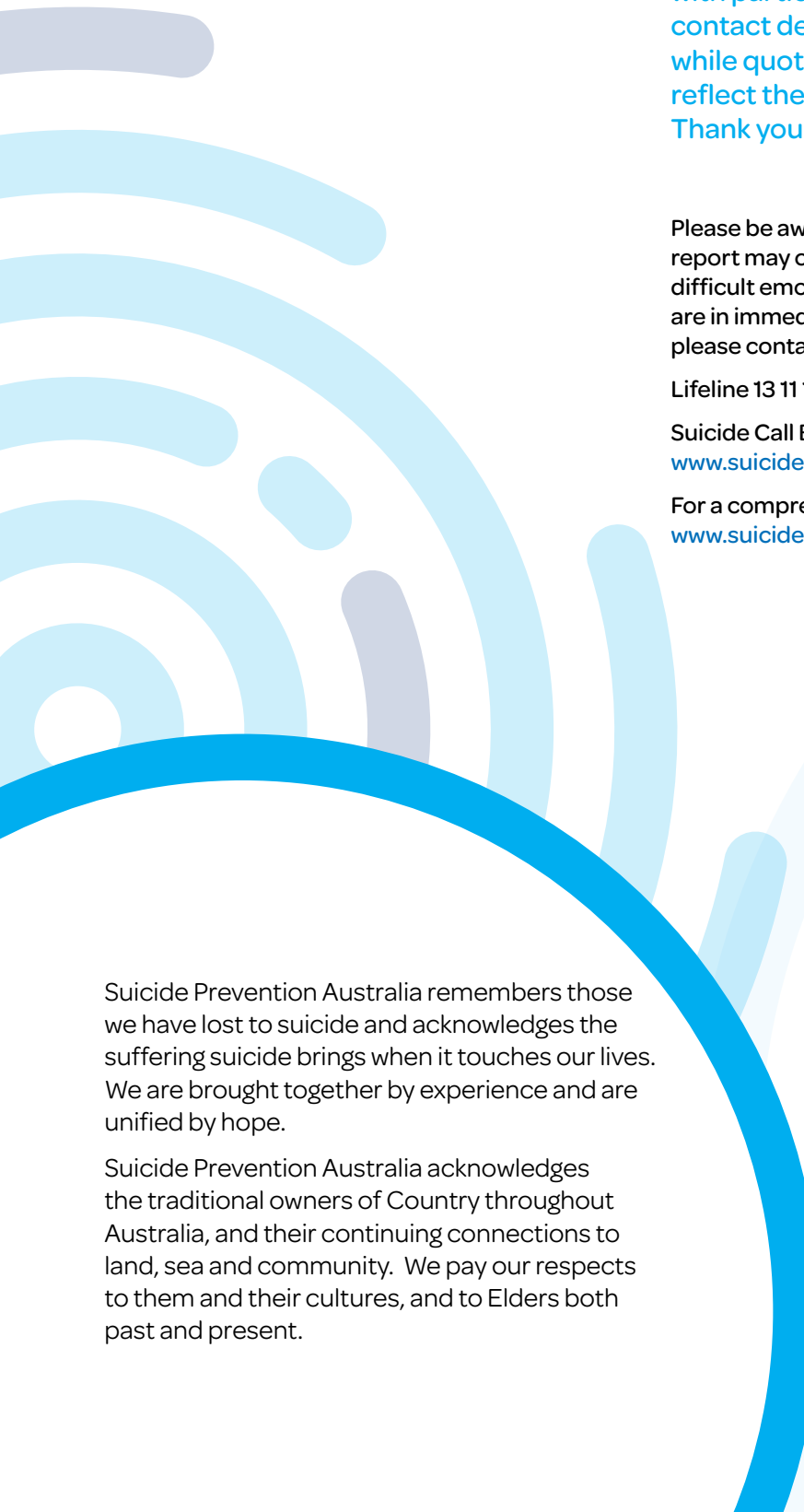




**THE RIPPLE EFFECT:  
UNDERSTANDING THE  
EXPOSURE AND  
IMPACT OF SUICIDE  
IN AUSTRALIA**



A heartfelt thank you to all who contributed to this research and our collective efforts to support more Australians to live. We deeply value your time and willingness to share your experience, particularly given the very personal nature of the survey questions.

A special acknowledgement to our co-authors for their expertise and collaboration. Thank you to our research partners at the University of New England, led by Associate Professor Myfanwy Maple.

Experiences were shared anonymously via the survey, with participants being given the option to disclose contact details for future communication. However, while quotes used in this report are true, images do not reflect the person quoted to protect individual privacy. Thank you for understanding.

Please be aware that the topics and information discussed in this report may cause some distress. If reading this report brings up difficult emotions for you, please reach out for support. If you are in immediate danger, please call 000. For counselling support please contact:

Lifeline 13 11 14 [www.lifeline.org.au](http://www.lifeline.org.au)

Suicide Call Back Service 1300 659 467

[www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)

For a comprehensive list of services visit [www.suicidepreventionaust.org](http://www.suicidepreventionaust.org) and click on Get Help

Suicide Prevention Australia remembers those we have lost to suicide and acknowledges the suffering suicide brings when it touches our lives. We are brought together by experience and are unified by hope.

Suicide Prevention Australia acknowledges the traditional owners of Country throughout Australia, and their continuing connections to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

© Suicide Prevention Australia 2016

For more information contact Suicide Prevention Australia

E: [admin@suicidepreventionaust.org](mailto:admin@suicidepreventionaust.org)

W: [www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)

GPO Box 219, Sydney NSW 2001 Australia

Suicide Prevention Australia acknowledges the funding provided under the Australian Government National Suicide Prevention Program.

**Suggested citation:** Maple, M., Kwan, M., Borrowdale, K., Riley, J., Murray, S. & Sanford, R. (2016) 'The Ripple Effect: Understanding the Exposure and Impact of Suicide in Australia'. Sydney: Suicide Prevention Australia.

ISBN: 978-1-921597-70-1



# CONTENTS

Foreword	4
Executive summary	5
Headline findings	5
Headline recommendations	6
Introduction	7
About the Survey	8
Aim and methodology	8
Who we surveyed	9
Key findings	11
Exposure, impact and relationships	11
Impact and perceived closeness of relationship	14
Impact and distress levels	17
Access to support and services	19
Supporting vulnerable groups	23
Aboriginal and Torres Strait Islander insights	25
Commentary: What has helped and what remains a concern?	27
Conclusion: Be part of the positive ripple effect	31
Recommendations	32

## **What do we mean by Lived Experience?**

Individuals with a lived experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone who has attempted suicide, been bereaved by suicide, or been touched by suicide in another way.

## **What do we mean by exposure to suicide?**

For the purposes of this research, we understand exposure to suicide as being individuals who self-identify as knowing someone who has attempted suicide (including themselves), cared for someone who has been suicidal, or has known someone who has died by suicide.

## **What do we mean by impacted by suicide?**

An individual impacted by suicide may experience a variety of responses and this is a broad continuum – from immediate, short term emotional response, to long term, profound distress.



## FOREWORD

Suicide is a significant public health issue for Australia. To meet the National Coalition for Suicide Prevention's goal to halve suicides in ten years, our efforts to address the rate and number of suicides in Australia needs to be increased and diversified. These include strong national leadership, coupled with well-coordinated regional efforts, particularly for those with high levels of need, in crisis or otherwise vulnerable to suicide.

The results set out in this report, released on World Suicide Prevention Day 2016, is the first research of its kind in Australia aimed at uncovering the extent of the ripple effect of suicide –how suicide affects people in our community. The purpose of the survey was to gain a clearer understanding of how individuals are affected by suicide to better inform where we recommend funds and expertise is directed in suicide prevention. This supports the National Research Action Plan for Suicide Prevention's priority to increase knowledge in suicide prevention, particularly from those with lived experience.

You will see a lot about percentages, numbers and data referenced in this report. This information is essential to measure the exposure and impact of suicide so as to understand the magnitude of the public health problem we are facing in Australia today. However, as you review the findings, know that we recognise and remember each and every person represented. While suicide is a devastating event, the survey brought to light incredible stories of survival, resilience and growth. This report only provides a very brief snapshot.

There is also much we can learn from the qualitative survey data in this report. That is, the personal experiences shared by individuals on their story: what they think could have helped and what they would like to see as a prevention priority.

Lead researcher and Suicide Prevention Australia Director, Associate Professor Myfanwy Maple tells me that in every piece of research she does, after reviewing thousands of lines of data and code,

there is always a quote that sticks long after the analysis is complete. For this piece of work, it was this, shared by a 26-year-old transgender person who has lost multiple friends to suicide:

*"Loss after loss makes it feel like continual grief. It almost becomes expected. When someone in my community dies, my first thoughts often include: 'Was it suicide?' Heart attack, cancer or a car accident always seems like the least likely cause of death. I don't want that to be normal anymore. I don't want that to be normal for the kids growing up now."*

That is exactly why we have undertaken this research. We not only need to be acutely aware of the problem but more importantly use these results to inform action (see our report recommendations). As well as working alongside government and the broader suicide prevention sector to review and reform health and social care systems, we must draw lessons from this research on how we can better educate ourselves on suicidal behaviours and how our communities can support those vulnerable to suicide.

Many thanks to the team who worked on this invaluable research project and those who shared their personal experiences. We deeply value your participation.



**Murray Bleach**  
Chairman



# EXECUTIVE SUMMARY



In collaboration with the University of New England, Suicide Prevention Australia has conducted a national research project investigating the exposure to and impact of suicide in Australia. A total of 3,220 Australian residents responded to the survey, self-identifying as having been touched by suicide in some way.

## Headline findings

### About the Respondents

- When comparing geographic location of our survey respondents to that of the Australian population (Australian Bureau of Statistics (ABS))<sup>1</sup>, the distribution of respondents is somewhat aligned.
- In this sample we did see a higher response rate from those in rural, remote and regional areas in comparison to ABS population, as well as 7% of the sample identifying as Aboriginal and/or Torres Strait Islander, significantly above the national representation<sup>2</sup>.
- Of the 3,220 respondents, 21% identified as male, 78% as female and 1% preferred not to say or identified in another way. Men reported statistically higher levels of exposure to suicide deaths generally as well as close deaths compared to women, yet women reported statistically higher levels of impact following exposure to suicide attempt and death than men.
- Six per cent of respondents were aged 18-24, with the highest number of respondents (26%) being in the 45-54 age group.

