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**Department for Health and Wellbeing
Draft Suicide Prevention Action Plan
2026-2029**

Compassion, Connection, Hope and Care

CONSULTATION DRAFT

November 2025

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Consultation draft prepared for Department of Health and Wellbeing (DHW)
by the Office of the Chief Psychiatrist

Support and help

We do not know the lived experience of people in regard to suicide and self-harm related distress. Therefore, if you feel worried or upset during, or after reading this document, or at any time, please stop reading and reach out for supports and seek help.

This may be in the form of contact with friends, family, colleagues, services and supports available through your employment, professional and personal networks as soon as possible.

Statement from the Chief Executive

Death by suicide is a human tragedy that is preventable. Perspectives from research and engagement with persons who have a lived experience of suicide, inform us that the suicidal process can be interrupted, where explorations of hope and reasons for living can help to overcome the seemingly unendurable and intolerable situations and experiences of suicidal thoughts and urges.

We do not know who, or how many people have a lived or living experience of suicide, yet we know from those persons, it is the emotional pain and distress they experience that leads a person to consider self-harm or suicide. However, there are key elements that provide an opportunity to intervene in helping a person who may be experiencing suicide or self-harm related distress. These form the basis of this action plan, namely Compassion, Connection, Hope, and Care.

Compassion is the core concept of suicide prevention. It is embedded in suicide prevention research and is the crux of multiple national and state approaches. If compassion and therapeutic engagement are the drivers of our healthcare responses, persons in distress are more likely to disclose their concerns and experiences, where compassionate staff and lived experience peer workers can be more effective at delivering care and ultimately improving the quality of care we provide. South Australia (SA) has been at the forefront of delivering compassion-based suicide prevention training since 2016, and it is something we must build upon further to improve outcomes for persons who experience suicide or self-harm related distress.

Connection is to be seen, to be heard, to be understood, and not to be alone. To be a part of a greater whole and identify as part of a community, no matter how small, can be empowering and lifesaving. Connection must also extend to cultural connections to family, land, lore and language. Consideration of a person's cultural context and identity, and how this may influence suicidality and pathways to recovery, should be routine for any interaction regarding interventions and care planning.

Hope, along with connection, is central to the critical moments for the suicide experience of a person in distress. If a person experiences isolation through loss of connection and a loss of hope that things may ever get better, this then is part of the final trajectory towards suicide.

Suicide prevention efforts should extend beyond merely addressing pain, discomfort, and life difficulties. They should also prioritise the cultivation of positive experiences, the improvement of life quality, and the support of individuals in creating a fulfilling and meaningful existence.

Care is the provision of authenticity in the therapeutic engagement of a person who experiences suicide or self-harm related distress. To provide a non-judgemental approach that supports validation of the experience of the individual, where hope may need to be held for the person, especially if none exists within themselves, and to uncover reasons for living, is key to reducing deaths by suicide. Care must be culturally safe and appropriate, as well as being trauma sensitive, informed and relevant.

When reinforced by clinical pathways of care that are specific to suicide, quality improvement approaches can be utilised to improve provided care. This can drive our recognition of system gaps for people in distress, thereby promoting our understanding of the suicidal experience and, of how to engage collaboratively with both the person and their supports.

Statement from the Chief Psychiatrist

It is now understood and accepted that suicide is a behaviour and not an illness. The provision of a diagnosis and medication alone does not reduce suicidality or change the contributing circumstances that lead to the emergence of suicide related distress.

Compassion based approaches to care, where a person's ability to express their experiences of distress openly, in a humane and supported manner and to encourage them to accept help in their moment of need, are fundamental in reducing the prevalence of suicide in persons who encounter our services.

Suicide prevention is "everybody's business" and requires action across our communities and across government. Within health services, suicide prevention awareness and skills may potentially be needed in any clinic or hospital at any time. While mental health services provide a referral and support role, any service may need to recognise a person at risk and respond.

Similarly, suicide prevention in this plan extends to staff suicide prevention. SA Health is a large organisation, and any person could potentially experience suicidal distress, a risk that is greater in an industry such as healthcare.

We must also acknowledge that the composition of the workforce in suicide prevention must adapt and change, to bolster the number of lived experience peer workers and provide opportunity to engage when they are needed most. Importantly, it is imperative that peer workers are recognised as an integral part of the workforce and not a body of persons who sit outside of the respective team. This is an area of priority development within the services we provide.

Connection and validation play a crucial role in supporting individuals in distress. When someone with similar experiences engages, it can help to foster trust and build meaningful relationships, offering hope and reasons to persevere. This approach emphasises that our interactions should be relational rather than purely procedural, ensuring that dignity and respect is woven into every aspect of our systems and organisations.

We recognise that suicide can touch many facets of our lives, and we all have the potential to contribute to engaging and supporting someone who is experiencing suicide or self-harm related distress. Opportunities for intervention can arise unexpectedly or may be planned, but we must be able to respond and encourage those in need to reach out and accept available or offered supports and help.

We have observed in broader society the lifesaving effects of individual and community responses to cardiac and stroke events in everyday life. Adopting a universal approach to suicide prevention education would provide an opportunity for all staff to become conversant in engaging with persons who are experiencing suicide or self-harm related distress, thereby building capacity, capability, and opportunity to engage with persons in need.

This action plan primarily aims to reduce deaths by suicide within our healthcare services and workforce. However, it represents just one chapter in the Department for Health and Wellbeing (DHW) Suicide Prevention Action Plan. This is an iterative plan that will have an oversight committee to review its implementation. As this Action Plan includes specific initiatives, we expect that this will be updated as both our services develop capability and new National agreements are made in future years.

We are committed to ensuring that our workforce receives the necessary support during this critical endeavour.

Acknowledgements

We acknowledge that the lands that we work and live on are the traditional lands of the Aboriginal people of South Australia and we pay our respects to Elders past and present. We acknowledge and respect that Aboriginal and Torres Strait Islander people are the First Nations people of this country and recognise Aboriginal people as traditional owners and occupants of Australian land and waters. We also acknowledge that First Nations people have never ceded sovereignty and remain strong in their enduring connection to land and culture.

We recognise the role of lived and living experience in suicide prevention. The strength and resilience, the values, the contributions to research, the practice and service development, that bring a unique perspective to enhance the capacity of our services to care and to heal.

We would also like to acknowledge the important work currently underway in First Nations suicide prevention. This work is happening at both National, and State-wide levels.

Aboriginal and Torres Strait Islander peoples are a diverse people of great strengths, power and endurance with a profound understanding of human beings and the environment. In 2023, suicide was the 5th leading cause of death for Aboriginal and Torres Strait Islander people compared to 16th for non-Indigenous people.

Aboriginal Australians die by suicide at more than twice the rate of non-Indigenous Australians. There is much for us to learn from Aboriginal people as they can teach us what is needed for Community.

Terminology

Please note that Aboriginal people is used throughout this document as inclusive of people who identify as Aboriginal, Torres Strait Islander, or both.

Support and help

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This may be in the form of contact with friends, family, colleagues, services and supports available through your employment, professional and personal networks as soon as possible.

