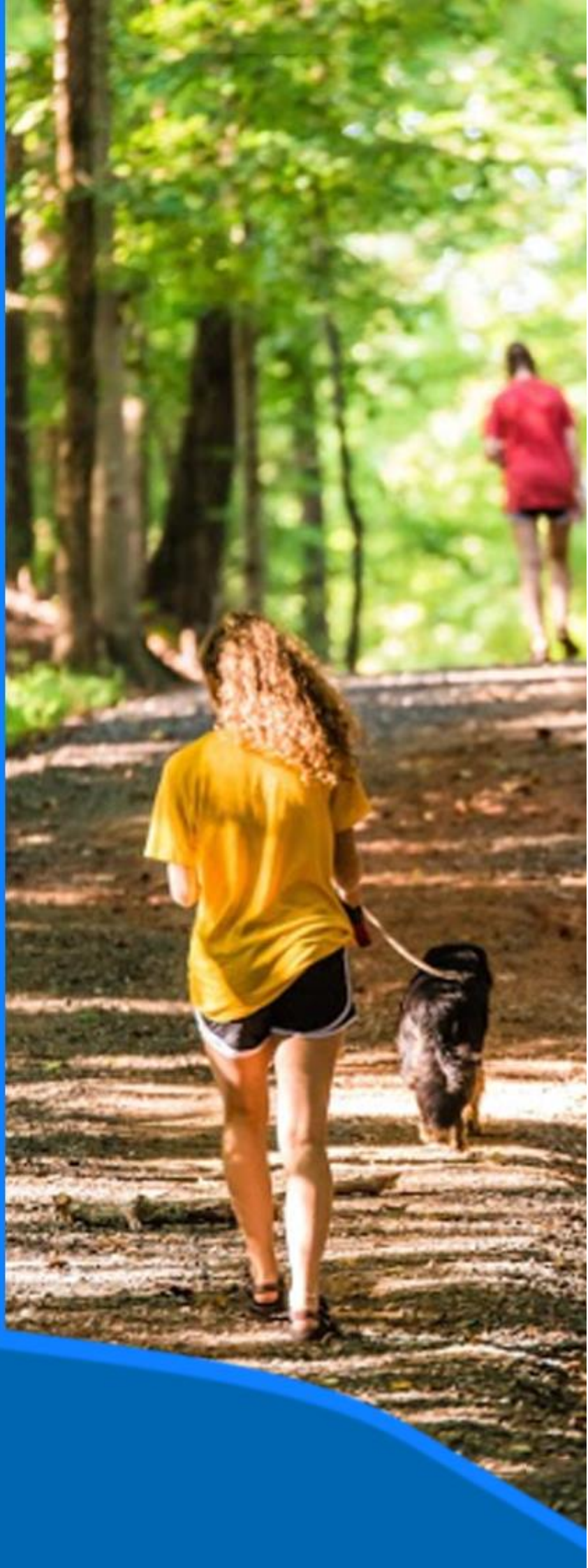




# Leading with empathy

Embedding the voice of lived  
experience in future service  
design



# Executive summary

Suicide and attempted suicide is heartbreaking and leaves long term effects on families and friends – the lives of a growing number of Australians are impacted every year. In response, governments and the community are focussing significant attention and funding on suicide prevention. Each State and Territory have enacted suicide prevention strategies and frameworks in line with the National Suicide Prevention Strategy and Fifth National Mental Health and Suicide Prevention Plan 2017-2022.

There are many initiatives working to reduce the number of people who attempt and die by suicide each year. However, it is not yet known the extent to which the interactions with services and support contributes to, or alleviates, distress for those directly experiencing suicidality. This report explores the lived experience of suicide through the individual's perspective.

Suicide Prevention Australia recognises that lived experience comes in different forms and that this shapes each person's journey with suicide - whether through experiencing ideation, attempts, caring for or bereaved loved ones who experience suicidality, or providing support services. The journey for people experiencing suicidality is complex and varied.

The ability to design and implement prevention initiatives requires consideration of suicide at a population level. However, an understanding at the individual level is also needed to holistically inform policy, research and sector responses. This can be achieved through the identification of critical points where an individual's journey is impacted by the service system.

This report details our qualitative research into individual experiences which highlights the complexity and variability of people's experience with suicidality, whilst also drawing out the common aspects of these experiences. This approach supports people impacted by suicidality to provide input to sector considerations of ways to better target and improve prevention, intervention and aftercare.





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## **Acknowledgement Statement**

*Suicide Prevention Australia remembers those we have lost to suicide and acknowledges the suffering suicide brings when it touches our lives. We are brought together by experience and are unified by hope. Suicide Prevention Australia acknowledges the traditional owners of country throughout Australia, and their continuing connections to land, sea and community. We pay our respects to them and their cultures, and to elders past, present and emerging.*



## How we developed this report

This report has been developed through research conducted by KPMG, commissioned through the National Suicide Prevention Research Fund, managed by Suicide Prevention Australia. It seeks to better understand consumers' lived experience of suicidality. Specifically, it maps the journey of people who have attempted suicide, and their continued journey post-attempt.

A Human Centred Design (HCD) methodology was applied to develop the understanding of people's lived experience. This methodology places the person with lived experience of suicide at the centre of every step. In doing this, it ensures future state service experiences are developed with the individual in mind.

The foundational input into this report is a piece of qualitative research which produced 'critical moments' along one's lived experience, and key themes relating to the individual experiencing suicidality, their carers, and the suicide prevention sector more broadly. Our research targeted the following cohorts of people:

- People with personal lived experiences
- Bereaved family, friends, carers
- Service providers and peer support.

