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It's very intangible, … to really assess the impact of individual actions. … It all comes down, to a very broad definition of suicide prevention, which is life affirmation. And any act of kindness is, by definition, suicide prevention (Jake)

CSAPHN National Suicide Prevention Trial Evaluation: Final Report

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We thank all of the participants who completed various surveys over time, and gratefully acknowledge the valuable contribution of the focus group and interview participants for their time and openness in sharing their lived experiences, particularly during the National Suicide Prevention Trial.

I think it takes a lot of courage to actually put yourself in a space where you are the person that's actually there for that person as well … (Kay)

Executive Summary

Overview of Main Findings

It is well known that access to health mental health services in regional areas of South Australia are impacted by barriers such as distance when compared to easier access in urban areas. Similarly, regional rates of suicide deaths exceed those in urban areas by twice the number of deaths per 100,000 (ABS 2020). In response to this, the National Suicide Prevention Trial initiated in South Australia by the Country SA PHN, aimed to reduce the impact of suicide across five target local government areas. Namely, Port Augusta, Port Lincoln, Port Pirie, Whyalla, and Yorke Peninsula.

This report aims to evaluate a range of community-based suicide prevention events in the form of guest speakers, training, and travelling road shows that were initiated in the trial region between January 2017 and November 2020. Thereby, providing insight into the value of these community events as experienced by attendees to identify those events that had the greatest positive impacts.

Specific outcomes of the report include:

Phase 1

An evaluation of the retrospective community, general practitioner, and youth consultation data; participant aftercare service data collected at time points across episodes of care; and data collected pre- and post-, or immediately following community-based suicide prevention events in the trial region. With a focus on the factors within the descriptive results that indicate which community events worked best.

The main findings were as follows:

- *Community Consultation* (N=130) revealed provision of services were general mental health (58%) and counselling (62%), while remaining services ranged from 43% for brief intervention services, 42% for Indigenous services, 40% for social and housing services, 30% for people at risk of suicide attempt, 27% for postvention services, 26% for education and awareness, 22% for specialized clinical services, 20% support groups, and 16% non-clinical specialized services. Client groups with perceived access to services were youth aged 12-25 years and adults over 25 both at 60%, Indigenous populations (42%), families and children (34%), bereaved (33%), services for males (19%), while a free response format of 'Other' indicated 'women' and 'transgender'. Level of perceived service need was reported as high by 51%, a further 25% reported as moderate, 5% indicated low and 17% were unsure. The highest perceived gaps in services were follow up after suicide attempt at 72%, suicide prevention training opportunities at 66%, discharge planning and youth-specific services both at 59%, Indigenous services at 42%, stigma around mental health services 71%, and digital mental health 42%. Almost half, 47% indicated that they had not attended any suicide prevention training and 34% were aware of the Lifespan Model while 65% were not.
- *GP Consultation* (N=21) showed 52% reported their mental health workload was 0-15%, 29% reported a workload of 16-30%, and 19% reported it was at 31-51%. The mean score for confidence to support people with mental health issues and thoughts of suicide was 2.48 (SD=0.68) from a range of 1=not confident to 4=very confident. 70% had not undertaken suicide prevention training. Interest to learn about specialist mental health, suicide prevention and local

mental health services was at 76%, interest in electronic mental health screening was 43%, and the mean score for connection to the mental health system was 2.50 (SD=0.76) from a range 1=not connected to 4=very connected.

- *Youth Consultation* (N=215) A moderate sample of respondents (22%) indicated they had not been impacted by suicide although 78% did not respond to this question. However, 43.7% reported experiencing suicidal thoughts, 19% had attempted suicide, 35% had cared for someone who attempted suicide, 25% were bereaved by suicide and 11% reported being impacted by suicide in other ways. A majority sample 52% had sought help for mental health problems, of these most sought help from a friend (24%) or parent (22%). When seeking help from an adult 34% indicated support was provided, 23% reported that they were more likely to go to an adult for help, and 7% said help-seeking made things worse. Of those who sought help from local services 19% reported that support was provided, 18% said they were more likely to go to a local service for help, and 6% reported help-seeking was made worse. Perceptions of community suicide risk mean score was 2.41 (SD=0.89) from a range of 1=very high to 5=very low. When asked which youth sub-groups were most at risk of suicide 49% indicated that all young people are equally at risk. The main reasons for youth suicide were considered depression (74%) and bullying (73%). Respondents felt most comfortable talking to friends (54%) or parents (30%) if feeling suicidal. The highest proportion (20%) believed youth suicide is the responsibility of individuals themselves and 23% would be most comfortable attending headspace for suicide prevention training.

The Community, GP and Youth consultations were conducted in 2017 and 2018, thus, it is timely to conduct these consultations again, and compare any change in findings in light of all of the trainings, events and activities implemented during the National Suicide Prevention Trial.

- *Aftercare Services* (N=209). A total of 3212 contacts were recorded within the three-year timeframe. Almost half of all contacts were for psychosocial support (49.7%), a further 22% were for assessment, 14% were for clinical care coordination or liaison and the remaining contacts were for specific psychological interventions, clinical nursing services and suicide prevention assistance. The highest proportion of contacts were at larger regional centres while contact modality was predominantly by telephone (47.4%) and face-to-face (31.6%). 54% had experienced a suicide attempt in their lifetime and 38% had experienced suicidal ideation without an attempt. Most services provided were suicide mitigation (70%) and postvention (26%). The highest service use was General Practice (20%), and most referrals were made by mental health nurses. The greatest social factors impacting attendees were unemployment (30%) or were not in the labour force (40%) and 38% were receiving a pension or benefit. Incidence of mental health conditions by primary diagnosis was depression-related (30%) and the highest medication type was antidepressants (20%). Total (N=322) mean scores on the Kessler K10+ depressive symptoms scale was 33.91 (SD=9.18) with a possible range of 10 (none of the time) to 50 (all the time). However, mean symptom scores reduced over time from episode start, review and end showing the success of aftercare service treatment. The Suicidal Ideation Attribution Scale mean score at the review point in episodes of care was 23.04 (SD=13.7) with a range of 0 (low) to 100 (high).
- *Suicide Prevention Training.* The community training delivered by Mates in Construction (MiC) conducted ASIST, GAT, SafeTALK and Connector Training. Significant differences in these four

MiC training types were shown on the variables: confidence to help, knowledge, usefulness of training, relevance to role, community change, knowing where to connect someone at risk of suicide, and workplace raising awareness. Less favourable scores were shown for GAT compared to the other three training types at this first post-training time point (N=702). At 6-month follow-up participant numbers were less (N=164) and significant difference results were not maintained over the longer-term, however, high mean scores were maintained for help-offering and help-seeking.

- In the remaining training types, there were differences in the strengths of each on the key variables. Increasing *confidence to help* occurred as a result of training by Accidental Counselling Training, Applied Suicide Intervention Skills Training (ASIST), GPEx Education, and Question Persuade Refer (QPR). Training that increased *suicide prevention skills* was GPEx (managing a suicidal person in practice), and QPR (persuading people to get help). Training that increased *knowledge about suicide* were Accidental Counselling, GPEx and QPR. Most training evaluations reported favourable scores on *acceptability of trainer/presentation*, and/or *usefulness* of the training.

Phase 2

Results of prior attendees' survey responses about their experience of community suicide prevention events focused on the factors that interrupt the pathway or trajectory to suicide, reduce stigma, and raise awareness of suicide.

- Please note that mean scores indicated positive results on all the most frequently attended community events i.e., the top 12 events out of a possible 56 that were trialled. Positive mean scores were shown on *knowledge attainment* that suicide is preventable, suicide risk factors and suicidal warning signs; low mean scores were apparent for *stigma*; high mean scores were indicated for skills on how to *refer people in suicidal distress for professional help.* Feelings of *compassion* towards people who are suicidal, having *confidence to help others*; and intentions to *seek help for oneself* were all factors that scored highly. Understanding *cultural difference* and the likelihood of sharing by recommending events to others also achieved high mean scores. When looking closely at the results tables there is negligible difference between mean scores on each survey item indicating little difference between the effectiveness of the community events trialled.

Phase 3

The findings of the focus groups/interviews need to be viewed with caution due to a predominantly Whyalla, female, older age group sample, most of whom attended QPR, ASIST, the World's Biggest Comic Book events and the Roses in the Ocean Walks.

However, as most participants reported lived experience of suicide in some way, important insights, which confirm the results of Phase 1 and 2 findings, are significant to understanding the impact of the NSPT training, events and activities.

Following activities there was an increased awareness of suicide and suicide prevention, with a decrease in judgement and stigma, and an increase in confidence and competence to openly communicate and connect with those in suicidal distress. As a result, there was an increase in compassion, a determination to help and make a difference, and some participants interrupted

suicidal pathways of those in distress. Subsequently, there were flow on effects within the community and increased capacity building in suicide prevention as participants applied what they had learnt.

The most impactful strategies were those that were community driven, relevant and relatable to the local population, and included participant engagement and connection. The least effective were those that were disconnected from the local community and any that lacked safety protocols.

Recommendations

Phase 1

Consultation data suggest reducing perceived service need by:

- Increasing services providing brief interventions to those at risk of suicide attempt, and after suicide attempt,
- Increasing access to services for males aged in high-risk groups and Indigenous populations,
- Increasing suicide prevention training opportunities to the general community,
- Increasing suicide prevention training for GPs while there is an interest to do so,
- Offering free suicide prevention training to young people,
- Linking GPs more closely with local mental health services,
- Targeting youth interventions that address depression and bullying,
- Reducing stigma associated with mental health services to increase community confidence in help-seeking, and
- Increasing youth confidence in services such as headspace by increasing access to youth-specific services.

Aftercare service data suggests service provision is effective in reducing and maintaining depressive symptoms at low rates (i.e., see K10+ and SIDAS scores) where depressive symptoms contribute to the highest scoring mental health conditions, and medication for depression are the most used of the medication types. Therefore, continuation of these services is recommended.

Suicide Prevention Training data suggests targeting specific training needs with the most appropriate training service type that addresses the corresponding need.

Phase 2

Results overwhelmingly strengthen the success of the NSPT strategy in achieving high mean scores on all suicide prevention variables in the survey on the top twelve attended community events. Reinforcing the positive effects of the community events on populations in regional South Australia. Given the higher incidence of suicide in regional compared to urban areas it is recommended that the community events most valued by individual communities be retained and funded in an ongoing capacity to build on the momentum achieved and maintain the shift in attitudes towards more compassion towards people experiencing suicidal states, increased help-offering, reduced stigma and increased help-seeking.

Phase 3

Several recommendations arise from the focus groups/interviews, and these primarily relate to continued capacity building.

- Continue to give voice to those with lived experience.
- Continue to engage with those suicide prevention networks, organisations and small groups who are already in the suicide prevention space.
- As a priority, continue Aftercare/postvention services and increase the follow-up from 3 months to 6 months for those who require it.
- Provide face-to face crisis services to prevent presentations at hospitals (only to be turned away).
- Actively encourage collaboration between hospitals and community services.
- Offer the 'basic' knowledge and awareness raising events for free.
- Increase child and youth programs.
- Invest in Aboriginal and Torres Strait Islander counsellors in schools.
- Invest in the creation of community drop-in centres (listening spaces, Hubs, by whatever name).
- Provide subsidised mental health education for regional health professionals.
- Provide education and /or funding for grant writing workshops and/or assistance.
- Review & change funding and policy models that separate substance misuse and mental health.

1.0 Background

1.1 Suicide in rural South Australia

In Australia in 2019, suicide was the 13th registered leading cause of death (Australian Bureau of Statistics (ABS) 2020). There were 3,318 Australians who died by suicide in 2019, an increase of 180 more suicide deaths than in 2018 (ABS 2020). Of those who died by suicide, males accounted for 75.4% of all suicide deaths, being 3 to 4 times more likely to take their own life by suicide compared to females (ABS 2020). Suicide was the leading cause of death for people aged 15-49 years and the second leading cause of death for people aged 50-54 years in 2019 (ABS 2020). For South Australia specifically, suicide was the leading cause of death for people aged 15-44 and the second leading cause of death for those aged 45-54 (ABS 2020). However, suicide rates steadily increase as distance from the metropolitan areas also increases. In South Australian urban areas, rates of suicide deaths are 7.5 deaths per 100,000 whereas regional South Australia records double the number of suicide deaths at a rate of 15 per 100,000 (ABS 2020). Of regional suicide deaths in South Australia 50% are labourers, and of these 87% are male. Highlighting the continued and urgent need for suicide prevention initiatives to be targeted in regional South Australia.

1.2 Current Approaches to Suicide Prevention

Theoretical understanding of suicide and its related distress is central to effective suicide prevention. Suicide is not an illness. Rather it is a behaviour resulting from events and experiences in the past, as well as thoughts, feelings, and perceptions of oneself and others in the present. For many non-suicidal people, it can be difficult to fully understand feelings of emotional pain, excruciating and unendurable emotional states, thwarted belongingness, and perceived burdensomeness. The interpersonal model of suicide developed by Joiner (2005) and then further progressed through the work by Van Orden (2010), hypothesizes that when individuals experience feelings of perceived burdensomeness and thwarted belongingness, that suicide desire emerges; and near-lethal or suicidal behaviour occurs in the presence of suicidal desire (Chu et al. 2017). The capability for suicide encompasses the dimensions of the interpersonal theory of suicide and the potential genetic risk for suicide together, that is suicidal desire and the capability of suicide together leads to suicidal behaviour (Chu et al. 2017). Dimensions of thwarted belongingness are inclusive of loneliness and the absence of reciprocal care such as living alone, being socially withdrawn, having few friends and self-reported loneliness (Van Orden et al. 2010). All factors that place males (including transient labourers) in regional areas at higher risk. Perceived burdensomeness encompasses perceptions of self-hate and liability, that is the miscalculation that people come to believe their life is worth less than their death (Chu et al. 2017). Notably, one or more psychosocial risk factor was identified in 64% of suicides registered in Australia in 2019, including ‘a personal history of self-harm’, ‘disruptions of family by separation and divorce’ and ‘problems in relationship with spouse or partner’ (ABS 2020). Problems with spousal relationship circumstances were the most common psychosocial risk factor among 25% of suicides in 2019 (ABS 2020).

Building upon Joiner’s Interpersonal Theory, the LifeSpan model developed by Black Dog Institute targets these social and interpersonal dimensions of suicide capability building and developing social capital within communities (Long et al. 2021). Putnam (1995) defined social capital as ‘the value in social networks’. In such strategies as LifeSpan, building upon the social capital of the local community provides support, a sense of belonging, access to practical assistance, resources,

expertise, experience and has a positive influence on mental health (Long et al. 2021). By targeting suicide prevention initiatives towards communities in regional areas, community social capital may grow and build stronger and more supportive networks. The LifeSpan model works towards this through the implementation of nine evidence-based community-wide prevention strategies (Long et al. 2021). This includes improving emergency and follow up care for people in suicidal crisis; evidence based treatments; better equipping primary care to identify and support those in distress; improving the competency and confidence of frontline workers to deal with suicidal crisis; partnering with schools to promote help-seeking, mental health and resilience; engaging the community and providing opportunities to be part of the change; training the community to recognise and respond to suicidality; encouraging safe and purposeful media reporting; and improving safety and reducing access to means of suicide, such as firearms accessibility in regional areas (Black Dog Institute 2020).

1.3 The National Suicide Prevention Trial

In 2016-2017 Country South Australia was announced as one of 12 national suicide prevention trial sites by the Commonwealth Government. The National Suicide Prevention Trial (NSPT) gathers evidence from the Primary Health Networks (PHN) in relation to suicide prevention activities in regional Australia; and aims to understand what strategies are most effective in preventing suicide for at-risk populations. CSAPHN NSPT targets three population groups, Aboriginal and Torres Strait Islander people, Youth (12-24 years) and Adult Males (25-54), in the following South Australian local government areas: Port Augusta; Whyalla; Port Pirie; Port Lincoln; and Yorke Peninsula. These populations groups are appropriately targeted, as the highest proportion of suicides in 2019 occurred in young and middle-aged cohorts (ABS 2020).

1.4 Aims of the Evaluation

Country SA PHN initiated 56 community suicide prevention events (refer to Table 2) across all five South Australian local government areas in the trial region, modelled on the LifeSpan suicide prevention initiative; with a focus on meeting the needs of, and building the capacity of each local community region. The primary aim of this mixed methods project is to firstly, evaluate publicly available reports and previously collected data on NSPT community education, training, and awareness raising program activities within Country SA PHN (CSAPHN) between January 2017 and November 2020. For evaluation are community-based suicide prevention events in the form of guest speakers and travelling road shows about suicide prevention from a range of groups and invited speakers. Secondly, CSAPHN will invite NSPT attendees from this time period to participate in a brief evaluation survey to investigate the impact of these program activities on attendees' self-reported attitudes towards suicide, and their confidence and competence when helping people at risk of suicide. Thirdly, we aim to qualitatively explore attendees' experience of the community events and elicit narratives about putting the training into practice since then. Users of Aftercare services will also be invited to participate in separate focus groups to explore their experiences of these. It is anticipated that the findings will contribute to understanding the impact of each of the program activities delivered within the NSPT region as a whole, and within each CSAPHN region, to determine which activities had the greatest impact, and to inform decision-making around future suicide prevention program activities undertaken in the PHNs. For consumers of mental healthcare, it is also important to evaluate the lived experience of people who are aftercare service users.

1.5 Objectives

The primary objectives were to identify what strategies or activities were most effective in prevention of suicide in the Port Augusta, Port Lincoln, Port Pirie, Whyalla, and Yorke Peninsula Regions of South Australia.

Secondary objectives were to:

- **Phase 1:** Describe the impact of suicide prevention strategies, activities, and training, on communities within the trial region, reporting on any notable impact and or improvements that occurred;
- **Phase 2:** Conduct an evaluation survey with participants from the NSPT strategy, activity, and or training from 1 July to 31 October 2020.
- **Phase 3:** Conduct subsequent interviews and focus groups to explore which suicide prevention strategies had the greatest impact; and
    - Report on the interview and focus group findings highlighting individual descriptions and identify any narratives that could provide further insights for future research.

1.6 Research Questions

1. What do attendees who have taken part in regional NSPT education and community events have to say about the impact of such activities on their attitudes towards suicide, as well as their self-reported confidence and competence when working or interacting with people experiencing, or at risk of experiencing, suicidal states? After undertaking suicide prevention activities, has the community-based education provided by the local CSAPHN helped? If so how, and in what way?
2. For participants' who have had direct experience of supporting a person at risk of suicide, what do they say has helped them after undertaking suicide prevention activities? For aftercare service attendees, what do they say has helped them after utilizing services provided for aftercare in their regions?

1.6.1 The Present Study

In recent times researchers have highlighted the need for methodological diversity in evaluation of suicide prevention initiatives (Kolves, Sisask, Varnik, & De Leo, 2021). A mixed-methods evaluation of the suicide prevention initiatives, using retrospective data (Phase 1), a prospective survey (Phase 2), and information from focus groups and interviews (Phase 3) to identify which strategies are most effective at raising awareness, reducing stigma, increasing compassion, and examines the variables within implemented strategies that reduce the rates of suicide. The findings from this evaluation will help to inform future planning for suicide prevention initiatives in the Country SA PHN, the wider South Australian suicide prevention sector, the general communities throughout the trial regions and other PHNs nationally.

1.7 Scope

1.7.1 Phase 1 Scope

Analyses and reports on existing data provided by Country SA PHN presenting descriptive information obtained from the following retrospective data outlined in Table 1.

Table 1: Data Provided for Phase 1 Analysis

Data Provided for Phase 1 Analysis	
1.	Community Consultation Reports
2.	NSPT GP Consultation data
3.	Youth Consultation Report
4.	Aftercare Service Primary Mental Health Care Minimum Data Set
5.	Accidental Counselling
6.	Applied Suicide Intervention Training (ASIST)
7.	GPEx GP Education1 Nov 2019 Webinar
	GPEx GP Education2 Jan 2020 Webinar
	GPEx GP Education3 July 2020 Webinar
	GPEx GP Education4 PGU Workshop
	GPEx Education5 PLO Workshop
8.	Mates in Construction feedback data 1
	Mates in Construction feedback data 2
	Mates in Construction summary 3 (percentages for information only)
9.	NSPT Minimum Data Set Community Activity (codes for information only)
10.	Question Persuade Refer
11.	SafeTALK

The impact of the implemented suicide prevention strategies were explored to determine which strategies worked best at the local level by highlighting the particular strengths and impacts of each.

1.7.2 Phase 2 Scope

The survey used a constructed measure to invite participants who attended all NSPT strategy training, activities and community events, as outlined in Table 2, from 1 July to 31 October 2020 to further evaluate:

- which suicide prevention initiatives worked best,
- what key improvement outcomes occurred as a result of the initiatives, and
- which training, strategies, activities or community events listed in Table 2 had the greatest community impact.

Table 2: NSPT Strategy Training, Activities and Community Events

NSPT Strategy Training, Activities and Community Events		Hosted By
1.	Accidental Counselling	Lifeline
2.	ASIST Workshop	Lifeline, Mates in Construction, Centacare, CSAPHN
3.	Building skills in acute suicide management (by Dr Jacob Alexander)	GPEx
	Building skills in acute suicide management (by Dr Jacob Alexander)	GPEx
4.	Business Port Augusta Mental Wellbeing Event	SILPAG
5.	Community Calendar Launch Event	SOS Yorkes
6.	Connecting with People Training	SA Health
7.	Connector Development (SafeTALK)	Mates in Construction
8.	Deadly Thinking Training	Mentally Fit EP
9.	Family Fun Day	Pika Wiya
	Family Fun Day	Empowering Lower Eyre
10.	First Responder Awareness Films	Whyalla Suicide Prevention Network
11.	First Responders Wellness Dinner	Whyalla Suicide Prevention Network
12.	General Awareness Training (GAT)	Mates in Construction
13.	Having the Courage to ask the Suicide Question Webinar	GPEx
14.	ifarmwell and Plant a Seed for Safety Workshop	Mid North Health Cluster
	ifarmwell and Plant a Seed for Safety Workshop	Mid North Health Cluster
15.	Ladies WOTL Circle	Mentally Fit EP
16.	Limitless Exhibition	Davenport Community
17.	LivingWorks Start Online Training	CSAPHN
18.	Look Good Feel Good	Whyalla Suicide Prevention Network
19.	Men and Women's Health Day	Pika Wiya
20.	Men's Health Event	SOS Yorkes
21.	Men's Health Forum	Pika Wiya
22.	Mental Health First Aid Training	Pika Wiya
	Mental Health First Aid Training	Whyalla Suicide Prevention Network
23.	Mental Health Football Round	Empowering Lower Eyre
24.	Mindframe Plus Workshop	EveryMind
25.	Port Neill Wellbeing Family Session	Mentally Fit EP
26.	QPR Online Training	CSAPHN
27.	QPR TV Campaign	CSAPHN

28.	Reflection Seat Project	Lincoln Alive
29.	Roses in the Ocean Our Voice on Action	Roses in the Ocean
30.	Roses in the Ocean Voices of Insight	Roses in the Ocean
31.	Roses in the Ocean Walk	Whyalla Suicide Prevention Network
32.	Rotary Men's Wellness Campaign Event	Mentally Fit EP
33.	SafeTALK Workshop	Lifeline
34.	Save Our Mates Wellbeing Roadshow	Hart Wellbeing
35.	Sharing your Story - Short Film Event	Mentally Fit EP
36.	Social media QPR campaign	CSAPHN
37.	SOS Copper Coast Website	SOS Copper Coast
38.	Stand up for Mental Health workshops	Whyalla Suicide Prevention Network
39.	Suicide Prevention - TRUST Group	Uniting Country SA
40.	Suicide Prevention Calendars	Mentally Fit EP
41.	Suicide Prevention Calendars - Eyre Peninsula	CSAPHN
42.	Suicide Prevention Calendars - Yorke Peninsula	CSAPHN
43.	Suicide Prevention Drink Coasters	Mentally Fit EP
44.	Suicide Story Workshop	Centacare
45.	Suicide The Ripple Effect Documentary	Mentally Fit EP
	Suicide The Ripple Effect Documentary	SOS Yorkes
46.	Support after Suicide Webinar	GPEx
47.	Toolbox - Coping with stress during OVID-19 Outbreak	Mates in Construction
48.	Totally Mental Film Animation	Whyalla Suicide Prevention Network
49.	The Wayback Football Club Wellbeing Presentation	Mentally Fit EP
50.	Wellbeing Event	Empowering Lower Eyre
51.	What next after a suicide attempt Webinar	GPEx
52.	World’s Biggest Comic Book	Whyalla Suicide Prevention Network
53.	World’s Biggest Comic Book Launch	Whyalla Suicide Prevention Network
54.	World’s Biggest Comic Book Workshop	Whyalla Suicide Prevention Network
55.	You Me Which Way	Centacare
	You Me Which Way	Centacare
56.	Youth Aware of Mental Health Training	CSAPHN

1.7.3 Phase 3 Scope

Respondents from the survey participant pool and the local Lived Experience membership were invited to participate in focus groups and interviews which were offered in the five local government areas (LGA): Port Augusta, Port Lincoln, Port Pirie, Whyalla and the Yorke Peninsula either in person or via videoconferencing. The qualitative data collection was conducted in a culturally appropriate manner, has been thematically analysed to determine how the suicide prevention training, activities and community events, listed in Table 2, influenced regional communities' capacity to manage suicidal crises, and to highlight any narratives suitable for future filmmaking.

2.0 Methodology of the Evaluation

2.1 Design

The methodology for this study is a three phase, mixed methods evaluation study, using mixed methods of data collection (retrospective data, prospective survey, focus groups/interviews) and analysis (quantitative + qualitative). Interviews and focus groups are frequently used techniques for gathering data in suicide prevention evaluation research (Testoni, De Vincenzo and Zamperini 2021) The three phases include: 1. retrospective quantitative descriptive data analysis, 2. quantitative descriptive survey analysis, and 3. qualitative thematic analysis of focus group/interview data. A mixed methods approach triangulates the data for richer information than if using quantitative methods alone (Hennik, Hutter & Bailey 2017). Please refer to Appendix 1: Evaluation design.

2.2 Participant inclusion and exclusion criteria

Inclusion criteria: NSPT program activity attendees in the five CSAPHN regions from January 2017 to October 2020 and who have been invited to participate in the research by CSAPHN will be eligible to participate. These individuals must be adults (aged 18 years+) and be fluent in written English.

Exclusion criteria: Potential participants who have not attended NSPT program activities in the five CSAPHN regions from January 2017 to October 2020; any potential participants who do not volunteer, or decide to withdraw from the research prior to engaging in the hard copy survey, online survey, focus group and or interview.

Number of participants >250

2.3 Recruitment

In Phase 1, CSAPHN provided de-identified retrospective survey data for researchers to analyse and report on and there was no contact with participants.

In Phase 2, recruitment was by purposive sampling to recruit participants who attended the NSPT program activities in the five identified CSAPHN regions within the required timeframe. An approach letter via email, as well as a Participant Information Sheet, was provided to NSPT program activity attendees from 2017 to 2020. This was sent via a senior staff member/team leader at CSAPHN. Participants registered their interest by following an online link to the survey within the invitation email, or by contacting the researchers directly via email. The invitation was also disseminated to attendees via CSAPHN social media platforms where the participants were originally recruited. The Facebook and Twitter sites are: Country SA PHN, Country and Outback Health, Suicide Prevention Networks in the trial region, Whyalla Suicide Prevention Network, Mentally Fit EP, Lincoln Alive, SOS Yorkes, SOS Copper Coast, Centacare Catholic Country SA. The survey was available for completion from 21st December 2020, until 31st January 2021. However, due to lower numbers than expected, completion time was extended to the 8th of February 2021.

In Phase 3, survey participants were invited to participate in focus groups or interviews at the end of the survey, they followed an online link to register their interest. In addition, an approach letter via email, as well as a focus group Participant Information Sheet, was provided to NSPT program community event attendees from 2017 to 2020 sent via a senior staff member/team leader at CSAPHN. The *Participant Information Sheet* and a link to the focus group registration survey via was

sent via email invitation throughout the CSAPHN network, social media platforms where the participants were originally recruited, word-of-mouth, and discussion at various meetings. In addition, snowball recruitment occurred, whereby participants recruited people they knew, who had also attended NSPT community events. Participants registered their interest by following an online link within the invitation email, or by contacting the researchers directly via email. Contact was then made by a member of the research team and focus groups or individual interviews scheduled. Aftercare participants (clinical) were recruited without social media platform use and invitations were sent by email via a senior staff member/team leader at CSAPHN. Once focus groups/interviews were scheduled, participants were sent a link to a demographic survey. Registrations and conduct of focus groups were open from 16th December 2020, and due to be completed by 16th April 2021. However, due to lower numbers than expected, registrations were extended until 30th April 2021 and the last interviews conducted on 7th May 2021.

2.4 Procedure

2.4.1 Phase 1

The researchers did not have contact with participants – retrospective data was collected comprising analyses and reports on anonymous de-identified retrospective NSPT program evaluation data completed by attendees between 1 July 2017 and 31 October 2020, and publicly available reports on NSPT strategies during this time period (refer to Table 1).

2.4.2 Phase 2

All potential participants received an Information Sheet online on SurveyMonkey prior to deciding whether or not to participate in the survey. Participants completed the survey by following an included link online to SurveyMonkey. Completing the survey online constituted consent. At the end of the survey in Phase 2, participants were able to follow a link online to a separate registration survey where they were asked to volunteer for the Phase 3 focus groups. An Information Sheet was located at the end of the survey in Phase 2 and interested participants contacted the researchers directly. Survey participants were invited to go into the draw for a $200 prepaid Visa card by opting in and providing their email contact details.

2.4.3 Phase 3

Interested survey and aftercare participants who elected to participate in subsequent focus groups or interviews contacted the research team directly in response to their invitation email from CSAPHN, or their invitation at the completion of the survey in Phase 2. In addition to contact details, interested Phase 3 participants were asked to provide basic demographic details (i.e. age, gender, Aboriginal identity, regional area, work role, lived experience, and whether a NSPT community event or if aftercare was attended). Focus groups and interviews were conducted in person or remotely via videoconferencing (i.e., Zoom). In-person qualitative research was conducted at the local Country and Outback Health Service, School, or local Public Library. Focus group and interview participants were also invited to go into the draw for a $100 prepaid Visa card by opting in and providing their email contact details.

2.5 Risk management

We believe that there were minimal risks associated with participating in this research, however, because some participants may find the topic of suicide distressing the Participant Information Sheets provided details of relevant support services that participants could access for support (e.g. EAP, Lifeline, Suicide Call Back Service, Men's Help Line, and the BeyondBlue Helpline) should participants require these. This information was further be reiterated by the researchers at the start and end of the online survey (in writing), and upon completion of the interviews (provided in writing). If distress occurred during focus groups or interviews, the team members utilized a safety protocol for people with Lived Experience and were present to provide immediate support as they are all experienced academics/health professionals as well as directing them to the support services listed on the Information Sheets. Please refer to the Project Flow diagram in Appendix 2.

2.6 Outcome measures

Phase 1 analyses and reports on anonymous de-identified retrospective NSPT strategy evaluation data completed by program attendees between 2017 and 2020, and publicly available reports on NSPT community events during this time period. This research project presents descriptive information obtained from the NSPT strategy community events outlined in Table 1, for example, Community Consultation Reports; Youth Consultation Report; NSPT General Practitioner Consultation data/report; NSPT MDS Community Activity data; Question, Persuade, Refer (QPR) data/report; GPEx GP Education data/report, SafeTALK, and Mates in Construction data (for the complete list refer to Table 1). The impact of the implemented NSPT community events are synthesised to report on which strategies worked best in the NSPT region according to the key variables across the whole of the data.

Phase 2: A quantitative self-report survey (T1), is a brief 10 item, Likert scale questionnaire, which address the same NSPT program attendees' attitudes to suicide, and confidence or competence interacting with people at risk of suicide, since attending NSPT program activities between 2017 and 2020. The survey also included the demographic variables such as gender, age, current work or health work role, and specific NSPT community event attended[1]. The research evaluates which suicide prevention strategies worked best across the key variables; what improvement outcomes occurred because of the trial strategy; and which activities had the greatest community impact across the trial region.

Phase 3: Focus groups were conducted with two separate cohorts. Firstly, respondents from the survey participant pool (non-clinical) were invited to participate in focus groups/interviews (T2). Qualitative responses to questions in focus group discussions and interviews explored participants' retrospective experience of their attendance at NSPT community events, any subsequent changes in attitudes towards suicide, confidence interacting with people at risk of suicide, or awareness of local suicide support networks in their PHN region. Please refer to the Phase 3 semi-structured community focus group or interview question items in the Research/Data Collection Tools document for further details (in Appendix 3). The qualitative data were used to highlight how NSPT community events influenced individuals' attitudes towards suicide, and their capacity to better interact with

[1] Please refer to the Phase 2 survey questionnaire in the Research/Data Collection Tools Appendix 3 for further details.

people at risk of suicide in their regional communities. Secondly, attendees of Aftercare services during the same time period (clinical) were invited to participate in separate focus groups. Qualitative responses to questions in focus group discussions and interviews explored participants retrospective experience of their attendance at Aftercare services in each of the NSPT regions. Please refer to the Phase 3 semi-structured aftercare focus group/interview question items (clinical) in the Research/Data Collection Tools document for further details (in Appendix 3).

2.7 Data Analysis

2.7.1 Phase 1

After UniSA HREC approval[2], copies of all data were received securely from CSAPHN to the Research Team's university NextCloud shared storage. The names of files were retained as received, the scope of the data was checked and ordered for analysis. Community consultation data, Aftercare and suicide prevention training evaluation data were received. The titles of each data set were recorded alphabetically by their file extension name into a purpose-designed Excel data extraction spreadsheet. The following information were extracted from the results of each of the included data sets: aim, study design, study location, and setting, participants (sample size, population description, age, gender); intervention (training name), and the key outcome measures variables. These were: suicide, depression, hopelessness, confidence to help, skills, knowledge, acceptability of presentation, usefulness of training, and outcomes other.

There were 12 sets of data provided, eight were in Excel and three were in Portable Document format (.pdf). The files in Excel were explored for scope and there were between one and thirteen separate sheets of data for analysis in each of the 12 Excel files which combined were 49 in total. Two data sets were for information only which included codes or brief frequency results used for reference and these were not analysed.

Each relevant Excel sheet was imported separately into SPSS Statistics v26 software (IBM 2020) for analysis after data cleaning according to Pallant (2011). Each variable had the corresponding value labels applied according to the variable label keys which were either supplied in Excel with the data, separately in Excel, or available via a provided URL online. The pdfs provided limited descriptive information and no raw data however, data were extracted manually and analysed with the results reported.

A meta-analysis was not justified given that the heterogeneity of the data, interventions, and outcome variables, instead a sequential analysis is reported with a synthesis of key findings on the key outcome variables. Statistical analyses used descriptives and frequencies to determine the characteristics of each sample. Survey results were examined for descriptives, frequencies, means and standard deviations as applicable. ANOVA investigated differences in means between groups for significance. Phase 1 data included qualitative components in eight studies and six were included with the relevant quantitative study results. General comments were excluded from the main quantitative findings in this study.

[2] UniSA HREC approval, with Project ID 203559, was granted on the 10th December 2020.

2.7.2 Phase 2

Survey data were collected via SurveyMonkey (online) and imported into SPSS for analysis. Descriptive statistics were used for sample characteristics and survey results after data cleaning according to Pallant (2011). A new categorical variable was created to collapse the 56 NSPT strategy community events from duplicated listings under regions/towns into each of the community event names only. t-tests were conducted on all suicide prevention survey items. ANOVAs were conducted to investigate significant differences in means on the outcome variables, which experienced ceiling effects due to high rates of favourable results. Multi-level modelling was used according to Heck[3] to split the data file which provided accurate results indicating the frequency and cumulative percent that each of the 12 top-rating community events (out of a possible 56) were attended. In addition, means and standard deviations of the top-rating community events could be compared across the suicide prevention survey items to determine which scored best on the key outcome variables (e.g., to investigate impacts on participants since attending NSPT strategy community events during the trial time period including: attitudes about suicide, competence and confidence to interact with and refer people at risk of suicide, acceptability and usefulness of training).

