



# Relationships and Suicide Risk

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## Executive Summary

There is a body of existing research that highlights the broad importance, function and impact of healthy relationships on individuals. This report however seeks to draw from this knowledge and better understand how relationships function as protective mechanisms against suicidal distress. In addition, the report builds on this to identify the risk factors of unhealthy relationships and how they can act as a risk factor for suicidal distress.

This report provides an in-depth breakdown of the impacts of relationships across different demographics, their experiences, and consequently their needs. At its core, it is about identifying how to effectively and sustainably support people who love, care for and support people experiencing suicidal distress. The purpose is to illustrate how by coordinating and concentrating supports on relationships, we will be able to improve the wellbeing of those in distress, and those who try their best to support them.

Whilst distress is felt uniquely by every person experiencing it, this report sheds light on collective opportunities for communities, services and systems to work together to alleviate its impact. In undertaking this, a key tool is the National Suicide Prevention Strategy.

One of the groundbreaking features of the National Suicide Prevention Strategy is that it looks at both risk factors and areas in which support is needed through a whole-of-Government, whole-of-community perspective to suicide prevention. In doing so, the Strategy clearly identifies how relationships can act as a mechanism for unifying these factors. As a result, implementing the National Suicide Prevention Strategy provides an ideal starting place to address how to best support families, partners, carers and kin and the accompanying risks and protective factors of these relationships.

The report is divided into three main sections:

- a scoping review of the research evidence
- identifying critical gaps and opportunities – the pathways for change
- providing actionable recommendations



## Scoping review of research evidence

A review of published suicide research literature was undertaken to clarify the association between relational factors, life stages, and events with suicide. The key relational risk and protective factors and suicide interventions addressing them were described.

Family conflict and dysfunction (including intergenerational conflict), domestic and family violence, abuse or neglect, and social disconnection show the strongest associations with suicide. Poor attachment, relationship breakdown or bereavement, and experiences of rejection, discrimination, and bullying also consistently increase risk.

Research on protective relational factors is less developed than on risk factors, but there is clear evidence that social support, relationship satisfaction, and family support protect against suicide. For children and young people, key protective factors include family and social connection, cohesion, and positive attachment, while for older adults the strongest protections are social connectedness, social support, and community participation such as volunteering.

## Identifying gaps and opportunities for impact (pathways)

The intervention evidence base is largely focused on children and young people, with most programs targeting populations already recognised within established socioeconomic and environmental determinants of suicide (SEDS). Effective relationship based interventions include family and couples therapy, attachment based approaches, cognitive behavioural therapy (CBT), safety planning, parenting programs, and social support interventions. Many of these interventions are delivered through emergency departments or health settings following a crisis, typically involving family members through counselling, psychoeducation, skills building, and safety planning.

While the published literature does not capture the full range of practice, it shows a growing recognition of the value of family involvement, peer support, and group-based approaches, with emerging evidence supporting interventions that strengthen social support and connection.

## Recommendations

Building on the research, consultations with stakeholders were undertaken to further identify protective and risk factors, systemic gaps, and key priorities for policy and service reform. Based on the research and consultations several key recommendations emerged:

- **Recommendation 1:** That Governments, Commonwealth, State, and Territory, recognise multi-agency responsibility to incorporate relationships and families as protective and risk factors in the implementation of and investment in the National Suicide Prevention Strategy.
- **Recommendation 2:** That actions 10.1a, 10.1b, and 10.1c of the National Suicide Prevention Strategy in particular be implemented and invested in with urgency, to comprehensively review barriers to involving families, carers and kin in care planning and delivery for people who experience suicidal thoughts and behaviours; co-designing, trialling and evaluating face-to-face and online support programs for families, carers and kin of people who have experienced suicidal thoughts and behaviours; and trialling the integration of carer peer workers in services supporting people who experience suicidal thoughts and behaviours to aid the engagement and support of families, carers and kin.
- **Recommendation 3:** That funding processes for organisations assisting families in preventing and diminishing suicidal risk, and in supporting them following an attempt, be administered in a way that allows the optimal continuity, skilling, sustainability, and growth of the services. These must also allow for partnerships between health and other social services to enable delivery of coordinated and holistic support that addresses diverse drivers of distress for people experiencing suicidal thoughts and behaviours and their family, carers and kin.
- **Recommendation 4:** That families, partners, carers and kin are able to access support at times of distress, equipping families to deal with suicide risk factors. Universal access to aftercare services and the ability to extend that towards supporters, and the provision of Medicare-funded psychological sessions are suggested resources that could ensure families, carers and kin are able to continue supporting the people they love and care for.
- **Recommendation 5:** The Commonwealth Government, and State and Territory Governments, should provide for the development of preventive resources and services for families to access at critical junctures including times of transition such as children leaving school or home, separation or divorce, aged parents entering care, deaths in the family, unemployment, and other distresses that are suicidal risks.
- **Recommendation 6:** That training be increased to equip people likely to encounter people in suicidal distress so they are able to adequately and effectively respond. This includes Government agency personnel in public-facing roles. It also involves enabling the provision of short suicide prevention courses within the community to relevant points of contact, such as sports coaches, pharmacists, barbers, and community groups; to equip community leaders to recognise signs of suicidal distress and referral pathways.
- **Recommendation 7:** That hospital Emergency Departments adopt suicidal distress guidelines to ensure consistent and compassionate approaches to suicidal behaviours, including interactions with families.
- **Recommendation 8:** That data gaps on distress and parental or relationship status be addressed by implementing Action 13.1c of the National Suicide Prevention Strategy to broaden the reporting of suicide-related data, including indicators of wellbeing and suicidal distress associated with the social determinants of suicide, and the experiences of families, carers and kin and those bereaved by suicide.

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**“The protective factor [of relationships] isn’t the absence of risk; it’s the presence of someone who can sit with another person’s pain without trying to fix, assess, or refer it away.”**

(AMY B)



# About us

## Suicide Prevention Australia

Suicide Prevention Australia is the national peak body for the suicide prevention sector. We exist to provide a clear, collective voice for suicide prevention, so that together we can save lives. We support and advocate for more than 300 members ranging from national household name agencies to small community-based organisations and local collaboratives in every State and Territory; as well as individual service providers, practitioners, researchers, students and people with lived experience. This represents more than 140,000 staff and volunteers across Australia.

We aim to drive continual improvement in suicide prevention policy, programs and services. We believe that through collaboration and shared purpose, we can work towards our ambition of a world without suicide.

## Relationships Australia

Relationships Australia is a federation of community-based, not-for-profit organisations that has for over 75 years, provided a range of relationship services to families across Australia, including individual, couple and family group counselling, dispute resolution, services to older people, children's services, services for victims and perpetrators of family violence, and relationship and professional education. We aim to support all people in Australia to live with positive and respectful relationships and believe that people have the capacity to change how they relate to others and develop better health and wellbeing.

While Relationship Australia's services are not specifically designed for suicide crisis intervention, they play a major role in the suicide prevention landscape for two main reasons. Firstly, a disproportionate number of clients accessing services are potentially experiencing a higher risk for suicidality. For example, persons experiencing relationship distress or who are being supported through the family court system. The support provided to these clients by Relationship Australia's tailored programs, can provide the early intervention required to prevent suicidal distress. Secondly, services provided by Relationships Australia address the quality of relationships and positive coping skills at the individual, interpersonal and community levels. This early support can have a beneficial ripple effect across families and communities, fostering suicide prevention further upstream of relational distress, or mental ill-health or crisis.



# Introduction

Family and partner relationships are a cornerstone of everyday life. When these relationships are supportive, families, carers and kin can play a vital role in suicide prevention, with connectedness, warmth, and support allowing families and relationships to offer a unique support to people in suicidal distress. This support is a private but essential protective factor, and one which needs recognition for the comfort it provides.

However, distress caused through breakdown or harm within these relationships increases suicidal risk. Social isolation and loneliness, also strongly associated with suicidality, can originate from interpersonal relationship dysfunction as well as from individual, community, or societal level influences.

This connection to suicidal risk is well recognised, and repeatedly underscores suicide prevention frameworks, including the National Suicide Prevention Strategy. It is also well established that relationships can alleviate or diminish suicidal risk through protective factors that are similarly highlighted throughout frameworks. However, there has not yet been a concerted effort to align these risks and protective factors into a cohesive response. They remain an essential but disconnected aspect.

Governments invest significant budget allocations into family support, dealing with the impact of harm and breakdown, clinical and medical responses, but there is no strategic, coordinated response to addressing distress and investing in the protective factors. Because relationships, their impact, and their risk factors are embedded across multiple life domains, there is a paradoxical tendency for investment in them to be haphazard and disjointed. This is evident where multiple government departments are delegated responsibility for different aspects (from education to aged care, family support to priority populations) without necessarily engaging in coordinated efforts.

People living in Australia need meaningful, safe and supportive interpersonal and social relationships for mental health and wellbeing. However, relationship distress and social isolation are major contributors to suicidal distress.<sup>1</sup> It is well understood that periods of relationship difficulties, especially relationship breakdown, present heightened risks of suicidal ideation among adults. They also have a significant impact on the wellbeing and resilience of children.

Suicide Prevention Australia conducts a regular Community Tracker to provide timely insight into the social and economic issues driving distress and subsequent suicide risk in Australia. Family and relationship stress is currently the second biggest suicide stressor, with 27.5% of respondents citing its impact.<sup>2</sup> Family and relationship stress has consistently recorded levels between 20-30% since the survey was initiated in December 2022, always appearing in the top four causes of distress.

<sup>1</sup> Wilson, M. J., Mansour, K., Seidler, Z. E., Oliffe, J. L., Rice, S. M., Sharp, P., Greenwood, C. J., & Macdonald, J. A. (2025). Intimate partner relationship breakdown and suicidal ideation in a large representative cohort of Australian men. *Journal of affective disorders*, 372, 618–626. <https://doi.org/https://doi.org/10.1016/j.jad.2024.12.071>  
<sup>2</sup> Suicide Prevention Australia. (2025) Community Tracker – September 2025. Suicide Prevention Australia. <https://www.suicidepreventionaust.org/wp-content/uploads/2025/09/Suicide-Prevention-Australia-Community-Tracker-1.pdf>

Social isolation, defined as having ‘...*objectively few social relationships or roles and infrequent social contact*’<sup>3</sup> is also a serious risk factor for suicide, identified in 24.6% of respondents in the Community Tracker. In 2023, around 15% of people in Australia (aged 15 years and over) were experiencing social isolation, according to the Household, Income and Labour Dynamics in Australia (HILDA) survey,<sup>4</sup> which was more pronounced for males (17%) compared to females (13%). Loneliness is defined as ‘*A subjective unpleasant or distressing feeling of a lack of connection to other people, along with a desire for more, or more satisfying, social relationships.*’<sup>5</sup>

At the same time, the protective nature of healthy, supportive relationships cannot be overstated. People who are connected and enjoy respectful relationships experience greater wellbeing and are more resilient to psychosocial risk factors of suicide.<sup>6</sup> Fostering interpersonal and community level relationships are crucial to preventing suicidal distress and supporting those with experiences of suicide (either directly or through those close to them).

