



ISSUES PAPER
NON-CLINICAL SUICIDE PREVENTION:
EVIDENCE FROM LIVED-EXPERIENCE OF SUICIDE
2026


Roses in the Ocean
stemming the tide of suicide

Acknowledgements

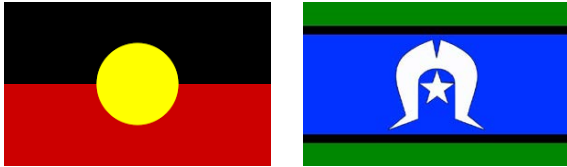
A Recognition Of People With A Lived Experience Of Suicide

Roses in the Ocean recognise those who have considered ending their life, and those who have attempted to do so. We admire your courage and tenacity to carry & move through the immense pain.

We recognise those who support loved ones through a suicidal crisis. We acknowledge the fear and helplessness you experience, and your endless endeavours to empower them to live.

We recognise those bereaved through suicide. May your immeasurable loss define a legacy and mission to discover healing and a new purpose.

We remember all the lives we have lost to suicide and extend our thoughts and support to those who are struggling with life today. Everyone's lived experience is unique. Everyone's lived experience is valuable. Everyone's lived experience can make a difference.



Acknowledgment of Country

Roses in the Ocean acknowledges the traditional custodians of the unceded lands and waters on which we live, work and dream.

We pay our respects to Elders past, present and emerging.

We stand with all Aboriginal and Torres Strait Islander people and acknowledge their strength and fortitude while enduring the ongoing impacts of colonisation and trauma.

We would like to acknowledge the wisdom, insight and enduring spiritual connection to land that the people of the oldest continuous living culture so generously share.

Suggested Citation

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Executive Summary

Roses in the Ocean is Australia's national lived experience of suicide organisation. Drawing on more than fifteen years of lived experience engagement, partnership, and co-design, this paper presents evidence for the critical role of non-clinical responses in a comprehensive suicide prevention system. Through consultation and co-design with people with a lived experience of suicide, we have consistently heard that clinical and crisis responses alone do not meet the full range of needs experienced by people in distress. Participants described the importance of having access to a broader range of support options—particularly non-clinical, peer-led, and community-based responses that are relational, accessible, and grounded in connection, safety, and choice.

This paper brings together those insights with Roses in the Ocean's practice-based knowledge and service delivery experience. It highlights the role of non-clinical responses across prevention, early intervention, and crisis support, and demonstrates how lived experience of suicide provides essential expertise for designing supports that are effective, acceptable, and responsive to real-world needs. The findings draw on qualitative data gathered through consultation and co-design activities undertaken between 2022 and 2025.

Together, they show that non-clinical responses are not an optional addition to suicide prevention, rather they are a necessary and valued part of the support system. This includes peer-led safe spaces, warmline support, peer companionship, navigator or community connection, practical assistance, and other alternatives that respond to distress in ways that people experience as helpful.

At its core, this paper argues that suicide prevention must extend beyond a predominantly clinical lens and non-clinical responses to suicide sits across all levels of suicide prevention. A stronger national response requires sustained investment at scale in an ecosystem of diverse non-clinical supports, including interconnected, community-based, peer-led services that have been co-designed and implemented to supplement existing responses and provide genuine options and choice for all members of the community.

We acknowledge and thank the people with a lived experience of suicide who so generously contributed their stories, insights, and expertise through consultation and co-design. Direct quotations from people with a lived experience of suicide are used throughout this report not only to illustrate the key themes and actions, but also to ensure that the voices, perspectives, and wisdom of those most affected are central to the conversation. Their words resonate at the heart of the concepts explored and provide a powerful foundation for the evidence supporting non-clinical responses to suicide.

Policy Recommendations



1. Embed non-clinical responses to suicide as core suicide prevention system components
 - a. Explicitly include non-clinical responses across prevention, community capacity building, early intervention, and crisis support in national and jurisdictional strategies.
 - b. Plan and fund non-clinical responses to suicide as an integral part of system design, not as pilots or add-ons.
2. Ensure accessible non-clinical crisis options for people experiencing suicide
 - a. Invest in non-clinical crisis alternatives to emergency departments for people experiencing suicide, including community-based peer-led safe spaces.
 - b. Support co-located hubs that bring together multiple non-clinical supports working holistically to support people experiencing suicide.
 - c. Embed non-clinical lived experience of suicide peer roles within crisis and emergency pathways.
3. Invest in prevention that addresses drivers of distress that contribute to experiences of suicide
 - a. Support social prescribing and community connector models linking people to practical, social, and community support.
 - b. Fund lived experience led health promotion, storytelling, and education to reduce stigma and shift culture.
 - c. Invest in universal social and emotional wellbeing literacy across the life course.
4. Build community capacity for suicide prevention
 - a. Fund lived experience led and co-designed community training that builds confidence and supports collective support.
 - b. Invest in physical and social infrastructure that enables community participation and connection.
 - c. Support local suicide prevention networks, particularly in rural, regional and remote communities.
5. Strengthen non-clinical early intervention pathways
 - a. Fund community based, peer-led supports that foster connection, belonging and participation.
 - b. Support structured and informal peer support options tailored to lived experience and identity.
 - c. Enable wraparound, multidisciplinary non-clinical networks to reduce system fragmentation.
6. Design systems for navigation, continuity and follow-up
 - a. Fund peer navigator, community liaison, and connector roles.
 - b. Invest in shared, consent-based information sharing to support continuity of support.
 - c. Require active, assertive follow-up after crisis, guided by collaboratively developed support plans.

Background

“We need to open up to other ways of healing”

- Participant, Townsville, Qld, Consultation

The majority of those who die by suicide have **not** had contact with the mental health system.

The Role of Non-Clinical Services in Suicide Prevention

Suicide is a major cause of death in Australia and the leading cause of premature death for Australians aged 15 to 44.¹ Around 60% of people who die by suicide have a diagnosed mental illness.¹ This has contributed to suicide being viewed primarily as a mental health challenge, with prevention efforts heavily weighted towards clinical and treatment-based responses. This has seen suicide prevention efforts disproportionately weighted towards mental health frameworks and clinical responses.

Suicidal distress is a response to intense emotional, psychological, social, or practical pressures that feel overwhelming. It is rarely caused by one single issue. Instead, it usually results from a combination of factors in a person's life. These can include challenges such as financial hardship, housing instability, unemployment, difficulties accessing support, experiences of trauma, discrimination, abuse, or major life stresses. Physical health conditions, mental health challenges, alcohol or other drug use, as well as personal, family and demographic factors, can also contribute.¹

Additionally, research has confirmed that the majority of those who die by suicide have not had contact with the mental health system in the year prior to their death,² and people who experience thoughts of suicide are reporting that they are not accessing care from mental health services.^{3,4,5}

This lack of engagement occurs for a broad range of reasons including access barriers such as a lack of availability and affordability (especially in rural locations);⁶ self-stigma surrounding suicide and help seeking;³ a mistrust of clinical services and fears of hospitalisation;⁷ previous unhelpful or negative experiences with health care;^{4,7} and not believing that clinical treatment will be helpful or effective.⁴ This is also attributed to the fact that some may not feel there is a need for clinical treatment as their experience of suicide is not related to mental health and they have lower levels of psychological distress.^{3,4,6}

This indicates that placing responses to suicide solely within a clinical mental health framework is problematic. Suicide prevention requires a more comprehensive approach to

support that recognises suicide as a complex human response shaped by social, cultural, relational and structural factors. This includes strengthening non-clinical responses outside of formal systems that meet the holistic social, emotional, cultural, and physical wellbeing needs of people experiencing suicidal distress.

Research has begun to demonstrate promising outcomes of non-clinical responses, including peer support⁸ and peer-base interventions,⁹ social prescribing,¹⁰ safe havens¹¹ and safe spaces¹² with The National Suicide Prevention Strategy recommending that non-clinical and peer-led approaches are a part of a comprehensive suicide prevention system.¹³

Lived Experience as Evidence

Despite these encouraging findings, the growing evidence supporting non-clinical suicide prevention responses has not yet translated into consistent policy, commissioning, and investment approaches. As a result, non-clinical supports have often struggled to be embedded, scaled, and sustained as core components of the suicide prevention system.