2.7.3 Phase 3

Demographic data were downloaded from SurveyMonkey (2020) into SPPS, aggregated, and descriptive statistics conducted. Focus group and interview transcripts were transcribed verbatim, and imported into QRS NVivo Pro version 12 (2018) software for coding, content and thematic analysis. Following Braun and Clarke's (2006) six stage procedure: data familiarisation, generating initial codes, collating codes into themes, reviewing themes, defining and naming themes, and discussing the themes through use of participant quotes and extracts. Informed by the aims of the study, there was a non-clinical focus on: attendees experience of the community events; the impact of the activities on attendees and the community; how attitudes, confidence and competence in responding to people at risk of suicide had changed; capacity to better interact with people at risk of suicide and manage people experiencing suicidal crises; eliciting narratives about putting the training into practice since; the strategies that were most effective; and community capacity building. In addition, narratives suitable for future filmmaking were identified. There was a clinical focus on aftercare service participant's experience of aftercare accessed in the NSPT region.

2.8 Ethics

Ethical approval was granted by the University of South Australia Human Research Ethics Committee on 10 December 2020.

3.0 Phase 1 Retrospective De-identified Data: Findings

Phase 1 findings are reported according to the data provided in Table 3, with Consultation Reports first, followed by Aftercare Counselling, and training evaluation findings are reported last.

Table 3 shows the sequence that results are reported in this section.

Data Provided for Phase 1 Analysis	
1.	Community Consultation Reports
2.	NSPT GP Consultation data
3.	Youth Consultation Report
4.	Aftercare Service Primary Mental Health Care Minimum Data Set
5.	Accidental Counselling
6.	Applied Suicide Intervention Training (ASIST)
7.	GPEx GP Education1 Nov 2019 Webinar
	GPEx GP Education2 Jan 2020 Webinar
	GPEx GP Education3 July 2020 Webinar
	GPEx GP Education4 PGU Workshop
	GPEx Education5 PLO Workshop
8.	Mates in Construction feedback data 1
	Mates in Construction feedback data 2
	Mates in Construction summary 3 (percentages for information only)
9.	NSPT Minimum Data Set Community Activity (codes for information only)
10.	Question Persuade Refer
11.	SafeTalk

3.1 Community Consultation Data Results

The Excel data file 'National Suicide Prevention Trial consultation data' was imported into SPSS version 26 and analysed.

3.1.1 Sample Characteristics

There were 338 respondents with data collected in 2017 (130 responses) and 2018 (207 responses); 23 percent had participated in NSPT face to face consultations and 77% had not. The majority lived in the Whyalla LG (22%), while the other LGAs were represented by between 14 and 17% of participants. The majority were aged between 41- 50 years (30%) and 51-60 years (26%), followed by 18% aged between 31- 40, 12% aged 21-30 and less than three percent under 20 and over 70 years. 92% did not identify as Aboriginal or Torres Strait Islander, 70% identified as female and 22% identified as male, see Tables 4 to 7.

Table 4: Region respondents resided.

Council LGA		Frequency	Percent
	Other	47	13.9
	Port Augusta	58	17.2
	Port Lincoln	52	15.4
	Yorke Peninsula	45	13.3
	Whyalla	73	21.6
	Port Pirie	59	17.5
	Total	334	98.8
Missing		4	1.20
Total		338	100.0

Table 5: Respondent gender.

Gender		Frequency	Percent
	Male	75	22.2
	Female	259	76.6
	Total	334	98.8
Missing		4	1.20
Total		338	100.0

Table 6: Respondent age ranges.

Age Range		Frequency	Percent
	11-20 years	9	2.7
	21-30 years	41	12.1
	31-40 years	59	17.5
	41-50 years	99	29.3
	51-60 years	85	25.1
	61-70 years	36	10.7
	71-80 years	4	1.2
	Total	333	98.5
Missing		5	1.5
Total		338	100.0

Table 7: Respondent cultural identity.

Aboriginal or Torres Strait Islander identity		Frequency	Percent
	Yes, Aboriginal	309	91.4
	No	23	6.8
	Prefer not to say	2	0.6
	Total	334	98.8
Missing		4	1.2
Total		338	100.0

3.1.2 Experience of Suicide.

Twenty one percent did not have lived experience of suicide and 79% did not respond to this question. Similarly, 36% had experienced suicidal thoughts, 12% had survived a suicide attempt, 32% had cared for a suicide survivor, 34% were bereaved by suicide and 18% reported 'other lived experience' of suicide. A greater proportion of respondents left these question items unanswered see Table 8.

Table 8: Respondents'' lived experience of suicide.

Lived experience of suicide	Frequency	Percent
No	71	21.0
Missing	267	79.0
Total	338	100.0

3.1.3 Organization membership.

Thirty two percent of respondents reported that they were not a member of any organisation, while the majority 27% and 23% were with State Government or Not for Profit organizations respectively. Up to 7% reported identification with Commonwealth Government (7%), Indigenous organizations (4%), school-based services (5%), higher education sector (4%), telephone-based organizations (4%), and headspace (2%).

3.1.4 Service provision.

Respondents indicated the suicide prevention services available to them. The majority indicated provision of general mental health services (58%) and counselling (62%), while remaining services ranged from 43% for brief intervention services, 42% for Indigenous services, 40% for social and housing services, 30% for people at risk of suicide attempt, 27% for postvention services, 26% for education and awareness, 22% for specialized clinical services, 20% support groups, and 16% non-clinical specialized services.

3.1.5 Access to services.

Respondents indicated which client groups had access to the services above and the highest were youth aged 12-25 years and adults over 25 both at 60%, Indigenous populations (42%), families and children (34%), bereaved (33%), services for males (19%), while a free response format of 'Other' indicated 'women', 'transgender', and several indicated 'don't know'.

When asked if there were additional services or client groups that could be provided if funds allowed, 46% responded yes, 15% said no, and 32% said not applicable. If workplaces worked collaboratively with other suicide prevention organizations, there were 29% who responded yes, 36% responded no and 33% responded not applicable.

3.1.6 Service need.

Level of perceived service need in the NSPT region was reported as high by 51% of respondents, a further 25% reported need as moderate, 5% indicated low and 17% were unsure. The highest perceived gaps in services were: follow up after suicide attempt at 72%, suicide prevention training opportunities at 66%, discharge planning and youth specific both at 59%, Indigenous services at 42%, stigma around mental health service 71%, and digital mental health 42%, see Table 9.

Table 9: Respondents indicate the level of service need in their region.

Level of SP service need in your region		Frequency	Percent
	High	171	50.6
	Moderate	86	25.4
	Low	19	5.6
	Unsure	57	16.9
	Total	333	98.5
Missing		5	1.5
Total		338	100.0

Barriers to accessing services. Problems associated with accessing services were identified as: availability of services (81%), waiting time (77%), travel at 61%, financial reasons for 53%, perceived stigma and discrimination (59%), culturally appropriate services (33%).

3.1.7 Suicide prevention training programs

Almost half, 47% indicated that they had not attended any suicide prevention training. When asked whether respondents organization delivered accredited training 17% said yes and 78% said no. For those who did attend the Suicide Prevention training sessions, rates were as follows:

- APS - Australian Psychological Society Suicide Prevention Training 3%
- ASIST - Applied Suicide Intervention Skills Training 22%
- Black Dog Institute Advanced training in Suicide Prevention 3%
- Connecting with People 10%; Safe talk 7%
- QPR - Question, Persuade, Refer 3%
- SRAM-ED - Suicide Risk Assessment and Management for Emergency Department Settings 2%
- Wesley Life Force Suicide Prevention Training 11%

3.1.8 The Lifespan Model

Thirty four percent of respondents were aware of the Lifespan Model and 65% indicated they were not. The nine LifeSpan strategies are, 1. Improving emergency and follow-up suicidal crisis, 2. Using evidence-based treatment for suicidality, 3. Primary care to identify and support ppl in distress, 4. Improving the competency and confidence of frontline workers, 5.Promoting help-seeking, mental health and resilience, 6. Training the community to recognise and respond, 7.Engaging the community, 8.Encouraging safe and purposeful media reporting, 9.Improving safety and reducing access to means of suicide. Community consultations showed awareness of the LifeSpan model mean scores ranged between 2.45 and 2.99 (2 indicates agree and 3 indicates unsure) see Table 10 Part A. Table 10 Part B shows what needs to be done to improve suicide prevention against the same LifeSpan model strategies. Respondents mean scores ranged between 1.28 and 1.50 (1 indicates strongly agree and 2 indicates agree). Overall, this shows that there was moderate awareness of the LifeSpan Model and that the need against the nine strategies was deemed as high.

Table 10: Respondent's mean and SD showing awareness of the nine LifeSpan strategies (Part A) and what needs to be done to improve suicide prevention (Part B).

Part A. Awareness of the nine LifeSpan strategies	*N*	Mean[a]	Std. Deviation
1. Improving emergency and follow-up suicidal crisis	296	2.88	1.17
2. Using evidence-based treatment for suicidality	298	2.88	1.16
3. Primary care to identify and support ppl in distress	294	2.75	1.11
4. Improving the competency and confidence of frontline workers	295	2.78	1.19
5. Promoting help-seeking, mental health and resilience	300	2.45	1.11
6. Training the community to recognise and respond	298	2.99	1.18
7. Engaging the community	298	2.81	1.20
8. Encouraging safe and purposeful media reporting	297	2.92	1.12
9. Improving safety and reducing access to means of suicide	295	2.87	1.15
Part B. To Improve SP we need to...			
1.Improve emergency & follow-up suicidal crisis	329	1.35	0.65
2.Using evidence-based treatment for suicidality	328	1.50	0.73
3. Primary care to identify and support ppl in distress	331	1.36	0.63
4.Improve the competency and confidence of frontline workers	331	1.36	0.66
5.Promote help-seeking, mental health and resilience	330	1.28	0.54
6.Train the community to recognise and respond	330	1.34	0.61
7.Engage the community	330	1.39	0.64
8.Encouraging safe and purposeful media reporting	329	1.44	0.67
9.Improve safety and reduce access to means of suicide	328	1.57	0.78

[a] Scores range from 1= strongly agree to 5= strongly disagree.

Table 11 shows respondents mean scores on perceived services and support that is available to people experiencing suicidal thinking. Scores that were not reverse coded (all items except 4 and 10) indicated ranges from 3.00 (3= unsure) to 3.64 (4= disagree). Reverse coded items indicated agreement (mean score 2.09 and 2= agree) that knowledge of where to go for help is low; and disagreement (mean score 4.27 and 4= disagree) that access to psychiatrist is generally poor.

Overall, there is some ambiguity about the services and support available, except that access to psychiatrists is quite good.

Table 11: Respondent's mean and SD showing services and support available for people experiencing suicidal thinking.

Services and support available for people experiencing suicidal thinking.			
In my local community ppl experiencing SI,	N	Mean[a]	Std. Deviation
1.Early intervention is easily accessible	328	3.58	1.02
2.SP promotion and education is provided	326	3.19	1.09
3.GP's are equipped SP know/skills	327	3.24	1.06
4.Access to psychiatrists is generally poor	327	4.27	1.01
5.Access to social support is good	327	3.34	1.02
6.Support is available to carers and families	328	3.34	1.01
7.Services are available for youth experiencing suicidal thoughts	328	3.00	1.10
8.Support for someone feeling suicidal is easily accessible	328	3.64	1.01
9.Services for family and friends after a suicide attempt are available	326	3.30	1.04
10.Knowledge of where to go for help is low	329	2.09	1.10

[a] Scores range from 1= strongly agree to 5= strongly disagree.

Finally, Table 12 shows perceived contributing factors to suicide in their community. Mean scores that indicated agreement (2 = agree) were stigma and discrimination associated with people who have attempted suicide; and culturally inappropriate services. All other mean scores were between 1 (strongly agree) and 2 (agree) showing social problems, distance, lack of trained staff, lack of support for family and carers, poor understanding of mental health and lack of community coordination around mental health services are all perceived problems facing community members.

Table 12: Respondent's mean and SD showing factors contributing to suicide in their community.

Factors contributing to suicide in their community.			
Contributing factors to suicide in OUR community are:	*N*	Mean[a]	Std. Deviation
1.Family Breakdown	333	1.83	0.77
2. Unemployment	331	1.89	0.85
3. Lack of community coordination regarding mental health services	333	1.93	0.86
4. Distance to appropriate services	331	1.92	0.90
5. Poor understanding of suicide and mental health	331	1.81	0.79
6. Drug and Alcohol use	332	1.65	0.83
7. Stigma associated with suicide	332	2.02	0.93
8. Discrimination associated with those who have attempted suicide	332	2.14	0.94
9. Lack of adequately trained health care providers in suicide prevention	331	1.83	0.88
10. Lack of support for families and carers of persons with ongoing suicidal thoughts	330	1.82	0.82
11. Culturally Inappropriate services	330	2.42	1.00

[a] Scores range from 1= strongly agree to 5= strongly disagree

3.1.9 Community Consultation: Qualitative findings

For the community consultation survey there were 338 respondents. Following removal of those responses that indicated "don't' know" to *what were the barriers to accessing services*, 11% (*n*=38) of responses were analysed. The most frequently reported barrier to accessing services was lack of access to, and availability of services, followed by not knowing what services are available. Refer to Table 13 for further detail.

The Community Consultation Survey was conducted in 2017 and 2018, thus, it is timely to conduct another community consultation and compare any change in findings in light of all of the trainings, events and activities implemented during the National Suicide Prevention Trial.

Table 13: GP Consultation Survey: Barriers to supporting people experiencing mental health

Barriers to accessing services [a]	Example responses	*n*=38	%
Lack of access & availability of help	Lack of trained personnel.	17	45
	Paucity of available services in remote locations.		
	Lack of effective IT to support innovative service model.		
	Lack of support for family.		
	Need early prevention.		
Don't know what's available	Not knowing what is available & who can access it, & when are they bad enough to need it.	6	16
	Being familiar with the services & how to access them would assist in breaking down the anxiety a person may feel in accessing services and disclosing their needs.		
Lack of knowledge & understanding	Need male oriented services.	5	13
	Provider not having the skills &/or knowledge, compassionate care to support the individual.		
	Staff need to not tell people who are in crisis "we are busy. Are you sure it's an emergency?" When you call for help.		
Stigma	… attached to approaching service.	4	11
	Support needed from those in authority to access help & openly be able to provide ongoing support without stigma		
	Reach a point when the only other option is to go to the hospital which is full of stigma.		
	Reducing the negativity & bullying which is so strong in the community at every level.		
Financial & perceived greed	… a HUGE issue.	3	8
	No funding for transport.		
Lack of bulk billing	Not willing to bulk bill.	3	8
Lack of trust	Lack of confidence in services, self or others .	3	8
	Some mental health staff seem to not care about clients' needs with ongoing care.		
Reluctance to help	Lack of interest from service providers/differing priorities	2	5
	Staff sitting and having lovely chats.		
Culturally appropriate	… services for at risk groups (rather than people with mental illness) & importantly, male oriented services with appropriately trained counsellors / psychologists.	1	3
Not supporting	the Connecting with People roll out.	1	3
Reluctance to seek help	Uncomfortable & not worthwhile.	1	3

[a] Respondents gave more than one response in a number of areas

3.2 General Practitioner Survey Data Results

The Excel data file 'General Practitioner Survey(renamed)' was imported into SPSS version 26 and analysed. After data cleaning, there were 21 valid respondents and data was collected from 16th February to 9th March 2018.

3.2.1 Sample Characteristics

There were 57% males and 43% females, the majority were aged between 31- 40 years (38%), no participants were under the age of 31 and the remaining age groups were 41-50 years (19%) and 14% were over 61 years. Almost half (48%) lived in the Port Lincoln LGA (22%), while the other LGAs ranged between 5% and 24% of participants. 100% did not identify as Aboriginal or Torres Strait Islander Peoples. There were 15 GPs and 6 nurses in the participant pool (see Table 14).

Table 14: General Practitioner Survey sample characteristics.

Factor (N=21)	Frequency (n)	Percent %
Gender		
Male	9	57
Female	12	43
Age Range		
31-40	**8**	**38**
41-50	4	19
51-60	6	28
61+	3	14
Region (work)		
Pt Augusta	2	10
Pt Lincoln	**10**	**48**
Whyalla	3	14
Yorke Peninsula	5	24
Other	1	5
Work role		
GP	15	71
Nurse	6	29

3.2.2 Survey question items

This data set survey asked the following questions: 1. *What percentage of your workload involves supporting people experiencing mental health difficulties including thoughts of suicide?* 2. *How confident are you in supporting people experiencing mental health difficulties including thoughts about suicide?* 3. *Which of the following suicide prevention training programs have you undertaken?* a) ASIST - Applied Suicide Intervention Skills Training b) *QPR - Question, Persuade, Refer* c) *SRAM-ED - Suicide Risk Assessment and Management for Emergency Department Settings* d) *APS - Australian Psychological Society Suicide Prevention Training* e) *Black Dog Institute Advanced Training in Suicide prevention* f) *Connecting with People* g) *Have not undertaken any suicide prevention training*. 4. *Would you be interested in specialised training in mental health and suicide prevention?* 5. *How connected are you with other parts of the mental health system?* 6. *Do you have identified referral pathways or strategies you use to connect people with mental health or suicide prevention services?* 7. *Would you be interested in more opportunities to learn about mental health services in your area and how they can assist you in supporting your patients?* 8. *Would you be interested in exploring the*

use of an electronic mental health screening tool to be used in practice waiting rooms? See results in Table 15 below.

Table 15: GP Survey question items.

Survey question (N=21)	Frequency (n)	Percent %	Mean (SD)
1. Percentage of workload is mental health			
0-15%	11	52	
16-30%	6	29	
31-51%	4	19	
>51%	0	0	
2. Confidence to support MH & SI (1=Not confident to 4=Very confident)	-	-	2.48 (0.68)
3. Which SP programs attended			
a. ASSIST	0	0	
b. QPR	0	0	
c. SCRAM ED	0	0	
d. APS	0	0	
e. Black Dog	0	0	
f. CwP	0	0	
g. No training	14	70	
h. Other*	6	30	
4. Interest to learn specialist MH and SP			
Yes	16	76	
No	4	19	
5. Connectedness with the MH system (1=Not connected to 4=Very connected)	-	-	2.50 (0.76)
6. Do you have MH referral pathways			
Yes	15	71	
No	5	24	
7. Interested to learn about local MH services			
Yes	16	76	
No	4	19	
Interested eMH screening			
Yes	9	43	
No	6	29	
Unsure	5	24	

*Other Specify: Mental Health First Aid; One in 2017 at KMA, can't remember the name, was not helpful. Learned much more on the job and on psych term as RMO and through working across different EDs; GP training + training with my supervisor who has developed suicide prevention programs himself; Undergraduate and post graduate counselling training over the years; GP Focused psychological strategy skills training; Adolescent Mental Health training.

3.2.3 General Practitioner consultation survey: Qualitative findings

Of the 21 survey respondents, 90% (*n*=19) provided responses to the question asking about the *key barriers to supporting people experiencing mental health difficulties including thoughts of suicide.* The most frequent barrier to supporting people with mental health challenges was reported to be lack of access and availability of services and help, including lack of human resources (100%). Time to assess people requiring mental health assistance, particularly those at risk of suicide was reported as

a barrier (26%), as was the reluctance of some people to seek help (16%). Refer to Table 16 for further detail.

The GP Consultation Survey was conducted in 2018, thus, it is timely to conduct another GP consultation and compare any change in findings in light of all of the trainings, events and activities implemented during the National Suicide Prevention Trial.

Table 16: GP Consultation Survey: Barriers to supporting people experiencing mental health difficulties and suicidal thoughts

Barriers to supporting people [a]	***n*=19**	**%**
Lack of access & availability of help (including human resources, telephone access only)	19	100
Time to assess (extraordinary wait times, assessment itself takes a lot of time)	5	26
Reluctance to seek help (not wanting help)	3	16
Financial (no bulk billing, no $$ support for carers, cost of private services)	2	11
Geographical isolation (from specialist facilities, lack of telelink services)	2	11
Not wanting help (patients reluctant to see mental health professionals)	2	11
Reactive nature of services (rather than proactive)	2	11
Nature of the work (Dr energy, can be emotionally draining seeing consecutive mental health patients, even if enjoy mental health practice)	1	5
Lack of knowledge & understanding (of mental health issues)	1	5
Poor services (& lack of variable options)	1	5
Prompt discharge	1	5
Reluctance to help (not wanting *to* help)	1	5
Ongoing stigma	1	5
Admission to hospital (no further comment was provided)	1	5
Bureaucracy (discontinuing a successful program)	1	5
Difficulties assessing (poor correlation between assessment tools & risk of suicide)	1	5

[a] Respondents gave more than one response in a number of areas

3.3 Youth Consultation Report

The Excel data file 'Youth Suicide Prevention Survey_numerical.xlsx' was imported into SPSS version 26 and analysed.

3.3.1 Sample Characteristics

After data cleaning, there were 215 valid respondents and data was collected from 31st August to 11th November 2018. The majority lived in the Port Lincoln LGA (31.2%), while the other LGAs were represented by between 13 and 18% of participants. The majority were aged between 16- 16 years (28.8%) and 17-18 years (23.7%), followed by 14% aged between 12-14 and less than ten percent each in the remaining age groups. 87.9% did not identify as Aboriginal or Torres Strait Islander, 8.8% did and 3.3% preferred not to say. 66.5% identified as female and 29.8% identified as male, 1.4% were non-binary, 0.5% said unsure, and 0.9% preferred not to say. See Tables 17 to 20.

Table 17: Participant ages

Age range	Frequency	Percent
12-14 years	30	14.0
15-16 years	62	28.8
17-18 years	51	23.7
19-20 years	16	7.4
21-22 years	13	6.0
23-24 years	14	6.5
25 years	10	4.7
26+ years	19	8.8
Total	215	100.0

Table 18: Cultural identity

Aboriginal or Torres Strait Islander identity	Frequency	Percent
No	189	87.9
Yes, Aboriginal	19	8.8
Prefer not to say	7	3.3
Total	215	100.0

Table 19: Gender

Gender		Frequency	Percent
	Male	64	29.8
	Female	143	66.5
	Non-Binary	3	1.4
	Unsure	1	.5
	Prefer not to say	2	.9
	Total	213	99.1
Missing		2	.9
Total		215	100.0

Table 20: Sexuality

Sexuality		Frequency	Percent
	Heterosexual (Straight)	176	81.9
	Lesbian	2	.9
	Gay	3	1.4
	Bisexual	16	7.4
	Unsure	7	3.3
	Prefer not to say	4	1.9
	Other	7	3.3
	Total	215	100.0

3.3.2 Experience of Suicide.

Twenty two percent had not been impacted by suicide and 78% did not respond to this question. However, 43.7% reported experiencing suicidal thoughts, 19% had attempted suicide, 35% had cared for someone who attempted suicide, 25% were bereaved by suicide and 11% reported being impacted by suicide in other ways. A greater proportion of respondents left these question items unanswered see Table 21.

Table 21: Proportion of people impacted by suicide

Respondents' impacted by suicide	Frequency	Percent
No	47	21.9
Missing	168	78.1
Total	338	100.0

3.3.3 Experience of mental illness

The proportion of youth who had sought help for mental health problems are shown in Table 22.

Table 22: Prior help-seeking

I have sought help for mental health issues in the past		Frequency	Percent
	Yes	112	52.1
	No	102	47.4
	Total	214	99.5
Missing		1	.5
Total		215	100.0

3.3.4 Help-seeking

Of the youth who had sought help, most had sought help from a friend (24%), parent (22%), boyfriend or girlfriend (13%), psychologist (17%), 16.3% from a counsellor, 14.9% from a GP, 7.9% from a teacher, 14.9% from a School Counsellor, 9.8% from an 'other mental health professional', 8.4% from 'other family', 4.2% from an 'other trusted adult'.

3.3.5 Help-seeking from adults

If adults helped young people the survey asked firstly, whether support was provided and 33.5% responded yes, 3.7% responded no, and 4.2% indicated not applicable, the remaining 58.9% did not respond. Secondly, young people were asked whether help-seeking helped youth to get through the situation 24.7% responded yes, 7.4% responded no, and 8.4% indicated not applicable, the

remaining 59.5% did not respond. 6.5% of young people indicated that help-seeking made things worse, 26.5% answered no to this question, and 7.4% indicated not applicable, the remaining 59.5% did not respond. Finally, 23.3% of youth said that they were more likely to go to an adult for help, 9.3% responded that they would not, 7.9% indicated not applicable, and 59.5% did not respond to this item.

3.3.6 Help-seeking from local services

The same questions were asked about local services with greater than 50% not responding to these survey items. The survey asked firstly, whether support was provided 18.6% responded yes, 3.7% responded no, and 18.6 responded not applicable. Secondly, whether help-seeking helped young people to get through the situation 15.8% responded yes, 5.6% responded no, and 18.6% responded not applicable. Thirteen youth (6%) indicated that help-seeking made things worse, 15.3% answered no to this question, and 18.6% responded not applicable. 38 youth (17.7%) said that they were more likely to go to a local service for help, 5.1% responded that they would not, and 18.1% indicated not applicable to this item. Finally, 12.6% of young people said they were still engaged with their local service, 24.1% said no, 7% reported not applicable and almost 60% did not respond.

3.3.7 Perception of suicide risk and reasons for youth suicide

Young people were asked what the level of suicide risk is in your community, and with response options of 1='Very high' 2='High', 3='Unsure', 4='Low' and 5='Very low' the mean score was 2.41 (SD=0.89). When asked which groups of young people they thought were most at risk of suicide and highest proportion (49.3%) indicated all young people are equally at risk, see Table 23.

Table 23: Perception of risk

The group of young people who are perceived most at risk of suicide		Frequency	Percent
	All young people equally	106	49.3
	Young people affected by violence	25	11.6
	LGBTIQA+ youth	22	10.2
	Aboriginal & Torres Strait Islander Youth	3	1.4
	Young people bereaved by suicide	9	4.2
	Youth at risk of homelessness	3	1.4
	Young women	4	1.9
	Young men	5	2.3
	Total	177	82.3
Missing		38	17.7
Total		215	100.0

When asked what the reasons were for youth suicide, respondents were given the following choices and more than one survey item could apply, see Table 24.

Table 24: Respondents' perceptions of reasons for youth suicide

Perceived reasons for youth suicide (N=215)	Frequency	Percent
Books, TV or movies	39	18.1
Loneliness or isolation	143	66.5
To get attention	42	19.5
Stress	140	65.1
Depression	159	74.0
Mental illness	149	69.3
Bullying	158	73.5
Abuse or violence	138	64.2
Drug or alcohol use	118	54.9
Relationship issues/breakdown	121	56.3
Lack of access to services	85	39.5
None of the above	2	0.90
Other	14	6.5
Total responses	1308	-

3.3.8 Help-seeking if feeling suicidal

Youth were asked if they would seek help if feeling suicidal with response options 1=Very likely, 2=Likely, 3=Unsure, 4=Unlikely, 5=Very unlikely and the mean score was 2.62 (SD=1.22). Following this, the next question item asked respondents who they would feel comfortable seeking help from if feeling suicidal, and response options are listed in Table 25 with the results alongside.

Table 25: Who youth seek help from

If feeling suicidal, most comfortable seeking help from (N=215)	Frequency	Percent
Friends	117	54.4
Parents	65	30.2
Internet	25	11.6
Relative/family friend	45	20.9
Brother/sister	32	14.9
School Counsellor	40	18.6
Teacher	23	10.7
Online counselling	33	15.3
Telephone hotline	18	8.4
Community agency	26	12.1
Magazines	2	0.90
Total responses	426	-

Next, youth were asked if they would be interested in participating in suicide prevention training, 48.8% responded yes, 24.2% said no, and 27% did not respond to this question. Of the youth who were interested, they were asked where they would feel more comfortable attending. The results are presented in Table 26.

Table 26: Preferred locations for suicide prevention training

Proportion of youth most comfortable attending suicide prevention training at the listed locations		Frequency	Percent
	School	34	15.8
	Sporting Club	18	8.4
	headspace	50	23.3
	Church	8	3.7
	Online	40	18.6
	Other	15	7.0
	Total responses	156	-

Finally, young people were asked whose responsibility it was to reduce youth suicide and the results are shown in Table 27 where almost 20% of respondents thought it was up to the individual to seek help.

Table 27: Perceptions of responsibility to reduce youth suicide

To reduce youth suicide, the responsibility is		Frequency	Percent
	Individuals themselves	41	19.1
	Community Services	20	9.3
	Healthcare system	19	8.8
	Schools & Teachers	11	5.1
	Families	29	13.5
	Government	13	6.0
	Other	27	12.6
	Total responses	160	74.4
Missing		55	25.6
Total		215	100.0

3.3.9 Youth consultation survey: Qualitative findings

Of the 233 survey respondents, 63% (n=147) provided responses to the questions related to the main barriers restricting young people from seeking help from a service in their community, and the most important things that can be done to reduce youth suicide in their community.

The most frequent barrier reported by respondents was stigma (31%), followed by fear of judgement (16%), lack of resources (17%) such as access to services and health professionals, and lack of knowledge (16%) such as of services available, where to seek help, and from whom. In addition, many young people did not feel comfortable asking for help (11%). Refer to Table 28 for further details.

Table 28: Youth Consultation Survey: Main barriers restricting young people from seeking help

Barriers [a]	***n=147***	**%**
Stigma	46	31
Fear of judgement (of being 'weird', feeling of being weak)	24	16
Lack of resources (access, people, services, wait lists)	17	12
Lack of knowledge (of services, places to go, of the right people)	16	11
Fear of asking for help (don't feel comfortable, of opening up & being honest)	11	7
Low self esteem (aren't important enough, a burden, no one cares)	8	5
Own beliefs (don't want to talk, want to fix it myself, nervousness)	8	5
Feeling of isolation (people don't' understand, won't get help, don't know who to talk to, unmotivated	6	4
Social and peer pressure (bullying)	6	4
Fear of the reaction/response (family response, how services will respond)	6	4
Mental health issue(s) (depression	3	2
Money (parental permission, no money for transport/services)	2	1
Overprotective parents	2	1
Lack of trust	2	1
Low self-awareness (of how bad the situation is, can get through by myself)	2	1
Scared	2	1
Fear no one will listen	1	0.7
Fear of handling/identifying emotions	1	0.7
Fear of privacy being exposed	1	0.7

[a] Respondents gave more than one response in a number of areas

The most frequent area reported to address to reduce youth suicide was awareness raising (32%) by talking about mental health and suicide and providing education and training, followed by youth access to help and support (32%) such as increasing access and the number of youth services available. Non-violence (16%) was reported as an area to address by tackling bullying, violence in the home, and being "nice". Talking to someone you can trust (11%) and building stronger community relationships (10%) were also seen as important. Refer to Table 29 for areas to address for reducing youth suicide.

Table 29: Youth Consultation Survey: Most important things that can be done to reduce youth suicide

Areas to address to reduce youth suicide [a]	***n=147***	**%**
Awareness raising (of mental health, that they can be helped, education)	32	22
Youth access to help & support (increase access, more services & programs)	32	22
Non-violence (reducing bullying, home violence, being nice)	16	11
Talk to someone you trust	11	7
Stronger community relationships (educate everyone about how to treat others, keep everyone engaged, make the town safer)	10	6
Help seeking (encourage youth to ask for and get help)	7	4
Advertising helplines (promoting helplines & services e.g., in schools)	7	4
Openness (more open conversations about mental health, listening)	5	3
Acknowledgement (acknowledge & empower youth, confidentiality)	3	2
Youth activities (inclusive & safer places to go)	3	2
Drug and Alcohol awareness (including checking parents for substances)	3	2
Face to face (a physical location for help, especially for face-to-face counselling)	2	1
Supported accommodation (Places to stay for youth with no support)	2	1
Ask if they are OK (make sure others are OK)	2	1
Ask them (ask young people what the need)	1	0.7
A break/time away (a way to get away for a bit)	1	0.7

[a] Respondents gave more than one response in a number of areas

The Youth Consultation Survey was conducted in 2018, thus, it is timely to conduct another youth consultation and compare any change in findings in light of all of the trainings, events and activities implemented during the National Suicide Prevention Trial.

3.4 Aftercare Service Primary Mental Health Care Minimum Data Set

3.4.1 Key findings

1. Suicidal Ideation Attributes Scale scores were static at the review point and therefore partway through their episode of care and no trends over time can be interpreted. It is important to note that the highest scores on the SIDAS at this time point was 'control over thoughts' with a mean score of 5.52 (SD 3.14) and all other mean symptom scores were less than five out of 10.
2. K10 psychological distress scores reduced progressively over three time points during one episode of care per client indicating successful aftercare treatment.

3.4.2 Data cleaning

Excel spreadsheets x 11 titled: 'cobh_nspt_2018-01-01_to_2020-12-21_generated_2020-12-21'; were imported into SPSS software to examine number service contacts; demographics; suicide, depression K10+ and SINAS scales. The date range of the data collected was from 01/01/2018 to 21/12/2021. An 'episode' of care starts at the point of first contact and concludes at discharge. Episodes comprise a series of one or more service contacts.

3.4.3 Service Contacts – type and location

There were 3212 contacts recorded within the three-year timeframe. Almost half of all contacts were for psychosocial support (49.7%), a further 22% were for assessment, 14% were for clinical care coordination or liaison and the remaining contacts were for specific psychological interventions, clinical nursing services and suicide prevention assistance. The highest proportion of contacts were for larger regional centres which may reflect the need for people in very remote areas to come to regional towns for services. Unfortunately, 68% did not state their postcode. However, the remaining towns represented the highest number of contacts were Whyalla Norrie/Stuart (10.6%), Port Pirie (8.1%), Wallaroo/Kadina (4.9%), Port Lincoln (3.9%) and Port Augusta (1.7%). See Tables 30 and 31 and Figure 1.

Table 30: Service contact type.

Service contact type	Frequency	Percent
No contact took place	349	10.9
Assessment	711	22.1
Structured psychological intervention	2	.1
Other psychological intervention	79	2.5
Clinical care coordination or liaison	454	14.1
Clinical nursing services	13	.4
Suicide prevention specific assistance NEC	7	.2
Psychosocial support	1597	49.7
Total	3212	100.0

Figure 1: Type of service contact.

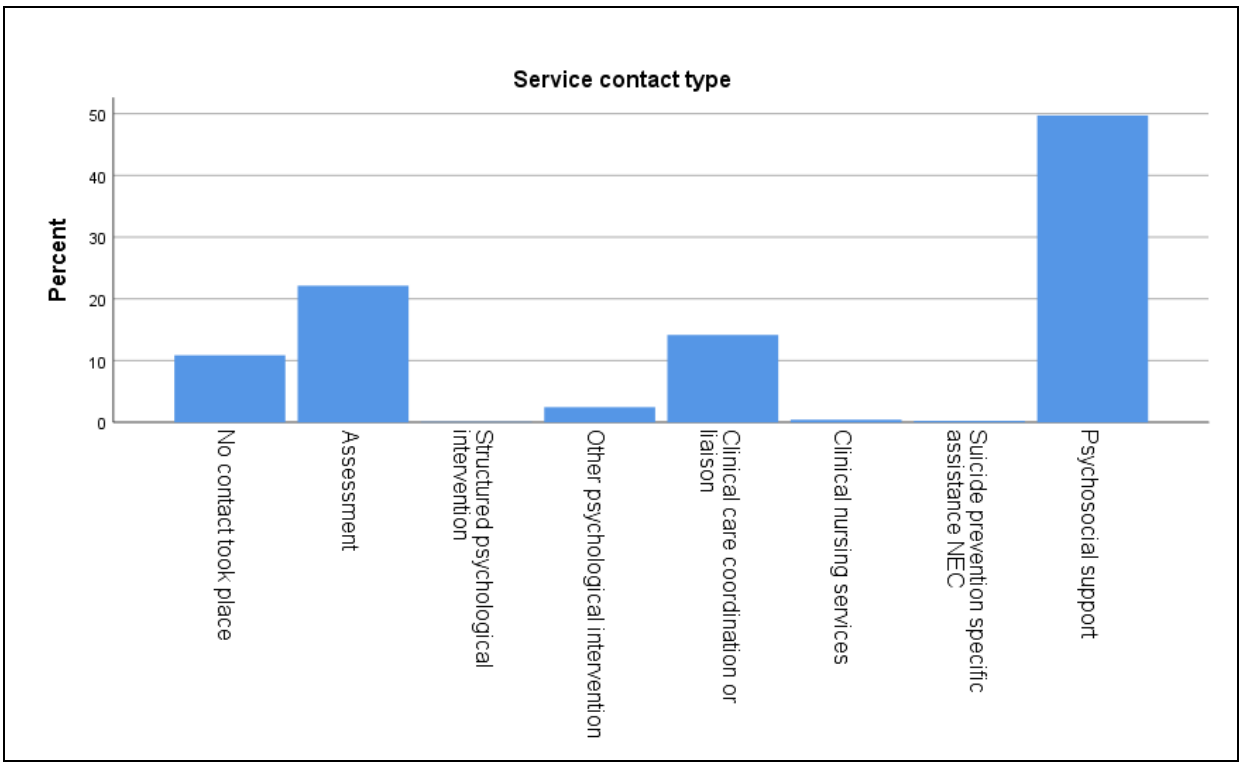


Table 31: Service contact region.