Despite this, public policy in the suicide prevention space has been largely focused on medical interventions and acute responses (secondary prevention), with insufficient focus on the significant benefits of promoting strong interpersonal and social relationships (primary prevention). The aim of this white paper is to draw attention to the importance of focusing on relationship wellbeing as a critical preventative tool for policy makers and service providers.

### Definition:

*In the context of this paper, a relationship can be defined as a significant connection one person has with another, through origin or through choice. For many, the most direct and immediate relationships include those with family, carers and kin. In addition, people can be connected through shared culture, interests, workplaces and community settings such as religious groups, education institutions and sporting communities). Whilst this paper focuses on the risk and protective factors of relationships with family members, partners, carers and kin, it will also address the role of these broader social relationships. Particularly, this paper recognises and emphasises that community members and everyday social interactions can play a key role in recognising and responding to distress to reduce suicide risk.*

## Family and relationship distress in the Suicide Prevention Australia Community Tracker

- The Suicide Prevention Community Tracker has been measuring distress causes in the community since 2022. Over that time, on average around a quarter of people in Australia aged 18 and older have experienced distress due to family and relationship breakdown (24%).
- Longitudinally, this distress ranged from 2 to 3 in 10 people in Australia.
- Females more often experience distress of this nature than males (27% vs 21%).
- Among age groups, 18 to 24 year olds had the highest percentage of distress, with a third experiencing distress (33%). Other age groups ranged from 23-27%, while those aged 65+ only had 17% cite family and relationship breakdown distress.
- Persons who are not married had a higher percentage of distress vs married people (27% vs 22%).
- Those with children had a higher percentage of distress compared to those without (29% vs 22%).
- There were no significant differences between states with South Australia recording the highest percentage (28%) and Western Australia the lowest (21%) with most around 25%.
- 37% of people who sought advice from a suicide prevention provider cited family and relationship breakdown distress while 21% of those who didn't seek advice cited it.
- 41% of people who experienced suicidal behaviour cited relationship breakdown distress compared to 21% who did not experience suicidal behaviour citing relationship breakdown distress.

3 Badcock JC, Holt-Lunstad J, Garcia E, Bombaci P and Lim MH (2022) Position statements on addressing social isolation, loneliness and the power of human connection, accessed 9 February 2024, Global Initiative on Loneliness and Connection. P.11 <https://www.gilc.global/about-us/our-position-statements>

4 Wilkins, R., Vera-Toscano, E., & Botha, F. (2023). The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 21. In *The 18th Annual Statistical Report of the HILDA Survey*. Melbourne, VIC: Melbourne Institute: Applied Economic & Social Research, the University of Melbourne.

5 Badcock et al. (2022) p. 11

6 Relationships Australia. (2018). *Is Australia Experiencing an Epidemic of Loneliness?: Findings from 16 Waves of the Household Income and Labour Dynamics of Australia Survey*. Kingston, ACT: Relationships Australia.

# Methodology

This report follows a mixed methods methodology comprising a scoping review of the research evidence followed by stakeholder consultation.

## Scoping review of published literature

A scoping review of the published literature took place during January 2025. A systematic search was performed using Ovid Medline, Ovid PsycINFO, CINAHL, Joanna Briggs Institute, and the Cochrane Database of Systematic Reviews for terms relevant to family and relationship and suicide risk and protective factors and suicide prevention.

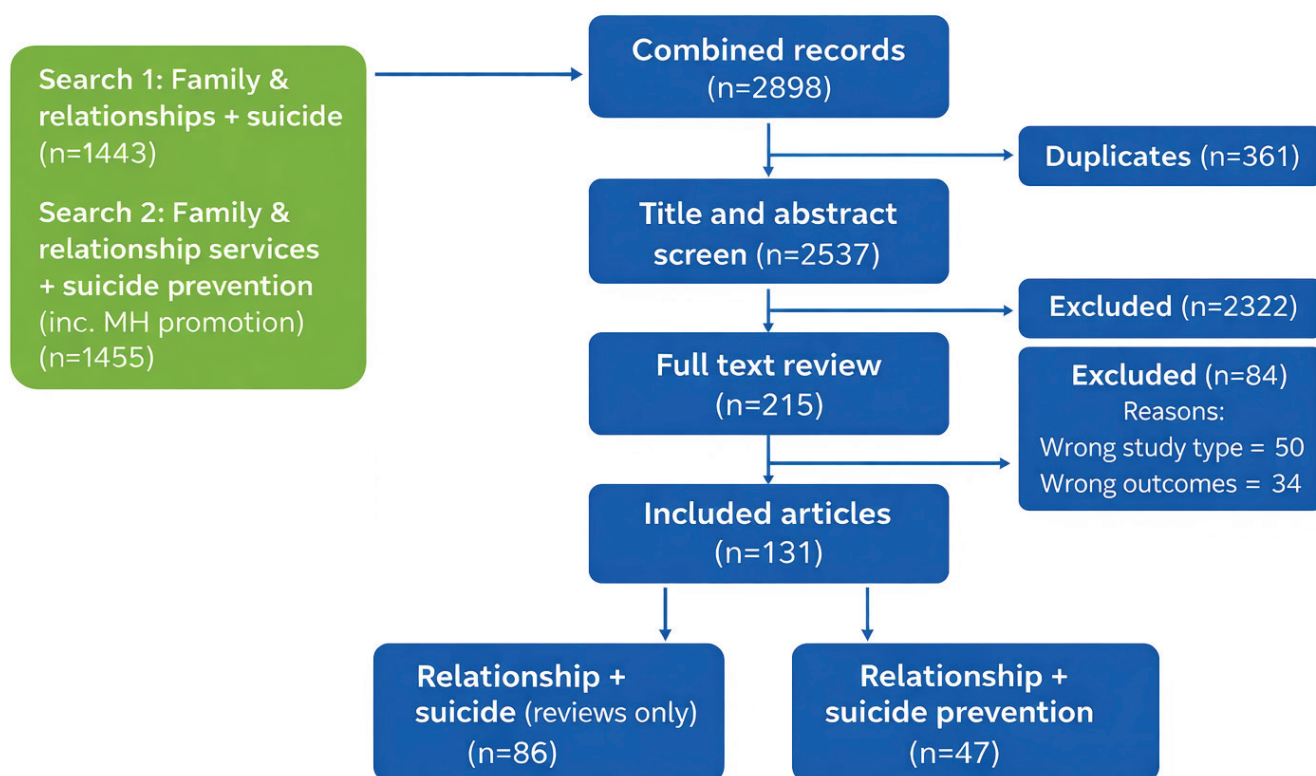
After screening and full text review, a total of 131 articles were included. The first part comprised review articles involving relational risk and protective factors and suicide. Half of the reviews (n=43) were not age group specific, with 33 concentrating on children and young adults (n=33), and ten describing older adults aged 65 years. The second part comprised of 47 intervention studies and reviews that both addressed relational factors and measured suicide as an outcome (see Table 2). Most of the published prevention research pertained to children and young people (n=35).

This report also refers to publicly available data from Relationships Australia and Suicide Prevention Australia, along with relevant Australian reports and literature.

## Stakeholder consultation method

Suicide Prevention Australia conducted one-on-one consultations with key representatives across the organisation's membership base. Participants were selected based on their direct involvement in service delivery and advocacy relating to relationship support, family dynamics, suicide prevention protective factors, loneliness, and work with targeted or priority populations.

A deliberate sampling approach was adopted to ensure diverse representation, including organisations and services working with men, women, young people, culturally and linguistically diverse (CALD) communities, Aboriginal and Torres Strait Islander peoples, and older adults. Consultations were conducted between May and October 2025, and comprised 45-minute online sessions using a structured discussion guide. Questions were primarily open-ended to elicit qualitative insights, with a focus on identifying protective and risk factors, systemic gaps, and key priorities for policy and service reform.



# Scoping review of research evidence

International studies show that a lack of warm, supportive family relationships can increase the risk of suicidality. In adolescents, studies have found that lack of parent support can predict suicidal ideation<sup>7</sup> and that family discord, troubled mother-child relationship, and familial lack of warmth can increase risk of suicide.<sup>8</sup>

While partnered relationships can provide positive physical and mental health benefits,<sup>9</sup> difficulties in relationships with a partner are also linked to suicide, with one study finding that the period up to four years before a separation was a time of increased risk for suicidal thoughts and behaviours.<sup>10</sup> In the Australian context, the Australian Institute of Health & Welfare (AIHW) includes 'problems in relationship with spouse or partner' and 'disruption of family by separation and divorce' in the most frequently occurring psychosocial risk factors in coroner-certified suicide deaths.<sup>11</sup> A report by the AIHW also indicates that Indigenous Australian children who die by suicide are more likely to live in a non-parental residence.<sup>12</sup>

Relationship distress can affect individuals across the lifespan, including intergenerationally, for example between older adults and their adult children.<sup>13</sup> Distress and dysfunction can also originate from groups outside of the family, for example having peers that experience suicidality, and from workplaces and the broader community, for example bullying, discrimination and social exclusion. Broader relational risk factors for suicidality include lack of social support, inclusion and connection, and experiences of loneliness. While outside of partnered relationships and the immediate family, these relational factors are known to affect mental and physical health and potentially contribute to suicidal crises.<sup>14,15</sup>

Intersecting with these interpersonal, community and social risk factors, are established factors referred to here as the socioeconomic and environmental determinants of suicide (SEDS).<sup>16</sup> These include: chronic pain and health conditions; contact with the justice system; damage to cultural continuity/connection; discrimination/stigma; domestic, family, sexual violence; education disruption; financial distress; harms of alcohol and other drugs; harms of gambling; housing insecurity and homelessness, impacts of adverse childhood experiences and traumatic events; social isolation and loneliness.

7 Brausch, A. M., & Decker, K. M. (2014). Self-esteem and social support as moderators of depression, body image, and disordered eating for suicidal ideation in adolescents. *Journal of abnormal child psychology*, 42, 779-789.

8 Hollis, C. (1996). Depression, family environment, and adolescent suicidal behavior. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 622-630.

9 Wilson, M. J., Scott, A. J., Pilkington, V., Macdonald, J. A., Rice, S. M., Oliffe, J. L., & Seidler, Z. E. (2025). Suicidality in men following relationship breakdown: A systematic review and meta-analysis of global data. *Psychological Bulletin*. <https://doi.org/10.1037/bul0000482>

10 Batterham, P. J., Fairweather-Schmidt, A. K., Butterworth, P., Caley, A. L., Mackinnon, A. J., & Christensen, H. (2014). Temporal effects of separation on suicidal thoughts and behaviours. *Social Science & Medicine*, 111, 58-63

11 The Australian Institute of Health and Welfare. (2023). *Psychosocial risk factors and deaths by suicide*. Available from: <https://www.aihw.gov.au/suicide-self-harm-monitoring/data/behaviours-risk-factors/psychosocial-risk-factors-suicide>

12 The Australian Institute of Health and Welfare. (2021). *Connection between family, kinship, and social and emotional wellbeing*. Available from: <https://www.indigenoumshspc.gov.au/getattachment/e129c621-58a4-4966-8730-dcf6e3a533a8/dudgeon-et-al-2021-family-kinship-20210802.pdf>

13 Wong, S., Harvey, S., Frost, M., and Althor, G. (2023) *Hidden Gems: The Unique Role of Collaborative Approaches in Preventing and Responding to the Abuse of Older People*. Sydney: Relationships Australia NSW.

