

Commentary

Suicide Prevention in Australia: A Person-Centred and Whole-of-Community Approach

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Abstract

Suicide prevention in Australia is conducted under the guidance of National Suicide Prevention Office's, the 'National Suicide Prevention Strategy'. This is a 10-year Strategy that aims to embed suicide prevention activities across all levels of government and expand further than just health departments. In this commentary the authors outline the key principle of the Strategy, why it is necessary, and how the latest theories, research, and practice relate to its implementation. Central principles of this Strategy include embedding lived experience of suicide in the design and delivery of suicide prevention activities, applying person-centred care principles, and drawing upon the elements of safety planning to reduce future levels of suicidal thoughts and behaviours. It was created under the belief that through consistent and genuine focus, suicide is preventable. This article discusses these major themes alongside the role of compassion in the suicide prevention strategy, emphasising the importance of human connection in reducing hopelessness. It is hoped that through genuine multi-sector leadership, suicidal distress can be reduced in the Australian population.

Keywords: Suicide prevention, Policy, Safety planning, Lived experience, Person-centred care

The Context

Australia's current national policy settings for suicide prevention are guided by the landmark document titled, *The National Suicide Prevention Strategy 2025–2035* (the Strategy).¹ This is Australia's ten-year plan to significantly reduce suicide deaths, attempts, and the conditions that lead to suicidal thoughts and behaviour. Developed by the National Suicide Prevention Office (NSPO), the Strategy marks a major shift in national policy, positioning suicide prevention as a whole-of-government and whole-of-community responsibility.

Approximately 3,000 Australians end their lives each year (about 8 people a day). Australia loses more people to suicide than die in motor vehicle accidents each year. Suicide is the leading cause of premature death from injury or disease, and the main cause of death among people aged 15-49 years.²

Prevention of suicide efforts are directed throughout the life course, and across settings and contexts. Until recently, suicide was conceptualised as a purely mental health issue. Contemporary thinking recognises that suicide is impacted by several factors, rather than a single cause. Suicide is considered a public health

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priority and the result of a complex interplay between social determinants and individual factors that give rise to people being vulnerable to suicide. This means that the prevention of suicide is not something that sits simply within the domain or responsibility of health and human service workers or the health system. Suicide and its precipitants, drivers, and prevention sit within and across all areas of government, social care, and civil society. This approach is grounded in both the pervasiveness and persistence of suicide and self-harm (with an estimated 150 suicide attempts per day) and the various touch points to interrupt an individual's trajectory toward suicide.

Against this background Australia has adopted a whole of government and whole of sector Strategy to prevent suicide. The Strategy incorporates the voices of thousands of people with lived and living experience of suicide, aligns with contemporary research, and includes Aboriginal and Torres Strait Islander frameworks of social and emotional wellbeing. The Strategy is noteworthy for being structured around two core domains – the prevention of suicidal distress and support for people experiencing suicidal thoughts and behaviours.

The Strategy is deliberately and strategically designed to guide federal, state, territory, and local governments, non-government organisations, community groups, educators, employers, health services, and individuals. It emphasises that suicide is preventable through focussed effort and attention, systemic reform, cultural change in the way that systems and services operate, and long-term collaboration.

Embedded Lived Experience

The Strategy embeds lived experience of suicide in both design and practice. In Australia, lived experience peer support workforces are expanding, making it one of the fastest growing emerging disciplines in transdisciplinary mental health and suicide prevention settings.³ It is essential that service and system leaders value and support lived experience through a

supportive organisational culture. This means having a workplace culture with foundations to support and promote person-centred suicide prevention efforts. Building lived experience capability requires necessary infrastructure, financial and social investment. This means adequate remuneration, support, mentoring and development and inclusive recruitment.⁴ Australia's national policy settings promote the importance of clear roles and responsibilities, governance frameworks and co-produced outcomes measurement.

