Report for the Sunlight Centre: Understanding the mental health needs, concerns and priorities of the greater Brisbane community

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Executive Summary

In 2022, the Sunlight Centre commissioned the Australian Institute for Suicide Research and Prevention, Griffith University to undertake a study of the mental health needs and concerns of the Brisbane community to help shape and promote the services provided by the Centre. Three objectives were to be addressed:

1. Collect information on and explore the mental health needs, concerns, and priorities of the local community (defined as Greater Brisbane).
2. Better understand what encourages and leads individuals to seek out help when they are self-harming or suicidal.
3. Advise the Board of The Sunlight Centre regarding what the above suggest about how the Centre should shape its services and promote them in their local community.

A mixed methods approach was applied, comprising a Data Snapshot summary, a Focus Group study, and an Online Survey. All research has received ethical approval from the Griffith University Human Ethics Research Committee (Ref No: 2022/494). Preliminary results of each of the studies were presented in-person to members of the Sunlight Centre board and their valuable feedback has been incorporated into this report. Below is a general summary of the findings from the three studies and recommendations based on the evidence obtained.

- Consistent with Australian data and other that of other high-income countries, Queensland suicide and self-harm data show a ‘gender paradox’, where males are more likely to die by suicide than females, but females are more likely to be hospitalised for self-harm and suicide attempts. There is a clear opportunity to provide intervention for young females experiencing self-harm in greater Brisbane.
- The key areas of concern regarding mental health for greater Brisbane focus group participants were the safety of at-risk groups (youth, males, veterans, the elderly); accessibility of mental health services (particularly the issues of costs, waiting lists, and the need for referrals and mental health plans); roadblocks to accessing help; authenticity of mental health services; help for families and friends; and the need for human connection.

- There were relatively high levels of suicidality in the sample of online survey participants (although this is likely to be impacted by response bias). Only about 18% of those who reported suicidal behaviours had sought help. Young people are one of the most vulnerable groups. Suicidal ideation and suicide attempts were higher among this group, despite having less positive attitudes and the least experience of help-seeking.
- The main barriers to help-seeking were costs and difficulties finding appropriate services. The highest-rated enablers to seeking help were the service being cheap or free, private, not requiring referrals, having a website that provides detailed information on what to expect, and having an online booking function.
- Issues identified as being important regarding formal and informal help services were being empathetic and welcoming, confidential, tailored and reliable, expertise and credibility of the mental health professional, being accessible, and the client feeling empowered and having control over how they receive help. In terms of preferred methods for professional help sources to communicate their services, participants highlighted social media, the internet and technology, authenticity, face to face and via recommendation (formal and informal).

These results from these combined studies provide important evidence regarding the mental health support needs, concerns and priorities of the greater Brisbane community. These valuable insights have strategic implications for informing and shaping the support services of the Sunlight Centre and promoting these in the local community. Some key areas are highlighted below:

1. The main barriers identified to accessing mental health services were costs, waiting lists, and needing a GP's referral or mental health plan. Given the services provided by the Sunlight Centre do not have any of these barriers, there would be a clear benefit from strong promotional strategy to highlight these positive features.

2. Authenticity, respect, empathy and understanding, non-judgement, compassion, human connection, expert counsellors, and individual face-to-face services were all emphasised as highly valued components of mental health services. It will be crucial to consider framing and wording of services to highlight these attributes when promoting the Centre's services.
3. Social media and the internet were highlighted by participants as the most effective way to promote mental health services. It will be important to tap into these sentiments by tailoring the Centre's website and developing a strategy for social media.
4. Consider obtaining guidance from a company with expertise in areas such as PR, communications, social media, and understanding of how to authentically promote services to young people.
5. When promoted more extensively, there is likely to be strong interest in the Centre's services (especially given the costs, waiting lists and other barriers of many alternative mental health services). The Centre will need to consider its capacity to continue providing the same high-quality services if there was a sharp growth in clients.

Snapshot Data Report

June 2020

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Background and Aims

This report was prepared on 21 June 2022 upon request by The Sunlight Centre. It presents statistics on suicides in Queensland State and Australia. Data are broken down by age and sex in Queensland State for the period of 1990 to 2020. Data are broken down by age and sex in Australia from 2000 to 2020.

This report seeks to inform the Sunlight Centre Evaluation Objective One - Collect information on and explore the mental health needs, concerns, and priorities of the local community (defined as Greater Brisbane).

Existing health mortality and morbidity surveillance data was utilised to create a comprehensive profile of suicide and self-harm across Queensland and Greater Brisbane. Understanding how the local region compares to national and state averages is prioritised to 'know the knowns and unknowns' that will be useful for strategic planning of the Sunlight Centre.

Data Source

Data presented in this report was obtained from the Queensland Suicide Register (QSR), the Australian Bureau of Statistics (ABS) and the Australian Institute for Health and Welfare (AIHW).

The QSR is a comprehensive database of suicide mortality data, managed by the Australian Institute for Suicide Research and Prevention (AISRAP) and funded by the Queensland Mental Health Commission. The database gathers information on all suicides by Queensland residents since 1990. Data included in the QSR are collated from police reports, and autopsy and toxicology analyses.

The QSR provides an assessment of the incidence of suicide in Queensland, independent from data released by the Australian Bureau of Statistics. All received cases are scrutinised to determine the level of certainty that the death was due to a suicide. Cases are classified through a decision-making process which determines the probability of suicide following the Suicide Classification Flow Chart, developed by AISRAP (Appendix 1):

1. Confirmed: the available information refers to one or more significant factors that, in combination, constitute a pattern highly indicative of suicide.
2. Probable: the available information is not sufficient to allow for a judgement of

'certain' but is still more consistent with a death by suicide than by any other means.

3. Possible: the available information is suggestive of suicide but there is the substantial possibility that the death may be due to other internal or external causes of death. These cases are excluded from analyses and are not included in this report.
4. Unlikely: the available information suggests the death is unlikely to be a suicide and is instead due to other internal or external causes of death. These cases are excluded from analyses and are not included in this report.[1]

Important considerations:

- For this report, values based on numbers of deaths <5 have been suppressed to maintain data confidentiality.
- Where we are presenting data that is still preliminary, we acknowledge this by referring to the suicide rate as suspected. Suspected suicides refer to a death that appears to be a suicide, however the coronial investigation and determination of the type of death is still ongoing. Until a coroner finalises their investigation, deaths are referred to as suspected suicides. Deaths in the iQSR with a probability code of 'probable' or 'confirmed' are termed 'suspected suicides' to acknowledge the ongoing coronial processes.
- Suicide numbers refers to the number of deaths by suicide, also known as a count or frequency.
- Age-standardised rates refer to rates which adjust the crude rate to consider differences in population age structures over time.

[1] For more information on the decision-making processes of the QSR and iQSR, see Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

Key Data

Suspected suicides in Queensland in 2020:

- There were **790 people** in Queensland who died by suspected suicide in 2020.
- In 2020, **778 (98.5%)** people who died by suspected suicide in Queensland **were Queensland residents**, 6 were interstate visitors, and 6 were overseas visitors.[2]
- For Queensland residents, the age-standardised suspected suicide rate was **15.1 suspected suicides per 100,000 people.**
- This averages to **one suspected suicide every 11 hours, or about 2 people per day** who died by suspected suicide in Queensland in 2020.[3]

At risk groups in Queensland in 2020:

- There were **65 suspected suicides by Aboriginal and Torres Strait Islander people** in Queensland in 2020 (8.3%). The age-standardised suspected suicide rate for Aboriginal and Torres Strait Islander people was 27.9 per 100,000, compared to 14.3 per 100,000 for non-Indigenous people in Queensland.
- The age-standardised suspected suicide rate for males in Queensland in 2020 was 24.0 per 100,000. The rate for females was 6.6 per 100,000. **The male rate of suspected suicide was 3.6 times higher than the female rate in 2020.**
- **Males aged 35 to 39 had the highest number (74) of suspected suicides** and the highest age-specific suspected suicide rate (42.8 per 100,000).
- **Females aged 30 to 34 had the highest number (22) of suspected suicides.** Females aged 75 to 79 had the highest age-specific suspected suicide rate (12.4 per 100,000).[4]

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[2] Note that total 2020 numbers in the remainder of the report may indicate that the total number of suspected suicides in Queensland was n=776. As we have incomplete data for 2 suicides in Queensland in 2020, we are not counting these in the remainder of the paper.

[3] Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

[4] Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

Section 1: Self-harm in Queensland and Australia

The true extent of self-harm behaviour in Queensland and Australia, is unknown.[5][6] Obtaining comprehensive and accurate surveillance of self-harm behaviour can be difficult due to a variety of factors such as stigma, access to services and use of non-clinical support. However, obtaining this data is crucial as previous self-harm is a significant risk factor for suicide.[7] Research estimates that for every suicide, there are likely to be more than 20 suicide attempts.[8] Data on self-harm behaviour can be difficult to identify as a large proportion of people do not seek support after self-harm injuries or suicide attempts[9], meaning not everyone who self-harms or attempts suicide seek medical assistance, are attended by ambulance, or admitted to hospital.

In Queensland, ambulance attendance rates to cases of self-harm behaviour in 2020 were:

- 38.3 per 100,000 population (nearly 2,000 attendances) where self-injury has occurred;
- 72.4 per 100,000 population (over 3,700 attendances) for suicide attempts;
- 130.9 per 100,000 population (around 6,800 attendances) for suicidal ideation.[10]

In Queensland, the rate of ambulance attendance for self-injury increased from 8.6 per 100,000 population in March 2020, to 10.4 per 100,000 population in March 2021.[11] The rate of ambulance attendance for suicidal ideation increased from 30.6 per 100,000 population in

[5] For this report, self-harm behaviour includes suicidal ideation, self-injury (without suicidal intent), and suicide attempt (with suicidal intent). Commonly suicidal ideations and suicide attempts are considered mutually exclusive, self-injury is not.

[6] Australian Institute of Health and Welfare. 2021. Suicide & self-harm monitoring: Ambulance attendances, accessed 30 May 2022.

[7] World Health Organisation. 2016. Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. *World Health Organisation*.

[8] World Health Organisation. 2016. Practice manual for establishing and maintaining surveillance systems for suicide attempts and self-harm. *World Health Organisation*.

[9] Australian Institute of Health and Welfare. 2021. Ambulance attendances: suicidal and self-harm behaviours, accessed 30 May 2022.

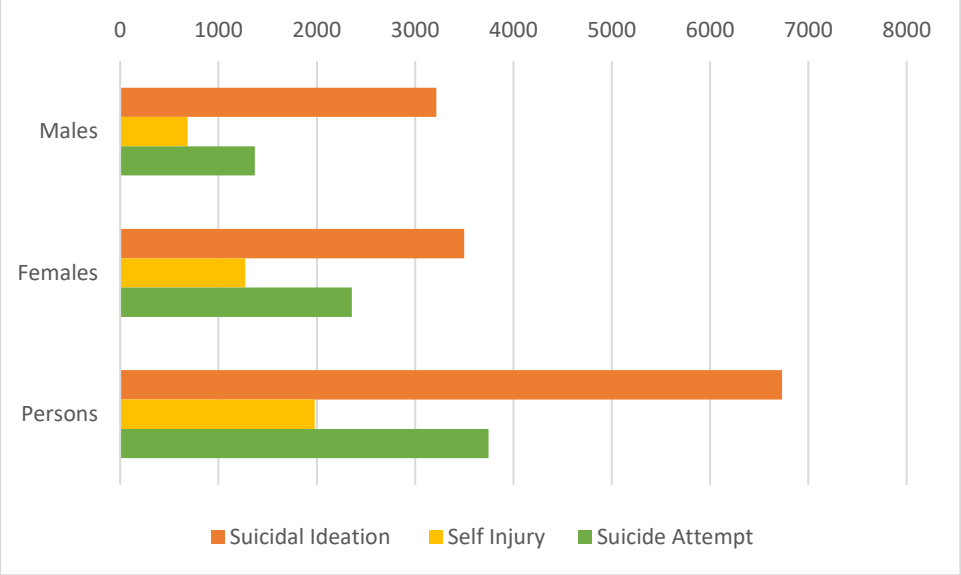
[10] Australian Institute of Health and Welfare. 2021. Ambulance attendances: suicidal and self-harm behaviours, accessed 30 May 2022.

[11] Australian Institute of Health and Welfare. 2021. Ambulance attendances: suicidal and self-harm behaviours, accessed 30 May 2022.

March 2020, to 35.2 in March 2021.[12]

Figure 1.1 shows ambulance attendances for self-harm behaviours in Queensland in 2020 were more common for females who self-injured (1,272) or attempted suicide (2,357), than males who self-injured (686) or attempted suicide (1,370). Numbers for ambulance attendances for males (3,215) and females (3,500) who experienced suicidal ideation were similar.

Figure 1.1: Ambulance attendances for self-harm behaviours, by gender and persons, Queensland, 202013



Source: Australian Institute of Health and Welfare. 2021. Data Tables: 2021 National Ambulance Surveillance System – self-harm behaviours. Table AMB S1: Ambulance attendances for self-harm behaviours, by gender, selected states and territories, 2020, accessed 30 May 2022.

There were more than 28,600 hospitalisations for intentional self-harm in Australia from 2019 to 2020.[14] The highest proportion of these hospitalisations for self-harm was in Queensland

[12] Australian Institute of Health and Welfare. 2021. Ambulance attendances: suicidal and self-harm behaviours, accessed 30 May 2022.

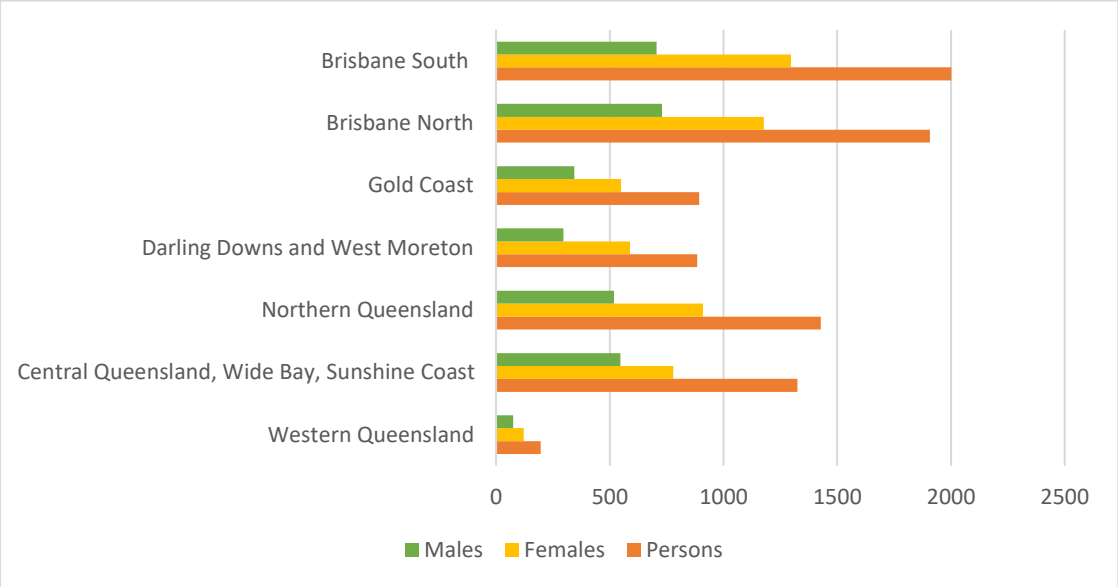
[13] Numbers for demographic variables may not sum to the total due to missing or not reported data.

[14] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations by states & territories, accessed 30 May 2022.

(30.2%).[15] Throughout Australia, the rate of hospitalisation for self-harm behaviours was higher for females (141 per 100,000 population) than males (84 per 100,000 population).[16]

Figure 1.2 illustrates the number of intentional self-harm hospitalisations in Queensland Primary Health Networks (PHNs). PHNs are Australian government funded independent organisations which coordinate primary health care in their region. Brisbane South and Brisbane North PHNs largely cover the Greater Brisbane region, however this boundary is not based on statistical areas (for more information on PHN boundaries see Appendix 3). Figure 1.2 shows that hospitalisations for self-harm were more common for all persons in Brisbane South and Brisbane North regions, than in other PHNs.

Figure 1.2: Intentional self-harm hospitalisations, by Queensland Primary Health Network (PHN) areas, sex, 2019 to 2020



Source: Australian Institute of Health and Welfare. 2021. 2019-20 National Hospital Morbidity Database – Intentional Self-Harm Hospitalisations. Table NHMD S7: Intentional self-harm hospitalisations, by Primary Health

[15] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations by states & territories, accessed 30 May 2022.

[16] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations by age groups, accessed 30 May 2022.

Network areas, age and sex, 2019–20, accessed 30 May 2022.

In Australia, young people have the highest rates of hospitalisation for self-harm behaviours. The rate of hospitalisation for self-harm behaviours for young people aged 15–19 was highest (354 hospitalisations per 100,000 population).[17] Rates for 20–24-year-olds was lower, (252 per 100,000 population), and the rate for children aged 14 and below was the lowest (24 per 100,000 population).[18]

Young females had consistently higher rates of hospitalisation for self-harm behaviours than young males.[19] Over the 2008-09 to 2019-20 period, the rate of self-harm hospitalisations in females aged 14 and below doubled (from 19 hospitalisations per 100,000 population to 41).[20] The rate of self-harm hospitalisations in females aged 15–19 rose from 374 hospitalisations per 100,000 population to 552.[21] Rates of self-harm hospitalisations for young males (in the 15-19 age group) increased from 124 per 100,000 population to 165 in the 2008-09 to 2019-20 period. https://www.aihw.gov.au/suicide-self-harm-monitoring/data/populations-age-groups/intentional-self-harm-hospitalisations-among-young[22]

[17] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations among young people, accessed 30 May 2022.

[18] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations among young people, accessed 30 May 2022.

[19] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations among young people, accessed 30 May 2022.

[20] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations among young people, accessed 30 May 2022.

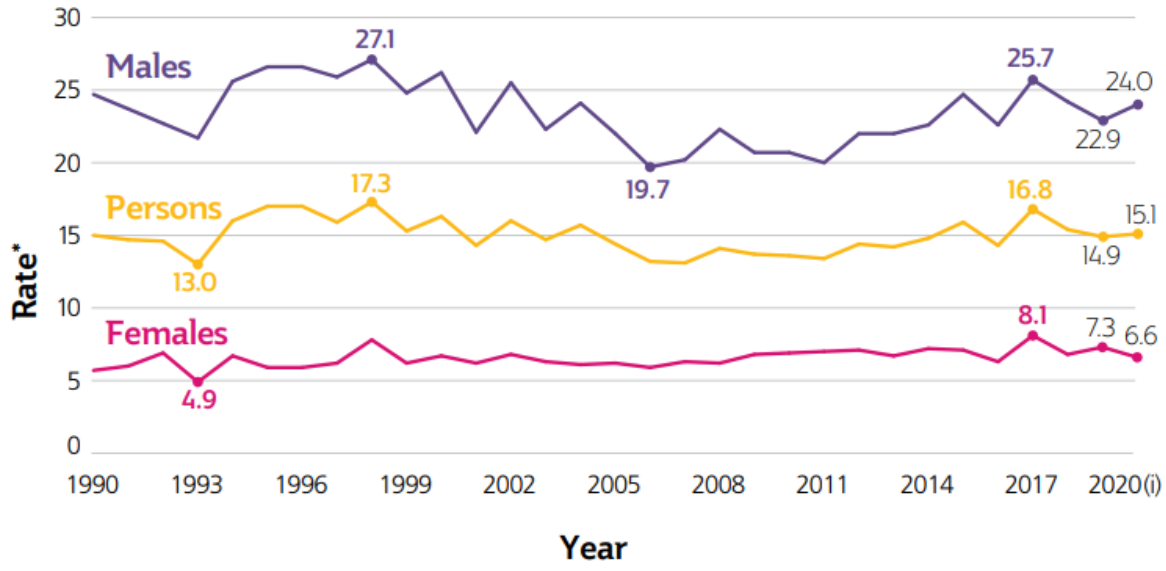
[21] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations among young people, accessed 30 May 2022.

[22] Australian Institute of Health and Welfare. 2021. Intentional self-harm hospitalisations among young people, accessed 30 May 2022.

Section 2: Deaths by suicide in Queensland [23]

In 2020, Queensland had the second highest number of deaths by suspected suicide (790) compared to all other Australian states and territories. The highest number of suicides in Queensland was in 2017 (815). Of the 778 Queensland residents who died by suspected suicide in Queensland in 2020, 605 (77.7%) were male, and 173 (22.3%) were female. The age standardised suspected suicide rate in Queensland has fluctuated over time. The age standardised suspected suicide rate for males increased from 22.9 in 2019 to 24.0 per 100,000 males in 2020 (Figure 2.1). For females, it decreased from 7.3 in 2019 to 6.6 per 100,000 per females in 2020. The highest male age standardised suspected suicide rate from 1990 to 2020 was in 1999 (27.1), the highest female age standardised suspected suicide rate was in 2017 (8.1).

Figure 2.1: Age-standardised suicide rates by sex, Queensland residents, 1990 to 2020



Source: Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention,

[23] The data discussed in Section 2 is sourced from: Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

Most suspected suicides in Queensland in 2020 occurred in the age groups from 20 to 59 years old (72.6% of men and 66.7% of women). In 2020, men aged 35 to 39 accounted for the greatest number (74) and proportion (12.2%) of male suspected suicides and had the highest age-specific suspected suicide rate at 42.8 per 100,000 men (Table 2.1).

In 2020, women aged 75 to 79 had the highest age-specific suspected suicide rate per 100,000 women (12.4). Females aged 30 to 34 had the highest number (22) and the second-highest age-specific suspected suicide rate per 100,000 women (11.9).

Table 2.1: Suspected suicide numbers and rates by age group and sex, Queensland residents, 2020

	Males		Females		Persons	
Age group	Number	Rate	Number	Rate	Number	Rate
10 to 14	np	np	np	np	8	2.3
15 to 19	35	21.4	11	7.1	46	14.4
20 to 24	63	37.0	15	8.9	78	23.0
25 to 29	49	26.6	17	9.1	66	17.8
30 to 34	54	30.5	22	11.9	76	21.0
35 to 39	74	42.8	11	6.1	85	24.0
40 to 44	49	30.8	16	9.6	65	20.0
45 to 49	55	32.3	15	8.5	70	20.1
50 to 54	49	31.4	11	6.7	60	18.7
55 to 59	46	29.7	8	4.9	54	17.0
60 to 64	39	27.7	9	6.1	48	16.6
65 to 69	20	16.1	9	6.9	29	11.4
70 to 74	24	21.5	9	7.9	33	14.6
75 to 79	15	19.7	10	12.4	25	15.9
80+	28	33.6	8	7.2	36	14.9

Source: Source: Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

Section 3: Deaths by suicide in Australia

Deaths by suicide are known to change over time as social, economic and environmental factors influence and impact risk factors for suicide. Analysis of Australian rates and numbers of suicide can identify modifiable risk factors for suicide, such as restricting access to most commonly used means of suicide and alleviating the impact of social or economic stressors In 2020, there were 3,139 suspected suicide deaths in Australia (12.1 per 100,000 population).[24] Overall, the national age-standardised suicide rate in 2020 was 12.1 per 100,000 people, this was the lowest national rate since 2016 (11.9 per 100,000 people).[25]

Of suspected suicide deaths in 2020, 2,384 were males (18.6 per 100,000 population) and 755 were females (5.8 per 100,000 population).[26] Suicide was the 10th leading cause of death for males, and the 22nd leading cause of death for females.[27] New South Wales had the highest number of suicide deaths registered in 2020, Queensland had the second-highest number (Figure 4.1).[28]

Table 4.1 contains some critical statistics on suicide from the Australian Bureau of Statistics (ABS) Causes of death, Australia, 2021 release for the 2020 reference period. Statistics in this table show that, although suicide was not a top-ten leading cause of death in Australia, it was the leading cause of death for younger age groups (15 to 44 years).[29] Additionally, suicide accounts for the *most* years of potential life lost[30] in Australia of all premature causes of death, above ischaemic heart disease and lung cancer.[31] While Queensland had the second-highest number of suicide deaths registered in 2020 (Figure 4.1), the age-standardised suspected suicide rate per 100,000 persons was lower than in the Northern

[24] Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

[25] Australian Bureau of Statistics, Causes of death, Australia, 2020, accessed 30 May 2022.