Postcode	Region	Frequency	Percent
5522	Upper Yorke Peninsula	10	.3
5540	**Port Pirie**	**260**	**8.1**
5552	Upper Yorke Peninsula	1	.0
5554	**Wallaroo, Kadina**	**131**	**4.1**
5556	**Wallaroo, Kadina**	**26**	**.8**
5558	Moonta, Moonta Bay	4	.1
5560	Bute	2	.1
5571	Ardrossan	14	.4
5572	Arthurton, Port Arthur	3	.1
5573	Point Pearce, Maitland, Port Victoria	13	.4
5576	Lower Yorke Peninsula, Yorketown	8	.2
5600	Whyalla	11	.3
5605	Tumby Bay, Butler	8	.2
5606	**Port Lincoln**	**124**	**3.9**
5607	Lower Eyre Peninsula	4	.1
5608	**Whyalla Norrie/Stuart**	**339**	**10.6**
5609	Whyalla Jenkins	1	.0
5631	Cummins	2	.1
5652	Wudinna	1	.0

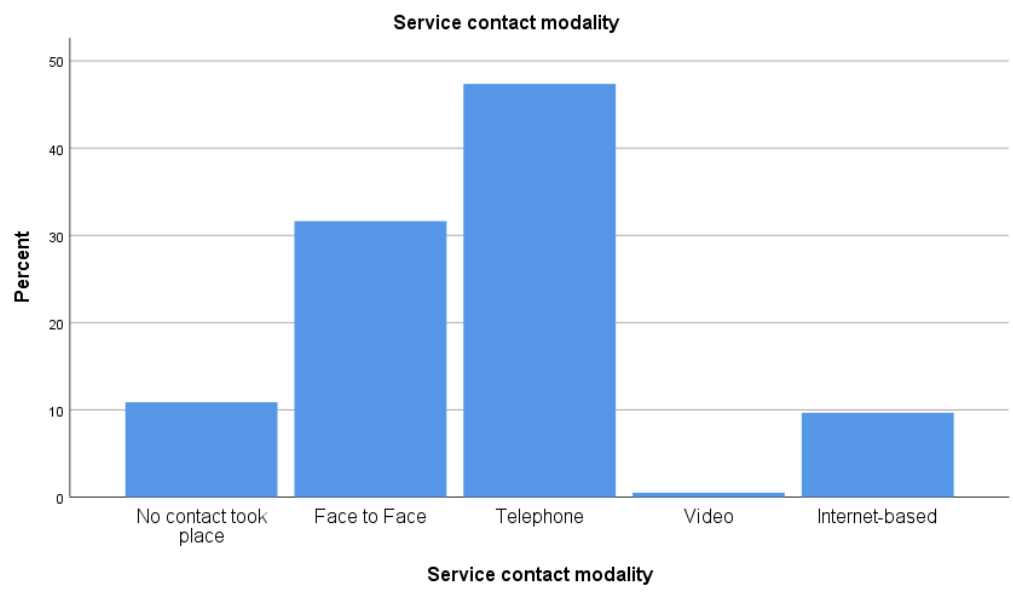
	5700	**Port Augusta**	**54**	**1.7**
	9999	Not stated	2196	68.4
	Total		3212	100.0

3.4.4 Service Contacts – modality and venue

Service contact modality was predominantly by telephone (47.4%) and face-to-face (31.6%), while fewer contacts were via internet (9.7%) and videoconference (0.5%), see Figure 2. Aftercare service participants were mostly individual clients (84.0%), some were families (2.4%), client groups (0.3%), and 'other' (13.3%). Since most service contacts were via telephone the service contact venue was not applicable (61.5%), however most face-to-face contacts occurred in the service provider's office 27.2%), the client's home (2.7%), or 'other location' (5.2%) most likely in a public place such as a library or café.

Figure 2: Mode of service contact.

Mode of service contact



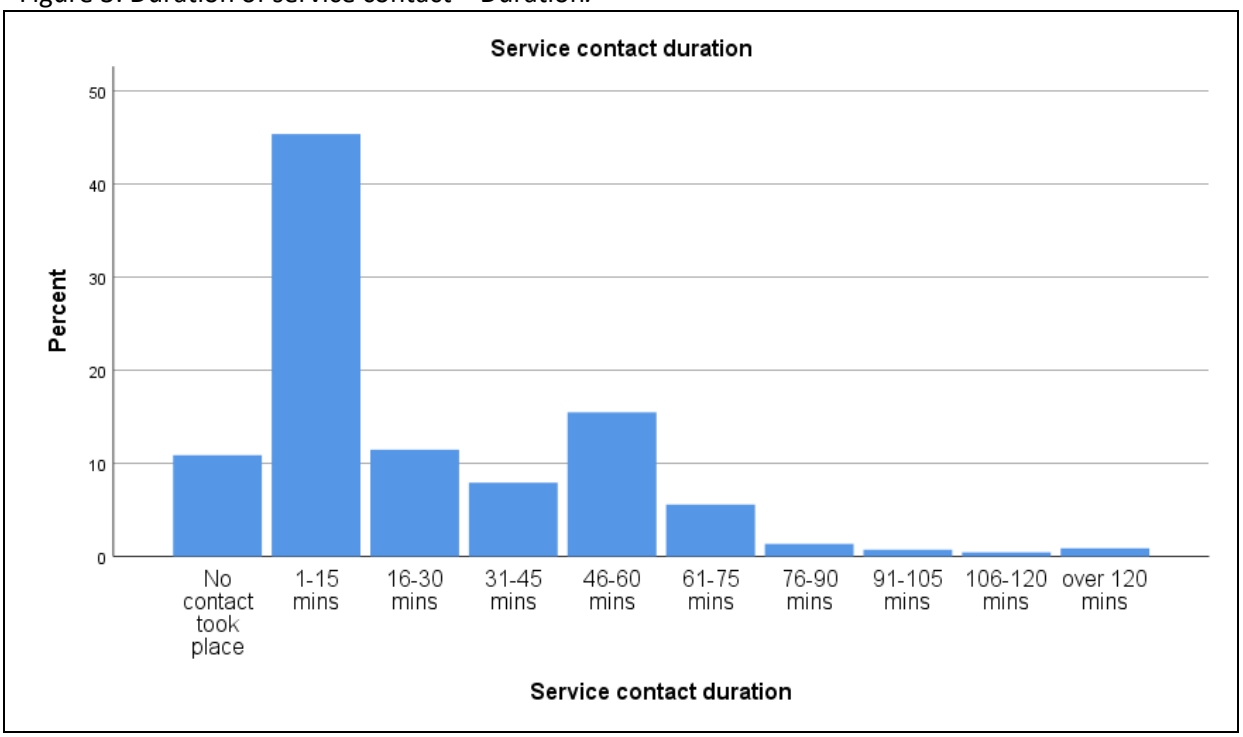
3.4.5 Service Contacts – duration and participation

Most contacts were of 1 to 15 minutes duration (45.4%), followed by 46 to 60 minutes (15.5%), then 16 to 30 minutes (11.5%), and 31 to 45 minutes (7.9%), please see Table 32 and Figure 3 below. Results indicated that most clients attending participated in the contact session (86.5%), while fewer did not participate (13.5%). Non-participation may have been due to reasons such as involuntary treatment, severe symptoms, cultural differences, or impaired ability to cope. In almost all instances an interpreter was not utilised (96.7%), less than 1% did use an interpreter and almost 3% indicated 'not stated'. Most contacts did attend their appointments (89.1%), while 10.1% were recorded as 'no shows'. Most contacts were in the middle of their episode of care (90.6%), 3% were not requiring any further service contact, and 6.4% for this item was unknown.

Table 32: Duration of service contact – Frequency.

Duration	Frequency	Percent
No contact took place	349	10.9
1-15 mins	1457	45.4
16-30 mins	368	11.5
31-45 mins	254	7.9
46-60 mins	497	15.5
61-75 mins	179	5.6
76-90 mins	43	1.3
91-105 mins	23	.7
106-120 mins	14	.4
over 120 mins	28	.9
Total	3212	100.0

Figure 3: Duration of service contact – Duration.



3.4.6 NSPT Episodes

3.4.6.1 Sample Characteristics

Tables 33 to 43 and Figures 4 to 6 show the sample characteristics, the lifetime history of suicide attempt or ideation, the main focus of therapy provided by the NSPT Aftercare service, other services being accessed by the service user and the referrals to other services made during the episode of care.

Table 33: Gender.

	Gender	Frequency	Percent
	Not stated	1	.5
	Male	96	45.9
	Female	108	51.7
	Other	4	1.9
	Total	209	100.0

Figure 4: Gender distribution.

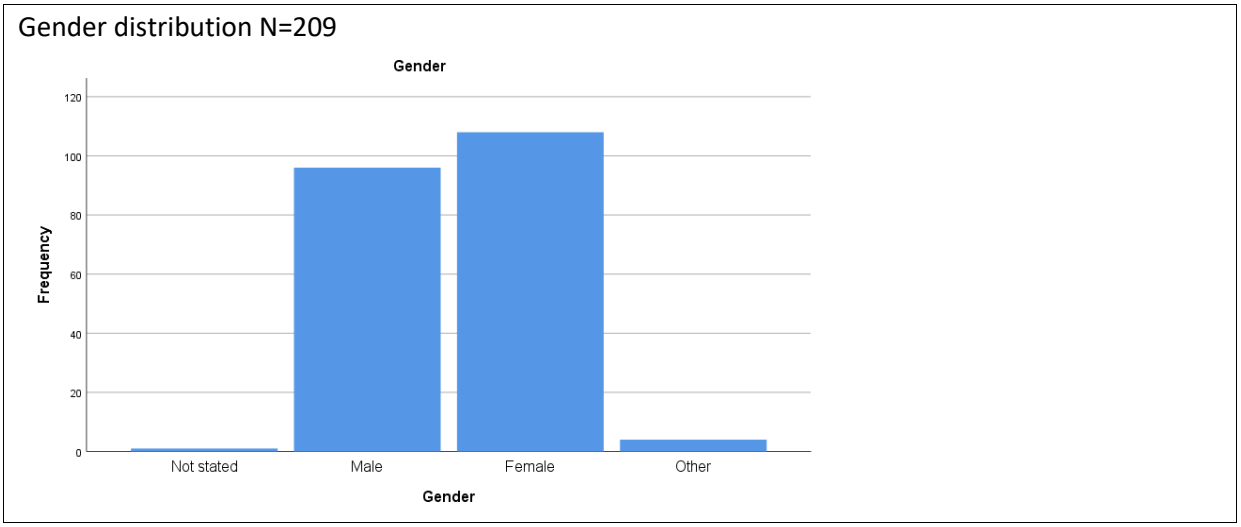


Table 34: Age groups.

Age groups	Frequency (n)	Percent
17-20 years	26	12.4
21-30 years	47	22.5
31-40 years	48	23.0
41-50 years	41	19.6
51-60 years	24	11.5
61-70 years	13	6.2
71-80 years	6	2.9
80+ years	4	1.9
Total	209	100.0

Figure 5: Age groups.

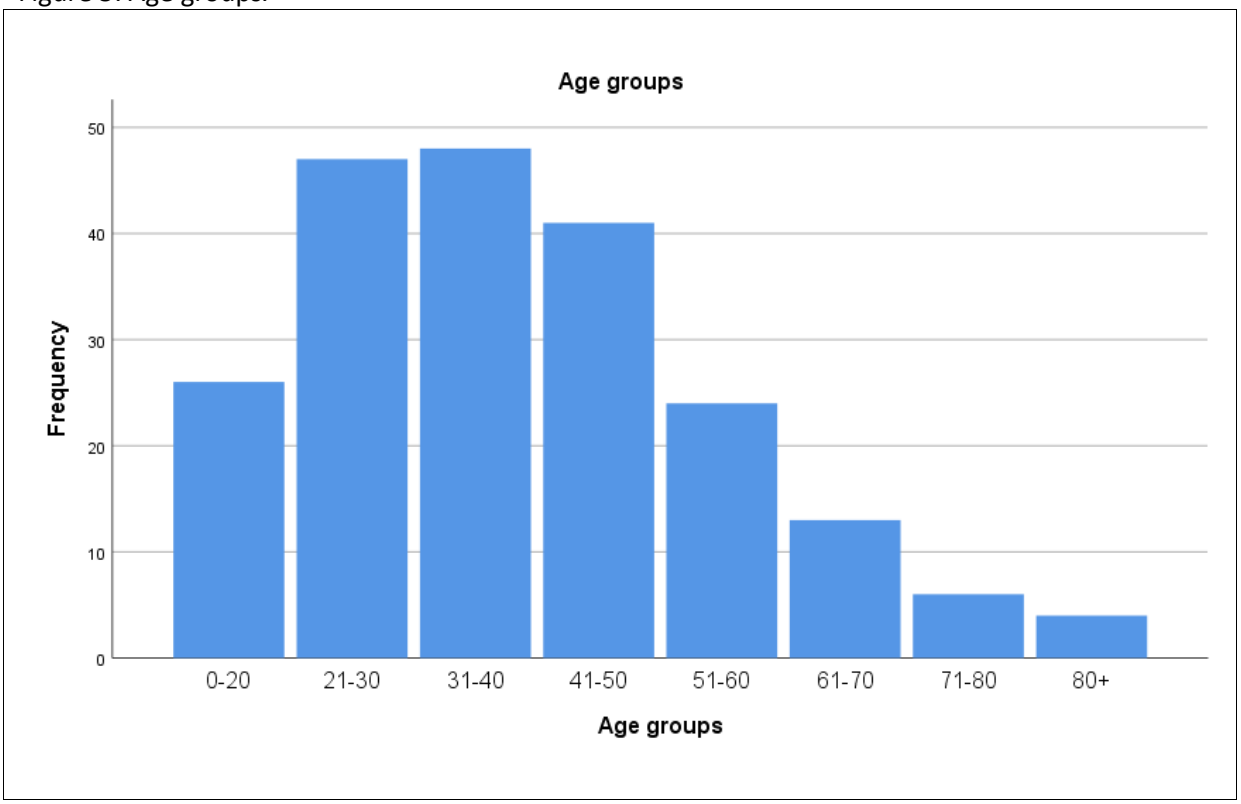


Table 35: Cultural identity.

Cultural identity	Frequency (n)	Percent
Aboriginal but not Torres Strait Islander origin	18	8.6
Torres Strait Islander but not Aboriginal origin	2	1.0
Both Aboriginal and Torres Strait Islander origin	2	1.0
Neither Aboriginal nor Torres Strait Islander origin	114	54.5
Not stated	73	34.9
Total	209	100.0

Table 36: Sexual identity.

	Sexual identity	Frequency (n)	Percent
	Lesbian, gay or homosexual	6	2.4
	Straight or heterosexual	150	61.2
	Bisexual	1	.4
	Something else	7	2.9
	Don't know	25	10.2
	Not stated	55	22.4
	Total	244	99.6
	Missing	1	.4
Total		245	100.0

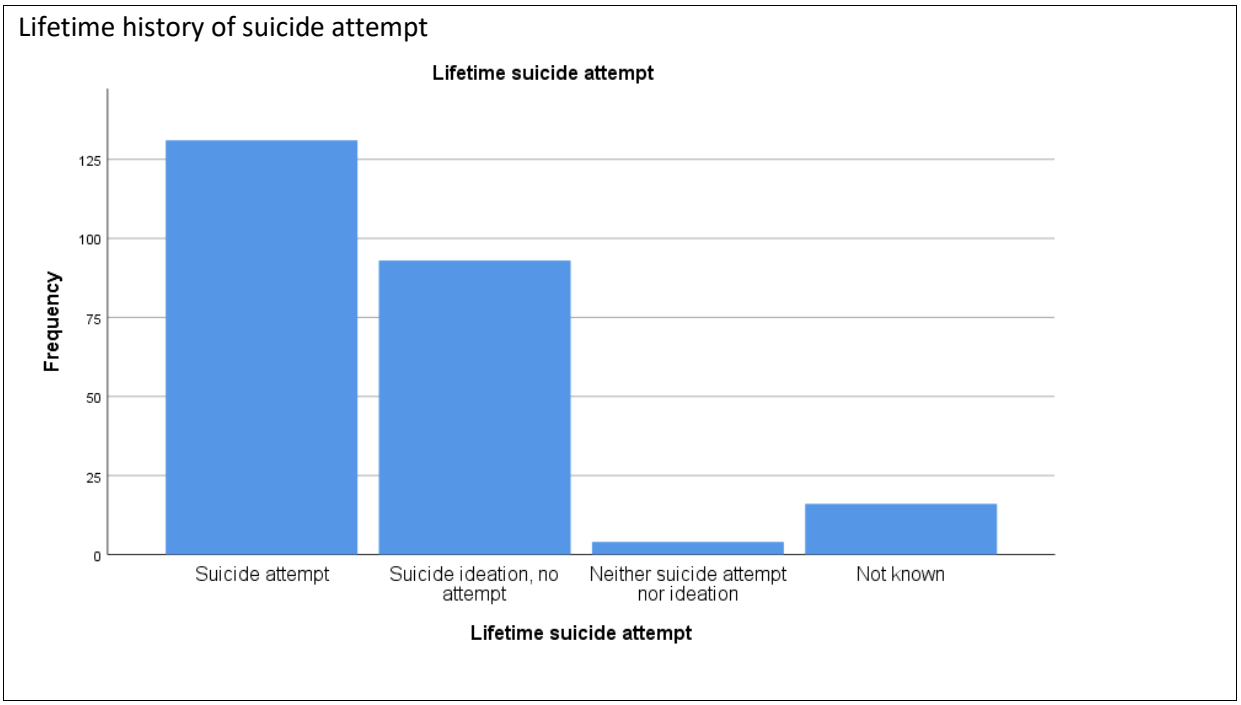
Table 37: Veteran status.

	Veteran status	Frequency (n)	Percent
	Yes	2	.8
	No	211	86.1
	Unknown	31	12.7
	Total	244	99.6
	Missing	1	.4
Total		245	100.0

Table 38: Lifetime history of suicide attempt.

	Lifetime history of suicide attempt	Frequency (n)	Percent
	Suicide attempt	131	53.5
	Suicide ideation, no attempt	93	38.0
	Neither suicide attempt nor ideation	4	1.6
	Not known	16	6.5
	Total	244	99.6
	Missing	1	.4
Total		245	100.0

Figure 6: Lifetime history of suicide attempt.



3.4.7 Types of service and referral

Table 39: Main focus of therapy.

Main focus of therapy		Frequency (n)	Percent
	Suicide Mitigation	172	70.2
	Postvention	63	25.7
	Other support	9	3.7
	Total	244	99.6
	Missing	1	.4
Total		245	100.0

Figure 7: Main treatment focus.

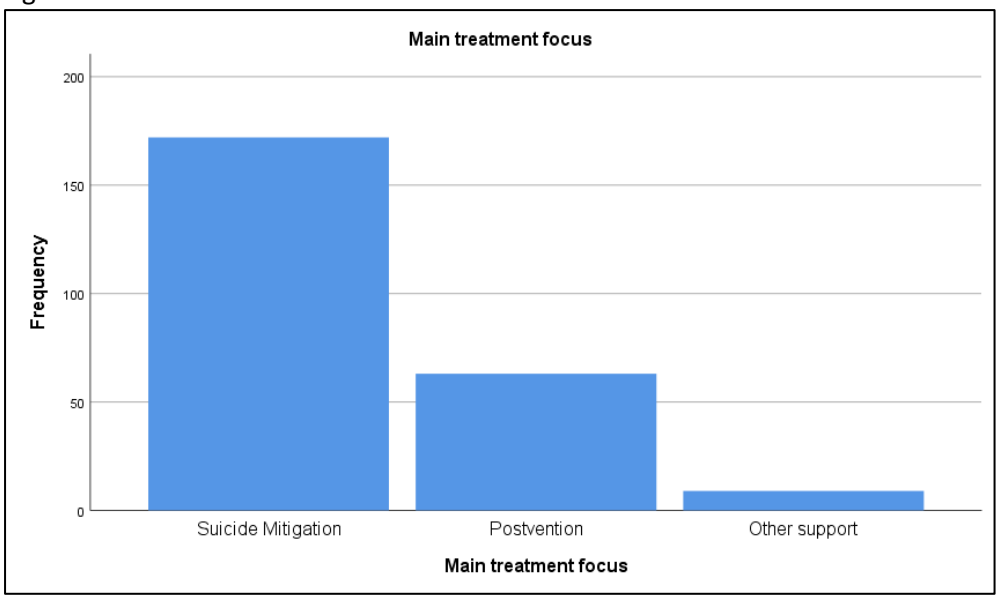


Table 40: Other services used in the last six months.

Services		Frequency (n)	Percent
	None	3	1.2
	General Practice	50	20.4
	Public mental health service	4	1.6
	Public Hospital	2	.8
	Drug and Alcohol Service	2	.8
	Primary or Secondary School	1	.4
	PHN psychological therapies	1	.4
	Other	2	.8
	Not stated	6	2.4
	Total	71	29.0
	Missing	174	71.0
Total		245	100.0

Table 41: Referrals made during entire episode of care.

Referrals		Frequency (n)	Percent
	None	13	5.3
	General Practice	21	8.6
	Public mental health service	5	2.0
	Drug and Alcohol Service	4	1.6
	Community Support Organisation NFP	14	5.7
	Indigenous Health Organisation	1	.4
	Telephone helpline	22	9.0
	Digital health service	1	.4
	Family Support Service	1	.4
	PHN psychological therapies	8	3.3
	Other	4	1.6
	Not stated	43	17.6
	Total	137	55.9
Missing	System	108	44.1
Total		245	100.0

Table 42: Referrer profession.

Profession	Frequency (n)	Percent
General Practitioner	16	6.6
Psychiatrist	1	.4
Other Medical Specialist	4	1.6
Maternal Health Nurse	6	2.5
Psychologist	2	.8
Mental Health Nurse	42	17.2
Social Worker	21	8.6
Occupational therapist	2	.8
Educational professional	5	2.0
Early childhood service worker	1	.4
Other	79	32.4
Not applicable - Self referral	50	20.5
Not stated	15	6.1
Total	244	100.0

Figure 8: Referrer profession.

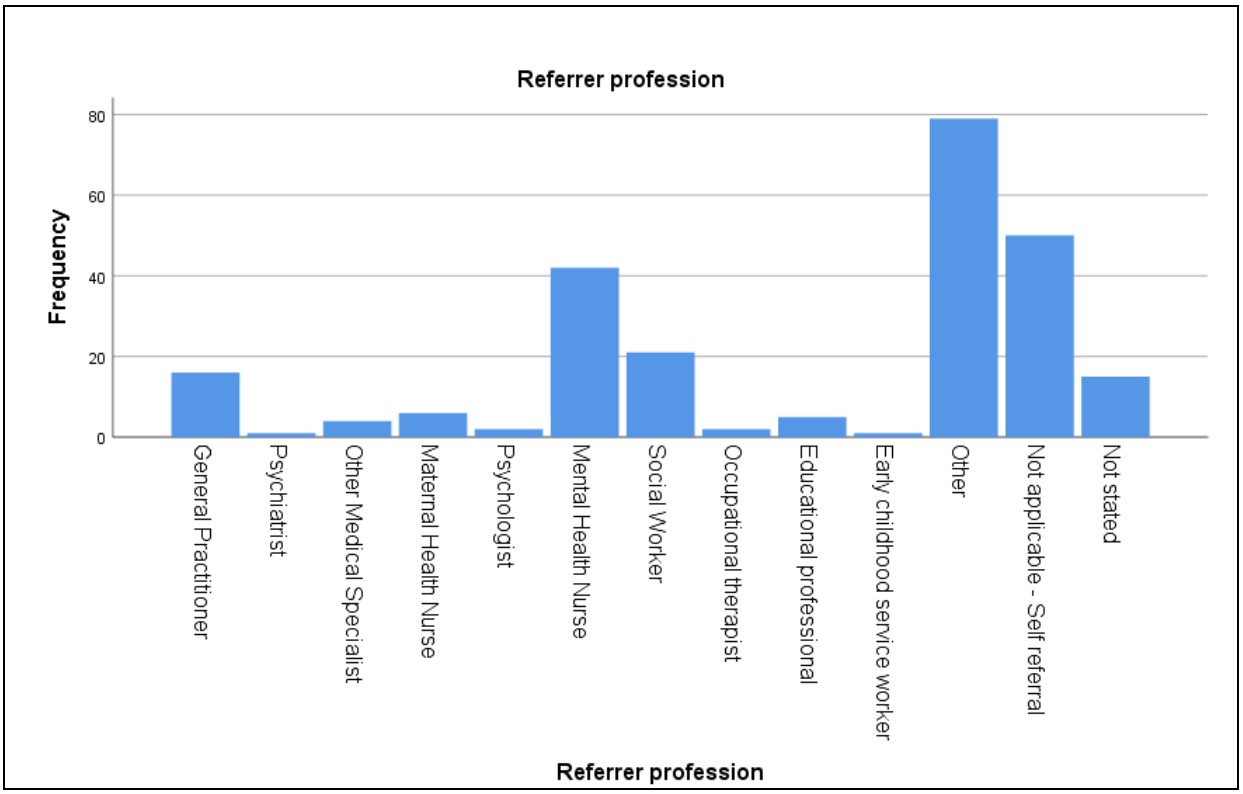


Table 43: Referrer organisation type.

Organisation type	Frequency (n)	Percent
Public mental health service	3	1.2
Community Support Organisation NFP	2	.8
Other	2	.8
Not applicable - Self referral	50	20.5
Not stated	187	76.6
Total	244	100.0

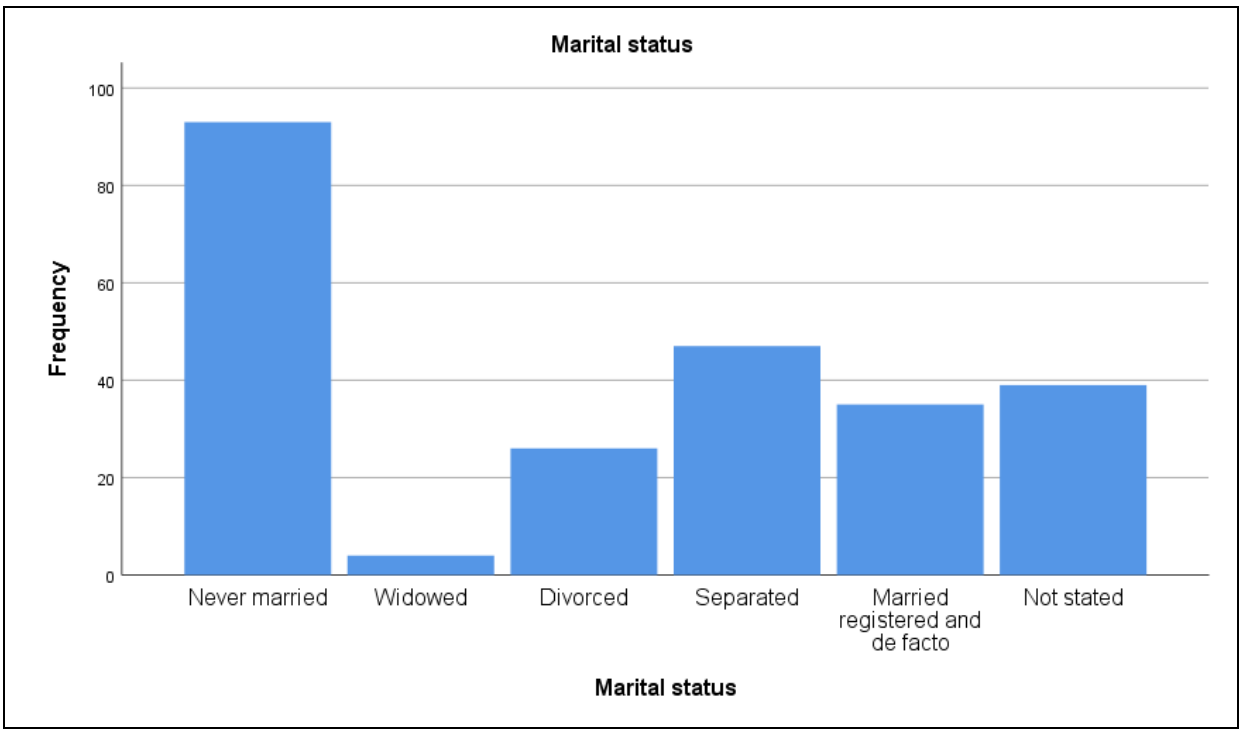
3.4.8 Service provision

Of the 244 registered in this time period, the principal focus of service was low intensity psychological intervention (26%), psychological support (0.4%) and other focus not stated (74%). Fifty percent had a mental health treatment plan, 25% had not, and 25% were not stated.

3.4.9 Social factors – Marital status, homelessness, employment and income

Thirty eight percent had never married, 2% were widowed, 11% were divorced, 19% were separated, 14% were married or de facto, and 16% did not answer. Most were not homeless (86%), 8% were in short-term or emergency accommodation, 3% were sleeping rough, and 4% were not stated. Thirty eight percent had a health care card, 11% did not, for 36% it was not known, and 15% it was not stated. Six percent were National Disability Insurance Scheme participants, 78% were not, and 16% were not stated.

Figure 9: Marital status.



Tables 44 to 46 and Figures 10 and 11 show Aftercare service clients' labour force, employment status and income sources. Almost 30% were unemployed or not in the labour force (40.6%), 17.2% were employed and 12.3% were not stated. The majority were either on the Disability Support Pension (17.2%) or 'other pension or benefit' (37.7%).

Table 44: Labour force status.

Labour force status	Frequency (n)	Percent
Employed	42	17.2
Unemployed	73	29.9
Not in the Labour Force	99	40.6
Not stated	30	12.3
Total	244	100.0

Figure 10: Labour force status.

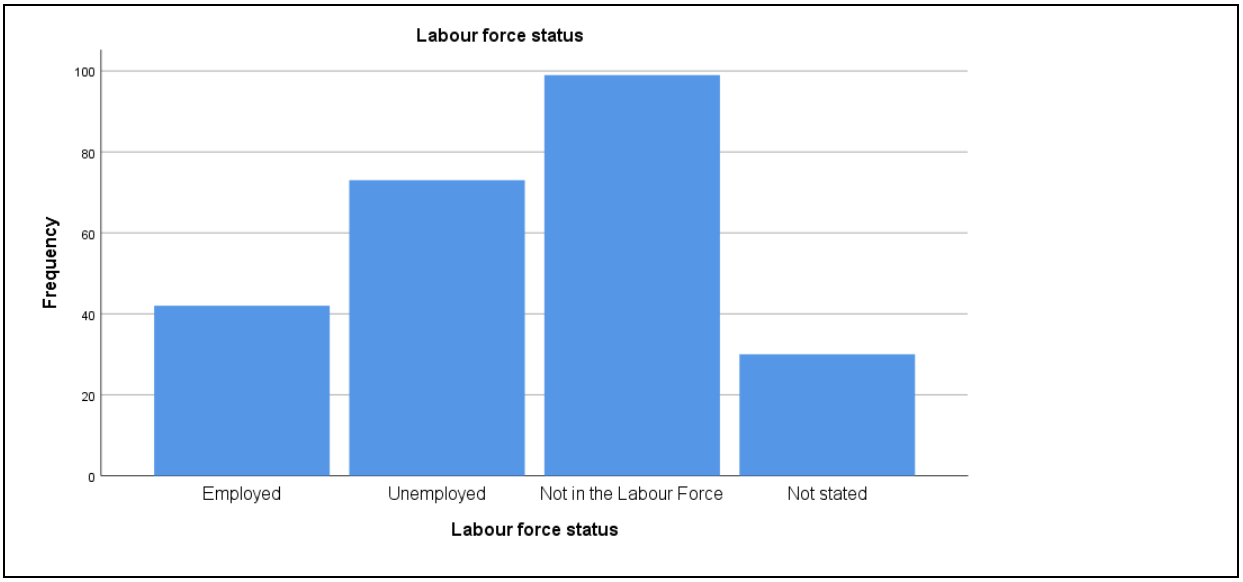


Table 45: Employment.

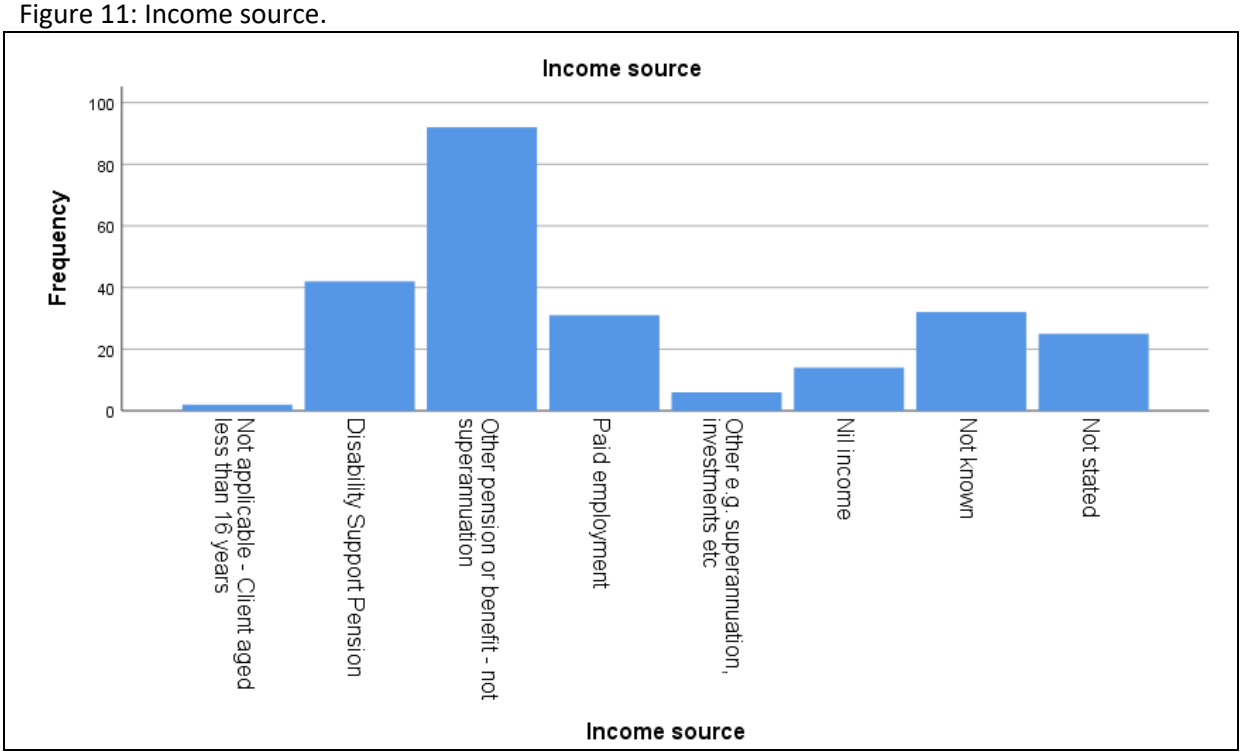
Employment	Frequency (n)	Percent
Full-time	14	5.7
Part-time	23	9.4
Not applicable - not in Labour force	164	67.2
Not stated/inadequately described	43	17.6
Total	244	100.0

Table 46: Income source.

Income source	Frequency (n)	Percent

	Not applicable - Client aged less than 16 years	2	.8
	Disability Support Pension	42	17.2
	Other pension or benefit - not superannuation	92	37.7
	Paid employment	31	12.7
	Other e.g. superannuation, investments etc.	6	2.5
	Nil income	14	5.7
	Not known	32	13.1
	Not stated	25	10.2
	Total	244	100.0

Figure 11: Income source.



