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Peer Specialists in Suicide Prevention: Possibilities and Pitfalls

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The emergence of peer specialists with histories of suicidality in mental health care services is a recent but scarcely researched societal phenomenon. The current study aimed to explore how peer specialists who have experienced suicidality (either attempted suicide or suicidal ideation) use their experiences to contribute to suicide prevention in mental health care services. Qualitative interviews with 20 peer specialists who have personally dealt with suicidality in their past were conducted. Interviewees perceived their work to have unique value in terms of their approach to making contact with suicidal care consumers on an emotional level, which was perceived to lead to less reluctance on the part of suicidal care consumers to talk about suicidality, as well as affect feelings of being acknowledged and heard. However, the lack of professional distance was perceived to carry several risks, including burdening clients with the peer specialists' own suicidal experiences, perceived reluctance of coworkers to let peer specialists work with suicidal clients, and the burden of working with suicidal clients for the peer specialists. Specific conditions that were perceived to be needed in order to work with suicidal clients consisted of personal distance to own process of recovery and suicidality, establishing boundaries with the team or colleagues for the peer specialists' work concerning suicide risk assessment, safety, privacy, and sharing responsibility. Further discussion between mental health care clinicians and peer specialists regarding the role of the peer specialist in suicide prevention is needed to further clarify and optimize their role.

Keywords: peer specialists, suicide prevention, mental health care

Suicide is a serious mental health problem that should be addressed through prevention. Mental health care services can therefore play an important role in suicide prevention. However, some care consumers who struggle with suicidality are dissatisfied with their treatment (Peterson & Collings, 2015); for instance, health care staff is perceived by some (former) suicidal care consumers as unempathetic, judgmental, or as falling short of meeting their needs (Cerel, Currier, & Conwell, 2006; Lindgren, Wilstrand, Gilje, & Olofsson, 2004). Furthermore, research suggests that some suicidal care consumers perceive health care staff to focus exclusively on suicide risk assessment (Segal-Engelchin, Kfir-Levin, Neustaedter, & Mirsky, 2015), when they would appreciate a caring conversation instead (Ross, Kelly, & Jorm, 2014). Suicidal care consumers observe discomfort, taboo, and fear around health care staff discussing suicidality (Lindgren et al., 2004).

The emergence and visibility of peer specialists with histories of suicidality (i.e., attempted suicide and/or suicidal ideation) who address suicide prevention is an important and recent societal phenomenon. The American Association for Suicidology (2018) launched the suicide attempt survivor movement in the United States, and several national suicide prevention strategies in the Western world have included peer specialists in their approaches, such as the Zero Suicide Movement (United States) and Suicide or Survive (Ireland). In Michigan, the Army National Guard has implemented peer support services aimed at suicide prevention in war veterans (Greden et al., 2010).

Only a few empirical studies have existed on the effects of peer specialists with regard to suicide prevention in mental health care services, although several editorials in scientific journals have emphasized the relevance and the particular need for empirical scientific research in this area (see, e.g., Thomas, 2011). The most well-known approach to recovery from mental illness, the Wellness Recovery Action Plan (WRAP), explicitly highlights suicide prevention, but its effectiveness has only been studied indirectly (Fukui et al., 2011). There are a few studies that have examined the effects of the addition of peer specialist or peer support services to mental health care on levels of suicidality or hopelessness. Simpson et al. (2014) conducted a pilot randomized controlled trial (RCT) in which peer support was added to the usual aftercare provided to mental health care consumers recently discharged from the hospital. The results showed no significant differences in hopelessness after a 3-month follow-up, although there was a trend toward a larger decrease in hopelessness in the peer-supported group compared to the care-as-usual group. In an RCT study on the effects of peer specialists on depressed care users, Valenstein et al. (2015) found no significant differences in suicidality when comparing the impact of a mutual peer support intervention to the use of self-help materials alone. Pfeiffer et al. (2017) found no significant differences in suicidality in a small-scale pilot study of depressed care consumers, who were discharged from the hospital and received either weekly visits or phone calls from their choice

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of either a family member/friend or a certified peer support specialist for a period of 6 months. However, the numbers of participants in this study were deemed too small in order to draw conclusions, and large-scale follow-ups were recommended.

