



Preliminary Evaluation of Lived Experience of Suicide Training: Short-, Medium- and Longer-Term Impacts of Our Voices in Action Training

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Abstract

Despite increased participation and multiple workforce roles of those with lived experience in suicide prevention, there are no evaluated training programs to support this population. This study evaluated a training program aimed to prepare people for these important roles. Survey data at pre-, post- and at three- and 12-month follow-up were used measuring knowledge, attitudes, and self-efficacy, as well as psychological distress as a safety measure. Participants experienced significant gains in knowledge after training, although not all aspects of knowledge were maintained at follow-up. Self-efficacy was examined through confidence and empowerment. Confidence gains were significant at immediate and longer-term follow-up but gains in empowerment were not maintained over time. Participants' positive attitudes improved but this was not significant. There was no indication of increases in psychological distress in participants throughout the training and follow-up periods. Implications of these outcomes are discussed.

Keywords Lived experience · Suicide prevention · Training evaluation

Introduction

Learning from people who have lived experience and have been impacted by suicide themselves has been recognised as an essential component of effective suicide prevention strategies (Commonwealth of Australia, 2021; Nicholas et al., 2017; Suomi et al., 2017; Watling et al., 2020). The present study defines lived experience of suicide as “having experienced suicidal thoughts, survived a suicide attempt, cared for someone through suicidal crisis, or been bereaved by suicide” (Roses in the Ocean, 2016). In suicide prevention, the multiple workforce roles of people with lived experience include co-design, development, implementation, and evaluation of suicide prevention programs, advising on policy and speaker engagements for awareness raising, undertaking research, and the provision of support to others who are

bereaved by suicide and/or who are suicidal (Suomi et al., 2017; Watling et al., 2020). Despite the increasing focus on participation of those with lived experience (Suomi et al., 2017), there are no training models to support this population in undertaking their important roles in the suicide prevention workforce. Targeted evidence-informed and culturally safe training is needed to prepare this workforce for these important roles.

Lived Experience Program Outcomes

Reviews have found that mental health services led by or involving consumers can result in positive outcomes equivalent to those of traditional services (Doughty & Tse, 2011; Simpson et al., 2014). While lived experience of mental illness has long been acknowledged and validated as a critical component of consumer care, the purposeful inclusion of lived experience in suicide prevention activities is an emerging and different concept for policy, practice, service provision, and research (Bellamy et al., 2017; Hawgood et al., 2018). There are several reasons why training programs for mental illness advocates fail to meet the training needs of those with lived experience of suicide. Firstly, research has demonstrated that failure to discuss suicide safely can

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increase suicide risk and stigma (Joiner & Silva, 2012; McTernan et al., 2018). There is a clear need for targeted training on suicide-specific safe language for lived experience representatives in this field to avoid further harm and trauma to individuals and communities. Secondly, despite being associated with mental illness (Gunnell et al., 2020; Hjorthøj et al., 2014), suicide is fundamentally a “behavioral act” and not a manifestation or symptom of mental illness (De Leo, 2011). As such, representatives with lived experience of suicide require an understanding of these differing aetiologies and prevention pathways to apply evidence-informed knowledge and skills in the workforce.

Currently, there is no evidence in the literature for the impact of lived experience suicide prevention training on the participants of these programs. While researchers have started to focus on lived experience in suicide prevention training (for example, Wayland et al., 2020), following a literature search, to the authors’ knowledge, this study is the first to report on the training impacts and effectiveness of suicide prevention-specific lived experience training. There is some evidence derived from the ‘lived experience of mental illness’ domain that can provide some insight into the psychological impacts of training involvement of potentially vulnerable populations. Evaluations of these programs have reported no negative impacts on participant wellbeing (Simpson et al., 2014). In fact, positive impacts such as increased participant knowledge of mental illness symptoms, confidence in supporting people experiencing mental illness, and confidence in personal recovery have been reported (Meehan et al., 2002; Simpson et al., 2014; Tse et al., 2014). However, while positive, these findings and indeed the training programs themselves cannot necessarily be directly translated to understandings of lived experience in suicide prevention training.

Research continues to reveal the unique suicide-related stigma experienced by people who have lost someone to suicide (Pitman et al., 2016) and those who have attempted suicide themselves (Rimkeviciene et al., 2015, 2021). As such, training for a suicide-specific lived experience workforce must incorporate these distinctive experiences. Importantly, given those who have been previously affected by suicide are at an elevated risk of suicide themselves (Franklin et al., 2017; Pitman et al., 2016), participant safety must be embedded throughout program design and delivery.