[26] Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

[27] Australian Bureau of Statistics, Causes of death, Australia, 2020, accessed 30 May 2022.

[28] Australian Bureau of Statistics, Causes of death, Australia, 2020, accessed 30 May 2022.

[29] Australian Bureau of Statistics, Causes of death, Australia, 2020, accessed 30 May 2022.

[30] Potential years of life lost refers to premature deaths before the age of 78. For example, if dying before the age of 78 is considered premature then a person dying at age 40 would have lost 38 potential years of life. As suicide has a low median age at death (43.5) than other causes of premature death, this translates to a high number of potential years of life lost.

[31] Australian Bureau of Statistics, Causes of death, Australia, 2020, accessed 30 May 2022.

Territory or Tasmania.[32]

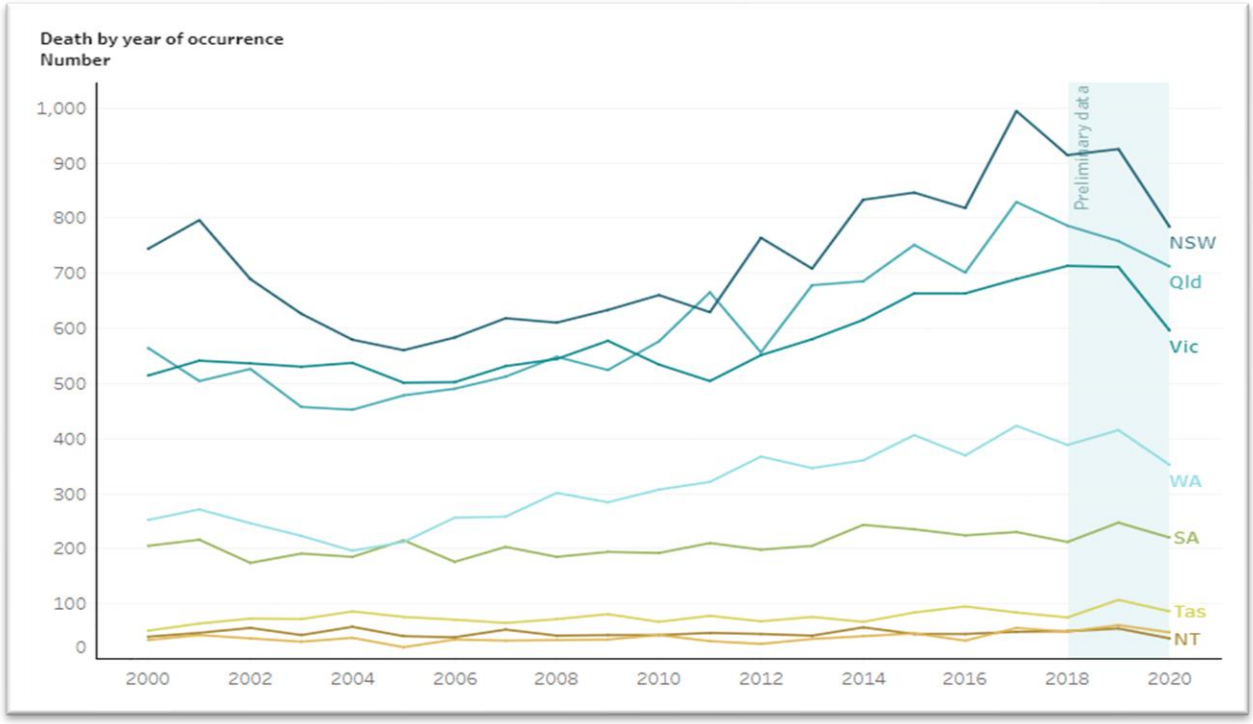
Table 3.1: Queensland and Australian suicide statistics

Statistic	Value
The age-standardised suicide rate for Australia	12.1 per 100,000 people
The age-standardised suicide rate for Queensland	14.7 per 100,000 people
Suicide's position in the leading causes of death in Australia	15th
Suicide's position in the leading causes of death in Australia for people aged 15 to 44	1st
The Queensland proportion of all deaths by suicide registered in Australia	24.2%
Queensland position in all Australian jurisdictions on the number and proportion of suicides	2nd, after New South Wales
Queensland position in terms of the age-standardised suicide rate	Third, after the Northern Territory (20.4) and Tasmania (15.9)

Source: Australian Bureau of Statistics (2020), *Causes of death, Australia*, ABS website, accessed 30 May 2022; Leske, S., Schrader, I., Adam, G., Catakovic, A., Weir, B., and K. Kõlves. 2021. Suicide in Queensland: annual report 2021, Australian Institute for Suicide Research and Prevention, https://www.griffith.edu.au/__data/assets/pdf_file/0037/1498870/QSRAnnualReport2021.pdf

[32] Australian Bureau of Statistics, Causes of death, Australia, 2020, accessed 30 May 2022.

Figure 3.1: Suicide death numbers by states and territories, Australia, 2000 to 2020



Source: Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

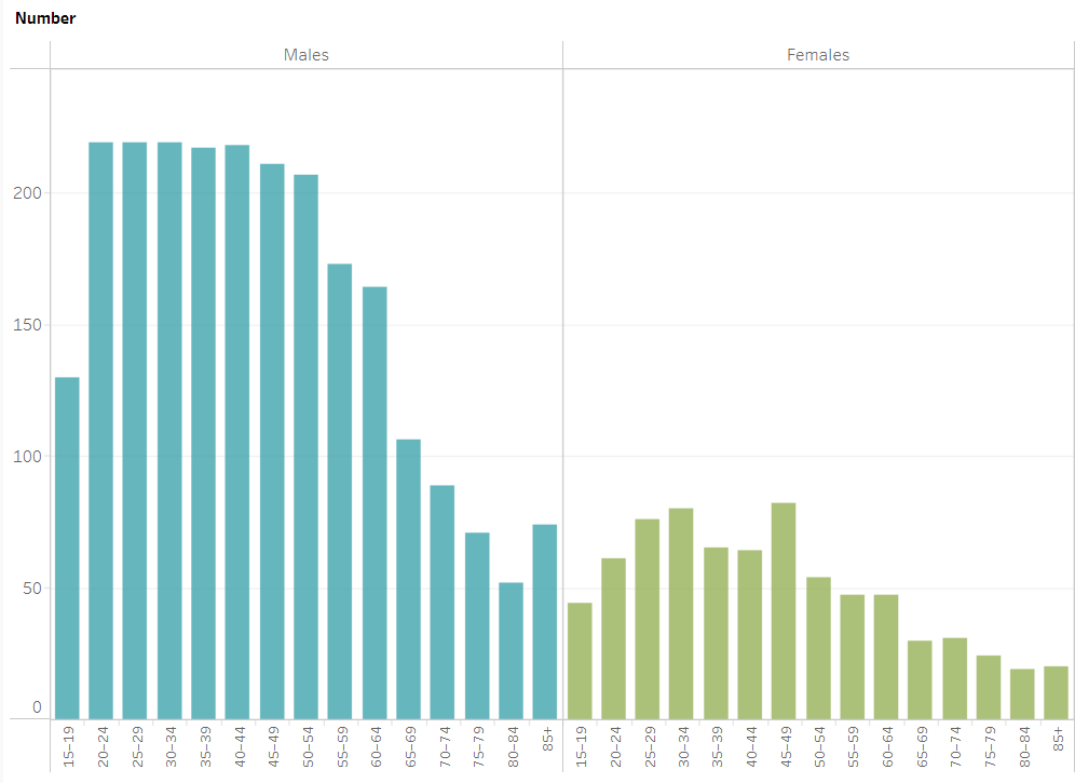
In Australia, suicide rates and numbers for males are consistently higher than those for females (Figure 3.2 and Figure 3.3). In 2020, 52% of all deaths by suspected suicide in 2020 occurring in people aged 30 to 59, compared with 24% for those aged 15 to 29, and 23% for those aged 60 and over (Figure 3.2).[33] In 2020, males aged 20-49 had the highest numbers of suicide in Australia, and females aged 30-34 and 45-49 had the highest numbers (Figure 3.2).[34] Overall, the rates of suicide for males, females, and persons, decreased from 2019 to 2020 (Figure 3.3).[35]

[33] Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

[34] Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

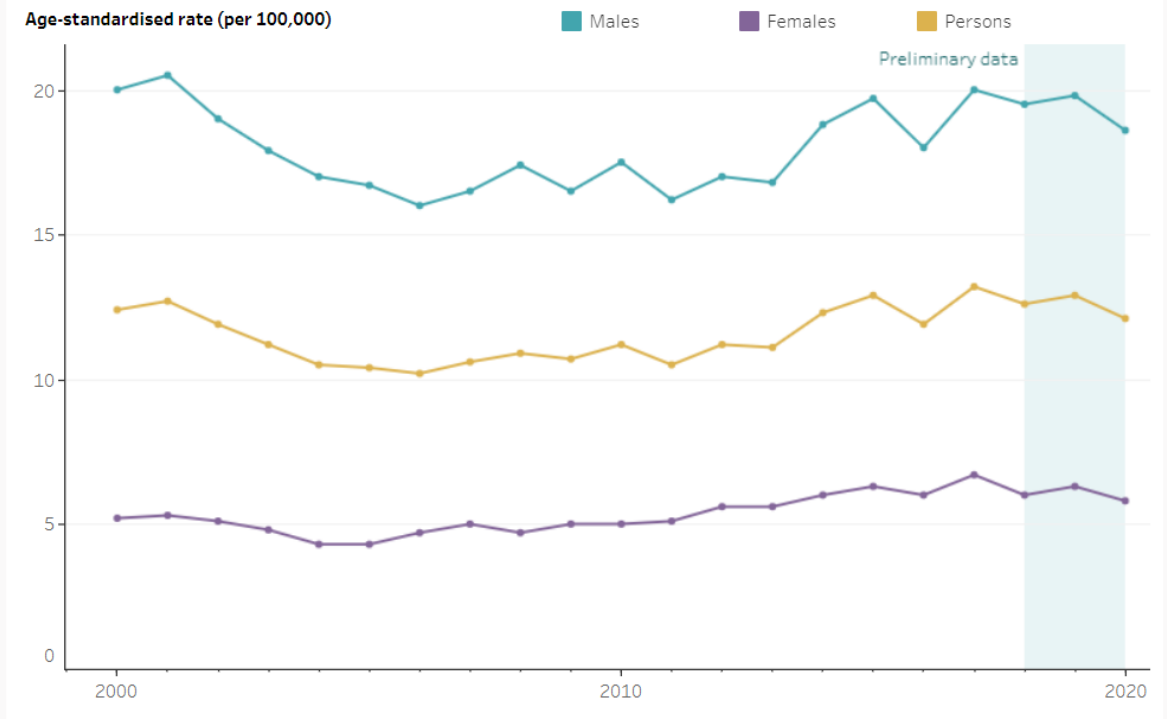
[35] Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

Figure 3.2: Suicide death numbers by age and sex, Australia, 2020



Source: Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

Figure 3.3: Age-standardised suicide deaths by sex, Australia, 2000 to 2020



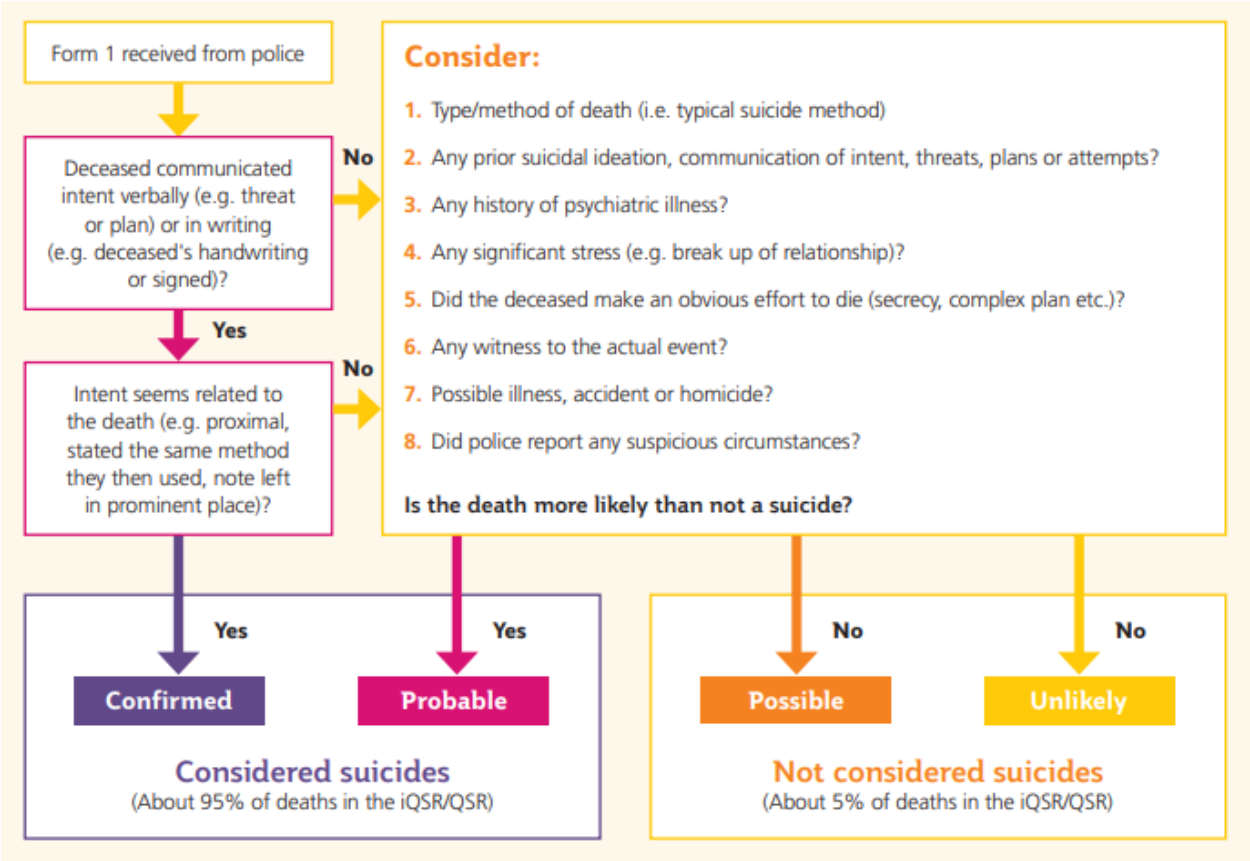
Source: Australian Institute of Health and Welfare. 2021. Deaths by suicide over time, accessed 30 May 2022.

Summary

This report informs the Sunlight Centre Evaluation Objective One - Collect information on and explore the mental health needs, concerns, and priorities of the local community (defined as Greater Brisbane). This report provides a snapshot of existing health mortality and morbidity surveillance data from Queensland and Australia to create a profile of suicide in these areas.

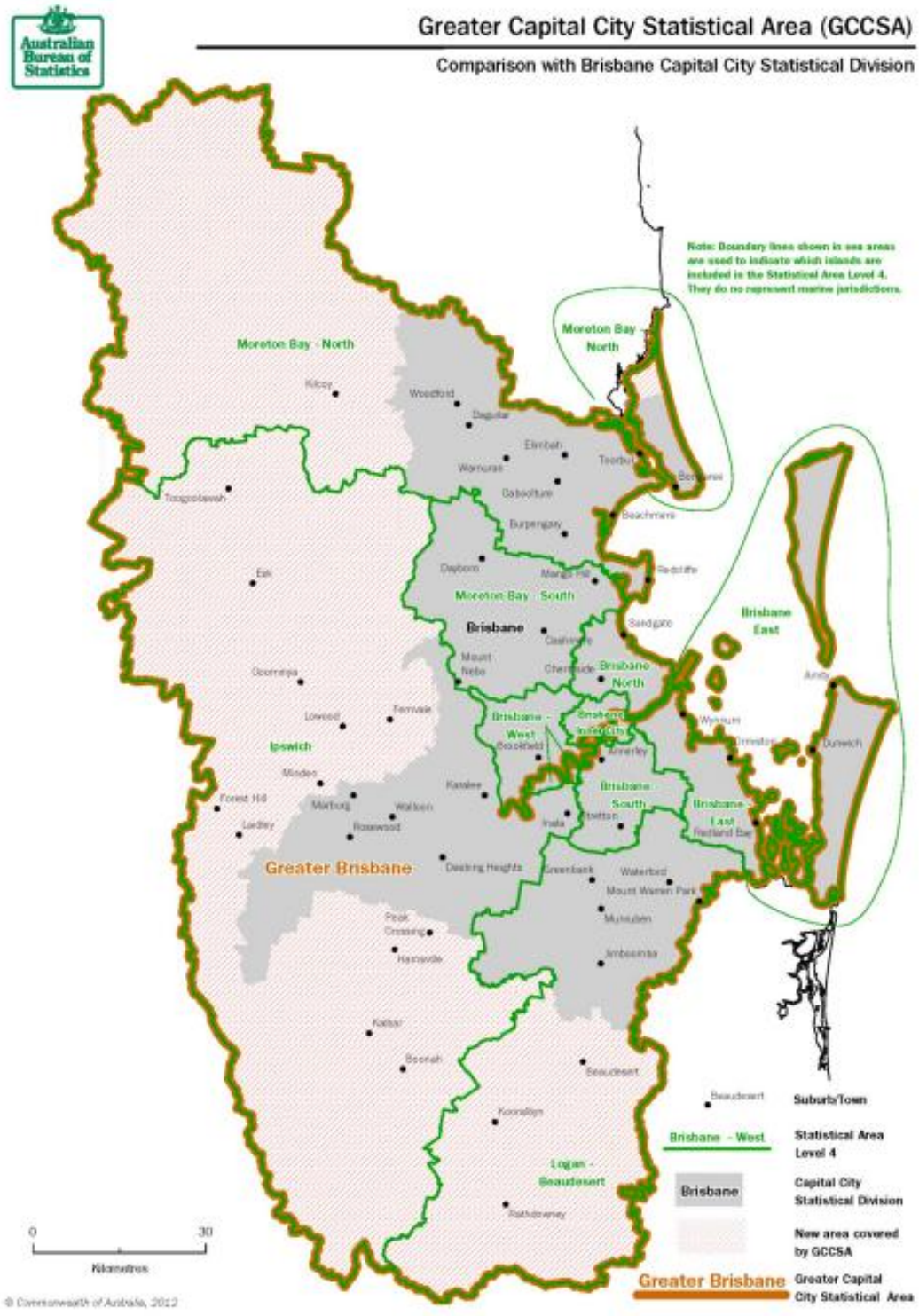
Appendix 1

Decision tree for coding the probability of suicide death in QSR and iQSR



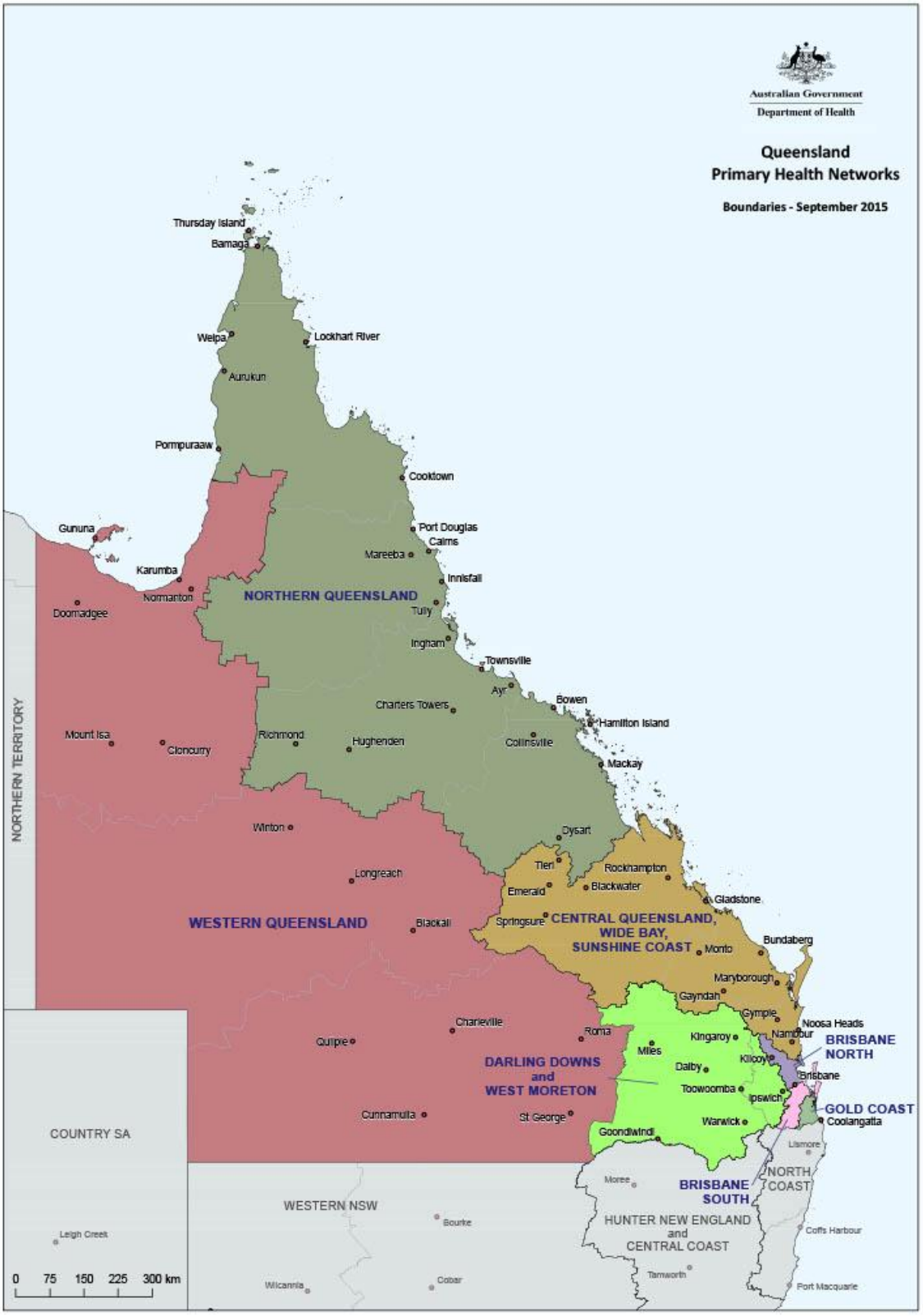
Appendix 2

Greater Brisbane Area Map



Appendix 3

Queensland Primary Health Networks (PHN) boundaries



Focus Groups Report

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Method

Procedure

A series of seven focus groups were conducted in the Greater Brisbane area between September and November 2022. Focus groups were split by age and by social group to ensure a representation of key community stakeholders. Recruitment was conducted by the Sunlight Centre to leverage existing networks. The research team collaboratively developed and refined a topic guide with the Sunlight Centre to obtain a sense of community priorities and service needs (See Appendix A for the topic guide). Experienced focus group facilitators used this guide to direct conversation where needed but group members were encouraged to talk freely and discuss issues that were important to them. All focus groups were recorded and transcribed. Transcriptions were all deidentified to protect the anonymity of participants. Data analysis was conducted by the research team and preliminary findings were presented to the Sunlight Centre board prior to finalisation.

