

“They can only talk
themselves out of it
if they’re talking”

A report prepared for the National Suicide Prevention Advisor
and National Suicide Prevention Taskforce

June 2020

The logo for the University of New England (UNE) is located in the bottom right corner. It consists of a black square containing the letters 'une' in a stylized, lowercase, light green font. Below the 'une' text, the words 'University of' and 'New England' are stacked in a smaller, white, sans-serif font.

une
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Authors

This report was led by:

Professor Myfanwy Maple, PhD

Project Team:

Dr Sarah Wayland, Dr Sacha Kendall, Ms Phuong Hua, Ms Tania Pearce, Mr Jackson Newberry-Dupe, Dr Dorothy Ratnarajah and Dr Lesley Douglas

School of Health

Faculty of Medicine and Health

University of New England

Armidale NSW Australia

Funding

The National Suicide Prevention Research Fund commissioned this work to deliver on behalf of the National Suicide Prevention Advisor

Suggested Citation

Maple, M., Wayland, S., Kendall, S., Hua, P., Pearce, T., Newberry-Dupe, J., Ratnarajah, D. & Douglas, L. *'They can only talk themselves out of it if they're talking.'* A Report for the National Suicide Prevention Advisor and Suicide Prevention Taskforce. University of New England. June 2020.

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Glossary

Anorexia Nervosa	An eating disorder characterised by a distorted body image with an unwarranted fear of being overweight
Autism spectrum disorder	A serious developmental disorder that impairs the ability to communicate and interact
Attention-Deficit/Hyperactivity Disorder	A chronic condition including attention difficulty, hyperactivity and impulsiveness
Autonomy	Ability to make decisions concerning one's own life
Beneficence	Moral obligation to act for the benefit of others
Bereavement	A response to the loss of someone to which a bond or affection was formed
Biomedical	A model that diagnoses a disease based on empirical data that has been collected
Bipolar disorder	A disorder associated with episodes of mood swings ranging from depressive lows to manic highs
Borderline personality disorder	A mental disorder characterised by unstable moods, behaviour and relationships
Burnout	A state of emotional, physical and mental exhaustion caused by excessive or prolonged stress
Capacity building	Process by which individuals and organisations obtain, improve and maintain the skills and knowledge needed to perform their jobs competently
Chronic fatigue	A disease characterised by profound fatigue, sleep abnormalities, pain and other symptoms that are made worse by exertion
Climate change anxiety	Fears about the current and predicted future state of the environment caused by human-induced climate change
Commentary	Type of publication that contains a detailed analysis of an article, story or passage of text
Comorbidity	The presence of one or more additional diseases or disorders that co-occur with a primary disease or disorder
Coronavirus	An infectious disease caused by a newly discovered coronavirus
Coroner	Government official who conducts or orders an inquest into the manner or cause of death and to confirm the identity of an unknown person who has been found dead within the coroner's jurisdiction
Cumulative/compounding distress	Repeated exposure to psychological distress which can lead to adverse health outcomes
Critical perspective	Approach to research that is based on the belief of empirical testability

Data modelling	Process of creating a data model for an information system or database
Duty of care	A moral and/or legal obligation to oversee the safety and wellbeing of others
Emotion dysregulation	Inability of a person to control or regulate emotional responses
Exposure to suicide	Knowing and/or identifying with someone who has died by suicide
Epistemological	Relating to a branch of philosophy concerned with knowledge, justification and rationality of belief
Focus group	Small and demographically diverse group of people whose perceptions, opinions, beliefs and attitudes are studied – often used in qualitative studies
Gatekeeper training	Training that teaches specific groups of people to identify people at high risk for suicide and then to refer those people for treatment.
Heterogeneous group	Referring to groups with a degree of similarity
Holistic	Characterised by the treatment of the whole person, taking into account biopsychosocial factors, rather than the separate symptoms of a disease
Intergenerational	Involving members of several generations
Inter-subjective	Psychological relations between people
Lived experience	People with lived experience are individuals who have experienced a suicide attempt, suicidal thoughts and feelings, or a suicide loss (as defined by the US-based Suicide Prevention Resource Center)
Motor neurone disease	A neurodegenerative disease that causes rapidly progressive muscle weakness
Narrative methodology	An interpretive approach in the social sciences involve storytelling
Non-maleficence	Inflicting the least harm possible to reach a beneficial outcome
Ostracism	Exclusion from a society or group
Paradigm	Distinct set of concepts or thought patterns, including theories and research methods
Pathology	Study of the causes and effects of a disease or injury
Person-centred care	Model of care where the patients are actively involved in their own medical treatment in alliance with health professionals
Positivistic research methods	Research methods with the underlying view that only factual knowledge gained through observation and measurement is reliable
Post-traumatic stress disorder	A disorder characterised by failure to recover after experiencing or witnessing a terrifying event
Postvention	Activities which reduce risk and promote healing after a suicide death

Private sector	Part of the economy owned by private individuals or groups for profit
Psychoeducation	Education that allows a person to better understand their health condition
Psychometric scales	Comprises multiple items measuring the same variable in a reliable and valid manner to yield parametric data
Public health	In this report, the authors use the term public health, in a context of suicide prevention, to refer to the efforts made by society (including the general population, and the health systems that respond to people) as a way to protect, promote and restore people's mental health and emotional wellbeing.
Public sector	Part of the economy composed of public services and enterprises
Qualitative studies	Research that gains insight and understanding of phenomena through intensive collection of narrative data
Quantitative studies	Research that seeks to explain, predict or control phenomena through the collection of numerical data
Resilience	Process of negotiating, managing and adapting to significant sources of stress or trauma
Schizophrenia	A disorder that affects a person's ability to think, feel and behave clearly
Self-harm	The deliberate taking of one's life or self-injurious behaviour
Silo approach	Attitude characterised by reluctance to share information with other members within a group
Social-constructivist sociological perspective	Sociological theory that views knowledge as created by the interactions of individuals within a society
Stigma	Discrimination based on social characteristics that distinguish individuals from other members of a society
Stoicism	Philosophy relating to endurance of pain or hardship
Suicide ideation	A range of thoughts and/or plans that centre upon suicide
Suicide attempt	Occurs when an individual deliberately causes harm to him or herself with at least some intent to die (this also includes self-inflicted poisoning or injury-suicide attempted, as defined by the ICD-10)
Touchpoint	Any way an individual can interact with an organisation or service
Universal	Universal programs are those that offer interventions designed to reach an entire population

Abbreviations

ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ADHD	Attention-Deficit/Hyperactivity Disorder
ASD	Autism Spectrum Disorder
ASIST	Applied Intervention Skills Training
ATSI	Aboriginal and Torres Strait Islander
BPD	Borderline Personality Disorder
CALD	Culturally and Linguistically Diverse
CAMHS	Child and adolescent mental health
CATT	Crisis Assessment and Treatment Team
CBT	Cognitive Behavioural Therapy
CIU	Crime Investigation Unit
CPR	Cardiopulmonary resuscitation
C-PTSD	Complex Posttraumatic Stress Disorder
CTO	Chief Technology Officer
COVID-19	Coronavirus
ED	Emergency Department
GP	General Practitioner
H2H	Home to Home system
INQ-15	Interpersonal Needs Questionnaire
ICU	Intensive Care Unit
LIFE	Living for Everyone (framework)
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex and queer
NDIS	National Disability Insurance Scheme
NITV	National Indigenous Television
NMHC	National Mental Health Commission
NSW	New South Wales
PHQ-9	Patient Health Questionnaire
PTSD	Posttraumatic stress disorder
RAS	Resilience Appraisal Scale
RCVMHS	Royal Agricultural Society of New South Wales
SBS	Small Business Server
SIDAS	Suicide Ideation Attributes Scale
SOSA	Survivors of Suicide Attempt
SRCS	Suicide Related Coping Scale
SPA	Suicide Prevention Australia
WHO	World Health Organization
WSPD	World Suicide Prevention Day

Executive Summary

Background and purpose

Suicide remains a public health priority in Australia. In 2018, 3046 Australians ended their own life (ABS, 2019). Reflections as to why people die by suicide often remains speculative, however are always a result of complex challenges that overwhelmed the person until such time as they were unable to find any solutions other than suicide; 80% die with comorbidity, with mood disorders being the most common (ABS, 2019). Some vulnerable or marginalised groups have multiple and overlapping challenges and this is where higher rates of suicide occur, notably, among young people, Aboriginal and Torres Strait Islander people and older adults. Male's die by suicide three times more often than women (ABS, 2019).

The result of each of these individuals dying is thought to be 135 others impacted (Cerel et al., 2019), and this impact of exposure to suicide is thought to be long-standing and can result in a myriad of physical and mental health challenges including those exposed to suicide being more likely to go on and die by suicide. This has been found among kin (Pitman et al., 2014) and non-kin (Maple et al., 2017). Over 3000 lives being lost to suicide each year demonstrates an unacceptable level of suffering in the community.

In addition to the impact of exposure, awareness as to the scope and impact of how many Australians attempt suicide each year, is limited to those medically serious enough to be reported through hospital admission, but are thought to be significantly higher, with predictions of 65,300 suicide attempts each year (Lifeline, 2020). For every death by suicide, it is estimated that as many as 30 people attempt to end their lives (Lifeline, 2020). Those who live with passing or persistent, suicidal ideation in the Australian community is unknown. The journey of living with suicidal thoughts and attempts is poorly researched.

The World Health Organisation report 'Preventing Suicide: A Global Imperative' (2014) highlights the need for systematic, multisectoral national responses to suicide. In Australia, policy initiatives, include the 'Living is for Everyone' (LIFE) framework underpinning suicide prevention activities since 2007 have been based upon Mrazek and Haggerty's (1994) model for health interventions. Primarily, the focus is on universal, selective and indicated interventions, where those who are at most risk are the focus of the highest level of care. Such a model inherently requires identification of risk factors, and these are most often described within a medical model, specifically in psychiatric or psychological frameworks.

With rapid increase in government and private investment in suicide prevention in Australia in recent years, many new initiatives at whole of community levels through to indicated and post-attempt support have been established and are in design and delivery phases at the present time. Many have robust evaluation, or indeed are research trials, which will add

significantly to the evidence base on what works to prevent suicide. Within this, there has been a steady rise of the importance of those with lived experience of suicide informing suicide prevention, intervention and postvention programs. In Australia, the term 'Lived Experience of Suicide' broadly refers to those who have survived their own suicide attempt, been bereaved by the death of someone who died by suicide or supported someone who was/is suicidal. Organisations such as Suicide Prevention Australia, Black Dog Institute and Beyond Blue have developed definitions, guidelines and principles so that inclusion of Lived Experience voice is done safely. This is a sound achievement by a small number of dedicated champions who have campaigned tirelessly to have lived experience included in suicide related programs, policies and research.

This report utilises three strategies to extend the diversity of voices discussing insights into suicide well beyond those who are already dedicated to sharing their experience to inform the direction of suicide prevention and support in Australia. Utilising these strategies, we explored;

- [Report 1: Public Voices](#): *How suicide is portrayed in the public domain*, through unidirectional formats (including traditional formats such as media and books) and through self-published and often multi-directional formats (including Facebook, Twitter and podcasts).
- [Report 2: Private Voices](#): *How suicide is experienced in private domains*, through an open-ended, open format online survey. In this survey, we simply asked people to tell us about what suicide and lived experience of suicide means to them. The survey offers the opportunity to express these experiences in a completely anonymous fashion.
- [Report 3: Empowered Voices](#): *How suicide is understood in supported environments* by re-analysing suicide attempt survivors who have completed a psycho-educational support group offered by Lifeline centres in New South Wales.

This report provides the findings of each of these studies. Importantly, we view these data through a structural, systems lens whereby positions of power are considered. This is important as suicide is silenced (Batterham et al, 2013) and results in people being stigmatised, disempowered and often unheard in relation to their experiences, needs, care and treatment and life courses perspectives.

Understanding suicide through a structural, systems lens

Given the focus of this report on understanding the lived experience of suicide as a way of promoting integration of first-hand experience into national suicide prevention strategies, it is relevant to consider a number of factors. The relationship between power and knowledge, in determining how suicide is publicly understood and represented, allows for the authentic exploration of first-hand narratives of people with lived experience particularly their descriptions of contact with decision-makers. In addition, this lens challenges systems to identify how this approach can be harnessed to de-stigmatise suicide. This in turn has scope to promote better health outcomes for those who experience suicidal thoughts and behaviours or are exposed to them.

Critical social theory points to the importance of looking at the construction of knowledge in relation to power and the knowledge that is excluded, as well as how dominant paradigms can sustain inequity through the production of 'evidence' that inherently denies or marginalises alternative points of view (Habermas, 1984). Reflecting on this power and knowledge, it is important to conceptualise that the role of health promotion strategies and the dissemination of information is often controlled by those who are appointed or self-appoint as an expert voice. Yet, whether experts acknowledge in the process of dissemination, the limitations of their expertise or alternate versions of the truth, is at their discretion. Because experts can create and sustain self-explanatory knowledge vacuums on their subject area, there is an imperative to examine the role of power in the construction of knowledge and discourse (Foucault 1980). This is an important step in the critical analysis of suicide prevention narratives given what is at stake has direct consequences for the lives of others. In addition, examination of the role of power is important when the dominant discourse of a subject has been shown to be marginalising, oppressive or stigmatising of the community and the expert voices make a claim to have complete understanding about a complex social issue.

The report offers insight into the role and complexity of public and private voices in suicide prevention in Australia. In reviewing the literature, we know that inclusion of service users in the broad field of mental health is not new (Filia et al., 2018). In the case of suicide prevention, the voices of people with lived experience have increasingly been at the fore of advocacy and awareness raising in addition to inclusion on committees and health promotion initiatives (Suomi et al., n.d.). The opportunity thus exists for the perspectives of people with lived experience of suicide to challenge dominant discourses that have heretofore now have been marginalising. Success, however, is dependent on whether those with the current authority are willing to genuinely confer expert status to the knowledge of this group.

Through the analysis conducted for *Report 1: Public Voices* identified that while people with lived experience are often included in media – following MindFrame media guidelines

(Skehan et al, 2006) – their story is most often positioned before that of psychiatrists or medical professionals, academics or people working in suicide prevention. Oftentimes, such portrayals followed similar patterns, with suicide-bereaved mothers expressing their distress at the loss of their offspring to suicide, while those in authority campaign for higher funding for the suicide prevention sector. Perhaps unintentionally, this creates an ‘anecdotal versus expert evidence’ dichotomy with the latter receiving the powerful, final authoritative word. This is in contrast to when individuals provide their own narrative, through other public arenas, including narrative non-fiction, podcasts, Twitter and Facebook. Interestingly though, in the bi-directional, social media publications, this dichotomy becomes more evident and can provide insight into the distress, and anger, that simmer when individuals do not feel their voice is being heard.

In *Report 2: Private Voices* people with lived experience were asked to respond to an anonymous survey. Here individuals’ stories are testament to incredible resilience in the face of traumatic events that shape lives from early childhood through the lifespan, mental ill-health and illness, and pervasive systemic inequity. In this context, encounters with public systems were often characterised by interactions where they reported being unheard, judged, and problematised. The traumatic and systemic factors that often contribute to suicide were rarely acknowledged. The unintended consequence of this is an individualistic, deficit approach to providing services to people with lived experience of suicide. From the point of view of service users, it was evident that this translates into ‘risk-managing’ someone rather than providing compassionate care. Individuals described experiences of rejection, disempowerment, invalidation and delegitimization of their worthiness of care when they interacted with the health system. These experiences were traumatic and constituted a health care barrier by further stigmatising a serious health issue, cultivating distrust of the system and health professionals, and sometimes discouraging people to seek help again.

Report 3: Empowered voices explores the inclusion of experiences of individuals who have participated in Lifeline Australia’s Eclipse Program. An 8-week psychoeducation group that seeks to provide space to discuss attempting in a person’s life, and exploring coping strategies and safety planning to allow people not to overcome their thoughts, but to learn to live alongside them. The reasons for suicide identified by the participants, and on reflection by the facilitators, were similar to those highlighted in Reports 1 and 2. The suicide journey is characterised by lack of engagement with health services, and impact on family and friends when suicide risk is the focus rather than distress that sits behind it acknowledged. Across these narratives’ stories of shame and fear of speaking up about suicide is present. Yet, the power of common experience when sharing within the small group is evident, as is the power of being able to speak about suicide journeys without the fear of a crisis response.

An individualistic, deficit approach maintains stigma by relinquishing the community of responsibility. The positioning of the lived experience voice at the front of a newspaper article and never as the last word, for example, casts that person as non-expert and reassures the public that there is a workforce aware of and managing this issue (albeit with a plea for greater funding). Whilst this may be the case, such a stance also conveys the message to the public that they do not need to act and that people with suicide experience are 'other' to, or different from, them. It places the blame for suicide on the person who made the attempt and the impact of suicide on the surviving family. This positions suicide in the private domain, absolving responsibility for where systemic failures have led an individual to consider suicide or act on those thoughts.

The professional incentive to confer expert status to the knowledge of people with lived experience of suicide is to be part of a community-collaborative paradigmatic shift that could result in tailored suicide prevention strategies that are destigmatising, decrease suicide rates, and result in empathic care when and where it is needed. Yet, this requires a degree of professional courage; especially when the performance of your professional role revolves around competently applying your institutional training and displaying your expertise as is particularly the case in Medicine (Atkinson 1995, 1999). Simultaneously, this can also apply to the media reporter wanting to be seen favourably by an editor, while also following established media reporting guidelines to report on suicide safely.

Professional role performance is challenged in consistently under-resourced areas such as acute health care services, which can result in a lowered capacity to work in alignment with the goals of healthcare and health professional ethics. This may contribute to risk aversity, workforce burnout and lack of capacity to work with people with complex needs, which are often acute presentations of chronic, traumatic issues ill-addressed in acute settings. This was emphasised across the narratives informing this analysis, where a commonly reported issue was a perceived lack of safety within the health system when suicidal. This was demonstrated across the continuum of care, from negative experiences in hospitals emergency departments, traumatic inpatient experiences, premature discharge, no follow up or poorly organised referral. Underlying this was a fear of being scheduled under the mental health act and losing freedom. Distrust of the system is not due to pathology of the individual, but rather a consequence of a trajectory of systemic and interpersonal experiences that have not succeeded in disrupting the person's suicide journey. When a medical crisis is not present, acute health care systems are rarely experienced as places able to manage the needs of a person experiencing suicide ideation or behaviours.

Risk averse approaches paradoxically increase risk if people actively avoid health services when they feel unsafe. Yet, when people are supported and able to talk openly in a safe environment about living with being suicidal, their lived experience of suicide can change from one of feeling 'other' and separate from, to being included and valued, as found among participants in the Lifeline Eclipse Group (*Report 3: Empowered Voices*).

In keeping with these learnings from the analysis, this report privileges the perspective of lived experience of suicide. Throughout we focused on: 1) What causes suicidal thinking and behaviours? 2) Where do people come in contact with any system that has the potential to offer support? And, 3) what are the barriers and enablers of support to someone experiencing suicide related distress?

Key findings and recommendations

Throughout this report we focused our attention on the three key questions relating to reasons people gave for suicide, what services they came in touch with as potential touchpoints and what barriers and enablers there were.

In summary, the causes of suicide were multiple, and complex. We did not come across any story of a simple lead up to a decision to end one's life. Of course, this is not surprising. However, the current focus on risk groups to focus suicide prevention activities on does little acknowledge these multi-faceted causes of ongoing distress that can, for some, end in suicide. Further, many situations were devoid of mental illness. Mental ill-health was always present. However, more often than not the causes of mental ill-health and distress were due to trauma, disadvantage and inequity.

The touchpoints for suicide prevention therefore must reside in everyday places where people come in contact with services and supports, well beyond mental health services. These locations include where people can develop relationships with service providers; early childhood programs, schools and higher education, financial institutions, rural services, services aimed at sub-groups in the population (including specific services for those already marginalised, Aboriginal and Torres Strait Islander peoples, sexual and gender diverse communities, people from refugee and migrant backgrounds), as well as health clinics and other allied health services. Prevention of suicide needs to be well beyond the remit of crisis support. While broader in scope, all interactions for suicide prevention and distress reduction must be approached in meaningful and empathic ways.

Barriers to suicide prevention fell almost solely on either self-stigmatisation or traumatisation of vulnerable people as they came into the care of potential support services. Enablers were found where relationships were paramount and people were viewed within the context of their lives. Our services systems are currently set up to respond to crisis through a risk management framework. However, this results in marginalisation and trauma for people in distress and closes off the opportunity for them to voice their experience. A further unintended consequence of this framework is that it is rejecting or unacknowledging of the resilience and strengths of individuals who have typically experienced years of trauma, denying them an identity that can support coping strategies, healing, and safety around future help seeking. These were core elements to therapeutic relationships described by participants in this study who had positive experiences with services.

Following are three high level recommendations from the data analysed for this report. Within the body of the report, each major section ends in a summary section from which these recommendations are drawn.

Recommendation 1: Suicide can be a constant companion in a life lived

Oftentimes suicide is viewed as a point in time, a passing event that needs to be resolved. However, given the complex, multi-faceted reasons people come to consider suicide, it is unlikely that thoughts of suicide will resolve easily or quickly. Rather, people explain that having these thoughts and feelings are aspects of everyday life that can be comforting or concerning; the capacity to live with them highlights they have some control over their lives. Resolution of suicide is not a treatment goal for many. However, supporting people to understand the role that suicide plays in their life, and strategies to manage suicide thinking prior to, and during, crisis is an effective prevention strategy that is founded in self-determination and empowerment of the individual. As one participant noted,

I believe the experts need to listen to people who have lived it & 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 & seek help before it gets out of control. People with experience can provide essential insight into these situations.

When people build a relationship with a supportive person, place or resource that is grounded in being able to understand their experiences and what suicide means to them, they are able to begin to learn new ways of coping with stressors that do not have to be life threatening. This includes places and spaces where suicide can be freely discussed, where a fear-based response or crisis intervention is not immediately enacted. Rather, where dialogue and understanding are encouraged, will build relationships within these safe spaces, where new insights into the complexity of suicide can be gained.

This requires taking a bird's eye view of a person's life to understand the events and actions that have led to suicide being a constant companion, and what is needed for that person to move beyond suicide being the only option available to end the taunting of thoughts and the associated pain and suffering.

Recommendation 2: Revisit and revise how information is shared about suicide to include broader stories of diverse experiences

There are many opportunities to talk about suicide and bring the conversation into the social domain. However, how this is being done in traditional as well as social media is limited. The first limitation is due to a formulaic approach being driven by those interest groups with personal or organisational agendas (usually more funding for their research cause) and utilising lived experience of suicide death or suicide death data to personalise, as a way to gain attention to their cause. This inhibits a broader, perhaps 'dangerous,' conversation that allows for a variety of views that people are able to identify with. Feeling silenced results in internalising feelings of being different, feeling 'othered' and shame. This can also result in feelings of 'I am dangerous' rather than 'I feel heard'. We need people to

be able to disclose feelings of suicide to be able to support, yet this is not what is currently encouraged, as one participant highlighted,

One conversation can be a lifeline and all it takes to give a grain of hope and a lifeline.

Lived experience of suicide is messy. There are complex and multifactorial challenges that lead, and then lead again, to a point of suicidal crisis. However, this messiness is not represented in social discourse. It is evident that frustration exists in the community via comments on social media pages triggered by posts that do not portray suicide in the way that they have experienced it. From the outside, organisations do not seem to have coherent social media strategies to engage with those for whom their service is funded to deliver services. Conversations then have the potential to be missed or misunderstood. Yet, the analysis of comments on social media posts reiterate that people want to talk publicly about their experiences. This is further evident in self-published content through podcasts, twitter, narrative non-fiction and submissions to Inquiries and Commissions. Strategies and policies that consider how others will relate to the content, and what they can learn from this as a way to apply new ways of thinking about their own lives or local environment is needed.

[Recommendation 3: Suicide prevention must be viewed through a public health lens rather than a risk focus](#)

Suicide is the outcome of complex, multi-faceted experiences and often systemic abuses and traumas suffered yet are often viewed as individual deficits. This is seen in funding models, service delivery and commentary on suicide. Yet, current funding models do not work. There has not been a reduction in suicide as a result of risk group identification. Rather, this focus only allows for the identification of vast swathes of the population, without ever identifying the person who is suicidal until they are 'on the precipice of death' (Caine et al., 2018). By far the majority of members of these risk groups do not die by suicide, and people just need to be heard, as this participant notes,

Having worked with lots of people with significant mental health issues and currently caring for a partner with major depressive illness what I have found to be most important is to be available to listen without judgement, be aware of what services are available to assist and do not hesitate to utilise those services when necessary.

Australian services, focused on crisis intervention rather than prevention, is damaging to people in severe and life-threatening distress. Throughout the crisis intervention process people are further traumatised by staff who are ill-prepared for their critical care responsibilities, who are working in resource strained environments and who medicalise the existence of suicidal thoughts rather than understanding the suicide journey that people have travelled to that point in time. Such added burden, on the already distressed person,

rarely succeeds in preventing suicide, rather the person remains alive despite the service offering.