A qualitative investigation by Wayland and colleagues (2020) explored the narratives of 20 participants with lived experience of suicide in Australia. These participants had undertaken speaker training to support their participation as representatives within the suicide prevention sector. The study “was designed to explore what it means to be a representative with lived experience of suicide, what motivates people to become involved in these activities and how undertaking these events is experienced” (p. 3). Study outcomes

revealed diverse perspectives on several themes, which differed based on participation in speaking and other engagements since training. Specifically, the four themes included definitional challenges and a lack of consensus; awareness of the benefits from lived experience participation; challenges that stem from lived experience involvement; and the need for prioritizing ongoing care. These invaluable findings provide long term perspectives of lived experience engagements and impacts, as well as critical considerations for safety of this workforce.

There is a need to conduct evaluations of lived experience of suicide initiatives to develop evidence-informed policy, practice, and service delivery in suicide prevention. Specifically, there is a need to determine impacts of this training on psychological well-being and self-esteem of participants, as well as their perceptions of competency and actual competency in elements of the lived experience role (Hawgood et al., 2018; Tse et al., 2014). In addition, we also need increased understanding about the processes and impacts of conducting such evaluation research involving those with lived experience. To address these needs, we evaluated a lived experience training program, which was developed and delivered by Roses in the Ocean (RITO), a national lived experience organisation in Australia, to determine a range of training impacts on participant capabilities and experiences. The mission of RITO is to empower people with lived experience of suicide to inform, influence, and enhance suicide prevention. RITO has designed and developed several training programs that aim to build the capacity of individuals with lived experience of suicide, to communicate their stories effectively and safely, and participate in the suicide prevention workforce. The focus of the current evaluation is on the training program, *Our Voice in Action*.

‘Our Voice in Action’ Training Program

Our voice in action (OVIA) is an introductory capacity building program for people with a lived experience of suicide. It is designed for all experience levels as a foundation for developing competency around meaningfully participating in a range of suicide prevention activities (Roses in the Ocean, 2016). The two-day program is delivered by facilitators with lived experience of suicide who have completed OVIA and undergone ‘Train the Trainer’ facilitator training. OVIA learning outcomes include enhancement of knowledge of suicide, safe language when discussing suicide, self-efficacy/empowerment, attitudes to lived experience suicide prevention, perceived confidence, collaboration and conflict management, communication skills, and self-care. Each training program has a small number of participants, which allows for the scope and depth of the training to understand one’s own experiences and the diversity of lived experience perspectives, as well as the complexity of

managing group dynamics in a dynamic setting. Two facilitators are appointed as part of creating a safe and supportive environment and for providing personalized attention for all participants.

The Current Study

The Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University was commissioned by RITO to undertake a formal evaluation of OVIA training across different jurisdictions of Australia in which the program was delivered. Data for this study was derived from AISRAP collected data from OVIA, as well as from the Black Dog Institute (BDI) who collected data from OVIA (as part of the LifeSpan suicide prevention trial) in New South Wales (Shand et al., 2020). Once all data was collected AISRAP analyzed the total data pool, which are the results presented in this study.

The aim of this evaluation was to assess the effectiveness of the OVIA program on learning outcomes, which included participant knowledge, attitudes, and self-efficacy. We used a conceptual model proposed by Burnette et al. (2015), as well as the learning outcomes of the OVIA training program, to guide the design and development of key constructs for the evaluation measures.

The Burnette and colleagues' (2015) model describes the pathways between training and intervention behaviours. The authors propose that an individual's decision to intervene with someone who is suicidal is based on the influence of four factors; knowledge about suicide, beliefs and attitudes about suicide prevention, reluctance and stigma, and self-efficacy to intervene. They further propose that individual characteristics (demographic and professional background factors) and systemic issues (social context including workplace resources and support) can influence how training impacts these four factors. The developed measures in the current study were based on the constructs of knowledge of suicide, knowledge of safe language for discussing suicide, attitudes to lived experience in suicide prevention, confidence in lived experience tasks, and self-efficacy or empowerment. Given the lack of lived experience training evaluation in the suicide prevention literature, as well as the critical emphasis placed on 'do no harm' principles and safety of OVIA facilitators and participants, a measure of psychological distress was also included. Two researchers with lived experience of suicide provided advice on methodology and design, as well as reviewing measures and interpretation throughout the project to guide sensitivity and safety mechanisms concerning those affected by suicide.

Based on the previous evaluations of lived experience of mental illness and peer training programs, as well as the factors influencing outcomes, we expected significant

differences to be observed between pre and post, and follow-up measures on all outcome measures. This included increases in knowledge of suicide and safe suicide-related language, attitudes to lived experience in suicide prevention, confidence in lived experience tasks, and increased sense of self-efficacy. We did not expect significant increases in psychological distress over time in the sample due to the standardized safety measures implemented at training recruitment and readiness processes as part of RITO training approach.

