Our words matter: Guidelines for language use

Mindframe

Mindframe

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An EVERYMIND program

About these guidelines

Our words matter. The language we use to communicate about mental health and wellbeing, mental health concerns, suicide, and alcohol and other drugs (AOD) can have either a positive or negative impact. We have an opportunity to be more inclusive of people with diverse experiences and views, to reduce harm and stigma and to encourage more people to access and offer support through the words we choose.

We acknowledge that the language used in these guidelines may not reflect the views of all people living in Australia. While using consistent terms and language can have benefits in our public communication, people and communities must also be empowered to find their own way to put words to experiences.

Language evolves. The broad guidance given in this document is a snapshot at this point in time and may not necessarily reflect views of language in the future. These guidelines will continue to be updated to reflect the changes as language evolves, through the voice of people with lived and living experience and the latest research.

Our words matter: Guidelines for language use, was developed by Everymind with funding from the National Mental Health Commission. The resource builds on the most recent research and was developed in consultation with a diverse group of stakeholders in Australia. This included: people with lived and living experience of mental health concerns, suicide and AOD, media and other professional communicators, research experts and diverse community members. The work was steered by a Project Advisory and Research Leadership Group. Please refer to *Development of the guidelines* on page 34 for more information.

Key principles

These guidelines are founded on three principles: firstly, ‘do no harm’; secondly, ‘aim to do good’ and finally, ‘stay curious and be open to change’.

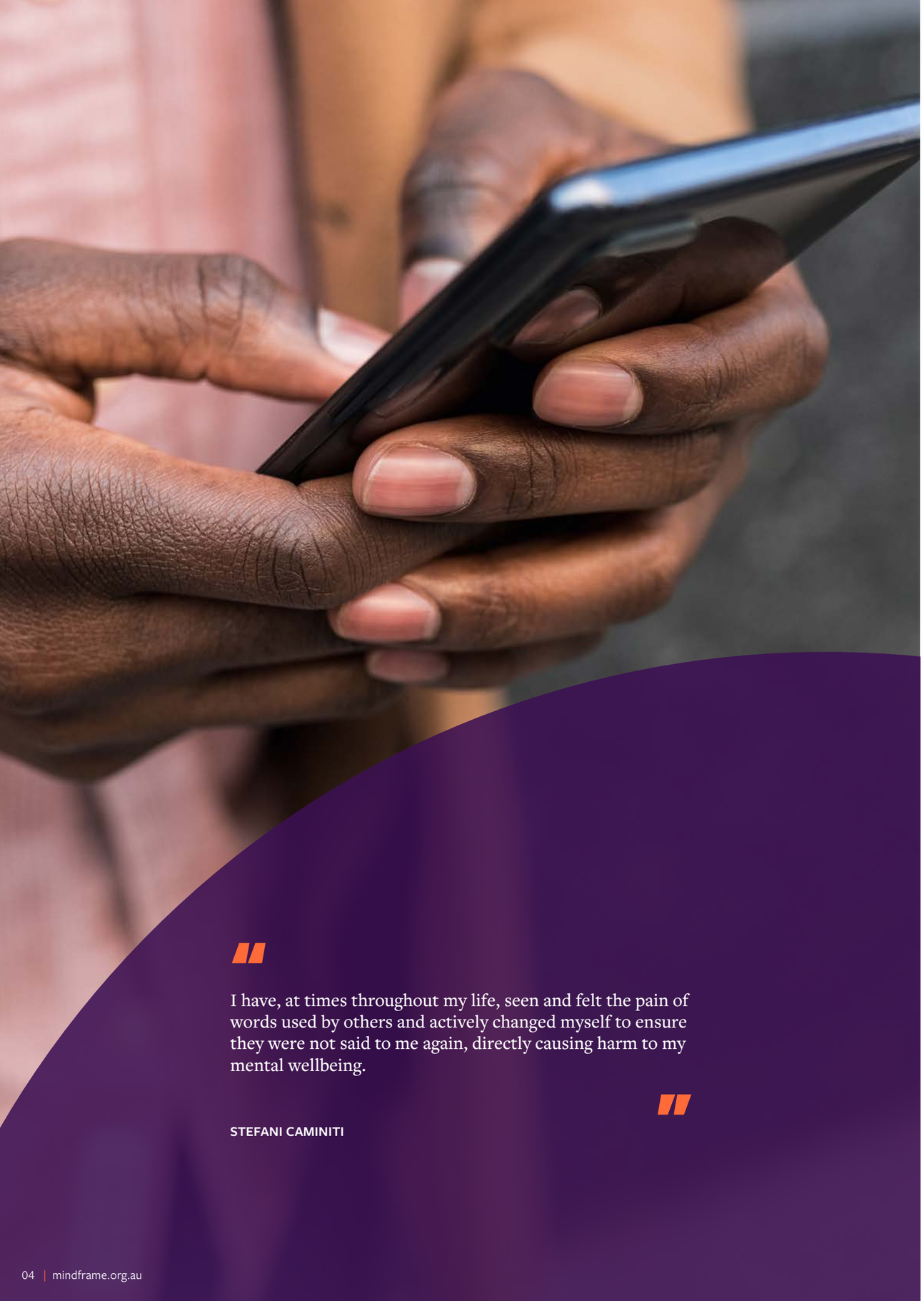
Some words and language that we use can be harmful, with the potential to increase distress, to reinforce stereotypes or to contribute to stigma and discrimination.

