"What Supports and Hinders Sustainability in Suicide Prevention Peer Work? A Systems Perspective"

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Abstract

Objective: Little is known about how organisations can best support the Suicide Prevention Peer Workforce. The present study sought to identify and understand the systemic barriers and enablers influencing the sustainability of Suicide Prevention Peer Work.

Method: 12 participants elected to participate, majority of whom were currently or previously employed as Suicide Prevention Peer Workers. Qualitative research involving focus groups and individual interviews were used to identify and understand how various systemic factors inhibited or empowered each participant's professional practise. Transcripts were analysed using Reflexive Thematic Analysis and a Dialogical analysis.

Results: Three primary themes emerged from the data: (1) *"Passion and Good Work, There's Plenty of That"*; (2) *"Poor Preparation for Peer Integration"*; and (3) *"Is There an Up?"*. Participants reported that limited career opportunities, low pay, and devaluing of Lived Experience expertise were barriers to sustaining their professional practise. Accessible supervisory support and improved understanding of the peer work role were among some of the systemic enablers.

Conclusion: In conclusion, this research makes a novel contribution to the identification of the systemic barriers and enablers influencing the sustainability of Suicide Prevention Peer Work. The present study offers several recommendations to stakeholders to improve the working conditions of the Suicide Prevention Peer Workforce.

Keywords

Suicide Prevention Peer Work

Systemic Barriers

Systemic Enablers

Lived Experience

Reflexive Thematic Analysis

Dialogical Analysis

Co-Design Research

Key Points

What is Already Known About this Topic:

1. Suicide Prevention Peer Workers are continuously confronted with various systemic barriers that impact the sustainability of their professional practice.

2. Poor compensation and a lack of Lived Experience leadership in the workplace were among some of the previously identified systemic barriers.

3. Little is known about how to best sustain Suicide Prevention Peer Workers in their professional practice.

What this Topic Adds:

1. Detailed insights into the systemic barriers and enablers influencing the sustainability of Suicide Prevention Peer Work. Poor compensation and limited career progression opportunities were some of the barriers most frequently cited by participants.

2. Recommendations for stakeholders for how to best improve the working conditions of the Suicide Prevention Peer Workforce. Ensuring Lived Experience expertise is valued equally to other types of professional expertise emerged as an important recommendation.

3. An example of how co-design research can elevate Lived Experience expertise throughout all phases of the research process.

Introduction

How Can We Support and Sustain the Suicide Prevention Peer Workforce? Reflections from a Unique and Emerging Field

Suicide Prevention Peer Workers are individuals with a Lived Experience of suicide who support and advocate for individuals experiencing suicidal distress (NSW Ministry of Health, 2020). A Lived Experience of suicide may include a personal experience of suicidal crisis or suicide attempt(s), suicide bereavement, or caring for a loved one following a suicide attempt (National Mental Health Commission, 2025, p.92). Suicide Prevention Peer Workers offer a non-clinical approach to mental health care, utilising their Lived Experience to offer hope and psychosocial support to the individuals and communities in their care (Roses in the Ocean, 2025).

A Suicide Prevention Peer Worker's Lived Experience of suicide is their first and foremost qualification, but they may also choose to complete additional training, such as a Certificate Four in Mental Health Peer Work or Intentional Peer Support training (Neami National, 2025). Suicide Prevention Peer Workers may work in hospitals, community outreach, public health, non-government organisations, or in programs targeting suicide prevention specifically (Australian Government Department of Health, Disability and Ageing, 2021).

Suicide Prevention Peer Workers strive to uphold a myriad of peer work values and guiding principles, namely those of equality, self-determination, choice, and hope (Byrne et al., 2021). It can be challenging for Suicide Prevention Peer Workers to uphold these values when working under clinical models of mental health care that endorse antithetical values, such as power, restraint, and forcible treatment (Fennell, 2010; Gooding et al., 2018).

Existing clinical models of mental health care are often criticised for endorsing a stringent biomedical approach that deemphasises the social and environmental influences that contribute to mental illness (Deacon, 2013; Engel, 1977). These intensively risk-averse models may force people experiencing mental ill health into treatment they do not want, which is often experienced as traumatising and frightening (Department of Health and Social Care, 2018; Gooding et al., 2018; Foxlewin et al., 2012). Non-clinical approaches to mental health care, such as peer-led 'safe spaces' are regarded by service users as a safer, preferrable alternative to presenting to the emergency department in suicidal distress (Chakouch et al., 2025). These approaches attempt to strike a more nuanced balance between maintaining client safety and respecting an individual's dignity of risk (National Mental Health Strategy, 2013). Respecting an individual's dignity of risk involves respecting a person's right to make decisions that involve risk or harm to themselves (NSW Department of Communities and Justice, 2025). This should not be misconstrued with being passive or non-interventionalist; rather, it involves supporting an individual to decrease or remove risks to self without restricting their own decision-making capacities (Davidson, 2025; NSW Department of Communities and Justice, 2025).