Method

Volunteer participants of OVIA workshops conducted between March 2018 and March 2020 were recruited for this study. Each training session included a minimum of six and maximum of eight participants due to safety and facilitation requirements. All OVIA participants completed a readiness exploration process, which is a protocol for ensuring people make an informed decision as to their readiness before undertaking training. This is consistent with the RITO safety and support principles when engaging those with lived experience of suicide, and was a requirement by the training organizations, rather than as a requirement for participation in this research study. Additionally, this process involves discussions around, and identification of, important support structures and self-care rituals both for involvement in training and for future work in suicide prevention. The study was approved by Griffith University Human Research Ethics Committee (GUHREC No: 2018/315). Evaluation approval pertained only to the analysis and reporting of de-identified evaluation questionnaires. All data collection activities were conducted by the facilitators through the training organisation (RITO). The study undertaken by Black Dog Institute for the LifeSpan suicide prevention trial sites, was approved by the Hunter New England Human Research Ethics Committee (REF No: 16/09/21/4.05).

Sample Size and Participant Demographics

Demographics of the sample ($N = 89$) are outlined in Table 1. The majority of participants were female (74.2%) with a mean age of 46.9 years ($SD = 13.6$). Just over 10% of participants identified as Aboriginal and/or Torres Strait Islander. Sixty-four participants were included in the AISRAP data collection and 25 in the BDI evaluation.

All participants reported a lived experience of suicide, as shown in Table 2. Almost half of participants had cared for someone who was suicidal or had attempted suicide, and 41% had attempted suicide themselves. Over three quarters of the participants had multiple types of lived experience of suicide.

Table 1 Demographics of participants

	<i>n</i> (%)
Sex	
Male	23 (25.8)
Female	66 (74.2)
Total	89 (100)
Age	
18–44	36 (41.4)
45–64	46 (52.9)
65–71	5 (5.7)
Missing	2 (2.2)
Total	89 (100)
Aboriginal and/or Torres Strait Islander	9 (10.2)

further to 22 and 17 matched participants for analysis at three and 12 months respectively.

Measures

Evaluation measures were guided by both theory (Burnette et al, 2015) and OVIA program learning objectives and expected outcomes. These outcome indicators included domains of knowledge (suicide literacy and safe language when discussing suicide), attitudes to lived experience suicide prevention, and self-efficacy (confidence in carrying out lived experience tasks and empowerment). An additional construct, psychological distress, was identified as important for evaluating potential impacts of training on participants with lived experience. Standardized scales were used if there was alignment with the identified learning outcomes in the OVIA training. Where no standardized measures existed, the authors developed scales following a detailed examination of the program materials and learning outcomes. Table 3 provides a list of study measures (standardized and author developed) and their characteristics. Due to differences in the scope of work across the two sites of this study, three scales (Distress Questionnaire, Safe Suicide Language Scale, and Attitudes to Lived Experience Scale) were only used by AISRAP for this study.

Table 2 Lived experience of participants

	<i>n</i> (%)
Lived experience of suicide	
I have had or continue to have suicidal thoughts	60 (67.4)
I have attempted suicide	41 (46.1)
I am bereaved by suicide	63 (70.8)
I have cared/continue to care for someone who is suicidal or attempted suicide	49 (55.1)
Two or more types of lived experience	68 (76.4)

Data Collection

Participants completed the evaluation survey before and after training, as well as at three-month and 12-month follow-up in order to examine differences in knowledge, attitudes, and self-efficacy across these time points. There was some attrition over time in the sample, where 69 matched participants completed both the pre- and post-training surveys, reducing

Literacy of Suicide Scale (LOSS) (Calear et al., 2012)

This 12-item scale measures knowledge of suicide and suicide-related warning signs, and includes items associated with a range of common suicide myths. A multichotomous response format was used in which participants responded to statements about suicide with corresponding True/False/Don't Know response options. An overall total score was calculated as the percentage of correct responses, where 'Don't Know' responses were scored as incorrect.

Table 3 Details of study measures: standardised and developed for study

Measure	Items	Measuring	Author	Reliability (sample)
Literacy of Suicide Scale (LOSS)	12	Knowledge of suicide and suicide-related warning signs	Calear et al.(2012)	Not available
Safe Suicide Language Scale (SSLS)	5	Knowledge of safe language in suicide-related communication	Developed for study	$\alpha = 0.79$ ($N = 62$)
Confidence in Lived Experience Tasks	5	Confidence in key activities as a lived experience representative	Developed for study	$\alpha = 0.85$ ($N = 88$)
Attitudes to Lived Experience Scale (ALES)	3	Value of lived experience contributions to suicide prevention activities	Developed for study	$\alpha = 0.93$ ($N = 64$)
Empowerment Scale (adapted)	20	Locus of control, self-efficacy, and self-esteem	Rogers et al. (1997)	$\alpha = 0.72$ ($N = 84$)
The Distress Questionnaire-5 (DQ-5)	5	Psychological distress	Batterham et al. (2016)	$\alpha = 0.86$ ($N = 1559$)

Safe Suicide Language Scale (SSLS)

This 5-item scale was developed by the authors to assess participant knowledge of safe language use. A dichotomous response format was used in which participants were asked to choose the safest terminology between two alternative statements or phrases pertaining to suicide language. Item content was drawn from the Mindframe-media guidelines on reporting and portrayal of suicide (Department of Health & Ageing, 2006; Everymind, n.d.), which were included in both training programs. An overall score was calculated as the percentage of correct responses.

