



# What we heard about suicide in South Australia

A consultation feedback report to inform  
the development of South Australia's  
next Suicide Prevention Plan



Government  
of South Australia

Supporting your state of wellbeing

Wellbeing SA

## If you need help

Talking and reading about suicide can raise all sorts of feelings. If you're worried about how you're feeling and would like to talk to someone, here are some places you can contact for support:

### South Australian supports

**Mental Health Triage 13 14 65** 24/7 advice and information in a mental health emergency.

**Lived Experience Telephone Support Service 1800 013 755.** Non-crisis support for mental health conditions between 5pm–11:30pm 365 days a year.

**Regional Access 1300 032 186.** 24/7 telephone and online counselling for people 15 years and older living or working in regional South Australia.

**Grieflink** Online information ([grieflink.org.au](http://grieflink.org.au)) for people who are dealing with the grief caused by the death of someone close to them, and for those who are supporting them.

### National supports

**StandBy - Support After Suicide 1300 727 247.** 24/7 support for anyone bereaved or impacted by suicide.

**Lifeline 13 11 14.** 24/7 phone counselling, and online crisis support chat available each evening.

**Suicide Call Back Service 1300 659 467.** National 24/7 professional telephone and online counselling for anyone affected by suicide.

**Kids' Helpline 1800 55 1800.** 24/7 phone and online counselling for youth (5–25 years).

**MensLine Australia 1300 78 99 78.** 24/7 advice, therapy and support for men with family and relationship concerns.

**Thirrili National Indigenous Postvention Service 1800 805 801.** 24/7 telephone support.

**Beyond Blue 1300 22 4636.** 24/7 telephone, online and e-mail counselling.

**QLife 1800 184 527.** Online chat or phone counselling for lesbian, gay, bisexual, transgender and intersex people, 3pm–midnight, 7 days a week.

**Open Arms 1800 011 046.** 24/7 phone and online counselling for veterans and their families.

People who are deaf or have a hearing or speech impairment can contact us by phone using the **National Relay Service**.

## Acknowledgements

The Premier's Council on Suicide Prevention and Wellbeing SA gratefully acknowledge the more than 3,200 people of South Australia from community groups, organisations and individuals who responded to our survey, participated in group discussions, had a telephone conversation with us, wrote to us, and everyone else who gave so generously of their time, knowledge and experience.

We humbly acknowledge the generosity of the traditional custodians who welcomed us onto their ancestral lands and pay our respect to Elders past, present and emerging.

We dedicate this report to everyone who has died by suicide, experienced suicidal distress or been bereaved by suicide.

## Cover art

*The Transilience Tree* artwork depicts a child whose gaze is firmly fixed on a tree. Behind, a plant uncurls, while the child's right hand cups another. The tree canopy offers shade, while also fruitfully budding a bird in flight – a yellow bird of hope. The child's legs are connected in the earth, demonstrating the inherent connection nature provides for the wellbeing of humanity. The artwork incorporates a series of small circles or dots to create the artwork to send a message that everyone is valued and important in the tapestry that is a healthy community.

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# Executive summary



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## Background

Behind each and every statistic is a human life. In South Australia, suicide is the leading cause of death for people 15-44 years of age. In 2019, around 251 people in South Australia lost their lives to suicide<sup>1</sup>; it has a devastating impact on families and communities of this state. Each and every death affects many more; up to 34,000 people are thought to be impacted by suicide in South Australia<sup>2</sup>. For every person who dies by suicide, it is estimated at least 20 more attempt suicide<sup>3</sup>.

Suicide is often preventable. Reducing the number of suicides and the impact left by suicide on South Australians is a high priority for the Government of South Australia. That is why the Premier's Council on Suicide Prevention and Wellbeing SA are currently developing the next South Australian Suicide Prevention Plan.

We understand that South Australia's approach to suicide prevention must be informed by the experience and wisdom of South Australians, particularly those with lived and living experience of suicide and recovery. Between March and July 2021, we ran a public consultation to hear what South Australians consider will make a difference in preventing suicide. People generously shared with us many personal and heartfelt stories, along with ideas of what could make a difference.

## 3,200 South Australian voices

This report is a summary of what you – the South Australian community – told us in our public consultation about what is important to be considered for suicide prevention in South Australia.

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In all, we heard from more than 3,200 South Australians – individuals, community groups, peak bodies, government agencies, and more. People got in touch with us by e-mail and telephone, social media, joined us in group conversations across the state, and participated in an online survey. We promoted the consultation widely, taking care to reach as many people as possible across Adelaide and country South Australia.

We heard from a wide range of South Australians, including people with diverse identities and experiences and people across the age range. We heard from people living in rural and remote areas and from Aboriginal people in numbers representative of the South Australian population<sup>4</sup>. The majority of people shared that they had personal experience of suicide, had supported a loved one experiencing suicidal distress, or both. At least half of our survey respondents alone stated that they had experienced the suicide of a loved one or friend.

We have used direct quotes throughout this report to reflect the insights and thoughts South Australians shared with us through the consultation. Please note that the content and language used in these quotes is that of people's direct experience and may be distressing to some readers. Reading about suicide can raise all sorts of feelings; if you are worried about how you are feeling and would like to talk to someone, at the beginning of this report we have provided details of some places you can contact for support.

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1 Based on Australian Bureau of Statistics data, 2019. *Causes of death, Australia*.

2 J Cerel, et. al., 2018. *How many people are exposed to suicide? Not six*. *Suicide and Life-Threatening Behaviour*, volume 49, issue 2, pp. 529-534. DOI: 10.1111/sltb.12450

3 <https://www.sane.org/information-stories/facts-and-guides/suicidal-behaviour>

4 See further information in *Who we heard from* on page 30.

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## Where next?

### South Australian Suicide Prevention Plan

This report and the feedback we receive on it will inform the South Australian Suicide Prevention Plan. We will also take into consideration the latest data and research, along with existing strategies, programs, plans and initiatives focussed on preventing suicide. The Plan will be specific for South Australia and will consider recent challenges faced by South Australians emerging from experiences such as COVID-19, drought and bushfires.

We all have a role to play in reducing preventable suicide and our work will not be finished once we have released the Plan. We are committed to embedding community engagement and co-design processes into policy and practice and we will ensure that our dialogue with communities will be continuing and ongoing. We want everyone – including individuals; communities; philanthropic, private and not-for-profit organisations; research institutions; and federal, state and local government – to continue to work together to make meaningful change in preventing suicide in South Australia.

‘This better not be the last time we see or hear from you’



# Key themes



‘People are all unique, so we require various options.’

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## Key themes from the public consultation

There were many things people wanted to tell us that would make a difference for suicide prevention. The main themes that emerged from peoples’ feedback were: respecting people as individuals; building stronger communities; building community capacity and strengthening services.

### Respecting people as individuals

People told us that everyone has individual needs that cannot be simplified into a ‘one size fits all’ policy. We heard that suicidal behaviour is a complex problem without simple explanations or solutions. The importance of taking time to listen and be with people, to treat each other with kindness, and to respect human rights and cultural views of suicide was emphasised.

### Building stronger communities

We heard a loud call for work to build a stronger, more cohesive society in which people can have a sense of belonging. Tackling underlying causes of social, economic and cultural disadvantage was felt to be important in this. People also want communities to have the skills to provide support to one another, to be more aware that all of us can do something to improve our understanding of suicide, and to be better able to intervene to reduce the risk of suicide.

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## Building community capacity

There was a call to stamp out the stigma and taboo that surrounds suicide, to help people be able to identify and talk about their feelings, and for education in knowing how to help others through their distress. There was a need expressed for more supportive services, school and workplace environments and for a community that respects our cultural and social diversity. Supporting families bereaved by suicide was also said to be important, as was ensuring people most in need could be identified and provided with access to appropriate support.

### Strengthening services

People told us they wanted better responses from services and access to care services. We heard that people wanted to experience services that put people first and which were provided appropriately for different cultures, populations and individual needs. There were issues raised around the crisis care model, with suggestions to reduce involvement of ambulance, police and hospital emergency departments. We heard calls for workforce training, to help professionals trust people’s self-awareness and to have better capacity to support people experiencing suicide distress.

### Do it right

During our consultation, we heard some of you tell us with frustration that what you are saying is not new, that you have given your views and experiences to governments before. Suicide is a serious issue and we understand from you that it is more important to do it right than to do it fast.

‘Don’t you dare rush this!’

# What we heard: in detail

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## Respecting people as individuals

### Responding to individual needs

‘Take it seriously in a kind way so that I feel seen and heard’

People from all backgrounds, communities and walks of life told us that they and the communities with whom they identify are not the same. Men, women and non-binary people are not three groups each with unified needs; there is no approach that is necessarily right for all older people or all younger people; country South Australia is home to some half a million unique individuals; Aboriginal people are from many different nations and language groups that should not be over-generalised.

The core premise was that we cannot write public policy on the notion of ‘one size fits all’, not for all of South Australia and not for any identified group or sub-population. Instead we were told to use data, including the stories and experiences of the people, to ensure communications and services meet the needs of people when, and in the ways, they are needed.