14 Motillon-Toudic C, Walter M, Séguin M, Carrier J-D, Berrouguet S, Lemey C. (2022). Social isolation and suicide risk: Literature review and perspectives. *European Psychiatry*, 65(1), e65, 1-22. <https://doi.org/10.1192/j.eurpsy.2022.2320>

15 Heuser, C., & Howe, J. (2019). The relation between social isolation and increasing suicide rates in the elderly. *Quality in Ageing and Older Adults*, 20(1), 2-9.

16 Suicide Prevention Australia. (2023). *Socio-economic and environmental determinants of suicide*. Sydney: Suicide Prevention Australia.



Individuals may experience several of these at once; particularly vulnerable groups and populations of interest in terms of suicidality can also be identified via these factors. Groups known to experience suicide at higher rates in Australia include: males; young persons; those living in regional, rural and remote areas; older persons; First Nations Peoples, members of the LGBTQIA+ community; culturally and linguistically diverse persons, including migrants, refugees and asylum seekers; and people living with disabilities. Keeping these socioeconomic and environmental determinants in mind when addressing other suicide risk factors can lead to more sensitive and nuanced approaches to prevention.

Our scoping review identified 86 review articles describing relational factors associated with suicide in the published research literature; of these 33 described children and young people, ten addressed older adult suicide, and 43 were not age or life stage specific. Table 1 provides an overview of the relational factors studied, and those found to be significantly associated with suicide, alongside typical life events.

## The protective factors of families and relationships

We found fewer reviews (39/86, 45.3%) describing relational factors that were protective against suicide, and of these, there was less statistical evidence of the association of these factors with suicide (21/39, 53.8%). There is clear evidence, however, that social support, relationship satisfaction and family support are protective against suicide (Table 1).

Of the 33 reviews describing relational factors in children and young people, 17 describe protective factors for suicide. The strongest evidence was for family cohesion/connection, and social support and support from family members. Other factors found to have a protective impact included family intactness, positive attachment or parent-child dynamics, and relationship satisfaction, as well as social connectedness (i.e. the frequency of social contact).

Seven of the ten reviews describing older adult suicide measured protective factors, of which two systematic reviews identified significant associations with reduced risk. Social support and relationship satisfaction were found in both studies.<sup>17</sup> Living with others and family support, as well as social connectedness, social inclusion (i.e. group membership), and community participation (including volunteering), were also linked to lower risk.

Fifteen of the 43 reviews described protective relational factors across age groups (excluding children), where the strongest evidence was for social support. Family support, relationship satisfaction, and social connectedness were also linked to reduced suicidality.

<sup>17</sup> Ki, M., Lapierre, S., Gim, B., Hwang, M., Kang, M., Dargis, L., Jung, M., Koh, E. J., & Mishara, B. (2024). A systematic review of psychosocial protective factors against suicide and suicidality among older adults. *International psychogeriatrics*, 36(5), 346–370. <https://doi.org/https://dx.doi.org/10.1017/S104161022300443X>

## Suicide protective factors and the Relationship Indicators survey

In 2024, the Relationship Indicators survey found that:

### Relationship quality and satisfaction

64% felt their relationship was very, extremely or completely friendly

People in partnered relationships reported 6.1% less loneliness (18.3% vs. 24.2%), and 7.6% more life satisfaction (71.7% vs. 63.1%) than the general population.

For respondents who experience long-term mental illness, good reported mental health in the last 6 months was characterised by: their partner being their most important person (56.4%); living with their most important person (73.1%); describing their relationship as good (50.6%); and identifying friendship groups as playing an important role in their life (64.1%).

### Social support, connectedness and inclusion

For 55.1% of respondents, groups played an important role in their life; predominantly friends (59%), colleagues (38%), community groups (16%) and sporting groups (13%). People who were involved with groups reported more life satisfaction, and less loneliness, than those who were not.

When respondents experienced relationship difficulties, 37% sought help from friends, and 33% sought family support.

Those who were not socially lonely tended to go to friends for support (and reported more satisfaction in their relationships). Those who were not emotionally lonely reported better relationship quality, for example feeling safer disagreeing in their most important relationship, compared to the population average



## The risk factors of families and relationships

Most of the 86 articles identified in the first part of the scoping review (n=81, 94.2%) described relational risk factors associated with suicide, and 86.4% (70/81) of these reported statistically significant associations. The most prolific associations with suicide were found with family conflict and dysfunction (including intergenerational conflict), domestic and family violence, abuse and neglect (including childhood abuse), and lack of social connection. Poor parent-child and other familial attachment, intimate partner relationship breakdown or bereavement, and rejection, discrimination and bullying were also consistently linked to suicidality.

These are detailed according to life stage and priority populations below.

### Children & young people (24 years and under)

The majority of the published reviews describing relational factors for children and young people included risk factors for suicide (31/33 reviews, Table 1). Most of these articles reported on lack of social connectedness, family conflict or discord, domestic and family violence, abuse and neglect (that includes childhood experiences), and relationship discord more generally, all of which are established suicide risk factors (Table 1). Factors most often significantly associated with suicide in children and young people were around family conflict (including intergenerational conflict), followed by domestic and family violence, history of family or parental suicidality or mental health challenges, and poor parent-child relating.

Family structure factors, including parental divorce and single-parent households, bullying and rejection, and lack of social support, were also significant risk factors for child and youth suicide. There was inconsistent evidence for loneliness as a suicide risk factor for children and young people, despite being measured by the majority of reviews.

Specific populations of interest included very young children, First Nations young people, and youth from migrant or military families, those with enduring mental health challenges or neurodiversity, LGBTQIA+ youth, youth at risk of and experiencing homelessness or that have been in contact with the justice system, those that have experienced abuse or parental suicide, or have transitioned to higher education.

### Older adults (65 years and over)

In the review articles specific to older adults, family dysfunction and conflict, as well as lack of social support, living alone, and loneliness were consistently found to be significant relational suicide risk factors (Table 1).

Lack of social connectedness and discord in relationships more generally, were also established factors for suicide in older adults, as was bereavement, living alone, and being unmarried, separated or divorced.

Life events affecting the older adult group included bereavement, long term illness, and transitions into long-term care.

### All adults (18 years and over)

Within the reviews that described suicide risk across age groups more generally, lack of social connectedness, loneliness, and lack of social support were the relational risk factors most often reported on. However, it was domestic and family violence (including childhood abuse and neglect), family dysfunction (including intergenerational conflict) and lack of social support that were the most often statistically associated with suicide (Table 1). Poor relationship quality (i.e. dynamics/attachment between family members), marital problems (including divorce or separation) and family histories of suicidality and mental illness were other relational factors commonly associated with suicide across the general population.

In addition to the groups identified among the papers describing younger and older age groups, these reviews included focus on carers, persons living with chronic disease and illness, victims of domestic and family violence, farmers and their families, members of the LGBTQIA+ community, people with mental health diagnoses, those who had a mentally ill or suicidal parent, migrant and culturally and linguistically diverse communities, those with multiple suicide attempts, and veterans of active military service.

## Suicide risk factors and the Relationship Indicators survey

The Relationship Indicators is a longitudinal survey of the state of relationships for a representative sample of people living in Australia.<sup>18</sup> Included in the findings of the 2024 survey were:

### Relational conflict and discord

In 2024, 23% less people strongly agreed their relationship was good or full, and 21% less people strongly agreed their relationship was sturdy or enjoyable, compared to 2022.

For those whose most important relationship was also their most challenging, 44% characterised the relationship as conflictual, 28% reported feeling distressed, or very distressed by the relationship, and reported higher relationship dissatisfaction.

21.2% (equivalent to 4.3 million people in Australia) reported that their partner was their most challenging relationship. 29.8% felt distressed about the relationship, and 18.8% did not feel safe disagreeing with their partner.

### Intimate partner separation

Research into the ongoing effect of partnered relationship breakdown using data from the 2022 Relationship Indicators survey, found that post-separation, the most common longer-term impacts among respondents were emotional or mental health issues (44%). This included depression, anxiety, low self-esteem, trust issues, trauma, PTSD, abandonment, grief, and loneliness. Those reporting lasting impacts from a relationship breakdown were also 1.5 times lonelier than those who didn't report ongoing effects.

### Domestic and family violence

12% felt unsafe disagreeing with their most important person, and among those who felt not at all safe in their closest relationship, fear for wellbeing / worried it could become verbally abusive or aggressive also emerged as a key concern (63%).

When asked about post-separation experiences, 7% felt hostile or hateful towards their ex-partner, and 5% had angry disagreements with them.

### Loneliness

24% of respondents (equivalent to 5.1 million people in Australia) reported they often felt very lonely; this increased to 42% for those distressed due to relationship pressures.

55.1% of those who said groups did not play an important role in their lives felt socially lonely (compared to 37% in population).

46.3% of those that did not rely on others for support, and 42.8% of those feeling unsafe agreeing with their most important person felt emotionally lonely (compared to 21% in the population).

<sup>18</sup> Relationships Australia (2024). Relationship Indicators 2024. Full Report. Kingston, ACT: Relationships Australia.