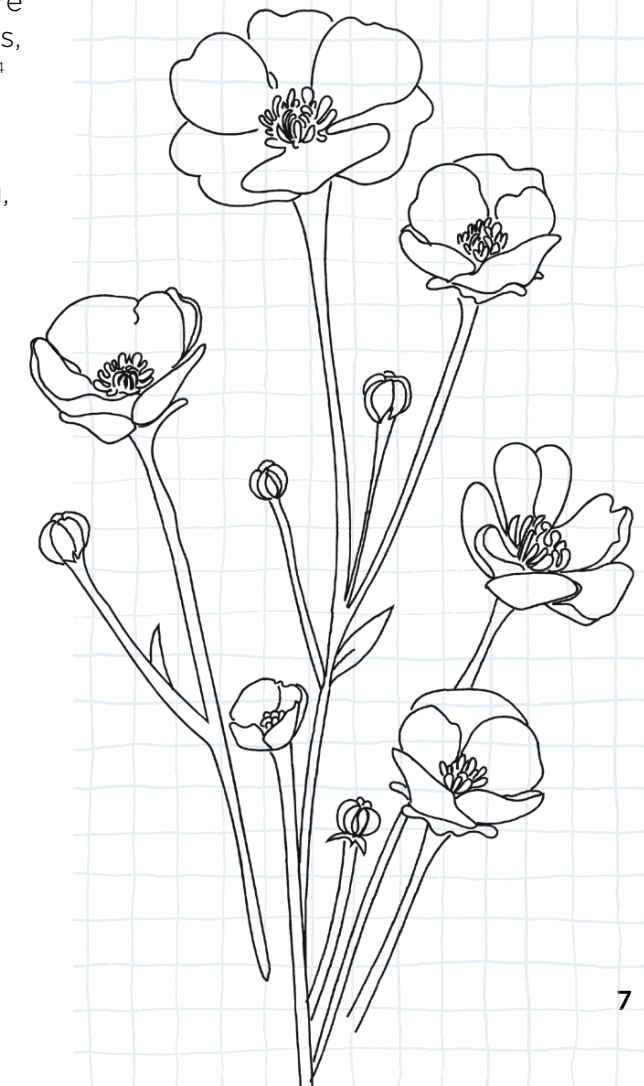
Roses in the Ocean recognises that there is expertise that can only come from a direct lived experience of suicide. This expertise is essential to understanding what is helpful, what is harmful, and what is missing in current responses. People with a lived experience of suicide must therefore have a central role in designing, delivering, governing, and evaluating suicide prevention activities, with their insights recognised as a legitimate and necessary form of evidence in their own right.¹⁴

This centring of lived experience of suicide is endorsed by the National Suicide Prevention Strategy that states, “for suicide prevention efforts to be of high quality and effective, it is vital that people with lived and living experience of suicide have a central role in designing, delivering, governing and evaluating suicide prevention activities.” The prioritisation of quantitative data collection methods in suicide prevention research severely limits what research participants with a lived experience can share. Conversely, qualitative research can more effectively capture the depth and detail of lived experiences of suicide through a reflexive thematic data analysis methodology where meaningful patterns and themes of significance can be identified.¹⁵

Through their participation in consultation and co-design activities with Roses in the Ocean, people with a lived experience of suicide share more than their personal stories. They also provide a wealth of deep and rich qualitative data through imparting their experiences, insights, and intrinsic knowledge about what is most effective in preventing, reducing, and responding effectively to experiences of suicide.

There is **expertise** that can only come from a direct lived experience of suicide.

It is vital that people with lived and living experience of suicide have a central role in designing, delivering, governing and evaluating suicide prevention activities.



What we Analysed

The findings presented in this report emerged from a thematic analysis of qualitative data collected from people who have a direct lived experience of suicide who participated in consultation and co-design activities facilitated by Roses in the Ocean.



Consultation and co-design activities



People with a Lived Experience of suicide



Pieces of qualitative data

The findings presented in this report emerged from a thematic analysis of qualitative data collected from people who have a direct lived experience of suicide who participated in consultation and co-design activities facilitated by Roses in the Ocean between 2022 and 2025. 2739 pieces of qualitative data from these consultations were identified as sharing insights into non-clinical responses to suicide. Using a reflexive thematic analysis process¹⁵ meaningful patterns in this data were identified, allocated codes, and grouped into themes that demonstrated significance. AI was not used in the analysis of this data or in the identification of relevant themes.

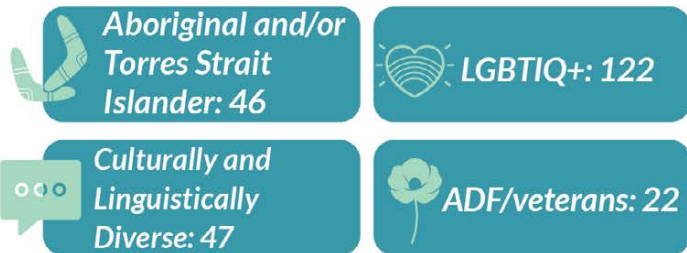
Gender Identity



Age Groups



Cultural & Community Identity



Lived Experience & Geography

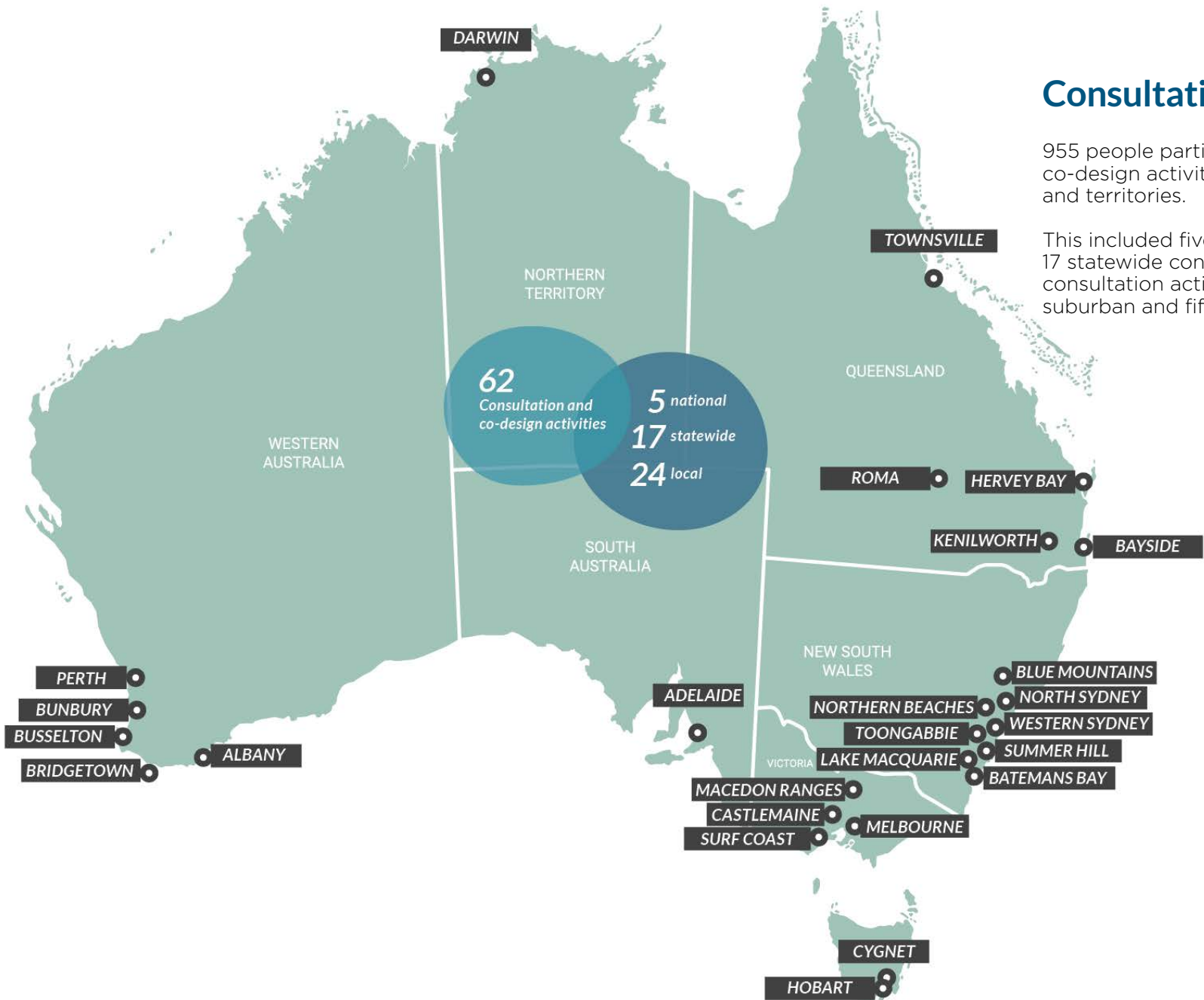


Please note that not all consultation activities analysed in this report collected detailed demographic information from participants. Figures represent number of participants, not percentage.

Consultations

955 people participated in 62 consultation and co-design activities facilitated across seven state and territories.

This included five national consultation activities, 17 statewide consultation activities, and 24 local consultation activities, including four held in outer suburban and fifteen in and rural locations¹.



¹Locations of consultation and co-design activities include: Adelaide (SA), Albany (WA) Batemans Bay (NSW), Bayside, South East Brisbane (Qld), Blue Mountains (NSW), Bridgetown (WA), Bunbury (WA), Busselton (WA), Castlemaine (Vic), Cygnet (Tas), Darwin (NT), Hervey Bay (Qld) Hobart (Tas), Kenilworth (Qld), Lake Macquarie (NSW), Macdon Ranges (Vic), Melbourne (Vic), Northern Beaches, North Sydney (NSW), Perth (WA), Roma (Qld), Summer Hill, Western Sydney (NSW), Surf Coast (Vic), Toongabbie, Western Sydney (NSW), and Townsville (Qld).