The National Suicide Prevention Strategy: Implications for the Suicide Prevention Peer Workforce

The 2025-2035 National Suicide Prevention Strategy outlines a range of recommendations to address the unacceptably high rates of suicide in Australia (National Mental Health Commission, 2025). Many of these recommendations relate directly to the provision of the Suicide Prevention Peer Workforce, namely Action 14.2b, which advises that a nationally consistent approach to *"attract, train and retain"* (p.88) the Suicide Prevention Peer Workforce should be prioritised. This nationally consistent approach would involve greater consistency in training and workplace supports for Suicide Prevention Peer Workers,

better integration into existing service delivery structures, accessible and affordable training, increased access to supervision, and greater professional development. The National Strategy also recommends that the organisations who manage Suicide Prevention Peer Workers must develop a greater understanding and appreciation of the value of Lived Experience expertise.

Factors Influencing the Sustainability of Peer Work Practice: What is Already Known

Whilst most of the literature is not specific to Suicide Prevention Peer Work, Ahmed et al. (2015) described some of the professional challenges experienced by mental health peer workers in the Georgia Mental Health Networks; these difficulties included poor compensation, limited job opportunities, and workplace stress. They also identified that mental health peer workers desired additional training opportunities and supervision; importantly, however, they stipulated that this supervision must be delivered by recovery-oriented professionals that *"champion"* peer-led services (p. 435). Using a similar sample from an Australian population, Scanlan et al. (2020) identified that mental health peer workers desired greater career progression opportunities, such as senior peer work roles. They identified a lack of understanding about peer work as a barrier to sustaining their professional practice, and rated supervision provided by a senior peer worker as more satisfying compared to supervision provided by non-peers.

A recent study from Riddell et al. (under review) explored how a group of Suicide Prevention Peer Workers experienced a Community of Practice established by the Illawarra Shoalhaven Suicide Prevention Collaborative. The results indicated that an inter-organisational, peer-driven Community of Practice was regarded positively by participants. Somewhat unexpectedly, however, participants within this study also raised numerous concerns related to the sustainability of Suicide Prevention Peer Work. Some of these concerns included poor pay for Lived Experience workers, pay differences between clinicians

and Suicide Prevention Peer Workers, and a lack of Lived Experience leadership in mental health care organisations. According to Mackay et al. (2022), unanticipated information that is offered independent of a research question is highly valuable and warrants additional exploration. As such, the present study intends to expand upon the systemic barriers initially identified in Riddell et al. (under review) due to their evident importance to the Suicide Prevention Peer Workforce.

Psychological Safety in the Workplace: A Systems Perspective

Decades of research on workplace safety has had a disproportionate focus on the physical, rather than the psychological determinants of professional wellbeing and longevity (Dong et al., 2024). A psychologically safe workplace is integral in maintaining job satisfaction, negating burnout, and improving professional performance (Dong et al., 2024; Rossler, 2012). For too long the onus has fallen on the individual, rather than the organisation to address the systemic factors that create psychologically unsafe working conditions for mental health workers (Rossler, 2012; Siddique et al., 2024). Whilst individual coping skills such as maintaining self-care and accessing social supports are helpful proponents of wellness, the effectiveness of such strategies are easily undermined when broader, system-level factors are left unaddressed (Kaapu et al., 2024). A study from Hawgood et al. (2023) identified that better support is needed from the systems that employ individuals with a Lived Experience of suicide. These supports included better remuneration, greater flexibility in working arrangements, and increased access to employee assistance programs (EAPs).

Whilst Hawgood et al. (2023) offered valuable insights into the factors that are impacting the sustainability of Lived Experience work in suicide prevention, their sample was not specific to the Suicide Prevention Peer workforce; only three out of thirteen participants were employed as Suicide Prevention Peer Workers. Most participants in this

study worked in Lived Experience advisory groups, strategic planning for suicide prevention, or had contributed to the co-design of suicide prevention services. To the authors' best knowledge, no study has been dedicated to identifying the systemic changes that are necessary in the context of Suicide Prevention Peer Work specifically. The present study intends to address this prominent gap in the literature.

The Present Study

The present study aims to identify and understand the systemic barriers that are limiting ongoing participation in the Suicide Prevention Peer Workforce. Conversely, we also hope to understand what systemic enablers can foster sustained participation in the Suicide Prevention Peer Workforce. In identifying these barriers and enablers, we hope to understand what system-level changes are necessary to improve the working conditions of Suicide Prevention Peer Workers. If Suicide Prevention Peer Workers are better supported by the systems and organisations that they work under, they can continue providing an extremely valuable service to the community in a psychologically safe and sustainable manner.