**"A clear understanding of the customer experience within the suicide prevention system will help Government to prioritise services and programs which will best meet the needs of the end user."**

- SPA submission to Productivity Commission 2020

Together with this qualitative research we reviewed the outputs of the journey to further understand the impact of critical moments and their broader implications. In doing this we sought to quantify the costs associated with the identified pathways, and to identify where changes may be most effective.

Within this report, we consider the opportunities and actions that arose from the research findings, and the importance of using a human centred approach for future decision making within the sector.

The four areas of opportunity are outlined below:

- Improve the first experience of help-seeking for people living with suicidality
- Ensure resources and supports are accessible and easy to navigate
- Better equip society to respond to suicide
- Embed lived experience throughout system touchpoints

The following pages of this report provide an overview of the journeys identified and explore each of the opportunity areas in more detail. Key evidence found from the critical moments that arose in people's journeys, in addition to the broader themes relating to the suicide prevention system within Australia and the costs associated with the pathways are also detailed.

These outputs highlight the current experience and needs of people living through suicidality, and the expectations they have regarding the suicide prevention sector broadly. Priority actions identified through collaborative Innovation labs have also been illustrated for each opportunity.

Suicide Prevention Australia will use these areas moving forward as a basis for future design and innovation. This work will continue to inform decisions that centre on the underlying needs of consumers experiencing suicidality.

The following page provide an overview of each of these outputs and defines how they were interpreted within this report.





**22** hours  
of qualitative data



**3** participant  
cohorts interviewed



**7** organisations  
represented

## Research Output

**Journey maps:** A communication tool that enables connection with people with lived experience of suicide. They are focused on what consumers do, feel and what their needs are at each phase in their journey. Journey Maps act as a tool to help understand where to redesign or reallocate resources to improve people's experience.

### Pre-Attempt



**Themes:** Groupings of similar sentiment and behaviours that are relevant to those interviewed. Although this research involved a relatively small sample, a point of saturation regarding themes and insights was achieved.

**Design principles:** A set of guiding principles to inform the design and delivery of future experiences within the suicide prevention service system.

### Post-Attempt



## Research cohorts

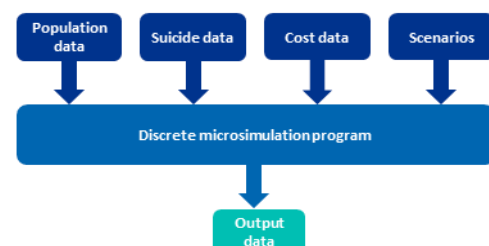
As this was qualitative research, a small number of participants were interviewed. A level of saturation was achieved through in-depth experience interviews which also highlighted that many individuals had experienced suicide from multiple perspectives.



Note: in some instances participants interviewed shared experiences across multiple cohorts

## Economic analysis

A discrete microsimulation modelling approach was adopted for the economic analysis because the transitions through ideation to attempt, can vary considerably. Under this approach, the model itself calculates the outputs based on the individual attributes of the person.



## Innovation labs

A series of collaborative workshops with approximately 30 stakeholders representing perspectives of lived experience, service provision, policy and research to identify priority action areas which respond to the opportunities identified through journey mapping activities.

## Overview of the journeys

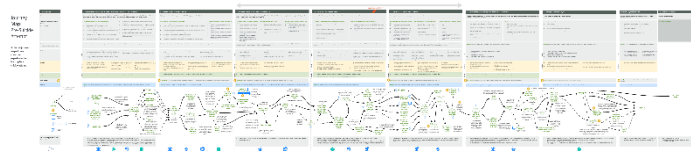
From information gathered in the interviews, we were able to map out the participants' experiences and shape the overarching phases and characteristics of their journey with a lived experience of suicide. Our research revealed two distinct journeys: pre- and post- suicide attempt (Appendix 1 and Appendix 2 respectively).

It was clear from participant accounts that the experience with suicide varies. People may experience all identified phases in order or may skip, or repeat phases in their journey. A person may stay in a journey phase for long periods of time, and/or never progress to an attempt.

Additionally, the journey itself can often be circular, and complex, with many factors playing a role in the experience that individuals have leading up to an attempt.

### Pre-Attempt Journey

The Pre-Attempt Journey illustrates the experience for someone progressing from a triggering event(s) to a suicide attempt. The full Pre-Attempt Journey map can be viewed in Appendix 1.



**Triggering event(s):** many people's experience of suicidality is built over a lifetime of events or stressors, which may include suffering from a mental illness(es). Childhood, adolescent and adult experiences shape each individual and their response and resilience to future events. We know from existing research that people who die by suicide can experience acute situational or extended pathways to suicide with an accumulation of stressors.<sup>1, 2</sup> This highlights the impact of life experience, and connection with situational events.



**Significant change:** Some of the array of experiences that may accumulate and intersect to increase risk of suicide include: a previous attempt at suicide, mental disorders, harmful use of alcohol, job or financial loss, hopelessness, chronic pain, a family history of suicide, and genetic and biological factors.<sup>3, 4</sup> People with a history of suicide attempts in particular, are 1.4 to 2.1 times more likely to transition from ideation to an attempt, than those without history of suicide.<sup>5</sup> In the pre-attempt journey, we can see these risks as being precursors to a change in behaviour and an early indicator of suicidality.

We identified a critical moment in this phase being *the first time someone opens up about their experience* with these factors, which influenced how the person proceeded in their journey.



**Withdraw, self-loathe/self-harm or visualise suicide:** at some point in their lives, 13% of Australian adults will have serious thoughts about taking their own life.<sup>6</sup> Our participants identified moments where their inner dialogue was most negative, and their thoughts turned to suicide as a distinct step in their journey. We found that in this phase, connecting with someone who could empathise or relate to their situation was critical in preventing ideation from becoming unmanageable.