Immediate focus on how crisis care is delivered, particularly in areas where services are limited in urgently required. At the same time, local level consultation about the services and supports that are being drawn upon and that are missing within a community, from the perspective of those in the community is needed. The purposes of this are twofold. Firstly, acknowledgement of the need for this community collaborative strategies and appreciation for social and cultural context is a first-step in recognising that one-size-fits-all approaches potentially oppressive of people's experiences, which constitutes a service barrier. Secondly, diversity in suicide prevention strategies is needed in order them to be responsive to the local social and cultural context that underpin the needs of any community. A move from medically trained health professionals being the only source of referral to Medicare supplemented therapeutic services when general practitioners across the country are stretched in a priority to deliver services for those in immediate need of crisis support. Supporting those who provide informal care, and addressing issues in privacy legislation, are a priority for non-clinical care or psycho-educational models of intervention, following suicide attempt, need to be prioritised.

Policy implications

The data analysis for Reports 2 and 3 demonstrate respondents are often in contact with potential suicide prevention touchpoints before and throughout the suicide journey. Thus, suicide prevention both needs to take a broader focus to where and when support services and interventions can be implemented. A lifespan approach, acknowledging that many challenges commence in childhood or adolescence, is needed, as this survey participant captures,

I think the most important thing is communicating that suicide is a timeline, not an act. It's the whole play not just a scene.

Such an approach must include a trauma-informed focus, within a critical public health perspective to ensure full consideration of the interconnection of health, social and equity factors that contribute to mental health and wellbeing over time.

If the health, social and equity issues contributing to suicide are understood and touchpoints along people's journeys are identified and resourced to provide support, there are numerous opportunities to assist people before they reach crisis point. Yet, our analysis demonstrates that health and social care systems are not designed to respond to, or compatible with, holistic, preventative approaches. People typically come into contact with systems when there is a crisis or acute or high-risk. Our systems respond with short-term, risk management focused approaches, often focused on individual deficits.

The unintended consequence of this for most people, is that responses do more harm than good, perpetuating a vicious cycle where individuals in distress are blamed, judged, and held responsible for their situation and punished for not seeking help earlier. Interactions with health workers are for the most part described as uncompassionate and unhelpful, as this survey participant noted,

The system is totally stuffed. We need a functional mental health system. We need qualified people working in that system. We need the system to be resourced - doctors, housing, proper care...something other than band aid solutions. With all due respect to the well meaning staff in these system, CATT teams, crisis teams, emergency room visits are just a total waste of time. Band aids, ways of avoiding the real issues and sending people back home.

The following themes were developed to explore the service and policy implications of the analysis in relation to rebuilding trust and developing models of care that correspond with what service users said they need.

Collective Responsibility

Suicide has social, economic, occupational, and interpersonal dimensions that impact on individual and community mental health and wellbeing. Looking only at how this presents in individuals fronting to services, at best, focuses on how individual disadvantages across these dimensions are implicated in the person's pathology or distress. In this way, responsibility for addressing the issues experienced by the individual is held between the community, service provider(s) and the service user. There is limited scope to address social, economic, occupational, and interpersonal factors using this approach because it is constrained by what can be achieved by the service provider(s) and service user within existing resources. Arguably, this is the context of service-user's complaints when they say they can only access band-aid support from services and that nothing changes for them in between episodes of treatment. From the supply side of service delivery, this possibly explains the context of worker hostility towards service-users, as they know there is very little they can do, and this undermines their professionalism.

In contrast, attention to the equity and social justice issues that underpin individual disadvantage promotes collective responsibility for the role of power, privilege and oppression in health. Drawing on the survey data we identified a lack of accessible and affordable health services, financial distress, job loss and unemployment, and class differences between service providers and services users as barriers to service accessibility and factors that contribute to people's reasons for suicide. A collective responsibility approach to these issues would therefore encompass:

- acknowledgment of how privilege and socioeconomic status are implicated in suicide at a government level
- talking about how privilege and socioeconomic status are implicated in suicide to shift the public perception away from suicide being an individual deficit
- meaningful resourcing to address socioeconomic disadvantage, particularly in the current context of recession, wide-spread job loss, and the financial hardship experienced in rural communities after years of drought and bushfires
- equitable access to affordable, high-standard care, regardless of location or personal resources

Collective responsibility is also relevant for thinking about how to bolster our responses within the current service framework. Suicide cannot be the remit of mental health services alone. Coordinated, interagency approaches more responsive to the multi-factorial health and social determinants contributing to suicide are needed to support people before they reach crisis point. Moreover, there is a need for services tailored to meet the diversity of needs, which was particularly highlighted by our findings around the culture of distrust towards health professionals in regional and rural communities. Community collaborative approaches are needed to inform and promote the development of community responsive

strategies, services, and models of care. A collective responsibility approach in this context would involve:

- Acknowledgement that people who experience traumas, abuse and disadvantage are vulnerable to enduring health issues, including suicide.
- Acknowledgment that dominant knowledge paradigms are fallible, and that health professional power can be experienced by service users as oppressive, resulting in negative treatment experiences, lack of help seeking behaviour, and rejection of services. This is not 'treatment resistant' or 'non-compliance' of the individual needing care.
- Acknowledgment that many service-users have previous trauma and experiences with social systems where they have been treated punitively and the system has not helped them.
- Development of community/context responsive suicide prevention strategies and models of care through local consultation with community (geographic, or social or cultural membership) groups.
- Resourcing for research to examine service-user data across multiple systems, including patient journeys, to identify services that should be included in inter-agency approaches and the ways in which services can work together at various touchpoints.
- Resourcing of multi-disciplinary services with specialised staff with capacity to support people with complex, long term needs.

Collective responsibility can also be conceptualised as a de-stigmatising strategy, which is required. People with lived experience of suicide are a heterogeneous group, not confined to people reliant on public services or without family support (for example). The evidence presented throughout this report points to the need for a serious shift in the public representation of suicide, including who it affects, how it is responded to, transparency around the shortcomings of current systemic responses, and who is responsible.

This involves further shifting of power away from professional 'experts' so that the voices of people with lived experience can be heard, not just as anecdotal 'quasi-evidence' but with the same epistemological value as the knowledge of academics and people in the mental health and suicide prevention workforce. A wide variety of personal 'expertise' is required to present a breadth of views and experiences (Wayland et al., 2020). With acknowledgment that the previous disempowerment of this knowledge may be implicated in the shortcomings of our systemic responses, service-user or lived experience knowledge now needs to be privileged. This is an empowering and anti-oppressive practice that can promote healing, rebuilding of trust, and encourage the community to become more active in suicide prevention building community capacity to recognise and respond to people needing support. It can also provide vital, intimate evidence to inform suicide prevention strategies and models of care, which many are willing, ready and able to provide, as this participant noted,

I believe that more literacy and keeping communication channels open about suicide would make a difference. People commit suicide when they have no hope. If we can teach people how to have hope-engendering conversations - not wantonly optimistic conversations, but conversations that can have space to hold the real complexity of both the person's distress and the hope to be heard, understood and feel connected to the helper - then I think we have a chance to make a difference.

Holistic models of care

For people currently in contact with the health system or in need of support, our evidence points to the need for more holistic models of care and trauma-informed services, and a trained and specialised workforce to deliver these models with compassion.

Holistic models of care encompass multidisciplinary approaches, support and practical assistance alongside clinical intervention (where this is indicated), and attention to the context of underlying factors contributing to the person's health and wellbeing. Holistic models of care challenge pathologizing, deficit approaches to working with people with suicide ideation and/or who have made a suicide attempt. In turn, they have the potential to promote the strengths and resilience of service-users, which can be helpful in building trust and establishing a therapeutic relationship. We know from the survey data, that trusting therapeutic relationships between service-users and providers are foundational to the provision of continuity of care, interventions perceived as compassionate and helpful, and the ongoing resources available to service-users to access support when they feel unsafe. This model is somewhat of a challenge to the risk-aversity that is usually triggered when people access health services and will therefore require the resourcing and buy-in of health services and a trained and specialised workforce.

There was also strong evidence for resourcing of trauma-informed services (as part of a holistic model of care). Early adverse childhood experiences were very common across the data, in both the private and empowered voices datasets, demonstrating:

First, childhood sexual abuse was named as the first experience in a long journey of poor mental health (depression, anxiety, PTSD), violent relationships, social isolation and suicidal ideation and attempts.

Second, in many cases domestic/family violence was part of the person's childhood experience. Intervention that was needed to disrupt the trajectory of trauma for their parent (for example domestic violence services), but typically this did not occur, creating intergenerational trauma.

Third, respondents described childhood experiences of growing up with a parent with undiagnosed or untreated mental illness, resulting in exposure to parents' suicide attempts,

caring responsibilities as a child for the parent and other siblings, lack of supervision and vulnerability to abuse from intimate partners of their parents and other family members. These respondents described depression in adolescence as a result of this trauma and subsequent suicidality in either adolescence or adulthood or both.

A two-pronged approach is needed to address those who are now adult with these experiences, as well as preventative and early intervention support services for children and families that recognise the full, long-term impact of adverse childhood experiences.

A specialised workforce of mental health nurses or other trained health professionals would be needed to support existing services through this transition and then remain as a permanent fixture on multi-disciplinary teams. It will take time to shift this paradigm and rebuild community trust in the system, particularly among people with feelings of shame from past experiences of being stigmatised by health professionals repeatedly and over time. There is also evidence for wide-spread training across the health and allied health sector. Survey respondents highlighted the need for more training of GPs; hospital staff and medical students so that it is not arbitrary whether someone receives adequate care when they go to hospital; alcohol and other drug workers; psychologists; allied health professionals in contact with people with workplace injuries; and health professionals working with people living with chronic pain.

Limitations

Our report is limited by several factors, as is each report. First and foremost, utilising existing data and survey tools limits the diversity of our participants. Importantly, groups where suicide is disproportionately high are under-represented. We did not ask participants about cultural or gender diversity in our lived experience survey which was used for this study, and our ethics approval was only for adult Australians. Thus, this report should be read recognising it does not adequately represent the views and experiences of a range of diverse groups – LGBTIQ+, ATSI, CALD, Young people, refugees – other than where individuals from these groups participated in any of the three data source.

Report 1: Public Voices was limited to a ten-month review (September 2019 through late June 2020) of posts of well-known Australian media (traditional and social) and a brief review of individuals public facing pages. While we reviewed number of interactions with these posts, and were able to determine trends in responses, we were not able to delve more deeply into the simmering tensions evident between commenters on posts. This tension demonstrates high levels of emotion in the community when there are public posts about suicide – some positive (i.e. ‘it’s about time someone is doing something to stop suicide’) and some aggressive (i.e. ‘how dare you speak about suicide in public’). This tension needs further attention to understand the different prevention messages that are aimed at different groups of people with a variety of experiences.

Overall, the scope and timeframe was a limitation in relation to the depth we were able to analyse the datasets. This is particularly evident in *Report 2: Private Voices*. The survey has continued to attract more participants, with more than 1825 survey entries (as at 28 June 20). The responses from most were long and detailed. We focused only on analysing the causes for suicide in these entries, where people were in contact with any service and the barriers and enablers they experienced. The data is significantly richer than this narrow focus and it is likely we will continue to reveal similar and different experiences than detailed in this report. We did not analyse the questions relating to advice from those with lived experience of suicide about how they can contribute to suicide prevention, and for those who have, what they hoped to achieve and whether this occurred. This is an important consideration as more people enter into suicide prevention activities. For some, these activities will provide positive, and healing experiences. However, for others new triggers can be experienced which require further support.

We re-purposed qualitative data in *Report 3: Empowered Voices* from participants in a facilitated suicide attempt survivor support group to examine where the participants spoke of the reasons for suicide, what services they used, and the barriers and enablers to access support. These interviews – along with quantitative outcomes data – reveal deeper insights into what works to reduce suicide distress among this group.

Report 1: Public Voices

Background

Mass media plays a significant role in shaping identification and awareness of public health issues in the community. In so doing, some views are included, while others are excluded. This division is not always purposeful. In the case of suicide, there is an additional layer which both guides and influences reporting of suicide, that is via the Mindframe Media Guidelines (Skehan et al, 2006). Launched by the then Hunter Institute for Mental Health (now Everymind) in the early 2000's, Mindframe provides evidence informed guidance to media and public relations professionals to reduce the *Werther Effect* (Philips, 1974) whereby individuals who may be vulnerable to suicide can be influenced by sensationalised reporting, particularly where the focus of the story is a celebrity. The *Papagino Effect* (Niederkrotenthaler, 2017) is the desired outcome, where the influence is toward resilience and help-seeking through the inclusion of stories of survival. To adhere to guidelines, a common pattern of reporting is now popular – the issue is raised, a spokesperson who has lived experience of suicide is quoted and then an 'expert,' usually a medical professional or head of a mental health service is quoted and then support information finishes the story. This pattern fits comfortably with the Mindframe recommendations to decide whether to report on an individual suicide death, to reduce the prominence of suicide stories, to remove information that may increase risk (particularly method, location) and to be mindful of vulnerability when interviewing family and friends of the deceased.

This report focuses on examining how those with lived experience of suicide are portrayed in the Australian media (traditional and social). We examined unidirectional sources, including newspapers and narrative non-fiction, and bidirectional sources where interaction with the original publication is available and, in some instances, encouraged. Each source is presented below, with the methods utilised to allow the research team to collect and analyse each source with first-hand accounts used to illustrate the ways in which suicide is presented from a lived experience perspective.

As the report contains different data sources, each section details the methods used to collect and analyse the data, concluding with a summary from that data source.

Newspaper Analysis

Australian newspapers have traditionally been the mechanism through which information can be shared at a local, state and Commonwealth level. Whilst readership has declined in recent years, the role of newspapers (paper and online) in shaping public opinion and adding to the public discourse still remains. For the purposes of this report, we focused on Australian media content, specifically focused on suicide to determine how this media is presented and what information is shared as a way to identify the role of traditional media as a conduit for inclusion and engagement of the public voice of suicide.

Methods

Using the database ProQuest Australia and New Zealand News Stream, all articles reporting on suicide were collected. Inclusion criteria focussed on news articles, commentary and opinion-editorial pieces published within the timeframe, published in Australia and using search terms of SUICIDE +/-OR SUICIDE ATTEMPT* (truncated to include all possible derivatives). The timeframe for data collection was to ensure a spread of information gathered as well as to allow trends to arise, to illustrate shifts in perceptions and discourse (Altheide, 2000). This time period was chosen to include World Suicide Prevention Day (10 September 2019), Mental health Month (October 2019) and reactions to social isolation and concerns for individual's wellbeing due to COVID-19 (March 2020 onwards).

The purpose was to explore the ways in which traditional delivery of mainstream newspapers (including print and online) present first-hand experience and how this is utilised in media related to suicide prevention and public health awareness. We focused on whose voices were prioritised, who was included (and who was not) and considered the call to action from the journalists who produced the content.

Results

A search of ProQuest Australia and New Zealand news stream database for the selected time period yielded 326 articles. Some content was replicated across publications, often where regional papers utilised stories from larger metropolitan centres, or media releases from organisations were picked up by a variety of media outlets. Following further analysis for unique content 26 duplicates were removed, resulting in 300 articles for analysis: 188 from September to December 2019, and 112 for 2020 (January to May 2020). The articles were published across 72 Australian locations; 10 metropolitan locations including capital cities and the remainder regional or remote Australia.

More than half of the articles reviewed placed emphasis on sharing suicide death data, suicide risk factors or suicide prevention messages from an organisational or institutional perspective. Newspaper articles were also utilised as a platform for organisations such as Beyond Blue, Black Dog Institute or Lifeline Australia providing a lens by which the focus of

the articles (in identifying issues relevant to the community, or strategies) centred on a particular organisation in terms of their specific suicide prevention activities. Regional based collectives in Victoria were prominent in terms of generating their own publicity about national and state-based reports or events, partnering with mental health initiatives like RUOK day and World Suicide Prevention day. Not surprisingly, more recently published articles focused on COVID-19 and the potential impact on suicide. This was particularly evident from academic institutions (including Western Sydney University, and the Brain and Mind Centre, University of Sydney) where the focus was on data modelling predicting potential surges in suicide during and post COVID-19. Personal perspectives were included in a quarter of the articles reviewed. 31 articles included the perspective of those bereaved by suicide, nine from the perspective of a person who had previously attempted suicide. About one fifth of the articles related to a mix of organisational and lived experience perspectives.

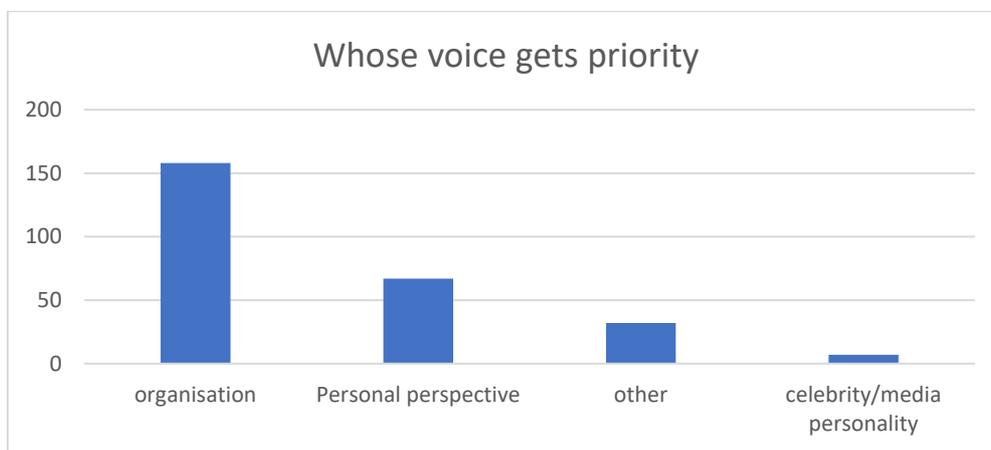


Figure 1: Priority voices in Australian media

Articles tended to place their emphasis on mental health information or statistics relevant to suicide prevention, rather than personal perspectives. While personal quotes were used to provide personal context to data stories almost half of all articles used statistical information (such as Commonwealth health data, or the Australian Bureau of Statistics).

Other commonly reported stories focused on the draft report on the Productivity Commission into Mental Health, including the need for better resourcing across the system and improved follow up. There was an emphasis on higher rates of suicide in regional and remote areas, especially suicide among farmers, and in communities affected by drought as well as recognition of social determinants of mental health problems and the need to address underlying issues such as homelessness, financial hardship, and unemployment. Some of this was contextualised by the COVID-19 shutdowns. Priority populations were included as a way to emphasise different risk groups when discussing suicide prevention – this included rising suicide rates among young people, suicides and mental health problems among police, suicides of refugees and people in Australia’s offshore detention centres.

The broad definition of 'lived experience of suicide' used among suicide prevention peak bodies and service providers which includes those who have lived through suicide attempt/s, have suicide ideation and those who provide care to them, as well as those bereaved by suicide is not represented in the newspaper media. Interestingly, even where first person accounts were provided, the type of exposure to suicide was not always presented. Over half of the articles did not identify what type of suicide exposure the person quoted had experienced, rather broad statements such as 'suicide prevention' was used. Where specific information was provided it was most often in relation to the impact of suicide on those left behind; referred to in 87 of the articles. Just 17 articles focussed on the suicide attempt, and only two specifically referring to suicide ideation, including the story below,

She thought often about dying by suicide. "I would ... cry all day and think about ways of killing myself. I thought my husband and daughter were going to be better off without me because I was worthless and a crap mum," she says. (Perkins, The Age, November 2019)

Of the 300 articles reviewed, 265 referred to suicide prevention activities as a way to summarise the news story or provide a call to action to conclude their report. However, given the brevity of much of the content (800 words or less) there is limited capacity to engage deeply in the initiatives mentioned or strategies to assist vulnerable groups. An example of this is in the report 'Baring all for a crucial cause', Townsville Bulletin, 8 February 2020. This article provided a commentary from a war historian about veteran suicide, stating,

'They conveniently neglect that the decision to commit suicide is and always remains with the person who does so for reasons that we may never, fully know'

No further information was presented, and the language used (i.e. commit) is discouraged due to alignment with criminal behaviour and is viewed as stigmatising (Skehan et al, 2013) with calls to end such language use being prominent (e.g. Beaton et al, 2013).

Only five articles referred to postvention activities, 19 reporting on a novel or innovative intervention and a further 39 focussed on prevention, intervention and postvention activities relevant to the suicide prevention sector. Interventions were characterised by one-off sentences, often noting the name of a new program being trialled. In some instances, the needs of carers were considered, such as or a statement such as an article in Regional Victorian newspaper, The Standard,

"When these people (people who have suicide attempted) are released from professional care it's their family and friends that care for them," he said. "We need to make sure they are adequately resourced and supported." (Pattison, November 2019)

Yet, no information on how this support could be resourced or provided to carers. Hyperlinks to organisations or intervention programs are not included in online articles, limiting further awareness raising opportunities.

A strong focus on veterans was present in the review period. 174 articles focused on suicide rates amongst veterans, with an emphasis on the recent petition for a Royal Commission into veteran suicide and announcement of an independent commissioner to be appointed in early 2020. Often the emphasis focused on commentary/editorial pieces from ex-serviceman reflecting on their perspectives as to whether or not a royal commission should be held. Quotes from mothers bereaved by their veteran son's suicide featured heavily in these articles alongside quotes from ex-servicemen, the Prime Minister Scott Morrison, leader of the Opposition Anthony Albanese, and other government officials. There were no inclusion first-hand accounts from service personnel,

"Sadly, it hasn't been the voice of parliamentary figures who have raised the need for a Royal or Productivity Commission, Senate Inquiry or Coronial hearing," Mr Bird's partner, Connie Boglis, said. "It has been grieving mothers, partners and families who have honoured the voices of our loved one's past." In Canberra yesterday Mr Morrison said veterans were "champions" and "heroes" who left the military to lead successful lives but that some "struggle". "Some are in a daily battle. And they're the veterans that we have in mind here in the announcements that we're making," he said (Benns, Beanini & Armstrong, The Courier Mail, February 2020)

Quotes from people with lived experience tended to highlight the inadequacy of follow up and support services when people separate from the Australian Defence Force, including the culture within the ADF that can result in vulnerability. All authors of these articles were male; where soldiers' personal experiences were represented this was by males. Yet all the bereaved perspectives from women, and primarily mothers of sons who had died by suicide.

While celebrity endorsement of health issues is now commonplace (with sports people donning pink for breast cancer, for example), there was an absence of suicide prevention articles involving celebrity or media personalities. Mindframe recommends reporting suicide deaths among celebrities based on the evidence for suicide contagion, however this does not extend to preventing stories of resilience among well-known personalities. Only one other article focused on the impact of suicide, this time from a band member recalling the death of a fan,

The band wrote on social media that their fan, Louie, would often travel from Melbourne to catch The Chats' Sydney shows and hoped to draw attention to youth suicide rates and depression, particularly during the COVID-19 lockdown. That really hurt me," Sandwith said. "I've never had anyone I've known in my life who did that. I didn't know him particularly well, but we did meet him a few times and he was always really nice to us

and loved our band. It something I'd never felt before."
(Leeson, Newcastle Herald, May 2020)

Other events were reported in relation to increased distress among the community, including the long-standing drought in rural Australia, then the November 2019 through February 2020 bushfires. The most recent stories focused on commentary related to COVID-19 and predictions of increased suicide. Interestingly, these reports took broader social determinants of health into account, along with suggestions for data sharing and regional suicide prevention networks that intervention plans needed to be developed in order to address wellbeing of communities. All were presented on behalf of mental health organisations of academic institutions, with a prevention not intervention focus. A deficit-based approach as to what to expect, rather than 'how to' respond, was noted in the tone and language of the articles, for example,

"This tragically higher rate is likely to persist for up to five years if the economic downturn lasts more than 12 months," AMA president Tony Bartone said in a statement with experts Ian Hickie and Patrick McGorry.
(The Advertiser, Adelaide, May 2020).

Attention was paid to those with dominant voices across the retrieved articles. In approximately two thirds of the articles, male voices were prioritised. Generally, these were from men leading suicide prevention organisations, male academics, and male journalists. Spokespeople were used across many of the articles. These were primarily politicians. For example, Federal Health Minister Greg Hunt, as well as Prime Minister Scott Morrison, were often quoted in relation to suicide data, reports or strategies to address interventions. Other spokespeople often referred to included Professor Ian Hickie, Professor Patrick McGorry and twice from Professor Helen Christensen. National Suicide Prevention Advisor, Christine Morgan, was referred to, specifically in relation to the future outcomes of the role, rather than a voice of authority on suicide prevention. There was no one 'go to' voice for championing suicide prevention activities and shaping social discourse. Comments from Politicians appeared to be shaped by media releases, or echoing the organisations included in the articles.

Few women, beyond the aforementioned bereaved mothers, Professor Christensen and Ms Morgan were present. There was minimal focus on Aboriginal and Torres Strait Islander people being over-represented in the suicide statistics and a specific mention of the dramatic rise in suicide rates among young Aboriginal women and girls. Only one article reported on a female, community-led initiative to encourage open conversations about suicide – 'Walkabout Barber rig to roll into Taree to transform hair and mindsets' using,

"a travelling barber shop to provide people with a haircut and "open up conversation to do with healing, hope and happiness," (Dennis, A. The Manning Rover Times, November 2019).