To our knowledge, the few studies on the effects of peer specialists with regard to suicide prevention do not answer the "how question," in what ways are peer specialists expected to decrease suicidality in care consumers, and no studies have been conducted that have focused on the underlying mechanisms of the work of peer specialists with suicidal care consumers. From research in the tradition of recovery from suicidality, it can be derived that the potentially unique value of using peer specialists in suicide prevention may consist of their emphasis on the crucial role of constructive coping, support, empowerment, and (re)discovering meaning in life among formerly suicidal persons (Chi et al., 2014). Several qualitative studies have indicated that peer support has a positive impact on the recovery from suicidality as a result of mutual understanding and commonality, and it supports moving toward self-acceptance and feeling accepted by others in a nonjudgmental environment (Bergmans, Langley, Links, & Lavery, 2009; Chi et al., 2014; Sun & Long, 2013).

The current study intends to contribute to the small evidence base concerning the role of peer specialists in suicide prevention by presenting an exploratory interview study of 20 peer specialists who have struggled with suicidality in the past and currently work in mental health care and related services. The main research question is how peer specialists use their previous experiences with suicidality and mental health care to aid in the recovery of suicidal care consumers and what they perceive to be the role of peer specialists in the prevention of suicide. We aim to generate directions for further research on the role of peer specialists in suicide prevention and set up scientific trials into the effects of peer specialists in this field. The present study could benefit current discussions on the further professionalization of peer specialists and inform mental health care services of the possibilities and pitfalls in employing peer specialists in their suicide prevention strategies.

Method

Selection of Participants

This study was carefully prepared over a period of more than 1 year, and key stakeholders were consulted in order to create a meaningful topic list. The training and employment of peer specialists in the Netherlands vary significantly, from no training to a 2-year associate degree, and employment can involve many different roles, which made it difficult to draw a representative sample. We selected potential participants through a stratified random sample of 30 large mental health care services throughout the Netherlands ($n = 11$) and used our contacts with suicide prevention experts and mental health care services that are known for their employment of peer specialists and interest in the field ($n = 8$). We deliberately sought out a diversity of characteristics among the participants (Silverman, 2000), in order to form a broad insight into the different kinds of activities that peer specialists carry out in terms of suicide prevention.

Considering that the number of peer specialists with a history of suicidality who work in the mental health care field is small in the Netherlands, we also included one from the United States. The response rate was generally high: 12 of the 15 mental health care services that were approached agreed to participate, and almost all of the contacts in our network agreed to participate.

Participants

Of the 20 interviewees, 14 were female and 6 were male. Age ranged from 26 to 66 years, with almost half of the sample ($n = 9$) aged between 40 and 50 years old, and 6 were older than 50 years. The majority of the interviewees were of Dutch heritage ($n = 17$), 3 had an immigrant background, and 1 lived and worked abroad. Sixteen of the 20 peer specialists had received some formal training as a peer specialist; 9 peer specialists were certified after extensive training (up to 2 years at the undergraduate level), and 7 of them had received a limited or short amount of training, such as a WRAP course.

All peer specialists in the sample had experienced suicidal ideation in the past, and most were suicide attempt survivors. Furthermore, the peer specialists interviewed had suffered from diverse mental health issues, including affective disorders, psychosis, and personality disorders.

Topic List

We intended to explore how peer specialists were employed in suicide prevention and how they used their recovery process and past experiences in their work. Furthermore, we explored what peer specialists with a history of suicidality perceived as their potential unique contribution and to discuss possible problems and pitfalls they encountered in their work in suicide prevention, as well as whether they experienced stigma. Last, we discussed what critical steps should be taken for further development of the use of peer specialists in suicide prevention.

Qualitative Analysis

The qualitative interviews and focus group interviews were digitally recorded and transcribed verbatim and analyzed with the support of the software ATLAS.ti. The analysis was focused on the thematic analysis of the transcripts, in line with the initial steps of grounded theory (Corbin & Strauss, 2008).

The coding of the data took place on the basis of a qualitative approach, which was both inductive (hence data driven) and deductive (i.e., sensitive to the themes of a semistructured topic list; Silverman, 2000). The analysis began with open coding for each of the interviews, which were analyzed separately. This resulted in a number of main codes, which were constantly refined and added throughout the analysis. The next step was axial coding: the comparison of clips from various interviews with the same main codes and subcodes (Boeije, 2002). The interviews were coded by the first author and checked by the second author; differences in coding (which happened for approximately 5% of the coding work) were discussed until agreement was reached. Our analysis revealed that saturation was reached by the last few interviews.