Attitudes to Lived Experience Scale (ALES)

This three-item scale was developed by the authors to assess participants self-rated value of lived experience towards suicide prevention activities within their community. It uses a 5-point Likert Scale ranging from 'Strongly Disagree' to 'Strongly Agree' with total scores ranging from 3 to 15.

Confidence in Lived Experience Tasks (CONF LE)

This five-item scale was developed by the authors to assess perceived confidence regarding capability to participate in suicide prevention activities as a person with lived experience of suicide. Participants were asked to rate their current level of confidence on a five-point Likert Scale ranging from 'Not confident at all' to 'Extremely confident'. Total scores ranged from 5 to 25, with higher scores indicating greater confidence in these lived experience activities.

Empowerment Scale (Rogers et al., 1997)

This 20-item scale assesses locus of control, self-efficacy, and self-esteem using a four-point Likert scale ranging from 'Strongly Disagree' to 'Strongly Agree'. This scale was adapted by the authors of this study by removing eight

items that were deemed either irrelevant, inappropriate, or potentially emotionally distressing for the lived experience sample. The final version was reviewed by the lived experience consultants prior to the study and had adequate internal reliability [as shown in Table 3, the internal validity in the current study sample was adequate, $\alpha = 0.72$ ($N = 84$)]. Total scores ranged from 4 to 80, where a higher score indicated a greater sense of personal empowerment.

The Distress Questionnaire-5 (DQ-5) (Batterham et al., 2016)

This five-item scale is a population screener of psychological distress. Items are scored on a five-point Likert scale ranging from 'Never' to 'Always'. Total scores ranged from 5 to 25, where higher values reflect greater psychological distress.

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Results

Data Analysis

Matched pair sample analyses were conducted between the pre and post surveys, and between the pre- and the follow-up surveys. The means and standard deviations across all survey administrations are shown in Table 4. The number of matched pairs were reduced for responses to the DQ-5, ALES, and the SLSS as they were only used in the AISRAP evaluation samples (see Table 5). All analyses were calculated using SPSS Statistics 26.

There was a statistically significant increase from pre- to post-workshop in the correct responses on the Literacy

Table 4 Means and standard deviations pre- to post-training and pre-training to follow-up

Outcome measures	Pre		Post		Follow-up (3 months)		Follow-up (12 months)	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
LOSS	76.50	14.95	87.32	12.26	86.74	12.51	86.74	12.51
SLSS	84.06	26.47	95.91	14.03	90.91	21.14	93.33	20.00
ALES	13.89	2.33	14.18	1.96	14.14	2.64	14.56	0.88
Empowerment	58.88	6.03	60.96	6.35	62.76	7.89	62.56	7.75
DQ-5	11.63	4.51	10.91	3.75	11.67	4.52	11.81	4.58
Conf LE	12.68	3.32	14.84	3.09	14.68	3.14	15.30	3.08

LOSS Literacy of Suicide Scale; *SLSS* Safe Suicide Language Scale; *ALES* Attitudes to Lived Experience Scale; *ES* Empowerment Scale; *DQ-5* Distress Questionnaire-5; *Conf LE* confidence in lived experience tasks

Table 5 Wilcoxon signed ranks outcomes from pre- to post-training and pre-training to follow-up

Outcome measures	Pre- Post			Pre- 3-month follow-up			Pre-12-month follow-up		
	<i>n</i>	<i>Z</i>	<i>p</i>	<i>n</i>	<i>Z</i>	<i>p</i>	<i>n</i>	<i>Z</i>	<i>p</i>
LOSS	69	5.92	0.000**	22	3.01	0.003**	17	3.81	0.003**
SLSS	44	3.19	0.001**	21	1.03	0.305	9	0.816	0.414

* $p < 0.05$; ** $p < 0.01$

of Suicide Scale (LOSS) in a Wilcoxon Signed Ranks test ($Z = 5.92$, $p < 0.000$), as shown in Table 5. There were also significant increases observed between pre- and follow-up evaluations (for both three- and 12-month follow-up) indicating that knowledge increases were maintained following training ($p = 0.003$; $p = 0.003$). The scores of the Safe Suicide Language Scale (SSLS) were statistically significant between pre- and post-training ($Z = 3.19$, $p = 0.001$), but this difference was not maintained at three or 12-month follow-up ($p = 0.305$; $p = 0.414$).