Service	Contact details	Website
South Australian Supports		
Mental Health Triage (Metropolitan Adelaide)	13 14 65	
Emergency Triage and Liaison Service (Rural and Remote) For help in a mental health emergency		
Medicare Mental Health Centres	1800 595 212	https://www.health.gov.au/our-work/medicare-mental-health-centres
AnglicareSA	1300 077 798	https://anglicaresa.com.au/services/suicide-loss-grief/
Suicide, Loss and Grief Services Star Bear Loss and Grief Camps StandBy Support After Suicide		
Lived Experience Telephone Support Service (LETSS)	1800 013 755	https://letss.org.au/
A South Australian resource offering free afterhours phone and web chat support, available every day from 5 pm to 11:30 pm		
Urgent Mental Health Care Centre - Adelaide	8448 9100	https://umhcc.org.au/
The UMHCC offers an alternative to hospital Emergency Departments for a mental health crisis, accepts emergency services referrals 24/7		
Regional Access	1300 032 186	https://saregionalaccess.org.au/
Free professional phone and online counselling for regional, rural and remote South Australia, 24/7		

National Supports		
Headspace Australia's National Youth Mental Health Foundation, providing early intervention mental health services to 12–25-year-olds.	1800 650 890	https://headspace.org.au/
Lifeline Access for all Australians experiencing emotional distress, 24hr crisis support and suicide prevention services	13 11 14	https://www.lifeline.org.au/
Brother to Brother The Brother to Brother crisis line provides phone support for Aboriginal men who need someone to talk to about relationship issues, family violence, parenting, drug and alcohol issues or who are struggling to cope for other reasons.	1800 435 799	https://dardimunwurro.com.au/brother-to-brother-crisis-line/
13YARN Confidential, national crisis support line for mob who are feeling overwhelmed or having difficulty coping. crisis support 24 hours a day, 7 days a week.	13 92 76	https://www.13yarn.org.au/
Thirrili - Postvention Response Service Responds to the collective trauma of suicide with coordinated services to provide holistic care.	1800 805 801	https://thirrili.com.au/
Suicide Call Back Service A free nationwide service providing 24/7 phone and online counselling to people affected by suicide.	1300 659 467	https://www.suicidecallbackservice.org.au/
Kids Helpline A free support and counselling (talking through problems) to people aged 5-25.	1800 55 1800	https://kidshelpline.com.au/

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QLife provides anonymous and free LGBTIQ+ peer support and referral for wanting to talk about sexuality, gender, bodies, feelings or relationships.	1800 184 527	https://qlife.org.au/
Mensline Australia A free telephone and online counselling service, offering support for Australian men anywhere, anytime.	1300 789 978	https://mensline.org.au/
Open Arms Mental health assessment and counselling for Australian veterans and their families. 24/7	1800 011 046	https://www.openarms.gov.au/

About the Department of Health and Wellbeing (DHW) and the context of suicide prevention

Health and Wellbeing strategies identify priorities for the health and wellbeing for both state and local populations and the approaches that will be taken to bring about improvements in these areas. To this end, the vision of SA Health (which comprises both DHW and services DHW commissions through LHNs)) is to have the best health for all South Australians. More details about SA Health and the suicide prevention context are described in Appendix A.

Strategic Context

Understanding of the risk of suicide is key in driving a prevention response, this includes:

- recognition that suicide distress is fluctuating and not a static experience
- suicide is not inevitable
- people who experience suicide related distress are ambivalent, and can be interrupted
- changes in approaches to care that support compassionate conversations that provide opportunities for connection and the uncovering of hope,
- the provision of hope that can help the person who is experiencing intolerable or unendurable thoughts of suicide, to uncover reasons for living that help them 'flash forward' to a better future, where life can be lived with meaning and purpose.

Our aim is to reduce the number of deaths by suicide for persons in contact with SA Health Services.

Health Service suicide prevention planning is reflected by the application of national and state suicide prevention strategies and plans, such as the [National Suicide Prevention Strategy 2025-2035 \(the Strategy\)](#), the [South Australian Suicide Prevention Act 2021 \(The Act\)](#), the [South Australian Suicide Prevention Plan 2023-2026 \(The Plan\)](#) and the [National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025-2035 \(NATSISPS\)](#).

Whilst the Plan drives the action plans of state authorities, all plans and strategies - whether at a national or state level - should be translatable and implementable within both the health service and local community partners.

Under ss 22 and 25 of the Act, every State authority must have regard to, and seek to give effect to, the Suicide Prevention Plan. As a prescribed State Authority, the Department for Health and Wellbeing (DHW) is required to prepare an Action Plan setting out the strategies and measures that will be put in place to prevent suicide.

This Action Plan focuses upon strategies and measures that are put in place by DHW, with further development and review taking place through the life of the plan.

From a health workforce perspective, the protection and prevention of psychological harm is reflected in the [Work Health and Safety Act 2012 \(SA\)](#), [Work Health and Safety \(Psychosocial Risks\) Amendment Regulations 2023](#), and the [Health Care \(Governance\) Amendment Act 2021 \(SA\)](#).

This action plan will build upon the goals of both National and State Suicide Prevention Plans and strategies, which have the following commonalities:

- To reduce suicide related distress and death by suicide in South Australia and Australia.
- To reduce distress that may contribute to suicide.
- To improve community understanding and responsiveness to reduce suicide.

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To this end, the Priorities of the South Australian Suicide Prevention Plan calls on state authorities to develop their own Suicide Prevention Action Plan which covers five areas. These priorities were developed in by engaging with community and lived experience wisdom, along with current research, evidence and data. The priorities are:

Partner

Enable multisectoral and whole of community approaches to suicide prevention.

Respect

Promote social and emotional wellbeing in and prevent and respond to suicide risk for Aboriginal South Australians.

Prevent

Create compassionate, safe and resilient communities.

Respond

Meet the needs of people and communities when, and in the ways, they are needed.

Review

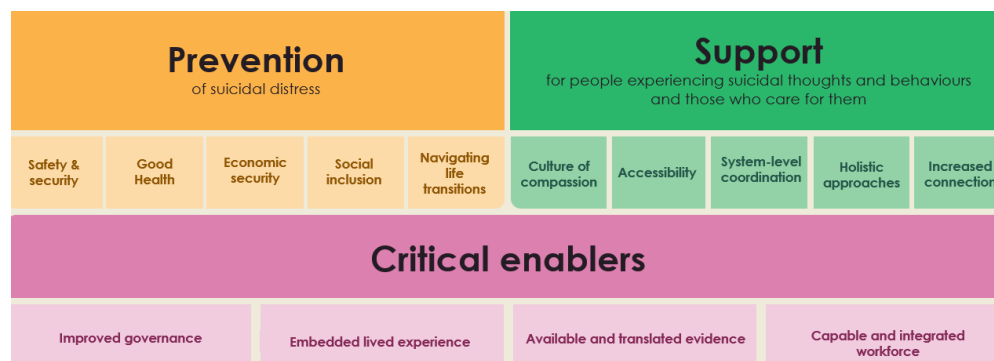
Monitor and evaluate suicide prevention strategies and support evidence informed practice.



National Suicide Prevention Strategy

The release of the [National Suicide Prevention Strategy \(NSPS\) 2025 - 2035](#) in February 2025, has now, more than ever, identified the critical need to address suicide prevention more strategically and considers the prevention of suicidal distress, support, and critical enablers to improve responses.

The SA Health Towards Zero Suicide Initiative (TZS) across South Australian health services, as well as collaborative approaches with government agencies and communities are consistent with the National Strategy. More details of the strategy are described in Appendix E:



The National Suicide Prevention Strategy model: National Suicide Prevention Office. The National Suicide Prevention Strategy 2025-2035. Canberra: 2025.

The National Aboriginal and Torres Strait Islander strategy was released in late 2024. It has 6 priorities that are listed below.

Strategy snapshot

Purpose statement					
To achieve a significant and sustained reduction in suicide and self-harm of Aboriginal and Torres Strait Islander people towards zero through Aboriginal and Torres Strait Islander community leadership and governance.					
Core principles					
Aboriginal and Torres Strait Islander-led	Underpinned by Culture	Lived experience informed	Holistic and integrated systems and services	Place-based responses	
Enabling factors					
Sustained and targeted funding					
Rigorous implementation					
Governance, monitoring, and evaluation					
Priorities					
Priority 1: Leadership and self-determination Outcome: Aboriginal and Torres Strait Islander peoples and communities are empowered to lead responses to suicide and self-harm in Community.	Priority 2: Thriving communities Outcome: Aboriginal and Torres Strait Islander communities are supported to thrive through culture and deep connection to family, community, and Country.	Priority 3: Informed and supportive communities Outcome: Aboriginal and Torres Strait Islander communities are empowered with the knowledge, resources, and skills to identify and support groups and individuals experiencing or most at risk of suicide-related distress and self-harm.	Priority 4: Culturally safe, accessible, targeted, and coordinated care Outcome: Aboriginal and Torres Strait Islander peoples are able to access culturally safe, and coordinated care, where and when needed.	Priority 5: Responsive workforce Outcome: The suicide and self-harm prevention workforce is sustainable and culturally and clinically capable of responding effectively to the needs of Aboriginal and Torres Strait Islander peoples at risk of suicide and self-harm.	Priority 6: Evidence and data Outcome: All activities aimed at preventing suicide and self-harm amongst Aboriginal and Torres Strait Islander communities are culturally informed and evidence-based, including in its research, design, implementation, and evaluation.