**Seeking help:** as individuals' situations and/or inconsistent behaviour became more obvious to those around them, this often prompted them to seek help, or prompted loved ones to seek help on their behalf. This phase is cyclical in nature, as people sought help at multiple points in their journey depending on the severity of their situation. Studies have shown that family and friends are the most frequently consulted group of people prior to near-lethal suicide attempts,<sup>7</sup> and can either increase or decrease the likelihood of accessing help.<sup>8</sup> This means that service providers are not exclusively responsible for responding to people with suicidality in a compassionate and authentic way, rather there is a shared responsibility with the community for providing this support. Further, it highlights that all individuals have an integral role to play in influencing someone's journey toward suicide.





**Receive support:** For those that seek help, this was provided in the form of informal support, therapy or treatment with drugs or other psychiatric treatments. However, while some access help in the early stages of suicidality, we know that many people do not tell health professionals of their plans to attempt suicide, mainly due to not wanting to be stopped, feeling ashamed, not thinking anyone could help them, or wanting to avoid admission to inpatient care.<sup>9</sup> This sentiment was echoed by our participants: *the connection between people and their supports or clinicians* was said to be critical in shaping people's ability to approach or continue accessing help.



**Plan and seek closure:** It is estimated that 4% of Australians (approx. 600,000) aged 16-85 have made a suicide plan at some point in their lifetime.<sup>10</sup> Through our research we identified that there was often a transition from ideation to intent in the form of a plan. Many participants shared the steps taken to prepare for the end of their life.

This planning phase highlighted a critical moment where *people can effectively draw on supports or coping strategies to prevent acting on their plan*, which showed the importance of effective, early intervention in someone's journey.



**Attempt:** Every year, approximately 65,000 Australians make a suicide attempt.<sup>11</sup> Many will touch on all or some steps in the pathways distilled from this research, however, there is existing research to suggest that nearly 60% of attempts will occur on the same day as onset of ideation.<sup>12</sup>

This again highlights the criticality of early steps in the journey, where a lifetime of events, or an initial unrelated reach out for help may impact whether people are able to prevent their ultimate progression to an attempt.



**Survival:** Our research participants who had survived suicide attempt(s) said this was often due to the critical moment of *interruption by a third party such as first responders, or that an individual's plan did not eventuate*.

We know that first responders often attend suicide attempts. For example, ambulances attend approximately 2.5 million emergencies each year, with over 10% of calls involving self-harm, mental health symptoms or substance use.<sup>13, 14</sup> The number of suicide attempts made every year is difficult to quantify, however the scale of existing estimates shows the toll that all suicidality takes on those involved.



**Life is taken to suicide:** In 2018, 3046 Australians died by suicide.<sup>15</sup> We at Suicide Prevention Australia remain concerned as to the impact on the mental ill-health of community in response to of COVID-19 and the pandemic response measures. Despite the sector's best efforts to maintain and adapt service provision, our research highlighted concerns about instances where demand may not be met now and into the future.



## Post-Attempt Journey

The Post-Attempt Journey illustrates the experience for someone from the moment they make an attempt on their life. The full Post-Attempt Journey map can be viewed in Appendix 2.



**Receive immediate support:** The most common first point of contact after a suicide attempt is ambulance or police, followed by an emergency department, a family member, friend, neighbour or stranger, then a telephone helpline.<sup>9</sup> We heard that the *relevance, appropriateness and availability of immediate support* is critical, as we know that this contact at this time can contribute to further trauma. For example, psychosocial assessment processes can contribute to shame and negative self-perceptions for those experiencing suicidality.<sup>16</sup> Our research participants highlighted that this immediate point of support had major implications for the direction of their continued journey.



**Transition:** The stories recounted in this research uncovered the challenging transition that people make back to everyday life following a suicide attempt.

Again, the nature and accessibility of care in this phase is critical. Aftercare following an attempt is often seen as fragmented, inconsistent or inadequate<sup>9, 16</sup> For some, this phase may include another suicide attempt as we know that a prior suicide attempt is the strongest predictor of death by suicide.<sup>9</sup>

Conversely, the transition and reconnection with others can be associated with recovery or resolution of crisis after a suicide attempt.<sup>9</sup> This was echoed in participants' stories as being a facilitator of coping and recovery.



**Further support:** After a suicide attempt and initial treatment or support, many people do not have contact with a second health service, but those who do seek help mainly contact psychiatrists.<sup>9</sup> Of our research participants, further support, therapy or treatment sometimes included learning coping strategies



and seeking out alternative therapies or self-guided resources. The process was heavily influenced by participants' prior experiences of care, where negative experiences discouraged further engagement with services. This shows the importance of every individual interaction with people experiencing suicidality and its influence on their ability to move on from an attempt.



**Checking in:** Research participants disclosed that they often had their network, mental health outreach teams or first responders check on their wellbeing, either unprompted or in response to directions from loved ones. For some, the unprompted check-in was viewed negatively. It was considered that any outreach or follow up should be 'person-centred, respectful of individuals' agency and experiences.



**Continue to live with negative or suicidal thoughts:** People who have made a suicide attempt do not instantly 'recover' from their experience nor are immediately able to change their circumstances. As such they may still have episodic or ongoing suicidal thoughts. Again, we saw that *past experiences with services and support* can critically influence this phase of life where stigma or negative experiences with prior treatment can lower help-seeking intentions toward mental health professionals. Error! Bookmark not defined.