The ‘do no harm’ principle encourages us to reflect on the language we use, to avoid terminology that may reinforce harmful stereotypes or contribute to stigma, or that discourages connection and support.

The ‘aim to do good’ principle encourages us to use language that supports connection, promotes inclusion and acceptance of diverse experiences within our communities, and encourages people to seek help and offer support when it’s needed.

The ‘stay curious and be open change’ principle reminds us that language is complex and evolving. Getting this right requires us to act on what the research tells us, listen to people with lived and living experience and continually adapt based on what we have heard.

The guidelines that follow provide best practice advice for how we can apply these principles in everyday communication.



> I have, at times throughout my life, seen and felt the pain of words used by others and actively changed myself to ensure they were not said to me again, directly causing harm to my mental wellbeing.
>
> **STEFANI CAMINITI**

Foreword

From the co-chairs of the Words and Images Project Advisory Group

The words and language we use matters. What we say and how we say it can either engage or alienate others. It can also break down or exacerbate stigma and harm.

For those of us with a personal or lived experience, the day-to-day reality can too often involve exposure to hurtful, stigmatising and thoughtless words and phrases that can dominate thoughts and derail individual and community wellbeing.

Language continues to change and evolve over time and so it is is important that each of us pays attention to the words we use - in our personal and professional communication and in the material we produce.

We are grateful to each member of the project advisory group and to each person, community and organisation that contributed their expertise in the development of these guides and resources.

Please use them and champion their adoption with others, appreciating that what each of us considers to be preferred language will be different and may change over time.

STEFANI CAMINITI
FOUNDER AND CEO, THE INNER NINJA FOUNDATION

DR JAELEA SKEHAN OAM
DIRECTOR, EVERYMIND

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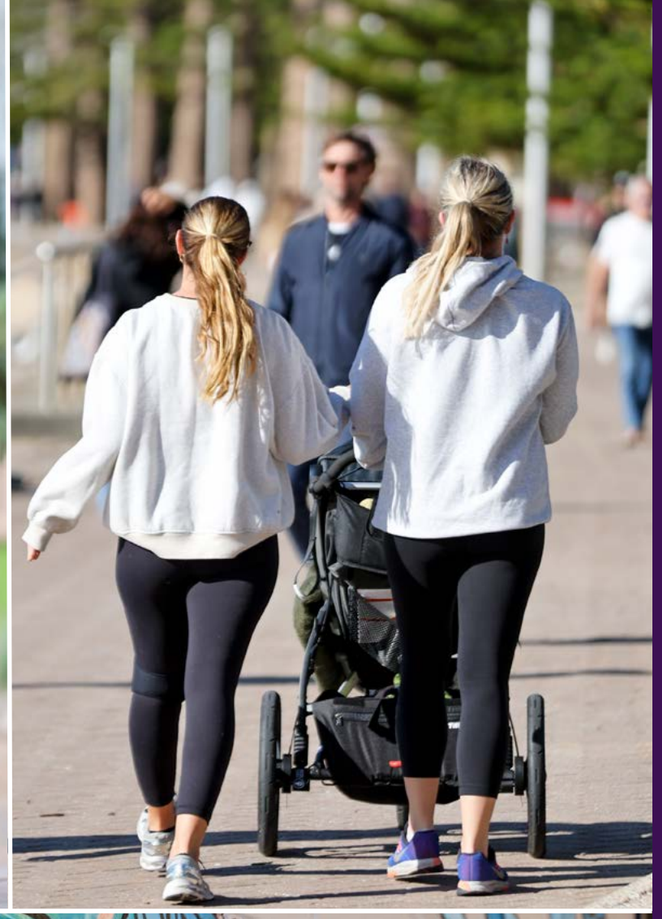


The guidelines

Whether we work in media or communication roles, as clinicians or service deliverers, in policy or programs, or are sharing our personal or community experiences, we all have a role as communicators. The choices we make when using language can have a huge impact.

Use language that empowers and reflects people's lived and living experiences

Adapt language to suit preferences or audience

Use language that is understandable

Avoid language that is sensationalised, including in headlines and titles

Consider the language you use as it can be helpful or harmful depending on the context

- Mental health and wellbeing
- Mental health concerns
- Suicide
- Self-harm
- Eating disorders
- Alcohol and other drugs (AOD).

Use language that empowers and reflects people's lived and living experiences

When we share stories of people with a lived and living experience, it can be powerful. These stories have been shown to reduce stigma, increase understanding and provide hope for others. Language can also empower and promote the ability of individuals and communities to live with complex experiences and enact positive change.

- When deciding on the language to use, it is important to consult with people who have lived and living experience, particularly those whose story you may be sharing.
- Person-first language should be used when describing someone's experiences to avoid defining or labelling a person by their experience.
- Unless a person uses the terms themselves, avoid words that suggest a lack of quality of life, such as 'victim' or 'suffering'.
- Use language that conveys messages of hope, recovery, and overcoming challenges. But take care not to apply this narrative if it doesn't align with an individual's personal experience or story.
- Care needs to be taken with terms that can imply judgments about a person accessing supports, e.g. 'treatment resistant', 'non compliant'.

Preferred	Problematic
Ask a person how they would prefer their experience to be described	Using medical terms without asking if this is a person's preferred way to describe their experience
Someone who lives with suicidal thoughts; a person with a diagnosis of a mental illness	A suicidal person; a mentally ill person
She lives with a depression; he has an experience of mental health concerns	She is a victim of depression; he is suffering from a mental illness
Treatments have not alleviated their symptoms; they have survived a lot; there is hope	They are treatment resistant; they are a lost cause
His needs are not being met; they are needing connection	He is manipulative; they are attention-seeking

"If they see someone that they can identify with and go, "... that could be me". I think that's more powerful than anything else.."