Snapshot from page 10 of the National Strategy.

DHW Support for LHNs

DHW in its system lead role will provide coordination and support to LHNs in their suicide prevention work.

In keeping with other strategic priorities Suicide Prevention for both service users and staff will be added to Service Level Agreements between DHW and LHNs, with reference to the Departmental SPAP.

Priority Population Groups

This Action Plan is for all South Australians, and Australians, who engage with, or provide care within, SA Health Services.

Based upon the key requirements of the South Australian Suicide Prevention Plan, and in line with Section 21 of the Suicide Prevention Act 2021, this Suicide Prevention Action Plan identifies priority actions for Aboriginal People.

All initiatives in the plan Consideration will also need to consider the response to priority population groups at greater risk of suicide. Examples of people who have been shown to be over-represented in current suicide rates can be seen in the [Table in this link](#).

The use of data to identify key groups within a given community or area of service provision may also be useful. Health services can assess the profile of their region, partner with available support services and adapt the strategies within the plan to meet the needs of their community. This will ensure that health services are both informed and responsive.

Responding to incidents

We will also transform our approach to how we respond to both suicide related incidents in Health Services, and other incidents where organisational culture is developed via a Restorative Just and Learning Culture (RJLC) approach. This is built on trust, is forward looking in its accountability and seeks to learn from adverse incidents.

This requires all of health leadership to embrace recovery, healing, learning and improvement for all those affected by an adverse incident, such as suicide to support our health services to move to this approach.

RJLC contributes to the development of psychologically safe workspaces. It seeks to shift away from a blame and retribution approach, to one that involves staff in incident reviews and subsequent recommendations, to promote learning for improvement.

It is important to note that RJLC does not only apply in instances of deaths by suicide, but it also embraces a broader culture change across of all of health services, an approach towards psychological safety that contributes to staff wellbeing.

Staff working in all areas of health are at risk of experiencing significant distress, to the point of suicidal ideation, following incidents where they might feel responsible or experience retribution. A RJLC approach retains accountability but focusses on improvement and support. This has been shown to improve staff retention and safety.

Additionally, research and studies indicate that health workers have an increased exposure to suicide are a cohort who are at increased risk of suicide themselves. This action plan outlines the ways we will support staff who have been affected by suicide, including in the instance of especially in terms of the loss of a colleague, where postvention supports can play a role and means restriction for staff at risk is also considered and reviewed.

Addressing means of suicide

The Suicide Prevention Act 2021 allows the Minister, the Chief Public Health Officer, or the Chief

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Psychiatrist to make recommendations relating to suicide prevention. We will continue to support site visits to respond to deaths by suicide/ or related areas of concern. This approach will allow greater understanding of the context of suicide risk and to lead efforts to reduce the risk of suicide in public locations.

We will also continue to support the responsible reporting of suicide in conjunction with key partners, whilst also acting as expert advisers to minimise the risk of harm in relation to obligations under the Suicide Prevention Act 2021, the Mental Health Act 2009 and its statutory office responsibilities.

Community Responses

While primarily focused on suicide prevention within health care, the impact of community distress stemming from events such as climate change and adverse occurrences such as bushfires, floods, droughts, COVID-19, and algal blooms can significantly affect community wellbeing, necessitating supportive measures from a health standpoint. We will collaborate with various government agencies, NGOs, community organisations, and local communities to support suicide prevention initiatives in South Australia.

Next Steps

The Draft Action Plan will be placed on the YOURSAY website to receive public submissions on the plan. To support the public submissions to the DHW Services Action Plan, the DHW will organise two virtual public consultation webinars to obtain face to face feedback on the SPAP as well as seeking feedback through YOURSAY and direct with stakeholder groups.

The consultations will be held by the OCP for DHW, with invitations co-ordinated via the communications department, the invite will also be disseminated to Lived and Living Experience organisations and individuals, CALD, cultural communities and other priority populations. These sessions will form an opportunity to review and further inform the development of the action plan by priority populations.

The Suicide Prevention Action Plan

One of the key aims of this plan is to improve responses to care for persons who experience suicide and/or self-harm related distress.

These responses include specific actions to improve the quality of suicide related services, that are informed by evidence-based approaches to care, quantitative and qualitative data driven quality improvement, and the provision of a caring, competent and confident workforce.

Many key elements are already underway within health services, with the TZS Initiative being a key example of changing approaches within healthcare provision. This is being implemented in line with National approaches to care, with LHNs in SA leading the implementation in the development of pilot sites for suicide prevention pathways in conjunction with Restorative Just and Learning Culture approaches.

What will the plan do?

It is well known that our health system cannot possibly hold all the answers to the provision of care. The key approach is to be working collaboratively with persons who have a lived experience of suicide, support persons and communities who are engaged with health services. This Action Plan contains elements which aim to drive service implementation, evidence-based approaches to care, and data driven insights. These approaches will lead towards:

- strengthening approaches to suicide related care and responses
- developing a caring, confident and competent workforce specific to suicide prevention

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- protecting staff from risk and trauma
- providing supportive frameworks for all those who are involved in the care of people who have died by suicide
- developing effective approaches to sharing information and best practice
- developing a lived experience peer workforce, that is specific to suicide prevention.

Who is the plan for?

This plan is intended for:

- persons who engage with services and are experiencing suicide or self-harm related distress
- their support persons or carers
- leadership of Local Health Networks
- the South Australian workforce
- South Australian organisations and communities who engage with SA Health Services.

The implementation of this Action Plan requires a whole of health system approach to effect significant change and to maintain momentum of already commenced elements.

A whole of health system response includes:

- ownership of approaches to care by those in executive and leadership positions, where organisational authority, resources and funding are provided to enable changes in systemic practice for persons who experience distress, their support persons, and the workforce, for the respective health service providing care
- leadership to and from senior managers, to enable adoption of changes in practices and to proceed in active engagement of the workforce and key stakeholders
- the workforce itself, who require support and organisational permission, to implement suicide related approaches to care, to be open to learning and developing new skills
- Identification and mitigation of psychosocial risks for staff exposed to suicide and other trauma.
- persons with a lived experience of suicide and their support person(s). Collaborative engagement is supported through shared learning, communication, provision of information and feedback to support quality improvement and assurance processes.

Approaches to suicide related care are not in competition with existing health care systems, it is a reminder of what we already do when engaging with persons in distress. As per the example noted above, the TZS Initiative provides a quality improvement process and framework that needs to be integrated into existing Quality Improvement approaches to provide a Business as Usual (BaU) approach to care.

Staff workforce surveys have indicated that clinicians may be uncertain when engaging persons who present in suicide related distress, especially when working environments are high demand and high pressure, which can lead to perceptions of a non-caring workforce.

Suicide prevention initiatives need to be accepted as being on an equal footing with other clinical pathways. This requires parity of care, where an understanding that a person who presents in suicide related distress is at a comparative risk of dying as a person who presents with a myocardial infarct or a stroke episode. Additional support is also be offered to support persons, to aid their own wellbeing in supporting those in distress, to ensure they do not become unwell

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themselves.

However, responsibility for implementing the plan cannot be an isolated approach to one agency, one team or one person. The plan requires an all of health approach, to embed approaches to care that will reduce the instance of suicide within health services. This requires the development of data systems, that can record the reporting of data required for service practice and practice improvement monitoring.

Many items within the action plan are already in progress. The colour coding scheme in the Action

Plan below indicates the progress of the named actions for ease of reading.

Action Plan



Ongoing



Commenced



Not yet commenced

PRIORITY 1 – PARTNER - Enable multisectoral and whole of community approaches to suicide prevention

From the State Suicide Prevention Plan:

- Ensure local, state and federal government work together with communities and lived experience and cultural wisdom to co design suicide prevention initiatives.
- Undertake collaborative action on social determinants/factors that create trauma and impact on suicide related distress.