Ethical Approval

The study received ethical approval from the ethics committee in the Department of Pedagogical and Educational Sciences at the

University of Groningen. All data were encrypted and stored anonymously. All potential participants received information sheets, and signed informed consent was obtained prior to the interview.

Results

Ways Peer Specialist Interviewees Were Active in Suicide Prevention

The education, experience, and functions of the peer specialists interviewed differed considerably. Fourteen of the 20 interviewees were working in large mental health care services, which offered both inpatient and outpatient treatment and focus on treatment of all mental health issues. Six of the 14 were employed as a peer specialist team member in a functional assertive community team (FACT); 3 were mainly involved in suicide prevention policies within their mental health care institution (suicide prevention board); 1 led a group of suicide attempt survivors from a peer specialist perspective; 2 worked for a unique housing facility for those individuals who cannot formulate reasons for continuing to live (contemplation of suicide), which is run mainly by peer specialists; 1 worked in an outpatient substance abuse setting; and 1 worked in outreach for those who were deemed in need of mental health care.

Furthermore, the six peer specialists outside of mental health care services worked in settings aimed at or related to mental health care: One worked as an educator for peer specialists in training, one as an advisor for a governmental agency on health care (and suicide prevention), two as ambassadors with the mission of ending the stigma surrounding suicide, and one as a trainer of mental health care professionals in suicide prevention and self-harm (from the perspective of a suicide attempt survivor). Twelve of the 20 peer specialists had direct experience working with suicidal clients in inpatient or crisis settings and in outpatient settings, and the other 8 did not—some of these were not allowed to work with suicidal clients as the team considered this to be too risky. Several of the interviewees were also active in sharing their experiences with the public at large, in order to reduce the stigma and encourage help-seeking behavior for suicidality.

Peer Specialist Interviewees' Recovery Process From Suicidal Urges

In the narratives of peer specialists' recovery from suicidality, it was striking that others—such as family and friends, fellow care users, and sometimes clinicians—played a crucial role. Important recovery themes were "feeling understood and connected to others" and "crisis prevention and management by reaching out and talking about suicidality." Furthermore, certain personal insights (e.g., allowing depressed mood or feelings to be there), philosophies (e.g., Buddhism), or therapeutic techniques (e.g., cognitive–behavioral therapy, mindfulness) had helped in dealing with suicidality. Notably, several peer specialists volunteered that certain aspects of the WRAP helped them deal with their suicidality (e.g., their crisis plan). Recovery approaches varied greatly among the interviewees. Although almost all peer specialists considered themselves to be recovered, most volunteered that they still experienced mild to severe suicidal episodes. One of the 20 peer specialists volunteered that her suicidal ideation had become more prominent in the months leading up to the interview, and several other peer specialists described that they could not rule out that they would eventually die by suicide or stated that they still felt ambivalent about suicide; some of them possessed written farewell letters. Suicide as a deliberate choice or option for themselves or others was not rejected by most peer specialists, as illustrated by the following quote:

> If I have no other options, I will end my life, but not until I have done everything in my power to make a change in my life. I have always left the option of suicide open. . . . It is allowed. . . . That gives me a peaceful feeling. I am still here, so apparently, things went well for quite some time. . . . It has always been a theme for me and so I found ways to wriggle myself out of difficult periods. But I do not know for sure if it will always be that way. (Male, age 51 years)

Contact With Suicidal Care Users: Use of Own Recovery Narrative and Professional Attitude

All interviewees strongly felt that they successfully contribute to suicide prevention and provide added value compared to the contributions of mental health care clinicians (also see Table 1 for these perceived positive effects). This contribution mainly consisted of the different ways in which they perceived themselves to interact with suicidal peers, which is an approach based on their own suicidal experiences, as opposed to a clinical or professional approach. As a result of their own experiences with suicidality, interviewees made contact with suicidal clients in a distinctive manner, that is, an open, nonjudgmental way of connecting with suicidal persons, thus creating space for conversation and openings for recovery. In this respect, many peer specialists noted that they could also use their negative experiences with mental health care services, such as unfelt empathy, avoidance of the subject of suicidality, stressed responses to suicidal statements, and an immediate focus on solutions, advice, or the "bright side of life."

