Mental ill-health and suicide: A *Mindframe* resource for stage and screen

Mindframe

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Foreword

Good writing comes from good research, when the writer knows the subject well and can build good characters and a strong narrative in circumstances, which ring true. In an age when anything can be Googled, it seems that research is easy. Some subjects, however, are easier to research than others. When it comes to mental ill-health and suicide, it's not hard to find facts and statistics – it's much harder to find what a writer really needs; first-hand stories about what it is like to live with mental ill-health.

As someone who has written about a related area, dementia, I was interested when the Writers' Guild was asked by the Australian Government Department of Health and Ageing to take part in the preparation of this resource. Members of the Guild, working in partnership with mental health agencies and people directly affected by mental illness and suicide have assembled something invaluable for anyone contemplating a story in this subject area. There are nuggets in here, real gold. And not only is this booklet a wonderful resource for writers, it contains much useful information for producers, directors and anyone involved in putting these challenging stories onto the stage or screen.

GEOFFREY ATHERDEN, AUSTRALIAN TELEVISION SCREENWRITER AND PLAYWRIGHT

About this resource

This resource is aimed at stage and screen content creators. It was developed by **Everymind** in partnership with the Australian Writers' Guild and SANE Australia (SANE), with assistance from screenwriters and consumers, carers and service providers in mental health and suicide prevention.

Mental ill-health and suicide: *A Mindframe resource for stage and screen* was created with funding from the Australian Department of Health. It provides practical advice and information for people involved in the development of Australian film, television and theatre. The resource is designed to help inform truthful and authentic portrayals of mental ill-health and suicide, and includes information about audience impact and key issues to consider when developing storylines that include either mental ill-health or suicide. It is also available online at mindframe.org.au

Contents

Introduction

In Australia, 45% of people will directly experience a mental illness in their lifetime[1] and around three thousand people take their own life each year.[2] In 2017-18, one in five (20.1%) or 4.8 million Australians had a mental or behavioural condition, an increase from 4 million Australians (17.5%) in 2014-15.[3] Many more people are indirectly affected by mental ill-health and suicide as a family member, friend or colleague.

Film, television and theatre exert a powerful influence on community attitudes towards mental ill-health and suicide. In March 2007, a workshop brought together Australian screenwriters with people directly affected by mental ill-health and those working in mental health. This established the need for resources that would enhance the development of more truthful and authentic portrayals of people with mental ill-health rather than portrayals that perpetuate current myths and stereotypes. This document is a response to that need.

Portrayal of mental ill-health

When developing a storyline that includes mental ill-health, ask yourself the following:

- Why am I introducing mental ill-health into the story?
- Will my portrayal be fresh and original?
- Am I perpetuating or challenging common stereotypes?
- Will my portrayal be truthful and show a range of experience?
- Can I improve the accuracy and authenticity of my portrayal?
- Can the storyline model or promote help-seeking behaviour?

When developing a storyline that includes suicide, ask yourself the following:

- Why am I introducing suicide into the story?
- Should the suicide act be portrayed?
- Might my portrayal of suicide be wrongly interpreted as a solution to a problem?
- How can I explore the issue with more depth?
- Have I checked the accuracy and authenticity of my portrayal?
- Can I encourage people who are distressed to seek help?

Audience impact

Because of their broad reach and appeal, film, television and theatre may exert a powerful influence on community attitudes towards mental ill-health.[4] Handled well, storylines involving mental ill-health provide an opportunity for sensitive, engaging and powerful material. Handled poorly, storylines can have harmful effects, perpetuating the stigma associated with mental ill-health. Stigma can reduce the likelihood that people who experience mental ill-health will seek appropriate help.

People living with mental ill-health and their families report the information below[5]:

- They experience stigma regularly and the effects of stigma are often more distressing than the symptoms of the illness.
- Less stigma is the number one thing that would make their lives better.
- Negative or stereotyped depictions of mental illness make life more difficult for them.