Collaboratively develop multisectoral approaches to support people and communities after exposure to suicide as a further prevention measure.

Action	Outcome	Measure
1.1 Develop a Lived Experience workforce Promote the development of lived experience peer interventions in mental health services capability, for persons experiencing suicide related distress. Work with Government Departments, The Premier's Advocate for Suicide Prevention, the Mental Health Commissioner, LHNs, lived experience peak bodies and organisations to develop and implement a peer workforce that has suicide prevention skills in areas such as crisis response and aftercare for people who experience suicidal	A lived experience of suicide component of a DHW Peer Workforce framework supports recruitment and selection, training, staffing requirements and operational leadership. Peer workforce is accessible within SA Health Services	• Evidence of consultation and engagement with relevant stakeholders and finalisation of an agreed framework. • Increase in SA Health operated and commissioned services with a lived experience peer workforce supporting individuals at the time of suicide related distress, and at follow up.

distress.

1.2 Further progress Suicide Prevention Initiatives within clinical services

Continue to support the embedding of an evidence-based suicide prevention framework across all SA Health Services to incorporate evidence-based practices such as:

1. Lead – instilling the belief that suicide can be prevented
2. Train – developing the skills for a standardised approach to suicide prevention practise
3. Improve – developing continuous improvement based on lessons learnt
4. Identify – developing a centralised, consistent and systematic identification of suicide risks
5. Engage – developing practices and processes for effective engagement with suicidal persons
6. Treat – providing effective and proven treatment of suicidal ideation and behaviours directly
7. Transition – transferring of persons out of healthcare with follow up care and support

*These are 7 elements of a Towards Zero Suicide Approach)

1.3 Partnership with Preventive Health SA to link their community wide initiatives with DHW clinical prevention work

Preventive Health SA oversee community suicide prevention that interacts with the clinical roles of DHW and specific community functions of the Chief Psychiatrist and Chief Public Health Officer.

Commitment at all levels of SA Health to the elimination of suicide for persons in suicide distress who are receiving healthcare.

Organisational leaders actively engaged in suicide prevention.

SA healthcare system has a just culture of recovery, healing, learning and improvement: when losing a person, and/or colleague, to suicide; or when a staff member experiences suicide related distress

- Relevant measures against priorities are identified in each priority section below.
- Performance agreements contain measures on suicide prevention.
- Continued monitoring of deaths by suicide for people engaged with SA Health Services.

Regular collaboration meetings with Preventive Health SA, related to interface between community and clinical responses including responses to disasters, cluster responses, and postvention

Evidence of collaboration reported in the Annual Report of the Plan.

1.4 Maintain and develop current partnerships in the use of data to improve suicide prevention.

DHW oversees the South Australian Suicide Prevention Registry (SASR) (managed by the OCP), and Safety and Quality Data to monitor suicide and self-harm in services. The aim is to maintain relevant data to inform multi-agency working groups, initiatives, community monitoring and associated responses on both a national and jurisdictional level.

The use of robust data and evidence to inform suicide prevention and postvention actions.

Data may be utilised to identify areas such as, but not limited to: Priority population groups at risk.

The effects upon community of the cyclic nature of disaster experiences, e.g. drought/flood/fire. Frequently used locations for suicide

Ongoing LHN briefs on Statewide Safety and Quality Data.

Commence reports for LHNs on Suicide Register data to inform their community roles.

- SASR data on trends, clusters, patterns or incidents of suicide that may have a direct effect upon community distress.
- Safety and Quality incident reports of suicide attempted suicide and self-harm in services.
- SASR provides collaborative data in conjunction with SA Health data to guide epidemiological and clinical quality improvement, targeted responses to suicide related events in mental health services and the South Australian community

1.5 Develop data and information sharing with postvention providers to improve uptake of postvention counselling (Postvention is the follow up of people bereaved by suicide who are also at risk of suicide)

DHW to engage with National and State Postvention providers to develop interagency data sharing agreement to improve community referral processes for people and communities bereaved by suicide, ensuring that those in distress are afforded the opportunity to receive postvention support in all situations.

Data sharing agreement and processes are in place, supporting postvention referrals in the state.

- Data is analysed to capture the number of postvention referrals compared to the number of deaths by suicide in the state
- Increase in the number of referrals for postvention support for bereaved persons.

PRIORITY 2 – RESPECT – Promote social and emotional wellbeing and prevent and respond to suicide risk for Aboriginal people in South Australia

State Suicide Prevention Plan priorities:

- Ensure transparent partnerships with Aboriginal and Torres Strait Islander people and communities through collaboration and building trust.
- Build social and emotional wellbeing, strengths and capacity of Aboriginal and Torres Strait Islander people, communities, families, with a focus on children and young people, and resilience in times of crisis.
- Build whole of community knowledge, compassion and understanding by recognition of the enduring grief, loss and trauma experienced in Aboriginal and Torres Strait Islander communities.
- Create opportunities for development and delivery of Aboriginal and Torres Strait Islander led and created, culturally competent training and suicide awareness programs.
- Deliver targeted, culturally appropriate and collaborative suicide prevention initiatives and timely postvention responses to Aboriginal and Torres Strait Islander people and kinship networks impacted by suicide.
- Identify and/or create quality standards and indicators for data collection in Aboriginal and Torres Strait Islander suicide prevention.
- Utilise data to measure the effectiveness of suicide prevention activities for Aboriginal and Torres Strait Islander people.
- Identify and/or create qualitative methods for gaining feedback from Aboriginal and Torres Strait Island people who attend our services – listen and hear their ideas, feedback and ways to improve.

Action	Outcome External	Measure
2.1 Closing the Gap Target 14. This outcome is for Aboriginal people to enjoy high levels of social and emotional well-being.	Operation of the Committee and reporting progress through Annual SPAP reports. Support for progress on specific actions in Priority 2 of this SPAP see below.	Actions from the Committee related to Priority 2 of the SPAP. Effectiveness in engaging community partner organisations

The target is for a significant and sustained reduction in suicide of Aboriginal people towards zero.

DHW has facilitated an across government Aboriginal Mental Health and Suicide Prevention Committee co-chaired by the Principal Aboriginal Mental Health Officer and the Chief Psychiatrist.

This Committee will be refocussed to support the State Plan and work towards the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy.

2.2 Expand partnerships with Aboriginal community-controlled health services and seek leadership in the development of plans from communities

Ensure Aboriginal and Torres Strait Islander representation wisdom to:
build on partnership pathways to support and guide suicide prevention initiatives,
improve health outcomes for First Nations People and communities through collaboration and trust.

2.3 Maximise the impact of the statewide Aboriginal Social and Emotional Wellbeing Centre in suicide prevention

Partnership pathways for First Nations people established through collaborative action/approaches, including but not limited to the following groups and organisations:

- Aboriginal and Torres Strait Islander workers, communities and people
- Aboriginal Health Council of South Australia
- Aboriginal Community Controlled Health Organisations
- South Australian Aboriginal Community Controlled Organisations Network (SAACCON)
- Wakwakurna Kanyini – Peak Body for Aboriginal Children

Federal and Jurisdictional Government and non-Government agencies

SEWBC SPP developed in consultation with Aboriginal Community Control sector, both state and national.

- Collaboration requirements identified in relevant policies, procedures, frameworks and guidelines.
- Feedback from Aboriginal organisations on their experience of collaboration.
- Number of Aboriginal SPP developed.

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Support the Social and Emotional Well Being Centre (SEWBC) to develop a culturally specific Suicide Prevention Pathway (SPP) in line with the Towards Zero Suicides expectation of the national plan.
Be guided by SEWBC partnerships with community in supporting statewide plan.

2.4 Facilitate the development and access to Aboriginal specific suicide prevention training for SA Health staff

Aboriginal specific suicide prevention training (including adapted *Connecting with People* training) must involve the Aboriginal workforce and those with lived experience in development, design and delivery
Provide culturally appropriate Employee Assistance Program providers to Aboriginal staff.

