National Eating Disorders and Suicide Prevention Roundtable

Australian Government

National Suicide Prevention Office

National Eating Disorders Collaboration

Evidence Experience Expertise

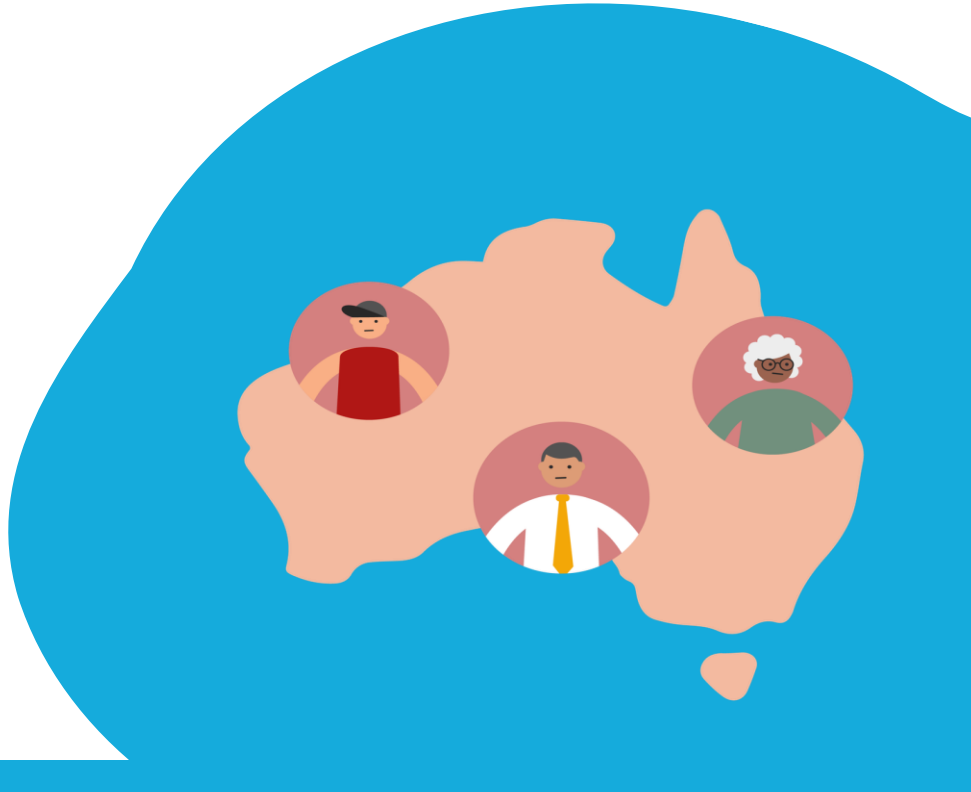
NEDC acknowledges the Traditional Custodians of Country throughout Australia and recognise their continuing connection to land, water, and community.

We pay our respect to Aboriginal and Torres Strait Islander cultures and peoples; and to Elders past and present.

Sovereignty was never ceded.

Background to today

- National Eating Disorders Strategy 2023-2033
- National Suicide Prevention Strategy 2025-2035
- How do we ensure these are active and effective strategies?
- Creating partnerships and reducing siloed work
- Bringing expertise together to drive change



NEDC recognises the individual and collective contributions of those with a lived and living experience of eating disorders or suicide, and those who love, have loved and care for them to both influence and drive change in the stepped system of care.

Each person's experience is unique, and we value and uphold lived experience leadership and contribution in improving the system of care for people impacted by eating disorders and suicide.

Objectives for this meeting

- Create a shared understanding of why suicidality is high amongst people experiencing eating disorders
- Map out the service and system challenges undermining effective suicide prevention
- Identify current or possible approaches to reducing suicidality
- Identify pathway forward – what do we need to do as a sector to reduce the prevalence of suicide amongst people with eating disorders?
- Create partnerships

Session roadmap

1:00 pm	**Welcome, acknowledgments, overview**
1:10 pm	**Framing the challenge** Overview of the literature and lived experience perspectives
1:25 pm	**Sharing the challenge** Explore together the system and service challenges facing the sector in providing support for people experiencing both eating disorders and suicidality
2:05 pm	**Break**
2:15 pm	**Driving and sustaining progress in suicide prevention** Overview of the systems and processes needed to implement and sustain a coordinated, evidence-based, an effective approach to suicide prevention
2:35 pm	**Finding the solutions** Explore together what best practice care could look like, and key next steps to translate our ideas into practice
3:15 pm	**Wrap up** Next steps, including plan for future collaboration
3:30 pm	**Close**

How the meeting will run

- Diverse group including people with lived experience, clinicians, researchers, and government across suicide prevention and eating disorder sectors
- Opportunity to contribute to group discussions, including chat function
- Opportunities for future conversations and relationships will be explored
- Please introduce yourself in the chat and when contributing
- Slides and summary will be provided

Ensuring safety in the conversation

Eating disorders and experiences of disordered eating, body image concerns, and suicidality are common and affect people in different ways.

You, or someone you know may have personal or professional lived experience with this.