Materials and Methods

Positionality Statement

The first author, Ava Riddell, is a Master of Clinical Psychology Student living and working on Wodi Wodi land. She is a white, cisgendered woman with a Lived Experience of suicide bereavement. The last author, Dr Anna Sidis, is a cisgendered European White settler living and working on Wodi Wodi land. She is a Critical Clinical Psychologist who is interested in privileging lived and living experience in research and care related to human distress. She has over 20 years' experience supporting young people and families during suicidal crisis and is interested in systemic and community-based responses to suicide. The remaining co-authors were a diverse group of researchers, most of which had a Lived Experience of suicide. Some worked currently or previously as Suicide Prevention Peer Workers; others worked more broadly in suicide prevention advocacy roles.

Participants

The sample comprised of 12 participants (six male, six female) between 20 to 67 years of age. Most participants had a Lived Experience of suicidal ideation, although some had also been bereaved by suicide, or had cared for someone following a suicide attempt. 11 of the 12 participants were currently or previously employed as Suicide Prevention Peer Workers. Years of experience in a Suicide Prevention Peer Work role varied from under 2 years to over 20 years. One of the participants (P3) had interviewed for various Suicide Prevention Peer Worker roles but was yet to secure a position at the time of their focus group. P3 had completed training in mental health peer work and had experience working in suicide prevention advocacy.

Nine participants engaged in focus groups [P1, P2, and P3 participated in Focus Group One; P4, P5, and P6 participated in Focus Group Two; and P7, P8, and P9 participated

in Focus Group Three]. P10, P11 and P12 participated in individual interviews due to last minute cancelations from other focus group members. Participants were geographically dispersed, working in both rural and metropolitan areas across Australia. Participants worked across government and non-government organisations.

Data Collection

Prior to data collection, the present study received ethics approval from the University of Wollongong's Human Research Ethics Committee [HREC 2024/317]. A study advertisement with an invitation to participate was emailed through the Illawarra-Shoalhaven, Bega-Valley and Eurobodalla Suicide Prevention Collaborative's mailing list. Invitations to participate were also emailed to professional contacts by the researchers to support the recruitment process. Individuals who wished to participate reached out to the first author via email to access the Participant Information Sheet and Written Consent forms. After consent was obtained, participants completed a demographics questionnaire asking for each participant's age, gender, and years of experience in a Suicide Prevention Peer Work role [see Appendix A].

Once consent and demographic information was obtained, the first author liaised with each participant over email to organise a convenient focus group time. Each focus group lasted for 120 minutes. The three individual interviews lasted for approximately 90 minutes each. All focus groups and interviews were conducted online, over the meeting platform 'Zoom'. All focus groups and interviews were facilitated by the first author. Focus Group Two and P11's Interview were co-facilitated with the second author. Focus Group Three and P12's Interview were co-facilitated with the third author. The second and third authors were Lived Experience researchers. They were unable to co-facilitate every focus group and interview simply due to scheduling conflicts.

The three focus groups and three interviews were audio recorded and saved on a Microsoft Teams site, which was provisioned by the local university. Focus group and interview audios were transcribed manually by the first author.

Methodology: Co-Design Research

Co-design research involves an ongoing partnership between individuals with Lived Experience and traditional researchers. The intention of co-design is to produce meaningful research outcomes that are sensitive to the needs of Lived Experience communities (Bellingham et al., 2022). Co-design research is done *with* individuals with Lived Experience; not *to* them (National Disability Research Partnership, 2025). It is partly inspired by the 'nothing about us without us' consumer movement; a movement which advocates for the inclusion of consumers and communities in discussions that directly impact their health and wellbeing (Jackson & Moorley, 2022). In ensuring that Lived Experience expertise directly informed all phases of the present study, it is our hope that the results of this research better reflect the needs, perspectives, and experiences of the Suicide Prevention Peer Workforce.

Project Team

To endorse a co-design approach, the first author established a Project Team comprised of individuals with a Lived Experience of suicide, researchers from the University of Wollongong, and members of the Illawarra-Shoalhaven, Bega-Valley and Eurobodalla Suicide Prevention Collaboratives. As such, individuals with a Lived Experience of suicide were actively involved in the planning, recruitment, data collection, data analysis, and distribution of this research. The Project Team met online on two occasions for one hour and were regularly contacted via email. They also convened for an additional two-hour meeting to conduct a Dialogical analysis on de-identified focus group and interview transcripts. The

second and third authors, who were also Project Team members, co-facilitated some of the focus groups and interviews. They were included as facilitators to endorse a co-design research framework and to foster a stronger sense of safety amongst participants during the data collection process.

Data Analysis

Phase One: Developing Focus Group Prompts

Focus group prompts were created by the first author and reviewed by the last author. The results from Riddell et al. (under review) were used to inform the focus group prompts. The Project Team elected to develop focus group prompts (i.e. statements), rather than questions to avoid being overly directive and eliciting invalid responses from participants (Mackay, 2022). These prompts were then reviewed by the Project Team to ensure that they were relevant to the project aims. Some statements included *'Suicide Prevention Peer Workers are encouraged – explicitly or implicitly – to work in alignment with peer work values'* and *'Lived Experience leadership and expertise is necessary in all suicide prevention work'* [see Appendix B for the full schedule of statements].