People with mental illness have also made the following suggestions about ways to improve portrayals of mental illness[5]:

- Researching for accuracy
- Directing viewers how to get help
- Showing well rounded and factual portrayals
- Using appropriate language.

Research has revealed that people living with mental ill-health are often inaccurately portrayed as having: a violent or aggressive nature; being eccentric, seductive, self-obsessive; objects for scientific observation; or simpletons.[4]

A skewed picture of mental health treatment is often presented, emphasising the more dramatic psychotherapy and Electro Convulsive Therapy (ECT) rather than more common forms of treatment such as medication and talking therapies.

Alternatively, the impression can be given that all treatments are ineffective and instead love will conquer all.

Mental health professionals are variously portrayed as incompetent, sinister, unrealistically selfless or seductive (in the case of women), or only to be proved wrong as the plot unfolds.

For a full review of the research evidence, visit mindframe.org.au

Key issues to consider

45% of Australian's will directly experience a mental illness in their lifetime[1] with many more supporting a family member or friend through that experience. Your audience will include people directly affected by mental ill-health as well as people who have limited knowledge of mental ill-health. When developing a storyline that might include mental ill-health, you may want to ask yourself the following:

Question	Answer
Why am I introducing mental ill-health into the story?	– Is it to explore the issue from a personal perspective or is it just an easy way to resolve a storyline? – How will introducing a character with a mental illness impact the storyline? Will it be different for an ongoing character or a guest character? – Will my character with mental illness be viewed as credible? Do I have sufficient grasp of the subject matter to do it justice?
Will my portrayal be fresh and original?	– Consider the value in talking to people who are directly affected by mental ill-health when developing storylines. First-hand research will give the story/character both originality and authenticity. (see "Contacts and other sources of information" on page 28). – Consider the whole human context of the person living with a mental illness, their relationships, work, goals and ambitions. – Exploring the impact on the carers, families, friends, colleagues and others in the community can be powerful. – Consider exploring cultural, religious and age diversity in characters. Mental ill-health is conceptualised, accepted and managed in varied ways across cultures. Am I perpetuating stereotypes? – A person with mental ill-health does not need to be evil, nor does the evil character need to have a mental illness. – Someone with a mental ill-health is far more likely to be a victim of violence than a perpetrator. – Consider using one or more characters to challenge negative and stereotypical attitudes expressed by another character.
Will my portrayal of mental ill-health be truthful?	– Remember that people can manage and live with their mental illness; it is not 'traumatic' every day. – Consider exploring a character's recovery or ongoing management of mental illness. The 'quick fix' is not necessarily a reality, especially when the mental illness is given to a time-poor guest character. – A resolution does not have to be the 'cure' or the 'death' of a character with mental illness. – Consider balancing a more negative storyline with a more positive or counter-balancing storyline. What language will my characters use? – Terms such as 'schizo', 'psycho', 'mad' and 'emo' may reflect the language of a particular group (eg. young people) but, unchallenged, may cause immediate distress to audience members. – Incorrect use of psychiatric labels can misinform and confuse audiences. For example when the word schizophrenia is used to indicate split personality, or psychotic is used to refer to psychopathy.
Can I improve the accuracy and authenticity of my portrayal?	– Take time to research the details of each mental illness that is portrayed to ensure representations are accurate. – Some characteristics associated with mental illness (eg. twitching) are side effects of treatments rather than the illness itself. – Consider the range and type of services and service providers that are portrayed to ensure they are accurate and reflect current trends in treatment approaches. – Check the portrayal of the physical environment of mental health care and treatment facilities is accurate.
Can the storyline have a positive effect on the audience?	– Consider whether there are opportunities to show how people can get effective help. Many people who are experiencing mental ill-health do not access support because of the stigma associated with mental ill-health. – Including phone numbers and contact details for services at the end of a piece (or as part of the drama) provides immediate support for those who may be prompted to seek assistance.

