National Suicide Prevention Taskforce

CALD Lived Experience Research Stage 1 Report

20 August 2020

Evidence Check (or Research) prepared for the National Suicide Prevention Adviser and the National Suicide Prevention Taskforce, commissioned through the Suicide Prevention Research Fund, managed by Suicide Prevention Australia.

circa

Developed by the Cultural & Indigenous Research Centre Australia 2019

All research conducted by CIRCA for this project was in compliance with ISO20252

CONTENTS

1. INTRODUCTION

1.1 The Lived Experience Research

CIRCA Research has been engaged by the National Suicide Prevention Taskforce to undertake research that will help to build a better understanding about the lived experience of suicide in Australia to inform recommendations to the government. The focus of this research piece is on people who have attempted suicide or experienced a suicidal crisis and who are from culturally and linguistically diverse (CALD) backgrounds.

This research is important in providing the Taskforce with a broader diversity of experiences around suicide and suicidal crisis. A focus on the lived experience of people from CALD backgrounds also allows the consideration of immigration and its consequences as a factor in suicidal behaviour and crisis.

This document is the Stage 1 Report which is based on the lived experiences of five individuals around the consistent themes specified for lived experience research which are:

- What factors contributed to a person's suicide attempt or crisis?
- What was helpful and not helpful to get them through the crisis?
- What supports were helpful and how did they find the supports?

It is understood that the research will continue into a second stage to increase the number of research participants and to more specifically focus on a narrower selection criterion of men from CALD backgrounds aged 18 to 35.

CIRCA worked through existing community networks to provide information about the project and sought people from CALD backgrounds to volunteer for interviewing. While the initial intention was to focus on males from discrete cultural and linguistic backgrounds between the ages of 18 and 35, the cultural sensitivities around the issue have required us to broaden the recruitment approach and open it beyond this initial set of parameters.

The interviews were undertaken between 29 July and 14 August 2020.

2. METHOD

2.1 Participant Recruitment

2.1.1 The Recruitment Method

The initial recruitment task sought to find people from CALD backgrounds with a lived experience of suicidal crisis from the following demographic groups; self-identifying as male, aged between 18 and 35 years old; in recovery and not presently experiencing a crisis.

Added to this the direction given by the suicide prevention task force was to seek respondents from the following language/cultural backgrounds; Chinese, Vietnamese, South Sudanese, Congolese and Maori/Pacifica. This CALD specific research lives alongside other research being carried out to understand the lived experience of people who have attempted suicide or experienced suicidal crisis.

The specificity of the recruitment criteria created an initial difficulty in identifying people given the significant cultural sensitivities across CALD groups around the issues of mental health and suicide. As such the approach was predicated on developing pathways through community engagement of organisations and structures who themselves would have contact with or access to people experiencing suicidal crisis.

As such, CIRCA utilised a purposeful community engagement approach which included.

- Identifying key cross-cultural and transcultural mental health services and structures to gain access to networks of people with lived experience of suicide crisis. These included the NSW Transcultural Mental Health Centre, the Queensland Transcultural Mental Health Service, Embrace Multicultural Mental Health (Mental Health Australia) and STARTTS NSW (Refugee Torture and Trauma Service).This was an important component of the work as these organisations would have to both support the research and buy in to the recruitment process;

- Identifying multicultural community structures that currently provide mental health services to people in the initial target populations, especially given the narrow range of cultural and linguistic groups being sought. These included SydWest (Sydney), and Access Community Services (Queensland). These organisational opportunities were more limited as the few language or culturally specific services that exist such as the Italian service Co.As.It. fell outside the recruitment specifications.

- Engaging with these organisations to seek support for the distribution of information about the research to enable people with lived experience to self-nominate the participation in research. Initial feedback from them acknowledged the difficulty of the recruitment task and

suggested that the most appropriate approach would be to distribute information about the research and request that people with lived experience directly contact the researchers.

- Developing a research flyer to provide consistent information to intermediaries and to be used for recruitment purposes (attached in Appendices);

The research flyer was effective in that it resulted in people coming forward wanting to share their lived experience stories and fully understanding the nature of the research and their role within.