First person narratives were rarely the central focus of the stories. Inclusion of personal or lived expertise was limited to 1-2 lines generally used to provide some insight into a political or organisational statement, or as an addendum to the launch of report findings or update on statistics relevant to suicide prevention.

Summary

Any news reporting suicide death, new data or suicide prevention initiative brings the opportunity for conversation about suicide into the public discourse. Yet, when analysing print media this reporting is dominated by male voices; often males within organisations, sharing their interpretation of suicide on behalf of others. Statistics and reports are used as a vehicle to consider suicide, with very limited inclusion of lived experience of suicide. In keeping with Mindframe guidelines, suicide methods were not discussed in the reviewed media. However, the lack of first-person accounts with the focus on professional, often medical or academic viewpoints, has the potential to isolate those with suicide thinking and behaviours. This can result in real or perceived stigma, and reinforces social role valorisation, where groups are made to feel different and of less value than the majority. Paradoxically, while offering support through crisis lines at the end of media reports, those who feel alienated or excluded from the experiences presented are unlikely to reach out.

Lived experience of suicide is often used as a way to personalise statistics, descriptions of services or lend narrative to the release of a report. This has the potential to be interpreted as tokenistic or simplistic in the face of the complexities that underlie individuals' experiences of suicide. The prominence of a few key spokespeople, often focused on using the media to highlight risk and advocate for higher funding, further limits the opportunity for a broader discussion about suicide, particularly stories of survival and resilience, through which others can learn.

Facebook analysis

Facebook originally began as a social networking site in 2004 and in recent years the growth in its role as a mental health resource has been acknowledged as well as the attempt to bridge the knowledge gap on effective use of Facebook by health organisations in Australia (Kite et al, 2016). Individuals also use this platform, including public figures, to share more diverse content regarding lived experience of mental health, including suicide attempt, caring and suicide bereavement. Facebook has substantial opportunities for understanding the ways in which conversations are introduced, and the engagement of those who choose to connect with a page or a post. Unlike the unidirectional stories reported in traditional media, conversations are encouraged by organisations posting content to their public facing Facebook pages. Content creation is rapid and depending on user preferences can offer bidirectional information sharing and conversations with varying points of view being offered through commenting, liking or sharing posts.

Methods

Given the scope of this report, we limited our search of Facebook content to organisations with publicly accessible pages, acknowledging that some organisations may engage a social media strategist to assist with content, as well as graphic design to ensure branding of the material in which they share. We did not include any closed Facebook groups. We included personal pages only where these were shared publicly, and no posts were included that require a user to 'like' a page nor be a 'friend' if the page was run by an individual. Thus, all information analysed is considered to be in the public domain, and thus consent to analyse is not required (Manthiou, 2014). This was to ensure that any information analysed would be seen as publicly accessible and posted in the sense that the content was 'speaking' to a wider audience.

The research team identified relevant Australian suicide prevention and mental health organisations with a Facebook presence and reviewed timelines for frequency of posts that included #suicide #livedexperience or #suicideattempt. In addition to analysing posts that met the inclusion criteria, information regarding number of comments and shares associated with the posts was also recorded, included sentiment analysis of the comments (that is, categorising opinion of a text noting positive and negative responses to the post).

An alphabetical list of organisations are presented in Table 1, along with the number of individual accounts 'liking' the page and the number of posts specifically related to suicide. One organisation, Roses in the Ocean, solely dedicated to lived experience of suicide is reported separately at the end of this section.

Organisation and Facebook name	Number of individual accounts that like the page (18 June 2020)	Number of posts about suicide or suicide prevention	Total number of posts 1/9/19 – 20/6/20
Beyond Blue	615000	15	171
Black Dog Institute	184000	29	207
Everymind	4200	50	209
Headspace	716000	10	164
Kids Helpline Official	18000	5	240
Lifeline	117000	33	177
Mensline Australia	4400	2	126
Movember Australia	95000	23	190
National Mental health Commission	1900	14	194
RU OK Day	401000	19	265
SANE Australia	47000	12	175
Suicide Prevention Australia	85000	49	184

Table 1: Facebook organisational pages included in analysis

A total of 261 items were posted during the inclusion period (1 September 2019 and 20 June 2020) from the 12 organisations listed above. Analysis by month of the post indicates that the primary sharing opportunities occurred in September (due to World Suicide Prevention day), December (with a primary focus on the Bushfire crisis) and in May and June 2020 in terms of the effect of social distancing due to COVID-19, illustrated below

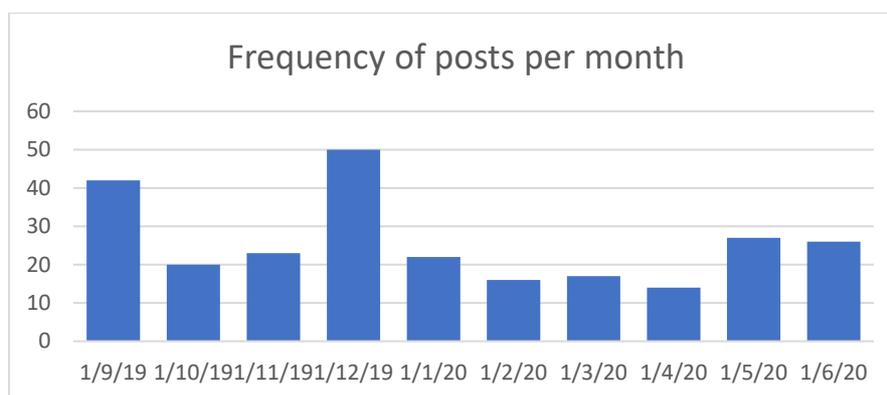


Figure 2: Frequency of posts during study period

A descriptive analysis of the purpose of each post was undertaken, with the tagline, or key focus of the post noted and then grouped by type. These included 'event', 'suicide prevention initiative', 'announcement of funding', 'announcement of report', as well as posts sharing 'mental health or public health information' and 'identification of lifespan issue' where posts typically targeted a priority population groups at risk of suicide (such as men, women, post-birth transition, transgender etc).

Results

Across the organisations a significant focus of shared posts was to promote suicide prevention initiatives (n=96) – these included the #youcantalk initiative, #betteroffwithyou, RUOK day, World Suicide Prevention Day #WSPD and events during Movember (men’s health initiative). These posts were not specific to the organisations tasked with leading these initiatives, cross posting (where a page shares another page’s content) was noted. 69 of the 96 posts about initiatives were shared by centring the conversation on the organisations who shared them (SANE Australia, SPA, Black Dog Institute, Beyond Blue, NMHC) with minimal inclusion of lived experience of suicide. Posts that did prioritise personal perspectives inclusion was generally used as the ‘hook’ or the purpose/supporter narrative of the initiative, rather than a standalone post. These included the examples such as ‘#YouCanTalk: Suicide prevention ambassador speaks about lived experience of suicide’ (18/12/2019 Black Dog Institute), and ‘having access to online support literally saved my life’ (Kids Helpline World Suicide prevention day initiative 10/9/19).

The second theme prominent was a focus on sharing information about suicide prevention events (n=74). These included community walks, marathons seeking fundraising for organisations, or ‘challenges’ such as the Movember push up challenge. These posts were often an addendum to suicide prevention initiatives identified above, and events were found to have more prominent inclusion of lived experience voice from a bereavement perspective, where the sharing was facilitated by an organisation (e.g. SANE Australia speaking on behalf of a brother bereaved by suicide) or by individuals who were suicide bereaved (‘Mo Bro of 14 years shares story of how Father's suicide motivated him to start...’ 22/11/2019 Movember). Only five posts regarding events were from the perspectives of people living with attempting or ideation.

Facebook posts that focussed on mental health information was often identified as ‘signs to look out for...’ or ‘tips to respond to’ as well as infographics that condensed large volumes of information into shareable images to convey a public health message. Blackdog Institute and Lifeline were more likely to utilise this type of engagement – focussing on crisis telephone numbers, availability of support and information about mental health conditions were concerns about suicide risk might be enhanced, for example, ‘Depression can interfere with the way we go about our everyday lives and make it hard to cope. Understanding what it is and how it appears in different people is an important first step. Read more at...’ (Blackdog Institute, 11/2/20). The remaining posts focussed on sharing of information about funding opportunities and information regarding the outcomes of reports. This limited focus on individuals’ experiences is no doubt due to our methods of restricting inclusion to publicly available pages.

Across the posts varying audience numbers and engagement was noted. A range of interactions with posts varied considerably from zero comments or shares to thousands of

comments and shares. In addition, it was also noted that some posts had no comments, but multiple shares, and vice versa. This may suggest that some conversations are not suitable for public commenting, but that the sharing of the information into the privacy of a person's own Facebook page, may be of interest.

In further analysing post engagement, we sought to identify what experience of suicide was focussed on. The lowest engagement tended to focus on posts that had already gained leverage on other posts (such as the re-sharing the #youcantalk initiative) or posts focussed on niche areas such as stigma of new parents with mental health issues (Sane Australia, 23/2/20). The highest engagements related to initiatives where information was shared about a public health messaging campaign, combined with practical information about how to act on concerns about another's wellbeing. For example, Beyond Blue's World Suicide Prevention day post highlighting 'warning signs' for those at risk of suicide (10/9/19) was shared 17000 times and garnered 873 comments. Using a sentiment coding strategy (exploring positive and negative attributes attached to comments), only 11% were classified as positive. For example,

'On Saturday night i lost my cousin (and best friend) to suicide. I'm completely heartbroken and just wish there was something i could have said or done to make him realise how loved and adored he was by everyone he touched. I will forever support the cause of Beyond Blue and want everyone know that it is ok to not be ok and to always know its ok to reach out 

An overwhelming majority of the audience responding to posts took the opportunity to use the space to discuss anger, the invisibility about individual's mental health, concerns for others or lack of support from the mental health system,

'I agree with this and recognising the warning signs are important. However, I have called beyond blue whilst feeling helpless and desperate and begging for help. The guy on the other side of the phone was rude and arrogant and I for one would NEVER EVER recommend calling them! It was lucky I was not suicidal all those years ago on that day myself! sorry bit passionate about this one!

The administrators of this page attempted to engage with all individuals who commented, especially concerning posts that suggest risk of harm, however once the image was shared, the capacity to comment or interact with users would have been impossible for the organisation to seek out the offer or provision of targeted support beyond responding on the Facebook platform. In a similar situation, a post by RU OK within the same time period (8/9/19), focussed on individuals 'learning the signs' regarding this at risk of suicide,

'It's R U OK? Day, our national day of action and a reminder to Trust the Signs, Trust your Gut & Ask R U OK? any day it's needed. Today we're calling on Australia to learn when and how to start a conversation that could

change a life. Learn the signs and how to ask and help us move closer to our vision of a world where we're all connected and protected from suicide'

This post captured more than 500 comments, and 21000 shares. While many responded positively to this post, responding with statements such as,

'Wonderful to see that this is out there now. Our world is truly changing, and people are becoming more aware every day'

Over one fifth were coded as negative, with responses such as,

'R U OK Day referrals and support 10 to 10? People in need pleading for help turned away from hospitals and Drs!'

Such interactions with Facebook posts provide some insight into how people feel at an individual level within their scope of experience in a manner that is not able to be sourced in unidirectional traditional media. Further, responses to social media posts were more likely to elicit personal accounts of experience of suicide through comments related to it and through 'tagging' others to draw their attention to the post.

Almost one half of all original posts included information about suicide from the perspectives of responding to those with suicide ideation or behaviours, with a focus on initiatives or mental health information. The remainder focussed either on suicide bereavement or general reference to suicide prevention. Personal perspectives in the original posts were limited. Continued conversation between the organisations and the people who engaged with the page were perfunctory in terms of the organisation 'liking' a comment. For example, Beyond Blue liking this comment,

Thank you Beyond Blue for being brave and promoting awareness of this day, while so many other organisations are willingly turning a blind eye to the health of our men and boys for political gain. 19/11/2019.

In addition to identifying the primary message of the post, we further coded the gender representations of the posts to identify both the images shared and the gender of the personal perspectives included. Overall, when caring for someone who has been, or is currently, at risk of suicide, women were generally portrayed as carers through perspectives included and stock images used. Where male images were this was generally in relation to accompanying discussions about the high incidence of male suicide, or exploding myths about men and mental health. Inclusion of women did not correspond with information targeted at women.

Not surprisingly given the user generated content, approximately one third of the information posted on Facebook was anecdotal, with 83 of the 261 posts utilising anecdotal or personal experiences as a way to consolidate the information shared. 52 of these posts reflected on experiences of attempt or ideation, with the remaining 31 focussing on bereavement or a broad definition of lived experience of suicide. Quotes presented by

organisations were used to personalise information provided by the organisation or to legitimised the information shared by connecting it back to an individual. For example,

I wanted to support Beyond Blue as my family and friends have been affected by depression and suicide. With family living in rural Queensland, we have known too many lives taken by suicide and the rate amongst farmers is alarming. I decided to take part in my first triathlon. (29/10/19 Beyond Blue)

Data informed posts were also common; 47 of the 261 posts included health statistics. For example, using one statistic to illustrate the nature of the post,

During adolescence, 1 in 13 young people will seriously consider suicide Black Dog Institute (8/11/19)

Other times, statistics were used to to generate engagement or to link to health information, such as this post from Suicide Prevention Australia (8/9/19),

More than 10 million Australians have been touched by suicide: Suicide affects us all and we all have a role to play in #suicideprevention

Only 11% of the posts referred to evidence informed reports, primarily as a social media release to circulate information about recommendations or findings. This strategy was used primarily by Black Dog Institute and Suicide Prevention Australia and focussed more on priority population groups within suicide data such as men, health professionals, or people with eating disorders. A large number of posts were coded as 'other'. Posts coded as 'other' referenced a person or organisation with expertise in the topic area, without citing any specific report, data or other publication associated with that entity.

Roses in the Ocean

In addition to these agencies and organisations, the research team conducted an additional review of Roses in the Ocean Facebook page given their unique role as a lived experience organisation. The Roses in the Ocean Facebook page was created in 2012 and has 2135 followers.

During the same analysis period, 1 September 2019 to 20 June 2020, Roses in the Ocean posted 4-5 times per week minimum. 100% of their posts have a focus on suicide prevention through the lens of lived experience. Post text including invitations to training opportunities, research inclusion, interspersed between self-care images that tracked social factors such as COVID-19 and the Australian bushfire crisis. The difference with the messaging on Roses in the Ocean Facebook posts was the privileging of lived experience of suicide voice and perspectives. On this page, posts speak directly to people with lived experience rather than about them,

Do you have a lived experience of suicide and are ready and keen to explore opportunities to be involved in suicide prevention activities (19 June 2020).

In addition, posts provided scope to include lived experience voice from cultural and linguistically diverse background (for example, 18 June 2020 focus on Sundanese communities and again in November, 2019.) There were also monthly self-reflection prompts for people to explore their own lived experience in written form. While some of the larger national organisations had significant reach in relation to their posts encouraging engagement and sharing, this was not the case for Roses in the Ocean. Generally, there were likes on posts, with occasional 'shares' but very few comments during the review period. Broadly, the page offers new ways to include lived experience of suicide in social media, and community dialogue.

Summary

As with the analysis of newspapers, Facebook as used by organisations, is limited to following a similar manner of including individuals first-hand accounts through using narrative to personalise suicide prevention initiatives of the organisation. This was most likely to focus on the experience of suicide bereavement. Posts that included a call to action, and those that asked for a specific response, received the highest level of engagement. Inconsistent responses to engagement with posts was noted, particularly where an individual responding to an organisational post did so with their own lived experience of suicide. Given this, it is unclear how organisations decide which comments to respond to, and which to leave.

In posts detailing the release of reports or statistical information, the reason behind posting was unclear. Those posts with clearer information or infographics were more likely to be shared.

Regular commentators appeared across different organisational pages. Whether these individuals are 'influencers' or looking for engagement in relation to support for their own experience of suicide is unclear.

Twitter analysis

Twitter was launched as a social media platform in 2006, and currently provides a networking opportunity for sharing information via shortened links and hashtags with millions of tweets shared each day.

Methods

Using the Twitter API software, we collated and downloaded tweets every 4 days between 24 April 2020 and 20 June 2020 to analyse the real time discourse regarding how suicide is discussed on twitter and the volume of information shared about suicide prevention activities. Twitter data was filtered with the inclusion of the keyword #suicide, however it is important to note that this data cannot be refined to Australian only accounts, given only 1% of users offer location data, in order to refine the results. Initial searches of the term 'suicide' increased the dataset exponentially, therefore data was captured only where the #suicide was included. Data was excluded in relation to American politics and in relation to the movie franchise *Suicide squad*.

In total, during the two-month period 13074 tweets were shared via twitter using #suicide. The extracted data allowed us to review the screen name, and account name of the user, text used within the tweet, how many tweets were either responded to or retweeted and the additional hashtags used alongside #suicide. In some instances, up to 30 additional hashtags were used alongside #suicide to further refine the intended audience of the tweet.

Given the breadth of tweets, and to further refine the dataset and allow for meaningful analysis, tweet text that included the term 'Australia' was used. This resulted in 107 tweets using #suicide and referencing Australia during the time period. This analysis is outlined below, followed by an overview of additional twitter data explores the top tweeters using the #suicide in their sharing. Top tweeters were identified as those who appeared more than 30 times.

Results

The majority of tweets during our analysis period were shared by individuals, rather than organisations. It is important to note that none of the prominent Australian suicide prevention organisations tweeted during this period using #suicide. This may be a result of the timeframe we undertook the analysis not being within periods where suicide is primarily discussed (e.g. WSPD, Mental Health Month, release of ABS death data). Those tweeting heavily during our analysis period included: @Suicide in the media, @ johno0910, @ Living_Works, @LifeinMindAU, Academic institutions (@GriffithNursing, @CurtinUni) @MindframeMedia, Lived experience advocates (e.g. @ingioz, @PaulVittles), Academic journals (@theMJA, @PolicingInsight).

Analysis of the content of tweets is difficult to explore and describe in a meaningful way due to the brevity of Tweets and the ways in which tweets are retweeted and liked. We undertook a line by line analysis of each of the Australian tweets. During the analysis period, and the prominence of the COVID-19 pandemic in Australia at that time, not surprisingly the focus was primarily on speculating the connections between COVID-19, lockdowns and distancing and the impact this might have on vulnerability that can lead to suicide.

The choice of language, alongside the character count limitations of Twitter, result in more direct and far more pointed posts than were observed on Facebook. For example,

The Mental Health Pandemic Prior to #COVID, #suicide was the leading cause of premature death in Australia's young adults. This will undoubtedly worsen... Read more in my blog @ceda_news @EY_Australia @EY_Sustainable @BrogdenLucy @SafetyOz @jononicholas

And,

Australia's #suicide rate could surge up to 50 per cent as the mental health impacts of the economic fallout from the #coronavirus #pandemic take hold. So, what is Australia's pandemic mental health plan? Listen here: #SuicideAwareness @RadioNational'

The timeliness of twitter allows for information to trends in real time. During the analysis period there was a strong focus on new research identifying concerns about youth suicide and the use of anti-depressant medication. These two priority populations were highlighted with no focus on any other priority population groups during the analysis period. The remaining tweets focussed primarily on sharing lived experience of suicide or offers of support, for example,

*6 Australians die every day from suicide...my loves YOU ARE worthy of life!
#AustralianSuicides #Australia #NotAlone #Worthy #Suicide #Six #Love
#MentalHealth #MentalHealthAwareness #Life #Smile #BeHappy #Strong*

Tweets can be shared in a number of ways, they can be 'liked', 'bookmarked' which allows the user to save the post for future reference, 'retweeted' to share the tweet within their own network or 'retweeted with comment' to add to the conversation. From the posts reviewed in the time period 4 of the 106 tweets were retweeted more than 10 times (one was retweeted 43 times) with the most popular tweet from an anonymous user stating,

#Suicide Rise to Kill More than Coronavirus in Australia

Mindframe tweets continuously—which may be automatic—urging users to use safe and responsible reporting on suicide in the media. This continual focus on how to share utilising the Mindframe guidelines was not noted on other social media platforms analysed, yet provides a good reminder that scheduling posts can help to support consistent messages over time, particularly on a platform where information is shared rapidly.

In addition to the hashtag #suicide, users also included up to 12 other hashtags to support and refine their Tweet. Common additional hashtags were #mentalhealth, #coronavirus #PTSD #Australia #lockdown #loneliness and #trauma.

Summary

The limited number of characters permitted in a Tweet results in sharp, timely tweets responding to contemporary topics. The manner of engagement with Tweets also allow for an ongoing conversation between people across broad locations, and with different contexts. Meanwhile, scheduling posts can shape conversation (e.g. Mindframe media) providing continual reminders about safely sharing suicide information.

While organisations used this platform less, individuals from within organisations, academics and those with lived experience of suicide use this platform to share and engage with information. How hashtags and ‘tagging’ are used to further conversations have the opportunity to both extend the conversation (if used well) or inhibit the impact of Tweets.

Podcast analysis

Podcasts provide a relatively new genre for self-publishing from relatively short one-off recordings to longer series that explore all topics, including health and behavioural podcasts. This genre of storytelling has exploded since the series *Serial* which explored the impact of a missing young woman and a contentious issue of justice and racism in the American legal system. Each month 1.6 million Australians download a podcast to listen to (Morgan Gallup, 2019), thus this is a powerful and popular way in which to present information to wide and diverse audiences. Podcasts provide an opportunity for curated, as well as unpolished narratives to be directly shared to listeners via apps and streaming services at no cost, or via a subscription service. There are no current guidelines regarding the role of mental health information sharing as a public health messaging tool, yet podcasts and their exponential growth provide a unidirectional opportunity to profile different aspects of suicide within the Australian community.

While unidirectional in a podcast reaching out to listeners, many narrators also have other platforms through which to engage with their audience, as well as podcast servers having 'like' or 'comment' functions. Oftentimes, podcasts include multiple voices, through dialogue, interview style or investigative reporting. For example, in September 2019, writer and comedian Rosie Waterland spoke to podcast host and Australian media presenter Osher Gunsberg on the 'Better than yesterday' podcast. She explored her lived experience of childhood trauma, suicide attempt, mental illness and being admitted to a psychiatric hospital. The 90-minute episode explored the impact of being a continual survivor in the context of suicide prevention and the impact of sharing personal stories of suicide attempt and recovery. An important aspect that Rosie Waterland highlighted during this interview was that while, in her shows she shares personal information about her history and she is emotionally prepared for that, what she struggles with is the deluge of others stories shared with her post show as people feel compelled to share their story with her. This is a poignant reminder of the readiness of people to tell their suicide story, but the unintended consequences that are potentially burdensome when one does open this dialogue.

Methods

Using Listen Notes, podcasts narratives were extracted. Listen Notes is a database that aggregates podcast information from multiple sources allowing the research team to capture all episodes published in Australia in the past twelve months. Inclusion criteria focussed on episodes where suicide was mentioned in the title or description of the episode and using search terms of SUICIDE +/-OR SUICIDE ATTEMPT*.

The initial database extraction identified over 1000 episodes in the time period. Further manual searching to remove duplicates, and irrelevant episodes (for example, information regarding conspiracy theories relevant to the US, information regarding the release of the

US film 'Suicide squad' and episodes where a suicide crisis number was included but suicide was not the content of the episode) were removed. This resulted in 545 episodes being collated in a spreadsheet for analysis identifying, date, producer, production company and episode description. A line by line analysis was conducted on the podcast description.

Results

Descriptions for episodes stretched from 1-2 sentences (primarily those where podcasts were an alternate publishing source after a live to air broadcast such as ABC Radio national) to over 800 words. There was a correlation between length of description and the inclusion of support line phone numbers for listener distress, with longer episodes identifying both phone numbers as well as providing distress or trigger warnings for listeners.

The analysis was divided in to 6 categories based on the perspective of the main narrator of the podcast. Each is briefly presented below.

Lived experience of suicide attempt: When suicide attempt was the focus of the podcast, as was the case for 133 of the 545 episodes retrieved, the complexity of suicide was explored. This included a variety of topics including (in order of prominence) workplace, mental health, childhood abuse and adversity, men's health, sexual abuse, domestic violence, sexuality, relationship breakdowns and economic hardships. Migration issues and challenges for refugees were also explored. This was in stark contrast to the brevity of the stories and lack of diversity noted in the mainstream media, Facebook and Twitter. Many of the podcasts followed the narrator's journey through adversity to finding support to engage in a meaningful life. Language used to describe suicide was broader than in the curated feeds in other media, using a variety of terms including deliberate self-harm, self-harm, attempt, or attempted to kill themselves. Of note where podcasts where the workplace featured as a key reason for the suicide attempt, including for veterinarians, police, hospitality, mining and construction and the defence forces.

Suicide bereavement: While the prior analysis of mainstream news media and Facebook more often included suicide bereaved individuals, only 10% of podcasts contained bereavement narrates (51 episodes). The majority shared stories of the suicide death of a friend or a son (primarily from the perspective of mothers, or from male friends of a male deceased). Interestingly there was more scope to explore bereavement from a community perspective when clusters of suicides occurred, or where the ripple effects of a death by suicide were able to be discussed. Outlier conversations such as a teacher's perception about the impact of a young person's death were also shared, as were the disfranchised stories of ex partners reflecting on a death by suicide.

Organisations: 198 of the 524 episodes included details about organisations and service offerings, while also including information about stories of people engaging with those organisations.