Tensions can and do exist in health care settings. Progressive concepts such as person-centred care shape the way mental health and suicide prevention is conceived, delivered, experienced and evaluated. Person-centred care aims to redistribute knowledge and power between healthcare providers and consumers to ensure that healthcare is meeting the needs of consumers. However, despite many years of Australian services attempting to deliver person-centred care, multiple reviews and inquiries into services find these attempts failing. Person-centred care challenges the traditional ways in which mental health and suicide prevention care have been conceived and delivered, reflecting tensions in the mental healthcare system. Tensions can be theoretical, legislative and cultural.⁵

Understanding Suicide to Prevent Suicide

One way to understand suicidal thoughts and behaviours is the Interpersonal Theory of Suicide.⁶ This theory is based on the premise that interpersonal processes influence thoughts and actions towards the likelihood of suicide: thwarted belongingness (perception of loneliness and absence of reciprocal relationships), perceived burdensomeness (feelings of being a burden to oneself and others), and capability for suicide. A person experiencing all three processes may be prone to attempting suicide. Individuals may move between states of experiencing suicidal thoughts and behaviours and not. These fluctuations in states can be driven by personal

circumstances, such as responses to trauma and changes in social determinants of health. Important in this discussion are the ways in which suicidal thoughts and behaviours fluctuate and can rapidly intensify. This highlights suicide as a complex phenomenon. Recently, thinking about suicide risk has shifted away from an over-reliance on risk assessment tools towards narrative and relationship-based engagement and care.

The Strategy adopts a broad definition of suicidal distress: a human response to unbearable suffering, shaped by an interaction between social determinants such as financial stress and income, employment, education, housing stability, access to healthcare, social inclusion, discrimination, community safety, experiences of violence, trauma, or systemic inequity. There is also an emphasis on distress caused by unexpected or unsupported life transitions impacted by social and cultural factors.

An example of a social determinant of mental health that has been a focus in recent times has been ex-serving Australian Defence Force members. This population is known to be at a higher risk of death by suicide than nonveterans. Ex-serving males and ex-serving females are, respectively, 26% and 100% more likely to take their own life than Australian males and females. Veterans who leave the Australian Defence Force for involuntary medical reasons are two and three times (females and males respectively) as likely to take their own life than those who leave voluntarily.

A recent shift is to bring together perspectives of lived experience/peer work, clinical, government and non-government sectors to advance compassionate trauma informed support and care for people experiencing suicide-related distress and their loved ones. Australia's national suicide prevention policy settings view compassion as kindness, with a deep awareness of and connection to the suffering of oneself and others, along with desire and effort to relieve it.⁷ The consensus thinking brought to education and

training of workers is guided by this belief. For clinicians the focus is on personalised, compassionate inquiry into the drivers of suicidal suffering. This means helping a person come to know and understand: their personal distress triggers for suicidal thoughts, intentions and actions; their personal warning signs; and how they can be safe in future suicidal crisis.

A practical example of this is understanding how for some individuals trauma, fear and suicidal intentions are related to specific dates and anniversaries helping family members, clinicians, and supportive community understand when someone may need greater care and support.⁸ For frontline clinicians the suicide assessment and engagement inquiry should (a) not be based solely on a 'tick-a-box' checklist; (b) involve staff who are properly trained to ask questions and value the answers given; (c) focus on suicidal thoughts and associated feelings states, i.e. encourage staff to enter into a person's conceptualisation of distress, at the same time confidently tackling difficult questions and nuanced conversations; and (d) involve carers and family members where this is possible and permissible.

So, the priority of how to understand and make meaning through suicide becomes just as critical as 'what to assess'. Humanising compassionate engagement also embraces psychological safety for people. Psychological safety is a concept informed by psychoanalytic notions of secure attachment and containment within relationships. It also includes practical utility of establishing and maintaining trust, interpersonal security within interactions, and being able to be curious in interpersonal interactions.

