



Compassion First

Designing our national approach
from the lived experience of
suicidal behaviour



Australian Government

December 2020



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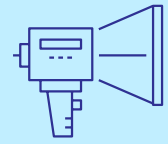
To cite this document:

National Suicide Prevention Adviser. Compassion First:
Designing our national approach from the lived experience
of suicidal behaviour. Canberra; December 2020.



Foreword

Australia's approach to suicide prevention must be informed by the experiences and wisdom of people with lived experience of suicide and recovery.



In Australia, we often cite the number of people who die by suicide each year to highlight the scale and impact of the issue, but this is only one part of the overall picture. Behind each of those numbers is a person, a journey and a network of other people.

Suicide prevention efforts must learn from those who experience suicidal distress and suicidal thoughts, and from the resilience displayed by people who are recovering from suicide attempts. These experiences are poorly understood, but provide an important opportunity to reform our approach based on what people need to live hopeful, contributing lives.

It is important to make urgent improvements to the accuracy and timeliness of suicide-related data, to prioritise research and to hear from academics, clinicians and service providers. This, alone, however, is not enough. We also need to elevate the voice of people with lived experience of suicidal behaviour. Not as an anecdote or story to strengthen advocacy, but to shape and guide our reform efforts in Australia.

Our Initial Findings presented to the Prime Minister in November 2019 identified the need for a coordinated response to suicide prevention and an urgent need to better understand the journeys and experiences of those who have lived experience of suicidal distress and suicide attempts. This knowledge and insight is needed to guide the shift to a more connected and compassionate, whole of government approach to suicide prevention.

This report draws on research undertaken during 2020 to learn from those with first-hand experience. An earlier version was submitted to the Prime Minister as part of the *Interim Advice* delivered in August 2020. It has since been updated with additional research to form an integral part of the *Final Advice*. It is essential reading for anyone interested in how we can improve not only our understanding of suicide but how we can more effectively reduce suicide deaths, reduce suicide attempts and support people earlier in their distress.

The research highlights the importance of a national approach to suicide prevention that spans all ages, acknowledging that challenges can commence early in life, and then be exacerbated by stressors and co-occurring adverse events across the lifespan. If the health, social, cultural and equity issues contributing to suicide are understood and touchpoints along people's journeys identified and resourced to provide support, there are many opportunities to assist people before they reach crisis point.

We need to do all we can to prevent suicidal behaviour by intervening much earlier with services and supports delivered where people live, work and learn. We must also urgently transform our service system. People with a lived experience currently describe this as disconnected, crisis-driven and dehumanising, with little ability to acknowledge or address the traumatic and systemic factors that often contribute to suicidal distress.

To drive genuine change, we must position lived experience knowledge at the forefront of research, policy and practice. Without it, our reforms and service improvements will fall short of what people need and what they deserve.



Christine Morgan

National Suicide Prevention Adviser

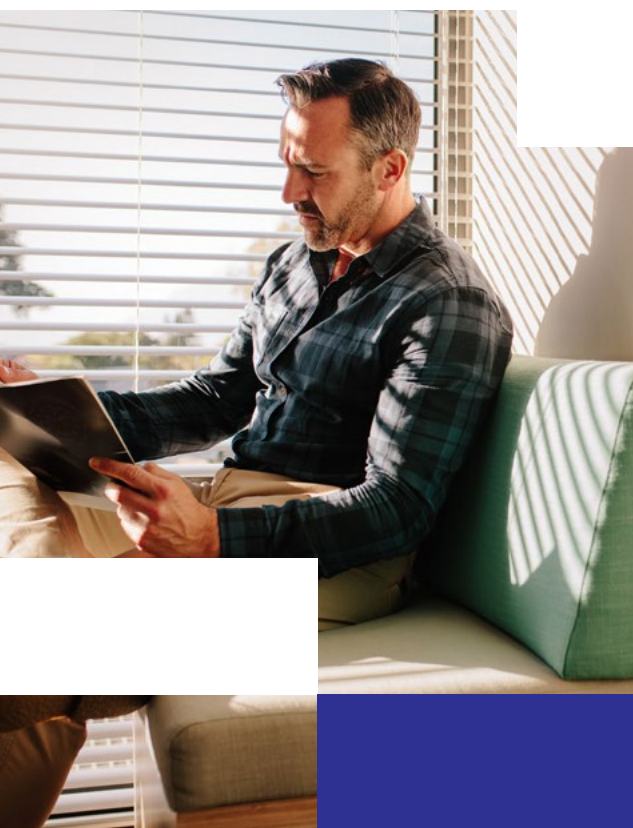
Acknowledgements

“We know the desperate powerlessness that is inherent in feeling suicidal... so much energy must go into healing one’s self and building a life worth living that challenging the stigma and discrimination that exists even in the field of suicide prevention is beyond any individual – let alone challenging the complex, entrenched systems that contribute to suicide. Reassuringly, the collective voice of those who have lived experience of suicide, standing on the shoulders of the giants who have fought for social justice, has finally gained traction and momentum, kindling the spark of hope for change.”

– Statement from lived experience contributors at the Black Dog Institute

The National Suicide Prevention Adviser, the National Suicide Prevention Taskforce, and all researchers who contributed to studies used for this report would like to acknowledge the people with lived experience of suicidal behaviour who contributed via the online survey, or in one of the consultations or yarning circles. We value their open and honest contributions, knowing that these will directly contribute to our future work in suicide prevention. Without this input, we would not have their expert insights to guide national reforms.

The National Suicide Prevention Adviser would like to acknowledge all researchers who contributed to this report (see reference section for a full list) and members of the Expert Advisory Group with lived experience of suicidal behaviour who contributed to the planning and review of this report: Ingrid Ozols AM, Stefani Caminiti, Graeme Holdsworth, Parker Forbes, Leilani Darwin and Lucinda Brogden AM.



‘Lived experience’ is a broad term used to describe people who live with suicidal thoughts, who have survived a suicide attempt, who have been bereaved by suicide and those who care and support someone who was or is suicidal. All of these experiences are important in informing our suicide prevention work and are reflected through this report.

For Aboriginal and Torres Strait Islander people, lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community. People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and true to Aboriginal and Torres Strait Islander peoples ways of understanding social and emotional wellbeing.¹





Snapshot

There is an imperative to harness the knowledge of those who have lived experience of suicidal behaviour to inform our national approach.

- This report draws on and summarises commissioned research to learn from thousands of people with first-hand experience of suicidal behaviour.
- While there are some common experiences that may precede a suicide attempt, there was no simple or singular pattern of experiences. Suicidal behaviour is described as very personal and deeply distressing.
- For many, suicidal thoughts and behaviours could be traced back, in part, to early life experiences of abuse, violence, trauma, family conflict or bereavement. People also reported experiences with mental illness, alcohol and other drug problems, discrimination and cultural taboos as well as the role of co-occurring and complex life stressors closer in time to a suicide attempt. For others, trying to identify discrete contributing factors was more challenging.
- Regardless of the factors contributing to suicidal thoughts, what people need when in suicidal distress is a connected and compassionate response. Instead, people described feeling “unheard, judged and problematised” by disconnected and crisis-driven services.
- The research described a common and distressing scenario where, precisely when people are highly distressed and in need of a compassionate response, our health system and other related systems provide disjointed care that is lacking in empathy, hard to navigate, or not available at all.
- The unintended consequence of this for many people is that responses can do more harm than good, perpetuating a vicious cycle where individuals in distress can only access support when in crisis – at which point they are judged for not seeking help earlier. Often this judgement extends to their caregivers.
- People spoke of needing to try and navigate support options on their own, which could be isolating and distressing. This was especially the case when the referral systems were siloed – attempting to ‘diagnose and treat’ just one presenting issue at a time rather than supporting a person as a whole.
- This research points to the need for a seismic rather than small shift in the current approach. Multiple drop off points, a lack of integration and communication between services, cultural and safety barriers, and a lack of supports for caregivers were all frequently highlighted as problems with the current approach.
- A range of other potential supports and services were identified through the research, but they were often described as lacking the capabilities to respond to suicidal distress. These included housing and homelessness services, legal centres and the family law courts, family and community services – including services that support people through domestic and family violence, schools, universities, workplaces and a range of financial and other community services.
- The research conducted for this report points to the need for a serious shift in the public representation and discussion around suicide, including who it affects, how it is best responded to and transparency about the shortcomings of the current system – for people and their caregivers.
- In media and other public messaging, lived experience is often presented as anecdote to reinforce an ‘expert’ or clinical view or opinion, with limited coverage of people who have lived through a suicide attempt.
- A greater focus on integrating lived experience into the service system and into our public narratives about suicide prevention would be of benefit. Diverse lived experience voices particularly need to be heard that can support engagement with young people, older people, Aboriginal and Torres Strait Islander people, men, women, Lesbian, Gay, Bisexual, Transgender, Intersex, Queer plus (LGBTIQ+) communities, people from culturally and linguistically diverse backgrounds, veterans and their families, and rural communities.

This research has identified some clear opportunities for change

i.	Prioritise and integrate lived experience knowledge and expertise into the planning and delivery of whole of government suicide prevention action.
ii.	Intervene early in life to mitigate the impacts of abuse and build capability across workforces to deliver trauma-informed care, recognising the impacts of trauma across the lifespan.
iii.	Deliver effective interventions and support options that are co-designed with young people to mitigate the impacts of co-occurring psychological, identity and relational stressors.
iv.	Use all available government and community services to provide outreach and support to people at the point of distress to ensure they get the right supports in a timely way – especially at critical points of disconnection and transition.
v.	Invest in, further develop and scale community-based and compassionate services and supports to ensure that people who do seek help in suicidal distress, get the support that they need. This includes: 1. New community-based service models that align with a compassionate response - including 'safe spaces' and peer-led services. 2. Improved health service and emergency department responses for individuals and their caregivers presenting in a crisis. 3. Service models that support psychosocial needs, care-coordination and ongoing follow up – including broad access to aftercare. 4. Safe, inclusive and culturally appropriate services for all people.
vi.	Provide immediate and ongoing practical and emotional support for caregivers, many of whom experience suicidal thinking themselves.
vii.	Better coordinate timely bereavement and postvention supports for individuals and communities exposed to the suicidal behaviour of others.
viii.	Develop and support the broad range of workforces involved directly and indirectly in suicide prevention to respond with compassion to underlying distress.
ix.	Provide a more comprehensive approach to suicide prevention that addresses the multiple impacts of alcohol and other drug use on suicidal behaviour.
x.	Implement population-level interventions that address key social and economic stressors that impact on people's lives.



About the research

Positioning knowledge from lived experience at the forefront of research, policy and practice has the potential to richly communicate the complexities of suicidal behaviour and highlight key considerations for preventing suicide and better supporting people.

To expand on existing research and practice knowledge, the National Suicide Prevention Taskforce partnered with the Suicide Prevention Research Fund (managed by Suicide Prevention Australia) and the Commonwealth Department of Health to commission research that focused on learning from people in Australia who have first-hand experience of suicidal distress and suicidal behaviours. This report is a synthesis of this research, drawing from thematic analysis conducted across multiple research studies.

Ten separate studies were commissioned that explored: (1) what people reported as the most significant factors contributing to their suicidal distress or suicide attempt; and (2) their experiences with a range of health and non-health services in the lead up to, during and following a suicide attempt or time of suicidal distress. While efforts were made to capture diverse views, these studies drew on convenient samples rather than representative samples, so the full diversity and intersectionality of lived experience may not be captured.

Findings presented in this report are drawn from all ten studies, including:

Analysis of...



110
research studies



300
newspaper articles



368
social media posts



545
podcasts



48
books



338
public submissions

First-hand accounts through...



1,652
survey responses
from people with
experience of
suicidal distress



1,486
survey responses
from caregivers
across two
separate surveys



32
support group
participants



32
interviews with
caregivers



13
Aboriginal and
Torres Strait
Islander people in
a yarning circle



11
young people
sharing journeys



10
in depth interviews
with people from
a culturally and
linguistically diverse
background



6
in depth interviews
with people who
identified as
LGBTIQ+



12
in depth interviews
with men

Summary of commissioned research

Ten separate studies were commissioned, including a review of existing research, a large online survey, analysis of public commentary about lived experience of suicide and targeted consultations with identified groups, as summarised below.