Participants

The focus groups were comprised of one group of secondary school boys, one with older men from a local Walk & Talk group, one with parents/teachers from a local school, one community group and three groups from various workplaces. The groups ranged in size from three to six participants.

Ethical Approval

Ethical approval for the current study was provided by Griffith University's Human Research Ethics Committee (Ref No: 2022/494). All participants provided written and informed consent to participate. Parents provided written informed consent for students aged 16 years or younger and students provided assent. Approval was obtained from school executives and ethical committee to approach students and conduct focus groups on site.

Data analysis

An inductive thematic analysis of focus groups transcripts was conducted by the research team (Bradbury-Jones et al., 2017; Braun & Clarke, 2006; Nowell et al., 2017). Themes were generated by the content of the focus groups as opposed to an a priori coding schedule. Transcripts were read independently by two authors (VR & SM) to determine preliminary codes and themes which were discussed for consensus.

Results

Six overarching and interconnected themes were identified from the transcripts that characterised the needs, concerns, experiences, and the help-seeking journey of the Greater Brisbane community in relation to mental health and self-harm. Each theme had several sub-themes which are described, and illustrative quotes are provided.

'At risk' groups

This overarching describes the various demographic groups or life situations identified by focus group participants as being more susceptible to mental health issues. Participants in the focus groups expressed concerns about these groups and identified specific factors contributing to their increased risk of mental health challenges. The subthemes were youth, males, veterans, and the elderly.

Youth

The focus groups discussed concerns about the mental health and well-being of young people, particularly in high school. There were mentions of increased stress and pressure on students, which can lead to issues such as drug use, self-harm, and suicide attempts. Participants also expressed worry about the impact of technology on young people's mental health, and how mental health professionals may not be equipped to handle these new challenges. The discussions highlighted the need for support and resources to address these issues and provide help to young people.

Grade 9 and 10 that's when a lot of the, in particular, like very specific friend groups get more into drugs and things like that, and it, that was around the time where a lot of my mates started, yeah, and you could really see the affect that it had on them and stuff like that.

Youth, particularly with what's going on in the schools, in that particular area, we've had a number of, not only suicides, but self-harm attempts – major ones.

High school kids have so much more pressure on them to do well, to compete, what's happening…

I'm really worried about this generation with technology, and all of the psychologists that are qualified now, they won't know how to deal with these kids, because there's no case studies. It's only just happening now.

Males

The focus group discussions highlighted the challenges that men, particularly middle-aged males, face when dealing with mental health issues. The quotes provided indicate concerns that many men are struggling with mental health, particularly around stresses of living such as the 'midlife grind' and financial pressures. There is also a generational and gender split in attitudes towards mental health, with a stigma attached to men seeking help or showing vulnerability. The traditional expectation of men being strong and not showing emotions was perceived as a barrier for men to reach out for support. The discussion suggests a need for a change in attitudes and perceptions towards men's mental health and the promotion of seeking help as a sign of strength.

I'm dealing with dozens of people that have just split [from a relationship], and they're suicidal, and just about all of them are men.

I call that the midlife grind. Because that's all you're doing, and that's all I feel like I'm doing, or I've been doing, since I was 30, and had kids. I'm just grinding. Like you said now, I'm working in the trade, work six days a week. I was working a 64-hour week. I did that for 10 years, up till three, four months ago, and I got out of it and backed off a little bit, but it's a grind. It's just the grind. There's so many – I work in a very male-oriented workplace, and the young fellows, as well, apprentices, mates, from 20 up, they're all there. They're all there.

Maybe a bit of judgement. Again, maybe linking back to the masculinity thing; it's like you know, you reaching out is, do you really want to do that? Do you want other people - not necessarily other people to know, but other people to know that you're having a difficult time or something like that.

Veterans

The discussion among the focus group participants highlighted that veterans have been somewhat forgotten in recent years, making it challenging for them to transition back into civilian life, particularly those who have been involved in the Afghan war. Despite improvements over time, the need was identified to provide adequate support and assistance to veterans to help them reintegrate into society successfully.

The veterans - it is getting better as time goes on, but probably the last decade it's been – everyone's sort of forgotten about the veterans, unfortunately. It is quite difficult for some of those guys to come out of, especially the Afghan war and come into civilian life again.

[My concerns] are mainly in the veteran community, being ex-military. COVID was a pretty rough time on the veterans. Everyone was pretty much isolated, so we didn't have that camaraderie that we're

used to. It was quite a difficult time for everyone.

Elderly

The focus groups highlighted concerns that the elderly, particularly men who have lost their life partner, can experience a loss of connection and struggle to cope with their new circumstances. Participants emphasised how social isolation and loneliness can affect individuals at any age and stage of life. It was also noted that there is less knowledge about mental health issues in the older community and that there may be many older people who may not be aware or understand that they have a mental health condition.

The elderly, as well. We've got quite a lot of gentlemen that come along… once they lose their life partner, they don't know what to do.

There's a massive stigma amongst their community [the elderly] about mental health as well, the way that they grew up. It wasn't a conversation that you had, and I think there's a lot of our older community that have mental health issues that don't actually realise they have mental health issues.

Accessibility of services

This important theme highlights the challenges participants reported in accessing mental health services. The sub-themes reveal specific barriers, including the intimidating nature of general practitioners, difficulty in finding appropriate help, time-related challenges, costs, and long wait times.

GPs can be off-putting

The discussions across the focus groups revealed that some individuals find general practitioners intimidating and uncomfortable when discussing mental health, which makes them hesitant to seek further help. The term "general" in general practice was identified as a potential source of discomfort for those seeking help with mental health issues. This could be seen as an accessibility issue for those seeking help for mental health concerns.

Because they're obviously general practice, it's in the name, general, so when you go in there and you're talking about that sort of stuff it can be really uncomfortable and it's enough to turn you off even going that step further.

Difficulties in finding appropriate help

Participants identified difficulties in finding help as a key accessibility issue. While some

participants reported feeling overwhelmed by the amount of information and different types of mental health concerns, others reported little awareness or knowledge of available resources. Younger participants noted that a helpline would not be their first point of call and emphasised their preference instead for meeting face-to-face with a psychologist or a therapist. It was suggested that more awareness campaigns and personalised approaches to reaching out to those in need could help address this issue.

I think that just comes back to awareness and knowing what's out there. If you've got people with different issues going on, it can be really overbearing with the amount of information out there and the different people to go to, and where are they, and can I get there.

I don't think of like, when I think of like where to go for help, I don't really think about a helpline. I more think of a psychologist or a therapist, because they're just like there with you face-to-face on a personal level. I don't think of a helpline.

Time-related challenges

The focus groups identified time-related challenges as accessibility issues for sourcing help. Participants described how people are busier than ever, and time management is a challenge. Many young people are focused on school or work and find it difficult to find time to seek help for mental health issues. Additionally, the introduction of technology and the use of screens has created an addiction to technology, making it even more challenging to find time for face-to-face conversations. Moreover, young families are struggling to pay their mortgages, forcing parents to work multiple jobs, which reduces their availability to connect with their communities. The lack of community connectedness makes it challenging to find support and help from others. The participants suggested that face-to-face connections are essential for seeking help and building relationships.

I think face to face is really important. I don't think any amount of telephones, Zooms [are useful]. [It's about] time and commitment. Connections and relationships.

I think with like, you know, Twenty-first Century everyone's working, everyone's going to school; you go to school like eight to three, you go home you have to do homework and it's just like sometimes you just kind of like ignore, push your health to side, and that's one of them that could hinder your ability to go seek help.

What they teach you at school, like about time management, and they're like 'you should be able to just get your subjects done'… but like when you're on a timetable you're not planning for bad days, you're not planning for like having a really bad afternoon, not planning for arguments with your parents, whatever it is.

Costs

The focus group participants identified the cost of accessing mental health services as a major accessibility issue. They discussed the high cost of seeing a psychologist even with a mental health plan discount, which can make it difficult for individuals and families to seek help regularly. The lack of affordable options for mental health services was identified as a barrier to getting the support needed.

That was my biggest eye-opener, was the cost, the absolute cost of it.

There's not enough psychologists around, and even if you can get one, they're very expensive. Even if you get the mental health plan with the discount, you're still paying $150 a session, and that one session a week, or a fortnight, or a month for your kid, it's not enough.

Long waits

Long wait times as a major accessibility issue for sourcing help. Participants expressed concern over the overwhelmed and ill-equipped state of the current school and hospital systems. There were reports of desperation from parents, families, siblings, and friends who are unable to access the help they need. Participants also noted issues with the criteria used to determine eligibility for emergency care, which could lead to vulnerable young people being turned away despite their urgent need for help. The quotes below illustrate the frustration and despair of individuals who feel that the system is failing them in their time of need.

School at the moment is incredibly overwhelmed with it and ill equipped and I also know that the current systems, the hospital locations, you can't get your child in there when you need to. I know that that's huge as well.

The waiting lines, the emotion that I see and hear and have felt, the desperation of parents, the desperation of families, the desperation of siblings, the desperation of friends who can't access the help that they need. You can't access the services. You can't access the beds in hospitals. I also have a bit of an issue with some of that and how it kind of directs these extremely vulnerable young people in a direction that says well, you can access this emergency care once this has happened. So for somebody who is super desperate and there is nothing left for them and it doesn't how much support is elsewhere, when they are told by the system I see you, we see that you need help, but you don't qualify for this because you haven't done this yet. What is it telling them?

Roadblocks

The "Roadblocks" theme from the focus groups refers to various barriers and challenges that prevent individuals from seeking and accessing mental health services. The quotes in this theme indicate that people face a range of roadblocks, including stigma and past negative experiences, historical lack of support, work-related challenges, and personal and systematic barriers.

Stigma and past negative experiences

The focus groups identified that there is a stigma surrounding mental health issues and seeking help, especially among low socio-economic groups and those with past negative experiences with mental health services. The fear of being judged or labelled as "crazy" and the negative experiences of being held in a psych ward and losing control over their own lives were cited as reasons why some people are hesitant to seek help. This highlights the importance of providing non-judgmental and personalised support to individuals experiencing mental health issues, to break down the stigma associated with seeking help and to increase accessibility to mental health services.

I think it's more or less your low socio-economic group of people that are coming through the door. Then you've also got your watching houses around – for us it's the people at watch houses and stuff like that. They're the people who've got drug abuse, alcohol use in their– they're the ones that are getting shunned to the side.

I know from some people it's been passed experiences that have been bad. Where they've been in the psych ward before and they're like, 'I'll never go back'. Because like, especially back home if you've been there before, they keep an eye on you. So, if there's any welfare checks that have been done and if there's anything out of the [blue] you get put back in for a couple of days at least, for holding and observation. So, a lot of times people just won't say anything.

Personal and systematic barriers

The discussion in the focus groups revealed that there are both personal and systemic barriers that prevent people from seeking help for their mental health issues. Personal barriers include a lack of awareness or understanding that their situation can be improved by seeking help, as well as a reluctance to open-up due to feeling that helplines and other services are too scripted and impersonal. Systemic barriers include difficulties in accessing mental health plans through GPs and a societal bias towards prioritising physical health over mental health. Additionally, people may wait too long to seek help for their mental health

issues, making it more difficult to address them effectively.

[Regarding helplines, feeling scripted] it degrades your problems, your issues, if you're opening up and you have all these issues that are really affecting you and your life, and it's kind of just like, they just like, 'oh okay that goes there, we say this'. It kind of, I don't know, might just…it's not personal at all.

I think even with that initial conversation that you have with the GP to try and get a mental health plan; it can take a lot to actually get to that point and be like, 'right, I'm going to do something now'. Then you walk away and like, 'cool, I've got this piece of paper', but you actually can't do anything with it.

I suppose another part of it is that if you think in terms of mental health versus physical health, you cut your finger, you go see a doctor. You break your leg, you go see a doctor. Mentally, people tend to get past the point of breaking their leg, and suffering with it for a couple of years, before they even think of engaging, and then, by then, it's sort of too late.

Authenticity of help sources

This theme focuses on the importance of authenticity in seeking help for mental health issues identified by focus group participants of all ages. The subthemes explore the trustworthiness of different sources of help, the relatability of the helper, the effectiveness of different types of help, and the accessibility of help sources.

Trustworthiness

The discussion in the focus groups revolved around the trustworthiness of help sources and how this relates to the authenticity of the help sources. Participants expressed concerns about the relatability of those they turn to for help, with some feeling embarrassed or worried that they would be laughed at or insulted by their friends or family. Others shared the belief that professional help sources lack care or compassion, are too focused on following a script, and lack the ability to relate to their personal experiences.

In contrast, some participants believed that help sources do not necessarily need formal qualifications or training to be helpful, if they have personal experience and strategies to manage their issues. They also highlighted the importance of having a genuine and authentic relationship with the help source to establish trust, which is crucial for the success of any intervention or treatment. Overall, the focus groups emphasised the need for help sources to be authentic and relatable to establish trust and build a meaningful relationship with those seeking help.

I would kind of feel like, almost like embarrassed or like feeling that I shouldn't talk about this with my parents, because I'm just not allowed to.

Well, if you were to ring up, say, Beyond Blue, I know that their response is going to be all by rote. So, for me, as a reasonably learned person, I'm going to be feeling like I've been treated like –nothing. I have no value.

It's things like R U OK? Day and things like that, but it feels so like just a systematic thing that they're just doing, but so not genuine if that makes sense. It's like a, oh, you know, this is R U OK? Day, and then the next day it's forgotten. So like a thing that the government is just telling the school to do, which I'm pretty sure it is, just like the thing that the government's telling the school to do to tick a box or something, 'yeah, we've done that now'.

They have no care or compassion, but they know the book, and you're going, 'you don't know how to relate to the person', and without relating to person, they don't trust you, and without trust, there's no relationship. So, you're basically just wasting everyone's time. So, it needs to be the right approach, the right psychologist, the right mentality.

Relatability

The focus groups discussed how the relatability of help sources can impact the authenticity of the support provided. They highlighted the importance of finding sources of support that are relatable and relevant to one's own experiences. This can be a challenge in a world where social media often presents unrealistic images and expectations, and where everyone has unique lives and circumstances. Participants emphasised the need for support groups where individuals can connect with others who can truly understand what they are going through, rather than relying solely on medical professionals or online resources. Overall, the focus groups identified the need for relatable and personalised sources of support to effectively address mental health concerns.

I think with social media you can hide yourself in not real life and show whatever you want to show. People believe that other's life is better than yours. It's not reality at all because you don't show that you're crying. You just show that you're smiling. So, there's kind of a scenario now to share with each other is not real and it's very depressive. Because we are not perfect, we are not happy all the time, and when we open the social media, everyone is. So, why are they happy and I'm not? Why are they rich and I'm not? Why do they have everything, and I don't, and that's not true.

There's a lot more support out there now than what there used to be before. Like it's just your GP and you get medicated and this and that. But now they have support groups for all sorts of mental health, and they're for anyone that can join and access, so it doesn't just have to be a GP. Then you're with people that can understand what you're going through. It's better to talk to them than your GP

sometimes.

You don't have to have letters after your name, or anything. If you've got experience with this disease, this health condition, and, to a certain extent, you've found your way through the forest and out the other side, and now it's a situation where you manage it with strategies, and regular reviews from you GP or your counsellor, you can be a resource to be tapped into. All you need to do is have enough confidence to talk – whether it's a neighbour or a friend or a mate.

Effectiveness

The focus groups discussed the effectiveness of different sources of help and identified that people tend to prefer talking to friends about their problems rather than going to someone they don't know. However, this can put pressure on the friend and may not be the best solution. Participants suggested that having a simple process to follow would be helpful for those who don't know what to do when someone talks to them about their problems. The discussion also touched on the negative impact of social media and the challenges of managing its exposure, particularly for young people. The group acknowledged that sometimes people may need professional help but may not initially recognise it or may have a preconceived notion of what kind of help they need. The authenticity and fit of the help source were seen as an important factor in its effectiveness.

In friend groups there's often like the friend therapist; like he talks to everyone about their problems. And people tend to like prefer going to their friends to talk about their problems rather than going to someone that they don't know. It puts a lot of, almost pressure on that person, because they're now the go to person that everyone kind of dumps their thoughts onto, and that can have an impact on that person.

I think social media generally is probably one of the most arguably socially cancerous things that have been created at a global scale, so intensely, and the challenge is not its exposure, it's the inability to manage that exposure at such a young age, like 12. I've got a six-year-old, and it's like, holy hell, you've got to start reeling stuff in really quick in trying to manage platforms and things, but they're clued up, and they know how to get around things.

Changing attitudes towards mental health

The discussion in the focus groups highlighted that attitudes towards mental health have been changing over the past few years, particularly among younger generations. Mental health was described as no longer seen as a taboo topic, with less stigma attached to seeking help. However, participants also identified the importance of self-awareness and knowing how to find reliable sources of help, as not everyone knows where to turn to for

support or information. As identified in previous themes, this highlights the need for authentic and trustworthy help sources that can be easily accessed and relied upon. Participants also discussed the importance of personalisation and targeted support, which makes people feel more comfortable and willing to seek help. Overall, the focus group discussion emphasised the need for authentic and reliable sources of mental health support, which are tailored to individuals' needs and accessible to everyone.

Between COVID, Gen Z and the younger millennials, the stigma has also been quite removed in the last few years. Like, it's no longer a dirty word to have mental health as a topic of conversation.

I think that the biggest part of mental health is self-awareness. Being able to recognise what's rational, what irrational, and being able to deal with it and control it in a way that is healthy, and whether that's seeing a psychologist, whether that's taking medication, whatever it might be, but a lot of people don't know because they either don't want to know, or they don't know how to find out more information.

Help for families and friends

Lack of support for family and friends

Participants suggest that there is a lack of support available for those who support family and friends going through mental health difficulties or crises. Participants felt that support was often only available to those experiencing the problem directly, and not to their loved ones who are trying to support them. This lack of support for supporters may create a sense of isolation and frustration, leaving them without the resources they need to effectively support their loved ones.

There is no support unless you happen to have it. That's my other huge thing. There is nothing for those who support.

I actually think that a lot of the ads around suicide hotlines are aimed at the people who are having suicidal thoughts, they're not aimed at the friends and family, you should do this if your mum is doing this, or you should do this if your friend is doing this. I think there needs to be more of that. Because how often does the person in that situation call, compared to the mum, the dad, the brother, the sister…

Importance of family involvement

The focus group discussion suggests that family involvement is crucial in providing help and support for individuals who are struggling with mental health issues. Participants noted that family members have played a significant role in recognising when someone is in crisis and

seeking help for them. They also emphasised the need for mental health professionals to involve family members and partners in the care plan, even if it's just a phone call to provide guidance on how to support the individual. Overall, the discussion highlighted the importance of considering the role of family and friends in the care and support of those experiencing mental health issues.

Every time that someone that I've known has been in that situation [self-harm], it's always been family members that have acted for them, that have called the hospital and put them into care.

I think there should be more, like with, including family and partners and things like that. I think it would be a wise move is to – if you are married or you're living under the same roof, the psychologist, or whoever they're dealing with, or that person that's within the household, should probably have a phone call. They don't have to go and see the person. They get a phone call – 'hey, this is what stuff can be – you can help support them this way'.

Challenges around technology

The focus group discussions highlighted challenges around technology, particularly social media, and the impact it has on families and children. Parents spoke of struggling with understanding and controlling their children's use of technology, with some reporting incidents of cyberbullying and feeling unsupported by schools. The intrusion of technology into family homes has led to a need for setting boundaries and parameters, but it was reported that this can be difficult to police and implement. The discussions emphasised the need for support and assistance in navigating these challenges, with some questioning who the family unit can turn to for help.

The big one for parents right now is just they are lacking understanding and they're struggling with the controls around technology. Social media is massive right now, with the parents. They just – I've got mums in tears at [unclear], going, 'mate, my kid's being bullied, I don't know what to do'. We've got mums saying that schools don't want to know about it, because they're just sticking their heads in the sand.

The change has been over a period of time, and technology and social media has intruded, and continues to intrude, in our family home – and will do, into the future. So, who is it up to, to set the boundaries and the parameters? Who does the family unit look to for support and assistance, in terms of – and it's really simple little house rules, but obviously, they're very hard to police and put in place.

The younger kids, they do use like the technology a lot more - especially laptops and other things like that - than we might of at that age. I see it in my little brother. At home he is just always like glued to a screen, which I don't think – he was before coming to [school], but the introduction of a laptop in every

lesson I think has kind of like made him just, created almost an addiction to the technology; like a need for it.

Need for 'Connection'

Loss of community connectedness

The focus group discussions revealed that a loss of community connectedness is a driving factor for the need for connection when sourcing help. Participants described how social media has led to seeking validation from online followers instead of finding validation and support from friends and family. They also noted that younger people appear to have higher expectations of support and are more willing to talk about their problems, which is a positive shift. However, participants also noted that some traditional notions of masculinity can make it difficult for men to talk about their emotions and seek help. Additionally, veterans may feel more comfortable talking to other veterans who have shared similar experiences rather than civilians who may not understand.

When I was a kid, and when you had an aunty and uncle who would just stop by your house unannounced. It was the best thing ever, but then slowly over the years any time there was a knock on the door it is,' who's this'? The phone goes off, 'who's calling at 5:30 in the evening'?

Just with technology and stuff. So many kids, particularly – and not just kids, but even people in their 20s now, I think use social media – they seek so much validation with everything. It's like validation from mums and dads and your mates are no longer enough. It's like, 'oh, all my followers and my fans have got to tell me how great I am'.

Well, I think that the societal thing of younger people expect it. They expect support, and they expect to be able to talk about it, which is great. Whereas, in other places it's not socially acceptable to talk about your problems, especially if you're a man.

As a veteran as well - talking to a civilian about it, because if you haven't experienced it you don't really know what's gone in, it's actually really hard and difficult to tell even your own partner. But when you get with one of the boys around the beers it comes pretty naturally, and you can actually talk about in depth about what happened.