For examining changes in scores on the Attitudes to Lived Experience Scale (ALES), Confidence in Lived Experience Tasks (CONF LE), Empowerment Scale, and the Distress Questionnaire-5 (DQ-5), parametric tests were conducted as assumptions were met for these measures, which are reflected in Table 6. For the ALES, no significant differences were observed between pre- and post-training ($t = 1.56$, $df = 1$, $p = 0.126$) or at three- or 12-month follow-up ($t = 0.85$, $df = 1$, $p = 0.404$; $t = 1.78$, $df = 1$, $p = 0.113$). The mean CONF LE scale scores increased significantly from pre- to post-training ($t = 6.57$, $df = 1$, $p = 0.000$), and were maintained at the 12-month follow-up ($t = 8.68$, $df = 1$, $p = 0.000$), but interestingly not at three-month follow-up ($t = 1.54$, $df = 1$, $p = 0.138$). Empowerment Scale scores increased between pre- and post-training at a significant level ($t = 3.50$, $df = 1$, $p = 0.001$). These improvements, however, were not maintained at three- or 12-month follow-up ($t = 0.93$, $df = 1$, $p = 0.364$; $t = 1.48$, $df = 1$, $p = 0.160$). Lastly, participants reported experiencing less psychological distress after training, with a statistically significant change from pre- to post-training on the DQ-5 ($t = 2.07$, $df = 1$, $p = 0.044$). This difference was not significant at either three- or 12-month follow-up ($t = 0.32$, $df = 1$, $p = 0.751$; $t = 0.25$, $df = 1$, $p = 0.630$).

Discussion

The aim of this study was to evaluate the effectiveness of the RITO OVIA program on three main domains of learning outcomes, which according to Burnette and colleagues' (2015) theoretical model, should in turn result in positive intervention behaviours. The learning domains in this study proposed to be influenced by OVIA training included knowledge (literacy and safe language), attitudes (towards lived experience of suicide), and self-efficacy (perceived confidence in carrying out lived experience tasks/activities and empowerment). Overall, we found that after the training, participants experienced increased significant improvements in knowledge about suicide, specifically on literacy around suicide and suicide warning signs and responses to suicide. However, knowledge of safe language use did not significantly improve. Notably, there were also no significant differences in attitudes towards the role of lived experience in suicide prevention, which could be attributed to a combination of a sampling procedure that included lived experience participants who already had positive attitudes, as well as restricted measurement ability. That is, these participants were actively seeking and expressing an interest in suicide prevention, while a three-item measure restricted the ability for gains to be measured. However, participant confidence in implementing lived experience tasks increased following training as did their sense of self-empowerment, which was consistent with the study hypotheses. Finally, there was a significant decrease in psychological distress experienced immediately after training. The results of this study indicate that the training program had positive impacts on participants and that the OVIA learning objectives are suitably matched with the desired outcomes. These findings and limitations of the study are detailed below.

Table 6 T-test outcomes from pre- to post-training and pre-training to follow-up

Outcome measures	Pre- post			Pre- 3-month follow-up			Pre-12-month follow-up		
	<i>n</i>	<i>t</i>	<i>p</i>	<i>n</i>	<i>t</i>	<i>p</i>	<i>n</i>	<i>t</i>	<i>p</i>
ALES	44	1.56	0.126	22	0.85	0.404	9	1.78	0.113
Empowerment	68	3.50	0.001**	21	0.93	0.364	16	1.48	0.160
DQ-5	43	2.07	0.044*	20	0.32	0.751	16	0.25	0.530
Conf LE	68	6.57	0.000**	21	1.03	0.305	16	8.68	0.000**

* $p < 0.05$; ** $p < 0.01$

Training Program Outcomes

Knowledge

We found that the OVIA program successfully increased participant knowledge following training. Participants' suicide literacy was significantly enhanced, not only in the immediate and short term, but at 12-months after OVIA training. Literacy of suicide has been defined as understanding warning signs and contributing factors towards suicidality and suicide and identifying appropriate responses for prevention of suicide (Batterham et al., 2013). OVIA may therefore contribute to participants' understanding and recognition of warning signs (and the enhanced ability to identify these signs in others), as well as their general knowledge of suicide to support their work in the suicide prevention sector. That literacy gains were maintained over time in our study is remarkable as other studies with non-lived experience training samples have found that immediate knowledge gains on the LOSS do not necessarily sustain over time (Perceval et al., 2020). However, our findings regarding increases in safe language knowledge immediately after training were not maintained at the three- and 12-month follow-up assessments. This may indicate a need for reinforcement of safe language use after training for knowledge retention on this construct. Importantly, however, due to the smaller numbers in our sample at follow-up for this knowledge indicator as compared to others, these findings should be interpreted with caution. Exploration of whether the use of safe language is sustained over time with a larger population is necessary to determine whether this outcome is a true reflection of poor learning outcomes, or whether it is a function of the study parameters. Nevertheless, retention of knowledge of safe language use remains important for working in this suicide prevention sector. While we were unable to find other similar studies of training in appropriate suicide-related language use, we propose that additional emphasis on this learning domain as part of RITO's ongoing mentoring or as part of regular psychoeducation and support would be beneficial. In the context of the Burnette et al.'s model (2015), the influence of OVIA training on participant knowledge suggests a potential positive impact on the likelihood of participants to intervene or apply the knowledge acquired.