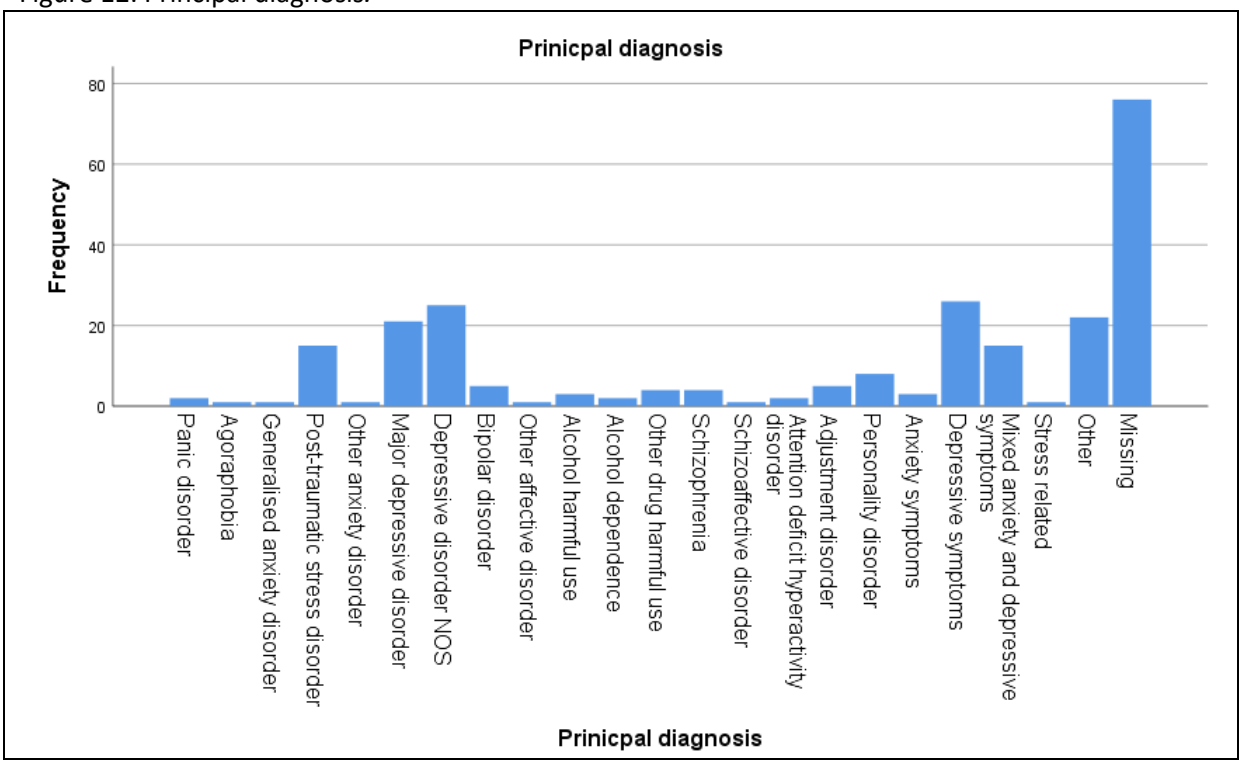
3.4.9 Diagnosis

The principal diagnoses were primarily depression related, i.e., depressive symptoms (10.7%), depressive disorder not otherwise specified (NOS) comprised 10.2%, major depressive disorder (8.6%). Secondary diagnoses were mainly bipolar disorder (5.3%) or stress related also 5.3% (see Table 47 and Figure 12).

Table 47: Aftercare service client diagnosis.

Diagnosis	Principal diagnosis		Additional diagnosis	
	Frequency (n)	Percent	Frequency (n)	Percent
Panic disorder	2	.8	1	.4
Agoraphobia	1	.4	1	.4
Generalised anxiety disorder	1	.4	5	2.0
Post-traumatic stress disorder	15	6.1	1	.4
Other anxiety disorder	1	.4	7	2.9
Major depressive disorder	**21**	**8.6**	1	.4
Depressive disorder NOS	**25**	**10.2**	3	1.2
Bipolar disorder	5	2.0	**13**	**5.3**
Other affective disorder	1	.4	4	1.6
Alcohol harmful use	3	1.2	1	.4
Alcohol dependence	2	.8	1	.4
Other drug harmful use	4	1.6	2	.8
Schizophrenia	4	1.6	3	1.2
Schizoaffective disorder	1	.4	1	.4
Attention deficit hyperactivity disorder	2	.8	1	.4
Adjustment disorder	5	2.0	1	.4
Personality disorder	8	3.3	1	.4
Anxiety symptoms	3	1.2	1	.4
Depressive symptoms	**26**	**10.7**	2	.8
Mixed anxiety and depressive symptoms	15	6.1	2	.8
Stress related	1	.4	**13**	**5.3**
Other	22	9.0	10	4.1
Missing	76	31.1	7	2.9
Total	244	100.0	4	1.6

Figure 12: Principal diagnosis.



3.4.10 Medication

The majority of medication responses were not stated or inadequately described; however, the following summary table shows the statistics for valid responses regarding the various groups of medication used in mental health, the highest usage group was antidepressants for 20% of participants which is not surprising given the principal diagnosis for the majority were depression related, see Table 48 for more medication details.

Table 48: Medication type.

Medication type	%Yes	%No	%Not stated/inadequately described
Antidepressants	20	12	68
Antipsychotics	2	19	79
Anxiolytics	0	17	83
Hypnotics	4	16	80
Psychostimulants	0	15	85

3.4.11 The Kessler 10 + scale

The first 10 items measure participants' level of depressive symptoms during the previous four weeks, and the subsequent four items measure how these symptoms impact on the ability to work and the degree that physical health problems cause the preceding feelings. Scores for the first 10 items are rated from 1 to 5 (1 = *none of the time,* to 5 = *all of the time*). Questions ask about tiredness, nervousness, inability to calm down, hopelessness, restlessness, inability to sit still, depression, effortfulness, sadness, inability to cheer up and worthlessness. Total scores range from 10 to 50 (lowest to highest scores). The final four items measure the of number of days lost from work due to the feelings associated with items 1 to 10; the number of times a GP or other health professional was consulted during the time period level that physical health problems were attributed as the main cause using the rating scale above (Kessler et al. 2002). The participant pool for this scale after removing missing cases according to Kessler et al. 2002 was N=322. Table 49, 50 and Figure 13 show the results of the K10+.

Table 49: Kessler 10+ mean and SD of each item, scores reflect feelings or occurrences in the previous four weeks.

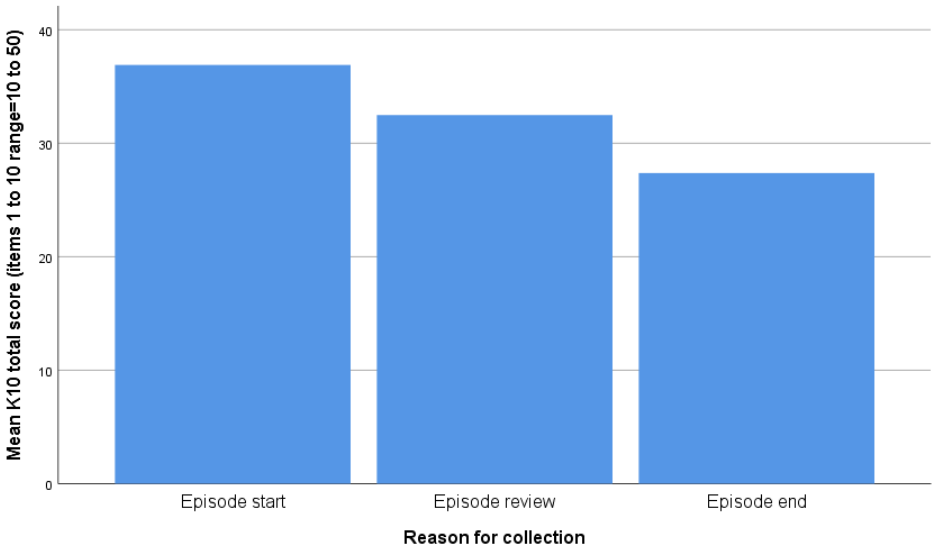
Scores for items 1 to 10 and 14 range from 1 to 5 (1 = *none of the time,* to 5 = *all of the time*).	M (SD)	Total *N*=322
1. How often did you feel tired out for no good reason	3.71 (1.11)	*n*=321
2. How often did you feel nervous?	3.45 (1.10)	*n*=321
3. How often did you feel so nervous that nothing could calm you down?	2.80 (1.15)	*N*=322
4. How often did you feel hopeless?	3.55 (1.21)	*n*=321
5. How often did you feel restless or fidgety?	3.38 (1.12)	*n*=320
6. How often did you feel so restless you could not sit still?	2.86 (1.25)	*N*=322
7. How often did you feel depressed?	3.75 (1.18)	*n*=320
8. How often did you feel that everything was an effort?	3.66 (1.21)	*N*=322
9. How often did you feel so sad that nothing could cheer you up?	3.25 (1.12)	*n*=321
10. How often did you feel worthless?	3.60 (1.27)	*n*=321
1-10 Total scores (range 10 – 50 *none of the time* to *all of the time*)	33.91 (9.18)	*N*=322
Scores 11 – 13 indicate the number of days applicable		
11. How many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	10.45 (9.75)	*n*=157
12. How many days were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	6.50 (7.27)	*n*=153
13. How many times have you seen a doctor or any other health professional about these feelings?	2.90 (3.59)	*n*=151
14. How often have physical health problems been the main cause of these feelings?	4.37 (3.21)	*N*=322

Table 50: Means and SDs of K10 total scores and effects on ability to work over the duration of an episode.

Effects on ability to work over the duration of an episode				
Reason for collection	N=	K10 total score M (SD)	Days totally unable to work	Days cut down on work
1. Episode start	199	36.89 (7.64)	12.63 (9.21)	8.17 (7.55)
2. Episode review	41	32.49 (9.31)	3.73 (5.64)	4.40 (6.12)
3. Episode end	82	27.38 (9.09	7.42 (10.48)	3.05 (5.39)

Figure 13: Mean scores over time, showing a decrease in symptoms on the K10.

The lowest possible score is 10 and the maximum possible score with the highest severity of symptoms is 50.



3.4.12 Suicidal Ideation Attributes Scale (SIDAS)

"Suicidal Ideation Attributes Scale" (SIDAS). The SIDAS is a five-item scale assessing frequency (item 1), controllability (item 2), closeness to attempt (item 3), distress (item 4), and interference with daily activities (item 5) on 10-point scales over the past month" (Bregje et al. 2014). Scores range from 0 to 10 indicating low to high level of symptoms. There were 305 Aftercare Service Clients who completed the SIDAS and they were all at the review point in their episode of care (see Table 51). All data collected from this cohort of aftercare clients were from Country and Outback Health (CObH) - Port Augusta (Head Office). Given participants were at the review point and therefore partway through their episode of care, it is important to note that the highest scores on the SIDAS at this time point was 'control over thoughts' with a mean score of 5.52 (SD 3.14) and all other mean symptom scores were less than five out of 10.

Table 51: Suicidal Ideation Attribute Scale (SIDAS).

SIDAS Survey items[1]	N	M (SD)	Percent
SIDAS 1 Suicidal thoughts	304	5.22 (3.0)	99.7%
SIDAS 2 Control over thoughts	304	5.52 (3.14)	99.7%
SIDAS 3 Suicide attempt	302	3.97 (3.64)	99.0%
SIDAS 4 Tormented by thoughts	305	4.88 (3.30)	100.0%
SIDAS 5 Interference with functioning	305	4.56 (3.46)	100.0%
SIDAS Total score[2]	305	23.04 (13.70)	100.0%

[1] Scores range from 0 to 10 low to high. [2] Scores range from 0 to 100 low to high

3.5 Accidental Counselling

3.5.1 Key Findings

1. Post-training outcome measures indicated increased confidence to help scores i.e. range=1-5, all means >4.
2. 80% improved knowledge, positive assessment of trainer, presentation, and usefulness of the event.

3.5.2 Data cleaning

Accidental Counselling data were provided in pdf format and incorporated five occasions from 18/09/2018 to 05/10/2018. These data were entered into SPSS software for analysis.

3.5.3 Results

Accidental Counselling Training delivered by Lifeline occurred in five regions on five occasions between the 18th September 2018 and the 5th October 2018. Events were hosted in Whyalla, Peterborough, Port Augusta, and Port Pirie and there was a 75% attendance rate. Table 52 shows post training self-reports of knowledge to recognise suicidal triggers and crisis, confidence to respond and refer a suicidal person to appropriate support agencies. Table 53 indicates self-report responses of attendees on usefulness of the training, trainer's knowledge, workshop presentation and how equipped attendees felt about supporting a person in crisis. Qualitative analysis follows in section 3.11.

3.5.3.1 Quantitative data

Table 52: Knowledge and confidence to help showing percentage improved after training.

Knowledge and confidence items N=89	Unchanged	%	Improved	%
Level of knowledge to be able to recognise a crisis state and triggers	11	12	78	88
Confidence in responding to people experiencing crisis and mental health issues	11	12	78	88
Confidence in referring someone to an agency for crisis support	15	19	66	81

Table 53: Self-report measure evaluating attendees' perceptions of the training and their competence to help others.

Survey items N=89 Range[a]	Poor=1	Fair=2	Good=3	Very Good=4	Excellent=5	M (SD)
How useful was the training (n=85)			5	29	54	4.62 (0.56)
How knowledgeable was your trainer (n=86)			1	8	77	4.88 (0.36)
How well was the workshop presented			2	20	64	4.72 (0.50)
How equipped do you feel to support someone in crisis or mental health issues		1	17	40	28	4.13 (0.85)

[a] Range: 1=poor to 5=excellent

3.5.3.2 Attendance numbers, Roles and Community affiliations

*Lifeline Broken Hill Country to Coast - **5th October 2018** – Kadina - Attended 16*

Job Roles and Community Affiliations:
Uniting Country SA
Mental Health Service
Country Outback Health
Kadina School
Dept Education
Baptist Church
Radio presenters
Community members

*Lifeline Broken Hill Country to Coast - **2nd October 2018** – Peterborough - Attended 14*

Job Roles and Community Affiliations of Participants:
United Country SA
Education
Volunteers
Community Members
Nurses

Job Roles and Community Affiliations of Participants:
Uniting Country SA
Country and Outback Health
Child and Family Health Service
Fire Service
Secondary School
Aboriginal Family Support Services
Royal Flying Doctor Service
headspace Youth Mental Health Service

*Lifeline Broken Hill Country to Coast - **21st September 2018** – Pt Pirie - Attended 25*

Job Roles and Community Affiliations of Participants:
Country and Outback Health
Uniting Country SA
Baptist Church
Community Members
Environmental Health
Snowtown Hospital
Aboriginal Health
Country Fire Service
Mental Health Workers

*Lifeline Broken Hill Country to Coast - **18th September 2018** – Whyalla - Attended 12*

Job Roles and Community Affiliations of Participants:
Uniting Care
Catholic Care
Mission Australia
Community Members
headspace
Teachers
Social Worker

3.6 Applied Suicide Intervention Skills (ASIST) Training Results

3.6.1 Key findings:

1. Moderate to high level of agreement to ask a person directly about suicide, have confidence to conduct an intervention, be confident and prepared to help a person at risk of suicide.
2. Participants indicated training was useful and would recommend to others.

3.6.2 Data cleaning

There were three pdf reports that the data were extracted from to interpret the results.

3.6.3 Results

Applied Suicide Intervention Skills Training (ASIST) two-day training was delivered by Lifeline to staff with various job roles (*N*=40) at Port Augusta and Port Pirie in June 2018, and by Centacare to Department of Education and Child Development staff (*N*=8) at Port Lincoln during the month of April in 2019. The job roles for attendees at Lifeline ASIST sessions included Clergy, Casual Employee, SES Worker, Project Worker, Youth Workers, Case Managers, Counsellor, Employment Officer, Home Tutors, Support Worker, Educators, Social Worker, Ambulance, Youth Worker. The results were provided as pdf statements from Lifeline and Centacare's evaluations pre- and post-training and are shown where applicable in the tables to follow. Qualitative responses to training are shown at the end of the tabled results which indicate most attendees felt very supported in their learning, confident to talk about and assist a person who is feeling suicidal, and high subjective satisfaction with the training delivery.

3.6.4 Lifeline training

From the available pdf data, Table 54 shows post-training all attendees were in moderate to high level of agreement that they were able to ask a person directly about suicide, that they were confident to conduct an intervention, and that they were confident and prepared to help a person at risk of suicide. Table 55 shows the usefulness of the ASIST to attendees personal and professional lives which was rated at least 8 out of 10 by 80% to 95% of attendees, and the workshop recommendation ratings that were also rated at least 8 out of 10 by 95% to 100% of attendees across the two groups. Qualitative analysis follows in section 3.11.

Table 54: Lifeline ASIST attendees' confidence to help, showing post-training levels agreement with question items.

Lifelines ASIST attendees N=40	Post-training	
Question item (Range of scores not shown)	Level of agreement	%
Ability to ask directly if a person is thinking about suicide	Agree or strongly agree	100
Confidence in conducting an intervention with a person thinking about suicide	Agree or strongly agree	100
Confidence in feeling prepared to help a person at risk of suicide	Agree or strongly agree	100
Confidence to help a person at risk of suicide	Agree or strongly agree	100

Table 55: Lifeline ASIST attendees' responses post-training.

Lifeline ASIST attendees' response *N*=40 Question item Range of scores 1=poor to 10=excellent	Group 1 rating (*n*=20)	%	Group 2 rating (*n*=20)	%
Overall workshop rating	8 or above	95	10	100
Would recommend the training to others	8 or above	100	8 or above	100
Practical use of ASIST in personal life	8 or above	80%	8 or above	84%
Practical use of ASIST in professional life	7 or above	95%	7 or above	95%

3.6.5 Centacare training

Table 56 shows, from the available pdf data, pre- and post-training self-report scores on Centacare attendees' confidence to ask, to conduct an intervention, and to help a person at risk of suicide. Table 57 indicates self-report responses on perceptions of practicality of the training, and whether attendees would recommend the training to others. Results show an increase in confidence and preparedness to help a person at risk of suicide after training when compared to pre-training, and excellent scores on the practical nature of the training to attendees' work life and their recommendation of the training to others.

Table 56: Centacare ASIST attendees' confidence to help showing scores pre- and post-training.

Centacare ASIST attendees' confidence	Pre-training		Post-training	
N=8 Question item	Score[a]	%	Score[a]	%
Ability to ask directly if a person is thinking about suicide (n=8)	M=3.13	-	5	100
Confidence in conducting an intervention with a person thinking about suicide (n=8)	M=2.88	-	5	100
Confidence in feeling prepared to help a person at risk of suicide (n=8)	M=2.6	-	5 4	95 5
Confidence to help a person at risk of suicide (n=8)	1 2 4	25 38 38	5 4	95 5

[a] Range of scores 1=not confident to 5=very confident

Table 57: Centacare ASIST attendee' responses post-training.

Centacare ASIST attendees' responses N=8 Question item	Score[a]	%
How practical was the training for your work life (n=8)	10	100
Would you recommend the training to others (n=8)	10	100

[a] Range of scores 1=poor to 10=excellent

3.7 GPEx Webinars and Workshops

3.7.1 Key findings

Webinars and Workshops differed in their results on key variables.

1. Webinar results indicated:
   - High mean scores on skills in asking about suicidality, implementing a safety plan and follow up care,
   - High mean scores for speaker quality ranged from good to excellent,
   - Relevance to practice - learning needs were partially to entirely met.
2. Workshop results indicated:
   - High mean scores for increased knowledge and confidence to identify and assist someone at risk of suicide,
   - High mean scores on skills to manage a suicidal person in practice, identify risk factors, and implement follow up via systems,
   - Delivery was by a high-quality speaker.

3.7.2 Data cleaning

The GPEx data comprised five Excel spreadsheets titled: 'Copy of De-identified SP Data for PHN GPEx' and were imported into SPSS software to examine demographic variables and attendees' responses to the key outcome variables. Results were incorporated from the November 2019 Webinar (N=33), the January 2020 Webinar (N=32), the July 2020 Webinar (N=41), the PGU Workshop (N=28), and the PLO Workshop (N=29). Each of the results are discussed in turn to follow.

3.7.2.1 November 2019 Webinar

3.7.2.1.1 Sample Characteristics

The November 2019 dataset (N=33) provided information about each respondent's profession, while there were 15 professional options to choose from, six were identified that attended this Webinar. Of the 33 respondents in total were Administrative staff (n=3), GPs (n=9), Management (n=1), Mental Health Clinicians (n=2), Mental Health Nurses (n=2), and the majority who were Nurses (n=16). Other demographic variables such as age, gender or location were not available.

3.7.2.1.2 Webinar Experience – Learning Outcomes

Thirty-three respondents were asked three questions about their experience of the Webinar and indicated by selecting from the options 1=not, met 2= partially, and 3= entirely, whether their learning outcomes were met. The first question asked participants if they could, *recognise when to ask, and demonstrate how to ask about suicidality* (M=2.97, SD=0.17). The second question asked if they could *develop the skills to implement a safety plan for the suicidal patient* (M=2.76, SD=0.44). The third question asked if participants could, *implement strategies for follow up of mental health patients through practice recall systems* (M=2.76, SD=0.50). Learning outcomes are explored by profession* in Table 58 below.

Table 58: Mean and standard deviations of learning outcomes by professions.

Learning Outcomes	Admin M (SD)	GP M (SD)	MH Clinicians M (SD)	MH Nurses M (SD)	Nurses M (SD)
1. Recognise when to ask, and demonstrate how to ask about suicidality	2.67 (0.58)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)
2. Develop the skills to implement a safety plan for the suicidal patient	2.67 (0.58)	2.67 (0.50)	3.00 (0.00)	3.00 (0.00)	2.81 (0.40)
3. Implement strategies for follow up of mental health patients through practice recall systems	2.67 (0.58)	2.44 (0.73)	3.00 (0.00)	3.00 (0.00)	2.94 (0.25)

*Note. Management were omitted because *n*=1.

Scores indicate that learning outcomes were rated highly between 'met' and 'entirely' demonstrating confidence in help-offering, having acquired the skills for safety planning development with people experiencing suicidal distress, and the ability to follow-up with people afterwards using practice recall systems. Scores were high across all professions including administrative staff.

3.7.2.1.3 Webinar Experience – Clinical Relevance and Speaker Rating

1. Respondents were asked to rate, 1=not relevant, 2= partially, 3= entirely, *the degree to which this activity is relevant to your practice.*

2. Respondents were asked to rate, 1=very poor, 2= poor, 3=average, 4=good, 5=excellent, *the quality of the speaker today.*

Scores on relevance to clinical practice, as expected, indicate greater congruence with mental health specialty professions than other more generalized health professionals and administrative staff. However, high rating scores were achieved overall for both relevance to practice and quality of the speaker. Please see Table 61 below.

Table 59: Clinical relevance and Speaker rating by profession.

Ratings 1-3	Admin M (SD)	GP M (SD)	MH Clinicians M (SD)	MH Nurses M (SD)	Nurses M (SD)
1. The degree to which this activity is relevant to your practice.	2.33 (0.58)	3.00 (0.00)	2.50 (0.71)	3.00 (0.00)	2.75 (0.00)
Ratings 1-5					
2. The quality of the speaker	4.67 (0.58)	4.78 (0.44)	5.00 (0.00)	5.00 (0.00)	5.00 (0.00)

*Note. Management were omitted because *n*=1.

3.7.2.2 January 2020 Webinar

3.5.2.2.1 Sample Characteristics

The January 2020 dataset (N=32) provided information about each respondent's profession, while there were 15 professional options to choose from, nine were identified that attended this Webinar. Of the 32 respondents in total were Clinical Social Workers (n=3), GPs (n=11), Nurses (n=11), Mental Health Clinicians (n=2), and one each of the following: Enrolled Nurse, Medical Student, Support Worker, Pharmacist, and a Physiotherapist. Other demographic variables such as age, gender or location were not available.

3.7.2.2.2 Webinar Experience – Learning Outcomes

Thirty-two respondents were asked to rate four questions about their experience of the Webinar and indicated by selecting from the options 1=not, met 2= partially, and 3= entirely, to what degree their learning outcomes were met. The first question asked participants if they could, *Recognise the extent of the continued risk for suicide after a suicide attempt* (M=2.97, SD=0.18). The second question asked if they could, *Engage with organisations and personal supports to ensure ongoing safety* (M=2.94, SD=0.25). The third question asked if participants could, *implement strategies for follow-up of mental health patients coordinating shared care of GPs and specific psychological services* (M=2.75, SD=0.44). The final question asked, '*Has this education session increased your knowledge and confidence to identify and assist someone at risk of suicide and or after a suicide attempt?'* (M=2.91, SD=0.30). Learning outcomes are further explored by profession* in Table 60 below.

Table 60: Mean and standard deviations of learning outcomes by profession.

Learning Outcomes	Clinical SW M (SD)	GP M (SD)	Nurses M (SD)	MH Clinicians M (SD)
1. Recognise the extent of the continued risk for suicide after a suicide attempt	3.00 (0.00)	3.00 (0.00)	2.91 (0.30)	3.00 (0.00)
2. Engage with organisations and personal supports to ensure ongoing safety	3.00 (0.00)	2.91 (0.30)	2.91 (0.30)	3.00 (0.00)
3. Implement strategies for follow-up of mental health patients coordinating shared care of GPs and specific psychological services.	2.67 (0.58)	2.91 (0.30)	2.82 (0.41)	2.50 (0.71)
4. Has this education session increased your knowledge and confidence to identify and assist someone at risk of suicide and or after a suicide attempt	3.00 (0.00)	2.91 (0.30)	2.91 (0.30)	3.00 (0.00)

*Note. Med Student, Support Worker, Pharmacist, Physio and EN were omitted because *n*=1 each.

Scores in Table 60 indicate that learning outcomes were rated highly between 2 =‘met’ and 3 =‘entirely’ demonstrating confidence in risk assessment, engaging with organisations to ensure ongoing safety, implementing strategies for follow-up of mental health patients by coordinating shared care of GPs and specific psychological services, and increased knowledge and confidence to identify and assist someone at risk of suicide and or after a suicide attempt.

3.7.2.2.3 Webinar Experience – Clinical Relevance and Speaker Rating

1. Respondents were asked to rate, 1=not relevant, 2= partially, 3= entirely, *the degree to which this activity is relevant to your practice.*

2. Respondents were asked to rate, 1=very poor, 2= poor, 3=average, 4=good, 5=excellent, *the quality of the speaker today.*

Scores on relevance to clinical practice, as expected, indicate greater congruence with mental health clinicians and GPs than other more generalized health professionals. However, high rating scores were achieved overall for both relevance to practice and quality of the speaker. Please see Table 61 below.

Table 61: Clinical Relevance and Speaker rating.

Ratings 1-3	Clinical SW M (SD)	GP M (SD)	Nurses M (SD)	MH Clinicians M (SD)
1. The degree to which this activity is relevant to your practice.	2.67 (0.58)	3.00 (0.00)	2.73 (0.47)	3.00 (0.00)
Ratings 1-5				
2. The quality of the speaker	4.00 (0.00)	4.73 (0.48)	4.64 (0.51)	5.00 (0.00)

*Note. Med Student, Support Worker, Pharmacist, Physio and EN were omitted because *n*=1 each.

3.7.2.3 July 2020 Webinar

3.7.2.3.1 Sample Characteristics

The January 2020 dataset (N=41) provided information about each respondent's profession, while there were 15 professional options to choose from, 11 were identified that attended this Webinar. Of the 41 respondents in total were Clinical Social Workers (n=3), GPs (n=14), Nurses (n=9), Mental Health Clinicians (n=3), Administration (n=3), Management (n=3), Volunteers (n=2) and one each of the following: Enrolled Nurse, Medical Student, Clergy, and one Teacher. Other demographic variables such as age, gender or location were not available.

3.7.2.3.2 Webinar Experience – Learning Outcomes

Forty-one respondents were asked to rate four questions about their experience of the Webinar and indicated by selecting from the options 1=not, met 2= partially, and 3= entirely, to what degree their learning outcomes were met. The first question asked participants if they could, *Understand the complexities of suicide grief and its impact on individuals and families and how to support them* (M=2.98, SD=0.16). The second question asked if they could, *recognise strategies to discuss post-mortem and coroner outcomes with patients and families* (M=2.85, SD=0.36). The third question asked if participants could, *discuss accessible resources and local support available for primary health care practitioners, individuals and families* (M=2.88, SD=0.33). The final question asked, '*Has this education session increased your knowledge and confidence to identify and assist someone at risk of suicide, and or, after a suicide attempt?'* (M=2.78, SD=0.43). Learning outcomes are further explored by profession* in Table 62 below.

Table 62: Mean and standard deviations of learning outcomes by profession.

Learning Outcomes	Clinical SW M (SD)	GP M (SD)	Nurses M (SD)	MH Clinicians M (SD)	Admin M (SD)	Manage-ment M (SD)	Volunteer M (SD)
1. Understand the complexities of suicide grief and its impact on individuals and families and how to support them	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)
2. Recognise strategies to discuss post-mortem and coroner outcomes with patients and families	3.00 (0.00)	2.71 (0.47)	2.89 (0.33)	3.00 (0.00)	2.67 (0.58)	3.00 (0.00)	3.00 (0.00)
3. Discuss accessible resources and local support available for primary health care practitioners, individuals and families	3.00 (0.00)	2.86 (0.36)	2.89 (0.33)	3.00 (0.00)	2.67 (0.58)	3.00 (0.00)	3.00 (0.00)
4. Has this education session increased your knowledge and confidence to identify and assist someone at risk of suicide and or after a suicide attempt (n=18)	2.00 (0.00)	2.71 (0.49)	2.75 (0.50)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)	3.00 (0.00)

*Note. Med Student, Teacher, Clergy and EN were omitted because *n*=1 each.

3.7.2.3.3 Webinar Experience – Clinical Relevance and Speaker Rating

1. Respondents were asked to rate, 1=not relevant, 2= partially, 3= entirely, *the degree to which this activity is relevant to your practice* (M=2.80, SD=0.40).

2. Respondents were asked to rate, 1=very poor, 2= poor, 3=average, 4=good, 5=excellent, *the quality of the speaker today* (M=4.80, SD=0.40).

The range of higher scores on relevance to clinical practice were varied in this data, indicate greater congruence with mental health clinicians, clinical social workers and management. High rating scores were achieved across the range of professions for quality of the speaker. Please see Table 63 below.

Table 63: Clinical Relevance and Speaker rating by profession, means and standard deviations.

Ratings 1-3	Clinical SW M (SD)	GP M (SD)	Nurses M (SD)	MH Clinicians M (SD)	Admin M (SD)	Manage-ment M (SD)	Volunteer M (SD)
1. The degree to which this activity is relevant to your practice.	3.00 (0.00)	2.71 (0.47)	2.78 (0.44)	3.00 (0.00)	2.67 (0.58)	3.00 (0.00)	2.50 (0.71)
Ratings 1-5							
2. The quality of the speaker	5.00 (0.00)	4.86 (0.36)	5.00 (0.00)	4.67 (0.58)	4.33 (0.58)	4.67 (0.58)	4.50 (0.71)

*Note. Med Student, Teacher, Clergy and EN were omitted because *n*=1 each.

3.7.2.4 PGU Workshop

3.7.2.4.1 Sample Characteristics

The PGU Workshop dataset (N=32) provided information about each respondent's profession, while there were 15 professional options to choose from, only six people responded to identify five GPs (n=5), and one Pharmacist (n=1). Other demographic variables such as age, gender or location were not available.

3.7.2.4.2 Webinar Experience – Learning Outcomes

Thirty-two respondents were asked five questions about their experience of the Workshop and indicated by selecting from the options 1=not, met 2= partially, and 3= entirely, whether their learning outcomes were met, and 24 to 25 people responded. The first question asked participants if they could, *Build confidence in the acute management of patients who are suicidal within their practice* (M=2.79, SD=0.42). The second question asked if participants could, *Identify modifiable risk factors in patients who are suicidal* (M=2.88, SD=0.34). The third question asked if participants could, *Recognise resources within their area to assist with the management of patients who are suicidal* (M=2.76, SD=0.44). The fourth question asked if participants could, *Implement strategies for follow up of mental health patients through practice recall systems* (M=2.80, SD=0.41). The fifth question asked whether, *the education session increased knowledge and confidence to identify and assist someone at risk of suicide, and or, after a suicide attempt* (M=2.96, SD=0.20). Learning outcomes were not explored by profession because only six respondents answered this question.

However, overall mean scores indicate that learning outcomes were rated highly between 'met' but closer to 'entirely', demonstrating increased knowledge and confidence in help-offering, having acquired skills to identify risk factors, manage a suicidal person in practice, and implement relevant follow up.

3.7.2.4.3 Webinar Experience – Clinical Relevance and Speaker Rating

1. Respondents were asked to rate, 1=not relevant, 2= partially, 3= entirely, *the degree to which this activity is relevant to your practice* (M=2.96, SD=0.20, *n*=25).

2. Respondents were asked to rate, 1=very poor, 2= poor, 3=average, 4=good, 5=excellent, *the quality of the speaker today* (M=4.92, SD=0.28, *n*=25).

Limitations of data prevented exploring outcomes by profession, however, overall mean scores indicate that the Workshop was clinically relevant and delivered by a high-quality speaker.

3.7.2.5 PLO Workshop

3.7.2.5.1 Sample Characteristics

The PGU Workshop dataset (N=29) did not provide information about each respondent's profession, other demographic variables such as age, gender or location were also not available.

3.7.2.5.2 Webinar Experience – Learning Outcomes

Twenty-nine respondents were asked five questions about their experience of the Workshop and indicated by selecting from the options 1=not, met 2= partially, and 3= entirely, whether their learning outcomes were met, and 26 to 29 people responded. The first question asked participants if they could, *Build confidence in the acute management of patients who are suicidal within their practice* (M=2.79, SD=0.41). The second question asked if participants could, *Identify modifiable risk factors in patients who are suicidal* (M=2.97, SD=0.12). The third question asked if participants could, *Recognise resources within their area to assist with the management of patients who are suicidal* (M=2.82, SD=0.38). The fourth question asked if participants could, *Implement strategies for follow up of mental health patients through practice recall systems* (M=2.79, SD=0.50). The fifth question asked whether, *the education session increased knowledge and confidence to identify and assist someone at risk of suicide, and or, after a suicide attempt* (M=2.90, SD=0.31). Learning outcomes were not explored by profession because these data were unavailable.

However, overall mean scores indicate that learning outcomes were rated highly between 'met' but closer to 'entirely', demonstrating increased knowledge and confidence in help-offering, having acquired skills to identify risk factors, manage a suicidal person in practice, and implement relevant follow up.

3.7.2.5.3 Webinar Experience – Clinical relevance and Speaker rating

1. Respondents were asked to rate, 1=not relevant, 2= partially, 3= entirely, *the degree to which this activity is relevant to your practice* (M=2.79, SD=0.41, *n*=29).

2. Respondents were asked to rate, 1=very poor, 2= poor, 3=average, 4=good, 5=excellent, *the quality of the speaker today* (M=4.77, SD=0.43, *n*=26).

Limitations of data prevented exploring outcomes by profession, however, overall mean scores indicate that the Workshop was clinically relevant and was delivered by a high-quality speaker. Qualitative analysis follows in section 3.11.

3.8 Mates in Construction

3.8.1 Key Findings

1. *Immediately post-training survey evaluated ASIST, GAT, SafeTALK & Connector Training.* N=702; 28% female, 72% male.
    a. Target risk group middle-age range for males: all age ranges represented i.e., from 15-19 yrs to 70+ yrs; most were 45-49 yrs (14.5%) and 50-54 yrs (17.4%).
    b. 12 towns, most in Pt Pirie 33.5%,Whyalla 25.5%, and Maitland 14.7%.
    c. Significant differences on training type but not age groups on key variables, i.e., confidence help, knowledge, usefulness of training, relevance to role, community change, know where to connect someone at risk of suicide, and workplace raising awareness all moderate to high mean scores except for stigma which was lower.
    d. GAT scored lower than other types of training on key variables.
2. *3-6mo & 6-12mo post-training survey evaluated ASIST, GAT, SafeTALK & Connector Training.* N=164; all age ranges 18-74 years, most were 45-54 years (gender, location data not available).
    a. All high mean scores for quant answers, no significant results between groups for training type or age on each survey item.
    b. Increased confidence to help scores 1-5, all means >4; used skills learned 34% Yes/66% No; more likely to seek help if suicidal M=4.09; recommend MiC to others rating out of 10 M=9.04 SD=1.28.

3.8.2 Data Cleaning

The Mates in Construction data comprised 3 separate data files titled:

1. 'MIC CSAPHN Feedback (No Names)' comprising 2 Excel spreadsheets; Evaluates ASIST, GAT, SafeTALK & Connector Training immediately post-training located in Sheet 1 data, (Sheet 2 no data); N=702.
2. 'MATES IN CONSTRUCTION SAFEEDBACK QUESTIONNAIRE_NO NAMES' comprising 1 Excel spreadsheet; Evaluates ASIST, GAT, SafeTALK & Connector Training 3-6mo & 6-12mo post-training, different survey questions to immediate post-training survey questions.; N=164.
3. 3. 'SUMMARY_NO NAMES_MATES IN CONSTRUCTION SAFEEDBACK QUESTIONNAIRE' comprising 13 Excel spreadsheets showing percentage results on each survey question (12 in total) – for information only, no raw data; N=164).

The first two data files were imported into SPSS software separately to examine demographic variables and attendees' responses to the key outcome variables. Each of the results are discussed in turn to follow.