The desire to feel connected

The focus groups identified a strong desire for connection when seeking help, with people wanting to know that there is someone who wants to listen to them and hear what they have to say. Participants discussed the importance of having friends and family to turn to when in

need, as well as the value of sharing personal stories and showing vulnerability to establish a connection with others. The need for face-to-face connections was highlighted, with people feeling that it is harder to connect with others when living alone or having family far away. The importance of having a supportive community was also emphasised, with some participants mentioning the value of local groups, such as a bowls club, where men can gather and talk about their problems. Overall, the focus groups suggest that a desire for connection is a key driver in seeking help, and having a supportive network can make a significant difference in a person's ability to cope with difficult situations.

It'll be harder for people that do live alone or have family further out or only talking to them on the phone. Because it is a bit different having that face-to-face connection. People don't really want to know their neighbour or help them out sort of thing, which is pretty sad.

A lot of the local blokes would go and catch up at the bowls club, or something, after work, and have a beer, and that's where a lot of men would sort out a lot of their problems, or whatever. Now, you speak to a lot of men, they're not getting that - it's six, seven days a week, grinding. Their wives are doing the same thing. They're not seeing their children – and that's just to put food on the table.

Sharing our own stories is invaluable to someone. We always find that people gravitate to people, and you don't know how it happens.

Whether it's a friendship issue, partner issue. Yeah, and that's how humans connect with each other, isn't it? Showing vulnerability. Adolescents want to help each other. They want to fix things for each other, but they're just not equipped to do it. That's more often than not, their first port of call.

Desire for services at a more personal level

The focus groups discussed the need for a more personal level of services when seeking help, as opposed to relying solely on large campaigns and advertisements. They emphasised the importance of feeling personally targeted and understood by those offering help, rather than feeling like just another anonymous recipient of a general message. The focus groups highlighted the impact of a personalised approach. In the student focus group an example was given of how a speaker visited the school and made the students feel like the message was specifically directed towards them. The participants agreed that this approach made them feel more comfortable and open to approaching the speaker for help.

Some of the services out there right now are cold – full of information, but where's the wisdom? Treated like numbers. They're trying to do a thousand calls an hour, so, how the hell do you do that on a personal level?

You see ads on TV for the things like Beyond Blue and those sorts of organisations and you think, well, it's reaching out to everyone. I remember that I had a chat at school one day and – honestly, for the life of me I can't forget this group. They had a speaker come in from the school and it just personalised it so much. It just felt like, okay, this is now directed at me, not just anyone watching the TV. I think just made it a bit more comfortable to then go and approach these people back then. It was sort of like – because you sort of think to yourself when it is a big campaign, you're like, 'oh why would I go there for my little issue'. As soon as it's personalised and they've come to you, to talk to you, it automatically changes how you feel about it. It all of a sudden is a bit more targeted at you.

Discussion

This study aimed to explore the mental health concerns of the community, identify the most effective sources of help for mental health issues, examine gaps in service delivery, and understand the barriers and facilitators to help-seeking. Despite the differences among the participant groups, which included high school-aged boys, older men, parents/teachers, community groups, and workplace groups, the study revealed clear interrelated themes that highlight the common challenges and concerns faced by individuals when seeking help and accessing mental health services.

- At-risk groups (youth, middle-aged males, veterans, and the elderly) face unique challenges when it comes to mental health issues. These groups may experience difficulties in accessing services, encountering roadblocks, or connecting with help sources.
- Barriers to accessing mental health services highlighted the intimidating nature of discussing mental health with general practitioners and the need for more awareness campaigns and personalised approaches to reaching out to those in need. Additionally, time-related challenges, such as busy schedules and technology addiction, should be taken into account when offering mental health services. Moreover, the cost of accessing mental health services and long wait times were identified as major barriers to getting the support needed. Therefore, offering more affordable options and reducing wait times should be a priority for mental health service providers.
- Roadblocks, such as stigma, past negative experiences, historical lack of support, work-related challenges, and personal and systematic barriers, can prevent individuals from seeking help or accessing mental health services. These roadblocks can be particularly challenging for at-risk groups, who may already face unique struggles related to their specific circumstances.

- Authenticity of help sources is crucial for establishing trust and rapport with individuals seeking help. Trustworthiness, relatability, and effectiveness of help sources are important factors that can influence the willingness of at-risk groups to seek help and engage with mental health services.
- Help for families and friends is essential as they often play a critical role in supporting at-risk individuals. The lack of support for families and friends can exacerbate the challenges faced by at-risk groups, making it even more difficult for them to access mental health services and overcome roadblocks.
- The need for connection is a common theme among all at-risk groups. Loss of community connectedness can exacerbate feelings of isolation and loneliness, further complicating mental health issues. A strong desire for connection drives individuals to seek help, and personalised services can be particularly effective in meeting this need.

Based on the identified themes, the following recommendations are proposed to address the concerns and challenges faced by individuals seeking help and accessing mental health services:

1. Promote Connection: Encourage and facilitate opportunities for individuals to build connections with others in their community, such as through support groups, social events, and online forums. This will help to strengthen social networks, reduce isolation, and provide much-needed support for those experiencing mental health issues.
2. Authenticity and Tailored Services: Ensure that mental health services are provided by trustworthy, relatable, and empathetic professionals who are equipped to address the unique needs of each individual. Personalised care plans and targeted interventions can significantly enhance the effectiveness of mental health support.
3. Support for Carers: Develop and implement resources, training, and support services specifically designed for family members and friends who provide care to those experiencing mental health issues. This will help to alleviate the burden on carers and enable them to better support their loved ones.
4. Cost and Time-Efficient, Flexible Services: Address barriers to accessing mental health services by offering affordable, time-efficient, and flexible options, such as telehealth consultations, extended hours of operation, and sliding scale fees. This will make it easier for individuals to seek help and engage with mental health services.
5. Raise Awareness and Education for Community and Friends/Family Members:

Implement public awareness campaigns and educational programs aimed at increasing understanding and knowledge of mental health issues among the public, as well as friends and family members of those affected. This will help to reduce stigma, foster a more supportive environment, and empower individuals to better support their loved ones experiencing mental health challenges.

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Appendix A

Focus Group Topic Guide

Instructions: The interviewer will provide a brief preamble (including housekeeping, safety information, confidentiality and respect, purpose, and rationale of the activity) and inform everyone how the focus group will proceed (e.g., that there are certain fixed questions and prompts however it is encouraged to discuss whatever flows naturally from these, that there are not right or wrong answers and all opinions). Written informed consent will be obtained and the recording device switched on.

[1] How big of a concern is mental health and self-harm in your child's school?
   a. Are there any specific groups (age groups, gender etc) that you are particularly concerned about?
   b. Which types of mental health and wellbeing concerns are you particularly concerned about for your own child/children?

[2] Have the wellbeing needs of your child's school changed? If yes, why might this be and to what extent?

[3] There are lots of different ways that someone might seek help for a mental health concern or if they're experiencing self-harm related thoughts or behaviours – this can vary from simply Googling information, interacting with social media posts such as on Instagram or TikTok, calling helplines, talking to friends or family, getting a mental health care plan from a GP to see a therapist, or going to the emergency department or inpatient facilities. What do you think makes a help source useful or not?
   a. Are certain help sources more useful or effective than others? Why is this?
   b. Are certain help sources more useful or effective for certain groups than others? Why is this?

[4] If a young person was experiencing mental health difficulties or self-harm related thoughts/behaviours what may encourage or prompt them to seek help from their chosen help source?
   a. Are existing help services suited or accommodating of these factors?

[5] On the other hand, what may stop them from seeking help from their chosen help source (can be at the service level or systemic/resource level)?
   a. Are existing help services more or less likely to have these factors?
   b. How can help services best address these factors?

[6] In your community where do you see the biggest gaps in service delivery for mental health and well-being?

[7] Sometimes people can feel uncomfortable or avoid talking about their mental wellbeing or self-harm related thoughts or behaviours – with both their friends and family as well as health professionals. Why do you think this is? Why isn't this the case for everyone?

[8] How comfortable would you be if your child told you about their mental health concerns or self-harm related thoughts/behaviours?
   a. For those who are uncomfortable why do you think this is? For those who are comfortable why do you think this is?
   b. What does your level of comfort depend on?
   c. What might make someone feel more comfortable discussing these things?

[9] How important is it for services to include friends and family in someone's help seeking journey?
   a. What may encourage this?
   b. What may hinder this?

[10] What other recommendations would you have for supporting the wellbeing of young people?

Online Survey Report

Prepared by:

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Griffith UNIVERSITY

Australian Institute for Suicide Research and Prevention



Method

Participants

Survey participants were a convenience sample of greater Brisbane community members, aged 14 years and older, recruited via the Sunlight Centre's community networks and through AISRAP's social media channels.

Procedure

Participants accessed the online survey via a link provided in the survey promotional materials. As per ethical requirements, the survey provided an online information sheet and consent form. Participants were required to select 'consent' before they could access the survey. Parents also had to provide consent for children aged 17 years prior to participation.

Materials

The online mental health needs survey was developed by AISRAP researchers in close collaboration with the Sunlight Centre. The survey was comprised of a range of items and validated scales that measured mental health-seeking beliefs and attitudes, and intentions, as well as barriers to help-seeking and personal help-seeking behaviours and experiences. (See Appendix B for online survey). The survey also measured demographic information (age, gender, level of education, employment status etc) and contained a range of open-ended questions, for example, 'In your own words, what do you believe makes a help source useful?', 'In your own words, how should professional help sources advertise or communicate their services?'. Contact details for support and counselling services were provided throughout the survey in the event a participant may become distressed due to the sensitive nature of the questions.

Ethical Approval

Ethical approval for the study was provided by Griffith University's Human Research Ethics Committee (Ref No: 2022/494).

Results

Demographic Information

A total of 336 individuals accessed the survey. However, 75 did not answer the consent questions nor completing any of the measures, one did not consent to participate in the

survey, 20 consented but did not start the survey, and 32 only completed the questions about demographic information. These responses were excluded from analysis and the final sample was 208 participants.

The age of the participants ranged from 12 to 80 years old, (*Mean* = 41.24, *SD* = 14.46). Most participants (*n* = 148, 71.2%) were in adulthood to middle-adulthood (aged 26-55 years old). The participants' sex at birth were mostly female (*n* = 168, 80.8%), and most also identified as female gender (*n* = 158, 76%). They were predominantly straight (*n* = 146, 70.2%), speak English at home (*n* = 201, 96.6%), had a Year 12 qualifications or higher (*n* = 177, 85.2%), and resided in Greater Brisbane Region (*n* = 180, 86.5%). The majority of participants were employed full-time, with nearly a third were unemployed. Of those unemployed, over 70% were in the working age group according to the Australian Bureau of Statistics (2020). Detailed demographic information is presented in Table 1.

Table 4.1: Participant demographic information

Characteristics	*n* (or Mean)	% (or SD)
Age	41.24	14.46
Age group		
Under 18	20	9.6
18-25	15	7.2
26-35	29	13.9
26-45	54	26.0
46-55	65	31.3
56 and older	25	12.0
Missing	0	0.0
Sex at birth		
Male	36	17.3
Female	168	80.8
Intersex	0	0.0
Prefer not to say	4	1.9
Missing	0	0.0
Gender		
Male	36	17.3
Female	158	76.0
Non-binary	11	5.3
Prefer not to say	2	1.0
Missing	1	0.5
Aboriginal and Torres Strait Islander		
Aboriginal	6	2.9
Torres Strait Islander	1	0.5
Aboriginal and Torres Strait Islander	0	0.0
Neither Aboriginal or Torres Strait Islander	197	94.7
Prefer not to say	4	1.9
Missing	0	0.0
Primarily speak English at home		
Yes	201	96.6
No	7	3.4
Missing	0	0.0

Characteristics	*n* (or Mean)	% (or SD)
Sexuality		
Lesbian	4	1.9
Gay	8	3.8
Bisexual	24	11.5
Asexual	5	2.4
Pansexual	6	2.9
Straight	146	70.2
Prefer not to say	10	4.8
Other*	5	2.4
Missing	1	0.5
Currently in high school		
Yes	20	9.6
No	188	90.4
Missing		
Employment		
Yes, full-time	84	40.4
Yes, part-time	28	13.5
Yes, casual or fixed term	27	13.0
No	61	29.3
Missing	8	3.8
Highest level of education		
Year 8	9	4.3
Year 9	5	2.4
Year 10	12	5.8
Year 11	5	2.4
Year 12	18	8.7
TAFE Certificate or Diploma	58	27.9
Undergraduate degree	53	25.5
Postgraduate degree	48	23.1
Missing	0	
Location		
Greater Brisbane Region	180	86.5
Outside of Greater Brisbane Region	17	8.2

Characteristics	*n* (or Mean)	% (or SD)
Interstate (NSW, VIC, ACT, TAS, SA, NT, or WA)	11	5.3
Missing	0	0.0

Descriptive Findings

Suicidality

Table 2 presents the descriptive results of suicidal ideation and suicide attempt in the past 12 months. Approximately 26% participants reported they had experienced suicidal ideation in the past 12 months, and 14% reported suicide attempt in the past 12 months. When asked whether they sought help for these thoughts or behaviours, only about 18% of those who had suicidal ideation or suicide attempt answered 'yes'.

Table 2. Frequencies of suicidal ideation and suicide attempt in the last 12 months and help-seeking experience.

	Yes		No		Prefer not to say	
	n	%	n	%	n	%
Suicidal ideation in the past 12 months (*N* = 146)	55	26.4	85	40.9	6	2.9
Suicide attempt in the past 12 months (*N* = 146)	30	14.4	112	53.8	4	1.9
Help-seeking for suicidal thoughts or behaviours (*N* = 56)	38	18.3	18	8.7	N/A	-

Participant responses on the usefulness of help-seeking experience for suicide-related behaviours are displayed in Figure 1. Though overall responses were varied, most participants seemed to think that their help-seeking experience was somewhat useful (*Mean* = 3.53, *SD* = 1.41).

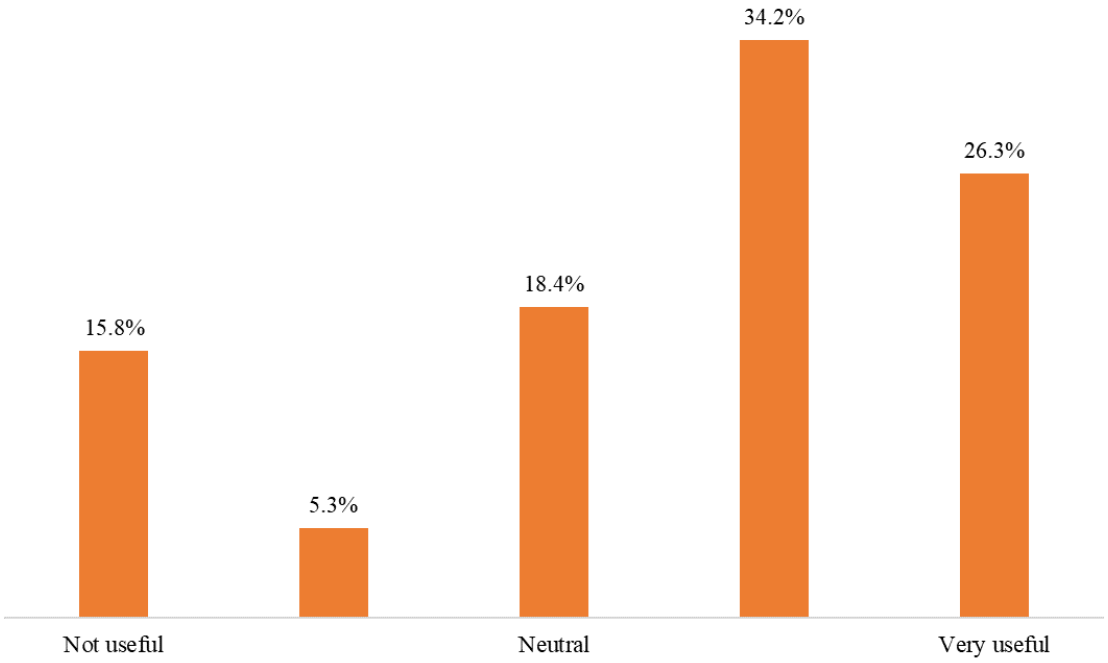


Figure 1. Participant responses to question about usefulness of their help-seeking experience for suicide-related problems ($N = 38$)

Views on help-seeking

Participants were asked several questions about the views of their own and other people about help-seeking. Figure 2 illustrates their responses to questions on the values of help-seeking, such as whether it is useful and effective. Most participants responded that help-seeking would likely to be useful (34%), important (43%), healthy (46%), good (37%), and desirable (32.2%). There were more mixed responses on whether help-seeking would be empowering, satisfying, or healing, with approximately 16-20% participants gave neutral response.

Figure 3 presents the response distributions to statements about help-seeking. Most participants tended to agree that it is important for people to seek help (56%), that most people who are important to them would think it was a good idea to seek help (51%), and that they would choose to seek help if they were experiencing mental health and wellbeing problems (35%). The response to whether they would feel confident to seek help were more varied, although the majority still indicate confidence.

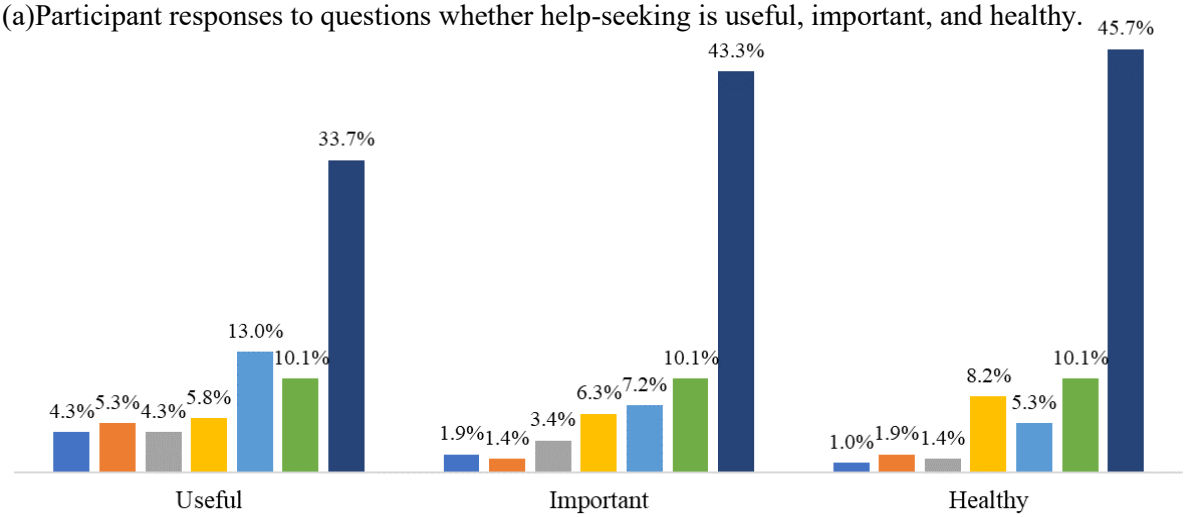
Responses to questions regarding concerns from other people, specifically friends/peer

group, school or workplace, and community about mental health, wellbeing and self-harm issues are displayed in Figure 4. On average, participant **ratings suggested that mental health and wellbeing issues are likely a big concern** among their friends/peer group (*Mean* = 5.22, *SD* = 1.83), school or workplace (*Mean* = 5.43, *SD* = 2.23), and the community (*Mean* = 5.41, *SD* = 1.81).

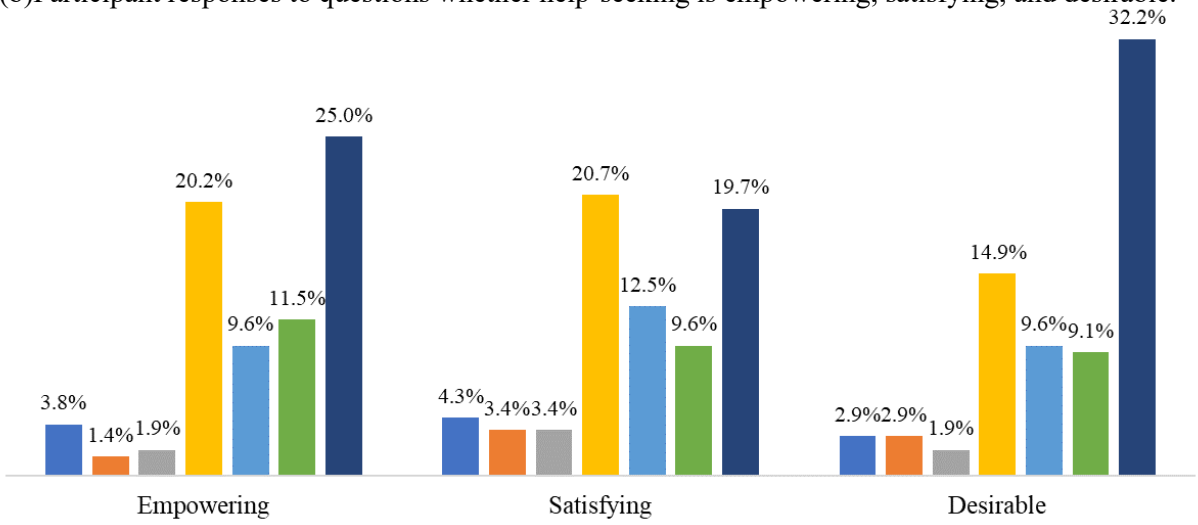
However, compared to concerns about general mental health, the average of participant **ratings on self-harm concerns suggested that overall, their friends/peer group, workplace or school, and community tend to be less concerned** (Friends/peer group *Mean* = 3.45, *SD* = 2.08; Workplace or School *Mean* = 4.13, *SD* = 2.68; Community *Mean* = 4.56, *SD* = 2.00). In fact, most responses to this question were 'not at all' or 'neutral'. In addition, approximately half (51.9%) of the participants thought that the level of community concern for self-harm has changed in the recent years.

Finally, when asked about how **confident they are about support services being provided in each setting, participants reported highest confidence in the workplace or school setting** (*Mean* = 4.51, *SD* = 2.52). A detailed response distribution is presented in Figure 5.

(a)Participant responses to questions whether help-seeking is useful, important, and healthy.



(b)Participant responses to questions whether help-seeking is empowering, satisfying, and desirable.



(c)Participant response to questions whether help-seeking is effective, good, and healing.