### Suicidal Behaviour

- At present there is no way to measure the number of people affected by each suicide death, nor the way in which these events impact on those affected. Similarly, there is limited understanding of how people are

affected by a broader spectrum of suicidal behaviours such as attempts, plans and/or ideation.

- Australian findings indicate that 89% of respondents knew someone who had attempted and 85% knew someone who had died by suicide. 80% of people had been exposed to both suicide attempt and death. In this finding it is possible that the reported attempt and death occurred to the same person. 75 people (2% of the sample) reported their own suicide attempt without being prompted. This is a clear message we need to include this lived experience of suicide in our work to prevent suicide.

### Relationships

- When asked about the relationship with the person whose suicide death or attempt affected them most, respondents most commonly reported “friend”, followed by “brother”.
- Results indicate that 32% of people reported a very close relationship with the deceased and 37% expressed that the death had a significant impact that they “still feel”.
- Aboriginal and/or Torres Strait Islander respondents experienced a higher number of suicide exposures reporting an average of seven people known to them who had died by suicide, more than twice that of non-Indigenous respondents.
- Results showed a higher than expected exposure to non-kin suicide attempts for 18-24 year olds and 25-34 year olds. In contrast, higher exposure to kinship related suicide attempts for older groups (45-54 year olds) and higher than expected exposure to self-suicide attempt for 35-44 year olds.
- Findings from our research showed high levels of distress, over long periods of time ranging from one to 58 years after the reported suicide death.

<sup>1</sup> ABS 2014, Internet activity, Australia, December 2015, Cat. No. 4364.0.55.001, ABS, Canberra, accessed 31 August 2016, <<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001-2014-15-Main%20Features-About%20the%20National%20Health%20Survey-3>>

<sup>2</sup> Ibid

## Service Implications

- It is clear from our research that those touched by suicide are a highly distressed population in comparison to National Health Survey results<sup>3</sup>.
- More than half of those who knew someone who had died by suicide reported that the person did not have access to some form of healthcare or they were not aware of any access.
- The significant impact that suicide has in Aboriginal and Torres Strait Islander communities was resounding, with over 25% of open text responses referring to multiple exposures to suicide deaths, and 20% discussing the devastation that this ripple effect has had on their community.
- A number of qualitative comments highlighted the need to address a range of vulnerable populations such as Culturally and Linguistically Diverse (CALD), rural and remote communities, people with severe and persistent mental illness, people of LGBTI experience, those experiencing or who have experienced abuse, refugees and asylum seekers, people who have experienced a bereavement intervention or a trauma during childhood, carers of people who have attempted suicide, vulnerable communities (such as construction and emergency services workers) and those suffering from severe eating disorders.

## Headline recommendations

- 1. Increase community awareness** about suicide prevention and educate communities on suicide and the broad spectrum of suicidal behaviours to help build capacity within the community to give and get help.
- 2. Recognise lived experience of suicide** as a public health issue of significance in Australia.
- 3. Develop and support a National Suicide Prevention Strategy**, including a dedicated component addressing the long-term exposure and impact of suicide.
- 4. Prioritise Aboriginal and Torres Strait Islander suicide prevention and culturally appropriate suicide prevention strategies.** National Aboriginal and Torres Strait Islander Suicide Prevention Strategy implementation funds must be released as a matter of urgency.
- 5. Ensure consistent comprehensive discharge plans are developed and implemented** for all patients upon being discharged from the health system including the involvement of family, close contacts and community services.
- 6. Engage the Productivity Commission to conduct a detailed independent assessment of the cost of suicidal behaviour in Australia.** This assessment should include the costs associated with exposure to and impact of suicidal behaviour, as well as suicide deaths.

## Translating research into practice

Suicide Prevention Australia is working with government on how to implement the promised \$12m suicide prevention research fund, as recommended by the National Research Action Plan for Suicide Prevention. Management of the fund must sit independently of those undertaking research to ensure no vested interest other than ensuring the best research, which is outcomes focused and responsive to community needs, is funded. As this commitment is \$12m over three years, we will also need the ability to leverage those funds in order to increase philanthropic and community donations. Our scarce research dollars must be directed into what is proven to work so we can take action where it is most needed.

<sup>3</sup> ABS, op. cit.



# INTRODUCTION



The World Health Organization estimates that over 800,000 people die by suicide each year – that's one person every 40 seconds. In Australia more than 2,500 people die each year with latest figures showing that 2,864 Australians took their own life (2014)<sup>4</sup>. Research also tells us that 65,000 attempt suicide and almost 600,000 think about suicide each year<sup>5</sup>.

This creates a ripple effect resulting in many people being impacted by, or exposed to, suicide and the pain it brings when it touches our lives. Suicide Prevention Australia in collaboration with the University of New England has conducted a national research project investigating the exposure to and impact of suicide in Australia.

At present there is no way to measure the number of people affected by each suicide death, nor how these events impact on those affected. From the late 1960's there has been an estimate that six people are bereaved by each suicide death<sup>6</sup>. This estimate was based on the knowledge of the time, and while lacking in evidence, it has become a standard measure in suicide prevention literature. Over the decades since, several researchers have attempted to quantify the number of people affected by each suicide death, with estimates ranging from 10 to 115<sup>7</sup>.

Recent research from the United States has shown that every suicide leaves 135 people exposed<sup>8</sup>.

Exposure to suicide and/or suicide bereavement has long been identified as a risk factor for suicide<sup>9,10</sup>. Both supporting people affected by suicide in their grief journey and reducing the potential morbidity and mortality associated with this exposure is an important suicide prevention strategy.

Traditional responses to suicide (and research on suicide) have been bereavement focused. Suicide Prevention Australia's Lived Experience Network (LEN) recognises the full spectrum of lived experience from which we need to learn. In addition to recognising suicide bereavement, the LEN also acknowledges suicide attempt survivor exposure and impact, carers, those managing suicidal thoughts and behaviours and people who have been touched by suicide in another way.

---

<sup>4</sup> ABS, op. cit.

<sup>5</sup> Suicide Prevention Australia (SPA). 2014, 'Discussion Paper: One World Connected: An assessment of Australia's progress in suicide prevention'. Available at [https://www.suicidepreventionaust.org/sites/default/files/resources/2016/NCSP\\_Australian%20Response%20to%20WHO%20World%20Suicide%20Report\\_doublepage\\_.pdf](https://www.suicidepreventionaust.org/sites/default/files/resources/2016/NCSP_Australian%20Response%20to%20WHO%20World%20Suicide%20Report_doublepage_.pdf)

<sup>6</sup> Schneidman, E 1972, 'Forward', in Caine, A (ed), *Survivors of Suicide*, C.C. Thomas, Springfield.

<sup>7</sup> Berman, A. 2011, 'Estimating the population of survivors of suicide: seeking an evidence base', *Suicide and Life Threatening Behavior*, vol. 41, no. 1, pp. 110-116.

<sup>8</sup> Cerel, J. (2016, July 25). Connecting to the Continuum of Survivorship. Paper presented at the National Suicide Prevention Conference: Connecting culture, context and capabilities, Canberra.

<sup>9</sup> Maple, M., Cerel, J., Sanford, R., Pearce, T. & Jordan, J. (in press), 'Is exposure to suicide beyond kin associated with risk for suicidal behavior? A systematic review of the evidence', *Suicide and Life Threatening Behavior*, Accepted 10 June 2016.

<sup>10</sup> Pitman, A., Osborn, D., King, M., Erlangsen, A 2014, 'Effects of suicide bereavement on mental health and suicide risk', *The Lancet, Suicide 3 Series*, DOI: [dx.doi.org/10.1016/S2215-0366\(14\)70224-X](https://doi.org/10.1016/S2215-0366(14)70224-X).





# ABOUT THE SURVEY

## Aim and methodology

Suicide Prevention Australia partnered with the University of New England to better understand suicide from a broad public health perspective to better understand what individuals, businesses, communities and government need to do to prevent it. That is, how Australians can proactively contribute to a positive ripple effect of prevention.

In this research we refer to exposure as meaning the death by suicide (or a suicide attempt) of someone known to the respondent, however we acknowledge that there is a broad continuum of suicidal behaviours including suicidal ideation and self-harm, which can also have a significant impact on carers, health professionals and wider familial and social networks.

The research was undertaken via an online survey, distributed through Suicide Prevention Australia members, networks and partners.

Respondents self-selected to participate in this convenience sample of 3,220 people. It was designed to understand the level of exposure, how much this impacts on people (including their mental health using the K10 psychological assessment questionnaire), service use prior to death, and other issues related to impact and exposure to suicide attempt and death. Respondents were asked to recount any exposure to suicide with some events taking place many years ago, and some with multiple encounters. As a result, self-reports may have been subject to recall bias.

The study targeted adults over the age of 18 years, living in Australia at the time of survey completion. It was distributed in English only with the research team recognising limitations of this and other accessibility challenges (including cultural and geographical).

All data presented is based on valid responses to each question. This research was approved through the University of New England's Human Research Ethics Committee.

When comparing geographical location of survey respondents to that of the Australian population distribution Bureau of Statistics (ABS), the spread of respondents is somewhat aligned. In this survey we did see a higher response rate from those in rural and remote areas in comparison to the the ABS population, as well as a 7% survey completion rate by those identifying as Aboriginal and/or Torres Strait Islander, significantly above the national representation of 2%.