This is done by addressing person specific needs with an emphasis on (a) modifiable factors; (b) validation of and response to what they say are the causes of their life distress and stressors; and (c) individualised assessment which informs evidence-based service and care experienced 'as care'. This recognises that there is something for everyone who has contact with a service provider.

Implications for Suicide Prevention Education and Training

The authors of this article work in suicide prevention research and education. Given shifts in Australia's national policy settings, the structure, content, and approach to education and training programs incorporate co-design with staff who are representatives of future training participants. In one recent example the authors worked with a government organisation supporting military veterans receiving support for mental health and suicide related challenges. The service provider employees taking part in the co-design process represented peer workers, clinicians, and administrative staff. Each engaged in three 90-minute co-design sessions with led by a lived experience leader. The purpose of the co-design was to collaborate within and between staff on the work they do, and how evidence based a suicide prevention training program could be shaped to best meet their needs.

In this example, administrative staff play a potentially important role in the therapeutic environment.⁹ The interactions they have with people in distress and their family members can be both meaningful and important. Administrative staff support people in distress in ways that are not typically defined as therapeutic. This is consistent with Australia's national policy settings. It recognises and values the contribution made by administrative staff as client facing staff who provide an extension of the positive overall care experience generated by clinicians and peer workers. For many people, administrative staff are the first and frequent point of contact as people in distress make physical contact with a service or make contact by email or phone.

Similarly, peer workers contribute to the organisational environment and through direct client contact. Through peer support, clients come into conversation with a person who has similar life experiences of distress and help seeking, which can affirm and validate many of difficult experiences of the client, promote connection and personhood. Individuals with

lived and living experience of mental health or suicide related distress, who are bereaved or have supported a person who has experienced suicidal crisis, can be our teachers. This is reflected in the steadily accumulating evidence in support of contributions made by lived experience and peer support work within government and on-government sector mental health services.^{10, 11}

Peer workers are widely considered essential in suicide prevention, mental health recovery, and system reform. It is expect that national mental health action plans and policy include consumers in all levels of mental health service development and delivery.⁴ Changes to Australia's national policy settings has brought increased focus to implementing lived experience expertise in services provided by government and non-government sectors, sharing greater awareness and support for peer workforces through initial integration and ongoing role support.

A core theme and binding element across all these actions is listening 'to listen' rather than listening to respond to people in distress. For clinicians, administrative staff and peer workers, it can sometimes be hard to find the right words during critical moments. However, what we know from many people in distress is that it is less about the words and more about being genuinely engaged and compassionate. It is the intent that sits behind the words that matters most. So go gently, go slowly when responding to people in distress.¹²

Careful listening and probing further into the drivers of distress aligns with contemporary developments in relational practice and clinical suicidology. Suicidal thinking is not a fixed state. It can both diminish and rapidly intensify. This brings us closer to understanding intensity and variability of suicidal thoughts as it applies to people who contact services.⁷ At the same time the risk factors for suicide also vary. They range from social determinants to medical and biological factors in the life of a client.¹³

Person-Centred Safety Planning

The above considerations guide current evidence to best prevent suicidal distress and support people during the onset or worsening of suicidal thoughts and behaviour. The Stanley & Brown safety planning intervention is a well-established indicated intervention for general adult populations experiencing suicide related distress, primarily in face-to-face, community and clinical settings.¹⁴ It is a brief intervention taking 20–45 minutes to complete, in which the worker and the client collaborate to identify reasons for living, individualised distress triggers and internal feeling states that occur during the onset or worsening of a suicidal thoughts and behaviour.

A safety plan is quite literally a plan for ‘future safety’.¹⁵ Safety planning is designed to interrupt the trajectory towards suicide. It is best communicated as a compassionate conversation between the client and worker with clear person-specific actions to increase safety. A typical safety plan includes six components:

- (1) recognising individual warning signs and distress triggers;
- (2) identifying and employing internal coping strategies;
- (3) using trusted networks, social supports and connections as distractions;
- (4) contacting trusted family or friends to help;
- (5) contacting specific mental health services; and
- (6) reducing access to/use of lethal means.