The methodological issue was that those coming forward did not specifically meet the recruitment specifications. Following discussions with the Suicide Prevention Taskforce. It was decided that we would broaden specifications to allow their participation. A significant consideration at this time was the need to ensure that the lived experiences of people from CALD backgrounds could be included in the lived experience component of the interim report of the Taskforce.

As a consequence, the second stage of the research will be focused on achieving five further interviews from men meeting the criteria.

As an added safety measure, CIRCA decided not to recruit any participants who were presently experiencing a crisis, but only those deemed to be in recovery and who, with professional support, are effectively managing their mental health. All interviewees were assessed to be appropriate for interview.

CIRCA was successful in identifying community specific mental health workers as conduits for recruitment which has resulted in achieving an interview with a Congolese man with lived experience, as well as identifying potential candidates for Stage 2 interviews.

2.1.2 Engaging appropriate research interviewers

An important consideration in undertaking the interviews was to ensure that the interviewers were themselves appropriate to and capable of undertaking the interviews with these candidates.

As such CIRCA undertook a search process to identify skilled research consultants with experience in trauma-informed practice and a knowledge of suicide prevention and mental health first aid. With respect to the latter, CIRCA developed a Distress Protocol to help researchers manage and mitigate any distress or anxiety that might emerge among participants during or following the interviews.

The second consideration was to ensure that the interviewer was both linguistically and culturally appropriate. CIRCA undertook an initial screening discussion with each person with lived experience to assess their linguistic needs and any other cultural considerations which needed to be accommodated by the research consultant.

This matching process was effective in ensuring that all interviewees felt culturally safe and were able to express themselves in their preferred language. As a result, three individual research consultants were contracted to undertake the interviews. Each of these research consultants were trained in trauma informed interviewing and were able to demonstrate capacity and willingness to deliver a culturally safe interview process.

Where interviews were carried out in English, CIRCA research personnel sought permission to sit in on interviews as non-participants. Agreement was received in all but one interview. In the case of the interview with the Vietnamese background woman, an assessment was made that the involvement of the third person would not be appropriate.

In conducting the interviews, CIRCA allowed for participants' personal stories to be told by way of a 'semi-structured' approach. This means that, with the help of the discussion guides co-developed by CIRCA and the Suicide Prevention Task Force, each interview was sufficiently structured to address the research aims while at the same time allowing space for participants to offer new meanings and tell their own stories. This storytelling approach was essential for this project and is a proven and safe method of achieving qualitative understandings of the lived experiences of participants.

It should be noted that although the interview discussion guides were in English, the interviews themselves were conducted in each of the interviewees preferred language. This allowed our researchers to convey the questions in a culturally sensitive and appropriate manner.

Due to COVID-19, the interviews will necessarily take place over the phone. In all but one case the zoom platform was used which enabled the recording of all interviews.

2.2 Participant Profile

Table 1: Overview of participants

Participant	Gender	Age	Cultural/Migration Profile	Recency in Australia
Participant 1 Tasmania	Female	27	Mandarin Speaker form Taiwan initially coming to Australia as an International Student, now a permanent migrant.	5 years
Participant 2 Queensland	Female	50	English speaking South African Indian woman migrating as a child as part of a family migration. The participant identified her religion as Muslim as it was nominated as being relevant to her suicidal crisis experience.	43 years
Participant 3 ACT	Female	>55	Vietnamese speaking woman coming to Australia as a refugee with her parents and siblings in 1980 after spending 7 months in an Indonesian refugee camp.	40 years
Participant 4 Queensland	Male	72	Greek speaking background man migrating to Australia in 1981 from Greece via a significant period of residency in the UK.	39 years
Participant 5 Queensland	Male	25	Congolese background man coming to Australia in 2016 as part of a refugee family (with 4 siblings) having spent 5 years in a refugee camp in Malawi.	4 years

2.3 Presentation of Findings

The results of the five first-round interviews have been examined for patterns and key themes as well as reflecting the broader lines of enquiry consistent across all lived experience research being undertaken or commissioned by the Suicide Prevention Taskforce.

These are:

- What factors contributed to a person's suicide attempt or crisis?
- What was helpful and not helpful to get them through the crisis?
- What supports were helpful and how did they find the supports?

