

Suicide Prevention Position Statement

A note on language

Wellways acknowledges that the language we use when communicating about mental health and suicide holds power - words can wound or heal, and they carry different meanings for different people. We use the term suicide prevention throughout this statement because it is widely used and understood across the sector and reflects what we do. At the same time, we recognise that this framing does not capture the full picture. Many people with lived experience prefer language that is more life-affirming, and we share that goal.

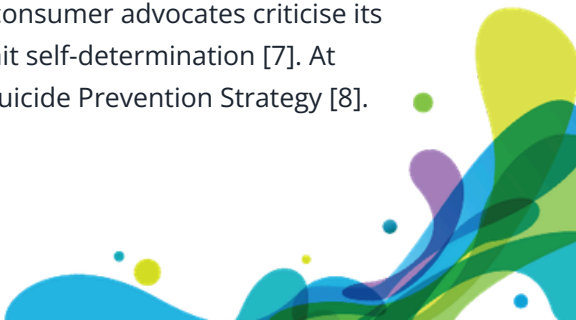
In this context we adopt the Suicide Prevention Australia definition of lived experience, as including those who have experienced suicidal thoughts and behaviours, survived a suicide attempt, cared for someone through suicidal crisis, or are bereaved by suicide. Every experience of suicidal distress is different, and no definition or description can capture them all. Where a particular experience is not reflected in this statement, this in no way diminishes its significance or relevance. Where this statement speaks to the experiences of First Nations people, we follow the lead of Aboriginal and Torres Strait Islander staff, communities and organisations. We use social and emotional wellbeing language with attribution to its First Nations origins and authority [1].

We use the terms relational and person-centred care throughout. Again, there is no single definition for these terms however we are referring to care that is grounded in respect, trust, compassion and shared humanity, which sees and supports the whole person. When referring to a person's support network, we use the terms families, carers, kin and supporters - recognising there are meaningful distinctions within these terms. We also recognise these people frequently carry their own distress and need for care.

We acknowledge the tension between concepts of duty of care and dignity of choice in suicide prevention. Dignity of choice means supporting someone in suicidal distress by honouring their autonomy, dignity, and preferences while engaging collaboratively to enhance their experience of safety. Our 'duty of care' is to take reasonable steps to prevent harm. We do this in ways that are respectful, transparent and as least restrictive as possible. In our practice, this means walking alongside people, respecting their dignity, being honest about our responsibilities, and supporting informed decision-making wherever possible.

Context

Australia's suicide prevention system is shifting toward an integrated, whole-of-government approach that recognises the social and emotional drivers of suicidal distress, positioning suicide prevention alongside the mental health system, aligning it with international public-health and human-rights-based models [2,3,4] Wellways supports this shift, noting it is yet to be fully implemented, resourced or realised. Suicide rates have not improved in a decade [5,6], implementation of the National Mental Health and Suicide Prevention Agreement remains incomplete with monitoring and data gaps persisting [2,7], while consumer advocates criticise its continued reliance on a medical model that can perpetuate stigma and limit self-determination [7]. At publication, there was still no dedicated Federal funding for the National Suicide Prevention Strategy [8].



CONTEXT (CONTINUED)

Wellways acknowledges the growing movement within lived experience communities and research literature that challenges mainstream approaches as overly focused on containment and crisis management, rather than on creating the personal, social and structural conditions that support a life worth living, or 'liveability' [9,10,11]. We advocate for social and structural change to improve people's circumstances, while also walking alongside people who need support in the moment. At Wellways, it is not an either/or - it is both.

Unmet need is well documented. Australian research indicates that although around one quarter of people who died by suicide had contact with acute mental health services in the year before their death, the majority received no professional mental health support during their final year of life [5,12]. This reflects broader gaps in access to care, with an estimated 500,000 Australians not receiving the psychosocial supports they need [13]. Addressing this gap requires a significant expansion of community-based, holistic psychosocial supports, recognising that biomedical models do not respond to the full scope of suicidal distress [14,15].