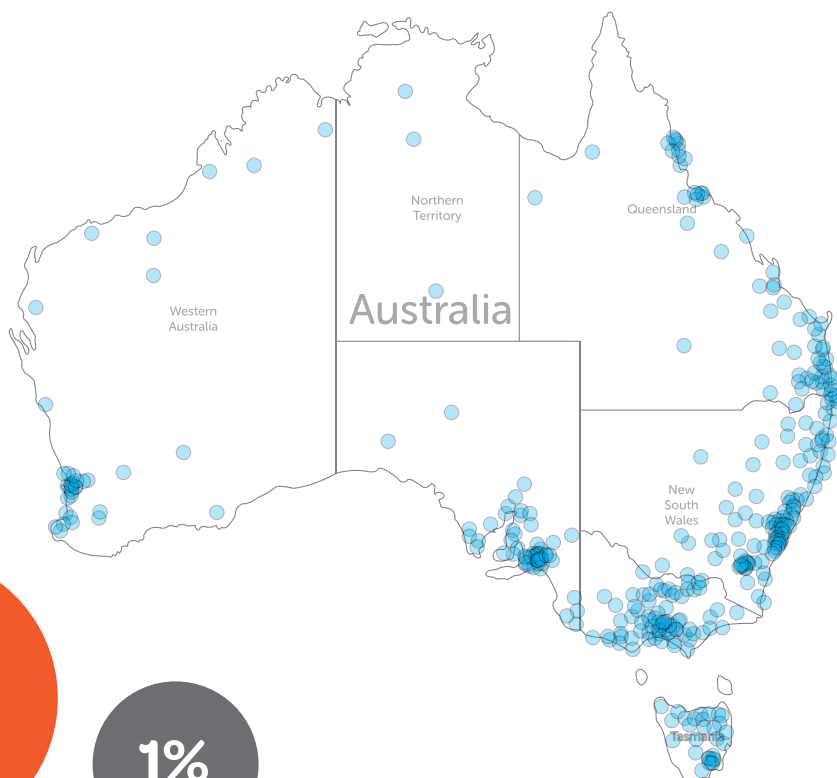




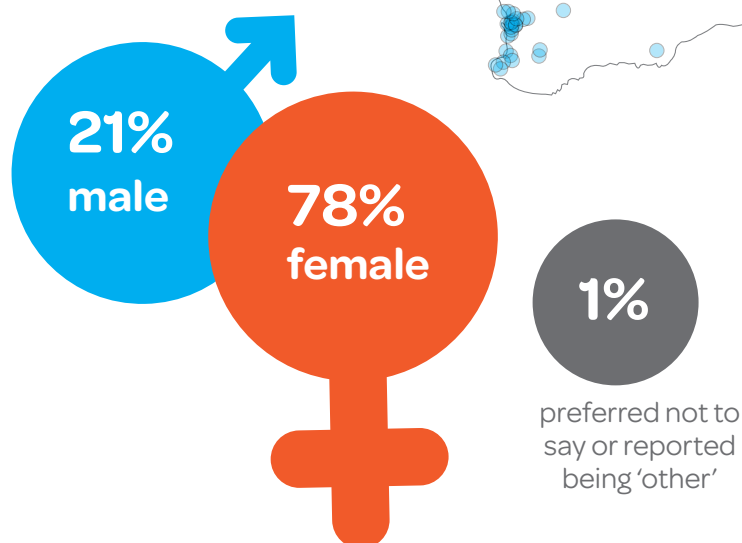
## Who we surveyed

### Demographics

Heat map of  
respondents across  
Australia

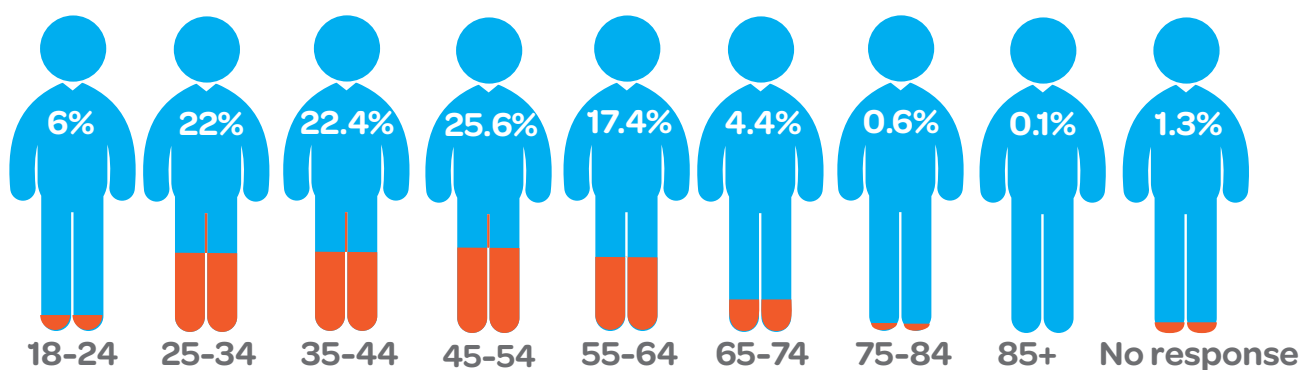


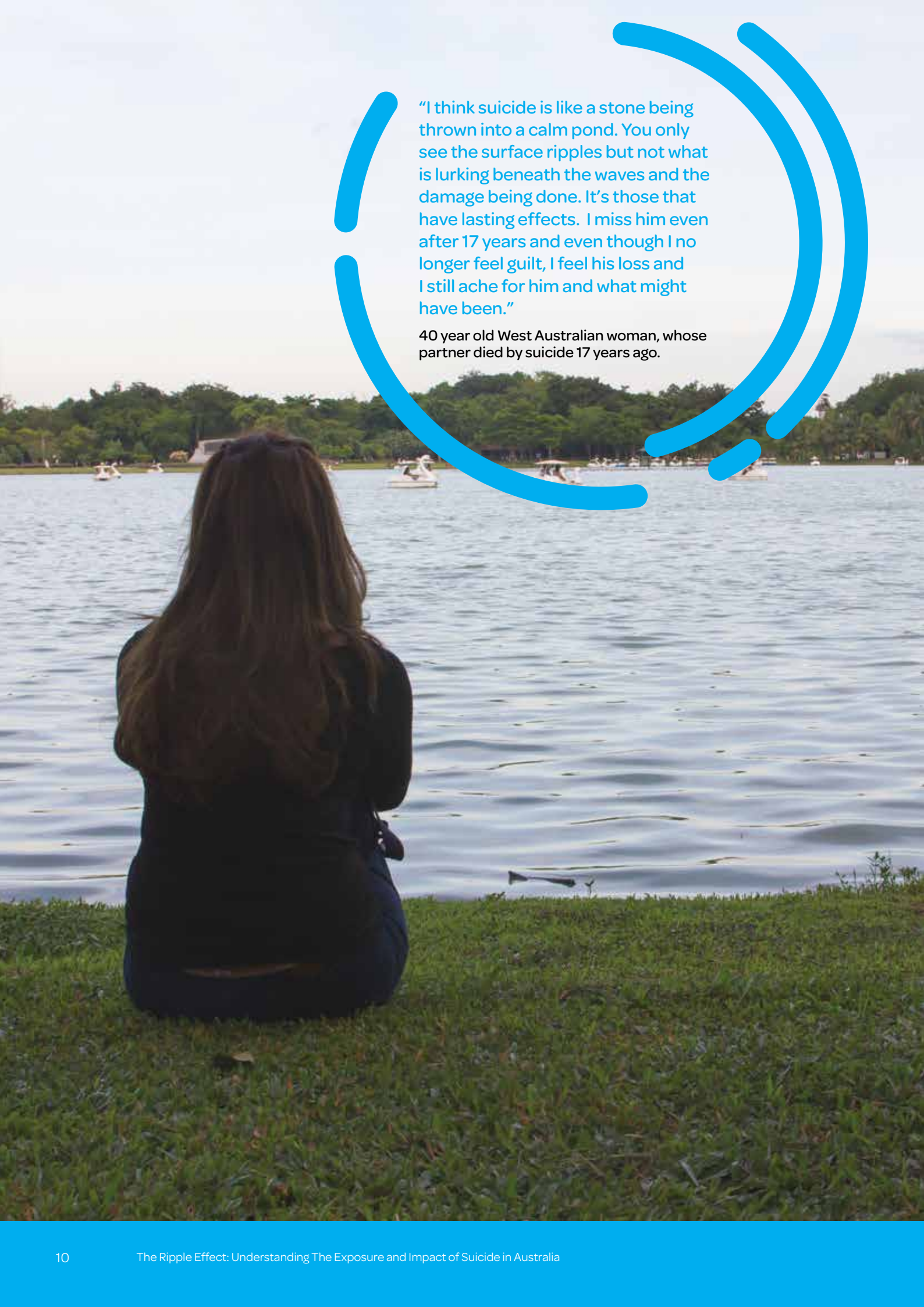
### Gender



### Age Groups

Age breakdown of respondents





"I think suicide is like a stone being thrown into a calm pond. You only see the surface ripples but not what is lurking beneath the waves and the damage being done. It's those that have lasting effects. I miss him even after 17 years and even though I no longer feel guilt, I feel his loss and I still ache for him and what might have been."

40 year old West Australian woman, whose partner died by suicide 17 years ago.



## KEY FINDINGS



### Exposure, impact and relationships

Recent research from the United States has shown that every suicide leaves 135 people exposed<sup>11</sup>. In Australia, we surveyed more than 3,220 Australians to give us a firmer indication of the impact of suicide.

Due to our non-representative sample, we cannot report on a single figure that shows the number of people impacted by a single exposure to suicide, however Australian findings indicate that 89% of respondents knew someone who had attempted and 85% knew someone who had died by suicide. Eighty per cent of people had been exposed to both suicide attempt and death. In this finding it is possible that the reported attempt and death occurred to the same person. Seventy-five people (2%) reported their own suicide attempt without being prompted.

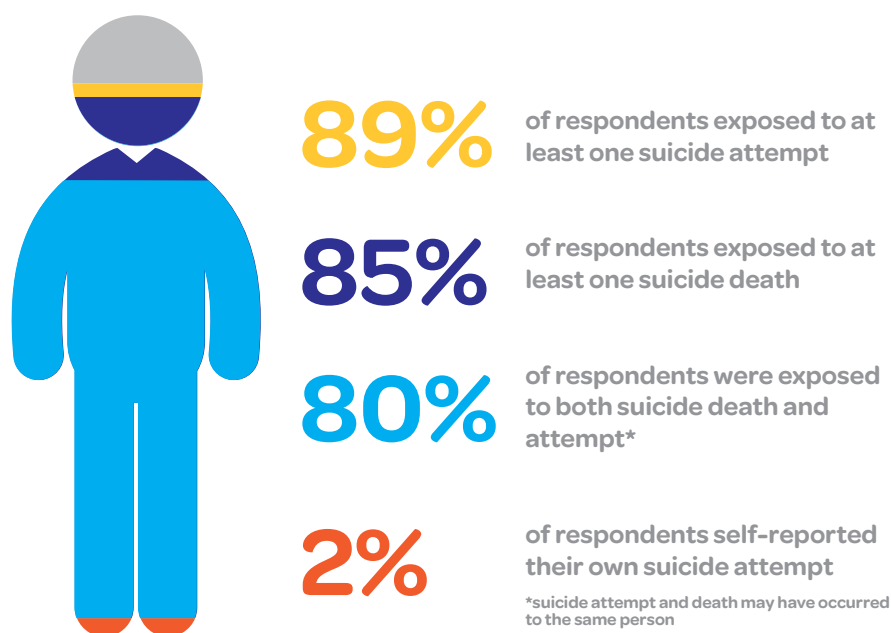
When asked about the relationship to the

person whose suicide death or attempt affected them most, respondents most commonly reported “friend”, followed by “brother”.