Attitudes

Results showed that after attending the OVIA program, participants had more positive perceptions about lived experience stories and the essential nature of lived experience in suicide prevention programs. However, this was not a statistically significant change over time. It appears that a combination of pre-existing positive attitudes, along with measurement issues on the developed scale, may have

contributed to a ceiling effect preventing discrimination of higher positive scores on attitudes over time and therefore attitude change was inadequately measured for this sample. Given that Burnette and colleagues' (2015) identify attitudes as important for influencing an individual's decision to intervene or in this case engage positively in the lived experience role in suicide prevention, this construct remains worthy of further exploration. Indeed, the findings highlight a need for test construction with a more robust measure of attitudes of those with lived experience engaging in suicide prevention. A new robust measure for this specific construct, or a wider battery of existing attitudes to suicide prevention measures, may be required to more rigorously explore the impact of training on attitude change in future replication studies.

Self-Efficacy

Perceived confidence in capabilities has been found to predict utilization of skills in mental health even in the absence of training programs (Rossetto et al., 2016). Confidence following suicide prevention gatekeeper training has been widely investigated as an important factor in contributing to changes in intervention behaviour (Burnette et al., 2015; Hawgood et al., 2021). Confidence improvements have also been found to be one of the most enduring in suicide prevention gatekeeper training, despite equivocal evidence for impacts on changed behaviour (Holmes et al., 2019). In line with the literature, we expected significant increases in confidence after training and that this would be maintained to promote higher likelihood of future engagement in respective lived experience tasks. Results showed that while confidence improved significantly from pre- to post-training, interestingly, confidence reduced at the three-month follow-up measurement, yet increased again to significantly higher levels at 12 months follow up compared to pre-training levels. We found only one other suicide prevention training study which found fluctuating confidence levels over time (Jacobson et al., 2012). These results may reflect the fluctuating nature of self confidence in different participants over time, potentially influenced by the different levels of engagement in, and opportunities for, working in the suicide prevention sector. Nevertheless, there is a need to determine the extent to which one feels more confident in the different capabilities for working in the lived experience role within the suicide prevention sector. More research is required to disentangle the influence of perceived confidence following training, and the respective influence on lived experience contributions in the sector.

In the mental health literature, the construct of empowerment has been identified as critical to effective consumer-led services (Rogers et al., 2010). It encompasses both a sense of self-worth and value, and the confidence to impact or enact change in the community (Corrigan et al., 1999). Our study

is the first in suicide prevention lived experience training to investigate whether training can enhance empowerment in participant self-efficacy. We perceived empowerment as universally applicable to the role of lived experience in suicide prevention. In the present study, significant increases in empowerment scores from pre-training to post-training suggest that the training may have resulted in participants feeling better equipped to participate in suicide prevention activities in their lived experience role. However, the significant differences were not maintained at three- or 12-month follow-up, which may suggest that while participants experienced an immediate feeling of empowerment post training, the training itself was unable to sustain this over time. Thus, in the context of the Burnette et al.'s (2015) model, this factor may not contribute to, or influence the ability to, enact different capabilities in the lived experience of suicide workforce without further maintenance training. It is worth noting that opportunities for lived experience contributions in suicide prevention are new and developing, and so the concept of feeling empowered to participate in any related role is not yet well understood. In any case, further exploration of the underlying reasons for the lack of retention around empowerment as measured in this study is warranted.

Psychological Distress

Analysis of psychological distress in our sample was considered essential as it is a commonly held concern that any discussion of suicide will be traumatizing or harmful (Batterham et al., 2013). This is especially so for those considered to be within 'at-risk' groups, such as those who have made previous attempts or those bereaved by suicide. Our results indicate that suicide can be discussed safely and sensitively with people with a lived experience of suicide (Sheehan et al., 2019). Participants reported significantly less psychological distress after attending the OVIA program compared to the pre-training measurement, suggesting that engaging in the program did not have a negative impact and may have in fact resulted in decreased psychological distress. Further, this finding may suggest that speaking about personal experiences in the context of learning about different suicide prevention capabilities, and their future role in suicide prevention can be done in a safe manner. However, our findings should be interpreted considering the following. Firstly, all RITO training involves a pre-training discussion where participants are given the opportunity to explore and self-assess their 'readiness' for the training (see [Method](#) section for reference to the additional focus on support structures and self-care rituals as part of the readiness process). The outcome of this process may mean that our sample of participants already had lower psychological distress upon entering the training, and therefore, may not be representative of the entire lived experience of suicide