- 1. Rapid evidence review.** Researchers and Lived Experience Advisers at the Black Dog Institute conducted a rapid review of the available evidence,¹ with a total of 110 papers or reports included in the review, 26 of which were from Australia. Most studies were qualitative and examined individuals with direct experience of suicidal thoughts and behaviours. They focused on a variety of populations such as men, young people, older people, military veterans, people identifying as LGBTIQ+, and people from culturally and linguistically diverse backgrounds.

The University of New England conducted and reported on four studies across two separate reports:^{3,4}

- 2. Public Voices:** Exploring how lived and living experience of suicide is portrayed in the public domain, including news media, books, social media, podcasts and submissions to public enquiries.
- 3. Private Voices:** Examining responses of 1,652 people who completed an open-ended, open format online survey, with this study reporting on responses from people who had first-hand experience of suicidal distress or suicide attempt. In this survey, the researchers simply asked people to tell them about what suicide and lived experience of suicide means to them.
- 4. Empowered Voices:** Re-examining data from 32 people who had attempted suicide and completed a psycho-educational support group offered by Lifeline centres in New South Wales.
- 5. Families, caregivers and people bereaved by suicide:** Examining 728 responses from the survey reported in the *Private Voices* study, with a focus on people who identified themselves as a caregiver or someone bereaved by suicide. The majority of people had multiple exposures of caring and three quarters were bereaved. The study also reanalysed data from the SANE Australia and UNE Better Support Research Project 2017-2020, including 758 survey responses and 32 in depth interviews to further investigate caregiver experiences over time.

Five organisations were commissioned to conduct targeted consultations with particular groups:

- 6. Consultation with young people.** Orygen conducted consultations with 11 young people regarding their lived experiences of suicidality and associated help-seeking.⁵ Young people were recruited from across Australia and ranged from 17 to 25 years of age. Seven identified as female, three as male, and one as non-binary. Five of the young people identified as LGBTIQ+, including two transgender young people.
- 7. Consultation with Aboriginal and Torres Strait Islander people.** The Aboriginal and Torres Strait Islander Lived Experience Centre in partnership with the Seedling Group and Black Dog Institute conducted virtual yarning circles with 12 Aboriginal and 1 Torres Strait Islander person with a lived experience of suicide to explore factors contributing to suicidal behaviour and experiences with services.⁶ The yarning circles included four males, eight females and one gender fluid person. Participants lived in five different states and territories, including metropolitan, rural and remote areas.
- 8. Consultation with people from culturally and linguistically diverse backgrounds.** Ten in-depth interviews were conducted by Cultural and Indigenous Research Centre Australia (CIRCA)⁷ with people from a Chinese, Taiwanese, Vietnamese, South Sudanese, Zimbabwean, South African, Greek, Congolese and Maori/Pacific background, with ages ranging between 18 and 72 years.
- 9. Consultation with people who identified as LGBTIQ+.** The National LGBTI Health Alliance conducted six in-depth interviews with people who identified as lesbian, gay, bisexual, transgender or queer, aged between 24 to 60 years.⁸
- 10. Consultation with men.** The Australian Men's Health Forum, in partnership with Western Sydney University, conducted 12 in-depth interviews with males aged between 25 and 65 years.⁹



Contributing factors in a person's journey



Being suicidal is exhausting and all-consuming. Most of the time, those who are suicidal are also trying to keep their and their family's day-to-day life afloat. Expectations on us to reach out, follow up, navigate siloed services and systems, chase referrals, do extra or self-advocate are completely unrealistic.

– Statement from lived experience contributors at the Black Dog Institute



Key themes: Factors contributing to a person's suicidal distress

In the thousands of stories shared through the research, not one participant described a simple lead up to a suicide attempt. Suicidal behaviour was described as a passing event for some people, but others highlighted that thoughts of suicide do not resolve quickly or easily for everyone. Suicidal thoughts and behaviours could be traced back, in part, to childhood and adolescent experiences of abuse, violence, trauma, family conflict or bereavement for some people. Experiences with mental illness, alcohol and other drug problems, stigma, discrimination and cultural taboos as well as the role of co-occurring and complex life stressors were also reported. The table on the following page summarises some of the contributing factors that were mentioned across life stages, noting that for some people there were no clear or obvious contributing factors.

Adverse experiences and trauma in childhood

Adverse childhood experiences were reported across the studies commissioned for this report.⁹ Childhood sexual, physical, psychological and verbal abuse was often identified as the first experience in a long journey of poor mental health, unstable or violent relationships, social isolation and suicide attempts. This abuse often occurred in the home, but abuses from institutions such as churches and schools as well as services responsible for the removal of children from their homes was also reported. For some, suicide attempts occurred close in time following the abuse, while others reported that a suicide attempt occurred decades later.

Participants across the ten studies reported experiences of family violence in childhood, as well as parental experiences with mental illness, alcohol and other drugs and suicidality, sometimes requiring children to take on caring roles for other family members. Participants spoke of how they and their families did not receive adequate support to mitigate some of the impacts of these early life experiences.

Some people spoke of a 'pipeline' between childhood trauma, early experiences with the juvenile justice system and re-entry into the justice system as an adult, with comorbid mental illness and drug and alcohol problems presenting for some people. Intergenerational experiences of parental mental illness, substance dependence and incarceration can have a cyclical, compounding impact that lasts throughout life.



I live a life where suicide will always be a risk factor – for myself and for my loved ones. Neglect, incest, sexual abuse and sadistic parents gave all my family a life sentence of severe trauma and life-long mental health challenges. Suicide has never been far from any of our minds. I have attempted suicide and I've sat beside siblings and called ambulances as I watched them after their attempts to suicide. I lost two friends to suicide and I still sit overnight with others in hope that my company means they live to see the next morning.

– Personal story, Private Voices study



For people from different culturally and linguistically diverse backgrounds, childhood trauma was often discussed in the context of migration experiences, which often occurred at a young age. As children and adolescents, people also experienced conflict between expectations of parents to maintain behaviours that aligned to their culture of origin and a desire to take on values and behaviours of their new country.



The mental health journey of migrant children is very undervalued and there are two sets considerations, the first is the issues and traumas they bring when they come to Australia, the second is the issues associated with trying to fit in here.

– Personal story, culturally and linguistically diverse interview participant



Male participants reported that childhood trauma and experiences could be carried into adulthood, resulting in toxic relationships, chronic loneliness and despair, and feelings of being a failure when life events – such as job loss or relationship breakdown – did not align with intergenerational social constructs of masculinity.



Childhood depression led to divorce at 27, and mid-life crisis with lack of financial stability. Over time, multiple situations created a sense of despair and incompleteness leaving with a sense of total failure in life. This caused dependency and extreme loneliness.

– Personal story, male interview participant



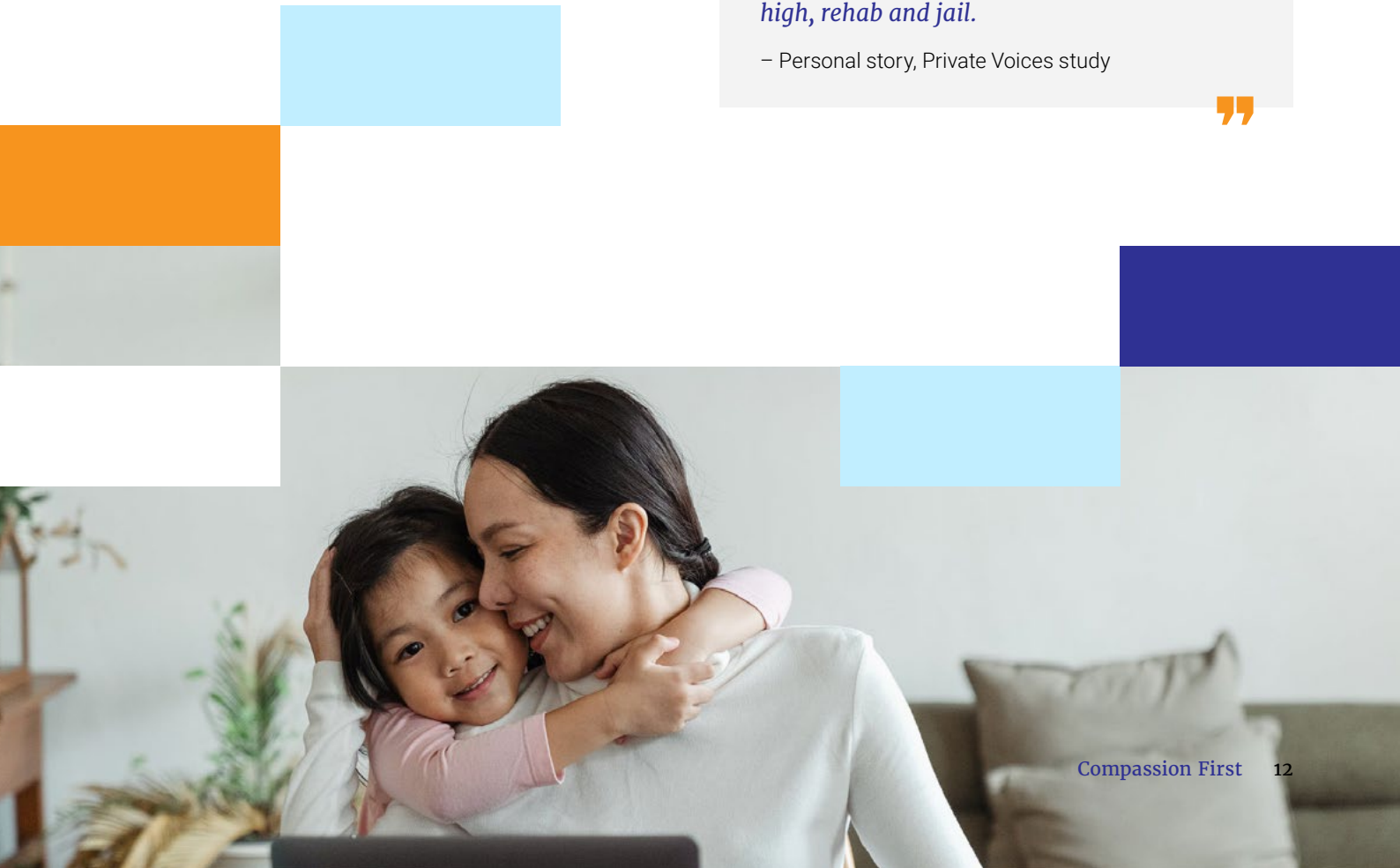
Mental illness and alcohol and other drug problems

Mental illness and alcohol and other drug problems were present in many people's stories across all studies, often with onset in adolescence or early adulthood. While young people and a number of adults talked about ongoing challenges with mental illness close in time to their suicide attempt, more often than not it was described as sitting in the background in the context of trauma, disadvantage, negative societal and cultural attitudes and inequity. Lack of access to mental health or counselling services or poor experiences of care were also described. Alcohol and other drug issues emerged in adolescence for many people, with some reporting ineffective treatment or a lack of treatment at the time. Many people, particularly men, described a change or increase in alcohol or substance use co-occurring with life stressors close in time to a suicide attempt, especially in the context of relationship breakdown.

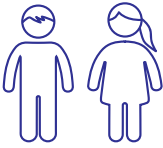
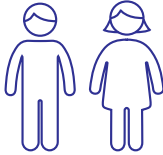
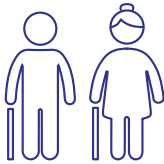


I have had multiple family members attempt suicide and I have as well. I am a recovering addict and have been sober for 20 years. My attempts to take my life were wrapped up in my addiction and looking back, I did not want to die... I felt alone, I had no family support and my life was a revolving door of getting high, rehab and jail.

– Personal story, Private Voices study



Underlying factors and life stressors which can occur across the lifespan

 Children A large proportion of people report risk factors that emerge in childhood – including sexual, verbal, psychological and physical abuse, exposure to family violence, trauma experienced during migration and settlement, and bereavement, including suicide bereavement, during childhood.	 Young People Adolescence and early adulthood is often when psychological and interpersonal risk factors emerge or are exacerbated. This includes onset of mental ill-health and alcohol and other drug problems, study and work stresses, challenges with interpersonal relationships, identity and cultural challenges for some young Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) people and those from a culturally and linguistically diverse background.	 Adult Most suicide deaths in Australia occur amongst adults (75% are males) with many experiencing multiple life stressors just prior to an attempt or death. Many people report a change in alcohol or drug use (AOD) in combination with relationship breakdown, family violence, legal and child custody issues, workplace stresses, injury or illness, unemployment and financial distress.	 Older People High rates of suicide occur among older men, however risk factors can be quite different and often include limitations on daily functioning due to illness, disability or chronic pain, social isolation, grief and bereavement.
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Key transition points and points of disconnection across the lifespan present unique stressors and opportunities for intervention

Disengagement and transition from school or university, discharge from hospital following a suicide attempt, discharge from the Australian Defence Force to civilian life, release from correctional facilities, divorce or a change in family structures, impacts of migration and settlement, change in work status due to unemployment, illness or injury.