**Table 1. Summary of life events and relational risk and protective factors for suicidality according to life stages**

LIFE STAGE	LIFE EVENTS	RISK FACTORS	PROTECTIVE FACTORS
<b>Children &amp; young people</b> (≤24 years) (33 reviews)	Leaving care/ entering care Leaving/ entering school Migration & asylum seeking Homelessness	Bereavement Detention or expulsion of family members* [1] Discord in relationships – general* [2] Domestic and family violence, abuse and neglect (inc. childhood)* [2-10] Family conflict/ discord/ dysfunction/ poor relating (inc. intergenerational conflict)* [1, 2, 4, 5, 11-22] Family history mental illness/ suicide* [4, 9, 13, 14] Family structure - single parent household* [16] Family structure married/ partnered relationship (inc. parental divorce)* [4, 5, 15, 16] Lack of social connectedness (i.e. low contact, social isolation)* [7, 20, 23] Lack of social inclusion Lack of social support* [2, 5, 12, 16, 21, 23-25] Living alone Loneliness Marital problems (inc. divorce or separation)* [15] Parent in prison/ legal problems Parental mental health* [1, 4, 14] Parental physical health (i.e. cancer) Parental substance use* [1] Parental suicidality* [1, 26, 27] Peer suicidality* [20, 27] Poor attachment/ parent child dynamics* [2, 11, 16, 17, 19, 23-25] Rejection/ discrimination/ bullying* [4, 6, 7, 9, 16, 22, 25] Separation from parents	Family cohesion/ connection* [4, 15, 21, 23, 28, 29] Family intactness* [2, 15, 21] Family structure married/ partnered relationship Family support* [6, 20, 25, 28, 30] Positive attachment/ quality/ parent child dynamics* [4, 28, 29] Relationship satisfaction* [28, 29] Social connectedness (i.e. frequent social contact)* [4, 20, 29] Social inclusion (i.e. group membership) Social support* [2, 6, 23, 25, 28, 29]
<b>Older adults</b> (≥65 years) <sup>a</sup> (10 reviews)	Bereavement Change in residence/ Transition to care Health challenges (i.e. chronic disease, cognitive decline) Retirement/ loss of income	Bereavement* [31, 32] Discord in relationships – general* [33-35] Domestic and family violence, abuse and neglect (inc. childhood)* [32, 36] Family conflict/ discord/ dysfunction/ poor relating (inc. intergenerational conflict)* [32, 34, 35, 37, 38] Family structure married/ partnered relationship (inc. parental divorce)* [38] Lack of social connectedness (i.e. low contact, social isolation)* [32, 34, 37, 38] Lack of social inclusion Lack of social support* [32, 34, 35, 37, 38] Living alone* [32, 34, 35, 37, 38] Loneliness* [32, 34, 35, 38] Marital problems (inc. divorce or separation)* [15] Poor attachment/ parent child dynamics	Community participation (inc. volunteering)* [39] Family cohesion/ connection Family structure married/ partnered relationship Family support* [40] Living with others* [40] Positive attachment/ quality/ parent child dynamics Relationship satisfaction* [39, 40] Social connectedness (i.e. frequent social contact)* [39] Social inclusion (i.e. group membership)* [39] Social support* [39, 40]

LIFE STAGE	LIFE EVENTS	RISK FACTORS	PROTECTIVE FACTORS
<b>All adults</b> (18 years and over) (43 reviews)	Bereavement Health challenges (i.e. cancer) Caring Migration and asylum seeking Pregnancy/new family Relationship breakdown Returning from military service	Bereavement* [41-43] Carer role* [44, 45] Discord in relationships – general* [46] Domestic and family violence, abuse and neglect (inc. childhood)* [42, 43, 47-54] Family conflict/ discord/ dysfunction/ poor relating (inc. intergenerational conflict)* [44, 55-60] Family history mental illness/ suicide* [42, 44, 59, 61, 62] Family structure - single parent household* [59] Family structure married/ partnered relationship (inc. parental divorce)* [47, 59] Lack of social connectedness (i.e. low contact, social isolation)* [44, 57, 63, 64] Lack of social inclusion* [64] Lack of social support* [55, 57, 64-67] Living alone* [42, 44, 65] Loneliness* [44] Marital problems (inc. divorce or separation)* [42, 46, 47, 52, 60] No children Parental mental health Parental suicidality* [68, 69] Peer suicidality Poor attachment/ parent child dynamics* [46, 50, 57, 66, 70, 71] Rejection/ discrimination/ bullying* [50, 56, 65, 66] Separation from parents	Community participation (inc. volunteering) Family cohesion/ connection Family structure married/ partnered relationship* [72] Family support [57, 73, 74] Living alone* [62] Living with others* [72] Positive attachment/ quality/ parent child dynamics* [57] Relationship satisfaction* [63, 72, 73] Social connectedness (i.e. frequent social contact)* [57, 63, 64] Social inclusion (i.e. group membership) Social support* [57, 64, 65, 72-76]

\* Statistically significant findings

One study using 60 years and older for inclusion, was included in this category.

# Identifying gaps and opportunities for impact (pathways)

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The majority of intervention research from the review was focused on children and young people (n=35), with two targeted to older adults and ten not age-specific (Table 2). Populations of interest that were targeted by these intervention studies included: at-risk kindergarten students; homeless youth; LGBTQIA+ and minority youth; parentally bereaved children; veterans and their partners; and youth with mental health diagnoses or self-harm history. These are all in keeping with the established SEDS, though no interventions were described that targeted First Nations young people, youth from military families or that have been in contact with the justice system, had experienced abuse, or were transitioning to higher education. Priority groups across the life stages that appeared in the literature for risk and protective factors, but not within the published intervention studies include: people who were experiencing bereavement; those with long term illness; carers; persons living with chronic disease and illness; victims of domestic and family violence, particularly female victims of intimate partner violence and during the perinatal period; farmers and their families; members of the LGBTQIA+ community; people with mental health diagnoses, and those who had a mentally ill or suicidal parent; and migrant and culturally and linguistically diverse communities.

Suicide interventions relevant to family and relationships include: attachment-based family therapy; family therapy; CBT for families; couples-based CBT; dyadic safety planning intervention; family-based crisis intervention; positive parenting and effective coping skills program, and social support interventions.

Many of these interventions operated from Emergency Departments (ED) or healthcare settings, often via an initial ED presentation and included the involvement of family members in addition to a standard suicide prevention program. This was usually in the form of engaging parents in family counselling, and psycho-education, skill-building and safety planning with their family member post-suicidal crisis. An example of a successful program that initiated outside of this setting was an after school program with psychoeducation and group work.<sup>19</sup> The interventions described were mostly face-to face, and varied in intensity and program length, though generally involved 1-2 weekly counselling and/or group sessions lasting between 1 and 2 hours over 10 to 20 weeks.

While the published literature provides valuable evidence for effective therapeutic modalities that address relational risk factors, it is limited to biases associated with academic publishing criteria, for example bias against negative or inconclusive results,<sup>20</sup> or restraints such as around the time and resource required to conduct and publish data from clinical trials, and should not be taken as the whole picture. The review demonstrates a growing body of published intervention research focusing on, or at least including family relationships as a component, and that recognise the beneficial effects of peer-support and group work. Though scant, there is promising evidence on effective interventions addressing social support and connection which is particularly important given the recognition of these elements as protective against suicide.

<sup>19</sup> Humensky, J. L., Coronel, B., Gil, R., Mazzula, S., & Lewis-Fernández, R. (2017). Life is precious: A community-based program to reduce suicidal behavior in Latina adolescents. *Archives of suicide research*, 21(4), 659-671. <https://doi.org/10.1080/13811118.2016.1242442>

<sup>20</sup> Joaber, R., Schmitz, N., Annable, L., & Boksa, P. (2012). Publication bias: what are the challenges and can they be overcome?. *Journal of psychiatry & neuroscience : JPN*, 37(3), 149-152. <https://doi.org/10.1503/jpn.120065>

**Table 2. Interventions addressing relational factors with evidence of impact on suicidality outcomes** (Suicidal ideation, suicide attempt, completed suicide, other<sup>a</sup>)

	CHILDREN & YOUNG PEOPLE (≤24 YEARS)	OLDER ADULTS (≥65 YEARS)	ALL AGES (EXCL. CHILDREN)
<b>THERAPEUTIC MODALITY</b>			
<b>Attachment-based Family Therapy (ABFT)</b>			
Original studies	Suicide ideation; suicide attempt; other [78-81]	-	-
Review articles	Suicide ideation; suicide attempt; other [82-89]	-	Suicidal ideation; Suicidal attempt; Completed suicide [90, 91]
<b>Brief intervention</b>			
Original studies	Suicide ideation; suicide attempt; other [81, 92-100]	-	Suicidal ideation; Suicidal attempt [101-104]
Review articles	Suicide ideation; suicide attempt; other [82, 83, 87, 88, 105-107]	-	Suicidal ideation; Suicidal attempt; Completed suicide; Other [90, 91, 108]
<b>Cognitive Behavioural Therapy (CBT)</b>			
Original studies	Suicide ideation; suicide attempt; other [94, 95, 98-100, 109]	-	Suicidal ideation; Suicidal attempt [102]
Review articles	Suicide ideation; suicide attempt; completed suicide; other [82-84, 86-89, 106, 107, 110, 111]	-	Suicidal ideation; Suicidal attempt; Completed suicide [90, 91]
<b>Couples therapy</b>			
Original studies	-	-	Suicidal ideation; Suicidal attempt [102, 103]
Review articles	-	-	
<b>Dialectical Behavioural Therapy (DBT)</b>			
Original studies	Suicide ideation; suicide attempt; other [95, 100]	-	-
Review articles	Suicide ideation; suicide attempt; completed suicide; other [83, 86, 87, 106, 110, 111]	-	Suicidal ideation; Suicidal attempt; Completed suicide; Other [90, 108]
<b>Family based crisis intervention</b>			
Original studies	-	-	-
Review articles	Suicidal ideation; Suicidal attempt; Other [82]	-	Suicidal ideation; Suicidal attempt [91]
<b>Family therapy (general)</b>			
Original studies	Suicidal ideation; Suicidal attempt; Other [78, 80, 81, 92-96, 98-100, 109]	-	Suicidal ideation [104]
Review articles	Suicide ideation; suicide attempt; completed suicide; other [82-89, 105-107, 110, 111]	-	Suicidal ideation; Suicidal attempt; Completed suicide; Other [90, 91, 108, 112]

	CHILDREN & YOUNG PEOPLE (≤24 YEARS)	OLDER ADULTS (≥65 YEARS)	ALL AGES (EXCL. CHILDREN)
<b>Group-based</b>			
Original studies	Suicidal ideation; Suicidal attempt; Other [97, 113]	-	-
Review articles	Suicidal ideation; Suicidal attempt; Completed suicide; Other [83, 84, 86, 87, 106, 110, 111]	-	Suicidal attempt; Completed suicide [114]
<b>Interpersonal psychotherapy</b>			
Original studies	-	-	-
Review articles	Suicidal ideation; Suicidal attempt [84, 86-88]	Suicidal ideation; Suicidal attempt; Completed suicide [38]	-
<b>Psychodynamic therapy</b>			
Original studies	-	-	-
Review articles	Suicidal ideation; Suicidal attempt [84, 86, 87, 111]	-	-
<b>Psycho-educational/ skill building</b>			
Original studies	Suicidal ideation; Suicidal attempt; Other [80, 92, 96-100, 109, 113, 115]	-	Suicidal ideation; Suicidal attempt [101-103]
Review articles	Suicidal ideation; Suicidal attempt; Completed suicide; Other [82, 86-89, 105-107, 110, 111]	Suicidal ideation; Suicidal attempt [116]	Suicidal ideation; Suicidal attempt; Completed suicide [90, 91, 112]
<b>Safety planning</b>			
Original studies	Suicidal ideation; Suicidal attempt; Other [94, 98, 100, 109]	-	Suicidal ideation; Suicidal attempt [101, 102]
Review articles	Suicidal ideation; Suicidal attempt; Other [87, 105, 111]	-	Suicidal ideation; Suicidal attempt; Completed suicide [91, 112]
<b>Social support-based</b>			
Original studies	-	-	-
Review articles	Suicidal ideation; Suicidal attempt [83]	Suicidal ideation; Suicidal attempt [116]	Suicidal attempt; Completed suicide [114]
<b>Systems (family/multi)</b>			
Original studies	-	-	Suicidal ideation [104]
Review articles	Suicidal ideation; Suicidal attempt; Other [82, 84, 85, 87, 89]	-	Suicidal ideation; Suicidal attempt; Completed suicide [90]

	CHILDREN & YOUNG PEOPLE (≤24 YEARS)	OLDER ADULTS (≥65 YEARS)	ALL AGES (EXCL. CHILDREN)
<b>Study author recommendations</b>	Better intervention evidence (general); RCT's (more or larger); Cost-benefit analyses; Mechanism/ detail (inc. mediators, moderators); Longer follow-up/ longitudinal research; Larger sized studies; Expand population groups; Expand intervention delivery and setting; More intervention types; Expand outcome measures; Consensus on definitions, methods & measurements (inc. robust/ validated measures); Collaborative approach (inc. w patients & families); Process evaluation	Better intervention evidence (general); RCT's (more or larger); Longer follow-up/ longitudinal research; Expand population groups; More intervention types; Expand outcome measures	Better intervention evidence (general); RCT's (more or larger); Mechanism/ detail (inc. mediators, moderators); Longer follow-up/ longitudinal research; Larger sized studies; Expand population groups; Expand intervention delivery and setting; Expand outcome measures; More intervention types; Consensus on definitions, methods & measurements (inc. robust/ validated measures)



## Identifying the gaps

Methodological concerns about testing the effectiveness of interventions were numerous and specific, ranging from the need for more randomised controlled trials, longer follow-up over more time-points, larger sample populations, and the inclusion of cost-benefit analyses and process evaluation in trial design for real-world application.