population participating in suicide prevention. Finding a balance between ensuring a broad range of lived experience expertise is contributing to and participating in the suicide prevention sector, while mitigating any potential exposure to distress and/or re-traumatization during training is paramount. Secondly, while immediate significant declines in psychological distress scores were observed post-training, these were not maintained over time. Fortunately, there were no significant changes pointing to increases in psychological distress over time. Indeed, recent research has highlighted the importance of monitoring participant safety and psychological well-being not only post training but in an ongoing way to support the differing roles and participation frequency and experience of those with lived experience in suicide prevention (Wayland et al., 2020). In their qualitative paper on the experiences of those with lived experience, these authors identified 'ongoing care' as a primary theme for post-training support. Despite the lack of evidence for psychological distress in our sample, taken together with these authors' findings, there is a clear need for evaluation measures to determine readiness not just for training per se, but in terms of ongoing readiness and perceived capability of participants with different levels of experience once they enter the suicide prevention sector. Future evaluations could investigate factors unrelated to psychological distress, that likewise may affect readiness such as whole of life circumstances, changes in employment status, or changes in levels of interest in lived experience work. Such insights may assist the understanding of 'ongoing readiness' of participants, as well as informing strategic policy and planning needed to support the rapidly emerging lived experience workforce in an appropriately resourced, sustainable, and supported manner.

Impact for Future Lived Experience Training Programs

Previous studies have identified that the involvement of people with lived experience of suicide in all levels of the sector, from program design, evaluation, and policy to service delivery, should include adequate and ongoing education and training (Lloyd & King, 2003; Mahlke et al., 2014; Meehan et al., 2002). Evaluation of the OVIA training program has revealed positive outcomes on several measured factors known to influence behaviours—in this case, factors specific to contributing to lived experience informed suicide prevention. We found that OVIA training modules associated with knowledge (literacy of suicide and suicide prevention) results in immediate and ongoing knowledge retention. Safe language related knowledge may require further emphasis in refresher or other training support offerings in the three to 12 months post initial training. It appears that self-efficacy

improved, although some fluctuations in confidence may offer an opportunity for additional support, mentoring, and/or an opportunity for skills application of gained lived experience expertise. Our findings on participants' feelings of empowerment were not unlike their self-rated confidence levels. In the time since completion of this study, several recommendations from the findings have been implemented by RITO. For example, a brief workshop called LaunchPad has been offered to all participants post training to assist the group to develop an action plan for future expertise implementation, to maintain group momentum, and to empower group engagement over time. Other post-training initiatives have been developed and piloted, which focus on establishing community engagement, developing advocacy and decision-making skills, and to provide assistance in identifying pathways to working in suicide prevention peer worker roles. Finally, RITO are in the process of establishing a 'Community of Practice' and associated initiatives for supporting OVIA participants and their engagement in roles of lived experience advisory groups.

From the results of this study, it appears that the process of self-rated readiness for training may play an important role in ensuring participants enter the training with minimal distress. The low levels of observed psychological distress both at entry to and after the training may be due to participants' pre-existing self-care strategies, which are enquired about in the readiness assessment process. Self-care strategies may therefore be an important additional factor for entering lived experience of suicide training workshops, in terms of preparedness for the impact of suicide related training content.

Limitations and Future Evaluation Research

There are several limitations of this study that can inform future research. Firstly, assessing training outcomes was limited by the number of available and valid measures. Therefore, the authors of the study developed measures of perceived confidence, safe language around suicide, and attitudes around the value of lived experience in suicide prevention. These measures have not been psychometrically validated and therefore require rigorous evaluation on larger samples. Given the measurement issue for attitudes, a re-developed or modified attitudes scale is required for training evaluations and lived experience in suicide prevention. Additionally, while the Empowerment Scale was adapted by a lived experience consultant for this study and we assessed its reliability in the adapted form, we did not compare its reliability to the reliability of the original scale. Given the infancy but rapidly growing nature of lived experience of suicide workforce in suicide prevention worldwide (Watling et al., 2020), we recommend increased attention to

the development and validation of training evaluation assessment tools specific to lived experience suicide prevention. Further, despite the unique training format of delivery for lived experience of suicide populations in the suicide prevention sector (i.e., specific sized training groups), there is a need for larger sample sizes and longer project timeframes allowing for more meaningful and reliable training impacts.

It should be acknowledged that there is a lack of evidence regarding training programs for lived experience of suicide representatives in the domain of suicide prevention worldwide, and so we were unable to make comparisons with training program literature to examine nuanced outcomes from our study. Nonetheless, the current study provides valuable contributions to the literature base which can be used to pave the way for more research in this field.

The issue of participant attrition at three- and 12-month follow-up points is both remarkable and challenging in our study. It is possible that the high attrition is related to participants not engaging in the workforce sector subsequently, or not being contacted and engaged in support networks that might sustain their connection with participants from the training or the sector generally (Wayland et al., 2020). Nevertheless, this lack of deep understanding of the key reasons for attrition rates in our study represents an important limitation, which may have benefited from more systematic analysis and exploration of attrition trends, offering deeper insight into these trends for current and future research studies. Small numbers of participants also may reduce the reliability of results on all measures and the generalizability of results. However, it is noteworthy that lived experience of suicide training necessarily requires small numbers of participants by design. Further qualitative research may therefore be required to capture and understand lived experience in suicide training programs. In any case, the importance of retention of program learning outcomes of the training is critical to inform subsequent refresher, mentoring, and other forms of required support for the emerging lived experience workforce in suicide prevention.