Understanding that recovery is individualised and non-linear is important, as individuals who have made multiple suicide attempts are at especially increased risk compared with people experiencing suicidal ideation and first-time attempters.<sup>17</sup>





**Practice coping strategies:** From participants' stories, we saw that people who were in longer-term recovery were drawing on coping strategies which included helping others or working towards broader suicide prevention and change. A commonality in some stories pointed to the criticality of *a shift in mindset where people felt self-worth and developed a resolution to continue living*, which these strategies contributed to. This final 'critical moment' is reflected in the literature where positive change has been associated with

extending one's repertoire of coping strategies and gaining a sense of control over one's life.<sup>18</sup>

Furthermore, participation in peer support as both a provider and recipient can increase survivors' sense of independence and empowerment and facilitate recovery, however, can also be detrimental without adequate support.<sup>19</sup> This highlights that there may be multifaceted benefits to supporting people with lived experience in continuing to contribute to others' recovery.



## Using qualitative methods to support our research

Qualitative research with people with lived experiences of suicide and suicide prevention service providers is invaluable to help understand the key intervention points where experiences can be modified to improve outcomes for the consumer.

In our review, several pieces of work were identified that quantify help-seeking behaviour for mental health or suicide prevention services, however there was a lack of in-depth, qualitative research describing help-seeking for suicidality in a detailed and sequential way.

As part of the sector's ongoing work to improve our prevention of and responses to suicide, approaches and tools such as human-centred design and journey mapping will be highly useful in designing appropriate resources, policies, programs and services.

Eliciting detailed accounts of service interactions enables the sector to form a collaborative response to suicide, drawing on lived experience in an authentic way.

### Experience design principles

To meet consumer needs and expectations, Suicide Prevention Australia has developed a set of guiding principles, derived from the journey mapping research, to inform the design and delivery of future experiences within the suicide prevention service system.

**Connect with me authentically:** Care, compassion, empathy and being relatable are core requirements for anyone who helps me.

**Make it easy for me to access support:** Provide support at times, in places, and through modalities that I can access when I need.

**Support me as an individual:** There's no one-size-fits-all approach to helping me- my experience is different from others' and so are my needs.

**Speak to me in my language:** I need services and supports to be inclusive- of my gender, ethnicity, sexual orientation, and understanding of how to articulate my experience.

**Stay with me through my experiences:** The impact of my suicide attempt, or my ideation, will go through ebbs and flows, and there are critical moments where I will need help along that pathway. I need continuous and coordinated support to match my needs.

**These design principles have informed our assessment of key opportunity areas and should be considered in developing any service response for people with lived experience of suicide.**



## Emerging opportunities for the sector

Reflecting on the learnings from this research and what we already know about suicidality and the service system, the following sections describe where we see key opportunities for improving suicide prevention and the principles by which this work can be done. This work can lead the suicide prevention sector's collective efforts to reduce suicides and attempts in Australia.

### Improve the first experience of help-seeking for people living with suicidality

An important area that arose from the research was the need for better support to all clinicians in understanding the significant role they play in preventing suicide. The pre-attempt journey highlighted a critical moment in the first time someone opened up to a clinician. The response they receive directly influenced the trajectory of those who did open about their suicidal ideation, or have attempted in the past. This draws attention to the importance of early intervention and its role in the suicide pathway.

Relating to people in an authentic manner was viewed as a core ingredient in building trust with those opening up about their lived experience of suicidality. Furthermore, connection was commonly cited throughout the pre- and post-attempt journeys as critical in positively influencing people through their experience of suicidality.

Clinicians, particularly GPs, are well placed to build trust at this critical moment. Our research revealed that trust is earned when people connect with someone who 'gets it' – people need connection, real connection, when sharing how they're feeling. This is something that is earned and can be lost very quickly. Clinicians need to connect by being authentic and relating to the person in front of them, with this being vitally important the first time an individual shares their suicidality.

Once a connection has been established, trust is further developed when clinicians speak to the person living with suicidality *in their language* – meaning, they must exhibit cultural competence, and be inclusive in the way they interact, communicate and provide on-going support. It is important that lines of communication continue to remain open, as suicidal ideation is known to be easier to suppress when there is stigma attached or perceived with interactions.

It was highlighted that for some, the act of accessing services within a local community can be highly stigmatising in itself. Therefore, people stick to what they know, such as their family or friends –

who in some instances may not know how to respond or provide the necessary support.



***...the first point of contact .....  
if it's not a great experience it puts  
that back a step. It's reliant upon  
the skill of the practitioner."***

One of the characteristics of the pre-attempt journey was *"I withdraw or those around me begin to withdraw from me"* – this was evident in many of the experiences shared in our research. In some instances, withdrawal occurred as a direct result of a feeling that the person they initially opened up to did not consider their situation seriously. This may have been a family member or friend rather than a service provider. The pathway someone follows can therefore be altered by the ability of people to respond appropriately to the first disclosure of a lived experience. Ensuring this is positive, and that people have someone they can relate to is vital in preventing a future suicide attempt.

In assessing the economic impacts at this point in the pathway it can be seen that the downstream effects of early, and successful, intervention in the ideation stage can fundamentally change an individual's life course. This is because intervention can potentially save a downward transition to multiple non-fatal attempts, or worse, a fatal suicide attempt.

The economic consequences of this are significant. In the short term, such an intervention can save an average of \$5,517 per individual with suicidal ideation. The longer-term impacts can be 39% higher than the direct short-term savings.<sup>20</sup>

Consideration for the strength of an initial connection, and how to *'connect with me authentically'* as well as ways to *'speak to me in my language'* should inform future design or provision of suicide prevention or aftercare service.

**Key action area:** Establish a suicide prevention specific competency framework.



## Better equip society to respond to suicide

In recent times, it has been evident that awareness levels of suicide and its impact have improved in Australia. Through interviews, our research highlighted that a key next step for prevention is building tools to assist society with responding in a way that doesn't cause harm.