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## Treating people with kindness

‘Compassion, kindness and understanding is what I need’

People said that they wanted to be listened to, believed, and treated with genuine empathy whether or not they were at risk of suicide. People wanted to know that they could share their worries and feelings in any setting, to be met with someone who would take the time to connect and understand without being judged or labelled. There is a need to be able to just talk and be heard.

‘Simple kindness is all that’s needed’

‘Don’t try to fix me because you can’t’

### Respecting different views

‘My husband’s suicide was a shock to others, but we (immediate family) knew he tried everything he could to stay alive. He had suffered so much for so long’

Some people told us that it was hurtful to be told that the death of a loved one was preventable, that it was the result of a failure, or was a missed opportunity for intervention. We heard that the implementation of government policy should not discriminate against those who choose to end their life. This could be the case for anyone, but it was particularly so for some groups in society who see suicide differently, we were told, and these differences should be respected.



‘You don’t have to be a professional to provide an intervention. You just need the skills and the heart.’

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## **Building stronger communities**

### **Cohesion, connection and belonging**

People told us how important it was to foster and maintain a strong connection to community and family groups. These connections were especially important in some cultures, including for Aboriginal people. There was a widespread concern that suicide could arise from social isolation and we had people from across South Australia from various backgrounds tell us of the benefits of connections built through conversation, shared moments, eating together, and strong relationships.

‘Western views of what constitutes therapeutic interventions ignore the realities that in many Aboriginal communities and cultures learning and sharing along with healing happens through connection’

Putting resources into building gyms, playgrounds, sports clubs and other social groups and community facilities was said to be of great but under-valued importance in creating a connected and people-focussed community. Programs in the community for young people were felt to be worth concentrating on to build a better community, especially for young Aboriginal people. We were told that lifelong learning programs and volunteering opportunities would help to alleviate the loneliness and isolation that could be experienced by older people and new migrants. However, some people told us that local facilities must be governed with care as they could feel exclusionary and inaccessible to people who did not ‘fit the mould’ such as members of the LGBTIQ+ community.

‘We shouldn’t have to hide’

Some people told us that smaller, regional communities were better connected. But we also heard that tightknit communities could have downsides. In country South Australia and in more well identified cultural groups for instance, being part of a small community was said to be very hard at times. Some people felt pressure ‘not to let their guard down’, and to show a positive attitude in case they revealed themselves to their community as feeling down or depressed.

‘The most healing thing for me through all of this has been time spent with safe friends’

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‘I love living here but you can’t have an off-day, so I just don’t leave the house’

Recent times of trouble, such as bushfires and the COVID-19 pandemic, were felt by some to have encouraged people to start reconnecting with one another in their local communities and at home with their families. These troubles were said to have had a positive effect in bringing people together, but as unpredictable events people worried about what would happen next: effort is needed to ensure that the community benefits could continue.

‘Creating spaces for people to talk [...] natural spaces like the garden or popping by with something for them’

Building more connected communities with a sense of belonging meant different things to different people. For Aboriginal people, for example, we heard that it was important to help build connection to country, family and community to provide hope that life can be worth living; going onto lands, holding community events, and providing yarning spaces were given as examples of things that could be facilitated.

Communities need leadership, we heard, and it is necessary that younger people be encouraged and supported to step up into leadership roles to help build the stronger society of the future.

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### Care and compassion

‘I was going to [attempt suicide]. My neighbour turned up out the blue [...] and asked me if I was ok.’

People wanted us to know of the great comfort they took from feeling they could rely on their fellow community members to ‘be there’ for them at a time of need. These feelings were more commonly expressed to us by people who identify with defined community groups such as diverse cultural backgrounds. Smaller regional communities in South Australia were said to be places where most people would look out for one another.

Some people said that it is not enough just to ‘be there’ for someone, but what matters is thinking about someone in a way that is authentically centred on them as a person. We were urged to distinguish compassion from the concept of resilience. Some people felt that an emphasis on ‘resilience’ turned blame onto individuals for not coping or being sufficiently resilient to resist emotional distress and thoughts of suicide.

We heard that people need help knowing how to build a connection with people in need, and understanding the importance of accepting others as they are.



‘Let the Community decide what will work for the community’.

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### **Self-determination**

‘Let’s make communities self-supporting’

People felt that a focus on the formal provision of government and agency services had taken away much of the ability for them to have a voice about what was the right way to support their community. There was a desire for more to be done to help people to help themselves, although the solution did not just sit with government or health services. Communities wanted to be enabled to take the lead on self-support and it was suggested that government could support communities to support each other.

The desire for self-determination was heard particularly strongly for Aboriginal people and people from diverse culture, language and migrant backgrounds. People from these communities said it was important to let them take the lead in knowing what is best for them. There were views that policies and strategies for suicide prevention should always be created in partnership with communities, so enabling them to support themselves.

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‘Let the community decide what will work for their community’

We heard that people really wanted to do all they could to support each other through tough times but sometimes they felt that ‘red tape’ made this more difficult than it need be. People also wanted to feel more able to help others in their community and suggested that resources be put into upskilling local community groups and volunteers with the knowledge and training they needed. Helping embed these skills would look different in each community according to local and cultural needs, we heard. For instance, in some Aboriginal communities, this might mean providing one male and one female community member with the skills not only to look out for others but to be able to pass on training to the community.

‘An excellent way to prevent suicide is to prevent people from having traumatic experiences’

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### **Challenging societal norms**

‘An excellent way to prevent suicide is to prevent people from having traumatic experiences’

The pace of social change was felt by some of our respondents to be too slow. They said this needs to be addressed.

Some people felt that women continue to feel an expectation to conform to traditional roles and responsibilities. This was felt particularly strongly in some communities in regional South Australia. But in a society that is adapting to more modern ways of thinking, some women felt they were losing their purpose and identity. There was a need expressed to continue to challenge the stereotypes about roles in the home that are still often seen as ‘women’s work’.

Breaking gender stereotypes was said to be important and education was called for, starting from early childhood and into adolescence. For example, there was concern about ‘toxic masculinity’ and how young boys may need help in how to respond when facing pressure to act in ways seen as traditionally male.

Some men felt that there was too much ‘guilt shaming’ and negative messaging about men and that they sometimes felt disconnected. Some men were experiencing thoughts of suicide as a result of feeling that their contributions to society are not welcome and that public policy can be against them.

‘It is sad that men are constantly feeling the pressure of being suspected of being a threat.’

Older people told us that they perceived a tendency towards a more ageist society which no longer valued its older members and in which younger people had lost respect for their elders. This was said to manifest as a sense by some older people that they were a burden on society and that, as an older person, their life being lost to suicide would not be felt so greatly as for a younger person.

‘[There is] no proper support for older persons over 65. Not enough in the way of groups that allow connection. [We] need to combat grief and loneliness.’

A potential barrier to help-seeking was said to be fear of having mental health issues and thoughts of suicide disclosed to others. This was particularly the case for younger people, who might have issues that they do not wish to talk to their parents about or where their parents might even be part of their reason for wanting help. Some people told us that it was important to find ways – without breaching privacy – to share information with loved ones and involved organisations and services so that they could better provide support. For example, some parents of adult-aged children regretted that they had not been included in conversations and consent decisions about their children’s suicidal behaviour. But some younger people thought that the law and policy needed to recognise that parental consent might not always be appropriate.



‘Recognise that we have a diversity of communities with a diversity of needs that need to be considered and addressed’

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### **Racism and discrimination**

We heard much concern about the effects of racism in our society and institutions. For Aboriginal people, we heard of a need to continue to consider and address the effects of intergenerational trauma in contributing to levels of suicide for Aboriginal people. Stereotyping of anyone – on account of their gender, age, skin colour, neurodiversity (e.g., people on the autism spectrum), or for any other reason – led to assumptions about behaviours that were unwarranted and acted as a barrier to help-seeking.

‘I experience racism every day. I just can’t be bothered doing anything about it because nothing changes, and you won’t be believed or helped – but it still gets to you’

We were told that people in prison were subject to systemic discrimination and this was demonstrated by the increased rate of death by suicide in prison, which was particularly marked for Aboriginal people. There was a suggestion that this could be improved by building community-based peer support schemes to improve the wellbeing of Aboriginal people in custody.

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‘If you want to stop suicides you have to start at the foundations. Women [prisoners] at risk of suicide need to be met with compassion and hope and given connections to others, not isolated’

We heard that emigration can be a great stressor and that immigrants could be better supported to be connected to others in the community. It was said to be hard for people who are not proficient in English and who could be more prone to suffer loneliness. People from diverse culture, language and migrant backgrounds told us that they would like to see an end to messaging that suggested the idea of a single multicultural or ‘CALD’ community.

We were told that there was much discrimination and prejudice in society towards LGBTIQ+ communities. Although people felt that there was more acceptance of diverse sexuality and genders than there had been in the past, discrimination and stigma remained to be tackled. Within institutions such as churches and schools, and in the messaging abundant in the media and generally across society, the enduring negative attitudes to people with different sexual orientations, gender expressions and gender identities was said to be leading to mental ill health for many and contributing to deaths by suicide.