3. SUICIDE IS A COMPLEX BEHAVIOUR WITH MULTIPLE TRAJECTORIES

While caution should be exercised in drawing too much out of five interviews, the life stories and information provided within these interviews do indicate a number of factors that were identified by interviewees as significant to their suicidal crisis.

3.1 Immigration and Refugee Impacts

There were different experiences of suicide amongst the interviewees including the age at which suicide was attempted or suicidal crisis was experienced: one attempted suicide as an early teen; two attempted suicides in their early 20s, one had multiple attempts at ages 14 and 42 and the other in their 40s. Within the interviews the following issues were consistent:

- The existence of early childhood trauma associated with migration and relationship issues. In each case mental health issues developed during childhood and in some cases being linked to issues related to migration at a young age or refugee experiences at a young age.

> *"In the African refugee camp right life was really hard. The treatment was inhuman. When you are young you don't have the necessary skills to cope. I saw no point in being alive."*

- Issues around cultural differences and cultural clashes between the home environment (which is predominantly framed around cultural expectations and behaviours) and the out-of-home environment to which younger people aspire to be part of.

> *"The mental health journey of migrant children is very undervalued and there are two sets of considerations, the first is the issues and traumas that bring when they come to Australia, the second is the issues associated with trying to fit in here."*
>
> *"My first attempt was at 14 resulting from multiple trauma but the main trigger was my conflict with my mother. Home life was difficult but outside of home I experienced racism and bullying and is Islamaphobia."*
>
> *"Coming to Australia I experienced cultural shock. Being different from everyone as well as being a person of colour. I would ask myself 'am I not human enough' as everyone around me made me feel different."*

- Relationship issues in two of the cases were associated with failed marriages. In both experiences, the nature of the relationship itself or leaving the relationship were seen as significant contributors to suicidal crisis. In one case the responsibilities to care for a spouse who had suffered a brain injury exacerbated feelings of stress, especially given cultural expectations to provide care regardless of personal capacity.

> *"In 2012 I took a drug overdose. I was severely depressed due to marital issues which in my case were complicated because I had sponsored my husband to Australia as a senior religious figure."*
>
> *"His leaving me left me feeling betrayed, led to me losing family support and cost me my friendship networks."*
>
> *"My grief was enormous as all the blame was on me. As a woman I was expected to accommodate my husband which I had done for 14 years, it was traumatic to lose my friendships but as he was a religious leader, he got community support and I didn't."*
>
> *"I took care of him as well is his mother and stepfather, as part of our Vietnamese culture we would never leave our loved ones or other people who are in crisis or unfortunate."*

- In the second interview in which relationships were identified, the interviewee attempted suicide as a 25-year-old. The factors influencing the attempt were almost totally relationship specific. He had migrated to England from Greece as a young adult on his own to be accommodated with family friends. He entered into a married relationship with a much older woman who had two children. The nature of the relationship was traumatic and caused him to consider suicide.

3.2 Family/community as stressor not helper

Family relationship issues were present in all interviews. Invariably the range of cultural and religious belief issues around mental health and suicide impaired the ability of family to be supportive to the person experiencing suicidal crisis.

The consistent view was that there was minimal cultural understanding of mental health and indeed in most cases it was stigmatised and related to some form of behavioural retribution or punishment.

- Two of the interviewees had parents who were both medical practitioners and in both cases interviewees felt that their parents had minimal understanding of mental health, with cultural values overriding any clinical understanding of mental health conditions.

> *"They are really black-and-white, they don't understand mental health. The response was 'if you can't get a job come home."*
>
> *"I challenge them on their views I believe that having more space is good as they have their own beliefs and lifestyles and the far more likely to worry about what other people think about them. According to them if I do the wrong thing they think it is their fault so having them overseas is easier."*

- One of these interviewees identified parental hostility to the person's mental health.

> *"In my community mental health issues are problematic, there is stigma, branding and spiritual abuse. Suicide attempts are frowned on and are used to question religious observance and faith."*

- Mental health was seen in all the communities represented as a cultural taboo and a shaming matter. As such parental responses and potential support was coloured by concern over community perception and blame.

> "In my culture we don't deal with suicide that well, it is a shame to talk about it."
>
> "The Congolese culture is very conservative. There are things not to be talked about. If you tell them about how you are feeling, they will suggest you are possessed, using terms like 'you have a witch attached to you or someone is jealous about your family and discussing you."