Peer specialists perceived themselves to lack professional distance, since they do not have an explicit professional agenda (e.g., assessing suicide risk and applying a suicide prevention protocol). Thus, they felt the contact they had with clients was based on an equal footing, that is, shared experiences with suicidality, instead of having unequal "client–clinician" contact. Furthermore, many of the respondents described being able to respond in a calm way to suicidal communications, possibly as a result of having accepting views of suicide and familiarity with the suicidal process. This encompassed their ability to accept the suicidal urges in suicidal care consumers without feeling the need to act immediately and without expressing fear or panic with regard to the revelation, thereby allowing the suicidal peer to openly talk about and explore their suicidal urges. The following quote illustrates this point:

> For psychologists, psychiatrists, or nurses who engage in a conversation with a suicidal client, their main goal is not to establish contact or to solve problems. They frequently assess suicide risk first: That is their agenda. Clients know that and feel that, and that may result in a conversation that is spoiled before it could set off in the first place. As a peer specialist, I do not need anything as such from a client. One of my best conversations started with a half-hour silence. (Male, age 51 years)

Peer specialists may thus be able to fulfill a need in care consumers that is frequently unmet, through acknowledgment of their struggle with despair and suicidality, by allowing them to feel

Table 1
Themes That Emerged in the Interviews With 20 Peer Specialists Regarding Their Interaction With Suicidal Clients

Subject	Theme	Description
Professional attitude toward suicidal care consumers	Open contact	Nonjudgmental way of connecting, open to discussing the subject of suicidality in a sincere and nondirective manner
	No professional distance	Contact on equal footing without professional agenda
	Calm response to suicidal communications	When there is no imminent suicide risk, an open, nondirective conversation about suicidal feelings is offered without immediate focus on solutions or action and without explicitly rejecting suicide as an option
Perceived positive effect on suicidal care consumers	Opening up about suicidality	A client generally experiences less reluctance and shame in discussing the sensitive subject of his or her suicidal thoughts and feelings
	Recognition, acknowledgment, and being heard	As a result of shared experience, the peer specialist can provide recognition and acknowledgment
	Better connection to needs	It may be difficult to express your needs when you are suicidal, which is easier to understand as a peer specialist
	Fostering hope for the future	A peer specialist can function as a role model for recovery from suicidality
	Educating colleagues	The peer specialist can advise team members on how to understand, approach, and talk to suicidal persons or function as a liaison between a team and a client
	Addressing stigma	The peer specialist can break the taboo surrounding suicide and foster understanding and support
Perceived pitfalls in working with suicidal care consumers	Burdening care consumers	Providing care consumers with details of your suicide attempts or current suicidal ideation may be too burdensome
	Role when someone is highly suicidal	When a client is highly suicidal, you may have to act immediately as a clinician, which may be conflicting with your role as a peer
	Reluctance of coworkers	Your coworkers may need to be convinced that you are able to work with suicidal clients
	Emotional burden	Working with suicidal clients may be taxing or trigger own suicidality
	Vulnerability	The peer specialists may experience a relapse in suicidal thoughts, complicating their work with suicidal clients

heard and listened to and by openly exploring with a care consumer what is possible without explicitly rejecting the option of suicide. Subthemes that emerged in this respect were "reducing reluctance of care consumers in opening up about suicidality"; "recognition, acknowledgment, and being heard when feeling suicidal"; "better connection to the needs of someone who is suicidal"; and "fostering hope for the future." Below, each subtheme will be described in more detail (also see Table 1).

The vast majority of the interviewees described the suicidal care consumers with whom they interacted as generally experiencing less reluctance and shame in their suicidal thoughts as a result of their approach and their shared experiences with suicidality. Peer specialists indicated that they are better able to provide peers with recognition and acknowledgment of their suicidal feelings, thereby allowing them to show more of their true selves, since they shared (previous) experiences of shame and anxiety as a result of being judged for their suicidality. Moreover, respondents indicated that, as a peer specialist, it is sometimes easier to gain a sense of what a suicidal person needs and how to meet those needs in an adequate and fitting way. The following quote clearly illustrates this point:

> I think that one of the things that's difficult, from a client's perspective, is trying to talk about what you're going through at a time where you think that you have no value. You do not necessarily trust other people as much, because you hate yourself. If you do not think that you are valuable . . . then it's less likely that you're going to reach out, and being able to pick up on things very quickly (as a peer specialist), means that somebody has to spend a lot less effort to try to get a point across, to try to tell you about how they're feeling. Having that personal experience to draw on, makes it easier to have that type of understanding. (Male, age 40 years)

As emphasized in the quote above, the connection between a peer specialist and the care consumer is on an emotional or experiential level.