‘No place is safe unless all the people working there are safe’

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‘Compassion is everything, which means keeping company to someone’s struggle and not making them feel like a freak, ashamed and like a failure. Sometimes this means not speaking. Eating together, hanging out together. Not panicking. Not judging. People don’t reach out because they are scared of being judged, because they are scared of moralised views of suicide, which are damaging. Shame kills’

We were told that all organisations need to ensure they are safe for transgender people, and take care not to put people in the position of being ‘deadnamed’ (referred to by their previous names), mis-gendered (referred to by their birth-assigned gender) or exposed as a transgender person in front of others such as to potentially put them in danger of violent reprisal. A person’s gender identity is private information and we were asked to ensure that no government agency disclose this information to family or other government agencies without express permission. Thinking about what information was necessary to collect on official forms and using gender-neutral language were small but helpful steps that were suggested be taken.

We heard a call from LGBTIQ+ people for society to ‘stand up’ and take notice of the discrimination and harassment of people with other genders and sexual orientations. Education alone was not enough and did not address the systemic drivers of the discrimination, they said. People who were transitioning and others who were experiencing hormonal changes were said to be especially vulnerable to experiencing thoughts of suicide. It was suggested that organisations and employers should have policies and procedures to help create a structural shift in society.

#### **Tackling social and economic disadvantage**

People told us of the many factors that they felt needed to be addressed to alleviate suffering and reduce suicide.

#### **Poverty**

Some told us that poverty, including lack of housing security, was increasing distress and leading some to consider that suicide was the only option for them. For people in regional South Australia, this was said to be especially so. It was suggested that people experiencing financial insecurity were vulnerable through feeling that they were reliant on someone else for housing which they felt should be a basic right. We heard that this also means that anyone who is identified as being at risk of suicide needs to be assessed for housing security.

‘Raise welfare and age pension rate so people don’t feel like suicide is an option’



‘They seem to need to put you in either the box of “person with disability” or in the box of “person with mental health problem”’

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### Domestic and family violence

We were told that abusive relationships left people vulnerable to the potential for suicide. More support was needed for victims of sexual and domestic violence. Women experiencing abuse said they found it hard to get help and hard to be believed that help was needed. It was vital to be believed given how difficult it could be to speak up in the first place.

While some women told us that they observe a public policy focus on domestic and family violence, there needed to be a much stronger focus on providing the right support to survivors of rape and violence to engage with their distress and be supported appropriately. To help address trauma and mitigate the impact of mental pain as a driver of suicidal thoughts, it was felt that there needed to be efforts to change a societal perception that rape and violence were a woman’s problem rather than a problem with society.

Male survivors of childhood sexual abuse told us that trauma-informed care is crucial. We were also reminded that men could also be victims of violence. It was suggested that services and supports should reach out to people rather than expecting people in need to reach out. We heard about the importance of men’s support groups being funded for longer periods of time than two or three years under government contracts.

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‘I’m part of a community, I can go to a monthly meeting, I can call someone and the guys there really get me. There’s a lived experience person I can talk to. Getting to the core of the issue rather than just skating on the surface’

### Impact of addiction

There was some concern for the effects of drug usage, especially for communities in regional South Australia where this was said to be a serious problem that needed to be dealt with not as a criminal justice issue but as a matter of public health. People said that it was necessary to tackle addiction, including alcohol and gambling, as a contributor to mental ill health and, ultimately, to suicide.

### Multiple barriers to opportunities

We were told an added risk of suicide could arise for people who experienced multiple barriers to opportunities because of ‘intersectionality’ – discrimination and disadvantage from overlapping characteristics such as race, age, gender identity, religion, ethnicity, disability, sexual orientation and Aboriginal identity. The idea that a person could be experiencing more than one form of discrimination seemed to cause difficulty for services due to a need to place the person in one category or another.

‘The term suicide is just not in the community comfort zone’

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## **Building community capacity**

### **Community education**

#### **Tackling myths and taboos**

People from a diverse cross-section of society told us that the topic of suicide remains shrouded in stigma and taboo. People told us of both personal experiences of feeling shame of having thoughts of suicide and also of the difficulty of speaking openly because of society’s negative perceptions.

Some people felt the shame attached to suicide might be more strongly held in their communities than in broader society. Men, women and people of other genders all felt there was some unique stigma attached to suicide for their gender identity. Some of our respondents in regional South Australia felt that there was distinct stigma in their areas. People from a variety of diverse cultures and backgrounds told us of unique stigma that they felt existed in their communities. Work was called for programmes to address cultural and other community specific stigma.

‘In my community, we don’t talk about these issues’

We were told that there were some gender-based stigmas that should be identified and tackled separately. Men were said to carry a personal sense of shame around its not being ‘manly’ to talk about suicide, and women a shame around mental health and suicide issues generally. It was felt important to break the stigma and encourage men and women and people of other genders to seek the specific gender-appropriate help they need.

We heard some suggestions that it was important to encourage people to feel free to talk more openly about suicide and to feel able to engage with what is often seen as an uncomfortable topic. Just the word ‘suicide’ was said to be hard enough for some to bring themselves to say. It was believed that educating society to talk about thoughts, feelings and actions of suicidal distress would help to reduce stigma and encourage people experiencing thoughts of suicide to seek timely help.

‘It’s not hard to talk about; it seems hard for people to hear what someone says they need’

People were open to normalising the subject of suicide, noting that feelings of distress are part of the human condition. However, a discrete sense of shame was felt by some in society who thought they should not be experiencing suicidal distress. For example, some expressed that there is a perception that anyone who is famous, successful or working as a health practitioner should not experience thoughts of suicide. This perception was thought to further inhibit their likelihood of seeking help for themselves.

‘If I’m worried about my safety, who could I talk to?’

We heard media campaigns should be run to help change mindsets, with government leading the way by promoting the subject of suicide and making more widespread dissemination of official suicide statistics and information. The media could also have a role to play in breaking the stigma by influencing



‘We as males are vulnerable because we do not talk about feelings and mental health’

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thinking through how they present the news. It was suggested that the media could report more frankly and openly on suicide and show that it is not a taboo subject for them. However, some media professionals expressed that reporting on suicide can be distressing.

‘[Journalists] stand just behind that front line [...and are impacted by what] is known as vicarious trauma.’

Language was felt to have great power to influence feelings and to be used as a driver for change. We were urged to work to stop using terms such as ‘commit suicide’ in favour of phrases felt to be less stigmatising, such as ‘died by suicide’, in order to avoid the association with crime or sin. And some people suggested that it would be helpful and destigmatising should there be a shift to using more positive language. For example, instead of talking about preventing suicide, it may be better to talk about preserving life or life promotion.

#### **Learning to identify and talk about feelings**

People told us that it was important to make it easier for people to speak about their feelings and to recognise the power in being able to engage with their emotions. People spoke of wanting to be able to communicate how they felt in ways that made sense to them. For example, through sensory or somatic descriptions of experience. Some people told us that there needed to be consideration of their preferences to speak indirectly, to connect with others, or to relieve distress in more active ways.

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It was felt that there needed to be more done to ensure that people could know that it was ‘ok not to be ok’ and to know what to do about it when experiencing such feelings. We heard that this was particularly the case for men who more commonly reported struggling with knowing how to talk about their feelings. We were told that this may contribute to men letting things get to a danger point before seeking help. However, we also heard that many men do seek help and support but that established systems did not meet their needs or styles of communicating.

Although we were told that women might generally be better than men at recognising and talking about their feelings, they nevertheless also needed improved support to recognise and engage with their distress and to properly understand the impact of their feelings.

Building of capacity should start at a young age, we heard, with education programs using appropriate means of communication for children and teenagers to learn how to recognise and handle distress and thoughts of suicide. We were told that this needed to include:

- gender-specific training for young people
- education for young men to boost self-esteem and to help them not feel victimised, and
- support for young women to build their ability to be comfortable with themselves and to recognise and cope with distress.

## ‘Communities / people need to be encouraged to stay connected to people with suicide ideation’

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### Knowing how to help others

People told us that it was difficult to know when family, community members, colleagues, and others around them are experiencing suicide distress. People wanted education on how to recognise the signs of suicide distress in their relatives, friends and colleagues. Parents called for access to education that was specific to picking up signs of distress in their children.

People recognised that it was possible for someone experiencing thoughts of suicide to mask their symptoms and feelings. Men in particular were said to be prone to denying, including to themselves, that they were experiencing thoughts of suicide. It was suggested that men in distress, particularly young men, may be more likely to have passive thoughts of being content not to continue living as opposed to having a more active desire to die by suicide. It was felt important to learn how to recognise thoughts which were suicidal but not framed as such.

‘Nobody wants to say they want help, get them the help, they just need to be surrounded by help straight away. That ‘go to your GP’ business doesn’t work’

When people do identify that someone may be in need of support, they told us that they needed help to learn how to offer assistance. People said they were scared they might ask the wrong question or that they did not know how to broach the subject. Existing mental

health initiatives were seen as well-meaning but of limited value if they did not help those who feel that they do not have the necessary skills to start a conversation about mental health with someone. What was felt to be missing and necessary was a public education campaign on how to cope with and be able to help someone when they express they are not ok.