Understanding the 'type' of lived experience of suicide that participants identified as having and its relationship to training outcomes is a valuable future endeavour with larger samples. As indicated in Burnette et al.'s (2015) model, individual characteristics can influence the role of key training outcomes being measured (e.g., knowledge, attitudes, confidence, empowerment as measured in this study). It is plausible that different types of lived experience of suicide influences scores on evaluation measures, and these were not assessed in our study due to small sample sizes. Alternatively, training needs and outcomes may differ based on the roles people wish to engage in within suicide prevention irrespective of their 'type' of lived experience. That is, OVIA and other training programs offered by RITO are delivered to all types of lived experience participants

together, and “based on 10 years of observations, there does not appear to be benefits when delivery capacity building workshops to separating training participants based on the nature of their lived experience of suicide. To the contrary, we have observed and received much feedback about the benefits of being able to hear perspectives from all different types of lived experience—many saying they learn from each other which often helps fill in some of the missing pieces for them in their understanding of what others experience” (B. Edwards, personal communication, 28th April, 2021).

Just over 10% of our sample identified as Aboriginal and/or Torres Strait Islander persons, which is relatively small despite this group experiencing a disproportionate rate of suicide in Australia. Inclusion of Aboriginal and/or Torres Strait Islander and culturally and linguistically diverse people, and other priority populations groups such as LGBTIQ+ and men with a lived experience of suicide to review and contribute to this program content may support the recruitment of more participants from these communities. Due to the small numbers of this evaluation, it was not possible to examine whether training outcomes varied with cultural differences. Further research with larger sample sizes is needed to address this limitation of the current study. This would ensure the developing lived experience of suicide workforce is reflective of the broader lived experience of suicide in Australian communities.

At this stage there is no information regarding sexually and/or gender diverse peoples’ participation or experiences in these training workshops, though these groups also experience higher suicidality. As a result of the recommendations from the current study, future RITO training evaluations will include surveys reviewed by LGBTIQ+ people with a lived experience of suicide. Specifically, more suitable gender and sexuality demographic identification items have since been developed to better understand the impact, and appropriateness of training on this diverse and other populations. Involvement of lived experience from all population and cultural groups who attend lived experience training should be considered as essential in future training evaluation planning, design, delivery and translation. Since the completion of this study, Roses in the Ocean have established an LGBTIQ+LE of suicide attempt action group who have reviewed and enhanced the OVIA workshop and have commenced review work on the Voices of Insight (VOI) program.

Conclusion

To our knowledge, this is the first study to explore the effectiveness of training programs for people with a lived experience of suicide to increase their capabilities to participate

and provide unique ‘lived experience’ contributions in suicide prevention. The OVIA program increased knowledge about suicide literacy (in the immediate, short, and longer term), safe language (immediate term), perceived confidence (in the immediate and long term), empowerment (in the immediate term), and reduced psychological distress. Although no attitudinal change was observed, this was likely due to pre-existing positive attitudes and the use of a limited attitude measure developed for this study. Further examination of the impact of the OVIA training program on attitudes is required. Replicating these findings in larger sample sizes and over longer time periods will assist understanding of training outcomes for this population. One notable finding from this study was that people with a lived experience of suicide participating in the OVIA program did not demonstrate increased psychological distress post-training. However, ongoing monitoring and support to ensure that participants continue to feel safe and supported over time, particularly in relation to their key lived experience roles in the sector would be beneficial (Wayland et al., 2020).

The outcomes of this evaluation provide unique and novel research findings contributing to our understanding of lived experience in suicide prevention activities. It is essential that rigorous research on the effectiveness of lived experience of suicide training programs build on these learnings to continue to explore participant learnings and experiences to guide suicide prevention policy, practice, and research safely and effectively.

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Declarations

Conflict of interest This study was funded by Roses in the Ocean who are the developers of the training (Our Voices in Action) being evaluated in this study. This may represent a potential or perceived conflict of interest. Author Martina McGrath is a consultant working for Roses in the Ocean. Authors Jacinta Hawgood, Martina McGrath and Jo Riley are expert workforce advisory committee members of Roses in the Ocean. All authors certify responsibility for the manuscript.

Research Involving Human Participants and/or Animals Ethics approval for this research was granted by Griffith University’s Human Research Ethics Committee (Griffith University ethics reference number: 2018/315)

Informed Consent Informed consent was requested in the context of a full and comprehensive online and hard copy information pack for participants. Full ethics approval was provided by the Griffith University Human and Research Ethics Committee.

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