This does suggest a counter narrative to the prevailing view of CALD families providing support for their children which is often portrayed as a protective factor. When considering mental health, prevailing community norms stigma and taboos can tend to override familial relationships and reduce available support.

Dealing with CALD community stigma around mental health and suicide is a particularly difficult issue but one which appears to be at the heart of the complexity of both causes and responses to suicidal crisis for these interviewees.

One of the interviewees who currently works in the National Disability Insurance Scheme (NDIS) describes situations in which she witnesses families from CALD backgrounds with

children with disabilities exhibit shame and try to hide their children from both community and the outside world.

> "I work in the NDIS with children with disability. I find it difficult with parents who want *to hide the children away because of the disability.*"

3.3 Experiences of Racism & Prejudice

Experience of racism in Australia was identified by three of the five interviewees as being extremely relevant to their mental health and suicidal crisis. This type of discussion fell into a number of streams.

- The first was that while the public narrative around Australian culture is that it is not racist and inclusive, the experiences of a number of interviewees indicated that their feelings of being victims of racism or not being accepted within Australia were more covert and operated 'under the radar'.

> *"When I came to Australia, I was in shock they spoke the same language as me, but it was different. It was like walking a minefield, standing on the landmine and not knowing why"*
>
> *"Racism in Australia is not in the open, it is under the radar, that's what hits me most. People just look at you."*
>
> *"My mother is not fluent in English and she finds it hard to express herself which has contributed to her mental health issues. I believe that she receives poor treatment because she is black. This upsets and frustrates me."*
>
> *"I have suffered racism, is homophobia and the family difficulties are being Muslim. Some people say I am a role model because I have spoken but I feel that I am a damaged role model."*
>
> *"People here view war and displacement as normal for Africans therefore they underplay the associated traumas that we carry."*

One of the interviewees spoke at length about the ongoing negative impacts of experiences of discrimination affecting her feelings of identity, confidence and self. She cited numerous occasions in which she had been directly discriminated against in service situations and referenced the general anti-Asian sentiment prevalent in Australia during the 1980s and 90s.

> *"During this time you could see writing on the walls in the streets with something like Asians go home', 'go back to where you came from' or when I passed someone on the street, I could hear them say to my face 'go home'. This is the kind of discrimination I've constantly experienced."*

- The second was more concerned with structural discrimination in which many available services failed to cater for the linguistic or cultural backgrounds of the individuals. This sense of not having needs met by mainstream structures, and not having bilingual and bicultural structures available to them impacted on feelings of isolation and lack of agency.

  Within this there was a strong current that services existed for other people but not for them, and that their situations and needs were marginal to the mainstream of service sets. Equally the interviewees felt that there were few if any services that started from a cultural context in which their migration experiences and cultural norms and pressures would be understood.

> "I wasn't a permanent resident at the time so I can get services without paying for them *which I could not afford. It was there very difficult as an international student in a place like Tasmania which I found very hard due to isolation."*

- The third notable stream was the combination of race and religion. The Muslim background interviewee identified Islamophobia as a consistent presence in her life. In her case being from a Muslim background provided minimal solace or support and she deemed herself to be losing on both fronts. What concerned her most at this current time was the experience of her nieces and nephews who she identified as going through the same difficult social situations as she had.

3.4 Employment

The third consistent issue impacting on the mental health of all three individuals was their difficulty in gaining employment, especially employment that was conducive to and supportive of their mental health situations. These specific issues were:

- Not being able to fulfil work requirements due to mental health episodes.
- A reluctance to disclose mental health issues or suicide crisis behaviour in workplaces for fear that it would affect their ability to retain the job.

- Employers who are exploitative especially for vulnerable workers such as international students. In the experience of the international student whose undisclosed need for leave to accommodate mental health episodes led to her being dismissed.

> *"My suicide attempt followed my graduation. I found it hard to find a job. When I did find a job I found I was not able to cope but I had not disclosed my mental health issues. I knew the workplace would not be supportive. When I asked for leave, I was told you better just quit. I will give you one week or just quit."*

- Equally employers who are understanding and supportive of people with mental health issues or who have had suicidal crisis are essential in ensuring ongoing and beneficial work situations.