About mental ill-health

Common misconceptions about mental ill-health

There are many myths and misconceptions about mental ill-health in the community. Some common myths are listed below.

MYTH:
People who are mentally ill are violent[6]

- Most violent people have no history of mental disorder.
- Most people with mental ill-health have no history of violent behaviour.
- The use of drugs or alcohol has a stronger association with violence than does mental ill-health.
- People living with a mental illness are more likely to be victims of violence, especially self-harm.
- When it does occur, violent behaviour usually happens in the context of distressing hallucinations or treatment that has not been effective.

MYTH:
Mental ill-health is a life sentence[7]

- Most people will recover fully from mental ill-health, especially if they receive help early.
- Some people will only experience one episode of mental ill-health and recover fully, others may be well for long periods with occasional episodes, and a minority of people will experience persistent mental ill-health.
- Most people with mental ill-health will be treated in the community.

MYTH:
Mental illnesses are all the same[7]

- There are many types of mental illness and many types of symptoms. Not everyone with the same diagnosis will experience the same symptoms.
- A mental illness may also include physical as well as psychological features, such as insomnia, weight gain or loss, increase or loss of energy, chest pain and nausea.

MYTH:
Some cultural groups are more likely than others to experience mental ill-health[8]

- People from any background can develop mental ill-health.[1]
- Cultural background may affect how people experience mental ill-health and how they understand and interpret the symptoms of mental illness.
- Many Aboriginal and Torres Strait Islander people carry a significant burden of grief and loss from an early age, due in part to the high rates of mortality, illness, incarceration, and deaths in custody.[9,10]
- Pre-migration experiences and the process of resettlement in a foreign land can impact on the mental health of people from Culturally and Linguistically Diverse (CALD) backgrounds and their children.[11]

Specific mental disorders[12]

Disorder	Characteristics
Anxiety disorders	Anxiety disorders occur when a person has an intense and paralysing sense of fear or a more sustained pattern of worrying when there is no real danger or threat. Anxiety can occur in almost all age groups and severe disorders left untreated can cause great distress and disruption to a person's life. Some common anxiety disorders include generalised anxiety disorder, simple phobias, posttraumatic stress disorder, agoraphobia, panic disorder and obsessive-compulsive disorder. Symptoms may include: – A persistent and excessive sense of worry or impending doom – Feeling irritable or unable to relax – Body sensations such as difficulty breathing, a pounding heart, dizziness, sweating, upset stomach – An overwhelming feeling of panic – Difficulty concentrating – Altered perceptions whereby the world may seem unreal. Treatments for anxiety may include counselling, behavioural and cognitive therapies and/or medication. For most people experiencing an anxiety disorder, seeking professional help will result in recovery.
Depression	Clinical depression is more than just temporary unhappiness or feeling down. It is a mood disorder that may be felt as sadness that will not go away and/or an ongoing loss of pleasure and enjoyment in most activities. Depression may impair a person's ability to fulfil their usual social roles. Depression is often accompanied by a range of physical and psychological symptoms including: – Sleep disturbance – Loss of sexual interest – Loss of energy and concentration – Feeling extremely sad or tearful – Feelings of worthlessness, hopelessness and guilt – Inability to cope with decision making – Physical aches and pains – Weight loss or gain – Thoughts of death. Depression may be triggered by major life events such as the loss of a loved one, separation, repeated stress, unrealistic expectations of oneself or ongoing abuse. However, depression may also occur without apparent cause and in people who have previously coped with life well.