You’re welcome to step out, stretch, or use any self-regulation tools if you need.

We will aim to create an environment that prioritises curiosity, safety, and containment.

Looking after yourself and each other

If you, or someone you know, is experiencing distress, you may wish to speak with a trusted friend, colleague or health care professional, or access one of the following services:

Butterfly National Helpline - 1800 33 4673

Lifeline – 13 11 14

Suicide Helpline – 1300 651 251

Switchboard - 1800 184 527

Yarning SafeNStrong - 1800 95 95 63

Framing the challenge

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The role of sector collaboration in suicide prevention

There is a clear imperative to broaden our concept of suicide prevention to encompass both:

1. **A truly preventative approach** – which builds wellbeing and addresses negative impacts of social determinants of suicide to reduce the emergence of suicidal distress in the first place

2. **Compassionate and holistic support** – for people who do experience suicidal distress, designed to meet diverse individual needs both health and non-health related

This will require effort across all parts and levels of government, alongside service providers and the broader community.

Understanding suicide

Suicidal distress is a human response to overwhelming suffering. It is rarely caused by a single factor; rather, it usually arises from a combination of influences.

These influences span both social determinants and individual-level factors, such as life circumstances, clinical conditions, personality traits, genetic predispositions, and demographic characteristics.

Often, it is the interaction between broader social conditions and a person's individual vulnerabilities that contributes to the experience of suicidal distress (National Suicide Prevention Strategy, 2025).

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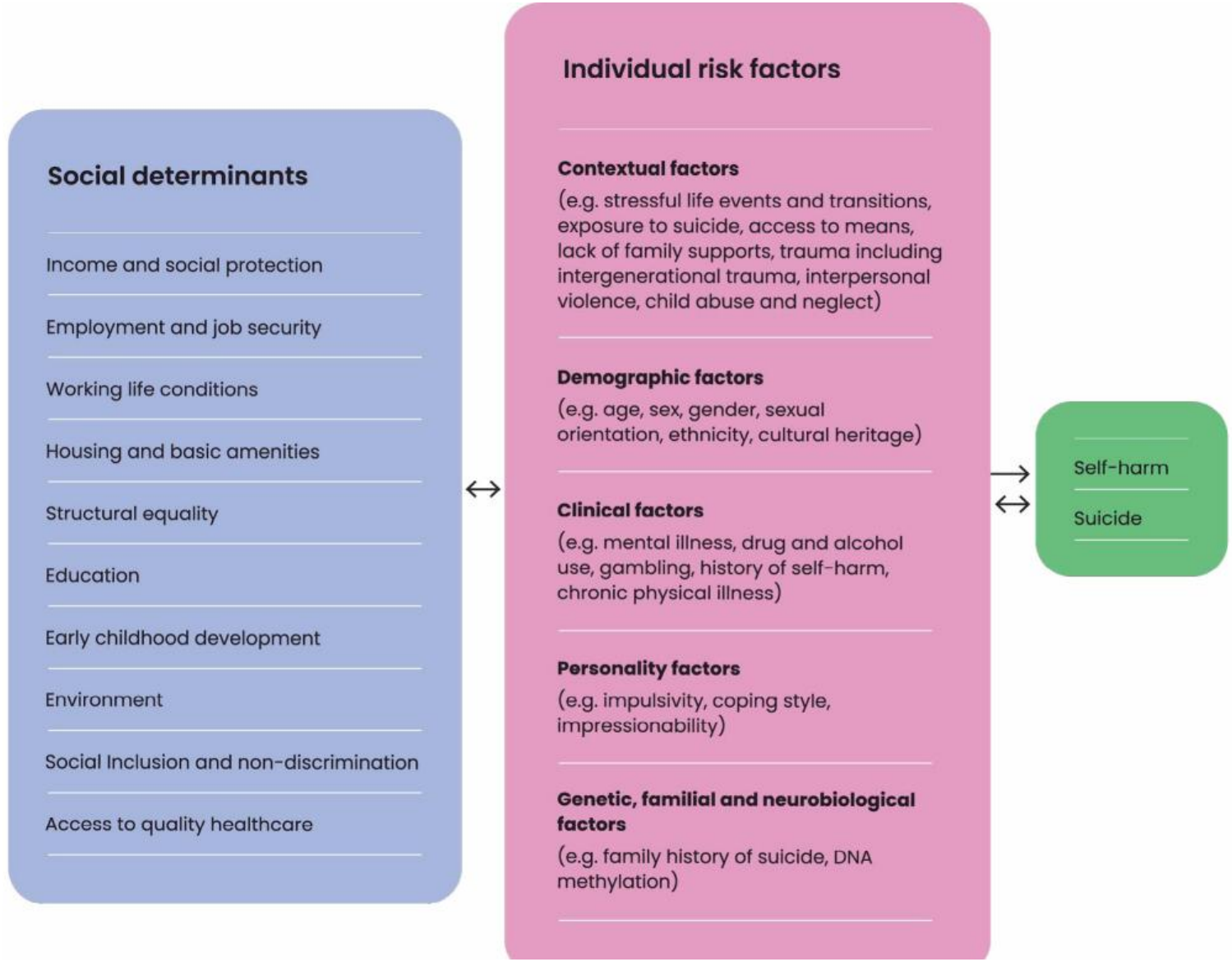
Figure 1: Social determinants and individual risk factors for suicide and self-harm