3.8.3 First dataset (immediately post-training T1) Mates in Construction Dataset

3.8.3.1 Sample Characteristics

This first dataset ('*MIC CSAPHN Feedback (No names).xls'*) provided Time 1 survey information from people who attended Mates in Construction training opportunities namely General Awareness Training, ASIST, SafeTalk, and Connector Training **immediately following completion of training**. The time period was from 1st December 2018 to 31st December 2020. There were 702 attendees in total, 28% were female (n=199) and were 72% male (n=503). The majority attended General Awareness Training (n=599), and the remainder attended Connector Training (n=74), SafeTalk (n=15) and ASIST (n=14). The Majority of participants were in the 45-49 and 50-54 age groups (see Table 64 and most

resided in the Port Pirie, Maitland and Whyalla LGAs (see Table 65). Data about profession was not available.

Table 64: Number of respondents by age group.

Age Groupings	Frequency	Percent
15-19 years	11	1.6
20-24 years	55	7.8
25-29 years	56	8.0
30-34 years	62	8.8
35-39 years	80	11.4
40-44 years	62	8.8
45-49 years	**102**	**14.5**
50-54 years	**122**	**17.4**
55-59 years	88	12.5
60-64 years	41	5.8
65-69 years	15	2.1
70+ years	3	.4
Total	702	100.0

Table 65: Participant numbers by location.

Location	Frequency	Percent
Balaklava	11	1.6
Port Pirie	**235**	**33.5**
Streaky Bay	21	3.0
Whyalla	**179**	**25.5**
Burra	19	2.7
Ceduna	26	3.7
Gladstone	12	1.7
Jamestown	11	1.6
Kadina	29	4.1
Maitland	**103**	**14.7**
Port Broughton	22	3.1
Port Lincoln	34	4.8
Total	702	100.0

3.8.3.2 Training Experience

This survey questions comprise the following items: 1. People who suicide are selfish, 2. The training was relevant to my role, 3. This training improved my confidence to respond to someone in crisis, 4. I feel this training will enable me to be part of the change in my community, 5. My workplace works collaboratively with other organisations to raise awareness of suicide prevention, 6. I know where to connect someone who may be at risk of suicide to appropriate services. The response options were 1=strongly disagree, 2= disagree, 3=neither agree nor disagree, 4=agree, 5=strongly agree.
The means and standard deviations of survey responses are in Table 66 as follows:

Table 66: Means and standard deviations of survey responses.

Survey item (characteristic)	N	Mean	Std. Deviation
1. People who suicide are selfish (stigma)	701	2.13	1.11
2. The training was relevant to my role	701	4.09	0.78
3. This training improved my confidence to respond to someone in crisis	701	4.11	0.73
4. I feel this training will enable me to be part of the change in my community	701	3.96	0.76
5. My workplace works collaboratively with other organisations to raise awareness of suicide prevention	697	3.65	0.86
6. I know where to connect someone who may be at risk of suicide to appropriate services	701	4.21	0.75

Note. Response options were 1=strongly disagree, 2= disagree, 3=neither agree or disagree, 4=agree, 5=strongly agree.

3.8.3.3 Differences between training types on survey items

Significant results were revealed with comparisons of means on the survey items by training type, please see Table 67 and Figures 14 to 19 below. Note. Response options were 1=strongly disagree, 2= disagree, 3=neither agree nor disagree, 4=agree, 5=strongly agree.

Table 67: ANOVA comparisons of means on the survey items by training type were significant.

Survey item		Sum of Squares	df	Mean Square	F	Sig.
1. People who suicide are selfish	Between Groups	32.013	3	10.671	8.946	**.000**
	Within Groups	831.383	697	1.193		
	Total	863.395	700			
2. Training relevance to role	Between Groups	20.381	3	6.794	11.821	**.000**
	Within Groups	400.592	697	.575		
	Total	420.973	700			
3. Improved confidence to respond to crisis	Between Groups	32.652	3	10.884	22.211	**.000**
	Within Groups	341.537	697	.490		
	Total	374.188	700			
4. Enable change in my community	Between Groups	33.306	3	11.102	20.877	**.000**
	Within Groups	370.654	697	.532		
	Total	403.960	700			
5. My workplace raises SP awareness	Between Groups	11.013	3	3.671	5.003	**.002**
	Within Groups	508.457	693	.734		
	Total	519.469	696			
6. Know where to connect at-risk person to services	Between Groups	30.676	3	10.225	19.872	**.000**
	Within Groups	358.654	697	.515		
	Total	389.330	700			

Figure 14: Significant differences between training type (GAT > ASIST and SafeTALK) on the survey item relating to stigma.

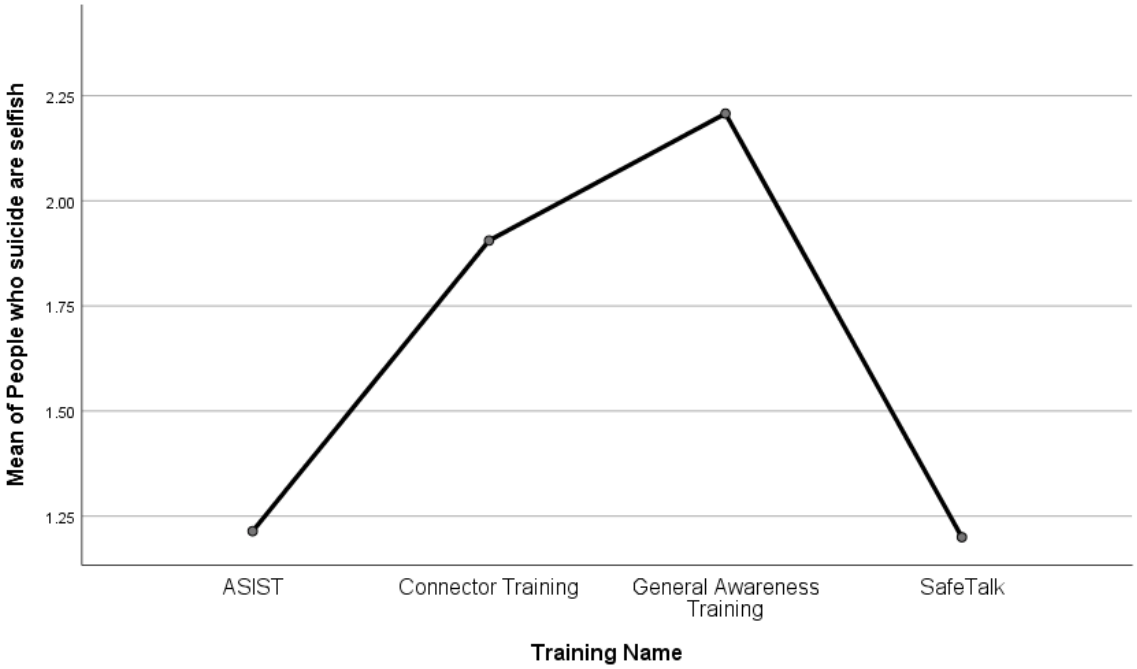


Figure 15: Significant differences between training type (GAT < all others) on the relevance to role survey item.

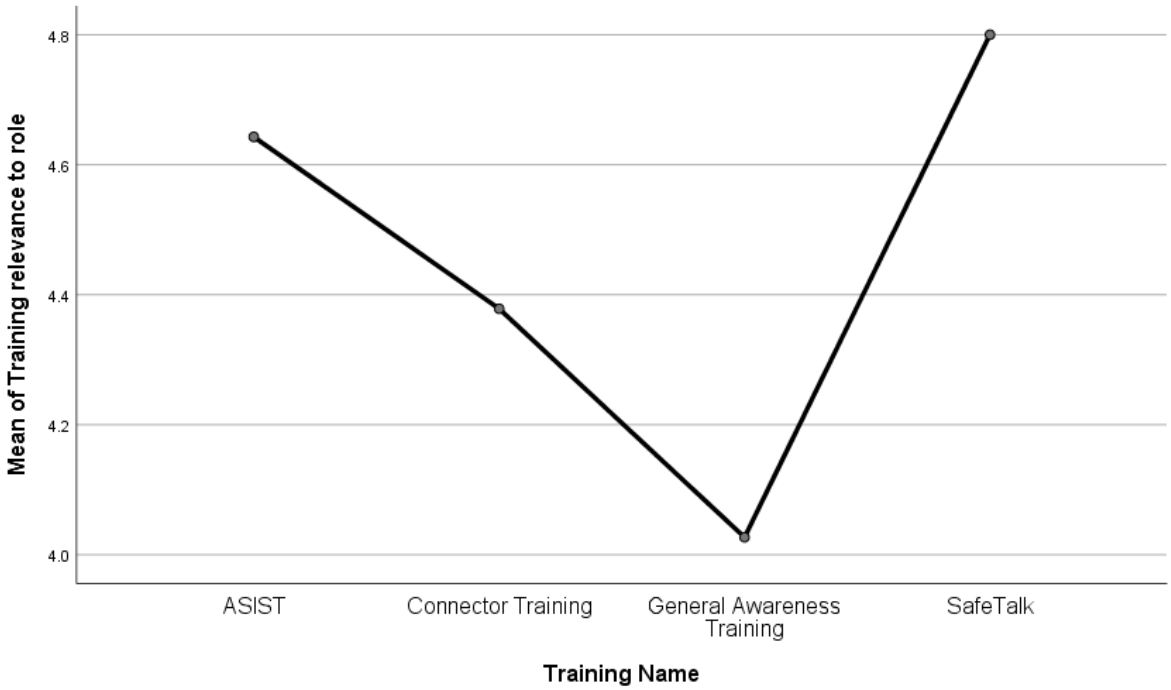


Figure 16: Significant differences between training type (GAT < all others) on confidence to respond in a crisis.

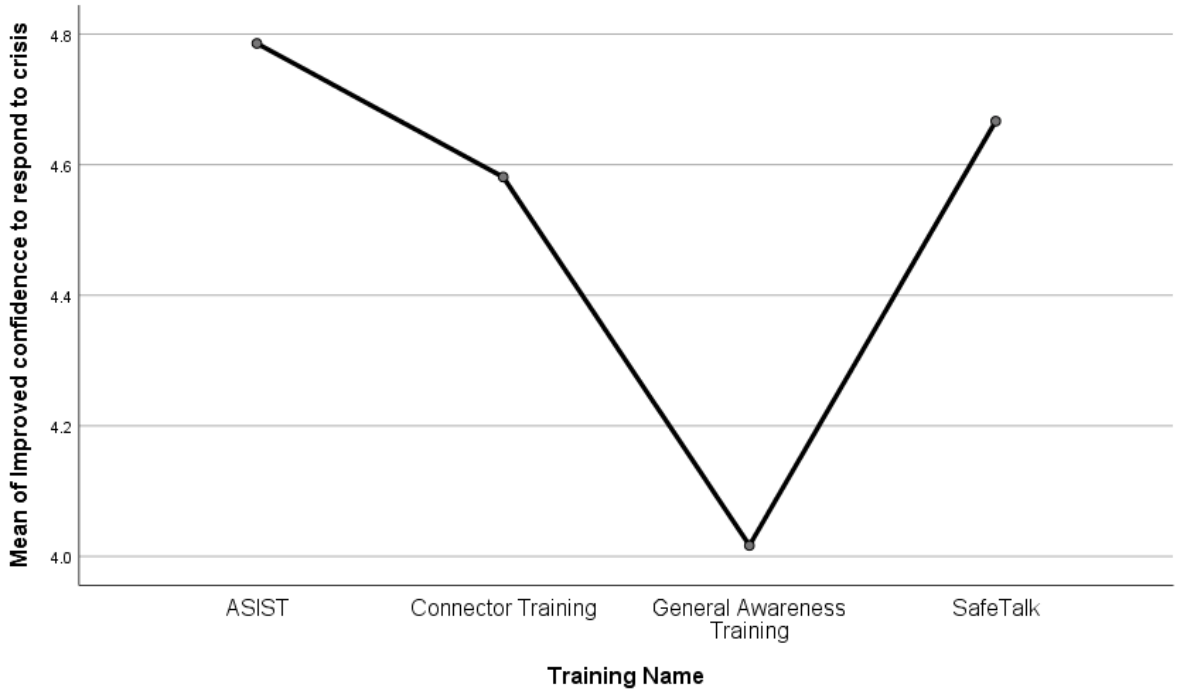


Figure 17: Significant differences between training type (GAT< all others) on the survey item enabling community change.

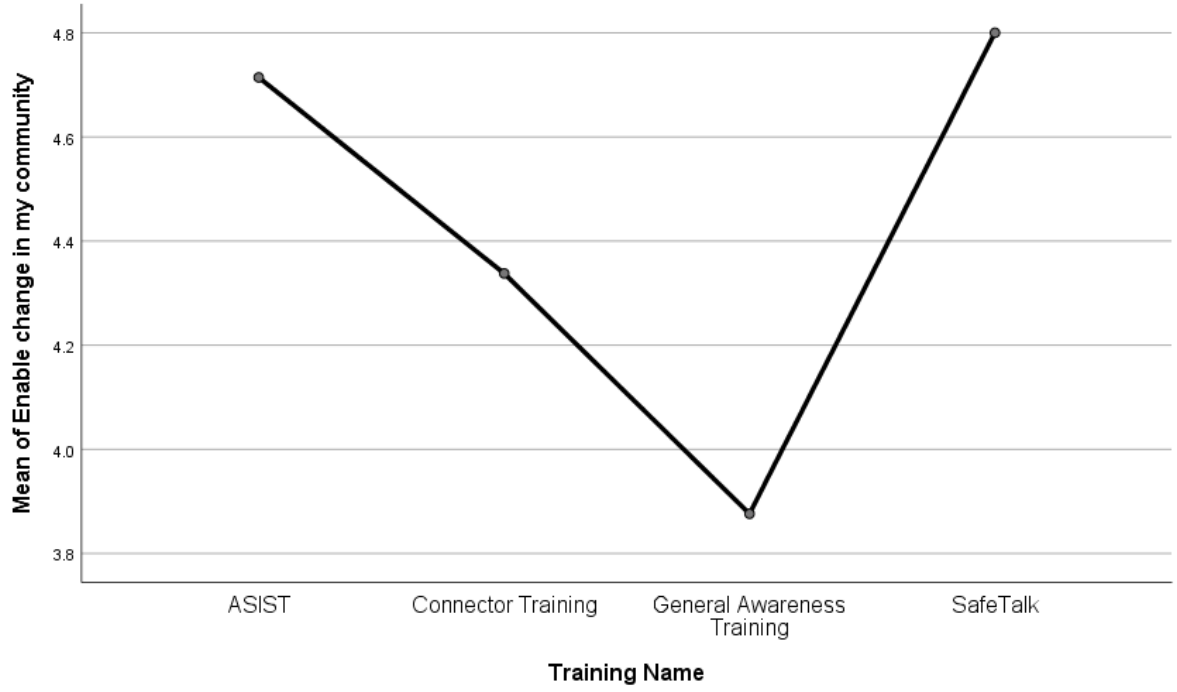


Figure 18: Significant differences between train type (GAT < all others) on workplace raising SP awareness.

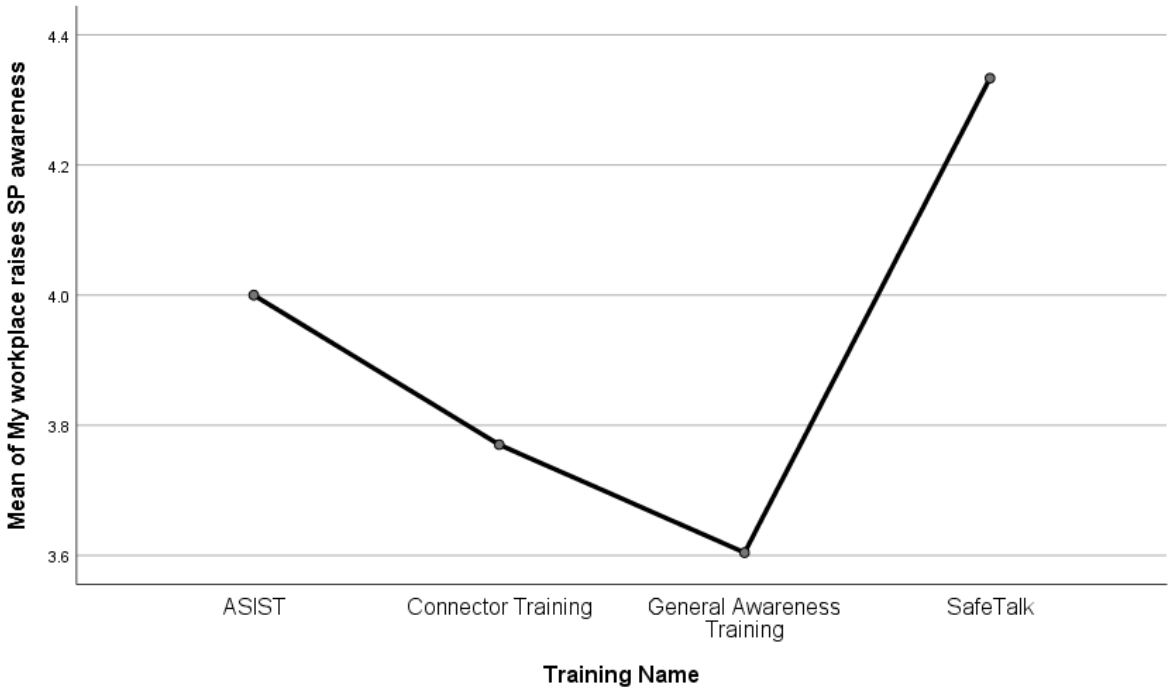
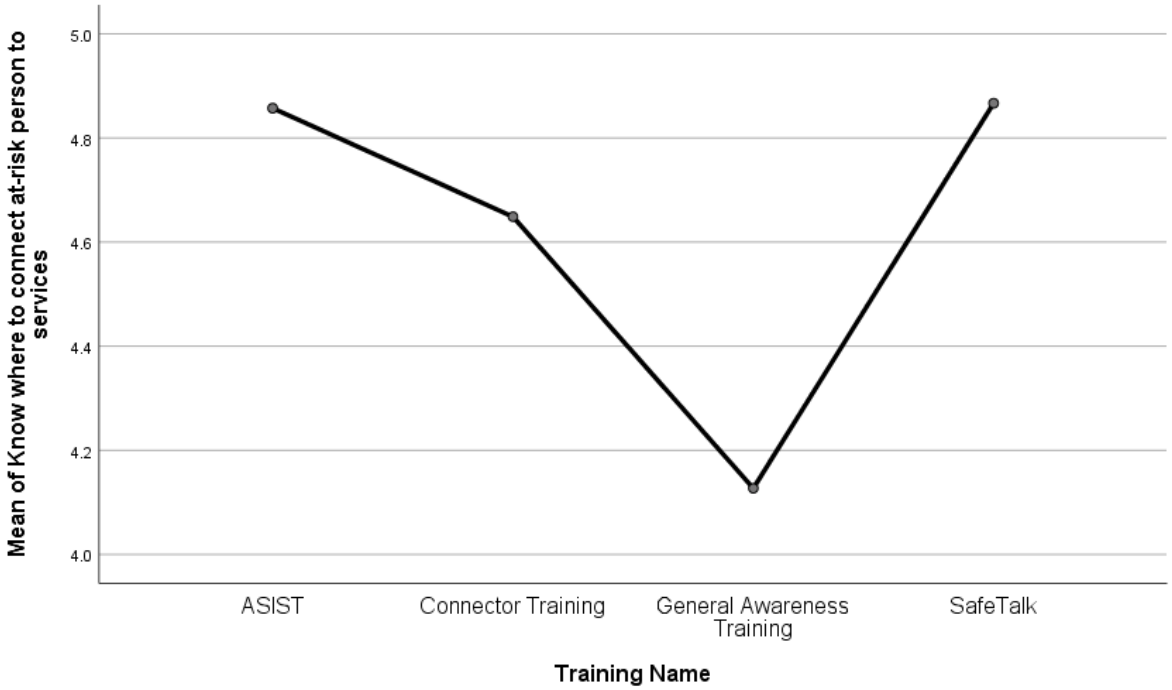


Figure 19: Significant differences between training type (GAT < all others) on knowledge to connect at-risk people to services.



3.6.3.4 Differences between age groups on survey items

ANOVA was conducted comparing differences in means between age groups on each survey item however, results were non-significant. Figures 20 to 25 show the age difference trends.

Figure 20: Showing age-group differences in means on the survey item relating to stigma.

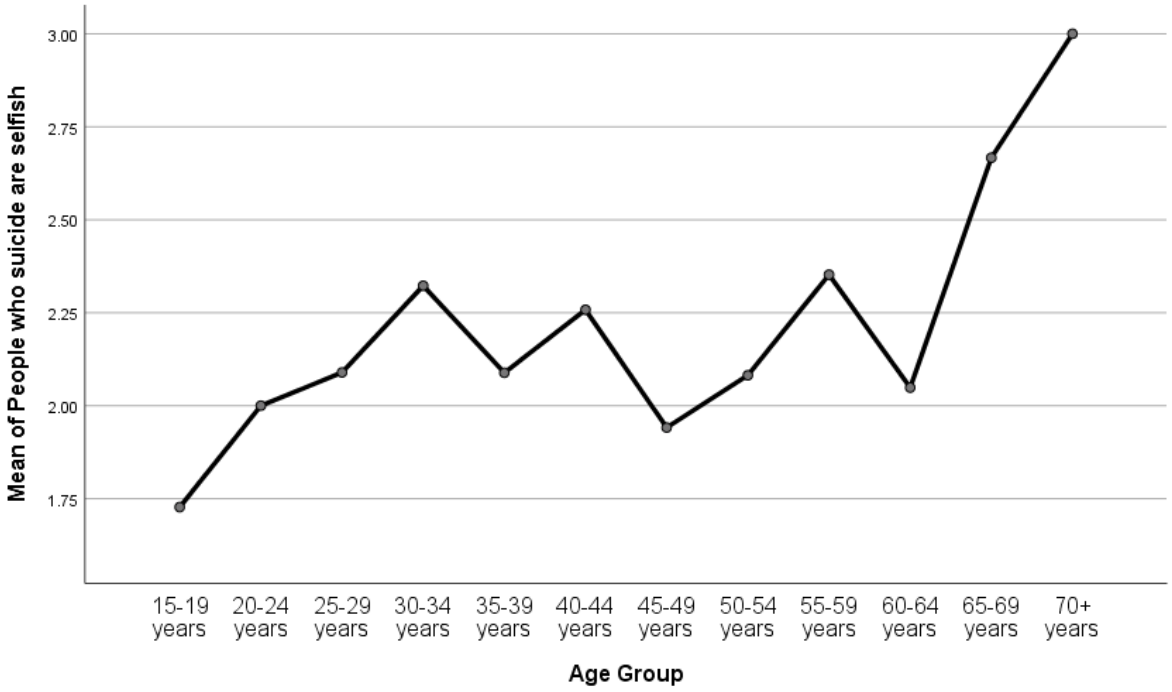


Figure 21: Showing age-group differences in means on the relevance to role survey item.

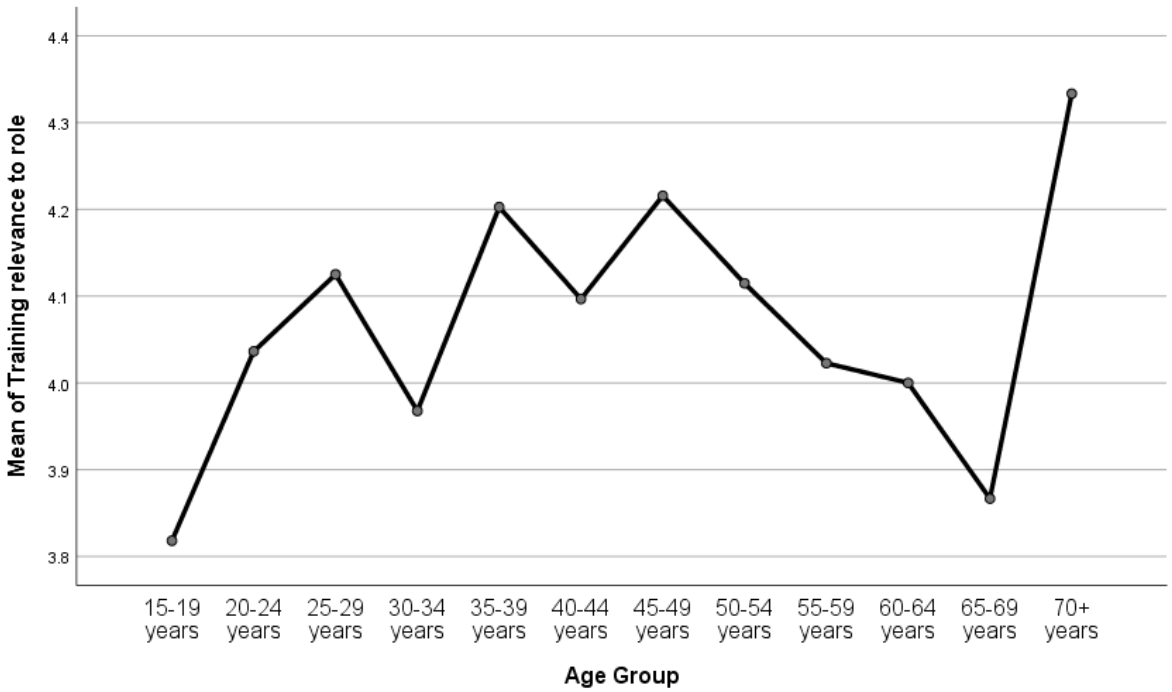


Figure 22: Showing age-group differences in means on confidence to respond in a crisis.

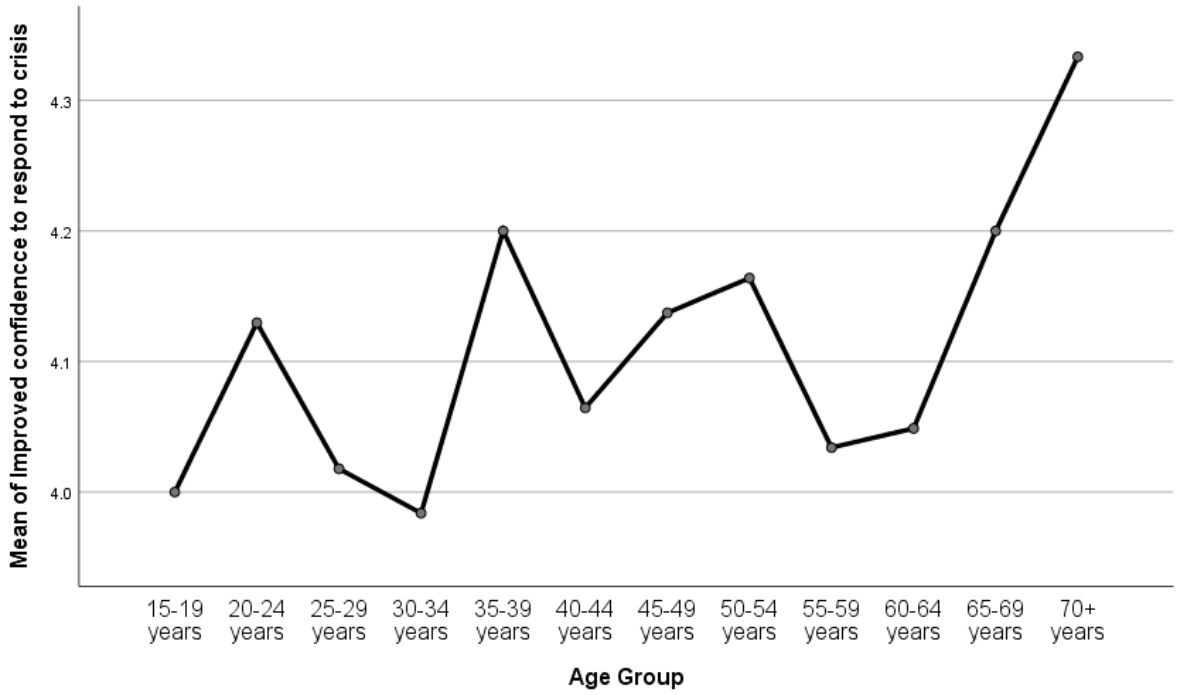


Figure 23: Showing age-group differences in means on the survey item enabling community change.

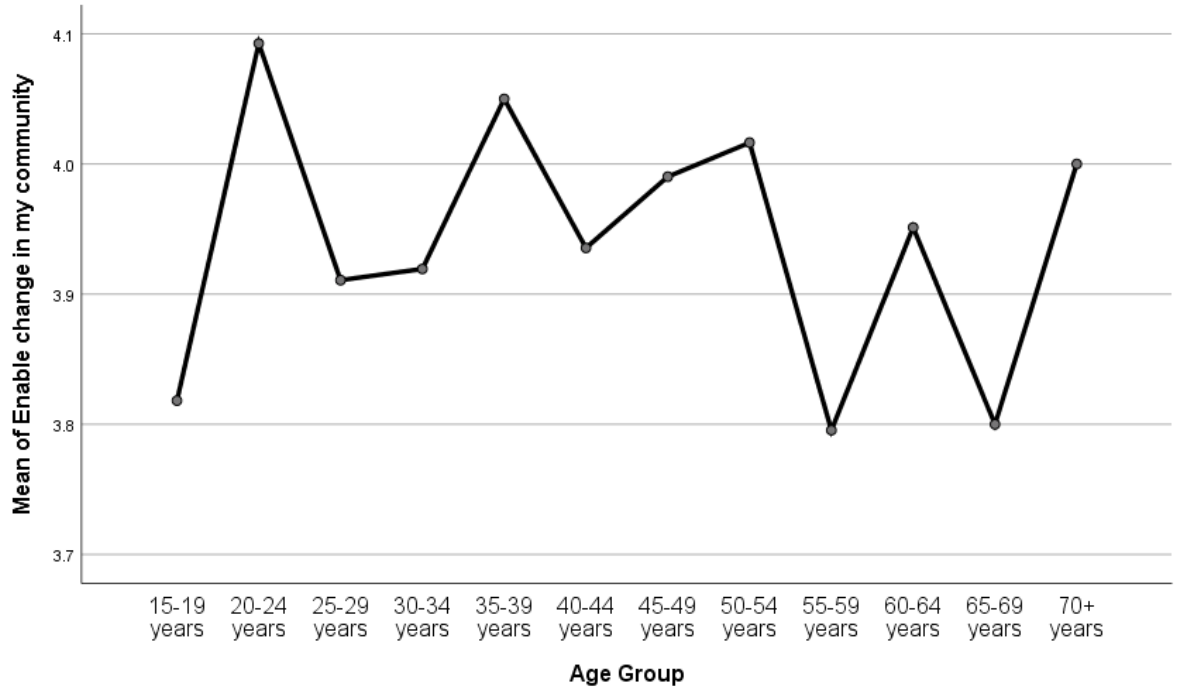


Figure 24: Showing age-group differences in means on workplace raising SP awareness.

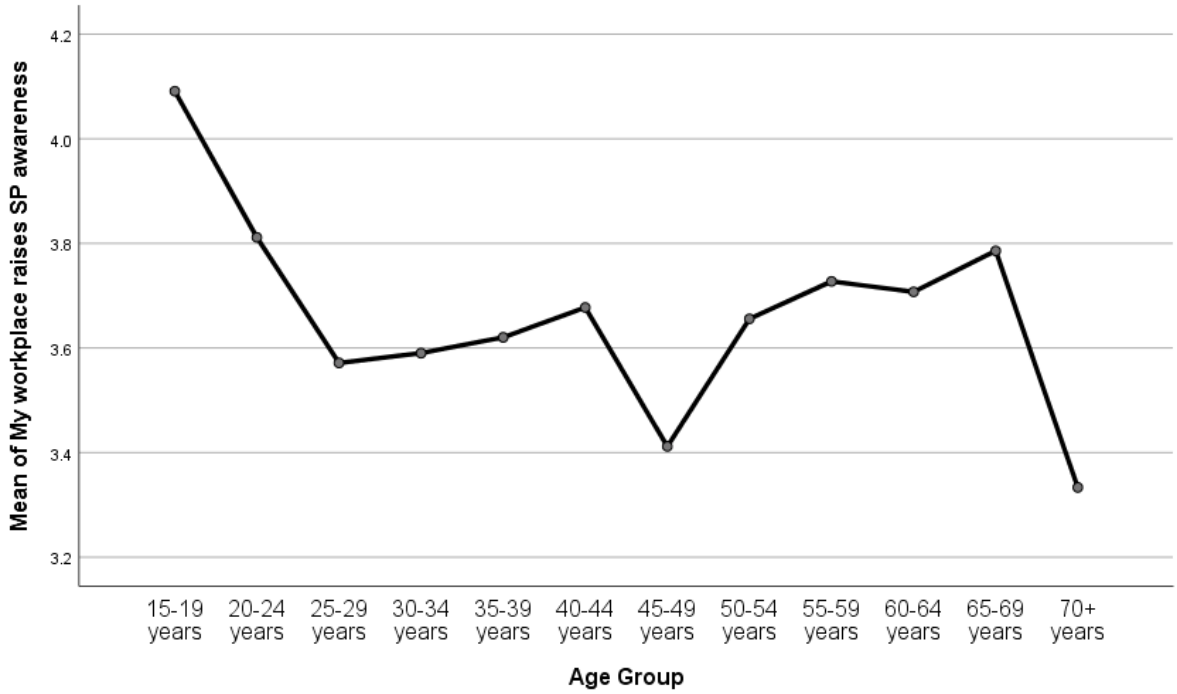
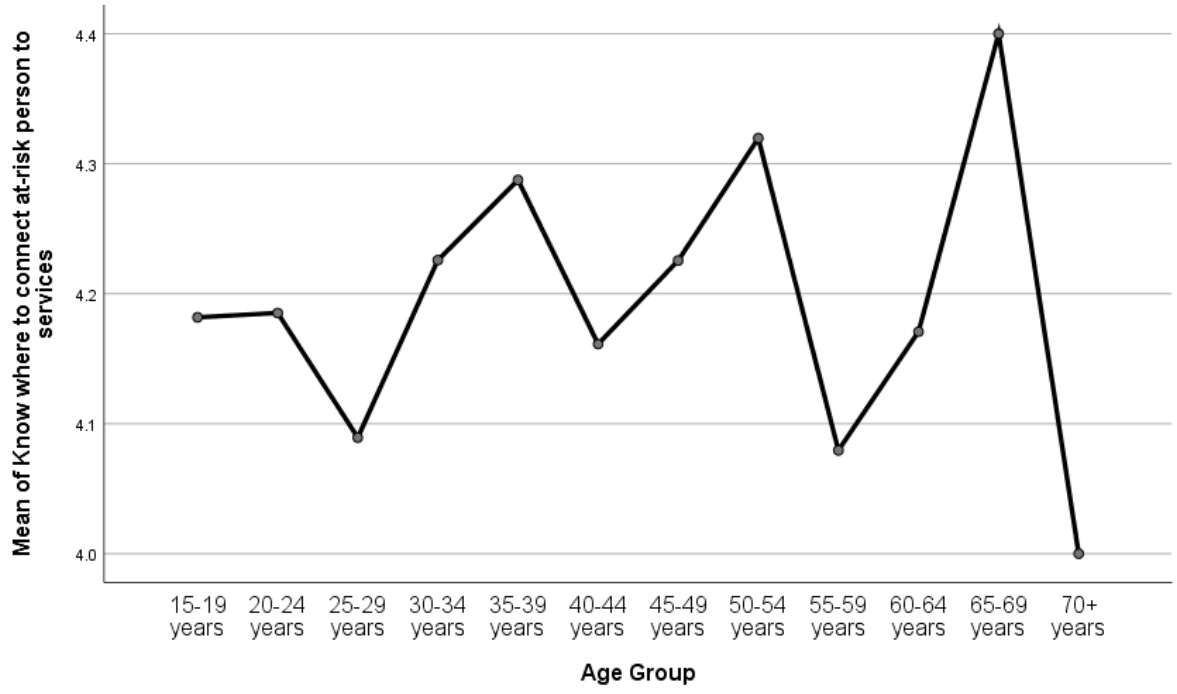


Figure 25: Showing age-group differences in means on knowledge to connect at-risk people to services.



3.8.4 The second (3-6 and 6-12 months post-training T2) Mates in Construction Dataset

3.8.4.1 Sample Characteristics

This dataset ('*SUMMARY_NO NAMES_MIC_SAFEEDBACK QNNAIRE.xls*') provided information from people who responded to a follow up survey questionnaire after attending attended Mates in Construction training **3 to 6 months and 6 to 12 months following completion of training**. There were 164 respondents in total. The majority attended General Awareness Training (n=114) either 3-6 months post training (n=3) 6-12 months post training (n=65), or time elapsed not specified (n=46). The remainder attended Connector Training (n=21) either 3-6 months post training (n=4), or time elapsed not specified (n=17); ASIST (n=15); and SafeTALK (n=14), see Table 68. Most participants were in the 45-54 age group (see Table 69). Data about gender, location and profession were not available.