Finally, peer specialists noted that their recovery may give suicidal care consumers hope for their own futures and recovery from suicidal impulses, since they themselves function as a role model:

> I share a vulnerable piece of me (suicidality), but I am employed as a professional. That is sometimes a paradox. That in spite of your vulnerability, you can show that you can be there for someone and that you can function. . . . Hereby, you give hope. People [care consumers] ask a lot of questions about how I was able to get out of that deadlock. Clients want to hear from me how I came out of that and what I did about it, about recovery. (Female, age 40 years)

Although not all interviewees indicated that their recovery story was always used as a way of advising their clients, it was felt to be a tool to establish contact on equal footing and inspire hope.

Interaction between peer specialists and their colleagues or teams. Another theme that emerged in the interviews was that the peer specialist could also fulfill an important role in a mental

health care services team. They advised team members on how to understand, approach, and talk to suicidal persons, and some of them functioned as a liaison between the team and those who were inclined to refuse help from mental health services. For example, they encouraged their colleagues to repress the compulsion to "save" a suicidal person by acting too quickly and instead emphasized listening to the person and his or her needs first, and they educated and sensitized their team to experiencing suicidal ideation. The following quote provides an example of the positive experience of one of the peer specialists when she shared her expertise with team members:

> I am member of a FACT team in which peer expertise is embraced. I showed the initiative in presenting about the subject of suicide and expanding my expertise in this respect . . . when a client is suicidal, my colleagues ask me: what is your view, what can we do? . . . I hope this shift in culture will happen for the entire mental health care system. (Female, age 40 years)

As is clear in this quote, this peer specialist was held in high esteem by her team, and her team members found her input regarding suicidality very valuable.

Pitfalls and Potential Problems of Working as a Peer Specialist With Suicidal Care Consumers

When asked about the potential pitfalls and problems of working with suicidal care consumers, five subthemes emerged: "burdening care consumers with your own suicide story," "reluctance of coworkers to let peer specialists work with suicidal clients," "your role as a peer specialist when someone is highly suicidal," "the emotional burden of working with suicidal clients," and "the vulnerability of the peer specialists themselves" (see Table 1 for these perceived pitfalls).

First, a commonly described dilemma referred to peer specialists telling their personal stories about suicidality. Many of the peer specialists interviewed explained that telling their stories to care consumers or colleagues exposes them, since it is such personal information and they may be perceived as "patients," or vulnerable individuals. Moreover, doing so may also create a burden for their clients, as some peer specialists were concerned that telling care consumers about their past suicidality might make them worry about the peer specialist's mental health, which may even result in a future reluctance to open up about this theme out of fear of upsetting the peer specialist. Most peer specialists therefore mainly focus on their recovery narrative and carefully avoid revealing too much about their past suicidal experiences, only sharing the most relevant points and sometimes explicitly phrasing issues in the past tense, as is illustrated by the next quote:

> I think that it is important that a peer specialist knows how to use his or her experience. If someone is suicidal and you visit this person and you tell them all about the difficulties in your life . . . that can work out all wrong. . . . If I would feel suicidal and my peer specialist would say, I felt the same way and I felt that bad as well, I would lose all hope. (Female, age 41 years)

However, some peer specialists deliberately use their suicidal experiences as a way of conveying to care consumers that they are not afraid of what they might tell them about their suicidal ideation of plans, since this expresses that they "have been there" themselves:

> Some clients feel the tension of not being able to talk about it [feeling suicidal], or not daring to talk about it, as a result of feelings of guilt, anger, or anxiety to upset me. . . . That is always an issue, you do not want to burden someone else. . . . But you do not burden me with it, since I have been there, I understand. Then you get an entirely different conversation. (Male, age 51 years)

Next, problems with coworkers in relation to professionalism were frequently described. For several peer specialists, their colleagues were reluctant to let them work with suicidal care consumers, out of concern for the peer specialist's "vulnerability" and the conviction that dealing with suicidal persons was too burdensome for peer specialists:

> Peer specialists are not often not allowed to work with suicidal clients because their colleagues think they do not know how the protocol works, or how it is done, even though I have the experience that if you try something completely different, and you employ a peer specialist that talks from a peer perspective and shared experiences, that it can work miracles. . . . But I have noticed that a lot of regular clinicians are skeptical. (Male, age 32 years)

Some peer specialists mentioned that teams were downright negative toward them, usually as a result of having had bad experiences with peer experts who were frequently on sick leave or who "behaved liked patients instead of colleagues." This means that peer experts should be assertive and able to handle these reactions, as well as know how to gain trust from colleagues:

> I proved myself in that area . . . I am very aware that it [suicidal care consumers] concerns a matter of life and death. I understand that if your colleagues do not trust you, you cannot participate. . . . As a peer specialist that has recently started working, you should show what you are capable of and you should win the trust of both the team and your clients. (Male, age 51 years)

A third subtheme concerned the tension between respecting the personal autonomy of care consumers and your role as a peer specialist. Especially in acute suicide crisis situations, the peer specialist might be obliged to act in a way that conflicts with this role. If there is an imminent suicide risk, or if a peer specialist is not sure about safety, the role of a peer versus a health care worker may conflict:

> What I find to be difficult, and that is also difficult for clinicians, is what to do if I am with someone who is suicidal and think: Now what? Can I leave with a safe feeling? Should I intervene or not? Because if I intervene, I might rob someone of their own choices, and then I have to take on the role of a mental health care worker. (Female, age 40 years)

Some (mostly more acute) situations with suicidal care consumers may enhance taking on the role of a mental health care worker, which does not align with the peer specialist role. Some of the peer specialists noted that they always discuss these decisions and doubts with their colleagues, thus making it a shared responsibility, next to openly discussing their doubts about safety with their clients, in order to clarify conflicting roles.

The last subtheme is the vulnerability and burden of peer specialists working with suicidal persons. Whether someone a peer

specialist is up to the task was said to largely depend on his or her personality, skills, and knowledge. Interviewees summarized the main risk of working in suicide prevention as the following: Working with suicidal peers might trigger their own suicidality (which happened to one interviewee) or past feelings of despair and suicidality. As such, the work was highly demanding for a few interviewees. As one participant remarked, "Supporting and motivating others is a pitfall for me, I do it 24/7. With energy I don't have, whether I feel suicidal or not. It tires me out completely" (female, age 48 years).

Moreover, some peer specialists mentioned that their work led to overinvolvement with suicidal care consumers and the blurring of personal boundaries since they stand next to consumers as peers without the benefit of professional distance. Sometimes, this even endangered their safety:

> As someone who helps suicidal persons, you should watch out for your own safety first. That was a difficult lesson I had to learn as a peer specialist. I used to have a good contact with a suicidal lady that was always in conflict with my coworkers on my team. . . . Until one day, when I was at her house, and she threatened to blow up her flat with her and me in it. That was an intense experience. (Female, age 51 years)

Telling their personal recovery stories can also make them vulnerable to their suicidal care consumers or colleagues and potentially create feelings of guilt and helplessness upon the suicide of a care consumer to whom they were more personally connected than the mental health care clinicians. Several interviewees gave examples of such undesirable situations regarding overinvolvement and blurred personal and professional boundaries, such as the following:

> A therapist asked me if I could have a few conversations with a severely suicidal client. . . . After five meetings with her, she was still suicidal. At that point I should have said, this is it, I gave you what I have to offer. But I did not and it became a never-ending story. . . . She kept asking for more, and she learned a lot of personal information about me and I became too involved. Eventually, it went horribly wrong because of this, ending in a terrible conflict involving this client and some other staff members. I feel deeply ashamed. (Female, age 49 years)

The situations described in the quotes above were unfavorable for the peer specialists involved and served as lessons for the future. Situations that are usually considered to be undesirable for regular health care professionals were also observed by the interviewees (usually in their peer specialist colleagues), such as taking suicidal care consumers into their homes (some of those care consumers died by suicide during this period), taking phone calls outside of working hours from severely suicidal care consumers (without team backup), and, for some interviewees, keeping the suicidal urges of the care consumers a secret from clinician colleagues (at the request of the consumer).

Interviewees indicated that as a result of the potential pitfalls of working with suicidal clients, several conditions need to be met before doing so. First, it is important for them to have enough personal distance from their own process of recovery and suicidality, and it is very important that they discuss with their team the boundaries of their work concerning suicide risk assessment, safety, privacy and keeping (suicide) secrets, sharing responsibility, and their role as a peer specialist.