We know that exposure to suicide is a risk factor for subsequent suicide therefore bereavement support is an important step in suicide prevention. Understanding this ripple effect, and where trauma exists following this exposure, can help us to identify opportunities to intervene, support and educate. This research gives voice to personal experiences. To prevent suicide, our efforts and our investments must match the magnitude of the public health challenge we face.

Community driven suicide prevention must be sustainably supported by national, state and local infrastructure. As well as increasing public awareness of the impact of suicidal behaviour we must look to educate and empower individuals and communities in how to get help, give help and save lives.

### Respondents' Exposure to Suicide



<sup>11</sup> Cerel, 2016 op. cit.

Thinking about the effect of the person's death on your life,  
please indicate the rating that best describes your experience



Relationship to person who died







"At one time it felt like there was one after the other and the grief goes on. And with so many family and friends, some so young, I'm not sure how I feel sometimes. One good thing is there is more talk about suicide and self-care. People need self-care and need to talk about the hard topics."

54 year old Northern Territory man, who has lost multiple family and community members to suicide



## IMPACT AND PERCEIVED CLOSENESS OF RELATIONSHIP

While, for the purposes of this report, we asked specifically about the closeness of the relationship to the deceased, we acknowledge the importance of looking across the full spectrum of suicidal behaviours. This is particularly so in designing support systems and processes. More research is required in this area.

When respondents were asked to report on the suicide death that had the most significant impact on them, almost one third of respondents identified as being “very close” to the deceased. Of those who reported their relationship with the deceased, 46% of relationships were listed as kin and 54% non-kin. This shows us that the majority of the notions of closeness are not familial connections, and among some groups, such as young people, this connection with non-kin was more noticeable.

When we looked at the non-kin results in more detail, we found that workplace exposure was prevalent in these results – either as a result of respondent profession (such as frontline responder or health professional), or a colleague who attempted or took their own life. There was also recognition of diverse families and community that have a high level of perceived closeness but are not necessarily kin.

Of those who reported a very close relationship with the deceased, 37% felt that the death had a significant impact that they “still feel”.

Perceived closeness to the deceased can have a profound impact on the individual exposed, with adverse social and health outcomes<sup>12</sup>, including increased risk of depression, anxiety and suicide<sup>13</sup>.

This has implications for accessibility and service provision, and we therefore advocate for inclusive eligibility criteria for public health services that are not restricted to identifying as kin, thus increasing diversity in access points for support information for prevention and postvention (bereaved and attempt).

When developing key messages in public awareness campaigns and community programs and services, we recommend recognising both kin and non-kin with perceived closeness to the deceased as target demographics. These campaigns must also look to use broader community networks and access points for postvention such as workplaces, sporting teams, schools, funeral homes etc to reach a wider group who are exposed and therefore potentially impacted.

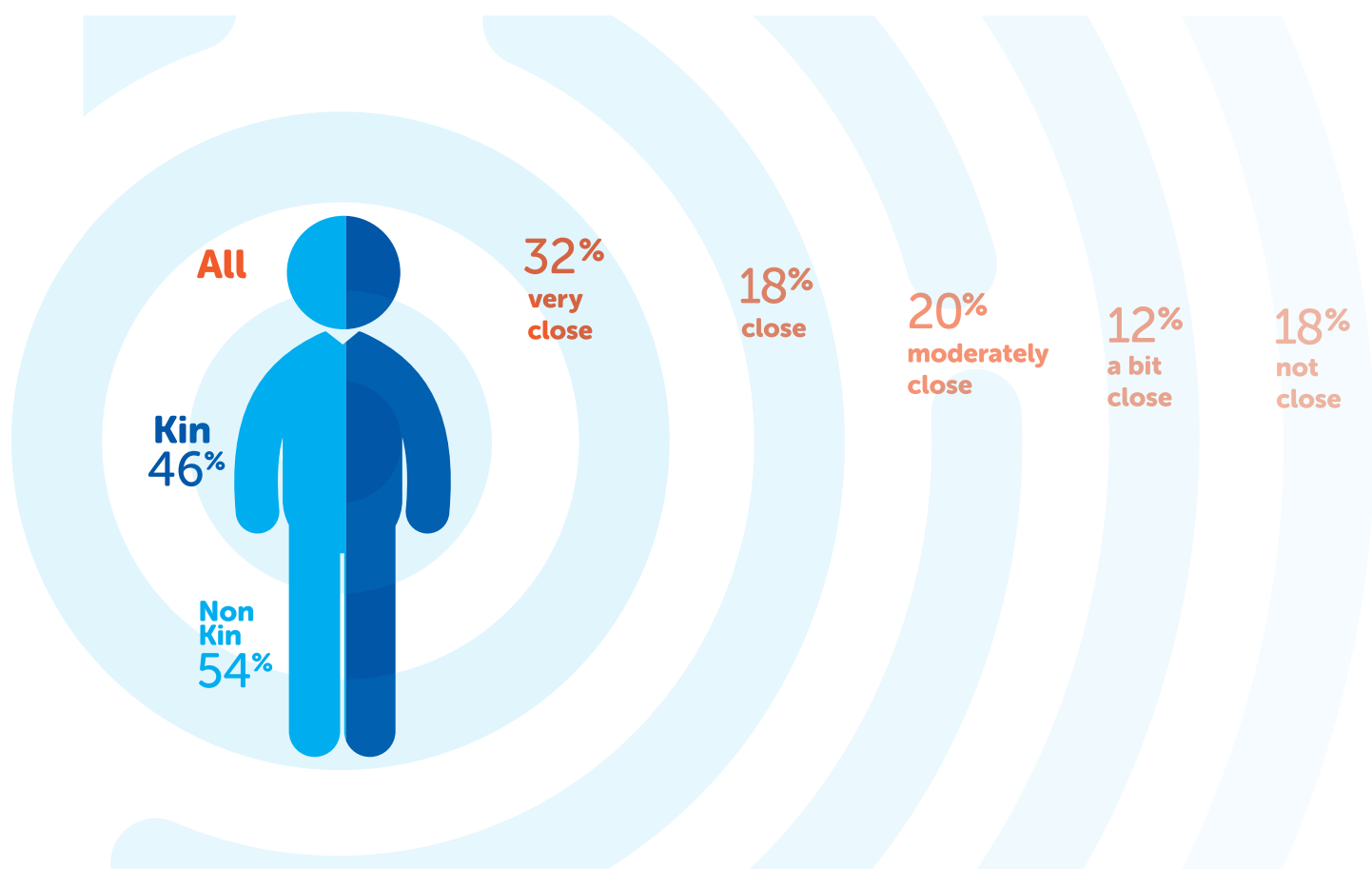
---

<sup>12</sup> Maple, op. cit.

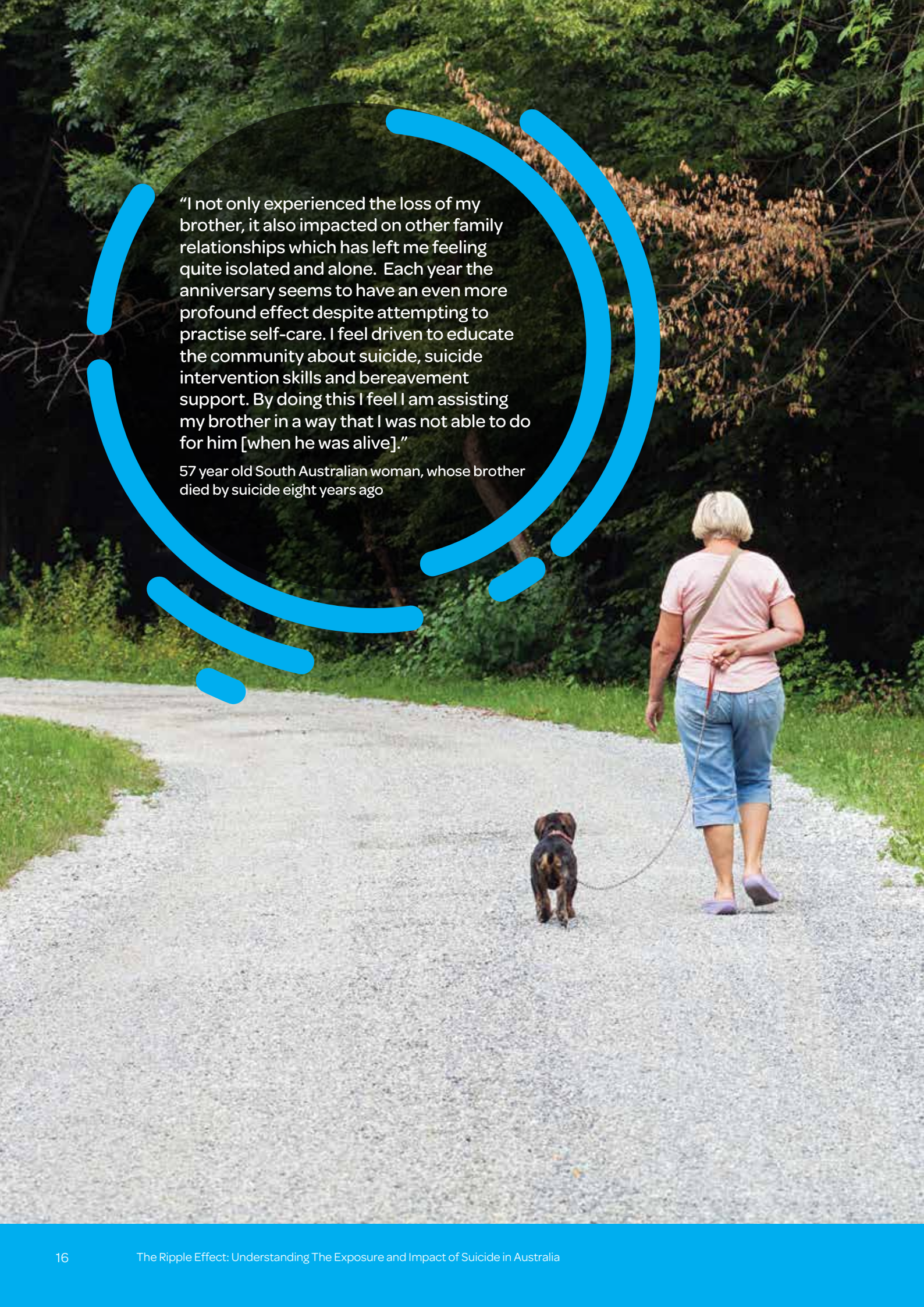
<sup>13</sup> Pitman, op. cit.