A range of factors have been identified that can impact on families and communities across the life course

Access to means of suicide or availability of information online Exposure to suicidal behaviours of family, peers or through media	Ineffective treatment for mental illness and alcohol and other drug problems Disadvantage, inequity and poverty Homophobia and transphobia	Stigma associated with mental illness and discrimination Intergenerational trauma and loss of connection to culture Cultural taboos about suicide	Having made a previous suicide attempt Ineffective responses to past suicidal behaviour
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Co-occurring stressors and adverse life events

Most people reported that a number of life stressors and events co-occurred close in time before a suicide attempt. These included: interpersonal conflict; intimate partner and family violence; relationship breakdown and/or child custody issues; being bereaved by suicide; experiencing legal problems; and financial problems related to housing and employment.

Some adverse life events were unique to particular groups. For example, in children and young people, suicidality was impacted by factors such as development of self-identity, suppressing sexuality, bullying, isolation from peers, issues with body image, study pressures and challenges associated with navigating one's culture of origin and new social norms in Australia. Adults were more likely to report stressors such as relationship breakdown, child custody or child removal issues, contact with the justice and legal system, unemployment, financial stress, workplace conflict or a workplace transition – such as transition from the Australian Defence Force to civilian life. Older people were more likely to talk about bereavement, social isolation and chronic pain or physical ill-health.



Losing my job in the Army was just a start of my downfall, one damn thing after another. In a span of one year seven people I knew killed themselves, I was noticing things happening around me, which pushed me to the moment of attempt.

– Personal story, male interview participant



Events or stressors that were adversarial in nature or involved conflict or disconnection were particularly prevalent in people's journeys. This included relationship breakdown, which was the most common adverse event reported across the studies, as well as legal matters, contact with the police or justice system or issues surrounding workplace injury and workers compensation claims. Male participants, in particular, reported relationship breakdown and associated legal issues as being a significant factor in suicidal distress. Aboriginal and Torres Strait Islander people talked about the vulnerable state people were left in when having children removed. The use of alcohol or other drugs to 'cope' with trauma and stressors was commonly reported, as were other addictions such as gambling – often making the situation much worse for people.



Abusive relationship for three years in the mid-2000s, took another three years to get out of. Next relationship also destructive. Work history patchy... workplaces have been chaotic (and) stressful, and short-term contracts have meant ongoing financial stress. This recent incident was preceded by high level of stress rather than suicidal ideation, and wanting pain to stop rather than wanting to die.

– Personal story, Private Voices study



Discrimination, stigma and inequity

Discrimination and stigma, whether towards a person's culture, their identity or towards their suicidality, occur at both an individual and systemic level and were reported across the research. For example, people identifying as LGBTIQ+ experienced homophobic bullying, transphobic bullying, abuse, and violence,¹¹ further exacerbated by stigma directed towards their suicidality.¹² This systemic adversity and negative social and family attitudes and responses could lead to feelings of isolation, of being 'different' or 'other'. Often, people reported this resulted in them suppressing their sexuality and identity and delaying support for suicidal thoughts.

People from culturally and linguistically diverse backgrounds experienced stigma and discrimination from a number of sources. The experience of covert racism, negative public narratives about some cultural groups in Australia, and the lack of bilingual and bicultural services contributes to a perception that health services are there for other Australians and not for them. This can be exacerbated by negative attitudes towards mental illness and suicide within their own communities and families, which makes it difficult for people to seek help. Cultural norms and taboos could at times override familial relationships and reduce support for people who experienced suicidal thoughts.



In my community mental health issues are problematic, there is a stigma, branding and spiritual abuse. Suicide attempts are frowned on and used to question religious observance of faith.

– Personal story, culturally and linguistically diverse interview participant



Racism and discrimination was reported as isolating and disempowering by Aboriginal and Torres Strait Islander people within the yarning circle and through other national hearings analysed through the research.¹³ Racism and discrimination contribute to intergenerational trauma and can prevent equitable access to resources and services. This in turn can result in health inequalities, homelessness and overcrowding, educational and employment disadvantage, substance misuse, impulsive behaviour in relation to life stressors and overrepresentation in the justice system, especially for young people.

Discrimination in the context of cultural or social norms, together with the role of intersectionality, is important for contextualising the individual experience of suicidality. For example, Aboriginal and Torres Strait Islander people who also identify as LGBTIQ+ can experience multiple layers of stigma and discrimination. The historical and contemporary experiences of this for Aboriginal and Torres Strait Islander people continue to affect their holistic wellbeing and intergenerational experiences.

A loss of individual, family and societal value

The loss of a person's sense of value, social role or status could contribute to suicidality, and this was particularly apparent in older populations, who often struggled with the loss of functioning and self-sufficiency. An increased reliance on others resulted in significant distress, due both to the feeling of losing autonomy and to perceptions that this made them a burden on others.



I come from generational dysfunction and a history of issues of comorbidity, I have had many years of therapy trying to break the cycle. I lack support due the stigma of mental illness, I don't share my journey, the cycle is hard to break, I have been admitted to hospital due to suicide attempts after my son died by suicide...

– Personal story, Private Voices study



Male participants talked about the impact of gender stereotyping and the value placed on them as husbands and fathers when relationships broke down. For example, some men reported concerns about the systematic biases that affected on men within the legal system, where experiences of being the victim of domestic violence were often dismissed, where they were more likely to lose custody of children, and where they felt pressured to provide child support regardless of their financial status.



...long pending case with family court and ultimate loss of child custody followed by unemployment and inability to provide for child support made life a miserable journey.

– Personal story, male interview participant



People from culturally and linguistically diverse backgrounds talked about experiencing a sense of failure from not being able to achieve life objectives due to ongoing settlement issues, not meeting family expectations, or not being able to find employment commensurate with their qualifications and skills. For others, a loss of value or role was described in relation to job loss or financial stress and the subsequent loss of meaningful contribution.¹⁴ This was particularly significant for men, where identity was associated with their occupation and relationships, especially the masculine roles of ‘father’ and ‘provider’.



Working in a café and bar after losing my job felt like I had lost my status and identity, which were the major reasons for recurring suicidal ideation.

– Personal story, male interview participant



A range of different groups reported issues related to educating others about their culture or their identity, for example, some Aboriginal and Torres Strait Islander people spoke about the impact of needing to ‘prove’ identity or having identity denied, as well as the energy required to constantly advocate on behalf of oneself and one’s community. In another example, people who identified as LGBTIQ+ reported feeling as though they had to continually educate people about sexuality and identity to have their own identity acknowledged and understood.

Loneliness and isolation

Loneliness and isolation were major precipitators to suicide and manifested in different ways across many different groups. Though the reasons for loneliness and isolation were not always provided, they could be caused by interpersonal conflict with peers and family members, disconnection from society and community, loss of support networks due to aging, experience of stigma and discrimination, poverty, and isolating coping mechanisms. Men who were interviewed for this research believed that the combination of childhood trauma and norms around masculinity could contribute to toxic relationships in adulthood, making it difficult for men to connect emotionally with friends and romantic partners. This contributed to chronic loneliness and despair among some men. In other cases, isolation was caused by geographical isolation, including rurality and limited service options, or through forced separation from support networks, such as in refugees and migrants and impacts associated with the removal of Aboriginal and Torres Strait Islander children from families, culture, language and country.



I have lived with suicide ideation and many attempts. However, the most recent was back in 2013. Just prior to this attempt I was in severe financial stress. I was about to become homeless for the second time in a short period of time. I was isolated and estranged from family and friends.

– Personal story, Private Voices study



Feelings of hopelessness and emotional suffering at the time of crisis

A range of the factors already mentioned, especially in combination, can culminate in hopelessness and extreme emotional distress. In some cases, suicidal behaviour was described as a method of coping with trauma and distress or an action people took because the self-harming behaviours they were using to manage distress no longer provided sufficient emotional relief.



I've had more services than most and I'm still not ok. So I feel trapped in a kind of hell where I can't seem to find the way out of misery and I just wish I had cancer or something then it wouldn't be my fault.

– Personal story, Private Voices study



At the point of crisis, people across interview groups talked about feelings of being a “failure” or being unable to cope with the intensity of their feelings. For example, participants in the Aboriginal and Torres Strait Islander yarning circle talked about feeling unable to cope with “overwhelming emotions”, with some using substances as a way to cope. For people in detention, factors related to the detention environment itself – such as confinement, deprivation, loss of liberty, overcrowding, limited meaningful activities and exposure to others’ suicidal behaviour – were noted as significant.¹⁵



I began selling off some of my belongings to make my mortgage payments, which reinforced my feeling of failure and unworthiness.

– Personal story, male interview participant



Exposure to suicide and availability of methods

Research has identified that individuals can learn about suicide methods from television and film, news stories, the internet and healthcare professionals.¹⁶ Within this research, it was common for participants to talk about their exposure to other people’s suicidal behaviours – both suicide attempts and deaths – within their family, school environments, among peers, in the workplace and through online communication. For Aboriginal and Torres Strait Islander people ‘sorry business’, including other suicides in the extended family, could increase feelings of being overwhelmed in the lead up to a suicide attempt.



Lives are never the same after that, addictions, regret, anxiety, anger, waiting for the phone.

– Personal story, Aboriginal and Torres Strait Islander Yarning Circle



Mapping journeys

While each person's journey is unique, there were some common types of experiences identified through the research. By mapping the common experiences and themes identified in the previous section, we were able to highlight the interaction between experiences, their compounding effects, and how they can contribute to suicidal behaviour. Previous research has mapped the journeys of people who die by suicide.¹⁷ This report builds on that work by mapping the journeys of people who have survived a suicidal crisis and/or attempt. The common pathways identified have been mapped below to assist with identifying opportunities to intervene in a person's path towards suicide earlier and ideally prevent vulnerability to suicide developing in the first place. They should not, however, be used to simplify the complexity of experiences, which are different for each person. It should also be acknowledged that for some people, suicidal thoughts could occur without clearly identifiable factors that have contributed to their distress. Each person's distress must be responded to, regardless of their journey.



It is extremely challenging to understand the complex phenomenon of suicide...the extensive knowledge base of risks and protective factors have relevance. But we ask that these are used with awareness of their limitations – they do not reflect every individual's experience of suicidal thoughts and behaviours. Our complex internal experiences and interactions with an equally complex external world cannot be reduced to variables. We do not all follow the same theoretical pathway from suicidal thoughts to actions.

– Statement from lived experience contributor at the Black Dog Institute



Journey 1: Compounding experiences across the life course

A journey that started early in life and was built on by experiences across the life course was described in more than half of the stories shared by adults across the different research studies. This experience could be broadly summarised as including: (1) adverse experiences that occurred in childhood; (2) psychological, relational and social challenges that occurred as a young person; and (3) co-occurring stressors in adulthood, often combined with a change in alcohol and other drug use immediately preceding a suicide attempt. The map below shows some of the experiences reported in each of the life phases, with people reporting at least one event within each grouping.

Adverse childhood experiences	Stressors as a young person	Co-occurring life events in adulthood
• Child abuse and neglect • Exposure to family violence • Childhood bereavement • Peer-based difficulties or school adjustment	• AOD use • Onset of mental ill-health • Onset of self-harming behaviours • School or university pressures and disengagement from studies • Identity issues, especially for LGBTIQ+ young people • First or multiple suicide attempt/s • Ineffective treatment and support	Changes in AOD use accompanied with life stressors, including: • Relationship breakdown • Contact with the justice system • Legal issues, including child custody issues • First or further suicide attempt/s

Journey 2: Co-occurring psychological, financial and relational stressors in adulthood

A number of adults across the studies described the co-occurrence of psychological, financial or workplace stressors in combination with relational stressors. While the timeline for these factors was not always clear, they were most commonly described as co-occurring within the space of one to five years, describing a build-up of multiple stressors close in time. These included three categories of stressors: (1) health and psychological stressors; (2) financial and/or workplace stressors; and (3) relationship stressors. For people who described this journey, they did not report challenges occurring in childhood or adolescence as significantly related to their journey towards suicidality.