Some conversations about safety planning with people in distress may begin by identifying reasons for living. Suicidologists report that when we have reasons for living, living a life with meaning and purpose, we are less likely to take action that threaten that motive.¹⁶ Reasons for living can also encourage hope for the future and

establish a rationale for the safety plan. These reasons can be returned to if/when the person is having difficulty implementing their plan.

Sample questions include: *“What has helped you get through difficult times in the past?”* and *“When everything else seems unendurable or hopeless, what keeps you going?”*

A sample question to help a client recognise individual warning signs and personal distress triggers is: *“What do you experience inside (your internal states) when you start to think about suicide?”*

The purpose of identifying activities to engage in without contacting other people (both established and new activities) in safety planning is to identify and act upon internal coping and self-support activities. This might include distractions, calming activities, and activities that lift the individual’s mood.

Sample questions include: *“What can you do on your own if you become suicidal again, to help you not to act on your thoughts?”* and *“What activities can you do to help take your mind off the feeling state you have at the time?”*

It is critical to discuss the likelihood of the client using the identified self-management strategies and to identify any possible barriers or hesitations along with possible solutions.

Sample questions include: *“How likely do you think it is you’ll be able to use these support and coping strategies in a crisis?”* and *“Can you think of anything that might stop you from thinking about these activities, or doing these activities even after you’ve thought of them?”*

The purpose of facilitating the client to identify social connections and supports is to distract and bring comfort when internal coping and support strategies are not effective. This can include family, friends, groups or social settings. It is recommended that specific names, contact details

and locations of individuals and groups are listed in the plan.

Sample questions include: *“Who helps you feel safe/good when you spend time with them?”*, *“Who helps you to take your mind off your difficulties/troubles/problems?”* and *“Where can you go to be around people in a safe environment?”* It is critical to avoid social connections that might exacerbate the person’s uncomfortable thoughts or internal feeling states. Interaction as a form of social support and settings it occurs in should be safe environments.

Trusted networks, family and friends that the person can inform at the onset or worsening of crisis and when in need of support should be listed in detail on the plan. Specific names and contact details should be listed in the plan.

Sample questions include: *“Of your family, friends, network or community, who do you think you could contact for help during a crisis?”*, *“Of your family, friends, network or community, who is supportive of you in times like these?”* and *“Of your family, friends, network or community, who you feel you can talk to when you are reaching a difficult situation – including crisis?”* Sample responses include spouse/partner, parent, uncle, aunt, sibling, close friend, or religious figure such as a chaplain (all named groups and individuals are agreed and confirmed in advance).

Next is to help the person to identify professional support when the previous strategies are not effective, as well as how to access these supports. This can include existing and new support. The safety plan should include specific names (agreed in advance), contact details, locations and opening hours.

Sample questions include: *“Who are the professionals you turn to for support?”* and

“Who are the mental health professionals that should be listed on your plan?”

It is also important to discuss potential barriers to accessing professional support. Some individuals may be reluctant to access support for fear of reprisal, punishment, stigma, or previous experience. These concerns should be discussed along with potential solutions, such as asking a friend or family member to assist with making the initial contact.

When discussing lethal means, research and consensus opinion in clinical suicidology suggests that the term ‘means safety’ can be more acceptable to people than ‘means restriction’. Means restriction can be experienced by people in distress as a negative consequence, can sound punitive and permanent, and can limit autonomy.¹⁷ The language change is important for firearms. The behavioural goal is to safely store lethal means until the client recovers. Storing firearms away from the home temporarily is regarded by many as the safest choice.