The World Health Organisation, Suicide Prevention Australia and a growing evidence base show this distress is strongly shaped by social conditions, including relationship dysfunction, financial hardship, family violence, damage to cultural continuity, chronic illness, discrimination and marginalisation, supporting stronger prioritisation of social determinants in policy [16,17,18,19,20]. Recent Australian research identifies unemployment, insecure employment and poor working conditions as among the strongest drivers of suicide risk, yet these remain largely overlooked in Australian suicide prevention programs [21]. Systematic review evidence identifies intimate partner violence (IPV) as a significant and modifiable risk factor for suicidal distress among women, with psychological abuse notably impactful [19].

While understanding and responding to risk remains a part of suicide prevention, the way systems currently assess and predict risk is consistently challenged in contemporary research. Risk stratification tools show poor predictive accuracy and limited clinical value [22,23,24] and many common inpatient and emergency department risk assessment and restrictive practices lack supportive evidence and may contribute to harm [28]. Paternalistic, risk-oriented approaches can also reduce a person's experience to a tick-box exercise that fails to capture the narrative of their distress, weakening the empathetic partnerships that effective support depends on [25,26,27].

By contrast, people experiencing suicidality report better experiences and outcomes when they actively shape their own care, feeling heard and valued through person-centred listening [29, 30, 31], supporting personalised safety planning and collaborative, relational approaches over standardised, risk-focused practice, and the continued development of this evidence base [32].

Studies highlight the tension between duty of care and people's dignity of choice, and its impact on trust and person-centred safety planning. They attribute non-beneficial coercive interventions and limited implementation of Shared Decision-Making (SDM) to inadequate training, fear of adverse outcomes, cultures of blame, clinician anxiety and low tolerance for uncertainty – all of which drive defensive, risk-averse practice [33–38].

Participant-centred evidence calls for a wider conception of safety than technical and physical terms alone, finding that safety for a person experiencing suicidal distress depends heavily on psychological safety and fulfilment of their needs [39].



CONTEXT (CONTINUED)

Emerging evidence supports sitting with people and exploring their distress - decoupled from diagnoses - through open conversation, connection and mutual agreement in support and recovery [26,40-43]. Peer support models, where outcomes and conversations occur without threat of coercion, produce overwhelmingly positive outcomes, and lived experience involvement consistently enhances intervention effectiveness [6,41,44,45]. Global research links place-based, peer-centred community alternatives to emergency departments with reduced suicidal distress, greater connection and, in some cases, lower ED use.[46]

The limitations of individual-focused clinical approaches are especially evident for First Nations people, whose suicidal distress is inseparable from the ongoing impacts of colonisation including intergenerational trauma, racism, discrimination, and loss of culture and identity [47,48,49]. The research evidences the need for strength-based, community-led approaches grounded in social and emotional wellbeing, restoration of identity and culture, and genuine self-determination [47,50,51]. Cultural continuity - connection to Country, culture, language, spirituality, family and community - is widely evidenced as protective [52,53]. First Nations lived experience groups call for investment in First Nations structures of care and recognition of social justice as suicide prevention [54]. This urgency is reflected in worsening outcomes under the National Agreement on Closing the Gap. Despite Target 14 committing governments to a significant and sustained reduction in suicide towards zero, the age-standardised suicide rate for Aboriginal and Torres Strait Islander people increased from 2018-2024, with the Productivity Commission assessing overall progress as worsening. Suicide remains the leading cause of death among First Nations people aged 15-39 [65,66].