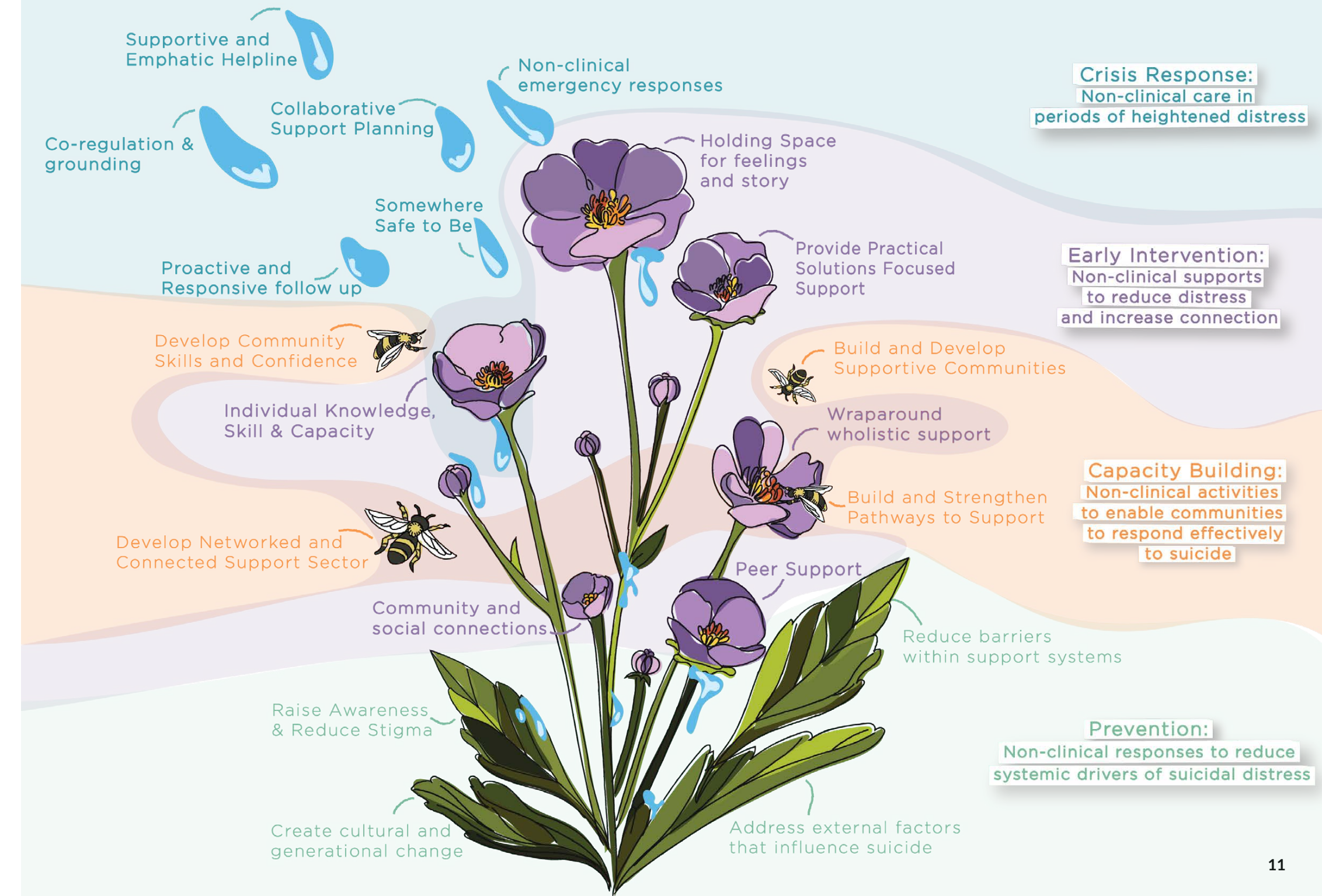
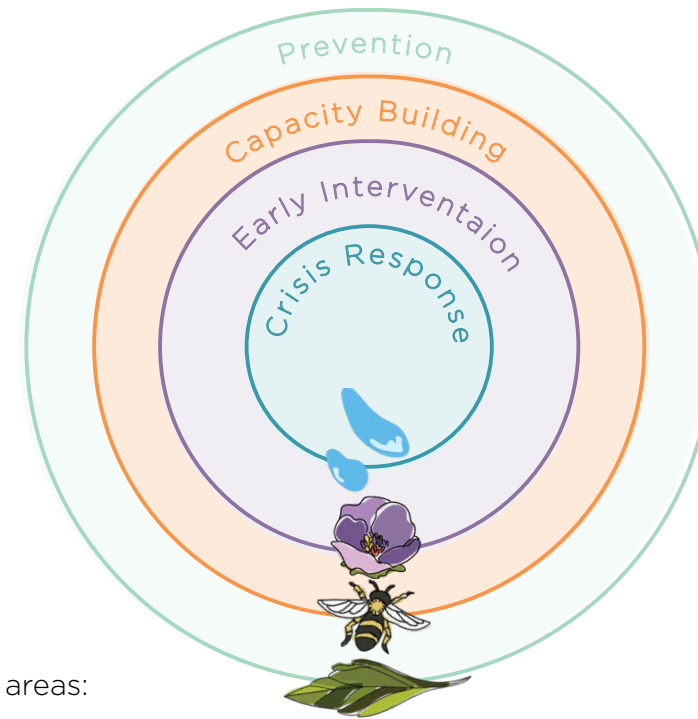
Key Findings

The key findings that emerged from the thematic analysis of qualitative data are presented in **four key themes: prevention, capacity building, early intervention and crisis response**. These four theme areas are interdependent on one another, and no one level of response can meaningfully address suicide if implemented in isolation.

- 1. Prevention:** Non-clinical responses to reduce systemic drivers of suicidal distress
- 2. Capacity Building:** Non-clinical activities to enable communities to respond effectively to suicide
- 3. Early Intervention:** Non-clinical supports to reduce distress and increase connection
- 4. Crisis Response:** Non-clinical care in periods of heightened distress

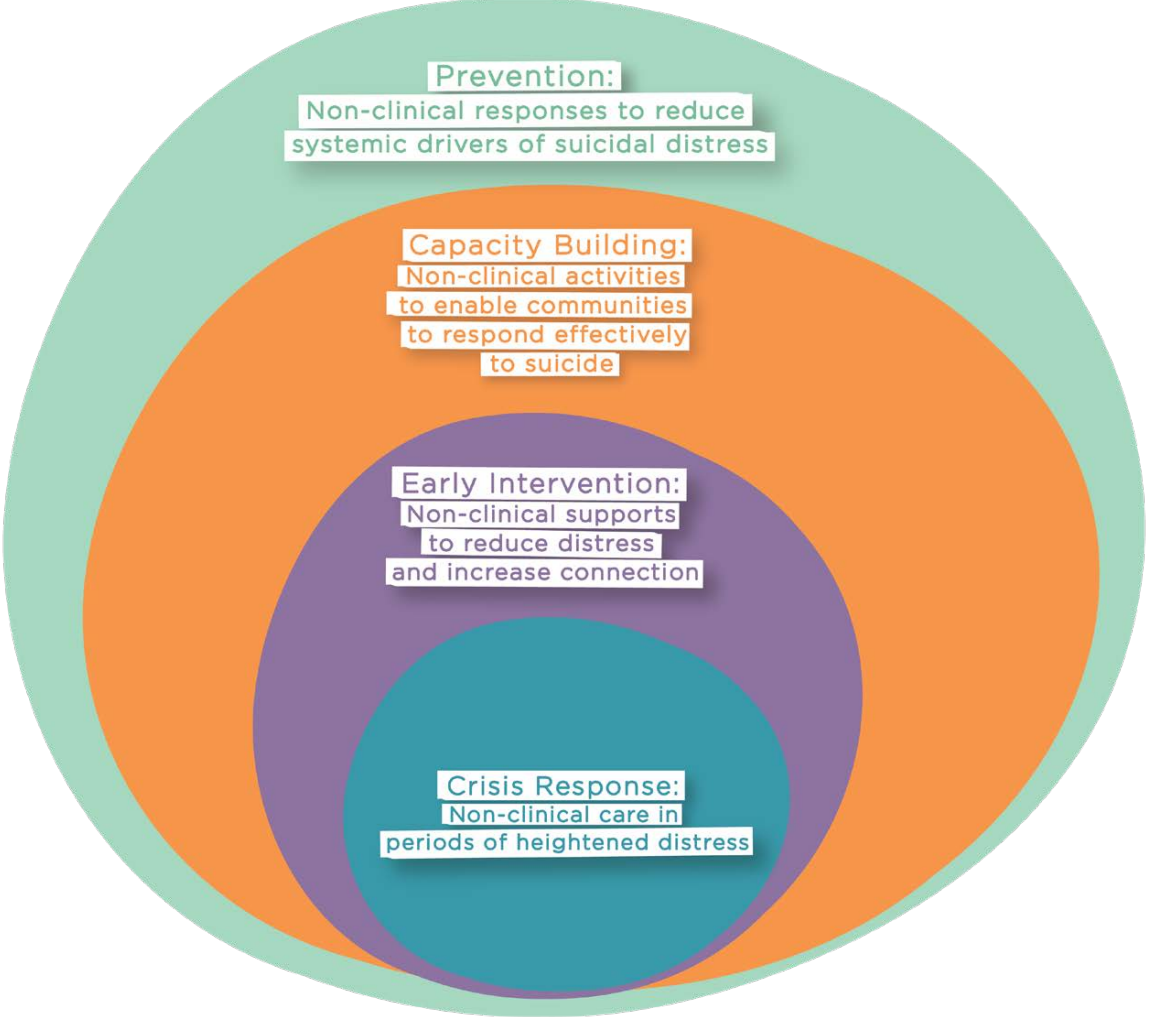
Activities that demonstrated significance in the data are nested within the four theme areas:

- 1. Prevention:** Non-clinical responses to reduce systemic drivers of suicide
 - a. Address external factors that influence suicide
 - b. Reduce barriers within support systems
 - c. Raise awareness and reduce stigma
 - d. Create cultural and generational change
- 2. Capacity Building:** Non-clinical activities to enable communities to respond effectively to suicide
 - a. Build and develop supportive communities
 - b. Develop community skills and confidence
 - c. Develop a networked and connected suicide prevention support sector
 - d. Build and strengthen pathways to support
- 3. Early Intervention:** Non-clinical supports to reduce distress and increase connection
 - a. Holding space for feelings and story
 - b. Practical solution focused support
 - c. Wraparound holistic support
 - d. Community and social connections
 - e. Peer support
 - f. Individual knowledge, skills, and capacity
- 4. Crisis Responses:** Non-clinical care in periods of heightened distress
 - a. Supportive and empathetic helpline
 - b. Somewhere safe to be
 - c. Co-regulation and grounding
 - d. Non-clinical emergency response
 - e. Collaborative support planning
 - f. Proactive and responsive follow up



As with the interdependent theme areas, the non-clinical activities identified are also intrinsically interconnected, with each activity having a symbiotic relationship with other activities, both within the same theme category and with activities across themes. With this interconnected nature, no single activity can be implemented in isolation without considering its relationship with other activity elements. Therefore, investment in non-clinical responses to suicide needs to be across a diverse range of non-clinical activities in contrast to a single activity being selected, invested in, and implemented in isolation.