Disorder	Characteristics
Bipolar disorder	– Bipolar mood disorder (formerly called manic-depression) is defined by recurrent episodes of extreme mood variation from major depression (as outlined on page 13) to very elevated mood (known as mania). – The symptoms of mania tend to include the following: – Feeling very high and full of energy – Increased levels of activity – Reduced need for sleep – Rapid speech and thought – Irritability and a tendency to get angry – Lack of inhibition – Engaging in risky behaviours – Grandiose plans and beliefs. Bipolar disorder usually has its first onset in the early twenties and occurs equally among men and women. Between episodes of low or high mood, people experience normal mood variation and are able to live full and productive lives. For some people, extreme mood swings occur regularly; for others, the highs or lows may be occasional with years in between.
Schizophrenia	Schizophrenia is a type of psychotic disorder. The term schizophrenia covers several related disorders, all with overlapping symptoms. People with schizophrenia have one personality; they do not have a 'spilt personality'. Some symptoms experienced by people with schizophrenia include the following: – Thought disorder – thought and speech may become jumbled and difficult to follow. – Delusions – where the person holds false beliefs about being persecuted, being under outside control, or of being in some way 'special' or 'powerful'. – Hallucinations – although these can occur in any of the five senses, they most commonly involve hearing voices. The person may experience one or more voices, often threatening or pejorative, commenting on their behaviour or thoughts. Hallucinations are experienced as very real by the individual and can be relentless and disruptive. Other symptoms can include: loss of initiative or motivation, reduced ability to express emotions or respond appropriately to people, withdrawal from contact with other people, and denial of the illness. Onset of schizophrenia is usually in adolescence or early adulthood. Some people experience only one or two brief episodes and recover fully. Others may have to manage their illness throughout their lives. Auditory hallucinations are a common symptom of schizophrenia.

Disorder	Characteristics
Eating disorders	Eating disorders are a group of illnesses characterised by disturbed eating patterns and a preoccupation with body image. Both men and women experience eating disorders, however far more women are affected. There are two major types of eating disorders: – Anorexia nervosa is characterised by a preoccupation with control over body weight, eating and food, with at least 15% weight loss. Symptoms include distorted beliefs about body shape and weight, self-induced weight loss, intense fear of becoming fat, and cessation of menstrual periods. Other symptoms can include depression, exercise rituals, laxative abuse, insomnia, low blood pressure and poor health. – Bulimia nervosa is characterised by an intense fear of weight gain, controlled by restrictive eating patterns, binge eating of calorie-rich foods and attempts to compensate by self-induced vomiting, laxative abuse, or compulsive exercise. While people with anorexia may lose weight to the degree that they endanger their lives, people with bulimia generally maintain a normal weight. Treatment may include nutritional treatment to recover physical health, cognitive-behavioural therapy around beliefs and distorted body image, psychotherapy and/or medication. *Mindframe* has developed specific guidance for the reporting and portrayal of eating disorders which you can access at mindframe.org.au
Personality disorders	Although people who have a personality disorder may experience some of the difficulties listed below, there are many people who lead happy and fulfilling lives. With appropriate support and treatment, it is possible to learn effective strategies to manage some of the challenges associated with these disorders. Personality disorders are a group of mental health issues which involve pervasive and persistent patterns of thoughts, emotions and behaviour that can be distressing, and make daily life difficult.[13] People with personality disorders may find it difficult to adapt their behaviour to different situations and can experience challenges with interpersonal relationships. This can cause distress to the person experiencing the disorder and to others, such as friends, families and colleagues. There are many different types of personality disorders and the signs and symptoms for each one is diverse.[14] Some people with a personality disorder may appear withdrawn, some dramatic and emotional, and others odd or eccentric. People often develop the early signs of a personality disorder in adolescence. People with a personality disorder don't choose to feel the way they do, and they are not responsible for developing the disorder. Personality disorders include: – Antisocial personality disorder – Avoidant personality disorder – Borderline personality disorder – Dependent personality disorder – Histrionic personality disorder