Health and psychological stressors	Financial and workplace stressors	Relationship stressors
• Mental health problems • AOD problems or a recent change in AOD use • Injury, pain or onset of physical illness	• Unemployment • Workers compensation or workplace injury • Financial distress	• Relationship breakdown • Family-related conflict • Child custody issues

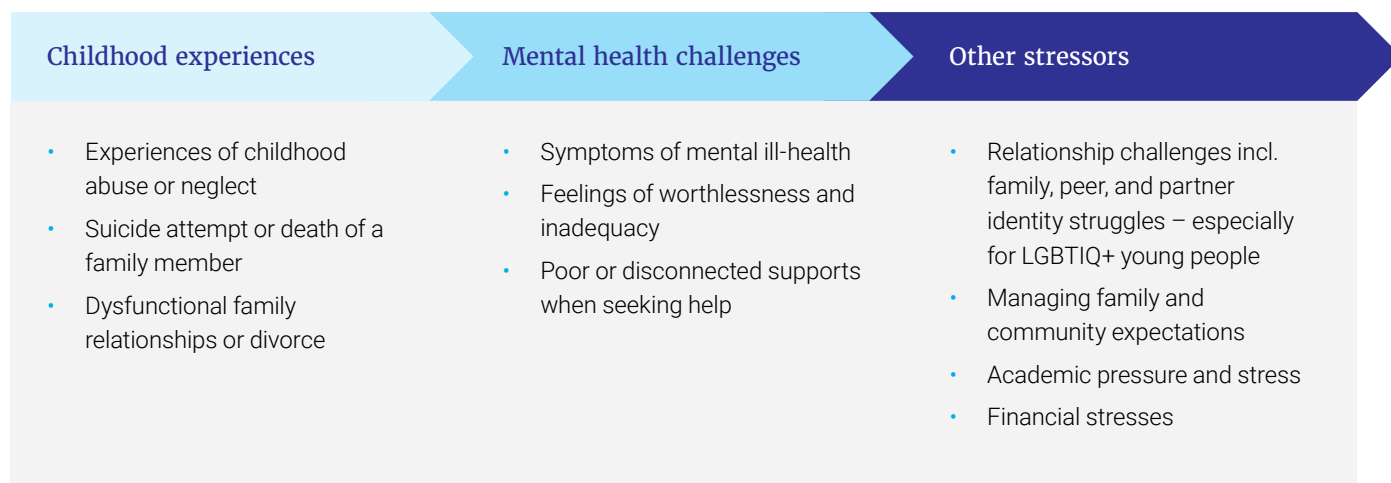
Journey 3: Complex mental illness and disadvantage contributing to suicidal behaviour of young people and adults

For some people, suicidal behaviour was described in the context of complex mental illness and comorbidity in adolescence or early adulthood, ineffective or disconnected treatment at the time followed by social disadvantage and contact with the justice system. This pathway often described poorly treated mental illness as the catalyst for other harms and challenges.

Youth mental illness	Disadvantage in adulthood
• Onset of mental illness, with psychosis and bipolar disorder most commonly described • Comorbid AOD issues • Emergence of self-harm and/or suicide attempt/s	• Justice system contacts in youth and as an adult • Financial insecurity and unemployment • Further suicide attempt/s • Breakdown of family relationships and/or friendships

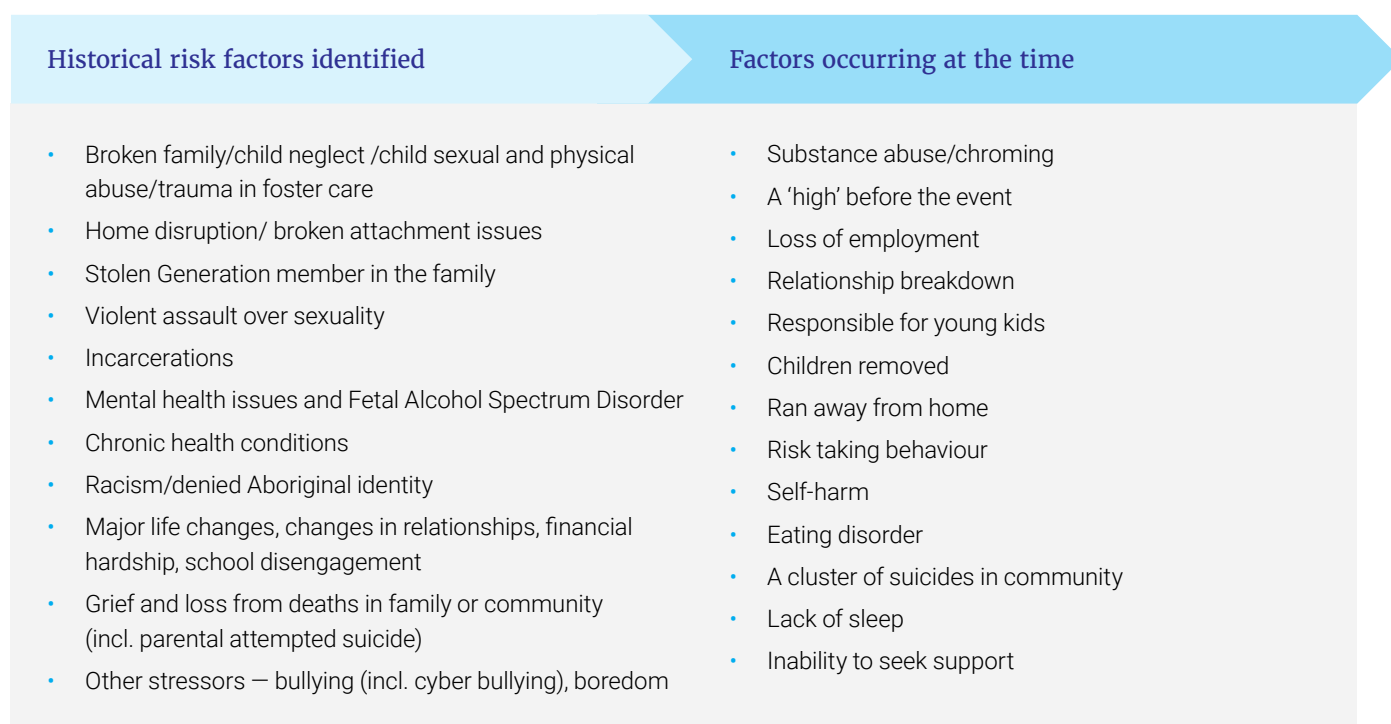
Journey 4: Experiences of young people

A specific consultation with young people was conducted for this research, in addition to experiences shared by young people in the online survey. This revealed that there was a range of diverse factors impacting on young people who had experienced suicidal distress. These often (but not always) included: (1) adverse experiences in childhood; (2) the onset of mental ill-health; and (3) a range of stressors related to identity, relationships, fitting into cultural norms, academic achievement and financial stressors. There are opportunities to intervene early with young people and ensure they receive effective and connected supports when they do actively 'seek help'.



Journey 5: Experiences of Aboriginal and Torres Strait Islander people

Virtual yarning circles with Aboriginal and Torres Strait Islander people identified a number of ongoing and recent stressors prior to suicidal crisis. While there were some similarities with other journeys with multiple stressors across the lifespan, disruptions to family life because of child removal, incarceration, trauma and 'sorry business' were common experiences shared in the yarning circle, leading to increases in disconnection, alcohol and substance use and other risky behaviours close in time to a suicide attempt. Experiences of racism, inequity and limited safe options to seek help were also mentioned.



Journey 6: Experiences of people from a culturally and linguistically diverse background

It is difficult to determine whether there are particular journeys for people from culturally and linguistically diverse backgrounds given the diversity of cultures and experiences and the limited data available. There were some overlaying vulnerabilities identified in the research, but experiences are likely to differ by:

- Age of migration and family structure both overseas and in Australia.
- The type of migration – for example, international education leading to permanent residency, skills and economic migration is a different experience from refugee and humanitarian migration.
- The impact of migration – including the reasons for migration and experiences during migration.
- Service capacity and responsiveness to linguistic and cultural diversity.
- Gender, with specific cultural expectation overlays for women and girls from in terms of their behaviour and cultural conformity.

Stressors reported in childhood and adolescence	Stressors reported as adults	Factors that moderate experiences
• Migration and settlement experiences • Exposure to trauma • Family disruption or conflict • Parental attitudes towards mental illness and suicide • Racism and discrimination	• Relationship conflict and breakdown • Unemployment and underemployment • Financial distress • Ongoing settlement issues • Community attitudes and discrimination	• Age of migration/ generation of migration • Type and impact of migration • Gender – including community expectations • Access to culturally and linguistically appropriate services and supports

Journey 7: Journeys of people who identify as LGBTIQ+

People who identify as LGBTIQ+ in this research reported that suicidal crisis often occurred when adverse childhood experiences, such as physical and sexual abuse, domestic violence and neglect, intersected with experiences of systemic adversity of being a LGBTIQ+ person. This was described as creating feelings of isolation, of being 'different' or 'other', and suppressed sexuality in the context of negative social and family attitudes and responses to their sexuality and identity.

Adverse childhood experiences	Systematic adversity and inequity	Other psychological and social stressors
• Sexual, physical and psychological abuse • Emotional neglect • Exposure to family violence • Close family experiences with mental illness or alcohol problems • Childhood bereavement	• Isolation and loneliness • Feeling 'different' or 'other' – at home, at school, in society • Suppression of sexuality and identity • Negative family and social attitudes • Homophobia, transphobia and heteronormative assumptions	• Onset of mental illness • Alcohol and other drug problems • Exposed to the suicide death of a peer or family member • Financial distress

Journey 8: Experiences of Men

Men who were interviewed in this study, or who responded to the online survey, reported a range of contributing factors across the lifespan. These included: (1) adverse childhood experiences which impacted on their mental health and relationships in adulthood; (2) co-occurring stressors and sudden changes occurring in adulthood, such as loss of employment, relationship breakdown and legal issues; and (3) a range of barriers to services and supports that often led to men trying to manage without any supports.

Adverse childhood experiences

- Experiences of physical, sexual and psychological abuse in childhood
- Exposure to family violence
- Hyper-masculine role models

Acute and co-occurring stressors

- Loneliness and isolation from peers and family
- Loss of identity resulting from relationship breakdown or loss of employment
- Financial distress – sometimes as a result of family breakdown and/or gambling issues
- Relationship breakdown and access to children
- Homelessness and/or housing stress
- Mental illness and AOD problems

Barriers to care and support

- Stoicism and masculinity which can contribute to men 'toughing it out'
- Fear of misdiagnosis or the impact of diagnosis on their life or relationships
- Self-stigma
- Previous negative experiences of seeking help





Factors impacting on caregivers



Lived experience is not just those who attempt suicide, it is those who are affected by it, the constant surveillance... the anger, the guilt, and the grief even when those who [attempt suicide] live.

– Personal story, Caregiver and bereavement study



The previous chapter focused on factors contributing to suicidal distress, from the perspectives of people who have experienced that distress. This chapter focusses on the experiences of caregivers, including people bereaved by suicide, and the factors that have impacted on their journeys and wellbeing. It must be noted, however, that these groups are not mutually exclusive, with 53 per cent of participants in this research reporting caring roles and 72 per cent being bereaved by suicide. Over half of those surveyed (54 per cent) reported having their own suicidal thoughts, while a quarter (28 per cent) had previously attempted suicide.

There is currently very limited information about the impact of suicide attempts on the wellbeing of those close to the person before, during or after the attempt. Available research suggests that the impact of caring for someone through suicidal distress can be profound, with impacts on a person's physical and psychological health, financial distress, changes to work and social activities, and a reported risk of suicidal thoughts and behaviours among caregivers.⁴ However, people providing care for a person experiencing suicidal distress often do not define themselves as 'carers', even though they provide emotional support, practical assistance, personal care and, at times, surveillance-like activities to ensure the person they are caring for stays safe. The intersection of practical up-skilling in suicide first aid, together with emotional support away from the person they care for, was reported as desperately needed.