A recent study¹⁸ has suggested peers as effective in lethal means counselling when using conversational and non-confrontational style approaches that are aligned with a person’s value system. This finding is consistent with the intent of Australia’s national Strategy. Research suggests that firearm owners prefer to engage in conversations about firearm safety with credible messengers from within firearm culture (e.g., police officer or military veteran) or with those whom they have established a trusting relationship (e.g., family member) rather than a clinician.

At a deeper level of analysis, the way that safety planning is enhanced by inclusion of support persons and peer workers.¹⁹ This acknowledges that:

- Peer workers may have different language and ways of talking about supports, practices and meanings that are also discussed in safety planning.

- Peer work is lived experience driven, while safety planning is theory/research driven. There are mutual learning possibilities.
- Theory of suicide and safety planning draws attention to relational safety, personal story, and finding meaning. These are also important to peer practice.
- Peer lived experience of safety and coping can draw on finding themes and practices that work for them. These maybe therapeutic practices (e.g. distress tolerance skills), or unique ideas (e.g. looking after a pet), or personal meaning (e.g. spiritual growth).
- Safety planning is focused on pathways out of patterns of crisis: other therapy supports or peer conversations can focus on longer term growth and healing (e.g. from trauma and loss).

Compassion and Relational Safety in Suicide Prevention

A compelling aspect of Australia's national approach to suicide prevention is the location of compassion being central in the prevention of suicide. At its core, the aim should be to embrace the human connection that exists between worker and client. This means being truly present in the space where someone struggles. The focus is on relational safety, an experience that comes from being together with others. When hope seems hopeless, the narrative must continue to be around relationships. This is what binds human connection and compassion as a crucial part of Australia's national policy settings to prevent suicidal suffering and death.¹ Work towards a situation where the person 'feels felt by the worker'. When human connections are absent, or when they are not felt or experienced by the person 'as intimate, authentic and relational', they may be of limited protective value.

Conclusion

In recent years Australian government policy at all levels has been directed to ensure that suicide prevention efforts are grounded in the latest

contemporary research. This includes a genuine commitment to the expertise of people with lived and living experience of suicidal thoughts and behaviours. This direction is outlined by the *National Suicide Prevention Strategy* which plans for the next decade of work in reducing suicidal distress and preventing suicide at a population health level. Through concepts of compassion, relational safety, and 'listening to listen', the Strategy acknowledges that genuine and meaningful human connection is at the centre of suicide prevention efforts. These concepts can be brought into the clinical context through safety planning, to create future safety by identifying stress triggers and strategies to reduce levels of distress. It is hoped that if the Strategy is implemented with genuine commitment, suicidal distress across the Australian population can be reduced.

References

1. National Suicide Prevention Office. *The National Suicide Prevention Strategy 2025-2035*. Canberra; 2025.
2. Department of Health Disability and Aging. *Suicide in Australia*. 2024 [cited 2026 Apr 21]. Available from: <https://www.health.gov.au/topics/mental-health-and-suicide-prevention/suicide-in-australia?language=en>
3. Reeves V, Loughhead M, Halpin MA, Procter N. "Do I feel safe here?" Organisational climate and mental health peer worker experience. *BMC Health Services Research*. 2024;24(1):1255. DOI: 10.1186/s12913-024-11765-8.
4. Reeves V, Loughhead M, Teague C, Halpin MA, Procter N. Lived experience allyship in mental health services: Recommendations for improved uptake of allyship roles in support of peer workforces. *International Journal of Mental Health Nursing*. 2024;33(5):1591-1601. DOI: <https://doi.org/10.1111/inm.13322>.
5. McDonough J, Loughhead M, Rhodes K, Ferguson M, Procter N. 'Am I Safe Here? Am I Going to Be Let Down?'