Stigma

All interviewees mentioned that there is still a lot of stigma around the subject of suicidality. Many of the interviewees had felt it was taboo for them to discuss their suicidality in the past in a social context and had observed that even some clinicians in mental health care services had difficulty openly discussing the subject. Most peer specialists felt they had an important role to play in breaking the taboo around suicide in mental health care and beyond by openly talking about suicidality and making it a "normal" subject to discuss. Lessening the taboo surrounding talking about suicide was expected to have a positive influence on suicide risk:

> I do not plant suicidal thoughts into my client; instead, by talking about it, by providing recognition and acknowledgment of suicidal feelings, I hope that the stigma will fade into the background. . . . You can feel ashamed of your suicidal thoughts . . . I think that by talking about it and reducing the stigma, you can reduce suicidal ideation and it will influence the intensity of suicidal thoughts in a positive manner. (Female, age 40 years)

It was striking that several peer specialists explained that they had never talked to their team about their past experiences with suicidality. Anxiety around being perceived as incompetent seems to play a role in these feelings, as the next quotes illustrate:

> I have, as a peer specialist, never talked to my team about my suicide attempts. So there are a lot of taboos that should be broken, if you are able to do that the threshold to enter into a dialogue with each other will be lower. (Female, age 36 years)

However, many peer specialists also expressed positive experiences with telling their own stories of recovery from suicidality to their colleagues and peers, as well as witnessing positive reactions, such as the following quote illustrates:

> For me, I have heard a lot that people find it wonderful that I was able to climb up from the position I was in 7 years ago. I hear a lot that people think it is a great achievement instead of stigmatizing remarks. If there are any stigmatizing remarks, they are usually made by me. (Male, age 32 years)

As demonstrated above, sometimes self-stigmatization is a hurdle that needs to be overcome by peer specialists.

Discussion

The current study aimed to explore how peer specialists use their previous experiences with suicidality to aid in the recovery of suicidal care consumers and what they perceive to be the unique roles and pitfalls of peer specialists in the prevention of suicide. The peer specialists in our study fulfilled different roles regarding suicide prevention, with some having extensive experience working with care consumers in suicidal crisis settings, whereas others were either not or rarely allowed to talk to suicidal clients. According to our interviewees, the role of peer specialists in suicide prevention is neither self-evident nor embraced by mental health care providers per se, and the issue

of peer specialists working with suicidal care consumers seems to be a delicate matter that is under debate by professionals in mental health care and beyond.

The recovery narratives of the peer specialists in our study emphasized the critical role of social support and loved ones in this process, in line with Alexander, Haugland, Ashenden, Knight, and Brown (2009) and Bergmans et al. (2009). However, their recovery should not be understood as the absence of suicidality, since several of the interviewees still experienced suicidal ideation to some degree at least, and suicide was still considered an acceptable option for most interviewees. Mental health care professionals might perceive peer specialists' more accepting view of suicide as worrisome, since suicide prevention and "Zero Suicide" (Erlich & the GAP Committee on Psychopathology, 2016) is generally the main goal of mental health care treatment. Although it may seem to be a paradox, the interviewees regarded their more accepting position to lower the risk of suicide, since it facilitates an open discussion of the subject, allowing for a reduction of the tension commonly connected to suicidality. Although the risks and benefits of peer specialists discussing suicide have never been studied, several review studies have shown that there are no detrimental effects to encouraging people to openly discuss suicide (DeCou & Schumann, 2017; Fitzpatrick & Kerridge, 2013). Additionally, with regards to the unique role that peer specialists may fulfill in suicide prevention, peer specialists felt that sharing their story of recovery from suicidality was seen as a tool to establish an emotional connection with clients. Although peer specialists were generally careful as to how and when they would share their past experiences of attempted suicide and suicidal urges, sharing their stories of recovery was felt to serve the function of fostering hope. However, some interviewees pointed out that their own recovery story was not meant to be advice on recovery, since they felt that recovery from suicidality is a highly diverse process and personal in nature, but mainly to serve as inspiration for recovery.

When asked about additional unique aspects of the role that peer specialists can play with regard to those care consumers struggling with suicidal urges, the particular advantages of a peer specialist were perceived to exist on the level of contact. The peer specialists in our study felt that they can understand or sense what being suicidal feels like and considered it an advantage that they do not have the agendas that clinicians are obliged to follow, such as protocols and risk assessment. In this respect, the criticism previously leveled toward traditional mental health care staff approaches, such as their strong focus on suicide risk assessment, was confirmed in this study (Ross et al., 2014; Segal-Engelchin et al., 2015). The open, nonjudgmental approach of peer specialists was perceived to assist care consumers in opening up about their suicidality. Peer specialists may thus fulfill a need in care consumers that is sometimes not met by mental health care providers, through acknowledgment of their struggle with suicidal despair and creating a sense of being heard and listened to. The interviewees felt they were different from nonpeer specialist staff in the sense that they openly explored the suicidal feelings of the care consumers without explicitly rejecting suicide as an option.