LIVED EXPERIENCE OF ALCOHOL AND OTHER DRUGS FOCUS GROUP PARTICIPANT

Adapt language to suit preferences and audience

The words we use are more likely to connect and engage with people when they reflect the preferences and needs of the audience.

Although consensus about the language we use is sometimes difficult to obtain, where possible, the words used to describe a person's experience should be aligned with their preferences. When sharing a person's story in the media, using their story in a policy or case study or having one-on-one discussions, we should seek clarification on preferred ways to describe their experience.

- Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities may have different beliefs or understandings when communicating about these challenges.
- Terms often used to describe mental illness or suicide may not exist or translate easily in other languages.
- Words used to describe a specific community or population group's experience should be aligned with their preferences.
- Language that acknowledges and honours the diversity of personal experiences, identities, sexualities, genders and bodies can be empowering or healing.

Preferred	Problematic
Asking a person what words they would like used to describe their experience	Making assumptions or adding labels to a person's experience that they do not use
Use of language guides or glossaries prepared by community groups or cultural organisations	Assuming or applying medical or English-based terms that may not be accepted or used by particular communities
Checking for updated guidance on a specific community or population group's language preferences	Using outdated language

Use language that is understandable

To increase understanding, we should use language that is non-judgemental and non-stigmatising, and avoid terms that may not be known or are confusing to a broader audience.

- Public communication should use simple, everyday language, rather than only using medical or clinical terminology, unless the medical or clinical terminology is widely understood and accepted within a particular audience.
- Some terms used in data collection, data releases and academic writing can be stigmatising when used in public communication and should be reworded.
- When presenting data, ensure use of descriptive terms such as 'significant' are consistent with the scientific meaning of the word.
- Care should be taken to use plain English terms to describe outcomes of research rather than research terms that can cause distress.

Preferred	Problematic
Experiencing suicidal distress; thoughts of suicide	Academic terms like suicidality; suicidal ideation
Suicide or self-harm	Intentional self-harm; deliberate self-harm
Further suicides; increase in suicidal behaviour following a suicide death	Coding or data related terms that can be stigmatising such as intentional self harm; deliberate self harm
Comparing the likelihood of suicide between groups; impact of living with illness or injury	Academic terms such as survival modelling; burden of disease; non-fatal burden
Impact of caring for someone who is experiencing mental health concerns	Academic terms like carer burden
Measuring the years of life lost (YLL) due to premature death; years lived with a disability (YLD)	Using only acronyms e.g. DLYs; YLLs; YLDs
Where a person's day-to-day life, relationships with other people or the ability to work are impacted.	Service related terms like psychosocial disability without defining them

Avoid language that is sensationalised, including in headlines and titles

Language should help to inform rather than alarm people. While elements of communication such as headlines or titles are designed to gain attention and encourage audiences to click-through or read further, engagement is not an excuse for sensationalised or alarming language.

- When presenting current data or data modelling of predicted distress or suicides, avoid sensationalist language and use more neutral terms.
- Avoid descriptions of behaviour that imply the existence of mental illness or are inaccurate. Focus instead on terms that more accurately describe individual behaviour.
- Where possible, opt to paraphrase quotes where people have used stigmatising or otherwise inflammatory language in relation to issues such as mental illness or suicide.
- When writing a headline, reflect on whether mentioning a person's diagnosis will sensationalise the issue and is therefore likely to reinforce stigma. Language selection of this kind may miss the key messages within the story, or simply generate an opinion based on the headline itself.

Preferred	Problematic
Increased number of suicide deaths; high risk period; higher rates of suicide	Suicide epidemic; shadow pandemic; surge in deaths; rates skyrocket
Suicide rates predicted to rise unless action taken; action needed to prevent suicide deaths; town with high rates of suicide	Sensationalist language like rates to soar
Unusual behaviour	Labelling language like crazed; deranged; psychotic
Predicted increases in mental distress	Mental health time bomb
Area with high rates of drug use; area of concern	Alarmist language like drug affected town
Person currently using methamphetamine; person seeking treatment for drug dependence	Derogatory language such as meth head; junkie

Consider the language you use and ensure it is appropriate for specific contexts

Context matters. When communicating about these experiences, we need to consider the contexts in which words are used and the ways in which they may affect identity, understanding, attitudes or behaviours.

Mental health and wellbeing

The term 'mental health' should be used to describe a positive concept of wellbeing. We should take care to avoid using it interchangeably to describe mental illness or mental health concerns as these terms have different meanings.

- Avoid using language that implies mental health is a negative state or implies that mental health and mental illness are the same.
- The term 'social and emotional wellbeing' is the preferred term for Aboriginal and Torres Strait Islander peoples as well as some other groups or communities.