Source: National Suicide Prevention Strategy 2025–2035

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The disproportionate impacts of suicide

Females

Accounted for 66% of intentional self-harm hospitalisations

Higher rates of suicide attempts and self-injury among young females compared to males

Aboriginal and Torres Strait Islander peoples

More than twice as likely to die by suicide compared to non-Indigenous populations

Younger Australians

Nearly one-third of deaths in younger Australians (15–24 years) are due to suicide

LGBTIQ+ communities

Higher levels of suicidal thoughts and self-harm than non-LGBTIQ+ people

61% of suicide attempts occur within 5 years of recognising LGBTIQ+ identity

Transgender and gender diverse people have higher suicide risk than cisgender individuals

Perinatal period

5–14% of expectant and new parents experience suicidal thoughts and behaviours

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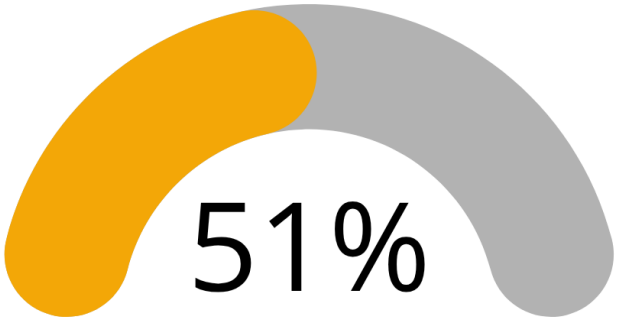
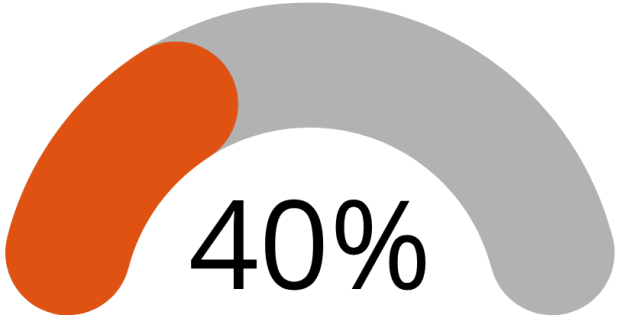
Source: National Suicide Prevention Strategy 2025–2035

Suicidality and Eating Disorders

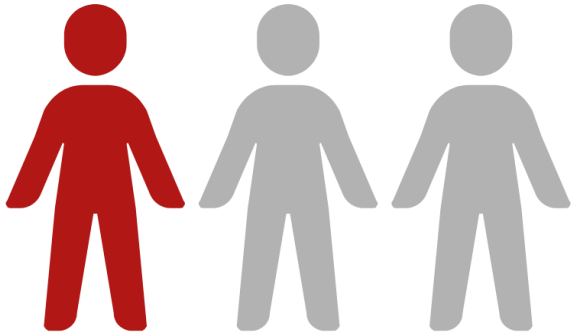
Suicide is a leading cause of death among people with eating disorders, and suicidal behaviour and self-harm are elevated in this group relative to the general population (Smith, Zuromski, & Dodd, 2018).



Have experienced suicidal ideation



Have intentionally self-harmed



1 in 3 have attempted suicide

(Amiri & Khan, 2023, Xu et al., 2023)