The need for more intervention outcome measures and greater uniformity and consistency of measures and key definitions was identified. The need to better understand the mechanisms that facilitate an effective response were mentioned by almost half of study authors (44.7%). For example, Frey<sup>21</sup> identified the need for more family-level outcome measures to understand how interventions change family systems and whether these changes mediate improvements in suicidality.

While lack of social connection and social support were regularly identified as suicide risk factors, interventions addressing these factors in the published research literature was scant, and as such there is little available information about their effectiveness.

### Social connection can be addressed by:

<b>Advocacy &amp; campaigns</b>	<ul style="list-style-type: none"><li>• Neighbours Every Day</li><li>• Loneliness Awareness Week</li></ul>
<b>Policies</b>	<ul style="list-style-type: none"><li>• National strategies, e.g. National Suicide Prevention Strategy 2025-2035</li><li>• Peak bodies, e.g. Ending Loneliness Together, Suicide Prevention Australia, Mental Health Australia</li><li>• Relevant ministers in social services and health fields</li></ul>
<b>Community infrastructure and services</b>	<ul style="list-style-type: none"><li>• Social infrastructure (libraries, parks, social policies)</li><li>• Social prescribing (referrals to non-medical care, including social and community groups and services.)</li></ul>
<b>Individual and relationship strategies</b>	<ul style="list-style-type: none"><li>• Therapeutic interventions</li><li>• Education programs, e.g. Groups 4 Health</li></ul>

Adapted from WHO<sup>22</sup>

Consultations across the sector highlighted that there is an opportunity to better explore the risk and protective nature of relationships on suicide. Families, carers and kin can be vital points of support in an individual's experience of suicidal distress. However, many systems, services and processes fail to include these relationships within an individual's ecosystem of care. Consultations highlighted that there is a significant gap in how the system equips supporters to deal with distress, and how systems support families, carers and kin to act as sustainable supporters in a way that considers their own lived experience, carer fatigue and experiences of burnout.

Recognising that the ecosystem of relationships for individuals is both far-reaching and complex; it is also vital that key members of community (beyond family, carers and kin) are equipped to identify and respond to people experiencing suicidal distress. Consultations identified that people may turn to educators, coaches, community leaders, and faith groups for support. In addition, key community members such as pharmacists, GPs, and barbers may be more likely to engage with people who may be disproportionately at risk of suicide. With this in mind, ensuring that people acting in these roles are trained to recognise the signs of distress and respond compassionately becomes integral in providing a wraparound system of support.

Whilst there is currently a small suite of services that exists to support people experiencing suicidal distress, consultations highlighted that greater investment into targeted, whole-of-family services are needed. Many existing suicide prevention services are not fully funded to work with families whilst providing support to a person experiencing distress. In addition, many of these services operate in siloes or with condensed funding and workforce capacities that ultimately reduces their capacity to provide wraparound, ongoing and coordinated care across services and systems. In our scoping review, authors consistently raised similar issues in their recommendations for future intervention studies (see Table 2). Most (85.1%) called for better quality interventions in some form, including expanding the target population group, for example to a larger number of populations experiencing vulnerability, more alternative therapies/intervention types for comparison, greater variety in intervention delivery and settings and a collaborative approach with participants and their families.

21 Frey, L. M., Hunt, Q. A., Russon, J. M., & Diamond, G. (2022). Review of family-based treatments from 2010 to 2019 for suicidal ideation and behavior. *Journal of marital and family therapy*, 48(1), 154–177. <https://doi.org/https://dx.doi.org/10.1111/jmft.12568>

22 Garcia, L., Hunter, R., & Anderson, N. (2025). *From loneliness to social connection-charting a path to healthier societies: report of the WHO Commission on Social Connection*.

Research highlights that the role of family, carer and kin relationships is unique for every individual. Consultations highlighted that workforces within services providing care need to be able to work with people in distress to establish safe, compassionate and effective processes around family, carer, kin inclusion whilst upholding appropriate confidentiality and privacy arrangements. These processes must be embedded across service systems, but to be implemented effectively there must be workforce training and skill development. This extends not just across the primary suicide prevention sector workforce, but requires training across all services beyond health that interact with people at an increased risk of experiencing distress.

Emergency departments (EDs) are a common intervention access point for people experiencing suicidal distress, however many individuals accessing EDs report experiencing long wait times, insufficient or inappropriate care, and inconsistencies in follow up and referral. Consultations highlighted that it is essential that EDs provide consistent and compassionate approaches to people experiencing distress, as well as their families' carers and kin. EDs and other health services act as a key point in time during someone's help-seeking journey for suicidal distress, and without trauma-informed and compassionate care for both the individual and their supports, services miss critical opportunities to provide genuine preventative care.

### **Other areas of concern which require further investigation:**

#### **1. Confidentiality**

Consultations highlighted that workforces within services providing care need to be able to work with people in distress to establish safe, compassionate and effective processes around family, carer, kin inclusion whilst upholding appropriate confidentiality and privacy arrangements. These processes must be embedded across service systems, but to be implemented effectively there must be workforce training and skill development. This extends not just across the primary suicide prevention sector workforce, but requires training across all services beyond health that interact with people at an increased risk of experiencing distress. It is recommended that State and Territory health services review confidentiality and privacy policies to ensure families caring for a person in suicidal distress are not excluded by default use of privacy considerations.

#### **2. Loneliness and isolation at risk groups**

Multiple State and Territory Parliaments have undertaken committee enquiries into loneliness and social isolation in recent years, underscoring the importance of these issues within communities. It is recommended that there be a collaborative approach between jurisdictions to share findings and expand knowledge, and invest in effective action, especially through a suicide prevention lens.

#### **3. Aboriginal and Torres Strait Islander peoples and the role of relationships in suicide prevention**

This report does not specifically address the role of relationships for Aboriginal and Torres Strait Islander peoples. This was a decision made because of the uniqueness of the relationships and culture forming these relationships, and expertise required to understand and examine the protective and risk factors present. This is an area that would benefit from a specialist report.

#### **4. People from culturally and linguistically diverse backgrounds and the role of relationships in suicide prevention**

This report also does not provide recommendations specifically for people from culturally and linguistically diverse backgrounds, as the diversity of culture, age, isolation, language, and other factors is complex. While several of the protective and risk factors outlined in this report will be relevant to some people of culturally and linguistically diverse backgrounds, there will be many factors unique to them. In many cases, the research itself is needed to be undertaken rather than collated.

## Leading with expertise

Suicide Prevention Australia and Relationships Australia are embedded across Australia's suicide prevention ecosystems. As the national peak body for suicide prevention, Suicide Prevention Australia provides clear sector leadership by advocating for whole-of-system approaches that encompass social, economic and community risk and protective factors. In addition, Suicide Prevention Australia supports workforce capability through tailored industry specific Psychosocial Risk Frameworks and accreditation programs, and represents a wide network of service providers, researchers and lived experience voices to amplify best practice and policy influence. Relationships Australia delivers a broad suite of services nationally, and supports over 150,000 people each year, building and maintaining healthy relationships, supporting individuals and families through counselling and dispute resolution; and facilitating community education and training programs across life stages and a variety of circumstances.

## Relationships in the National Suicide Prevention Strategy

The actions within the National Suicide Prevention Strategy address both the need to support families, carers, and kin in their responses to suicidal distress, as well as the network of distress factors that directly impact the accumulation of distress within families and relationships. These both emphasise the necessity of a whole-of-Government approach, with distress factors occurring in education, gambling, alcohol and other drugs, emergency departments, family services, LGBTQIA+ communities, data collection, and multiple other agencies.

- **Action 2.2c:** Provide support services for families, carers and kin to better recognise and respond to any suicidal distress being experienced by families, carers and kin while acting in a support role.
- **Action 2.2i:** Increase access to peer and support programs for families, carers and kin of people who are experiencing difficulties due to alcohol- and other drug-related harm.
- **Action 4.2a:** Address loneliness and social exclusion in Australia. Conduct a review of relevant programs in Australia and the latest evidence to guide investment on initiatives that effectively address loneliness and social exclusion. Improve community understanding of loneliness and social exclusion and relevant resources and programs through community awareness campaigns. Implement and evaluate programs to build social connectedness and a sense of belonging, and improve relationships,
- **Action 5.2i:** Increase support for LGBTQIA+ young people and their families, carers and kin, to facilitate good mental health and supportive relationships, with a focus on the intersections between key coming out milestones and increased suicide risk.
- **Action 10.1a:** Comprehensively review barriers to involving families, carers and kin in care planning and delivery for people who experience suicidal thoughts and behaviours. Use the findings of this review to develop, trial and evaluate solutions
- **Action 10.1b:** Co-design, trial and evaluate face-to-face and online support programs for families, carers and kin of people who have experienced suicidal thoughts and behaviours. Use findings to inform service planning and improve accessibility of effective programs.
- **Action 10.1c:** Trial the integration of carer peer workers in services supporting people who experience suicidal thoughts and behaviours to aid the engagement and support of families, carers and kin.
- **Action 13.1c:** Resource the National Suicide and Self-Harm Monitoring System to broaden the reporting of suicide-related data. Include indicators of wellbeing and suicidal distress associated with the social determinants of suicide. Include the experiences of families, carers and kin and those bereaved by suicide.

