Evaluation of the Roses in the Ocean Lived Experience Training Programs

Final Report

Presented to

Roses in the Ocean

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Australian Institute for Suicide Research and Prevention

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1 Background

Championing the voice of service users through incorporating consumer consultants and peer workers has become common practice in many mainstream mental health services over the last two decades (Fuhr et al., 2014; Pitt et al., 2013). Comparatively, learning from people who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through suicidal crises, or bereaved by suicide has more recently been recognised as an essential component of effective suicide prevention strategies (Suicide Prevention Australia, 2013). Despite this greater focus and awareness, no training models exist to support those with a lived experience of suicide in this important role. There are a number of reasons why training programs designed specifically for the mental illness advocates field fail to meet the training needs of those with lived experience of suicide. Firstly, research has demonstrated that failure to discuss suicide safely can in fact increase suicide rates and stigma (McTernan et al., 2018; Joiner, 2011). There is a clear need for targeted training on suicide-specific safe language for lived experience representatives in this field to avoid further harms and traumas to communities. Further, while associated with and, at times, comorbid, suicide is fundamentally a “behavioural act” rather than a mental illness (De Leo, 2011). As such, suicide prevention lived experience representatives require understanding on these differing aetiologies and prevention pathways. Additionally, research continues to reveal the unique stigma experienced by people who have lost someone to suicide (Pitman, Osborn, Rantell, & King, 2016) and those who have attempted suicide themselves (Rimkeviciene, Hawgood, O’Gorman & De Leo, 2015). Training workshops for these populations must be cognisant and guided by these distinctive experiences. As people who have been previously affected by suicide are at elevated risk of suicide themselves (Franklin et al., 2017; Pitman et al, 2016) participant safety must be embedded throughout program design and delivery.

2 Roses in the Ocean

Observing this gap, *Roses in the Ocean* was founded in 2011 by Ms Bronwen Edwards, Chief Executive Officer, who lost her brother to suicide. *Roses in the Ocean* was initiated with a purpose of building a safe, well-trained and supported lived experience “workforce” equipped with the expertise and skills needed to bring the voice of lived experience to all aspects of suicide prevention. *Roses in the Ocean* engage in a number of activities towards this goal including lived experience informed community suicide awareness events to increase suicide

literacy and connect people with local service providers, and formalised Lived Experience advisory groups and a range of training programs. The guiding philosophy behind each initiative is that permeating the collective voice of those with lived experience through the sector will fundamentally change the way suicide is understood, spoken about and prevented.

Roses in the Ocean's signature innovations are their capacity building training workshops for people with a lived experience of suicide to empower people to engage meaningfully in suicide prevention activities in their local communities and on local, state or national advisory or reference groups, in ways that are relevant to their expertise and desired level of involvement.

Since that time, *Roses in the Ocean* has become a lead organisation for lived experience of suicide both in Australia and, increasingly internationally.

3 Roses in the Ocean training programs

Roses in the Ocean have designed and developed a number of training programs to build the capacity of individuals with lived experience of suicide to both effectively and safely communicate their stories to increase awareness and effect change. As the programs have been created by and for people who have been personally affected by suicide, the content is continually informed and enhanced by the personal stories of suicide from within the *Roses in the Ocean* community. The Australian Institute for Suicide Research and Prevention (AISRAP) at Griffith University was commissioned by *Roses in the Ocean* to undertake a formal evaluation of a suite of their training programs, beginning with the programs below which are the focus of the current report:

Our Voice in Action – an introductory capacity building program for people with a lived experience of suicide; designed to develop the skills required to meaningfully participate in a range of suicide prevention activities; designed for any level of previous experience;

Voices of In-Sight – a more advanced training workshop focused on effectively structuring and communicating a lived experience story safely for greatest impact and influence, with a significant practical/rehearsal component.

4 Project Background

There is limited evidence in the literature of evaluations of the impact of lived experience suicide prevention services and programs on the participants of these programs. The limited evidence-base largely targets the 'Lived Experience of Mental Illness' domain or focuses evaluation activities on satisfaction of training (Meehan, 2002; Simpson, Quigley, Henry & Hall, 2014; Tse, Tsoi, Wong, Kan & Kwok, 2014). There is a need to conduct methodologically rigorous evaluations of lived experience initiatives to develop the body of evidence needed to inform policy, practice, and service delivery in suicide prevention. An additional reason for undertaking evaluations is to increase understanding about the processes and impacts of conducting such research involving those with lived experience. Based on recommendations made in the report, *Preliminary Evaluation of Suicide Prevention Lived Experience Speakers Bureau, Train the Trainer Program* (Hawgood & Howe, 2016), AISRAP, Griffith University, was commissioned by *Roses in the Ocean Suicide* to conduct an evaluation on the impact of the Lived Experience Training programs. As the previous evaluation focussed on the effectiveness of the training and operational procedures, and participants' perceived confidence and capability, this current project evaluates the impact of the training on participant knowledge (e.g. associated with safely discussing suicide), skills in effectively communicating their stories, and attitudes towards suicide prevention activities; with measures of the former aligned specifically with identified learning objectives of the training programs.

To the authors' knowledge there is currently no existing evidence-base or piloted methodology used to evaluate the impact of training program effectiveness of suicide prevention lived experience representative programs (such as the *Roses in the Ocean* programs) on participant learning outcomes. Due to the lack of evidence regarding training programs for lived experience representatives in the domain of suicide prevention, there were no comparable evaluation frameworks or findings available to guide the current study. The researchers therefore aspired to 'pave the way' for a larger more rigorous evaluation subsequently, and to use the current findings for internal guidance regarding future study design and evaluation.

5 Aim

The aim of this evaluation study is:

I. To develop and implement a targeted evaluation framework to assess the effectiveness of the *Roses in the Ocean* training programs (*Our Voice in Action, and Voices of In-Sight*) on identified participant learning objectives and expected outcomes.

6 Governance

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 concept – for policy, practice (service provision) and research. Evaluation methodology must be reflexive and sensitive to potential impacts on those who are suicidal, carers, and those bereaved by suicide. To ensure that the voice of lived experience is privileged and valued in this evaluation (consistent with the ethos of *Roses in the Ocean*), a lived experience consultant and co-author (MM) was formally contracted to provide advice on methodology and interpretation throughout the project.

7 Development of Evaluation Surveys for Training Programs

7.1 Identifying key indicators

In order to identify key learning indicators as measurable outcomes for this evaluation, AISRAP requested from *Roses in the Ocean* the key documents or training materials of the two programs which were expected to include program objectives, and learning outcomes as well as associated modules, topics and learning materials.

The following documents were obtained:

- Facilitator Handbook
- PowerPoint slides
- Self-care materials
- Training program advertisements
- Participant screening materials

Typically, in designing any training evaluation framework, learning objectives and outcomes should be used that seek to answer questions such as: 'did participants gain capabilities

(knowledge, attitudes or skills) in line with the espoused training objective and outcomes?' AISRAP therefore reviewed the above documents to identify stated objectives and intended learning outcomes of both programs, as well as to gain context for interpreting findings and recommendations. In the absence of locating any clearly defined or formally identified learning objectives that could be used for alignment with evaluation measures, (although overall goals were apparent), AISRAP liaised with *Roses in the Ocean* to define a process to establish these. The researchers used information from the training materials which aligned with the broader training program goals and created key measurable learning indicators. These indicators were developed and discussed between two lead AISRAP researchers (JH and MG) to reach a consensus. These indicators also represented the key domains of enquiry on the evaluation surveys.

7.2 Design of the Survey

Socio-demographic items were included in the first section of the pre-training surveys for both Programs. Additionally, the pre-training surveys included items seeking past and present suicidality and/or experience of loss and impact from suicide; and previous work in suicide prevention. To match participant surveys completed at different time points, participants were asked on all surveys to provide a 'secret code' which was "the street name that you first recall living in". Post-surveys included just a few demographic items, for the sole purpose of assisting with the 'matching' of secret codes in the event of common and reoccurring street names or mismatching text on surveys (e.g. age, gender).

For each of the *Our Voice in Action* and *Voices of In-Sight* training programs, the investigators used the identified key learning indicators for directly informing the development of pre-, post- and follow-up training evaluation surveys testing changes in participant's outcomes (knowledge, awareness and confidence). Validated standardised scales previously used in peer-reviewed publications were utilised only where such measures matched the identified learning indicators. Where an existing measure matching the learning objectives did not exist, items and scales were constructed by the investigators through detailed re-examination of the program materials, in order to adequately capture training objectives and effects. Co-author and lived experience consultant (MM) contributed to the selection of questionnaire items and advised on the suitability and safety of the survey and the accompanying support and risk information provided to participants. After which, researchers liaised with *Roses in*

the Ocean staff to ensure final training evaluation materials were appropriate and valid to the trainee population. Together, these measures were compiled into a unified word document (later to be transferred to online survey using the Qualtrics software system) to test associated training effects.

7.3 Measures

Specific descriptions of these scales appear below and scales themselves appear in the full pre- post- and follow-up surveys in Appendix A and B:

1. *Perceived Confidence in Learning Scale:* This scale, designed by the research team, measures participant's perceived confidence associated with the training program objectives and outcomes. Participants were asked to rate their current level of confidence on a 5-point Likert Scale ranging from 'Not confident at all' (1) to 'Extremely confident' (5) with regards to their involvement in suicide prevention activities as a person with a lived experience of suicide. Due to the differences in the identified key learning objectives between the *Our Voice in Action* and *Voices of In-Sight* training programs, the different Perceived Confidence in Learning Scales differed slightly in the number of items (consisting each of 15 and 13 items respectively).
2. *Declarative Knowledge Scale:* This scale, designed by the research team, measures factual/knowledge-based learning objectives using multiple choice item response format, directly aligned with the identified learning objectives. One (1) point was given for correct answers and zero (0) for incorrect. Total scale scores were calculated from the sum of responses. Due to the differences in the identified key learning objectives between the *Our Voice in Action* and *Voices of In-Sight* training program, the two Declarative Knowledge Scales had different numbers of items; being 8 and 5 items respectively. The *Declarative Knowledge Scales* covered all learning objectives except for the 'factual knowledge about suicide terminology' and 'suicide literacy' as these constructs were measured in other stand-alone scales.
3. *Safe Suicide Terminology Scale:* On each of the five items in this scale, participants were asked to choose the safest terminology between two alternative statements or phrases. Item content was drawn from the Mindframe-media guidelines on reporting and portrayal of suicide (Department of Health and Aging, 2006) which were included in both training programs. An overall score was calculated by totalling one (1) point for all the correct answers and zero (0) for incorrect.

4. *Lived Experience Opinion Scale:* This 3-item scale measures participants perceived value of lived experience towards suicide prevention activities, including the value of participants' own lived experience towards suicide prevention activities within their community. Participants are asked to rate statements about lived experience on a 5-point Likert Scale ranging from 'Strongly Disagree (1) to 'Strongly Agree (5).
5. *Literacy of Suicide Scale (LOSS) (Calear, Batterham & Christensen, 2012):* This 13-item scale measures knowledge of suicide and suicide-related warning signs, and includes items associated with a range of common suicide myths. Participant are presented with statements about suicide with corresponding True/False/Don't Know response options. An overall total score is calculated by totalling one (1) point all the correct answers and zero (0) for incorrect. (This was only included on the *Our Voices in Action* evaluation survey).
6. *Attitudes to Suicide Prevention Scale (ASP) (Herron et al, 2001):* This 14-item scale measures attitudes to suicide and suicide prevention, and includes items associated with a range of themes around responsibility for suicide and its prevention, to behaviours such as asking about suicide. A 5-point Likert scale was used to measure a strongly negative attitude as 5 and a strongly positive attitude as 1. An overall score was calculated by adding all items with higher scores indicating more negative attitudes; and two items are reverse scored. This Scale was only included on the *Our Voice in Action* evaluation survey.
7. *Suicide Support Ability Scale*: This 5 item scale measures participant perceptions of suicide prevention capabilities on a list of skills that are relevant when acting as a 'gatekeeper' and supporting someone at risk of suicide. Participants are asked to rate statements about their current level of capability on a 5-point Likert Scale ranging from 'Strongly Disagree (1) to 'Strongly Agree (5).
8. *The Distress Questionnaire-5 (Batterham, et al., 2016):* This 5-item population screener of psychological distress was found to be more accurate than the K6/K10. Items scored on a 5-point Likert scale ranging from Never (1) to Always (5). Total score is based on addition of each item values where higher values mean greater psychological distress.
9. *Empowerment Scale (Rogers, Chamberlin & Ellison, 1997):* This 20-item scale includes items scored on a 4-point Likert scale ranging from Strongly disagree to Strongly agree.

This instrument includes both negatively and positively worded items to assess locus of control, self-efficacy, and self-esteem. This scale was adapted for this current evaluation by removing 8 items which were deemed either irrelevant or inappropriate/potentially triggering for this lived experience of suicide context. The final version was reviewed by our lived experience consultant prior to the study. Total score is based on addition of each item values where higher values mean greater sense of personal empowerment.

10. *Participant Experience and Feedback:* includes items scored on a 5-point Likert scale ranging from Strongly disagree to Strongly agree which assess participant experiences of the facilitation, content, opportunities to apply learnings, and support provided during the program. Additional items were included for participants to report whether the program met their needs and expectations including open-ended items where participants could provide information about what they found most valuable and any recommendations to improve future program delivery.

8 Survey administration and data collection procedures

8.1 Participants

All attendees at all *Roses in the Ocean Our Voice in Action* and *Voices of In-Sight* training programs delivered between March 2018 and August 2018 were invited to participate in the evaluation study. Specific sample information appears under the Results section below.

8.2 Data collection time points

In this proposed research design participants completed the evaluation survey at pre- and post- and at 1 month and 3 months post the training workshops. While the differences between knowledge and skills acquired, distress and empowerment reported between the pre- and post- surveys was the primary focus of this evaluation research, this research design also included survey completion at 1 month and 3 months post the training workshops. The main rationale for these additional data collection points after post training data collection was to detect potential attrition points for participant knowledge, attitude and skill gains associated with training. This is important for determination of need for refresher training, since it has been suggested that training programs in suicide prevention have demonstrated little effective impacts beyond training completion (Hawgood, Pasmore, Lowe, Ross, Kõlves & De Leo, 2018).

8.3 Data collection procedures

Due to the breadth and variety of individual lived experiences of suicide within Australian communities, *Roses in the Ocean* delivered these training workshops within a diverse range of environments with varying access to resources (such as internet access). As such, several different procedures were employed collaboratively by *Roses in the Ocean* facilitators and AISRAP researchers to maximise data collection.

A combination of emailing participants an embedded online link prior to training (pre -survey) and following the training (post-training) as well as providing paper surveys during the training workshops were performed to capture pre- and post-program data.

All follow-up surveys for (1 month and 3 months) were administered by emailing participants the links to the surveys. Ethical approval required that participants provide their own email addresses to AISRAP researchers for subsequent follow-up contact (rather than *Roses in the Ocean* staff providing the researchers with participant email addresses). In instances where there was an inadequate number of email addresses provided to AISRAP, *Roses in the Ocean* staff directly emailed participants the survey links to post-surveys. For each time period, participants were emailed between 2–4 times as a reminder to complete the follow-up surveys.

9 Ethics

Ethical clearance was obtained for this evaluation study from the Griffith University Human Research Ethics Committee (GU HREC), GU Reference Number: 2018/315.

10 Results

10.1 Sample sizes

This report captures responses received from attendees to workshops conducted between 28th March 2018 and 3rd September 2018. Due the limited number of follow-up surveys received all were collapsed into a single 3-month follow-up time point for analysis in this report. As of 3rd September 2018, the numbers of participants, their attrition rate and subsequent sample sizes of matched samples were the following:

Our Voice in Action

Time	Number of completed surveys	Attrition rate		Matched samples
PRE	35	2.9%	74.3%	**PRE & POST = 34 persons**
POST	34	73.5%		**PRE & POST & 3 months = 8 persons**
3 month follow-up	9			

Voices of In-Sight

Time	Number of completed surveys	Attrition rate		Matched samples
PRE	32	34.4%	68.8%	**PRE & POST = 18 persons**
POST	21	52.4%		**PRE & POST & 3 months = 9 persons**
3 month follow-up	10			

10.2 Testable sample size

As seen in the tables above more pre- and post- questionnaires were able to be matched for participants attending the *Our Voice in Action* program than the *Voices of In-Sight* program. Reviewing the data collection procedures, the most noticeable difference between the two training workshops was that the majority of the *Our Voice in Action* participants completed both the pre- and post- surveys using paper versions within the workshops, whereas a greater number of *Voices of In-Sight* participants used online procedures to complete pre- and/or post- surveys. Additionally, in one *Voices of In-Sight* workshop, *Roses in the Ocean* facilitators reported that due to complex groups dynamics and one participant's concerns about privacy, the post survey was not offered to any participants in that delivery.

As seen in the tables above both programs observed a decrease in the number of follow-up evaluation surveys received which were only collected using online procedures. It is not expected that any differences would reach statistical significance with only 8 and 9 matched pairs for the *Our Voice in Action* and the *Voices of In-Sight* programs respectively at the follow-

up time point. Nonetheless, these analyses have been included in this report purely to present all data received to date and to guide future data collection procedures.

The main identified issue, as mentioned earlier, is the low response rate of participants completing the online follow-up surveys. New data collection protocols were applied which included emailing participants up to 4 times to remind them to complete the surveys. Though there is no comparison data on retention rates for training programs with participants with a lived experience of suicide, this data collection would suggest that online modalities outside of training workshops may be less suitable in this context.

11 Participant Demographics

11.1 Our Voice in Action

		N	%
Sex	Men	7	20
	Women	28	80
Age	20-29	3	8.6
	30-39	3	8.6
	40-49	10	28.6
	50-59	12	34.3
	60-69	7	20
Aboriginal and/or Torres Strait Islander		9	26.5
Culturally and Linguistically Diverse		1	2.9
Education	Less than Year 12	4	11.4
	High School (Year 12)	5	14.3
	Trade/apprenticeship	1	2.9
	Some university/college	12	34.3
	Associate/Undergraduate diploma	7	20
	Bachelor's degree	5	14.3
	Postgraduate degree or higher	1	2.9
Employment	Employed full-time	18	52.9
	Employed part-time & looking for full-time work	1	2.9
	Employed part-time	4	11.8
	Unemployed – looking for work	3	8.8
	Not in the paid labour force	5	14.7
	Carer – to dependent child(ren)	1	2.9
	Carer – to other eg; adult	2	5.9

As seen above, the majority of participants attending the *Our Voice in Action* workshops were female. Most participants were between 40-60, and the mean age was 48.5 (SD = 12.07). More than a quarter of participants identified as Aboriginal and/or Torres Strait Islander. Nearly two-thirds of participants were in the workforce with over half of the participants working full-time. More than a third had qualifications beyond high school completion.