Aboriginal and Torres Strait Islander specific suicide prevention training by March 2027.

- Aboriginal and Torres Strait Islander specific suicide prevention training is developed and implemented
- Number of training programs being delivered by services.
- Evidence of feedback, analysis and evaluation on training delivered

2.5 Provide culturally appropriate Employee Assistance Program providers to Aboriginal staff.

Culturally appropriate EAP providers are available for staff

- Number of engagements with Culturally appropriate EAP providers

2.6 Increase the cultural safety of mainstream health and mental health services for Aboriginal people seeking help for distress or a mental health service.

This is to encourage earlier responses.
Improved access to cultural supervision for health staff responding to people in distress.

Culturally safe care.

Improved perception of services by Aboriginal communities.

- Increased presentations for support and care earlier.
- Engagement of Aboriginal Health staff in the delivery of care.
- Reduction of complaints from aboriginal communities about lack of access to care or provision of care.
- Access to cultural supervision for staff.

2.7 Include Suicide Prevention in the Stretch Reconciliation Action Plan

Suicide prevention approaches incorporated within the Stretch Reconciliation Action Plan

- Suicide prevention approaches incorporated into the Stretch

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To collaborate with the Aboriginal Mental Health Strategy and Planning Team to provide a suicide prevention perspective and feedback on the DHW Stretch Reconciliation Action Plan.

Reconciliation Action Plan

PRIORITY 3 – PREVENT – Create compassionate, safe and resilient communities

State Suicide Prevention Plan strategies:

- Connect people and communities to culturally appropriate and accessible activities, information and resources on suicide prevention.
- Empower communities to determine and deliver suicide prevention and postvention activities that are most appropriate for them.
- Support suicide prevention education and awareness raising across community to:
 - build understanding
 - develop skills to respond compassionately to distress
 - reduce social stereotypes
 - challenge taboos about suicide
 - promote hope and wellbeing managing (pro and reactively) sensationalism.
- Undertake actions at individual, service and systems level to reduce stigma, including self-stigma, about suicide.
- Promote safe messaging and responsible reporting.
- Assist communities to identify risks and take action to create safer communities.
- Identify and reduce, remove or mitigate ready access to means of suicide from a community/environmental perspective and at a person in distress level.
- Review and update any workplace wellbeing strategies to include specific strategies that support mental health workplaces.
- Develop policies, processes and training that define the responsibilities of the organisation and rights of workers and members of the public who disclose thoughts of suicide to ensure safe, inclusive and compassionate responses.

Action	Outcome External	Measure
3.1 Universal access to suicide prevention awareness training for all SA Health staff Promote and make available suicide prevention training for all leaders, staff members and volunteers within SA Health services, relevant to their roles and responsibilities. This training will support them with 1. responses to a member of the public who may be in suicidal distress. 2. responses to a work colleague who may be in suicidal distress. 3. increase the awareness of suicide prevention in the context of knowledge about mental health conditions and their treatment. DHW will provide training guidance, develop a Universal online training tool for all staff, and provide advice to support specific LHN training for staff.	Increased competence and confidence of all to engage in conversations with persons experiencing distress and their support person/s. Training programs co-designed (or chosen) with input from mental health staff and those with lived experience of suicide and self-harm related distress. This may include, but is not limited to: • Connecting with People (CwP) approach to suicide mitigation. • SafeSide approach • Compassionate Foundations • Aboriginal suicide prevention training • Disaster Response Training • Other identified training • In addition to the broad training across the organisation existing training programs will provide more specialist skills for clinical groups, technical skills related to the use of the Suicide Prevention Pathway, and Lethal Means Suicide Prevention training (see next). Organisations have identified the need for improved mental health knowledge for non-mental health staff which will be incorporated into training.	• Number of staff attending Suicide Prevention training on an annual basis, reported by each organisation within SA Health Services.

3.2 Promote recently developed Lethal Means Safety training

Lethal Means Safety education is available to all SA Health clinical staff through *ilearn* and incorporated into the safety planning process.

- LMS Modules implemented.
- Promoted and available on iLearn for staff access.

- Number of staff commenced, completed and withdrawn from Lethal Means Safety training by OCP.
- Analysis, reporting and evaluation feedback for LMS modules via OCP to TZS meetings.

3.3 Support existing Suicide Prevention clinical pathway work undertaken by LHNs

Evidence indicates at least a 23% reduction in mortality when a clinical pathway is in place to prevent suicide.

Evaluate Suicide Prevention Pathway (SPP) impact on the early identification and ongoing support for persons in suicide-related distress (and their support persons), who engage with services and are experiencing suicide or self-harm related distress. Refine as necessary and provide system wide feedback and guidance.

Contemporary best-practice processes for identifying, engaging, treating and transitioning people experiencing suicidal distress are governed by the LHN Suicide Prevention Pathway (SPP)

- Number of SPPs implemented in LHNs
- Reduction in deaths by suicide by people on a SPP.

3.4 Development of guidance and support in the use of Safety Plans

DHW will work with lived experience representatives to develop collaborative approaches to safety planning. This will include resources for persons in distress and their support persons that are provided to explain the safety planning process and the SPP.

Variations in service delivery minimised through co-created resources.

- Evidence that statewide resources have been co-designed with those with lived experience and are best practice. Evidence of resources located on Chief Psychiatrist, TZS internet sites and SA Health and LHN intranet sites.
- Biennial review of statewide resources.

3.5 Stigma reduction and suicide prevention

Suicide prevention activities and events

- Number of events promoted in

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awareness

DHW Communications and Marketing Department will promote awareness of suicide prevention such as World Suicide Prevention Day, RUOK? Day, World Mental Health Day etc whilst building understanding that these approaches are part of every day in work in suicide prevention and not just related to those specific days.

supported and attended by SA Health staff.

DHW media releases and CE Weekly Updates.

3.6 Safe Communication

Promote safe messaging and responsible reporting regarding self-harm and suicide related distress. Work with Preventive Health SA in undertaking this work.

Self-harm and suicide related distress and events reported safely and responsibly.

- Understanding of safe communication of SA Health staff post suicide prevention training.
- Periodic review of SA Health communication.
- Evidence of engagements with national agencies such as Everymind and Stigma Watch, to improve the portrayals of suicide, and traumatising events within the community.

PRIORITY 4 - RESPOND - Meeting the needs of people and communities when, and in the ways, they are needed

State Suicide Prevention Plan strategy:

- Build community capacity to manage life adversity and sources of suicide related distress.
- Develop, and connect people experiencing distress to accessible, culturally relevant and compassionate community-based health care and practical supports.
- Improve community knowledge and skills in responding to people bereaved by suicide.
- Develop compassionate and timely aftercare services for anyone who has attempted suicide or experienced a suicide crisis.
- Increase compassionate and timely community-based supports for people bereaved and impacted by suicide loss.
- Identify actions with and for, priority populations (see page 12). Identify actions for occupations and industries with higher rates of suicide.
- Develop organisation-wide Suicide Postvention Protocol including preparedness, response, and recovery practices suitable for implementation at all levels and worksites.