Disorder	Characteristics
Personality disorders *cont*.	– Narcissistic personality disorder – Obsessive-compulsive personality disorder – Paranoid personality disorder – Schizoid personality disorder – Schizotypal personality disorder. It is not currently known exactly what might cause a personality disorder, though there are some known risk factors which might make someone more vulnerable, which include: – A family history of personality disorders or other mental illnesses – Abuse or neglect during childhood – An unstable or chaotic family life during childhood – Being diagnosed with childhood conduct disorder – Loss of parents through death, or a traumatic divorce, during childhood – Other significant traumas. Diagnosis of a personality disorder requires a mental health professional looking at long-term patterns of functioning and symptoms. Diagnosis is typically made in individuals 18 or older. People under 18 are typically not diagnosed with personality disorders because their personalities are still developing. Some people with personality disorders may not recognize that there is a problem. There is support and treatment available for people with personality disorders and their friends and families. For many people, evidence-based psychotherapy is the key to effective treatment. This involves talking and learning about thoughts, feelings and behaviours with trained mental health professionals.
Substance use disorders	Substance use disorders are generally diagnosed when a person has taken one or more drugs over an extended period, and are showing various behavioural, physical and psychological symptoms. Substance use disorders are classified as either substance dependence or substance abuse. Features include: – Tolerance – Withdrawal – Lack of success in cutting down or controlling the use of the drug – Spending a lot of time trying to get hold of the drug or recovering from its effects – Inability to meet obligations with work, family etc.. *Mindframe* has developed guidelines on the portrayals of people who use alcohol and other drugs. According to the guidelines, inaccurate or alarmist portrayals of Alcohol and Other Drugs in the media can lead to the stigmatisation and marginalisation of people impacted by alcohol and other drugs, and their families. People who experience stigma are less likely to seek appropriate help in a timely manner. You can find the guidelines at mindframe.org.au[15]

Disorder	Characteristics
Dissociation and dissociative disorders	Dissociation is a mental process where a person disconnects from their thoughts, feelings, memories or sense of identity. People who experience a traumatic event will often have some degree of dissociation during the event itself or in the following hours, days or weeks. For example, the event seems ‘unreal’ or the person feels detached from what’s going on around them, as if watching the events on television. In most cases, the dissociation resolves without the need for treatment. Some people, however, develop a dissociative disorder that requires treatment. Dissociative disorders are controversial and complex problems that need specific diagnosis, treatment and support. If you are concerned that you or a loved one may have a dissociative disorder, it is important to seek professional help. Symptoms and signs of dissociative disorders depend on the type and severity, but may include: – Problems with handling intense emotions – Sudden and unexpected shifts in mood – for example, feeling very sad for no reason – Depression or anxiety problems, or both – Feeling as though the world is distorted or not real (called ‘derealisation’) – Memory problems that aren’t linked to physical injury or medical conditions – Other cognitive (thought-related) problems such as concentration problems – Significant memory lapses such as forgetting important personal information – Feeling compelled to behave in a certain way – Identity confusion – for example, behaving in a way that the person would normally find offensive or abhorrent. Mental health professionals recognise four main types of dissociative disorder, including: – Dissociative amnesia – Dissociative fugue – Depersonalisation disorder – Dissociative identity disorder. Most mental health professionals believe that the underlying cause of dissociative disorders is persistent trauma in childhood, and the dissociation emerges as a coping mechanism. There are treatments and support available to people who experience dissociation, which typically involve psychotherapy and medication.

Portrayal of suicide

Audience impact

The portrayal of suicide in television drama, film and theatre internationally is widespread. It has increased over time, with depictions of the act of suicide becoming lengthier, more graphic and more sensationalised.[4]

While the portrayal of suicide can be shocking and engaging, evidence suggests that the dramatic portrayal of suicide can have an impact on vulnerable audiences.

- Fictional on-screen suicide may impact on actual suicidal behaviour, increasing the possibility of 'copycat' suicides. For example: A study in the United States found a significant increase in the number of suicides immediately following soap opera stories in which there was a suicide theme.[16]

- A succession of stories about suicide can normalise suicidal behaviour as an acceptable course of action.