11.2 Voices of In-Sight

		N	%
Sex	Men	7	21.9
	Women	25	78.1
Age	20-29	2	6.3
	30-39	6	18.8
	40-49	9	28.1
	50-59	12	37.5
	60-69	1	3.1
	70-79	2	6.3
Aboriginal or Torres Strait Islander		1	3.1
Culturally and Linguistically Diverse		2	6.3
Education	Less than Year 12	4	12.9
	Trade/apprenticeship	2	6.5
	Some university/college	5	16.1
	Associate/Undergraduate diploma	8	25.8
	Bachelor's degree	8	25.8
	Postgraduate degree or higher	4	12.9
Employment	Employed full-time	9	28.1
	Employed part-time & looking for full-time work	6	18.8
	Employed part-time	9	28.1
	Unemployed – looking for work	1	3.1
	Not in the paid labour force	4	12.5
	Carer – to dependent child(ren)	2	6.3
	Carer – to other eg; adult	1	3.1

As seen above, the majority of participants attending the *Voices of In-Sight* workshops were female. Most participants were between 40-60, and the mean age was 47.7 (SD = 11.47). Asides from the 3 participants identifying as First Australian or culturally/linguistically diverse, all other participants identified as Caucasian and/or only spoke English at home. Most

participants were in the workforce. More than 60% had tertiary qualifications beyond high-school.

12 Participants' Lived Experience of Suicide

12.1 Our Voice in Action

		N	%
Lived Experience of Suicide	I have had suicidal thoughts in the past	19	54.3
	I continue to have suicidal thoughts	9	25.7
	I have attempted suicide	14	40
	I am bereaved by suicide	27	77.1
	I have cared/continue to care for someone who is suicidal or has attempted suicide	13	37.1
Lived Experience Central to Role	Yes	7	20
	No	19	68.6
	Maybe / Unsure	4	11.4

All participants reported that they had a lived experience of suicide. Over three-quarters of participants had been bereaved by suicide. Forty percent of participants had previously attempted suicide with a quarter currently experiencing suicidal thoughts. Over three-quarters of participants had a lived experience in more than one area of suicide experience. For 20% of participants, having a lived experience of suicide was a central to their employment.

12.2 Voices of In-Sight

		N	%
Lived Experience of Suicide	I have had suicidal thoughts in the past	14	41.2
	I continue to have suicidal thoughts	7	20.6
	I have attempted suicide	10	29.4
	I am bereaved by suicide	21	61.8
	I have cared/continue to care for someone who is suicidal or has attempted suicide	12	35.3
Lived Experience Central to Role	Yes	9	26.5
	No	19	59.4
	Maybe / Unsure	4	12.5

All participants attending the *Voices of In-Sight* training workshops reported that they had a lived experience of suicide. Over sixty percent of participants had been bereaved by suicide and over a third have cared (or continue to care) for someone who has attempted suicide. More than two-thirds of participants reported more than one form of lived experience of suicide.

13 Data analysis

In prospective cohort studies, the recommended methodological approach is to perform matched pair sample analyses where the pair is the unit of analysis, and the focus is on the difference in measured variables within each pair. In other words, the sample size is the number of distinct pairs formulated within the sample. Therefore, in the current study, we conducted matched pair sample analyses between the pre and post surveys, and between the pre- and follow-up surveys. As mentioned, due to only 8 and 9 pairs of data able to be matched for pre- and follow-up surveys, it was not anticipated that any observed differences would reach statistical significance. However, these analyses have been included in the results section to summarise and illustrate all data collected to date.

14 Results: Our Voice in Action

14.1 Perceived Confidence in Learning Scale

After attending the workshops, attendees reported feeling more capable on the key skills and abilities that the *Our Voice in Action* training program was designed to increase. The total score rose from an average value of 48.71 at pre-workshop to 57.36 post-workshop. This difference was statistically significant in a Sign Test (Z = 3.005, p = .003). As anticipated, with the smaller number of matched pairs at follow-up (N = 8), the difference was not significant (p = .125).

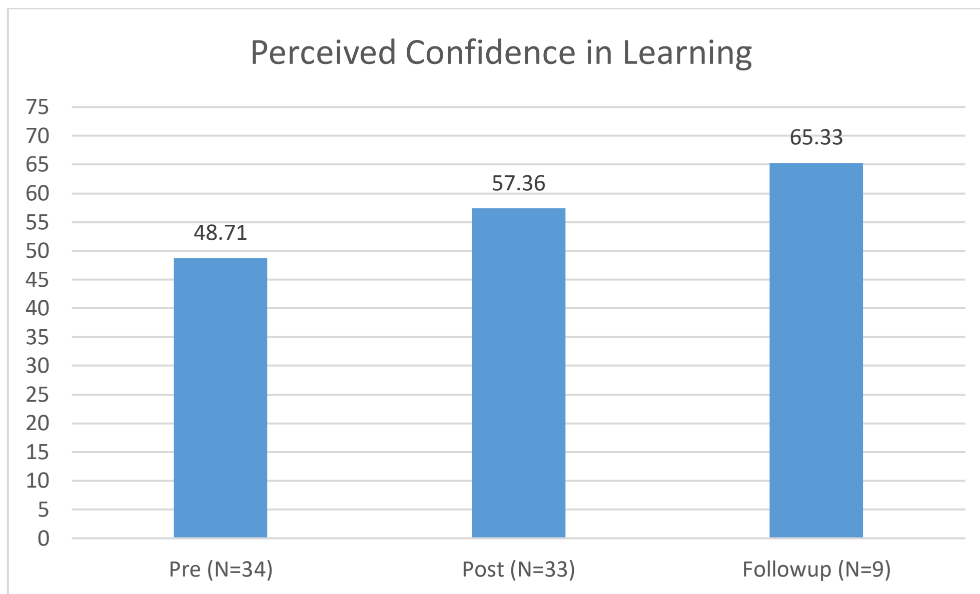

Figure 1. Pre-, Post- and Follow-up Mean Perceived Confidence in Learning Scale scores

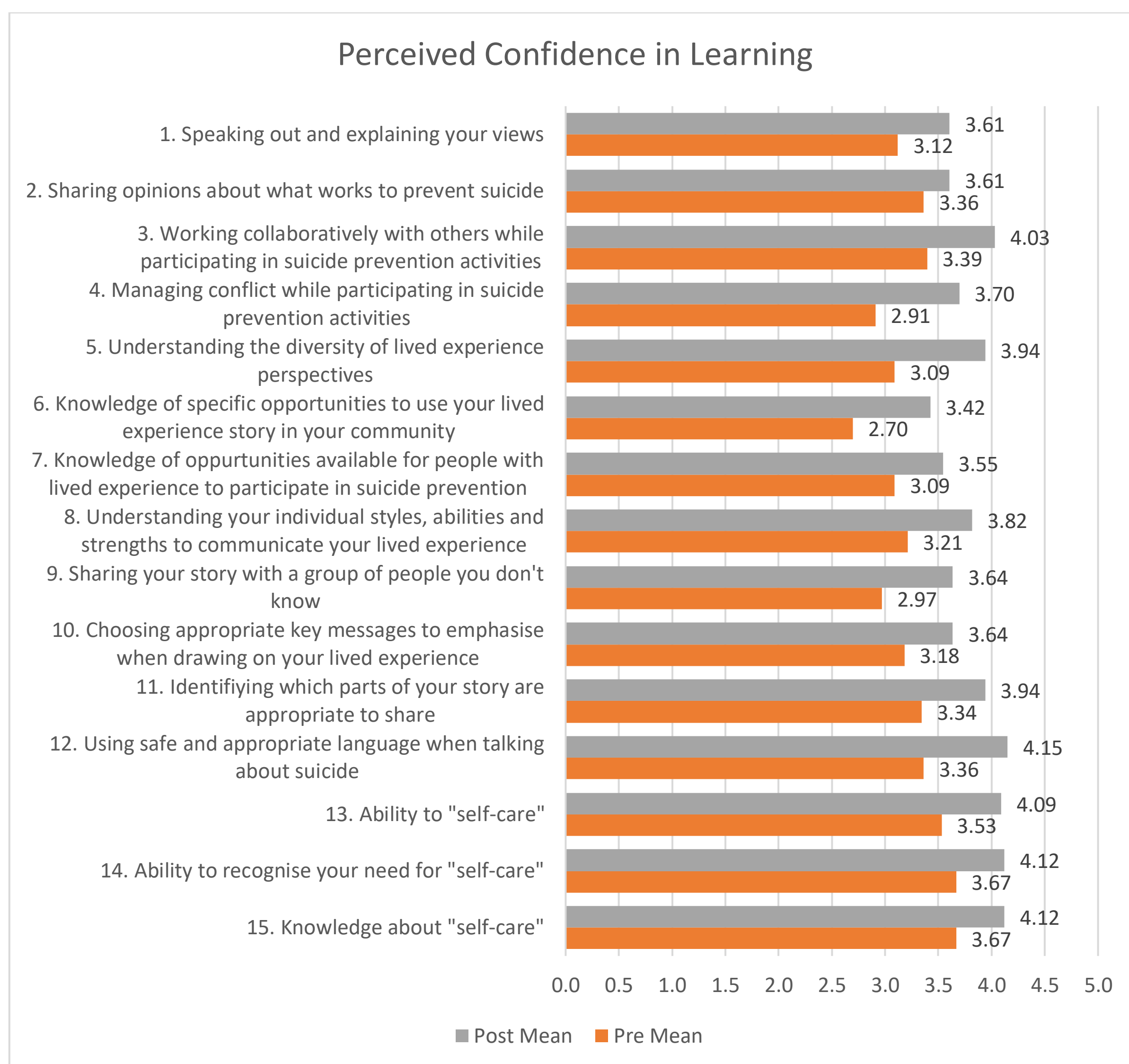

Figure 2. Pre- and Post- Mean Perceived Confidence in Learning items

As seen in Figure 2, participants felt more confident in all the learning objectives after attending the Our *Voice in Action* program. The improvements in confidence were significant for learning objective items 3, 4, 5, 6, 8, 9, 11, 12, 13, 14, and 15. The learning objectives participants reported the greatest increase in confidence after attending the training program were *'Understanding the diversity of lived experience perspectives' and 'Using safe and appropriate language when talking about suicide.'* The only individual learning objective item for which the increased confidence was not significant in this sample were items 1, 2, 7 and 10.

14.2 Declarative Knowledge Scale

After attending the workshops, attendees answered more of the declarative knowledge items correctly than prior to the training. The mean total number of correct answers at pre- and post- time points rose from an average value of 6.49 to 7.30, which was statistically significant in a Wilcoxon Signed ranks test ($Z = 2.722$, $p = .006$). As anticipated, with the smaller sample of pairs at follow-up ($N = 8$), the difference was not significant ($p = 1$).

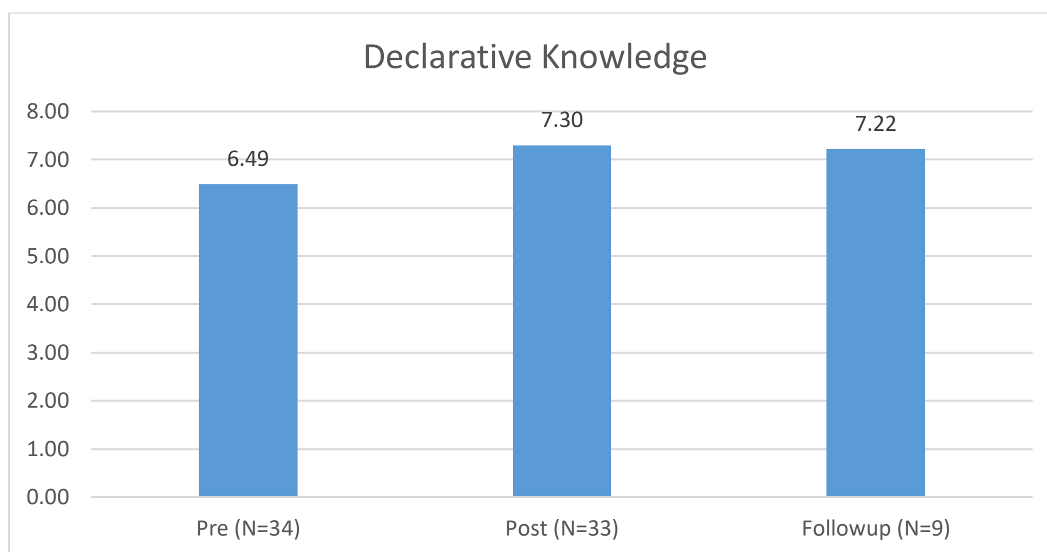

Figure 3. Pre-, Post- and Follow-up Mean Declarative Knowledge Scale correct answers

As seen in Figure 4 below, all items were answered correctly by more participants after the program except for one which maintained the same percentage of correct answers. The declarative knowledge item with the greatest increase in correct responses was after attending the *Our Voice in Action* program was *'Which are not actions in effectively managing conflict?'* In this sample there were no significant differences in the percentage of participants answering correctly in individual item analysis.

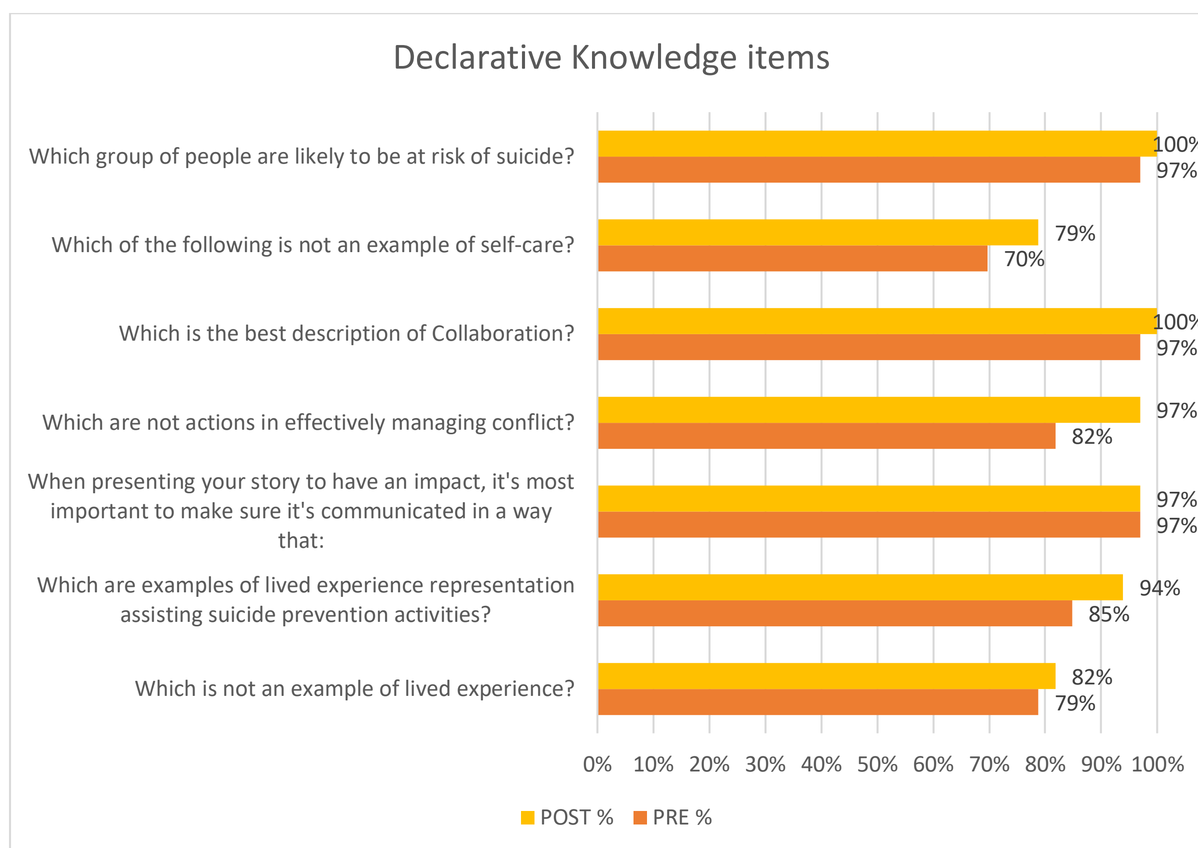

Figure 4. Pre- and Post- percentage correct answers Declarative Knowledge items

14.3 Safe Suicide Terminology Scale

The mean Safe Suicide Terminology Scale scores increased after attending the program, from 3.97 to 4.82, and this difference was statistically significant in a Sign Test ($Z = 3.098$, $p = .001$). As expected, with the limited sample at follow-up ($N = 8$), the difference was not significant ($p = .375$).

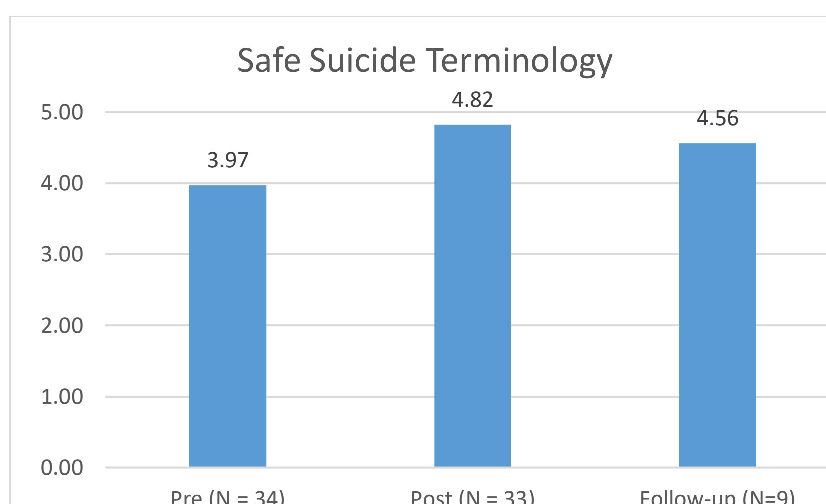

Figure 5. Pre-, Post- and Follow-up Mean Safe Suicide Terminology Scale scores

14.4 Lived Experience Opinion Scale

After attending the workshops, attendees reported greater value of the contributions of lived experience voices in suicide prevention activities. The average Lived Experience Opinion Scale scores at pre- and post- time points rose from an average value of 13.46 to 14.03. This difference was not significant in a Sign Test (p = .424) after the program or at follow-up (p = 1).

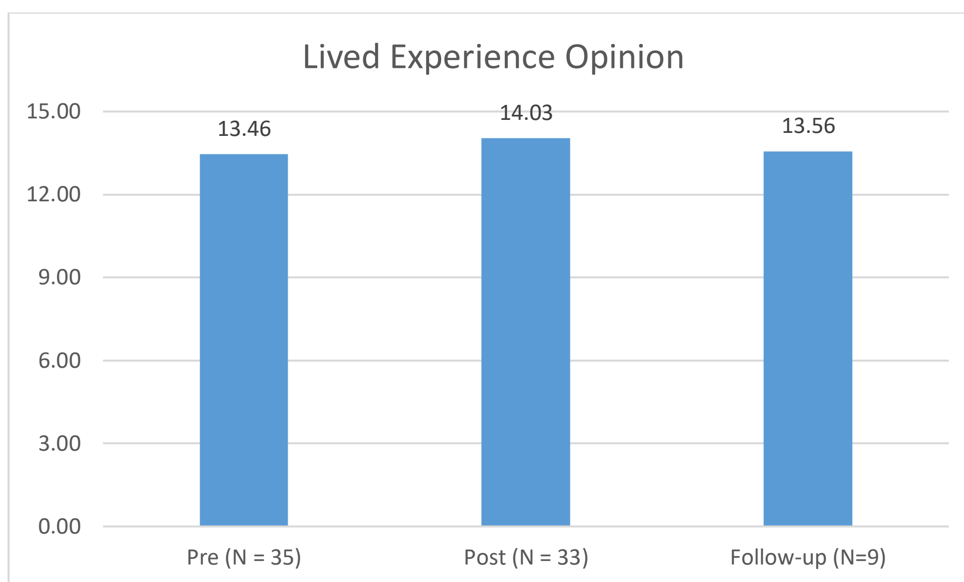

Figure 6. Pre-, Post- and Follow-up Mean Lived Experience Opinion Scale scores

14.5 Literacy of Suicide Scale (LOSS)

After attending the workshops, attendees answered more of the suicide knowledge items correctly than prior to the training. The average total number of correct answers at pre- and post- time points rose from an average value of 9.35 to 11.27. This difference was statistically significant in a Sign Test (Z = 3.834, p < .001). As anticipated, the difference was not significant in the smaller sample (N = 8) for follow-up analysis (p = .219).