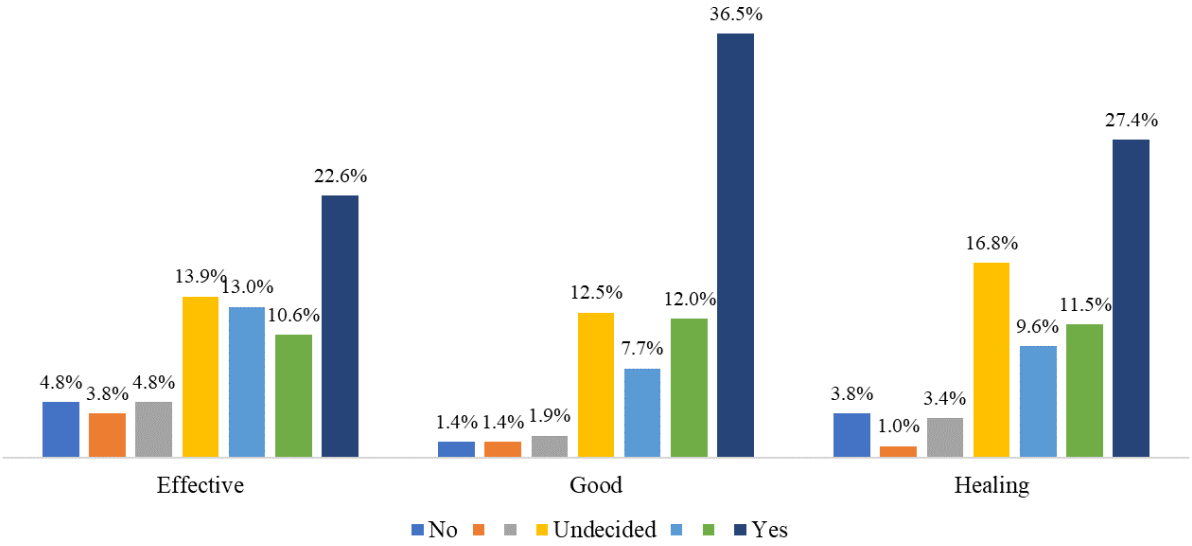


Figure 2. Participant response distributions what extent they place value on help-seeking. Responses are from the scale of (a)'Useless', 'Unimportant, 'Unhealthy', to 'Useful', 'Important', 'Healthy';

(b)‘Disempowering’, ‘Unsatisfying’, ‘Undesirable’, to ‘Empowering’, ‘Satisfying’, ‘Desirable’;
(c)‘Ineffective’, ‘Bad’, ‘Hurting’, to ‘Effective’, ‘Good’, and ‘Healing’, respectively (*N* = 153).

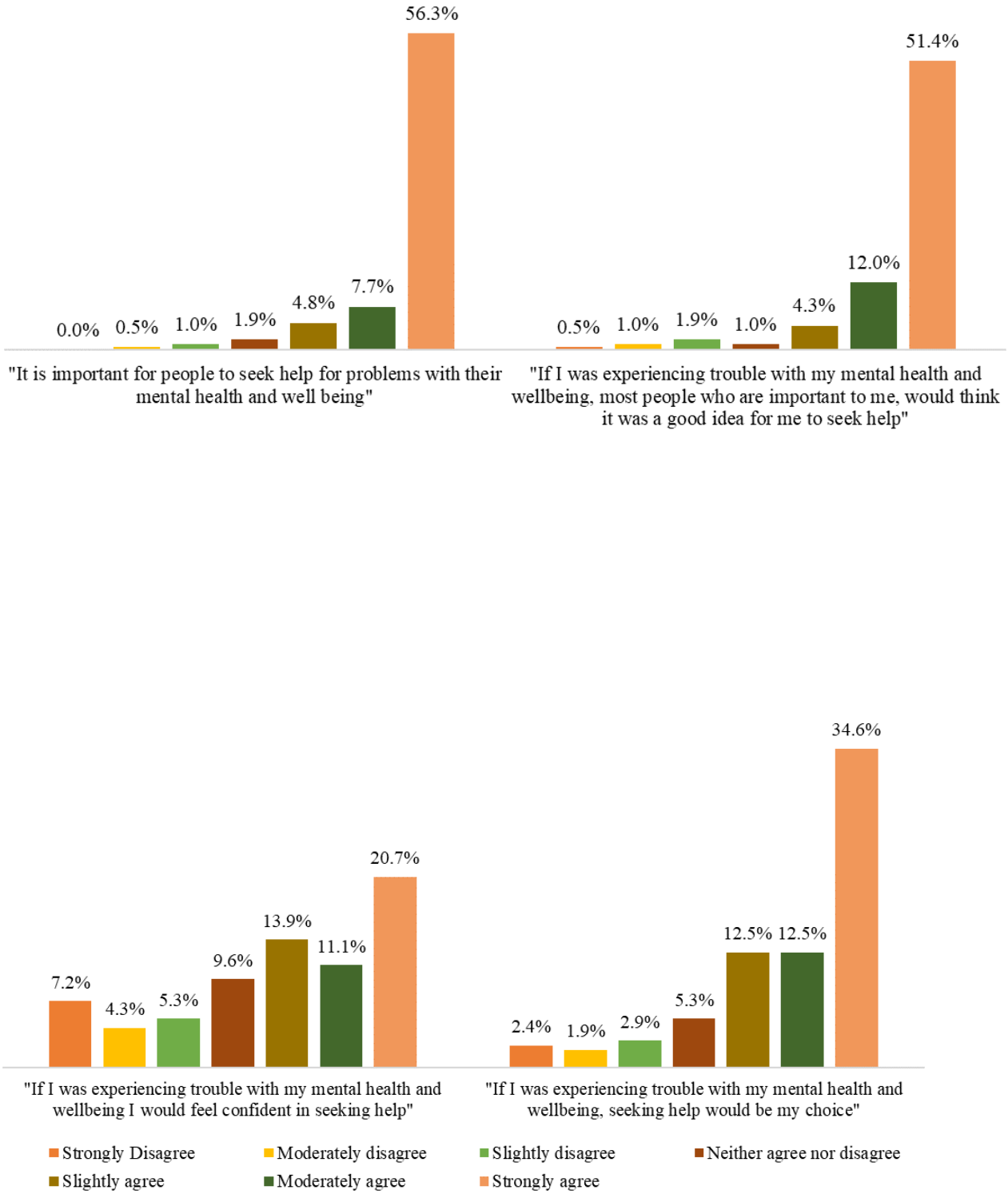
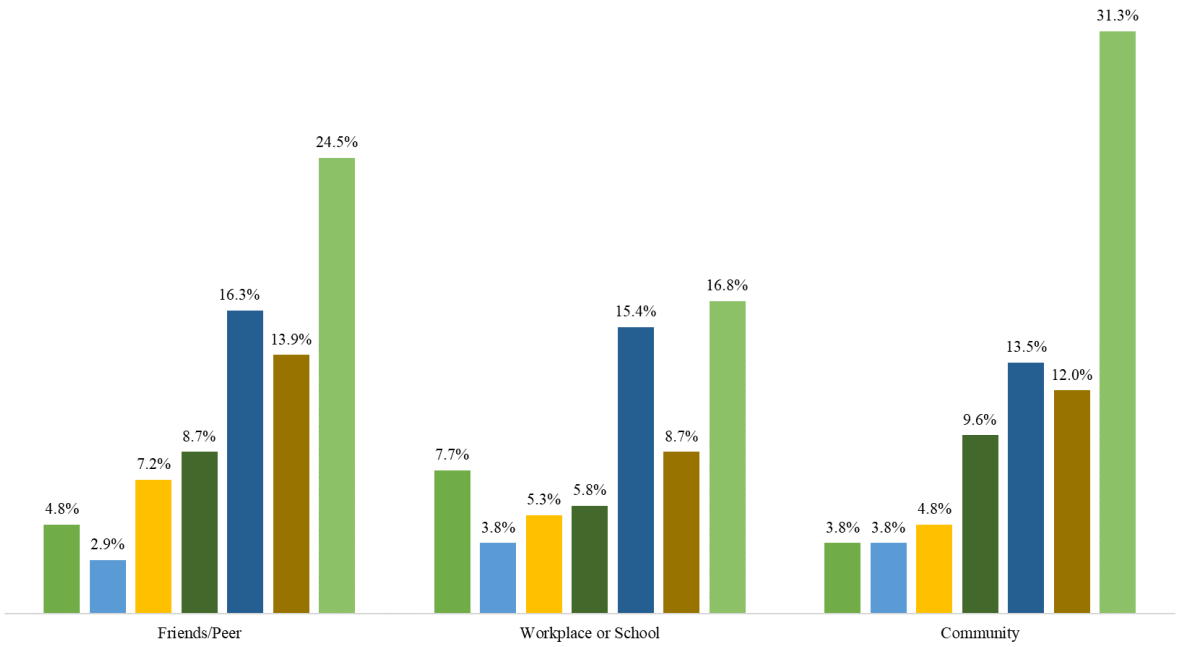


Figure 3. Participant responses to what extent they agree to each statement about help-seeking (N = 150).

(a) Concerns about mental health and well-being



(b) Concerns about self-harm

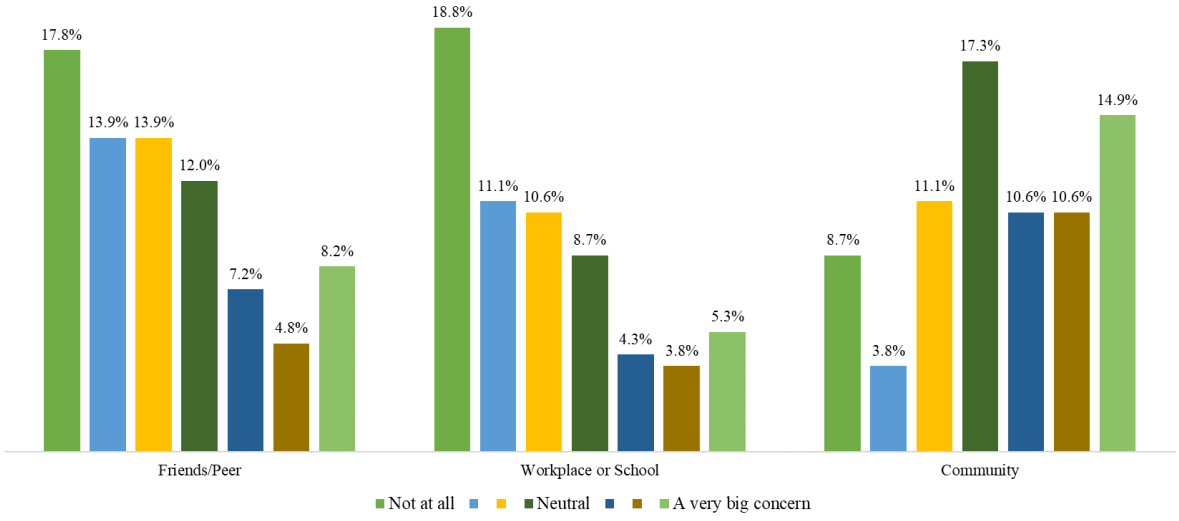


Figure 4. Participant responses to questions about how much concern (a) mental health and well-being, and (b) self-harm, among their friends/peers, in their workplace or school, and their community ($N = 167$).

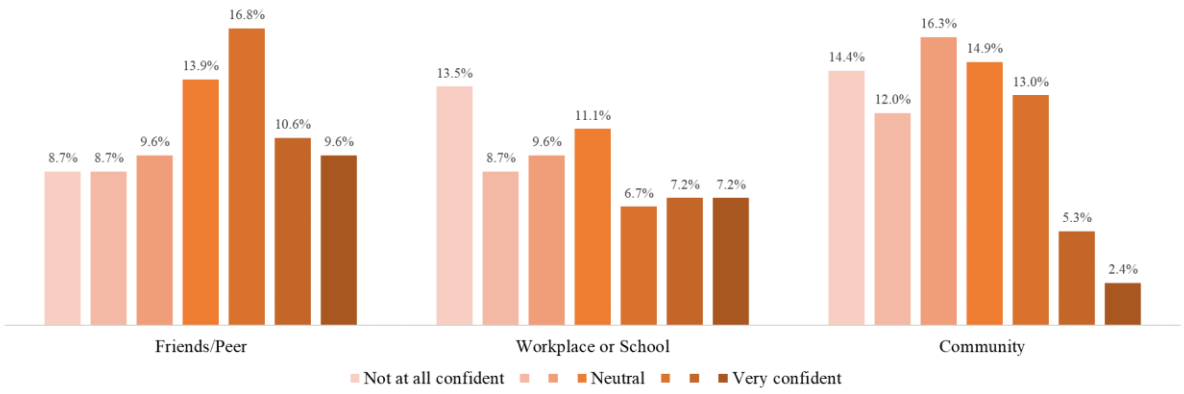


Figure 5. Participant ratings of their confidence in the support services for mental health and well-being being offered in each setting ($N = 150$).

Help-seeking intentions

The means for likelihood of seeking help from various sources are presented in Figure 6. The results suggest that participants would **most likely seek help from a friend, partner, or health professionals such as a counsellor, doctor (GP), psychologist, or psychiatrist, for both mental health issues and suicide-related behaviours**. In addition to these sources, participants also indicated that they would likely seek help through **Google or informational websites for general mental health issues**. For both mental health and suicide-related issues, the results show that participants would be **least likely to seek help from religious leaders, social media, and community/sport group.** Notably, the average likelihood of not seeking help from any of the sources was low to moderate.

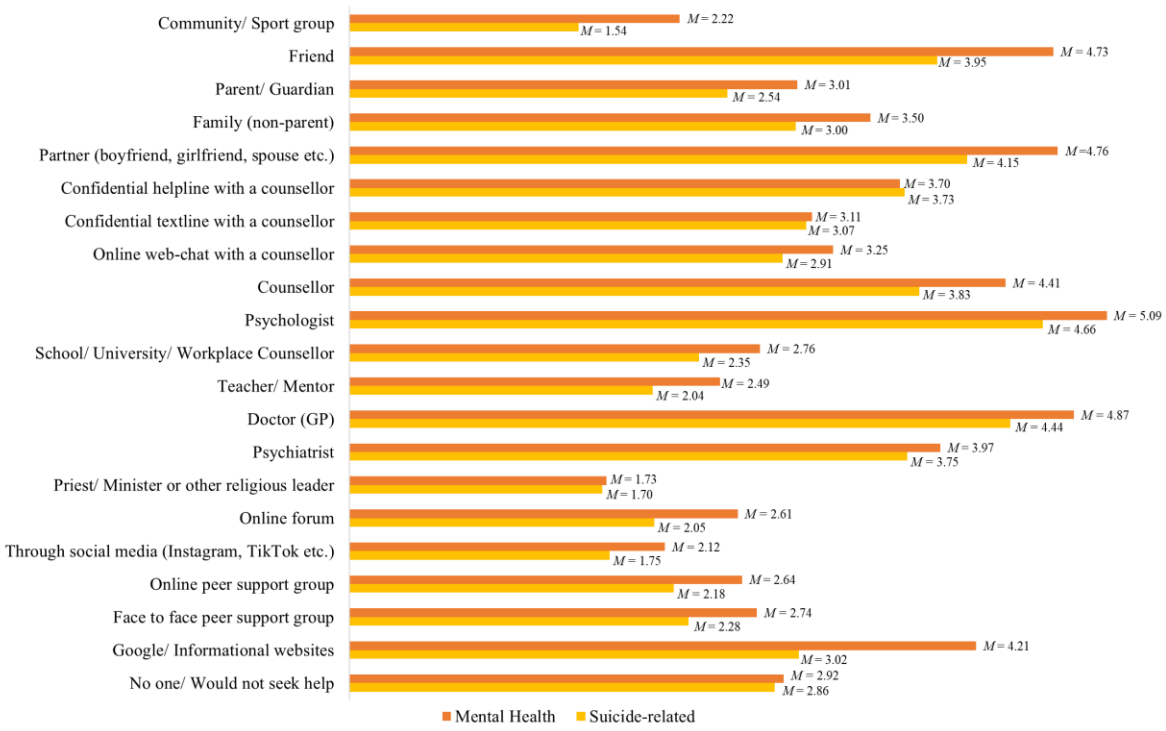
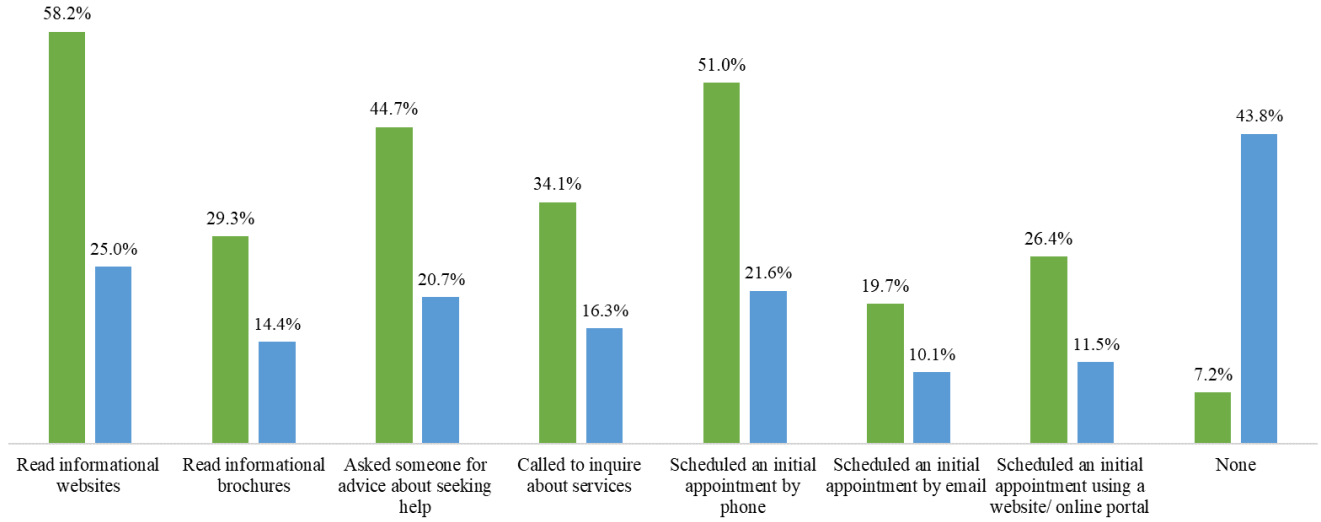


Figure 6. Means likelihood of help-seeking intentions from each source. Ratings are from 1 – 'Extremely Unlikely' to 7 – 'Extremely Likely' (*N* mental health = 206, *N* suicide-related = 184).

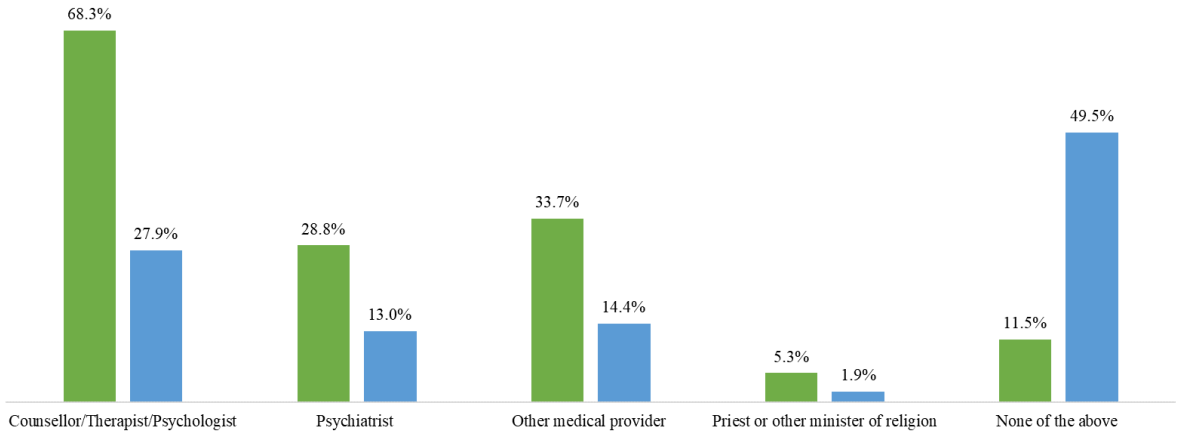
Help-seeking experiences

Figure 7 presents the results of help-seeking behaviours, use of formal mental health service, and use of informal sources of care, respectively. Overall, **participants have sought help for general mental health issues more often than for suicide-related issues, with around 50% have never sought or used any services for suicidal thoughts or suicide attempt**. The **most common help-seeking behaviour for both general mental health and suicide-related issues was reading informational websites, followed by making a call for initial appointment**. In terms of formal mental health service use, most participants have attended sessions with a counsellor, therapist, or psychologist. Friends or family were the most common informal sources of care used by the participants for both mental health and suicide-related issues.

(a) Help-seeking behaviours



(b) Use of mental health services



(c) Informal/non-traditional sources of help

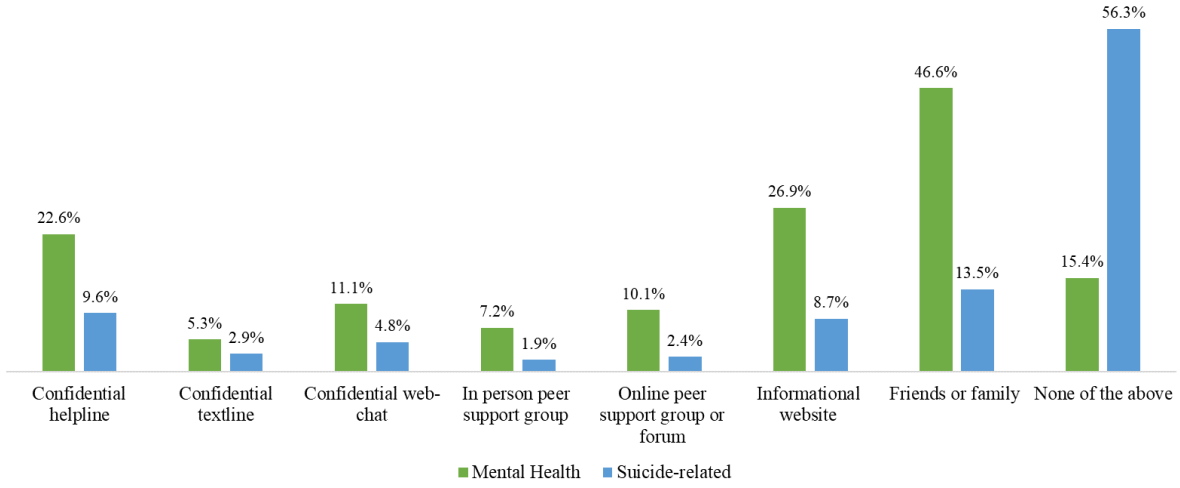


Figure 7. Proportion of participants with experiences in each help-seeking type: (a) help-seeking behaviours, (b) use of formal mental health services, (c) help-seeking from informal/non-traditional sources of care (*N* mental health = 174, *N* suicide-related = 174).

Additionally, 53 participants (25.6%) reported they had been encouraged to seek help, mostly by family members, friends, or health professionals. Figure 8 presents the responses to questions on whether being encouraged or forced to seek help was useful for them. While **most rated that being encouraged to seek help was helpful (*Mean* = 3.78, *SD* = 1.36), the perceived usefulness of being forced to seek help was mixed among participants who reported the experience** (*Mean* = 2.89, *SD* = 1.54).