# Recommendations for action

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## Whole-of-Government approaches

Research presented within this report highlights the distinct role relationships and family dynamics play as both risk and protective factors for suicide. Having a suicidal family member or peer is of itself a risk factor for mental distress and suicide.<sup>23,24,25</sup> The impact of caring for a family member can be substantial,<sup>26</sup> including increased difficulty in day-to-day tasks and attending to other family members, as well as feelings of shame, secrecy and guilt, and should be recognised by providers.<sup>27</sup> In the published literature, family support was one of the most frequently cited protective factors against suicide regardless of life stage. Satisfaction with family relationships is protective against suicide attempts, with perceived family support linked to lower numbers of suicide attempts.<sup>28</sup> Specifically, positive parental attachment and support have been consistently demonstrated to protect against suicide behaviours.<sup>29</sup>

Recognising that suicide is complex and often the result of co-occurring determinants, any approach to suicide prevention must ensure a whole-of-government and whole-of-person responses.

Consultations articulated a strong need for improved dialogue on the protective factors of suicide prevention; including the role of relationships, family, carers and kin, across broader systemic constructs and government departments. This requires effective system communication between health, justice, childcare and housing settings that involves considerations for both people experiencing distress, and their families, carers and kin.

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**Recommendation 1:** That Governments, Commonwealth, State, and Territory, recognise multi-agency responsibility to incorporate relationships and families as protective and risk factors in the implementation of and investment in the National Suicide Prevention Strategy.

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The National Suicide Prevention Strategy (the Strategy)<sup>30</sup> provides a valuable framework for working towards a whole-of-government approach to suicide prevention that recognises the role of family, carers and supporters in reducing suicide risk.

23 Hauser, M., Galling, B., & Correll, C. U. (2013). Suicidal ideation and suicide attempts in children and adolescents with bipolar disorder: a systematic review of prevalence and incidence rates, correlates, and targeted interventions. *Bipolar disorders*, 15(5), 507–523. <https://doi.org/https://dx.doi.org/10.1111/bdi.12094>

24 O'Halloran, L., Coey, P., & Wilson, C. (2022). Suicidality in autistic youth: A systematic review and meta-analysis. *Clinical psychology review*, 93(cnx, 8111117), 102144. <https://doi.org/https://dx.doi.org/10.1016/j.cpr.2022.102144>

25 Cassidy, R. M., Fang, Y., Kapczynski, F., & Passos, I. C. (2018). Risk Factors for Suicidality in Patients With Schizophrenia: A Systematic Review, Meta-analysis, and Meta-regression of 96 Studies. *Schizophrenia Bulletin*, 44(4), 787–797. <https://doi.org/10.1093/schbul/sbx131>

26 Hennipman-Herweijer, C., Amerongen-Meeuse, J. V. N., Schaap-Jonker, H., & Boonstra, N. (2024). The experiences of living with a suicidal family member, and the impact on daily life: A systematic review and meta-aggregation. *Journal of Psychiatric and Mental Health Nursing*, 31(5), 883-903.

27 McLaughlin, C., McGowan, I., O'Neill, S., & Kernohan, G. (2014). The burden of living with and caring for a suicidal family member. *Journal of Mental Health*, 23(5), 236–240. <https://doi.org/10.3109/09638237.2014.928402>

28 Harris, K., Haddock, G., Peters, S., & Gooding, P. (2020). Psychological resilience to suicidal thoughts and behaviours in people with schizophrenia diagnoses: a systematic literature review. *Psychology and Psychotherapy: Theory, Research and Practice*, 93(4), 777-809.

29 Lai, D. W., Li, L., & Daoust, G. D. (2017). Factors influencing suicide behaviours in immigrant and ethno-cultural minority groups: a systematic review. *Journal of immigrant and minority health*, 19(3), 755-768.

30 The National Suicide Prevention Office. (2025). *The National Suicide Prevention Strategy 2025-2035*.



Specifically, action 9.2a calls for the trial and evaluation of models that facilitate partnerships between health and other social services to enable delivery of coordinated and holistic support that addresses diverse drivers of distress for people experiencing suicidal thoughts and behaviours and their family, carers and kin.<sup>31</sup>

The comprehensive approach of the National Suicide Prevention Strategy in identifying the socioeconomic and environmental determinants of suicide as integral, demonstrates that responsibility for suicide prevention lies across multiple Government agencies, and beyond a mental health focus. The implementation and investment in the Strategy will enable this approach and better address the needs of families, carers, and kin who are supporting someone in suicidal distress. Within the Strategy, there is a pronounced focus on the importance on families caring for people with suicidal thoughts and behaviours, and the need for them to themselves be equipped to provide this care.

The following three actions are essential to this provision of care, and in helping to manage distress within the families, carers, and kin who are in this situation.

- **Action 10.1a:** Comprehensively review barriers to involving families, carers and kin in care planning and delivery for people who experience suicidal thoughts and behaviours. Use the findings of this review to develop, trial and evaluate solutions

- **Action 10.1b:** Co-design, trial and evaluate face-to-face and online support programs for families, carers and kin of people who have experienced suicidal thoughts and behaviours. Use findings to inform service planning and improve accessibility of effective programs.
- **Action 10.1c:** Trial the integration of carer peer workers in services supporting people who experience suicidal thoughts and behaviours to aid the engagement and support of families, carers and kin.

Implementation of these key points is required to enable a better structure of support for families and partners in order to equip them to support their loved ones. During consultations, a consistent theme was the need to support the supporters.

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**Recommendation 2:** That actions 10.1a, 10.1b, and 10.1c of the National Suicide Prevention Strategy in particular be implemented and invested in with urgency, to comprehensively review barriers to involving families, carers and kin in care planning and delivery for people who experience suicidal thoughts and behaviours; co-designing, trialling and evaluating face-to-face and online support programs for families, carers and kin of people who have experienced suicidal thoughts and behaviours; and trialling the integration of carer peer workers in services supporting people who experience suicidal thoughts and behaviours to aid the engagement and support of families, carers and kin.

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<sup>31</sup> *Ibid.*

## Secure funding environments

Community services are an integral part of the care framework for people experiencing suicidal distress, ideation or attempt. It is crucial that these services are appropriately connected to broader social, clinical and non-clinical supports where relevant for the individual; and have the capacity to provide long-term, continuity of care.

Current funding models for suicide prevention services remain short-term, often experience significant delays in funding implementation, and fail to provide transparency over long-term access. These challenges pose significant issues for the sustainability of services that work with families in preventing and reducing suicide risk. Consultations highlighted that funding models must be administered in a way that allows for continuity, upskilling and growth of services to both meet demand and respond to evolving community needs. In addition, funding models must embed considerations for how programs and services for people in distress include their families, carers and kin. Consultations further highlighted that the current competitive funding models are not conducive to effective, long-term and sustainable care pathways, and workforce planning.

The ability of service organisations to provide care and support for families, carers, and kin depends on their own sustainability. This is evident when stop-start contracts affect factors such as service provision, workforce retention and development, and continuity of care. Funding processes need to be longer-term, transparent, sufficient, and accountable to ensure services can meet and match demand, and do so sustainably. It also requires a breakdown in the focus between clinical and non-clinical services to allow cooperation and collaboration to deliver the best possible outcomes.

In addition to long-term investment considerations, greater support for evaluation of services that are already provided is needed. Intervention and evaluation efforts need to be robust,<sup>32</sup> and the role of family post-hospitalisation better understood.<sup>33</sup> Multiple reviews have established the value of therapeutic alliance, and the need for accessible and longer-term interventions for program efficacy, while calling for better understanding of what factors help or hinder intervention delivery in clinical settings. and determining effectiveness of individual intervention elements.<sup>34,35</sup>

The review found strong evidence for the protective benefits of positive family relationships, including connection, support, relationship quality and relationship satisfaction, as well as broader social relationships that include social connection, inclusion and support, including peer support (see Table 1).

**Recommendation 3:** That funding processes for organisations assisting families in preventing and diminishing suicidal risk, and in supporting them following an attempt, be administered in a way that allows the optimal continuity, skilling, sustainability, and growth of the services. These must also allow for partnerships between health and other social services to enable delivery of coordinated and holistic support that addresses diverse drivers of distress for people experiencing suicidal thoughts and behaviours and their family, carers and kin.



- 32 Trubey, R., Evans, R., McDonald, S., Noyes, J., Robling, M., Willis, S.,...Melendez-Torres, G. J. (2024). Effectiveness of Mental Health and Wellbeing Interventions for Children and Young People in Foster, Kinship, and Residential Care: Systematic Review and Meta-Analysis. *Trauma, Violence, & Abuse*, 25(4), 2829-2844. <https://doi.org/10.1177/15248380241227987>
- 33 Burns, J., Dudley, M., Hazell, P., & Patton, G. (2005). Clinical management of deliberate self-harm in young people: the need for evidence-based approaches to reduce repetition. *Australian & New Zealand Journal of Psychiatry*, 39(3), 121-128. <https://doi.org/10.1080/j.1440-1614.2005.01532.x>
- 34 Newton, A. S., Hamm, M. P., Bethell, J., Rhodes, A. E., Bryan, C. J., Tjosvold, L., Ali, S., Logue, E., & Manion, I. G. (2010). Pediatric suicide-related presentations: a systematic review of mental health care in the emergency department. *Annals of Emergency Medicine*, 56(6), 649-659. <https://doi.org/https://dx.doi.org/10.1016/j.annemergmed.2010.02.026>
- 35 Meza, J. I., Zullo, L., Vargas, S. M., Ougrin, D., & Asarnow, J. R. (2023). Practitioner Review: Common elements in treatments for youth suicide attempts and self-harm - a practitioner review based on review of treatment elements associated with intervention benefits. *Journal of child psychology and psychiatry, and allied disciplines*, 64(10), 1409-1421. <https://doi.org/https://dx.doi.org/10.1111/jcpp.13780>



## Equipping families to deal with distress

Research has demonstrated that families, carers and kin can play a vital role in suicide prevention.<sup>36</sup> A systematic review by Henson et al.<sup>37</sup> found family connectedness to be the most powerful protective factor, with 11 studies identifying positive family relationships, parental support, and maternal warmth as protective against multiple negative outcomes including substance use, suicide attempts, and violent behaviour. Additionally, there is an obvious need to develop new interventions in collaboration with adolescents and their families to ensure their specific needs and expectations are met.<sup>38</sup>

In many instances family members and supporters of people experiencing acute or ongoing suicidal distress provide support in ongoing, full-time, and unpaid capacities. Consultations with the sector have highlighted that there is an opportunity to increase the support for, and recognition of individuals who support people experiencing acute and ongoing suicidal distress.

Supporting a loved one through suicidal distress, ideation and attempt(s) require compassionate, person-centred and ongoing care approaches. Many supporters of someone experiencing distress are not provided with the time, tools, or training to navigate both the needs of the individual, and their own needs as supporters.

In addition, many targeted clinical and private services are ill-equipped to include family, supporters and carers in long-term support processes for people experiencing acute and ongoing suicidal distress. This can be due to factors including the lack of inclusion within existing service structures, funding challenges and lack of training on the role of family, supporters and carers as a protective factor for distress.