Action	Outcome External	Measure
4.1 Review current Workplace Wellbeing Strategies and Action Plans to ensure they incorporate effective suicide prevention interventions tailored to the needs of healthcare workers. Key issues include identifying work-related causes of psychological distress, provision of and adequate access to appropriate support to staff exposed to trauma, and historical barriers that can prevent people working in health coming forward to seek help. Critical incidents and the response to critical incidents can have a significant impact on worker mental health. Suicide prevention awareness will complement existing workplace mental health training.	Staff undertaking awareness training Leadership capability building around creating psychologically safe workplaces DHW Workplace Wellbeing Frameworks and Action Plans to incorporate suicide prevention strategies with support given to LHNs to incorporate this into their own strategies.	• Change in attitude to seeking help personally if required, or responding to another person in distress. • Increased use of EAP, and peer programs. • Monitoring workplace wellbeing indicators and staff perception results. • Number of mentions of workforce wellbeing in SA Health Strategies and Plans • Number of psychological risk assessment plans in place.
4.2 Workplace health initiative review. Review current initiatives and implement workplace wellbeing strategies for employees.	Workforce wellbeing is measured to ensure accountability and continual improvement. Commitment to healthy and safe systems, the management of psychosocial hazards and good work design are evident in all SA Health workplaces Leaders and managers demonstrate visible	• Employee wellbeing measurement across SA Health • Percentage of senior leader roles who have completed leadership training in the last 5 years • The percentage of “Hazard and Incident- No harm” reports as a proportion of all incidents. • The total FTE allocated to Healthy Workplace or Wellbeing program development and delivery (as at census date).

	commitment to employee wellbeing and build their capability to demonstrate wellbeing centered leadership. Employees feel safe and supported to speak up in the workplace. Support for mental health is available to employees.	• Percentage of employees who have completed psychological safety training • EAP usage rates
4.3 DHW Aftercare and Postvention Guidelines for Staff Exposed to Suicide Develop and implement aftercare and postvention policy and guideline that supports staff, who are or have been, impacted by suicide or self-harm related distress either personally or as a result of their work. Linked to this concern is the greater knowledge and access to lethal means of staff working in health which also needs consideration.	Collaboratively developed organisational aftercare and postvention response policy and guideline. Staff express satisfaction with aftercare and postvention support following incidents of self-harm or suicide related distress.	• Evidence of aftercare and postvention policy and guideline
4.4 Culture change to support staff post critical incidents (across health) Review existing policies and procedures and apply a Restorative and Just Learning and Culture (RJLC) lens to review processes for employees regarding complaint processes, disciplinary actions, reviews, and injury management from a suicide prevention and mitigation approach.	Relevant DHW policies and procedures reflect RJLC principles. Application of RJLC principles to incident responses within services.	• Number of policies and procedures that have been reviewed and incorporated RJLC.

4.5 Establish a Suicide Prevention Committee to have oversight and implementation of the Suicide Prevention Action Plan.

Suicide Prevention Committee in place

- Membership established and terms of reference endorsed.
- Reporting quarterly to Health Chief Executives Council, and annually to the DHW CE on progress of SPAP action implementation and measures.

Suicide Prevention Action Plan activity report provided to the Suicide Prevention Council.

PRIORITY 5 - REVIEW - Monitor and evaluate suicide prevention strategies and support evidence informed practice

State Suicide Prevention Plan strategy:

- Increase quality of data collection relating to suicide and suicide related distress.
- Regularly review the availability of supports and services to communities.
- Utilise data to inform activities related to suicide prevention.
- Activate mechanisms to enable the sharing of information and ideas across government and sectors.
- Use data to identify emerging priority populations that may experience higher rates of suicide.
- Design and pilot suicide prevention activities informed by evidence to test efficacy and gather further data

Action	Outcome External	Measure
5.1 DHW Engagement with the suicide prevention sector Participate in inter-agency meetings/forums/communities of practice to ensure cross-sectoral collaboration on policies and practice in suicide prevention, to ensure strategies and policies are implementable and at a national, state and community level. DHW had a significant role in the development of a current Trans Tasman community of practice involving Australian	There is strong national and jurisdictional engagement in suicide prevention. Communities of Practice (CoP) are formed and implemented based on the identified needs of that CoP.	Number and type of engagements with relevant bodies, such as, but not limited to: • National Suicide Prevention Office (NSPO) • National Mental Health Commission • Other relevant Commonwealth Offices • Jurisdictional Suicide Prevention and Mental Health Commission offices • Postvention and Aftercare service providers • Preventive Health SA • Local Health Networks (LHNS) • Primary Health Networks (PHNs) • Non-Government Agencies • Implementation Science Unit (DHW)

and New Zealand jurisdictions.

5.2 Develop data linkages with suicide prevention data.

Use existing and newly developed data linkages, and organisational relationships, to identify themes and trends for priority populations that may experience higher rates of suicide and self-harm.

Relevant data informs responses to identified areas of community and clinical concern.

- Outcomes reported on findings that identify themes and trends for priority populations.
- Recommendations are documented and action plans developed and updated as required.
- Suicide data available at jurisdictional, National and International levels.
- Data related to priority population groups informs relevant areas of work.

5.3 Further data collection development supported by DHW

Increase the quality of data collection related to suicide and self-harm related distress in health services, to provide evidence-based suicide prevention activities and outcomes.

Evidence-based suicide prevention activities and outcomes informed by qualitative and quantitative data.

Report on quantitative data measurements and qualitative findings for fidelity to the Suicide Prevention Pathway (SPP).

Qualitative feedback from service providers and receivers on implementation of evidence-based suicide prevention activities

Public facing reports and dashboards are available on websites.

- The number of SPPs developed in SA by service.
- Reporting on such outcomes but not limited to:
 - The number of deaths by suicide for people engaged with SA Health Services
 - The increase in the number of safety plans, lethal means safety conversations, risk and clinical formulation completion
 - The number of re-presentations to SA Health Services.
 - Qualitative audits on the quality of risk and clinical formulations.
 - Feedback from the persons in suicide-related distress and the support people who engage with services

5.4 Engagement with researchers both within and outside SA Health

Engage in opportunities for research-based

Approaches to suicide prevention in SA informed by evidence-based and evidence-informed research.

- Number of applications to engage in funding for research.
- Proportion of successful applications
- Number of presentations based on the outcomes of

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approaches of care and evaluation in conjunction with academia and expert advisors in suicide prevention. DHW has had productive research and training collaborations in suicide prevention which will be continued.

5.5 Means reduction site visits

Under the auspices of the Suicide Prevention Act (2021), undertake visits to frequently used locations or areas of concern, where death(s) by suicide have occurred. these visits are collaborative visits in conjunction with key agencies, affected government and public bodies, private organisations and communities.

Note: Outcomes of site visits and associated data will be anonymised and is not for public reporting, due to sensitivity and location in restricting access to method and means of suicide.

SASR informs site visit locations

implementation of evidence based best practice at International and National Conferences

- Report on education and training undertaken as an outcome of the site visit.
- Report on the effects of interventions identified and completed in reducing the incidence of suicide.
- Changes in number of deaths by suicide using data from SASR.
- Monitoring and/or notification of attempted deaths by suicide via such places as SLS, SAAS, SAPOL, PHNs, SPNs etc where relevant.
- Tracking and evaluation of recommendations from site visits reports.

Relationship to other policies, strategies, frameworks

- The Draft Advice on the National Suicide Prevention Strategy
- The Fifth National Mental Health and Suicide Prevention Plan
- The National Aboriginal and Torres Strait Islander Suicide Prevention Plan (NATSISPS)
- The Mental Health Act 2009
- The South Australian Suicide Prevention Act 2021
- The South Australian Suicide Prevention Plan (SASP) 2023-2026
- The SA Mental Health Services Plan 2020-2025
- The South Australian Health and Wellbeing Strategy 2020-2025
- The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy (NATSISPS)
- National Agreement on Closing the Gap
- National Safety and Quality Health Service Standards (Standards 1, 2, 4, 5, 6, 8)
- Australian Human Rights Commission – Rights and Freedoms: Right by Right
- The Chief Psychiatrist “Suicide Prevention Pathway (SPP) Standard and accompanying Guideline.
- SA Health Climate Change and Health Framework
- Plan for Learning and Development – Mental Health 2025 – 2030

Implementation, monitoring and reporting

Progress of the actions will be monitored by existing strategic committees, groups, and existing reporting processes that receive, analyse and report data.

A suicide prevention committee will be established to have oversight and implementation of the Suicide Prevention Action Plan moving forward, to then incorporate and develop the SA Health wide action plan. The committee will engage priority populations, lived and living experience (inclusive of employee lived and living experience) as a key part of its membership.

The implementation of actions is occurring and will continue to occur at service levels of care, with broader contexts supported by incorporation into existing policies and procedures and the development of indicated initiatives.

A report, providing progress on the action plan will be provided to the Suicide Prevention Council, as required under s 26(1) of the *Suicide Prevention Act 2021*.

Appendices

Appendix A – SA Health and the broader South Australian Context

Health and Wellbeing strategies identify priorities for the health and wellbeing for local populations and the approaches that will be taken to bring about improvements in these areas. To this end, the vision of SA Health is to have the best health for all South Australians.