> *"Having a job and a workplace that is supportive is very important. In my present position they know about my suicidal crisis and they support me by listening to me, giving me positive feedback, involving me in teambuilding as well is allowing me to work from home. I also receive regular supervision and positive support."*

- It can be assumed that negative employment experiences faced by migrants, failure to compete in the labour market due to lack of English language skills or local experience, or underemployment, due to skills and qualifications not being recognised, could all be considered issues that can increase anxiety and be potentially causes for suicidal ideation.

3.5 Housing/Accommodation

The issue of housing was brought up in two interviews, both identifying housing vulnerability as a major factor in their suicidal crisis. Stress associated with housing availability and vulnerabilities for those in social housing is notable.

> *"I have witnessed this (forced evictions) happening in my community which had an impact on my mental health. The relocation of residents of the housing commission where I live triggered my fear of ending up like my neighbours. Thinking about this left me feeling that I would rather die."*
>
> *"I have been waiting for public housing for nine years. This has been a very difficult. And I'm close to homelessness. I have been bailed out by print in the past but now I'm 101 days in arrears on my rent."*

4. CALD SUICIDE JOURNEYS

It is very difficult to develop any particular model around the journeys of people from CALD backgrounds as they are so very different. They differ by:

- Age of migration.
- Family structure both overseas and in Australia.
- Type of migration (international education leading to permanent residency, skills and economic migration, refugee and humanitarian migration).
- Mental health service capacity and responsiveness with regards to linguistic and cultural diversity (this consideration is further explored when discussing access to and satisfaction with available mental health services later in this report).
- Gender, with specific cultural expectation overlays for women and girls from CALD backgrounds in terms of their expected behaviour and cultural conformity.

What is extremely important is to consider that the migrant journey within the suicide consideration frame is not necessarily linear as it delivers people into an Australian context at very different ages, life situations, familial and cultural community responsibilities.

The practical effect is to have people parachuting to existing journey models at points which do not necessarily reflect the journeys experienced by people born and who have grown up in Australia. For many of these people the ability to understand their past experiences and the impacts of traumas that they may have suffered, further complicates the issues settling into a new country that impact on mental health and suicidal ideation.

The other clear consideration is that the migration process itself is a stressor which may have significant causative impacts on suicidal behaviour. Use interviews the following migration impacts can be identified:

- Issues around the reasons for migration or refugee movement which may in themselves represent trauma, dislocation, or economic necessity. Those were the refugee experiences identified the refugee journey and time in refugee camps as particularly difficult and traumatic experiences.
- Vulnerability due to not having family supports through the migration process (this is particularly relevant to the growing number of international students coming to Australia with the intention of achieving permanent residency).
- Issues around both initial settlement and ongoing attainment of education and employment outcomes where there is a perception of an unsupportive mainstream population or the

experience of both overt and covert racism and discrimination. In fact the issue of racism or perceived racism and discrimination permeated the interviews.

> *"Coming to Australia from a refugee background there are huge expectations that life will be better and easier here. This is a myth. We carry with us the idea of a developed world, but the reality is you always have to prove yourself as everyone has assumptions about you because of the way you look for colour."*

- Increased difficulty in achieving life objectives such as employment, housing and education due to the difficulties of migration and in some cases the poverty associated with the initial settlement period.
- Intergenerational conflict associated with migrating into a country or community which may differ culturally, linguistically and religiously.
- Impacts associated with family agency and capacity as protective measures within a successful migration journey. Where this does not exist, it can be argued that there are increased pressures around both personal and family relationships and experiences which are more likely to be culturally bound.

As such, modelling of adverse experiences in childhood, psychological, relational and social challenges in adolescence and co-occurring stresses in adulthood needs to:

- Broaden the monies to be able to accommodate people coming to Australia with different experiences of trauma at different ages, and under vastly different circumstances. The ability to understand previous experiences and traumas prior to arrival in Australia will have significant impact on understanding the factors contributing to suicidal crisis for immigrants and refugees.
- Consider migration as a journey which in itself has the potential for significant negative impacts that may increase stress and trauma leading to suicidal crisis.