‘There are lots of little things that anyone can do to help people. Smile, listen, talk’

‘Communities / people need to be encouraged to stay connected to people with suicidal ideation’

We heard that there was a need to recognise that some people find themselves as ‘accidental counsellors’, who are not in a formal counselling or mental health support role. People reported finding themselves in a position of responding to the pain and distress of friends, colleagues and strangers. For some people this ‘accidental counsellor’ role was seen to be difficult. It was suggested that people should be given access to education and support to be better equipped to navigate these conversations safely.

People also called for help in knowing how to behave as a community after a death by suicide. Advice would be welcome on how to talk to people after a suicide, what to say at funerals, how to support community members who had been affected and how to put bereaved families in touch with appropriate organisations who could offer structured support.



‘Suicide [is] the end result of a person’s path of pain – it is not the beginning’

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### Respecting cultural and social diversity

We were told that respecting diversity was felt to be missing in how prevention and clinical care services were promoted to the community. This could take many forms and thoughts varied: for instance, some felt that promotional activity was targeted primarily towards white adult males; others that services treated women better. The broad consensus was that there needed to be the right services and promotional activity targeted to reach everyone appropriately, and that this was not currently happening. A cultural lens needed to be applied to this too, we heard, for example to recognise that in many Aboriginal cultures it might not be appropriate for someone to seek help from a service run by someone of a different gender.

People wanted us to know that a plan to build capacity to prevent and cope with suicide must take account of different customs, practices, and traditions. For example, the ways to destigmatise suicide will vary for different communities because of their differing cultural norms. The ways in which people can be taught to provide comfort to one another will vary. For instance we were told that in many Aboriginal communities, people can comfort one another without the use of language, and in some cultures there just is not the language to talk about suicide. There was a suggestion to work with cultural and religious leaders to help understand the needs of different communities and to break down myths and develop specific plans to build capacity for each community in appropriate ways.

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### Creating more supportive environments

There was concern about bullying in schools and calls to protect children who are victims of bullying and to work to stop children becoming bullies themselves. Children who are gender or sexually diverse were frequently bullied, we were told, as were children of same-sex and other non-traditional families, leading to mental health issues and suicide. It was suggested that the importance of breaking down stereotypes should be part of the education curricula.

We also heard that bullying continued beyond the school years, with many workplaces not yet being seen as safe spaces for people who, perhaps, were living with disability or because of their diverse genders or sexualities. Shaming of disability and despair over inadequate support for people with disability and their families was seen to increase suicidal distress. People wanted more and better disability awareness training for employers and educators.

We heard from some that managers could not be relied on to provide pastoral care to their staff and that some workers felt the need to avoid notifying their managers of any personal issues. Supporting employees through worker wellbeing initiatives such as employee assistance programs were noted with approval, but some felt that there was a lack of authenticity in them – a sense of their provision being more about box-ticking than genuine efforts to improve employee wellbeing which is what is thought should be encouraged and supported.

## ‘Not being heard is a trigger’

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‘The processes in place to get what [services] you need [are] exhausting’

Social media was said to be risky for younger people. We heard concerns that use of these platforms could lead to distress and negatively impact younger people at a time in their lives when they are forming their identity. Younger women were felt by some to be the group most at risk, but regardless of gender there was worry about the ability for social media to affect self-image and to be used as a conduit for bullying and a major contributor to suicidal distress. There were calls for social media to be better monitored and more tightly regulated.

## Supporting people at times of risk

‘There is stigma of what a suicidal person should look like’

People said they wanted a society that considers the needs of people who might be particularly vulnerable or in need. It was important to people to be able to build and strengthen community ties for those who were especially vulnerable. People wanted work done to identify groups in society who may be more vulnerable to suicide and for whom there may need to be a greater emphasis on suicide prevention work. Others sounded a note of caution: by appearing to concentrate efforts on certain groups in society, people not in those groups could feel that public policy considers their lives less important.

We were reminded that serving and veteran defence personnel had a high rate of suicide which warranted action to reduce. There was said to be not enough support for veterans or serving members. Links were suggested between veterans and male suicide issues, with many male suicides believed to be former defence personnel who were not provided with adequate follow-up.

The ending of a relationship was a time of concern. The system needed to recognise that both parties in a court-contested relationship breakup may require support with their mental health and wellbeing as they litigated matters around their ongoing relationship with each other and with their children. We were told that parents needed better support for any mental health issues arising from being separated from their children.



## ‘There is a stigma of what a suicidal person should look like’

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Some people felt that there was too great a focus on reducing male suicide and that women were often overlooked with their distress minimised compared to that of men owing to a historically lower rate of death by suicide. We heard that new and young mothers should be given more of a priority focus, especially when risk of distress was compounded by the effects of financial insecurity and relationship breakdowns. Women said they were particularly vulnerable during peri-natal and post-natal times, often feeling stigmatised and not taken seriously when seeking help. It was felt that attitudes to peri-natal and post-natal depression need to change: new mums could fear trying to get help when in distress because, even if they were taken seriously by their doctors, they felt that there was too great a risk that their babies would be removed from them.

‘If a woman speaks up understand that it took a lot of effort to say something and it might be the only time she ever does’

People told us to be alert to those who might be vulnerable to distress but not commonly thought of as being in a group or situation commonly at risk. Teachers, for example, could feel the impact from the death by suicide of one of their students but their need for support through grief and distress might not be recognised in the initial response.

Work also needed to be done, we were told, to support people in occupations which might not be commonly thought of as being at risk of trauma, such as where people work alone with members of the public or individual clients.

Through their jobs, they were noted to be at risk from exposure to trauma and having to counsel their often-fearful clients while they were in a vulnerable position themselves. High levels of stress, a lack of support, isolation and (in some professions) the access to means of suicide contributes to a higher rate of suicide. The trauma that could be experienced by first responders to emergencies – including suicides – was also important, we heard.

‘You can be paid all the money in the world, but if you have burnout, traumatic stress... it’s not worth it.’

### **Preventative services and actions**

We were told it was important that people be supported through skills development to provide local suicide prevention approaches in ways that suited their community. The South Australian Suicide Prevention Networks were cited by some as needing more support to be able to fully represent their local community and to enable them to drive benefits of value to everyone equally. There was concern that not all preventative services were inclusive as they seemed designed in ways that people from different cultures should conform to the expectations of a service targeted at the majority of the population. It was suggested there could be services provided specifically for each cultural group.

‘If people are reaching out it’s for a reason, take it seriously’

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Noting that a lot can happen before someone gets to the point of acting on thoughts of taking their life, it was said that resources and priorities be shifted from crisis care to providing help in the community much earlier to prevent problems worsening and leading to suicide. People said that we need to work as a society to recognise the reasons why people feel the need to take their life by understanding individual circumstances and needs, and working to address them before they became a serious issue.

‘Prevention is better than cure’

We heard that it was important to build capacity in communities to be better able to identify issues of concern with members of their communities and intervene early. It was suggested that this could be done by creating a strong network of peer support to include training people from diverse backgrounds with lived experience to be able to support others in their communities.

People told us that if someone talks about taking their life, they should be believed and not ‘shrugged off’, but that means that networks of support structures must be in place.

Some people called for reducing access to lethal implements, substances and actions as a way of preventing suicide, and it was thought that this could be aided by, for example, creating standards for building constructions.

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### **Supporting people bereaved by suicide**

When bereaved by suicide, families reported that an already difficult time was being made harder by what seemed to be unnecessary obstacles. For example, legal restrictions on which family members could have access to information from the coroner meant that it was not easy for all loved ones to find closure.

Families of people who experience suicide distress or who die by suicide said they need more support to cope with the loneliness and isolation that could follow the death by suicide of a loved one and to work through feelings such as guilt and sense of being judged. Family members and friends were said to be ill-equipped to provide this support but were doing an important job in caring for people who had been bereaved. It was suggested that there be provision made to teach the skills and understanding that were necessary to be able to provide this valuable support to those who had been bereaved by suicide. We heard that recognition and support should also be provided to those who were assisting their bereaved friends and families.



‘Don’t treat me as something that needs to be managed, ask me how I am and want to really know the answer’

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## Strengthening services

### Putting the person first

We heard a call for services to be more sensitive to and to offer compassionate understanding of the trauma experienced by many people who seek their help. We were reminded that everything that happens to a person has an impact and can contribute to the development of thoughts of suicide. Providers (whether health, housing, social service or any other support service), should deliver services through a non-judgemental approach which is mindful of and skilfully responsive to possible trauma experienced by people seeking their help. Some told us of workers who trivialised their trauma and distress, dismissing their lived experience as insignificant, having the effect of re-traumatising.

‘Help people get calm enough to be able to tell you what they need. If I say “I’m going to [attempt suicide]” believe me’

Once a person in need has reached out for help, we were told that they needed to know that the clinician or other professional would continue to look out for them and provide the ongoing support they needed. They don’t want to be or feel judged, but they needed to be listened to and feel validated. We heard that a simple act of compassion from a service provider, showing empathy, could make all the difference.