Political messages: 38 episodes focused on political issues in relation to suicide. Published by SBS, NITV or ABC, the prominent voices within these episodes included Health Minister Greg Hunt, Prime Minister Scott Morrison and former Prime Ministers Turnbull and Gillard. Conversations generally focused on funding boosts for suicide prevention activities. Former Prime Ministers spoke more critically about Aboriginal and Torres Strait Islander suicide rates, as well as the need to engage in a more meaningful debate about strategies to reduce deaths by suicide. Political narratives regarding rates of concerns for deaths by suicide or suicide attempts on Manus Island were also raised, however these episodes were presented more as news segments rather than meaningful conversation or storytelling narratives noted in the inclusion of lived experience.

Professional experts (academics, health professionals): 31 episodes involved a focus on reporting research, and/or included academic or a mental health clinician to explore new advances in suicide prevention or extend the conversation regarding how the listener could engage in linking theory to practice. Similar to the newspaper analysis the inclusion of statements such as ‘according to a survey/new research...’ or ‘a study states that...’ In such episodes it was rare that a balance with ‘personal expertise’ from someone with lived experience of suicide would be included.

Summary

Podcasts are a fast-growing medium for lived experience voice to be captured and shared with a large audience. Analysis of the Australian data identified 545 episodes that mention suicide or suicide attempting in the last nine months.

Podcasts provide scope for highly produced content to be shared, as well as self-published content sharing insight into the experience of attempting, death by suicide and suicide bereavement.

In comparison to other new media, podcasts prioritise the lived experience voice with an emphasis on lived experience of attempting. Organisations have a small focus in these narratives as well as experts in the suicide prevention space.

Narrative non-fiction

Individual's narrative non-fiction accounts of suicide were also analysed within the Public Voices arena. These self- or -professionally published books provide for in-depth accounts of suicide from the perspective of the teller. Broader examination of the topic is able to be performed within this lengthier format. The analysis included the use of the National Library of Australia database, from 1991 onwards, following the landmark publication of Anne Deveson's (1991) 'Tell Me I'm Here,' where the author recounts the challenges she experiences in caring for her mentally unwell son through his battle with schizophrenia, suicide attempts, drug addiction and ultimately suicide death.

Reflecting on the process of penning the memoir of her brother's death by suicide, *On My Brothers Shoulders* (2015) Tara Lal noted that 'what had started as an expression of my confused emotions and in many ways, a repressed grief, turned subtly into what I can only reluctantly describe as a memoir based on a vague chronological flow through the defining events in my life. There was something about writing beyond the cathartic process that made me view my life very differently' (Lal, 2015). The therapeutic benefit of writing has long been established in the realms of socio-narratology, with Arthur Frank, author of *The Wounded storyteller* (2013), suggesting that, as similar to Lal, that allowing our stories to breathe outside of ourselves allows the writer to connect with the reader by externalising experiences as a way to understand how lived and living experiences can shape an individual.

In this section of the report the research team sought to identify how the social discourse of lived experience of suicide is included in written text. Not all lived experience is consumed by listening to speakers, sharing a social media post or reflecting on a statement, the use of books as a way to share expertise without relying on the teller to constantly 'tell' is the earliest forms of lived experience sharing.

Methods

Through analysis of keywords used to describe the books, identification of memoir, biography, autobiography or review are noted, as well as the perspective of what type of lived experience was included. Due to time constraints review of the books were limited to title and blurb analysis. Quantitative analysis of the sample of 48 books retrieved from the National Library of Australia (Trove) database reveal a gender bias with more female writers (n=27) publishing autobiographical stories on their experiences with suicide compared to male authors (n=21).

Results

The amount of information offered in the summaries or the book reviews vary. The search results revealed a complexity of perspectives in which the narratives were shared, including

perspectives from sportspeople and people with disabilities who reported suicide as a part of their life narrative. This search was supplemented by one member of the research team who had reviewed narrative non-fiction for her doctoral studies. The most common types of suicide events, covered by both male and female authors, include suicide bereavement (n=20) followed by accounts of suicidal ideation (n=13) and attempted suicide (n=13). Only 3 books referred to a combination of experiences involving both bereavement (following the suicide of family members or peers) and subsequent suicide attempts.

We further examined the gendered differences between topics presented by male and female authors. The majority of male authors shared stories of their personal experiences with suicidal ideation and suicide attempts. Few male authors spoke about experiences involving suicide bereavement. Factors leading to the authors' suicide ideation and suicide attempts, and included mental health issues, substance abuse, relationship breakdowns, financial difficulties, unemployment, PTSD, physical trauma and complex grief and loss as precursors to suicide.

Meanwhile, the types of suicide experiences covered by female authors (personal experiences versus suicide bereavement) were broader and included family abuse, mental illness, childhood trauma (including Stolen Generations). These experiences were identified as triggers for suicide ideation and attempts. When writing about suicide bereavement, female authors appear to be focused on understanding and making meaning from the suicide death. Many concluded with a call to action to use their experiences to inform others and shape community awareness about suicide prevention.

Summary

Memoir is a traditional medium utilised as a way of sharing insight into a life experience or reflecting on coping strategies to share with others who may have similar experiences.

Narrative non-fiction works in Australia, that explore suicide and suicide attempting are primarily written by women and focus on reflections on suicide bereavement. Male authors explorations focus more on responses to trauma and strategies to overcome distress.

The role of writing as a therapeutic activity may be the trigger for people to explore their experiences, however the scope for awareness about lived experience is impacted by books only offering a point in time reference rather than an ongoing reflection on the suicidal journey.

Submissions to Government Commissions or Inquiries

While the other sources analysed thus far detail highly public commentary on suicide, submissions to Government appointed commissions or inquiries are also generally made public but are not as prominent in the public domain. The submissions to the enquiries are confronting, and often detail horrific stories of abuses and injustice. The general remit of these commissions and inquiries is to find new ways of ensuring these events are not repeated. As part of our review of 'Public Voices' of suicide in Australia we reviewed submissions made to three current hearings to understand the background reasons for suicide and the key topics being presented.

These public submissions, for the purposes of this project were sourced from three enquiries:

- Royal Commission into Institutional Responses to Child Sexual Abuse
- Productivity Commission Inquiry into mental health
- Commission into Victoria's Mental Health System (where suicide was recorded in individual submissions)

A fourth, The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (currently in progress), had been planned to be included but was excluded. This was due to COVID-19 resulting in a break in hearings and the submissions not yet being made public. It is important to note that inclusion of suicide has been identified in the preparation of the development of the terms of reference for the commission.

Methods

The scope of submissions sourced were selected based on public submissions where the intersection between inclusion of suicide journey or engagement in health services was included. The search strategy utilised for the analysis involved online filtering as a way to identify public submissions that have been provided on public facing websites managed by each Commission/Inquiry. All submissions using the search term 'SUICIDE' were downloaded into a spreadsheet and thematically analysed. In addition to the public submissions, outcomes of each enquiry including inclusion of public narratives in the development of policy or service changes were also included for analysis.

Given the varying Terms of Reference and the focus of each inquiry, each section has been analysed individually. Each dataset was analysed to identify reasons for suicide death (reported by kin or non-kin of deceased), reasons for suicide attempt, engagement with others (included health services) and identified touchpoints where support may have been able to have been provided to change the course of action.

Royal Commission into Institutional Responses to Child Sexual Abuse (2013-2017)

The Royal Commission into Institutional responses to child sexual abuse was conducted over a five-year period to identify the incidents and impacts of child sexual abuse that occurred in institutional contexts. The final report, published in 2017, identified the stories of those who experienced abuse, as well as recommendations regarding safeguarding of Australia children into the future.

The call for submissions was broad and allowed people to reflect on their own stories of abuse, as well as organisational responses and experiences of families who told stories on behalf of those unable to share. In reviewing public submissions and inclusion of public narratives in summary findings the research team identified 273 records where 'suicide' was included from the perspective of an individual.

Reasons for suicide

Given the focus of the Commission was on the institutional response to sexual abuse against children, the connection between sexual abuse and trauma, alongside significant distress and ongoing impacts of childhood trauma were predominant. The commonality between each submission related to disclosure regarding sexual abuse that occurred within institutional settings. Commonly these events occurred within religious institutions (both in Church and in settings where religious organisations provided services such as in care homes, respite services or recreational activities), in school settings (centred on instances of child to adult abuse, child to child abuse or instances where multiple children were abused by an adult in a position of power – principal, teacher, teacher's aide), and finally settings where care was provided to children who were unable to remain in their family home. Members of the Stolen Generations of Aboriginal and Torres Strait Islander people making submissions often reflections on intergenerational trauma experienced due to further injustices as a result of Government removal of children which places these people into abusive environments.

Submissions stretched from 1-2 paragraphs to full page submissions, exploring the scope and impact of the childhood sexual abuse. There was not one predominant theme related to individuals' journeys of suicide attempts. Some submissions noted suicide early - soon after experiences of abuse commenced, with others not engaging in behaviours that would clinically be described as attempting behaviours until decades after the abuse was perpetrated. The submissions focussed on the behaviours that developed as a result of the abuse– drugs and alcohol use, significant reflections on relationships where domestic violence was perpetrated or experienced, disconnected relationships with family members exacerbated by lack of disclosure by some, or where disclosure had occurred yet the criminal justice system had not responded appropriately. There was also significantly reflection on criminogenic behaviours and descriptions of a pipeline between trauma

experienced, entering the juvenile justice system, continuing to reoffend as adults and then re-entry into the criminal justice system as an adult.

Many of the participants narratives concluded with a focus on identifying what strategies may be able to address or support the suicidal ideation; feelings of not wanting to be here, or ways to address their experiences of trauma as they continue to attempt to live their lives after the abuse. Significantly the opportunity to speak openly in a protected space such as the commission was described as transformative for many of those who submitted their stories, in addition being appropriately acknowledged by the national redress scheme, or receiving compensation was integral to feeling acknowledged and a by-proxy apology for the experiences of trauma they had experienced.

In addition to the mechanisms that sought to acknowledge that the trauma happened in the first place, a number of submissions focussed on the protective strategies developed as a result of subsequently having their children – that in order to stay alive, or challenge pervasive thoughts about wanting to die by suicide – people shared that thoughts of their children, and not wanting those children to experience trauma via suicide bereavement inhibited their capacity to harm themselves. Some of the submissions reflected on having their own children taken into care, and the fear and further traumatisation by engagement in the care and protection system. For those in gaol as a result of criminality following abuse, unable to access the redress scheme or seek legal advice regarding compensation, further, ongoing trauma continues while their voices remain silenced.

Those bereaved by suicide, who shared their perspectives as carers of people who have died, echoed the same touchpoints shared by those with lived experience of suicide attempting. Sense of guilt at not being able to protect or resolve the impacts of trauma, also identified carers of those who died by suicide in response to child sexual abuse may also be an at-risk group. Being invited to share the stories of those who had died by suicide provided scope therapeutic to share stories, in the same way those with lived experience were able to.

Connection with services

Often simplistic descriptions of engagement with health services were noted, if present at all. Submissions identified a sense of not being heard in relation to descriptions about coping with trauma, or lack of awareness about the extent of the abuse or extent of the impact of the abuse on the person for decades after it occurred. Health services that focussed on drug and alcohol issues, to the exclusion of trauma-informed practices were noted, failing to appreciate the interconnectedness of abuse and co-morbidity with addiction and mental ill-health/illness. Management or dismissal of aggressive behaviours was commonly reported, rather than understanding of the reasons below difficult behaviours. Siloed referral systems that sought to resolve each issue separately were not viewed as useful when people experienced intense feelings of shame, disconnection and

cultural or familial disruption experienced by these adults when they were children seeking care and protection in institutional settings.

Productivity Commission Inquiry into Mental Health

The Commonwealth Productivity Commission identified the need to consider the role of mental health of individuals and how this supports economic participation. The goal of the Inquiry (please note the final report is due June 2020) seeks to make recommendations regarding strategies that may improve population health specific to mental health as well as long term approaches to participation and inclusion.

In reviewing public submissions and inclusion of public narratives in summary findings, the research team identified 48 records where 'suicide' was included from the perspective of an individual. These summaries have been explored below. Where parts of submission text are used they are presented verbatim with identifying information redacted.

Reasons for suicide

Many of the submissions including 'suicide' centred on the role of productivity and the ways in which it inhibited inclusion of people living with mental ill-health, trauma or significant challenges caused by social determinants of health that impacted their wellbeing. Submissions were from those working in the health and human services industries reflecting on cases where interventions lead to better outcomes for individuals (see touchpoints analysis below) or alternatively from people (primarily parents or adult siblings) who were bereaved by suicide.

Risk factors identified for suicide including living with complex and persistent mental illness, particularly where this resulted in frequent or long hospitalisation and lack of opportunity and/or ability to participate in meaningful occupation. Longstanding issues with 'treatment-resistant' mental illness particularly related to psychotic disorders such as schizophrenia or difficult to manage bipolar disorder were also described as triggers for suicide death or attempt.

Co-morbid alcohol and other drug addiction was common, as was addictions to gambling, increasing individual's distress and ability to manage life's challenges. Exposure to other's suicide attempts or deaths were also reported. Broader health issues such as the inclusion of co-morbid conditions were described, alongside engagement with NDIS as a result of lifelong disability, or trauma-induced disability where a person's life stage was impacted by a change in their mobility or wellbeing. Those living with Autism spectrum-disorder were also included in submissions along with adverse childhood experiences and trauma and disclosures of child sexual abuse within submissions that mentioned suicide.

How these factors have impacted the person related to both external and environment influences. These included workplace stress, workplace discrimination and bullying as well

as a pervasive identification that workplaces fail in their duty of care to provide safe working conditions for individuals leading to high levels of distress. Given the focus of the Inquiry, housing and homelessness were common issues related to developing suicidal thinking or alternatively a result of suicide behaviours. This included risk of long-term homelessness, distress regarding ongoing housing stability, lack of stable housing to allow for engagement in the workforce, intergenerational impacts of lack of housing affordability as well as insecure accommodation by housing services were described as factors that impacted a person's death by suicide. Health system policies were reported as rigid, and resulting in an inability to provide the care and support needed,

At HOSPITAL, discussions about accommodation and the possibility of going back to his public housing unit distressed NAME, resulting in his mental health relapsing. HOSPITAL protocols prevent clients being discharged to homelessness. NAME was therefore unable to leave hospital even though there were other people with more critical needs for acute care.

Relationship distress was a prominent theme in the submissions – domestic violence that led to suicide attempts, relationship breakdowns that exacerbated disconnection between family members (particularly through the family law court) were described, as well as those who had been suicide bereaved (primarily death of a parent) in childhood were also identified as life journeys that impacted long standing suicidal behaviours later in life.

Concerns and anxiety from carers, as they aged, was also identified as a risk, both to the person receiving care as well as the carer. One submission stated broadly that *'the problem is the problem'*, meaning that the systems created to provide a safety net for individuals in terms of their health, welfare housing and work was 'broken' and that this was a factor leading to distress amongst people in the community.

Connection with services

Given the invitation for services to offer submissions to the commission, a number of health and welfare agencies reflected on case studies as a way of identifying how addressing social determinants of health, as well as inclusion of psychoeducation services could impact reduction of suicidal thoughts and behaviours. Services such as 'Living beyond suicide' were promoted, as a way of addressing behaviours without an institutional focus such as crisis response by emergency departments. Housing support was also key, in terms of the health economic costs, and the ripple effect of the way in which housing triggers underlying concerns for safety of individuals,

'Staying in hospital costs the NT government about \$1500 per day. The cost of TeamHEALTH providing short-term care in a supported accommodation is \$550 per day. NAME stayed in TeamHEALTH's short term accommodation rather than hospital for 6 days.'

Touchpoints

The submissions presented insight into the ways in which the lives of people who may be at risk of suicide, or died by suicide could have been supported to change the course the person was on. Calls that advocated for health services to practice from a strengths-based, humanistic perspective, allowing individuals to see the possibility within their own life experiences and current environment, was viewed as a way of minimising distress.

Submissions from carers spoke to the need for increased involvement of carers, particularly parents, in the lives of their unwell adult children. Submissions noted awareness of the implications of privacy legislation but also reinforced the need to include those with knowledge about the current and historical factors that led to distress, needing to be acknowledged. Some submissions focused on the responsibility of workplaces,

have to take on more responsibility when it comes to its employees and they will also benefit from this with more productivity

Family-friendly practices were suggested as a way of minimising the impact of work-related stress and anxiety on people who may be vulnerable to suicide attempts trying to manage multiple and competing interests.

The distress caused by overlapping issues that were dealt with by a variety of organisations, often with no coordination was reported. Suggestions provided included provision of safe housing, responsive mental health support that viewed the persons individual needs, and addressing problematic addiction behaviours as a way to uncover why a person was feeling unable to cope. When this occurred, it was lifesaving,

Something changed when I moved into Ngatti House. Ngatti House did not save my life, instead it helped me save myself, for this I am forever grateful. I have hope now, I have dreams back... I'm not afraid anymore.

Where a suicide attempt was reported to have occurred, and suggestions for minimising ongoing risk were provided, these focused again on person-centred care provided within a strengths-based service delivery model,

A previous suicide attempt is a strong indicator of risk, which in this case was compounded by NAME's involvement in an abusive relationship, and the sense of loss over this relationship. Her worker recognised these as risk factors and sought to take appropriate action.

The need to ensure that services were incorporating a bird's eye view of the whole of person and their wellbeing, understanding that situational life events and crises created distress, and in turn, provided an environment of risk behaviours, suggests that a holistic case management approach is required,

NAME was connected into financial counselling as she had a number of bills she was unable to pay. NAME was also supported with a number of practical matters including assistance in obtaining school uniforms for her son, and some emergency assistance with food. The Financial Counselling also recommended talking to the Bank and seeing if there were ways they could assist her to manage her Mortgage repayments. Living Beyond Suicide supported her with the meeting at the Bank, and they worked with her on a management plan, so she could successfully make her repayments. NAME has been connected to an Arabic speaking counsellor to provide support her with her grief. Amal's son was assisted in developing a "memory box" where he could store photos and other keepsakes from his father.

And,

Without the support NAME has received from SERVICE, the combination of grief and financial stress means she is vulnerable and at risk of developing a mental illness herself. The kind of wrap-around intervention service she has received that addresses her multiple needs is critical for minimising that risk.

Royal Commission into Victorian's Mental Health System

The remit of this commission is to 'provide the community with a clear and ambitious set of actions ... and enable Victorians to experience their best mental health now and into the future' (RCVMHS, 2020). Submissions were requested from the public to share their experiences of the mental health system to assist in the Commissioners meeting this aim.

The Commission highlights several of the current issues within the mental health system in relation to suicide and mental health. When searching the submissions for those containing the word 'suicide' 17 were identified and analysed by the research team.

Reasons for suicide

The submissions identified a number of factors that may lead to suicide, including exposure to childhood trauma, persistent and complex mental illness that required multiple interventions by health services that appeared inconsistent or non-existent,

It seemed to me that no-one was helping him

Frustration at the lack of services present or seemingly intervening prior to death was a clear frustration. Across those where a person had died by suicide, systemic failures followed them across health and social care services highlighting concerns about post-discharge from mental health facilities or emergency departments and people dying very

soon after leaving a facility. Difficulty in accessing care was noted. Attitudes of staff in mental health facilities were noted as negative, flippant, rude or demeaning in their initial consultation, further negatively impacting on a person's deteriorating mental health. A predominant theme was a sense of not being heard,

I was told NAME was an attention-seeker who would not take his own life

Touchpoints

Most submissions made recommendations for how the suicide outcome could have been averted and managed better throughout a course of events. These include the need for front line health staff to be adequately equipped to effectively and professionally manage a person who expresses suicidal ideation/plan or intent, and that this could be enhanced by education and training that steps beyond the potential risks and understands the triggers for distress.

The challenges faced with poor post-discharge care, is also a potential for intervention. This is particularly where carers are asked to become guards on 'suicide watch' without adequate support for what this means, and how to do this. The overarching comments were that families were ignored while the family member was in care, however as soon as discharge was looming they were expected to be on standby to take over. Most tragically, in the case below, the health service only engaged with the carer following their daughters death,

My daughter suffered mental health issues and it took 12 years for someone to talk to me but by then the damage was done. She tried to take her life in the hospital and [METHOD]. We went to the hospital and it was taped up, and she was sent home. They told us someone would call tomorrow, and no one rang. In early December she got sent into hospital to review her medication and cut her wrists in hospital with a CD. They let her out and she suicided nine days later. Now they all want to talk to me, only once she has died

Summary

The three commissions/inquiries reviewed identified a total of 338 submissions where 'suicide' was included in the submission narratives.

The reasons for suicide attempt/ideation or reflective analysis regarding reasons for death by suicide noted a spectrum of life events that culminated in a suicide death, or was a trigger for distress leading to thoughts of attempting or attempting.

Diverse factors such as adverse childhood experiences – death of parent, child sexual abuse perpetrated by those in power, child to child sexual abuse, domestic violence, intergenerational trauma, being placed in the care of the state as well as school related trauma such as bullying were described.

Additional factors that were described as exacerbating risk were also included – long term association with health services due to complex mental illness, treatment-resistant disorders, disability and trauma-related distress were also seen to exacerbate risk. Especially when care was fragmented, not person-centred or reliant on a silo approach to addressing a person's needs.

Social factors such as poverty, housing, work-related engagement and experiences of distress in terms of managing responsibilities such as having young children, or relationships were also seen as key factors that needed to be addressed when developing suicide prevention initiatives.

Report 2: Private Voices

Background

The perspectives of people with lived experience of suicide have been increasingly acknowledged as vital to informing suicide prevention research. Historically, suicide prevention research has been dominated by biomedical framings of the issues and positivistic research methods that exclude people with lived experience by positioning them paternalistically as persons with impaired decision making or too high-risk to participate. The relatively recent emergence of critical approaches to suicidology is a challenge to this individual deficit approach, highlighting the way it ‘deflects blame away from other persons, relations, or social arrangement that may be implicated in the emergence of hopelessness and suicidality’ (White & Morris, 2019: 6). From a critical perspective, the moral, social and structural arrangements that produce and sustain dominant paradigms are relevant to how we understand public health issues. At the same time, a critical approach opens a space for people with lived experience to contribute their own narratives, and challenge deficit constructions of their subjective reality.

Studies examining the motivations of people with lived experience to participate in suicide prevention research concomitantly show ‘sharing without censure’ is a primary reason to participate. The opportunity to tell one’s story anonymously through an online survey without being faced with the judgments of others provides a rare opportunity to speak freely and feel heard (Gibson et al., 2014). This is particularly important for people who feel they cannot speak to family and friends due to fear of their reaction (Littlewood et al. 2019). Participants also describe being motivated to participate because it provides an opportunity to make meaning of their situation, overcome stigma and promote healing (Dyregrov et al. 2010; Gibson et al. 2014; Maple et al. 2020). The other primary reason for participation offered by research participants, and not disconnected from wanting to reframe this space through telling their story, is that they want to help. This is described in connection with wanting to expand the knowledge base about suicide prevention; wanting to improve service delivery so others do not have negative experiences as they did; and to challenge the psychiatric lens (Dyregrov et al. 2010; Gibson et al. 2014; Littlewood et al. 2019; Maple et al. 2020).

Numerous studies have shown that participating in suicide research does not increase risk of suicide for people with lived experience (Andriessen et al. 2018; Owen et al. 2016). In studies where participants reported some distress, they also reported this was manageable for them and did not offset the benefits of participating (Maple et al. 2020; Owen et al. 2016). Whilst individual research narratives are inter-subjective and partial in what they can tell us about the causes of suicide (Bantjes and Swartz 2019), there is a clear ethical imperative in the context of rising suicide rates and in line with the biomedical principles of

respect for autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress 2009) to create discursive opportunity for people with lived experience to speak and be heard. Lived experience research is an empowering and therapeutic space for the construction of agency and resilient identity, in addition to space for the validation of knowledge and feelings and new knowledge to inform models of care.

Methods

The survey used for data for this report was already open for data collection at the time it was agreed for it to be included, and had ethics approval from the University of New England Human Ethics Committee (HE19-242). The survey is ongoing and hosted on the Qualtrics website. It is an open-ended survey with broad questions regarding experiences of suicide for individuals over the age of 18 to respond to. Depending on the amount of information entered, the survey could take between around five to 30 minutes to complete. The only demographic information collected is gender (male, female, non-binary), age and country of residence (as this is a global survey, only Australian participants are included in this report). Participants can then select multiple experiences of suicide including suicide ideation, suicide attempt, care for someone who has made an attempt/subsequently died, bereaved by suicide, or any combination of these experienced. Survey questions were open-ended and focused on the person’s suicide journey through broad questions asking the participant to provide details of the contributors to suicide, how they define ‘lived experience of suicide’ and the role that lived experience can offer suicide prevention. For the purposes of this report, we specifically focused our analysis on examining the reasons participants gave for being suicidal, what supports and services they had been, or are in touch with and where barriers and enablers of suicide prevention activities might be present.

At the time of analysis for this report (downloaded 31 May 2020) 1780 individuals had opened the survey, with 1652 survey respondents included in the analysis after empty records, those not located in Australia, and 1 under 18 years were removed.