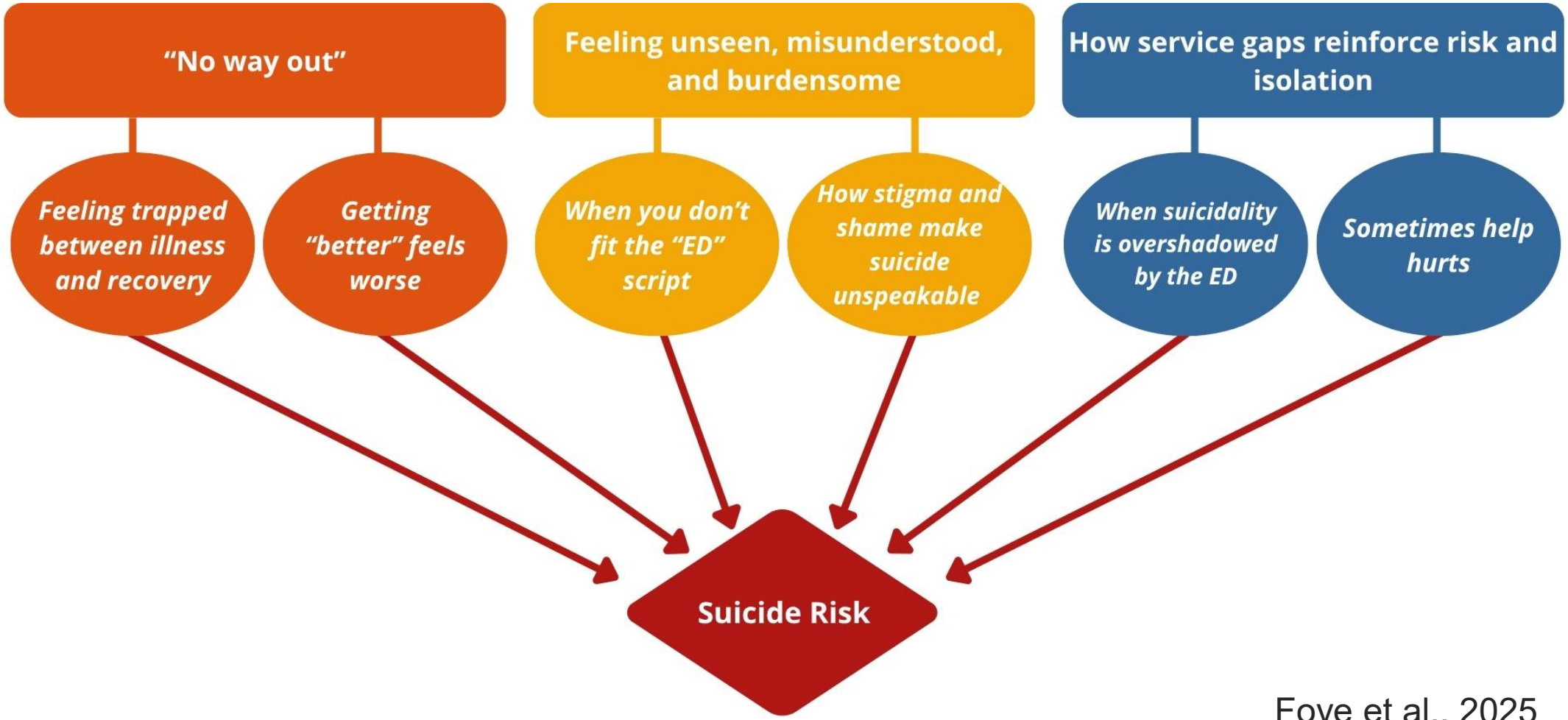
What drives suicidality in people with eating disorders?

Findings from a meta-analysis show that having an eating disorder alone does not fully explain the high suicide rates (Smith et al., 2019).

Disordered eating symptoms are weak predictors of suicide attempts and do not predict death by suicide.

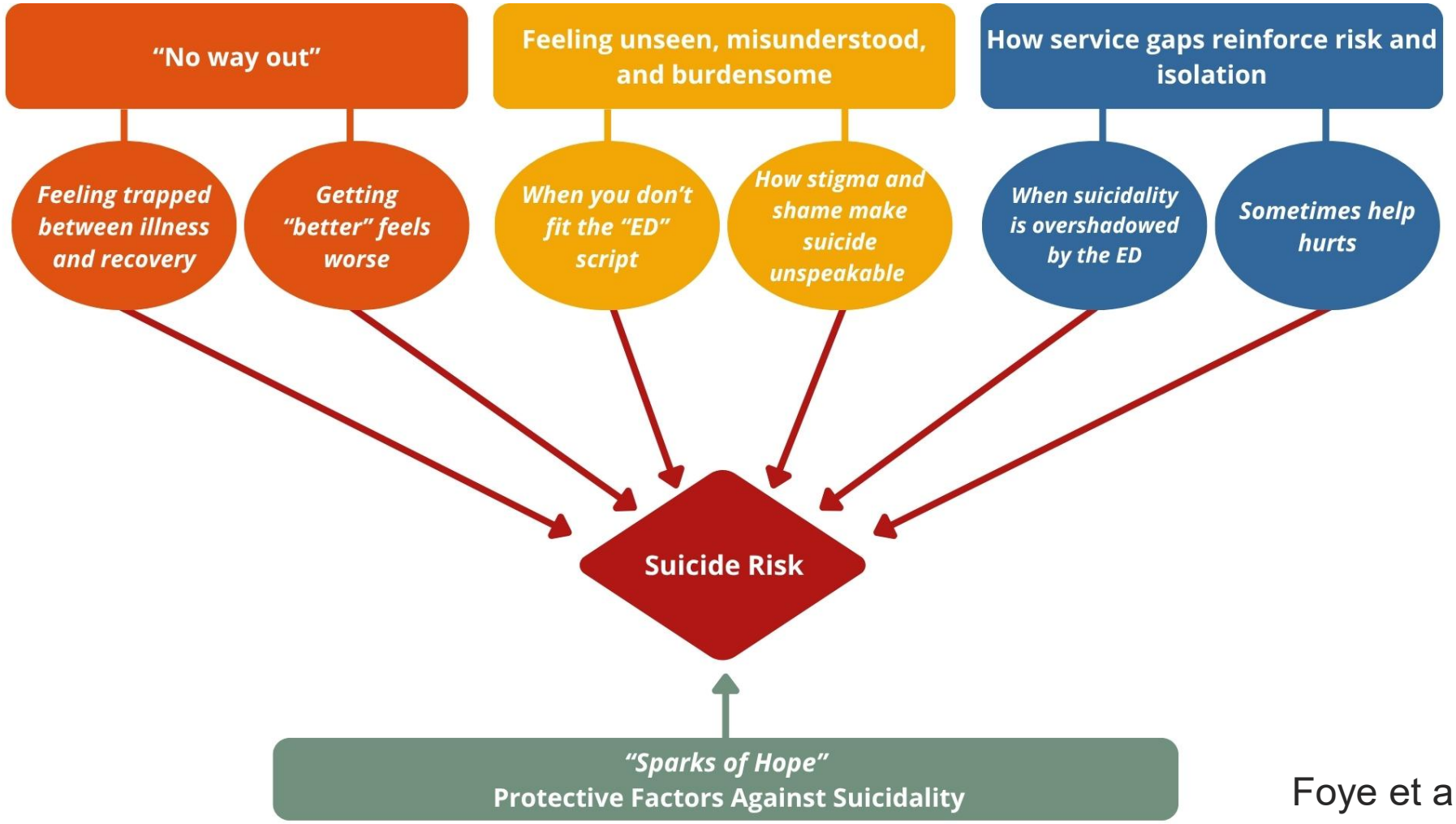
So, what drives suicidality in people with eating disorders?