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‘I’m so sorry you’ve been through so much to make you feel like [suicide]’

People told us that attending professional care could feel like they were ‘being processed’, when what they wanted was to feel like they were being treated as a person with individual needs. We heard that people do not want to feel that they are being objectified as a ‘risk’ to be managed by ‘the system’.

‘If I say I’m thinking about suicide what you do next should protect me, not you’

Instead of feeling that they are being processed through a checklist and risk assessment, people said they want to feel they are being supported by a caring person who will work with each individual who comes for help to provide the right ongoing support.

‘If people are reaching out it’s for a reason, take it seriously’

‘There is nowhere to go if feeling suicidal!’

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### Changing the care model

‘I feel like I’m forced to hurt myself to get help which makes me feel untrustworthy. Trust is important to me because I was abused as a kid’

We were told that suicide should cease being considered as a policing and justice issue. It was said to be unhelpful that someone at risk of suicide might be detained and controlled against their will. We were told by some that police and ambulance are not necessarily the most appropriate agencies to be first responders for people at immediate risk of suicide. It can be overwhelming and add to the distress if an ambulance is called when someone discloses that they are thinking about suicide.

A hospital emergency department, the first point of call for many in crisis, was felt to be an inappropriate facility to provide support to someone at risk of suicide. When taken to an emergency department by ambulance or police, we heard that the handover to the medical service was not always done well and the overall history of why a person had been brought to the hospital often ignored. To the frustration of and potential harm to the person, decisions were often based only on what was immediately apparent at presentation to hospital.

‘When I need help I end up crying at home because I am too scared to risk going to hospital’

As well as not being thought of as suitable places for crisis care, we were often told that emergency departments would sometimes discharge people experiencing thoughts of suicide back into the community unless there was physical injury, leaving people in need without help and at great risk. As an alternative, it was suggested that perhaps there could be specialist emergency care units at mental health services to which people could be taken by first responders, or that there could be specially trained teams to provide crisis response in more appropriate ways based on providing non-traumatising support to the individual.

‘There is no I.V. line for emotional crisis’

People told us that when they talked to medical professionals about thoughts or feelings of suicide, they did not want the first and only response to be given a prescription for medication. People said that properly resourced services and access to evidence-based prevention and treatment services was important. However, they would like services which do more than ‘just prescribe drugs’ and refer on to other clinicians. It was suggested that



‘Just because I’m calm and polite doesn’t mean I’m not highly distressed’.

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this might involve reconceptualising the model of care for people experiencing suicide distress. This is, moving away from a health care model and more towards a multidisciplinary model that puts human connection first. People told us they wanted to build a trusting relationship and be provided appropriate care by service providers.

‘Suicide should not [just] be considered a health issue’

Some clinical practitioners agreed that there needed to be changes in the care model. A multi-disciplinary approach was suggested to be taken, recognising that mental health professionals were not always best suited to dealing with the complexity and intensity of care that people could need. Changes were said to be needed to the funding model with more resources put into mental health and suicide prevention, and we were told that this was not wholly a state government responsibility, but that change was also needed at the federal level.

‘People (workers) fear speaking up inside the system about abuse and lack of care. Everyone is covering themselves, not looking after the people in need’

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### Knowing how to get help

When help was needed, we were told that it was hard to know what services were available or where to go to get help. It was naïve, we heard, to expect that people should have to seek out support when they needed it; instead, services should reach out to people who may be in need for themselves or someone else. A good way to achieve this, it was suggested, was to make use of other touchpoints between people and society’s institutions: schools, for instance, might be an appropriate place to actively reach out to those they identify as being at risk, to find out what was needed and to help signpost to appropriate services.

Education and promotional materials were felt by some to be too broadly aimed. It was suggested that there should be mental health and suicide prevention campaigns targeted specifically at people identifying with the many different cultural and diverse communities of South Australia. Using appropriate language and methods of communication to get the message across was said to be important. Young people suggested using social media campaigns to reach them, but also that we be mindful that not all young people were alike and to also use traditional print advertisements and other methods to communicate what help was available and how to access it.

## ‘Fund services, there just aren’t enough services and help’

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### **Appropriate services for different cultures and populations**

Clinical services were said to not always be culturally appropriate. Some people from diverse cultural and language backgrounds and from LGBTIQ+ communities expressed feeling uncomfortable with the services provided by professionals such as psychologists, psychiatrists and social workers, who provided services that did not feel inclusive.

Racism and other discrimination was said to persist among some clinicians which did not help with feeling comfortable when receiving services from them. For example, preferences regarding personal pronouns were not always respected. It was suggested that staff in clinical and community services needed to be trained better in how to build a rapport with men. Increased diversity in the workforce of services, especially gender (including non-binary practitioners) and culture, was also suggested as being needed. Some people expressed that not knowing whether a service was going to be provided in a way that would be respectful of one’s culture and identity, could make it harder to trust the professional (e.g. clinician, service) charged with their care and that this could lead to being undiagnosed or not seeking help in the first place.

People said that models for providing services must be set to account for the differing needs of different sectors of the community. Being responsive to cultural needs was important: in Aboriginal communities, for example, providing support might involve speaking with the community to understand the full story, something that a mainstream service might not understand. Recognising and working to overcome barriers to access and the effects of intergenerational trauma were said to be important to make services meet the needs of Aboriginal people.

Some people suggested that there be services which were specifically targeted for different genders, cultural groups, and other communities. These could provide specific services for their target audiences: for men, women, Aboriginal people, LGBTIQ+ people, and people from a variety of cultural backgrounds. Services could be culturally embedded, we heard, run by and for people in each community in a way that suited their community and who share their diversity.

It was also suggested to us that investment in service improvement be prioritised based on need: that proportionately more, for instance, be directed to services for Aboriginal communities and for LGBTIQ+ people given that these communities are at higher risk of suicide.



## ‘My GP is good but not about emotional stuff’

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### **Access to services**

It was reported to be hard to get appointments with GPs for mental health issues and to talk about experiences of suicidal thoughts and feelings. When referred on to psychiatrists and psychologists, people found them to be over-subscribed and with long waiting lists. There was criticism that help was rarely available out of hours and on weekends. The sense that there was not enough provision of clinical services came from people from across the state. People living in country South Australia felt that there were not enough resources put into the regions, making access to necessary supports and services much harder for them.

For people who secured access to clinical care (e.g., psychology), we were told that the fixed number of sessions available under a mental health plan was considered too few to be of use, sometimes to the point of being counterproductive. We also heard concerns about the expense of getting care, with large gap payments and out-of-pocket costs for appointments being unaffordable for many.

We heard of difficulties in obtaining a continuity of care when help was sought, with different services seeming disconnected and operating in ‘silos’. A rigid application of confidentiality rules was also felt to be hindering continuity and handover between services.

# ‘Believe me!’

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## Workforce training

### Being comfortable with mental health issues and distress

We heard that GPs and other clinical service providers needed to be provided with better information to boost their knowledge about what services existed to refer people to for further help. Medical practitioners said they wanted more training and suggested that professional courses include modules on how to engage with people compassionately about mental health issues and suicide.

We were told that medical professionals and support services need to receive more training and support to be able to respond appropriately when people come to them for help with mental health issues and thoughts of suicide. Both staff and people accessing help shared that services were not always equipped to ask the right questions in compassionate ways so that they could respond to meet people’s immediate needs. Health professionals, as with everyone in society, needed to learn how to see through the mask that people could wear to hide their distress.

The workforce generally, we were told, should receive more training in and have a stronger understanding of the particular needs and concerns of diverse groups in South Australian society, such as (but not limited to) LGBTIQ+, Aboriginal, age-specific, migrant, language, or cultural background; and including where more than one social characteristic or identity intersect.

## Trusting self-awareness

We heard that some groups faced added barriers to receiving care because of a tendency reported by some service providers to medicalise their cause of marginalisation. For example, some people told us they had to battle to have their gender identity believed, and in addition that some clinicians would wrongfully assume that their distress was caused primarily by their gender identity.

People told us that when they did seek professional help, they sometimes had a difficult time convincing clinicians that they were at risk of suicide. It was felt that people were not being trusted as the best judges of their own selves and of their lived experiences, and that when they reached out at a time of distress that they always need to be believed. For some people, the consequence of not being believed meant that they felt the need to take extreme measures to get access to help, including physically harming themselves. When someone talked about taking their life, we were told that they should be provided with all the necessary support and assistance at that moment, without having to make out a case to convince their service provider that they meant it.

# A message from the team who listened



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We want to offer our heartfelt appreciation to you – the people, organisations and communities in SA who took the risk to share your wisdom, ideas and experiences about suicide prevention with us. This report would not be possible without you.

Suicide can be challenging to talk about and we hope the ways we offered for you to engage with us were comfortable (and if not we'd love to know how we could do things differently). Whether you took the time to do our survey, send us a submission or a quick email, attended a consultation or called us. Thank you.