The advantages of the peer specialists' role in suicide prevention, as perceived by the peer specialists interviewed, were not entirely in line with the benefits suggested by Salvatore (2010), who perceived peer specialists to function as suicide risk assessors. In contrast, risk assessment was perceived as an undesirable role for the peer specialists in our study as this was generally considered to be carried out by people to whom care consumers perceived themselves to be at a distance, or hierarchically inferior. In accordance with Salvatore (2010), some peer specialists viewed themselves as being part of the suicidal care consumers' network. However, our results show that this role could also conflict with the demands of their mental health care clinician colleagues or with the personal mental health of the peer specialists themselves. Situations in which suicidal crises of care consumers need intervention were experienced as conflicting with the role of a peer, especially in cases of involuntary hospitalization or forced medication.

The absence of professional distance was not merely seen as an advantage, as it sometimes led to the overinvolvement of the peer specialist and the blurring of personal boundaries, as well as reluctance by team members to accept peer specialists as coworkers. Working with suicidal care consumers can be burdensome for peer specialists, as confirmed by other literature describing the challenges for peer specialists to cope with their own personal mental health and potential relapse (Moran, Russinova, Gidugu, & Gagne, 2013). Team members feared that it might be too stressful for the peer specialist to work with suicidal care consumers or that they might not be capable of doing so—despite the peer specialists' professions of competence in this respect. Moreover, the unstructured or intuitive approach "on an emotional level" of peer specialists' treatment of suicidal care consumers might be at odds with the pressure felt by coworkers (e.g., clinicians) to prevent suicide in their clients, and peer specialists working in suicide prevention seem to be hindered by the problems with which all types of peer specialists struggle generally, such as collegial reluctance and stigma (Vandewalle et al., 2016). In order to improve working relations and optimize the potentially beneficial role of peer specialists, more mutual trust seems to be essential for peer specialists to function. More dialogue between mental health care clinicians and peer specialists is therefore necessary, as pointed out by Thomas (2011).

In conclusion, our study implies that peer specialists may fulfill a unique role in suicide prevention, providing support to suicidal peers, inspiring empowerment through recovery narratives, and breaking the silence around discussing suicide in a caring conversation. As such, their role is promising for reducing the number of suicides, on the condition that the pitfalls, issues, and burdens are alleviated and addressed by further professionalization and supervision of this group.

Limitations

Our study is qualitative in nature, and it relies on exploring the perspectives of peer specialists, which seems appropriate considering the nascent stage of the field's development. Regardless, future work would eventually also need to make use of large-scale studies using effect measurements. Our study design might have resulted in self-selection bias in the sense that half of the sample was contacted via our network. Nevertheless, this potential bias was mitigated by also recruiting half of our sample through random procedures; no differences between the participants in the

sample were observed. The work settings and organizations providing mental health care and related peer specialist training in our sample varied substantially. This was deliberate, as we wanted to capture the various ways in which peer specialists are active in the field of suicide prevention. However, this prevented us from systematically comparing and reporting on specific types of mental health care.

Implications for Practice and Further Research

In our study, peer specialists articulated several conditions that they felt need to be met in order for them to successfully work with suicidal care consumers. Peer specialists need to find a balance between being involved with a suicidal client but at the same time still maintain some distance. The peer specialist should be reluctant to share details of their own suicide attempts or suicide plans with clients. Most important, they should discuss with their colleagues the role and boundaries of a peer specialist's work with regard to suicide risk assessment, suicidal crisis situations, personal safety, privacy (e.g., keeping secrets), and sharing responsibility. Both peer specialists and their team members should be encouraged to talk about their suicidal experiences and recovery in order to break the taboo surrounding the subject. More education as well as supervision for peer specialists in this regard might be beneficial to help tackle these issues.

In terms of further research studies into the effects of peer specialists on suicide prevention, it should be noted that the role of a peer specialist seems to be more personal in nature than that of health care clinicians and seems to be more difficult to describe or standardize. Taking on this role may depend a great deal on the individual's personality, skills, and knowledge in order to determine if someone is up to the task. Consequently, there may be a lot of variation in the type of (unprotocolled) care that peer specialists offer, which may influence their effectiveness in preventing suicidality, as well as serve as a complicating factor in terms of taking systematic testing of empirical effect in future research.

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