Unique experiences and risk mechanisms specific to eating disorders



Foye et al., 2025

Unique experiences and risk mechanisms specific to eating disorders



Foye et al., 2025

Diverse and layered experiences of suicidality in eating disorders

There is no single pathway or experience

- People experience suicidality in different ways, at different times
- The relationship between eating disorders and suicidality is not linear
- For some, the eating disorder may function as a way of managing distress, while also contributing to increased risk over time
- Risk may increase at unexpected points, including during recovery
- Experiences are shaped by identity, context, life circumstances, and access to support

System gaps and considerations

- People are often excluded due to risk or complexity
- People move between services that cannot hold both experiences together
- People are expected to stabilise one experience before the other
- Suicidality is not always safely held within eating disorder care

Our collective responsibility

- Who are we not reaching?
- Where, and why, are people falling through gaps?
- What would more integrated, person-centred care look like?

Sharing the challenge

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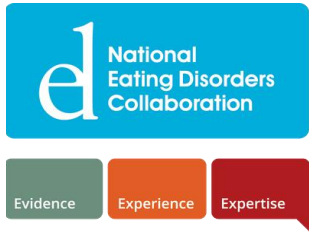
Sharing the challenge:

Breakout room activity

- Participants will spend 25-minutes working in small groups to identify the key challenges the sector is facing in providing evidence-based, consistent, and comprehensive care for people experiencing both eating disorders and suicidality.
- NEDC and NSPO will facilitate the discussion.
- This will be followed by a 10-minute whole of group discussion.

Group feedback



Challenge themes

Risk management-centric care approaches
Care approaches prioritise safety concerns and risk management in ways that can erode trust and psychological safety. Need for trauma-informed and harm minimisation-focused approaches that uphold autonomy

Lack of focus on prevention
Lack of resourcing for early intervention in suicide prevention to reduce the distress early. Preventing eating disorders may also help prevent suicide. Lack of a prevention-focused policy on the intersection between EDs and suicidality.

High acuity of people accessing services
Lack of prevention services means those seeking help are often acutely unwell/suicidal. This acuity often leads to people being excluded from services, hesitation from providers to work in this space and long wait times

Lack of integration
Treatment approaches only focus on treating the eating disorder or suicidality in isolation. Need for approaches which address both. Importance that we understand the functional role that ED or suicidality may have for a person – key to understanding their unique risk and protective factors for both experiences in a wholistic way

Evidence gaps
Lack of systems or resourcing to capture health data and conduct research into suicide prevention in eating disorders (e.g., risk factors, what works for who, peer support interventions, what periods of treatment/recovery are associated with heightened risk) to support the research translation for evidence-based care approaches

Lack of capable workforce
Workforce lacks the confidence and skill to identify and manage both suicidality and eating disorders. This is across emergency and primary care settings, and medical and psychiatric settings, and is compounded in rural and remote communities.

Lack of focus on intersectionality
Those affected by suicide and eating disorders are often from marginalised and/or intersectional identities, social disadvantaged, and cultural or linguistically diverse backgrounds. Services and care approached are not always responsive to the needs of these communities.

Service gaps reinforce risk
A lack of integrated services which can meet the needs of people with complex needs and co-occurring conditions who experience suicidality (e.g., neurodivergence, malnutrition, weight restoration), can lead to disengagement from services, or treatment experiences which contribute to suicidal distress

Treatment Gaps
Lack of services for people experiencing chronic suicidality, or people with eating disorder with higher weight, lack of psychosocial supports and affordable treatment. These gaps can contribute to repeated experiences of being turned away, treatment exhaustion, and distress

Stigma
People experience stigma when accessing services. Assumptions made by health/mental health professionals about who experiences eating disorders and/or suicidality. People feel their distress is not validated if they don't fit this stereotype. Feel "responsible" for their recovery.