Phase Two: Analysing De-Identified Transcripts

Once the focus groups and interviews were complete, the first author transcribed each transcript verbatim. Reflexive Thematic Analysis was then conducted for each transcript, following Braun and Clarke's (2019, 2021) six-step procedure: (1) become familiar with the data; (2) code the data; (3) generate themes from the initial codes; (4) review the initial themes; (5) define and name the themes; and (6) write the final report. As advised by Braun & Clarke (2019), the first author also created a 'thematic map' of the themes and subthemes before proceeding to undertake a Dialogical analysis with members of the Project Team. Our

Dialogical analysis was inspired by the theoretical principles of Dialogical Inquiry, as outlined below:

Phase Three: Dialogical Analysis

Defining Dialogical Inquiry. Dialogical Inquiry is a qualitative analysis technique that endorses multivocality in data analysis and interpretation (Wells et al., 2021). It acknowledges that each researcher brings with them a unique epistemology that will influence how they analyse and interpret qualitative data. As such, Dialogical Inquiry advocates for the inclusion of multiple researchers to broaden the number of data analysts beyond the epistemic stance of the primary researchers. In doing so, Dialogical Inquiry favours a polyphonic theoretical framework, meaning that multiple 'truths' (i.e. interpretations of participant quotes) can co-exist without the need to achieve a unified monological truth (Phillips, 2011; Sidis et al., 2023; Wells et al., 2021).

Operationalising the Dialogical Analysis. Following a thorough Reflexive Thematic Analysis, the Project Team met for 120 minutes to complete a Dialogical analysis, inspired by the theoretical principles of Dialogical Inquiry. Project Team members collectively analysed de-identified participant quotes, offered corrections to language, and discussed differing interpretations of preliminary themes. After reviewing the feedback from the Dialogical analysis, the first author amended the final report and updated the initial thematic map accordingly. Reflexive Thematic Analysis and a Dialogical analysis were exercised in tandem as they possess analogous epistemologies, being that data interpretation inevitably reflects the experiences and perspectives of the analysts (Braun & Clarke, 2019; Braun & Clarke, 2021; Wells et al., 2021). The first author intended for this Dialogical analysis to function as a powerful countermeasure against the epistemic biases that are inherent to qualitative analysis.

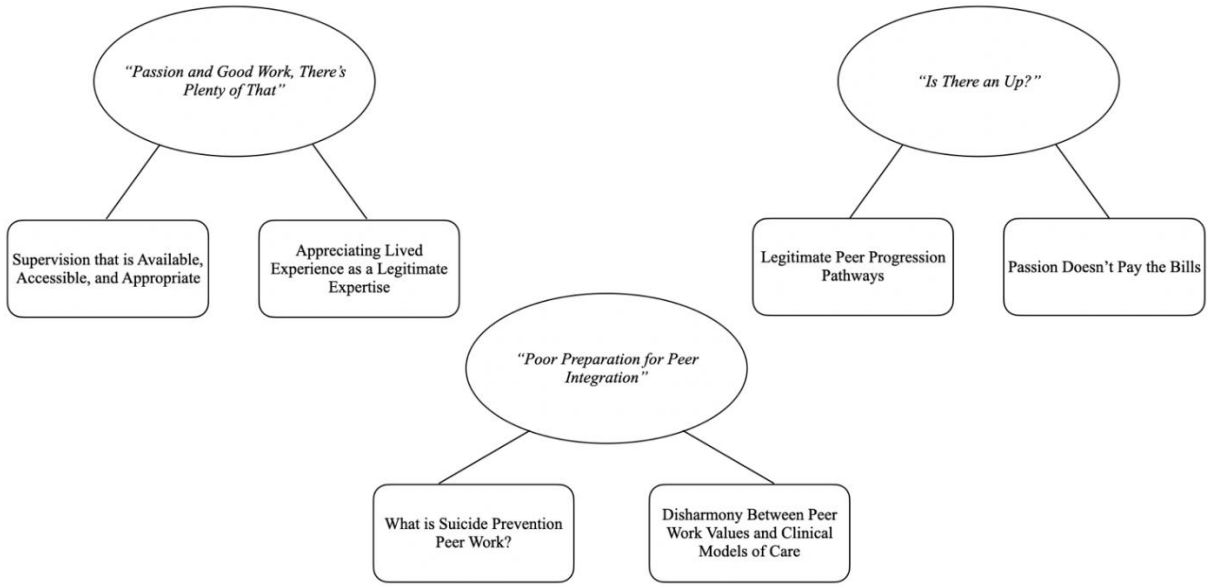
Phase Four: Participant Feedback

Once analysis was complete and results were drafted, a de-identified copy of the results section was emailed to each participant. This procedural decision endorsed a co-design research approach and intended to give participants the opportunity to correct any results they felt were misinterpreted or misunderstood by the analysts. Four participants responded to the review opportunity. All respondents reported that the results felt reflective of the perspectives shared in the interviews and focus groups.