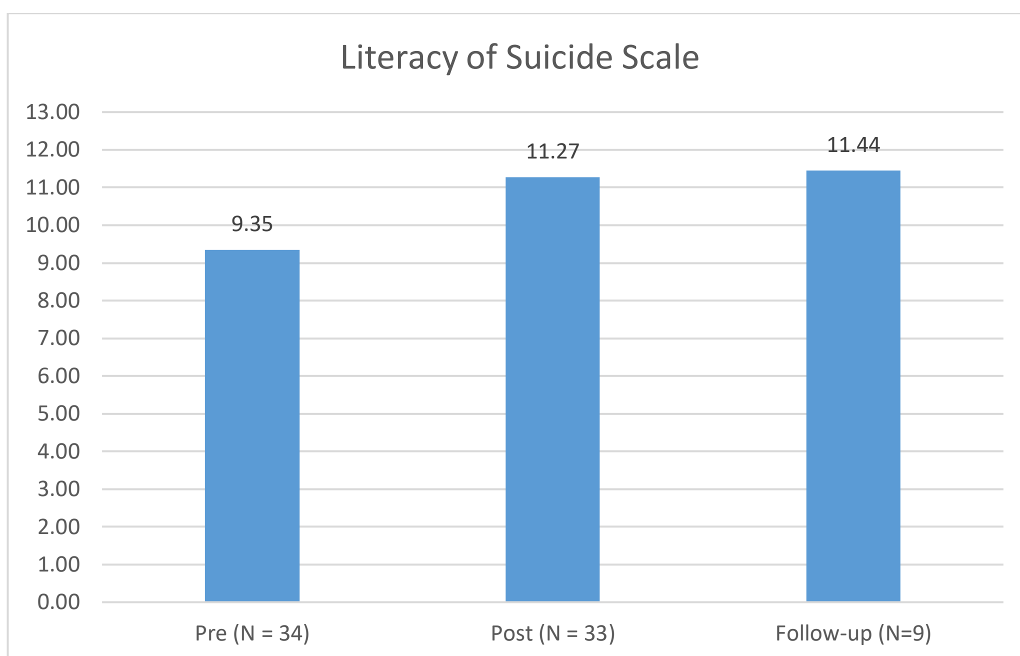

Figure 7. Pre-, Post- and Follow-up Mean Literacy of Suicide Scale correct responses

14.6 Attitudes to Suicide Prevention Scale (ASP)

The mean Attitudes to Suicide Prevention Scale scores decreased from an average value of 31.88 to 30.79, though this difference was not statistically significant in a Sign Test (Z = .359, p = .719) post-program or at follow-up (p = .453).

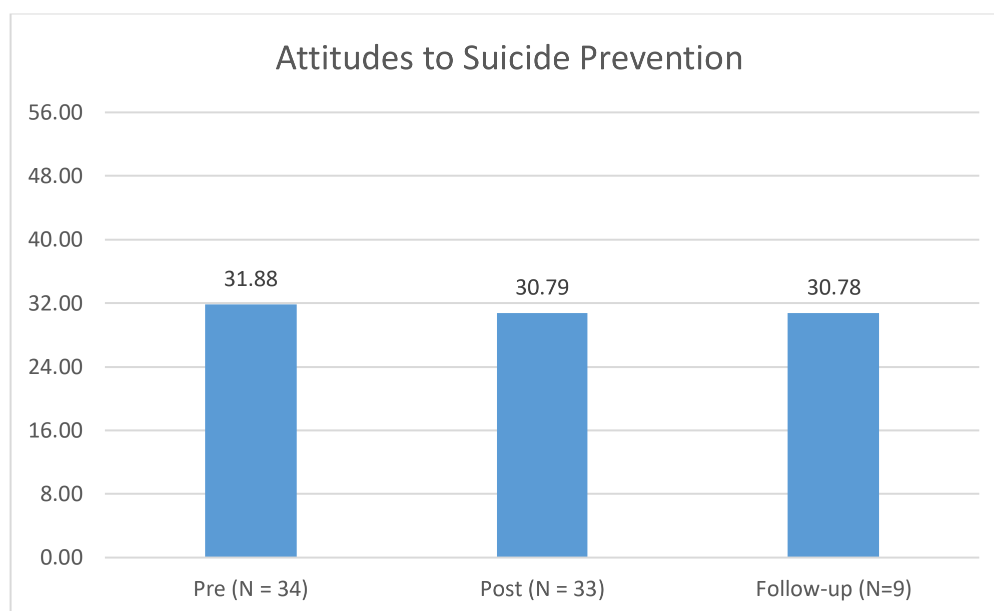

Figure 8. Pre-, Post- and Follow-up Mean Attitudes to Suicide Prevention Scale scores

14.7 Suicide Support Ability Scale

After attending the workshops, participants reported greater confidence in their ability to support people experiencing suicidal thoughts and/or behaviours. The mean total score increased from an average value of 17.12 at pre-workshop to 20.55 post-workshop. This difference was statistically significant in a Sign Test ($Z = 4.619$, $p < .001$). The difference failed to reach significance at follow-up ($p = .07$) as anticipated due to the decreased sample for analysis ($N = 8$).

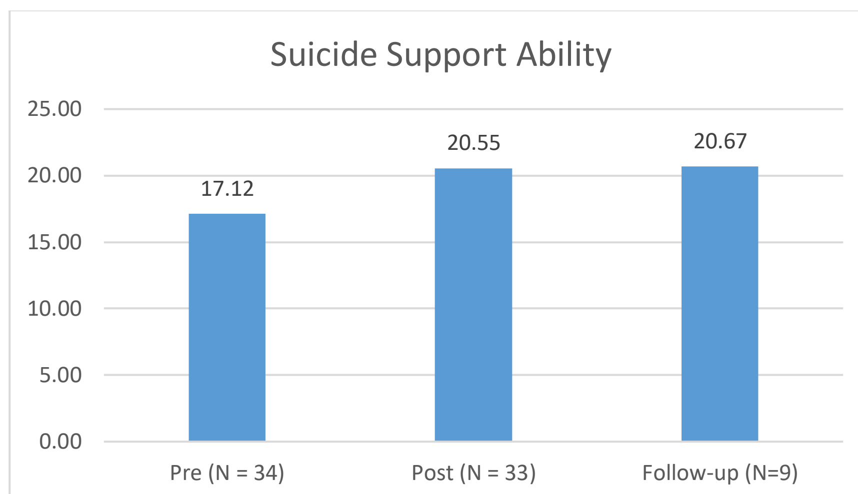

Figure 9. Pre-, Post- and Follow-up Mean Suicide Support Ability Scale scores

14.8 The Distress Questionnaire – 5 (DQ-5)

After attending the workshops, participants reported experiencing less psychological distress. The mean total score decreased from an average value of 12.35 at pre-workshop to 11.21 post-workshop. This difference was statistically significant in a Sign Test ($Z = -2.694$, $p = .007$). As expected, with the limited sample at follow-up ($N = 8$), the difference was not significant ($p = .219$).

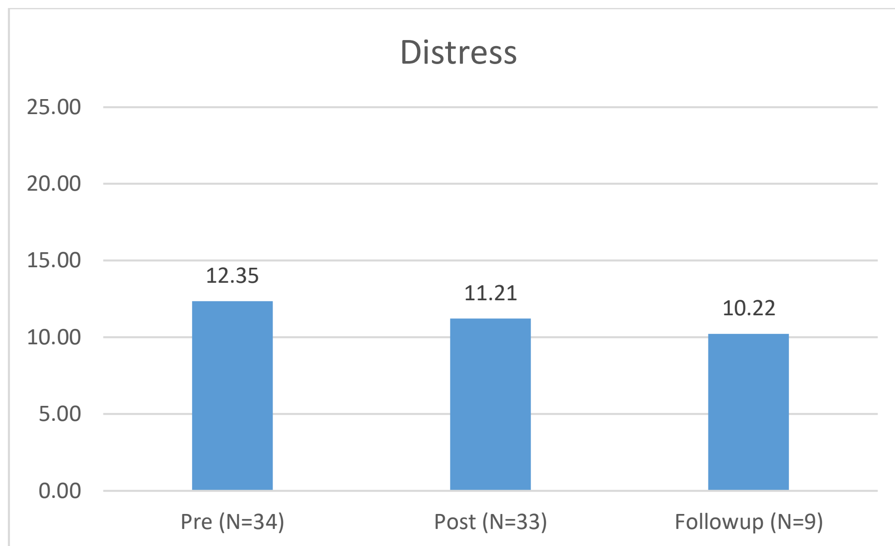

Figure 10. Pre-, Post- and Follow-up Mean Distress Questionnaire - 5 scores

14.9 Empowerment Scale

After attending the workshops, attendees reported greater sense of personal empowerment. The mean Empowerment Scale scores rose from an average value of 60.26 to 62.21, though this difference was not significant in a Sign Test (Z = 1.486, p = .137) after the program or at follow-up (p = .125).

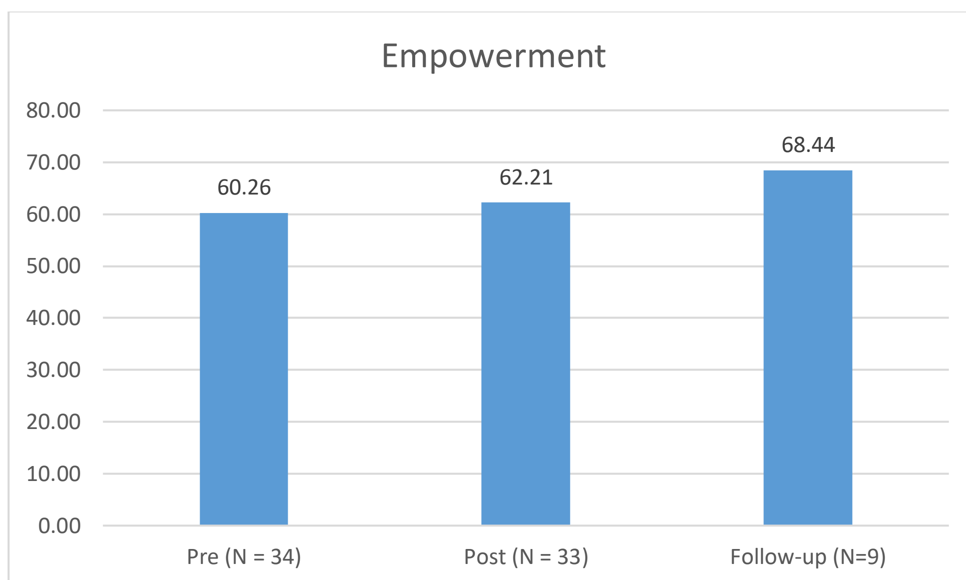

Figure 11. Pre-, Post- and Follow-up Mean Empowerment Scale scores

15 Results: Voices of In-Sight

15.1 Perceived Confidence in Learning Scale

After attending the workshops, attendees reported feeling more capable on the key skills and abilities that the *Voices of In-Sight* training program was designed to increase. The mean confidence score rose from an average value of 41.58 at pre-workshop to 51.56 post-workshop. On a Sign Test this difference was statistically significant ($Z = 2.193$, $p = .008$). As expected, with the limited sample at follow-up ($N = 9$), the difference was not significant ($p = .289$).

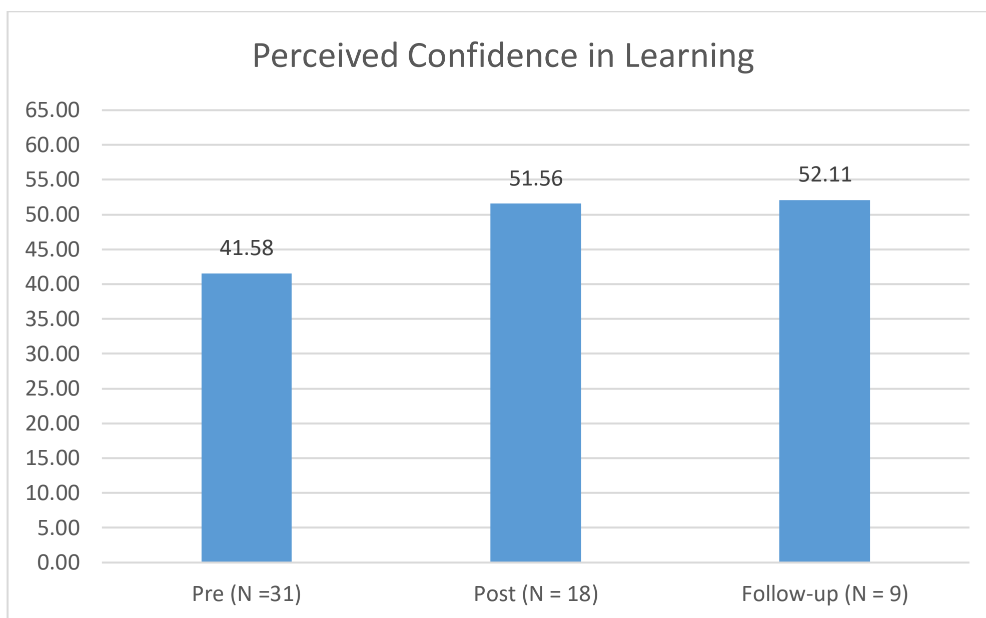

Figure 12. Pre-, Post- and Follow-up Mean Perceived Confidence in Learning Scale scores

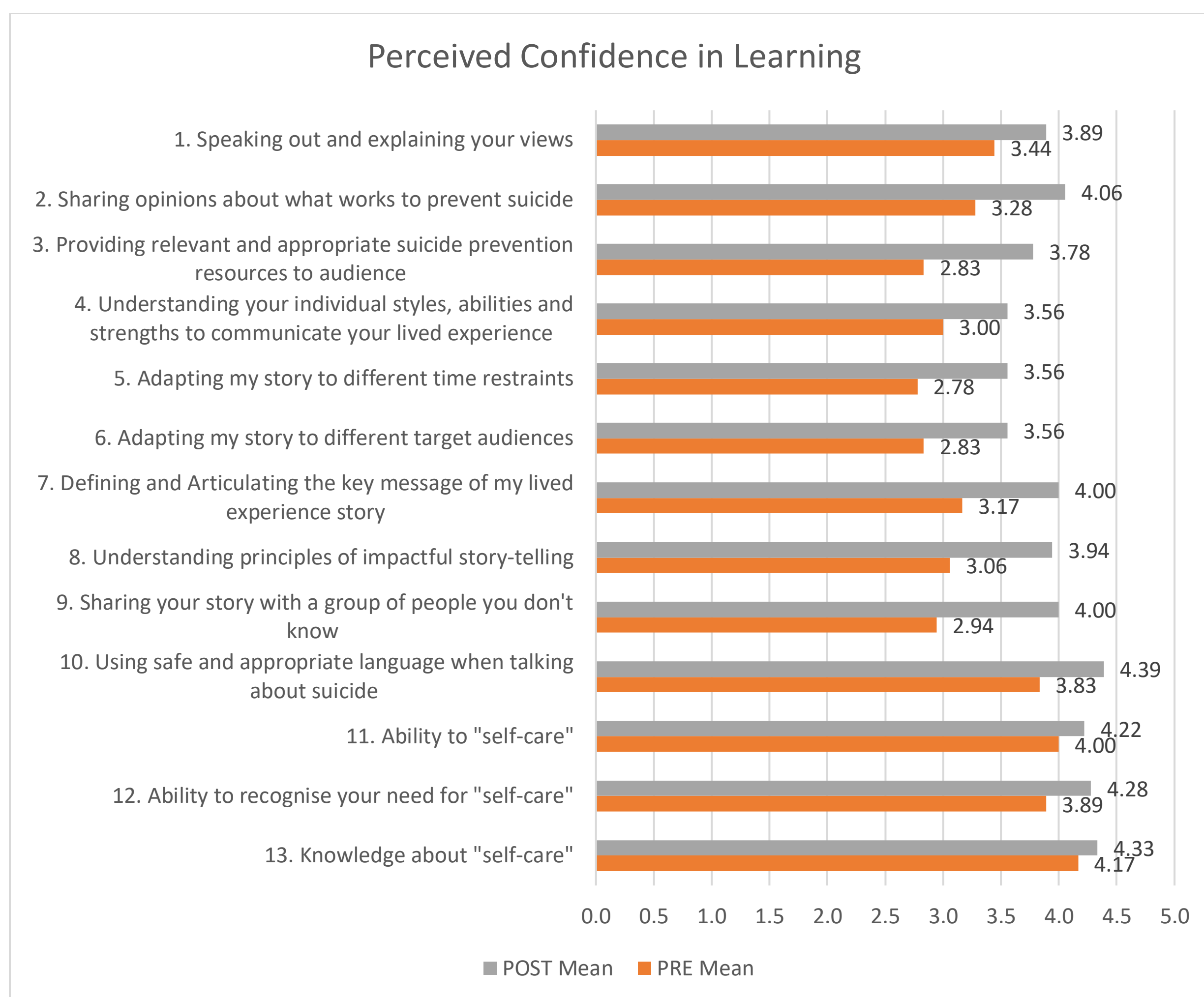

Figure 13. Pre- and Post- Mean Perceived Confidence in Learning items

As seen in Figure 13, participants felt more confident in all of the learning objectives after attending the *Voices of In-Sight* program. The improvements in confidence were significant for learning objectives 2, 3, 6, 7, 8, 9, and 10. The learning objective with the greatest increase in confidence after attending the *Voices of In-Sight* training program was *'Sharing your story with a group of people you don't know'.* The individual learning objective items for which the increased confidence was not significant in this sample were items 1, 4, 5, 11, 12, and 13. The learning objective with the least mean increase in confidence after attending the *Voices of In-Sight* training program was *'Knowledge about self-care,'* though it should be noted that participants perceived the most confidence in this item before the program.

15.2 Declarative Knowledge Scale

After attending the workshops, attendees answered more of the declarative knowledge items correctly than prior to the training. The mean number of correct answers at pre- and post-

time points rose from 3.42 to 3.67. In this sample, this difference was not statistically significance post-program (p = .508) or at the 3-month follow-up point (p = .063).