We are currently in a break

The National Eating Disorders and Suicide Prevention Roundtable will resume at 2:15pm

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Finding the solutions

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The National Suicide Prevention Strategy

Launched 20 February 2025

- Endorsed by:
  - All States and Territories
  - 8 Commonwealth Ministers
  - Prime Minister

The National Suicide Prevention Strategy - Model

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Prevention
of suicidal distress

- Safety & security
- Good Health
- Economic security
- Social inclusion
- Navigating life transitions

Support
for people experiencing suicidal thoughts and behaviours and those who care for them

- Culture of compassion
- Accessibility
- System-level coordination
- Holistic approaches
- Increased connection

Critical enablers

- Improved governance
- Embedded lived experience
- Available and translated evidence
- Capable and integrated workforce

Prevention- Navigating Life Transitions

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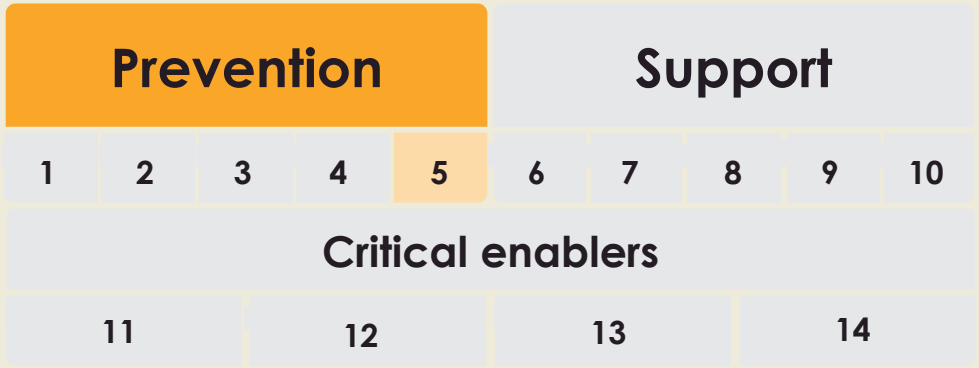
- Life transitions (retirement, bereavement, becoming a parent) often require significant adjustment
- Transitions are an important focus for suicide prevention
- Feelings of stress can escalate into suicidal distress



Support- Culture of Compassion

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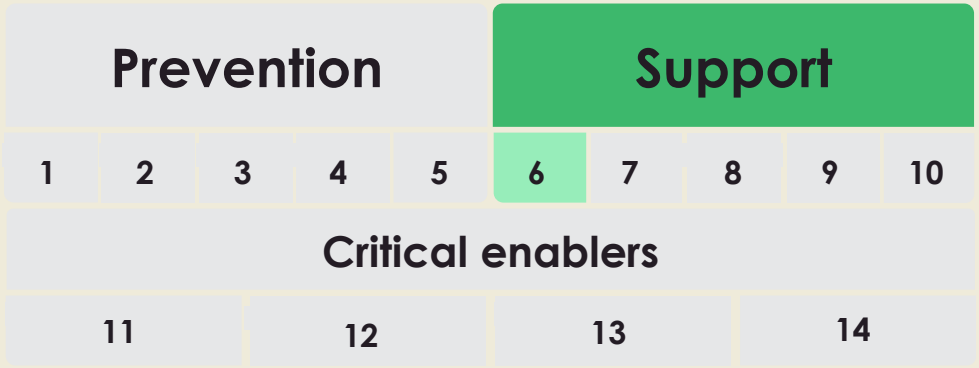
- People impacted by suicidal thoughts and behaviours should experience a compassionate response that helps them feel understood and empowered by the support system and society
- Restorative and just learning culture creates environments with higher psychosocial safety and trust
- Trust and safety lead to more capable and motivated staff who are supported to deliver high-quality care



Support- Accessibility

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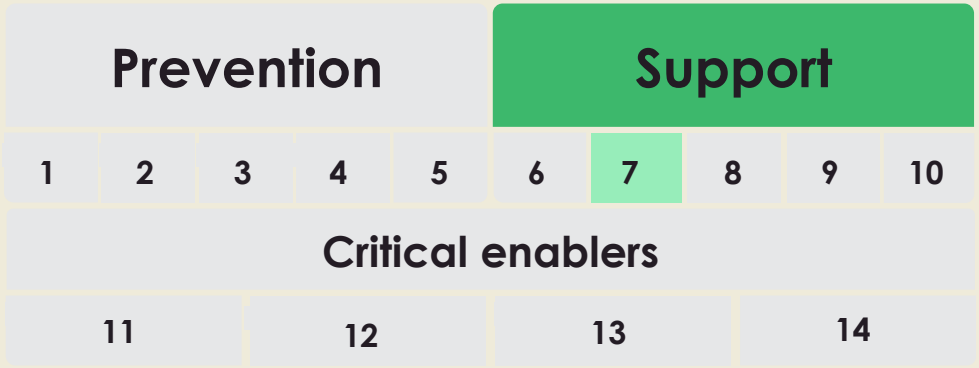
- Services should be easily found and readily available, regardless of where a person lives, their support needs or their disability status or type
- Effective programs are diverse. These range include:
  - Community led services
  - Crisis-lines with phone, chat and relay service integration
  - Non-clinical spaces