We heard from over 3,200 of you and that tells us that suicide prevention is a topic important enough for you to expect us to take your responses seriously. We are.

We hope that you feel your views and ideas are represented in this report. We hope too, that in your experience of connecting with us to share your thoughts that you felt heard and were met with compassion – something you frequently shared would make all the difference when you or a loved one may be experiencing distress.

We want you to know too, that alongside creating this report that we've personally learnt and built our skills from listening to you and reading your responses – some of which were moving and hard to hear.

Here is some of what our team has shared about their experience of hearing from you:

*'[it] was such a privilege to be able to listen to the people who took the time to call us and share their very personal stories. I learnt a lot about our community and about myself and feel that this has been the most important*

*piece of work I have been involved with since my time at Wellbeing SA'*

*'the raw honesty and trust of those we spoke with...so many magic moments - all was so moving and so vulnerable and once again - extraordinary individuals sharing tough stuff'*

*'It felt very special to be a part of the conversations even in a note taker role. It connects you more to the work you are doing and adds a face to it. It makes you realise even more how important the work is and the diversity in SA (of experiences, backgrounds etc.)'*

*'hearing the first person who called me share their doubts about being listened to by a government department, and then to have them express surprise and gratitude at actually feeling heard. Feeling the weight of responsibility to honour what so many people have entrusted us as a team, and me as a public servant, with'*

*'It was a very rewarding and humbling experience and one that I will not forget. It represents a highlight in my working life! Real work, doing real conversations with real people for a really important cause/purpose'*

We hope our approach has been one that you feel should become the 'norm' for any consultation process - flexible, compassionate and offering multifaceted opportunities to connect with, and shape the response of government.

Thank you once again for allowing us to witness and utilise the wealth of your experiential knowledge.

[WellbeingSA.SuicidePrevention@sa.gov.au](mailto:WellbeingSA.SuicidePrevention@sa.gov.au)

# Appendix 1: Our consultation process

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## What we did

We ran a major public consultation through which we gave individuals and groups in the community many ways to get in touch and share their views with us about what should go into a new suicide prevention plan for South Australia. We had an online survey, took written submissions by email, invited people to join one of our trained team in individual conversations on the telephone, and had detailed dialogue with communities and organisations in small group discussions.

The consultation was designed to allow stakeholders the freedom to tell us what was important to them in relation to the topic of suicide. As a guide to assist, we gave stakeholders prompts to think about, including about whether our state was getting suicide prevention right as a whole and for different groups, what could be done better to prevent suicide, what were the most important things that we should know, and if we needed to be more aware or supportive of any particular groups in society.

Principal engagement started on 15 March 2021 and ran until 17 May 2021. However, we did not turn away any submissions received or invitations to group discussions after that date, our engagement with stakeholders being a continuous and ongoing process. Principal data analysis was conducted using a qualitative method known as inductive thematic analysis whereby topics and issues emerged from a comprehensive exploration of the data without any preconceived notions as to what the themes should be. Emerging themes were discussed and validated with community stakeholders and with our governance bodies during the analysis period.

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## How we promoted the consultation

- We created an online hub on the Wellbeing SA website with information about the development of the new suicide prevention plan, an invitation to South Australians to share their views, and details of the various methods of getting in touch or participating.
- We worked with the South Australian government's YourSAy service to promote the consultation through their website and to their e-mail subscribers and social media followers.
- We reached out directly to many community groups, peak bodies, government agencies, members of parliament, and to other organisations, groups and communities to inform them about the consultation and encourage them to share the news, to join us in a group conversation or to participate in the consultation in other ways.
- We placed advertisements in newspapers with readership in Adelaide and across several country South Australian regions.
- We played promotional messages and gave interviews about the work on local radio stations. Our local radio marketing work had a strong focus on reaching communities across country South Australia and included some targeted messaging in the Pitjantjatjara language.
- We placed adverts on the internet and published posts on Wellbeing SA social media.
- We sent an e-mail to all state government employees with information about the consultation and how to take part.

Other people and organisations also promoted the consultation through their websites, newsletters, media releases and on some of their social media pages.



## Who we heard from

### Online survey

We received 2,766 responses to our online survey. Not everyone chose to disclose information about themselves, and the breakdowns that follow are limited to those who did. We recognise that the survey did not capture a fully representative sample of people from across the diverse South Australian population, however the survey was just a part of our broad community consultation which included a variety of different means of engagement to suit different preferences.

### Location

Over three quarters (77%) of our survey respondents identified as being from metropolitan Adelaide and one fifth (22%) from regional or rural South Australia – either by telling us their residential postcode or by noting expressly that they were living in a regional, rural or remote area. This is very close to official estimates of the South Australia population which show 74% as living in the Adelaide area and 26% in regional, remote and very remote parts of the state<sup>5</sup>. A map of the location of our respondents is Location of survey respondents on page 36.

## Lived experience

A large fraction of our survey respondents said that they have some personal lived experience of adversity:

Adversity	Per cent
Lived/living experience of distress and/or mental health issues	68%
Carer of someone living with a psychosocial disability	16%
Living with other chronic illness	16%
Carer of someone living with other disability/chronic illness	15%
Lived experience of a disaster/s (e.g. bushfires)	11%
Lived experience as a veteran or first responder	10%
Living with a psychosocial disability	8%
Living with other disability	6%

*Note: people could indicate more than one type of lived experience*

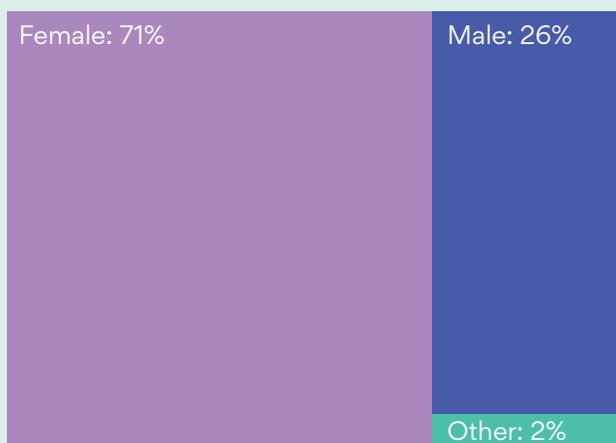
5. Based on Australian Bureau of Statistics data, 2021. *Regional population, 2019-20 financial year.*

In addition, a majority of respondents said that they have some personal experience of suicide distress or crisis:

Distress or crisis	Per cent
I have previously supported someone whilst they were experiencing suicide distress/crisis	57%
I have experienced the suicide of a loved one or friend	50%
I have experienced suicidal thoughts in the past	49%
I am currently supporting someone who is experiencing suicide distress/crisis	16%
I have survived a suicide attempt/s	15%
I currently experience suicidal thoughts	10%

### Gender diversity

*Age distribution of survey respondents, where stated*



Men were under-represented in the responses, a quarter of the 1,701 respondents who identified their gender saying that they were male. Only two per cent identified as other than male or female.

### Sexual diversity

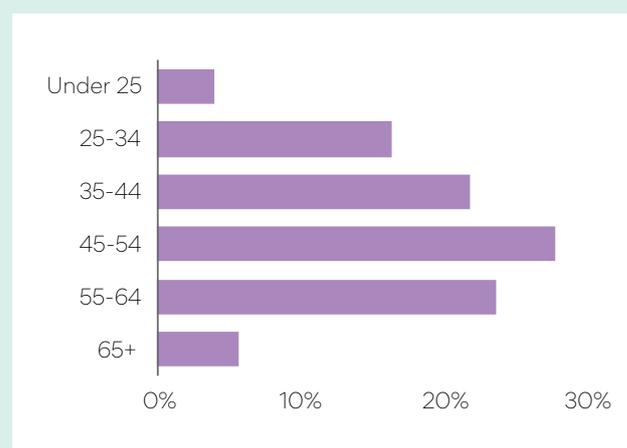
One in nine of our survey respondents who gave demographic information said that they were sexually diverse.

### Cultural diversity

One in thirty (3.3%) of our respondents identified as being Aboriginal or Torres Strait Islander or both, which is similar to official estimates of the Aboriginal and Torres Strait Islander population at 2.5% of the total South Australian population<sup>6</sup>. Additionally, one in seven of our survey respondents identified as being from diverse cultural, language or migrant backgrounds.

### Age diversity

*Age distribution of survey respondents, where stated*



6. Based on Australian Bureau of Statistics data, 2018. *Estimates of Aboriginal and Torres Strait Islander Australians*.



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Of those who gave their age, one in 17 (6%) said they were 65 or older, somewhat lower than the 1 in 5 (19%) of South Australians overall aged 65 or older<sup>7</sup>.

One in 20 (5%) of respondents told us they were under 25. For context, under-25-year-olds make up almost a third of the state's population, and we recognise that young people may be under-represented<sup>8</sup>.