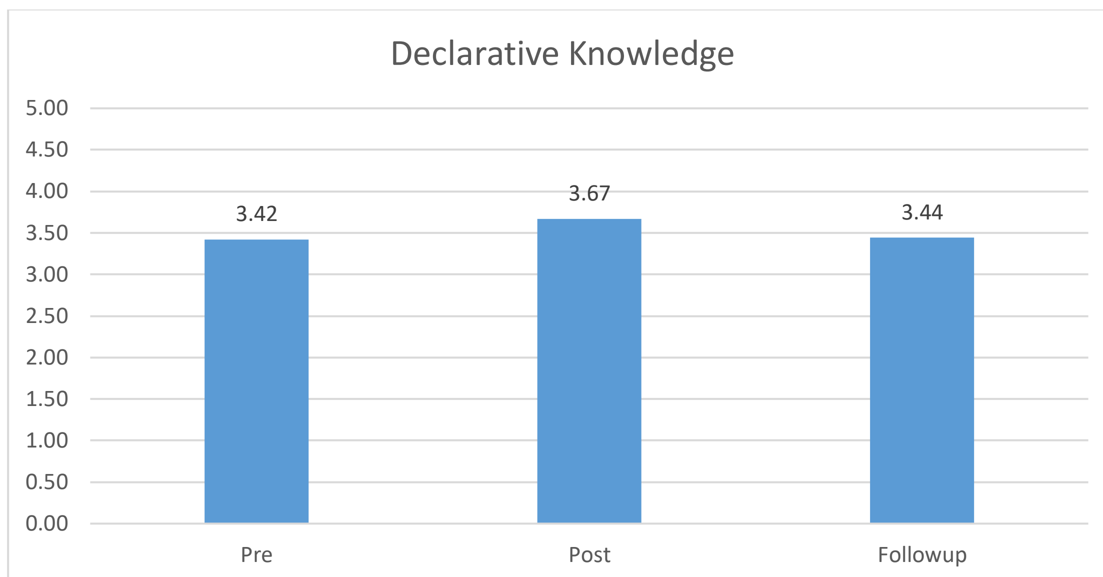

Figure 14. Pre-, Post- and Follow-up Mean Declarative Knowledge Scale correct answers

As seen in Figure 15, all items were answered correctly by more participants after the program except for the item *'Which is not a component of setting the context of the story to help listeners relate?'* The declarative knowledge item with the greatest increase in correct responses was after attending the *Voices of In-Sight* training program was *'Which option is least effective to use to start a piece of communication?'* In this sample there were no significant differences in the percentage of participants answering correctly in individual item analysis.

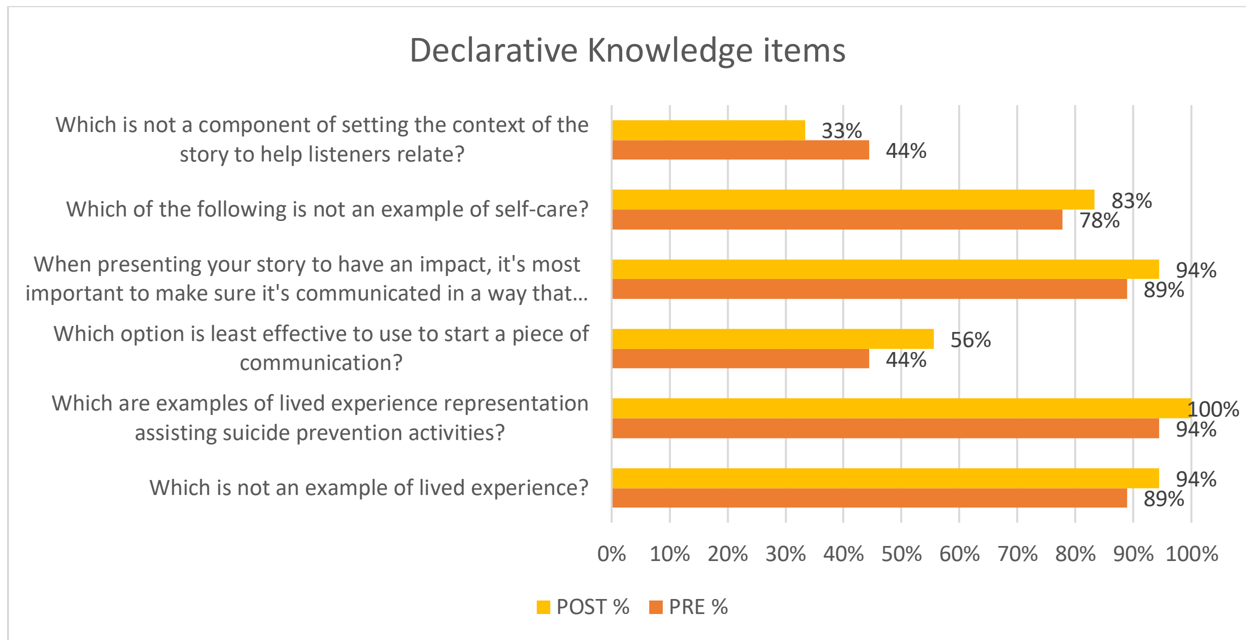

Figure 15. Pre- and Post- percentage correct answers Declarative Knowledge items

15.3 Safe Suicide Terminology Scale

The mean number of correctly answered Safe Suicide Terminology Scale items slightly increased after attending the program, 4.2 and 4.67, though this difference was not significant in a Wilcoxon Signed Rank Test (p = .48) at this point or at follow-up (p = 1).

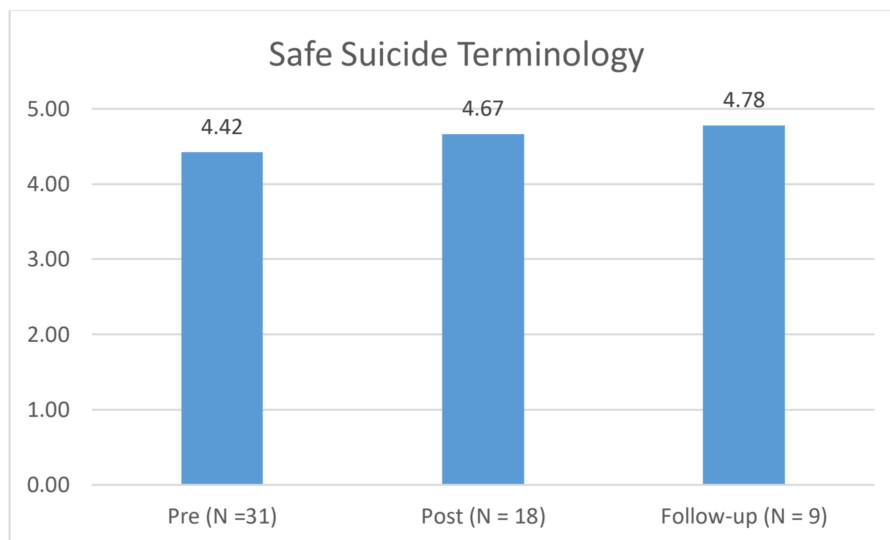

Figure 16. Pre-, Post- and Follow-up Mean Safe Suicide Terminology Scale correct scores

15.4 Lived Experience Opinion Scale

After attending the workshops, attendees reported greater value of the contributions of lived experience voices in suicide prevention activities. The Lived Experience Opinion Scale scores

at pre- and post- time points increased from an average value of 13.23 to 14.67. This difference was significant in a Sign Test (Z = 2.00, p = .039). As expected, with the limited sample at follow-up (N = 9), the difference was not significant (p = .50).

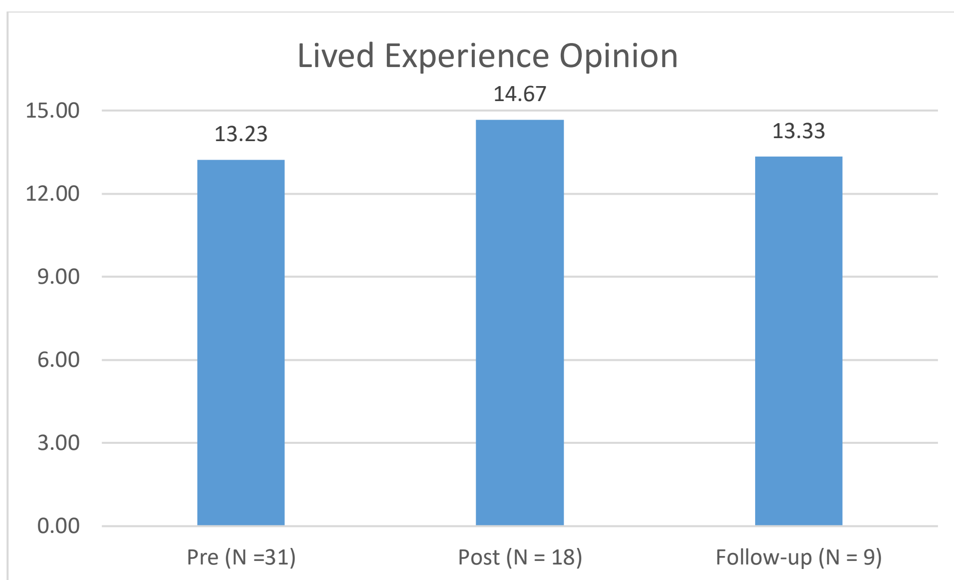

Figure 17. Pre-, Post- and Follow-up Mean Lived Experience Opinion Scale scores

15.5 The Distress Questionnaire – 5 (DQ-5)

The mean Distress Questionnaire (version 5) scores were higher after attending the program, 10.26 and 11.83, though at both pre- and post- the means scores were below the clinically indicated level for current psychological distress. Additionally, this difference was not statistically significant in a Sign Test (p = .312) at either the post-program or follow-up time points (p = 1).

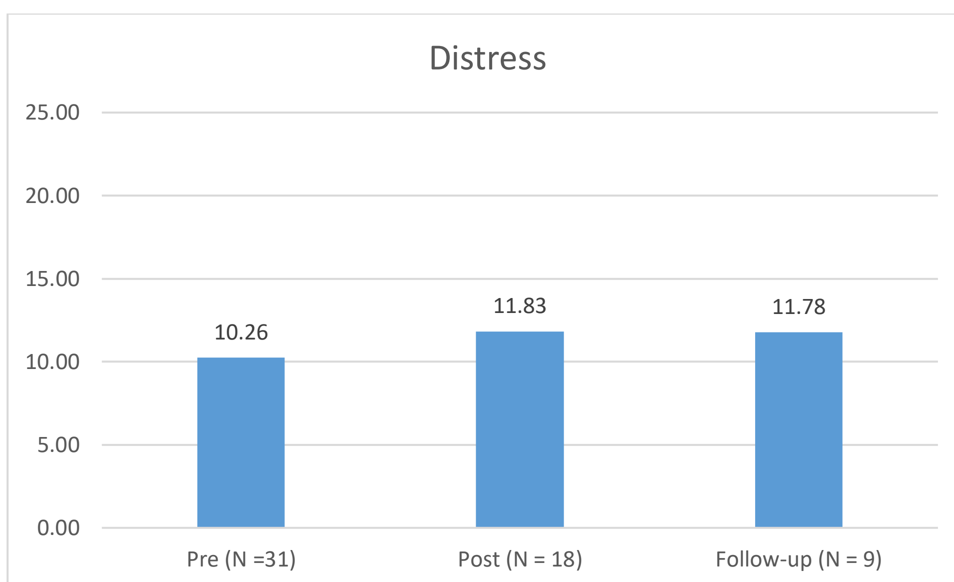

Figure 18. Pre-, Post- and Follow-up Mean Distress Questionnaire - 5 scores

15.6 Empowerment Scale

The mean Empowerment Scale scores were lower after attending the program, 61.84 and 61.06, though this difference was not statistically significant in a Sign Test (p = 1) or at follow-up (p = .453).

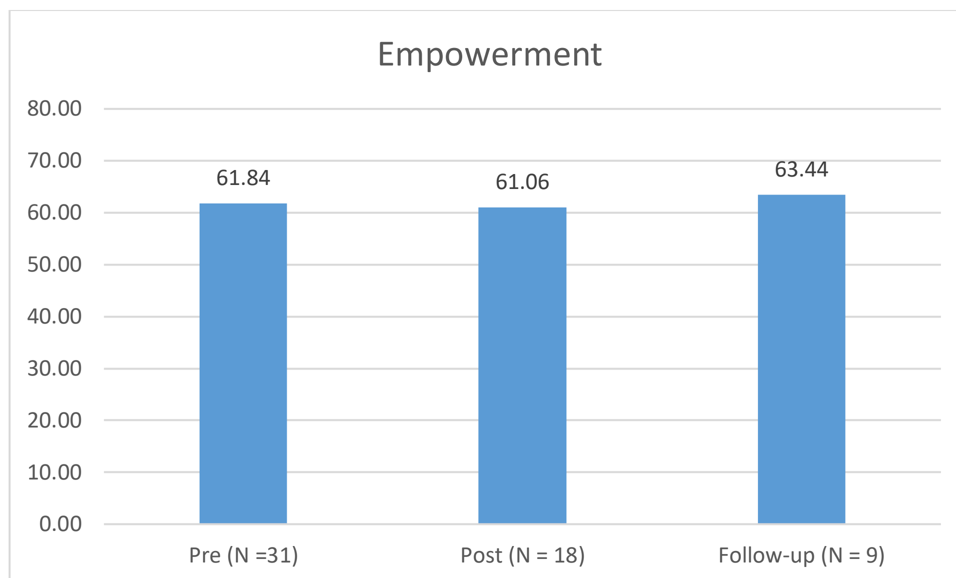

Figure 19. Pre-, Post- and Follow-up Mean Empowerment Scale scores

16 Participant Experiences and Feedback

In order to determine how participants experienced the workshops, we administered a satisfaction feedback section within the overall survey battery. The following table depicts overall high level ratings (scored on a 5-point Likert scale where 1 indicates strong disagreement and 5 indicates strong disagreement) by participants on all items concerning delivery, process and content domains of the training programs.

16.1 Our Voice in Action

	Mean Response	SD
The facilitator(s) managed group dynamics well	4.81/5	.397
I felt supported and safe throughout the workshop	4.88/5	.336
The content of the workshop was relevant	4.81/5	.397
The activities in the workshop provided me with sufficient practice and feedback	4.59/5	.615
As a result of this workshop, I feel better equipped to carry out a role as a lived experience representative	4.59/5	.560

A primary theme that emerged from participants responses about their experiences of *Our Voice in Action* training was that it provided a safe and supportive place for people to share their experiences *"in a non-judgemental capacity"* where they could discuss and learn about suicide. Reference was also made to how uncommon it was for participants to find a *'safe place'* to discuss suicide outside of this context. One person reported that the main benefit to them of the program was *"having a safe place to mirror my story to others and be heard."*

Further, *"Sharing with other people affected by suicide"* was articulated as an essential component of the program. Participants spoke of the *"connections"* formed with other attendees due to their *"similar life experiences."* One person explained a most valuable component as *"the people I was lucky enough to meet and have shared their stories."*

Overall, the most pronounced theme in participants' responses to this workshop was the gained sense of empowerment to make a difference in suicide prevention in their communities; providing a *"sense of being and purpose in how to help others.* As a result of the program, they felt they *"had a voice"* and *"the confidence to help others.*" Poignantly, one person felt that now they could *"start my journey to prevention in the community."*

Several people reported that the knowledge and information provided about community suicide resources and the clear guidance in safe language around suicide had been most beneficial to them. Many participants further articulated that in addition to the increased learning, the program had a personally beneficial *"self-help"* effect as participants were able to *"open up"* and reflect on their experiences. One person summarised that the *Our Voice in Action* program had *"taught me about myself."*

Only three participants provided any suggestions for improving the *Our Voice in Action* program. These suggestions were to provide printed copies of the slides and to facilitate an additional workshop where participants can apply and practice the skills learnt.

One final satisfaction item was asked of participants, in order to obtain a 'global rating' of their overall experience of the training "Did the program meet your needs and expectations?" All (100% of) participants reported that the program did successfully meet their needs and expectations.

16.2 Voices of In-Sight

	Mean Response	SD
The facilitator(s) managed group dynamics well	4.89/5	.323
I felt supported and safe throughout the workshop	4.83/5	.383
The content of the workshop was relevant	4.89/5	.323
The activities in the workshop provided me with sufficient practice and feedback	4.78/5	.428
As a result of this workshop, I feel better equipped to carry out a role as a lived experience representative	4.78/5	.548

The main theme in participants' responses to the most valuable component of the *Voices of In-Sight* workshop was learning how to prepare an effective message. Participants identified that they learnt both the *"theoretical basis"* of the *"art of story-telling"* as well as practical techniques and transferrable skills required to structure effective speeches and presentations. One person voiced that because of the workshop they now had *"the skills to bring clarity to story-telling."* Many people extended this further to indicate that they now had the skills to structure and share their own personal lived experience story effectively; one person articulated that now they were able to *"put my story in a beautiful format."* In addition to the general story-telling information, participants identified that they benefitted from the individualised feedback on their presentations, such as learning *"aspects of my story that would be most beneficial to an audience."*

Many participants identified that the *"supportive environment that was created"* was essential to the success of the workshops; the *"support and openness of all participants and the presenters"* enabled them to effectively learn and safely share such sensitive and personal experiences.

An interesting theme in participants' description of their experiences was how *"cathartic"* and *"healing"* it was for them to prepare and tell their lived experience story in this workshop. One person summarised that *"What could have been a major trigger was actually another positive and meaningful step forward in my journey".*

Similar to the *Our Voice in Action* results, *Voices of In-Sight* participants expressed the benefit of sharing their stories with other people with a lived experience of suicide. Several people described it as *"a privilege"* to hear the diversity of lived experience stories; gaining insights

into how other people, from different backgrounds, communities and ages, had been touched by suicide. One person voiced that this taught them that *"I was not alone and my story was worth sharing."*

Few participants provided suggestions on how to improve the program, with over half the provided comments indicating that no changes were required (eg., *"all good as is"* or *"no changes needed"*). Two participants reported that more individualised assistance to identify the key messages in their stories would be beneficial; with another three participants suggesting more time, such as an additional day or regular ongoing groups. The need for more culturally sensitive materials in the content was also suggested (for example, Churchill was an example of an esteemed orator though he is a contentious figure outside of Anglo communities).

On the final satisfaction item to obtain a 'global rating' of their overall experience of the training all participants reported that the program met their needs and expectations.

17 Discussion

The aim of this study was to evaluate the effectiveness of the *Roses in the Ocean* delivered training programs (*Our Voice in Action, Voices of In-Sight*) on identified participant learning objectives and outcomes (impacts) by observing responses of training participants engaged in the two programs from March to August 2018.