## Closeness to person who died





A woman with short blonde hair, wearing a pink t-shirt and blue jeans, is walking away from the camera on a gravel path. She is holding a leash for a small black and brown dog. The path is surrounded by green grass and dense trees. A large, stylized blue circular graphic with several concentric arcs is overlaid on the left side of the image, framing the text.

"I not only experienced the loss of my brother, it also impacted on other family relationships which has left me feeling quite isolated and alone. Each year the anniversary seems to have an even more profound effect despite attempting to practise self-care. I feel driven to educate the community about suicide, suicide intervention skills and bereavement support. By doing this I feel I am assisting my brother in a way that I was not able to do for him [when he was alive]."

57 year old South Australian woman, whose brother died by suicide eight years ago





## IMPACT AND DISTRESS LEVELS

It is clear from our research that those exposed to suicide are a highly distressed population in comparison to National Health Survey results. Evidence tells us that those bereaved by suicide are at increased risk of suicidal behaviours<sup>14,15</sup>. However, there is also some evidence that suggests bereavement support can be cost effective and may reduce suicide risk in the long-term<sup>16,17</sup>. While the responses were predominantly focused on bereavement by suicide, we must listen to all lived experience voices– including those who have made prior attempts – to fully understand and address suicide in our community.

Suicide exposure and the long-term impact it has on individuals and communities is pervasive and devastating. While it was not surprising to have found that there are high levels of distress immediately post exposure to suicide, this does ease over time. Yet, for some, continued distress remains for a lifetime – the longest period of time in this sample was 58 years after the suicide. Findings reveal a notable shift taking place at the five year mark after the suicide, with a decrease in the severity of distress levels, which is worthy of further research.

Australia is leading the way globally with suicide bereavement services that not only provide tailored support for individuals but also are evidence generating<sup>18</sup>. However, there is no reliable and valid measure of

the number of individuals exposed to or bereaved by suicide in Australia, nor any way to identify them. While this research provides a snapshot of suicide exposure within the Australian community, collection of national data on exposure to, and impact of, suicide must be a priority so that we can understand the magnitude of the public health issue and provide adequate responses. Longitudinal data would ideally provide the insight needed to tailor support to those who need it in the future.

In recognising non-linear grief and length of distress over time post death or attempt, sustained access to services and support must be available, not limited to immediately post experience, and not limited by identification via kinship or immediate friendship groups. Such support must also extend to workplaces impacted by suicide death and/or attempt.

The growing voice of lived experience is shedding greater light on the needs of those bereaved and impacted by suicide attempt, including the individual and those providing support. We must listen to the stories and recommendations of those who have lived through suicide attempt, cared for them, or have been bereaved by a suicide death. Those with lived experience have a vital role to play in developing responses that compassionately and effectively help those in suicidal crisis find a life worth living.

---

<sup>14</sup> Maple, op. cit.

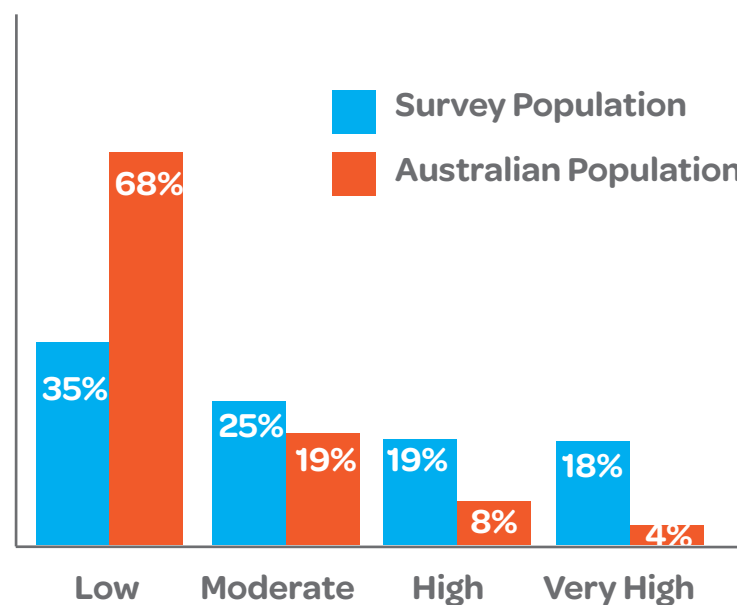
<sup>15</sup> Pitman, op. cit.

<sup>16</sup> Doran, C., Ling, R., 2014, The economic cost of suicide and suicide behaviour in the NSW construction industry and the impact of MATES in Construction suicide prevention strategy in reducing this cost, report, Mates in Construction, New South Wales.

<sup>17</sup> Comans, T., Visser, V., Scuffham, P. 2013, 'Cost effectiveness of a community-based crisis intervention program for people bereaved by suicide', The Journal of Crisis Intervention and Suicide Prevention, Advance online publication. DOI: 10.1027/0227-5910/a000210.

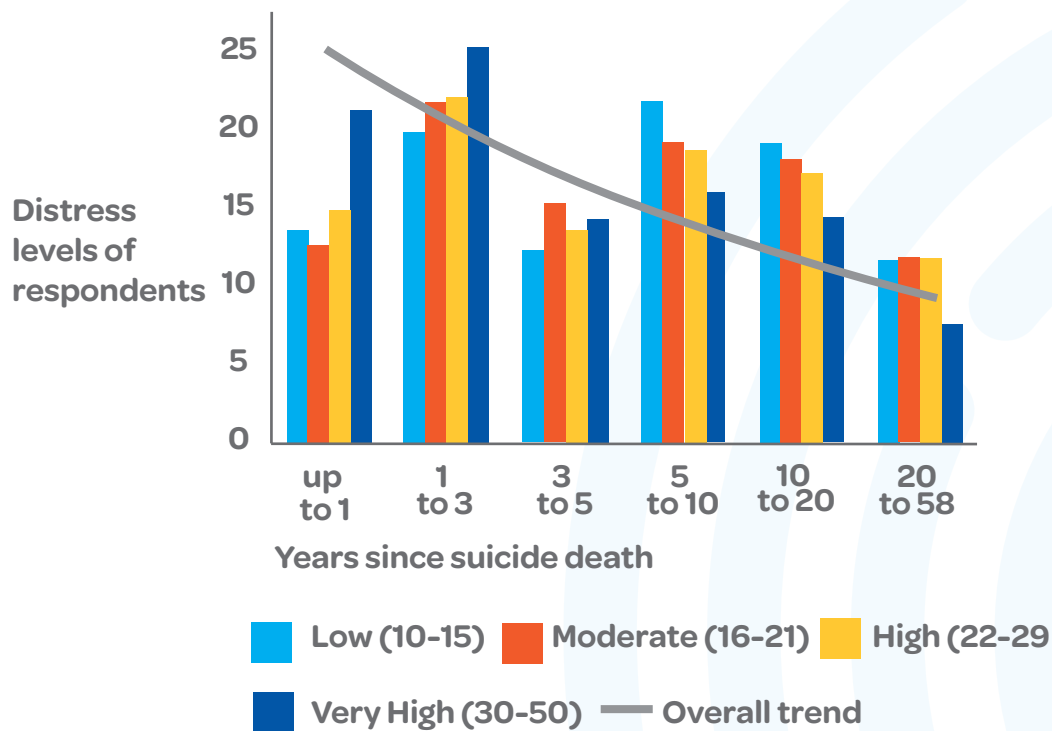
<sup>18</sup> SPA, op. cit.

## Distress levels of survey respondents vs national population\*



\* 2014 ABS National Health Survey

## Distress levels of respondents based on time since death





## ACCESS TO SUPPORT AND SERVICES

Findings from this research indicate access to services prior to a suicide death may not always be achieved. More than half (55%) of those who knew someone who had died by suicide reported that the person was not in contact with health services prior to their death (23%) or they did not know if they were in receipt of health care (32%).

A common theme raised, particularly from carers and bereaved family members, was a sense of confusion when faced with service options, both in terms of accessibility (geographical limitations and navigating service channels) and mental health literacy, that is, knowing how to find the right service at the right time for the issue being experienced. This tells us there is a need for better coordination and communication of support services available.

Further, there was a clear need identified in relation to bridging gaps in healthcare and social support services for those vulnerable to suicide, their families and carers. This was particularly true with a number of comments in relation to follow-up and care information following treatment for an attempt.

The linkage between hospital, health services and community based crisis support services must be strengthened to create an effective system of crisis intervention for suicide prevention including appropriate and timely care for assessing suicide risk in an individual, following a suicide attempt, and support when a suicide death occurs. This should be supported by coordinated, quality, evidenced based systems and services that are appropriate and accessible. Care should be person-centred with those leaving our healthcare system supported by a follow-up plan designed in partnership with the individual, their clinician, family and carers and the appropriate community services. These need to acknowledge the difficulties of distance (for those outside metropolitan

centres) as well as isolation of those within our communities (for example, those who are culturally and linguistically, sexuality or gender diverse).

We must utilise digital opportunities and information resources to engage the wider community in understanding they have a role to play in providing early identification, support and referral to additional appropriate services and supports. Further quality assurance must be supported by nationally accredited, competency-based training systems for both community and health settings.

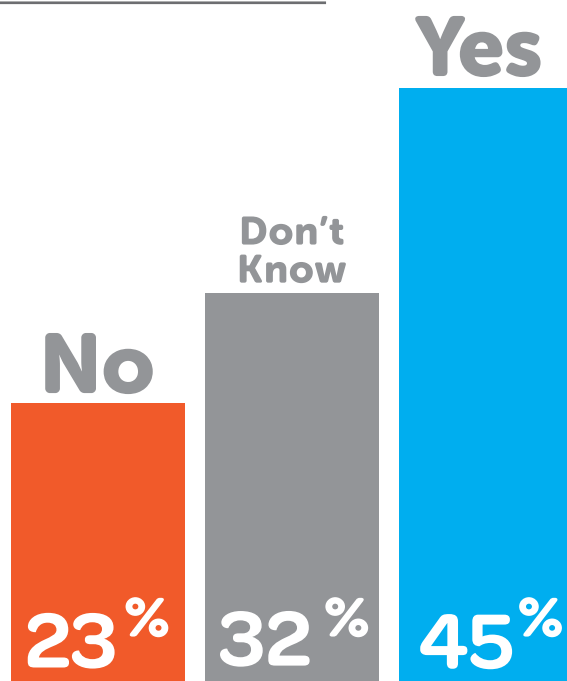


“My family felt powerless and uninformed when dealing with the health system during my aunt’s many attempts. She was not in a position to comprehend the support she was being offered or needed. They were not given follow-up support after discharge and did not have the knowledge or assertiveness to ask for anything more than they were provided – which was not enough, not nearly enough.”