Preferred	Problematic
Mental health and wellbeing; mental wellbeing; social and emotional wellbeing	Suffering from mental health
Promote mental health; enhance wellbeing; prevent mental illness; respond early to distress; supporting people with mental health concerns	Prevent mental health; respond to mental health; the concerns of people living with mental health

The term 'social and emotional wellbeing' includes and goes beyond conventional concepts of mental health and mental illness. For Aboriginal and Torres Strait Islander peoples it is the preferred terminology to describe mental health. It is a holistic and whole-of-life view of health that incorporates the physical, social, emotional, cultural and spiritual wellbeing of individuals and their communities[1]. Underlying this perspective is the interconnected nature of individual and community, with community a fundamental part of identity and concepts of self within Aboriginal and Torres Strait Islander cultures. "It also recognises the importance of connection to land, culture, spirituality and ancestry, and how these affect the individual." [2]

The language of distress

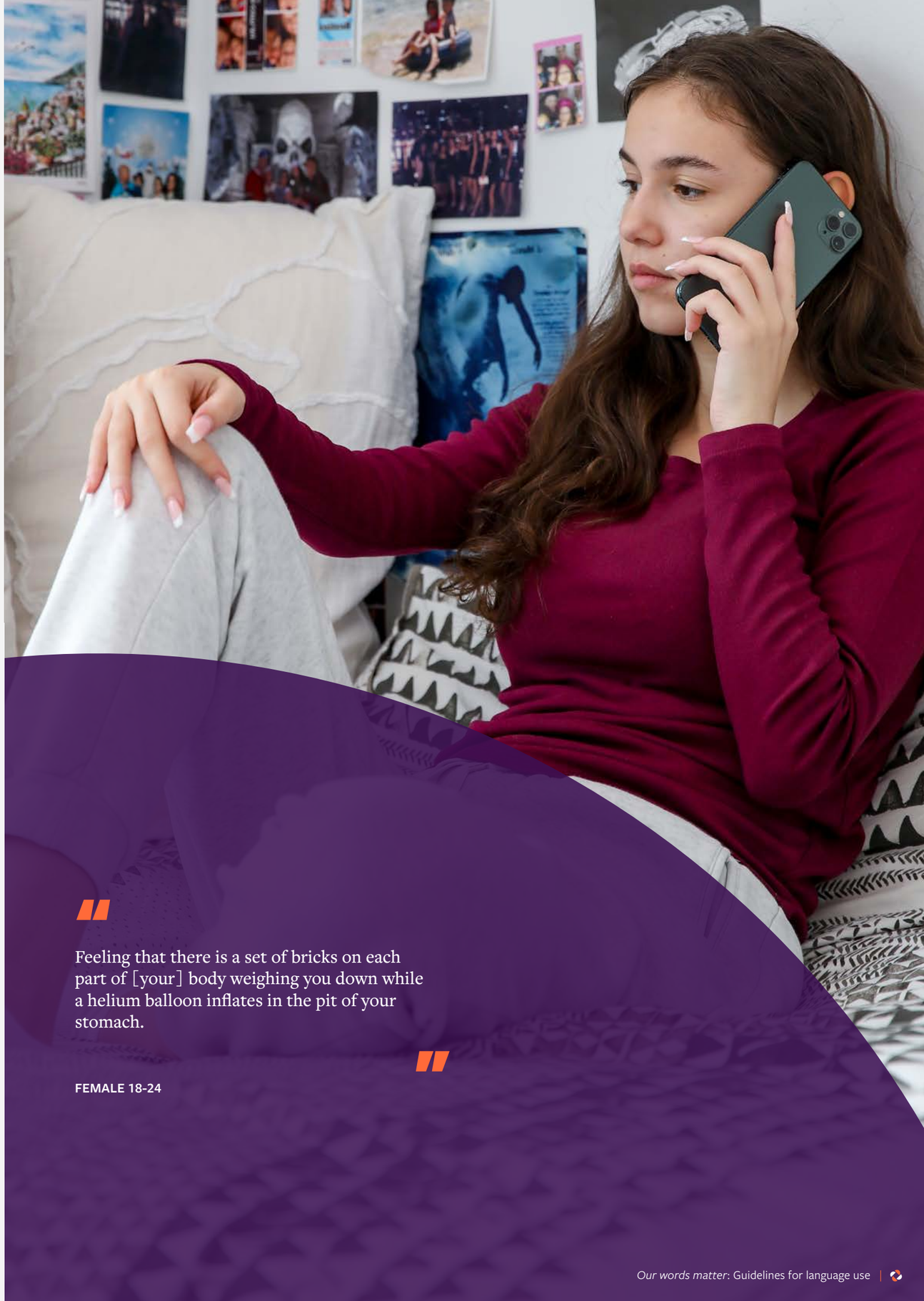
People use a range of words and terms to explain their own experience that may not align with common definitions or diagnostic terms[3].

The language people use is often more descriptive of what it feels like or the impact of the experience.

When people with lived and living experience were asked to describe ‘distress’ they detailed intense physical and emotional experiences.

Despite the intensity of these experiences, distress is often seen as ‘less serious’ in the eyes of the broader community and the service system, creating a disconnect between people who experience distress and what the word indicates to health professionals and others.

Commonly used words	Emotional experiences	Physical experiences
Anxious	Rising panic; feeling of dread or impending doom	Being frozen or paralysed; breaking down in tears
Helplessness	Spiralling; feeling out of control or like everything is falling apart	A rock on my chest; churning stomach; heart racing
Pain	Internal emotional pain; intense emotion	Hands shaking; limb weakness; losing my voice
Unrelenting	Overload of emotions; persistent worry; racing thoughts	Can’t focus or concentrate; lack of sleep



> “Feeling that there is a set of bricks on each part of [your] body weighing you down while a helium balloon inflates in the pit of your stomach.”