- Disentangling Tensions in the Pursuit of Person-Centred and Consumer Directed Care in the Australian Mental Healthcare Context. *International Journal of Mental Health Nursing*. 2025;34(6):e70177. DOI: <https://doi.org/10.1111/inm.70177>.
6. Van Orden KA, Witte TK, Cukrowicz KC, Braithwaite SR, Selby EA, Joiner TE Jr. The interpersonal theory of suicide. *Psychological Review*. 2010;117(2):575-600. DOI: 10.1037/a0018697.
7. National Suicide Prevention Office. *National Suicide Prevention Adviser Final Advice*. 2025 [cited 2026 Apr 21]. Available from: <https://www.mentalhealthcommission.gov.au/nspo/projects/national-suicide-prevention-adviser-final-advice>
8. Leaune E, Hunt IM, Flynn S, Pitman A, McDonnell S. Views of Suicide-Bereaved Adults Regarding the Significance of the Deceased's Death Date. *Journal of Loss and Trauma*. 2025;1-20. DOI: 10.1080/15325024.2025.2553227.
9. Feder V, Fibiger K, Knaak S. On the Very, Very Frontlines of Mental Health Care. *Psychiatric Services*. 2019;70:148-150. DOI: 10.1176/appi.ps.201800355.
10. Loughhead M, Hodges E, McIntyre H, Procter N, Barbara A, Bickley B, et al. Pathways for Strengthening Lived Experience Leadership for Transformative Systems Change: Reflections on Research and Collective Change Strategies. *Health Expectations*. 2024;27(5):e70048. DOI: <https://doi.org/10.1111/hex.70048>.
11. Reeves V, McIntyre H, Loughhead M, Halpin MA, Procter N. Actions targeting the integration of peer workforces in mental health organisations: a mixed-methods systematic review. *BMC Psychiatry*. 2024;24(1):211. DOI: 10.1186/s12888-024-05664-9.
12. R U OK? *Ask the experts: Nicholas Procter*. 2020. Available from: <https://www.youtube.com/watch?v=Lx9qeY4WGTE>
13. Procter N. Financial stress is on the rise in Australia. Here's what to do if money worries are affecting your mental health. *The Conversation*. 2025 [cited 2026 Apr 21]. Available from: <https://theconversation.com/financial-stress-is-on-the-rise-in-australia-heres-what-to-do-if-money-worries-are-affecting-your-mental-health-262441>
14. Ferguson M, Rhodes K, Loughhead M, McIntyre H, Procter N. The Effectiveness of the Safety Planning Intervention for Adults Experiencing Suicide-Related Distress: A Systematic Review. *Archives of Suicide Research*. 2022;26(3):1022-1045. DOI: 10.1080/13811118.2021.1915217.
15. Zero Suicide Institute of Australasia. *Engage: what is safety planning?* [cited 2026 Apr 21]. Available from: <https://zerosuicide.edc.org/engage-australasia>
16. Bryan CJ. Rethinking suicide: Why prevention fails, and how we can do better. Oxford University Press; 2022. p. 224.
17. Stanley IH, Hom MA, Rogers ML, Anestis MD, Joiner TE. Discussing Firearm Ownership and Access as Part of Suicide Risk Assessment and Prevention: "Means Safety" versus "Means Restriction". *Archives of Suicide Research*. 2017;21(2):237-253. DOI: 10.1080/13811118.2016.1175395.
18. Houtsma C, Hohman M, Anestis MD, Bryan CJ, True G. Development of a peer-delivered lethal means counseling intervention for firearm owning veterans: Peer engagement and exploration of responsibility and safety (PEERS). *Suicide and Life-Threatening Behavior*. 2025;55(1):e13138. DOI: <https://doi.org/10.1111/sltb.13138>.
19. O'Connor E, Rhodes K, Procter N, Loughhead M, Procter A, Reilly J-A, et al. The experiences of consumers, clinicians and support persons involved in the safety planning intervention for suicide prevention: a qualitative systematic review and meta-synthesis. *Frontiers in Psychiatry*. 2024;15. DOI: 10.3389/fpsy.2024.1482924.