18 - 24	129	7.8%
25 - 34	152	9.2%
35 - 44	287	17.4%
45 - 54	505	30.6%
55 - 64	422	25.5%
65 - 74	137	8.3%
75 - 84	17	1.0%
85 or older	2	0.1%
No response	1	0.1%
Total	1652	100.0%

Table 2: Survey participants ages

The survey of lived experience of suicide, used for the purposes of this report is limited to the design of the original study and thus does not adequately reflect diversity across the community. There were no demographics questions to identify key groups, including LGBTIQ+, Aboriginal and Torres Strait Islander people, or those from culturally and linguistically diverse groups. While some people mentioned membership of these groups in their survey entries, this limitation must be acknowledged. Specifically, the balance was 84% female, 13% male, 2% non-binary, with 12 not responding/prefer not to answer this question. In the table below, the reported exposure to suicide is grouped by gender, noting the higher prevalence among non-binary participants in relation to suicide ideation and attempt. Participants could choose multiple exposures to suicide.

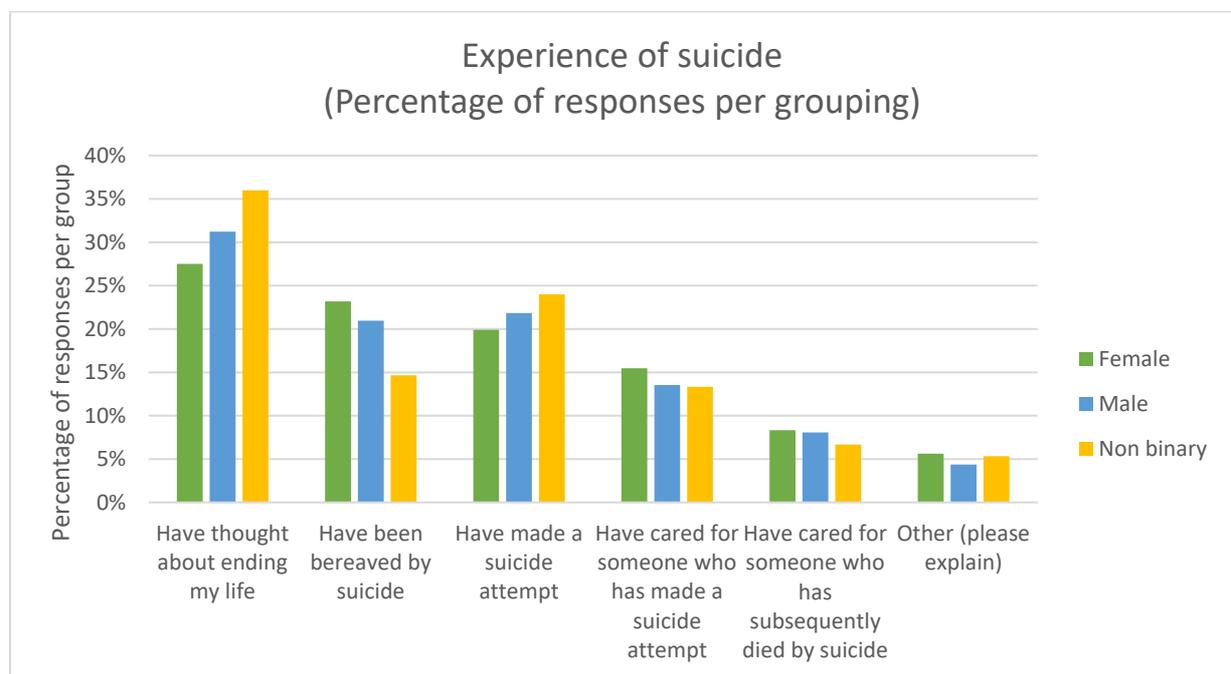


Figure 3: Survey participants reported exposure to suicide as percentage by gender

A critical public health perspective with consideration of the social determinants of health and health and social equity underpinned the data coding. Coding was performed in Excel using pre-determined headings to meet the objectives of the study in the time permitted for analysis for this report.

Where quotes are reported they are done so verbatim, with no changes to spelling or grammar. Some quotes have been truncated for the purposes of this report given the length of submissions were often extensive.

All language as used by participants in the survey is preserved. This applies even where words used are those which are not recommended for public use (e.g. 'committed' or 'successful'). We have retained the words as presented by the participants as an important

reminder of the language used by members of the community, even where this differs to how researchers, service providers and policy makers wish to see language used. This also includes spelling errors and grammatical errors. Specific suicide methods have been removed and replaced with [METHOD].

Overview

Survey respondents were a heterogeneous group. Reasons for suicide were multi-factorial. Many respondents described a life-long trajectory of cumulative and compounding trauma and distress, often beginning with childhood abuse, in addition to diagnosis of a mental illness or mental health disorder. Many respondents reported multiple psychiatric diagnoses. Interactions with family, friends, colleagues, health professionals and other services were pivotal in the course of the person's journey either compounding or alleviating the person's situation. Respondents came into contact with many potential service touchpoints throughout their lives, however, past negative experiences with health services, typically characterised as stigmatising, unhelpful and traumatic, and subsequent distrust of the system were significant barriers for people in accessing support. Affordability of services was another primary accessibility issue, particularly for respondents with low income, unemployment, or living in a rural community with limited services. There was a significant equity issue around lack of available public health services, waiting lists for public health services, not being able to afford private services, and lack of continuity of therapeutic care in the public health system. Access to ongoing, therapeutic and compassionate care was identified as the key enabler to service accessibility and integral to respondents' positive experiences with service providers. These findings pointed to the need for wide scale de-stigmatising strategies including resourcing of a trained and specialised workforce and enhanced inter-agency collaboration as part of a collective responsibility for addressing the antecedents to suicide and suicide prevention.

Reasons for suicide

The vast majority of respondents describe their suicide experience as multi-factorial and complex. Many respondents described a life-long trajectory of cumulative and compounding trauma and/or distress leading to a suicidal ideation or attempt(s). While many report psychiatric diagnoses, there were very few where suicidal ideation or attempt was related discretely to a mental illness that was resolved with treatment or support (or resulted in completed suicide). Among respondents who described a trajectory of cumulative and compounding trauma and/or distress, interactions with family, friends, colleagues, health professionals and other services were pivotal in the course of the person's journey, either compounding or alleviating the person's situation. In this way, reasons given for suicide experience are intertwined with respondents' interpersonal relationships and interactions with health and other systems. 'Touchpoints' are part of the story. Whilst we have categorised the reasons for suicide experience below, the narratives shared by respondents

paint a picture of intersecting health and social issues over time and emphasise strongly the need for a contextualised and holistic approach in supporting people with suicidal ideation or who have made a suicide attempt.

Due to the rich tapestry of reasons provided for suicide to be present in a participant's life, we first present issues identified across the lifespan from childhood through to older age.

Childhood and adolescence

Many participants told of devastating actions taken against them in childhood that created an unsafe environment, trauma and life-long challenges. We examined these first through all data where childhood events were mentioned, and then in the youngest age bracket completing the survey (18-24 years).

Adverse childhood experiences, including sexual and physical abuse were all too common, and were consistently reported to be the first recalled source of mental instability and suicidal ideation. Other adverse experiences in childhood were also reported, such as growing up in a household where domestic violence was present, where one or both parents had undiagnosed or ill-managed mental illness. Childhood exposure to suicide, for example through the death of a loved one and the stigma and silence that surrounded these events were also mentioned as a commencement for one's own suicidal journey.

Reasons for suicide given that relate to childhood are simply summarized by this comment,

Primarily due to cPTSD caused by adverse life events in childhood. Traumas experienced during that period led to a failure to develop essential life skills and healthy strategies for coping, along with faulty relational attachment patterns. Same circumstances in the friend, who has attempted suicide. We were both socially and economically supported through childhood, but not supported through in-family traumas.

While many of these comments were made by individuals who are now adults, so abuses of childhood occurred many years ago, time has not reduced the pain. Perhaps more open discussion about care and safety of children, including through the recommendations of the Royal Commission into Institutional Child Abuse reported elsewhere will reduce the number of children exposed to adverse childhood events, as this mother desires,

Four high school friends have died by suicide with one woman in particular that shook my world due to childhood abuse and then an abusive marriage. The secrets of childhood abuse has got to stop.

Many mental illnesses start to emerge during adolescence and participants told of their experiences of mental health issues commencing during adolescence (that sometimes became worse going into adulthood) including depression, anxiety, eating disorders (particularly Anorexia Nervosa), post-traumatic stress disorder (PTSD), low self-esteem,

feeling of social isolation. Some of the same abuses that were reported in childhood continued into adulthood, while for others new abuses commenced, particularly sexual abuse and sexual assault.

Social relationships were reported as key points of strain, including relationship breakdowns with peers and family, bullying and conflict. Participants reported feeling abandoned, particularly in relation to parental conflict, separation or divorce. Some respondents described self-medicating with substances during adolescence, and many reported first suicidal ideation or attempt during this developmental period. This was also a period when people were exposed to others suicidal thinking, attempts and deaths – primarily friends,

The first time i considered suicide i was about 14 i think - 3 very important people in my life died within a two week period and i felt very overwhelmed and kind of abandoned. At the same time, i was being harrassed by people at school and those two situations ended up making my anxiety really bad - it was roughly seven months before my mum felt comfortable enough to let me sleep by myself because at that point she thought i had passed the stage of wanting to kill myself. Recently i cleaned my room out and i found close to thirty suicide notes i'd written around that time. I'm really glad i never followed through with that.

Emerging sexuality was also a key stressor reported during adolescence, along with complex relationships,

I developed suicidal ideation and eventually made a few suicide attempts after enduring about four years of depression, anxiety, disordered eating, self harm, and chronic fatigue, exacerbated by my ADHD, which was only diagnosed well into my recovery (through therapy & medication) after multiple failed treatment plans. For me, symptoms of these mental illnesses first started emerging in early high school, when I was about 12, and culminated in suicide attempts at 16 and 17, with one short-term hospitalisation in my last year before graduating. There were a lot of different extenuating circumstances & challenges (I'm sure there are for everyone) but some of the main ones included living in quite a toxic, emotionally hostile household with a very controlling parent; swapping between two households weekly for years (divorced parents); dealing with my pretty extreme perfectionism, plus my parents; coming to terms with my sexuality (I'm gay); and trying to manage my friendships and relationships with other teenage girls, many of whom were also mentally ill.

Among participants who are currently in the 18-24years age bracket, the most common of these factors that contributed to their suicide experience included bullying, conflict at home with parents, abuse, sexuality, mental illness (depression, anxiety, and anorexia nervosa were frequently mentioned), and homelessness,

I attempted suicide multiple times throughout my life as a way to escape an abusive household. I have BPD as a result of trauma that affected my mental well-being. When I was 13, my friend killed himself. Nobody knew he was struggling.

Family dysfunction was particularly stressful, related to feelings of helplessness in not being able to resolve conflicts between their parents,

I have suffered from depression off and on since puberty. I attempted suicide on 2 occasions as a teen. I was living in a blended family and felt distanced from my mother as she had a new partner. My support network was made up of peers only.

Friends often provide the strongest support network for adolescents/young adults, although respondents also reported isolating from friends during this time. Bullying was a commonly mentioned issue, resulting in a cascading decline in many cases,

There was a point where I was bullied by people that I was very close to. And so my anxiety constantly played the things they said through my mind. I started to believe things about myself that I hadn't before. I stopped eating, stopped going to class. I thought maybe I was being 'dramatic' for feeling bad about being bullied, so I didn't tell anyone. When I did reach out, the bullying got worse and subsequently, my mental health declined further.

Caring for friends with suicidal ideation or an attempt, or a friend's death by suicide during adolescence, was also common,

My childhood best friend suffered from depression and anorexia from age 11. She attempted suicide several times during her teenage years. I was her closest friend and she swore me to secrecy about these attempts, so I felt unable to confide into anyone else. Her parents encouraged our friendship, as I was perceived as a positive influence on her. I loved her very much, but retrospectively I feel I carried an enormous responsibility for her well being. At age 16 she was admitted to a psychiatric clinic. I spent several days and nights there with her, while she was trying to recover her weight. She was given medications that led her to allucinate and had intense anxiety. After that her mental health was always unstable.

For some, suicidal ideation and attempting that commenced in adolescence remained throughout life,

Lifelong depression and anxiety from absent father and violent/narcissistic mother. Suicidal ideation since puberty. Gay, rural, fearful until travel overseas. A couple of attempts, at age 20, [METHOD], aborted, and 24, [METHOD], but was discovered by unexpected visitor. Continued ideation, manageable as i have responsibility for elderly surviving parent (mother). On and off counselling since age 24, some mediocre some very good, and

overall a good learning experience. I would say i am a soulful and intelligent but broken person who will survive.

It is clear that this is not the outcome that all experience, as many of the participants in this survey told of those who had died by suicide during adolescence.

For some, although rarely reported among this sample, suicidal thinking during adolescent resolved with time, even without finding adequate support,

When i was 17, last year, and in year 12 - i didnt so much want to kill myself because i was depressed, but moreso to try and avoid the constant anxiety attacks and nervous breakdowns and the side affects i guess that came with the anxiety (my hair was falling out in patches, when im anxious i scratch and there was a point where my entire arms, back, torso and thighs were covered in bandaids or bandages to hide the wounds i'd scratched into my skin). This was the first time i saw a therapist, at the insistence of a teacher who recognised how bad i was and pretty much marched me to the school counselor. I only went to three sessions because she kept calling me a "curious case". But im 2 months free of scratching, so i am improving! And my mental health has improved a lot since graduation because im not around those people anymore

Help and support was rarely expressed as beneficial. However, the following experience is a good reminder that when health professionals can be honest with their own limitations, there can be better outcomes,

I did seek support and saw two psychologists - the first one referred me to Headspace. This second psychologist was not useful to me but we both continued to work together. I eventually began to feel like the only solution to my problem was to end my life as I was the problem. It was after my attempt that I began to receive proper support - my Headspace psychologist disclosed she did not think she was the right worker for me and I began to see a counsellor who was better suited to me and I continued to see for about 18 months. My school made reasonable adjustments to help make my school life easier and my family put an emphasis on communication.

Adulthood

While many reported significant life traumas from childhood or emerging in adolescence as key periods for onset of suicidal thinking and attempts, similar and other issues emerged during adulthood. Mental illness continues as a major theme, with depression (major depressive disorder, chronic depression), postnatal depression, bipolar affective disorder (depressive episode), anxiety, ADHD, borderline personality disorder, PTSD, C-PTSD, Anorexia Nervosa, Schizophrenia, chronic suicidal thoughts, hopelessness, low self-esteem, cumulative stress, climate change anxiety all expressed,

I suffer from depression, anxiety, substance use disorder and anorexia nervosa and have done so for many years. Finding good professional support is extremely difficult. I am also very socially isolated as I find being around people very hard. Sometimes the battle just feels too great and I cannot see any point in living or continuing to try when nothing ever gets better no matter what I do.

During adulthood physical illness also becomes part of the suicide story for many – some reporting chronic illnesses (such as chronic pain, chronic fatigue) and others with degenerative conditions (including motor neurone disease) that will result in premature death, often preceded by significant pain and disability,

have chronic pain and experience mental health issues (depression, anxiety) because of it. Thought about suicide as a valid option because life didn't seem worth living if I was going to be in constant pain all the time with no end to it in sight.

Interpersonal and relationship issues continued to be reported among adults, particularly where domestic and marriage breakdowns were reported, or significant relationship conflict. Victims of domestic violence and abusive marriages were prominent,

When I was 18 my boyfriend committed suicide by [METHOD]. I have tried committing suicide several times since I was 18 until I was 42 years old. These were mostly due to situational crises being in violent relationships and feeling like I had no other way out. I grew up in a violent home and only got out of a domestic violence relationship 9 years ago. I still struggle with suicidal thoughts and feelings but now instead of acting on them I go to my doctor and get my medication adjusted

Issues related to pregnancy, custody and access to children through family court proceedings were also commonly reported by adult participants,

My daughter was taken from me by the courts and her mother was given full parental custody, her lawyers argument was that I was a jealous ex partner just trying to get back at her. Even tho I had photo evidence of drug abuse and neglect towards the children. After leaving the court room that late morning, I went to a park which I used to take my daughter to. [METHOD], I awoke on the ground to a friend of mine screaming for help, I was an emotional mess.

Parenting challenges across the lifespan were present. As children grow older, and themselves may experience suicide attempts, parents enter a difficult phase of caring, but not being able to access information to help them care for their adult children. This can become a stressor that results in suicide ideation,

Socially, I have been so grateful for Covid19 lockdown, as I don't have to see friends, or colleagues to explain what, or why - about myself, or my child.

As a parent of an adult child in stress, you have to take 2nd place, or even 3rd as the privacy acts prohibits 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, initially. This to me is absolutely despicable given that, as parents you have known the suicidal person the longest, and have more concerns for them than you do for yourself. This privacy act in cases like these is totally out of order. I also feel shame. Shame that I, as a single mother, have not seen my child coming to this, shame that I have a child who attempted suicide, not once but twice, and shame that I am too fearful to admit it to anyone as though there is a stigma attached to it. Those that do know are now bobbing along as though life is grand - and I feel bitter towards them to think that, now the crisis is over, that I am back to how I used to be. They are blind.

Caring responsibilities for older parents, particularly where the relationship was previously conflictual or violent, or where the parent has a mental illness and difficulties associated with caring were also reported. Further, complexities of care among older couples were identified,

My father committed suicide at age 83 when he was told that my mother, aged 79, would not be discharged from hospital into his care. My mother had advanced dementia and complications from diabetes. I felt extreme guilt when he died because I had offered to take extended leave from my employment to stay with him and my mother and help out. My father asked me not to because my sister would cause trouble. That is a long story so I won't tell it here but I believed that it was true that my sister would create more stress for him and so I didn't go down to Sydney to stay with them. I still feel guilty. I understand that my father struggled with suicidal thoughts all of his life also. I was with him holding his hand when he died as he did not die immediately from [METHOD]. He had been in a coma for over 24 hours before I arrived at the hospital as I had to fly down from North Queensland. He opened his eyes and looked at me and said "I am sorry" and then he died.

Death, including death un-related to suicide such as death of a child or other loved one (family member, friend, colleague) and bereavement due to death by suicide. For some, these experiences were multiple and overlapping,

God where to start. My mother suicided (voluntary euthanasia) in March 2019. My partner tried to suicide in June 2017 while in high dependency mental health unit. He subsequently suicided in November 2019 after going off his medication. My world collapsed. My dreams for the future died with him. I have cried every day for more than 6 months. I was unable to work for 2 months. I started part time after 2 months. I'd been very driven in my career before then. Covid19 hasn't impacted me because I'd spent 4 months

socially isolated. People don't understand grief. It makes them uncomfortable. I've lost friends because of it.

Unexpected life events were commonly reported as causes of, or escalation in, suicidal thinking behaviours or retrospectively recalled as reasons for another's suicide death,

I've been through a lot of trauma in my life, my twin died, 4yrs later my mother died at 60yrs. I was in and out of homelessness. I couldn't take anymore crap!! Half way through my studies I snapped. [METHOD] 3days later I woke from a coma. And have had many attempts after, most times alcohol was involved but 3 times I was sober. The first time I was suicidal I was 15yrs, my first serious attempt was when I was 37yrs. Enough was enough

To cope with these situational crises, and life stressors, substance use and abuse, including alcohol was a common method reported to attempt to end one's life,

I took a [METHOD]. I was found 8-9 hours later and airlifted to hospital.

Participants did also note that alcohol use was not a cure to the issues they were attempting to drown,

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 just wanted my life to get better but I didn't want to do the work. I felt alone, I had no family support and my life was a revolving door of getting high, rehab and jail.

Participants reporting issues causing suicidal ideation and attempt during adulthood also reported work and occupational related issues, including workplace bullying, workplace injury (especially if resulting in early retirement, disability, chronic pain, financial stress), job loss/unemployment, work stress/pressure, over-working, whistle-blowing, sexual harassment, institutionally sanctioned sexual and physical abuse (navy, historic), work-related trauma including (e.g. witnessing / being subject to violence, death and injury),

I tried to end my life after a workplace injury on my right ankle and I was told I would never be able to run again. Running was my life socially and physically. I would run marathons to raise money for charities. This all stopped after the accident, work was not much help either with my mental health and physically, they were trying to isolate me by not allowing me to go to work plus I felt hopeless to my family after the accident because I had to rely on them a lot to take care of me. Then one day it just got too much for me. I was isolated, felt lonely and nobody cared about me anymore because I was such a failure in life.

For some COVID-19 has impacted their mental health negatively,

I still struggle with depression & anxiety & had another major depressive episode May 2019. I sought out another psychologist & am still seeing her monthly. I'm finding covid ramps up my anxiety hugely. Suffered my first & so far only, panic attack January 2020. I'm not sure I can get through this life much longer. My monthly psychologist appointment (via Zoom for now) is tomorrow.

For others, new and immediate stressors result in acute distress. While COVID-19 is unprecedented, and most could never have imagined the extent of the disruptions, such an event can quickly lead people to consider the value of their life,

The Covid 19 lockdown has destroyed my business, taken my life savings, left me feeling like I've failed my family and have no future.

While others have welcomed some reprieve,

Socially, I have been so grateful for Covid19 lockdown, as I don't have to see friends, or colleagues to explain what, or why

Across the lifespan, people who experience suicide ideation, behaviours and attempts and those who care for them or are bereaved by their deaths, given the opportunity that an anonymous survey provides, provide long narratives of difficult situations that are poorly supported even when multiple agencies are involved. The following quotes give just an overview of some of the issues that have been raised, but provide some feeling for the scope of the issues people experience. While many are the result of long-term complex traumas others are strikingly commonplace; rarely limited to mental illness alone.