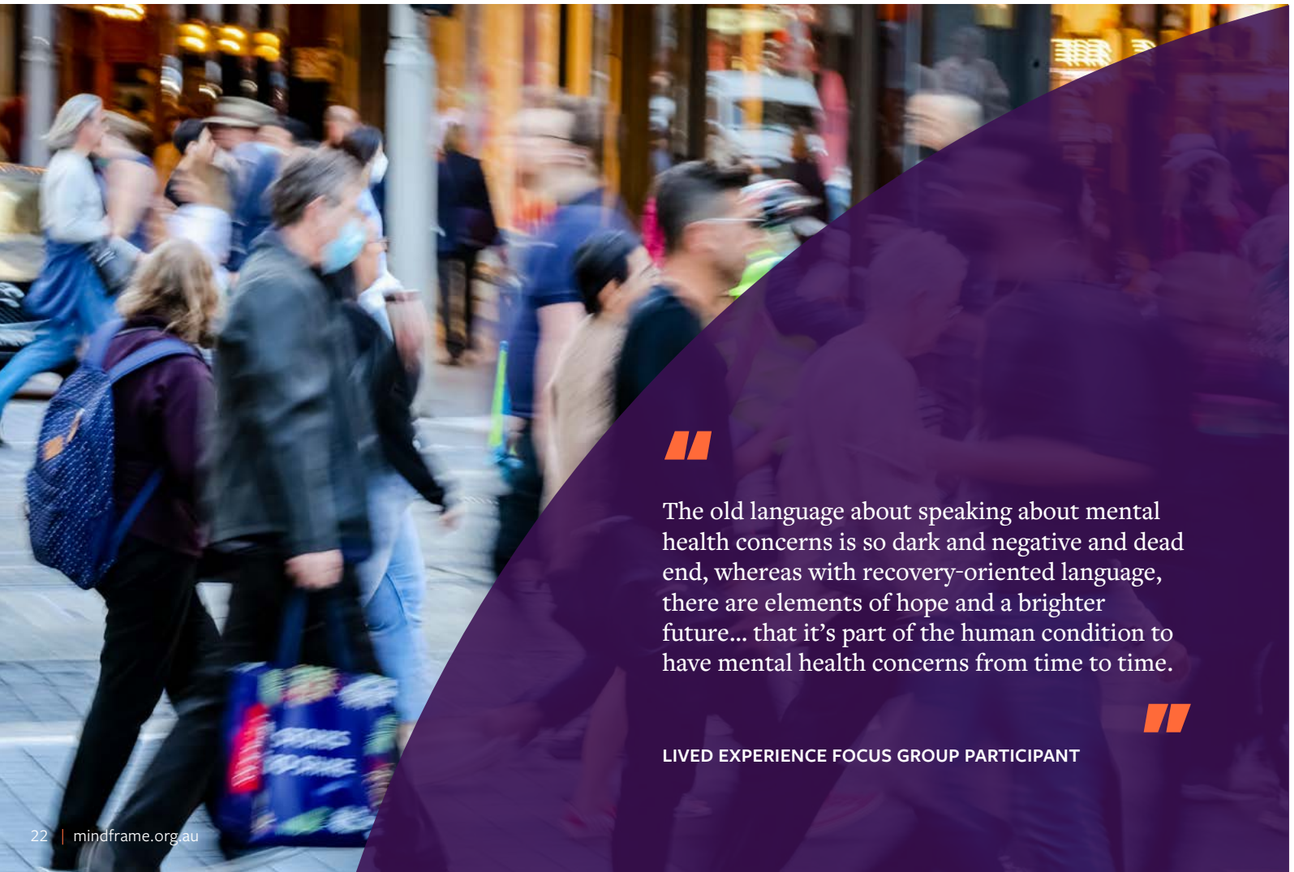
FEMALE 18-24

Mental health concerns

To date, there is no common consensus on whether it is best to use general terms like 'mental illness', 'mental ill-health' or diagnostic terms (e.g. depression, schizophrenia) or, terms that describe experiences, such as 'distress', 'mental health concerns' or 'mental distress' in our communication. However, when these terms are used, they should reflect current definitions (*Our words matter*: Glossary of terms *mindframe.org.au/glossary-of-terms*) and consider the context of the communication.

When we communicate about mental ill-health sensitively and accurately, we can change public misconceptions, challenge myths and encourage community discussion. However, when we use words that undermine a person's experience or are stigmatising, this can have the opposite effect. Where possible, we need to choose language that describes a person's experience of distress or trauma as this experience-focussed language can promote public empathy and understanding.

The current use of mental ill-health has been as an 'umbrella' term to describe mental health concerns and mental illness. This use has generally been in policy settings, in frameworks and strategy communications, and among some service providers. Increasingly, this term is not preferred by people who have a lived and living experience as it does not reflect or describe their own experience.



> The old language about speaking about mental health concerns is so dark and negative and dead end, whereas with recovery-oriented language, there are elements of hope and a brighter future... that it's part of the human condition to have mental health concerns from time to time.
>
> **LIVED EXPERIENCE FOCUS GROUP PARTICIPANT**

- Where possible, language that is being used to describe experiences should be defined or explained so that the audience is aware of the term's meaning and why it is being used.
- Use person-centred language when describing a person who lives with a mental illness or is experiencing mental distress.
- Avoid using outdated and derogatory terms associated with mental illness.
- Use accurate terms to describe treatment and support for mental illness.
- Avoid using language that implies mental health services are similar to prisons (e.g. 'discharged' rather than 'released' from hospital).
- Avoid using diagnostic terms out of context.