Table 68: Frequency of respondents who attended each training type.

Training Name	Frequency	Percent
ASIST	15	9.1
Connector Training	17	10.4
General Awareness Training	46	28.0
SafeTALK	14	8.5
Connector Training 3-6 months	4	2.4
General Awareness Training 3-6 months	3	1.8
General Awareness Training 6-12 months	65	39.6
Total	164	100.0

Table 69: Number of respondents by age group.

Age Group	Frequency	Percent
18-24 years	7	4.3
25-34 years	23	14.0
35-44 years	37	22.6
45-54 years	**50**	**30.5**
55-64 years	36	22.0
65-74 years	7	4.3
Total	164	100.0

3.6.4.2 Training Experience

This follow up survey comprised the following quantitative survey items with a response format of 1=strongly disagree, 2= disagree, 3=neither agree or disagree, 4=agree, 5=strongly agree: 1. *What impact did the MATES in Construction training have on your workplace?* 2. *Since completing the MATES in Construction training, I am confident I would notice signs or invitations that a workmate might be struggling.* 3. *Since completing the MATES in Construction training, I am confident that I could assist someone who is going through a difficult time, feeling upset or thinking of suicide.* 4. *Since completing the MATES in Construction training, I would be more likely to seek help if I was going through a difficult time, feeling upset or thinking of suicide.* Two items had a Yes/No response format: item 5. *Have you used the skills you learned in the MATES in Construction training to assist*

someone? and item 8. *Have you sought help or support for your own mental health since completing the training?* Item 11 had a 1-10 Likert scale rating from low to high for the question, 5. *How likely is it that you would recommend MATES in Construction to a friend or colleague?* Results can be seen in Table 70.

Table 70: Means and standard deviations of survey responses with scale responses.

Survey item Scores range from *1= Strongly Disagree to 5= Strongly agree**	N	Mean	Std. Deviation
Q1. Impact of training on workplace	164	4.28	.66
Q2. Confident I would notice that a workmate is struggling.	163	4.18	.52
Q3. Improved confidence to assist person in crisis	162	4.15	.55
Q4. More likely to seek help if thinking of suicide.	164	4.09	.67
Q11. How likely is it that you would recommend MATES in Construction to a friend or colleague? (*rating out of 10)	159	9.04	1.28
Percentage scores of survey responses with binary responses.	N	Yes %	No %
Q5. Have you used the skills you learned in the MATES in Construction training to assist someone? Y/N	164	34.10	65.90
Q8. Have you sought help or support for your own mental health since completing the training? Y/N	162	14.00	84.80

Note. Qualitative responses omitted: Q6. Who did you assist? Q7. Can you tell us a bit about the experience? Q9. Who did you seek help or support from? Q10. Do you have any other comments, questions, or concerns? Q12. Would you like a Mates in Construction Field Officer to contact you?

3.8.4.3 Differences between training types on survey items

Non-significant results were obtained with comparisons of means on the survey items by training type.

3.9 Question Persuade Refer (QPR) Training Results

3.9.1 Key findings

- Confidence, skills and knowledge all increased over time from pre- to post-training
- Approximately one third intended to reach out to a person they knew to offer help,
- Ten percent decided to seek help for themselves,
- One third were bereaved by suicide and intended to learn more,
- Overall training was rated as very good and would be recommended to others.

3.9.2 Data cleaning

1. Nine Excel sheets of summed results in one data file titled: 'QPR Data.xlsx'- no raw data, and
2. A second Excel file with one sheet containing variable labels 'NSPR QPR Training Data Attachment 6' (no raw data). Data were exported and reported on as follows below.

3.9.3 Sample Characteristics

Data from the first dataset were collected between 16/02/2018 to 26/11/2020. Eighty percent of participants were female and 18.4% were male (see Table 71). Age groups up to 80 years were represented and the greatest proportion (almost half) were aged 41 to 60 years (see Table 72). 92% were neither of Aboriginal nor Torres Strait Islander origin, 2.9% were Aboriginal, 2.04% were both of Aboriginal and Torres Strait Islander origin and 2.37% did not answer this question (see Table 73). Education level, most had a Bachelor degree, TAFE or trade certification (see Table 74). There were 774 occupation options that included clinical and non-clinical roles and the highest group were teachers (9.57%) Apart from the top 16 occupations outlined in Table 75, most were distributed amongst the many remaining options.

Table 71: Gender.

Gender (N=1515)	Frequency (n)	Percent
Not stated	1	0.000006
Male	280	18.4
Female	1216	80.2
Transgender	4	0.002
Missing	14	0.009
Total	1515	98.61

Table 72: Number of respondents by age group.

Age Groups	Frequency (n)	Percent
15-20 years	39	0.25
21-30 years	271	18.1
31-40 years	282	18.8
41-50 years	366	24.5
51-60 years	375	25.1
61-70 years	148	10.0
71-80 years	12	0.008
80+ years	0	0
Missing	22	0.01
Total	1493	96.76

Table 73: Cultural identity.

Cultural identity (N=1515)	Frequency (n)	Percent
Yes, Aboriginal	44	2.90
Yes, Torres Strait Islander	4	0.26
Both Aboriginal and Torres Strait Islander origin	31	2.04
Neither Aboriginal nor Torres Strait Islander origin	1400	92.40
Not stated	36	2.37
Total	1515	97.62

Table 74: Education levels.

Education levels (N=1515	Frequency (n)	Percent
Bachelor degree	403	26.60
Postgraduate degree	230	15.20
Primary School	23	1.51
TAFE or trade certification	494	32.61
Year 10	95	6.27
Year 12	238	15.70
No answer	32	2.11
Total	1515	100.0

Table 75: Occupation.

Occupation (N=1515)	Frequency (n)	Percent
Teacher	145	9.57
Student Services Officer	62	4.09
Student	47	3.10
Registered Nurse	43	2.83
Nurse	25	1.65
Support Worker	25	1.65
Medical Receptionist	23	1.51
Administration	23	1.51
Retired	21	1.38
Manager	18	1.18
Youth Worker	18	1.18
Receptionist	17	1.12
Case Manager	17	1.12
Disability Support Worker	15	0.99
Carer	13	0.86
Counsellor	12	0.79
Other < 9 in each group	917	60.52
Missing	74	4.88
Total	1515	98.28

3.9.4 Results

Scores from the first data set show pre-training and post-training ratings on 9 items related to the participants' knowledge and perceptions about suicide prevention (Table 76). Items 10 through 15 measure changes in participant perceptions of self-efficacy, confidence and competence to carry out the QPR intervention (see Table 77). Results show trends that *increase* positively on the key variables post-training (highlighted in green) when compared to pre-training. Two survey items (14 and 15) showed a positive *decrease* over time. Qualitative analysis follows in section 3.11.

Table 76: Pre-training and post-training ratings on Question Persuade Refer (QPR) relating to knowledge and perception about suicide prevention.

QPR **Survey Questions**	Pre-training					Post-training				
Scale scores range from 1=very low to 5=very high	Very Low	Low	Medium	High	Very High	Very Low	Low	Medium	High	Very High
1. Facts concerning suicide Prevention	57	422	800	285	43	1	15	197	915	386
2. Warning signs of suicide	52	357	815	325	56	0	12	144	897	461
3. How to ask someone about suicide	134	488	614	298	68	0	17	161	822	514
4. Persuading someone to get help	71	397	708	359	63	0	15	165	855	479
5. How to get help for someone	62	340	706	409	88	0	17	143	831	523
6. Information about resources for help with suicide	58	388	721	378	59	0	24	205	841	444
7. Please rate what you feel is the appropriateness of asking someone who may be at risk about suicide.	33	195	521	503	348	0	8	101	579	826
8. What is the likelihood you will ask someone who appears to be at risk if they are thinking of suicide?	39	198	515	558	294	0	6	114	628	766
9. Please rate your level of understanding about suicide and suicide prevention.	50	336	789	359	68	0	10	168	865	471

Table 77: Pre-training and post-training ratings on Question Persuade Refer (QPR) relating to perceptions of self-efficacy, confidence and competence to carry out the QPR intervention.

Action Items Questions	Pre-training					Post-training				
Scale scores range from 1=strongly disagree to 5=strongly agree	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
10. If someone I knew was showing signs of suicide, I would directly raise the question of suicide with them	17	117	312	802	362	1	12	55	581	865
11. If a person`s words and/or behavior suggest the possibility of suicide, I would ask the person directly if he/she is thinking about suicide	16	117	307	804	366	4	13	54	591	852
12. If someone told me they were thinking of suicide, I would intervene	6	13	91	848	651	1	0	24	463	1026
13. I feel confident in my ability to help a suicidal person	46	280	602	559	121	1	14	123	843	533
14. I don't think I can prevent someone from suicide	120	673	631	166	19	582	684	130	89	29
15. I don't feel competent to help a person at risk of suicide	162	610	507	291	39	574	726	115	71	28

Table 78 shows participants post-training frequency results to five survey questions. Of the 1515 respondents approximately one third intended to reach out to a person they knew to offer help, ten percent decided to seek help for themselves, one third were bereaved by suicide and intended to learn more, 29 participants sought immediate help for themselves or someone they knew, and 84% sent the free e-book to someone they knew who may need it.

Table 78: The impact that QPR training had on participants.

Impact (N=1515)

Action Item Questions	Yes	No
1. From what I just learned, I know someone who may need help and I intend to reach out to them now.	555	960
2. From what I just learned, I have decided to seek help for myself from the resources provided in this program.	138	1377
3. I have lost someone to suicide who was close to me, and I intend to learn more about the resources provided in this training.	495	1020
4. During this training session I used the Help Now button and got help for myself or someone I know.	29	1486
5. I have already sent the free e-book (Suicide the Forever Decision by Paul Quinnett, Ph.D.) to someone I know who may need it.	1279	236

Table 79 evaluates participants' experience of the training and its usefulness. The majority had a very good to excellent training experience and would recommend the training to others.

Table 79: Participant evaluations of the QPR training and its usefulness.

Survey Questions	Poor	Fair	Good	Very Good	Excellent
1. How well did this Training Program meet its objectives?	3	33	220	698	561
2. How would rate the multi-media presentation of this material?	6	45	209	642	613
3. My overall evaluation of this training is:	2	32	220	695	566
Question		Yes		No	
4. Do you believe this training will help you in helping someone suicidal?		1493		22	
5. I would recommend this training program to other people.		1316		199	

3.10 SafeTALK Training Workshops

3.10.1 Key findings

- Strong agreement trainer ratings on preparedness, encouragement and respect.
- 84.2% of participants were well prepared to talk to a person about suicide.
- 100% of participants had intentions to tell others that training was beneficial.

3.10.2 Data cleaning

One pdf; contained percentages and no raw data.

3.10.3 Sample Characteristics

There were a list of job roles only as available demographic data to report.

3.10.3.1 Job Roles and Community Affiliations Clare:

Lifeline Retail
Community Mental Health Aged Care
Nursing Schools
Community Health Community Women's Group Country and Outback Health

3.10.3.2 Job Roles and Community Affiliations Clare:

Community members
Farmers
Community Mental Health
Group Volunteers
Social Workers
Church School
Agriculture
Retail Workers
Counsellor
Health Workers
Massage Therapist
Life Coach

3.10.3.3 Job Roles and Community Affiliations Kadina:

Community members
Nurses
Midwives
Maitland Hospital
Youth Service
Wallaroo Hospital

3.10.3.4 Job Roles and Community Affiliations Port Augusta (Pika Wiya):

Royal Flying Doctor Service
Soccer Association Centrelink
St Vinnies
Pika Wiya Health Service Boxing Club
Secondary School Legal Services
Aboriginal Family Support Services

3.10.3.5 Job Roles and Community Affiliations Port Pirie:

Community members
Lifeline Volunteers
Nurses
Teachers
Health Workers

3.10.4 Results

SafeTALK training delivered by Lifeline occurred in the five regions Port Pirie, Port Augusta, Kadina, Cleve and Clare on five occasions between the 17th September and the 4th October 2018. Table 80 shows aggregated post-training self-reports of trainer ratings, trainer preparedness, trainer encouragement and respect, beneficence of training to tell others, and preparedness to talk about suicide. Qualitative analysis follows in section 3.11.

Table 80: SafeTALK training evaluation.

N=77 Survey item	 Ratings
Training rating out of 10 Range 1=poor to 10=excellent	99% rated 8 or above
Preparedness of trainer	100% agreed - strongly agreed
Trainer encouraged participation & respected responses	100% strongly agreed
Tell others training beneficial	100% intended to tell others
Preparedness to talk directly and openly about suicide	85.2% well prepared 40% mostly prepared

3.11 Combined qualitative findings

3.11.1 Impact of attending training events

For nine of the training events (Table 81), content analysis investigated open-ended responses to show the impact of attending the training. Not all respondents answered the open-ended questions. It is difficult to compare the impact of the training events due to the range of attendee numbers and roles within of the trainings, as well as the diversity of the aims, content, presenters, and mode of training delivered (Refer to sections above).

More than 50% of respondents in the Accidental Counselling, and the July 2020 GPEx Webinar experienced an increase in awareness in areas such as triggers, risk factors and signs of suicidal distress. They were more aware of resources available and the importance of providing postvention support, a non-judgemental space for people to tell their story, and the value of self-care.

More than 50% of respondents who attended the November 2019 GPEx Webinar were more confident to provide support for people in suicidal distress, particularly in being able to ask direct questions about suicidal ideation.

Further, more than 60% of respondents who attended the July 2020 GPEx Webinar and the SafeTALK training increased their knowledge and skills in areas such as assessment, safety planning, supporting families and using more appropriate language in suicidal situations. They also found these trainings practical and relevant, and they were going to share their learning with colleagues. Refer Table 64 for further detail.

3.11.2 Participant engagement and evaluation of the presenter

The majority of respondents were actively engaged with the training and were grateful for the opportunity to participate. Only one participant indicated that the QPR training was “a waste of time … given their level of education and experience”.

The various presenters received extraordinary recognition for their facilitation skills. Example comments included: “Excellent presentation that connected with the participants, making it relevant and helping engage students with the content” (Accidental Counselling); “fantastic at engaging with the group in a friendly safe environment” (ASIST); “great speaker - very knowledgeable and session thorough” (GPEx PLO Workshop); “Fantastic presentation. … knowledgeable, passionate, and very informative. … displayed respect for the subject and to people with mental health problems” (SafeTALK).

3.11.3 Training events recommendations

For webinars, respondents recommended being able to see faces, having a video component, being able to download recorded notes/replay, using case scenarios and more lived experience people. For QPR having captions on videos was recommended for hearing challenged people, having local content, and being able to see the correct answers to the questions they got wrong, was recommended. Respondents recommended that ASIST, QPR be available for all individuals and groups such as in schools, medical centres, workplaces, and on town libraries. In addition, one

person highlighted this further by recommending: “that this course be freely available to anyone at any time - and be able to access without requirements of login codes and personal information to be collected in the hopes that more people will complete it”.

Table 81: Impact of attending training events.

Training events	Impact of training responses [a]				
	Responses (*n*)	**Awareness raising (%)**	**Communication Engagement (%)**	**Confidence [b] (%)**	**Knowledge (%)**
Accidental Counselling	43	22 (51)	0 (0)	5 (12)	4 (9)
ASIST	35	9 (26)	0 (0)	7 (20)	6 (17)
Nov 19 Webinar	29	5 (17)	4 (14)	16 (55)	12 (41)
Jan 2020 Webinar	27	6 (22)	1 (4)	11 (41)	5 (19)
July 2020 Webinar	36	20 (56)	2 (6)	2 (15)	23 (64)
PGU Workshop	18	2 (11)	2 (11)	5 (28)	6 (33)
PLO Workshop	13	5 (38)	1 (8)	2 (15)	6 (46)
QPR	136	18 (13)	1 (0.7)	9 (7)	55 (40)
SafeTALK	47	3 (6)	0 (0)	1 (2)	32 (68)

[a] Respondents gave more than one response in a number of areas of impact

[b] One respondent did not “feel confident in how to manage these situations”

4.0 Phase 2 Survey: Findings

4.1 Data preparation

Data were checked for errors, range of scores, missing values and normality. There were 20 cases that contained no data and these were removed. After data cleaning, 162 participants completed the questionnaire. Not all participants completed each section of the overall questionnaire, however, all 162 participants completed the 10-item Suicide Prevention survey within the entire questionnaire.

4.2 Sample Characteristics

4.2.1 Demographics

Of the 162 respondents, 75% (*n*=121) identified as female, 23% (*n*=37) identified as male, one person identified as non-binary and 3 people did not answer. The majority were aged between 41- 50 years (37%) and 51-60 years (37%), 33% were aged 31-40, 26% were aged between 21- 30, 20% were aged 61-70, and less than three percent each were under 20 and over 70 years of age. 90% did not identify as Aboriginal or Torres Strait Islander and 6 percent did, four people preferred not to say and three did not answer this question. The majority of participants resided in Port Lincoln (*n*=30), while there was an even spread of participants that came from the Whyalla (*n*=22), Yorke Peninsula (*n*=21) and Port Pirie LGAs (*n*=16). Fewer were from Port Augusta (*n*=9) and while 'other' LGAs were represented by 38% of participants. The main work role was administrative (*n*=21), followed by trade/industry (*n*=15), volunteers (*n*=12) and the remaining groups comprised ten participants or less each. Please see Table 82 for more detailed information.

Table 82: Shows the online survey sample characteristics, N=162.

Characteristic	*n*=	%
Gender identity		
Male	37	23.0
Female	**121**	**75.0**
Non-binary	1	0.6
Missing	3	1.9
Age range in years		
18-20	3	1.9
21-30	26	16.0
31-40	33	20.4
41-50	**37**	**22.8**
51-60	**37**	**22.8**
61-70	20	12.3
71-80	3	1.9
Missing	3	1.9
Aboriginal or TSI identity		
Yes	10	6.2
No	**145**	**89.5**
Prefer not to say	4	2.5
Missing	3	1.9
Region		
Port Augusta	9	5.6
Port Lincoln	**30**	**18.5**
Port Pirie	16	9.9
Whyalla	22	13.6
Yorke Peninsula	21	13.0
Other	61	37.7
Missing	3	1.9
Work role		
Volunteer	12	7.4
Lived Experience Worker	8	4.9
First Responder	2	1.2
Administrative Worker	**21**	**13.0**
Nurse	10	6.2
Social Worker	7	4.3
Psychologist	2	1.2
GP	5	3.1
Trade/Industry	**15**	**9.3**
Farmer	3	1.9
Retired	2	1.2
Unemployed	4	2.5
Missing	3	1.9

4.2.2 Lived Experience of Suicide

Of the 162 participants in the survey, there was a diverse range of participants with a lived experience of suicide, ranging from people who self-reported experiencing suicidal thoughts (29%), or surviving a suicide attempt (10%), to caring for others after a suicide attempt (19%), and being bereaved by suicide (33%), while a further 16% were touched by suicide in other ways (see Table 83).

Table 83: Participants' lived experience of suicide, N=162.

Lived Experience Survey item	*n*=	%
1. Lived Experience of Suicide? No	44	27.2
Did not answer	118	72.8
2. Yes, suicidal thoughts	**47**	**29.0**
Did not answer	115	71.0
3. Yes, survived suicide attempt	16	9.9
Did not answer	146	90.1
4. Yes, cared for someone after suicide attempt	31	19.1
Did not answer	131	80.9
5. Yes, bereaved by suicide	**54**	**33.3**
Did not answer	108	66.7
6. Yes, other	27	16.7
Did not answer	135	83.3

4.2.3 NSPT Region top community events

Of the 162 participants in the survey, many attended more than one community event or activity within the NSPT region as a whole. Initial statistical modelling results in Table 67 below show that there were 230 attendances in the top twelve events and activities representing 60.7% of the 379 attendances altogether. Appendix 1 and 2 outline the number of attendances at all 55 community events in each region, and there were 379 attendances by our survey participants in the entire NSPT region overall. Table 84 outlines the events attended the greatest number of times in the NSPT region overall.

Table 84: Attendance rates at the top 12 NSPT events.

NSPT Regional Events & Activities	Frequency	Cumulative Percent
1. **Accidental Counseling**	**23**	10.0
2. **ASIST**	**27**	21.7
3. **QPR**	**50**	43.5
4. Rotary Men's Wellness	15	50.0
5. Roses in the Ocean	16	57.0
6. SafeTALK	14	63.0
7. **SP Calendar**	**21**	72.2
8. SP drink coasters	15	78.7
9. GPEx	11	83.5
10. Save our Mates	13	89.1
11. Ripple Effect Documentary	13	94.8
12. Connecting with People	12	100.0
Total	230	= 60.7% of all attendances

4.3 Survey Questionnaire

The survey was the main focus of **Phase 2** in the project, to obtain self-reported responses about the outcomes on participants since their attendance at suicide prevention community events and activities over the previous three years from 2017 - 2020. These data showed very positive responses indicating that the events attended impacted upon awareness raising, stigma reducing attitudes, knowledge about suicide risk factors, and capacity building to help others or themselves respond to people in suicidal crisis (see Table 85). There were no missing respondents in this section and all participants answered each question in this survey, scores ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). There was greater than 80% agreement on all items except for item 3 which reported on stigma: '*People who talk about suicide are not serious, but just seeking attention*' indicating that 87% of participants disagreed with this survey item. The highest scoring impact was an increase in compassion towards a suicidal person at almost 100% agreement with this survey item.

Table 85: Results of the online survey questionnaire.

Suicide Prevention Survey item*	*N*=162	M (SD)	% Agree	% Neither agree/disagree	% Disagree
1. Understand S is preventable	162	4.03 (0.70)	80.9	17.3	1.9
2. Understand S risk factors	162	4.20 (0.69)	88.9	9.9	1.2
3. S people are attention seeking	162	1.71 (0.73)	0.6	12.3	87.0
4. Knowledge S person refer services	162	4.26 (0.59)	93.8	5.6	0.6
5. Compassion towards S person	**162**	**4.52 (0.70)**	**95.7**	**2.5**	**1.8**
6. Confident to help S person	162	4.09 (0.64)	88.3	11.1	0.6
7. Likely to seek help myself	162	4.22 (0.71)	87.0	11.1	1.9
8. Understand cultural difference	162	3.93 (0.78)	76.6	19.1	0.6
9. Knowledge warning signs	162	3.98 (0.75)	83.3	14.2	2.5
10. Recommend event to others	162	4.40 (0.68)	92.0	7.4	0.6

*Response range 1=strongly disagree to 5=strongly agree

4.4 Examining differences in groups in response to the survey

4.4.1 Demographic characteristics with suicide prevention survey responses.

Investigations using two-way ANOVAs on each of the suicide prevention survey items examined whether there were any significant differences between age groups, gender, Aboriginal identity, work role and lived experience. Results revealed no significant differences on any of the survey items about suicide that reflected awareness raising, stigma reducing, help seeking or help offering, increasing knowledge, confidence or competence around these target areas in suicide prevention.

Age groups for example, older women aged 71 – 80 scored highest on all survey items, males aged 21-30, although responding positively, scored lowest on knowledge of where to connect people who may be at risk of suicide; males aged 51-60, although responding positively, scored lowest on compassion towards people thinking about suicide; males aged 18-20, although responding positively, scored lowest for help seeking if thinking about suicide themselves. However, 2-way ANOVAs revealed no significant differences between age groups on each survey item.

Gender Again, closeness of respondents' scores revealed no significant differences in gender identity on the suicide prevention survey items. This was confirmed by t-tests on each survey item by gender. See Table 86 for more detail.

Table 86: Means and standard deviations of survey item scores by gender identity.

Suicide Prevention Survey item*	Male M(SD) *n*=37	Female M(SD) *n*=121	Non-binary M(N/A) n= 1
1. Understand S is preventable	3.97 (0.55)	4.05 (0.75)	4.00
2. Understand S risk factors	4.05 (0.66)	4.26 (0.68)	4.00
3. S people are attention seeking	1.81 (0.62)	1.68 (0.77)	1.00
4. Knowledge S person refer services	4.16 (0.60)	4.29 (0.58)	4.00
5. Compassion towards S person	4.38 (0.89)	4.55 (0.63)	5.00
6. Confident to help S person	4.11 (0.57)	4.21 (0.66)	4.00
7. Likely to seek help myself	4.08 (0.60)	4.27 (0.74)	4.00
8. Understand cultural difference	3.78 (0.71)	3.99 (0.78)	4.00
9. Knowledge warning signs	4.08 (0.60)	4.12 (0.77)	4.00
10. Recommend event to others	4.46 (0.65)	4.39 (0.70)	4.00

*Response range 1=strongly disagree to 5=strongly agree

Aboriginal identity, out of the range of possible responses from 1 (*strongly disagree*) to 5 (*strongly agree*), for Aboriginal People, non-Aboriginal people and those who did not disclose, scores varied little from 4 (*agree*) on all 10 items except item 3 about stigma i.e., '*People who talk about suicide are not serious, but just seeking attention'*. There was slight variability among groups where people who preferred not to disclose had the strongest disagreement, non-Aboriginal people disagreed, and Aboriginal People disagreed less strongly. Due to low numbers of Aboriginal participants in this study (*n*=10) results could not be broken down further by gender or tested for any significant meaningful differences. This low number of Aboriginal Peoples in the participant pool is also insufficient for generalization to the Australian population. Again, further comparison of means revealed no significant differences between Aboriginal identity groups on each survey item when tested using ANOVAs.

Work role. There were a diverse group of work roles, both professional and non-professional represented across our sample. As might be expected, fewer professional roles were represented in the sample as they would be expected to have had the necessary skills and training built into their graduate degree education programs enabling them to respond to suicidal crises more appropriately than untrained community members. Nevertheless, all participants responded showing positive attitudes, considerable knowledge and confidence to assist a person in suicidal crisis. Investigation comparing means by 2-way ANOVAs revealed no significant differences between work role groups on each of the survey items.

Closer inspection of results show non-significant trends of interest, for example, first responders scored lowest (mid-way between *Agree* and *Disagree*) for item 1, '*I understand now that suicide is preventable*' which may indicate less hope due to higher exposure to people in suicidal distress who do complete suicide. In other areas, first responders show low levels of stigma, good understanding of risk factors and warning signs, knowledge of referral pathways, high scores on compassion, confidence to help others and themselves, and sufficient knowledge of cultural differences that people in suicidal distress may experience. The other observation of note from the graphs were some of the responses by farmers and unemployed people. While in the context of all work role scores showing results in the mid-range or above in the expected response direction, unemployed people and farmers scored lowest on knowledge of risk factors, farmers scored lowest on compassion and highest on stigma, farmers also scored lowest on knowledge of cultural differences. Since there were no *significant* differences in mean scores explored by 2-way ANOVAs and since all respondents scored positively – observations from trends need to be interpreted conservatively.

Lived experience of suicide on each of the 10-item survey questions. The research questions aimed to qualify what levels of characteristic had the greatest impact on awareness raising, stigma reducing, help seeking or help offering, increasing knowledge, confidence or competence around these target areas in suicide prevention. People with lived experience may show differences on some of these variables when compared to people with no lived experience, however, not everyone in the survey answered this question. Almost 30% of the sample self-reported that they did not have lived experience of suicide, whereas there were between 10-30% of respondents who had some form of lived experience of suicide. When comparing means for responses on each of the survey questions (see Table 6), two-way ANOVAs indicated there were no significant differences between people who had no lived experience and those who reported having any level of lived experience of suicide. The variations between groups can be seen more easily in Table 87.

Table 87: Means and standard deviations for each survey item according to lived experience of suicide.

Suicide Prevention Survey item*	No LE of suicide M(SD)	LE suicidal thoughts M(SD)	LE suicidal attempt M(SD)	LE bereaved by suicide M(SD)
1. Understand S is preventable	4.05 (0.68)	4.11 (0.81)	4.00 (0.73)	3.94 (0.76)
2. Understand S risk factors	4.14 (0.63)	4.36 (0.76)	4.75 (0.45)	4.15 (0.74)
3. S people are attention seeking	1.93 (0.82)	1.57 (0.68)	1.44 (0.73)	1.70 (0.69)
4. Knowledge S person refer services	4.11 (0.69)	4.43 (0.54)	4.44 (0.63)	4.24 (0.51)
5. Compassion towards S person	4.61 (0.49)	4.55 (0.83)	4.62 (0.62)	4.44 (0.63)
6. Confident to help S person	4.07 (0.66)	4.26 (0.64)	4.50 (0.52)	4.17 (0.58)
7. Likely to seek help myself	4.25 (0.65)	4.19 (0.74)	4.13 (1.03)	4.22 (0.72)
8. Understand cultural difference	3.84 (0.83)	4.09 (0.72)	4.13 (0.72)	3.91 (0.76)
9. Knowledge warning signs	4.14 (0.67)	4.26 (0.71)	4.25 (0.78)	4.06 (0.71)

10. Recommend event to others	4.34 (0.68)	4.53 (0.62)	4.75 (0.45)	4.46 (0.61)

*Response range 1=strongly disagree to 5=strongly agree

4.4.2 Effects of attendance at community events on responses to the suicide prevention survey.

The top 12 community events and activities with the greatest attendance rates (please refer back to Table 84) had the mean scores calculated by each survey item (see Table 88). In using the table as a matrix, one can quickly observe the factors on the left associated with highest or lowest scores by participants attending the respective community events. For example, participants who attended QPR had the lowest score for item 3, i.e., '*People who talk about suicide are not serious, but just seeking attention*'. Low scores on this item indicate low levels of stigma associated with participants attending this activity. In another example, participants who were exposed to the Suicide Prevention Drink Coasters were associated with high scores on item 1, i.e., '*I understand now that suicide is preventable'*, and Table 88 can be interpreted in this way for each factor and each community event. No further testing for *significant* differences between attendees mean scores on community activities were conducted due to the close similarity between scores, low cell numbers (i.e., events and activities with the number of attendees >15 were required for any further statistical comparisons, and ceiling effects (i.e., scores at the highest or lowest possible within the range of 1 to 5). The most likely explanation for ceiling effects noted within the study were because most participants responded favourably to each survey question. As Table 88 shows, results indicate that the majority of mean scores lay within a close range of each other and in the expected direction. Readers should also bear in mind that many participants attended more than one community event. See Table 85 for the entire survey questionnaire items.

Table 88: The means and standard deviations for each survey item according to the community events that were attended most.

Event Suicide Prevention Survey item*	Accidental Counseling M(SD)	ASIST M(SD)	QPR M(SD)	Rotary Men's Wellness Event M(SD)	Roses in the Ocean M(SD)	SafeTALK M(SD)	SP Calendar M(SD)	SP Drink Coasters M(SD)	GPEx training M(SD)	Save our Mates Roadshow M(SD)	Ripple Effect Documentary M(SD)	Connecting with People M(SD)
1. Understand S is preventable	4.09 (0.56)	4.26 (0.81)	4.14 (0.70)	4.20 (0.78)	4.25 (0.78)	4.07 (0.83)	4.29 (0.64)	4.40[2] (0.74)	4.00[1] (1.00)	4.23 (0.60)	4.23 (0.73)	4.33 (0.65)
2. Understand S risk factors	4.30 (0.77)	4.41 (0.69)	4.36 (0.80)	4.60 (0.51)	4.50 (0.63)	4.29[1] (0.73)	4.62 (0.50)	4.53 (0.52)	4.45 (0.69)	4.46 (0.66)	4.85[2] (0.38)	4.42 (0.79)
3. S people are attention seeking	1.91 (1.04)	1.70 (0.67)	1.42[1] (0.58)	1.87 (0.74)	1.44 (0.63)	1.79 (0.80)	1.57 (0.75)	1.67 (0.82)	2.09[2] (0.83)	1.54 (0.78)	1.62 (0.77)	1.83 (0.94)
4. Knowledge S person refer services	4.26 (0.75)	4.26 (0.76)	4.46 (0.61)	4.47 (0.64)	4.38 (0.62)	4.14[1] (0.86)	4.43 (0.60)	4.47 (0.64)	4.18 (0.75)	4.38 (0.65)	4.62[2] (0.65)	4.25 (0.87)
5. Compassion towards S person	4.48 (0.59)	4.56 (0.70)	4.60 (0.86)	4.73 (0.46)	4.44 (1.03)	4.50 (0.76)	4.57 (0.93)	4.53 (1.06)	4.55 (0.69)	4.23[1] (1.17)	4.85[2] (0.38)	4.42 (1.24)
6. Confident to help S person	4.30[1] (0.56)	4.37 (0.57)	4.42 (0.64)	4.47 (0.64)	4.37 (0.62)	4.43 (0.65)	4.43 (0.68)	4.47 (0.74)	4.45 (0.52)	4.38 (0.65)	4.77[2] (0.44)	4.67 (0.49)
7. Likely to seek help myself	4.22 (0.85)	4.30 (0.67)	4.34 (0.80)	4.60 (0.51)	4.25 (0.68)	4.14[1] (0.86)	4.43 (0.60)	4.53 (0.64)	4.45 (0.69)	4.38 (0.65)	4.62[2] (0.65)	4.33 (0.78)
8. Understand cultural difference	3.96[1] (0.88)	4.07 (0.83)	4.04 (0.73)	4.20 (0.68)	4.13 (0.62)	4.14 (0.66)	4.29 (0.64)	4.20 (0.56)	4.36 (0.81)	4.08 (0.86)	4.46[2] (0.52)	4.17 (0.72)
9. Knowledge warning signs	4.17 (0.83)	4.33 (0.68)	4.32 (0.82)	4.40 (0.63)	4.00[1] (1.10)	4.21 (0.70)	4.05 (0.97)	4.20 (1.15)	4.45[2] (0.82)	4.15 (1.14)	4.38 (0.77)	4.17 (1.19)
10. Recommend event to others	4.39 (0.72)	4.59 (0.57)	4.44 (0.81)	4.80 (0.41)	4.31 (1.08)	4.36 (0.63)	4.62 (0.92)	4.53 (1.06)	4.45 (0.69)	4.62 (1.12)	4.85[2] (0.38)	4.25[1] (1.29)

Note [1.] = lowest score [2] = highest score for community event within a given survey item. *Response range 1=strongly disagree to 5=strongly agree.

4.4.3 Discussion points for Table 88 results.

Firstly, it should be noted that mean scores show positive responses to all of the most attended community events because the possible response range was from 1=strongly disagree to 5=strongly agree. Indicating positive mean response scores on: knowledge attainment (survey items 1, 2 and 9) that suicide is preventable, suicide risk factors and suicide warning signs; stigma (survey item 3); how to refer people in suicidal distress for professional help (item 4); compassion (item 5); confidence to help others (item 6); intentions to seek help for oneself (item 7); understanding cultural difference (item 8); and sharing by recommending events to other people (item 10). When looking closely at the results tables there is negligible difference between mean scores on each survey item indicating little difference between the effectiveness of the community events listed. For example, the highest mean score across the suicide prevention survey (excluding item 3 which is negatively worded) was 4.85 and the lowest was 3.96 overall which is less than one point of difference between the lowest and highest scores.

Nevertheless, bearing these ceiling effects in mind, the Suicide Prevention Drink Coasters rated highest for understanding that suicide is preventable (M=4.40, SD=0.74) but did not rate highest on any other factor. Which may indicate that the intended message of the campaign was to address this point, and if so, it was very successful in doing so.

Similarly, Question, Persuade, Refer (QPR) training rated lowest (which is the most favourable response) to stigmatizing attitudes towards people who talk about suicide (M=1.42, SD=0.58). Therefore, QPR training might be the best option when targeting stigma reduction in the community or chosen organization. GPEx training had the best results for increasing knowledge around the warning signs of suicide (M=4.45, SD=0.82) and this may be relevant for clinical or frontline workplace applications. The Ripple Effect Documentary scored the highest on all of the other suicide prevention factors in the survey which included compassion, confidence to help oneself and others, knowledge of risk factors and cultural difference, and where to refer a person to appropriate services. The documentary was also the most highly rated for recommending the event to others.

5.0 Phase 3 focus groups and interviews: Findings

Please note: Language conventions used in quotes throughout this section have been changed from he/she to they/their to respect gender preferences and also to increase anonymity. Pseudonyms have also been used throughout to ensure anonymity.