Results

Our analysis of focus groups and individual interviews with Suicide Prevention Peer Workers exploring the systemic barriers and enablers influencing the sustainability of their practice produced three major themes. Each theme and corresponding subthemes are described below, alongside a thematic map:

Thematic Map



(1) *"Passion and Good Work, There's Plenty of That"*

Passion for supporting individuals in suicidal distress attracts Suicide Prevention Peer Workers to their roles, and this passion often leads them to stay, even under suboptimal working conditions. Participant Two explained that *"despite a lot of the barriers"* that she faces, the passion that she feels *"for peer work and, and the peer movement"* keeps her *"showing up every day"*. This theme outlines some of the organisational changes needed to sustain the professional practice of Suicide Prevention Peer Workers. Theme one produced two subthemes:

Subtheme One: Supervision that is Available, Accessible, and Appropriate

Participant's described instances where a lack of accessible supervision created a barrier to sustaining their professional practice. Participant Nine reported that on one occasion, he worked for *"...five months with no supervision and no co-reflection opportunities"* and that he had to seek his own supervision *"...outside of the organisation"* he worked within. Participant Four expressed a similar disappointment when recounting their efforts to initiate supervisory support for a new peer worker at their organisation:

> *"We've got a new peer at our workplace and I'm trying to get some supports in place for this person…he's new and he needs this mentoring support. 'But it's not your job'…whose job is it then? Because no one else is going to do it." [P4]*

Our participants' reflections capture the resourcefulness of the Suicide Prevention Peer workforce, who regularly described finding ways to source supervisory support independently.

Participants frequently referenced the importance of having supervision separate from line managers or people directly involved in the organisation they worked within:

> *"I need the degree of separation so I can open up, talk about things without fear of reprisals within the workspace…it's about having that psychological safety". [P5]*

External supervision was also regarded as helpful by individuals new to the peer work role. Participant Seven noted that whilst external supervision offered "*a fresh take on peer work for me because I'm new in the role',* he noted that this support was *"not always accessible":*

> *"[referencing external supervision] … it's supposed to be two hours and then I had an appointment with a client and had to leave. I had to leave halfway through." [P7]*

Subtheme Two: Appreciating Lived Experience as a Legitimate Expertise

Participants expressed a desire for Lived Experience expertise to be valued equally to other forms of expertise, clinical or otherwise. Participant Eight challenged the misconception that Lived Experience expertise must be accompanied by some form of clinical oversight:

> *"[At my organisation] we've got five people, they're all peer workers. We don't have a clinician at all, and it works completely fine. I think sometimes there's a systemic issue with they feel like they have to hold the hands of a peer worker". [P8]*

Participants were interested in, and open to working with clinicians, but were adamant that Lived Experience expertise should not be subsumed by clinical expertise when working alongside clinicians:

> *"I'm quite happy for clinical services to do what they do. I want them to embrace and listen to what people with Lived Experience can bring..." [P10]*

A systemic devaluing of Lived Experience expertise was also experienced in leadership contexts. Participants were frustrated at the lack of Lived Experience leadership and management in existing mental health systems. Participant Three used an analogy to describe the nonsensical nature of having clinically trained managers, without Lived Experience, manage those with a Lived Experience of suicide:

> *"Doesn't it just make sense, you know? - A train driver, if you've been on all the lines… you've worked there and you've been in the trenches - well, that knowledge combined with your leadership skills makes you a much better person than a person who's never even stepped foot in a train…" [P3]*

Some participants also spoke to the difficulty of having their Lived Experience minimised or erased when moving into leadership or managerial roles:

> *"For example, in a leadership position, if it's service leader, it then removes that title of 'Lived Experience'… now there's been a shift to Lived Experience Lead ... a lot of leaders have felt like if I do move up, then that [Lived Experience element] is lost." [P1]*

(2) *"Poor Preparation for Peer Integration"*

Participants raised concerns that existing mental health systems are poorly prepared to integrate with the Suicide Prevention Peer Workforce. Participants described instances where their professional practice was *"colonised [P6]"* by risk averse, clinical models of mental health care. A lack of understanding of the peer work role, as well as dissonance between peer work values and organisational policies were said to contribute to the erosion of bona fide peer work practice. Theme two produced two subthemes:

Subtheme One: What is Suicide Prevention Peer Work?