System and practice approach limitations apply similarly to culturally and linguistically marginalised (CALM) and LGBTIQ+ communities, who hold distinct identities and experiences of mental health and suicide, yet share experiences of shame, discrimination and stigma, requiring tailored, culturally appropriate approaches that respond to shame, marginalisation and exclusion and prioritise destigmatisation [55,56,57]. Despite being recognised as a priority, CALM populations remain significantly underrepresented in suicide research [58]. Recent studies identify stressors particular to this cohort including the sometimes traumatising experience of migration, social isolation, cultural dislocation, financial stress and language barriers, all of which can impede access to services and willingness to engage due to shame and stigma [59,60].

Finally, a small but meaningful body of research shows the psychological impact of suicidality on people who provide informal and unpaid support should not be underestimated. Caregiving stress disrupts family dynamics, while shame and stigma around suicide may affect families as frequently as the person experiencing distress [61,62]. International literature suggests family, supporters and kin (carers) may themselves be a high-risk group, commonly reporting depression and anxiety for which they receive little assistance [62,63]. While services and supports rarely target carers' suicidality specifically, carers are amenable to support and want greater involvement and education in supporting their loved ones [62,63]. These findings underscore the need to recognise suicidal thoughts as a risk across the unpaid support trajectory and to provide support at each stage [64]. Taken together, this evidence also supports approaches that hold the person and the people around them in view together [61,62,63].

While Wellways recognises we cannot address these gaps and tensions alone, the principles below express our commitment to driving change within our sphere of influence and in partnership with others.



Principles



Distress is shaped by life experiences, events and conditions

Suicidal distress is often connected to people's life experiences, events and the conditions of their lives, which are impacted by social, economic, cultural and structural factors including poverty, exclusion and discrimination, abuse and violence, colonisation and many more.

We ask rather than assume we know the source of someone's distress. For some it lies in these conditions, for others it may not; their pain is just as real and deserving of support.

- We aim to understand and respond to the whole person in the context of what they have lived and are living through not just their symptoms or diagnosis.
- We ensure people don't have to navigate supports and systems alone.
- We advocate for the social, economic and structural conditions that support people's wellbeing and make life feel liveable.



Relationships are prioritised

Relational support, grounded in compassion, trust, understanding and presence, is central to effective suicide prevention. Creating safety through relationship enables open conversations about suicidal distress, helping people feel heard, respected and less alone.

- We begin with conversation and human connection, keeping the relationship at the centre of our practice.
- We speak gently, openly and directly about suicidal thoughts and intentions, reducing shame and fear and creating space for people to express their distress safely.
- We listen deeply, with curiosity and without judgement, honouring people's uncertainty, doubt and hope.
- We recognise suicidal thoughts show up differently for everyone and we hold that complexity with care.



People lead decisions about their lives

People experiencing suicidal distress are experts in their own lives. We honour their agency, dignity and the right to self-determination, co-creating support with them. People's identities, cultures and priorities shape what meaningful support looks like for them. We acknowledge the inherent power imbalance between those providing and receiving support and aim to practice in ways that recognise and reduce this.

- We support people to make informed and consensual choices about their care and support.
- We practice in culturally safe, inclusive and respectful ways that honour each person's identity and community, including connecting people to Aboriginal and Torres Strait Islander supports where this is their preference.
- We recognise the importance of families, carers and kin to connection and healing. Their involvement is guided by the person and revisited over time as their circumstances and preferences change.
- We recognise that family and kinship are defined by the person and their community, not by the service.



PRINCIPLES (CONTINUED)



Safety is shared

Safety is built through trusting, transparent and collaborative relationships. We balance dignity of choice with duty of care, walking alongside people to support safety for now and over time.

- We listen deeply to understand what safety means and develop support pathways that honour each person's choice and voice. Safety planning happens gently, within conversation and connection.
- We stay present with distress, responding to the person's need rather than our own discomfort in the moment.
- Safety is a shared responsibility:
 - For participants, this means being transparent from the outset about the support we can offer and agreeing on the steps to take when more support is needed;
 - For our staff, this means reflective supervision, connected teams and an organisation that actively supports person-centred practice.