I think the impact of chronic stress and trauma and hyper vigilance that's required for me a carer is not really recognised, acknowledged or supported on a community level or by health professional[s].

– Personal story, Caregiver and bereavement study



Role ambiguity and changing relationships

This caregiver role was commonly an extension of a pre-existing relationship, but often conversations had not occurred to further define the boundaries of the existing relationship and the caregiver relationship. This could result in role ambiguity, with the caregiver being unsure about when or how to intervene or support someone, leading to feelings of hopelessness, despair and guilt. This role ambiguity appeared to be greatest when the person being supported was a friend rather than a family member or romantic partner. Being a caregiver within a pre-existing relationship also had impacts on the relationship in both the short-term and the long-term, for example children who provided care to parents having to re-learn their role as the child.

Ambiguity around roles and recognising caregivers was reinforced through government services and workplaces. The health and social care system does not generally recognise the care relationship provided to someone who is suicidal as 'formal care'. This can result in people feeling excluded from support, feeling 'invisible' when services are involved, and having limited capacity to seek financial support or take time away from work to provide care.



As a parent of an adult child in stress, you have to take second place, even third as the privacy acts prohibit the carers, and trained professionals, of giving you anything other than general information. This actually creates so much angst, and worry for the parent – I considered ending my own life in the midst of our crisis because I could get no answers on whether my child was going to survive or not.

– Personal story, Caregiver and bereavement study



Caregivers with their own suicidality

Factors that impacted on the caregiver were different for those who reported their own suicidality and those who did not. For those who did disclose their own history of suicidality, their individual experience and the care they provided were sometimes enmeshed – with a merging of personal experiences. This overlapping of personal experiences could be helpful as they too had 'been there' and could empathise with the situation. However, the caregiving role could also resurface feelings of grief and sadness, and trigger suicidal thinking in the caregiver.



...you know, thinking she would die because she was at grave risk of liver failure, I just found myself in a very dark place and I found myself thinking, if she was going to die, I would have to too and I found that appalling because I had two other children you know. That I could actually contemplate that that's what I would do if she didn't live.

– Personal story, Caregiver and bereavement study



Increased stress, distress and vicarious trauma

Repetitive stress was consistent throughout almost all of the stories, with short-term and long-term impacts on people's day-to-day lives. For some this meant a struggle to find the energy for everyday activities and tasks. Caregivers who did not disclose a history of their own suicidality were more likely to report high levels of distress and vicarious trauma from witnessing, or being intimately involved with, another's suicidal distress. People often felt a responsibility to keep the person safe, which could contribute to high levels of anxiety and sometimes a sense of failure if they were not able to do so. When engaging with health and social care support systems, caregivers reflected that a lack of follow up after a service contact left them feeling vulnerable and uncertain about how to keep their loved one safe and supported.



My then girlfriend [harmed herself] whilst in a small toilet cubicle. Long story short, it was... extremely traumatic. I still have flashbacks.

– Personal story, Caregiver and bereavement study



Physical, social and emotional impacts

Caregivers spoke of the impact that the caring role had on their physical health, including sleeping patterns, headaches, pain and an overall reduction in physical fitness. Because of the caregiver role, people often spoke about prioritising the needs and the health of their loved one over their own needs.

The research showed that often care was provided over a long period, through multiple crisis points and suicide attempts, and to multiple people. This can result in cumulative impacts of compassion fatigue and burnout. Caregivers reported higher levels of caregiver burden, psychological distress and suicide ideation than the general population at the time of their loved one's suicide attempt. People also reported financial strains, a change in other relationships and workplace pressures.



My sibling was receiving psychiatric help as well as taking multiple medications. Taking care of them for so long without sufficient support led to my own burnout and subsequent depression.

– Personal story, Caregiver and bereavement study



Stigma and judgement from services and society

Often caregivers felt they were being judged by the health and social care system, not only about the care they provided, but whether they contributed to the suicidality experienced by their loved one. They reported feeling 'scrutinised' for their caring efforts, with their intentions often questioned. This perceived (or actual) judgement undermined their confidence to continue in the caregiver role and negatively affected their self-identity as a carer. It also impacted on their ability to seek help for themselves.



Over ten years I have been absolutely scrutinised, so you do feel like you're being judged and you're not good enough and you don't know if you're being judged as a mother or a carer or both. It's very confusing

– Personal story, Caregiver and bereavement study



Suicide bereavement

It is recognised that the majority of people who are bereaved by suicide may have also been providing care to the person before their death. The research shows the experience of being bereaved by suicide is not only unique from the experience of bereavement by other sudden deaths but is also different from that of being a caregiver to people who are suicidal. People who are bereaved by suicide have poorer physical and social health outcomes than others, in particular partners and parents, with family and social relationships also negatively impacted long-term. Trauma can be experienced directly – for example by being exposed to the suicide scene, and indirectly – through managing the situation subsequently. Feelings of guilt, shame and regret can have a lasting impact, with the broader community response often being to withdraw, leaving people to feel lonely and alienated. Acceptance of loss was made difficult by not being able to understand the reasons why the person died by suicide. Self-blame and a focus on the perceived ‘catalyst’ often filled in the gaps left by this lack of understanding in providing a meaning behind the loss. People indicated there was a lack of appropriate support available at the time of the death and in the long-term, with very few postvention services offering bereavement support in any form.



It is a guilt driven grief for the person who has [died by] suicide. It plays on your mind often. It changes how you view life, how you view relationships and loved ones. It causes you to question many things in life, about yourself.

I have cared for two people who died by suicide. I have some regret that I did not do more and some frustration/surprise at the behaviour of others before and after the death. The lack of discussion and care from colleagues and [the] workplace was not helpful.

– Personal story, Caregiver and bereavement study





Experiences with services



I have attempted suicide several times when events in my life triggered PTSD which is the result of trauma in my childhood. I experienced some extremely negative responses by health professionals treating me, including a nurse who said I deserved to die and a doctor who said to me 'look at how much you're upsetting your mother'... I experienced attitudes that I was attention seeking and a general lack of understanding.

– Personal story, Private Voices



People described experiences of rejection, disempowerment, and invalidation when they interacted with the health system, often discouraging them from seeking help again.

People are often in contact with potential suicide prevention touchpoints before and throughout their journey. If the touchpoints along people's journeys are identified and workforces are skilled to provide support, there are numerous opportunities to assist people before they reach crisis point. Often however, people are required to seek help through disconnected health and community services that are crisis-driven and risk focused. People described feeling "unheard, judged and problematised", with the traumatic and systemic factors that often contribute to suicidal distress rarely acknowledged or understood.



A crisis-driven system with multiple 'drop-off' points

The research described a common and distressing scenario where, precisely when people are highly distressed and in need of a compassionate response, our health system and other related systems provide disjointed care that is lacking in empathy, hard to navigate, or simply not available at all. The unintended consequence of this is that responses can do more harm than good, perpetuating a vicious cycle where individuals in distress can only access support when in crisis – at which point they are judged for not seeking help earlier. This has a significant impact on the person and on their caregivers, who often report feeling 'invisible' and 'unsupported' by the system. These experiences were traumatic and cultivated a distrust in the system and in health professionals – often discouraging people from seeking help again.

In a recent study¹⁸ of people presenting to emergency departments for suicidal crisis, only a quarter reported being willing to return to there for a future crisis. Satisfaction with the care people received while in the emergency department was the strongest predictor of willingness to return and attendance at follow-up appointments. In an Australian data linkage study in 2016, only 41 per cent of people who had been admitted to hospital following a suicide attempt had any contact with a public health service after their discharge at that time.¹⁹

A number of individuals across studies reported being rejected from services as their problems were seen as not being 'serious' enough. Exclusion criteria was used by services or clinicians, impacting on treatment and support, with access to services or continuation of services limited by complicated criteria determining who could receive a service. For example, many young people reported experiencing a 'merry-go-round' journey, where their needs can be deemed too complex or severe for some services, but then cannot access others because they are deemed not severe enough. This was confirmed through the stories of caregivers who often described services only being available at the point of crisis. Caregivers also described the intense worry and panic that could emerge when trying to keep someone safe during the long wait times for services.

Waitlists for both public and private services were identified as a barrier to care, with limited alternatives other than 'one-off' calls to a 24/7 crisis line if needed. This was identified as a challenge with services including headspace, private psychologists, emergency departments, and inpatient admission. Long waiting lists and strict exclusion criteria for accessing supports through the National Disability Insurance Scheme were an additional problem.



I went to the hospital's emergency department and they done an assessment and sent me home. They decided that I wasn't at risk.

My experience at [a mental health service] was completely horrible. During the course of a year I had seen a total of five different psychologists and two different psychiatrists. There was a complete lack of consistency and it made treatment difficult. I felt patronised...

– Personal story, Private Voices study



I look back and think how wrong his treatment was – medicated, brain zapped, psychiatrists. It all just added to his distress and caused more problems. They did nothing to help us, his family, know how to support him.

– Personal story, Private Voices study



Being limited to ten sessions with a Mental Health Care Plan meant that people were often unable to continue treatment aside from receiving 'episodic care' and were often left without support whilst waiting for their sessions to restart. Young people and Aboriginal and Torres Strait Islander people reported significant financial costs to continuing to access regular professional assistance. Participants highlighted lack of coordinated care and case management services for people with mental health, trauma, chronic conditions, co-morbidities, or disability. This was particularly the case in regional and rural areas where there is a lack of both health and social services and long waiting lists for those that are available. People also noted the limited options for seeking help – with too few services operating outside of business hours or with flexible access arrangements.



Shit does not happen on Monday to Friday, it happens at 3 o'clock in the morning.

– Personal story, Aboriginal and Torres Strait Islander Yarning Circle



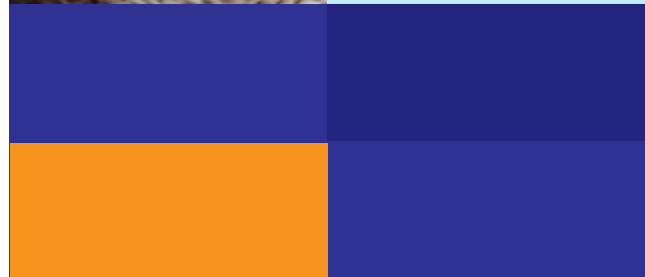
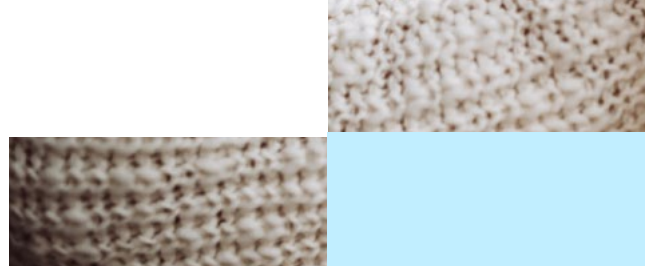
A focus on young people

Formal and informal supports were important in helping a young person recover from suicidality, however, these supports need to be better equipped to identify, manage, and respond to young people in ways that are validating and helpful. Young people's help-seeking journeys were frequently difficult and complex, and contained many 'drop-off' points influenced by service access and care continuation issues. Young people experienced a variety of negative responses where supports were ill-equipped to deal with young people in crisis and responded in ways that were dismissive, invalidating, or judgemental. However, young people also experienced a variety of helpful responses, including supportive, validating, and accepting attitudes, genuine care and empathy, holistic and individualised approaches, and people going out of their way to assist.²⁰



There was no cushion, and there was no assistance, it was just a big old drop-off... there's a lot of drop-off points, that could've made this ten year journey like four years.

– Personal story, youth consultation



Lack of communication, integration of services and follow-up

Poor integration and communication across services was described, leading to individuals having to tell their story multiple times to multiple health care providers, or decisions being made without consulting other appropriate members of a person's health care team, including their caregivers. People also spoke of needing to try and navigate support options on their own. This experience could be isolating and distressing, especially when the referral systems were siloed – attempting to 'treat' just one presenting issue at a time rather than supporting a person as a whole. This meant that often people were not followed-up at all or had to restart their journey and retell their story multiple times.



I was sectioned under the Mental Health Act, but they couldn't find a bed in a psych ward so was released with phone numbers and followed up once or twice, saw my GP a few times, found it really hard to navigate the system and couldn't afford ongoing therapy. So still struggling and still fighting alone.