Consultations emphasised that in order for family, carers and kin to provide support; they require support themselves. Universal access to aftercare services that extends to include supporters, a suite of targeted services available to carers, and the provision of Medicare-funded psychological sessions were all suggested resources that could ensure families, carers and kin are able to continue supporting the people they love and care for.

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**Recommendation 4:** That families, partners, carers and kin are able to access support at times of distress, equipping families to deal with suicide risk factors. Universal access to aftercare services and the ability to extend that towards supporters, and the provision of Medicare-funded psychological sessions are suggested resources that could ensure families, carers and kin are able to continue supporting the people they love and care for.

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<sup>36</sup> Lai, D. W., Li, L., & Daoust, G. D. (2017). Factors influencing suicide behaviours in immigrant and ethno-cultural minority groups: a systematic review. *Journal of immigrant and minority health*, 19(3), 755-768.

<sup>37</sup> Henson, M., Sabo, S., Trujillo, A., & Teufel-Shone, N. (2017). Identifying Protective Factors to Promote Health in American Indian and Alaska Native Adolescents: A Literature Review. *The journal of primary prevention*, 38(1-2), 5-26. <https://doi.org/https://dx.doi.org/10.1007/s10935-016-0455-2>

<sup>38</sup> Pereira Simões, R. M., Pereira dos Santos, J. C., & Costa Marques Martinho, M. J. (2019). Effectiveness of psychotherapeutic interventions targeted at adolescents with suicidal behaviour. *Revista de Enfermagem Referência*, 4(20), 139-148. <https://doi.org/10.12707/RIV18027>

Families, carers and kin can be vital points of support in an individual's experience of suicidal distress, however consultations highlighted that there is a significant gap in how the system equips supporters to deal with distress, and how systems support families, carers and kin to act as sustainable supporters. Consultations highlighted that there is a significant gap in the services and resources that are available to supporters, particularly at critical junctures of a person's help-seeking journey including first access to support, referral across care services, and general life transitions.

Action 9.3a of the National Suicide Prevention Strategy emphasises the need to *“co-design, implement and evaluate community-based long-term support models for people who experience chronic suicidal thoughts, and their family, carers and kin, to create, understand and continuously improve effective care.”*<sup>39</sup>

Within the scoping review literature, interventions designed to include families and carers generally did not specifically focus on providing support to those caring for someone experiencing suicidality. A recent review by Karolinska et al.<sup>40</sup> on psychosocial interventions for family members and support persons noted some improvement across studies in carers' mental health, as well as reduced burden, and an improved caring ability. However, they note inconclusive evidence due to study quality and the low number of eligible intervention studies.

Some targeted services currently exist, including the peer supporter phonenumber service delivered by Survivors & Mates Support Network (SAMSN).<sup>41</sup> This service allows supporters of people experiencing suicidal distress who have a history of child sexual assault, to connect with peer support. In addition, the Minds Together program, delivered by Everymind, has been developed specifically to support the mental health and wellbeing of those who care for someone experiencing mental health concerns or suicidal distress; in addition to providing them with the relevant tools and resources to provide ongoing support.<sup>42</sup> In addition, peer-led, culturally sensitive programs such as those delivered by StandBy<sup>43</sup> and Thirilli<sup>44</sup> provide vital support for families who become bereaved, across the short, medium and long-term.

Consultations emphasised that further supports are required, included increased funding for specialist services for survivors of suicide and their supporters, increasing the efficacy of online communities for young people, and broadening the accessibility for family-based therapies.

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**Recommendation 5:** The Commonwealth Government, and State and Territory Governments provide for the development of preventive resources and services for families to access at critical junctures including times of transition such as children leaving school or home; separation or divorce; aged parents entering care; deaths in the family; unemployment; and other distresses that are suicidal risks.

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39 The National Suicide Prevention Office. (2025). *The National Suicide Prevention Strategy 2025-2035*. P.61

40 Kryszynska, K., Andriessen, K., Ozols, I., Reifels, L., Robinson, J., & Pirkis, J. (2021). *Effectiveness of psychosocial interventions for family members and other informal support persons of individuals who have made a suicide attempt*. Crisis.

41 SAMSN. (n.d.). *Home – SAMSN Survivors & Mates Support Network*. <https://samsn.org.au/>

42 Everymind. (n.d.). *Minds Together | An Everymind program*. <https://mindstogether.org.au/>

43 Youturn Limited. (n.d.). *StandBy Support After Suicide*. <https://standbysupport.com.au/>

44 Thirilli. (n.d.). *About Us | Thirilli*. <https://thirilli.com.au/>



## Equipping the community to support families

Instead of turning to targeted crisis services, many people experiencing distress will often reach out to friends, family members, faith spaces and community services as a first point of contact in their help-seeking journey. It is a critical moment when a person discloses their experience of distress, or suicidal thoughts for the first time, and as such it is vital for key members of the community who commonly encounter people at risk of suicide to build the skills and knowledge to recognise and refer on.

People from culturally and linguistically diverse backgrounds, children and young people, men and older people are just some of the cohorts that are both at an increased risk of suicide, and who may experience greater stigma when it comes to accessing support. Men may be more likely to turn partners or members of sporting groups, people from multicultural communities may turn to faith leaders or settlement services, and older people may disclose to people they encounter regularly such as care teams, pharmacists or GPs. In addition, recognising that not all individuals experiencing distress will reach out for help, family and community relationships can be key instigators of 'in-reach' for people who may be experiencing suicidal distress.

*The Family Check-Up (FCU) is a school-based prevention program that uses motivational interviewing techniques in a three-session format to assess family functioning, enhance parent engagement, and provide tailored family management support.<sup>45</sup> The intervention follows an adaptive design with universal (family resource centre), selected (FCU for high-risk families), and indicated (intensive family management training) levels of support. Youth who received the FCU intervention showed significantly lower suicide risk at both ages 18-19 and 28-30 compared to controls, with effects persisting into early adulthood even after controlling for earlier suicide risk.*

Ultimately, consultations highlighted that any community training should include ensuring key community contacts can recognise the signs of suicidal distress, understand the referral pathways for people who require support, and increase people's capacity to deliver support in a way that is compassionate, trauma-informed and person-centred.

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**Recommendation 6:** That training be increased to equip people likely to encounter suicidal distress be able to adequately and effectively respond. This would include Government agency personnel in public-facing roles, as well as enabling the provision of suicide prevention training within the community to relevant points of contact, such as sports coaches, pharmacists, barbers, community groups, to equip community leaders to recognise signs of suicidal distress and referral pathways.

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<sup>45</sup> Connell, A. M., McKillop, H. N., & Dishion, T. J. (2016). Long-Term Effects of the Family Check-Up in Early Adolescence on Risk of Suicide in Early Adulthood. *Suicide & Life-Threatening Behavior*, 46 Suppl 1(v8g, 7608054), S15–22. <https://doi.org/https://dx.doi.org/10.1111/sltb.12254>



## Workforce skills and training

Workforce upskilling and training is essential to ensuring that individuals accessing support receive timely, targeted and compassionate responses. It should be noted that the suicide prevention workforce includes both the primary workforce that comprises targeted clinical and non-clinical staff, as well as the broader suicide prevention workforce that includes police, paramedics, education staff, justice systems and government services, and the broader community sector, that regularly interact with people at risk of suicide.

Consultations have highlighted that trauma-informed care must underpin all workforce training and be translated in any approaches to supporting both individuals and their families, carers and kin. This requires careful considerations for the way confidentiality and privacy are respected and considered in care interactions; in a way that supports an individual's agency when accessing support. These interactions must include ensuring shared language around information sharing, establishing personal definitions of family, carers and kin within the supporter context, and be driven by transparency and authenticity.

In addition, any training delivered to the broader workforce must equip individuals and staff with the skills to recognise the signs of distress, and provide compassionate, timely care in a way that enables effective referral. This requires greater understanding of the referral pathways available to both people experiencing distress, and their families, carers and kin.

In their review of family support programs for adolescent mental health, Kuhn and Laird<sup>46</sup> found that the more successful programs included a greater number of support elements, and that greater efficacy is achieved with higher risk populations. A review of psychosocial treatments for youth by Glenn and colleagues,<sup>47</sup> found that the most efficacious interventions included active family therapy or parent training components, with shared features including parent/family psychoeducation, emotion regulation skills, communication skills, and problem-solving training. Improved family functioning fully mediated the intervention effects in the parent training trial, demonstrating that targeting family relationships directly impacts treatment outcomes.

### Area for further consideration:

#### 1. Confidentiality

Consultations highlighted that workforces within services providing care need to be able to work with people in distress to establish safe, compassionate and effective processes around family, carer, kin inclusion whilst upholding appropriate confidentiality and privacy arrangements. These processes must be embedded across service systems, but to be implemented effectively there must be workforce training and skill development. This extends not just across the primary suicide prevention sector workforce, but requires training across all services beyond health that interact with people at an increased risk of experiencing distress. It is recommended that State and Territory health services review confidentiality and privacy policies to ensure families caring for a person in suicidal distress are not excluded by default use of privacy considerations.

46 Kuhn, E. S., & Laird, R. D. (2014). Family support programs and adolescent mental health: review of evidence. *Adolescent Health, Medicine and Therapeutics*, 5(null), 127–142. <https://doi.org/10.2147/AHMTS48057>

47 Glenn, C. R., Esposito, E. C., Porter, A. C., & Robinson, D. J. (2019). Evidence Base Update of Psychosocial Treatments for Self-Injurious Thoughts and Behaviors in Youth. *Journal of Clinical Child and Adolescent Psychology: the official journal for the Society of Clinical Child and Adolescent Psychology, American Psychological Association, Division 53*, 48(3), 357–392. <https://doi.org/https://dx.doi.org/10.1080/15374416.2019.1591281>

## Supporting families in distress

Public hospital Emergency Departments (EDs) remain a critical intervention point for people experiencing suicidal distress, yet without consistent adoption of best-practice guidance, care can be fragmented, rushed, and, at times, inadvertently harmful. The Black Dog Institute's guidelines for emergency departments emphasise that compassionate, person-centred, and non-judgemental care must be intrinsic to effective treatment and care. Embedding these guidelines across EDs could establish a consistent standard of care that prioritises dignity, privacy, and emotional safety.

Consultations highlighted that a system-wide commitment to these guidelines must also extend beyond the individual to include families, carers, and kin; aligning with recommendations from the National Suicide Prevention Taskforce report that emphasises compassion-first care for all those affected.

Representatives across the sector highlighted that emergency department services can often miss the nuanced risk profile of suicidal distress, where experiences of relationship breakdown, domestic family and sexual violence (DFSV) and social isolation can be early signs of risk. Individuals that present to EDs with distress stemming from these experiences may not qualify for clinical care. This provides a critical opportunity for referral to non-clinical supports such as Safe Spaces<sup>48</sup> and Safe Havens<sup>49</sup> where family, carers and kin may not be the safest or appropriate support mechanisms for someone experiencing distress.