- In particular, there appears to be a relationship between the method of suicide portrayed in a fictional film or television program and increased rates of suicide using that method. For example: A study in Germany found that after the screening of a television series depicting the suicide of a 19-year old male there was an increase in suicides by the same method.[17] A study in the UK found that there was a significant increase in cases of self-harm with ingestion of a product in the month in which it was depicted in an episode of Casualty.[18]

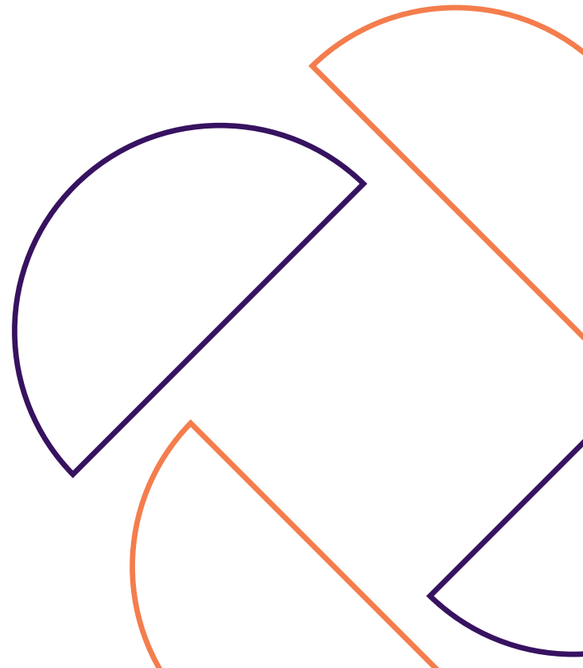
- Preferred portrayals of suicide do not glorify or romanticise it and do not provide visual details of or spoken references to the exact method. Rather more appropriate portrayals depict the consequences for others and provides sources of help for vulnerable viewers.

For a full review of the research evidence, please visit the *Mindframe* website mindframe.org.au

Key issues to consider

Suicide is a prominent public health issue in Australia with over 3000 people taking their lives each year.[2] While suicide used to be a taboo subject, many people are becoming more comfortable talking about it. However, dramatic portrayals of suicide can have a negative impact on vulnerable audiences, leading to increased rates of suicide attempts or deaths. When developing a storyline that might include suicide, you may want to consider the following:

Question	Answer
Why am I introducing suicide into the story?	– Is it to resolve a storyline, or to explore the issue from a personal perspective? – Consider that depictions of suicide may be harmful to vulnerable viewers. – Consider that people who have lost someone to suicide are themselves vulnerable to mental health problems and suicidal thinking and may also be affected by the story.
Should the suicide be portrayed?	– Detailed portrayal of particular methods of suicide have been linked to 'copycat suicides' by that particular method. – If portrayed, consider the length of the depiction and the impact this may have on vulnerable viewers or people affected by suicide. – Might this portrayal of suicide be wrongly interpreted as a solution to a problem? – Could less detail have a better dramatic effect than a graphic depiction? – Does the music, lighting, or setting romanticise or glamorise suicide?
How can I explore the issue with more depth?	– Understanding causes or risk factors for suicide can enhance the portrayal. Many people who attempt or die by suicide have a mental disorder, a drug related illness or other risk factors such as relationship breakdown, financial distress or physical illness. There is no one reason that people attempt suicide. – Showing the impact of suicide on other characters - such as family, friends, colleagues and the whole community - may place the death in a broader context of tragedy and loss, showing the wastefulness of the act. – Different communities, cultures and age groups (e.g. children) have different attitudes to suicide and ways of coping with loss that may provide new insights.
Have I checked the accuracy and authenticity of my portrayal?	– There are many myths and misconceptions about suicide and suicide risk. Accessing reliable information and expert opinion about suicide trends and risk factors is important. – Consider the value in talking to people directly affected by suicide when developing storylines. – For links to accurate information about suicide trends, risks and reflections from personal experience go to the *Mindframe* website at mindframe.org.au
What else can I do?	– Depictions that emphasise consequences for others and sources of support for vulnerable viewers may encourage people to seek help. – Including phone numbers and contact details for support services at the end of a piece (or as part of the drama) provides immediate support for those who may have been distressed or who are prompted to seek help. – Consider including a content warning stating the program, film or show includes depictions of suicide or mental ill-health.