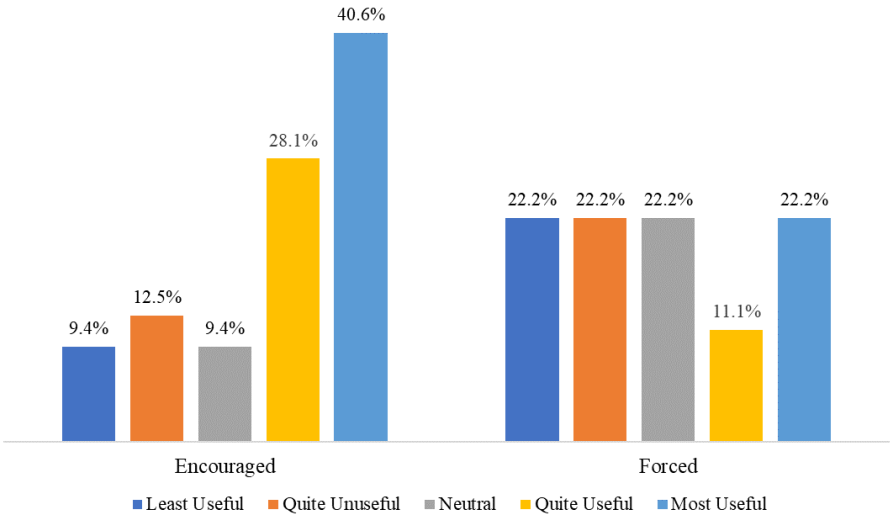


Figure 8. Usefulness ratings from participants who had been encouraged or forced to seek help. The ratings are from 1 for being least useful, to 5 for being most useful (*N* encouraged =

32, *N* forced = 9)

Barriers and enablers to help-seeking

The mean ratings for questions about barriers to help-seeking are presented in Figure 9. Participant ratings suggested that being unable to afford mental health services and difficulties in finding a suitable mental health service are most likely to be the barriers to help-seeking. However, participants also tended to agree that they can easily find information about mental health services.

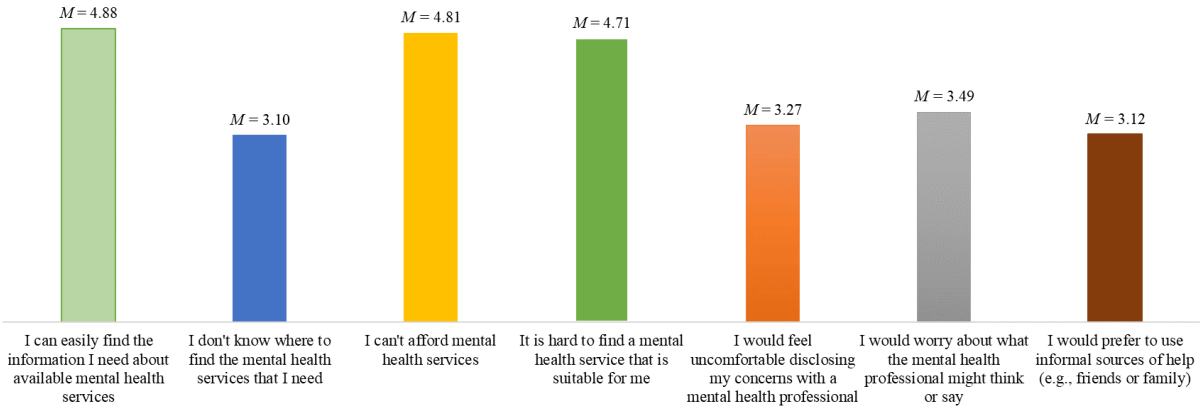
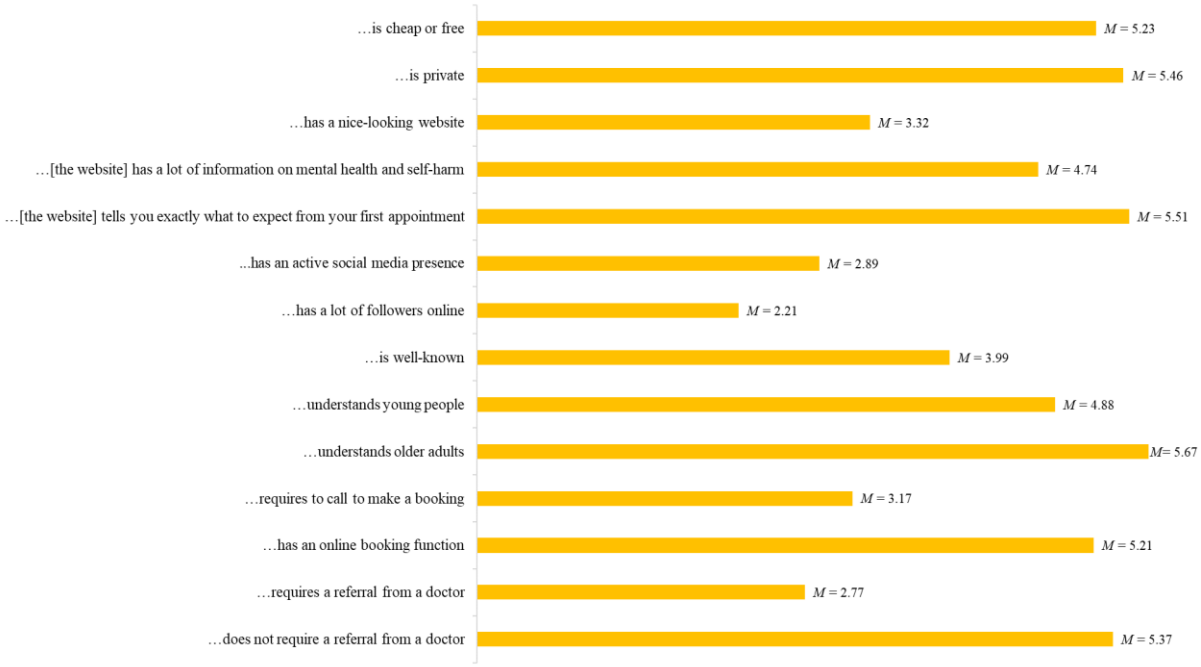


Figure 9. Mean ratings on barriers to seek help for mental health problems and easiness to find information. Ratings are from 1 – 'Strongly disagree' to 7 – 'Strongly agree' (*N* = 146).

The mean ratings on help-seeking enablers are presented in Figure 10. It appears that **participants regarded cost and practicality as the most important factors to consider when seeking help, such as the service being private, being cheap or free, has a website that provides detailed information on what to expect, does not require referrals, and has online booking function**. Participants also reported that it is highly important that the service understands older adults, which may reflect the majority of the participants' demographic. In terms of the service provider, participant **ratings suggest that having a therapist that is an expert is likely the most important factor**.

(a) Important factors to consider about the service



(b) Important factors to consider about the service provider

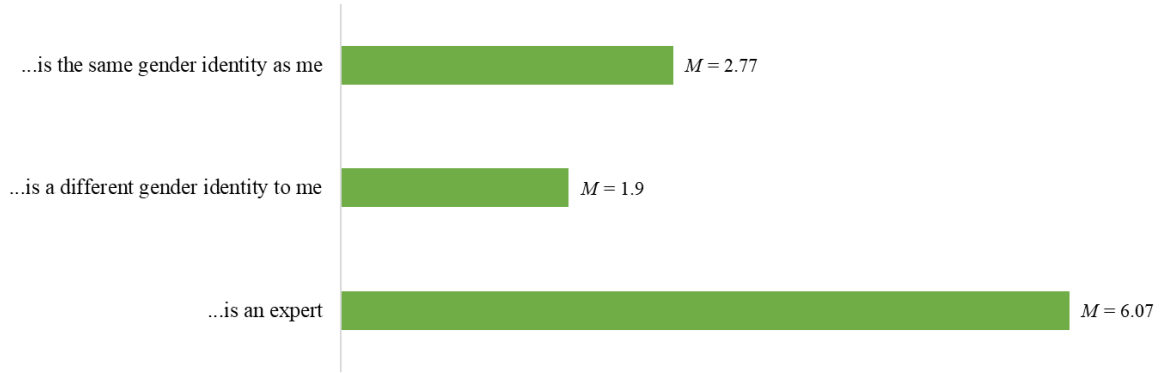


Figure 10. Mean ratings on the importance of each factor for participants when deciding to seek help in terms of (a) the service, and (b) the therapist. Ratings are from 1 – 'Not at all', to 7 – 'Very important' (N = 146).

Differences in Age and Gender

Differences in views on help-seeking

Responses to questions on others' concerns about mental health or suicide-related issues did not differ by gender or age, but there were some differences between age groups with regards to their own views on help-seeking.

Overall, **participants of older age groups tended to have more positive views on help-seeking than the younger groups. Specifically, those are aged between 46-55 years perceived seeking help as effective** (*Mean* = 5.70, *SD* = 1.49), more so **than those in the age groups of 18 to 45 years** (Overall F (5, 147) = 2.38, p = .041). The 46-55 age group also perceived more highly (*Mean* = 6.18, *SD* = 1.08) than the rest of the younger age groups that seeking help is healing (Overall F (5, 147) = 5.05, p < .001). There were also differences for whether seeking help is empowering, such that both the 46-55 (*Mean* = 5.82, *SD* = 1.37) and 56+ (*Mean* = 5.64, *SD* = 1.53) age groups perceived seeking help as more empowering than those aged 25 years and younger (Overall F (5, 147) = 3.12, p =.010). Meanwhile, the difference between the 46-55 and 56 and older age groups were non-significant, and no significant differences were found with those aged 26-35 or 36-45. The 46-55 age group perceived seeking help as satisfying (*Mean* = 5.61, *SD* = 1.47), significantly higher than all younger counterparts (Overall F (5, 147) = 4.34, p = .001). The 56+ age group (*Mean* = 5.45, *SD* = 1.22) also had significantly higher ratings that seeking help would be satisfying than those under 18 group (*Mean* = 3.64, *SD* = 1.60). Compared to all older age groups, those under 18 years old had significantly lower rating (*Mean* = 3.93, *SD* = 1.73) that help-seeking would be desirable (Overall F (5, 147) = 3.05, p = .012).

Regarding statements about help-seeking, the results also did not differ by gender, but some age differences were found (Overall F (5, 144) = 2.29, p = .049). **For the question on whether seeking help would be their choice, those under 18 years of age were less likely to choose to seek help (*Mean* = 4.71, *SD* = 2.05) compared to the age groups from 26 to 55 years**. The difference was not significant with the oldest age group of 56 years above, and no other significant differences were found.

Differences in suicidality

Reports of suicidal ideation and suicide attempt differ in age. **Participants who reported they have had suicidal ideation in the past 12 months were significantly younger (*Mean* age = 37.76, *SD* age, = 14.47), than those who reported no experience** (*Mean* age

= 45.71, *SD* age= 13.69, *F* [2, 143] = 5.45, *p* = .005). **Those who had attempted suicide in the past 12 months were also significantly younger** (*Mean* age = 32.13, *SD* =12.13) **than those who did not** (*Mean* = 45.76, *SD* = 13.49, *F* [2, 143] = 15.17, *p* <.001). However, there was no age difference between those who sought help for suicide-related behaviours and those who did not seek help. Furthermore, no significant difference was found by gender.

Differences in help-seeking intentions experiences

The age differences in overall intentions to seek help were non-significant. However, there was a difference by gender (Overall *F* [3, 179] = 3.19, *p* =.025). **Participants who were non-binary had significantly less intentions to seek formal help for suicide-related issues (*Mean* intentions = 2.10, *SD* = 0.83), compared to participants identified as males (*Mean* intentions = 3.18, *SD* = 1.32) or females** (*Mean* intentions = 3.37, *SD* = 1.33). The mean difference between males and females was not significant.

With regards to actual experiences of help-seeking, both age and gender differences were observed for general mental health help-seeking. **Participants under 18 years of age had the least mental health help-seeking experiences overall (*Mean* experience = 1.40, *SD* = 1.12), compared to all the older age groups** (Overall *F* (5, 168) = 4.47, *p*<.001). Meanwhile**, male participants also had the least help-seeking experiences for general mental health issues (*Mean* = 1.44*, SD* = 1.48*)* than females (*Mean* = 2.30, *SD* = 1.47) or non-binary persons** (*Mean* experiences = 2.50, *SD* = 2.12, Overall *F* (3, 169) = 2.97, *p* =.033). There were no age or gender differences in help-seeking experiences for suicide-related issues.

Relationship between help-seeking intentions and experiences

To examine whether help-seeking intentions are related to actual help-seeking behaviours, several correlation analyses were conducted between help-seeking intentions and help-seeking experiences for general mental health and wellbeing problems and suicide-related behaviours. For the purpose of this analysis, items in the help-seeking intentions were grouped into formal (e.g., psychologist, doctor, counsellor) and informal sources (e.g., community/sport group, friend, family).

For general mental health and wellbeing problems, the results showed a significant relationship between intentions to seek help from an informal source and actual help-seeking experience from an informal source (*r* = .16, *p* = .030). This means that higher intentions to seek help from an informal source is related to actual experiences of seeking help from an

informal source. No significant correlations were found between help-seeking intentions and actual help-seeking experience overall for suicide-related behaviours. The correlations are presented in Table 3.

Table 3

(a) Correlations between mean intentions to seek help and help-seeking experiences for mental health problems.

	Any help-seeking experiences for mental health issues	Formal help-seeking experiences for mental health issues	Informal help-seeking experiences for mental health issues
Intentions to seek any help for mental health issues	*r* = .07, *p* = .332	*r* = .08, *p* = .280	*r* = .16, *p* = .041
Intentions to seek formal help for mental health issues	*r* = .15, *p* = .047	*r* = .15, *p* = .055	*r* = .10, *p* = .205
Intentions to seek informal help for mental health issues	*r* = .11, *p* = .158	*r* = .03, *p* = .693	*r* = .16, *p* = .030

(b) Correlations between mean intentions to seek help and help-seeking experiences for suicide-related problems.

	Any help-seeking experiences for suicide-related behaviours	Formal help-seeking experiences for suicide-related behaviours	Informal help-seeking experiences for suicide-related behaviours
Intentions to seek any help for suicide-related behaviours	*r* = -.02, *p* = .849	*r* = -.02, *p* = .811	*r* = -.003, *p* = .964
Intentions to seek formal help for suicide-related behaviours	*r* = .01, *p* = .924	*r* = .01, *p* = .885	*r* = -.02, *p* =.815
Intentions to seek informal help for suicide-related behaviours	*r* = -.03, *p* = .734	*r* = -.04, *p* = .597	*r* = -.06, *p* = .428

Note. N = 174. Results in bold indicate statistical significance.

Relationships between barriers to help-seeking and intentions and experiences

The average of reported barriers to help-seeking was correlated with overall intentions to seek help and actual help-seeking experiences. There were **significant negative correlations between barriers to help-seeking and overall help-seeking intentions for mental health problems (*r* = -.18, *p* = .034) as well as suicidality** (*r* = -.24, *p* = .004). More specifically, **those who strongly perceived barriers to finding a suitable mental health service, feeling uncomfortable disclosing concerns to a professional, and worrying about what the professional might think or say would more likely have less intention to seek any help for suicide-related behaviours**. Meanwhile, **feeling uncomfortable disclosing concerns to a mental health professional also negatively correlated with intentions to seek any help for mental-health problems**. On the other hand, those who more strongly agreed that they can easily find information they need about available services also had higher intentions to seek any help for mental health and suicide-related problems. However, there was no significant correlation with actual help-seeking experiences.

Interestingly, the correlations between help-seeking barriers and experiences in seeking help for suicide-related behaviours were significant and in a positive direction, both for formal (*r* = .21, *p* =.012) and informal sources of care (*r* = .17, *p* =.038). When examined by the individual items, difficulty to find a suitable mental health service correlated positively with all types of help-seeking experiences for mental health and suicide-related problems. These **results suggest that those who perceived higher barriers in help-seeking tend to have had more help-seeking experiences**. Detailed results are displayed in Table 4.

Table 4. Correlations between barriers to seek help and help-seeking intentions as well as experiences for mental health and suicide-related problems.

	Intentions to seek any help for mental health issues	Intentions to seek any help for suicide-related behaviours	Any help-seeking experiences for mental health issues	Formal help-seeking experiences for mental health issues	Informal help-seeking experiences for mental health issues	Any help-seeking experiences for suicide-related behaviours	Formal help-seeking experiences for suicide-related behaviours	Informal help-seeking experiences for suicide-related behaviours
Overall barriers to help-seeking	***r* = -.18, *p* = .034**	***r* = -.24, *p* = .004**	*r* = .12, *p* = .142	*r* = .08, *p* = .311	*r* = .13, *p* =.122	***r* = .22, *p* = .008**	***r* = .21, *p* =.012**	***r* = .17, *p* =.038**
I can easily find the information I need about available mental health services	***r* = .19, *p* = .019**	***r* = .19, *p* = .024**	*r* = .02, *p* = .826	*r* = . 12, *p* = .166	*r* = -.003, *p* = .968	*r* = -.06, *p* = 497	*r* = -.003, *p* = .973	*r* = -.12, *p* = .164
I don't know where to find the mental health services that I need	*r* = -.05, *p* = .535	*r* = -.11, *p* = .180	*r* = -.02, *p* = .858	*r* = .003, *p* = .970	*r* = -.03, *p* = .693	*r* = -.06, *p* = .480	*r* = -.003, *p* = .967	*r* = .13, *p* = .118
I can't afford mental health services	*r* = -.07, *p* = .426	*r* = .10, *p* = .223	***r* = .20, *p* =.017**	***r* = .26, *p* = .002**	*r* = .04, *p* = .671	*r* = .14, *p* = .087	***r* = .17, *p* = .038**	*r* = .04, *p* = .604
It is hard to find a mental health service that is suitable for me	*r* = -.10, *p* = .221	***r* = -.17, *p* = .042**	***r* = .23, *p* =.005**	***r* = .17, *p* = .037**	***r* = .22, *p* = .009**	***r* = .22, *p* = .009**	***r* = .17, *p* = .037**	***r* = . 20, *p* = .017**
I would feel uncomfortable disclosing my concerns with a mental health professional	***r* = -.23, *p* = .005**	***r* = -.30, *p* <.001**	*r* = .02, *p* = .799	*r* = -.09, *p* = .260	***r* = .17, *p* = .045**	***r* = .19, *p* = .024**	*r* = .13, *p* = .124	***r* = . 20, *p* = .014**
I would worry about what the mental health professional might think or say	*r* = -.12, *p* = .140	***r* = -.17, *p* = .041**	***r* = .21, *p* =.012**	*r* = .11, *p* = .190	***r* = .26, *p* = .002**	***r* = 31, *p* = <.001**	***r* = .25, *p* = .002**	***r* = .28, p = .001**
I would prefer to use informal sources of help (e.g., friends or family)	*r* = .04, *p* = .639	*r* = .08, *p* = .340	*r* = -.06, *p* = .512	*r* = -.07, *p* = .397	*r* = -.01, *p* = .896	*r* = -.05, *p* = .533	*r* = -.02, *p* = .855	*r* = -.09, *p* = .293

Note. N = 146. Results in bold indicate statistical significance.

Open ended questions

Responses to the open-ended items ‘In your own words, what do you believe makes a help source (formal or informal) useful?’ and ‘In your own words, how should professional help sources advertise or communicate their services?’ were coded into categories and then developed into themes. Due to the large volume of responses to these items, the themes and actual responses from all participants have been presented in table form for practical purposes. (Unfortunately, for the remaining open-ended items there were not enough meaningful responses for analysis and/or presentation).

The themes for the item, ‘In your own words, what do you believe makes a help source (formal or informal) useful?’ were ‘Empathetic and welcoming’, ‘Confidential’, ‘Tailored and reliable’, ‘Expertise and credibility of professional’, ‘Accessible (in all forms)’ and ‘Client control’. The majority of responses to this item fell under the themes of ‘Empathetic and welcoming’ and “Accessible’ suggesting that these areas were of the greatest importance to respondents. Please see Table 5 for themes and the actual responses under each theme.

The themes for the item, ‘In your own words, how should professional help sources advertise or communicate their services?’ were ‘Social media, the internet & technology’, “Authentically’, ‘Face to face and via recommendation (formal and informal)’, ‘Not at all’, and ‘Miscellaneous’. Table 6 displays the themes and actual responses under each theme.

Table 5. In your own words, what do you believe makes a help source (formal or informal) useful?