A lack of understanding and recognition of the peer work role was identified as a barrier to sustaining peer work practice. Participant One explained how the devaluing of Lived Experience expertise in multidisciplinary teams can often be explained by an "*...inherent misunderstanding of the importance of Lived Experience and the skill set someone with a Lived Experience can have."*

Participants felt that organisations who employ Suicide Prevention Peer Workers have a responsibility to educate non-lived experience staff on the function and value of peer work. Participants expressed frustration that the pressure to advocate for peer work practise continuously falls to the peer workers themselves:

> *"I've had a number of struggles advocating for the peer workforce, peer integration into systems…acceptance of the peer work field of practise". [P6]*

Participant Ten explained how this pressure can be particularly exhausting for peer workers in leadership positions:

> *"If you put one Lived Experience leader into that team, that one person not only has to do their job in supporting the people under them - they also have to fight for their role and try and help the system or the service to understand what the peers do." [P10]*

Subtheme Two: Disharmony Between Peer Work Values and Clinical Models of Care

A lack of compatibility between peer work values and the mental health system was experienced as distressing for majority of participants. Participant Six reflected on peer work values being an *"... aspirational goal in the workplace because they get colonised by clinical values straight away."* Participant Five described how the current mental health system is strongly geared toward clinical, risk-averse practices:

> *"…one thing I wish I had been aware of [before becoming a peer worker] was that the policies that guide the way an organisation or how a service runs are most often not supportive of peer workers working in a way that's true to their values and principles. They set up for a clinical process that's incredibly risk averse." [P5]*

Participants felt that their ability to work in alignment with peer work values was compromised by clinical models with an inviolable focus on risk management. Participants expressed that these models typically do not respect the dignity of risk of those experiencing suicidal distress:

> *"…that idea of dignity risk, it's working from a model where risk is the focus … there's no benefit in it for anyone…" [P8]*

Respecting an individual's dignity of risk allowed participants to focus on providing safety and connection to the individuals they support. Participant Two felt that prioritising safety and connection was much more productive than prioritising restriction and risk aversion:

> *"We don't enter these roles like, 'I'm going to fix this person and I'm going to save this person's life'. [Alternatively], I'm going to provide connection, safety and support to this person, but I fully understand, and I fully accept that they have the right to choose whether they do or don't take their life. And that's a really difficult concept for many people." [P2]*

(3) *"Is There an Up?"*

Participants offered practical insights into the factors influencing the sustainability of Suicide Prevention Peer Work. Participant Eleven noted that there is *"…a really high turnover in this industry of peer workers"* and that *"…there's not a time when we don't advertise for peer workers."* Theme three sheds light on two systemic changes that are required to attract and retain the Suicide Prevention Peer Workforce; *"…pay, and career development"* [P12]:

Subtheme One: Legitimate Peer Progression Pathways

Perhaps one of the most frequently mentioned barriers to sustained participation in the Suicide Prevention Peer Workforce was a lack of career progression opportunities. Participant Eleven noted that *"once you hit that senior peer role, there's no natural progression …".* This lack of natural progression was experienced as disheartening by many participants:

> *"The lack of being able to progress professionally…within my previous roles, you start at the bottom, but you can work your way up…[in peer work] is there an up?" [P4]*

Difficulties progressing in the role are further exacerbated by *"limited options for full time or even permanent part time work"* [P4] and *"not having that ability to access sick leave and paid leave"* [P4] when working in casual positions. Participant Five was forced to work "*two other jobs to be able to continue to be a peer worker"* when he could only secure part time work.

Subtheme Two: Passion Doesn't Pay the Bills

Another commonly cited barrier was poor compensation. Furthering on Subtheme one, Participant Six wondered "*...whether the system wants peer workers in it if they haven't even got an award and they haven't even got a legitimate peer progression pathway, whether they want to go down leadership or specialised in frontline practise".*

Participant Two explained how poor compensation systematically devalues peer work practice and upholds the implicit expectation that 'passion is enough' to sustain those in peer work roles:

> *"…people look at peer workers and Lived Experience workers and think, 'oh, we don't actually need to pay them more because they're going to keep doing it because it's important to them'." [P2]*

Participant Twelve was concerned that a lack of knowledge and transparency around adequate remuneration may be leading newer peer workers to accept suboptimal rates of pay. Participant Twelve regarded this as a *"...fundamental and systemic devaluing of the peer workforce and what they contribute",* noting that newer peers may be viewed as *"motivated intrinsically"* and without the *"historical knowledge to be able to know that that role is being offered at a rate which is too low."*

Recommendations

After considering these results in the context of the relevant literature, Table One summarises the six most prevalent systemic barriers impacting the sustainability of Suicide Prevention Peer Work, as cited by participants. Accompanying these barriers are six respective enablers offered as recommendations to the stakeholders of Suicide Prevention Peer Work.