Support- System Level Coordination

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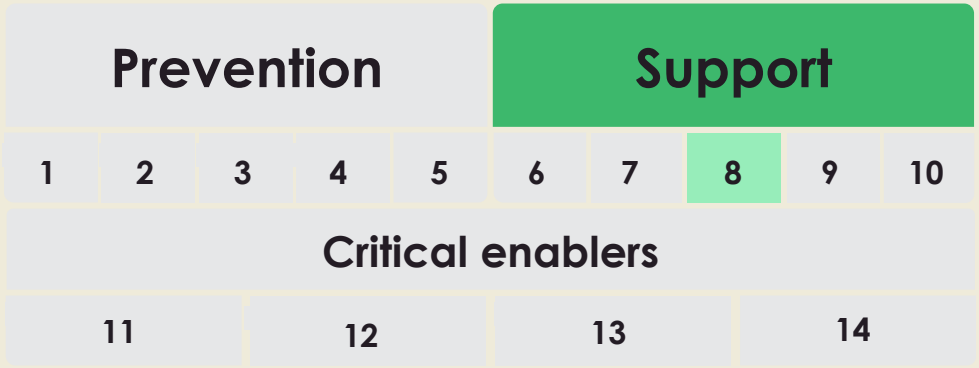
- When people connect with services, it is important that they encounter a system that has clear, coordinated responses
- Aftercare services that contact participants after hospital admission to offer support
- Transition between services is a critical time for people experiencing suicidality



Critical Enabler- Capable and Integrated Workforce

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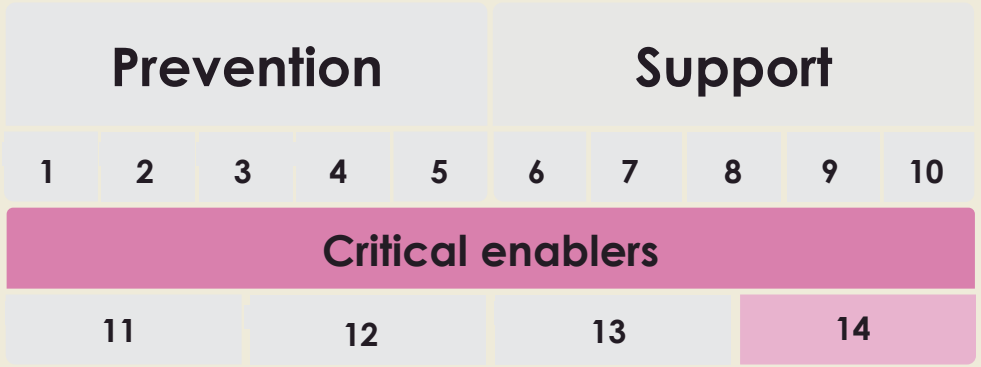
- A foundational requirements for the delivery of the Strategy's approach to suicide prevention is a robust, capable and well-supported suicide prevention workforce
- The suicide prevention workforce is defined by its focus on improving suicide prevention outcomes, not by profession
- Industry-led initiatives tailored to specific cohorts can lead to positive shifts in workplace culture and empower people to recognise their role in suicide prevention