5.1 Sample size

Due to challenges in scheduling in-person focus groups in the 5 regions under evaluation, individual face-to-face interviews and online focus groups and interviews were also conducted. Consequently, five in-person focus groups (FGs) were conducted with from 2 to 4 participants; three FGs in Whyalla during two visits, one FG in Port Augusta, and one in Maitland. Two in-person interviews were conducted in Whyalla during the two visits. Two FGs with two participants in each, were conducted via Zoom. Individual interviews were conducted via Zoom (*n*=15) and telephone (*n*=10). One person did not attend the last FG in Whyalla, one person decided not to participate, and there was loss of contact with 6 potential participants. Thus, a total of 34 FGs/interviews were conducted with a total sample size of 44, which included non-clinical and clinical (Aftercare) participants. Due to the small sample size of the Aftercare participants, non-clinical and clinical (Aftercare) data are aggregated to maintain anonymity of participants. Focus group duration was from 45 to 80 minutes and interviews from 30 to 60 minutes.

5.2 Sample characteristics

Of the 44 participants, the majority identified as female (*n*=33, 75%), in the 51-60 age group (*n*=14, 31.8%), living in Whyalla (*n*=15, 34.1%), and were non-Aboriginal or Torres Strait Islander (*n*=41, 93.1%). Most of the participants were volunteers (*n*=5, 11.4%), business owners (*n*=5, 11.4%), support workers (*n*=5, 11.4%) or were retired (*n*=5, 11.4%). Four (9.1%) participants did not report a lived experience of suicide, while 22 (50%) had been bereaved by suicide, 18 (40.9%) had cared for, or supported someone who has attempted suicide, or is at risk of suicide, 17 (38.6%) had experienced suicidal thoughts and 11 (25%) had survived a suicide attempt. Furthermore, most participants (*n*=31; 70.5%) were involved in some way, with implementation of the NSPT activities, training and/or events. Refer to Tables 89 to 91 for further details.

Table 89: Sample Characteristics of focus groups and interviews: Clinical and non-clinical.

Characteristic	*Responses n*=44 (*n*)	%
Gender identity		
Male	11	25.0
Female	33	75.0
Age range in years		
21-30	2	4.5
31-40	8	18.1
41-50	9	20.5
51-60	14	31.8
61-70	10	22.7
71-80	1	2.3
Aboriginal or Torres Strait Islander identity		
Yes	3	6.8
No	41	93.1
Region where live		
Port Augusta	4	9.1
Port Lincoln	7	15.6
Port Pirie	2	4.5
Whyalla	15	34.1
Yorke Peninsula	6	13.6
Adelaide	4	9.1
Cummins	2	4.5
Spaulding	1	2.3
Mt Gambier	2	4.5
Baroota, Mambray Creek, Pt Flinders, Pt Germain (5495)	1	2.3
Work role		
Volunteer	5	11.4
Business owner	5	11.4
Support Worker	5	11.4
Education & training	3	6.8
Lived Experience Worker	3	6.8
First Responder	1	2.3
Administrative Worker	1	2.3
Nurse	1	2.3
Social Worker	3	6.8
Psychologist	1	2.3
Trade/Industry	2	4.5
Counsellor	1	2.3
Retired	5	11.4
Other	8	18.1

Table 90: Lived Experience: Clinical and non-clinical participants.

Lived Experience	*Responses* *n*=44 [a] (*n*)	%
Experienced suicidal thoughts	17	38.6
Survived a suicide attempt	11	25.0
Care for, or supported someone who has attempted, or is at risk of suicide	18	40.9
Bereaved by suicide	22	50.0
Did not report lived experience of suicide	4	9.1

[a] Participants reported more than one category of lived experience

> *…accepting that something is wrong to begin with. … you need to inspire and motivate people to begin with, to even reach out, and once they accept within themselves that they don't have all the answers and they actually need help, that's when they will reach out (Tony).*

Table 91: Involved in implementation of NSPT activities.

Involvement	*Responses* *n*=44 (*n*)	%
Involved in various aspects of implementation of the NSPT; attended activities; have various other suicide prevention roles in community	31	70.5
Attended activities	6	13.6
Not involved in NSPT implementation, but work in suicide prevention space	5	11.4
Not involved in NSPT implementation, but involved in running non-NSPT groups/activities	2	4.5

5.3 Activities attended or experienced

The demographic survey for Phase 3 included a list of NSPT training and events from which to choose as a reminder prompt for participants to recall which ones they had attended. However, participants reported difficulty remembering, of all the events they had attended over the last few years (2017-2021), which were NSPT activities, and which were not. As highlighted by Hannah: "I've done so many different trainings, and stuff like that, I might have been getting confused". One person who attended one NSPT activity could not recall which one it was. Of the NSPT activities they could recall, the most frequent training reported was Question, Persuade, Refer (QPR) online training (*n*=21, 47.7%), and the Applied Suicide Intervention Skills Training (ASIST) Workshop (*n*=12, 27.2%). The most frequent community events attended or experienced were the World Biggest Comic Book (*n*=11, 25%), the World Biggest Comic Book Launch (*n*=11, 25%), and/or the Roses in the Ocean Walk (*n*=10, 22.7%). Refer to Refer to Table 92 for further details.

Table 92: Frequency of National Suicide Prevention Trial community activities attended or experienced: Clinical and non-clinical participants.

Activity (Participants attended or experienced more than one NSPT activity)	Activity Type	*n=44* (*n*)	%
QPR Online Training (hosted by CSAPHN)	Training	21	47.7
ASIST Workshop (hosted by Lifeline; Centacare; CSAPHN; Mates in Construction)	Training	12	27.2
World's Biggest Comic Book (developed by Whyalla Suicide Prevention Network)	Print Material	11	25.0
World's Biggest Comic Book Launch (hosted by Whyalla Suicide Prevention Network)	Community Event	11	25.0
Roses in the Ocean Walk (hosted by Whyalla Suicide Prevention Network)	Community Event	10	22.7
Stand Up for Mental Health Workshops (hosted by Whyalla Suicide Prevention Network)	Community Event	8	18.1
Suicide The Ripple Effect Documentary (hosted by Mentally Fit EP; SOS Yorkes)	Community Event	8	18.1
Save Our Mates Wellbeing Roadshow (hosted by hart Wellbeing)	Community Event	8	18.1
Connecting with People Training (hosted by SA Health)	Training	7	15.9
First Responders Wellness Dinner (hosted by Whyalla Suicide Prevention Network)	Community Event	6	13.6
QPR TV Campaign (developed by CSAPHN)	Campaign	6	13.6
Roses in the Ocean Voices of Insight (hosted by Roses in the Ocean)	Training	6	13.6
First Responder Awareness Films (developed by Whyalla Suicide Prevention Network)	Video	5	11.4
Suicide Prevention Calendars (developed by Mentally Fit EP; CSAPHN)	Print Material	5	11.4
World's Biggest Comic Book Workshop (hosted by Whyalla Suicide Prevention Network)	Community Event	4	9.1
LivingWorks Start Online Training (hosted by CSAPHN)	Training	5	11.4
QPR Social Media Campaign (hosted by CSAPHN)	Campaign	5	11.4
Roses in the Ocean Our Voice on Action (hosted by Roses in the Ocean)	Training	4	9.1
Totally Mental Film Animation (developed by Whyalla Suicide Prevention Network)	Video	3	6.8
You Me Which Way (hosted by Centacare)	Training	4	9.1
Men's Health Event (hosted by SOS Yorkes)	Community Event	4	9.1
Community Calendar Launch Event (hosted by SOS Yorkes)	Community Event	4	9.1
Deadly Thinking Training (hosted by mentally Fit EP)	Training	2	4.5
Family Fun Day (hosted by Empowering Lower Eyre)	Community Event	3	6.8
Suicide Prevention Drink Coasters (developed by Mentally Fit EP)	Print Material	3	6.8
Wellbeing Event (hosted by Empowering Eyre)	Community Event	3	6.8

Table 92 *continued*: Frequency of National Suicide Prevention Trial community activities attended or experienced: Clinical and non-clinical participants…

Activity (Participants attended or experienced more than one NSPT activity)	Activity Type	*n=44* (*n*)	%
Accidental Counselling (hosted by Lifeline)	Training	2	4.5
Connector Development (SafeTALK) (hosted by Mates in Construction)	Training	1	2.3
Mental Health First Aid Training (hosted by Whyalla Suicide Prevention Network)	Training	1	2.3
Mental Health Football Round (hosted by Empowering Lower Eyre)	Community Event	2	4.5
Mindframe Plus Workshop (hosted by Everymind)	Training	2	4.5
Port Neill Wellbeing Family Session (hosted by Mentally Fit EP)	Community Event	2	4.5
Reflection Seat Project (hosted by Lincoln Alive)	Community Event	2	4.5
Rotary Men's Wellness Campaign Event (hosted by Mentally Fit EP)	Community Event	2	4.5
SafeTALK Workshop (hosted by Lifeline)	Training	2	4.5
Sharing your Story - Short Film Event (hosted by Mentally Fit EP)	Community Event	2	4.5
Building acute suicide management Skills (hosted by GPEx: Dr J Alexander)	Training	1	2.3
Business Port Augusta Mental Wellbeing Event (hosted by SILPAG)	Community Event	1	2.3
Coping with stress during COVID-19 Outbreak: Toolbox (hosted by Mates in Construction)	Training	1	2.3
Family Fun Day (hosted by Pika Wiya)	Community Event	1	2.3
Ladies WOTL Circle (hosted by Mentally Fit EP)	Community Event	1	2.3
SOS Copper Coast Website (developed by SOS Copper Coast)	Website	1	2.3
Suicide Story Workshop (hosted by Centacare)	Training	1	2.3
Youth Aware of Mental Health Training (hosted by CSAPHN)	Training	1	2.3

5.4 Impact of attending NSPT activities

Most participants, including those who accessed Aftercare services (*n*=43, 98%), reported that attending had impacted on them in a variety of ways. Of those (*n*=43), the most frequent impact was an increased competence and confidence (*n*=25, 58%) to communicate more openly and connect with people (*n*=27, 63%), even 'strangers'. As highlighted by Vera:

> *"You learn how to talk to them in a real way, not in a clinical, … you learn how to actually have a real conversation, you don't mince your words, you're like, yeah, you're in a bad place, it's shit, it really is. … that it is okay to talk about it… (Vera)*

There was an increase in individual and community awareness of "mental health and mental illness generally" (Colleen), and of the statistics of suicide, with "head shaking moments" (Liz). As John stated: "I think we can all do more if we're more aware".

There was an increased consciousness that suicide does not discriminate and that it can be "preventable" (Grace). As highlighted by Karleen: "people are no different, we all go through the same things, and it can affect any one of us". Participants reported being "more aware of how people are" going within the workplace and community (Marg), including those identifying as gender diverse (Kay). Not only was there an increase in listening (*n*=10, 23%), talking and engaging with people (*n*=11, 26%), using more appropriate suicide-related language (*n*=7, 16%), but there was an increase in compassion (*n*=19, 44%), and help offering (*n*=14, 33%), with participants expressing that it was a privilege to 'be with' people at such vulnerable times in their lives. Responses demonstrated a felt sense of gratitude to be working in the suicide prevention space (*n*=7, 16%). There was also acknowledgement that "services and people are doing really amazing things" (Lucy) within the community. Tony emphasised the important role that awareness has on people being able to recognise that "they are *actually* struggling, and that they can *actually* do something about it" before they can even reach out for assistance. Refer to Table 93 for further detail.

There was also a flow on, or ripple effect from participants who had attended the NSPT activities as conversations and learnings were shared (*n*=10, 23%). Furthermore, there was an increase in community engagement and support for suicide prevention activities (*n*=6, 14%) and examples of businesses (such as gyms) partnering with service providers to run wellbeing events.

Two of the participants using the clinical (Aftercare) services reported that they had not attended any of the other NSPT activities. Tom was more aware of when to seek help and he did so more often. Wil felt more able to speak up, and discuss how they were feeling, which they would not do with their partner as they did not want to upset them. In addition, Wil felt listened to, without being judged stating: "it's really nice to speak with them … kind of like freedom … and it was good".

> *It's very intangible, … to really assess the impact of individual actions. … It all comes down, to a very broad definition of suicide prevention, which is life affirmation. And any act of kindness is, by definition, suicide prevention (Jake)*

Table 93: Areas of impact following NSPT activities: Frequency of participant responses.

Areas of impact	Responses *n*=43	%
Communicating, connecting and opening	27	63
Awareness raising	25	58
Increased competence and confidence	25	58
Compassion	19	44
Increased help offering	14	33
Reduced judgement and stigma	14	33
Talking and engaging with people	11	26
Listening	10	23
Flow on effect to the community	10	23
Language	7	16
Gratitude	7	16
Engagement and support from the community	6	14
Determination to make a difference	6	14
Recognition of own boundaries	6	14
Inspired	5	12
Reaffirming	4	9
Better Prepared Organised	3	7
Empowered to speak up	3	7
Event speaking	2	5
Life changing	2	5
Positive outlook	2	5
Recognising triggers	2	5
Recognition of gender diversity	1	2
Creative	1	2

[a] Participants reported more than one category of lived experience

5.5 Individuals' capacity to better manage people expressing suicidal crises in their regional communities

Not only were participants (*n*=44) able better manage others in suicidal crises, but they were also better able to manage their own mental wellness because of what they had learnt and experienced.

5.5.1 Applying knowledge and skills learnt

Participants reported that they applied the knowledge and skills (*n*=15, 34%) they learnt and were more able to link or refer people to appropriate resources and services (*n*=20, 45%). There was also "a direct increase in referrals to services" following events (Lucy), and people were "seeking help and information" (Max). Refer Table 94 for further detail. As highlighted by Marg and Phoebe, lived experience participants commented that apart from attending NSPT activities, they had gained knowledge, experience, and skills over time.

Some of the skills that I have, I've actually learnt myself through what I've gone through (Marg) … to have that knowledge of my own experience (Phoebe)

5.5.2 Interrupting suicidal pathway

Application of knowledge and skills learnt was also reflected in individuals' self-reported capacity to connect with people in suicidal crises and interrupt the suicidal pathway (*n*=19, 43%). The sample of participant responses in Table 94 illustrates some of the strategies used. Devising safety plans for themselves, as well as in partnership with others was also seen as an important aspect in suicide prevention (*n*=19, 43%), as was generating hope. Kay also raised the challenge of assisting people in suicidal crisis:

I think it takes a lot of courage to actually put yourself in a space where you are the person that's actually there for that person as well, as much as is it is for the person who is actually thinking about ending their life (Kay)

5.5.3 Suicidal pathway interrupted

Additional evidence for interruption of suicidal pathway is reflected in the feedback participants received from those they had helped (Table 95). Individuals who were helped during suicidal crisis were appreciative and grateful that someone was there to ask them the difficult questions and to support them in receiving additional assistance (*n*=23, 52%). There were instances however, where people were initially upset that someone had interrupted their suicidal pathway such as doing a safety check and calling the police, later to apologise (Elena). There was often a felt sense of safety conveyed to some participants as people sought them out for advice and assistance (*n*=16, 36%). Some individuals indicated that the participant had saved their life (*n*=12, 27%). There were examples of reconnection and carrying on after suicidal ideation or attempt (*n*=10, 23%).

… a lot of people have tried everything. … a lot, would you believe, do not want to go to the hospital. They'll say, no, flat out. … they'll say, oh, I went to the hospital, said I was suicidal, and they sent me home (Elli)

And maybe those staff members need more looking after and more support in their roles. So that's the way I would approach that, so I'd look into that in terms of mental health nurse support and support for first responders (Jake)

While participants had increased their ability to interrupt the suicidal pathway, they acknowledged that:

There are people there that don't want to live and yet, maybe there is a reason for living (Cora)

Table 94: Participants' capacity to manage suicidal crises.

Themes	Sample of focus group or interview responses
Applying knowledge and skills	*Learning what to say, but learning the questions that you should ask, how you can go around asking those questions, and learning some of the signs, learning the triggers that people may have. All of a sudden, they've gone quiet, they don't talk anymore, or they go the opposite, they talk too much (Marg).*
Able to link/refer	*I've now got in my little bucket of resources that I might be able to recommend. … personally, as well, if there's someone in my personal network that might be struggling, … making sure that they knew, the helplines, … because the NGOs or services out there are nine to five, so quite often when you're not feeling so good it's after-hours. So, making sure they knew what resources were available to them but having a plan so they are going to be safe (Amelia).*
	… give them resources so they then feel it's okay and they feel comfortable. … people come back to me and say, oh, this worked really well, thanks for these resources (Elena).
Interrupting suicidal pathway	*You don't discourage them from their thoughts of suicide, which a lot of us found that really weird. So I always remember that, because to me it's like you're trying to help them find their thoughts into a better place and see the positives (Claire).*
	I'm probably even more open about asking someone where they're at, … there have been times where I've then activated a circle of support and services around people after asking them directly where they were at with their suicidality (Casey).
	We always did a safety plan because of – and I have done a safety plan with my GP, for myself (Clara).
	… the different methods … the questions you ask …the resources … it was just the way how you deal with someone who's suicidal. Make sure they're safe. The whole aspect of it. I had no idea how to deal with anyone who was suicidal, until I did the course and went through the steps and the things that we talked about, and not talk about, and make them feel that they had strengths and so forth. It was all a really good learning experience (Elli).
	… you've had someone call and they say, right, I'm going to kill myself. I'm going to do it now. I'm going to do it today. And by the end of the call they're seeing life in a whole different way. And they're feeling positive (Elli).
	We set up the … framework, scaffolding for contact (Henry).
	We look at what are the protective factors. Touching base with people regularly. And not taking their face value presentation as an indicator of what's really happening under the surface. Because we all know that people can present really well but underneath, they're living in a storm (Liz).

Hope	*I noticed that they weren't really themselves. … I thought, well, I can either ignore it or I can maybe feel this bit of discomfort and ask the question anyway. … they were really in the preliminary stages … trying to figure out how they were going to do that. And so me being able to open up a conversation, according to them, was really helpful in them problem-solving the pain (Cecile).* *I take that card in with me and talk to the person. And then go through the steps of the PAL … I would use that tool to help navigate through what's happening for this person. Put a safety plan in place, all of those sorts of things (Elena).* *This young man approached Kingsley in the mall. … yeah, at that very moment, feeling like he wanted to suicide. He needed help then. Right then and there. So you were able to provide him that support (Matt and Amelia).* *I was just doing some work on the ward, … And someone … was going through a number of suicidal thoughts and feeling very defeated and like their life was over. … I was … at the right place at the right time … I was able to sit down and have a really long discussion. … normalise what they were going through. And also build that connection to life and build hope for the future and that sort of stuff (Jake).* *Once talking to them and asking the really hard questions, "Do you want to harm yourself?" "Have you got a plan in place?" It shocks them, and it's to the point where they just want to talk to you, and then they say, "Well thank you, I really appreciate you talking to me." (Marg).* *So if I don't hear for a couple of nights I'll ring. So to put the safeguards in place … to do what is feasible that can work for her and for me. And I keep phoning up and saying that she can ring me anytime even if she just wants to talk and doesn't want a conversation, she can just talk at me (Cora).* *A suicidal program doesn't have to be all dark and gloomy (Cora).* *There's hope. There's that sense of being able to say, I was in a shit place … But day by day, and second by second, I found something to hang onto. And now everything's turned around. My life has turned out really great. And I'm so glad that I'm here. … just to be able to give that little glimmer of hope when people are really unwell, or feeling in a crisis, in those situations it has helped them a tiny bit (Phoebe).* *They are rebuilding their life in a new area and getting some jobs and setting up a business and now they have that hope for the future (Liz).* *I just wanted them to feel loved and that there was hope (Grace).* *[We] did something different and had these big stencils that were put on the footpath with messages of hope (Amelia).*

Table 95: Suicidal pathway interrupted: Feedback received.

Themes	Sample of focus group or interview responses
Appreciative and grateful	*They said: "oh I'm so going to miss you, but you know, I don't think I need you anymore" (Liz).*
	Thank you for caring (Chloe).
	… going through really bad stuff internally and had never spoken to anyone in the world about it. So just a relief. Almost like a pressure valve. They just ring you and just offload (Don).
	"If it wasn't for you, I wouldn't be doing what I'm doing now" (Penny).
	I had one person tell me thank you because they had never had anyone who's helped them, give them information for local services (Elanor).
	People have been quite appreciative of that approach, not being forceful, but just like, I'm willing to listen to whatever is going on in that head of yours, like literally nothing will scare me (Cecile).
Safe person	*… just saying I'd listened and that's all that they needed was somebody to talk to, not give advice to, just to talk to. They said, just the expression on my face, they could see that I was really interested in what they had to say, and my caring, nurturing, just there, just listening (Marg).*
	I think it deepens … that sense of trust and being seen, and the fact that people are safe, they're safe to express themselves because there's a professional and empathetic response without there being any drama, or story, or gossip, or any of that stuff around it (Casey).
	They seem to appreciate the fact that I'm listening to them, whereas I lot of people fob them off. The next time I see them they will engage with me and talk to me (Ivy).
	That feedback is …it's just that the openness about it all and not being scared to talk about death, because that is a reality for some people in their minds, that's the solution (Cecile).
	I'll get people ring and it's usually someone who knows someone who's experiencing suicidal distress and they'll ring me because they know who I am and ask how can they get into a service? (Mia).
Saved my life	*I've tried twice [attempted suicide] and you've saved my little children from losing their dad now (Kelly).*
	You've saved me from thinking about all the bad things that I've been thinking about (Claire).
	One lady quite clearly said, "I saved her life" (Clara).

Reconnection and carrying on	*They're in crisis … And if you can get them through that … four months later they'll be just like, "I wouldn't have been here if you weren't here" (Vera).*
	I've got a good friend that swears, I saved her life at one particular time because she was so desperate (Ava).
	One of them said straight out, if it hadn't been for the help they got they would have, certainly, taken their own life (Henry).
	That moment saved my life. If you weren't there in that moment, I'm not sure I'd be here. The fact that you heard me when I was telling you that I was suicidal (Phoebe).
	They were happy as anything, because I didn't even recognise them. They came up to me and shook my hand and everything like that (Matt).
	Seeing a client who might come into you, initially, to closing that client off and seeing the growth within them (Amelia).
	A great outcome, then down the track they are happily married (Claire).
	After 5 or 6 months of living in the car, they got … a small unit which was just all they needed and wanted, and I link her in for other services (Clara).
	The felt that the program [My Life] had assisted them to reconnect with their two adult children … they felt they had the hope that was needed to carry on (Clara).
	We have had some people that don't need us anymore, and that's cool (Ava).
	They are rebuilding their life in a new area and getting some jobs and setting up a business, and now they have that hope for the future (Liz).
	From that point where they were, to where they are now, where they are taking on a leadership role with … company … it's great to see. But that moment of crisis could have been a very, very, different result (John).

5.5.4 People do die by suicide

Participants acknowledged that people do die by suicide and that there are times when no one can do anything to prevent that. Claire reported the grief felt within the community when someone, particularly a young person died by suicide: "[they were young] and being bullied, and they [died by] suicide, and that created a huge grief for the community". In addition, particularly for people with lived experience, the impact on family members was reported, especially of not knowing 'why' their loved one wanted to die. Furthermore, there was a strong recommendation that family members needed follow-up support after the suicide of a family member. Lil reported the availability of the *StandBy response*[4] to bereaved family members and other participants talked about attending homes to assist the family after suicide of a loved one (Refer Table 96 for further details).

5.5.5 Self-care, to care for others

An important aspect of being able to better manage people expressing suicidal ideation and experiencing suicidal crises, is the ability to care for oneself. As highlighted by Fiona:

> *Self-care is a massive part of being able to provide a good service … to be able to provide each person with the very best of us that we can, is to look after ourselves and do that self-care really well (Fiona)*

Recognition that self-care is "not about having a hot bath" (Julia) "or wine" (Zoe). To Julia, self-care was "more about … respecting the body". For Tony it was more about "finding meaning and purpose again, which is completely overlooked". Participants reported a variety of self-care practices: walking/hiking, driving/motor bike riding, the long drive home, going to the gym, swimming, walking and tending the farm after work, gardening, cooking, painting and art, dreaming, having a general chat with family/friends, listening to music/podcasts, singing, reading, photography, spending time with family, children and grandchildren, being in the bush and nature, walking the dog. Participants were supported by various family members, utilised the Employee Assistance Program, their general practitioner and psychologist or psychiatrist. They also talked with others in the suicide prevention space, as well as debriefed at the end of a workday. Being aware of self, triggers, body response and grounding, a daily gratitude exercise, meditation, yoga, lighting candles, aromatherapy, taking time out for themselves, and planning activities to look forward throughout the year, were also seen as important.

> *I'm not the same as what I once was. I guess I'm stronger in some ways, but more fragile in others (Tony)*
>
> *…accepting that something is wrong to begin with. … you need to inspire and motivate people to begin with, to even reach out, and once they accept within themselves that they don't have all the answers and they actually need help, that's when they will reach out (Tony).*

[4] Standby Support After Suicide [Available from https://standbysupport.com.au/#About

Table 96: People die by suicide: Participant responses.

Themes	Sample of focus group or interview responses
People do suicide	*… set up some really good links and things were going well but then something else happened, and it obviously spiralled … I believe that all that we did when we were working with them was all we could do, but it was their decision (Clara).*
	It was a decision they made and there's not really anything, anyone could have said or done to make a difference (Clara).
	I actually spoke to this person days before they died by suicide, and it was a bit of a shock, because I thought they were okay, but they weren't okay (Adam).
Impact on family	*… the impact is so much bigger because everyone's self-blaming saying, "I should have known" (Kelly).*
	… she always said, "There's no way I intend to have children because I'm scared that they'll do the same thing [die by suicide]" (Claire).
	I grew up with my mum saying, "I'm never going to love anyone again, because then they can't break my heart," so my mum's still single. I never got hugged or any of that stuff because she didn't let me, … they're all the things that flow on from suicide (Kelly).
	They were [very young] when their father suicided … how a child would never understand why and the processes that they went through in their life now, … their children being born, graduating and all the, sort of stuff, that the father will never … her own life with graduations and getting married, … you think your dad will be there, and that he chose not to be (Clara).
Post suicide family care	*Standby response is the response to the bereaved family. So after the event, they'll come along and offer help, whatever they need. Doesn't matter (Lil).*
	… someone should be coming alongside them and saying, we can do this for you because we don't want you to go through, … you've been through enough, enough is enough, let them go do their house, it might be a private thing that they want to do, but give them that option, I think there needs to be follow-up (Ruby).
	If they just get a team in that resets it back to normal … (Karleen).
	There was also a team that we had in place … if there was a death by suicide we would reach out to the family, regardless what time of night it was or even if there was an attempt. One of our team members would go to that person's place or go to the hospital, and that we were there to make sure that they weren't alone. We had little teddy bears available for children, we had little blankets, and we just made sure that everything was available (Marg).

5.6 Most effective strategies and activities

5.6.1 Strategies

While it is important to identify those strategies that worked best to inform future planning and ensure "value for money" (Jake), evaluating the effect of multiple, diverse, suicide prevention activities is a recognised challenge.

This is demonstrated by participants responses (*n*=11, 25%) indicating that 'one size does not fit all'. Many participants found it difficult to answer the questions: "Which one activity was the most effective? … If you could only attend or fund one, which one would it be?" ... And if you had to discontinue one, which one would it be? Some participants specifically indicated that all activities were effective in some way.

> *No blanket approach …they're going to effect different community members (Ivy) … only the people who live in this community know that (Phoebe) … it would probably vary in each community (Olivia) … contextualise it to your demographics and to the groups that you're speaking to (Tony)*

The most important approach recommended by participants was for a community driven approach (*n*=24, 55%), utilising the social capital of local community members (*n*=10, 23%). This includes recognition of informal networks (*n*=5, 11%), and the need for face-to-face (*n*=4, 9%) assistance for people in suicidal distress or at risk of suicide, with a free call number where face-to-face is not available (*n*=1, 2%). Early intervention (*n*=1, 2%) was also considered an important preventative strategy. Community approaches also need to be culturally, gender diverse, age and ability aware (*n*=2, 5%).

Participants reported the most effective strategies underlying choice of programs or activities for suicide prevention need to ensure that there is the opportunity for community connection (*n*=25, 57%), and normalising suicidal ideation and crises (*n*=18, 41%), while promoting life (*n*=2, 5%). Programs not only need to be relevant and relatable to the community in which they are provided, but they also need to be relatable to the target group (*n*=18, 36%). The importance of a non-judgemental and safe emotional space (*n*=9, 20%), with safety protocols in place (*n*=3, 7%) were emphasised. Further exploration of lived experience and peer-support programs was raised (*n*=5, 11%). The use of humour was appreciated (*n*=2, 5%), and this is evident in Table 75 where many people attended the World's Biggest Comic Book events and the Stand Up for Mental Health events. However, Hilda reported that the Stand Up for Mental Health program was costly (financially), and questioned if it could be sustained and repeated in the longer term.

5.6.2 Activities

Non-clinical participants (*n*=42) attended from 1 to 19 activities (median=4, mode=1), and not all of these could choose what was the most effective activity for them.

The most effective activities appeared to be: ASIST, the Drink Coasters, World's Biggest Comic Book, Stand Up for Mental Health and QPR. The Roses in the Ocean Walks were also highly valued, and participants looked forward to these. However, it is very important to view these results with caution, because 34% of the commenting sample were from Whyalla, thus all regions and activities were not equally represented.

Furthermore, those who attended the First Responders events, while a smaller sample providing a voice, were extremely impressed with the events and considered these activities essential for engaging first responders, many of whom identified as male. Additionally, although once again, smaller samples, the Rotary Men's' events were highly valued, and most of the Men's Roadshows were reported favourably. Refer to Table 97 for further detail.

Table 97: Most effective activities attended: Frequency of participant responses.

Areas of impact	Responses *n*=42[a]	%
ASIST	17	39
Drink Coasters	11	25
World's Biggest Comic Book	10	23
Stand Up for Mental Health	9	20
QPR	8	18
Roses in Ocean Walks	7	16
The Ripple Effect Documentary	7	16
Aftercare (Postvention)	6	14
Roses in Ocean: Voices	6	14
Mental Health First Aid	5	11
Connecting with people training	4	9
Save our Mates Wellbeing Roadshow[b]	4	9
First Responders Event	3	7
SafeTALK	3	7
YAM	3	7
Comic Book Launch	2	5
Living Works	2	5
Mates in Construction[b]	2	5
Mentally Fit EP	2	5
Rotary Men's Campaign	2	5
Save our Mates Roadshow (Mates in construction) [b]	2	5
Totally Mental 'Cloudy' Animation Film	2	5
You Me Which Way	2	5
Accidental counselling	1	2
Family Fun Day Get Out	1	2
Men's Health Event Yorketown	1	2
Mental Health football round	1	2
Suicide story workshop	1	2
Suicide summit	1	2

[a] Participants reported on more than one activity

[b] There was some confusion around the name and facilitators of each of these events

5.7 Least effective strategies and activities

The least effective strategies were those that were disconnected from the local community as described by John:

> *One's that are here today and gone tomorrow … but don't think about that long term connection in a community and building the resources and skills within that community … just quick and under-resourced, or create expectation and then can't deliver (John)*

There was also some debate about the ongoing effectiveness of having football players and celebrities as guest speakers, mostly preferring local people with lived experience (Lucy). In addition, Eli and Cora reported that some lived experience speakers focussed too much on themselves and their grief, rather than the event focusing more on learning about prevention. In these instances, it became "overwhelming [and] challenging" for the attendees (Eli). For some events, there was also concern expressed by Kelly, Claire, Clara and Ava about the financial costs of some events and that in some cases, safety protocols were not in place. Elena also raised the increased challenge of "making sure that everyone is kept safe as well" during virtual activities such as webinars. There were some events that were seen more as marketing and selling rather than focussing on suicide prevention (Ava). The very least effective strategy was highlighted by Elanor:

> *Not to do anything is the least effective (Elanor)*

One participant suggested that SafeTALK and Accidental Counselling may be the last effective because they were similar and perhaps, "could be incorporated into QPR (Clara). SafeTALK was also identified as the least effective for Mia personally, even though it was acknowledged as "a good program". The Men's Health Event SOS Yorkes was identified as least effective by Kelly and Clara, mainly because "one of the presenters was difficult to follow" (Clara). Cora, Kelly and Claire expressed was some hesitation about the Hart Wellbeing events suggesting the presentation be "honed' down a bit, while also recognising that for some attendees "it obviously struck bells" (Cora).

5.8 Capacity building

Local people with lived experience of suicide and suicidal distress were reported as important for building suicide prevention capacity within communities. They have "inside information" (Clara) about what others are going through, and Ivy reported that there were "changes in perspective" about suicide and suicide prevention as a result of their experiences. With the more recent changes in understanding about the importance of lived experience, people now "have a voice" (Lucy). The impact of voicing and sharing, is more connection, informal networks, and discussion about suicide within communities (Grace).

There is however, limited access to local people with lived experience in each of the regions under study. It was acknowledged that not everyone is ready or willing to share their story (Colleen, Clara, Chloe, Phoebe). Refer to Table 98 for further detail.

Table 98: Impact of lived experience.

Impact of lived experience	Sample participant comments
Have inside information	*… inside information as to, it's okay not to be okay (Clara)*
A change in perspective of suicide/suicidal distress	*I just went through a really difficult time, and so it changed my perspective, I suppose, about suicide and suicide prevention (Ivy).*
Having a voice	*I've shifted in my practice a lot … and it's been since really probably some of this with the NSPT programs. And being allowed to allow people with lived experience to speak. It's a big shift, you know (lucy).*
Connection	*Chloe reported that although people with lived experience are "on a different journey … different stages … they can be helpful to each other… you can get something from everyone" (Chloe).*
	Given my experiences in life, I feel like sometimes you have to know it to be able to see it, … And it seems for me the ones that I really pick up on are those 18- to 20-year-olds. And they sense something, I don't know, they seem to come to me for some reason. And there's just that connection there (Phoebe).
	The shift happened within the 12 months … from I'm just here because I wanted to be a part of the campaign, I don't have a mental illness, I've never suffered from depression and anxiety. To all of a sudden, the stories came out about actually why. And there were some phenomenal stories, including them disguising suicide attempts, stories around the mates that they'd lost to suicide (Lucy).
	I do try and use my lived experience in a positive way to help others and to build rapport which is necessary for a clinical relationship and to enable an opening up and a discussion of a deeper issue (Jake).
Impact on others	*… the way they tied it in with the family support and the connection, was brilliant, was really good. … it gave them a different perspective and a way to try and step into their [loved one's] position … took their own life and look at it from a different angle, other than selfishness, … as we know, in their mind it's a selfless act, as opposed to a selfish act (Henry).*
	Seeing somebody's story … I think lived experience is quite powerful for people that are going through their own suicidal thoughts and so forth (Clara).
	I've been through something for a reason, and to have that knowledge of my own experience, to be able to share with others so that they don't feel quite so alone in their pain and suffering in that moment, is a really wonderful feeling (Phoebe).

Didn't want to die	*I'm very, very lucky that I never succeeded in [attempting] suicide, because I don't want to be dead at all. And I'm very, very thankful that I got through that difficult period, because no, I don't want to be dead even though I might have at the time, but it would be a very big mistake (Adam).* *I find it a very positive experience and I find it heartening that my path can help them with their journey, I mean where I have ended up and what I've been through. I was low and … I have the experience but I'm really glad that I didn't die because I had the opportunities to talk and be with people, and to learn more about how other people get to that destination (Cora).*

5.9 Maintaining the knowledge, skills, connection and awareness gained

5.9.1 Engagement

Participants reported that maintaining what has been gained is now the "challenge" (Kelly). For some of the networks and/or groups there was "a real struggle to remain intact, to keep going" (Clara). The possibility of casual drop-in centres (Don) or listening spaces (Grace) was suggested whereby volunteers can be available for people to "come in and talk to us about what's bothering them. … very accessible, not many rules" (Mia). While targeting training to frontline staff was seen as important (John), ensuring that community members were also kept engaged with opportunities and activities was vital to suicide prevention, with suggestions of community hubs or community groups (Hilda). More involvement of local councils was also recommended (Henry, Lucy, Cora). Furthermore, participants (*n*=14, 31%) specifically recommended continuing a variety of existing activities and training events, making them more available (Ava), with free online training (Elanor). It was important to keep building upon existing programs and offering refreshers (Cora), and keeping information up to date (Elena). Further community consultation, continuing awareness raising and connecting were recommended. Participants also highlighted the need for resilience and capacity building (Table 99).

5.9.2 Children and youth

Participants reported a gap in engaging children and youth (*n*=19, 43%). Chloe suggested that "young people are definitely more open, … it seems every teenager knows someone who has [died by suicide]" and there is not the stigma attached as there is in some adults. Recommendations included: increasing school programs, suggesting a "player support officer in sporting clubs, … community groups and church groups" (Henry). Phoebe reported an "amazing … ripple effect throughout the young people" after events such as Get Out Music and Art Festival. Training and activities for young people need to be relatable for their age group and interactive (Lucy, Grace). Julia recommended teaching young people "about self-care and mental health", acknowledging that mental health or illness, is something that "you can't see" like you can with a physical challenge.