Parent-child conflicts have been identified as the most common precipitant among children that have died by suicide.<sup>50</sup> One review also found poor family communication, lack of parental support, and verbal abuse by parents were significantly associated with increased suicidal behaviour among Norwegian youth.<sup>51</sup> Conflictual family networks have actually been found to increase suicidal ideation risk more than supportive networks decrease it.<sup>52</sup> This can be exacerbated for more vulnerable populations, for example LGBTQIA+ youth.<sup>53,54</sup> One review of ED-based interventions for children and young people presenting with suicidal ideation specifically identified that family interventions may be inappropriate or unsafe in situations involving family conflict, domestic violence, or abuse,<sup>55</sup> a sentiment echoed across the intervention studies. This highlights the need for frameworks that allow for individual circumstances and support, to capture those who cannot rely on protective factors of relationships. For children, this must include considerations that prioritise the rights of the child and recognises their safety and care as paramount.

Conversely, peer support can be more important than parental support for some adolescents who have attempted suicide.<sup>56</sup> Consultations repeatedly highlighted the need for creating safe alternative community spaces for people to feel peer connection.

Consultations on presentation to clinical services highlighted the need for services that catered to targeted people. For example, family violence dynamics complicate disclosure, particularly when the family court system exacerbates fear regarding parenting and other issues. For young men, and others acutely impacted by stigma, the system can shut them down into silence, repressing the human connection that is needed to provide assistance.

48 Life in Mind. (n.d.). Safe Spaces. <https://lifeinmind.org.au/suicide-prevention/approaches/intervention/safe-spaces>

49 NSW Health. (2025). Safe Haven. <https://www.health.nsw.gov.au/towardszerosuicides/Pages/safe-haven.aspx>

50 Soole, R., K. Kolves, and D. De Leo, *Suicide in Children: A Systematic Review*. Archives of suicide research : official journal of the International Academy for Suicide Research, 2015. 19(3): p. 285–304.

51 Nrugham, L., Herrestad, H., & Mehlum, L. (2010). Suicidality among Norwegian youth: review of research on risk factors and interventions. *Nordic journal of psychiatry*, 64(5), 317–326. <https://doi.org/https://dx.doi.org/10.3109/08039481003628364>

52 Yoon, S., & Cummings, S. (2019). Factors Protecting against Suicidal Ideation in South Korean Community-Dwelling Older Adults: A Systematic Literature Review. *Journal of Gerontological Social Work*, 62(3), 279–305. <https://doi.org/10.1080/01634372.2018.1557310>

53 Luong, C. T., Rew, L., & Banner, M. (2018). Suicidality in Young Men Who Have Sex with Men: A Systematic Review of the Literature. *Issues in Mental Health Nursing*, 39(1), 37–45. <https://doi.org/10.1080/01612840.2017.1390020>

54 de Lange, J., Baams, L., van Bergen, D. D., Bos, H. M. W., & Bosker, R. J. (2022). Minority Stress and Suicidal Ideation and Suicide Attempts Among LGBT Adolescents and Young Adults: A Meta-Analysis. *LGBT Health*, 9(4), 222–237. <https://doi.org/10.1089/lgbt.2021.0106>

55 Virk, F., Waine, J., & Berry, C. (2022). A rapid review of emergency department interventions for children and young people presenting with suicidal ideation. *BJPsych Open*, 8(2), 1–13. <https://doi.org/https://dx.doi.org/10.1192/bjo.2022.21>

56 Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: a systematic review of population-based studies. *Clinical psychology review*, 24(8), 957–979. <https://doi.org/https://dx.doi.org/10.1016/j.cpr.2004.04.005>

Equally, cultural and LGBTQIA+ communities have been reported to avoid traditional services due to concerns about anonymity, judgment, and services not designed for their needs.

A review of family-based treatments for suicidal ideation and behaviour,<sup>57</sup> found attachment-based family therapy, family-based crisis intervention, family therapy, dialectical behavioural therapy combined with family training; and psychoeducation with family or a support team, all to be effective. Families that had higher baseline family conflict showed greater reductions in self-harm behaviours through treatment, suggesting these interventions may be particularly effective for high-conflict families.

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**Recommendation 7:** That hospital Emergency Departments adopt suicidal distress guidelines to ensure consistent and compassionate approaches to suicidal behaviours, including interactions with families.

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Consultations found that EDs could and did exacerbate distress for people experiencing relationship breakdown, with trivialisation of relationship problems in a clinical model. This left people feeling unheard, and sometimes increased distress levels. This highlights the need for both guidelines for EDs to deal compassionately and consistently with suicidal distress presentations through established guidelines, as well as ensuring referrals to specialist therapeutic and other support services. Services such as Safe Spaces offer a fundamentally different pathway that emphasises human connection over clinical triage, normalising, not pathologising, human distress.

Services that are not targeted run the risk of unintended consequences, and using EDs as a catch-all for suicidal distress is an example of this. Set up for medical emergencies, a person presenting in suicidal distress feels their pain doesn't fit, either because they are not 'sick' or not in the right place, and this compounds shame and isolation.

## Data and available information

While the data in this report combines multiple sources, there is a distinct lack of correlated and collected data of the indicators of wellbeing, suicide attempts, and the social, economic and environmental determinants of suicide. A key example of this is the National Mental Health and Wellbeing Survey conducted by the Australian Bureau of Statistics in 2023, following a 17-year hiatus. As highlighted in the recent Productivity Commission report into the National Agreement,<sup>58</sup> there is a need for this data to be collected and released regularly to ensure its efficacy and usability.

The Survey includes important information into suicidal behaviours, ideation, and attempts, but extreme time gaps between data sets reduced the capacity to identify trends, and the utility of its data.

Similarly, data that looks at areas such as determinants, parental and relationship status and experiences of families and relationships, can only add to the picture and improve outcomes.

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**Recommendation 8:** That data gaps on distress and parental or relationship status be addressed by implementing Action 13.1c of the National Suicide Prevention Strategy to broaden the reporting of suicide-related data, including indicators of wellbeing and suicidal distress associated with the social determinants of suicide, and the experiences of families, carers and kin and those bereaved by suicide.

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<sup>57</sup> Frey, L. M., Hunt, Q. A., Russon, J. M., & Diamond, G. (2022). Review of family-based treatments from 2010 to 2019 for suicidal ideation and behavior. *Journal of marital and family therapy*, 48(1), 154–177. <https://doi.org/https://dx.doi.org/10.1111/jmft.12568>

<sup>58</sup> Productivity Commission. (2025) *Mental Health and Suicide Prevention Agreement Review, Inquiry report no. 108*, Canberra

# Conclusion

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People who are connected and enjoy respectful relationships experience greater wellbeing and are more resilient to psychosocial risk factors of suicide. Public policy in the suicide prevention space has been largely focused on acute responses, while the significant benefits of promoting strong interpersonal and social relationships requires more attention.

In order to effectively and meaningfully drive down the impact of suicide in Australia, we need to tackle the risk factors and causes of distress cohesively through a suicide prevention lens. The work in this paper illustrates how relationships can be used to undertake that analysis and draw connections to ensure that people in distress are given comprehensive and connected support through their loved ones.

Funnelling people through narrow definitions of support denies them ease of access to the comprehensive range of clinical and non-clinical services which all play a role. Families, partners, carers, and kin are in a unique position to support their loved ones in distress, but they are not responsible for fixing the distress. They require the commitment and investment of a government prepared to act strategically and meaningfully.

We have the resources and frameworks ready to enable the introduction of that commitment and investment through the National Suicide Prevention Strategy, and its recognition of the importance of families and relationships.

The recommendations in this report are aimed at enabling those frameworks and resources to be used to alleviate distress and reduce deaths by suicide in Australia. That is both through supportive factors and through risk reduction, both of which are reflected through relationships. We need a comprehensive, strategic response that values the support relationships provide in times of distress, but also that aids those providing support through resources, training, services, and connected supports.

If our Governments fail to act on supporting families to maximise their protective factors, there will always be significant gaps in suicide prevention. Families and relationships are a core and fundamental resource to manage suicidal distress, but they cannot do so to best effect without the recognition and support they themselves need.

# Appendix 1

## Glossary

The definitions used in this paper are derived from earlier work by Suicide Prevention Australia, Relationships Australia, and the National Suicide Prevention Office.

**Family** - We use the term “family” to encompass both traditional and non-traditional groups, chosen families, blended families, same-sex and heterosexual headed households.

**Mental health** - is a state of wellbeing in which every individual realises their own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to their community.<sup>59</sup>

**Psychological distress** - unpleasant feelings or emotions that affect a person’s level of functioning and interfere with the activities of daily living. This distress can result in having negative views of the environment, others and oneself, and manifest as symptoms of mental illness, including anxiety and depression. Psychological distress is commonly measured using the Kessler 10 (K10). Someone experiencing psychological distress will not necessarily be experiencing mental ill-health or illness.<sup>60</sup>

**Mental health and behavioural disorders** - ‘are characterised by a clinically significant disturbance in an individual’s cognition, emotional regulation or behaviour. The term covers a range of disorders including (but not limited to) anxiety, affective and substance use disorders.’<sup>61</sup>

**Mental ill-health** - refers to diminished mental health from either a mental illness, mental health problem or chronic psychological distress.<sup>62</sup>

**Mental illness** – Mental illness or mental disorder is a health problem that significantly affects how a person feels, thinks, behaves and interacts with others. It is diagnosed according to standardised criteria.<sup>63</sup>

**Self-harm** – ‘is an act in which a person harms themselves with a motive that may or may not involve the intention to end their life.’<sup>64</sup>

**Suicide** – ‘is an action that a person takes to deliberately end their own life and that results in death.’<sup>65</sup>

**Suicide attempt** – ‘is an act in which a person harms themselves with the intention of ending their life and survives.’<sup>66</sup>

**Suicidal thoughts and behaviours** – ‘...the range of experiences that a person who is suicidal may be having. This range spans from having thoughts of suicide to attempting suicide. Suicidal thoughts and behaviours describe a person’s experience rather than risk.’<sup>67</sup>

**Stress** – ‘a state of worry or mental tension caused by a difficult situation.’<sup>68</sup>

59 World Health Organization. (2007). *Mental health: strengthening mental health promotion. In test (Ed.), Fact sheet (Vol. 220)*.

60 Australian Institute of Health and Wellbeing <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-content/prevalence-impact-and-burden-of-mental-health>

61 National Suicide Prevention Office. (2025). *National Suicide Prevention Strategy 2025-2035*. In. Canberra, ACT: Australian Government.

62 Productivity Commission [report](#) pg.89, Relationships Australia has added the concept of chronic psychological distress to this definition

63 NSW Health. (2020, January 20). *What is mental illness?* <https://www.health.nsw.gov.au/mentalhealth/psychosocial/foundations/Pages/mental-illness.aspx>

64 National Suicide Prevention Office. (2025). *National Suicide Prevention Strategy 2025-2035*. In. Canberra, ACT: Australian Government

65 Ibid

66 Ibid

67 Ibid

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# Appendix 2

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**If you or someone you know require 24/7 crisis support, please contact:**

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[www.lifeline.org.au](http://www.lifeline.org.au)

**Suicide Call Back Service: 1300 659 467**

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