### Group conversations

We engaged in 47 face-to-face group consultations with a wide variety of stakeholders from across South Australia. We travelled to regional communities, including Berri, Ceduna, Cleve, Cowell, Cummins, Kimba, Port Lincoln, Streaky Bay, Tumby Bay, and Wudinna. No two conversations were alike, as we engaged with peak bodies, agencies, workforce representatives, community groups, and informal groupings of like-minded people. A list of our group conversations is provided in *Appendix 2: consultation responses* on page 36.

### Individual contributions

We received 55 written submissions, 31 of them from individuals writing to us on their own behalf and 24 from a variety of organisations presenting their perspectives: two from academic institutions, seven from South Australian government agencies, and 15 from non-government organisations. We had 120 comments from people on social media platforms.

People had the opportunity in the consultation to speak directly with a trained member of the team if they wished. Altogether, we received 28 calls from 22 different callers, with a total talk time of 17 hours and 42 minutes – calls ranged in length from four to 166 minutes with an average of 38 minutes per call. We heard from 12 men, 9 women and 1 person who identified as non-binary. For callers who opted to disclose their age, the range was between 18 and 96 years old with most falling into the age range of 50–70 years. Personal experience of suicidal distress and/or loss of a loved one to suicide were common, 12 of the 22 callers specifically describing their lived experience or that of close loved ones. Our telephone service proved accessible for people to connect with us from across a range of metropolitan and regional areas; a map of caller locations is in *Appendix 2: consultation responses* on page 36.

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7. Based on Australian Bureau of Statistics data, 2020. *Regional population by age and sex*, cat. no. 3235.0

8. People aged under 25 estimated to be 30% of the South Australian population in 2019; people aged 15–24 were 12% of the population; people aged 20–24 were 7% of the population. Based on ABS data, cat. no. 3235.0.

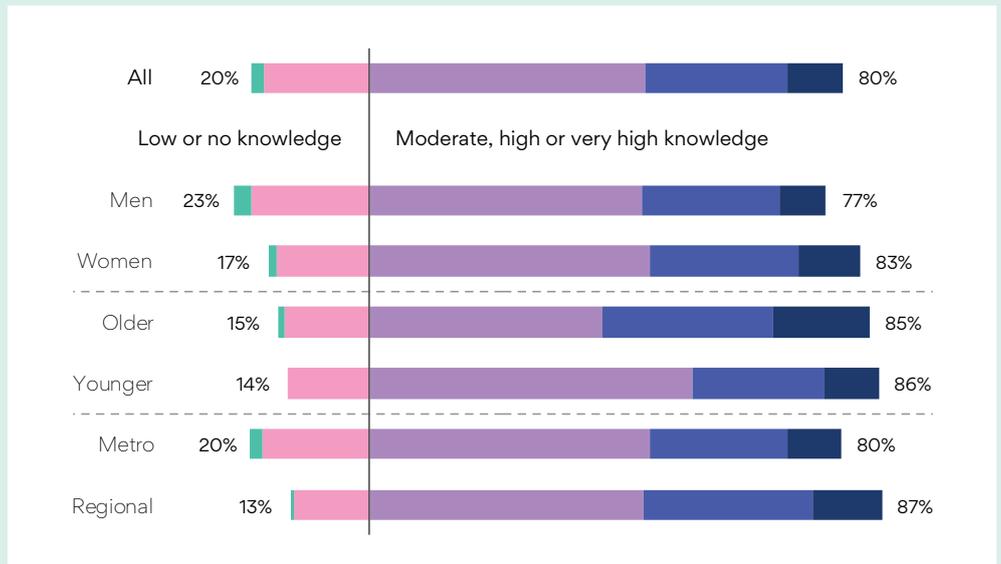
## Knowledge and experience

### Knowledge

The 2,766 people who responded to our online survey were asked to rate their level of knowledge about suicide prevention. There was some small variation between different groups of respondents: men were more likely than women to report low or no knowledge, as were people in metropolitan Adelaide compared to those in regional South Australia. However, broadly a good majority of respondents reported that they have very high, high or moderate levels of knowledge while one in five reported low or no knowledge.

#### Survey responses:

*How would you rate your level of knowledge about suicide prevention?*

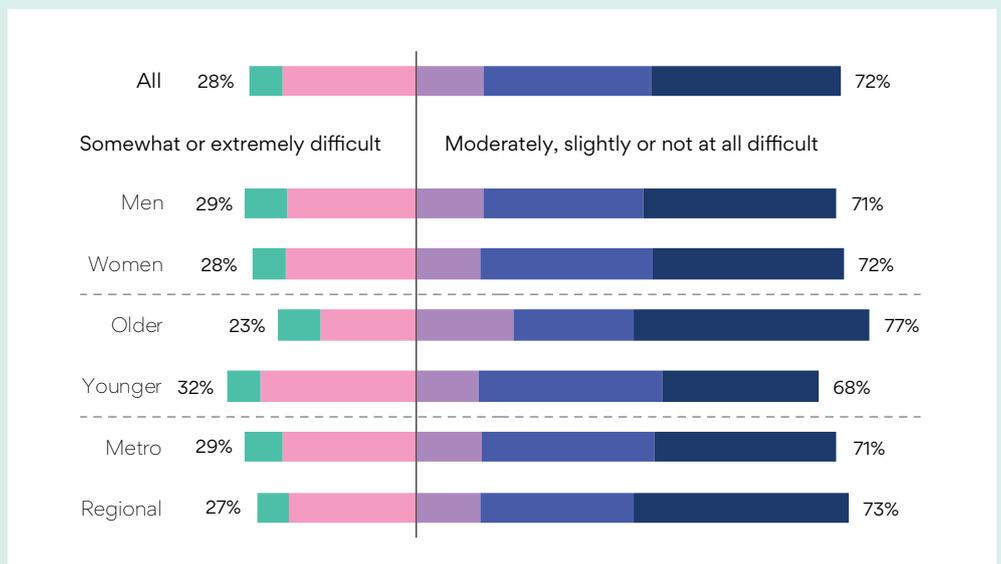


### Ease of talking about suicide

Our survey respondents rated the ease with which they felt they could talk about suicide. There was little difference between groups of respondents: regardless of gender, age range or location, around a quarter to a third of survey respondents reported finding it somewhat or extremely difficult to talk about suicide. The majority, around two thirds to three quarters of our survey respondents reported that it was only moderately, slightly or not at all difficult for them to talk about suicide. This might go towards suggesting that there could be a diminishing societal taboo on the topic, although we did hear from our informants in more detail about a great concern for remaining taboo and a need to address it (*Tackling myths and taboos* on page 16).

#### Survey responses:

*How difficult is it for you to talk about suicide?*

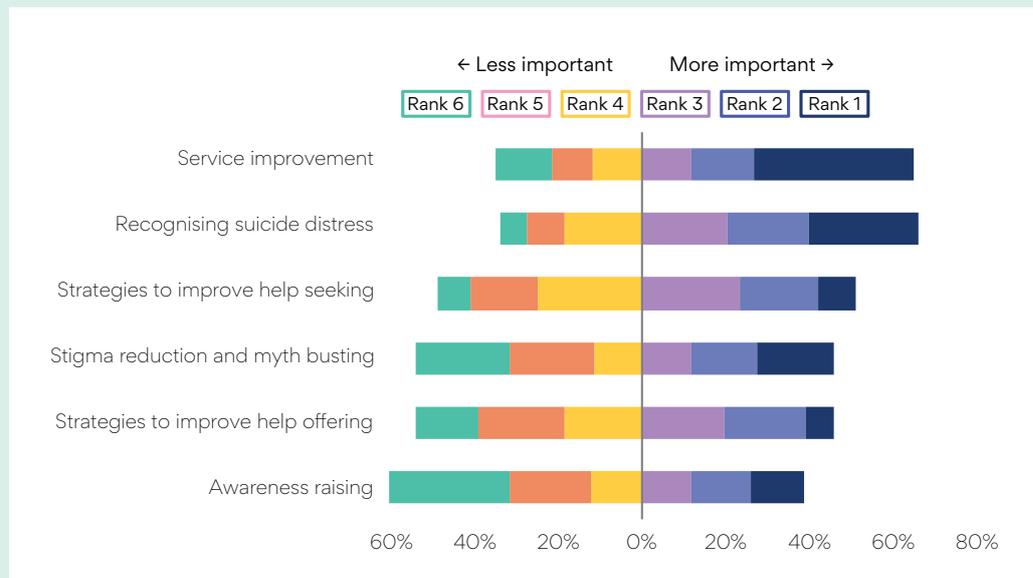


## Priorities

Our online survey respondents were also asked to rank in order of importance six suicide prevention activities: awareness raising, stigma reduction and myth busting, recognising suicide distress, strategies to improve help seeking, strategies to improve help offering, and service improvement (e.g. clinical services, postvention support).

Service improvement was most commonly ranked as the most important, although there was broadly less to say on this topic than on some others when people were given the opportunity to write or discuss with us at more length. In our analysis and reporting, we have read these relative rankings not in isolation but alongside the nuance with which people expressed their detailed comments.