5. EXPERIENCES WITH SERVICES AND SUPPORTS

5.1 Service Cultural Competency and Responsiveness

All interviewees had negative experiences with mental health professionals and services with issues ranging from a failure of the services and practitioners to understand cultural contexts to not having the experience to operate in a cross-cultural service approach.

There were two main types of support sought and commented on which were GPs and mental health professionals including psychologists and psychiatrists. Only one person had accessed online counselling services during their many years of experiencing mental health issues.

The following issues featured in the interviews:

- GPs being critical to both accessing support as well as providing a pathway to ongoing services. In one interview, the GP relationship was seen as extremely important and beneficial for the individual.

> *"In 2003 I went and saw a GP who had the same cultural background as mine. He was both understanding and sympathetic to my particular issues and my family situation. Other than my GP I have found most mental health services problematic. They are disjointed and they do not provide continuity of care. I am so tired of having to retell my story which is long and traumatic."*

- Two other interviewees were quite critical of their GPs, one case suggesting that they did not fully understanding mental health considerations and just offered medicines, in another that the advice was just off, "*you need to wake up in the morning, take a shower and go for a walk*". The interviewees take on this was that the GP had not asked her about her routine and behaviour.

> *"I exercise and take a shower at night, she didn't want to listen to me and then stated that she had a client who followed her advice and got better.''*

- Mental health services not being sympathetic or supportive to people from CALD backgrounds. This was referenced on numerous occasions though it should be noted that only one had attended transcultural mental health services of any description.

> *"At 14 my psychologist's response was, 'well in two years you can move out and live on your own'. This was his response to my ongoing issues with my mother and my deep depressions. He failed to understand that this is not the done thing in my community. He made me feel incompetent."*

> *"After a long time I was finally offered support locally in Logan through the World Wellness group who I believe are culturally appropriate and who used by cultural workers."*

- Other considerations about accessing services and supports coming from the interviews included:

  - A belief that cultural community organisations and services would neither be relevant or effective in meeting the needs of people suffering suicidal crisis or indeed having mental health issues. All interviewees indicated that there cultural and linguistic community were at best unhelpful or at worst compounding and reinforcing negative cultural values around mental health and suicide.

  - The binary nature of GPs from similar cultural and linguistic backgrounds. In one case this was seen to be extremely beneficial and effective, while the other two cases suggested that medical practitioners from the same cultural and linguistic background could in fact reinforce existing cultural stigma and taboos around both mental health and suicidal crisis.

    While this was the case when service options were discussed having bilingual and bicultural service providers and councils available was seen as a positive attribute.

> "I was uncomfortable in the service I was offered, firstly because she was a lady and would been better if a man and secondly I would prefer someone from my own culture who I can relate to and who can understand me. Our words and our expression have different meanings, they know."

  - A lack of knowledge or understanding of other available community supports with only two interviewees mentioning the unsatisfactory use of Lifeline. One of these sought out other available community support in Tasmania and achieves this through Google searches. She found the group helpful for a significant period of time. The other stopped using or seeking mainstream services.

> "I tried Lifeline but I don't feel comfortable talking over the phone I would prefer to talk to people face-to-face."

  - A consistent belief that cultural religious infrastructure was not helpful in dealing with mental health and suicide crisis. In fact, religious organisations or structures were seen as irrelevant around these issues and none of the interviewees sought assistance from religious leaders or organisations.

- A belief that English language skills enable people with mental health issues to seek assistance beyond their cultural and linguistic community, thereby mitigating potential negative impacts of cultural stigma or shame.

5.2 Helpful Services

The responses to identifying and talking about helpful services were limited as all interviewees felt dissatisfaction towards most services accessed. Overall, the picture emerging was a series of lived experiences in which individuals felt isolated and unsupported and to whom available services were either seen as irrelevant or through experience deemed to be non-effective.

Two interviewees identified and emphasised the importance of the services available to them at the University to provide significant and effective support. Both indicated initial reluctance to use the services but found them generally relevant.

> *"I was a Master's student and was able to access a wide range of university services which supported me through my studies and her recent graduation with a Master's degree. I believe university saved me it gave me a sense of belonging and achievement."*

The second interviewee indicated initial reluctance to access university counselling services as he believed they were not there specifically for people of colour or from refugee backgrounds. After accessing the service and finding it initially more concerned with academic considerations relevant personal and/or health considerations, felt that over time the counselling was effective as the counsellor made him feel comfortable.

