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EXECUTIVE SUMMARY

Shaping the Future of Suicide Prevention in Muslim Communities

SANAD: National Muslim Community Suicide Prevention Consultation
Final Report 2026

Muslim communities already hold significant knowledge, relationships, leadership and sources of resilience that can be recognised, connected and supported.

COMMISSIONED BY

embrace multicultural mental health

Mental Health Australia

DELIVERED BY
Educaid Australia
www.educaid.au

ABOUT SANAD

Centring community voices where the evidence is thin

SANAD is a national Muslim community suicide prevention consultation delivered by Educaid Australia as part of the Embrace Suicide Prevention Pilot – Community-Led Initiative. It explored how participating Muslim community members understand suicide, mental health and wellbeing; what shapes disclosure and help-seeking; which faith, family and community strengths may be protective; and what changes are needed across communities, services and systems.

The consultation sought to centre community voices in an area where the Australian evidence base remains limited. SANAD recognises that there is no single Muslim community experience. Cultural background, age, gender, religiosity, migration history, social circumstances, professional roles and lived experience intersect in different ways. The findings therefore identify recurring themes and priorities without assuming that every issue, barrier or response applies equally to all Muslim individuals or communities.

CONSULTATION AT A GLANCE

52	7	3	105
community participants	focus groups	individual interviews	expressions of interest

5	18	20+	17	57.7%
states	countries of birth	cultural or ethnic backgrounds	languages other than English	personally affected by suicide

Forty-nine people participated across seven focus groups, and three separate participants completed individual interviews. Nine Expert Advisory Group members contributed through three advisory sessions but were not part of the 52-person community sample or primary dataset. Anonymous Mentimeter contributions made during focus groups were analysed alongside the consultation material. More than half of participants (57.7%) reported being personally affected by suicide, either directly or through others.

SANAD was a commissioned community consultation rather than a population survey or HREC-approved academic research study; its findings should therefore be interpreted as community-informed insights rather than prevalence estimates.

KEY FINDINGS

Six things we heard

01

Faith was a major resource and context for care

For many participants, Islam provided meaning, hope, spiritual grounding and belonging. Prayer, Qur'ānic guidance, remembrance of Allah and community connection were described as important resources during hardship. Participants also stressed that religious teachings need to be communicated with theological clarity, compassion and awareness of mental-health risk.

02

Stigma, silence and misconceptions can obstruct disclosure

Participants described suicide as highly stigmatised and often avoided in community discussion. Shame, fear of judgement, family reputation, assumptions about weak faith and uncertainty about how Islamic teachings apply to suicide could discourage disclosure and help-seeking.

03

Community can function as a first system of care

Family, friends, peers, faith leaders, mosques, schools, and community organisations were often the first settings where distress was noticed or disclosed. Listening, validation, proactive check-ins, belonging and trusted relationships were repeatedly described as protective. Participants were equally clear that community actors should not be expected to replace qualified mental-health and suicide-prevention professionals.

04

Trust, confidentiality and choice shape help-seeking

People were more likely to seek support when they expected privacy, respect and non-judgemental responses. Participants valued both trusted community-based support and confidential options outside community structures. Help-seeking was also shaped by gender, age, migration history, social networks and familiarity with the Australian service system.

05

Services need to be culturally and faith-responsive, accessible and connected

Participants called for affordable care, stronger workforce representation, cultural humility, faith literacy, anonymous pathways and clearer referral systems. They cautioned that awareness campaigns must be matched by actual service capacity. They did not generally advocate a separate Muslim mental-health system but wanted safe and effective care wherever Muslim people seek help, alongside Muslim-led initiatives where mainstream gaps remain.

06

Structural and societal conditions matter

Participants located distress within broader conditions including Islamophobia, racism, discrimination, social exclusion, housing and financial pressures, visa insecurity and exposure to overseas conflict and humanitarian crises. Effective prevention therefore needs to operate beyond the individual level and address community, service, system and societal determinants.

STRATEGIC PRIORITIES

Five priorities for action

The consultation points to five interconnected priorities for action. These priorities should be implemented in ways that recognise diversity within Muslim communities, build on existing strengths and avoid creating unnecessary parallel systems.

PRIORITY 1

Community-led, faith-informed prevention and community capacity

Fund Muslim-led initiatives; strengthen community education, anti-stigma work and practical gatekeeper capability; resource trusted grassroots figures as well as formal leaders; and invest in belonging, peer support and intergenerational connection.

PRIORITY 2

Workforce representation and capability

Expand pathways for Muslim, bicultural, peer and lived-experience workers; strengthen cultural humility, anti-racist and faith-informed practice; and provide suicide-prevention and mental-health training for Imams, female faith leaders and youth workers with clear role boundaries.

PRIORITY 3

Trusted, affordable and coordinated pathways to care

Improve affordability and accessibility; match awareness and referral with service capacity; strengthen culturally and faith-responsive mainstream care; expand anonymous supports; and build clearer referral pathways and trusted service-navigation resources.

PRIORITY 4

Targeted responses and structural determinants

Develop targeted supports for groups at heightened risk of isolation; strengthen postvention; address Islamophobia, discrimination and social exclusion; and incorporate housing, financial, employment, visa and global-crisis-related stressors into prevention and referral strategies.

PRIORITY 5

Evidence, governance and collective action

Invest in community-led research and evaluation; improve data on faith, ethnicity, diversity and help-seeking with appropriate privacy safeguards; use measures that capture trust and community capability; and establish an enduring national coordinating mechanism inclusive of diverse Muslim communities.

CONCLUSION AND IMPACT

SANAD does not claim to represent every Muslim community or experience. Its contribution is to articulate a community-informed agenda for suicide prevention that recognises faith, family, belonging and community as potential strengths while addressing stigma, confidentiality concerns, fragmented services and structural pressures.

The next step is to translate these priorities into coordinated, sustained action while preserving the strengths-based principle that Muslim communities already hold significant knowledge, relationships, leadership and sources of resilience that can be recognised, connected and supported.

Read the full report

The full report, including methodology, detailed results and discussion, is available at **educaid.au/SANAD**.

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Contact

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Need support?

If anything in this summary raises concerns for you or someone you know, support is available 24/7.

Lifeline
13 11 14

Suicide Call Back Service
1300 659 467

In an emergency, call **000**

Multicultural mental health resources:
embracementalhealth.org.au

Disclaimer. The views and recommendations contained in this report reflect the perspectives shared through the consultation and do not necessarily represent the views of Mental Health Australia, Embrace Multicultural Mental Health or the Australian Government. The report should be read as a community consultation rather than a population-level or prevalence study.

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