Issue	Illustrative quote
Lack of treatment available historically and currently for complex mental health issues, e.g. cPTSD	<i>I have attempted suicide several times when events in my life triggered C-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 that I deserved to die and a doctor who said to me look at his much you're upsetting your mother (who was actually the problem to begin with). I experienced attitudes that I was attention seeking and a general lack of understanding.</i>
Limited access to mental health support, particularly in regional and remote areas	<i>My own experience of suicidal thoughts is associated with major depressive disorder and domestic violence, marriage ending, being a single parent, financial distress, social isolation. I visited my GP in a small rural community. Was put on antidepressants and given a referral to a psychiatrist who visited our town 6 weekly. You could only get a 10 minute appointment.</i>

	<p><i>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, lack of a sense of belonging.</i></p>
<p>Undiagnosed/misdiagnosed mental illness (sometimes since adolescence), particularly Bipolar Disorder</p>	<p><i>Have attempted suicide with active plans twice. Have recklessly decided to seriously injure myself/ not caring for death ([METHOD], financial expenses or hospital recovery instead) a few more times. None of these times resulted in professional help, I only confided to my partner of one reckless attempt after the fact. I kept them to myself and made excuses to cover it up. I have since gotten professional help after 10 years of having bipolar II.</i></p> <p><i>My daughter who took her own life in 2011 had mental health issues on and off for over 8 years, starting with post-natal depression. Eventually diagnosed with BPD. Took too long to get diagnosed and treatment. She suffered mental abuse from partner and then when she was diagnosed he refused to support her. I took her to drs, psychologists etc appointments. I found her after she had taken something. After her passing I suffered deep depression and also became suicidal.</i></p>
<p>Not prescribed with medication or prescribed with incorrect medication</p>	<p><i>"I went to my GP because I felt my depression setting in again. He prescribed an anti depression medication for me, my history of anti depression meds while growing up was Prozac. This GP prescribed a different medication at 75mg for 2 weeks. I went back for follow up telling him I felt weird, not right, something was amiss. He told me to double the dosage immediately. I followed his direction but still wasn't right. I felt like I was outside the box, watching in, I couldn't concentrate and was feeling more down... I was treated and interviewed by mental health teams. I was not admitted but was advised to cease the medication immediately. A different type of anti depression medication was prescribed for me. I under went counselling and it was noted that it was a one off attempt which may have been escalated by an incorrect prescription drug".</i></p>
<p>Not responsive to medication</p>	<p><i>Long term drug resistant depression over a long period manifested in a suicide attempt shortly after a relationship breakdown.</i></p>

<p>Feeling misunderstood</p>	<p><i>It was frightening how the things that would usually count - ie understanding impact on family did not count - I think because it was not about wanting suicide it was wanting pain to end and not caring if it was a permanent fix. I find that really really hard now. There's lots of stuff about suicide prevention - and it seems you can access much more mental health support if active suicidal ideation - but I don't think that's what I need. I need help to find meaningful ways to live, to cope with everyday life, to get through with this crazy disorganized scared brain. Dying is not my problem, that would be the end of my problem. It's living that's my problem. Unfortunately with suicide I know it would be the start of everyone else's problems. 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.</i></p>
<p>Chronic suicidality</p>	<p><i>I have Bipolar disorder and in the depressive side I have constantly thought about suicide & planned for it. I have lived through suicidality. I have had constant thoughts of suicide. I have set myself up & prepared myself to do it but as much as I wanted to I was never able to go through with it.</i></p> <p><i>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 been in and out of psychiatric wards because I could not conceive of a life that was better then the nothing of death. I have attempted suicide and I've sat beside siblings and called ambulances as I watched them after their attempts to suicide. I lost 2 friends to suicide and I still sit overnight with others in hope that my company means they live to see the next morning.</i></p>
<p>Chronic depression, with frequent visits and stays in mental health facilities</p>	<p><i>I spiralled deeper into depression. After about 6 or 7 years struggling my GP referred me to a new psychiatrist. The new psychiatrist diagnosed me with Bipolar II and set about getting me off anti-depressants which were making me worse and onto mood stabilisers etc. I went in and out of hospital probably 3 times over the next few years, for a couple of weeks at a time.</i></p>

	<p><i>I was diagnosed with severe depression when I was 14. First is me, who has lived a lifetime of drastic ups and downs. Self harming, addiction, in and out of hospital. Different diagnoses, medication and absolute confusion.... I now proudly have a husband and 2 sons. I continue to battle daily with my illnesses (depression, anxiety and ADHD), but seem to always get back up after a while.</i></p>
<p>Problematic substance use</p>	<p><i>It started when I was 11 when my father tried [METHOD]. I walked in on [METHOD]. At age 28 my best mate [METHOD] and subsequently died. I went into deep depression and got into drugs (marijuana and heroin to help alleviate the emotional pain. At age 29 my cousin [METHOD] and at age 30 I took my own life. I succeeded and was brought back by the ambos and was put into an induced coma for a few weeks while my body mended enough to have surgery.</i></p> <p><i>When I was younger I engaged in risky drug taking behaviour in hopes that I would die without having to 'try' to suicide.</i></p>
<p>Exposure to mental health issues of loved one, e.g. parent, sibling</p>	<p><i>Both of my parents struggle with thoughts of suicide, especially during times of emotional distress. Both have sought emotional support from me. They feel like no one else can bear to hear about their thoughts of suicide and hold that for them. They live in a rural area and are reticent to seek support from mental health professionals.</i></p> <p><i>Mother had depression tried to take her life over a period of 15yrs. My father and I had to stop or watch over her attempts for years. Had [METHOD]. My father took his life on the second attempt 7 yrs after my mum died.</i></p>
<p>Exposure to suicide, sometimes intergenerational, sometimes numerous loved ones died by suicide</p>	<p><i>My abuser (father) suicided by [METHOD]. My uncle who I cared for greatly [METHOD] himself. I've had several friends take their own lives. I have suicidal thoughts daily. As a adult who's been diagnosed with cPTSD caused by childhood abuse from within my family. I experience suicidal thinking everyday from around the age of 5.</i></p> <p><i>I lost my father at the age of 10, leaving my mother behind to care for 3 children under 10. I lost my younger brother to suicide 4 years ago (the same age as my father) and in the same place as my father - our family home's garage.</i></p>

<p>Intergenerational trauma</p>	<p><i>For my own suicidal feelings in my twenties I think it was contributed to by my dysfunctional family, lack of validation and an abusive environment. I also felt that way after the suicide of my father due to trauma and grief. Medication was a complete waste of time, psychiatrists were very unhelpful, cold and uncaring and many years of therapy with psychologist have been much more helpful.</i></p> <p><i>I attempted suicide at 15. My brother who was 7 years younger than me died by suicide aged 19 in 2013. Since his death I have been diagnosed with PTSD and have also had a near constant battle against suicidal ideation. Treatment programs have been recommended but I cannot afford them. I see a psychologist for 10 visits per year under Medicare. I have long term (8 years) stable full time employment and my PTSD has only affected this minimally but it has deeply impacted many of my close relationships with friends and partners. My brother's suicide has led to both my mother and father having long term and at times severe mental health issues too. Our family was torn apart.</i></p>
<p>Childhood abuse and domestic violence, and subsequent abusive relationships and domestic violence as an adult</p>	<p><i>My father died by suicide when he was 47. I was 16 years old. I was diagnosed with depression and anxiety not long after but believe I had it for at least a year or more before that time. My dad was an alcoholic and addicted to pain medication. He had committed domestic abuse to my mother in our presence for many years but was trying to make amends before he died. They had separated many years before but were still friends. Since that date I've also known at least 5 other people die by suicide. One was my best friend's mum, less than a year after my dad died. She [METHOD], and I was with my friend whilst they removed her mum from the house. I've suffered from many severe episodes of depression and felt at times like dying, but also knew what pain it caused those left behind, so I have always reached out for help. I've seen numerous Counsellors, psychologists and psychiatrists. My mum and my older sister also have depression and my younger sister has anxiety but denies it. I've also recently escaped an abusive relationship and have a 3.5 year old son. He is showing signs of trauma from the abuse from his father.</i></p>
<p>Guilt and despair, related to numerous of the issues listed above, including</p>	<p><i>My attempt was due to a feeling of pointlessness, despair and uselessness. I believed no one would care. I had presented to the hospital twice before the attempt seeking help, they sent me home. I truly wanted to go, but was</i></p>

<p>relationship difficulties, bereavement and DV</p>	<p><i>found and taken to hospital and psychiatric facility for a month. Have not attempted since, but do guard myself against my dark thoughts. I have Bipolar disorder and carried immense anger and denial about that. Have learned to manage that. My brother committed suicide some years before that. He had suffered a relationship breakup. I only know he must have being in a very bad place to do that.</i></p>
<p>Chronic pain, or other chronic health issue</p>	<p><i>Ongoing unresolved pain from back injury caused thoughts of suicide, then anxiety from workplace bullying (because of medical condition) caused horrible negative spiral in functioning. The mental health industry is virtually useless in terms of helping people in such situations and the workcover system causes more harm than good.</i></p>
<p>Cumulative and compounding distress</p>	<p><i>A childhood of abuse (sexual and domestic family violence), diagnosed with major depression, then Bipolar (mixed) then additionally borderline, current diagnosis Bipolar 2. My son has schizophrenia and made attempts during his early 20's when first diagnosed. 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.</i></p> <p><i>At 16 I made 2 attempts on my life. I was diagnosed with Clinical Depression, PTSD, and Anorexia Nervosa. In childhood I was sexually, physically and emotionally abused by my father. At school I was bullied constantly, I struggled with identity and sexuality. I also come from a lower socioeconomic demographic, my mother had an addictive personality and struggled with alcohol and other drugs. Not able to cope with all that had happened in such a short amount of time, I decided to make an attempt on my [METHOD]. At 21, I was in to drugs and alcohol again thing become messy and I made another attempt.</i></p> <p><i>During an extremely difficult divorce which included domestic violence and financial and psychological abuse I attempted suicide. I truly believed that removing myself from the equation was the best thing to do as everyone else would get what they wanted. It was a massive relief when I [METHOD].</i></p>
<p>Social wellbeing factors including loneliness,</p>	<p><i>I made multiple attempts, at least one per year from when the bullying happened. I reached out to a clinical psych 1.5</i></p>

<p>ostracism, isolation, bullying</p>	<p><i>years after the bullying and they made things worse, so I resulted to telling friends who supported me. Despite that I had many downward spirals leading on and suicidal ideation. Until recently when I found a new psych and she has been able to help me. Now I volunteer as a mental health advocate!.</i></p>
<p>Autism, communication issues / emotion dysregulation</p>	<p><i>My brother and myself were undiagnosed ASD, I believe that is what caused him to suicide ultimately but he also had a childhood sexual abuse history. I also have the same as well as a generally abusive childhood followed by domestic violence. My first attempt was at sixteen. My brother died at 24.</i></p>
<p>Difficulties forming, communicating in, or maintaining meaningful relationships</p>	<p><i>I come from generational dysfunction and a history of issues of co morbidity, I have had many years of therapy trying to break the cycle. I lack support due to 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, I still as a mother carry guilt and shame but no longer self harm I still struggle with depression and anxiety but on a surface level I function I hide my true feelings from friends.</i></p> <p><i>I believe that despite my intellectual capability, my psychological and social dysfunction interfere with my ability to function or to enjoy life. Mental illness has pushed me into poverty and abusive relationships. I do feel that my life is destined to end only one way (by my own hand). It is just a matter of time.</i></p>
<p>General life stressors that are too difficult to manage</p>	<p><i>Not really sure what is wrong with me but have been diagnosed with major depressive episode a few times. Was outed to family at 19, caused huge rift (now they're fine with me being gay) about five years later had huge breakdown following first teaching job and relocation to country not working out. Abusive relationship for three years in mid 2000s, took another three years to get out of. Next relationship also destructive. Work history patchy ...</i></p> <p><i>Workplaces have been chaotic stressful and short-term contracts have meant ongoing financial stress. Leave over last few years often absorbed by hospital admissions for depression ... My last admission to hospital I asked to be admitted because suicidal thoughts relentless and scary. This recent incident was preceded by high level of stress</i></p>

	<i>rather than suicidal ideation, and wanting pain to stop rather than wanting to die.</i>
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Touchpoints for prevention suicide

While suicide prevention activities generally occur in the community, and response to suicide attempts in acute settings, this survey with its much broader focus permitted identification of other locations that could be utilised as ‘touchpoints’ for people in distress. We review these below in relation to how participants in the survey experienced these services negatively, and also to identify where services were appropriate and timely.

Health services

Emergency Departments

Experiences in hospital emergency departments were generally negative except for a few rare exceptions. For people who had presented to hospital with a suicide attempt, negative experiences were attributed to interactions with health professionals including judgmentalism, hostility, lack of compassion and empathy, being labelled as an ‘attention seeker’ and lack of understanding and training,

Far too many staff at emergency departments lack insight and empathy into mental health issues and see parasuicidal behaviour as attention seeking behaviour, when it is in fact a symptom of a serious illness.

And,

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.

And,

The attitude of ED staff can often be negative towards suicide attempts as they are not ‘really’ sick.

Participants spoke of lack of intervention and follow up,

Even after my daughter had him taken by police to hospital for an unsuccessful attempt, he was released within hours. No follow up at all.

From the perspective of carers, the biggest issues were that their loved one had been prematurely released from hospital prior to or after a suicide attempt, or that the person they were caring for did not receive treatment due to insufficient facilities or resources,

*My son in law told almost everyone that he felt like he wanted to die.
Nobody knew how serious he was or what to say or do.*

Positive experiences were generally associated with experienced care providers,

Have had more positive experiences with senior nurses. Junior doctors the worst

Many respondents described numerous short admissions to general and specialist hospital wards following suicide attempts for acute care, with wholly inadequate discharge and follow up,

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 5 days later after I told the psych team there is nothing more they could do for me. Which is the truth. 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 and if I'm lucky those 10 sessions with a psychologist if I haven't already used them that year.

Mental health services

Experiences with mental health services delivered through hospitals tended to be negative. Some respondents described their hospital experience as traumatic and stigmatizing. Respondents spoke about an over-emphasis on pathology and medication coupled with lack of respect, support, and opportunity to be heard,

We are sick of the clinical side of things. Everyone telling us how to think or feel. Putting words into our mouths. I also believe people with lived experience are better equipped at shaping the world of mental health moving forward.

Some respondents said that health professionals never sought to listen or understand the context of their underlying trauma and rather took an individualistic, disempowering, pathologizing approach. This was exacerbated when there was also lack of continuity of care,

The build up of problems along with my mental health disorders had gone on for far too long and weary of waiting for help, I took matters into my own hands and did something to solve these problems permanently. I took [METHOD], and woke up four days later in hospital to a completely shocked and terrified husband and realised I had a lot of explaining to do. I told the psych assessors the whole story, but in their "wisdom," they decided my problem was all about the pain and if they just got that under control, I would be fine. There were no anti-depressants tried, no therapy offered, I

was simply kept in hospital for a few days and then sent home, deeply traumatised.

Inconsistency in treating teams was commonly reported as an issue in relation to care. This was particularly prominent when participants spoke of care received outside of metropolitan areas, but not exclusively so,

When I was admitted into hospital I saw a number of psychologists and psychiatrists. It wasn't helpful seeing so many who all had varying ideas.

Many respondents stated they have a diagnosis but then didn't describe any form of support,

Another time was seriously considering it when I was admitted as an inpatient for 3 days... Being inpatient didn't actually help me much. There was barely any support, I think I saw a psychologist once for a short time and barely spoke about anything, was prescribed medications and that was it, no links to support outside either. While I was inside I was berated by staff which made me feel worse.

Many respondents' stories highlighted significant unmet need around access to holistic and trauma informed care. There were also many respondents with psychiatric diagnoses and significant trauma that were not linked to counselling or psychology services. For example, participants spoke about getting treatment (medication) for depression but it not working because of unaddressed trauma. Particularly, for people with a family history of suicide,

Regarding my Dad's suicide, he suffered depression on and off for much of his adult life. I believe it was caused by unresolved trauma as both his parents took their lives in his twenties and he never received counselling or therapy for this and rarely discussed it. He took anti depressants for his depression but this clearly never helped him as he suicided anyway. He had been told it was biological depression but I believe it was more trauma based and that therapy would have helped him more than medication, but he never received it.

In contrast, other respondents described years of suffering and finally receiving a diagnosis as a turning point. There were several examples of respondents suffering for years with undiagnosed mental illness or learning difficulties,

Finally during my last year of my undergraduate. Overwhelmed by the research project as my supervisor was asking complex statistics of me, which I wrote a code to run and then said if the analysis didn't come with the SPSS package than I shouldn't be doing it. He told me my English was so poor he thought I was second language - which lead to me getting checked for dyslexia (which I have) and explained why I was never getting the marks which I thought I should be as I wasn't making logical arguments for another person to read. [METHOD]. Did not end up in hospital.

For some, a diagnosis also meant being better equipped to recognise signs of mental health deterioration for their family member, for example,

My husband and sister had me admitted to Joondalup Mental health where I became so we and was finally diagnosed with bipolar. Felt so much relief to have a diagnosis and no there was support and help. Seen a psychologist, now medicated and stable. My brother was hospitalized at greylands and diagnosed with bipolar. We now knew how to help more and learnt to look for signs he was spiralling.

Some described mis-diagnosis, incorrect medication, and lack of continuity of care exacerbating their suicide ideation and/or behaviours, at times when support could be intensively provided and known changes to medication which result in instability are known by the treating health care team,

I have had numerous suicide attempts over the past 10 years, each attempt seemed to coincide with a psychotic episode of some sort. All of my attempts were made once I was placed in the mental health system. I was struggling with medications changes and trials, while also struggling with misdiagnosis and constant changes to the professionals I was seeing.

Other respondents raised the issue of not being able to access inpatient psychiatric services when they (or the person they were caring for) needed to and not being able to afford private care,

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

Where individuals did receive appropriate care, this was often access trauma-informed and with adequate time to resolve the issues that led them to a suicidal crisis. In such situations, participants reported positive outcomes,

I ended up in trauma focussed treatment hospital for a month. That plugged me into further services and a start to trying to understand myself better instead of merely surviving...

Sometimes, rather than the hospitalization experience being about the treating team, the break from everyday stressors allowed for time to reconsider issues,

Following a serious suicide attempt, I ended up hospitalised for 3 days. This provided me with the space to think hard about what was happening in my life. I decided that I need to change, I couldn't continue to go on the way I was. I saw the impact my actions had on my family and I felt extremely guilty.

For others, sharing with others who had also experienced suicide ideation and behaviours was the support needed,

Admitted to psychiatric unit for 3 weeks which was good and bad experience.(medication counseling)and follow up by community health psyche team.6 months. The shared experiences and support of other patients really helped and listening to their stories was the greatest gift

Commonly among participants who were carers subsequently bereaved by suicide, difficult stories of trying – and failing – to find adequate and timely care were told, such as the view that their loved ones would have benefited from time in the hospital but were discharged or were unable to be admitted, either due to space restrictions or perceptions that they were not an acute suicide risk,

The first time he came home and sought medical help, the second time he was found by police and taken to the mental health unit of the nearest hospital. I will never understand why the doctors let him home without treatment.

When someone had died by suicide, reviewing the events leading up to the death became a source of intense frustration and anger at services unable to respond. Mental health professionals working in these services could appreciate this difficulty, as often there are no answers, and suicide risk is changeable,

For the adults in the family, one of the hardest challenges to deal with has been the conduct of supposed mental health practitioners at a particular mental health facility - they discharged her despite her pleas not to and three days later she committed suicide.

Community mental health, including psychiatric and psychological care

Experiences with community mental health teams were generally positive, although not frequently mentioned among participants in the survey. Those who did, spoke of pro-active and supportive intervention,

Usually end up in hospital for up to 2 months and take medication, sometimes on a CTO. I have a good psychiatrist and case manager.

Among respondents who said they were accessing mental health services in the community, the majority spoke about psychiatrists and psychologists or counsellors (the counsellor's professional background was usually not stated). There was a diversity of positive and negative experiences, with some respondents stating directly that they saw a psychologist or counsellor but it did not help them and/or their experience was detrimental to their mental state,

I had a psychologist that didn't really help my situation. They were not interested in working through the problems only moving forward. Due to the pain of not succeeding, I won't try again but I don't feel that my family or me were supported very well

Other respondents described helpful experiences with a psychologist or counsellor, particularly where they were supported in their choice about medication and had continuity of care. Sometimes finding a psychologist/counsellor with these attributes took several attempts,

During treatment finding a competent psychologist was difficult. I think I tried about 3 before finding one who did not have a chip on their shoulder about anti-depressants or psychiatrists.

When a relationship was formed between the individual and their treating specialist, the narrative was always a positive outcome,

The one constant in my mental health Journey so far, has been one particular Psychiatrist, who has stood by me, even when I left him for a couple of years to seek alternative treatment. Upon my return and willingness to continue working on myself, he has been a shining light in my story, even in those times where I struggled to understand his way of working.

Respondents also spoke about positive experiences with counsellors, psychologists, and psychiatrists who communicated clearly and directly and were pro-active in supporting them,

The external psychiatrist my family organised for me was brilliant and also did not prescribe any medication. His tone was measured and gentle, but he did not sugar coat the facts and provided a common-sense perspective for which I am eternally grateful.

While rarely reported, being provided with clear information, well delivered was positively regarded,

I have found for the most part the mental health workers pussy foot around. The professionals who have helped our family the most have been (males) nurses, advocate, go, psychologist who say v plainly this is what has happened, this is yr next appointment, no wiggle room and v clear language.

Many held the belief that there was *not much help out there* or services were inadequate and difficult to access. Waiting times for psychologists were long and then only provided 6-12 sessions. This was described as undermining of treatment. The financial burden of having to pay the gap between the Medicare rebate and the psychologists fees was also noted as a barrier to care,

10 sessions a year with a psychologist, that's incredibly unhelpful to build a connection with someone only to have to stop when you have just begun. Phone counsellors are somewhat helpful but not enough for chronic thoughts of suicide and chronic mental illness. There really isn't enough support and early intervention that is accessible. I was diagnosed with Bipolar type 2 which went untreated for years because of my circumstances, but 3 years on from diagnosis I still struggle with money and being able to access support.

Younger participants and some bereaved parents mentioned care provided by Child and adolescent mental health (CAMHS) and headspace. However, similar to adult mental health community services, the same issues about timely and appropriate care was mentioned,

My experience at CAMHS was completely horrible. During the course of a year I had seen a total of 5 different psychologists and 2 different psychiatrists. There was a complete lack of consistency and it made treatment difficult. I felt patronised sitting in a chair identifying the emotions on picture cards. I was told I had 'poor emotional intelligence' and 'barren emotional vocabulary'...

Headspace was mentioned as a possible support service offering, with mixed reports, some negative,

For example, psychologist assigned to the respondent through Headspace was not helpful and eventually (after 9 months) referred her to someone else. Another respondent (a bereaved mother) reported a 6 week waiting list for Headspace, which was too long for her daughter to wait, resulting in her booking a private psychologist.

While others experiences were positive, another reminder of the need for valued, human connection for support services to be experienced as helpful,

In terms of services that helped, Headspace and Lifeline are probably two of the biggest reasons I'm still alive. Headspace has talked me down from anxiety attacks that had me locked in bathrooms so I wouldn't [METHOD], and Lifeline talked me through some of my lowest points. CBT via psychologists has proven worthwhile in the past, but 10 Medicare sessions is nowhere enough when I'm experiencing points low enough to need regular contact.

Throughout the health service offerings, 'what worked' is always genuine human connection, that is offered in a trauma informed, compassionate manner.

General Practitioners (GPs)

GPs were identified as a point of contact for assessment, support, medication, and to obtain a mental health care plan. Some respondents described their GP positively as a source of support and continuity of care,

the best support was probably my GP

Others spoke about GPs as advocates when they were needing referral to a psychiatrist, particularly when this was viewed as the GP being willing to go the extra mile to get them help, even when psychiatric care was not readily available,

Being told it was a 2 month wait to see a psychiatrist after feeling suicidal. Went back to GP who rang them back on me behalf & try & get me in earlier. Told nothing available. GP asked if any other psychiatrist there could see me earlier. Again told no. 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. This is not good enough when someone is suicidal.

GPs were recognised as important health care professionals where people often first reach out for support,

I eventually went to my GP. He diagnosed me with severe depression and anxiety and started me on anti-depressants and a reference to a psychologist. I found this helped to a degree and the condition was manageable and under control for approximately a year. The psychiatrist was amazing. She changed the medication I was prescribed (from escitalopram to agomelatine) and discussed how I process emotions/memories. Since the new medication started to show effects I have not experienced any further suicidal ideation.

Examining nuance of language often those who made comment to 'my GP' had positive experiences of general practice care, while others who commented they went to 'a doctor' or 'the GP' did not. These negative experiences with GPs most often related to being rushed through the appointment time, unwillingness of doctors to give more time after the person had disclosed they were distressed, and lack of compassion resulting in sub-standard care,

I went to a doctor about a mental health plan but felt really uncomfortable as I was just told I hadn't booked a long enough appointment (needed to book a 60 minute appointment instead of a 30 minute one apparently) and they asked me questions about self harm and suicide/ideation, before asking me to make a longer appointment and come back.

And,

The GP... shouted in my face "you know it's hard for me too" and stormed out of the room. I was left crying in the consultation room. That experience

made me never want to seek help ever again and made my suicidal thoughts worse.

Some who were bereaved by suicide reported feeling vulnerable and ashamed when asking a GP for a mental health care plan to access psychology services,

I reluctantly went to see a GP to tell them I needed a MHTP it was horrible, i felt vulnerable and alone and rushed out of his office”.

Crisis Support lines and Not for Profit organisations

Similar to experiences of health services, social care services including crisis support lines and not for profit agencies were reported by some as providing the care and support needed and a positive outcome, while others experiences where negative.

Positive responses described crisis centres, call lines and care organisations as sources of support in a crisis. In particular, respondents felt these organisations offered social and mental health support when other services were unavailable. These extended beyond traditional suicide prevention services, which aligns to the complexity of reasons people find themselves contemplating suicide,

Rape crisis centre were a life line to me for 20 years and I am eternally grateful for their service as they were a big part in keeping me alive. I also relied on women’s health centres for social and mental health support as I was extremely isolated and didn't have any regular friends or family around...

Peer to peer support for those bereaved by suicide, was also noted as particularly helpful,

The best help I have had is Roses In The Ocean and StandBy. They have both given me the peer to peer and most important like for like contact that I needed.

While support groups, often for suicide bereavement were mentioned, they received both positive and negative reports. Some respondents felt that support groups were not for them, but still benefited from other aspects of care provided by the same agency,

I went to the Samaritan's shadows of suicide support group initially but I didn't feel I fitted in as I was still upset and angry... I also phoned the Samaritans frequently between psych visits when I felt overwhelmed.

Participants also spoke about using Lifeline’s 13 11 14 Crisis line as a source of confidential support. This was also an important avenue of support even when support was routinely been provided elsewhere due to perceived repercussions when disclosing suicide,

I've spoke to Lifeline when I wasn't able to voice how strong my suicidal thoughts to my therapist in fear she would admit me to hospital.

Participants who spoke negatively about these services referred to unhelpful advice from phone counsellors, phone counsellors not understanding their current mental state, and frustration with the system in general for only providing crisis 'bandaid' support,

The system is totally stuffed. We do not need another helpline. We need a functional mental health system. We need qualified people working in that system. We need the system to be resourced - doctors, housing, proper care...something other than band aid solutions.

There were also several participants who worked/volunteered for Lifeline as Crisis telephone counsellors. They reported this as a rewarding but challenging experience, never knowing if the intervention has been helpful, given the brevity of their interaction with callers.

Police

Police take on many roles in relation to suicide. They are actively involved in suicide prevention and intervention. Are often present when someone has died by suicide. They experience their own suicide exposure related traumas, and they are members of families where suicide is present.

Participants primarily spoke about the role of police in suicide prevention and intervention. However, some participants also spoke from their own experience as a police officer. In the latter case, this was primarily in relation to traumas experienced on the job, and the resultant post-traumatic stress disorder developed from work,

I have suffered PTSD anxiety and depression as a result of being a police officer and seeing so many things that a human should never have to see

Others responded in relation to caring for partners who are, or have previously been in the police force. Across these surveys, carers highlighted the high degree of exposure to suicide experienced by Police, including fellow Police officers dying by suicide, and the lack of support for Police officers experiencing PTSD. This is an enormous burden for Police officers and their families that can lead to compounding trauma and grief and subsequent suicidal ideation, leaving families reeling and unable to support each other,

My husband is a police officer. This year alone he has responded to 3 suicides, 2 successful and 1 attempt as well as losing a member of his unit to suicide. The impact is serious and long reaching, touching everyone and spreading like a virus. I myself was suffering depression and struggling with my own issues while my husband came home from work with heart breaking stories about families left forever broken after losing a loved one to suicide. I was feeling hopeless, we could do nothing to help, to stop it.