Preferred	Problematic
Mental health concerns; mental health challenges; mental health difficulties	Using the term mental health as a negative state or to imply an experience of mental illness
A person living with mental health concerns	Using labels, derogatory terms or slang that is offensive such as mentally ill; insane; mental patient; lunatic; psycho
A person accessing support or treatment for, or living with, a mental illness	Victim of; suffering from; afflicted with; hospitalised for
Has a diagnosis of schizophrenia; accessing treatment for anorexia; living with depression	A schizophrenic; an anorexic; a depressive
Their behaviour was unusual	Crazed; deranged; mad; psychotic
Antidepressants; psychiatrists; mental health workers; support services	Derogatory terms such as happy pills; shrinks; nuthouse
Discharged from hospital	Released from hospital
Clinical or medical terms used only within the correct context	Psychotic driver; schizophrenic economy; bipolar weather

Clinical terms

To date, there is little consensus on whether to use diagnostic terms in public communication about mental illness[4].

It is more common for health professionals, including people working in the mental health and suicide prevention sectors, to suggest using diagnostic language. It is less common for peer workers or people with a lived and living experience to hold this view.

Those against using diagnostic language argue:

- The terms are stigmatised and can have negative consequences for those who are labelled with such diagnoses.
- The terms are not a useful way to describe a person's unique experience.
- The terms are associated with a health system where they may have experienced harm.

Those in favour of using diagnostic language argue that use of these terms:

- Increases visibility and understanding of less common, complex mental illnesses (such as schizophrenia and bipolar disorder).
- Reduces stigma associated with mental illness by framing it like physical and other illnesses.
- Provides 'shorthand' information for health professionals.

From both perspectives, there is a desire to reduce stigma and promote understanding and empathy towards people experiencing mental health concerns.

When we communicate about this issue, we should take time to consider which words may work best to achieve this goal at that time and in that particular context.

> I have examples in my life where it's just appalling, the image people have of what you're capable of if you have a particular diagnosis. And I don't think we should presume that the public are knowledgeable, I think we presume the public have a limited capacity for this knowledge.
>
> **PEER WORKER**

> It's important to target that language, and also, just in the interest of normalising the terms themselves and ensuring that they're not these mysterious and scary labels.
>
> **HEALTH PROFESSIONAL**

Suicide

Discussions surrounding suicide can cover a range of behaviours and impacts. This includes thoughts about suicide, suicide attempts, deaths by suicide and impacts experienced by caregivers and those bereaved by suicide. The language we use to communicate about each of these experiences has the potential to isolate people and reinforce stigma or it can engage and empower people to take action.

- Avoid using language that suggests suicide is a positive or desired outcome, or a 'solution' to problems or life stressors.
- Avoid using the word suicide out of context.
- Avoid using the term 'commit' in communication about suicide as the term's association with crime and/or sin can be stigmatising.
- Avoid giving details about the method or location of a suicide attempt or death.
- Avoid language that broadly relates to methods when discussing suicide or self-harm.
- Avoid labelling people who have attempted or died by suicide by the method used.
- There is conflicting evidence about the use of content advice, but if adding this advice, avoid phrases like 'trigger' or 'trigger warning'.

Preferred	Problematic
Died by suicide; took their own life	Successful suicide; completed suicide; committed suicide
Suicide attempt; attempted to end their life	Unsuccessful suicide; failed suicide bid
Increased rates of suicide; higher rates of suicide	Skyrocketing rates of suicide; suicide epidemic
A person who attempted or died by suicide; he died by suicide	Labelling terms associated with suicide methods
Tragic death; a tragedy	Set free; free from his demons; finally at peace; can rest at last
Refrain from using suicide out of context	Political suicide; suicide pass/ball (in sports); suicide mission
Content advice; the content includes discussion of suicide	Trigger warning

Self-harm

There are many different reasons why someone may harm themselves. The language we use to communicate about self-harm can help to normalise experiences, offer hope or encourage people to seek help and offer support. Other language may be distressing or harmful, making self-harm seem like a solution or helpful coping strategy for our problems or encouraging others to self-harm.

- Avoid using language that trivialises self-harm. Self-harm should always be taken seriously as it indicates underlying distress and the need for effective support.

Avoid language that implies self-harm is manipulative or attention seeking.

- Avoid language that gives details about the method of self-harm.
- Avoid labelling people who self-harm by the method used.

Preferred	Problematic
A person with a lived and living experience of self-harm; she self-harms; he is a person who self-harms	Self-harmer; attempter; attention seeker
They have harmed themselves	Any description of self-harm methods
Experiencing self-harm; self-harming	Attention seeking; manipulating others; going through a phase

Eating disorders

The language we use to communicate about disordered eating and eating disorders can help to increase community understanding and encourage people to seek help or access support services when they need it. Other language may alienate members of the community, increase stigma, trivialise or sensationalise the issue or inadvertently contribute to disordered eating or eating disorders.

- Avoid using language that implies that all eating disorders are the same or all experiences are the same.
- Use person-centred language rather than labelling a person by their diagnosis.
- Use inclusive language. Eating disorders are experienced by all ages, demographics and genders, including men and gender diverse people.
- Always present eating disorders as a serious physical and mental illness and not a lifestyle choice.
- Avoid language that focuses on appearance, size, weight, shape or describing physical measurements.
- Use general terms (avoiding specifics that could be used as a 'how to guide') to describe behaviour without reference to the steps taken, frequency of behaviour or any implements used.
- Avoid language that presents eating disorders as glamorous or as an option for dealing with problems.
- Use plain terms to describe behaviour rather than adjectives or descriptions that imply a value judgement.