Societal awareness is not enough without a proactive response. This involves collective and consistent up-skilling of all members of society to recognise suicidal ideation and to accommodate the needs of at-risk people. The importance of connection and empathy in helping to respond effectively to those with suicidality was evident in all critical moments. Negative experiences at any point in the pre- or post-attempt journey can mean people have to look for new supports or alternatively, may prevent people from seeking help at all.

At the current time (global COVID-19 pandemic), physical connection is difficult, and this has altered the way traditional supports are delivered. While this led to positive changes and learnings for some, for others it has meant that once-reliable avenues of support are now inaccessible. Within this context, we believe that ensuring society can be proactive in communicating to those around them is imperative. Further understanding of what to say and do when someone detects signs of suicidality is the next step after recognition (or awareness).

It was evident that the provision of tangible tools to underpin people's understanding of suicidality has a role to play in prevention. In developing tools or resource, people will have references to assist in both recognising and responding to those living with suicidality. Every interaction is important with someone experiencing suicidality;

thus, emphasising the role of society is paramount to reducing suicide moving forward. As illustrated by the pre- and post-attempt journeys, the pathway that people take is impacted by the interactions they have when they experience suicidality. If the community was better equipped with a measured response, it could be life changing.



***Inclusivity- are we using language that the general population understand- what's lived experience? What's a gatekeeper? This is sector lingo. People think 'Oh I'm not a service provider so I don't belong here'..."***

There is also consideration needed to ensure resources are visible and applicable to a range of contexts. This includes workplaces and schools which were regarded in the research as being influential in shaping habits, experiences and behaviour that transcend into people's lives more broadly.

The accessibility of supports should be considered in all future design opportunities. By '***making it easy for me to access support***' prevention strategies may more effectively offer critical support at times, in places, and through modalities that people can refer to when they need. The focus on individual needs, and the unique and variable nature of lived experience with suicide, means that there is no one-size-fits-all resource that can be applied.

**Key action area:** Build capacity and capability through a tailored approach for the community to better enable local support for individuals experiencing suicidality.



## Ensure resources and supports are accessible and easy to navigate

We know from previous research that there is a general upward trend in the incidence of suicide in Australia, observed over the past 10 years.<sup>15</sup> One factor that could be contributing to this statistic is the lack of services for those living with suicidality, but are not considered to be in a 'high-risk' state.

This refers to people who are experiencing thoughts of suicide but may not have the intention to put a plan in place or make an attempt. There is a need to account for those who are ideating, but not considered 'high risk', as it was apparent that people may experience circular or complex journeys, with many unique, life-changing events, each having the potential to lead to an attempt.

Post-attempt, one of the critical moments highlighted that service providers need to better account for those who have been transitioned out of an ED environment, and back to daily life, one example being ensuring people have a safe environment to return to upon discharge. Our research highlighted that people needed supports which *'stay with me through my experiences'*.

We also saw a need for ongoing availability of support. For many, suicidality may escalate at any point, due to the nuanced events that play a role in shaping their experience. Consideration to *'support me as an individual'* represents the expectation from participants that their suicidality should be seen individually, due to the unique circumstances leading them to their current state.

In addition to early and successful intervention, targeted supports at critical moments are central to redirecting attempts of suicide to attempts of recovery. This is particularly true for young females (~20 years of age) who have the highest rates of

suicide ideation and attempts. Building resilience in this group, through accessible supports, has huge long-term economic pay-offs.<sup>21</sup>

We know that a previous attempt is the strongest predictor of a subsequent attempt increasing the risk of ideation and attempt by between 1.4 and 2.1 times. Significantly higher costs are associated with individuals post-attempt, with future support costs being around 103% greater than that for an individual with ideation. Our economic analysis indicates that assertive outreach services, which seek to negate the likelihood of re-attempts by effectively reaching those at critical moments in their post-attempt journey, can be a cost-effective way to help reduce suicide.<sup>22</sup>

Being able to access and navigate support services in the suicide prevention space was difficult for many people. Many of our research participants who had survived an attempt had also supported someone with suicidality. Both those experiencing suicidality, and those supporting someone, highlighted the challenges in knowing where and who to reach out to for support further indicating that the process was both confronting and confusing. It was evident that there are issues with coordination, accessibility, and navigating what is most relevant and appropriate for each individual's need. People mentioned this being even more difficult due to the heightened state of emotion individuals who are living with suicidality or who are in crisis are feeling. There was a strong expectation that those with lived experience can assist to *'make it easy for me to access support'* by incorporating co-design considerations in future innovation efforts.

**Key action area:** Co-design an awareness campaign that assertively tackles stigma.



## Embed lived experience throughout system touchpoints

The purpose of this research was to better understand the needs of those living with suicidality and identify areas to improve the suicide prevention system broadly. One of the key insights people shared was the importance of consistent and continued inclusion of the voice of lived experience in future decision making. Highlighting the need to further embed lived experience into service provision and the suicide prevention sector more broadly.

When referring to the journeys, specifically, the final phase of the post-attempt journey, we found those with lived experiences often wanted to be valued contributors to services and supports within the sector. Some discussed that their work has been an important part of finding purpose and fulfilment, and this realisation and shift in mindset was highlighted as a critical milestone in the post-attempt journey.



***My work keeps me going and my daughter keeps me going- more of a protective factor- helping others has been a massive help for me."***

It's important that people are encouraged to play a role in providing support to others in a way that is beneficial to their recovery. The potential benefit of incorporating lived experience in the system and being able to '**connect with me authentically**' was clear, whereby a key element of connection is relatability to the individual experiencing suicidality. This was reflected in a critical moment that showed how negative past experiences with sources of help could mean people had to find new supports or prevented people from seeking help at all.