Empathetic and welcoming	Confidential	Tailored and relatable	Practical and informative	Expertise and credibility of professional	Accessible (in all forms)
Feeling respected and heard	Discreet	It has to be specific to you	Facts about mental health and suicide, different ways to help	Supportive	easy to read & understand. does not use triggering language
not shaming the person who needs help	the option to be anonymous	Being able to help me	factual and accurate information	Consistency	Being accessible to the target audience
Understanding and non-judgemental	the ability to be anonymous	willingness to work with the person where they are at	That there are beneficial, useful strategies shared that don't feel like 'homework'. Supports wellbeing and healing	gives you a different way to look at thingsplace to vent your thoughts and frustrations	Easy access
Understanding	Confidentiality	Relevance and context. A specialist in suicide is not ongoing to be helpful for Autism and vice versa	providing helpful resources and following up	Their ability to have use. If you get something out of the interaction it is of use. If it helps it is of use	If it is practical, clear and low cost. Ways of getting in contact that do not require a phone call are very helpful
Patience, understanding and humility.	privacy, anonymity if wanted	personal experience with mental health issues	Tools and techniques to use at home	Strengths-based approach.	Easily accessible
empathy and understanding, not judgement and bias and ridicule	keeps your conversation private				free and readily available
Supportive, non judgemental,	I think it's helpful when there aren't necessarily a lot of people who become aware of you using the service. For me, I avoid clinics with multiple practioners in				
Non judgmental professionals who are					

open minded and not straight by the books . You feel heard and validated Compassionate. Caring Compassion, understanding, empathy, ability to suggest ideas without being pushy Being understanding, compassionate someone willing to listen and coach you through how to deal with situations that can be overwhelming They truly need to care Not saying I know how you feel That matrix about warm/cold competent/incompetent. For me a	favor of ones where there is simply the counseller/psychologist only. I have found this makes me more comfortable to deal with and actually go to a session. knowing your discussion is confidential Talking to an impartial person about problems in a confidential capacity should give relief and peace of mind. confidential and private	Tailored assistance that is empathetic Identifying what mental health issues address, what services they may offer, how to make contact with them Being relatable to the person You can relate to it down to earth, not too clinical and open to change processes as the need fits Personalised information Finding the right solution for the individual. Finding the right option that clicks with a person so	I'm very picky with how I engage. I have found my care team through a chain of recommendations. I feel they are useful when I go with a problem and come away with a management plan. The professional also needs to be able to allow the person to talk through their problems but ALSO give them tools to take away, practice and learn how to change or cope with situations that effect them. I am a strong believer in being able to take away tools or coping mechanisms as talking will only do	Low key and relaxed, but caring and professional Knowledge Knowing what to say for different situations. And what not to say. Informal but somewhat relevant gives honest advice to help solve issues technical experience Safety, expertise, best practice practical support including hands on support like a case worker, social worker and advocate	The cost is affordable, and no doctor referral needed Being available all of the time and the same person seeing you Accessibility without barriers (people don't need credit on their phone to access, or have to have data; maybe useful to have multi streams of communication available), user-friendly website & all relevant information given at beginning to manage expectations about peoples' own role in their own recovery.

cold/competent provider can often end up being harmful Connection Understanding and a lack of judgement of the person seeking help Not being treated like a liar or a defect by the mental health team at the hospital when presenting to ED. Being trustworthy and without judgment (having a reputation for being so) non judgmental Have empathyActively listenGive time to people to open up/talk at their own speed Someone to just listen People who genuinely care about you, who have a good		that the help works Applicable to someone's life and situation while being delivered with empathy Having people who have experience in dealing with various issues Tailored to me Hearing from people who are or have gone though similar experiences Understanding the issues/problems, being able to provide the right help or be able to point towards the right help,	so much (though talking is important too). If professional, having lots of information online. such as what a first appointment looks like, what kinds of help is offered. being detailed. If its a website, then having questionnaire that people can fill out so they can self-reflect. Sometimes people need a tool to help them see they need help. They need... permission? I think a really big fear people have it being told, they dont have a problem and they just need to stop being lazy, or try harder.	Proper trained professional I sought assistance at local DV clinics and no trained properly didn't assist. I felt alone Experience, bedside manner, discipline Practitioner profiles Professional/ appropriately qualified expertise commensurate with the help required Degree qualified counsellor Speaking to a professional	Availability and cost Ease of access. Accessibility - easy to read, clear and concise in language that is easy to understand. they need to be easily accessible Accessibility Also options other than talking over the phone, which can be anxiety inducing. Action. The ability to get help when and where you need it. Readily available appointments with a short turn

understanding of who you are and what is important to you, who shares or understands your beliefs and values. Who will kindly but firmly press the issue of personal safety and insisting that you are safe if they will phone an ambulance or your partner to help ensure your safety. Understanding, compassion, empathy, non judgment and connection. Welcoming and real stories - real life people - examples - not fabrication Understanding and compassion Empathy Personal experiences, deep understanding		accessible when needed Specialising in certain areas and being able to refer people to the correct area if they are not able to help Advice is relevant, appropriate, correct That it helps you Having to know somewhat of the person your talking to and having that trust in the first session. Provides relatable info client centred & guided by clients needs & desires	Helping Tools. I want practical instructions, if I am reaching out for help its because I need help now. Practical Facts, case studies/ examples Links to other support. What to do in emergency crisis. Providing useful information/ actions, practices. Contains specific information about how to get help useful tools and incite in self solution-focused, strengths based	Evidence based interventions delivered by a qualified and experienced professional Credibility well qualified (degree level) if formal source Credible, professional Someone who knows what they're talking about and is able to listen up to date in all aspects Expertise Being able to assess the urgency of help required.	around to being seen. Affordable availability of services bulk billed or cheap, 24/7, rollover effect (call back 24 hours later, booked urgency appointment at the next available local therapist, notification to local gp). Repeated 7 days later. All of it Accessible, flexible treatment types & options I also think that accessibility is important. But I would say accessibility isn't just a cost thing, it can be having

knowing the place is inclusive and non-judgement (it doesn't matter your gender, culture, sexual orientation, etc) Friendly. Welcoming to all people. They are caring and they listen without judgement Usually when you are in a heightened state they turn you away as the only place for crisis is a hospital - and they don't care. Someone who is knowledgeable and empathetic. Listens without judgement. Understanding and empathicNon-judgemental Willingness to listen		regarding treatment	good information about the service available offering useful ways to solve the problems long-term Giving out information that may be helpful and being able to validate the person's worries or their interest in the person. Giving information about mental illness and about the help source In informing the public providing correct diagnostic criteria Helpful information	Confidence in source Qualified practitioners	multiple modes for interacting (eg. being able to book online is useful for those who are deaf, socially anxious, forgot to book during office hours etc).I think accessibility is also why people often use informal supports- your community often already contains people who can accommodate your needs.Some problems definitely need professional specialist trained supports, but I think others can be helped (to some degree and reduced to a level people can manage) just by

showing empathy, being non-judgemental. It makes you feel understood. It reassures me that I'm not alone. Welcoming Impartial, non judgemental and approachable. people who believe you and are authentic in their service. good connnection with theapist feeling safe heard and a sense of trust established Ability to connect quickly with a client Empathetic, active listening skills Acceptance of my perspective kind and compassionate					people feeling connected Plain, easy language. Easy to follow and simply displayed That they have availability, mental health services especially during the Covid period were very stretched as a lot of people were seeking assistance. accessibility in all respects of the word. It needs to accessible to all people for all different types of conditions and also in forms that suits them .Being easily accessible

I used most of the apps and many mental health websites during Covid that set my depression backs for years and I have found teleservices were helpful, but nothing beats in person with someone I trust and feel safe to speak freely about difficult thoughts or feelings. Validation, not telling me what to do, listening, understanding of the whole context and not individualistic- I am more than me. understanding and compassionate Listening skills, followed by a supportive discussion Being caring towards people with mental health issues. Treating people with mental					(physically close, and requirements for access not too many steps being free or cheap Visiting in home immediate availability.... I don't want to talk to someone in two weeks about something that is depressing me today Available any time. Don't need to speak to anyone, but have the option. That it's not JUST for the help source, there are other things/topics to talk about too if you can't break the ice

health issues with respect. Good listening Feeling comfortable with the person if they listen to people and their concerns first before giving their opinion instead of interjecting and telling them what they need Knowing that they understand your experience whether that be through demonstrating empathy open and friendly to all people Staff who were easy to talk to That I feel important to them, that I don't feel like a number. Helplines seem to hide behind their 'scripts' and rules					Plain English without jargon affordability and accessibility Ease of access, affordable or free (as someone who is unwell is more likely to let a barrier like cost be an excuse not to go Ease of accessibility, which includes multiple ways to engage (txt, online messaging, zoom calls, in-person, etc), COST COST COST Open simple language.

instead of helping me one on one.					deaf friendly websites include Auslan Accessible Available and accessible when you need them Good access; flexible hours

Table 6. In your own words, how should professional help sources advertise or communicate their services?

Social Media, the Internet & technology	Authentically	Face to face and via recommendation (formal and informal)	Not at all	Miscellaneous
On social media In this day and age social media seems to be the go for everything Possible having ads on TV or online, eg Facebook, YouTube I think social media is the most convenient and would have the largest reach for the younger demographic Being easy to find online helps. Social media Social media Online Community online, emails? it's the way of the world now apparently Website is probably most accessible for the majority of the population just a website	Honestly BE OPEN It would depend. I think help lines might need to counteract the "my problem isn't that bad" or "I don't want to be an inconvenience" lines people tell themselves.I think Medicare needs better funding. Doctors should be able to fully bulk-bill and that the medicare pay-rate be fair compensation for their time and training.I think having to get a mental health plan from a GP creates a roadblock to accessing psychological/psychiatric care. Considering many mental health issues (depression, anxiety, adhd, asd etc) can struggle with motivation and stigma, the process for getting help should consider this and not needlessly complicate the	Through GPs/ other local medical practices, community centres and schools Community gatherings anonymous reviews - like a productreview for Drs Information boards at community spaces/neighbourhood centresEducated "gatekeepers" on services available (including public/free spaces such as libraries), teachers, police stations, churches.Easy-to-remember names/numbers: one to 2 word services, "Lifeline", "Beyond Blue", "DVconnect", "13 Yarn", that can be easy to communicate & recall. in doctor surgeries	No, medical advertisements should not be allowed not via social Media Prefer if referred through a doctor or a health service of some sort e.g. university student health centre. Don't like commercialisation of help services.	discounted prices to engage more people. In as many different ways as possible. Accessibility should be baseline through anyway they can YES, it would show a greater presence in the community and their services would be at the forefront of a persons mind and potentially encourage a person to book an appointment. In every way that would reach every person Be free letterbox drops In plain English

Facebook adds. social media, tv Website No just have an accessible website Website.SEO. Advertise availability on their website so that people don't need to call if fully booked out Online emailing/ online ads or profile on social media - radio ads TV, Radio Social media appears to be the best way to get a message across. Particularly if people struggle to get out of bed or leave their house. One government portal for all available mental health services. Search by area, cost, services, availability etc. Google adwords,	process.I think psychological and psychiatric professionals should try to talk about mental illness as it is for the person, not how the DSM describes it. 1.Being very specific about what is being offered2. what a first appointment will look like3. cost4. wait times for help 5. how to make an appointment6. Being clear about "what a problem looks like". I know too many people who think you need to be at the end of your rope to be seeking help. 7. I shouldnt have to look through every single professional bio page to find someone to help. It should be as simple at a search function including: gender, age (because older people dont want to be talking to someone who is in there 20s about there problems), areas of help required, etc. In a friendly and reassuring way.	through GPs, information websites through community networks gp offices, public spaces (parks etc), letterbox leaflets Word of mouth & personal recommendation is my personal preference. However they like, I would personally prefer they were advocated by a GP as that is where you start the first steps to seek assistance. doctors offices, schools, shops, sports Sharing their experiences, maybe some positive outcome from the client I think it would be great to hear from real life (well known and successful people) talking more openly about their own mental health struggles and about how they manage them to still be successful (or to outwardly		Every way possible. By listing their services in an organised directory indexed by demographic served and service specialty, with professional profiles and websites linked. In every way possible. Social media. Radio advertising. Flyers on supermarket notice boards. Posts in online community groups. Encouraging word of mouth. Making their presence known at community events (ie. Hiring out a marquee with their logo and contact information on it, for example). All traditional and non-traditional methods. Where ever humans are! Anyway that is findable - biggest problem is finding who is out there and

Social media Websites Online Google search (using keywords), social media Google/social media Social media Website Depends on demographic but sponsored ads on apps that match the age group you want to target. through tiktok and socials Good / helpful social media posts are a good form of advertising. A good website is also helpful Social mediaWorkplacesSocial eventsTraditional media Via social media and a website Maybe facebook	I think they should focus on advocacy and treatment. Publish content that actually helps people for free and encourage them to seek further assistance The most considerate way By stating that they care and that everyone is welcome. If they are full or treat only certain diagnoses or it is a wait time greater than 2 weeks they need to advertise that. Being open and transparent is key to consumers talk about costs up front Experts, confidential and approachable. With empathy Promoting impartiality indicating they are not governed by an overruling body that may well be the cause of my own personal mental anguish	appear that way). Mental health is a problem for everyone at some point in their life and I think that getting the message across that it is possible to suffer from mental health issues and still manage work, family and relationship commitments with the right tools and understanding. mentioned as support services at work, brochures at Dr's Through GP or schools Having the GP knowledgable or community centres knowledgeable about places is also helpful. Community notice boards both physical and online. Word of mouth Through doctors and websites Through peer networks and value of lived experience		whether they would understand your situation the best Like Blueknot foundation does Every method possible. Use market research. It depends on their target audience. Younger may respond to social media whereas older to website or flyers at the Dr's/Gp On as many platforms (word of mouth, traditional media, social media) as they can afford to engage. In a range of mediums depending on their target audience. Everywhere! Advertise everywhere. People do not know where to go or what to do. The more they see ad

Social media is one way, having a professional website. I have found websites are helpful if there is a really good description of the services that are offfered. For younger people, I think social media is an important source of communicatioin. TV Using online platforms Through google and website ads For me, if they have a website that shows up in Google that works. television- radio Website Informative website with information about the practitioners, skills, professional interests, availability Web pageOnline advertisementsPublicly available online mental health portal to		In the workplace Referrals. doctor Via GPs it is good to be able to access information about services in my area online, to read reviews. Endorsed by schools for students, endorsed by the workplace for workforce, endorsed by government departments. No advertisements needed anywhere else. Yes. It is hard to find information sometimes and you have to rely on your GP for a referral. It would be better is there was an online presence so that you could identify a potential suitable professional and bring to the GP		ertisments for servies the more chance of them getting help before it is too late As many ways as they can afford to get the message out there Posters in community / medical centers In person, maybe organising public and accessible meeting and speaking. I know this is telematic era but precisely for this reason real meetings with real people are necessary more than ever. New generation have to learn an healthy and comfortable way to stay together, to learn to be part of a group, a community because this is in the profound roots of human nature.

advertise professional counsellors/psychologist/psychiatrists etc and their service/contacts/key information together with helful services (BeyondBlue, etc) and contact details. Website Via television adds, Social media Website. Networks. Social media. Tv radio social media the internet, radio, tv More on social media because that's where everyone feels these thoughts On TV and on social media Social Media Most young people have social media, so that way Web Radio Online		Yes most definitely and if they are unable to help to refer to another helpful source. through schools and sport clubs Gp offices, pharmacy bus sheds libraries hospital waiting rooms Website and community groups, but also be active in seeking to have relationships with local doctors. I was referred by my doc who understood me and was able to refer me to a psychologist she believed would be good for me. My doc only could do this because she knew and had worked with multiple psychologists in her area.Community groups like Logan Healthy Living have also this larger understanding of local professionals and which might be good for the 'you' they know and understand. Logan Healthy Living was suggest to me by		visible places in the community eg billboards, notice boards etc In any way that other health services are advertised or communicated - with emphasis on evidence based results - so many therapies out there that are effective in as many ways as possible. there are people who don't always have access to every type of media, and that means that there needs to be multiple types of advertisements local community pages, business pages (eg Facebook Business, Nextdoor Business), , on business vehicles, billboards As widely as possible to all age demographics - kids, teenagers, adults,

There is nowhere else but the internet online, social media Online through social media Online Online information is useful to read/digest, with a comprehensive website outlining their services Through websites Web Website Website, various other online media platforms, cinema advertising		my very good doctor Dr Tam Trihn at Brownsplains Family Practice. Also at schools so students can access the information from their teachers/counsellors Through mental health organisations or I prefer a referral from another client or my doctor etc Notices in appropriate places public notices through GPs doctors' referral workplaces, public spaces (eg public advertising) I believe one good strategy would be to make contact with General Practitioners I guess referral through a doctor. I had a few friends		older people, LGBTIQ community, schools etc Sponsoring people or things and just traditional ads Yes they should to address a lack of awareness of where people can access professional help In every medium available

		who would offer there service but I was to embarrassed to ask for help Through GPs. Through schools I have always gone by word of mouth and not by advertisements, and I'm sure a lot of people would use word of mouth too. I have seen a lot of folks ask for recommendations in various FB groups.		

Discussion

It is known that stigma and personal attitudes towards help-seeking contribute to whether individuals would seek help (Schnyder et al., 2017). Therefore, it is important to investigate the perceptions, intentions, as well as experiences of help-seeking in the community. This survey was conducted to understand help-seeking experiences for mental health, self-harm, and well-being concerns among community members in the Greater Brisbane area, as well as preferences and perceptions on services being offered in the community. The survey respondents were mostly females and in middle adulthood. The majority also had a full-time job and a university degree.

One of the most important findings was perhaps regarding suicidal ideation and self-harm related issues. The reported rates of suicidal ideation (26%) and suicide attempts (14%) in the last 12 months were concerning when compared to the general population, where the 12-month prevalence of suicidal behaviours was 3.4%, and a lifetime prevalence was 16.7% for 2020-2021 period (ABS National Study of Mental Health and Wellbeing, 2022). Additionally, suicidal ideation and suicide attempts were more common among younger participants, while there was no significant difference found between gender. Moreover, participants generally had less intention to seek help for suicide-related issues and had less actual help-seeking experience for suicidality, compared to help-seeking for general mental health problems. Of those who had suicidal ideation or suicide attempts in the last 12 months, only less than 20% had ever sought help.

Notably, younger participants had significantly fewer experiences of help-seeking for mental health concerns in general, though no difference was found for help-seeking experience specific to self-harm. Furthermore, our findings revealed that younger participants held less-positive views about help-seeking in general, compared to older participants. In line with these findings, a recent systematic review reported that lack of mental health knowledge was the most common reason why young people did not seek help, followed by stigma and

embarrassment, and being unsure that they can trust a professional (Radez et al., 2021). Thus, mental health and help-seeking literacy might be particularly important for young people's perceptions about help-seeking and to engage in help seeking behaviours.

The most common barriers to help-seeking perceived by the participants were financial issues (i.e., cannot afford mental health services) and difficulty to find suitable services. National studies in the US and New Zealand reported the most common reason for not seeking help was the lack of perceived need or lack of distress, however financial reasons were among the most common structural problems related to lack of help-seeking, particularly among those with more severe problems (Kessler et al., 2001; Mojtabai et al., 2010; Wells et al., 1994). On the other hand, cost and practicality might be some of the most important factors for participants in our study when they consider seeking help, whilst an expert therapist was rated as the most important factor about the service provider to consider when seeking help. A similar finding was reflected on the participants' high likelihood towards seeking help from qualified health professionals, which may suggest that help-seekers value the expertise and quality of service providers.

While higher perceptions of barriers to help-seeking was associated with less intention to seek help for both mental health and suicide-related concerns, it was interesting that higher perceptions of barriers to help-seeking was also associated with experiences of help-seeking help for suicide-related concerns. Although this finding (based on a cross-sectional correlation analysis) does not necessarily imply a causal relationship, it is possible that participants' perceptions of barriers may be based on their negative help-seeking experiences (e.g., difficulties and challenges associated with seeking help).

Intentions to seek help from any source were calculated and separated into formal and informal sources. Interestingly, none of the intentions to seek help were associated with actual behaviours or experiences of help-seeking. This finding might suggest that simply having a strong intention to seek help may not necessarily lead individuals to actually seek

help for their mental health or suicide-related problems. Other factors, such as perceived barriers to help-seeking, attitudes and opinions surrounding help-seeking, as well as perceived community views on help-seeking may also be contributing to whether individuals would seek help.

With regards to the source of help-seeking, participants reported high likelihood that they would seek help from health professionals, such as psychologists, doctors, or GPs, for both general mental health and well-being concerns as well as self-harm. Consistently, more than half participants reported that they had sought help from counsellors, therapists, or psychologists for mental health concerns. Seeking help for self-harm concerns from counsellors, therapists or psychologists were reported by around a third of participants; however, nearly half reported that they had never sought any help for self-harm concerns. Seeking help from friends, family, or significant others appeared to be highly preferred by the participants, and most reported that they had sought help from these resources. On the other hand, the likelihood of seeking help from religious figures were relatively low, and only less than 5% had sought help from these sources for self-harm and general mental health issues.

Most participants perceived help-seeking favourably, as suggested by the tendency to endorse high likelihood in seeking help from most sources provided in the questions. When asked about the values of help-seeking, most rated these positively. The participants also held positive opinions about help-seeking, as most indicated strong agreements towards statements such as that it is important for people to seek help, that help-seeking would be a good idea, and that help-seeking would be 'my' choice. Despite these mostly positive views towards help-seeking, it is notable that responses on the question about feeling confident to seek help was more mixed. This may suggest that the positive attitudes and intentions to seek help may not necessarily be equal to having confidence to engage in active help-seeking.

There was no gender difference in the views about help-seeking; however, participants who identified as non-binary were less likely to seek formal help for suicide-related concerns. A previous Australian survey revealed that gender-diverse individuals were most vulnerable to mental health problems, yet they reported that the most common barrier to help-seeking was the lack of LGBTI-friendly services that they can access (McNair & Bush, 2016) which may have hindered them from seeking formal help. Meanwhile, men also appeared to be least likely to seek help for general mental health concerns. Issues surrounding gender role conflict, self-stigma with regards to help-seeking and disclosing personal problems, masculine norms in the society, as well as the lack of referral for men to seek help are some of the most common reasons that explain the lack of help-seeking among men (Brenner et al., 2017; Pederson & Vogel, 2007; Vogel et al., 2013).

This study was unique in the way that it investigated help-seeking in mental health and self-harm related concerns from various perspectives, namely intentions to seek help, actual experiences of help-seeking from multiple source types (including non-traditional/informal sources), attitudes towards help-seeking, as well as perceptions about their help-seeking and that of their community. Nevertheless, several limitations of the study should be considered when interpreting the results. Given the large area and population of the greater Brisbane area, it was not possible to obtain a random sample for practical and cost-related reasons. Therefore, the results, while informative will not necessarily be representative of the greater Brisbane area. Given the sample was not randomly selected, it is also possible that response bias was present in this study. Thus, participants who agreed to participate in the survey may have been biased towards those who had lived experience of mental illness or suicidality.

The responses to the open-ended items indicated that issues that were important regarding formal and informal help services were being empathetic and welcoming, confidential, tailored and reliable, the expertise and credibility of the mental health professional, being

accessible, and the client feeling empowered and having control over how they receive help. In terms of preferred methods for professional help sources to communicate their services, participants mainly mentioned social media, the internet & technology, authentically, and face to face and via recommendation (formal and informal).

Conclusions

This study has highlighted some important findings regarding individual help-seeking and how the current services could be improved. First, young people might be one of the most vulnerable groups, as suicidal ideation and suicide attempts were higher among this group, despite having the least experience of help-seeking and less positive attitudes towards help-seeking. Second, gender identity may contribute to the likelihood of help-seeking intentions as well as actual help-seeking behaviours. Lastly, despite generally positive attitudes and views about help-seeking among participants, participants perceived financial issues as a strong barrier to help-seeking, while having a service that is cheap or free, does not need a referral, and having an expert therapist were some enablers that were perceived as highly important by the participants.

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Overall summary and recommendations

Taken together, the findings from the three studies undertaken for the Sunlight Centre highlight the following:

- Consistent with Australian data and other that of other high-income countries, Queensland suicide and self-harm data show a 'gender paradox', where males are more likely to die by suicide than females, but females are more likely to be hospitalised for self-harm and suicide attempts. There is a clear opportunity to provide intervention for young females experiencing self-harm in greater Brisbane.
- The key areas of concern regarding mental health for greater Brisbane focus group participants were the safety of at-risk groups (youth, males, veterans, the elderly); accessibility of mental health services (particularly the issues of costs, waiting lists, and the need for referrals and mental health plans); roadblocks to accessing help; authenticity of mental health services; help for families and friends; and the need for human connection.
- There were relatively high levels of suicidality in the sample of online survey participants (although this is likely to be impacted by response bias). Only about 18% of those who reported suicidal behaviours had sought help. Young people are one of the most vulnerable groups. Suicidal ideation and suicide attempts were higher among this group, despite having less positive attitudes and the least experience of help-seeking.
- The main barriers to help-seeking were costs and difficulties finding appropriate services. The highest-rated enablers to seeking help were the service being cheap or free, private, not requiring referrals, having a website that provides detailed information on what to expect, and having an online booking function.
- Issues identified as being important regarding formal and informal help services were being empathetic and welcoming, confidential, tailored and reliable, expertise and

credibility of the mental health professional, being accessible, and the client feeling empowered and having control over how they receive help. In terms of preferred methods for professional help sources to communicate their services, participants highlighted social media, the internet and technology, authenticity, face to face and via recommendation (formal and informal).

These results from these combined studies provide important evidence regarding the mental health support needs, concerns and priorities of the greater Brisbane community. These valuable insights have strategic implications for informing and shaping the support services of the Sunlight Centre and promoting these in the local community. Some key areas are highlighted below:

6. The main barriers identified to accessing mental health services were costs, waiting lists, and needing a GP's referral or mental health plan. Given the services provided by the Sunlight Centre do not have any of these barriers, there would be a clear benefit from strong promotional strategy to highlight these positive features.
7. Authenticity, respect, empathy and understanding, non-judgement, compassion, human connection, expert counsellors, and individual face-to-face services were all emphasised as highly valued components of mental health services. It will be crucial to consider framing and wording of services to highlight these attributes when promoting the Centre's services.
8. Social media and the internet were highlighted by participants as the most effective way to promote mental health services. It will be important to tap into these sentiments by tailoring the Centre's website and developing a strategy for social media.
9. Consider obtaining guidance from a company with expertise in areas such as PR, communications, social media, and understanding of how to authentically promote services to young people.