17.1 Recruitment and Participant Sample

We were interested in the composition of attendees in terms of the relationship between several socio-demographic variables and training outcomes. However, we were particularly interested in the 'type' of lived experience that participants identified having and training outcomes. This particular interest was in the most part, based on the need to undertake multivariate analyses (eventually, with larger samples) to explore any potential differences in training impacts based on type of lived experience. It is also of great interest within the suicide literature to understand the impacts of research on participants who may be suicidal (or have been) and any factors that may relate to participation impacts. The majority of participants in both programs were bereaved by suicide with fewer people having a history of suicide attempts. This may reflect the unique experiences of stigma and internalised shame experienced by people who had attempted suicide which could manifest in a reluctance to

engage in activities to share their stories. This imbalance in type of lived experience representation may provide a rationale for informing future participant recruitment strategies by *Roses in the Ocean* - such as targeting more people with an experience of suicidality. Importantly, the result would be the development of a suicide prevention 'workforce' reflective of a range of lived experience input.

Less than 15% of participants identified as Aboriginal and/or Torres Strait Islander Islanders persons and less than 5% as cultural and linguistic diverse, though these groups experience a disproportionate burden of suicide in Australia. Additionally, participant feedback has indicated that parts of the program content has not been experienced as culturally sensitive for non-Anglo communities. Inclusion of First Australian people and culturally and linguistically diverse people with a lived experience of suicide to review and contribute to this program content may support the recruitment of more participants from these communities to ensure the developing lived experience 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. For future deliveries, surveys could be reviewed by LGBTIQA+ people with a lived experience of suicide to develop suitable additional gender and sexuality demographic identification items.

The results from these program deliveries indicate that *Roses in the Ocean* have successfully recruited people with a lived experience from all levels of education and all levels of employment and workforce participation. This is a promising observation for the future lived experience workforce, as suicide does not discriminate according to socio-economic lines.

Voices of In-Sight participants were more likely to be in employment where their lived experience of suicide was central to their role. As this workshop is a more practical program geared towards instructional aspects of presenting lived experience stories, it appears appropriate that *Roses in the Ocean* have recruited people who would have opportunities to implement the skills acquired from this workshop in their professional setting.

In both programs, knowledge of and confidence to implement self-care strategies was high prior to attending the program. The pre-program mean psychological distress scores were also below the clinical cut off levels. These findings suggest that the advertising and screening procedures employed by *Roses in the Ocean* have been successful at adequately selecting participants who have the self-care strategies required to engage in these emotionally involved and potentially triggering training workshops at this time. This is of course a critical 'do no harm' component of engaging those with lived experience in any formal and public setting or initiative within the suicide prevention sector. Roses in the Ocean have placed high emphasis on this 'screening process' of training participants, informed by essential risk management policies that govern all activities of their organisation, in order to protect the well-being of all members and participants.

17.2 Our Voice in Action

The results of this evaluation study indicate that the *Our Voice in Action* program was effective at increasing participants confidence in their abilities of the key skills that this program was designed to increase, such as safely and effectively sharing their stories, identifying appropriate parts of their stories to share, understanding their individual communication styles and strengths, self-care, and managing conflict and collaborating in suicide prevention activities. Average confidence scores rose significantly overall after attending the program, and despite the small sample, for 11 of the 15 individual identified learning objectives this improvement was significant. After the program, participants were also significantly more confident in their ability to support people experiencing a suicidal crisis. As personal confidence in abilities has been found to predict utilisation of skills learnt outside of mental health training programs (Rossetto, Jorm, & Reavley, 2016) the increase in both confidence scales supports the program's effectiveness. This is further demonstrated with participants overwhelmingly agreement that they were *'better equipped to carry out a role as a lived experience representative'* as a result of this training.

Overall, these results indicate that the program successfully increased knowledge on the identified information constructs that the program was designed to teach as participants provided significantly more correct responses on all three of the scales measuring knowledge acquisition. These results show that after attending the *Our Voice in Action* program people had greater suicide literacy and understanding of safe language to use when discussing

suicide. Participants demonstrated increased learning through significantly more correct responses on the *declarative knowledge scale* which covered communication strategies, collaboration, conflict mediation, suicide risk identification and self-care. The increase in the percentage of participants answering each item correctly was not meaningful in this limited sample. In further research with larger participant samples, the individual items (or smaller construct-related subscales) should be analysed to ensure that acquired knowledge occurs across all of the targeted program domains.

As all three of the suicide-related measures showed significant improvements (confidence in their ability to support people experiencing a suicidal crisis, knowledge about suicide and safely communicating about suicide), these findings indicate that *Roses in the Ocean* have delivered this training in an appropriate, accessible and effective way for this target audience of people with a lived experience of suicide.

The pre-program average Lived Experience Opinion Scale scores were near the highest possible scores on the scale, creating a "ceiling" effect in which there was little room to improve after the training which may have contributed to the lack of significant differences. This result may demonstrate that that the *Roses in the Ocean* screening procedures for program participants are targeting and selecting individuals who already value the contributions of lived experience in suicide prevention activities.

Interestingly, although pre-program distress scores were below clinically indicated risk levels, participants reported significantly less psychological distress after attending the *Our Voice in Action* program, suggesting that engaging in the program may have had a "treatment" effect for people with lived experience of suicide. Potentially speaking about their experiences in a productive context has a therapeutic effect for people with a lived experience of suicide. This is an important opportunity to explore in future research.

Participants identified that being in a *'safe place'* and getting to *'connect with other people with a lived experience of suicide'* were both key elements of why the program was effective. Potentially this reflects other research findings that those affected face difficulty in finding safe places where they can openly discuss their lived experiences of suicide (Frey, Hans &

Cerel, 2015). The learning objective with the highest confidence score after attending the *Our Voice in Action* program was *'Understanding the diversity of lived experience perspectives'* which may also indicate the limited opportunities in the community to hear from other people with a lived experience outside of *Roses in the Ocean* workshops. As previous research has found that ongoing stigma for previous attempters or those bereaved contributes to social avoidance, isolation and reluctance to disclose their experiences (Rimkeviciene et al., 2015; Hanschmidt, Lehnig, Riedel-Heller & Kersting, 2016), this further reinforces the need for suicide specific programs and deliveries and that general mental illness or grief programs may not be adequate for people with a lived experience of suicide.

Overall, that the most pronounced theme in participants' responses to the *Our Voice in Action* workshop was the *'sense of purpose to make a difference'* underscores the program's progress towards its stated goals. It is interesting that this finding was not corroborated in the quantitative analysis as the increase in the empowerment scale was not found to be significant in this sample. This may be due to the limited sample size for analysis or that this scale was adapted for the current study and has not been previously used. After further data collection and analysis with larger samples, additionally scales measuring related constructs (such as self-efficacy or self-esteem) could be included in the evaluation survey to explore and better understand the impact of the program.

Participants pre- program scores on the Attitudes to Suicide Prevention Scale were low, indicating that participants did not hold many negative attitudes before attending the program. This could contribute to finding that the changes on the Attitudes to Suicide Prevention Scale were not significant in this evaluation study. This measure was initially developed to assess the attitudes of healthcare professionals responding to people experiencing a suicidal crisis. Potentially, these findings suggest that the attitudes towards preventing suicide for people who have cared for or lost someone to suicide or managed their own suicidality may be less effected by short training programs.

17.3 Voices of In-Sight

The results of this evaluation study indicate that the *Voices of In-Sight* training workshops were effective at significantly increasing participants confidence in the key skills and abilities

the program was designed to increase, such as understanding principles of effective storytelling, defining the key message of their story, providing appropriate resources to audiences, and adapting their story to different audiences. Average confidence scores rose after attending the program in all of the 13 identified learning objectives. As the workshops involved considerable time practicing communicating and adapting participants' personal stories, it validates the effectiveness of the program that *'Sharing your story with a group of people you don't know'* was the learning objective with the greatest improvement. Average confidence scores rose significantly overall after attending the program, and despite the limited sample, for the majority of the 13 individual identified learning objectives this improvement was significant.

Interestingly, participants' reported value of lived experience contributions towards suicide prevention activities increased significantly after attending the *Voices of In-Sight* workshops, but this result was not found after attending the *Our Voice in Action* program. The *Voices of In-Sight* workshops have a greater focus on the practical communication components in which participants hear each other rehearse their stories. The greater exposure to lived experience stories may, promisingly, explain the greater increase in valuing lived experience contributions. This observation was further echoed through the qualitative analysis as many participants spoke of the benefit of hearing other lived experience stories, which several people described as a *"privilege"* or an *"honour."*

The improvements after workshop attendance did not reach statistical significance on either of the two knowledge acquisition scales. Likely, these findings are due to the limited sample of 18 matched pairs, as through the qualitative results, participants overwhelming reported that the most valuable component of the program was the practical information provided, and techniques taught on how to structure and deliver a message about their story. Additional data collection is required to adequately explore the impact of this workshop on learning and knowledge retention. In larger samples it should also be explored if participants are answering most items correctly prior to training, in which case the items may need to be adjusted to be appropriately challenging. Prior to the workshop, the average number of correctly answered suicide terminology items was close to the highest possible scores of the scale, creating a "ceiling effect" in which there was little room for improvement, likely contributing to the not

significant results. Substantiating this, *'Using safe language when talking about suicide'* was the learning objective that participants reported the most confidence after completing the program.

There were no significant differences found after *Voices of In-Sight* attendance for either empowerment or psychological distress, though it is difficult to determine if this is, again, due to a lack of improvement or the limited sample of 18 matched pairs. As the *'healing'* and *'cathartic'* effect of this program was a primary theme reflected through participants' experiences of the program, it would suggest that it is unlikely that this program has contributed to increased participant distress. However, this must be interpreted with caution as it is possible that the participants who may have experienced some distress were the same participants who chose not to complete the post-program survey. Future research on Roses in the Ocean training programs should follow-up those who withdraw or don't participate subsequently as well to determine whether or not this is the case.

It is interesting to note that approximately half of the *Voices of In-Sight* participants' identified that this program helped to bring *"structure"* or *"clarity"* to their stories. This could further reveal that people who have been affected by suicide have few opportunities to share and process their experiences (Frey, Hans & Cerel, 2015) and highlights the 'gap' in services to assist and support this target group.

18 Evaluation Study Limitations

As mentioned previously, the overall limited data collected during this pilot project timeframe limits the generalisability of the positive findings. It is also difficult to determine if the few significant differences reflect a genuine lack of change or inadequate sample size, particularly for the *Voices of In-Sight* training workshops for which only 18 matched pairs were collected. As only 8 and 9 follow-up surveys were collected for the *Our Voice in Action* and *Voices of In-Sight* programs respectively, at this stage no conclusions can be drawn with regards to the longer-term effect of these programs.

Due to the sensitive and personal topics discussed in each program, each program delivery tends to have a small number of participants. As such, it may require longer project timeframes to collect enough data for more meaningful analysis. It has also been suggested

that due to the complexity of suicide and therefore its impacts on the lives of people, it may be more effective to complete pre- and post-evaluation surveys during the training workshops. It has been suggested that there may be a greater reluctance to use technology in this cohort which could be contributing to the lower follow-up surveys received (which were all online) as this particular sample skewed towards older participant ages.

Although the consent forms for the study included the timeframes for follow-up survey completion, facilitators reported that several participants were confused by the additional emails participants received with surveys to complete. It may increase the follow-up retention rate if the data collection expectations and purpose are explained to participants during the initial screening phone calls. Potentially only one follow-up time point (at 3 or 6 months) could be attempted initially, as the multiple time point requirements may seem overwhelming to participants and decrease engagement. A refresher 'connect' meeting with participants (at 3 or 6 months) could be arranged as an opportunity for participants to complete the follow-up survey, or this could even occur informally as part of a face-to-face mentoring meeting.

19 Recommendations for future program deliveries

From the results of this evaluation study of the *Our Voice in Action* and *Voices of In-Sight* programs, the following recommendations are made for future training workshop deliveries:

- Continue the current participant screening strategies employed which have successfully selected people with existing knowledge and implementation of self-care strategies and low levels of current psychological distress.
- Continue to deliver training modules within both *Our Voice in Action* and *Voices of In-Sight* programs, with special attention to the content on appropriate language around discussing suicide, challenging suicide myths, communication skills, and self-care implementation.
- Include First Australian and culturally and linguistically diverse people with a lived experience of suicide to review and contribute to program content for improved cultural safety.
- Implement recruitment strategies to include more people with experience of personal suicidality in their training programs to ensure the programs are balanced between people who have been (or are) carers for people experiencing suicidal crises, people

who have been bereaved and people who have previously attempted and experienced suicidal thoughts.

- Extend the components on self-care towards more advanced concepts and strategies as the majority of participants commence the workshop already knowing the information taught in the program content (e.g., attitudes towards self-care and personal stigma). Update evaluation surveys to measure additional acquired knowledge.
- Include opportunities for participants to stay connected with *Roses in the Ocean* facilitators and each other, through either a follow-up 'refresher' meeting, ongoing smaller group meeting/deliveries, or informal face-to-face mentoring meetings.

20 Recommendations for future evaluation research

Following the implementation of this evaluation study of the *Our Voice in Action* and *Voices of In-Sight* programs, the following recommendations are made for future evaluation research of lived experience training programs:

- Continue to collect pre-, post- and follow-up surveys for the *Our Voice in Action* and *Voices of In-Sight* programs, and allow for longer project timeframes for future evaluations in order to collect enough data for more meaningful analysis.
- Complete pre- and post-evaluation surveys during the training workshops using paper survey versions and offer participants the choice to complete a paper version of the follow-up survey.
- Trial an initial single follow-up survey collection point at 3 or 6 months after program completion.
- Communicate to potential participants the data collection expectations and purpose during the initial screening phone calls, including the follow-up survey options.
- Include a person who identifies as from the LGBTIQA+ community with a lived experience of suicide to develop suitable additional gender and sexuality demographic identification items.
- Follow-up those who choose not to participant or who withdraw from the survey participation to enquire about reasons for their decision to do so.

21 Conclusion

This is the first piece of research to explore the effectiveness of training programs for people with a lived experience of suicide to increase their capabilities to participate with a 'lived experience' towards workforce contributions in suicide prevention.

The *Our Voice in Action* program successfully increased suicide literacy, knowledge of safe suicide language, and confidence to support people experiencing a suicidal crisis. Both the *Our Voice in Action* and *Voices of In-Sight* participants were more confident in their abilities in the key actions required to perform a lived experience representative role. Participants also demonstrated a greater value of lived experience contributions towards suicide prevention activities after the *Voices of In-Sight* workshops.

As mentioned previously, due to the small sample sizes collected during the project timeframes, ultimately increased data collection will need to occur to adequately explore these programs' impact.

One of the most notable findings from this study was that people with a lived experience of suicide participating in programs discussing suicide did not demonstrate increased psychological distress. Analysing changes in psychological distress was essential in this research as it is a commonly held concern that any discussion of suicide will be traumatising or harmful (Batterham, Calear & Christensen, 2013), especially for those in at-risk groups such as previous attempters or those bereaved. These results indicate that suicide can be discussed safely and sensitively with people with a lived experience. The significant decrease in distress from the *Our Voice in Action* results, in conjunction with the qualitative participant reports reflecting personal benefits, suggests that participating in these programs may also have a therapeutic effect. This further demonstrates that it is very possible to safely and effectively partner with those bereaved or with previous attempts (who may be often excluded from research programs due to perceived vulnerability) without doing harm. Following the *Voices of In-Sight* workshop many people reported that it was a *"healing"* and *"cathartic"* experience.

The findings of this report add to our knowledge, not only about how training of those with lived experience can be done safely, but also they shed light on the recovery and support of people with a lived experience of suicide. Participants from both programs indicated that they

benefitted uniquely from connecting with others affected by suicide and having a safe and supportive space to talk about suicide.

This evaluation project was commissioned by *Roses in the Ocean*, who's leadership, determination, commitment and considered caution around supporting lived experience workforce participation has, at its core, the need for evidence around 'what works' in this space.

It is our belief that the positive outcomes and benefits derived from the data received to date could not be extricated from the design and delivery processes without the ongoing partnership and collaboration between researchers and lived experience program designers and without privileging the contributions and insights of a lived experience consultant.

The need for rigour and critical appraisal around lived experience capabilities and participation in suicide prevention can be best explored via implementation and evaluation research; in a domain where very little had been conducted prior to this study. The outcomes of this evaluation provide unique and novel research findings contributing to our understanding of lived experience in suicide prevention activities. If implemented, the recommendations from the present study can well 'pave the way' to inform other lived experience suicide prevention evaluation methodologies and program development. It is essential that rigorous research on the effectiveness of lived experience training programs build on these learnings to continue to explore participant learnings and experiences in order to safely and effectively guide suicide prevention policy, practice, and research.

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22 Appendix A – Our Voice in Action Evaluation Survey

22.1 Pre-program

Evaluating the impact of *Roses in the Ocean* 'Our Voice in Action' training for people with lived experience of suicide

Introduction

You are invited to take part in a study examining the impact of a training program to help people with a lived experience of suicide communicate their stories to support suicide prevention activities in their communities. Surveys will be conducted before and after the training program. With your permission, we may also survey you at one, three, six, and twelve months after completing the program.

The Australian Institute for Suicide Research and Prevention (AISRAP, Griffith University) has been contracted by *Roses in the Ocean (RITO)* to evaluate the impact and effectiveness of the 'Our Voice in Action' program.

What would you be asked to do if you agree to participate?

Before beginning this survey, you will need to provide your consent to participation in it (see immediately below). Please know that we value your feedback in this important domain of understanding how best to support people who have been affected by suicide. Your feedback and the survey results will be used to inform improvements to the *Roses in the Ocean* programs delivered to people with a lived experience of suicide.

You will be asked to answer questions about your age and other details such as education, and employment status; your confidence in implementing skills associated with the training, your behaviours towards someone who you think might be at risk of suicide, and your knowledge and personal experience of suicide. You do not have to answer every question; and you may withdraw from the study at any given time. The survey will take approximately 15 minutes to complete and less time for the post survey and follow up surveys

Risks

It is not expected that you will be exposed to any risks as a result of participation in this study. However, you may potentially find some of the questions about the topic of suicide prevention or lived experience upsetting. If you believe that these questions may cause you to become distressed or upset or find that this occurs during your participation in this study, please do seek help using the support contacts provided in the survey (on this page and at the bottom of each survey page), OR, discontinue the survey. Should you require emotional support either prior to, during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (Jacinta Hawgood at Jacinta.hawgood@griffith.edu.au) who can provide assistance in referrals to suit your needs.

There are several 24-hour phone lines available if you need to get help, get a referral, or just want to talk to someone:

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Benefits

While we intend that this research furthers knowledge and may improve suicide prevention in the future, it may not be of direct benefit to you. Prior research conducted with people with lived experience of suicide

however, has indicated that the research has had therapeutic benefits for many participants.

How will your privacy be protected?

All the information collected from you for the study will be treated confidentially, and only the researchers named will have access to it. Participation in the evaluation surveys is voluntary and you may cease the survey at any time, however, once de-identified information is provided it cannot be withdrawn. The research results will be reported to Roses in the Ocean in a final evaluation report, and may be presented at a conference or in a scientific publication. Individual participants will not be identifiable in such a presentation; only group data that has been de-identified will be provided. All research data (survey responses and analysis) will be retained in a password protected electronic file at Griffith University for a period of five years before being destroyed.

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research (GU Ref No: 2018/315). If you have any concerns or complaints about the ethical conduct of this research project, you are encouraged to contact the Manager, Research Ethics on 07 3735 4375 or research-ethics@griffith.edu.au.

How do you receive further Information?