As someone's current circumstance is built through a lifetime of events, we need to support and treat

people based on the many events leading to their state of suicidality, rather than emphasising a single triggering event. This insight speaks to the need of supporting people holistically and using support systems both within and outside of the health sector. It also highlights the need to bring those with lived experience into the fold when providing services, as their experience and circumstance may resonate more strongly.

An example of this raised by one participant was that someone who came to a workplace to talk about their experience with suicidality shared a very similar life story to the participant in question. These similarities contributed to the speaker's message being highly effective in prompting the participant to seek help as they could see themselves reflected in the story.

It is therefore important that suicide prevention strategies, policies, programs and services are enhanced through incorporating lived experience accounts, and people with lived experience should be afforded support to leverage their experience for this aim. For people who are currently ideating, survivors post-attempt or bereaving a loved one, sharing the experience of suicide can also have positive impacts on their overall journey of recovery.

**Key action area:** Implement a peer workforce across key touchpoints.





## Innovation and change for suicide prevention

The Innovation Labs brought together consumers, people with lived experience of suicide, organisations, and researchers for a series of virtual co-design sessions. The objectives of the Labs were to:

- Explore the role of diverse stakeholders in the system and the role that they play at critical moments in the journey
- Identify what a positive experience can look like and the barriers that are hindering this outcome
- Document clear initiatives at a collective and individual level that will have the greatest impact in the journey of people pre- and post- suicide attempt.

Across the critical moments, four key action areas surfaced. These included:

### ***Establishing a suicide prevention competency framework***

This requires the development of a suicide prevention and postvention competency framework for both the clinical and non-clinical workforce. The competency framework will provide guidance for training needs and build core human skills into existing technical competencies, ensure specific suicide prevention capability becomes part of continual professional development.

### ***Implementing a peer workforce across key system touchpoints***

Non-clinical support options were a key enabler identified across the critical moments, particularly within Emergency Departments where peer support could compliment clinical care. Implementation of a peer workforce at critical moments through the journey will offer greater support to individuals experiencing suicidality.

### ***Building a strategy that integrates activity across the system***

We need to support the community to view suicide and mental ill-health in the same way as physical health, to support people to have conversations around suicide and equip them with the tools on how to reduce distress, as well as how to respond in crisis. This includes incorporating national policy and reform within a local response.

### ***Co-designing an awareness campaign that assertively tackles stigma***

The stigma of suicide needs to be shifted. Throughout the Labs it was apparent that on a individuals and community level there exists an opportunity to change the narrative around suicide across society. Leveraging story-telling platforms, and informed by people lived experience, we can create opportunities for meaningful connection that will lead to stigma reduction.



## The future of decision making in the suicide prevention sector

Producing this report during the global COVID-19 pandemic (September 2020) and acknowledging the associated increase in demand for mental health support certainly elevates the importance of grounding decision making in consumer need. Through interviews some participants reflected on the potential impacts of COVID relating to the suicide prevention sector:



***Stressors of COVID are going to have slow release impact- it'll take a while for true financial implications and job losses to hit home."***

Some also discussed the impact COVID on building relationships, highlighting that in an online forum there would be increased challenges in building trust without face-to-face contact. Trust has been cited in both previous literature and in our research, as a key component in developing meaningful relationships with those with suicidality. Our findings should also be considered in light of COVID and any associated impacts that the sector may not be aware of yet.

In preparation for a potential upswing in demand, the sector should be listening to those

experiencing suicidality, and their support networks, to inform and improve our responses. Leading with a human centred approach allows all actions within the sector to be led by need, rather than be restricted by what has gone before.

With this in mind, the four opportunity areas outlined in this report will help focus efforts in the sector to be aligned with the need of those living with suicidality.

Each opportunity provides direction to where the sector can focus its efforts in reducing future suicide. The pre- and post-attempt journey maps, alongside the themes identified provide detailed qualitative evidence directly from those with lived experience, and the connectors they have (i.e. family, friends, peers, service providers, and bereaved).

Design principles emphasised through our research will support future efforts to meet consumer needs and expectations. The design and delivery of future experiences should reflect solutions which:

- ***Connect with me authentically***
- ***Speak to me in my language***
- ***Make it easy for me to access support***
- ***Stay with me through my experiences***
- ***Support me as an individual.***







Suicide Prevention Australia believes that future decision making in this sector should consider the findings of this report as a guide to confirm that policy, programs, strategic communication and change are including the voice of those experiencing suicidality.

1

Collaborative engagement with the sector is needed to develop and co-create innovative solutions which meet the needs of our community.

2

Suicide Prevention Australia will continue to build-out, and develop responses to these opportunities, and will seek to drive a culture of collaboration and co-design.

We will continue to lead with empathy, and the needs of those experiencing suicidality, in order to design support effort that is most relevant individual's needs and expectations.

Suicide Prevention Australia and KPMG thank the individuals and organisations who contributed their time, narratives, experience, and wisdom to help drive and guide this research with such passion. For their considered input and pragmatic advice we are truly grateful.





## Appendix 1

## Journey Map: Pre-Suicide Attempt

A phased journey map of how consumers experience the lead-up to a suicide attempt

This figure presents a comprehensive model of suicidal ideation and behavior, structured into 10 sequential phases (1-10) that represent the progression from initial triggers to the final outcome of suicide. The model is organized into three main columns: 1. Triggers and Initial Thoughts (Phases 1-3), 2. Escalation and Seeking Help (Phases 4-6), and 3. Final Decision and Outcome (Phases 7-10). Each phase is represented by a box containing a description of the event, a list of associated needs, challenges, and delights, and a critical moment. The model is supported by a large flowchart at the bottom, which illustrates the complex interplay of factors leading to suicide, including personal, social, and environmental influences. The flowchart shows how various triggers and challenges can lead to suicidal thoughts, which are then influenced by social support, personal coping mechanisms, and the availability of help. The final outcome is determined by the balance of these factors, leading either to a suicidal attempt or to a successful recovery.