Preferred	Problematic
A person with a lived and living experience of an eating disorder; a person with a diagnosis of bulimia nervosa; they are accessing treatment for anorexia nervosa	An anorexic; bulimic; binge-eater
Using language that does not focus on appearance, size, weight or shape	Describing people as thin, skinny, or giving specific weights
If necessary, use general terms such as purging, bingeing, restricting	Detailed and specific information on how a person engaged in behaviours, or frequency of behaviours
Simple language without value judgements	Successful pursuit; unsuccessful attempt

Alcohol and other drugs (AOD)

Public attitudes and beliefs can have a significant impact on individuals who use AOD and have the potential to influence their ability to seek help or access support services. Some of the words we use can be stigmatising for people who use AOD, while more thoughtful language can accurately inform and positively influence community attitudes and lead to reductions in AOD use.

- A person should not be defined by their AOD use. Instead, use person first language and terminology that accurately describes a person's use of AOD.
- Use accurate plain language to describe AOD use rather than colloquial, informal or conversational terms.
- Avoid sensationalist language that may create or encourage moral panic within the community. This includes descriptive terms that may exaggerate facts. Instead, describe trends or patterns as an 'increase' or 'decrease' in use or prevalence.
- Avoid language that may glamorise AOD use, particularly pro-alcohol reporting as this can result in initiation or increased use, especially in young people.
- Avoid combat-related language and terms. General terms are preferred.
- Avoid outdated and derogatory terms associated with AOD use.
- Avoid terms that present people who use AOD as delinquent, violent and morally weak. Instead use language that reflects AOD use as a public health issue.
- Avoid describing someone who uses drugs or previously used drugs as 'dirty' or 'clean'. Instead use language such as 'person who uses or no longer uses drugs'.

Preferred	Problematic
Person who uses drugs; has an addiction to alcohol; a person who uses cannabis	Addict; junkie; crackhead; drunk; alcoholic; pot-smoker
Person with a dependence on drugs; substance use	Drug habit
Person who no longer uses drugs; person who currently uses drugs	Clean; dirty; fallen off the wagon
Respond to or address drug use in the community	Fight or combat drugs; war on drugs
Increased rates of crystal methamphetamine use; concerning rates of substance use	Ice epidemic

Development of the guidelines

Most people in Australia will be affected either directly or indirectly by mental health concerns, suicide, self-harm, disordered and eating disorders and AOD. These experiences are important and need to be discussed by and with the community. But how we communicate about them matters.

The language we use can have either a positive or negative impact on a person's life. Some language used to describe suicide, self-harm and eating disorders, for example, may encourage further harmful behaviours, while certain language around mental ill-health or AOD use can reinforce negative stereotypes and stigma[5,6,7,8].

Language is powerful and is an important tool. Incorporating these guidelines into our personal or professional communication, our work processes and practices, our policies and strategies, will help positively impact people's mental health and wellbeing, prevent harm and reduce distress and stigma.

The National Mental Health Commission funded Everymind to develop these guidelines focused on language related to mental health and wellbeing, mental ill-health, suicide, self-harm, disordered eating and eating disorders, and AOD.

This work was conducted within a research framework to ensure the scientific rigor of the approach, to build consensus and to support effective dissemination of the guidelines and supporting resources.

Everymind has ensured that consultation has included priority populations including people with lived and living experience, Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse populations, LGBTIQ+ communities, men and young people.

The project was initiated through consultation with people with lived and living experience of mental health concerns, suicide and AOD. Additionally, the Words and Images Project Advisory Group and a Research Leadership Group were established to inform project design.

The following activities also informed the development of the guidelines.

1. Scoping review of existing guidelines relating to language use, including guidelines used by media, sector stakeholders and governments in Australia.

2. Scoping review of language used on websites by member organisations from Mental Health Australia and Suicide Prevention Australia.

3. Consultation survey related to stigma, completed by media and professional communicators, sector organisations and people with lived and living experience.

4. Everymind worked with researchers at the University of Newcastle to conduct further consultation and a consensus study.

5. A series of 10 focus groups to further consult with key stakeholders, including people with lived and living experience and from priority population groups to explore their perceptions, attitudes, opinions and beliefs about safe, inclusive and non-stigmatising public representation of mental ill-health and suicide.

6. A Delphi survey to establish consensus between three expert groups (professional communicators including media, sector professionals, and people with lived and living experience) on guidelines statements.

To support these findings and delve further into language use, Everymind worked with researchers at the University of New England and the University of Melbourne to analyse two data sources[3,4].