Alongside describing the non-clinical activities to be implemented to respond to and support experiences of suicide, consultation and co-design participants also described the essential principles for how these activities should be developed and implemented in order for them to be most successful. These principles may extend over themes and across activities and will be highlighted when considered essential.



No one level of response can **meaningfully** address suicide if implemented in isolation.

Theme 1: Prevention



Whole of Government
Whole of Community
Cross-systems

Non-Clinical Responses to Reduce Systemic Drivers of Suicide

The theme of prevention focuses on reducing the likelihood of a person experiencing suicidal distress in the first place. This is achieved by addressing the underlying social conditions that can lead to a person experiencing suicide by increasing protective factors and reducing risk factors.

Prevention actions were consistently identified through our consultation and co-design activities and were markedly important for people with a lived experience of suicide. This was to ensure that both their own future wellbeing is supported, but also so that others — including whole generations — don't have to experience the harmful impacts of suicide in the future.

Prevention is a foundational component of a non-clinical approach to suicide prevention. It focuses on policy, social, and systems-based actions, alongside peer and community support to strengthen protective factors, address the drivers of suicidal distress, and promote wellbeing. Because these actions sit largely outside the health and mental health system, prevention requires a whole-of-community response involving government, the private sector, and broader society.

A Address External Factors that Influence Suicide

External social and economic factors such as education, housing, and income shape the conditions in which people live their lives and have a significant influence on a person's risk of suicide.¹⁶ People with a lived experience of suicide identified that they are acutely aware of the underlying social and systemic issues that contribute to and influence their experience of suicide and articulated that suicide prevention strategies need to address the root causes of suicide. This was especially pertinent for population groups who are disproportionately impacted by suicide,

including:

- Aboriginal and Torres Strait Islander people and communities
- LGBTIQ+ people
- Culturally and Linguistically Diverse people
- People who have a disability
- People living in rural, regional and remote areas

"This work doesn't just sit within a medical or social model, it interacts with education, housing, justice systems. The complexity of these systemic drivers should be acknowledged and addressed."

Participant, National Online Consultation

Poverty and Financial Insecurity

Housing Access and Insecurity

Systemic Discrimination and Inequality

Employment and Work Conditions

Poverty and Financial Insecurity:

Financial insecurity has been shown to have a direct association with suicide² and prevents access to circumstances that support wellbeing, such as housing, food, education, health care, and community participation. People with a lived experience of suicide identified that there is a need for the government to address cost of living pressures; rectify the growing income inequality between Australia's rich and poor; increase welfare payment rates and minimum wage to align with growth in the cost of living; and reduce the costs of accessing support for experiences of suicide.

Housing Access and Insecurity:

Access to safe and secure housing is essential for wellbeing and stress related to finding, accessing, and maintaining suitable housing contributes directly to high levels of distress and experiences of suicide. People with a lived experience of suicide identified the need to address the rapidly rising and high costs of housing, facilitate access to safe and suitable housing options, and develop adequate support systems for those who have insecure housing or are homeless.

Systemic Discrimination and Inequality:

Alongside reducing individual experiences of stigma, discrimination, and abuse, people with a lived experience of suicide identified the need to address systemic structural discrimination and facilitate social inclusion. This activity was especially pertinent for groups of people whose experiences of suicide are directly related to their experiences of discrimination inequality, including Aboriginal and Torres Strait Islander people and LGBTIQ+ people, in particular trans and gender diverse people.

Employment and Work Conditions:

People spend a significant amount of time at work, and employment facilitates access to income security and provides a sense of purpose and meaning. Poor employment conditions can lead to poor physical health and create stress that contribute to suicide. People with a lived experience of suicide identified the need to facilitate work/life balance, have working conditions that support wellbeing, and suicide prevention support within workplaces.

“The relationship with Centrelink is the greatest contributor to my distress”

- Participant, National Online Consultation

B Reduce Barriers within Support Systems

Structural barriers within government social support systems, despite being designed to provide assistance, can limit access to essential foundational supports and create significant stress. These challenges may compound existing difficulties and contribute to suicidal experiences. As a result, some individuals choose not to engage with these systems, reducing their access to support and potentially increasing their risk of suicide. People with a lived experience of suicide called for reforms to address known barriers and improve the accessibility, responsiveness, and adequacy of these social support systems as part of a broader non-clinical approach to suicide prevention.

Government Social Support Systems: Income and disability support systems play an important role in suicide prevention by reducing financial stress, social exclusion, and other circumstances that can contribute to suicidal distress. Participants highlighted restrictive eligibility criteria, complex application and administrative processes, inadequate payments, long waiting periods, and inaccessible service centres as barriers to accessing these essential supports.

Access to Counselling and Psychosocial Supports: People with a lived experience of suicide highlighted the importance of timely access to counselling and psychosocial support as part of a comprehensive suicide prevention system. Barriers included workforce shortages, particularly in rural and regional areas, long waiting times, limited affordability and administrative requirements associated with Medicare-funded services. Participants also highlighted the value of expanding access to non-clinical counselling and psychosocial support options, including recognising peer support within counsellor funding arrangements, to increase choice, improve accessibility, and complement clinical counselling services.

C Raise Awareness and Reduce Stigma

Meaningful progress in suicide prevention requires continued effort to create a fundamental shift in how suicide is viewed and understood through whole-of-community health promotion, awareness raising activities, and mainstream media by mindfully and responsibly reporting on suicide.¹⁷

This works to provide education and increase awareness of risk factors, key support strategies, and embed knowledge and awareness of information hubs and support pathways for suicide so that these can be easily recalled and accessed if required. In particular, hopeful lived-experience stories that emphasise resilience, survival, and recovery help challenge stigma, positively influence attitudes about suicide, and encourage early help-seeking and proactive early intervention support.¹⁸

Groups and populations disproportionately impacted by suicide benefit from tailored community-led messaging that is relevant to their context and specific lived experiences, including Aboriginal and Torres Strait Islander people, LGBTIQ+ communities, men, young people, culturally and linguistically diverse people, and people living in rural, regional and remote areas.

“Genuine suicide prevention is about empowering everybody; it’s about everybody having a basic understanding of what to do, say, and look for.”

- Participant, National Online Consultation

D Create Cultural and Generational Change

People with a lived experience of suicide consistently identified their vision for a whole cultural shift on how suicide is regarded that would contribute to the prevention of suicide. The hope was that future generations of children and young people would grow up embodying values and beliefs surrounding suicide that would facilitate early help-seeking and the provision of compassionate care. This was highlighted as being particularly pertinent regarding shifting attitudes around masculine self-reliance and stoicism that contribute to low rates of help seeking and high rates of suicide in men. Alongside generational change, anyone of any age can reflect and adapt their world view on suicide, with any individual shift in perspective best supported by a collective cultural movement to reframing suicide.

Early Childhood Education: Schools and early childhood education services were identified as key locations to implement universal programs educate children and young people on suicide, social and emotional wellbeing, and resilience skills. This would support raising awareness and reducing stigma and reshape how the next generations would come to understand and experience suicide.

Parent Education and Support: Education and support for all new parents to assist them to develop a secure attachment with their children and be able to role model social and emotional wellbeing within their families.

“Educate children with ideas that they can take with them into adult life.”

- Participant, Qld Statewide Men’s Consultation Session



Theme 2: Capacity Buildings



Community-Led
Local Responses
Consistent Resourcing
Integrated

Non-Clinical Activities to Enable Communities to Respond Effectively to Suicide

Communities play an essential role in suicide prevention. They facilitate social connection, a protective factor for people experiencing suicide,¹⁹ and are pivotal to the successful implementation of suicide prevention responses.²⁰ The theme of Capacity Building focuses on developing, building, growing, and nurturing the capacity, skills, and ability of local communities to effectively respond to suicide.

In addition to the benefits of a supportive community in and of itself, building the capacity of communities allows for suicide prevention programs and support services to be successfully implemented and delivered. People with a lived experience of suicide identified the value of local grassroots community-driven responses to suicide as the people of these communities intimately know the challenges relevant to their specific context and are best placed to develop and implement innovative solutions. As community is often local, these actions support suicide prevention efforts in rural, regional, and remote locations.