If you would like to receive further information about this study, including a summary of the results of this research, you may contact the Chief Investigator of this study, Jacinta Hawgood at Jacinta.hawgood@griffith.edu.au. or (07) 3735 3382.

Clicking below to continue to the next page of the survey, will confirm your consent to participate in the research study.

I consent to participate in the research study______________(continue survey)

Australian Institute for
Suicide Research and Prevention

Demographic Details

Before you begin this survey, it is important that you are informed of the need to match your answers on this survey with the survey ‘post’ (after) the training, and again at 1 month, 3 months, 6 months, and 12 months post the training you are about to undertake. This ‘matching’ of your own answers across each of these time periods is critical for us to understand what impacts the training is having on your retained knowledge over time.
Therefore, we need to identify your answers in a way that doesn’t identify who you are; hence we ask a ‘secret password’ (see just below) which will assist us in matching the data.

Secret Password - First street you recall living on *______________________

Please state the location of the workshop you are attending ____________________________

Gender: Male / Female / Non-Binary / Different Identity (please state): Age (age turned this year) ______________________________

Are you of Aboriginal or Torres Strait Islander origin?
- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, both Aboriginal and Torres Strait Islander

What ethnicity best describes you? (e.g., Caucasian, African, South-East Asian, Polish)
____

What language/s do you usually speak at home?
- English
- English and other language (please specify) _____________________________
- Other language only (please specify) __________________________________

What is your marital status?
- Married
- De facto
- Separated
- Divorced
- Widowed
- Not married/never been married

What is your current employment situation?
- Employed full-time
- Employed part-time and looking for full-time work
- Employed part-time
- Unemployed – looking for work
- Not in the paid labour force
- Carer - to dependent child(ren)
- Carer - to other eg; adult

What is the highest level of education you have completed?
- Some primary
- All of primary
- Some secondary
- All of secondary
- Trade/apprenticeship
- Some university/college
- Associate or undergraduate diploma
- Bachelor’s degree
- Postgraduate degree (e.g., Masters, PhD)

Personal Lived Experience

Do you have a lived experience of suicide?

- o Yes
- o No
- o Maybe

Please select all that apply to your lived experience of suicide

- o I have had suicidal thoughts in the past
- o I continue to have suicide thoughts
- o I have cared for someone, or continue to care for someone, who is suicidal or has attempted suicide
- o I have attempted suicide
- o I am bereaved by suicide

Please select all of the following that apply

- o I am impacted by suicide through my employment/professional capacity
- o I am impacted by suicide personally or in some other way (please specify) ______________________________________

Is your lived experience a central part of your current work (paid and/or voluntary) role?

- o Yes
- o No
- o Maybe
- o Other:____

How did you hear about the Roses in the Ocean program?

- o Through my Primary Health Network
- o Local advertisement
- o Roses in the Ocean Facebook
- o Roses in the Ocean Twitter
- o Roses in the Ocean LinkedIn
- o Through a friend/colleague
- o At an event I attended – please tell us the name of the event
- o Other ____________________

Professional Work/Training with Suicide Prevention

Please indicate whether you have completed any of the following suicide prevention training courses either face-to-face or online?

- o Question-Persuade-Refer (QPR)
- o Wesley Lifeforce (Community, Relationship Counsellor, Aged Care Nursing, GP)
- o Applied Suicide Intervention Skills Training (ASIST)
- o SafeTALK
- o Mental Health First Aid for the Suicidal Person
- o Screening Tool for Assessing Risk of Suicide (STARS)
- o Other (please specify) ______________________________________

How many years have you been working/volunteering in your role that relates to suicide prevention specifically?

- o -1
- o 1-3
- o 4-7
- o 8-10
- o 11+

Please describe the volunteering/work that you have been involved in that specifically relates to suicide prevention
____

Understanding of and Attitudes to Lived Experience

Which is **not** an example of lived experience? (Please **select one**)

	Caring for a person who has been suicidal
	Previous suicide attempts
	Clinical experience treating suicidal patients
	Having had suicidal thoughts
	Being bereaved by suicide

Which are examples of lived experience representation assisting suicide prevention activities? (Please select one)

	Providing local and regional information to service providers about which services people in crisis access
	Providing insights to emergency department staff about the experiences of people presenting after a suicide attempt
	Consulting on program materials to review how they may be perceived by people with a lived experience of suicide
	All of the above

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Lived Experience stories provide a unique capacity and opportunity to inform and improve suicide prevention activities					
Lived Experience is essential in delivering effective suicide prevention programs and strategies					
I feel my lived experience story is useful and valuable to inform suicide prevention activities in my community					

Understanding Communication

Story-telling is a powerful mechanism to influence other peoples' thoughts, beliefs attitudes, and behaviours. Which of the following statements are reasons for this? (Please **select all** that apply)

	When we hear a story we are more likely to imagine the impact on our own lives, and we respond with empathy in a way we don't with a list of facts.
	Stories tend to evoke an emotional response, and emotional responses are more likely to challenge our thinking and behaviours.
	People don't want to learn about information or facts.
	Humans are social creatures; so we are more likely to form a sense of connection and motivation to act that we don't with a list of statistics.

When presenting your story to have an impact, it is most important to make sure it is communicated in a way that: (Please **select one**)

	is based only on professional expertise of the topic

	is presented in a way that meets the needs of the audience
	uses highly skilled literary techniques

Conflict Management and Cooperation

Which are ***not*** actions in effectively managing conflict actions? (Please **select one**)

	Identifying that there is conflict between people
	Developing a fair solution to manage the conflict
	Avoiding individuals or collaborations where there is any chance of conflict or discomfort

Which are effective strategies to create understanding and mediate (manage) conflict? (Please **select all** that apply)

	Valuing feelings and attitudes
	Encouraging further elaboration and clarification
	Providing unsolicited advice
	Seeking to end discussions about contentious topics
	Supporting other people's attempts to find a solution
	All of the above

Which is the **best** description of **Collaboration**?

	Following a clear hierarchy and reporting structure to achieve a goal as efficiently as possible
	Co-equal parties voluntarily engaged in shared decision making as they work towards a common goal

Self-Care

Which of the following is ***not*** an example of self-care? (Please **select one**)

	Always putting yourself before others
	Knowing your role and limitations
	Finding ways to unwind and manage stress
	Being aware of how work can impact your wellbeing

Which are potential signs we need to focus on (perhaps neglected) self-care? (Please **select all** that may apply)

	Becoming more likely to poorer decisions or emotional responses
	Feeling more negative about your capacity to manage the challenges in front of you

	Being less able to come up with creative ways to meet the challenges you face
	Drinking many cups of coffee everyday
	Feeling more lethargic
	Occasional forgetfulness

Confidence in Learning Objectives

Thinking about your involvement in suicide prevention as a person with a lived experience of suicide, please rate your confidence in the following areas

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
Knowledge about “self-care”					
Ability to recognise your need for “self-care”					
Ability to “self-care”					
Using safe and appropriate language when talking about suicide					
Identifying which parts of your story are appropriate to share					
Choosing appropriate key messages to emphasise when drawing on your lived experience					
Sharing your story with a group of people you don’t know					
Understanding your individual styles, abilities and strengths to communicate your lived experience of suicide					
Knowledge of opportunities available for people with lived experience to participate in suicide prevention activities					
Knowledge of specific opportunities to use your lived experience story in your community					
Understanding of the diversity of lived experience perspectives					
Managing conflict while participating in suicide prevention activities					
Working collaboratively with others while participating in suicide prevention activities					
Sharing opinions about what works to prevent suicide					
Speaking out and explaining your views					

Knowledge about Suicide and Warning Signs

Please read the following statements and indicate whether you think they are true or false

	True	False	Don't Know
People who have thoughts about suicide should not tell others about it			
Seeing a psychiatrist or psychologist can help prevent someone from suicide			
Most people who suicide are psychotic			
Talking about suicide always increases the risk of suicide			
A suicidal person will always be suicidal/will always entertain thoughts of suicide			
Not all people who attempt suicide plan their attempt in advance			
Very few people have thoughts about suicide			
If assessed by a psychiatrist, everyone who kills themselves would be diagnosed as depressed			
Men are more likely to die by suicide than women			
People who talk about suicide rarely kill themselves			
People who want to attempt suicide can change their mind quickly			
There is a strong relationship between alcoholism and suicide			
People who talk about suicide or have previous attempts are only seeking attention			

Which group of people are likely to be at risk of suicide?

	Persons with mental disorders, such as major depression, psychotic illnesses or eating disorders
	Persons with alcohol or drug abuse problems
	Persons experiencing challenging life events or circumstances
	All of the above

Safely Talking about Suicide

Which terminology is safest when discussing suicide? (Please **circle one in each line**)

1.	He died by suicide	He committed suicide
2.	She completed suicide	She ended her life
3.	They took their own life	There was a successful suicide
4.	She had an unsuccessful suicide	She attempted to end her life
5.	There were several failed suicide attempts reported	There were several non-fatal attempts at suicide

Perceived Ability in supporting people experiencing suicidality

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
I am able to recognise signs that someone may be having thoughts of suicide					
If someone was showing signs of suicide, I would directly raise the question of suicide with them					
I have the skills to help or support someone experiencing thoughts of suicide					
I have the skills to intervene safely and constructively with someone considering suicide					
I can work together with someone to keep them safe from suicide					

When communicating with suicidal persons, it is important that you do not… (Please ***select one***)

	Only provide direction on how not to feel suicidal
	Ask direct questions about suicide
	Explore alternative courses of action
	Continue engaging on the present conversation

Attitudes to Suicide Prevention Scale

Please rate your agreement with the following statements

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
I resent being asked to do more about suicide					
Suicide prevention is not my responsibility					
Making more funds available to the appropriate health services would make no difference to the suicide rate					
Working with suicidal people is rewarding					
If people are serious about killing themselves they don't tell anyone					
I feel defensive when people offer advice about suicide prevention					
It is easy for people not involved in clinical practice to make judgements about suicide prevention					

If a person survives a suicide attempt, then this was a ploy for attention					
People have the right to take their own lives					
Since unemployment and poverty are the main causes of suicide, there is little that an individual can do to prevent it					
I don't feel comfortable assessing someone for suicide risk					
Suicide prevention measures are a drain on resources, which would be more useful elsewhere					
There is no way of knowing who is going to take their own life					

What proportion of suicides do you consider preventable?	(none)	(some)	(uncertain)	(many)	(all)

Psychological Distress Scale

In the last 30 Days…

	Never	Rarely	Sometimes	Often	Always
My worries overwhelmed me					
I felt hopeless					
I found social settings upsetting					
I had trouble staying focused on tasks					
Anxiety or fear interfered with my ability to do the things I needed to do at work or at home					

Empowerment Scale

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am able to do things as well as most other people				
People have more power if they join together as a group				
I have a positive attitude about myself				
When I am unsure about something, I usually go along with the group				
I feel powerless most of the time				
When I make plans, I am almost certain to make them work				

Working with others in my community can help change things for the better				
Experts are in the best position to decide what people should do or learn				
I am often able to overcome barriers				
I feel I am a person of worth, at least on an equal basis with others				
I generally accomplish what I set out to do				
Getting angry about something is often the first step toward changing it				
People are limited only by what they think possible				
Making waves never gets you anywhere				
I am usually confident about the decisions I make				
I see myself as a capable person				
Getting angry about something never helps				
Very often a problem can be solved by taking action				
I am generally optimistic about the future				
I feel I have a number of good qualities				

Please describe your three most important reasons for living (any further comments can be provided in the
comments section below)

1.

2.

3.

Comments:

Should you require emotional support during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (indicated also below).

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Kids Helpline:** 1800 551 800
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Chief Investigator of this study (GU ref no: 2015/315): Jacinta Hawgood (Jacinta.hawgood@griffith.edu.au).

Do you agree to be contacted by AISRAP to complete the additional surveys as part of this project to evaluate the Roses in the Ocean training programs? (click to confirm)

Do you agree to participate in any other research with AISRAP and Roses In The Ocean (RITO) on this topic following this training and follow-up surveys?

If you agree to further contact by the research team please email Jacinta Hawgood at: Jacinta.Hawgood@griffith.edu.au and provide your name email and/or best contact number.

Thank you for participating in this research. Your input will help RITO to further improve the quality of its training programs

22.2 Post-program

Evaluating the impact of *Roses in the Ocean* 'Our Voice in Action' training for people with lived experience of suicide

Demographic Details

Please write your Secret Password from the initial survey (First street you recall living on) *__

Please note the location of the workshop you are attending ______________________________

Gender: Male / Female / Non-Binary / Different Identity (please state): Age (age turned this year) ________________________________

Understanding of and Attitudes to Lived Experience

Which is **not** an example of lived experience? (Please **select one**)

	Caring for a person who has been suicidal
	Previous suicide attempts
	Clinical experience treating suicidal patients
	Having had suicidal thoughts
	Being bereaved by suicide

Which are examples of lived experience representation assisting suicide prevention activities? (Please select one)

	Providing local and regional information to service providers about which services people in crisis access
	Providing insights to emergency department staff about the experiences of people presenting after a suicide attempt
	Consulting on program materials to review how they may be perceived by people with a lived experience of suicide
	All of the Above

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Lived Experience stories provide a unique capacity and opportunity to inform and improve suicide prevention activities					
Lived Experience is essential in delivering effective suicide prevention programs and strategies					

I feel my lived experience story is useful and valuable to inform suicide prevention activities in my community					

Understanding Communication

Story-telling is a powerful mechanism to influence other peoples' thoughts, beliefs attitudes, and behaviours. Which of the following statements are reasons for this? (Please **select all** that apply)

	When we hear a story we are more likely to imagine the impact on our own lives, and we respond with empathy in a way we don't with a list of facts.
	Stories tend to illicit an emotional response, and emotional responses are more likely to challenge our thinking and behaviours.
	People don't want to learn about information or facts.
	Humans are social creatures; so we are more likely to form a sense of connection and motivation to act that we don't with a list of statistics.

When presenting your story to have an impact, it is most important to make sure it is communicated in a way that: (Please **select one**)

	is based only on professional expertise of the topic
	is presented in a way that meets the needs of the audience
	uses highly skilled literary techniques

Conflict Management and Cooperation

Which are ***not*** actions in effectively managing conflict? (Please **select one**)

	Identifying that there is conflict between people
	Developing a fair solution to manage the conflict
	Avoiding individuals or collaborations where there is any chance of conflict or discomfort

Which are effective strategies to create understanding and mediate conflict? (Please **select all** that apply)

	Valuing feelings and attitudes
	Encouraging further elaboration and clarification
	Providing unsolicited advice
	Seeking to end discussions about contentious topics
	Supporting other people's attempts to find a solution
	All of the above

Which is the **best** description of **Collaboration**?

	Following a clear hierarchy and reporting structure to achieve a goal as efficiently as possible
	Co-equal parties voluntarily engaged in shared decision making as they work towards a common goal

Self-Care

Which of the following is ***not*** an example of self-care? (Please **select one**)

	Always putting yourself before others
	Knowing your role and limitations
	Finding ways to unwind and manage stress
	Being aware of how work can impact your wellbeing

Which are potential signs we need to focus on (perhaps neglected) self-care? (Please **select all** that may apply)

	Becoming more likely to poorer decisions or emotional responses
	Feeling more negative about your capacity to manage the challenges in front of you
	Being less able to come up with creative ways to meet the challenges you face
	Drinking many cups of coffee everyday
	Feeling more lethargic
	Occasional forgetfulness

Confidence in Learning Objectives

Thinking about your involvement in suicide prevention as a person with a lived experience of suicide, please rate your confidence in the following areas

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
Knowledge about “self-care”					
Ability to recognise your need for “self-care”					
Ability to “self-care”					
Using safe and appropriate language when talking about suicide					
Identifying which parts of your story are appropriate to share					
Choosing appropriate key messages to emphasise when drawing on your lived experience					
Sharing your story with a group of people you don’t know					

Understanding your individual styles, abilities and strengths to communicate your lived experience of suicide					
Knowledge of opportunities available for people with lived experience to participate in suicide prevention activities					
Knowledge of specific opportunities to use your lived experience story in your community					
Understanding of the diversity of lived experience perspectives					
Managing conflict while participating in suicide prevention activities					
Working collaboratively with others while participating in suicide prevention activities					
Sharing opinions about what works to prevent suicide					
Speaking out and explaining your views					

Knowledge about Suicide and Warning Signs

Please read the following statements and indicate whether you think they are true or false.

	True	False	Don't Know
People who have thoughts about suicide should not tell others about it			
Seeing a psychiatrist or psychologist can help prevent someone from suicide			
Most people who suicide are psychotic			
Talking about suicide always increases the risk of suicide			
A suicidal person will always be suicidal/will always entertain thoughts of suicide			
Not all people who attempt suicide plan their attempt in advance			
Very few people have thoughts about suicide			
If assessed by a psychiatrist, everyone who kills themselves would be diagnosed as depressed			
Men are more likely to die by suicide than women			
People who talk about suicide rarely kill themselves			
People who want to attempt suicide can change their mind quickly			
There is a strong relationship between alcoholism and suicide			
People who talk about suicide or have previous attempts are only seeking attention			

Which group of people are likely to be at risk of suicide?

	Persons with mental disorders, such as major depression, psychotic illnesses or eating disorders

	Persons with alcohol or drug abuse problems
	Persons experiencing challenging life events
	All of the above

Safely Talking about Suicide

Which terminology is safest when discussing suicide? (Please **circle one in each line**)

1.	He died by suicide	He committed suicide
2.	She completed suicide	She ended her life
3.	They took their own life	There was a successful suicide
4.	She had an unsuccessful suicide	She attempted to end her life
5.	There were several failed suicide attempts reported	There were several non-fatal attempts at suicide

Perceived Ability in supporting people experiencing suicidality

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
I am able to recognise signs that someone may be having thoughts of suicide					
If someone was showing signs of suicide, I would directly raise the question of suicide with them					
I have the skills to help or support someone experiencing thoughts of suicide					
I have the skills to intervene safely and constructively with someone considering suicide					
I can work together with someone to keep them safe from suicide					

When communicating with suicidal persons, it is important that you do not… (Please ***select one***)

	Only provide direction on how not to feel suicidal
	Ask direct questions about suicide
	Explore alternative courses of action
	Continue engaging on the present conversation

Attitudes to Suicide Prevention Scale

Please rate your agreement with the following statements

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
I resent being asked to do more about suicide					
Suicide prevention is not my responsibility					
Making more funds available to the appropriate health services would make no difference to the suicide rate					
Working with suicidal people is rewarding					
If people are serious about killing themselves they don't tell anyone					
I feel defensive when people offer advice about suicide prevention					
It is easy for people not involved in clinical practice to make judgements about suicide prevention					
If a person survives a suicide attempt, then this was a ploy for attention					
People have the right to take their own lives					
Since unemployment and poverty are the main causes of suicide, there is little that an individual can do to prevent it					
I don't feel comfortable assessing someone for suicide risk					
Suicide prevention measures are a drain on resources, which would be more useful elsewhere					
There is no way of knowing who is going to take their own life					

What proportion of suicides do you consider preventable?	(none)	(some)	(uncertain)	(many)	(all)

Psychological Distress Scale

In the last 30 Days…

	Never	Rarely	Sometimes	Often	Always
My worries overwhelmed me					
I felt hopeless					
I found social settings upsetting					
I had trouble staying focused on tasks					

Anxiety or fear interfered with my ability to do the things I needed to do at work or at home					

Empowerment Scale

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am able to do things as well as most other people				
People have more power if they join together as a group				
I have a positive attitude about myself				
When I am unsure about something, I usually go along with the group				
I feel powerless most of the time				
When I make plans, I am almost certain to make them work				
Working with others in my community can help change things for the better				
Experts are in the best position to decide what people should do or learn				
I am often able to overcome barriers				
I feel I am a person of worth, at least on an equal basis with others				
I generally accomplish what I set out to do				
Getting angry about something is often the first step toward changing it				
People are limited only by what they think possible				
Making waves never gets you anywhere				
I am usually confident about the decisions I make				
I see myself as a capable person				
Getting angry about something never helps				
Very often a problem can be solved by taking action				
I am generally optimistic about the future				
I feel I have a number of good qualities				

Please describe your three most important reasons for living (any further comments can be provided in the
comments section below)

1.

