience, Sharing of knowledge. Group practices: ‘Be with’ instead of ‘do to’, Empower, being present, Connection, Dialogue, Connection, being understood, In-person, Online, create community., Not: Taking power away, Trying to fix, Risk focused, Power over, Medicalising distress, Goal oriented. Facilitation: Trust, embrace uncertainty, Peer-to-peer support, lived experience, cohesive approach. Not: intervention, risk assessment, ‘wraparound’ support, not run by professionals, no clinical setting, clinical power, silencing, saving, fixing, problem solving, Non-clinical, community focus, listening, self-acceptance, sharing, hearing, exploring, speaking without negative consequences, connecting, unlearning, being with others, human connection, explore root cause, self-awareness and self-check in, owning your own fears, cohesive approach, adaptable, culturally appropriate, slowing down, not just for groups, support for facilitators, self-determination. Not done: ‘you’ statements, yes or no questions, asking no questions at all, no agenda, not trying to control others, coming from a place of fear, risk management, diagnosing, assessment, not outcomes focused, no treatment plans, Process of development: Asking community, Continual improvement, Unlearning the system, Development of Charter, Not: Using consultation to replicate bias to system approach, Group practises: Open-ended questions, No topic off limits, Open attendance, Dialogue, Invitation to speak, Group culture of values, Community forum to realign to Charter, Not: Gate keeping who can attend, Forced turn taking, Fixing, Power over responses, Held in clinical environments. Facilitation: Balancing act, Facilitator owns their own distress, accepting not in control, facing uncomfortableness, Can lead to deeper involvement. Advocacy: Training, Teaching clinicians, Takes time, Using the approach broadly, Focus on power imbalances, Challenging, complex, commitment, generosity, precarious, mutual aid, colonialism, local, service, burnout, holding space, togetherness, pre-planning, labour of love, Empathy, connection, listening, recognition, curiosity, unconditional positive regards, power sharing, challenge ableist language, non-rescue, Dialogue, sharing experience, power sharing, group process, listening and reflecting, Relationship building, safety, checking in, sharing/listening. Participation (equality), Commitment, shared responsibility, lived experience leadership, relational safety, inviting suicide, exploration, standing up to oppression, voluntary, decentred facilitators, trust, modelling, holding space, humility, vulnerability, power balancing, curiosity, intimacy. Not: risk assessment, safety protocols, rescuing, asserting dominance, authority, procedure, scripted conversations, categorising others, using power, complicity in charter violations, further referrals, Non-directive, exploration, conversational safety nets, listening, deconstruction, open meaning making,

encouraging reflection, non-judgemental, curious, light touch facilitation, prudence, shared responsibility, mutuality/facilitation(?), consistency in values, modelling, validation, emotional safety, gentle, power balancing, noticing, adaptation, self-awareness. Not: leading, no clinical experts, no force, giving advice, Connection, honest conversations, permission to speak, meaning making, make own decisions, no gatekeeping, co-reflection, co-facilitation, curiosity, Deep listening, understanding, curiosity, co-reflection, debrief, deeply exploring experiences, non-intervention.

Improvements and recommendations

ATS needs an organisation home/context, training support/supervision/debriefing for facilitators, funding, non-clinical setting, hands-off support (governance), groups for different demographics (e.g., older men, victims of FDV), Funding, non-clinical setting/governance. Barriers: need funding, lack of resourcing, clinicians are risk adverse, Society caught in medical model, too radical, Not well known, living experience of suicidal thoughts, Lack of ways to join the movement, Lack of people power, Facilitator commitment is onerous, Interpersonal dynamics, Group problems, Facilitators aren't supported enough to have honest co-reflection. Opportunities: Places for facilitators to share about their own stuff, increase low-commitment opportunities, Community of practice, Parallel processes, when conversations turn to suicide training. Improvements: Reliant on individuals' personal investment, Clear articulation of Alt2SU, Barriers: Funding, Clinical governance, Lack of understanding, Dependent on relationship/allies, Low risk tolerance, Co-option. Opportunities: Community training, Community forums, Support for families, Misunderstandings, the cost of association, peer workers, resources for sustainability, facilitator support (training, co-reflection, venues), online development, myth busting, support, Intense resistance to letting go of power ('put down power-over roles), 'make our world more liveable', accepting suicide is solution not problem, increasing choices to more options, investment in community, more allies, myth busting at all levels (I.e., not just a dark space for talking about killing ourselves etc.), groups have limited time on them – need to transform the community approach to suicide with conversations training, improve access by seeding more groups, adaptations which make alt2su applicable to various communities, building 'a deep trust', financial investment, Improvements: Website, Easy to find information. Barriers: Perception of mandated reporting, Needing to be evidence based, Duty of care for under 18s, Resourcing and financial investment. Opportunities: Groups for young people, Resources for families and friends, Advocacy tools, Community investment, organisations, risk management, importance of values in implementation processes, sustainability, support, absence of collective responsibility, advocacy, solidarity, co-optation, overworked community, reaching the everyday person, availability, Maintain fidelity, care in clinical settings (if at all), supervision and high quality training, Support from mental health orgs, systems, Support from community and local councils, facilitator support, health/mental health professional education, visibility, training and nurturance of new facilitators, funding, co-optation, more population/community specific groups, awareness of systems of oppression, educating community, under 18s, consistency, cultural change, Facilitator consistency, support for facilitators, governance and scalability, word of mouth, normalise autonomy, financial support and investment, problem solving, suicide prevention, Paid facilitation, lived experience governance, lived experience project management, organisational readiness, More trainers/facilitators/venues, promotion and recruitment of facilitators.

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