A Build and Develop Supportive Communities

People with a lived experience of suicide spoke about their desire to be a part of a well-connected, supportive, and compassionate communities. Communities that practice collective care where there is an unspoken mutual responsibility for the wellbeing of others. In this community, any interaction - big or small - has the potential to be 'suicide prevention' in action.

For this to occur, people with a lived experience of suicide are seeking things to do in their community that brings people

together and celebrate, have spaces where they can drop-in without commitment or obligation to actively participate, and find cultural and social connections.

However, the ability for individuals to participate in community to support suicide prevention efforts is contingent on a community existing in the first place. With this in mind there is an important community development and capacity building piece of work to create the conditions for community to firstly function effectively and then thrive.

"It's important to understand the different needs of geographical and cultural communities."

- Participant, National Co-design Session

Investment in Community

Facilities Housing Access and Insecurity

Ongoing Funding and Resourcing

Investment in Community Facilities: Communities need physical locations where they can meet, connect, and provide support. This requires an investment in building and maintaining physical community structures and facilities that are accessible and fit for purpose. These may be community or neighbourhood centres, but also other central gathering points such as pubs, shopping centres, churches, sporting clubs, schools, and so on.

Building Community Skills and Capacity: How community functions within these physical places and spaces is equally important for community to effectively contribute to non-clinical suicide prevention. This can be supported by building the knowledge, skills, and capacity of local community members, businesses, and organisations to design, develop, implement, and facilitate a broad range of community activities, events, programs, and services that are responsive to local needs.

Ongoing Funding and Resourcing: While community activities often utilise volunteers, which has a range of benefits, sufficient ongoing funding and resourcing is still required to support communities to sustainably develop, deliver, and maintain community-led responses.

“Each community’s needs should be continually assessed, addressed and updated.”

- Participant, Macedon Ranges Co-design Session

B Develop Community Skills and Confidence

Community wide training and education about suicide contributes to raising awareness and reducing stigma around suicide. Training challenges myths and stereotypes, increases the knowledge, skills, and capacity of local communities to recognise when someone is in distress, proactively ask about suicide, and provide appropriate non-clinical suicide prevention support.

People with a lived experience of suicide identified that this training needs to be:

- Developed by people with a lived experience of suicide
- Available for free with no cost to attend
- Regularly and consistently available
- Delivered in local and informal community settings

- Facilitated by known and trusted local community members, preferably by those who have a lived experience of suicide themselves
- Facilitated by people who are trained and supported in its implementation.

Suicide prevention training also builds the capacity of people with a lived experience of suicide to contribute to local grassroots suicide prevention activities and take on informal and formal peer support roles if desired.

“Build capacity before crisis through community education that is inbuilt for all so that crisis is a thing that happens, but we can draw on preexisting knowledge and skills.”

- Participant, National Co-design Session

C Develop a Networked and Connected Support Sector

People with a lived experience of suicide identified that their support is often impacted by turn over in staff, poor collaboration across services, and short funding cycles that sees programs being inconsistently delivered or closed. To develop a sustainable networked and connected suicide prevention support sector, this requires a fundamental shift in how suicide prevention services are designed and funded that values and enables proactive networking, information sharing, and building and maintaining collaborative cross-sector relationships.

Multi-disciplinary Hubs of Support: People with lived experience of suicide described a preference for accessing a broad range of supports that are co-located within a single, non-health service setting. These support hubs would bring together diverse roles and services to deliver holistic, integrated, and coordinated care. By providing a central point of access, they would enable individuals experiencing suicide to more easily access comprehensive support that responds to the different aspects of their lives, circumstances, and needs.

Referral Pathways: When a person is needing to access a broad range of supports, people with a lived experience of suicide identified that they were seeking smooth transitions between different supports without complicated referral and intake processes and the burden of repeating their personal story of suicide. This requires more advanced integration of services, establishing comprehensive referral pathways, developing policies around confidentiality and consensual release of personal information, and the development of information sharing systems.

Continuity of support: Continuity of support was identified to be of upmost importance for effective suicide prevention support, where a person can receive long-term consistent and uninterrupted support with the same support person or program. As experiences of suicide extend over long periods of time and intensity can fluctuate, people with a lived experience of suicide need to be able to trust that a service or program will be there when they need it, and that they don’t need to find and form connections with new support options.

“Services just keep cross-referring back and forth to each other.”

- Participant, Busselton, WA Co-design Session



D Build and Strengthen Pathways to Support

Being able to find, access, and successfully engage with support - especially in moments of distress or crisis - is vital to suicide prevention initiatives being effective. While there is a small number of well-known national helplines that are promoted as the 'go-to' location for suicide support, many people with a lived experience of suicide are seeking different and broader range of formal and informal non-clinical supports but often don't know what these might be or how to find them.

"I feel clueless and like no support is available to help someone. I look at the person needing support, thinking 'Am I going to find anything?'"

- Participant, Busselton WA, Co-design Session

Information Hubs: To assist with finding and connecting with a broad range of supports for suicide, people with a lived experience of suicide are requesting information hubs and directories that link people with local community spaces, support programs, crisis support options, as well as the right helplines for them.. Importantly, these hubs need to be able to connect people with actual support that matches their needs, not just pass the person on to another 'referral' service causing people to get stuck in a 'referral-loop'. These information directories may be local or national; phone lines or online directories; but regardless of the form they take, they must be:

- Comprehensive and detailed
- Well-maintained and up to date
- User-friendly and accessible
- Well-known and broadly promoted.

Community Mapping: To build comprehensive and detailed directories of the broad range of services that can provide support for experiences of suicide, there needs to be thorough mapping of local suicide prevention supports across all regions that includes non-clinical and community-based initiatives.

Service Navigation: In the absence of the ability to find the right supports that matches a person's needs, dedicated roles - such as service navigators, community liaison, or link workers - were identified as essential components within suicide prevention support systems. These roles can determine a person's support needs and directly guide and assist people to successfully access the supports that matches their need. This was highlighted as being particularly important for priority populations who experience a range of intersecting systemic barriers that makes finding and accessing, and engaging with services challenging, such as Aboriginal and Torres Strait Islander people, LGBTIQ+ people, and people with disabilities.

Access Pathways: People with a lived experience of suicide identified that it is essential that accessing supports for suicide should not be dependent on closed referral pathway (such as a program only accepting referrals from hospitals after a suicide attempt) as this misses a significant amount of people who will not access clinical support systems but would benefit from the programs support. There was the request that all programs allow for self-referral and have a low threshold for eligibility criteria. People with a lived experience of suicide also indicated their desire for flexible access such as the ability to 'drop-in' to access support for suicide.

Non-Clinical Support Principles and Practice Frameworks

Alongside direct support activities, people with a lived experience of suicide identified the underpinning principles and practice frameworks that should be applied to non-clinical suicide prevention support.

- **Holistic Support:** Support that considers all aspects of a person's life that contributes to their specific lived experience of suicide, including their intersectional identities and experiences, individual strengths, challenging life experiences, and experiences of trauma.
- **Continuity of Support:** Coordinated and consistent delivery of services over a period of time where a person experiencing suicide has an uninterrupted and reliable relationship with their support.
- **Flexible and Responsive:** The ability to receive support in a way that aligns with an person's specific experiences of suicide, including being able to receive support over a longer period of time that has flexible re-engagement options that considers the fluctuating nature of suicide.
- **Intersectionality:** Centring a person's individual and unique lived experience of suicide that acknowledges and appreciates their overlapping identities and how these impact their experience of suicide and support needs.
- **Person-Centred:** Individualised and personalised support that recognises and values a person's strengths and capabilities where the person with a lived experience of suicide maintains choice and control over their support.
- **Compassionate and Relational:** Non-judgemental and compassionate support that is built around mutual trust and a connected collaborative relationship.
- **Trauma-Informed:** Support that acknowledges the relationship between trauma and suicide that prioritises emotional safety, trust and validation.
- **Autonomy and Self-Determination:** The ability for the person experiencing suicide to themselves choose what support they receive and how they engage with this support without their autonomy being removed and decisions being made on their behalf.
- **Accessible:** Programs that facilitate non-clinical supports for suicide have a broad eligibility criteria and open referral pathways that include self-referral options.

How should non-clinical supports be delivered?

Having a choice of a variety of engagement options for non-clinical support for suicide is important to support accessibility, including access outside traditional office hours and with 24-hour accessibility.

- In person, face-to-face support
- Via phone, text, and webchat
- Outreach into a person's home, school, workplace, and frequented community spaces
- Embedded within local community spaces, workplaces, and schools where people live their daily lives
- Embedded within clinical care (i.e. emergency rooms and hospital wards) where people experiencing suicide may access support.



Where should non-clinical support be available?

There are a vast variety of spaces that have the ability to facilitate non-clinical support for suicide, including places and spaces that traditionally would not have a direct relationship with formal suicide prevention activities.

- Formal and informal community spaces, such as sporting clubs, community centres, cafes, libraries, festivals, and local pubs, which were identified as a central gathering point in rural and regional areas and an essential location for suicide prevention responses to be embedded.
- Via phone, text, and webchat, especially for after-hours support and when local support options aren't available.
- Online spaces, including online forums, online groups and communities, and social media.
- Workforces and workplaces.
- Schools, in the form of wellbeing hubs and student supports.
- Clinical care spaces, including emergency rooms and mental health hospital wards.

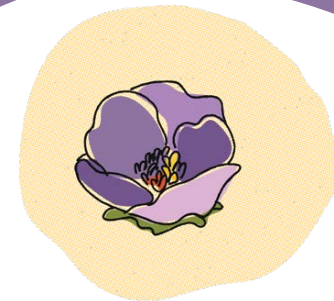
Who should be delivering non-clinical supports?