2.

3.

Comments:

Program Satisfaction and Feedback

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
The facilitator(s) managed group dynamics well					
I felt supported and safe throughout the workshop					
The content of the workshop was relevant					
The activities in the workshop provided me with sufficient practice and feedback					
As a result of this workshop, I feel better equipped to carry out a role as a lived experience representative					

Did the program meet your needs and expectations? Yes / No

Please provide reasons for your answer

____

How could this program be improved?

____

What was most valuable about this program to you?

____

Do you have any other comments about the workshop?

____

Lived Experience Involvement

In the past 12 months, have you been involved in any of the following activities as a person with lived experience of suicide?

Activity	Example	Tick if you have been involved
Co-design of programs/services	Participated in a co-design workshop	
Co-evaluation of programs/services	Helped design a piece of research or evaluation	
Participated in a Lived Experience Reference or Advisory Group	Associated with a PHN or other organisation including government, service providers, research organisation, etc	
Participated in strategic planning for a suicide prevention-related organisation	Could be a one-off or a series of workshops aimed at creating an organisational or departmental strategy	
Involved in governance activities	Sat on a Board or Project Steering Committee	

Employed as a Peer Worker	Work at a health service as a dedicated Peer Worker	
Helped deliver a lived experience or peer-led service/program	Ran a support group	
Delivered lived experience-led training to staff	Trained health professionals or police/ambulance	
Lived experience speaker	Shared your story at a public event or spoke to media	
General volunteer positions	Helped or ran a suicide prevention awareness event or volunteered as a Lifeline Crisis Supporter	
Attended a Community Consultation about suicide prevention	An event hosted by a PHN event to inform regional suicide prevention planning	

If you have been involved in any other activities as a person with lived experience of suicide, please describe these below:____

How frequently do you participate in suicide prevention activities as a person with lived experience?

- Daily
- Weekly
- Fortnightly
- Monthly
- Yearly
- Less than once a year
- I have not previously been involved in suicide prevention activities

Should you require emotional support during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (indicated also below).

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Kids Helpline:** 1800 551 800
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Chief Investigator of this study (GU ref no: 2018/315): Jacinta Hawgood (Jacinta.hawgood@griffith.edu.au).

Do you agree to be contacted by AISRAP to complete the additional surveys as part of this project to evaluate the Roses in the Ocean training programs? (click to confirm)

Do you agree to participate in any other research with AISRAP and Roses In The Ocean (RITO) on this topic following this training and follow-up surveys?

If you agree to further contact by the research team please email Jacinta Hawgood at: Jacinta.Hawgood@griffith.edu.au and provide your name email and/or best contact number.

Thank you for participating in this research. Your input will help RITO to further improve the quality of its programs.

22.3 Follow-up

Evaluating the impact of *Roses in the Ocean* 'Our Voice in Action' training for people with lived experience of suicide

<u>Demographic Details</u>

Please write your Secret Password from the initial survey (First street you recall living on) *__

Please note the location of the workshop you attended ______________________________

Gender: Male / Female / Non-Binary / Different Identity (please state): Age (age turned this year) _________________________________

Understanding of and Attitudes to Lived Experience

Which is **<u>not</u>** an example of lived experience? (Please **select one**)

	Caring for a person who has been suicidal
	Previous suicide attempts
	Clinical experience treating suicidal patients
	Having had suicidal thoughts
	Being bereaved by suicide

Which are examples of lived experience representation assisting suicide prevention activities? (Please select one)

	Providing local and regional information to service providers about which services people in crisis access
	Providing insights to emergency department staff about the experiences of people presenting after a suicide attempt
	Consulting on program materials to review how they may be perceived by people with a lived experience of suicide
	All of the Above

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Lived Experience stories provide a unique capacity and opportunity to inform and improve suicide prevention activities					
Lived Experience is essential in delivering effective suicide prevention programs and strategies					
I feel my lived experience story is useful and valuable to inform suicide prevention activities in my community					

Understanding Communication

Story-telling is a powerful mechanism to influence other peoples' thoughts, beliefs attitudes, and behaviours. Which of the following statements are reasons for this? (Please **select all** that apply)

	When we hear a story we are more likely to imagine the impact on our own lives, and we respond with empathy in a way we don't with a list of facts.
	Stories tend to illicit an emotional response, and emotional responses are more likely to challenge our thinking and behaviours.
	People don't want to learn about information or facts.
	Humans are social creatures; so we are more likely to form a sense of connection and motivation to act that we don't with a list of statistics.

When presenting your story to have an impact, it is most important to make sure it is communicated in a way that: (Please **select one**)

	is based only on professional expertise of the topic
	is presented in a way that meets the needs of the audience
	uses highly skilled literary techniques

Conflict Management and Cooperation

Which are ***not*** actions in effectively managing conflict? (Please **select one**)

	Identifying that there is conflict between people
	Developing a fair solution to manage the conflict
	Avoiding individuals or collaborations where there is any chance of conflict or discomfort

Which are effective strategies to create understanding and mediate (manage) conflict? (Please **select all** that apply)

	Valuing feelings and attitudes
	Encouraging further elaboration and clarification
	Providing unsolicited advice
	Seeking to end discussions about contentious topics
	Supporting other people's attempts to find a solution
	All of the above

Which is the **best** description of **Collaboration**?

	Following a clear hierarchy and reporting structure to achieve a goal as efficiently as possible
	Co-equal parties voluntarily engaged in shared decision making as they work towards a common goal

Self-Care

Which of the following is ***not*** an example of self-care? (Please **select one**)

	Always putting yourself before others
	Knowing your role and limitations
	Finding ways to unwind and manage stress
	Being aware of how work can impact your wellbeing

Which are potential signs we need to focus on (perhaps neglected) self-care? (Please **select all** that may apply)

	Becoming more likely to poorer decisions or emotional responses
	Feeling more negative about your capacity to manage the challenges in front of you
	Being less able to come up with creative ways to meet the challenges you face
	Drinking many cups of coffee everyday
	Feeling more lethargic
	Occasional forgetfulness

Confidence in Learning Objectives

Thinking about your involvement in suicide prevention as a person with a lived experience of suicide, please rate your confidence in the following areas

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
Knowledge about “self-care”					
Ability to recognise your need for “self-care”					
Ability to “self-care”					
Using safe and appropriate language when talking about suicide					
Identifying which parts of your story are appropriate to share					
Choosing appropriate key messages to emphasise when drawing on your lived experience					
Sharing your story with a group of people you don’t know					
Understanding your individual styles, abilities and strengths to communicate your lived experience of suicide					

Knowledge of opportunities available for people with lived experience to participate in suicide prevention activities					
Knowledge of specific opportunities to use your lived experience story in your community					
Understanding of the diversity of lived experience perspectives					
Managing conflict while participating in suicide prevention activities					
Working collaboratively with others while participating in suicide prevention activities					
Sharing opinions about what works to prevent suicide					
Speaking out and explaining your views					

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Please read the following statements and indicate whether you think they are true or false.

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Talking about suicide always increases the risk of suicide			
A suicidal person will always be suicidal/will always entertain thoughts of suicide			
Not all people who attempt suicide plan their attempt in advance			
Very few people have thoughts about suicide			
If assessed by a psychiatrist, everyone who kills themselves would be diagnosed as depressed			
Men are more likely to die by suicide than women			
People who talk about suicide rarely kill themselves			
People who want to attempt suicide can change their mind quickly			
There is a strong relationship between alcoholism and suicide			
People who talk about suicide or have previous attempts are only seeking attention			

Which group of people are likely to be at risk of suicide?

	Persons with mental disorders, such as major depression, psychotic illnesses or eating disorders
	Persons with alcohol or drug misuse problems
	Persons experiencing challenging life events

	All of the above

Safely Talking about Suicide

Which terminology is safest when discussing suicide? (Please **circle one in each line**)

1.	He died by suicide	He committed suicide
2.	She completed suicide	She ended her life
3.	They took their own life	There was a successful suicide
4.	She had an unsuccessful suicide	She attempted to end her life
5.	There were several failed suicide attempts reported	There were several non-fatal attempts at suicide

Perceived Ability in supporting people experiencing suicidality

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
I am able to recognise signs that someone may be having thoughts of suicide					
If someone was showing signs of suicide, I would directly raise the question of suicide with them					
I have the skills to help or support someone experiencing thoughts of suicide					
I have the skills to intervene safely and constructively with someone considering suicide					
I can work together with someone to keep them safe from suicide					

When communicating with suicidal persons, it is important that you do not… (Please ***select one***)

	Only provide direction on how not to feel suicidal
	Ask direct questions about suicide
	Explore alternative courses of action
	Continue engaging on the present conversation

Attitudes to Suicide Prevention Scale

Please rate your agreement with the following statements

	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree
I resent being asked to do more about suicide					
Suicide prevention is not my responsibility					
Making more funds available to the appropriate health services would make no difference to the suicide rate					
Working with suicidal people is rewarding					
If people are serious about killing themselves they don't tell anyone					
I feel defensive when people offer advice about suicide prevention					
It is easy for people not involved in clinical practice to make judgements about suicide prevention					
If a person survives a suicide attempt, then this was a ploy for attention					
People have the right to take their own lives					
Since unemployment and poverty are the main causes of suicide, there is little that an individual can do to prevent it					
I don't feel comfortable assessing someone for suicide risk					
Suicide prevention measures are a drain on resources, which would be more useful elsewhere					
There is no way of knowing who is going to take their own life					

What proportion of suicides do you consider preventable?	(none)	(some)	(uncertain)	(many)	(all)

Psychological Distress Scale

In the last 30 Days…

	Never	Rarely	Sometimes	Often	Always
My worries overwhelmed me					
I felt hopeless					
I found social settings upsetting					
I had trouble staying focused on tasks					
Anxiety or fear interfered with my ability to do the things I needed to do at work or at home					

Empowerment Scale

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am able to do things as well as most other people				
People have more power if they join together as a group				
I have a positive attitude about myself				
When I am unsure about something, I usually go along with the group				
I feel powerless most of the time				
When I make plans, I am almost certain to make them work				
Working with others in my community can help change things for the better				
Experts are in the best position to decide what people should do or learn				
I am often able to overcome barriers				
I feel I am a person of worth, at least on an equal basis with others				
I generally accomplish what I set out to do				
Getting angry about something is often the first step toward changing it				
People are limited only by what they think possible				
Making waves never gets you anywhere				
I am usually confident about the decisions I make				
I see myself as a capable person				
Getting angry about something never helps				
Very often a problem can be solved by taking action				
I am generally optimistic about the future				
I have a number of good qualities				

Please describe your three most important reasons for living (any further comments can be provided in the
comments section below)

1.

2.

3.

Comments:

Lived Experience Involvement

In the past 12 months, have you been involved in any of the following activities as a person with lived experience of suicide?

Activity	Example	Tick if you have been involved
Co-design of programs/services	Participated in a co-design workshop	
Co-evaluation of programs/services	Helped design a piece of research or evaluation	
Participated in a Lived Experience Reference or Advisory Group	Associated with a PHN or other organisation including government, service providers, research organisation, etc	
Participated in strategic planning for a suicide prevention-related organisation	Could be a one-off or a series of workshops aimed at creating an organisational or departmental strategy	
Involved in governance activities	Sat on a Board or Project Steering Committee	
Employed as a Peer Worker	Worked at a health service as a dedicated Peer Worker	
Helped deliver a lived experience or peer-led service/program	Ran a support group	
Delivered lived experience-led training to staff	Trained health professionals or police/ambulance	
Lived experience speaker	Shared your story at a public event or spoke to media	
General volunteer positions	Ran a suicide prevention awareness event or volunteered as a Lifeline Crisis Supporter	
Attended a Community Consultation about suicide prevention	An event run by a PHN to inform regional suicide prevention planning	

If you have been involved in any other activities as a person with lived experience of suicide, please describe these below:____

How frequently do you participate in suicide prevention activities as a person with lived experience?

- Daily
- Weekly
- Fortnightly
- Monthly
- Yearly
- Less than once a year
- I have not previously been involved in suicide prevention activities

Should you require emotional support during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (indicated also below).

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Chief Investigator of this study (GU ref no: 2018/315): Jacinta Hawgood (Jacinta.hawgood@griffith.edu.au).

Do you agree to be contacted by AISRAP to complete the additional surveys as part of this project to evaluate the Roses in the Ocean training programs? (click to confirm)

Do you agree to participate in any other research with AISRAP and Roses In The Ocean (RITO) on this topic following this training and follow-up surveys?

If you agree to further contact by the research team please email Jacinta Hawgood at: Jacinta.Hawgood@griffith.edu.au and provide your name email and/or best contact number.

Thank you for participating in this research. Your input will help RITO to further improve the quality of its training programs.

23 Appendix B – Voice of In-Sight Evaluation Survey

23.1 Pre-Program

Evaluating the impact of *Roses in the Ocean* 'Voices of In-Sight' training for people with lived experience of suicide

Introduction

You are invited to take part in a study examining the impact of a training program to help people with a lived experience of suicide communicate their stories to support suicide prevention activities in their communities. Surveys will be conducted before and after the training program. With your permission, we may also survey you at one, three, six, and twelve months follow up.

The Australian Institute for Suicide Research and Prevention (AISRAP, Griffith University) has been contracted by *Roses in the Ocean* to evaluate the impact and effectiveness of the 'Voices of In-Sight' program.

What would you be asked to do if you agree to participate?

Before beginning this survey, you will need to provide your consent to participation in it (see immediately below). Please know that we value your feedback in this important domain of understanding how best to support people who have been affected by suicide. Your feedback and the survey results will be used to inform improvements to the *Roses in the Ocean* programs delivered to people with a lived experience of suicide.

You will be asked to answer questions about your age and other details such as education, and employment status; your confidence in implementing skills associated with the training, your behaviours towards someone who you think might be at risk of suicide, and your knowledge and personal experience of suicide. You do not have to answer every question; and you may withdraw from the study at any given time. The survey will take approximately 15 minutes to complete and less time for the post survey and follow up surveys.

Risks

It is not expected that you will be exposed to any risks as a result of participation in this study. However, you may potentially find some of the questions about the topic of suicide prevention or lived experience upsetting. If you believe that these questions may cause you to become distressed or upset or find that this occurs during your participation in this study, please do seek help using the support contacts provided in the survey (on this page and at the bottom of each survey page), OR, discontinue the survey. Should you require emotional support either prior to, during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (Jacinta Hawgood at Jacinta.hawgood@griffith.edu.au) who can provide assistance in referrals to suit your needs.

There are several 24-hour phone lines available if you need to get help, get a referral, or just want to talk to someone:

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au
- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Benefits

While we intend that this research furthers knowledge and may improve suicide prevention in the future, it may not be of direct benefit to you. Prior research conducted with people with lived experience of suicide however, has indicated that the research has had therapeutic benefits for many participants.

How will your privacy be protected?

All the information collected from you for the study will be treated confidentially, and only the researchers named will have access to it.
. Participation in the evaluation surveys is voluntary and you may cease the survey at any time, however, once de-identified information is provided it cannot be withdrawn. The research results will be reported to Roses in the Ocean in a final evaluation report, and The study results may be presented at a conference or in a scientific publication. Individual participants will not be identifiable in such a presentation; only group data that has been de-identified will be provided. All research data (survey responses and analysis) will be retained in a password protected electronic file at Griffith University for a period of five years before being destroyed.

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research (GU Ref No: 2018/315). If you have any concerns or complaints about the ethical conduct of this research project, you are encouraged to contact the Manager, Research Ethics on 07 3735 4375 or research-ethics@griffith.edu.au.

How do you receive further Information?

If you would like to receive further information about this study, including a summary of the results of this research, you may contact the Chief Investigator of this study, Jacinta Hawgood at Jacinta.hawgood@griffith.edu.au. or (07) 3735 3382.

Clicking below to continue to the next page of the survey, will confirm your consent to participate in the research study.

I consent to participate in the research study______________(continue survey)

Australian Institute for Suicide Research and Prevention

Demographic Details

Before you begin this survey, it is important that you are informed of the need to match your answers on this survey with the survey 'post' (after) the training, and again at 1 month, 3 months, 6 months and 12 months post the training you are about to undertake. This 'matching' of your own answers across each of these time periods is critical for us to understand what impacts the training is having on your retained knowledge over time.
Therefore, we need to identify your answers in a way that doesn't identify who you are; hence we ask a 'secret password' (see just below) which will assist us in matching the data.

Secret Password - First street you recall living on. *______________________

Please note the location of the workshop you are attending ______________________________

Gender: Male / Female / Non-Binary / Different Identity (please state): Age (age turned this year) _________________________________

Are you of Aboriginal or Torres Strait Islander origin?

- No
- Yes, Aboriginal
- Yes, Torres Strait Islander
- Yes, both Aboriginal and Torres Strait Islander

What ethnicity best describes you? (e.g., Caucasian, African, South-East Asian, Polish)
____

What language/s do you usually speak at home?

- English
- English and other language (please specify) ______________________________
- Other language only (please specify) ___________________________________

What is your marital status?

- Married
- De facto
- Separated
- Divorced
- Widowed
- Not married/never been married

What is your current employment situation?

- Employed full-time
- Employed part-time and looking for full-time work
- Employed part-time
- Unemployed – looking for work
- Not in the paid labour force
- Carer - to dependent child(ren)
- Carer - to other adult

What is the highest level of education you have completed?

- Some primary
- All of primary
- Some secondary
- All of secondary
- Trade/apprenticeship
- Some university/college
- Associate or undergraduate diploma
- Bachelor's degree
- Postgraduate degree (e.g., Masters, PhD)

Personal Lived Experience

Do you have a lived experience of suicide?

- Yes
- No
- Maybe

Please select all that apply to your lived experience of suicide

- I have had suicidal thoughts in the past
- I continue to have suicide thoughts
- I have cared for someone, or continue to care for someone, who is suicidal or has attempted suicide
- I have attempted suicide
- I am bereaved by suicide

Please select all of the following that apply

- I am impacted by suicide through my employment/professional capacity
- I am impacted by suicide in some other way (please specify) ______________________________

Is your lived experience a central part of your current work (paid or voluntary) role?

- Yes
- No
- Maybe
- Other:____

Have you attended other Roses in the Ocean programs before?