When i needed my husband the most he was lost in his own grief unable to see what was happening in front of him. I felt like a failure, like I was not good enough to support him and my kids, like they would be better off if I was gone, then they would get the support they needed. That's when the police officer took his own life, I felt like I had failed again, it should have been me.

Where respondents spoke about Police responding to a suicide call out, the majority of respondents expressed gratitude for Police acting in time to prevent a death,

The police were great supported me with practical assistance like looking for him transporting him to hospital recommending hospitalisation but within an hour he was discharged.

The roles that police took in interrupting suicide attempts were generally very active, and involved, and for some sensitive with the family following a suicide death,

I wanted to do CPR but was prevented by a police officer who knew it was too late. She sat with me and let me touch him

And,

I will say that I want to thank the Police who got bereavement counselling volunteers to contact me, starting with printed resources. For them and all our first responders thank you.

While the views from those who were bereaved by suicide were generally positive, others spoke of more challenging engagements with police. This was particularly the case when assistance was required in relation to welfare checks, transport to hospital (with and without scheduling under state mental health acts). Many spoke of their frustrations and questioned whether police are adequately trained for these roles, including assessing the risk of suicide that an individual was currently experiencing,

Again, the biggest frustration was getting help for him. The night (a Saturday night) before he took his life, my husband and I frantically tried to seek emergency intervention via Lifeline, Alfred Hospital and Vic Police with limited success. Despite lots of phone calls on our part, Vic Police did do a welfare (we were geographically too far away to do it ourselves) and reported he was ok...

Education system

Many described traumatic experiences and/or onset of depression or other mental health issues during school or university years of their life. Some respondents described experiencing the death by suicide (or multiple deaths by suicide) of a family member or friend during school or university years. Some also spoke about academic pressure that contributed to their distress. The following quote highlights the multi-factorial and

interconnected way that stressors can accumulate and compound during school and university years resulting in suicidal ideation and attempts,

I have experienced suicidal thoughts on and off starting at age 12. At age 17, I had a resurgence of the thoughts and shortly after a schoolmate took her own life. This was a massive shock and re-positioned my view of suicide. However, a few months later I made my first suicide attempt. I had to drop out of university and move back in with my parents which made me feel like a failure. I have known a lot of people who have made suicide attempts and/or been very suicidal. It's very distressing trying to make sure that they will be okay until they can get more help from professionals. As a result of attempts/ acute suicidality, I have had to slow down university and lost income due to time in hospital. I feel like I am falling behind my friends and peers as it has taken me much longer to reach milestones. I also worry that I'll have suicidal thoughts for years to come

Changing life circumstances during adolescence and early adulthood, as highlighted in this quote, can result in young people not being connected to local services and support. It can also be a complex time in a young person's life when events can spiral out of control relatively quickly,

I have had issues with my mental health and suicidal ideations since I was 13. I have diagnoses of Major Depressive disorder, General anxiety disorder, and Borderline personality disorder, with corresponding suicidal ideations and self-harming behaviours. I [METHOD] last year in August, however thankfully told someone and got to hospital. At the time, I was in an abusive relationship, having issues with my identity, and struggling with what I should do regarding going back to university or not. I was under so much stress and it felt like it was never going to end, and that suicide was the only way I'd ever be free of the pain I was experiencing. In that moment all I could think about was the escape.

How individuals navigated finding support varied from moving back to the parental home – which generally resulted in leaving university studies, through to finding support within the local community and the university system. The latter resulted in a continuation of progress through studies, rather than 'falling behind' and 'feeling a failure.' Where friends and peers were able to offer support, the outcome was positive,

In my first year at uni, when I moved away I started experiencing severe anxiety and mild psychosis and severe money stress. Through my support services at uni and at my boarding residence, I was able to receive counseling at a community health centre and appropriate medication as well a scholarship from uni - all of which were life changing. Prior to receiving medication and counselling i would think about suicide everyday; it was habitual. Thankfully things have improved a great deal since 2009 and I'm far more mentally healthy and no longer taking medication, as well as healthy friendships, stable work and completing a second degree.

In contrast, where supports were not available or not appropriate, challenges continued and suicide remained present. Importantly, where suicide is not acknowledged by service providers, longer term ability to work with the person can be inhibited,

The therapy I accessed both provided for my school for free (which wasn't helpful at all) and paid for by my mum was unhelpful and heavily stigmatised and delegitimised my suicide attempt and made it so I was too embarrassed to bring it up genuinely in later therapy. As an adult I still have suicidal thoughts and am too embarrassed to discuss them with peers or health professionals as I feel that it will either be delegitimised or blown out of proportion.

While these young people were able to reach out, or others reached out to them, for others who became withdrawn and socially isolated, accessing appropriate support services was impossible. Alternatively, where support was accessed, this was not always enough to keep a person safe,

My son, Daniel, died by suicide on 21st June 2018. He was still at school, in year 12 and had just turned 18. Daniel disclosed to me, unexpectedly one day, that he thought he might be depressed. We went to the GP and psychologist who both diagnosed depression. Daniel started on medication and had 3 therapy sessions. He continued going to school and asked me not to tell anyone of his diagnosis. Approximately ten weeks after the initial GP visit, my beautiful, gentle boy [METHOD].

This was the case even when such services were present and others were keenly aware of the individuals struggles. Secondary school teachers for example, know young people in their classes well, but may not always be equipped to manage the wellbeing and safety of young people,

I have also had a friend who I was really close with who tried to kill herself multiple. She was struggling with depression. This was during year 10-12. The school did nothing to help. In fact the teacher she relied on and was close to was told not to help her and just refer to another teacher. This other teacher did not help at all. The teacher she was close to consistently asked the school how to help because she knew my friend trusted her but they didn't care.

Teachers also responded to the survey with their perspectives on their own lived experience of suicide, along with the experience of losing a student to suicide. The difficulties faced by teachers within the school system were viewed as a barrier to supporting young people who are struggling while at school, this includes not being sure of how to discuss suicide,

As a teacher of a students who suicided at 15 and 18 it was a completely different experience. Through my own experiences being suicidal I know how easy it is to get to that point but my heart breaks for the people left behind trying to make sense of it - especially the young person's friends.

Their confusion, grief and anger is difficult to experience and we just want to support them. There are so many constraints as a teacher. You can't use the word 'suicide' unless the family acknowledge that it is indeed a suicide and give permission for it to be referred to as such - in both these cases that consent was not given. The other kids knew it was suicide but we weren't allowed to refer to it that way. It made it difficult to really support the kids and validate how they were feeling. (I did anyway if the kids used the word but I would have got my arse kicked if the boss found out.)

Family, friends and partners

Informal care and support offered by family and friends, or the lack of it, was common in many of the participants narratives. Respondents spoke about supportive parents, spouses, partners and friends as pivotal in assisting them to access help,

My parents cared for me during this time and paid for private psychiatric hospital stay and treatment. I was not capable of looking after myself and am not sure what would have happened without their care. They continued this care for several years and support for longer as I recovered... nearest psychiatrist was a 2hr drive and after several visits he referred me on to Albert Road clinic in Melb, a 7 hour round car trip from our town. My mother drove this many times to get me to appointments.

And,

One very dear friend rang the police out of concern for me because I did not answer my phone. My friend & the police saved me, & for that I am forever grateful.

Why and how that particular friend knew how to provide this support at the time they did is unknown. However, the action taken was clearly what was needed at the time. Conversely, other respondents spoke about isolating or being estranged from family and friends. Stigma played a part in people's family and friend support systems, with some people choosing not to tell family or friends about their experience. For some respondents, the efforts of family members to provide support were appreciated but not always helpful,

I can't trust anyone anymore. I can't get close to people and so can't really say I have many friends. I enjoy spending time with them and going out, but none of them know my history nor would they ever suspect it. In this way, I feel I can't be my true self in social situations. My parents have and still are my biggest supports. They aren't helpful most of the time but they try their best and I appreciate that.

Due to suicide being present across generations within families, how suicide was talked about, or more commonly not, resulted in families being unable to support other family members,

25 years ago my uncle committed suicide, he was never allowed to be spoken of again. 18 years ago my cousin (His daughter) succeeded in her 5th attempt of suicide, leaving behind a 6 year old and a 4 year old child, the family would not talk about her and pretty much disowned her, we were not allowed to see or talk about her children, no photos were allowed of her around our grand parent house. when Jake was 14 on his mother 10th anniversary he succeeded committing suicide, he never reached out to any of the family...

Throughout the survey data there were many and varied services that could potentially act as touchpoints for those with suicide ideation and behaviours to be supported. Yet, all of these places, and the people who work within them, are also tasked with other roles that may inhibit their time and capability to reach out to a person in suicidal crisis. However, many of these services are places where people come in contact prior to crisis – when suicidal ideation may be present, but not being talked about, or acted upon. Yet.

The list below are examples of these services where early suicide support may be located.

Allied health: Psychology or counselling services for people bereaved by suicide or caring for someone following a suicide attempt. Marriage and relationship counselling services. Trauma-informed counselling services.

Aged care services: Particularly in relation to bereavement, isolation.

Carer Support services: for people experiencing stress caring for older parent(s) and then suicidal ideation and sometimes attempts after their death.

Domestic violence services: domestic violence counselling services and crisis support.

Employers and employment services: This includes workplace support in addition to Employee Assistance Programs, support following job loss and while people are unemployed, and workers compensation for workplace injuries and disability.

Family and Community Services: Child protection services, Family and community support services, family court and associated services.

Financial services: Banks, Credit unions and other financial institutions.

Health system (outside of mental health): Cancer support services, Motor Neuron Disease support services, Palliative care teams, Specialists/Surgeons.

Men's Sheds: to access men who are traditionally difficult to engage in support services.

Mental health system: mental health nurses, peri-natal mental health services, mental health support services for new parents. Services for children of parents with a mental illness, eating disorder services, PTSD services, community support groups.

Not for Profit organisations: Anglicare 'after suicide program'; Anglicare counselling services.

Personal care: hairdressers, beauticians, other personal care.

Schools and Universities: Counselling services, school psychologists, teachers and academics.

Women's health services: Antenatal health services, postnatal health services, midwifery, early childhood nurses, mothers' groups.

Youth services: Youth counselling services, drug and alcohol services, noting that headspace does not operate in all communities nor relevant for all young people.

Barriers and enablers to support

The list above contains many of the supports and services that can appropriately act as early intervention for suicide support services, where gatekeeper training has been undertaken in some sectors to act as early identifiers for suicide. Yet, there are many barriers to this support occurring. Enablers are more likely to be relational – where a service provider identifies a change in the customer/client/consumer and is able to ask them about suicide.

Systemic barriers

Providing care was both a key barrier and enabler of helpful experiences. Where the care was compassionate for the whole of person, the outcome was viewed as positive. Where this was not the case, the situation deteriorated.

Here a participant highlighted the difference in hospital experiences when her son was admitted to an orthopaedic ward following a suicide attempt compared to a previous admission to the mental health unit. The time in hospital being cared for by staff on the orthopaedic ward gave her son time and space to improve his mental wellbeing in contrast to a traumatic experience as an involuntary patient in the mental health ward,

Our family was traumatised and my son was scheduled into an adult facility even though he was 17. It was confronting on top of trauma. The next attempt he was physically hurt and went on to an orthopaedic ward for 10 days which went better bc they were looking after his physical needs which gave him time to get his head back together.

Other respondents also described traumatic experiences in mental health units compared to helpful experiences in other areas of the health service. For example, the participant quoted below was hospitalised after a suicide attempt in 2017. She had been raped and was subsequently diagnosed with PTSD. Where she received compassionate care she felt supported, and then as a scheduled inpatient her condition worsened,

ICU staff and mental health staff that visited ward – helpful. Inpatient 3 days - not helpful. Acute care team - not really helpful. Inpatient for 4 months under mental health act - harmful and not helpful. The experience made my PTSD worse.

Our analysis also found that those reporting a diagnosis of Borderline Personality Disorder (BPD) could add a further layer of stigma to an already stigmatised group. A diagnosis of BPD seemed to confer a deviant status on the person. Many respondents stated they had a diagnosis of BPD and then went on to describe being treated by health professionals as undeserving of care, and their suicidal state second to being viewed as manipulative, seemingly with little awareness of the connections between past trauma and a BPD diagnosis,

Her suicidal behaviours have contributed to significantly complex engagements with health services which multiple diagnoses being received, frequent medication changes, strained relationships with public and private inpatient clinics and I believe negative and rejecting/disempowering experiences of the health systems contributed to by a borderline personality diagnosis which has since been reviewed and changed.

Professional knowledge and paradigms (including diagnostic paradigms) intersect with the production of stigma and its effects in practice. The survey responses clearly show that there is a moral dimension of practice that is triggered when it comes to the treatment of people with suicidal behaviour (and even more so when there is a diagnosis of BPD), that is oppressive for service-users and a barrier to health care,

Brother who suicided. He had mental health issues (borderline personality disorder + other undiagnosed mental health illness) and became a shell of a person. He attempted several times. In the week before his final and successful attempt, we found out his plans. Contacted everyone possible to try and have him assessed, hospitalised. His own psychiatrist assured us he was not at any risk of suicide and hadn't shown any tendencies. Police became involved, two poor untrained officers sent to his house, asked him a series of questions and then informed us there was no risk. Less than 24 hours later, he met up with someone who also had suicide intentions and both attempted. One failed attempt, my brother successful.

This needs to be better understood in terms of professional/service provider attitudes, values and understandings of best practice and professional responsibility in order to discern whether this is about lack of understanding and training, or structural/organisation issues such as burnout of working in an under-resourced system, or a combination of both,

So much heartbreak. So much we didn't know about, so much the people charged with assisting him in his mental illness didn't know. Felt like apathy. Felt like the system let us down - we were powerless to act, even with knowing his intents.

Individuals work within systems and systems enable or prohibit behaviours and attitudes. The fragmented nature of services was viewed as a further barrier for people accessing services. This was particularly evident for people with complex care needs,

My parents had difficulty getting help for him, being handballed from service to service, with the responsibility seeming to belong to 'someone else'. The concept that crisis doesn't occur between 9 am & 5 pm is so true when it comes to mental health and wellbeing. He did find a great GP who was very helpful for him, but the GP unfortunately suicided.

Health services are siloed and lack coordination. Some people have difficulty accessing any specialised care when their needs are complex because individual health services tend to systematically identify the person's primary health issue as the responsibility of a different service. Further, services are not equipped to deal with the complex and often long-term issues that people present with,

The complexity of the trauma experienced by some people who are presenting to services with suicidal ideation or an attempt is undoubtedly challenging for health professionals, particularly doctors or those working in a sector where the medical model is dominant and perhaps more so if they are unsupported or working alone. Medical professionals are trained to believe that their professionalism is measured by their ability to identify the aetiology of the presenting health problem, diagnose it, treat it and either cure or manage the problem to promote the best quality of life outcome for the patient. Trauma, particularly where there are also social determinants of health undermining the person's resources to access care such as lack of stable housing, unemployment, low income, and lack of social support, does not lend itself to compartmentalisation and a clear cut treatment plan. Healing takes time and a holistic approach integrating social determinants of health and systemic disadvantage. There are very limited options for long-term trauma-informed care in the community if the person can not afford private services, which is likely to be the case.

At the most basic level of coordinated care there should at least be communication between services when a patient is transferred, and yet the surveys showed that this did not always happen. This was an issue for people moving from the private to the public system. It was also an issue for people accessing multiple services at the same time, diminishing the benefit of each service,

The mental health industry is virtually useless in terms of helping people in such situations. almost NO benefit in accessing mental health care plan type counselling services that DO NOT talk to other parts of the system, the system is fragmented and inadequate, impossible to access good support when required and NO inpatient service for people at the 'edge of the cliff' - mental health services need case management support from professional, qualified people like Social Workers. Support needs to be coordinated, responsive and professional.

Many participants expressed distrust of the health system due to their negative engagements with the systems previously. Participants spoke about choosing not to utilise the counselling sessions on their mental health plan on discharge from hospital because the inpatient treatment they received was traumatic. Some spoke about many attempts to find a counsellor or psychologist they could trust through the public system and only being able to access this in the private system. After this experience, they describe never wanting contact with the public system again,

My son has attempted suicide twice in past 4 years. Was sent to oxygen footscray as inpatient the first time which was absolutely horrible for someone suffering depression. I was able to upgrade his private health then he had a 3 week private hospital stay. Second time he refused hospital and drs. I think i still have PTSD from the 24/7 care he needed. I am on a disability pension only but feel i NEED to keep paying his private health insurance \$200 a month and he see's a psychiatrist at \$150 out of pocket monthly.

Other respondents highlighted the culture of distrust towards health professionals (from the city) in rural communities as a barrier to health seeking behaviour. The respondent quoted below explains that distrust of health professionals in rural communities is based on a perception that highly educated professionals have no understanding of the struggles of rural living and low socioeconomic status,

In rural communities, there is a strong culture of pulling themselves up by their bootstraps and denying the need for help and being distrustful of mental health professionals. Doctors and psychologists - who are educated, unlike my family - are experienced as 'not really getting it' when it comes to the struggles of rural living and low socio-economic status. Furthermore, traditional displays of warmth and empathy that are trained into psychologists often do not match the care language of rural clients who tend to be dismissive of emotion. Cognitive strategies are often also perceived as too mechanical and irrelevant and dismissing of the emotional experiences that the clients dismiss in themselves. This means that close others who are trusted and 'get it' in terms of the rural lifestyle are most relied on to provide suicide support - eg. Friends, family, religious members.

Barriers to help-seeking are further compounded by a culture of stoicism and denying the need for help. In practice, the skills and strategies that health professionals bring from their training are not always compatible with the needs of people living in rural communities because of these sociocultural differences,

When I was 11 we lived in rural Victoria. My father was a family lawyer. My mother was schizophrenic. My father attempted suicide as many men in the regions do: [METHOD] and, when found, explaining it away by saying the [METHOD]. I was the one that found Dad, and held him in the back of his bosses car all the way too hospital (about 45min drive). He bled all over me.

I was very frightened. My parents separated and Mum used his attempt at suicide to prevent me from seeing him. We lost the house...life fell apart. Mum descended into her own hell, and moved us to WA to live with a cult. I was left to cook and clean for us; until around 13, I managed to escape her and get back to Dad in Victoria. He was well again, mostly, and life was "normal" (to the extent things can be with 15 schools, 30 homes and psychiatrically ill parents can be). No one in the family, no professional, no one ever discussed it with me. I was left to work it all out for myself, and seek counselling as an adult.

These findings indicate that addressing service barriers in rural communities requires a community-driven, locally sensitive approach alongside national strategies targeting the socioeconomic stressors and mental health issues contributing to suicide rates in rural communities. The same respondent quoted above stated the ten counselling sessions available through a mental health care plan do not provide enough time to build trust, and other strategies such as suicide prevention activities in schools, and suicide first aid training such as the LivingWorks ASIST model would bolster community capacity and literacy around suicide.

There are clear indications across the dataset that these changes would be helpful on a national scale. However, there is an equally strong indication that this is not enough to address the barriers around people not wanting to seek help in the first place. A paradigmatic shift is required in order that people with lived experience of suicide and people with local knowledge and expertise are able to inform services and programs available to them. Acknowledgement among health professionals that they may not possess the local knowledge and expertise to provide the tailored care required for people living in rural communities would need to precede this.

The dismissing of emotional experiences and non-help-seeking behaviour among people experiencing mental health problems in rural communities is perhaps a signification of internalised stigma. Taking a social-constructivist sociological perspective, paradigms shape our framing of our experiences and what we perceive we can say and do in response. If these paradigms are experienced as stigmatising or deficit then they can perpetuate a vicious cycle of people not legitimising the validity of their emotions or worthiness of care. Alternately, they may result in an outright rejection of services on the basis that they are demeaning and dismissive of the person's experience. Resourcing to challenge and disrupt these paradigms on a wide-scale is required to rebuild trust. Arguably, this is about meaningful, sustainable resourcing to address the socioeconomic pressures felt in rural communities in addition to resourcing of health services and public health strategies. Resourcing for collaborative community consultation would be required to explore local needs and how to make health professionals a more accessible source of help. Community and stakeholder consultation could also inform the development of community-responsive

models of care. Resourcing of community consultation and service mapping to identify service gaps and scope for existing successful programs is also needed.

Service providers, while acting in professional or paraprofessional roles, are members of the community and hold a variety of views. This includes stigmatizing views that inhibit people being able to reach out for support, or for the person to offer it. This is also true of those experiencing suicidal thoughts and their willingness to tell others of these thoughts,

Suicide has been a huge part of my life and has occupied my thoughts from the moment I understood what the word suicide meant. When I was young I was too scared to tell people of my thoughts because I did not have a good relationship with family and refused to let them find out. So I hid it from everyone, some of my teachers knew I was sad some of my close friends knew I was struggling but I was always bound by the rules of confidentiality and was never able to say enough for me to get proper help. My thoughts of suicide led into my adult life where I began being bullied at work.

Stigma was a strong theme in many participants descriptions of trying to access help. Experiences of stigma took the form of judgmentalism, stereotyping, not being offered hospital admission/treatment/referrals. One of the ways in which individuals highlighted stigma was by juxtaposing the system response they received when the primary issue was suicide with their experiences of the health system for other health reasons.

For example, one participant contrasted the support and services she received when her baby died at birth to the response she received when her adult child died by suicide. When her baby died she was automatically booked into counselling by the public hospital and a nurse was automatically assigned to follow her up with several visits at home. When her adult son died by suicide she describes only having contact with the police and coroner's office. Her son's death was not treated as a public health issue and the family were not offered any counselling. Moreover, the contact with police and coroner's office was only by phone, took a long time to resolve, and the family had to proactively follow up for information. The family were never given the opportunity to speak to the Police in person. There was no consistency in terms of a contact person for the family to speak to. This experience was insulting, contributed to the family's grief, and gave them no sense of acknowledgment or closure,

One letter from Coroner noting possible 3 month before report and closure and a enquiries phone number. No one assigned to just ring to keep us informed, 3 different officers that CIU reception connected us to when we rang as time dragged on to a year with no advice, were never in the office and never returned our calls. After more than a year of no advice we rang the Coroners court office - our son's file still hadn't been opened by the CI Unit and no one assigned. To appease us a policewoman was pulled from Prosecutions and told to complete a report that weekend. They never gave us an opportunity to speak in person, I got 1 minute on the phone as she

wrapped up our case on the Sunday night. My husband was bitterly upset that he didn't even get that. The feeling of the insignificance of our son's death to this Unit and the fact that he was just a number to tick off the list really hurt. He really was a good wonderful human being but that was irrelevant to them.

There is ongoing harm caused by this type of systemic response (uncompassionate, criminalising, marginalising) via the positioning of suicide in the private realm of individuals and families (and outside the realm of collective responsibility). In this case, family members subsequently experienced their own mental health issues (including suicidal ideation and attempts) due to unresolved trauma of their loved one's death.

Participants also highlighted stigma by describing unhelpful interpersonal interactions with professionals/service providers, as shown by the examples below. These respondents' experiences shed light on how health professionals are implicated in reinforcing stigma and the barriers to health service accessibility for people experiencing suicidal ideation or a suicide attempt through judgmentalism, shaming, patronising and demeaning practices. Sadly, well known stigma among health professionals continues. In this analysis, we include only recent events to highlight that these situations continue,

Because I made those attempts, and because I am mentally ill, every health professional that knows this information are judgemental

And,

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

And,

Many of my experiences with mental health organisations has been patronising and demeaning, disempowering...

Fear of being scheduled under a state mental health act was a considerable barrier to help-seeking. Respondents described not reaching out to their therapist, doctor or crisis support lines due to fear of losing their own free will. This was described by individuals who had experienced suicidal crisis and suicide ideation. Yet, it is these supports that are required in a time of crisis. Nevertheless, this was also described by those who work in suicide prevention as a common issue. They explained their willingness to 'be with' others to keep them alive, taking time to listen and stay with them and contrasted this to the risk aversity found in the health system. In contrast to the experiences of participants who had approached health services for support, those who work for crisis support lines emphasised the importance of being able to make a distinction between when it is time to listen and time to act,

I think people worry that others will restrain them or take action against them when they describe suicidal thoughts. It is important to properly assess suicidal intention, and differentiate suicidal thoughts from intention, while validating the emotion and experience behind the suicidal thoughts. In this way, suicide care can be delivered in the same way.

This important distinction provides insight into the attributes of supportive suicide prevention work and the importance of a trained mental health/suicide prevention workforce, including members who can work collaboratively with clinical services and assist with risk assessment.

An enhanced understanding of the complexity surrounding suicide and capacity to discern between when to listen and when to act might result in less paternalism, less pathologisation, less use of coercive measures and also a more pro-active and holistic approach to care. Resourcing the workforce to provide this type care could in turn have a de-stigmatising and enabling effect via a) service-providers feeling supported to work with people with complex mental health issues and b) dispelling people's fears about being Scheduled because the system is staffed by workers who will appropriately respond to people seeking help.