For many people with a lived experience of suicide, it wasn't what non-clinical support is being delivered that was important to highlight, rather who was providing the support that was the most important element to consider.

- **People with a lived experience of suicide:** People with a lived experience of suicide are pivotal in volunteer and paid peer support roles, but are also essential in a range of other professional roles providing support to people experiencing suicide where they can be open about their lived experience.
- **Trained and experienced non-clinical supports:** Whether these are informal community supports, volunteer positions, paid employees, or qualified professionals.
- **Local organisations and local staff:** Non-clinical supports should be delivered by established local community organisations who employ staff from the local community that have pre-existing trust, relationships, and reputation in the local community.
- **Range of Supports:** Non-clinical support for suicide requires a broad range of non-clinical roles working collaboratively together, including lived experience peer workers, non-clinical counsellors, occupational therapists, social workers, case workers, service navigators, and support workers.



Theme 3: Early Intervention



Relational
Compassionate
Flexible
Responsive
Holistic

Non-Clinical Support to Reduce Distress and Likelihood of Suicide

The theme of 'Early Intervention' describes non-clinical suicide prevention activities that provide support before distress grows to a space where crisis intervention is then required. Within this theme, these non-clinical suicide prevention activities may not look like or even be called 'suicide prevention', but nonetheless contribute significantly to this outcome. People with a lived experience of suicide value a holistic and intersectional approach that considers all aspects of a persons life that contributes to suicide, not just mental health.

A Holding Space for Feelings and Story

People with a lived experience of suicide highlighted the significant benefit of simply being able to talk about their feelings and experiences of suicide openly and to know that they are being listened to. They are seeking a place where they can truly be heard; rediscover meaning, connection, and purpose; and reconnect with hope and joy.

A barrier to this simple but vital need is that talking about suicide can feel deeply uncomfortable, including for professionals who fear implications a death by suicide may have on their career and personal wellbeing. Consequently, a disclosure of thoughts of suicide often shifts focus to organisational and professional responsibility, duty of care, and risk mitigation away from the exploration of feelings.

- **Non-Clinical Counselling:** People with a lived experience of suicide are seeking non-clinical counselling that provides an empathetic space where they can openly explore thoughts, feelings, and experiences related to suicide with a compassionate and skilled person.
- **Peer Support:** Having space to talk openly with peers who share a lived experience of suicide was identified as adding significant value to meeting this need due to their direct understanding of the experience of suicide and knowing the value of being heard.

- **Bereavement Support:** Space for sharing stories for those who have been bereaved by suicide was identified as being particularly important due to shame, stigma, and the perceived inability to talk openly about suicide, grief, and loss in many places.

"Listen, sit with, hold, stay with, be with; don't be afraid to see my pain."

- Participant: National Online Consultation

B Provide Practical Solution-Focused Support

People with a lived experience emphasised that suicide is a multifaceted human response influenced by a wide range of external social, emotional, economic, and environmental factors that present as tangible life challenges that can seem far too big and complex to solve.

Life stressors that can drive distress resulting in suicide are varied but can include;

- Financial stress
- Homelessness and insecure housing
- Physical ill-health or disability
- Relationship breakdown
- Domestic and family violence
- Social isolation
- Bullying
- Addiction
- Loss, including being bereaved by suicide
- Significant life transitions (such as retirement, parenthood, separation, etc.)
- Barriers accessing social support (i.e. Centrelink, NDIS, etc).

Consequently, to address suicide the underlying cause of distress needs to be tended to with direct practical and solution focused support that provides tailored individual solutions to specific life problems.

Meet Priority Needs: People with a lived experience identified the value of support facilitating direct access to required basic human need, such as food, income, housing, warmth, comfort, and human connection. Where the financial aid may not be able to be directly provided, support may be to facilitate financial planning advice, or support to access social support payments.

Advocacy: Due to complex social support systems and access barriers within these systems, representative support, advocacy or system navigation can be helpful to support people get access to the resources that they require without additional stress.

Collaborative Support: People with a lived experience identified that collaborative support approaches such as support coordination, case management, or goal planning are useful for addressing practical support needs.

“I went home to the same four walls I left and thought ‘nothing has changed.’”

- Participant, Northern Beaches, Sydney, Co-design Session

C Develop Wraparound Networks of Support

As factors that contribute to suicide are multifaceted and experiences of suicide can be very isolating, people with a lived experience of suicide identified benefits of receiving support from comprehensive, complimentary, and coordinated multi-disciplinary network providing holistic wraparound support.

Wraparound Support: This network of support may include a broad range of non-clinical supports including peer support, case managers, social workers, non-clinical counsellors, creative therapists, group programs, service navigators, community liaison, and community connectors.

Warm Connections: An individual’s ability to find, access, and connect to the right support system can be challenging due to systematic inequality, lack of access to information, lack of resources, feelings of hopelessness and shame, and technology barriers. Dedicated support from service navigators or link workers can help someone to access and engage the supports that meets their specific need.

“There needs a set of robust and comprehensive referral avenues, and these may even need to be proactive rather than just responding to referrals.”

- Participant, National Co-design Session

D Facilitate Community and Social Connections

Community was identified as a foundational support for people experiencing suicide as it reduces isolation and facilitates social connections. Community enables the creation of formal and informal support networks, meaningful relationships, purpose, and feelings of belonging. People consistently identified community engagement, social connections, social support, and feelings of belonging as being important elements to supporting suicide prevention in individuals

Community Connectors: For those who find accessing and navigating community challenging - due to a lack of physical access, social anxiety, or isolation - support from link workers or community liaison roles can help link and support someone to access the community that matches their interests and social needs.

Safe Spaces: Alongside their role in supporting people at times of heightened distress, Safe Spaces were also identified as a supportive space for someone to simply be, connect with peers, participate in activities, and connect to community. Importantly, engagement with Safe Spaces outside times of distress builds trust and comfort to access these spaces when critical support is needed.

“The solution isn’t in services; it’s in participation within community. Services come and go, but community remains.”

- Participant, WA Statewide Consultation



Spotlight: Social Prescribing

Social prescribing is a holistic healthcare approach for health and wellbeing that connects people seeking support for suicide from clinical care services (such as GP’s and hospitals) into non-medical community-based services, supports and activities that meets their social and practical support needs.²¹

Social prescribing has a strong evidence base and models for suicide prevention support to improve social connectedness and wellbeing are beginning to emerge.²² Social prescribing acknowledges the social determinants of health and provides a tailored, individualised, co-designed early intervention approach to suicide prevention that can include multiple community programs and services. A review of social prescribing programs for suicide identified that warm and person-centred approaches with longer term connections that support trust are necessary for this support to be successful.²¹

There are several social prescribing programmes targeting risk factors associated with suicide that are being trialled in Australia, including a co-designed social prescribing initiative in Victoria that connects people with a lived-experience link worker who facilitated and supports engagement in inclusive spaces in local communities that matches the person’s needs.²³



E Access to Peer Support

People with a lived experience of suicide consistently identified the value of connecting with others who have a shared lived experience of suicide, which were also described as mentors or role models in the data. Peer support facilitates a meaningful mutual and reciprocal connection between those with a similar shared lived experience. Peers have a direct understanding of the experience of suicide where compassion, understanding, and respect is core.

Shared Lived Experiences: In addition to peer support from others with a lived experience of suicide, it was identified that there is additional benefit of peer support from those who have the same lived experience of suicide (i.e. carers, survived attempts, bereaved, etc.) or those who share the same culture or identity (i.e. First Nations, LGBTIQ+, CALD, etc.).

Informal Peer Support: While peer support may occur organically through sharing space with others, connecting through structured facilitated support, such as peer support groups, was identified as beneficial.

Formal Peer Support: Formal lived experience of suicide peer support roles can be embedded within a range of programs and support services, including non-clinical services as Safe Spaces as well as within clinical care spaces, such as emergency departments or mental health wards.

“There’s a difference between knowing you’re not alone and feeling you’re not alone.”

- Participant, WA Statewide Consultation

Value of connecting with others who have a shared lived experience of suicide



Spotlight: Alt2Su

Alternatives to Suicide



Alternative to Suicide (Alt2Su) is a non-clinical group peer support modelⁱⁱ that emerged in response to concerns about the way clinical mental health services and systems respond to suicide. Alt2Su groups focus on peer support, mutual connection, relationship, open conversations about suicide, and the willingness to sit with people in deep distress without calling on involuntary or coercive clinical interventions.²⁴ As a result, these groups have become a space of support for people who have had harmful experiences in mainstream mental health services who avoided contact with the clinical mental health and health care system.

Alt2Su groups have emerged in Australia in Western Australia,²⁵ South Australia,²⁶ and NSW²⁷ with many running online groups, and groups for disproportionately impacted populations, including LGBTIQ, trans and gender diverse people. With an emerging evidence base, evaluations of Alt2Su have shown that this model of support provides safe spaces for people experiencing suicide that supports participants to develop new ways of understanding and responding to their distress, reducing fear around suicidal thoughts and feelings and increasing people's capacity to respond with curiosity and self-compassion.^{28,29}

ⁱⁱThe Alternatives to Suicide approach was developed in 2008 in Western Massachusetts, USA, by members of the Wildflower Alliance <https://wildfloweralliance.org/alternatives-to-suicide/>

F Develop Individual Knowledge, Skill and Capacity

Alongside identifying and addressing external factors that contribute to a person's experience of suicide, there may be a role for developing and fostering a person's individual knowledge, skills, and capacity to navigate their experiences of suicide. This may include building skills to manage and navigate relevant external stressors, such as financial management and advocacy strategies, as well as emotional regulation and grounding strategies to navigate high levels of distress.