SA Health has a statewide reach to enable the delivery of a comprehensive and sustainable health system that aims to ensure longer, healthier, and better lives for all South Australians.

SA Health is committed to protecting and improving the health of all South Australians. It provides leadership in health reform, public health services, health and medical research, policy development and planning, with an increased focus on wellbeing, illness prevention, early intervention, and quality care.

SA Health's objectives are to improve the health of South Australians by:

- Protecting health: Protecting people from public and environmental health risks, and adapting to climate change
- Preventing illness: Preventing chronic disease, communicable disease, and injury
- Promoting health: Building stronger communities and healthier environments
- Improving care: Enhancing hospital care, strengthening primary health care, and reforming mental health care
- Improving the health of Aboriginal people: Working to improve the health of Aboriginal people
- Working with the community: Working with other government agencies and the community to address the determinants of health
- Delivering community-based services: Building capacity to deliver more community-based services closer to people's home.

SA Health has developed goals to enhance the well-being of South Australians by providing evidence-based treatment that is tailored to individual circumstances and delivered by well-trained, confident, competent and caring workforce, who are supported in the work they do. It further commits to supporting access to treatment and care that meets individual circumstances and is designed in partnership with each person and their support person/s.

These approaches are crucial when we endeavour to reduce the number of deaths by suicide relating to persons who encounter or engage with SA Health Services.

More broadly, approaches to suicide prevention across Australia and the globe are building our understanding of the fine grain experience of suicide. New approaches recognise that suicide is not a fixed state, and the intensity of experienced suicidal thoughts and urges can fluctuate from moment to moment.

Within SA Health Services, we have already moved away from risk stratification approaches of assessment, where the provision of low, medium and high risk of suicide does not reflect the fluctuating suicidal state, or the rapid intensification of thoughts and actions within the individual suicide experience of a person.

Increased understanding provides an opportunity to consider and shift how we engage with persons who experience suicide or self-harm related distress and their support persons, to provide exploration and collaboration of meaningful outcomes, and hope for the future.

As indicated in [SA Health data](#), there is an increased risk for persons to attempt suicide and an increased risk of death in the first 3 months following discharge from services.

Therefore, we must look within the assessment process to see what is helpful for persons in

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distress, and their support persons, to help uncover the effect of contributory factors that may cause a person to consider an attempt or experience emerging or increasing suicide related distress.

We need to change focus to how we ask about suicide, to enable persons in distress and their support persons, to let us know how they are, to overcome statements of denial or minimisation and to also breach barriers of stigma and self-shame that the person may also be experiencing.

Multiple sources of data from the Australian Bureau of Statistics (ABS), Australian Institute of Health and Welfare (AIHW), and South Australian Suicide Registry (SASR), inform us of our greater understanding of the effects of elements such as financial stress, domestic violence, relationship issues, gambling addiction, temporary visa status, amongst other life events and experiences that have a profound effect upon a person's suicide experience.

As indicated in the foreword by the Chief Psychiatrist, the building of relationships and relational engagement are key to the provision of compassion and connection in health services. The development of a caring, confident and competent workforce to build upon that connection and building of relationships is essential. This can encourage a person to reach out and accept help whilst also improving our understanding and non-judgemental consideration of the person's distress, and what it means to them.

Significant evidence based, best practice approaches to care are reflected in the use of the safety planning process. A co-designed, well-constructed safety plan recognises and reflects upon relational safety and what the person can do when suicidal thoughts or urges emerge or intensify.

The safety plan will reflect a person's individual situation, where elements such as gender, age, cultural issues, personal circumstances and protective factors can appropriately be discussed and considered within the development of the plan.

This then provides ownership of the plan for the person and considered others, which becomes relevant for the prevention of suicide for those persons, and their support persons.

The actions within the collaborative safety plan are the best way to understand future safety, as the content of the plan matches the anticipated future state of the person, where those actions are needed to help reduce the emergence or worsening of suicidal thoughts.

This improvement in understanding of the suicidal process is key in driving:

- recognition that suicide distress is fluctuating and not a static experience
- suicide is not inevitable
- people who experience suicide related distress are ambivalent, and can be interrupted
- changes in approaches to care that support compassionate conversations that provide opportunities for connection and the uncovering of hope,
- the provision of hope that can help the person who is experiencing intolerable or unendurable thoughts of suicide, to uncover reasons for living that help them 'flash forward' to a better future, where life can be lived with meaning and purpose.
- We will therefore gather, analyse, monitor, record and provide relevant data to develop and respond to services and communities that ultimately aim to reduce the number of deaths by suicide for persons in contact with SA Health Services.

Suicide in South Australia

Annually in Australia, there are more than 3200 deaths by suicide per year, and in 2023, 230 of those deaths occurred in South Australia (ABS Data).

Suicide is the:

- leading cause of death for South Australians, and Australians, aged 15 to 44 years

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- leading cause of child related death in Australia.
- fifth leading cause of death for First Nations people in Australia, compared to the 16th leading cause of death for the non-indigenous population (ABS 2023)
- second leading cause of Years of Life Lost (YLL), with over 159,000 years of life lost in Australia each year. (ABS 2023)

Work undertaken in the [UK by the Samaritans](#)¹ with David McDaid, an Associate Professorial Research Fellow, Care Policy and Evaluation Centre, Department of Health Policy, London School of Economics and Political Science, indicated that the societal cost of an individual suicide equated to approximately 1.5m GBP (approximately \$3m AUD). This work detailed areas such as:

- employment productivity losses
- suicide health care costs
- self-harm health care costs
- emergency services costs
- coroner / legal costs
- family costs.

These were conservative costings and although related to the UK, provide the most up to date cost analysis of suicide in relation to an economy.

This is reinforced by the [Productivity Commission's 2020 Mental Health Inquiry Report](#)². The report identified that "suicide and suicidal distress cost \$30.5 billion each year", This figure reflects the estimated economic cost of suicide and self-harm in Australia, encompassing factors such as premature death, disability, and associated medical and productivity losses.

When we consider statewide, the 230 deaths by suicide of persons in SA:

- there were 85 deaths by suicide by persons who were engaged with mental health services in the previous 6 months
- this is more than one third of all the deaths by suicide in SA in that year
- of the 85 deaths, 64% occurred within 30 days of their last contact with the service. (OCP SQR mortality monitoring data).

Based upon the work of McDaid, the 85 deaths by suicide of persons engaged with mental health services, this would attribute an estimated cost of \$255m AUD to the SA economy.

In addition to these economic costs, for each death by suicide, it is estimated that 135 people are directly affected ([Cerel et al 2019](#))³, many of whom will require clinical services or support following exposure.

Considering a longer-term view of SA data regarding suicide, since 2016 there have been 556 deaths by suicide by persons who were engaged with mental health services in the previous 6 months.

Furthermore, for persons who attempt suicide, it is well recognised that this is a high-risk factor for a further suicide attempt. This risk is heightened in the three-month period following a presentation to an Emergency Department with up to 40% of people who end their life by suicide having presented to an ED in the previous twelve months. ([Da Cruz et al 2011](#))⁴ [Hill et al \(2023\)](#)⁵

We also know that people who experience suicide or self-harm related distress who have a poor Emergency Department experience, are not only less likely to return to the ED in the future, but they are also less likely to attend their follow-up care ([Rosebrock et al 2021](#))⁶ It is also indicated that persons who have made a previous suicide attempt have an estimated 55.5 times higher risk of subsequent death by suicide than the general population.

When we relate this to a South Australian context, in the year 2023-2024, there were:

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- 595,957 presentations to Emergency Departments (ED) in SA,
- 21,067 (3.5%) were Mental Health related ED presentations, of which there were:
 - 1932 re-presentations within 48 hrs to the same facility, and
 - 931 representations within 48 hrs to a different facility
 - Overall, 2863 (14%) represented within 48 hrs.
 - The average wait time in SA, for persons with mental health presentations to ED in 2023/24 was 12.8hrs.