– Personal story, Private Voices study

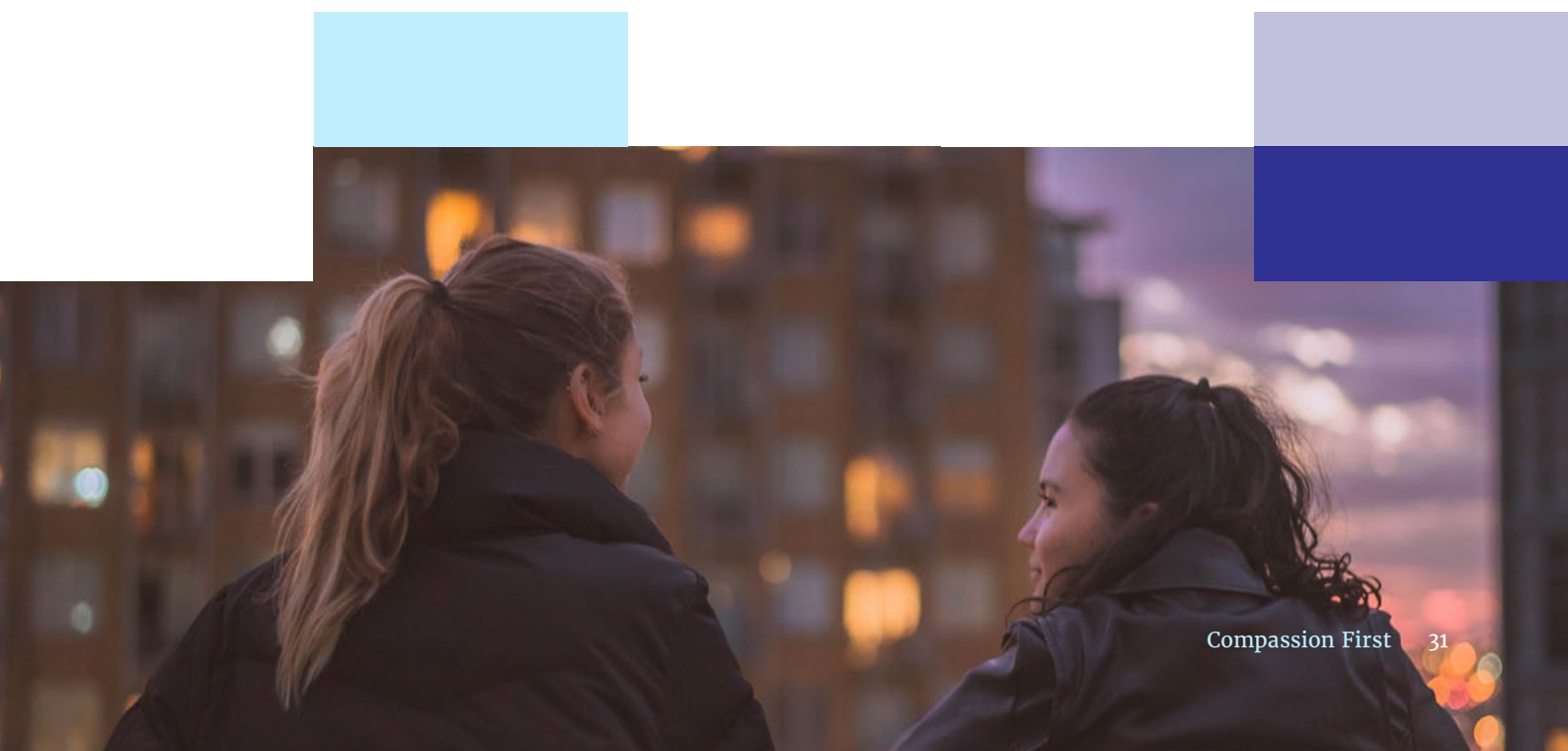


The period following discharge or initial contact with health services was also identified as a critical time for support. Adults and young people admitted to hospital with suicidal ideation or who had a lifetime history of suicidal behaviour reported feeling anxious at the prospect of discharge and how their long term needs would be met. Distress was often caused by overlapping issues that were dealt with by a variety of organisations, frequently with little or no coordination between services. This could include the need for safe housing, responsive mental health support, addressing alcohol and other drug problems as well as support with education, work and finances.



I had my most serious suicide attempt in September of last year. I ended up on a ventilator in ICU. I was also discharged home straight from ICU five days later after I told the psych team there is nothing more they could do for me...if I go into hospital I get a bunch of support only to come out to a follow up call from an acute care team who only ask a bunch of questions and move on to their next call...

– Personal story, Private Voices study



Variable responses about engagement with GPs were provided through the research. Some people talked about their GPs going “above and beyond” to link them to care or following up until they were linked to additional supports. Unfortunately, many others reported experiences of being “rushed through the appointment”, with a lack of compassion and medication provided in the absence of any psychosocial care. For people from a culturally and linguistically diverse background, the GP was critical to accessing services, although they also experienced variable responses and had mixed views about whether it was better or more challenging to see a GP from the same cultural background. In one case this was seen to be extremely beneficial and effective, while in other cases these participants suggested that medical practitioners from the same background could reinforce existing cultural stigma and taboos around mental health and suicidal crisis.



Being told it was a two month wait to see a psychiatrist after feeling suicidal. Went back to GP who rang them back on my behalf and try and get me in earlier. Told nothing available. In the end my GP just had to start ringing around all psychiatrists in the city to find someone who could get me in within a week.

I reluctantly went to see a GP to tell them I needed a mental health treatment plan – it was horrible, I felt vulnerable and alone and rushed out of his office.

– Statement from Lived Experience contributor
at the Black Dog Institute



Many people raised the issue of interventions or therapies being ineffective or unhelpful. Young people particularly experienced poor therapeutic relationships at times, unhelpful techniques, or inappropriate treatments, all of which can lead to disengagement. By contrast, where treatment and counselling was effective, people reported benefits.



Gaps in the system

Limited access for rural communities

Respondents described extremely limited access to health services in regional and rural towns. For example, there may be only one GP, and a GP is a gateway to other services by referral or via mental health care plans. Access to a psychiatrist was often limited to a brief appointment with a visiting psychiatrist once every six weeks. This was particularly problematic for people who did not respond well to the first anti-depressant they were prescribed and needed a medication review. Caregivers of people in rural and remote locations were acutely aware of the limited supports available and the increased access to means, feeling higher levels of worry and responsibility as a result with limited support to keep someone safe.



Challenges of living as a young person in a remote/regional area: limited access to mental health support; job opportunities; costs of relocation and issues with living at home; drug use; loneliness; perceived misunderstanding; burdensomeness; lack of resources; parental capacity to support emotional and financial needs; (and) lack of sense of belonging.

– Personal story, Private Voices study



Lack of aged care services

Some respondents described lack of services for older people experiencing mental health, suicidality and aged care issues. Carer experiences of taking elderly parents to the GP and geriatrician did not result in access to care even when the older person stated they were suicidal. Hospitalisation following a suicide attempt also did not always result in the older person accessing assessment from a geriatric psychiatrist.

Inequity and socio-economic disadvantage

Drawing on survey data, a lack of affordable health services, financial distress, job loss and unemployment as well as class and educational differences between some service providers and service users (especially in rural areas), were all cited as barriers to accessing services. These can be additional factors contributing to suicidal behaviour. The data highlighted the need to consider equity and social justice issues in our service system and address socioeconomic disadvantage, particularly in the current context of recession, wide-scale job losses and financial hardships experienced in rural communities affected by drought, bushfires and the pandemic.

Culturally and linguistically diverse service responsiveness and competency

People from culturally and linguistically diverse backgrounds reported that migration services did not include mental health or wellbeing supports and they were often left to navigate health systems alone. This is a challenge when there is also little understanding within communities of the services and supports that exist.



When I came to Australia...I did not know English, I didn't know anyone. I didn't know any services even existed. I had no contact with any services and organisations.

– Personal story, culturally and linguistically diverse participant



People reported being hesitant to seek help from mainstream health and community services as they felt they would reflect broader community attitudes where people from a culturally and linguistically diverse background were stigmatised. Mainstream services also often lacked the cultural and linguistic capacity to support access and ongoing engagement. There were, however, other challenges described in accessing support from professionals with the same cultural background, as in these environments there could be stigmatising views of mental illness and suicidality. People generally reported better outcomes from services that had the capacity to deal with linguistic and cultural diversity rather than services that were culturally specific.



At 14 my psychologist's response was, 'well, in two years you can move out and live on your own.' This was his response to my ongoing issues with my mother and my deep depressions. He failed to understand that this is not the 'done thing' in my community. He made me feel incompetent.

– Personal story, culturally and linguistically diverse participant

UNDERSTANDING



Family, friends, and caregivers are often left unsupported

The majority of caregivers described feeling 'invisible' to health professionals and the system. More often than not, caregivers were left out of safety planning and discharge planning for their loved one. They were also rarely offered information, practical or emotional supports to manage the impacts of the caregiving role on their own wellbeing.



I think when she turned 18, like they said she's an adult now, we don't have to talk to you and they wouldn't talk to us because she didn't want us to talk to them. And I said to them, well, hang on a sec. You know, we're the ones that's taking her home...you know, once this is all over, like we're going to be looking after her. What do you mean we're...you can't even talk to us? And they said, well you might be part of the problem.

– Personal story, Caregiver and bereavement study



This lack of support for caregivers was expressed across the continuum of care – from caring for someone with suicidal ideation, someone who had made suicide attempts and when a loved one had died by suicide. As discussed in the previous chapter, many of these respondents had experienced their own suicidal ideation or attempt since their loved one's suicide attempt or death.²⁰ Caregivers described a key gap in terms of the limited recognition of the carer role in suicide prevention, which meant there is little financial, practical and respite support available. There is also no training or support available to build their confidence, knowledge and skills in the role as a carer. People bereaved by suicide identified gaps in the supports available to them at the time of the death, and in the longer-term to mitigate the ongoing impacts of suicide bereavement.



They got my lawns mowed right and I got home and I sat in the car in the driveway and I cried tears of joy because that was the first bit of help I'd actually gotten through the whole thing. I know, mow someone's lawn, like who would've thought? You know like... but that's because... it was because that was a message of hey, someone cares and someone knows we're doing it tough and this is all we can do but we're doing all we can do for you. You know and that's what mattered...that's what mattered.

– Personal story, Caregiver and bereavement study



The need for a compassionate workforce

Many individuals described feeling disempowered, dehumanised and traumatised through contact with traditional services. This often started with emergency services personnel and the staff in emergency departments, but these experiences continued throughout the system. This occurred through interactions with staff who did not appear to take them seriously, were dismissive, stigmatising and judgemental, and excluded patients and their friends and family from treatment decisions.

Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds also reported experiences of racism and discrimination. People who identified as LGBTIQ+ reported health professionals referred to them as 'difficult' if they raised issues with a heteronormative culture, needing to constantly educate health professionals on sexuality and identity, even in the midst of their crisis. Many people reported receiving a medical or 'medication only' response, which could lead to secondary problems, further suicidal thoughts or addiction.



The paramedics lectured me about it being a bad decision. It seems anyone involved wants to use guilt tripping as a way to prevent suicide...which doesn't work. I needed validation not guilt trips.

– Personal story, Private Voices study



There were significant experiences of trauma, abuse and disadvantage through the stories of people who had attempted suicide or experienced a suicidal crisis. However, people also reported that current approaches rarely acknowledged underlying trauma and that services were rarely trauma-informed in their approach, sometimes exacerbating distress. Men reported a preference to seek support through local men's groups and peer-based support networks, where they felt safe to be vulnerable. Multi-disciplinary services with specialised staff and peers are needed to support people with more complex, long-term needs, ensuring the diversity of the workforce represents the diversity of the population and the diversity of lived experience.



We tend to get treated like, I would say criminals in a sense sometimes, if people are in crisis. For me, I have been probably quite traumatised...we may be unwell, and we may be not the best person to deal with, but you've got to be patient.

– Personal story, youth consultation



The research suggests that a seismic rather than small shift in approach is required. Survey respondents highlighted the need for more training for general practitioners, hospital staff and medical students so that adequate care is more consistently provided when people in crisis go to hospital or contact a service. Other workforces were mentioned, including alcohol and other drug workers, psychologists, allied health professionals working with people impacted by workplace injuries, and general health services supporting people living with chronic pain. There is also a need to ensure relevant workforces are skilled at working with caregivers and supporting people who have been bereaved by suicide.