Many spoke of not being able to afford the care they need; the prohibitive cost of psychiatric medication, the payment gap for psychology services provided under a mental health care plan, and not being able to afford private services. The cost of private services was a particular barrier for people who had negative experiences of the public system; for people requiring urgent care unable to wait for the first available appointment in the public system; and for people requiring long-term continuity of care, which respondents indicated was only available in the private system,

I lost my child to suicide. Following my child's death I made 2 partial attempts. I cared for my child before suicide - adequate support was not available. No follow up was available when my child's mental health deteriorated. I have been under psychiatrist/psychological care but it's too expensive to continue and the public system is not consistent and waiting lists are far too long

This is an equity issue as the public health system is under-resourced and experienced as stigmatising, and private health insurance is prohibitively expensive. When personal crises intersect with financial concerns, people are unable to find the support they need. This situation was particularly evident in those who reported living in rural areas,

My friend was in a domestic violence situation & lived in a rural community with little help. The mental health services labelled her with a personality disorder because they didn't have resources to help her. There is an economic burden for people who try to get help for suicidal thoughts - psychological assistance is expensive. There are a few psychiatric nurses left

but this is a significant gap. Also - mental health nurses are not provided provider numbers & so do not work privately. There simply is not enough help for people who need help & 'talk therapies'. There are few options for women in DV situations & in recovery. This lack of support contributed to her death.

This situation is reflected in those who reporting being unemployed or under employed who experienced the double disadvantage of low income and the stress of interacting with unsupportive employers and/or government agencies. Respondents who described the antecedent of their suicidality in relation to a workplace injury identified specific additional stressors and systemic barriers contributing to their distress and capacity to pay for health services. For example, the accumulative and compounding effect of physical injury, job loss, financial stress, lack of employer support, chronic pain, falling through cracks in the Centrelink system, and then not being able to afford to continue with support services that were helpful led some people to believe that another suicide attempt was inevitable for them,

The last time, I was injured at work and it took over 7 months for Workcover to find in my favour because the boss lied and said it didn't happen at work. Then said don't take it personally, it's business. My premiums for insurance will go through the roof. Anyway 4 surgeries later and I'm in constant pain. The insurance company stopped paying November last year and I've had zero income since then. Centrelink wouldn't help because they said I wasn't eligible because it's a workcover problem. I was seeing a Psychiatrist and a Psychologist (Clinical) and it helped but now the insurance company has stopped paying so I can't afford it. Eventually I know it will happen but I don't want to hurt my wife

The issues with workers compensation and significant change to circumstances led people to be in contact with potential sources of assistance, but these opportunities were missed and rather became additional stressors. Centrelink featured prominently as a barrier to assistance with participants describing being forced to meet unreasonable requirements, not being assessed for the appropriate payment, and lack of assistance from Centrelink staff. In one instance interactions with Centrelink was identified as a contributing factor in the circumstances leading to the death of a respondent's son by suicide,

I lost my son Shayne, he was on disability allowance from Centrelink and they took it off him told him he had a \$20 thousand debt with them. I was paying for his rent for 6 months and feeding him everyday. Centrelink did nothing to help and hindered his allowance, he just couldn't take anymore on the 11:11:16 at 8:45pm he [METHOD].

There is clear scope to improve people's interactions with decision-makers when they connect with touchpoints. Engaging with services should not become an additional stressor contributing to the person's suicidality. While systems may be disempowering, people working within them can be empowered to change their practice and treat those who come

in contact with them with compassion and support. This would require support from the top levels of organisations and government departments to determine that a humanistic, compassionate offering is the only acceptable way in which to deliver services to other members of the community. The following identify places where people come in contact with services, yet where barriers exist for them to access care that is needed.

Services for people with chronic suicidal ideation: Those living with chronic suicidal ideation described a lack of available services where they could access long-term care. Respondents described falling through a crack in the health system, explaining that crisis services only provide a very short-term solution, and 10 counselling sessions a year is not sufficient. In some cases, accessing 10 counselling sessions a year was too expensive with gaps between Medicare assistance and the amount billed by a private practitioner.

Services for people requiring care for complex needs: 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 what is available. Long waiting lists for the NDIS were an additional problem.

Services for carers: There is a clear lack of support for carers. This was expressed across the continuum of care from caring for someone with suicide ideation, who had made suicide attempts and who had died. Many of these respondents have experienced their own suicidal ideation since their loved one's death. Summing this ongoing issue up for those caring for someone right now,

For me and his siblings there was no support. There is a lot of support for families of people who are successful with their suicide but not for those who had survived.

Services in regional and rural areas: 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. Respondents in regional/rural communities also described no counselling services available in their local area,

In my town it can be difficult to access even gp appointments. There seem to be a lot of funding for support type programs and groups, however this would not have helped me. There still needs to be relatively easy access to doctors and psychiatrists, and mental health facilities in hospitals.

Lack of aged care mental health: Some respondents described lack of services for their elderly parent experiencing mental health and aged care issues. Carer experiences of taking elderly parents to the GP and Geriatrician did not result in access to a psychiatric assessment 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.

Gender specific services: Lack of gender specific services was raised in relation to the lack of women's domestic violence services. This was significant in the context of women being able to access support to escape environments that were traumatising for themselves and their children. For men, Men's Sheds as a space for mental health support were not always described positively. Some respondents spoke about being triggered if a member dies by suicide, and that some groups aren't helpful if there is an emphasis on substance use and domestic violence.

Gaps in community awareness: Participants spoke about the general community needing to be more informed about the signs of suicide. In this sense, the general community was not described as a barrier per se, but rather as a potential touchpoint that could be more of an enabler if there was more awareness and community capacity. Some respondents spoke about the suicide prevention and mental health sectors needing to be more pro-active in engaging the general community,

there is almost no information, written in plain English, to help people understand the signs, triggers, and the practical things they can do to help someone. The mental health organisations focus too much on literature reviews and reports rather than harnessing people in the community - parents especially - to help them reduce suicide in our community

Those aware of community gatekeeper training and the like passionately called for this to be more accessible, for more community members to be trained to identify those at risk, but also to assist in de-stigmatising suicide and community capacity building.

Enablers

Much of the narratives and experiences shared expressed frustration and despair. However, there were also those who told of their positive experiences. These positive experiences were often facilitated by service providers showing compassion and ensuring that the person with suicide ideation or behaviours knows they can return when needed. Positive experiences were characterised by the pro-action and support of doctors and mental health teams resulting in positive outcomes,

I went to the ER here in 2017 to get admitted, but my doctor had told the psych on call in advance and no one was annoyed that I was at the ER and not actively in crisis. at morning rounds the next day the message was more

or less that they weren't going to just switch my meds and discharge me (unlike in 2015, at a different hospital, where that happened). I think what really came through at that time also was that it felt like they were really committed to keeping me alive and not just... risk-managing my chronic suicidality. So I know that if I need more support at any point they will be there and I guess we trust each other? i.e. they trust me to come in if I'm not safe and I trust them to be there if I need help. That's kind of an anchor.

This highlights how one health professional can precipitate compassion throughout a patient's journey in hospital. In this case, the doctor's actions appear to have provided a pathway not experienced previously. Another participant similarly spoke of a proactive GP who able to access prompt assessment and a subsequent psychology appointment, averting this participant from a suicide attempt,

I went to my GP because the day before I had [METHOD]. My doctor called the mental health crisis assessment team and they assessed me, I'm pretty good at acting well so they didn't admit me (I refused anyway because I was too ashamed), but I did agree to see a psychologist who fitted me in to a cancellation and helped me immensely.

These examples highlight the positive outcomes that can occur for service users when health professionals provide co-ordinated, compassionate care. In the examples above, this was de-stigmatising, therapeutic, and resulted in accurate assessment leading to helpful interventions. Given the survey asked for people with lived experience of suicide to come forth and share their experiences, it is not surprising that by far the majority of stories focused on the contributing events to suicide ideation, attempt and death. However, as with these examples of enablers to care, there were also many participants where evidence of survival was a testament to the human spirit,

You have survived. Whether you survived your own attempt, or someone else's attempt. Whether you survived someone's suicide by not taking your own life.

You have survived and you will continue to survive because life goes on whether you want it to or not and you have more to experience even if they can't, even if you don't want to.

You have survived and there are people who need you to help them survive, even if you don't realise it, because every life that is saved is one less statistic on the evening news.

You survived suicide.

Summary

Every story told in this survey told of complex issues leading to suicide. These issues range across all of the events of life, but for some, these events became life threatening. For many, the challenges started from very young ages, and the complexities grew as they did, leading to disrupted developmental periods, lack of personal resources and exclusion.

The responses to this survey identify many gaps in health and social care services. The result of this is people falling through these gaps, and in relation to suicide, falling through the gaps often results in death. A lack of coordination between services, issues with information sharing and a profound lack of appreciation for the complex reasons that brings an individual to suicide crisis was shockingly apparent across most of the survey responses.

Compassionate care, focused on the individual and their needs at the time they present, is rarely provided. Many health professionals are poorly trained in relation to suicide and are focused only risk assessment within systems that are over-burdened. This results in a lack of judgement about when to act, and when simply to listen to a person, hear their pain and support them. People want to feel heard.

The majority of experiences were reported at the crisis end of a spectrum of suicide behaviours; as people are nearing or falling off the ledge. Proactive, early intervention across many services could have been implemented as people move between different agencies – well outside the mental health system – as they navigate life challenges.

Touchpoints are relatively easy to identify across the private and public service sectors from early childhood through to aged care services. Yet capacity building is needed to ensure that anyone providing any service at any time is able to identify a person early in their struggles and reach out to listen to what is happening for them in a kind and compassionate manner.

Report 3: Empowered Voices

*That's the hardest thing to do, to try and be brave and put yourself forward
but life's a challenge as it is. Every day it's a challenge.*

Eclipse participant

Background

The Eclipse group commenced as a pilot initiative in 2017 offered through Lifeline Mid Coast with an evaluation funded by the Lifeline Research Foundation by the University of New England embedded within the service delivery offering (Maple et al., 2020). The Eclipse program is an adaptation of the Survivors of Suicide attempt (SOSA) support group run by Didi Hersch Mental Health Services in the United States and evaluated by Hom and colleagues (2018). Since the successful pilot in 2017, the group is now offered at three locations — Port Macquarie in regional NSW (8 groups run by Mid Coast Lifeline), and two locations in Sydney - Campbelltown (3 groups run by Macarthur Lifeline) and Gordon (two groups run by Harbour to Hawkesbury (H2H) Lifeline).

The group is an 8-week psychoeducation program aimed at individuals with a history of suicide attempt. The closed group runs to the same curriculum each time, where participants are encouraged to explore their experience of attempting suicide, addressing coping strategies for longer term awareness, developing resilience via engagement regarding conversations focussed on hope and development of ongoing tools such as safety planning strategies. Participants experiences of suicide range from a one-off attempt to living with chronic suicide ideation and attempts. Ideally the group is facilitated by a clinical facilitator, with co-facilitation by a peer worker with lived experience. This model is used at MidCoast – Port Macquarie. However, Macarthur and Harbour to Hawkesbury have used two clinical facilitators, with the aim of training a peer facilitator in the future.

Eligibility for inclusion of the group is:

- Age over 18 years at commencement of group
- A history of suicide attempt/s
- Sound understanding of the English language
- Ability to attend the physical setting where the group is being run
- That the person referring is not actively suicidal

Participants are screened at intake and assessed as to these inclusion criteria by the lead facilitator. At that time, they are also told about the evaluation and if willing complete the consent form to have their information included in the evaluation. The evaluation uses an embedded model, where the facilitators of the group collect data on standardised

psychometric scales immediately pre- and post-group, with the researchers meeting with participants of the group for follow up data collection (1 and 6 months post group).

The following psychometric scales are used: Interpersonal Needs Questionnaire (INQ-15, Van Orden et al., 2012) Suicide Ideation Attributes Scale (SIDAS, Van Spijker et al., 2014), Patient Health Questionnaire (PHQ-9, Kroenke et al., 2001). Resilience Appraisal Scale (RAS, Johnson et al., 2010) and Suicide Related Coping Scale (SRCS, Stanley et al., 2017). In addition to these measures, a qualitative focus group is conducted one-month post completion of the group and in-depth interviews with participants at 6 months after completion of the group. Some participants have participated in more than one offering of the Eclipse group, however they complete the same measures and qualitative interviews and the group content remains the same each time they attend. Facilitators also participate in the evaluation through a structured, self-recorded debrief at the conclusion of each session, and an interview 1-month post group.

Methods

For the purposes of this report we have specifically analysed the qualitative interview data of Eclipse participants thematically to explore reasons participants gave preceding suicide attempts, the services they interact with, and how they manage to 'live well' with suicide. Prior to doing so, we sought permission from Lifeline Research Fund to provide this information, which was granted. Those participating in Eclipse groups, and subsequent evaluation interviews are empowered to speak openly about suicide. This is in sharp contrast to the data presented in *Report 1: Public Voices* and *Report 2: Private Voices*. This in turn provides insight into the layers of experiences shared from an individual into the social and community perspectives of living with suicide. In this report we have also analysed the data from the facilitator debriefs and one-month interviews to add this privileged professional/peer dyad experience of working with suicide attempt survivors in this psychoeducational group format.

Our analysis of the focus group and interview data was undertaken using a narrative methodology. 'Narrative' epistemology is premised on a concept of the self as socially, discursively, and intersubjectivity constructed. Narratives are an opportunity to construct identity and experience (Riessman, 1993). For persons who have previously been marginalised in the discourses determining how others understand them, narratives are a powerful mechanism to construct an identity on your own terms and challenge dominant frameworks that marginalise your experience. Qualitative research methods that open an opportunity for people to share their narratives are therefore particularly important in research with vulnerable and marginalised populations to ensure that the study does not reproduce oppressive structures and practices.

As with the other reports, we have included quotes verbatim. We have left language, even where it is viewed as inappropriate due to potentially further stigmatising people, to demonstrate how these people narrate their own experience in an un-sanitised manner.

Results - Participants of the Eclipse Groups

The analysis included thirty-two participants narratives sourced from one and six month follow up interviews. Of these, eight returned to subsequent groups so their additional one and six month follow up data is also utilised in this analysis. Across each of the three trial sites, participants spanned from 19 years to 75 years old. Male and females were represented, as well as people from regional and metropolitan NSW. When reflecting on the journeys that led them to a self-referral or health profession referral to Eclipse. As the qualitative research interview protocol focussed on the experience of taking part in the group, the participant narratives focus on their experiences of suicide thinking and attempts since the group ended, and explore identification of what aspects of the group resonated (if at all).

Reflections on the suicide journey

The reasons given for finding oneself thinking about suicide, and attempting to do so, reflect the same complexities explored in Report 2: Private Voices. Such issues include complex stories of intergenerational trauma, complex and persistent mental illness, social isolation, family disconnection and recovery from childhood abuse and other life stage traumas,

It is interesting looking at it from an aging perspective and from a life experience perspective, and being able to think that if you hadn't been here, what things you would've missed out on, but also giving space for hearing the other people's experiences too. You know, that's hard to sit with, isn't it?

Many spoke of long histories of engagement with the health system and decades of living with suicide being present in their lives. Yet, oftentimes, participating in the Eclipse group was noted as the first time they felt willing, ready and able to share their suicide stories in a group setting,

I've been in hospital, after committing suicide...maybe five or six times but fortunately, my wife has saved me or I've been saved by the police or other people and I've entered into psychiatric wards in a range of Sydney hospitals. Prince of Wales, Northshore, North Side Clinic, St John of God....and in those hospital settings, they had focus groups working out strategies to recover and post challenges and trigger mechanisms and a whole lot of...range of very good topics. So, I have participated in those and I found those very useful but apart from those, I haven't been involved in anything like Eclipse which I found really good.

What was at the forefront of many of the journeys described was less about the events that occurred prior to the suicide attempt, but about the perception of their behaviours. This was particularly noted by how participants understood others perceived their suicide thinking and behaviours, and the perception they were being judged by others as not being able to overcome trauma, mental health conditions or complex life situations,

I feel a lot more confident in what I've been through in the past I used to be extremely ashamed and just kind of just hide that part of my life away

Importantly as people remain silent (whether self-imposed or imposed by others) shame has fertile ground to grow and overwhelm people. This shame – and guilt – is then reinforced when trying to seek help for suicide attempts,

The health professionals just turned around basically and said ... you're made to feel guilty and I was angry at having survived and you know it wasn't about the whole attempt in the professional side, it wasn't about me and my needs. It was about what about your family? What about your husband, your children? Everybody else around except for me.

Given the scope of these interviews following high cohesion in the group and a sense of safety in telling their story, closer insights were gleaned about how health professionals interact with a suicidal person. It is often reported that health professionals were unhelpful, but perhaps also, they just do not know what to do,

Go see a psychiatrist and I say, 'hey I'm just completely exhausted. I don't know what to do any more' and they say...and they don't know what to do either

This open honesty about being outside of your skill set is rarely reported in psychiatry. Yet, with the complexity of reasons that people end up attempting suicide, it must be more frequently experienced.

Touchpoints

While Reports 1 and 2 examine where service touchpoints for suicide prevention may exist, the narratives from the Eclipse participants assist in providing insight into how individuals start to change their suicide thinking into a future, living focus – even where suicide remained a part of the person's life. These narratives are more aligned with the mental health recovery model, than cessation of suicide completely.

Participants talked about how the use of terms like 'overcoming' suicidal thoughts, or 'removing' thoughts was not consistent with their lived and living experience of suicide,

'From my perspective in talking to people it's less about overcoming suicidal thoughts and more about sitting with suicidal thoughts'

And,

Every time I used to the word overcome it kind of sounded like I just talking about getting on with it rather than living with it.

Learning to live well with suicide present in their lives, participants spoke about how suicide is the result of, and reaction to, their mental health/ill-health, social relationships or recovery from trauma. Therefore, they need new ways of addressing distress when it occurs to replace suicide attempting,

it's so straight forward...when I'm down and it's just that diagram! [pointing to that illustrates a table about managing emotions]. You know that list of things of what to do when you're down and I mean when I'm down I just can't think clearly, you know. And I mean I do I honestly go and get it you know and look at it and there's always something I can do. And I feel that bit better afterwards you know like it lifts a wee bit'

Finding strategies to address the suicide thoughts and connect with them was experienced as a way in which to understand new ways to keep safe. In addition to that, providing individuals with capacity to accept the existence of these thoughts offered validation and self-determination,

I felt that I'm finally normal or validated. Validated in that my actions past actions were not hidden or treated like they were something to be ashamed about. Sitting in a room full of complete strangers I finally felt like I belong it so odd to think that and odd to feel that for once in a very long time I didn't feel like I was hiding anymore'

Eclipse participants were satisfied with the simplicity of the group, they did not need complex interventions, rather they reported that the ability to sit with others who had also experience prior suicide attempts and to be able to speak about this in a supported environment met their needs.

Shared experience

Facilitation of groups relied on the inclusion of two staff per group. As mentioned above, ideally this is a professional/clinical and peer facilitator dyad. This is the model used at Port Macquarie utilised a clinical facilitator and a peer facilitator, with Macarthur and Harbour to Hawkesbury using two clinical facilitators with the aim to train a peer worker for future groups. The inclusion of a peer facilitator, in addition to the other participants all having experienced suicide attempt, is the shared experience,

there's no more valuable person than...a person that's gone through it themselves

There was strength in narratives that addressed the role of mutual understanding by normalising the experience of suicide, and talking openly about suicide, whilst being able to check behaviours with others in order to clarify '*this is my experience*' in a group setting. The predominant experience expressed by participants was a sense of relief in being able to

share without fear of misunderstanding or fear. Regardless of other demographic differences (older, younger; male, female, non-binary; married, not married etc) knowing that everyone in the room had tried to end their life and this is the reason they were attending the group was a source of comfort. Group member diversity also supported the view that suicide is not experienced only by one 'type' of person,

One of the best parts of the group where you could learn from others as to how they were adopting certain strategies to cope with their own illnesses and that sort of thing. My wife always thinks you should rule your illness rather than the illness ruling you and there are some very good strategies that came out of the group that helped me sort of do that. So...it was very, very useful to have the group and their ideas that came out. I found that to be very good. So, I was very grateful for that.

Participants were clear that despite the focus of the group being about suicide, it was not experienced as maudlin, or depressing. Rather, like with many group experiences there were highs and lows, and fun,

it was sort of information, plus hope and surprisingly a ball actually having a laugh together!

Despite this positive emphasis on common experiences, some participants did suggest that this should be approached with caution,

I'm quite introverted and it really, it takes a lot of energy out of me to be in a situation like that and I felt that while I loved that everyone got to share where they were at every week. It sort of started getting longer and longer each time and it started getting too much for me.

This points to the need for experienced facilitation to move through the content, and provide a safe sharing space that meets the needs of all participants,

I don't want to say that suicide is not a normal thing obviously but if I were to say to my partner you know I'm really feeling, and I've thought about this. He would naturally freak out about it. Whereas the group members are able to go yeah that's just something you going through. We know that it's not an issue like if you need to talk about it you do

This allowed for an open conversation in a safe environment where people could then move beyond using suicide as a coping strategy and explore new ways of living. Importantly, people want to stop thinking about suicide,

I want it to stop and...and to be able to go to the program and have other people there where I can freely talk about it without the stigma and the shame and the fear of you know, being carted off. That was huge.

De-escalating stress, in the moment

For participants the message of the group was always simple,

It's not about keeping somebody safe forever, it's just about that moment in time

One of the oldest participants explained that irrespective of individual strategies, health information and public health messaging, none of this would be useful unless conversations were centred on the reason for distress rather than the behaviours being exhibited,

we're reasonably intelligent people but it goes out the window when you're depressed

The reasons behind the suicide behaviours were many and varied, therefore constant reassurance that people are 'going through a hard time' centred the conversation on there being workable solutions that did not result in death. The psychoeducation focus of the group content assisted in finding what the other solutions may be and how to identify earlier when suicide may be closing in on someone so they could act sooner to keep themselves safe,

We were able to sort of put our stop signs and stop it because I've always been taught to put our stop signs when you're having these thoughts. So fortunately, it didn't actually eventuate and I didn't actually try and do anything, so it wasn't a physical thing. It was only mental.

Strategies that worked were shared by participants to other group members with a focus on reframing perspectives and allow people to engage in the reasons why they behave in a certain way rather than the only option being to take away the option of suicide. Importantly, participants reported comfort in knowing suicide was an option, but that they were choosing to incorporate other options, into their lives not removing the thoughts,

Positive thinking is very important. I used to think negatively about things, so positive thinking has really helped me as well and sort of coping with challenges, I guess. I've been able to sort of challenge thoughts and that sort of thing. If they're getting crazy, then I'll challenge the thoughts which the course has helped me with and put up stop signs and that sort of thing, which the course helped me with. So, there have been quite a range of strategies and coping mechanisms and other enjoyment that I've obtained since attending the course. So, I found it to be immensely helpful and I'm very grateful that I was able to participate in it. So, that's sort of really been a great outcome.

Group facilitators as suicide prevention experts

Six facilitators, including the one peer facilitator (who was instrumental in the initiation of the group) and the five professional facilitators participated in interviews. Facilitators were asked to reflect on the challenges and successes of facilitating the group. This was important for continued quality improvement in facilitating the group, but also for facilitators to improve their skills in supporting people in a suicide attempt survivor group which is relatively uncommon.

Facilitators are keenly aware of the hard work that participants are doing during the groups, and their need to feel heard and supported. For the peer facilitator, this is paramount,

they've all shared of themselves. And we, and I, never felt that I'm (different) from them.

Again, the simplicity of the group was a feature of the facilitator's perspectives on its success,

to give them the confidence that they're not alone and that they like, you know the younger one said, she's said, 'this is where I fit now. This is who I fit with and now I know I feel, I don't feel alone anymore.' So to me, my, the objective of, I would imagine the objective is to lessen that suicide thought.

'Risk groups' were not identified in the screening for the group. The key inclusion criteria was prior suicide attempt. However, given the limited population served by some of the groups, a cross over with other support groups has been noticed. This is an important reminder that suicide exposure is common and multi-faceted,

there really is that emerging connection between people who attend the suicide bereavement group coming across to Eclipse, but not...but not naming themselves in the suicide bereavement group

Facilitators expressed their awareness that while they were working in front line suicide prevention roles, that the participants are some of the highest risk of dying, but this did not dissuade them from their work to relieve distress today,

Some will go on to die, and some want to learn not to die. We had a couple of participants probably more mature participants would say that they will die by suicide one day. Like they are absolute resolved in that's what will happen to them one day but they're here for now.

To achieve suicide prevention, engagement is key and through relationships with people facilitated by the group format this allowed for such engagement to occur,

if someone's thinking about suicide and it gets to the emotional thought that they're going to act out because that part of the brain is now more

powerful than this part of the brain that can talk themselves out of it. They can only talk themselves out of it if they're talking

Summary

Initial evidence from the Lifeline Eclipse Suicide Attempt Support Group suggests that the 8-week psychoeducational group format assists people to identify alternate strategies to suicide when faced with escalating distress.

A group format, with experienced facilitators, provides a safe space in which people can share their suicide stories without fear, shame or guilt.

Facilitators can engage in conversations about suicide with participants to normalise the presence of suicide while simultaneously working on strategies to keep safe. A focus on acknowledgement of, rather than removal of thoughts, provides enhanced capacity to address the shame and stigma of attempting as a coping strategy.

Facilitated discussions regarding safety planning as a living document, rather than one-off, offers scope for participants to address future fluctuations in mental ill-health and situational distress.

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