Table One

Recommendations for Stakeholders

	Barriers	Enablers
1	(1B) Limited access to meaningful supervision.	(1E(a)) Organisations are to offer accessible supervision that peers can self-select as most meaningful, whether that be individual supervision, group supervision, co-reflection, or otherwise. (1E(b)) This supervision should occur at a relative frequency (i.e. weekly or fortnightly) and be protected by the peer's organisation (i.e. the peer should not be expected to skip supervision to manage their caseload).
2	(2B) Devaluing Lived Experience expertise.	(2E) Reframe Lived Experience expertise as equally valuable to other types of expertise, clinical or otherwise.
3	(3B) Poor understanding and recognition of the Suicide Prevention Peer Work role.	(3E) Organisations are to educate non-lived experience staff on the function and value of Suicide Prevention Peer Work.
4	(4B) Peer work values being largely incompatible with the policies that govern the current mental health system.	(4E) Re-design organisational risk-management policies in collaboration with individuals with Lived Experience.
5	(5B) Poor compensation.	(5E) Develop a national award wage specific to Suicide Prevention Peer Work.
6	(6B) Limited opportunities to progress professionally.	(6E(a)) Increase the number of dedicated Senior Peer Work roles within organisations that employ Suicide Prevention Peer Workers. (6E(b)) Empower individuals with Lived Experience to apply for managerial positions within their respective mental health organisation(s).

Discussion

The present study aimed to identify and understand the systemic barriers limiting ongoing participation in the Suicide Prevention Peer Workforce, as well as the systemic enablers that can increase the sustainability of Suicide Prevention Peer Work. Results suggested that hope for the future of Suicide Prevention Peer Work was obscured by poor compensation and limited job opportunities, which was consistent with the literature (Ahmed et al., 2015; Hawgood et al., 2023; Riddell et al. (under review); Scanlan et al., 2020). Participants felt that low rates of pay contributed to de-valuing of peer work practice, namely the perception that peers are so intrinsically motivated and passionate that they will continue in their roles even when compensation is inadequate.

As experienced by participants in this study, it may be worth considering whether the economical devaluation of peer work practice can best be understood through a socio-cultural lens, such as feminist theory; particularly how gender intersects with renumeration and the perceived value of different types of work in society (Lips, 2018). The sexual division of labour has meant that 'caring' or 'relational' work (i.e. work that was historically undertaken by women), has typically received poorer compensation and recognition than work that was typically undertaken by men (Barron & West, 2013). Poor compensation for peer work practice, which is inherently caring and relational, may reflect the ongoing impacts of the gendered division of labour and a systemic devaluation of 'feminine' work.

Participants cited a lack of understanding of the peer work role as a barrier to sustaining peer work practice and effectively integrating peers into existing mental health systems. Participants were adamant that the organisations who employ Suicide Prevention Peer Workers have a duty to educate non-lived experience staff on the function and value of peer work. These findings were echoed by Scanlan et al. (2020), who recommended that non-lived

experience employees receive ongoing education on the purpose and value of peer work practice to promote a sense of cohesion between employees with and without Lived Experience. These recommendations align well with the objectives of the 2025-2035 National Suicide Prevention Strategy, which called for better integration into existing service delivery structures for Suicide Prevention Peer Workers (National Mental Health Commission, 2025).

A lack of harmony between peer work values and clinical models of care were said to produce moral tensions in the workplace for many participants. As a non-clinical response to suicide prevention, many peers felt that their professional practice was compromised by coercive, risk-averse organisational policies that undermined their peer work values. Moreover, many participants felt that their workplaces failed to consider how their peer values could be preserved by incorporating Lived Experience expertise into the provision of mental health services. These concerns were supported by Gooding et al. (2018), who in their literature review found little evidence of hospital settings using Lived Experience expertise to reduce coercive mental health practices.

As experienced by many participants in this study, the current pattern of subsuming Lived Experience expertise into clinical expertise in response to perceived suicide risk represents a failure of service delivery structures to meaningfully collaborate with Lived Experience expertise, especially in a manner that is not performative. These sentiments were supported by the National Lived Experience Peer Workforce Development Guidelines, which recommend that Lived Experience workers not be placed in positions where they are expected to endorse coercive mental health practices that represent the very antithesis of peer work values (Byrne et al., 2021).

Finally, the importance of appropriate, available, and accessible supervisory support was made salient by majority of participants. External supervision was highly regarded due to its

ability to foster a sense of safety and separation from line managers and supervisors within the peer's own organisation. This finding was supported by the literature, which emphasised the contentions that arise when peers can only debrief to direct managers (Hawgood et al., 2023). Allowing peers to choose the *type* of supervisory support they receive, as well as *who* delivers this supervisory support was regarded as important, rather than having a universal standard imposed upon the workforce. These sentiments were supported by Scanlan et al. (2020) and Ahmed et al. (2015), who demonstrated that peers had different preferences for who delivered their supervision; some wanted supervision that was solely delivered by senior peers; others did not mind who the professional was, as long as they advocated for the value of peer-led services. In empowering peers to choose the type of supervisory support that is most relevant to them, the organisations that employ Suicide Prevention Peer Workers can directly uphold the peer values of *choice* and *autonomy,* both of which are integral for sustaining a peer's professional practice (Byrne et al., 2021).