Connection, belonging and participation are life affirming

Strong community connection, inclusion and belonging reduce suicidal distress. People who are connected and experience a sense of belonging in community are better able to access sustained wellbeing.

- Through community-led and peer initiatives, we connect people to supports and relationships that foster belonging, including Aboriginal Community Controlled Organisations, working alongside what communities already hold.
- We partner with communities and services to create connected systems of care, building trust through regular, visible presence in communities and on Country.
- We honour connection to Country, culture, spirit and kin as central to people's wellbeing.
- We recognise and support the people who matter in someone's life, offering information, connection and support in their own right.

These principles inform our advocacy priorities, which address both the immediate needs of the current system and the longer-term reform required to move towards a suicide prevention system grounded in human rights.

Advocacy Priorities

01

Coordinated whole-of-government action to address the social determinants of suicidal distress:

Addressing marginalisation, stigma, housing insecurity, poverty, family violence, justice involvement, educational disadvantage and employment barriers.

05

Peer support as a critical component of suicide prevention:

Recognise and invest in peer support as a profession through workforce development, formal support structures and collaborative peer-clinician models of care. Resource Dedicated peer roles in emergency and acute settings.

02

First Nations-led suicide prevention:

Achieving Closing the Gap targets requires sustained investment in Aboriginal Community Controlled organisations and First Nations-led models of care, enabling consistent, flexible community presence. Wellways supports First Nations-led advocacy, including priorities outlined in: [Priorities-for-Suicide-Prevention-A-First-Nations-Lived-Experience-Collective-Statement-2026.pdf](#)

06

Better training across the system:

Governments, education providers and professional bodies should make lived experience-informed, person-led practice central to training, professional standards and service frameworks.

03

A rights-based mental health and suicide prevention system:

The elimination of seclusion, restraint and other coercive interventions, acknowledging the trauma, shame, stigma and discrimination they inflict on people already experiencing suicidal distress, and the need for investment in the human rights-affirming alternatives that make coercion unnecessary.

07

Expansion of community-based, alternatives to emergency departments:

Expand warm, peer-led environments for people experiencing suicidal distress, consistent with contemporary evidence on effective, person-centred crisis support.

04

Continuity of support across services and the spectrum of suicidal distress:

Resourcing peer support staff to maintain contact with people across hospitalisation and service transitions. Warm handovers and post-discharge follow-up embedded as core practice in service models. Relationships should be able to stay warm beyond the end of a funded episode of care.

08

Expanded community-based supports:

Providing ongoing contact for people experiencing chronic or recurring suicidal distress, helping to sustain safety and prevent distress deepening.



ADVOCACY PRIORITIES (CONTINUED)

09

Equitable access for rural and regional communities:

Expand investment in place-based, locally co-designed rural and regional suicide prevention services with funding to meet the true demands of outreach. Flexible approaches that address practical barriers people face in accessing care, alongside increased telehealth and online options where in-person services are limited.

11

Funding models that prioritise longer-term, relational support:

Minimum five-year funding cycles and flexible episodes of care that allow time to build trust and connection before structured goal setting. Commissioning frameworks that prioritise relational outcomes in suicide prevention service models.

10

Prioritise family supports in suicide prevention:

Families, carers, kin and supporters should be recognised in their own right within suicide prevention, as supporters and as people who may experience suicidal distress themselves. This requires flexible carer-specific, trauma-informed supports and action to address carers' economic insecurity. Commissioning frameworks and service specifications should recognise work with families, carers, kin and supporters as part of core practice.

This position statement was developed in collaboration with service participants including families, carers and kin and Wellways staff, including peer staff, our Lived and Living Experience Authority, Lived Experience leadership team, First Nations staff, suicide-specific programs, psychosocial teams, clinicians, disability support teams. It reflects the insights shared across multiple engagements. We are deeply grateful to everyone who generously contributed their time, wisdom and experience.



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