About suicide

Common misconceptions about suicide

The community holds a number of myths and misconceptions about suicide and people at risk of, or affected by, suicide. Below are some common myths and some accurate information that may challenge these myths.

MYTH:
Most suicides occur without warning

- Although there may be some cases where suicide occurs without warning, many people who attempt or die by suicide give verbal or non-verbal clues before the incident.
- Often there has been a history of psychosocial concerns, interpersonal challenges, mental health issues, suicidal ideation and/or prior attempts.
- Many people thinking about suicide will tell someone and some will seek professional help.

Some warning signs: Spending less time with family and friends; expressions of hopelessness; written or verbal notice of intention; self-harm; thinking or talking about death; irrational behaviour; feelings of guilt.

MYTH:
People who attempt suicide are just selfish or weak

- People who attempt suicide are often experiencing strong negative feelings (depression, guilt, fear, anxiety) and may believe there is no other solution.
- People in this situation need professional and personal support, not judgement.

MYTH:
People who talk about taking their own life are just seeking attention

- Any suggestion of suicidal thoughts or threats of suicide should always be taken seriously.
- A person who expresses suicidal ideation or attempts to take their life is in need of support, whether or not they intend to end their life at that particular time.
- Addressing the underlying problems may reduce the risk of future attempts.

MYTH:
Talking about suicide with someone at risk will give them the idea and increase the chance they will take their own life

- Many people may be relieved if the issue is raised in a caring and non-judgemental way, allowing them to talk one-on-one about their feelings and to seek help.
- However, specifically raising the issue of suicide in a group setting (e.g. a school classroom), or in the media without providing an opportunity to talk about the issue one-on-one is not recommended.

For more information on how to talk about suicide, you can visit the web page for *Conversations Matter*, developed by **Everymind**: conversationsmatter.com.au[19]

Some facts about suicide

When portraying suicide and suicide risk, it is important to be aware of trends, risk factors, groups at risk and impacts of suicide so that the portrayal will be both authentic and accurate.

How many people die by suicide in Australia?

- Over the past decade, around 2700 people have died by suicide each year (ABS).[2]
- In 2018, preliminary data showed a total of 3,046 deaths by suicide.[2]
- Although in Australia men generally take their own lives at a rate three times that of women, suicide attempts are more common in women. According to hospital data, between 1999-2000 to 2011-2012, women were hospitalised as a result of intentional self-harm at a rate at least 40 per cent higher than men.[20]
- Using the 'Years of Potential Life Lost' (YPLL) measure, suicide was estimated to account for 80,170 potential years lost in males, 25,429 years in females, and 105,580 potential years of life lost for all persons in 2018.[2]
- During the mid-1980s, suicide rates for 15-19 year old males rose rapidly and peaked in 1988. These rates have gradually declined since the 1990s.[2]

What are some risk factors for suicide?[21]

Not all people who attempt or die by suicide have lived experience of mental health issues. Many factors influence a person to attempt to take their life. These factors may relate to the individual or be social, contextual or situational in nature, and people can experience more than one risk factor at any one time. Where risk factors are present, there is a greater likelihood of suicidal behaviours.

The table below, although not exhaustive, lists known risk factors.