**1. I experience a triggering event(s), which may include suffering from a mental illness(es)**

**Description:** I have an experience that is highly stressful and overwhelming and/or I have battled with many events leading up to this point. This may include childhood trauma, a death of a family member, the separation of my parents, inter-generational conflict, a physical or cognitive disability or physical, emotional, financial and/or sexual abuse.

**1.1 Activities, events, experiences or touch-point title**

**Description:**

- I experience a triggering event(s), which impacts my life significantly
- My relationship with my partner breaks down and we may separate
- My work/life is excessive, and causing constant stress
- I am let go from my current job or forcibly retired by my employer
- I continually experience verbal or physical altercations with friends and/or family
- I have alcohol and/or drug addictions
- I experience the death of someone close to me, which may be from suicide
- I move to another city or country
- There is constant instability and/or trauma caused by toxic relationships in my life
- I or someone close to me is diagnosed with a life-threatening illness, such as cancer or HIV
- I or someone close to me is in a major accident, such as a workplace or road injury
- I or someone close to me is diagnosed with mental illness, such as psychosis
- I or someone close to me experiences trauma, due to physical, mental and/or sexual abuse in their past
- My children go to live with my ex-partner, or move out of the family home
- I experience instability within my family or broader community, sometimes due to inter-generational conflict
- I choose to ignore changes in my mindset toward my weekly routine
- I am unable to care for my children properly due to my changing behaviour, e.g. alcohol consumption

**Connections:** Family, friends, community leaders, religious leaders, colleagues, teachers, school counsellors/principals, sporting and recreation groups

**Needs:**

- I need constant support or therapy relating to my event(s), this may range from financial, emotional, physical and/or occupational assistance through my workplace
- I need people in my life I can rely on through transitional periods of my life
- I need those around me to empathise with my situation, circumstance and/or life event(s)
- I need to feel safe and secure at home, school, work and within my community
- I need a stable support structure in order to support me during difficult periods

**Challenges:**

- My family are not a reliable source of support
- My workplace is not supportive of my situation
- I continue to experience traumatic events in my life and/or relieve past trauma
- My family and friends are sharing the challenges I am going through, and are starting to negatively respond to my behaviour
- I can't accept my "new normal", as my physical injury impacts all parts of my life
- My mental illness is acting as a barrier for me to enter society, and contribute to society in the way I want
- I am not too sure who I can rely on, or what support may be available to me when I experience different types of change
- My up-bringing and environment shapes the responses I have to situations that arise

**Delights:**

- At points in time of my life, I have someone who understands my situation, and provides appropriate support for my situation.

**Critical Moment:** [Star icon]

**Sentiment:** The grey dotted line indicates the end of the phase

**2. I experience significant change in my life**

**Description:** My lifestyle and behaviour begins to change as a result of all the challenging experiences I've had up until this point.

**2.1 The experience(s) I have cause my life to change direction**

- I begin to lose my sense of purpose with life
- I begin to feel worthless, as I can't seem to positively contribute to my home-life, work-life or community
- I begin to feel socially distant from those closest to me
- I have difficulty sleeping, irritability, memory loss, poor concentration and/or an inability to get out of bed
- I socialise less, as I feel less comfortable in social settings
- My performance and/or attendance at work begins to noticeably slip
- I experience a range of physical symptoms, e.g. irritable bowel syndrome, tremors, nausea, impotence, insomnia, headaches
- I am unable to care for my children properly due to my changing behaviour, e.g. alcohol consumption

**2.2 I or those around me begin to actively notice changes in my life**

- I begin to have physical reactions to my situation, (e.g. panic attacks)
- I begin to withdraw from my friends, family and/or peer group
- I begin to react quickly, sharply or disruptively those around me at work
- I develop a range of physical symptoms, e.g. irritable bowel syndrome, tremors, nausea, impotence, insomnia, headaches

**Connections:** Family, friends, community leaders, religious leaders, colleagues, community groups, sporting and recreation groups, GP

**Needs:**

- I or someone close to me needs to recognise and accept the changes occurring in my life
- I need stability in my daily routine
- I need institutions such as my school, university or workplace to recognise my change in circumstance and respond appropriately
- I need to feel connected with those around me, in order to accept any negative change that is occurring in my life
- I need to not feel judged if I decide to open up to someone close to me
- I need people in my life that I feel comfortable confiding in

**Challenges:**

- I struggle to understand the changes in my life
- I feel like those around me won't understand, relate or empathise with my situation
- I am not sure where and when to reach out to someone for help, support or treatment
- I am not too sure who I can rely on, or what support may be available to me when I experience different types of change
- I am offered advice that may not help my situation
- I ask loved ones for help but they are unable to provide me with what I need
- I am offered advice that may not help my situation
- I ask loved ones for help but they are unable to provide me with what I need

**Delights:**

- I recognise the change in my life and begin to open-up about my true thoughts and emotions to someone I know I can trust

**Critical Moment:** The first time I share my experience with someone is important, as it is vital in setting me up for appropriate support, therapy and/or treatment in the future.

**Sentiment:** I have feelings of loneliness, worthlessness, absence of purpose and anger with my situation.

**3. I withdraw, self-harm/self-harm or visualise suicide**

**Description:** I begin or continue to withdraw from my usual routine, which may include working, socialising, family interaction, community interaction and a regular hobby. My internal dialogue is very negative and I begin to think about death and suicide.