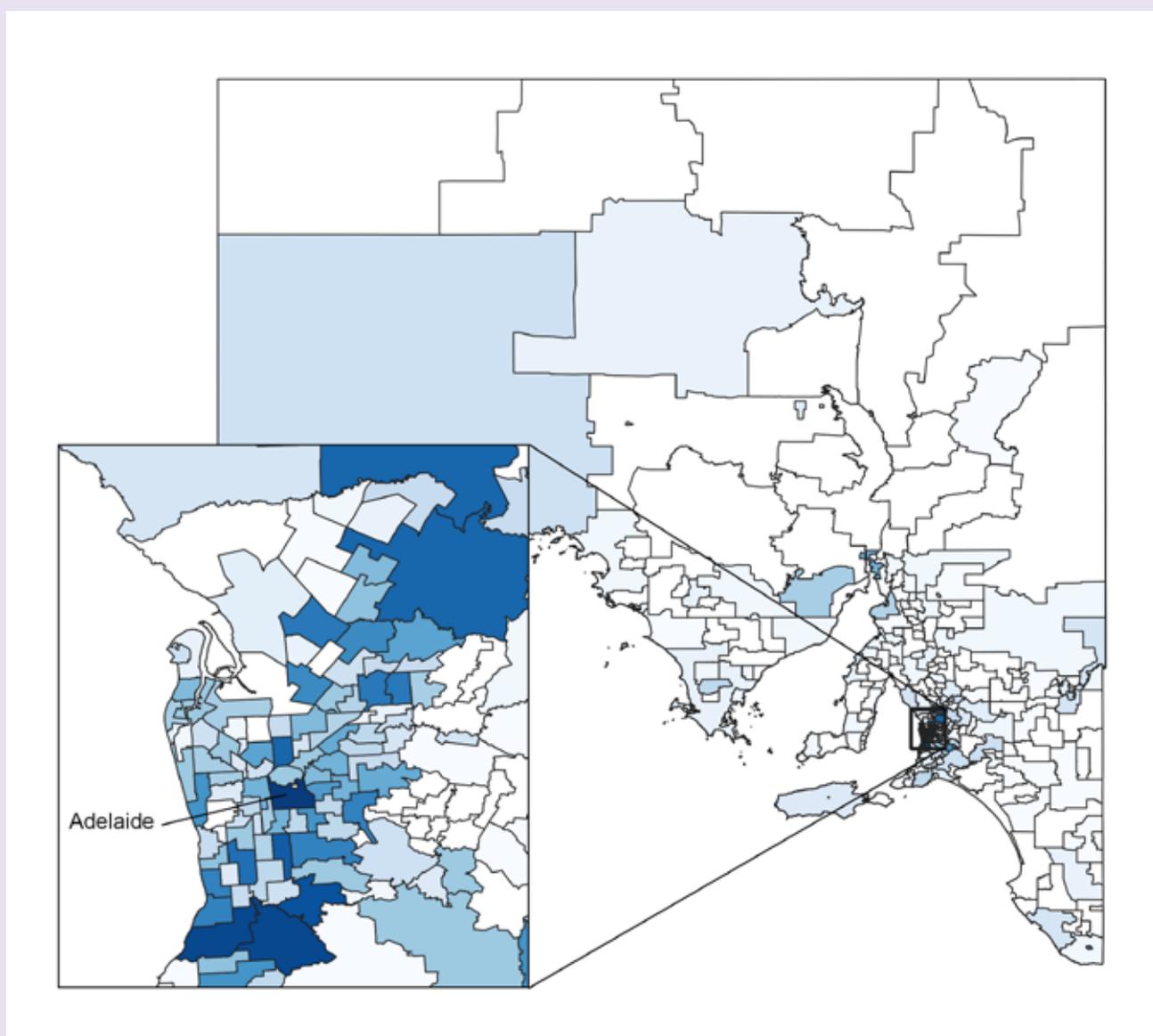
**Survey responses:**  
on a scale from 1 (most important) to 6 (least important), please rate how important each suicide prevention activity is to you



# Appendix 2: consultation responses

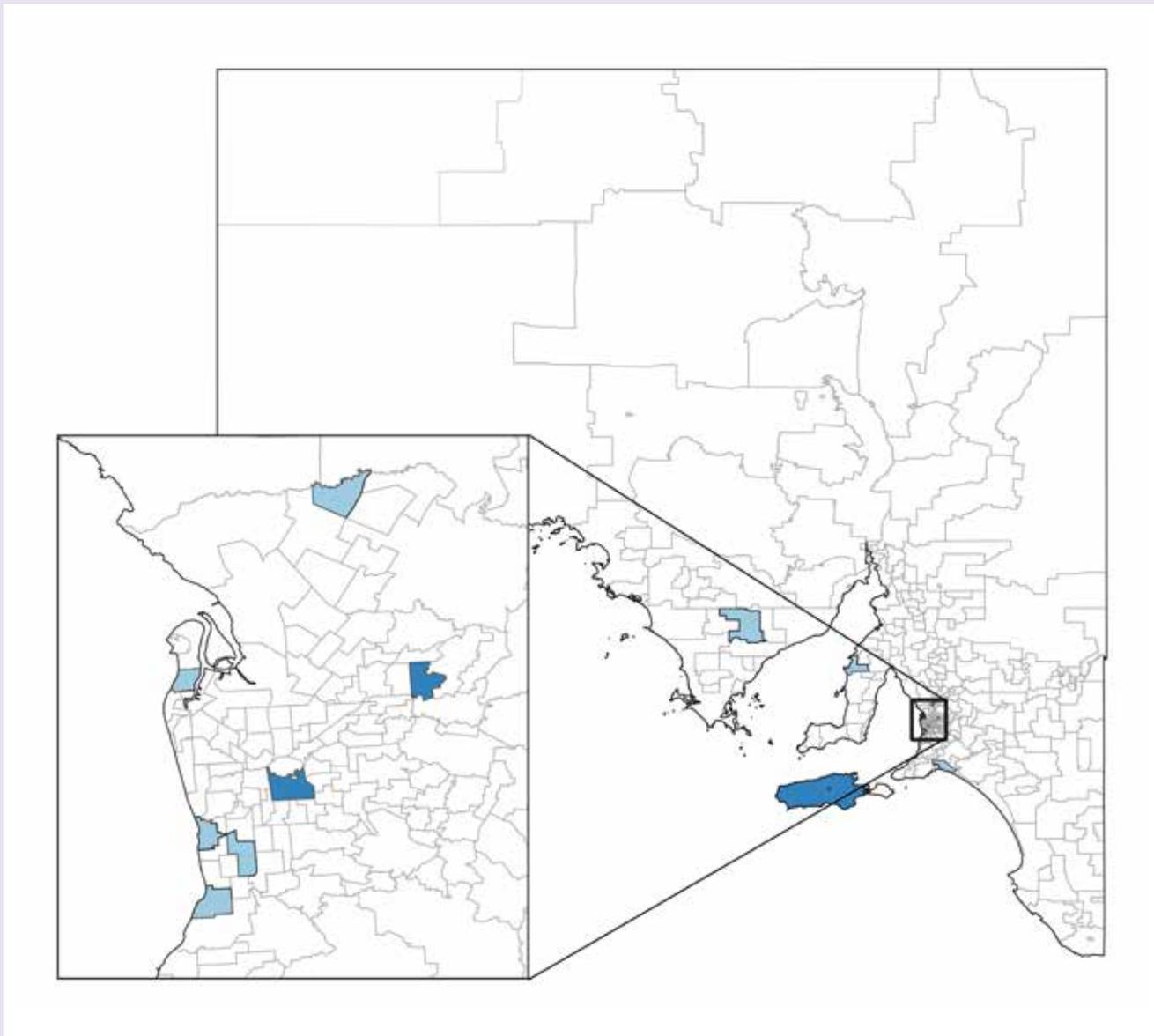
## Location of survey respondents

*Based on postcode stated by survey respondents, where given.*



## Location of telephone callers

*Based on postcode stated by survey respondents, where given.*



## List of group conversations

	Cohort
1	Aboriginal and Torres Strait Islander
2	Aboriginal and Torres Strait Islander
3	Adoptees
4	Advisory
5	Advisory
6	Advocacy
7	Community group
8	Community services
9	Community services
10	Community services
11	Culturally and linguistically diverse
12	Culturally and linguistically diverse
13	Disability
14	First Responders
15	Gig Economy
16	Government
17	Individuals
18	Individuals
19	LGBTIQA+
20	LGBTIQA+
21	LGBTIQA+
22	Lived Experience
23	Lived Experience

24	Lived Experience
25	Lived prison experience
26	Lived prison experience
27	Men
28	Men; Aboriginal and Torres Strait Islander
29	Men; Aboriginal and Torres Strait Islander
30	Older people
31	Peak Bodies
32	Peak Bodies
33	Peak Bodies
34	Peak Bodies
35	Peak Bodies
36	Peak Bodies
37	Peak Bodies
38	Regional and rural
39	SA Suicide Prevention Networks
40	SA Suicide Prevention Networks
41	SA Suicide Prevention Networks
42	Students
43	Students
44	Survivors of Child Sexual Abuse
45	Veterans
46	Veterinarians
47	Veterinarians



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