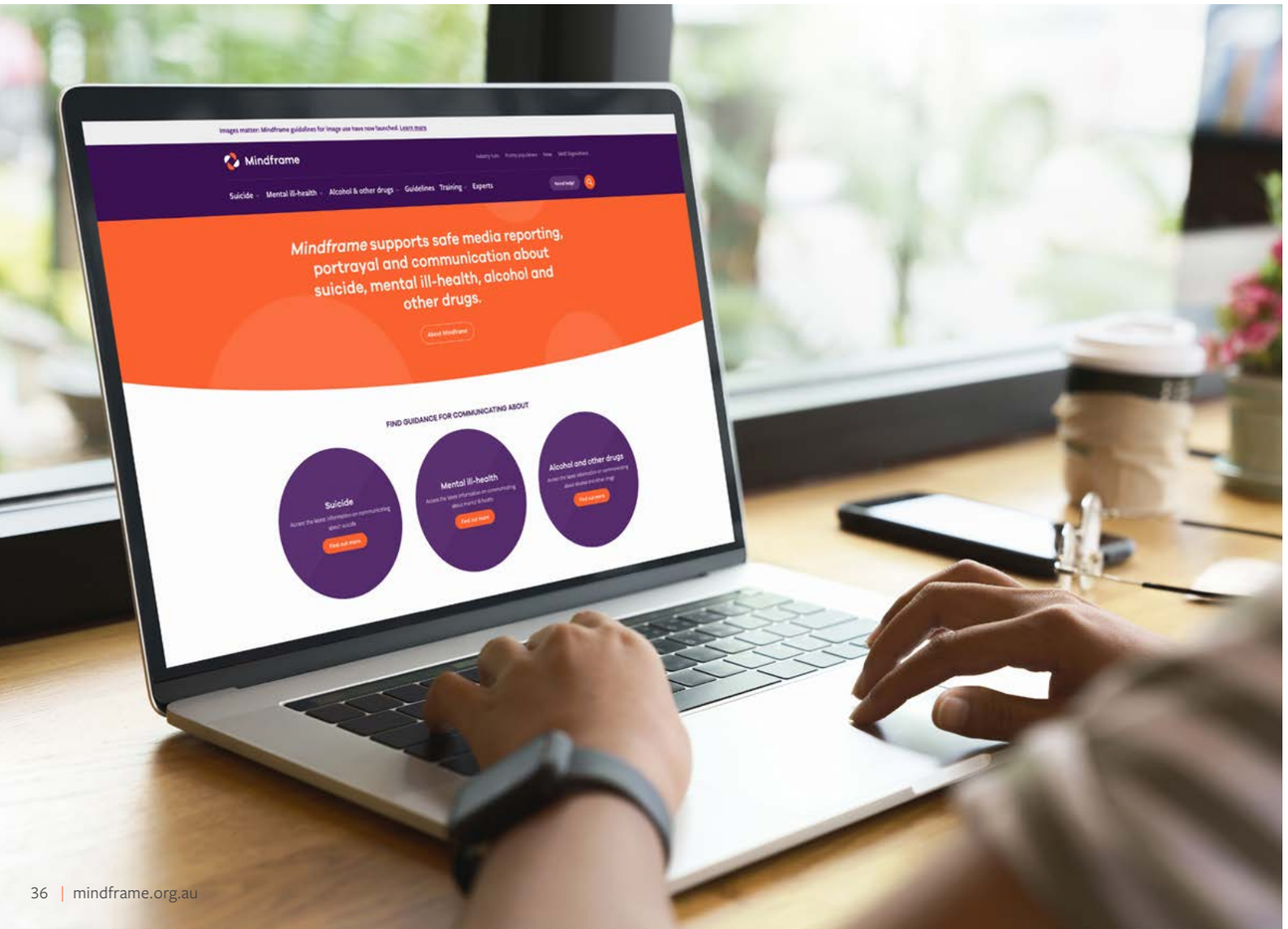
Everymind acknowledges the support of all those involved in the development of these guidelines including members of the: Words and Images Project Advisory Group; Words and Images Project Research Leadership Group; *Mindframe* Media Advisory Group; *Mindframe* Journalism and Public Relations Educators Advisory Group; and participants in the roundtables, focus groups and surveys.

As part of these guidelines, collateral will continue to be created by Everymind through the *Mindframe* program, to support the implementation of the guidelines.

Supporting resources

A suite of supporting resources has been developed to complement these guidelines and aid in their implementation.

- *Our words matter* Guidance cards – quick-use cards designed to provide specific examples of problematic and preferred language so communicators can consider the impacts of their language selection.
- Quick reference guide for researchers – a quick-use guide designed to help researchers apply the advice provided in *Our words matter* to their research outputs, such as journal articles, reports or presentations.
- Quick reference guide for service providers – a quick-use guide designed to help service providers apply the advice provided in *Our words matter* in all areas of service delivery including providing individual or group support, clinical documentation, supervision, and professional development.
- Glossary of terms – this online glossary provides descriptions of broad terms that are currently in use or emerging as preferred terms. This glossary is designed to be updated as the words we use evolve.
- *Our words matter* language checklist - this checklist provides a quick-use overview of the guidelines.



Support services

Lifeline
13 11 14 | Text 0477 13 11 14 | lifeline.org.au

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

StandBy Support After Suicide
1300 727 247 | standbysupport.com.au

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

MensLine Australia
1300 789 978 | mensline.org.au

Butterfly Foundation
1800 334 673 | butterfly.org.au

Priority populations

Aboriginal and Torres Strait Islander
13YARN (13 92 76) | 13yarn.org.au

Lesbian, Gay, Bisexual, Trans, and/or Intersex
1800 184 527 | qlife.org.au

Culturally and Linguistically Diverse
embracementalhealth.org.au

Defence and Veterans

Defence and Veterans Open Arms - Veterans and Families Counselling
1800 011 046 (24/7) | openarms.gov.au

ADF All-Hours Support Line (ASL)
1800 628 036

Youth

Kids Helpline
1800 551 800 | kidshelpline.com.au

Headspace
1800 650 890 | headspace.org.au

ReachOut
au.ReachOut.com

Other resources

Head to Health mental health portal
headtohealth.gov.au

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

SANE Australia online forums
saneforums.org

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