39 year old woman from New South Wales, whose Aunt died by suicide three years ago



## Access to healthcare support six months prior to death

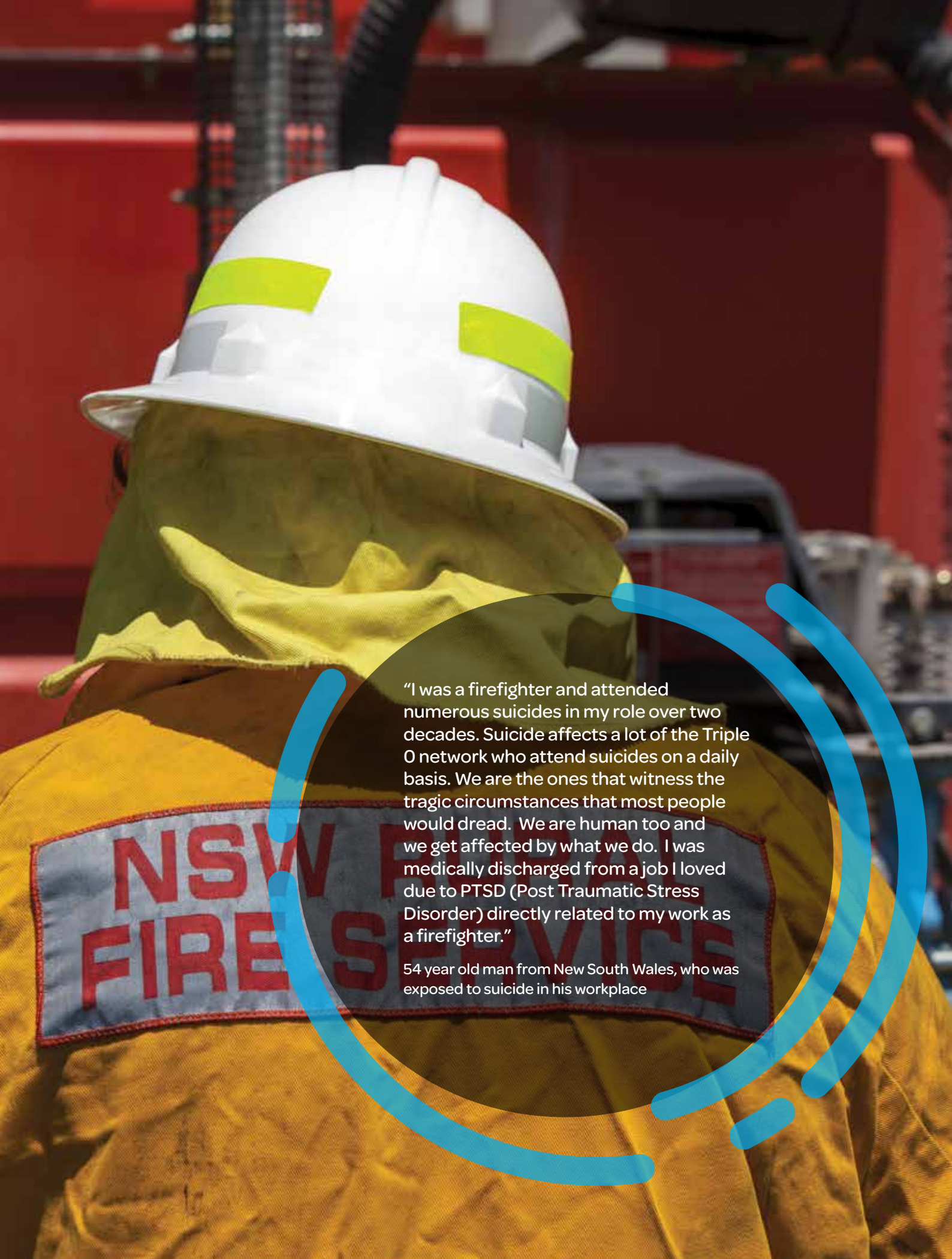


## Types of healthcare support accessed by person who died\*



\* Respondents were able to choose multiple supports.





"I was a firefighter and attended numerous suicides in my role over two decades. Suicide affects a lot of the Triple O network who attend suicides on a daily basis. We are the ones that witness the tragic circumstances that most people would dread. We are human too and we get affected by what we do. I was medically discharged from a job I loved due to PTSD (Post Traumatic Stress Disorder) directly related to my work as a firefighter."

54 year old man from New South Wales, who was exposed to suicide in his workplace





## SUPPORTING VULNERABLE GROUPS

We received a number of qualitative comments highlighting the need to address a range of vulnerable populations. Seventy-five (2%) survey respondents identified themselves as having attempted suicide with 7% of survey respondents identifying as Aboriginal and/or Torres Strait Islander. We also received comments specifically related to vulnerable populations such as Culturally and Linguistically Diverse (CALD), rural and remote communities, people with severe and persistent mental illness, people of LGBTI experience, those experiencing or who have experienced abuse, refugees and asylum seekers, people who have experienced a bereavement intervention or a trauma during childhood, carers of people who have attempted suicide, vulnerable communities (such as construction and emergency services workers) and those suffering from severe eating disorders.

Interestingly, as well as responses from health workers, we received responses from a higher than expected number of people

who were not health workers but who were nevertheless exposed to suicide in their line of work. These were not traditionally noted as occupations that specialise in suicide prevention or have a significantly high risk of suicide exposure. Some of these included train drivers, teachers and school counsellors.

In setting priorities for the delivery to communities, special interest groups and workplaces, the understanding of special population groups who are likely to be exposed needs to be addressed to lessen the impact for these people.

All service delivery should be culturally safe and respectful. To do this, a good understanding of the diversity of the target population is required and best practice principles on culturally safe and respectful practice must be incorporated. This includes, at a minimum, looking at diverse sexuality and gender identity, Aboriginal and Torres Strait Islander culture, and ethnicity. More research is required in this area.

### Vulnerable groups surveyed





“In the Indigenous community we hear of somebody weekly associated with our mob. My cousin brother went to get help from the hospital and because they wanted him to see a psychiatrist which many Indigenous people associate with being mad or crazy he left. Sometimes it’s about having appropriate places to go in times of need. Sometimes it’s about terminology.”

38 year old Aboriginal and Torres Strait Islander woman from Western Australia



# ABORIGINAL AND TORRES STRAIT ISLANDER INSIGHTS

Rates of Aboriginal and Torres Strait Islander suicide are more than twice that of non-Indigenous Australians. Among young Aboriginal and Torres Strait Islander males and females, rates are four and five times higher than their non-Indigenous counterparts<sup>19</sup>.

Our research sample included 7% representation from people identifying as Aboriginal and/or Torres Strait Islander. The majority of these respondents came from regional (37%) and metropolitan (25%) areas.

Overall, Aboriginal and Torres Strait Islander respondents displayed higher levels of distress compared to the non-Indigenous population. They experienced higher rates of suicide exposure, reporting on average seven people known to them who had died by suicide, more than twice that of non-Indigenous respondents. This was consistent across exposure to both attempts and suicide deaths of people close to them.

The impact that suicide has on Aboriginal and Torres Strait Islander communities is significant, with over 25% of open text responses referring to multiple exposures to suicide deaths. Twenty per cent of respondents discussed the devastation that this ripple effect has had on their community. These perceptions were reinforced with more than 25% sharing experiences of long-term

bereavement felt by themselves and their communities.

Additional issues were also present for Aboriginal and Torres Strait Islander participants, including more than a quarter self-reporting some form of trauma experienced by the individual who died by suicide or attempted suicide. This included inter-generational trauma, family issues, domestic violence, and drug and alcohol use as a contributor. Along with ongoing calls from our Aboriginal and Torres Strait Islander colleagues, we recognise the necessity of understanding suicide within the context of the social determinants of health<sup>20</sup>.

Almost a quarter (24%) discussed the lack of awareness about the appropriate steps to take to prevent a suicide or what and where to access appropriate bereavement support. A significant proportion (just under 20%) referred to family issues arising after a suicide, with some highlighting that health care services were culturally inappropriate.

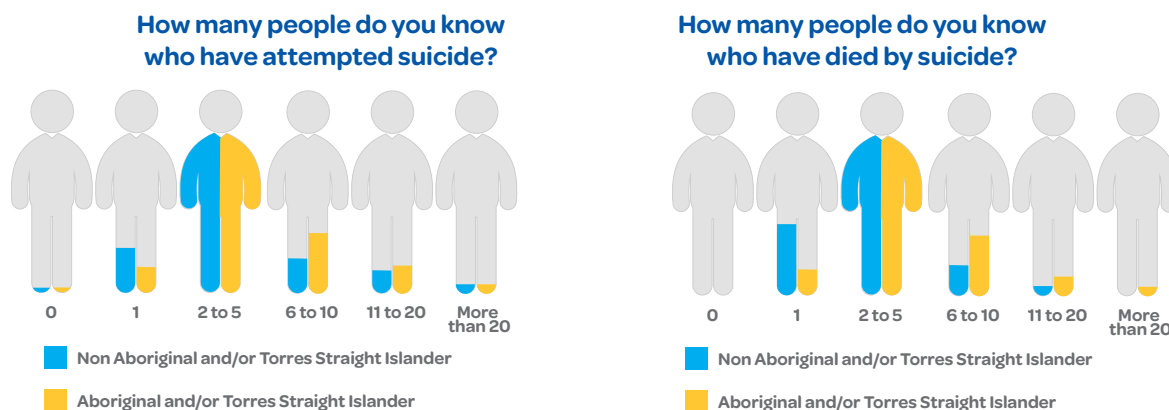
The experiences shared in the open text responses reinforce the urgent need to address the overwhelming number of Aboriginal and Torres Strait Islander people dying by suicide in Australia and the long term effect this has on Aboriginal and Torres Strait Islander communities.