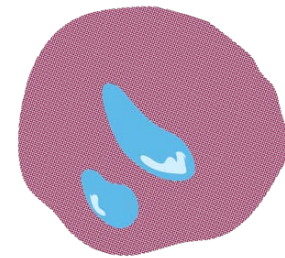
Importantly, building individual capacity and resilience to manage distress should not be the focus of support when there are tangible practical solutions to reduce or solve the underlying cause of distress.

Skills for People Providing Support: Building and supporting individual capacity was identified as being particularly important for carers and those who provide support to someone in their lives experiencing suicide, with a focus on self-care, managing burnout, and boundaries.

Skills for talking about suicide: While many identified the benefit of knowing how to talk about suicide, this was particularly pertinent for those who were bereaved by suicide who were wanting skills on how to talk about their personal experience of suicide without causing harm or distress to others.



Theme 4: Crisis Response



Agency
Choice
Autonomy
Self-Determination

Non-Clinical Care Provided During Period of Heightened Distress

The theme of 'Crisis Response' describes the specific non-clinical responses that people with a lived experience of suicide identified as being particularly effective for providing support at times of increased distress and during a suicide crisis. Central to a non-clinical crisis response is for the person experiencing suicide to maintain their agency, choice, autonomy, and self-determination; which are often overridden and dismissed in clinical crisis responses that focus on risk mitigation. Due to the time sensitive nature of distress that can lead to suicide, accessibility and responsiveness of supports are essential with these needing to be available outside traditional office hours and 24-hour accessibility considered ideal.

Crisis support needs to extend to family members, friends, carers, kin and people bereaved by suicide, providing timely non-clinical connection, practical support and service navigation when other supports may be unavailable, inaccessible, or not preferred.

“Service providers need to take my story at face value rather than making assumptions, support my autonomy when I state what my needs are, and support me to move in that direction.”

- Participant, WA Statewide Consultation

A Supportive and Empathetic Helpline

Telephone crisis helplines have been a long-standing support for suicide that are broadly promoted as the 'go-to' location for suicide support, meaning that many people have extensive experiences engaging with these services. However, throughout consultation activities many people with a lived experience of suicide shared that do not find the current practice frameworks of teleweb services helpful for experiences related to suicide.

Of particular concern is the lengthy wait-times to speak to a support person; the inability to remain anonymous; the time-limited engagement that sees support abruptly ended regardless of circumstances; and the focus on individual problem solving rather than establishing relationship and connection. Regardless of these criticisms, phone - along with online webchat services - continue to be requested by people with a lived experience of suicide due to its broad accessibility (especially in rural and regional areas with few suicide support services) and 24-hour availability.

Anonymity: The ability to choose to remain anonymous when accessing helpline services and not to be required to disclose their personal details in order to access to services.

Continuity of Support: Support provided by the same support person over multiple engagements, or have consent-based ways using their name, reference code, or pseudonym where essential information to be recorded so they do not have to re-tell their story of suicide, which can compound distress, disrupt trust, and undermine progress.

“In the suicide prevention space, creating connection is almost more important than a crisis response.”

- Participant, Qld, One-On-One Interview

B Somewhere Safe to Be

People experiencing suicidal distress or crisis are more often than not compelled to go to hospital emergency departments to access intervention, often against their free will. However, people with a lived experience of suicide consistently share that emergency departments are not helpful at reducing their risk of suicide but rather create additional anxiety and amplify distress. This is due to the clinical medical framework that has a focus on assessing risk, making a diagnosis, and providing a medical treatment as well as the harsh physical environment, including bright lights, cold temperature, noisy and busy environment, and challenging interactions with other patients.

“Hospitals aren’t the right place for people experiencing suicidal distress. We need alternative spaces.”

- Participant, Qld, Statewide Survey

Alternatives to Emergency Departments: Non-clinical spaces that are thoughtfully designed to have a calming environment where a person experiencing suicide can feel physically and emotionally safe in during moments of heightened suicidal distress and crisis.

Autonomy and Self-Determination: People with a lived experience of suicide are asking for the ability to maintain their autonomy during times of heightened distress and maintain the ability to choose how they engage with support and make decisions about their own care.

Peer Support: Peer support during times of heightened distress provided by people who have a lived experience of suicide that directly understand the experience of suicide that is grounded in compassion, connection, and mutual respect.

Spotlight: Community Based Safe Spaces

Safe Spaces and Safe Havens are non-clinical community-based alternative locations to a hospital emergency department for people experiencing suicidal distress to attend to access support.³⁰ A co-designed model for Safe Spaces was developed by Roses in the Ocean³¹ which describes key elements of this framework, including a warm welcoming environment, peer led workforce, ‘no wrong door’ accessibility, and holistic non-clinical supports. As Safe Spaces are designed, developed and delivered by local communities these services look, feel, and operate in different ways depending on the specific and evolving needs of a local community.

A growing number of Safe Spaces and Safe Havens are in operation across Australia,^{32,33} and evaluations have identified that these services have effectively supported people experiencing suicide to create safety and reduce distress. Additionally, Safe Spaces have been found to provide people experiencing suicide with a sense of connection, belonging, and hope, as well as provide practical solutions to the issues that were impacting suicide, such as housing and employment.^{9,12}



C Co-Regulation And Grounding Strategies

Reducing heightened feelings of distress is central to navigating a suicide yet this can be difficult to achieve alone. Soothing distress can be aided by a calming and comfortable non-clinical physical environment, such as low lighting, soft furnishings, and warm temperature along with warm drinks, relaxing music, distraction activities (i.e. jigsaw puzzles, craft) and sensory modulation tools (i.e. weighted blankets, fidget toys, noise cancelling headphones).

“Sit with the persons pain and fear, retain a calm environment and allow them to work through the moment in their own time and way.”

- Participant, Qld, Statewide Survey

D Non-Clinical Suicide Crisis Responders

As emergency services (such as ambulance, police, and hospital emergency departments) are often engaged in response to suicide, people with a lived experience of suicide identified the need for formal non-clinical and peer support roles embedded within emergency response systems. This includes non-clinical suicide crisis operators who assess suicide safety and triage and connect an appropriate, safe response; and non-clinical suicide crisis responders who provide immediate, compassionate, on-site support. These responders may attend alongside police or paramedics or respond independently where appropriate. Many people described a strong vision for a dedicated, peer-led, non-clinical suicide crisis response system. Designed specifically for people experiencing suicidal crisis, rather than relying on mental health responses that are often ill-fitted within physical health or law-enforcement emergency frameworks.

Emotional regulation and decreasing distress can be further aided by nurturing compassionate interaction with skilful peer supports who can provide co-regulation support using somatic or grounding practices. Animal therapy was also identified as a beneficial co-regulation and grounding support in moments of crisis.

Emergency Phone Operators Non-clinical telephone operators who are highly skilled in providing care for suicide who provide initial assessment, triage the need for support, and connect the person experiencing suicide with the most appropriate response for them.

Non -Clinical Suicide Crisis Responders: Non-clinical and peer supports who attend to provide immediate, compassionate, on site support. These responders may attend alongside police or paramedics or respond independently where appropriate.

Peer Support in Clinical Settings: lived experience peer workers available in the emergency rooms, mental health hospital wards, and other clinical health settings to provide support.

“There should be a different emergency operator for mental health.”

- Participant, Qld, One-On-One Interview

Spotlight: Suicide Prevention Outreach Teams

Suicide Prevention Outreach Teams (SPOT) provide mobile outreach care to people experiencing a suicidal crisis.³⁴ Support is provided by a collaborative partnership between a peer worker and a clinician that aims to keep people in their communities and link them with support services and care pathways that address the causes of their suicidal distress.

SPOT was developed through co-design process with people with a lived experience of suicide to established program requirements. Program elements include accessible out of hours support, holistic recovery-oriented support, flexible care that allows time for rapport and trust building, and being integrated with other care and support services.

Evaluation of this initiative has shown that alongside a reduction in emergency department presentations and ambulance call-outs, participants reported increased feelings of hopefulness for the future, reductions in distress, being supported to access the services that meet their needs.³⁵

E Collaborative Support Planning

While traditional safety plan proformas with standardised checklists were not seen as useful, collaboratively creating plans to engage support after the crisis has passed was seen as critical.

Self-Identified Needs: Support plans need to be focus on the self-identified needs of the person seeking support for experiences of suicide and is developed in a way that elevates self-determination, autonomy, and choice.

Discharge Plans: For those who have received care from the ambulance, emergency department presentation, or hospital admission discharge plans that engage follow up support should be developed collaboratively and utilise the guidance of a non-clinical and peer support roles.

Carers, Support People and Kin: With informed consent, these plans need to actively include and be shared with carers, support people, and kin who will be providing ongoing support after the period of distress and crisis has passed.

Holistic Support: The focus of the plan isn't about managing risk, ensuring safety, or crisis management, but rather is about connecting to and embedding wraparound holistic support that addresses and responds to the specific causes of distress.

“Stop talking about risk as risk, but risk as a space of support and recovery. People know the risks of suicide and suicidal thoughts but need to know they can collaborate on safety and moving forward without judgement and power over”.