Individual	Socio-cultural	Situational
– Previous suicide attempt – Mental disorder – Alcohol or drug abuse – Hopelessness – Sense of isolation – Lack of social support – Aggressive tendencies – Impulsivity – History of trauma or abuse – Acute emotional distress – Major physical or chronic illnesses, including chronic pain – Family history of suicide – Neurobiological factors	– Stigma associated with help-seeking behaviour – Barriers to accessing health care, especially mental health and substance abuse treatment – Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma) – Exposure to suicidal behaviours, including through the media, and influence of others who have died by suicide	– Job and financial losses – Relational or social losses – Easy access to lethal means – Local clusters of suicide that have a contagious influence – Stressful life events

Source: WHO Public Health Action for the Prevention of Suicide 201215 31

While suicide and self-harm are not exclusive to specific populations or groups, it is important to note that some groups of people are particularly vulnerable to suicide and self-harm. Many individuals fall into more than one of these groups. The table below shows people and groups at higher risk of suicide and suicidal behaviour.[21]

Individuals	Groups
– Children in out of home care – Care leavers (people who spent time in care as a child) – Children and young people in the youth justice system – People who have experienced bullying and victimisation – Survivors of abuse or violence including sexual abuse and domestic violence – People who use or experience domestic violence – People living with long-term physical health conditions – People with untreated depression – People who are socioeconomically disadvantaged – People who misuse drugs or alcohol – People bereaved or affected by suicide – People who do not have strong connections to their culture or identity	– Aboriginal and Torres Strait Islander people – Lesbian, gay, bisexual, transgender and intersex people – Young people – People with severe mental health conditions – Certain occupational groups with increased knowledge of and ready access to the means to attempt suicide (e.g. doctors, nurses, farmers and other agricultural workers) – Some male-dominated industries (e.g. construction and mining) – Some Culturally and Linguistically Diverse (CALD) communities – Asylum seekers and refugees – Prisoners and others in contact with the criminal justice system – Rough sleepers, the homeless and those at risk of homelessness – Older people, especially men – Residents of aged care facilities

Are there protective factors for suicide?

Similarly to risk factors, there are no clear universal protective factors that may decrease the likelihood of a person taking their life. Some known factors include:[21]

Protective Factors

- Being connected or belonging to a family, school or other community, such as a sporting or recreation group
- Having at least one significant person to relate to and bond with (whether that is a family member, a friend or other person)
- Having personal skills and resilience to deal with difficult situations
- Spirituality and cultural or religious beliefs that discourage suicide
- Economic security
- Good physical as well as mental health
- Access to a variety of clinical interventions and support for help-seeking
- Effective clinical care for mental, physical and substance abuse disorders
- Restricted access to means of suicide

What are some of the impacts of suicide?

- A death by suicide can have devastating impacts on family, friends, colleagues, and potentially the whole community. People who have been directly affected by suicide may themselves experience mental ill-health, and are at increased risk of taking their own lives.[21]
- People who identify with the person who has taken their own life (as someone in similar life stage or circumstances to themselves) may be adversely affected by their death and consider suicide themselves as a result.[22]

Contacts and other sources of information

Mindframe website

The website contains information on how to communicate safely and responsibly about suicide, mental ill-health or alcohol and other drugs, and also includes information about self-care, help-seeking and *Mindframe* training sessions.

mindframe.org.au

Support Services

Adult

Lifeline: 13 11 14
lifeline.org.au

Suicide Call Back Service: 1300 659 467
suicidecallbackservice.org.au

Beyond Blue: 1300 224 636
beyondblue.org.au/forums

MensLine Australia: 1300 789 978
mensline.org.au

Youth

Kids Helpline: 1800 551 800
kidshelpline.com.au

headspace: 1800 650 890
headspace.org.au

ReachOut: ReachOut.com

Other resources

Head to Health: mental health portal headtohealth.gov.au

Life in Mind: suicide prevention portal lifeinmind.org.au

SANE: online forums saneforums.org

Aboriginal and Torres Strait Islander: healthinfonet.ecu.edu.au

Lesbian, gay, bisexual, trans, and/or intersex: 1800 184 527 qlife.org.au

Culturally and Linguistically Diverse (CALD): embracementalhealth.org.au

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