I believe that often when we can connect with someone who truly understands, shares experiences — that can.... that can be a catalyst for helping. It can be as simple as listening and understanding a person who is struggling and they could very well to feel more heard from someone who has been there before.

– Personal story, Caregiver and bereavement study



Experiences with other services and agencies

Many people who had experienced a suicidal crisis reported that they would be more likely to speak to a friend, family member or trusted community member before they would access a health service. Aboriginal and Torres Strait Islander people who had experienced a suicidal crisis particularly reported that they were more likely to speak to someone they trusted rather than to a service. These people could include school teachers or university lecturers, as well as staff in specific programs targeted at young people who were disconnected from school.



I was a Master's student and was able to access a wide range of university services which supported me through my studies and recent graduation with a Master's degree. I believe university saved me, it gave me a sense of belonging and achievement.

– Personal story, culturally and linguistically diverse participant



A focus on community

Participants spoke about the general community needing to be more informed about the signs of suicide and how to respond to distress. In this sense, the general community was not described as a barrier per se, but rather as a potential touchpoint that could become more of an enabler if there was stronger awareness and community capacity. Those aware of community gatekeeper training passionately called for this to be more accessible, both to see more community members trained to support people, and also to assist in de-stigmatising suicide. To realise the benefits of a community focus on preventing suicide, we need to recognise that not all communities are the same, and not all attitudes towards mental illness and suicide are universally shared. Hence, any approaches will need to be targeted and nuanced to community needs and attitudes, and work within these contexts.

A range of government and community services could assist

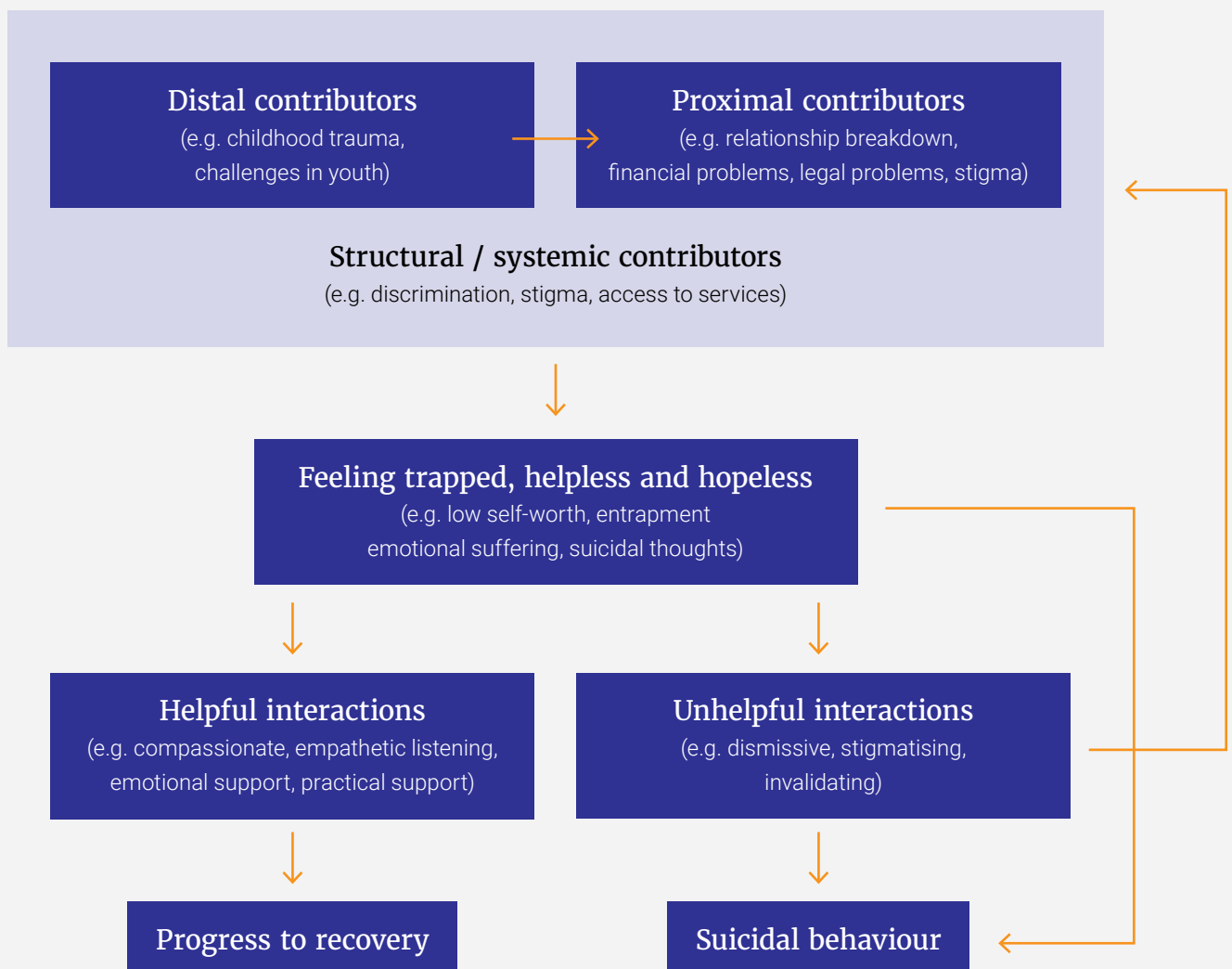
A range of other potential supports and services were identified as potential touchpoints for accessing help, including housing and homelessness services, legal centres and the family law courts, family and community services – including services that support people through domestic and family violence – and a range of financial and other community services. The following is a summary of the places where support was sought or offered outside of health or mental health:

- **Allied health:** Psychology or counselling services for people bereaved by suicide or caring for someone following a suicide attempt. Marriage and relationship counselling services.
- **Aged care services:** Particularly in relation to bereavement, physical illness and isolation.
- **Carer support services:** For caregivers of someone who is suicidal, living with disabilities or mental illness
- **Crisis phone support and online support:** Can be used in combination with other supports or may be the only support.
- **Domestic violence services:** Domestic violence counselling services and crisis support – focused on victims as well as perpetrators and linking people to additional support.
- **Emergency services:** Police and paramedics are often called upon to support people in a crisis.
- **Employers and employment services:** This includes workplace support, Employee Assistance Programs, support following job loss, and workers compensation for workplace injuries.
- **Family and Community Services:** Child protection services, family and community support services, family courts and associated services who are often interacting families during vulnerable times.
- **Financial services:** Banks, credit unions and other financial institutions which can amend practices to support people in distress and connect people to supports.

- **Healing services:** Opportunities for healing practices to be integrated with a range of mainstream and Indigenous services and supports.
- **Men's Sheds and other peer-based supports for men:** To access men who are traditionally not engaged with support services.
- **Not for Profit organisations:** Including NGO based 'after suicide programs' and counselling services provided in community.
- **Personal care:** Hairdressers, beauticians, other personal care providers.
- **Schools and Universities:** Counselling services, school psychologists, teachers, academics and peers, including coordinated responses to suicide attempts and suicide deaths to reduce distress.
- **Youth services:** Youth counselling services, drug and alcohol services, noting that headspace does not operate in all communities.

Helpful responses that shift trajectories

It is critical to understand what helpful and unhelpful responses 'look like' and 'feel like' from a personal perspective. It was clear from many of the responses provided for this research that while background factors interact with life events to produce thoughts about suicide or distress, helpful or unhelpful responses also play an important role in people's trajectories towards suicide.²¹ Suicidal behaviour can be cyclical, so there is a need for helpful interactions each and every time a person experiences distress.



Throughout the research, participants described what they thought would be most helpful:

- **Non-medical 'safe spaces':** An overwhelming number of people spoke of the need for places and spaces where suicide could be freely discussed, and where a fear-based response or crisis driven intervention is not immediately enacted. These are settings where people can build relationships and trust in a 'safe space'.
- **Lived experience-led approaches:** The inclusion of people with lived experiences in the education, programs and support for people increases trust and willingness to talk about suicidal thoughts and behaviours where people may not be willing to do so with others.
- **Community driven approaches that can respond to diversity:** Diversity in suicide prevention approaches is needed so they are responsive to the local social and cultural context that underpins the needs of any community.
- **Options for expanded community care and care-coordination:** With general practitioners stretched across the country and with a preference for community rather than hospital-based care, there is strong interest in alternate models of care that draw in other allied health professionals, peers and community agencies and enable care-coordination across multiple agencies.
- **Long-term, ongoing treatment:** The ability to access ongoing care rather than episodic care was identified as particularly useful as it gives people the ability to develop strong, positive relationships with service providers and address complicated problems. This can prevent the repeated need for crisis responses.
- **Recognition of family, caregivers and those bereaved:** The needs of family, caregivers and those bereaved should be considered in the suicide prevention approach, and proactive supports should be available to these groups, with focus on reducing the long-term impacts of these experiences.





Shifting the lived experience narrative



I believe the experts need to listen to people who have lived it and are still living with it. I have learnt to manage it but I can fall at any time so I have also learnt to know my triggers and seek help before it gets out of control. People with experience can provide essential insight into these situations.



– Personal story, Private Voices study, UNE

There is a need to shift the lived experience voice from 'anecdote' to essential input in the design and delivery of suicide prevention.

There has been an increasing acknowledgement about the role of lived experience in suicide prevention, with a range of Australian organisations now funded to support and upskill people with various lived experiences of suicide to share their knowledge. There have also been attempts to increase the diversity of those voices. This research, however, highlights the need for an acceleration of that work. It points to the need for a serious shift in the public representation and narrative around suicide – including who it affects, how it is best responded to and transparency about the shortcomings of the current system. That shift must then be reflected in changes to the system, earlier and more comprehensive intervention at times of distress, and a community wide understanding of the need for compassion and care.

Public voices: shifting from anecdote to expert

Analysis of the Public Voices research²² highlighted that while there was an increase in people with lived experience being included in public and media narratives about suicide, they were often positioned as providing the 'anecdote' or 'story' that was followed up by an expert or medical point of view. An analysis of print media stories highlighted that stories about suicide and suicide prevention were dominated by the voices of medical professionals and service providers. They were often called on to share their interpretation of suicide on behalf of others, including people with lived experience.

Statistics and reports were often used as a vehicle to discuss suicide, with limited inclusion of lived experience. Where lived experience was included, it was more likely to feature those bereaved by suicide – usually mothers – rather than those with direct experience of suicidality. This is despite the fact that research suggests the stories of people who have lived through or overcome a suicidal crisis are more likely to reduce stigma and reduce suicidal behaviour particularly when those stories reflect a diverse range of backgrounds and experiences. Stories focused on suicide deaths, including stories presenting facts and figures and expert voices, have been associated with increases in suicidal behaviour.²³

The lack of first-person accounts and the focus on professional voices has the potential to further isolate those living with suicidal thoughts. Indeed, analysis of social media accounts used by people with a lived experience of suicidality revealed that many felt frustrated, angry and distressed that the professional voice was 'privileged' and that the lived experience voice is not being heard. There were also some concerns shared that their experiences of suicidal crisis, what helped and what did not help, was different from the views shared by those who have been bereaved by suicide, often preferred in media reports. When media formats such as podcasts were used to explore suicidality, the complexities of the issue were more likely to be identified and discussed. This included an exploration of workplace factors, mental ill-health, childhood abuse and adversity, men's experiences, domestic violence, relationship breakdown, economic hardship and the experiences of particular population groups, including those who experienced migration challenges. These formats were also more likely to include those with direct experience of suicidality. This was in stark contrast to the brevity of stories and the lack of diversity noted through mainstream media stories.

Diversity in lived experience

While not fully explored through this research, there is a diversity of views and experiences among those with lived experience. This includes those bereaved by suicide, those caring for and supporting someone through suicidal distress, those who have attempted suicide and those who live with suicidal thoughts. Suicide prevention in Australia, and globally, owes much to people bereaved by suicide, who have often spear-headed community action, lead advocacy campaigns and called for service improvements. Their experiences are critical and should continue to be used to inform our suicide prevention activities – particularly in relation to bereavement support and postvention.