> *"It helped me. It made me feel that I'm not alone. If I need any help I can just go there and get help I don't just have to be tough, even tough people can be easily broke."*

The only other support identified as beneficial was the role of the partner in the two interviews.

> *"The most helpful person was my partner providing the practical support. He cooks for me and he takes me up for a walk".*

6. APPENDICIES

Participant Information Statement

CALD Lived Experience Research

This sheet is for you to keep

Principal Researcher: Pino Migliorino at the Cultural and Indigenous Research Centre Australia (CIRCA)

Who is doing the study?

The research is being done by the Cultural & Indigenous Research Centre Australia (CIRCA) for the Australian Government's Suicide Prevention Taskforce. The research is taking place between July and September 2020.

What is the study about and why am I being asked to participate?

We have been asked by the Suicide Prevention Taskforce to do research that will help to build a better understanding about the lived experience of suicide in Australia to inform recommendations to government. The focus of the research is on people who have tried to commit suicide or have gone through a suicidal crisis. We are doing interviews with people from different cultural backgrounds to ensure that these experiences are part of the Taskforce's considerations.

What am I being asked to do?

- If you agree to take part, we would like to talk to you about your personal experiences in either attempting suicide or experiencing suicidal crisis.
- A CIRCA researcher will talk to you individually, either face-to-face, via videoconference, or over the phone about your experiences. The researcher will have skills in trauma-informed practice and mental health first aid.
- The interview will take about 45 minutes to one hour.
- We will ask your permission to audio record any interviews so the researchers have a proper record of everyone's feedback, but you can say no if you don't want this, and we will then take notes.
- The information you provide in this interview will be written up as a story, but your name will not be used and we will remove any details of your story that might identify you. We will also prepare a small report looking at the overall themes from all of the interviews we conduct for this project.
- Both the short report and the stories will be provided to the Suicide Prevention Taskforce, but your name will not be shared with the Taskforce and we will remove any details of your story that might identify you.

Do I have to participate?

- You don't have to take part if you don't want to. You can say no.
- If you take part, you can pull out of the interview at any time without giving us a reason.
- If you decide not to take part or if you pull out, it will not affect your relationship with the Suicide Prevention Taskforce or the Australian Government.

Are there risks to me in taking part in this study?

You may experience some distress in talking about your personal experiences in either attempting suicide or experiencing suicidal crisis. If that happens, you can ask to take a break from the interview or stop the interview entirely.

Will anyone else know what I say?

- Everything you say in the interview will be confidential and private. Only the researchers will have access to the information you tell them.
- All files will be kept securely stored to protect your privacy.
- The results of the research will be reported in a written report. The results may be presented in a publication or at a conference, but individuals will not be identified.

How will the information be stored?

The recordings and any notes taken will be kept for 5 years on password protected computers or in locked filing cabinets in the CIRCA offices at 16 Eveleigh Street Redfern, NSW 2016 – this is a secure building with video at entry, pin-code entry and a back-to-base alarm system.

Will the study benefit me?

You may not receive any direct benefit from being part of the project, but the information will help the Suicide Prevention Task Force in its preparation of advice to the Prime Minister on how to deal with suicide prevention in Australia.

Will I be compensated for my time?

To thank and compensate you for your time, you will be provided with an incentive payment of $100.

What if I need more information?

If you would like more information about the study, or if you are worried about the study, please contact Pino Migliorino Managing Director, Research and Evaluation at CIRCA on 02 8585 1303 or pino@circaresearch.com.au.

What if I have any complaints or concerns?

If you have any concerns or complaints about the research, you can contact:

- Lena Etuk, Manager of Research and Evaluation at CIRCA on 02 8585 1353 or lena@circaresearch.com.au
- If you think there has been a breach of your privacy, you can write to the Office of the Australian Information Commissioner, GPO Box 5218 Sydney NSW 2001 or call 1300 363 992.

This information sheet is for you to keep

Tenancy 1, 16 Eveleigh Street

REDFERN NSW 2016

Tel: +61 2 8585 1353