10. When promoted more extensively, there is likely to be strong interest in the Centre's services (especially given the costs, waiting lists and other barriers of many alternative mental health services). The Centre will need to consider its capacity to continue providing the same high-quality services if there was a sharp growth in clients.

Appendix B

Community priorities and perceptions of services for mental health, wellbeing and self-harm

Researchers from Griffith University, in partnership with The Sunlight Centre, are conducting a survey to learn more about those things that help and those things that hinder (barriers and enablers) in seeking help for mental wellbeing concerns and self-harm, and the needs and preferences of community members with regard to service delivery. We are seeking interested community members (aged 14 and over) to complete a brief anonymous online survey. The survey will ask about your opinions of service delivery for mental health and wellbeing (including self-harm), barriers and enablers to services, and recent experiences of mental health concerns and/or self-harm. You do not need to have personal experience with mental health difficulties or self-harm to participate. All perspectives are welcome. Participation is completely voluntary and will help support important research aimed at improving service delivery in the future.

Your responses will be confidential and cannot be linked to your identity. Data will be stored in a secure, de-identified file at Griffith University and will be destroyed after 5 years. If you have any questions, you can contact Dr Victoria Ross, 07 3735 3381, or victoria.ross@griffith.edu.au Griffith University research is in accordance with the National Statement on Ethical Conduct in Human Research (2007). If you have any concerns about the ethical conduct of this study you should contact the Manager, Research Ethics on 07 3735 4375 or research-ethics@griffith.edu.au and quote GU Ref No: 2022/494. Completing this survey should not be a risk for you, but if you feel distressed at any time, you can get help at:

Beyondblue: 1300 224 636

Lifeline: 13 11 14

The Sunlight Centre – 1300 259 724

eHeadspace – https://headspace.org.au/online-and-phone-support/

Kids Helpline: 1800 55 1800

Mensline Australia – 1300 78 99 78

There are 53 questions in this survey

Study Information and Consent

Community priorities and perceptions on services for mental health and wellbeing and self-harm in Queensland

Online Survey Information Sheet

Purpose of the Online Survey

This project is a collaboration between researchers from Griffith University and The Sunlight Centre (https://www.sunlightcentre.com.au/). Funding to complete the project was provided by The Sunlight Centre. We want to hear from people (aged 14 and older) about their priorities, concerns and opinions regarding mental health and wellbeing, the help-seeking journey, and service delivery within the Brisbane community in Queensland. You do not need to have personal experience of mental health concerns or self-harm. The aim of the online survey is to allow you the opportunity to give us your thoughts and opinions regarding mental health and wellbeing (including self-harm) within the community. Your participation in this survey is voluntary and you can withdraw from participating at any time. A decision to withdraw or not to participate will not result in any negative outcomes for you.

What will the survey involve?

The short one-off survey will be completed online via a website link. The survey is not expected to take you longer than 15 minutes to complete. You will be asked questions related to your mental wellbeing, thoughts/acts of self-harm in the last year, and opinions on help services.

What will happen to the information which you give?

Your survey answers are anonymous. Findings from the survey will be published in academic journals and other sources such as reports. Findings will be reported on all data collected, not single individual data, and those completing data analysis will not have access to participants' names. Your data will be anonymous and aggregated in any publications. A plain language summary of the research results can be requested from the lead investigator at the conclusion of the project, via email (see below).

Will your participation in the study be kept confidential?

Your survey responses will be completely anonymous. Computer records will be password protected and stored using the GU Research storage platform (as recommended and supported by the University). Any hard copy data will be stored in a locked filing cabinet in the School of Applied Psychology, Griffith University. All data will be stored for a period of 5 years and will then be destroyed. Any information you provide will only be used for the purposes of this project. If you would like to access your information or if you would like your information to be deleted at any time you can contact the research team at the contact details below.

Are there any benefits to taking part?

Your participation in the online survey will allow you to indicate your priorities for service providers in the community regarding mental health and wellbeing (including self-harm). This will help service providers understand the barriers and facilitators to accessing care, advertising services, and engaging people in the type of support that may be seen of as useful and effective *by* community members. The survey is not expected to provide you with a direct benefit, however, overall outcomes may provide a benefit to future recipients of services in the local area.

Are there any risks to taking part?

In the unlikely event you become distressed as a result of completing the online survey please feel free to contact one or more of the numbers below for free anonymous access to counselling supports.

The Sunlight Centre – 1300 259 724 (Free face to face therapy appointments for crisis counselling)

Lifeline Australia – 131114 (24/7 Crisis support line)

Kids Helpline – 1800 55 1800 (24/7 Helpline for people under 18 years of age)

eHeadspace – https://headspace.org.au/online-and-phone-support/

Mensline Australia – 1300 78 99 78

Suicide Call Back Service – 1300 659 467

Alternatively, you may wish contact your local GP or consult the APS website to find a psychologist in your area (https://www.psychology.org.au/Find-a-Psychologist).

The ethical conduct of this research

The GU ethics reference number for the project is 2022/494. Griffith University conduct research in accordance with the *National Statement on Ethical Conduct in Research Involving Humans.* If you have any concerns or complaints about the ethical conduct of this research project you should contact the Manager, Research Ethics, Research Ethics to (07) 3735 4375 or research-ethics@griffith.edu.au.

Additional information

I understand that if I have any questions concerning this research, I can contact the Chief Investigator listed below. I understand that the study has been approved by the Human Research Ethics Committee of Griffith University and if I have further queries concerning my rights in connection with the research, I can contact HREC at research-ethics@griffith.edu.au

More information about the project is available from:

Dr Victoria Ross, Chief Investigator

Australian Institute for Suicide Research and Prevention & W.H.O Collaborating Centre for Research and Training in Suicide Prevention

School of Applied Psychology Griffith University

Email: victoria.ross@griffith.edu.au

Online Survey Consent Form

Thank you for expressing an interest to take part in the online survey. The purpose of this form is to confirm that you agree to take part in this project and that you know what the project and your participation involves.

If after reading the above information and the points below, you are still happy to participate, please select Yes to continue to the survey.

- I confirm that I have read and understood the information sheet for the project.
- I am over 14 years of age. If I am aged 17 years or younger I confirm that my parent is aware of my participation and has provided consent.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason, and that this does not have any adverse consequences.
- I understand that my participation will involve completing a short survey via online link.
- I understand that the data obtained within this project will be stored securely and in an anonymised manner.

- I understand that participation in this research is not expected to have any negative effects on my mental health. However, should participating in this research have a negative impact on my mental health I will use the referral numbers provided.
- I understand that the overall aggregated findings of this research will be shared with the study partners and may be published in academic settings as well as among the wider community but that my identity will remain anonymous.

Choose one of the following answers

Please choose **only one** of the following:

- ○ Yes
- ○ No (please close the survey)

Demographic Information

What is your age (in years)? *

Only numbers may be entered in this field.

Please write your answer here:

Sex at birth: *

Choose one of the following answers

Please choose **only one** of the following:

- ○ Male
- ○ Female
- ○ Intersex
- ○ Prefer not to say
- ○ Other

Which gender do you identify as? *

Choose one of the following answers

Please choose **only one** of the following:

- ○ Male
- ○ Female
- ○ Non-binary
- ○ Prefer not to say
- ○ Other

Do you identify as: *

Choose one of the following answers

Please choose **only one** of the following:

- ○ Aboriginal
- ○ Torres Strait Islander
- ○ Aboriginal and Torres Strait Islander
- ○ Neither Aboriginal or Torres Strait Islander
- ○ Prefer not to say

Do you primarily speak English at home? *

Please choose **only one** of the following:

- ○ Yes
- ○ No

Do you identify as: *

Choose one of the following answers

Please choose **only one** of the following:

- ○ Lesbian
- ○ Gay
- ○ Bisexual
- ○ Asexual
- ○ Pansexual
- ○ Straight
- ○ Prefer not to say
- ○ Other

Are you currently in highschool? *

Please choose **only one** of the following:

- ○ Yes
- ○ No

Do you have current paid employment? *

Choose one of the following answers

Please choose **only one** of the following:

- ○ Yes, full time
- ○ Yes, part time
- ○ Yes, casual or fixed term
- ○ No

- ◯Other

What is your highest level of education? *

Choose one of the following answers

Please choose **only one** of the following:

- ◯Year 8
- ◯Year 9
- ◯Year 10
- ◯Year 11
- ◯Year 12
- ◯Tafe Certificate or Diploma
- ◯Undergraduate Degree
- ◯Postgraduate Degree

Where in Queensland are you currently living? *

Choose one of the following answers

Please choose **only one** of the following:

- ◯Greater Brisbane Region (including Brisbane city, Ipswich, Logan, Redland City, Moreton Bay Region)
- ◯Outside of Greater Brisbane Region
- ◯Interstate (NSW, VIC, ACT, TAS, SA, NT or WA)
- ◯Other

Help-seeking Intentions

General Help-seeking Questionnaire (Wilson et al., 2005)

The following questions ask you to rate how likely it is that you would seek help from the following sources. There are no right or wrong answers. Please answer as honestly as you can.

If you were experiencing trouble with your mental health or wellbeing, how likely would you be to seek help from the following sources:

Please choose the appropriate response for each item:

	Extremely Unlikely					Extremely Unlikely
Community/ Sport group	○	○	○	○	○	○
Friend	○	○	○	○	○	○
Parent/ Guardian	○	○	○	○	○	○
Family (non-parent)	○	○	○	○	○	○
Partner (boyfriend, girlfriend, spouse etc.)	○	○	○	○	○	○
Confidential helpline with a counsellor	○	○	○	○	○	○
Confidential textline with a counsellor	○	○	○	○	○	○
Online web-chat with a counsellor	○	○	○	○	○	○
Counsellor	○	○	○	○	○	○
Psychologist	○	○	○	○	○	○
School/ University/ Workplace Counsellor	○	○	○	○	○	○
Teacher	○	○	○	○	○	○
Doctor (GP)	○	○	○	○	○	○
Psychiatrist	○	○	○	○	○	○
Priest/ Minister or other religious leader	○	○	○	○	○	○

	Extremely Unlikely					Extremely Unlikely
Online forum	○	○	○	○	○	○
Through social media (Instagram, TikTok etc.)	○	○	○	○	○	○
Online peer support group	○	○	○	○	○	○
Face to face peer support group	○	○	○	○	○	○
Google/ Informational websites	○	○	○	○	○	○
No one/ Would not seek help for my mental health or wellbeing	○	○	○	○	○	○

Which of these potential help sources do you think would be the <u>most</u> effective? *

Please write your answer here:

Where else might you be likely to seek help from? *

Please write your answer here:

Help-seeking Intentions for Suicidal thoughts or self-harm behaviour

Again, the following question asks you to rate how likely it is that would seek help from the following sources. There are no right or wrong answers. Please answer as honestly as you can.

<u>If you were</u> **experiencing trouble with your <u>suicidal thoughts or self-harm</u>, how likely would you be to seek help from the following sources:**

Please choose the appropriate response for each item:

	Extremely Unlikely					Extremely Likely
Community/ Sport group	○	○	○	○	○	○
Friend	○	○	○	○	○	○
Parent/ Guardian	○	○	○	○	○	○
Family (non-parent)	○	○	○	○	○	○
Partner (boyfriend, girlfriend, spouse etc.)	○	○	○	○	○	○
Confidential helpline with a counsellor	○	○	○	○	○	○
Confidential textline with a counsellor	○	○	○	○	○	○
Confidential web-chat with a counsellor	○	○	○	○	○	○
Counsellor	○	○	○	○	○	○
Psychologist	○	○	○	○	○	○
School/ University/ Workplace Counsellor	○	○	○	○	○	○
Teacher	○	○	○	○	○	○
Doctor (GP)	○	○	○	○	○	○
Psychiatrist	○	○	○	○	○	○
Priest/ Minister or other religious leader	○	○	○	○	○	○
Online forum	○	○	○	○	○	○
Through social media (Instagram, TikTok etc.)	○	○	○	○	○	○
Online peer support group	○	○	○	○	○	○
Face to face peer support group	○	○	○	○	○	○
Google/ Informational websites	○	○	○	○	○	○
No one/ Would not seek help for my mental health or wellbeing	○	○	○	○	○	○

Which of these potential help sources do you think would be the <u>most</u> effective for suicidal thoughts or self-harm? *

Please write your answer here:

Where else might you be likely to seek help from for suicidal thoughts or self-harm? *

Please write your answer here:

Actual Help-seeking experience

Actual help-seeking experience (adapted from Hom et al., 2021).

The following questions ask about your actual experiences of seeking help for both mental health difficulties as well as suicide and self-harm. There are no right or wrong answers.

Have you ever taken any steps toward seeking professional treatment or counselling for any problem you were having with your emotions, nerves, or mental health? *

Check all that apply

Please choose **all** that apply:

- ☐ Read informational websites
- ☐ Read informational brochures
- ☐ Asked someone for advice about seeking help
- ☐ Called to inquire about services
- ☐ Scheduled an initial appointment by phone
- ☐ Scheduled an initial appointment by email
- ☐ Scheduled an initial appointment using a website/ online portal
- ☐ None of the above

Have you ever taken any steps toward seeking professional treatment or counselling specifically to address thoughts of suicide or a suicide attempt? *

Check all that apply

Please choose **all** that apply:

- ☐ Read informational websites
- ☐ Read informational brochures
- ☐ Asked someone for advice about seeking help
- ☐ Called to inquire about services
- ☐ Scheduled an initial appointment by phone
- ☐ Scheduled an initial appointment by email
- ☐ Scheduled an initial appointment using a website/ online portal
- ☐ None of the above

Have you ever received any treatment or counselling for any problem you were having with your emotions, nerves or mental health? *

Comment only when you choose an answer.
Please choose all that apply and provide a comment:

- ☐ Counsellor/Therapist/Psychologist and number of sessions ___
- ☐ Psychiatrist and number of sessions _____

- ☐ Other medical provider and number of sessions ____
- ☐ Priest or other minister of religion and number of sessions ____
- ☐ None of the above

Have you ever received any treatment or counselling specifically to address thoughts of suicide or a suicide attempt? *

Comment only when you choose an answer.
Please choose all that apply and provide a comment:

- ☐ Counsellor/Therapist/Psychologist and number of sessions ____
- ☐ Psychiatrist and number of sessions ____
- ☐ Other medical provider and number of sessions ____
- ☐ Priest or other minister of religion and number of sessions ____
- ☐ None of the above

Have you ever sought support for any problem you were having with your emotions, nerves, or mental health? *

Comment only when you choose an answer.
Please choose all that apply and provide a comment:

- ☐ Confidential helpline and number of times ____
- ☐ Confidential textline and number of times ____
- ☐ Confidential web-chat and number of times ____
- ☐ In person peer support group and number of times ____
- ☐ Online peer support group or forum and number of times ____
- ☐ Informational website and number of times ____
- ☐ Friends or family and number of times ____
- ☐ None of the above
- Other: ____

Have you ever sought support specifically to address thoughts of suicide or a suicide attempt? *

Comment only when you choose an answer.
Please choose all that apply and provide a comment:

- ☐ Confidential helpline and number of times ____
- ☐ Confidential textline and number of times ____
- ☐ Confidential web-chat and number of times ____
- ☐ In person peer support group and number of times ____
- ☐ Online peer support group or forum and number of times ____
- ☐ Informational website and number of times ____
- ☐ Friends or family and number of times ____
- ☐ None of the above
- Other: ____

Priorities of your community

How big of a concern do you think mental health and wellbeing is <u>right now</u> in each of the following settings? *

Please choose the appropriate response for each item:

	Not at all							A very big concern	N/A
Friends/ peer group	○	○	○	○	○	○	○	○	○
Workplace	○	○	○	○	○	○	○	○	○
Community	○	○	○	○	○	○	○	○	○

How big of a concern do you think self-harm is right now in each of the following settings? *

Please choose the appropriate response for each item:

	Not at all							A very big concern	N/A
Friends/ peer group	○	○	○	○	○	○	○	○	○
Workplace	○	○	○	○	○	○	○	○	○
Community	○	○	○	○	○	○	○	○	○

In your opinion, has the level of community concern for self-harm changed in recent years? *

Please choose **only one** of the following:

- ○ Yes
- ○ No

Describe why this *might* be in your own words *

Only answer this question if the following conditions are met:
Answer was 'Yes' at question '26 [ChngConcern]' (In your opinion, has the level of community concern for self-harm changed in recent years?)

Please write your answer here:

How confident are you in the support services for mental health and wellbeing provided in the following settings: *

Please choose the appropriate response for each item:

	Not at all confident						Very confident	N/A
Your friends/ peer groups	○	○	○	○	○	○	○	○
Your workplace	○	○	○	○	○	○	○	○
Your community	○	○	○	○	○	○	○	○

Mental health help-seeking attitudes

MHSAS (Hammer, 2018)

Please mark the circle that best represents your opinion. For example, if you feel that your seeking help would be extremely useless, you would mark the option closes to 'useless'. If you are undecided you would mark the option closest to 'undecided'. If you feel your seeking help would be slighly useful you would mark the option closer to 'useful'.

If I had a mental health concern, seeking help from a mental health professional would be...

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Useless			Undecided			Useful
Usefulness	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Unimportant			Undecided			Important
Importance	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Unhealthy			Undecided			Healthy
Health	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Ineffective			Undecided			Effective
Effectiveness	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Bad			Undecided			Good
Goodness	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Hurting			Undecided			Healing
Helpfulness	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Disempowering			Undecided			Empowering
Empowerment	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Unsatisfying			Undecided			Satisfying
Satisfaction	○	○	○	○	○	○	○

If I had a mental health concern, seeking help would be... *

Please choose the appropriate response for each item:

	Undesirable			Undecided			Desirable
Desirability	○	○	○	○	○	○	○

How strongly do you agree with the following statements?

***In your opinion,* how strongly do you agree with the following statements? ***

Please choose the appropriate response for each item:

	Strongly disagree		Neither agree or disagree		Strongly agree
It is important for people to seek help for problems with their mental health and wellbeing	○	○	○	○	○
If I was experiencing trouble with my mental health and wellbeing, most people who are important to me, would think it was a good idea for me to seek help	○	○	○	○	○
If I was experiencing trouble with my mental health and wellbeing I would feel confident in seeking help	○	○	○	○	○

If I was experiencing trouble with my mental health or wellbeing, what would prevent people who are important to me from helping me? *

Please write your answer here:

Barriers and enablers to seeking help

Please select how strongly you agree with the following statements *

Please choose the appropriate response for each item:

	Strongly disagree					Strongly agree
I can easily find the information I need about available mental health services	○	○	○	○	○	○
I don't know where to find the mental health services that I need	○	○	○	○	○	○
I can't afford mental health services	○	○	○	○	○	○
It is hard to find a mental health service that is suitable for me	○	○	○	○	○	○
I would feel uncomfortable disclosing my concerns with a mental health professional	○	○	○	○	○	○
I would worry about what the mental health professional might think or say	○	○	○	○	○	○
I would prefer to use informal sources of help (e.g., friends or family)	○	○	○	○	○	○

[]Are there any other potential barriers to seeking help for mental health concerns? *

Please write your answer here:

When deciding where to seek professional help for health or wellbeing, how important do you believe the following are: *

Please choose the appropriate response for each item:

	Not at all important					Very important
The service is cheap or free	○	○	○	○	○	○
The service is private	○	○	○	○	○	○
The service has a nice-looking website	○	○	○	○	○	○
The website has a lot of information on mental health and self-harm	○	○	○	○	○	○

	Not at all important					Very important
The website tells you exactly what to expect from your first appointment	○	○	○	○	○	○
The service has an active social media presence	○	○	○	○	○	○
The service has a lot of followers online	○	○	○	○	○	○
The service is well-known	○	○	○	○	○	○
The service understands young people	○	○	○	○	○	○
The service understands older adults	○	○	○	○	○	○
The service requires you to call to make a booking	○	○	○	○	○	○
The service has an online booking function	○	○	○	○	○	○
The service requires a referral from a doctor	○	○	○	○	○	○
The service does not require a referral from a doctor	○	○	○	○	○	○
The therapist is the same gender identity as me	○	○	○	○	○	○
The therapist is a different gender identity to me	○	○	○	○	○	○
The therapist is an expert	○	○	○	○	○	○

Mental Health and Suicidality

The following questions will ask about your experience of self-ham (with or without the intention of dying) in the last year. Some people may find these questions distressing. You do not have to answer these questions if you do not want to. You can skip them. However, they will help our research study. All responses are kept private and confidential.

NB: Helpline and service information is provided at the beginning and end of this survey

During the past 12 months have you seriously thought about attempting suicide? *

Choose one of the following answers
Please choose **only one** of the following:

- ○ Yes
- ○ No
- ○ Prefer not to say

During the past 12 months have you attempted suicide or hurt yourself intentionally? *

Choose one of the following answers
Please choose **only one** of the following:

- ○ Yes
- ○ No
- ○ Prefer not to say

Did you decide to seek help for any of these thoughts or behaviours?

Please choose **only one** of the following:

- ○ Yes
- ○ No

How useful was this?

Please choose **only one** of the following:

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5

Were you encouraged by someone else to seek help for any of these thoughts or behaviours?

Please choose **all** that apply:

- ☐ No
- ☐ Yes, by family members
- ☐ Yes, by friends
- ☐ Yes, by colleagues or coworkers
- ☐ Yes, by teachers or superiors
- ☐ Yes, by doctors or health professional
- ☐ Other:

How useful was this?

Only answer this question if the following conditions are met:
Answer was 'Yes, by family members' *or* 'Yes, by friends' *or* 'Yes, by colleagues or coworkers' *or* 'Yes, by teachers or superiors' *or* 'Yes, by doctors or health professional' at question '47 [Encouraged]' (Were you encouraged by someone else to seek help for any of these thoughts or behaviours?)

Please choose **only one** of the following:

- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5

Were you forced by someone else to seek help for any of these thoughts or behaviours?

Please choose **all** that apply:

- ☐ No
- ☐ Yes, by family members
- ☐ Yes, by friends
- ☐ Yes, by colleagues or coworkers
- ☐ Yes, by teachers or superiors
- ☐ Yes, by doctor or health professional
- ☐ Other:

How useful was this?

Please choose **only one** of the following:

- ○1
- ○2
- ○3
- ○4
- ○5

General

The following questions are about your **opinions**. There are no right or wrong answers and you *do not need experience* to answer.

In you own words, what do you believe makes a help source (formal or informal) useful?

Please write your answer here:

In your own words how should professional help sources advertise or communicate their services?

Please write your answer here:

In your own words, what do you believe enables people to seek our help to support their mental health and wellbeing?

Please write your answer here:

Thank you for completing this survey. Your valuable input is much appreciated.

If you are experiencing any distress please contact one of the following:

Beyondblue: 1300 224 636

Lifeline: 13 11 14

The Sunlight Centre – 1300 259 724

eHeadspace – https://headspace.org.au/online-and-phone-support/

Kids Helpline: 1800 55 1800

Mensline Australia – 1300 78 99 78

Submit your survey.
Thank you for completing this survey.