– Participant, Qld, Statewide Survey



F Proactive and Responsive Follow-Up

People who have experienced suicidal distress or crisis along with those who have supported a loved one through a suicidal crisis, asked for proactive and responsive follow-up after a period of heightened distress has passed. This identified as being particularly important after an emergency services intervention, emergency department presentation, or hospital admission. This follow-up needs to be more than a single 'check in' phone call that if unanswered considers support 'declined' and their file closed without any additional follow-up provided.

In contrast this follow up needs to be intentional, proactive, and considered. Follow up should ensure that all connections, supports, and services required to reduce the likelihood of suicide are sufficient and successfully in place. If not, barriers and challenges should be identified and additional support engaged with further follow up actions planned.

“Follow ups after discharge need to be more than that one phone call. Build systems to walk alongside people, not push them to move on fast.”

- Participant, Qld, One-On-One Interview



References

¹ Australian Bureau of Statistics. (2024). *Intentional self-harm (suicide) deaths*. ABS. <https://www.abs.gov.au/statistics/health/causes-death/intentional-self-harm-suicide-deaths/latest-release>.

² Tang, S., Reily, N., Arena, A., Batterham, P., Cleave, A., Carter, G., Mackinnon, A. & Christensen, H. (2022). *People Who Die by Suicide Without Receiving Mental Health Services: A Systematic Review*. *Frontiers in Public Health*, 9. doi:10.3389/fpubh.2021.736948.

³ Tang, S., Reily, N., Arena, A., Sheanoda, V., Han, J., Draper, B., Batterham, P., Mackinnon, A. & Christensen, H. (2022). *Predictors of not receiving mental health services among people at risk of suicide: A systematic review*. *Journal of Affective Disorders*, 301, 172–188. doi:10.1016/j.jad.2022.01.054.

⁴ Hom, M. A., Stanley, I. H. & Joiner, T. E. (2015). *Evaluating factors and interventions that influence help-seeking and mental health service utilization among suicidal individuals: A review of the literature*. *Clinical Psychology Review*, 40, 28–39. doi:10.1016/j.cpr.2015.05.006.

⁵ Bruffaerts, R., Demyttenaere, K., Hwang, I., Chiu, W. T., Sampson, N., Kessler, R. C., Alonso, J., Borges, G., de Girolamo, G., de Graaf, R., Florescu, S., Gureje, O., Hu, C., Karam, E. G., Kawakami, N., Kostyuchenko, S., Kovess-Masfety, V., Lee, S., Levinson, D., Matschinger, H., ... Nock, M. K. (2011). *Treatment of suicidal people around the world*. *The British journal of psychiatry: the journal of mental science*, 199(1), 64–70. doi:10.1192/bjp.bp.110.084129

⁶ Christensen, H., Slade, A., Ravindra, S., Maidment, K., Zheng, W.Y. & Whitton, A. (2025). *Under the Radar Research Project: Final Report*. Developing a Comprehensive Care Pathway for Those at Risk of Suicide but Not in Care. Black Dog Institute. Sydney, Australia. <https://www.blackdoginstitute.org.au/research-projects/under-the-radar/>

⁷ Mok, K., Riley, J., Rosebrock, H., Gale, N., Nicolopoulos, A., Larsen, M., Armstrong, S., Heffernan, C., Laggis, G., Torok, M. & Shand, F. (2020). *The Lived Experience of Suicide: A Rapid Review*. The Black Dog Institute. Sydney, Australia.

⁸ White, S., Foster, R., Marks, J., Morshead, R., Goldsmith, L., Barlow, S., Sin, J. & Gillard, S. (2020). *The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis*. *BMC Psychiatry*. doi:10.1186/s12888-020-02923-3

⁹ Bowersox, N.W., Jagusch, J., Garlick, J., Chen, J.I. & Pfeiffer, P.N. (2021). *Peer-Based Interventions Targeting Suicide Prevention: A Scoping Review*. *American Journal of Community Psychology*. doi:10.1002/ajcp.12510

¹⁰ Chatterjee, H., Camic, P., Lockyer, B. & Thomson, L. (2017). *Non-clinical community interventions: a systematised review of social prescribing schemes*. *Arts & Health*. 10:1-27. doi:10.1080/17533015.2017.1334002

¹¹ Taylor Fry & ARTD Consultants. (2024). *Evaluation of the Safe Haven Initiative: Final Evaluation Report*, NSW Ministry of Health, Sydney, Australia. <https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven-evaluation-report.aspx>

¹² Nous Group. (2025). *Safe Space Evaluation: Summary of Evaluation Findings*. Brisbane North Primary Health Network, Brisbane, Australia.

¹³ National Suicide Prevention Office. (2025). *The National Suicide Prevention Strategy 2025-2035*. Australian Government, Department of Health and Aged Care, Canberra, Australia.

¹⁴ Roses in the Ocean (2025). *Recognising Lived Experience of Suicide as a legitimate form of Evidence in Suicide Prevention*, Roses in the Ocean, Brisbane, Australia.

¹⁵ Braun, V. & Clarke, V. (2006). *Using thematic analysis in psychology*. *Qualitative Research in Psychology*, 3(2), 77–101. doi:10.1191/1478088706qp063oa

¹⁶ Gallagher, K., Phillips, G., Corcoran, P., Platt, S., McClelland, H., O’Driscoll, M., & Griffin, E. (2025). *The social determinants of suicide: an umbrella review*. *Epidemiologic reviews*, 47(1). doi:10.1093/epirev/mxaf004

¹⁷ Pirkis, J., Blood, R. W., Sutherland, G., & Currier, D. (2018). *Suicide and the news and information media: A critical review*. Mindframe, Everymind. NSW, Australia.

¹⁸ Domaradzki, J. (2021). *The Werther Effect, the Papageno Effect or No Effect? A Literature Review*. *International Journal of Environmental Research and Public Health*, 18(5). doi:10.3390/ijerph18052396

¹⁹ Joiner, T. (2005). *Why People Die by Suicide*. Harvard University Press. doi:10.2307/j.ctvjghv2f

²⁰ King, K., Hall, T., Oostermeijer, S. & Currier, D. (2022). *Community participation in Australia’s National Suicide Prevention Trial*. *Australian Journal of Primary Health*, 28(3). doi:10.1071/py21083

²¹ Dash, S., McNamara, S., de Courten, M. & Calder, R. (2024). *Social prescribing for suicide prevention: a rapid review*. *Frontiers in Public Health*, 12. doi:10.3389/fpubh.2024.1396614

²² ASPIRE: Australian Social Prescribing Institute of Research and Education. (2025). *Creating Opportunities Together*. <https://www.creatingopportunitiestogether.com.au/> (accessed 23 July 2026).

²³ Victorian Department of Health. (2025). *Local Connections – a social prescribing initiative*. Victoria State Government <https://www.health.vic.gov.au/mental-health-wellbeing-reform/local-connections-social-prescribing-initiative>

²⁴ Rhodanthe, L., Wishhart, E., Watts, L., & Hodgson, D. (2023). *Clarifying the Alternatives to Suicide Approach: An Evaluation of the Theory, Values, Purpose and Practice (Version 1)*. Curtin University. doi:handle.net/20.500.11937/92141

²⁵ Discharged: An Alternatives to Suicide Approach. (2024). *Suicide Peer Support Groups*. <https://discharged.asn.au/our-groups> (accessed 24 July 2026).

²⁶ LELAN: Lived Experience Leadership and Advocacy Network. (No Date). *Alternatives to Suicide (Alt2Su) peer-led community-based groups*. <https://www.lelan.org.au/alt2su-groups/> (accessed 19 June 2026).

²⁷ Alternatives to Suicide. (2026). *Welcome to Alt2Su*. <https://alt2su-nsw.net/> (accessed 23 July 2026).

²⁸ Jerzmanowska, N., Franks, S., Tseris, E. & Finlayson, C. (2022). *Alternatives to Suicide: Research Report: Exploring the experiences and impacts of a peer-based approach to responding to suicidal distress*. *Social Work and Policy Studies*. The University of Sydney, Australia.

²⁹ Radford, K., Wishart, E., & Martin, R. (2019). *Evaluating DISCHARGED Suicide Peer Support Groups*. Curtin University. Perth, Australia.

³⁰ Roses in the Ocean. (2022). *Discussion Paper: A National Safe Spaces Network... the dream, the reality, the opportunity*. Roses in the Ocean. Brisbane, Australia.

³¹ Roses in the Ocean. (2022). *Report: A Safe Space Narrative – emerging outcomes of Safe Spaces codesign*. Roses in the Ocean. Brisbane, Australia.

³² NSW Health. (15 June 2026). *Safe Haven*. <https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven.aspx> (accessed 23 July 2026).

³³ Roses in the Ocean. (2026). *What are Community-Led Safe Spaces?* <https://rosesintheocean.com.au/community-led-safe-spaces/> (accessed 23 July 2026).

³⁴ NSW Health. (2026). *Suicide Prevention Outreach Teams*. <https://www.health.nsw.gov.au/towardszerosuicides/Pages/suicide-prevention-outreach-teams.aspx> (accessed 23 July 2026).

³⁵ Taylor Fry and ARTD. (2024). *Evaluation of the SPOT Initiative: Final Evaluation Report*. Mental Health Branch, NSW Ministry of Health. NSW, Australia. <https://www.health.nsw.gov.au/towardszerosuicides/Pages/suicide-prevention-outreach-team-evaluation.aspx>



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