---

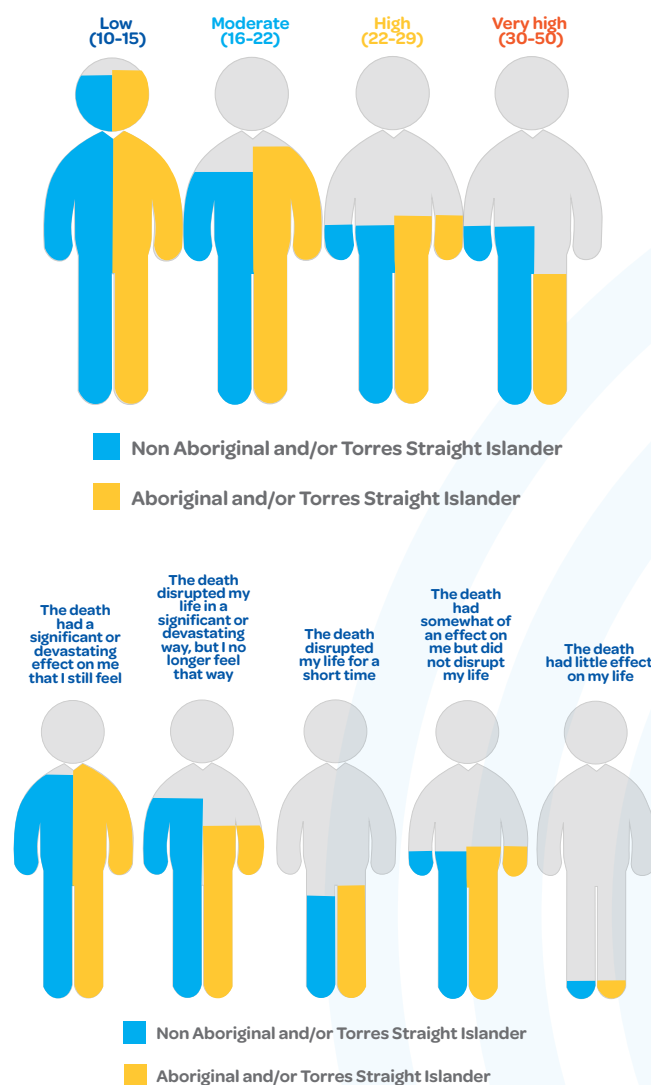
<sup>19</sup> ABS, op. cit.

<sup>20</sup> Calma, T. (2016, July 26). SPA Conference 2016 ATSI Suicide Prevention, Mental Health and SEWB. Paper presented at the National Suicide Prevention Conference: Connecting culture, context and capabilities, Canberra.

## Suicide exposures for Aboriginal and Torres Strait Islander respondents compared to non-Indigenous respondents for attempt and death.



## Distress levels of Aboriginal and Torres Strait Islander population compared to non-Indigenous population.





## COMMENTARY: WHAT HAS HELPED AND WHAT REMAINS A CONCERN?

As part of this brief survey, we gave respondents the opportunity to share additional free text comments or concerns with us. There is much we can learn from these qualitative responses, both in terms of areas needing urgent attention and positive post-traumatic reflections that may benefit from being more broadly communicated. These were all proactively provided by participants, rather than being pre-designed by the researchers.

The research team will continue to analyse this wealth of information so as to further inform Suicide Prevention Australia's Lived Experience Network priorities, the suicide prevention and postvention agenda, and to inform the sector of this information. We know that there is much work to be done on how to better involve those with lived experience of suicidal behaviours in the design, development and delivery of programs to prevent suicide. The meaningful inclusion of these voices is essential to meeting our shared goal of reducing suicide by half in ten years.

Below is a snapshot of some of the commonly reported themes overall.

### Suicide is not just about mental illness

**"I believe my partner could have been helped if there were more resources. He was put into emergency after a suicide attempt about three years before he died and they just let him go. Drugs and alcohol played a huge part in his and our lives and if he could have got more help maybe he would still be here. I wish he could have been helped."**

**41 year old West Australian woman, whose partner died by suicide seven years ago.**

There is a general lack of community awareness that suicide is preventable. Many individuals (health professionals included) assume suicide to be "only" a medical problem which is more often than not a response to a diagnosable mental illness. This association obviously and detrimentally ignores the broader health, social, cultural and economic determinants of suicide. We need to build community understanding of the preventability of suicide and awareness of appropriate support in times of suicidal crisis. Targeted awareness campaigns are required to educate professionals who are likely to come into contact with individuals during suicidal crisis, as well as community awareness campaigns that help us to support those who need it most<sup>21</sup>.

### Communities play a critical role in prevention

**"As suicide has affected the lives of many people within the town where I work, the community are being very proactive in establishing a suicide prevention network. There have been five suicides in the town within about 18 months, all male, different ages and some in business. A lot of community members are also doing Mental Health First Aid courses."**

**56 year old South Australian woman, whose close family friend died by suicide 18 months ago.**

Communities, families, organisations, social networks and local supports are well placed to recognise and respond to a person at risk of suicide, and those who care for them, and initiate offers of help and support or referral to the health system. Moreover, communities

---

<sup>21</sup> SPA, op. cit.



play an important role in fostering protective factors for suicide prevention through the provision of social support to vulnerable individuals including follow-up support, safety planning, stigma reduction on help-seeking and timely support for those bereaved by suicide.

Connection between government activity on suicide prevention and community action is essential for a fully effective suicide prevention plan. Through their specific task in developing and implementing regional suicide prevention plans, Primary Health Networks will perform a major role in ensuring these connections are made.

### **Better awareness of suicide warning signs and risks**

**“I believe the suicide of my best friend could have been prevented if those that were close to him were alert to the signs. I think it would be great to raise awareness about the symptoms of depression and what to watch out for when it comes to depression and suicide. Also, he belonged to a high risk demographic for suicide - he was a teenage male around the age of 20 at the time. I believe the cause of his suicide was due to social anxiety and pressure, as he was facing challenges and having many issues with his friends before his suicide (he probably felt very isolated and alone). He did not suffer any financial problems, health issues, and was smart, funny, and popular. He also had a loving family.”**

23 year old woman from New South Wales, whose best friend died by suicide four years ago.

Warning signs can be different for everybody so it's important to treat each person and their circumstances as individual and unique. But the more warning signs there are, the higher the risk. Some of the signs can be associated with everyday behaviour<sup>22</sup>. Some people might show none of these signs or only show them in very subtle ways, but still feel suicidal. On the other hand, others might show some of these signs but are not at increased risk. Suicidal behaviour is always a response to a complex set of issues. People may be driven to think about taking their own life for sociological, psychological or biological reasons, or any or all of these. Every Australian needs to know where they can find out more about identifying these warning signs and risks, the supports that are available if those signs and risks are there and how and where to access appropriate support.

### **We must change the way we talk about suicide and suicide prevention**

**“It is the stigma attached to suicide that had and continues to have a negative effect on my family. The shame and lack of support was incredible. I discovered that stigma is still very much alive and well. When someone you love dies of illness or a sudden car accident, it is common in most cases that your family and the community you live in will rally around you. When a loved one suicides this same level of support is not given to those left behind. Thank you for putting together this survey and for looking at ways of raising awareness.”**

41 year old woman from regional New South Wales, whose grandmother died by suicide 29 years ago.

---

<sup>22</sup> Communities Matter, Hunter Institute of Mental Health, Mental Health Commission NSW, Suicide Prevention Australia, accessed 31 August 2016, <<https://communitiesmatter.suicidepreventionaust.org/>>



The stigma associated with suicidal behaviour and mental illness inhibits help-seeking behaviour. We must educate the community about the preventability of suicide and encourage stories from those with lived experience of suicide that emphasise hope and recovery to reduce stigma<sup>23</sup>.

### **Workplaces exposed to suicide need better support systems and processes**

**“In working professionally with people who are suicidal for 20 + years I partake in clinical supervision and work with a team that helps by being able to debrief, yet some days I feel sad and slightly depressed and at the time I am unsure why. I usually realise later that it was after I have had multiple suicide assessments or a story that stays with me more than others. My point is that no matter how experienced and supported we are, hearing and knowing of people who are suicidal has an insidious effect.”**

**54 year old woman from New South Wales, whose client died by suicide two months prior to completing the survey.**

a suicide attempt or death occurring in the workplace or within the employee group. Lived experience of suicide can include thoughts about ending one's own life, making a suicide attempt, caring for someone who is suicidal, being bereaved by suicide, witnessing a suicide attempt or death, or being exposed to suicide in some other way. These experiences will take on different meaning and importance for every person and can have lasting impacts<sup>24</sup>. We need to engage lived experience in workplace training and implement better workplace support for health professionals and invest in the development of multifaceted suicide prevention programs tailored for the industry. This is especially urgent for industries characterised by relatively ready access to suicide means, elevated risk of suicide or a high proportion of male workers<sup>25</sup>.

Be prepared for suicide to touch the lives of your employees and have policies and procedures in place to respond appropriately. This applies well beyond services that are specifically tasked with working with people vulnerable to suicide. The survey data clearly demonstrates people from all walks of life are exposed to, and impacted by, suicide. This will include businesses, service providers, agencies and clubs. Appropriate responses are needed, and are best planned prior to