**3.1 I withdraw or those around me begin to withdraw from me**

- I begin to remove my self from social events with family and friends
- I begin to skip work meetings or full days of work
- I begin to distance myself from the hobbies I normally enjoy
- Those around me dislike my inconsistent behaviour and begin to withdraw from me
- I don't speak to anyone or seek help for a prolonged period

**3.2 I begin to self-harm and/or self-harm**

- I begin to speak negatively about my ability to complete daily activities to those around me
- I have a negative internal dialogue
- I have problematic alcohol and/or drug use
- I decide to inflict injuries to myself, e.g. through cutting

**3.3 I begin to visualise what suicide looks like, or what life would look like without me**

- I become consumed with thoughts of dying or death, including dreaming about methods I could use to take my life
- I begin to visualise what life for those around me would look like without me

**Connections:** Family, friends, community leaders, religious leaders, colleagues, community groups, sporting and recreation groups, clinicians (GP, Mental Health crisis team, Psychologist, Psychiatrist), Alcohol Anonymous (AA), Lifeline, School teachers/counsellors

**Needs:**

- I need to recognise and accept my feelings, thoughts and behaviours
- I need to feel connected with those around me, in order to accept any negative change that is occurring in my life
- I need to not feel judged if I decide to open up to someone close to me
- I need people in my life that I feel comfortable confiding in

**Challenges:**

- I don't want to accept the help that I may need
- I don't understand the severity of the situation I am in
- I don't receive helpful advice by those closest to me
- Those around me don't know where or who to turn to
- People in my life who may be able to help me aren't aware of how I'm feeling
- I am waiting in the ER for a long time - my case is not viewed as 'acute enough'

**Delights:**

- I open up to someone and am met with acceptance and understanding

**Critical Moment:** I connect with a clinician or peer-support worker who can empathise with or relate to my situation and speak to me at my level

**Sentiment:** I have feelings of discontent and a lack of care prior to withdrawal, self-harm/self-harm and/or visualising; my feelings are reinforced by others withdrawing from me.

**4. I or someone close to me seeks help**

**Description:** I or someone else seeks help, as my situation and/or inconsistent behaviour becomes more obvious to those around me.

**4.1 I seek help, as I know something isn't right with my thoughts or behaviour**

- I understand that I need help, and seek it out by talking to a family member, friend or peer
- I reach out to peers and trusted community members
- I request a GP appointment, which may include a mental health plan
- I attend a seminar or information session about mental health or suicide
- I begin to inquire about local community services
- I am approached by the ED
- I present myself to ED

**4.2 My family member, friend or peer seeks help on my behalf**

- My loved ones intervene and seek help on my behalf, e.g. from first responders, by taking me to the ED, or by calling local mental health services an making appointments for me
- Other service providers mandate treatment or therapy (e.g. family and child services)

**Connections:** Family, Friends, community leaders, religious leaders, colleagues, family or child services, first responders, clinicians (GP, Mental Health crisis team, Psychologist, Psychiatrist)

**Needs:**

- I need to recognise that help, support, therapy or treatment will improve my situation
- I need to accept the help, and agree to work with community support groups, NGOs and/or for clinicians
- I need to be able to trust in the professional help received
- I need to be able to trust in the process and system in which I am receiving help
- I need respect for the seriousness and urgency of my situation myself and from others
- I need someone who is educated in the signs and symptoms of mental illness and/or suicidality

**Challenges:**

- I don't want to accept the help that I may need
- I don't understand, recognise or respect the severity of the situation
- I don't know where or who to reach out to
- I find it difficult to find the right contact for my circumstances
- My local community and/or culture doesn't acknowledge the challenge of my situation
- I don't receive the helpful advice by those closest to me or clinicians
- I am waiting in the ER for a long time - my case is not viewed as 'acute enough'

**Delights:**

- I recognise my thoughts, feelings and behaviour needs attention, as I'm finding it difficult to manage my emotions
- I have a strong family, friend or peer network, who are able to assist me in seeking the help I need

**Critical Moment:** I connect with a clinician or peer-support worker who can relate to my situation and speak to me at my level

**Sentiment:** I have feelings of confusion, unfamiliarity, vulnerability, of being exposed, confronted, and/or conflicted.

**5. I receive support, therapy and/or treatment**

**Description:** I receive support, therapy and/or treatment, in response to my situation and behaviour.

**5.1 I receive support from a family member, friend or peer**

- I receive support, advice and direction from family members and/or friends
- I receive support from the HR function of my workplace, my manager or work or a colleague
- I receive support from a local community support network
- I receive support from a call-line, such as Lifeline, or through social media channels

**5.2 I receive assessment and therapy from a clinician**

- I receive therapy from a psychiatrist or psychologist either as a one-off, or on going
- I don't connect with my therapist, and try to connect with someone else
- Therapy helps me better understand my thoughts and feelings
- Therapy doesn't seem to improve my situation

**5.3 I receive assessment and treatment from a clinician**

- My GP or Psychiatrist conducts a risk assessment
- The mental health crisis team conducts an initial assessment
- I am prescribed medication by my GP or Psychiatrist
- My medication doesn't seem to improve or worsens my situation
- My medication puts a "Band-Aid" on my current situation

**Connections:** Family, friends, peer support, community leaders, religious leaders, colleagues, community groups, sporting and recreation groups, clinicians (GP, Mental Health crisis team, Psychologist, Psychiatrist), Alcohol Anonymous (AA), Lifeline, school teachers/counsellors, online support and counselling

**Needs:**

- I need to recognise and accept my feelings, thoughts and behaviours
- I need to not feel judged if I decide







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