Measuring outcomes

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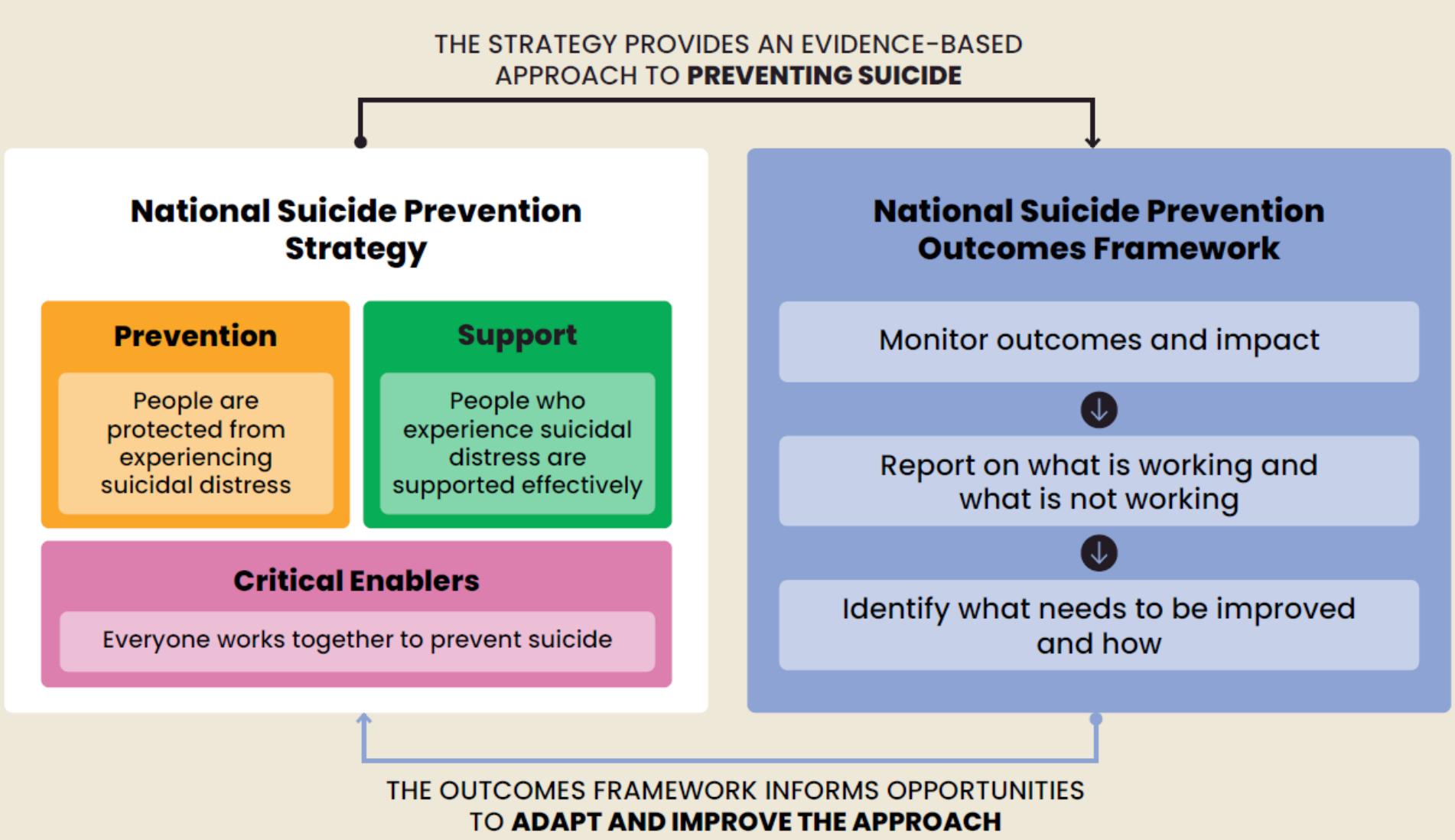
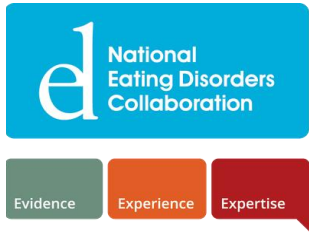


Finding the solutions: Breakout room activity

- Participants will spend 25-minutes working in small groups to explore what best practice care could look like by drawing upon existing frameworks and suicide prevention models that are working well. Participants will also brainstorm next steps to translate our ideas into practice.
- NEDC and NSPO will facilitate the discussion.
- This will be followed by a 10-minute whole of group discussion.

Group feedback



Solution themes

A no wrong door approach
Creating a coordinated and comprehensive mapping of eating disorders/suicide prevention/crisis support services and a skilled workforce ensures people are connected to appropriate services matched to their needs no matter where they start their help-seeking journey.

Improve care approaches
Need for care which is trauma informed and harm minimisation approaches which uphold dignity of risk, autonomy, and shared decision making. Need to include carers, supporters and family in treatment.

Workforce Development
Upskilling of eating disorder workforce in suicide prevention and suicide prevention workforce in eating disorders. Need for access to free evidence -based training/resources in risk assessments, involving of carer/kin, and peer support frameworks. Embedding this content in tertiary circular is important.

Positive initial interactions
Ensuring people have a positive initial interaction when seeking help to capitalise on this window of opportunity to prevent suicide/eating disorder related harm. The role of a competent and confident workforce across all levels of health/mental health services was emphasised.

Research
Additional funding for research to address knowledge gaps and better understand what are the unique risk factors and maintenance factors driving suicidality? What evidence-based suicide prevention initiatives exist? Increase knowledge translation as this evidence becomes available.

Top- Down initiatives
Consider alignment and coordination between financial and legislative models that underpin service delivery for suicide prevention and eating disorders services – consistency in these apcoordinatedproaches ensures adequate and resourcing. Partnerships between suicide prevention and eating disorder sectors to ensure consistency in priorities, advice to government, and messaging on key issues

Reducing barriers to eating disorder care: Eligibility, general access, holistic care, harm minimisation

Capitalise or scale services or models of care which are working well
e.g., Learning from services like 13 YARN to upskill broader workforce to provide culturally competent care

Embed lived experience in service delivery and design
Inclusion of peer support drawing upon existing models like Safe Space pilots. Lived experience embedded (non-designated) can strengthen motivation and understanding

Wrap up

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Next steps

- Evaluation survey
  - What else do you need to overcome these identified service challenges?
  - Are there other service challenges that you need support with?
- Connecting with others in the meeting
- Summary of the literature and notes from today

Get involved

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Register to be kept informed about the work of the NSPO and receive opportunities to help shape our work through the NSPO e-newsletter

www.mentalhealthcommission.gov.au/nspo/about-national-suicide-prevention-office/get-involved

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Register as an NEDC member to access eLearning, resources, and receive the latest updates straight to your inbox

www.nedc.com.au/member-registration

Thank you for attending the National Eating Disorders and Suicide Prevention Roundtable

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References

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