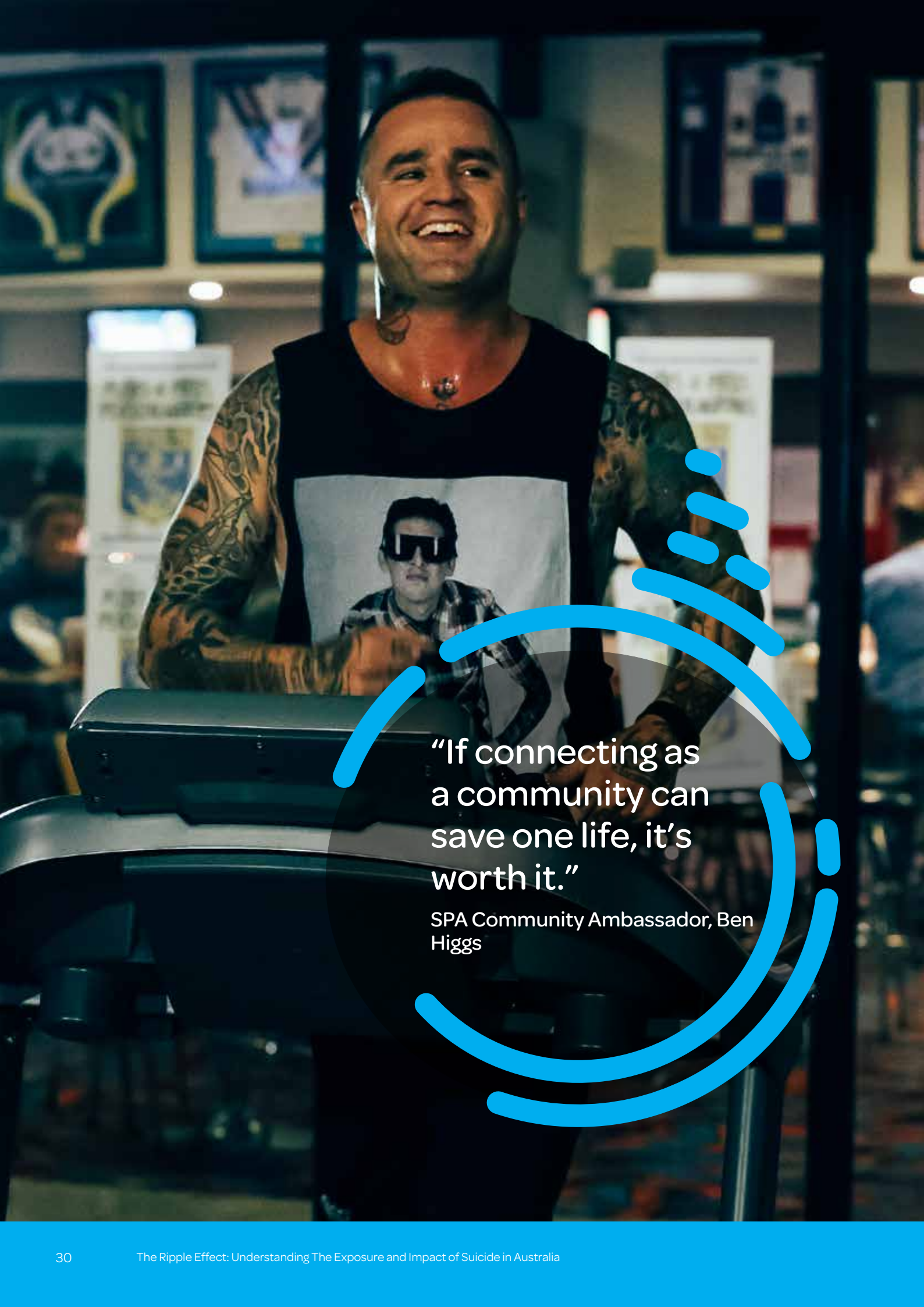
---

<sup>23</sup> Suicide Prevention Australia, op. cit.

<sup>24</sup> Suicide Prevention Australia. 2014, 'Work and suicide prevention: Position Statement'. Available at <https://www.suicidepreventionaust.org/sites/default/files/resources/2016/Work-and-Suicide-Prevention-FINAL%5B1%5D.pdf>.

<sup>25</sup> ibid





"If connecting as  
a community can  
save one life, it's  
worth it."

SPA Community Ambassador, Ben  
Higgs



## CONCLUSION: BE PART OF THE POSITIVE RIPPLE EFFECT

The information we have gathered from this research is both informative and heart-breaking. It shows the impact suicide has when it touches our lives. Moreover, suicide touches our lives more often, and in many more ways, than we were previously aware.

However, we have also learned through this survey, and by working with members of our Lived Experience Network, of the power of many voices coming together to work toward a common goal. Just as there is a negative ripple effect of suicide, there can be a positive ripple of change.

We strongly believe that if we all work together, through sharing information, expertise and time, we can do a great deal to help those who are in need or vulnerable to suicide. We believe that through a combined effort at an international and local level, a difference to the lives of many will be made, reducing the rates of suicide and the incidence of suicidal behaviours.

The date of this report's release coincides with World Suicide Prevention Day 2016, a day with the theme 'Connect, communicate, care'<sup>26</sup>. We stand with our colleagues at the International Association for Suicide Prevention (IASP) in recognising the importance of these three words and the actions we can take to put them into practice to globally, nationally and locally reduce suicide within our communities.

### Connect

Fostering connections with those who have lost a loved one to suicide or have been suicidal themselves is crucial to furthering suicide prevention efforts. Although every individual suicide is different, there are some common lessons to be learned.

Social connectedness reduces the risk of suicide, so being there for someone who has become disconnected can be a life-saving act. Individuals, organisations and communities all have a responsibility to help prevent suicide by connecting people at risk with formal and informal supports.

### Communicate

Open communication is vital if we are to reduce suicide. We need to discuss suicide as we would any other public health issue in order to dispel myths and reduce stigma. Equipping people to communicate effectively with those who might be vulnerable to suicide is an important part of every suicide prevention strategy.

### Care

All the connecting and communicating in the world will have no effect without care and compassion. We need to make sure that policy-makers and planners care enough about suicide prevention to make it a priority, and to fund it at a level that is commensurate with its significance as a public health problem.

We need to make sure that clinicians and other service providers care enough about it to make suicide prevention their core business. And we need to make sure that communities care enough about it to be able to identify and support those who may be at heightened risk. Most of all, we need to ensure that we are caring for ourselves and those around us.

Continue to help us learn from your experiences as a valued member of the Suicide Prevention Australia Lived Experience Network. Visit [www.suicidepreventionaust.org](http://www.suicidepreventionaust.org) to find out more.

---

<sup>26</sup> International Association of Suicide Prevention 2016, accessed 31 August 2016, <<https://www.iasp.info/wspd/>>



# RECOMMENDATIONS

## **1. Increase community awareness about suicide prevention and educate communities on suicide and the broad spectrum of suicidal behaviours to help build capacity within the community to give and get help.**

Our research has provided insights into the devastation and long-lasting impact that suicide has on individuals, families and communities. Education about suicidal behaviours, its impact and implications for access to services is essential to preventing suicide and reducing the impact of suicide when it does occur. SPA will work with its members and networks to build this capacity and increase awareness, and we support PHNs in their goal of preventing suicide in their regions.

## **2. Recognise lived experience of suicide as a public health issue of significance in Australia.**

Our research shows that the levels of exposure to suicide and suicidal behaviour are high and reach across the Australian community. The impact of this exposure can be profound, long lasting and comes with significant personal and social costs. Research has previously found that those bereaved by suicide are at elevated risk of suicide. Yet the comments provided by some survey respondents highlight what we already know: the long-term harm associated with exposure to suicide can be prevented by providing people with the right support when they need it. Australia can no longer ignore the devastation that ripples across the community with every suicide. Lived experience of suicide should be recognised as a priority public health concern and receive resourcing commensurate to the

burden it places on our community. SPA will work with key stakeholders including the Public Health Association of Australia to progress this recommendation. While suicide does cause devastation, there are also incredible stories of survival, resilience and growth. These are people who have found new meaning in life, who are valuable and contributing members of our communities. The lessons they have to share in how they have experienced these events are foundational to understanding better support for those who need additional support.

## **3. Develop and support a National Suicide Prevention Strategy, including a dedicated component addressing the long-term exposure and impact of suicide.**

This research has deepened our understanding that for every suicide death or suicide attempt there is a significant ripple effect, and those with close relationships to the individual in crisis also experience challenges that demand attention, and may require timely and appropriate support. In making this recommendation to the Australian Government, we build on the 2010 Senate Inquiry recommendation for the development of a National Suicide Bereavement Strategy and support the World Health Organization recommendation for inclusion of postvention in a national suicide prevention strategy.

The National Suicide Prevention Strategy should be supported by a National Suicide Prevention Act and monitored by a National Office for Suicide Prevention. This is essential for monitoring Primary Health Networks' regional strategies and ensuring alignment across the country.



**4. Prioritise Aboriginal and Torres Strait Islander suicide prevention and culturally appropriate strategies. National Aboriginal and Torres Strait Islander Suicide Prevention Strategy implementation funds must be released as a matter of urgency.**

Aboriginal and Torres Strait Islander populations are disproportionately over-represented in suicides, suicide attempts and suicide exposure across all age groups. Aboriginal and Torres Strait Islander communities experience increased risk due to a range of social determinants. Further research is necessary to understand the impact of inter-generational trauma as it relates to suicide and multiple exposures provide culturally appropriate suicide prevention interventions.

**5. Ensure consistent comprehensive discharge plans are developed and implemented for all patients upon being discharged from the health system including the involvement of family, close contacts and community services.**

Where people are coming into contact with health and social care systems, it is imperative that an adequate follow-up and discharge plan are put into effect, so that patients are linked to appropriate community services for ongoing support. This is a known service gap in the sector and identified by respondents as a major health system shortcoming in the provision of care for those who experienced suicide attempts and suicide.

**6. Engage the Productivity Commission to conduct a detailed independent assessment of the cost of suicidal behaviour in Australia. This assessment should include the costs associated with exposure to and impact of suicidal behaviour, as well as suicide deaths.**

We reiterate and expand on the recommendation made in the 2010 Senate Inquiry report 'The Hidden Toll: Suicide in Australia' for the Productivity Commission to investigate the financial cost of suicide. While acknowledging that the personal cost of loss, grief and trauma of suicide is often more significant than the financial cost, a better understanding of the financial burden of suicidal behaviour will facilitate allocation of appropriate resources to the prevention of suicide.




## MANY VOICES, ONE GOAL

The results in this survey represent just a selection of those in Australia who have been impacted by suicide, who heard about this survey and chose to participate.

Suicide Prevention Australia coordinates the national Lived Experience Network to support lived experience involvement in policy, program design, storytelling and more. Keep up to date on ways to get involved and add your voice to suicide prevention.

Join the Lived Experience Network today by visiting  
**[www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)**





If reading this report has brought up difficult emotions for you, please reach out for support. If you are in immediate danger, please call 000.

For counselling support please contact:

Lifeline 13 11 14 [www.lifeline.org.au](http://www.lifeline.org.au)

Suicide Call Back Service 1300 659 467  
[www.suicidecallbackservice.org.au](http://www.suicidecallbackservice.org.au)



---

**Suicide Prevention  
Australia**

---

**Contact Us**

**Web:** [www.suicidepreventionaust.org](http://www.suicidepreventionaust.org)

**Email:** [admin@suicidepreventionaust.org](mailto:admin@suicidepreventionaust.org)

**Phone:** +61 2 9262 1130

**Post:** GPO Box 219 Sydney NSW 2001



[www.facebook.com/SuicidePreventionAustralia](https://www.facebook.com/SuicidePreventionAustralia)



[@SuicidePrevAu](https://twitter.com/SuicidePrevAu)



[www.linkedin.com/company/suicide-prevention-australia](https://www.linkedin.com/company/suicide-prevention-australia)