> *… we created it for young people with sort of teenage kids in mind, what we found was that the impact for families as a whole was huge (Phoebe).*

5.9.3 Grant writing and funding

A review of funding opportunities was specifically recommended (*n*=15, 34%), with several participants suggesting the provision of free grant writing assistance. Additionally, increasing the scope and funding criteria of grants was considered necessary to ensure suicide prevention networks, organisations, and community members' more creative ideas were considered.

Table 99 provides a sample of participant responses in each area.

[SUICIDE PREVENTION IS] "A WAY OF LIFE NOW" (ELENA), "SHARING KNOWLEDGE" [AND PRACTISING SKILLS] "EVERY DAY IN THEIR OWN ROLES … AND EVEN PERSONAL [LIVES] (AMELIA) … "IT BECOMES PART OF WHO YOU ARE AND PART OF YOUR IDENTITY (ELENA)

Table 99: Recommendations for maintaining the knowledge, skills, connection and awareness gained.

Recommendation	Sample participant comments
Community consultation	*Have you asked the community what they want? … different ways, different times, because over the years there's been different community consultation of different topics in our town. And sometimes it's only been at night, or it's only been on during the day. Making sure you've got a number of approaches (Hilda).*
Continue awareness raising	*Suicide prevention … people need to be constantly reminded … whatever that environment is. … I am really frightened that that wave is going to slide off because it's not being kept top of mind (Cora).* *Something that's not going to be long and drawn out two days for example, I think, for a lot of people they just want to be made aware, "Give me the points and things I can do," and that kind of thing (Claire).* *… because of the trials we were able to test and trial ideas. And what I learnt from that is that we need to always include that education (Phoebe).* *Radio, TV, there's a lot of stuff on TV now, use that forum, Facebook, your Instagram, I'll do stuff like that, I would hit all those, Tik Tok even … All the social media that you can get to, that's what it's there for (Ruby).* *If we leave it as it is, we're not going to make anything happen. If we don't continue to have discussions and be really overt and loud about it. … if we don't dedicate some time to people in their roles, that we can actually have that as part of our core business, to have support … (Kay).*

Continue connecting	*… some people would say, I didn't use it because I didn't know how to do this bit, or I couldn't remember that bit. And so, one time when we did that, they'd forgotten to put some of the tools in the system, so they redid that and we've been back to that community a couple of times and now they seem to be picking it up (Mia).* *Ask for people to bring a group of people together, that have actually done the training and are using the tools, so that they can then talk about how it's worked, what didn't work, have reflection, … I did this, was that the right way to do it? It didn't seem to go that well. Or I did this, and it worked really well. … some people will do training and then they'll go off and never look at it again … forget everything .. never applied it (Mia).* *What happens when you have the training, that's it. You got your certificate, nothing happens. There's never follow up (Penny).* *It's like Men's Sheds or rotary catch-ups. You don't achieve anything unless you meet up on a regular consistent basis, and what other informal networks (Don).* *Keep those emails or communication open so we do know what's going on, … that really helps and it makes you feel that you're part of it and it gives you those opportunities to help out further if there's any ways that you can help out (Vera).* *Having ways for people to connect with each other that they can have opportunity to have a chat and recognise they have similar grounds … find alternative opportunities [as well as sport] for people to connect with each other [those that don't participate in sporting activities] (Phoebe).*
Resilience and capacity building	*Build up resilience (Ivy).* *The longer the term of the project, the more engagement, the more level of support around the people that are affected. … we wouldn't do a project unless we could resource it to go for … a minimum of two years. And that way, when you're engaging people, you made sure that the other supporting services were all engaged in that as well. The whole community infrastructure was involved in those projects, and the young people themselves were telling their story within the project … (John).* *You need more skilled people. …you need more clinical people but you also need more lay people. … You do need more psychologists (Lil).* *Build and establish rapport with clients. And the suicide prevention networks as well, … they're a real key part of the community and the service that we offer (Olivia).*

Creative ideas	*… we're forgetting little people here and their developing brain and their wellbeing and what are we doing to increase kindness, compassion, understanding, tolerance, all of these things that help to build resilience for students as they grow from preschool all the way through to high school and how do they contribute to society as a result of that? (Kay).* *…giving them access to some different means to test and try. … drumming circles, macramé workshops, skateboarding workshops, and a line-up of bands that played all day. So it was just a good way for them to come together … And it was really successful (Phoebe).* *… local church and bakery that connects with each other to do a pizza night. We've got the Stitches. We've got CWA. We've got the Men's Show. And we've got the community garden. … it's just finding avenues to find ways that everybody's got somewhere that they feel connected and safe and valued in our community (Phoebe).* *… explore avenues for suicide prevention that haven't been explored before. … that's how you can generate interesting solutions to complex problems … trying to figure a way out of the problem is going to take different thinking. It's going to take innovation and it's going to take a lot of different experimental approaches. And not all of those work. So we have to be willing to take those risks in a risk averse sector (Jake).* *We are in danger of doing the same thing over and over again and it would be good to see some fresh, younger faces in that environment … to bring fresh ideas to the table (Cora).* *The one time that they're actually truly open and honest about their feelings is when they've got a beer in their hands sitting with their mates. But yet if you put a beer in someone's hand and you talk about mental health, suddenly you get absolutely screamed at, going, "Oh my God, you're promoting substance abuse." (Tony).* *… a bus covered in decals, it could be the comic book … idea, because it's really relatable … and it also allows artists another opportunity to have their artwork up and seen and appreciated, not just the artwork, but all of the emotion and all that that comes with doing that, and their story. … rock up to caravan parks, to a local football match, into communities … just get to know people? What's your story? How did you get here? People from all walks of life. And so – and this isn't a new idea (Cecile).* *Creating Podcasts with the people you meet as you travel in the bus – sharing stories (Cecile).* *Bush camps for young people [again not a new idea] (Matt).*

Suicide prevention … people need to be constantly reminded … whatever that environment is. … I am really frightened that that wave is going to slide off because it's not being kept top of mind (Cora).

5.10 Barriers to suicide prevention

During analysis of focus group/interview data, barriers to suicide prevention were identified from the discussion with 34 (77%) of the participants.

The most frequent barrier identified was that of systems failure which included: separation of substance misuse from mental health issues, Federal versus State funding models; lack of resources and services, with available services being difficult to navigate, and reactionary rather than preventative. Gaps in services were also identified such as lack in health professional mental health education, limited face-to face assistance, particularly when in suicidal crisis and accessibility to psychiatrists. Aboriginality was identified as an issue. This included not having Aboriginal counsellors in a predominantly Aboriginal and Torres Strait Islander school population, being the only Aboriginal representing the Aboriginal Torres Strait Islander local population (the feeling of isolation without one's tribe), and being "not black enough" within a predominantly Aboriginal and Torres Strait Islander population (not quite one of the tribe). Refer to Table 100 for further detail.

Table 100: Barriers to suicide prevention.

Barriers	Responses *n*=44 [a]	%
System failure	17	39
Stigma	15	34
Mental health issues not visible	12	27
Turned away at hospital, including not listening to clients	11	25
Getting them there; message not getting through	11	25
Beliefs and attitudes	6	14
Uncooperative services (silos)	6	14
Extensive wait times for services	6	14
Gaps in services	5	11
Health professionals: can help or hinder	5	11
Accessibility and availability of NSPT activities	4	9
Immediate in-person care	4	9
Aboriginality	3	7
Gossip Lack of confidentiality	2	5
Building trust takes time	1	2
Lack of adequate data capturing systems	1	2
Homelessness	1	2
Lack of acute preventative care	1	2
Lack of knowledge	1	2
Lack of outreach services	1	2

[a] Participants reported more than one category related to barriers

People should get help before they're admitted and prevent that admission to hospital. Because we all know about that, hospital admissions are not good for anybody, let alone

We all have stigma in us. It's how we choose to use it (Rose).

5.11 Summary

The findings of the focus groups/interviews need to be viewed with caution due to a predominantly Whyalla, female, older age group sample, most of whom attended QPR, ASIST, the World's Biggest Comic Book events and the Roses in the Ocean Walks.

However, as the majority of participants have lived experience of suicide in some way, important insights, which confirm the results of Phase 1 and 2 findings, are valuable to understanding the impact of the NSPT training, events and activities.

Following activities there was an increased awareness of suicide and suicide prevention, with a decrease in judgement and stigma, and an increase in confidence and competence to openly communicate and connect with those in suicidal distress. As a result, there was an increase in compassion, a determination to help and make a difference, and some participants interrupted suicidal pathways of those in distress. Subsequently, there were flow on effects within the community and increased capacity building in suicide prevention as participants applied what they had learnt.

The most impactful strategies were those that community driven, relevant and relatable to the local population, and included participant engagement and connection. The least effective were those that were disconnected from the local community and any that lacked safety protocols.

5.12 Recommendations

A number of recommendations arise from the focus groups/interviews, and these primarily relate to continued capacity building.

1. Continue to give voice to those with lived experience.
2. Continue to engage with those suicide prevention networks, organisations and small groups who are already in the suicide prevention space.
3. As a priority, continue Aftercare/postvention services and increase the follow-up from 3 months to 6 months for those who require it.
4. Provide face-to face crisis services to prevent presentations at hospitals (to be turned away).
5. Actively encourage collaboration between hospitals and community services.
6. Offer the 'basic' knowledge and awareness raising events for free.
7. Increase child and youth programs.
8. Invest in Aboriginal and Torres Strait Islander counsellors in schools.
9. Invest in the creation of community drop-in centres (listening spaces, Hubs, by whatever name).
10. Provide subsidised mental health education for regional health professionals.
11. Provide education and /or funding for grant writing workshops and/or assistance.
12. Review & change funding and policy models that separate substance misuse and mental health.

6.0 Summary of Key Trends

Suicide prevention is a community wide, collective endeavour requiring widespread engagement and contribution. A public health approach to suicide can help us target universal interventions for the public, health, and human service workers as well as target individuals at risk groups. The need to raise the profile of help seeking and awareness of where to go for support in suicide prevention is a national priority. The data arising from this report highlights that this has been achieved among most of the participants who took part in this evaluation. The findings are also encouraging of practical information helping participants obtain confidence and competence in approaching someone in distress and encouraging them towards help and safety. The evaluation demonstrates the effectiveness of prevention programs for both community and professional groups alike. These are promising results for they contribute to the major aim of interrupting the trajectory towards suicide by encouraging people accept and receive help from others, as well as help offering and advocacy on behalf of others. While these findings are encouraging what is less clear is whether a particular program can effect changes over time as well as identify scope for improvements in future program content or delivery.

Key Trends

The trends overall are very positive in response to the community events initiated by the NSPT strategy as can be seen by the need's analysis from the community consultations and how many of these were addressed by targeted community events and training interventions. For example, the number of GPs who had not attended suicide prevention training before the trial and the overwhelming response from community in general taking up the opportunity to be involved in training. The outcomes of the retrospective data show high mean scores for most community events across variables that positively evaluate trainer performance, and increase performance of attendees' knowledge, skills and attitudes towards suicide prevention, and the ability to reach out to help others or themselves if experiencing suicidal states.

- Aftercare services reported trends of relatively low suicidal ideation mean scores, and importantly, steadily reducing depression symptom scores over three time points during attendees' overall episodes of care.
- One of the key trends was participant's self-reported compassion towards others which was the highest scoring variable in the survey of 162 participants with almost 100% agreement on this survey item.
- Within age groups, trends showed older women aged 71 – 80 scored highest on all survey items in Phase 2; males aged 21-30 scored lowest on knowledge of where to connect people who may be at risk of suicide; males aged 51-60 scored lowest on compassion towards people thinking about suicide; and males aged 18-20 scored lowest for help seeking if thinking about suicide themselves.
- There were slightly higher levels of stigma amongst Indigenous Peoples than non-Indigenous people in Phase 2, although it should be noted that numbers of participants were in unequal proportions and non-significant.
- Other trends of interest were that first responders scored lowest (mid-way between Agree and Disagree) for understanding that suicide is preventable which may indicate less hope due to higher exposure to people in suicidal distress who do complete suicide. In other areas, first responders show low levels of stigma, good understanding of risk factors and

warning signs, knowledge of referral pathways, high scores on compassion, confidence to help others and themselves, and sufficient knowledge of cultural differences that people in suicidal distress may experience.

- Of note were some of the responses by farmers and unemployed people. While in the context of all work role scores showing results in the mid-range or above in the positive response direction, unemployed people and farmers scored lowest on knowledge of risk factors, farmers scored lowest on compassion and highest on stigma, farmers also scored lowest on knowledge of cultural differences which may be an area for targeting.
- Participants who attended QPR had the lowest scores for stigma.
- Participants exposed to the Suicide Prevention Drink Coasters were most associated with understanding that suicide is preventable.
- The Ripple Effect Documentary had the highest scores on a number of key variables.
- GPEx Training scored the highest for knowledge of warning signs.
- The Worlds Biggest Comic Book captured the attention of the local community, with strong community engagement, a sense of pride, and acceptance by the wider community.
- The Roses in the Ocean walk enabled people bereaved by suicide to see each other together in a public place and subsequently know each other in order to open conversations later about suicide or enable people at risk of suicide to approach those involved for help.
- People with Lived Experience of Suicide were known in the community and enabled people at risk of suicide to approach them at any time, even after hours when services were closed.

7.0 Strengths and Limitations

Participants for Phases 1, 2 and 3 were voluntary, primarily female, self-selecting samples, therefore, the voices of all participants who attended aftercare services, provided consultations, or completed training and community events were not heard equally. Indigenous Peoples were not representative of the Australian population and while there was participation in the present study the findings cannot be generalized to this population group. Thus, whilst the findings may not be able to be generalised to the whole population, this study adds important insight into the impact and value of the NSPT community consultations, aftercare services and suicide prevention community events undertaken in the trial region. Overall, there was a risk for participants providing favourable responses due to those who enrolled in the study being interested in the topic of suicide prevention and also enrolling into suicide prevention community events or training. Social desirability response bias is another potential limitation that may have occurred if participants were interested in presenting themselves as socially pro-suicide prevention.

7.1 Phase 1

In Phase one, de-identified retrospective data were provided for analysis by the CSAPHN from a diverse repository of NSPT training and event evaluation data sources collected over the period 2017-2021. Due to the heterogeneity of the data which encompassed consultation data, aftercare service data, and suicide prevention training evaluation data, with sometimes more than one collection time point, and non-homogenous outcome variables, a meta-analysis was not possible. Instead, a sequential series of separate descriptive and inferential statistical analyses were conducted culminating in a synthesis of findings on the key outcome variables which provided insights into the needs generated by the consultation data, the impact of aftercare services, and the similarities and differences between suicide prevention training events on key outcome variables. Despite the complexities, differentiation between the training event types was achieved by constructing a purpose-designed spreadsheet that extracted the results from each of the 49 individually analysed data sets. Similarly, heterogeneity of these data sources, along with the different specific aims of the training, impacted on qualitative comparisons and determining which events may have been the most effective overall.

7.2 Phase 2

In Phase two, one limitation was the extension of time required to recruit participants to the study, while aiming for over for over 200 the study recruited a total of 162 participants (valid after data cleaning). There was a diverse range of community events that comprised the 56 being evaluated, and participants had attended more than one community event each. The spread of events was not consistent across each local government area (LGA) and at times were delivered outside of these boundaries. Therefore, the results may not be generalisable to each LGA and rather apply to the trial region overall. Furthermore, of the 56 community events in the trial, 60.7% of respondents attended the top 12 leaving the remaining events with too few participants in each to analyse effectively. Complex statistical modelling was required to provide even descriptive results showing mean differences that could be interpreted meaningfully. Nevertheless, the strength of this study was the findings of the overall participant pool and the effects that all of the events collectively had on participants' awareness raising, stigma reducing attitudes, knowledge about suicide risk factors, and

capacity building to help others or themselves to respond to people in suicidal crisis. There were no missing respondents in this section and all participants answered each question in the survey.

7.3 Phase 3

For Phase three, one limitation the study experienced was the extension of time required to recruit participants, while aiming for over 50, the study managed to recruit 44 in total. Most participants were community event attendees and only two participants had attended aftercare services, therefore, aftercare services were under-represented for qualitative detail in the report. However, 70.5% of participants were people directly and indirectly involved in the implementation of the NSPT activities, although most were also local community members. The strength of their involvement is threefold: they provided rich data in the form of real-life experiences and a more global view of strategies required for suicide prevention, and their lived experience, commitment and compassion illustrate the social capital in the various regions. There was a paucity however, of representation in the focus groups and interviews of community members who attended the activities only, and those who identified as male. Further, while each of the 5 LGAs was represented, the majority were from Whyalla, and this is reflected in the most frequently attended activities. Consequently, the individual impact and value of each of the activities was difficult to separately determine qualitatively.

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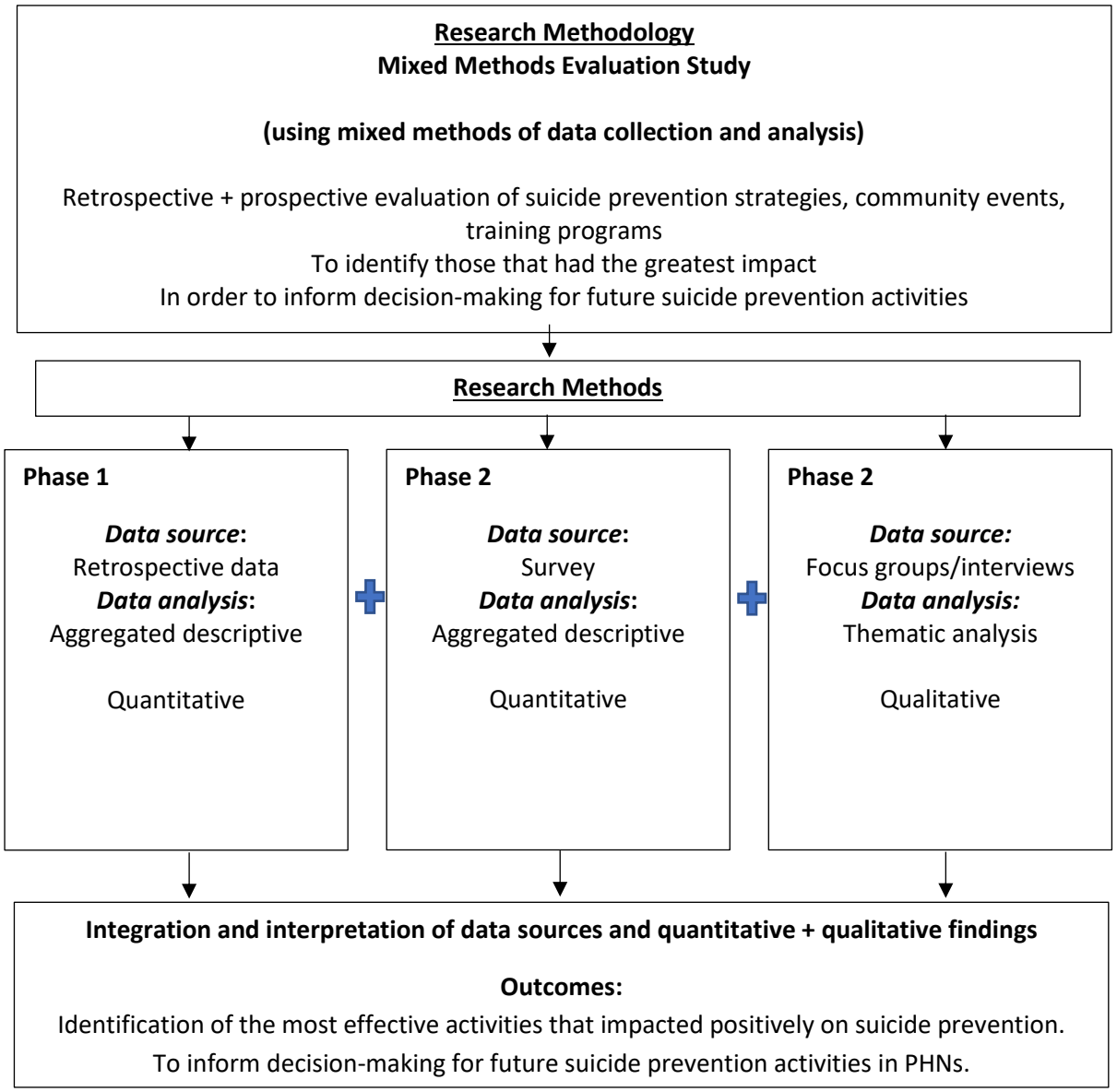
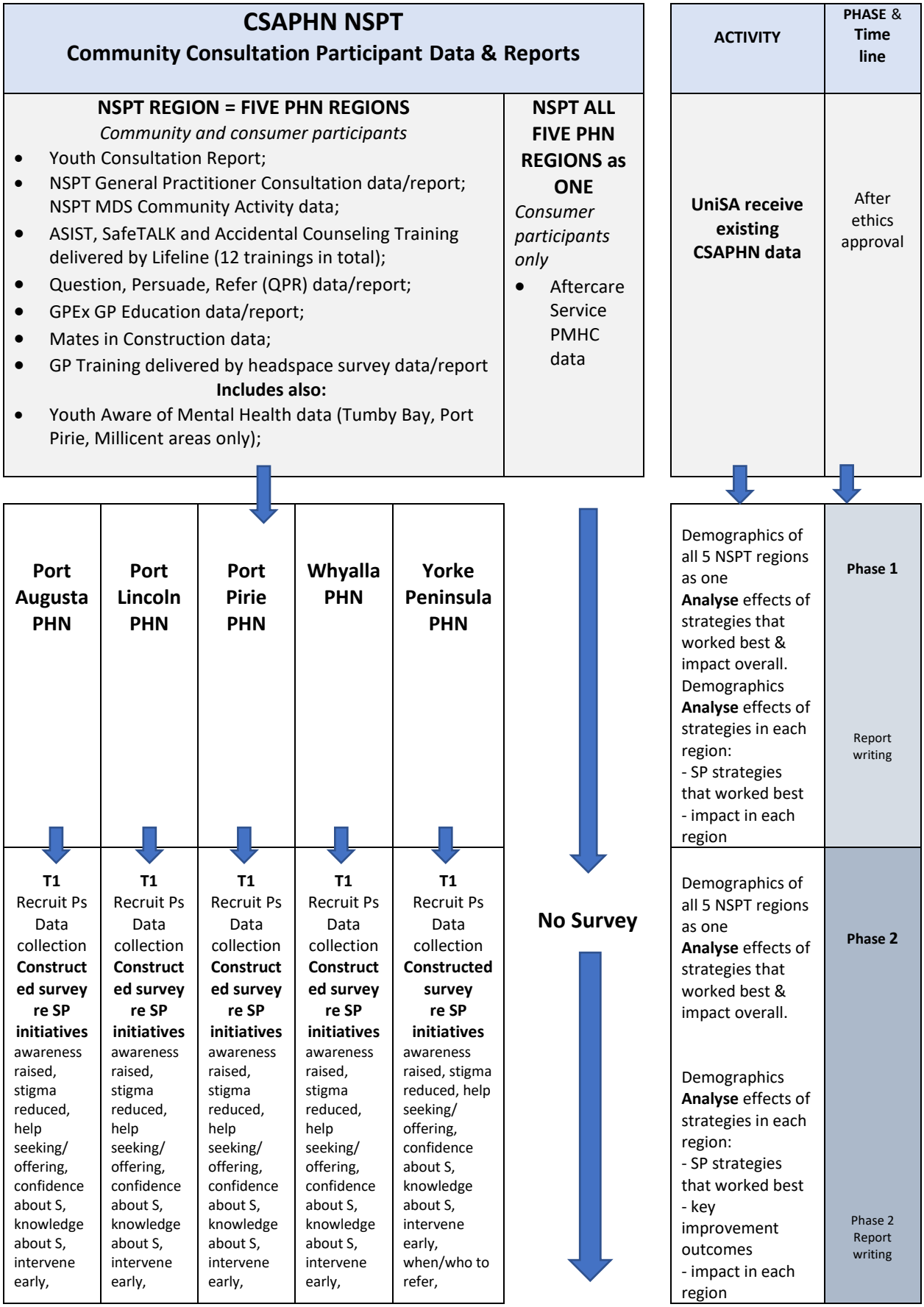
https://docs.nspt.info/data-specification/data-model-and-specifications.html#sidas-data-elements

9.0 Appendices

Appendix 1 Evaluation Design: Research Methodology and Methods



Appendix 2 Project Flow Diagram



when/who to refer, community impact	when/who to refer, community impact	when/who to refer, community impact	when/who to refer, community impact	community impact			
T2 Focus Groups/ Inter-views Recruit subset of survey Ps	**T2 Focus Groups/ Inter-views** Recruit subset of survey Ps	**T2 Focus Groups/ Inter-views** Recruit subset of survey Ps	**T2 Focus Groups/ Inter-views** Recruit subset of survey Ps	**T2 Focus Groups/ Interviews** Recruit subset of survey Ps	**T2 Focus Groups/ Interviews** Recruit Aftercare Ps	Demographics **Thematic analysis** Positive experiences, Specific activities, Aspects of content, Aspects of delivery, How/what was done well, Cultural safety, Capacity & confidence to manage suicidal crises **Extract narratives**	**Phase 3** Phase 3 report & Draft final Report 7th June 2021
Final Report Phases 1, 2 & 3							**18th June 2021**

Appendix 3 Research Tools

Phase 2 - NSPT Evaluation Survey Questions

NSPT activity attended: **Date NSPT activity attended:**

Part 1 In this section we are interested in which National Suicide Prevention (NSPT) community event or events you attended. Please indicate from the list below:

1. Which National Suicide Prevention (NSPT) community event or events have you attended?
   a. Youth Consultation
   b. Youth Aware of Mental Health (YAM; Tumby Bay, Port Pirie, Millicent areas only)
   c. NSPT General Practitioner Consultation
   d. NSPT MDS Community Activity:
      i. Whyalla Suicide Prevention Network
      ii. Lower Eyre Suicide Prevention Network
      iii. Roses in the Ocean
      iv. SIPLAG
      v. SOS Yorkes
      vi. Mentally Fit Ep
      vii. Mission Australia
      viii. Australian Red Cross
      ix. Other please specify _____
   e. Applied Suicide Intervention Skills Training (ASIST) Lifeline
   f. SafeTALK
   g. Accidental Counselling Training delivered by Lifeline
   h. Question, Persuade, Refer (QPR)
   i. GPEx GP Education
   j. Mates in Construction
   k. GP Training delivered by headspace
   l. LivingWorks
   m. Mental Health First Aid
   n. General Awareness Training (GAT)
   o. You Me Which Way
   p. Suicide Story training
   q. Other (please specify) _____

2. Please indicate the Region in which you attended the NSPT community event(s):
   a. Port Augusta
   b. Port Lincoln
   c. Port Pirie
   d. Whyalla
   e. Yorke Peninsula
   f. Other region (Please specify region or postcode) _____
3. What month and year did you attend the community event/s? _____

Part 2 In this section, we are interested in your knowledge and attitudes towards suicide prevention since attending any of the NSPT (NSPT) community event/s in your region. There are 10 questions to answer and the response format is a 5-point Likert scale ranging from 1 = strongly disagree, to 5 = strongly agree. As you read each statement, think about your day-to-day life and the people you interact with every day.

		Strongly disagree (1)	Disagree (2)	Neither agree nor disagree (3)	Agree (4)	Strongly agree (5)
1.	I understand now that suicide is preventable					
2.	I have a good understanding about the risk factors that contribute to suicide.					
3.	People who talk about suicide are not serious, but just seeking attention.					
4.	I now know where to connect someone who may be at risk of suicide to appropriate services.					
5.	If someone told me they were thinking of suicide I would be compassionate towards them.					
6.	I am confident that I could assist someone who is going through a difficult time, feeling upset or thinking about suicide.					
7.	I would now be more likely to seek help if I was going through a difficult time, feeling upset or thinking about suicide.					
8.	I have a good understanding of the cultural differences people might have when talking about suicide.					
9.	I know more about the warning signs of suicide than I did before.					
10.	I would recommend the program activity I attended to other people in my regional community.					

Part 3 Demographic questions (tick whichever applies)

1. In which region do you live?
    a. Port Augusta
    b. Port Lincoln
    c. Port Pirie
    d. Whyalla
    e. Yorke Peninsula
    f. Other (please specify town or postcode)

2. What is your age range?
    a. 18-20 years
    b. 21-30 years
    c. 31-40 years
    d. 41-50 years
    e. 51- 60 years
    f. 61-70 years
    g. 71-80 years
    h. 80 years +

3. Do you identify as being Aboriginal or Torres Strait Islander?
    a. No
    b. Yes, Aboriginal
    c. Yes, Torres Strait Islander
    d. Yes, Aboriginal and Torres Strait Islander
    e. Prefer not to disclose

4. What gender do you identify with?
    a. Male
    b. Female
    c. Non-binary
    d. Prefer not to disclose

5. Do you have a lived experience of suicide? (Tick all that apply)
    a. No
    b. Yes, experienced suicidal thoughts
    c. Yes, survived a suicide attempt
    d. Yes, cared for someone who has attempted suicide
    e. Yes, bereaved by suicide
    f. Yes, other

6. What is your current work role?
    a. Volunteer
    b. Peer-support worker
    c. Nurse
    d. Social Worker

e. Psychologist
f. GP
g. Other health professional
h. Trade/Industry
i. Farming
j. Unemployed
k. Other (please specify) _____

7. Some participants may find the topic of suicide distressing, if you experience distress at any time, please contact one of the following:

- Lifeline Australia: https://www.lifeline.org.au/ or 13 11 14 (24/7)
- beyondblue: http://www.beyondblue.org.au/ or 1300 22 4636 (24/7)
- MensLine Australia: https://www.mensline.org.au/ or 1300 78 99 78 (24/7)
- Suicide Call Back Service: https://www.suicidecallbackservice.org.au/ or 1300 659 467 (24/7)
- Mental health emergency in Country SA: 13 14 65 (24/7) or https://samentalhealthcommission.com.au/need-help/

Thank you for taking part in our survey!

Phase 3 - NSPT Evaluation Community Focus Group/Interview Questions (Non-Clinical)

PHN Region:	**Consent signed: Y/N**	**Participant ID:**
Facilitator:	**Note-taker:**	**Date:**

Preamble

Begin with a brief introduction about the interview, confidentiality, and rights: *"Remember you are free to stop the interview at any time or reschedule. If you don't feel comfortable answering any question, or would like the question repeated, please let me know. Also, if you discuss any client matters, please speak in general terms making sure that there is no information identifying a client".*

"Do you have any questions about the interview or the research before we begin?"

Pseudonym:

Demographics:

"Let's start off with a few background questions."

Age: Gender: M/F/Non-Binary

Professional background/ Community role:

Current employment/ Community role:

Name of NSPT community event completed: When?

Background / contextual questions

1. How long have you worked/ volunteered in your current role? How long have you been in your position as a volunteer/nurse/social worker/peer support worker/other role* in your lifetime? (*use their term)

2. Can you tell me what a typical day of work/ volunteering looks like for you?

3. In this role, have you had much experience with or exposure to working with people experiencing or demonstrating suicidal thoughts or behaviours?
4. Can you tell me what it's like to work with people who are at risk of suicide?

Overall impressions and experience of the NSPT community event

5. In thinking about your experience of the NSPT community event, what stands out for you as memorable? (prompts: i.e. Was it the something about the content? Was it something about the facilitator?)

6. Since the NSPT community event, have you noticed any changes within yourself or any impact that attending the event has had on you? (prompts: i.e., knowledge/ awareness, attitudes towards suicide, confidence about responding, self-efficacy, hope and the belief that suicide is preventable, lived experience, cultural diversity etc)

7. Did you observe or notice any impact, as a result of attending the event, on your work colleagues, team, management, or the community group/ organisation? Did you notice any other secondary impacts of attending the event? (prompts: people speaking more positively about people at risk of suicide, more compassion for people who express suicidal thoughts, self-harm, more aware of local regional supports and services etc.).

<u>Putting new knowledge into practice</u>

8. Have you had an opportunity to utilise or apply the knowledge and skills gained from attending the NSPT community event?

   How do you think attending the event has enhanced your own ability to connect with people and interrupt a person's suicidal pathway or thinking? (prompts: i.e., can you think of an example to explain when this might have happened in your role?)
   Did attending the event help you to know how and when to act in response to individuals expressing suicidality? (prompts: i.e., how might you handle suicidal crises now that is different?)

9. What are some of the positive experiences you have had with people in suicidal distress?

   What was it about attending the community event that has since helped you to engage with and support people experiencing suicidal crises? (prompts: i.e., strategies, safety planning, prevention of future crises, facilitate access to appropriate services, can you think of an example to explain when this has happened?)

   Can you think of a time when you have responded more positively to a person seeking help? (prompts: i.e., how do you think you are better and/ or more confident at offering appropriate help now than before attending NSPT community event/s?)

   Have you received any feedback or comments from people about the ways you have engaged with them around suicidal thoughts, safety panning?

<u>Post-attendance – maintaining the skills</u>

10. In your opinion, what, if anything, would help you maintain the *knowledge, skills, and confidence (*use their words) that you gained from attending the NSPT event/s?

11. Finally, would you recommend the NSPT event you attended to others? (prompts, i.e. what was the most effective? What was the least effective? Is there something else you think would help you?)

Check in

12. Your time and input have been very valuable, and I understand this may have been distressing to talk about. I want to check that you are okay and if there is anything I can do or anyone I can contact?

Tear off here and give to participant ----------

Support Services

13. Some participants may find the topic of suicide distressing, if you experience distress at any time, please contact one of the following:

- Lifeline Australia: https://www.lifeline.org.au/ or 13 11 14 (24/7)
- beyondblue: http://www.beyondblue.org.au/ or 1300 22 4636 (24/7)
- MensLine Australia: https://www.mensline.org.au/ or 1300 78 99 78 (24/7)
- Suicide Call Back Service: https://www.suicidecallbackservice.org.au/ or 1300 659 467 (24/7)
- Mental health emergency in Country SA: 13 14 65 (24/7) or https://samentalhealthcommission.com.au/need-help/

Thank you for taking part in our study!

Phase 3 - NSPT Evaluation Aftercare Focus Group/Interview Questions (Clinical)

PHN Region:	**Consent signed: Y/N**	**Participant ID:**
Facilitator:	**Note-taker:**	**Date:**

Preamble

Begin with a brief introduction about the interview, confidentiality, and rights: *"Remember you are free to stop the interview at any time or reschedule. If you don't feel comfortable answering any question, or would like the question repeated, please let me know. Also, due to the nature of the topic that will be discussed, if you experience any distress you are welcome to stop at any time, take a break, or leave and reschedule. You may also advise at any time if you do not want to continue and would no longer like to participate."*

"Do you have any questions about the interview or the research before we begin?"

Pseudonym:

Demographics:

"Let's start off with a few background questions."

Age: Gender: M/F/Non-Binary

Professional background/ Community role:

Current employment/ Community role:

Name of Aftercare service used: When?

Goals

1. When you became a patient of the Aftercare Service, what were you hoping to achieve?
2. Of the things you have mentioned, what were you able to achieve?
3. What was helpful about using the Aftercare Service?
4. What obstacles did you experience?

Services provided

5. How satisfied are you with the support that you received from the Aftercare Service?
6. What aspects of the Aftercare Service were most helpful in assisting your recovery?
7. Besides the Aftercare Service, what other service providers were involved in your care/recovery?
8. How satisfied were you with the support provided by the other service providers?

9. What other services or activities do you think you still need to support your recovery?
10. In what ways did you think the Aftercare Service involved you in planning your care and recovery?
11. In what ways were your views considered?

Changes

12. What changes have you been able to make because of the support/care that you received from the Aftercare Service?
13. What has helped you to make these changes?
14. Of the changes that you were able to make, which ones do you think you will be able to continue with your recovery in the short-term AND in the long-term?

Check in

15. Your time and input have been very valuable, and I understand this may have been distressing to talk about. I want to check that you are okay and if there is anything I can do or anyone I can contact?

Tear off here and give to participant ----------

Support Services

16. Some participants may find the topic of suicide distressing, if you experience distress at any time, you may also contact one of the following:

- Lifeline Australia: https://www.lifeline.org.au/ or 13 11 14 (24/7)
- beyondblue: http://www.beyondblue.org.au/ or 1300 22 4636 (24/7)
- MensLine Australia: https://www.mensline.org.au/ or 1300 78 99 78 (24/7)
- Suicide Call Back Service: https://www.suicidecallbackservice.org.au/ or 1300 659 467 (24/7)
- Mental health emergency in Country SA: 13 14 65 (24/7) or https://samentalhealthcommission.com.au/need-help/