There is also a need to now elevate the voices of those who have directly experienced a suicidal crisis and those that have accessed, or have tried to access, services and supports through the current system. Their voices must be heard if we are to rebuild trust, break down stigma and discrimination and design suicide prevention services and approaches that genuinely meet people's needs. While each person's journey and story is unique, their collective experience tells us much about what needs to shift. It will be critical to enhance the voice of young people, of Aboriginal and Torres Strait Islander people, of LGBTIQ+ people, of men and of other diverse groups with lived experience. This will also require a deeper understanding of the different types of lived experience and the insights that each can bring.



*I think the role of consumers and carers with lived experience of suicide is a historically overlooked and under recognised essential component for effective suicide prevention. Lived experience of suicide can be greatly enhanced by **listening** to the voice, needs and experiences of those with firsthand experience. I believe without this inclusion, understanding and suicide prevention is starkly incomplete.*

– Caregiver story, Private Voices study



Sharing as healing

Historically, suicide prevention research has been dominated by biomedical framings of the issues and research methodologies that exclude people with lived experience. Often this is done by positioning them paternalistically as people with impaired decision making or who are too high-risk to participate. Studies which have examined the motivations of people with lived experience to participate in research show that “sharing without censure” is the primary reason for participation. The opportunity to tell one's story anonymously is a rare opportunity to speak and feel heard.²⁴ Other primary reasons are to help others through expanding the knowledge base about suicide prevention, and a desire to change services so that others can have a better experience.²⁵

This was highlighted through the Aboriginal Lived Experience Yarning Circle where people felt their participation in the gathering was healing in itself. They felt it gave voice to those who cannot be heard. Some felt that by talking about this subject, younger people coming up in their communities would feel more able to discuss it. In the written feedback given by participants, many said that they felt reaffirmed that they were not alone and that there were others sharing similar stories. They indicated that they felt culturally and spiritually safe and respected in the space, with some stating that they felt empowered and uplifted at the conclusion of the session.



I personally feel privileged to have been in this circle, it was good to be able to talk about... suicide in a culturally, spiritually, safe and caring environment. I thought the debriefing session was really good and as we know the debriefing is one of the most important things for participating members and leaders in a session like this one.

– Aboriginal and Torres Strait Islander Yarning Circle





Opportunities for change

Personal accounts of over 3,000 people and analysis of public narratives have identified a range of opportunities to better understand the factors contributing to suicidal distress and suicidal behaviour and what is needed to deliver a comprehensive and compassion-first approach to suicide prevention.

Opportunity 1:

Prioritise and integrate lived experience knowledge and expertise into the planning and delivery of whole of government suicide prevention action

If systems and services are to truly meet the needs of people experiencing suicidal distress and suicide attempts, and the needs of those who care for them, they require active involvement of lived experience at all stages. This includes involvement through research that aims to build the evidence base, government policy and program planning, service design and delivery and evaluation. This capacity should continue to be developed within health as well as cross-portfolio agencies. It is also critical to have a diversity of lived experience represented. This means designing services, programs and priorities in collaboration with young people, men, Aboriginal and Torres Strait Islander people, LGBTIQ+ people (including Indigenous LGBTIQ+), people from culturally and linguistically diverse backgrounds, older people and all other groups that experience suicidal distress.

- Lived experience should be central to designing outcome measures for suicide prevention services and programs, ensuring that outcomes are focused on individuals and their caregivers.
- Further research focused on lived experience journey mapping should be conducted, with a focus on better understanding opportunities to support groups that are more vulnerable to suicide.²⁶
- Enhanced national work to advocate a more balanced use of lived experience narratives and the positioning of those with lived experience as experts.

Opportunity 2:

Intervene early in life to mitigate the impacts of abuse, and build capability across workforces to deliver trauma-informed care

Adverse childhood experiences were highlighted as the start of a journey of poor mental health, unstable or violent relationships, and social isolation and suicide attempts for many people. A greater focus on intervening early to mitigate the impacts of abuse, adversity and trauma is required, with opportunities for targeted approaches. Given the circumstances surrounding the entry of children into the out-of-home care system, a targeted approach to children in care is also required. This should be supported by action to build the capability of diverse workforces so that they are able to provide trauma-informed care across the lifespan. This recognises the impact that childhood and other trauma can have on suicidal distress.

Opportunity 3:

Deliver effective interventions and support options that are co-designed with young people to mitigate the impacts of co-occurring psychological, identity and relational stressors

Up to 75 per cent of mental health and drug and alcohol challenges emerge during adolescence, with young people highlighting the need for better coordinated and connected supports. Opportunities exist to design approaches with young people, considering the opportunities for prevention and early support through schools and universities, youth services and health services, and well as using digital services. Continued coordination and access to youth mental health services and peer-led models of support are required.

Opportunity 4:

Use all available government and community services to provide outreach and support to people at the point of distress

Stories of people who attempted suicide revealed there were usually a range of co-occurring stressors that occurred close in time to an attempt. Particular attention needs to be paid where these stressors involve conflict or disconnection from supports in combination with increases in risky behaviours such as alcohol and/or drug use. This may include outreach and targeted supports for people who are involved in family disputes, legal action, child custody arrangements, workplace disputes or workers compensation claims. Peer-support models and connection to face-to-face and digital services and screening may all be beneficial. This includes earlier and proactive responses to distress that meet people 'where they are' rather than requiring them to seek help in a crisis. It also provides an opportunity for targeted outreach and support at critical points of disconnection (from school, from work, from family), and transition (from justice settings and from certain workplaces such as the Australian Defence Force).

Opportunity 5:

Invest in, further develop and scale community-based and compassionate services and supports to ensure that people who do seek help in suicidal distress get the support that they need

Many people identified ineffective care as a contributing factor to future suicide attempts, with a particular concern that services and supports were not trauma-informed or compassionate. The following were suggested throughout the research.

- i. **New community-based service models that align with a compassionate response – including 'safe spaces' and peer-led services.**

There is a need to accelerate delivery of new service models that use non-hospital peer-led approaches. People in crisis often experience barriers to accessing care or receive sporadic, inconsistent care. Funding for a variety of services that complement and integrate with traditional services will ensure that individuals have a constant source of support in a compassionate environment. These models of care need to consider the needs of the caregivers and provide referral pathways to caregiver support services. This also requires training and development of a peer workforce to support these service models

- ii. **Improved health service responses – especially through emergency departments.**

While new service models are progressed, there needs to be immediate action to improve health service responses through a review of emergency department procedures, workforce development for all health and emergency services workers and better supports for families and caregivers.

- iii. **Service models that support psychosocial needs, care-coordination and ongoing follow up – including broad access to aftercare.**

People who experience a suicidal crisis often require a range of services. Unfortunately, this is a time when people are often left to navigate several complex and difficult systems on their own – for example, disability support, income support, housing services and health services. Care coordination is generally carried out by aftercare services, but this is often restricted to people who have already made a suicide attempt. Because of the siloed nature of care, there is often little accountability for ensuring continuity of care within and across services. The role of care coordination is critical and should be resourced to better assist people.

- iv. **Safe and culturally appropriate services for all people**

Equitable access to health and welfare services for Australia's diverse population is key to preventing suicide. This includes upskilling workers to ensure that they are culturally and linguistically capable, and expanding the diversity in hiring of staff. Where there are language barriers, translators should be made available. Detailed information should be provided online and in person about staff and available services – for example, languages spoken and training undertaken by staff. Clear statements of support for vulnerable populations such as LGBTIQ+ people, Aboriginal and/or Torres Strait Islander people and people from culturally and linguistically diverse backgrounds can also help create a safe and welcoming environment.

Opportunity 6:

Provide immediate and ongoing practical and emotional support for caregivers, many of whom experience suicidal thinking themselves

There is a clear lack of support for chosen caregivers, as outlined through the research. This was expressed across the continuum of care from caring for someone with suicide ideation, someone who had made suicide attempts and someone who had died by suicide. The role of caregivers and their needs should be recognised and proactively supported, so that carers can be: included in safety and treatment planning; provided financial, practical and social support; and supported to develop skills that will assist them to care for their loved one.

Opportunity 7:

Better coordinate timely bereavement and postvention supports for individuals and communities exposed to the suicidal behavior of others

Exposure to suicidal behaviour was reported frequently and needs to be considered as a point of distress for individuals and communities. Support to those bereaved by suicide should be proactive and coordinated. While bereavement support and postvention approaches for schools and communities has been progressed to some degree in Australia, further attention is required. The approach needs to be tailored and targeted to:

- particular ages, with a focus on children and young people,
- particular communities, with a continued focus on Aboriginal and Torres Strait Islander communities; and,
- workforces exposed to suicide, such as emergency services and occupations with high suicide rates.

Opportunity 8:

Develop and support the broad range of workforces involved directly and indirectly in suicide prevention to respond with compassion to underlying distress

There is a pressing need to develop and support the broad range of workforces involved in suicide prevention. Currently, health and other related professionals are required to complete separate training in overlapping areas such as, suicidality, domestic violence and substance use. Each of these areas require the same capacity for active listening, empathy, and compassionate care. Newer models of suicide prevention training emphasise the importance of a collaborative and therapeutic relationship. Training packages selected for delivery to health and other workforces should have compassionate responses as a stated foundation, be evidence based from the perspective of people accessing services, and have a focus on risk formulation and safety planning over risk identification and risk management. This should be supported by a review of policies, procedures and referral pathways across health and other government and community services.

Opportunity 9:

Provide a more comprehensive approach to suicide prevention that addresses the multiple impacts of alcohol and other drug use on suicidal behaviour

People with lived experience revealed that alcohol and other drugs had an impact across multiple points in their journeys. Many adverse experiences in childhood were described in the context of parental challenges with alcohol or substance misuse and many people reported their own alcohol and other drug use issues. A recent change in alcohol use was reported in the context of co-occurring life stressors such as relationship breakdown or job loss, particularly among men. There are opportunities for population level interventions to reduce access to alcohol across the life course, to intervene early with young people to change attitudes to alcohol and to ensure effective and early treatment through screening for alcohol use at key points of distress.

Opportunity 10:

Implement population-level interventions that address key social and economic stressors that impact on people's lives

Many of the contributing factors to suicidal distress identified through this research are beyond the remit of the health system and are aligned with the social determinants of health and wellbeing. This includes factors such as social isolation, discrimination and economic stress. There is good evidence that non-health policies, especially when consistently implemented, can have an impact on suicidal behaviour. A whole of government approach to suicide prevention must be adopted through consideration of the policy settings likely to contribute to a reduction in population risk. This will be supported by continuous monitoring and evaluation of initiatives, improving data collection and measurement to inform policy responses, and paying continual attention to emerging pressures that affect households, localities and communities.





Acknowledgements and references

Acknowledgements

The National Suicide Prevention Adviser and Taskforce would like to acknowledge Suicide Prevention Australia, the Commonwealth Department of Health and all of the individual researchers who contributed to commissioned research informing this report:

- Professor Myfanwy Maple, Dr Sarah Wayland, Dr Sacha Kendall, Ms Phuong Hua, Ms Tania Pearce, Mr Jackson Newberry-Dupe, Dr Dorothy Ratnarajah, Dr Lesley Douglas, Mr Andrew McMahon, Dr Katie McGill, and Associate Professor Navjot Bhullar (research lead by University of New England)
- Nicole Tujague, Kelleigh Ryan, Leilani Darwin, Tiarnee Schafer, Nathan Meteoro, Nicole Bloomfield, Catherine Carroll, Bonnie Love, Aunty Barbara Hubbert, Linda Medlin, Byanka Bilston, Roy Alick (research lead by the Aboriginal and Torres Strait Islander Lived Experience Centre)
- Dr Katherine Mok, Jo Riley, Hannah Rosebrock, Nyree Gale, Dr Ally Nicolopoulos, Dr Mark Larsen, Dr Susanne Armstrong, Cassandra Heffernan, George Laggis, Dr Michelle Torok and Dr Fiona Shand (research lead by Black Dog Institute)
- Associate Professor Jo Robinson, India Bellairs-Walsh, Pinar Thorn, Dr Louise La Sala, and Alexandra Boland (research lead by Orygen)
- Pino Migliorino AM and Lena Etuk (research lead by Cultural & Indigenous Research Centre Australia)
- Dragan Zan Wright (research led by LGBTI Health Alliance)
- Shravankumar Guntuku and Neil Hall (research conducted by Western Sydney University and the Australian Men's Health Foundation)
- Lifeline and SANE Australia for allowing access to prior research studies analysed by the University of New England.



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