Even when supervision is appropriate and available, participants were adamant that this support must also be *accessible*; a Suicide Prevention Peer Worker's schedule should not be so busy that they are routinely forced to exit supervision early to support their consumers. When considering the importance of accessible organisational support, it would be remiss not to highlight the difficulty some participants had trying to participate in this research. Of the twelve participants who participated in this study, an additional eight Suicide Prevention Peer Workers were unable to participate due to workplace demands. Some could not find a free hour or two in their schedule; others found that they had to cancel their interview or focus group last minute due to there being an insufficient number of staff at their workplace. The difficulty many peers had participating in research designed to help advocate for the sustainability of their professional practice is in and of itself a systemic barrier that must be considered.

Limitations

Limitations must be noted. The self-elected sample of participants may represent a specific subset of peers who are more readily engaged in research and advocacy, meaning that the results may not be representative of the entire Suicide Prevention Peer Workforce. Having individuals with Lived Experience co-facilitate the interviews and focus groups may be considered a simultaneous strength and a weakness of the present study; whilst Lived Experience facilitators may have helped ensure greater psychological safety for participants, these facilitators may also have subconsciously imposed their own perspectives of Suicide Prevention Peer Work onto the results.

Researcher bias is an inescapable element of knowledge production in qualitative research. It was not the researcher's intention to *eliminate* bias effects using a Dialogical analysis; instead, the researcher's intended to *reduce* their influence over the research outputs by involving a broader range of data analysts with a Lived Experience of suicide. Nevertheless, the results are still limited in terms of the perspectives that were *not included* in this Dialogical analysis process; for example, involving *consumers* of Suicide Prevention Peer Work may have offered an additional perspective that would have strengthened the richness and relevance of the results.

Future Research

Future research should continue to explore the nuances of these systemic barriers and enablers in a larger sample of peers across a broader range of organisations. The applicability and relevance of these systemic barriers and enablers should also be investigated among clinical mental health workers. In identifying how these systemic barriers are experienced by both clinical and non-clinical staff, policy makers and organisations should have a better foothold for developing organisational guidelines that allow both workforces to collaborate in

meaningful ways that do not compromise the values and expertise of the other. To increase the specificity of these results, it may also be beneficial to compare how these systemic barriers and enablers are experienced by newer and more experienced members of the Suicide Prevention Peer Workforce.

Conclusion

In conclusion, this research makes a novel contribution to the identification of the systemic barriers and enablers influencing the sustainability of Suicide Prevention Peer Work. The present study explored the experiences of twelve individuals with a Lived Experience of suicide, majority of which were currently or previously employed as Suicide Prevention Peer Workers. Based on participant experiences, six salient barriers influencing the sustainability of Suicide Prevention Peer Work were identified; (1) limited access to meaningful supervision; (2) devaluation of Lived Experience expertise; (3) poor understanding and recognition of the Suicide Prevention Peer Work role; (4) disharmony between peer work values and clinical models of care; (5) poor compensation; and (6) limited career opportunities. Increasing the number of dedicated Senior Peer Work roles within organisations, educating non-lived experience staff on the function of Suicide Prevention Peer Work, and developing an award wage for Suicide Prevention Peer Workers were among some of the enablers that were considered crucial for improving the sustainability of peer work practice.

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Declaration of Interest

There are no relevant financial or non-financial competing interests to report.

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Appendices

Appendix A

Research Title: What Supports and Hinders Sustainability in Suicide Prevention Peer Work? A Systems Perspective.

Researchers – Dr. Anna Sidis, Ava Riddell, Jay Gardener and Sophie Lucas

Thank you for agreeing to participate in this focus group and to completing the information requested below. Should you have any questions about this study please contact Ava Riddell (apr570@uowmail.edu.au) and/or Anna Sidis (asidis@uow.edu.au 02 4298 1301)

Demographic Information:

1. Please circle the appropriate range for your age in years:

Less than 20

20-29

30-39

40-49

50-59

60+

2. Please circle your gender:

Female

Male

Non-binary or other (please specify if comfortable doing so):
……

3. Please circle the amount of time you have worked as a Suicide Prevention Peer Worker.

Less than two years.

2-5 years.

6-10 years.

11-15 years.

16-20 years.

Greater than 20 years.

Appendix B

Focus Group Statements

1. *"... I don't have any issues with the support I feel, the groups I'm in, the work I do. I have issues with the systemic side."*
2. Organisations provide consistent and accessible support for Suicide Prevention Peer Workers.
3. Suicide Prevention Peer Workers are encouraged – explicitly or implicitly – to work in alignment with peer work values.
4. Varying definitions of 'recovery' across different workplaces creates a barrier to entering the Suicide Prevention Peer Workforce.
5. Lived Experience leadership and expertise is necessary in all suicide prevention work.
6. Embedding lived experience leadership in suicide prevention is challenging within current service delivery structures.