- Yes
- No

If Yes, which program and when ____

How did you hear about the Roses in the Ocean program?

- Through my Primary Health Network
- Local advertisement
- Roses in the Ocean Facebook
- Roses in the Ocean Twitter
- Roses in the Ocean LinkedIn
- Through a friend/colleague
- At an event I attended
- Other ____________________

Professional Work/Training with Suicide Prevention

Please indicate whether you have completed any of the following suicide prevention training courses either face-to-face or online?

- Question-Persuade-Refer (QPR)
- Wesley Lifeforce (Community, Relationship Counsellor, Aged Care Nursing, GP)
- Applied Suicide Intervention Skills Training (ASIST)
- SafeTALK
- Mental Health First Aid for the Suicidal Person
- Screening Tool for Assessing Risk of Suicide (STARS)
- Other (please specify) ______________________________

How many years have you been working/volunteering in your role that pertains to suicide prevention work?

- -1
- 1-3
- 4-7
- 8-10
- 11+

Please describe the volunteering/work that you have been involved in that specifically relates to suicide prevention

____

Understanding of and Attitudes to Lived Experience

Which is **not** an example of lived experience? (Please **select one**)

	Caring for a person who has been suicidal
	Previous suicide attempts
	Clinical experience treating suicidal patients
	Having had suicidal thoughts
	Being bereaved by suicide

Which are examples of lived experience representation assisting suicide prevention activities? (Please select one)

	Providing local and regional information to service providers about which services people in crisis access
	Providing insights to emergency department staff about the experiences of people presenting after a suicide attempt
	Consulting on program materials to review how they may be perceived by people with a lived experience of suicide
	All of the above

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Lived Experience stories provide a unique capacity and opportunity to inform and improve suicide prevention activities					
Lived Experience is essential in delivering effective suicide prevention programs and strategies					
I feel my lived experience story is useful and valuable to inform suicide prevention activities in my community					

Understanding the Power of Story-Telling

Story-telling is a powerful mechanism to influence other peoples' thoughts, beliefs attitudes, and behaviours. Which of the following statements are reasons for this? (Please **select all** that apply)

	When we hear a story we are more likely to imagine the impact on our own lives, and we respond with empathy in a way we don't with a list of facts.
	Stories tend to evoke an emotional response, and emotional responses are more likely to challenge our thinking and behaviours
	People don't want to learn about information or facts
	Humans are social creatures; so we are more likely to form a sense of connection and motivation to act that we don't with a list of statistics

Which are components of speech can affect the degree to which the message resonates with audiences? (Please **select all** that apply)

	Style
	Structure
	Gestures
	Clear key message
	Eye contact
	Metaphors

Which is not a component of setting the context of the story to help listeners relate? (Please **select one**)

	When story takes place?
	Who are the main characters?
	What do they want?
	What is in the way?
	How are the barriers addressed?

Which are examples of effective actions to take during the delivery of a message to increase the impact? (Please **select all** that apply)

	Making direct eye contact with people when making a point
	Speaking at a consistent volume and pace
	Keeping arms crossed to convey strength and composure
	Lowering volume to increase the sense of intimacy on sensitive topics
	Pacing and walking quickly around the stage
	Speaking faster to build to a point

When presenting your story to have an impact, it is most important to make sure it is communicated in a way that: (Please **select one**)

	is based only on professional expertise of the topic
	is presented in a way that meets the needs of the audience
	uses skilled literary techniques

Which option is least effective to use to start a piece of communication (Please **select one**)

	Personal Anecdote
	A Call to Action
	Start with a Statistic

	Quote
	A Question

Self-Care

Which of the following is ***not*** an example of self-care? (Please **select one**)

	Always putting yourself before others
	Knowing your role and limitations
	Finding ways to unwind and manage stress
	Being aware of how work can impact your wellbeing

Which are potential signs we need to focus on (perhaps neglected) self-care? (Please **select all** that may apply)

	Becoming more likely to poorer decisions or emotional responses
	Feeling more negative about your capacity to manage the challenges in front of you
	Being less able to come up with creative ways to meet the challenges you face
	Drinking many cups of coffee everyday
	Feeling more lethargic
	Occasional forgetfulness

Confidence in Learning Objectives

Thinking about your involvement in suicide prevention as a person with a lived experience of suicide, please rate your confidence in the following areas

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
Knowledge about “self-care”					
Ability to recognise your need for “self-care”					
Ability to “self-care”					
Using safe and appropriate language when talking about suicide					
Sharing your story with a group of people you don’t know					
Understanding principles of impactful story-telling					
Defining and Articulating the key message of my lived experience story					

Adapting my story to different target audiences					
Adapting my story to different time restraints					
Understanding my individual communication style and how to best use that in sharing my lived experience story					
Providing relevant and appropriate suicide prevention resources to audience					
Sharing opinions about what works to prevent suicide					
Speaking out and explaining your views					

Safely Talking about Suicide

Which terminology is safest when discussing suicide? (Please **circle one in each line**)

1.	He died by suicide	He committed suicide
2.	She completed suicide	She ended her life
3.	They took their own life	There was a successful suicide
4.	She had an unsuccessful suicide	She attempted to end her life
5.	There were several failed suicide attempts reported	There were several non-fatal attempts at suicide

Psychological Distress Scale

In the last 30 Days…

	Never	Rarely	Sometimes	Often	Always
My worries overwhelmed me					
I felt hopeless					
I found social settings upsetting					
I had trouble staying focused on tasks					
Anxiety or fear interfered with my ability to do the things I needed to do at work or at home					

Empowerment Scale

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Agree	Strongly Agree

I am able to do things as well as most other people				
People have more power if they join together as a group				
I have a positive attitude about myself				
When I am unsure about something, I usually go along with the group				
I feel powerless most of the time				
When I make plans, I am almost certain to make them work				
Working with others in my community can help change things for the better				
Experts are in the best position to decide what people should do or learn				
I am often able to overcome barriers				
I feel I am a person of worth, at least on an equal basis with others				
I generally accomplish what I set out to do				
Getting angry about something is often the first step toward changing it				
People are limited only by what they think possible				
Making waves never gets you anywhere				
I am usually confident about the decisions I make				
I see myself as a capable person				
Getting angry about something never helps				
Very often a problem can be solved by taking action				
I am generally optimistic about the future				
I feel I have a number of good qualities				

Please describe your three most important reasons for living (any further comments can be provided in the
comments section below)

1.

2.

3.

Comments:

Should you require emotional support during or post undertaking this survey, please utilise the following support contact details or contact the Chief Investigator of this study (indicated also below).

- **Lifeline**: 13 11 14 www.lifeline.org.au
- **BeyondBlue**: 1300 22 4636 www.beyondblue.org.au

- **Suicide Call Back Service**: 1300 659 467 www.suicidecallbackservice.org.au
- **MensLine Australia:** 1300 789 978
- **Kids Helpline:** 1800 551 800
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Chief Investigator of this study (GU ref no: 2015/315): Jacinta Hawgood (Jacinta.hawgood@griffith.edu.au).

Do you agree to be contacted by AISRAP to complete the additional surveys as part of this project to evaluate the Roses in the Ocean training programs? (click to confirm)

Do you agree to participate in any other research with AISRAP and Roses In The Ocean (RITO) on this topic following this training and follow-up surveys?

If you agree to further contact by the research team please email Jacinta Hawgood at: Jacinta.Hawgood@griffith.edu.au and provide your name email and/or best contact number.

Thank you for participating in this research. Your input will help RITO to further improve the quality of its training programs.

23.2 Post-Program

Evaluating the impact of *Roses in the Ocean* 'Voices of In-Sight' training for people with lived experience of suicide

Demographic Details

Please write your Secret Password from the initial survey (First street you recall living on) *__

Please note the location of the workshop you are attending ______________________________

Gender: Male / Female / Non-Binary / Different Identity (please state): Age (age turned this year) ________________________________

Understanding of and Attitudes to Lived Experience

Which is **not** an example of lived experience? (Please **select one**)

	Caring for a person who has been suicidal
	Previous suicide attempts
	Clinical experience treating suicidal patients
	Having had suicidal thoughts
	Being bereaved by suicide

Which are examples of lived experience representation assisting suicide prevention activities? (Please select one)

	Providing local and regional information to service providers about which services people in crisis access.
	Providing insights to emergency department staff about the experiences of people presenting after a suicide attempt.
	Consulting on program materials to review how they may be perceived by people with a lived experience of suicide.
	All of the above

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Lived Experience stories provide a unique capacity and opportunity to inform and improve suicide prevention activities					
Lived Experience is essential in delivering effective suicide prevention programs and strategies					
I feel my lived experience story is useful and valuable to inform suicide prevention activities in my community					

Understanding the Power of Story-Telling

Story-telling is a powerful mechanism to influence other peoples' thoughts, beliefs attitudes, and behaviours. Which of the following statements are reasons for this? (Please **select all** that apply)

	When we hear a story we are more likely to imagine the impact on our own lives, and we respond with empathy in a way we don't with a list of facts.
	Stories tend to evoke an emotional response, and emotional responses are more likely to challenge our thinking and behaviours.
	People don't want to learn about information or facts.
	Humans are social creatures; so we are more likely to form a sense of connection and motivation to act that we don't with a list of statistics.

Which are components of speech can affect the degree to which the message resonates with audiences? (Please **select all** that apply)

	Style
	Structure
	Gestures
	Clear key message
	Eye contact
	Metaphors

Which is not a component of setting the context of the story to help listeners relate? (Please **select one**)

	When story takes place?
	Who are the main characters?
	What do they want?
	What is in the way?
	How are the barriers addressed?

Which are examples of effective actions to take during the delivery of a message to increase the impact? (Please **select all** that apply)

	Making direct eye contact with people when making a point
	Speaking at a consistent volume and pace
	Keeping arms crossed to convey strength and composure
	Lowering volume to increase the sense of intimacy on sensitive topics
	Pacing and walking quickly around the stage
	Speaking faster to build to a point

When presenting your story to have an impact, it is most important to make sure it is communicated in a way that: (Please **select one**)

	is based only on professional expertise of the topic

	is presented in a way that meets the needs of the audience
	uses skilled literary techniques

Which option is least effective to use to start a piece of communication (Please **select one**)

	Personal Anecdote
	A Call to Action
	Start with a Statistic
	Quote
	A Question

Self-Care

Which of the following is ***not*** an example of self-care? (Please **select one**)

	Always putting yourself before others
	Knowing your role and limitations
	Finding ways to unwind and manage stress
	Being aware of how work can impact your wellbeing

Which are potential signs we need to focus on (perhaps neglected) self-care? (Please **select all** that may apply)

	Becoming more likely to poorer decisions or emotional responses
	Feeling more negative about your capacity to manage the challenges in front of you
	Being less able to come up with creative ways to meet the challenges you face
	Drinking many cups of coffee everyday
	Feeling more lethargic
	Occasional forgetfulness

Confidence in Learning Objectives

Thinking about your involvement in suicide prevention as a person with a lived experience of suicide, please rate your confidence in the following areas

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
Knowledge about "self-care"					
Ability to recognise your need for "self-care"					

Ability to "self-care"					
Using safe and appropriate language when talking about suicide					
Sharing your story with a group of people you don't know					
Understanding principles of impactful story-telling					
Defining and articulating the key message of my lived experience story					
Adapting my story to different target audiences					
Adapting my story to different time restraints					
Understanding my individual communication style and how to best use that in sharing my lived experience story					
Providing relevant and appropriate suicide prevention resources to audience					
Sharing opinions about what works to prevent suicide					
Speaking out and explaining your views					

Safely Talking about Suicide

Which terminology is safest when discussing suicide? (Please **circle one in each line**)

1.	He died by suicide	He committed suicide
2.	She completed suicide	She ended her life
3.	They took their own life	There was a successful suicide
4.	She had an unsuccessful suicide	She attempted to end her life
5.	There were several failed suicide attempts reported	There were several non-fatal attempts at suicide

Psychological Distress Scale

In the last 30 Days…

	Never	Rarely	Sometimes	Often	Always
My worries overwhelmed me					
I felt hopeless					
I found social settings upsetting					
I had trouble staying focused on tasks					

Anxiety or fear interfered with my ability to do the things I needed to do at work or at home					

Empowerment Scale

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am able to do things as well as most other people				
People have more power if they join together as a group				
I have a positive attitude about myself				
When I am unsure about something, I usually go along with the group				
I feel powerless most of the time				
When I make plans, I am almost certain to make them work				
Working with others in my community can help change things for the better				
Experts are in the best position to decide what people should do or learn				
I am often able to overcome barriers				
I feel I am a person of worth, at least on an equal basis with others				
I generally accomplish what I set out to do				
Getting angry about something is often the first step toward changing it				
People are limited only by what they think possible				
Making waves never gets you anywhere				
I am usually confident about the decisions I make				
I see myself as a capable person				
Getting angry about something never helps				
Very often a problem can be solved by taking action				
I am generally optimistic about the future				
I feel I have a number of good qualities				

Please describe your three most important reasons for living (any further comments can be provided in the
comments section below)

1.

2.

3.

Comments:

Program Satisfaction and Feedback

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
The facilitator(s) managed group dynamics well					
I felt supported and safe throughout the workshop					
The content of the workshop was relevant					
The activities in the workshop provided me with sufficient practice and feedback					
As a result of this workshop, I feel better equipped to carry out a role as a lived experience representative					

Did the program meet your needs and expectations? Yes / No Please provide reasons for your answer

____

How could this program be improved?

____

What was most valuable about this program to you?

____

Do you have any other comments about the workshop?

____

Lived Experience Involvement

In the past 12 months, have you been involved in any of the following activities as a person with lived experience of suicide?

Activity	Example	Tick if you have been involved
Co-design of programs/services	Participated in a co-design workshop	
Co-evaluation of programs/services	Helped design a piece of research or evaluation	
Participated in a Lived Experience Reference or Advisory Group	Associated with a PHN or other organisation including government, service providers, research organisation, etc	
Participated in strategic planning for a suicide prevention-related organisation	Could be a one-off or a series of workshops aimed at creating an organisational or departmental strategy	
Involved in governance activities	Sat on a Board or Project Steering Committee	
Employed as a Peer Worker	Worked at a health service as a dedicated Peer Worker	
Helped deliver a lived experience or peer-led service/program	Ran support group	
Delivered lived experience-led training to staff	Trained health professionals or police/ambulance	
Lived experience speaker	Shared your story at a public event or spoke to media	

General volunteer positions	Ran a suicide prevention awareness event or volunteered as a Lifeline Crisis Supporter	
Attended a Community Consultation about suicide prevention	An event hosted by a PHN to inform regional suicide prevention planning	

If you have been involved in any other activities as a person with lived experience of suicide, please describe these below:____

How frequently do you participate in suicide prevention activities as a person with lived experience?
- ○ Daily
- ○ Weekly
- ○ Fortnightly
- ○ Monthly
- ○ Yearly
- ○ Less than once a year
- ○ I have not previously been involved in suicide prevention activities

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Thank you for participating in this research. Your input will assist RITO to further improve the quality of its training programs.

23.3 Follow-up

Evaluating the impact of *Roses in the Ocean* 'Voices of In-Sight' training for people with lived experience of suicide

Demographic Details

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Please note the location of the workshop you attended ________________________________

Gender: Male / Female / Non-Binary / Different Identity (please state): Age (age turned this year) ___________________________________

Understanding of and Attitudes to Lived Experience

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	Consulting on program materials to review how they may be perceived by people with a lived experience of suicide.
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Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Uncertain	Agree	Strongly Agree
Lived Experience stories provide a unique capacity and opportunity to inform and improve suicide prevention activities					
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Which are components of speech can affect the degree to which the message resonates with audiences? (Please **select all** that apply)

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	Structure
	Gestures
	Clear key message
	Eye contact
	Metaphors

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Self-Care

Which of the following is ***not*** an example of self-care? (Please **select one**)

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	Becoming more likely to poorer decisions or emotional responses
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	Drinking many cups of coffee everyday
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	Occasional forgetfulness

Confidence in Learning Objectives

Thinking about your involvement in suicide prevention as a person with a lived experience of suicide, please rate your confidence in the following areas

	Not confident at all	Somewhat confident	Uncertain	Confident	Extremely confident
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Ability to recognise your need for "self-care"					
Ability to "self-care"					
Using safe and appropriate language when talking about suicide					
Sharing your story with a group of people you don't know					
Understanding principles of impactful story-telling					
Defining and articulating the key message of my lived experience story					
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Psychological Distress Scale

In the last 30 Days…

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My worries overwhelmed me					
I felt hopeless					

I found social settings upsetting					
I had trouble staying focused on tasks					
Anxiety or fear interfered with my ability to do the things I needed to do at work or at home					

Empowerment Scale

Please rate your agreement with the following statements

	Strongly Disagree	Disagree	Agree	Strongly Agree
I am able to do things as well as most other people				
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I have a positive attitude about myself				
When I am unsure about something, I usually go along with the group				
I feel powerless most of the time				
When I make plans, I am almost certain to make them work				
Working with others in my community can help change things for the better				
Experts are in the best position to decide what people should do or learn				
I am often able to overcome barriers				
I feel I am a person of worth, at least on an equal basis with others				
I generally accomplish what I set out to do				
Getting angry about something is often the first step toward changing it				
People are limited only by what they think possible				
Making waves never gets you anywhere				
I am usually confident about the decisions I make				
I see myself as a capable person				
Getting angry about something never helps				
Very often a problem can be solved by taking action				
I am generally optimistic about the future				
I feel I have a number of good qualities				

Please describe your three most important reasons for living (any further comments can be provided in the
comments section below)

1.

2.

3.

Comments:

Lived Experience Involvement

In the past 12 months, have you been involved in any of the following activities as a person with lived experience of suicide?

Activity	Example	Tick if you have been involved
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Co-evaluation of programs/services	Helped design a piece of research or evaluation	
Participated in a Lived Experience Reference or Advisory Group	Associated with a PHN or other organisation including government, service providers, research organisation, etc	
Participated in strategic planning for a suicide prevention-related organisation	Could be a one-off or a series of workshops aimed at creating an organisational or departmental strategy	
Involved in governance activities	Sat on a Board or Project Steering Committee	
Employed as a Peer Worker	Worked at a health service as a dedicated Peer Worker	
Helped deliver a lived experience or peer-led service/program	Ran a support group	
Delivered lived experience-led training to staff	Trained health professionals or police/ambulance	
Lived experience speaker	Shared your story at a public event or spoke to media	
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Attended a Community Consultation about suicide prevention	An event hpsted by a PHN to inform regional suicide prevention planning	

If you have been involved in any other activities as a person with lived experience of suicide, please describe these below:_______________________________________

How frequently do you participate in suicide prevention activities as a person with lived experience?

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- ○ Weekly
- ○ Fortnightly
- ○ Monthly
- ○ Yearly
- ○ Less than once a year
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- **Kids Helpline:** 1800 551 800
- **Emergency/Crisis:** 000 (ask for Police or Ambulance)

Chief Investigator of this study (GU ref no: 2018/315): Jacinta Hawgood (Jacinta.hawgood@griffith.edu.au).

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Do you agree to participate in any other research with AISRAP and Roses In The Ocean (RITO) on this topic following this training and follow-up surveys?

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