These figures indicate that the majority of people will not be experiencing suicide related distress. However, a significant portion will be experiencing distress. The figures provide a perspective for SA that specific, deliverable strategies, initiatives, and actions need to be implemented to have the most effect for people who attend services when experiencing suicide or self-harm related distress.

This highlights the necessity to enhance opportunities for engagement and intervention, which can be systematically advanced through quality improvement initiatives. To recognise this as an opportunity to embed a humanistic, person centred, culturally safe and compassionate response for persons who engage with our services is key. Each death is an individual story of human tragedy and a missed opportunity for intervention.

As indicated in the foreword, we also acknowledge that deaths by suicide are preventable, and that for people engaged in care, a 'Towards Zero Suicide' (TZS) approach is an aspiration to improve care and outcomes for people at risk.

The TZS approach has been implemented, both nationally and internationally, and is supported by a strong evidence and research base.

From an evidence-based perspective in Australia, the implementation of Suicide Prevention Pathways (SPP) by Gold Coast Health Services, a vital component of the TZS initiative, led to a 23.3% decrease in the suicide rate among mental health consumers and a 35% reduction in service representations.

If this reduction was applied to the 556 mental health consumers in SA who were engaged with services and who died by suicide between 2016 and 2023, this would mean:

- 130 lives could have been saved since 2016
- 20 lives could have been saved in 2023 alone

Appendix B: Summary of Approaches to Date

What is Towards Zero Suicides (TZS) Initiative?

The TZS initiative aspires to prevent suicide by those in care of health services and is a key priority of the South Australian Mental Health Services Plan 2020-25.

TZS provides a framework for health services to design systems and processes that enhance organisational capability through strengthening a Restorative Just and Learning Culture (RJLC), workforce training and data for improvement.

It helps the health service review, identify, and improve areas of practice and service delivery, engage stakeholders and promote organisational change in a way that supports staff, people who experience suicide and self-harm distress and their support person/s.

It is a long-term improvement approach that signals a journey towards zero suicides as an aspirational goal.

TZS is an approach that can help everyone. It helps people who may experience thoughts about harming themselves or ending their life by allowing them to:

- feel safer or safe enough to talk to health professionals about how they are feeling,
- receive the right support, better understand how they are feeling, and know how to take action to minimise any increase in distress and manage their distress.

The approach also educates and guides health professionals and organisations to reduce, remove or mitigate risk and effectively supports people and their support person/s.

Key to the implementation of TZS in SA is the development of the Suicide Prevention Pathway (SPP) and guideline.

A Suicide Prevention Pathway (SPP) provides a structure and guidance for a pathway of care for all persons who present to SA Health facilities in suicide and self-harm distress. It includes the elements of engagement, comprehensive identification, assessment and formulation, intervention, and transition of care.

The SPP and guidance also provides staff with important principles in working together with support person/s of the person in distress. This is reinforced by The Final Advice from the National Suicide Prevention Adviser, within the [Compassion First](#) document, which recognises 'the need for ongoing practical and emotional support for caregivers, many of whom experience suicidal thinking themselves.'

When introduced to the Gold Coast Specialist Mental Health Service, TZS has led to moving away from ineffective risk stratification for suicidal thoughts (i.e. rating suicide risk as low, medium or high), to evidence-based assessment and collaborative safety planning. This led to an increase in the use, and quality, of safety plans that were developed with persons and their families, from 0.8% to 52.7%.

Safety plans describe actions or strategies and sources of support that will help an individual manage their suicidal thoughts. It should incorporate actions that a person will undertake when their thoughts or urges, are present or becoming stronger.

Significant work has already been undertaken by both the LHNs and the OCP, to move forward in eliminating risk stratification processes in the engagement and assessment of a person who is experiencing suicide or self-harm related distress. This has encapsulated guidance and advice within Electronic Medical Records (EMRs) and a re-alignment of training approaches within LHNs.

Further TZS development work in Gold Coast services reported increases in addressing access to lethal means with consumers from 11.4% to 68.4%.

Lethal Means Safety Training is an evidenced approach in guiding conversations with a person in

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distress and their support person/s, in reducing access to means that may be used in a suicide attempt.

Additional improvements were noted in the community follow-up timeframes for consumers. For the 48 hours following discharge from the Emergency Departments in the Gold Coast, there was an increase from 13.6% seen within two weeks, to 74% seen within 48 hours.

Underpinning the SPP is the fundamental importance of establishing and providing a caring, compassionate, culturally safe, hopeful, and respectful connection with the person, and where appropriate, their support person/s when addressing suicidality. It is essential to provide care that is person-centred, trauma-informed, and recovery-oriented. The components are based on the latest evidence and reflect current best practice.

The quality and timeliness of access to care can have a significant effect upon wellbeing. [Pearlmutter et al \(2017\)⁸](#) identified that prolonged waiting times in emergency departments disproportionately affect people experiencing mental ill-health, which includes people experiencing suicide related distress.

Other Australian evidence concerning the additional benefits of suicide prevention strategies comes from Metro South Local Health District in Brisbane, which demonstrated a reduction in ED length of stay from 17.3 hours to 8.6 hours, through the implementation of a suicide prevention safety planning strategy at the [Princess Alexandra Hospital](#). This outcome was published in an article in the journal [Psychiatric Services in 2023⁹](#). Whilst it is difficult to confirm an exact cause and effect relationship, the authors suggested that the strategy led to an earlier formulation of an accurate opinion of community risks enabling discharge. The approach meant staff spent more time evaluating and treating patients as opposed to monitoring them. It is reasonable to anticipate that the delivery of high-quality care as part of suicide prevention initiatives will lead to better management of Emergency Department demand and reduced length of stay.

These strategies, in conjunction with TZS, could play a crucial role in decreasing the duration of hospital stays and alleviating potentially distressing trauma experiences. They may also enhance the assessment and support planning processes while contributing to a reduction in ramping.

Not all suicide related care is within hospital services. The South Australian Ambulance Service (SAAS) provide an emergency response and are often a first point of contact for persons who experience suicide related distress. This contact may be in isolation or with other services such as SAPOL, the Metropolitan Fire Service (MFS) and the Community Response (CORE) mental health team, amongst others. This first point of contact is an essential component of providing compassionate, lifesaving care and can be the forefront of quality improvements approaches to care and system-based responses to suicide related distress.

Lived Experience considerations

A crucial factor in achieving better outcomes for individuals seeking help for suicide and self-harm related distress is the integration of lived experience into the health workforce.

Within SA, under the TZS “Lead” element, significant improvements have been undertaken in engaging with those with lived experience of suicide and self-harm distress. Invaluable advice has been provided by both those who have experienced suicide and/or self-harm distress and those who have provided support along that person’s journey.

Many others provided their experiences and advice following the death of someone close. This advice has been important in the areas of postvention improvements and creating greater connection with non-Government suicide prevention and postvention services and in identifying areas of improvement for broadening workforce planning.

In partnership and collaboration with LHN services people with lived experience of suicide and self-harm distress will be involved in the development of the local SPP:

- The development of SPPs will be informed by and include, the specific needs of priority population groups utilising the various resources and plans, which have been

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developed by those with lived experience.

- Lived experience representatives will have a role in partnering with organisations and services from a governance, safety, quality, and improvement perspective.

Where possible, LHNs will embed a peer workforce, where the role of the lived experience peer worker will be part of the team providing care and support for the person in distress and their support person/s, as well as enhancing the learning experience of staff.

Furthermore, service providers have a limited impact on an individual's life when compared to the significant influence of family members, caregivers, and support individuals, whose engagement can last a lifetime. This involvement is essential for protecting and enhancing the mental health and well-being of those they assist. It is important for service providers to regard the viewpoints of support persons, including family and friends, as integral to the process of risk assessment.

The active involvement of support persons in all aspects of assessment, formulation, safety and care planning and, where appropriate, be aware of and assess a support persons capacity and willingness to be involved in the person's treatment and support. It is important to assess contraindications to support persons involvement such as family conflict, abuse, or domestic and family violence, age and capacity.

- This then provides an opportunity for both clinical and peer lived experience workforces to engage and provide education to support persons on:
- how to see the warning signs of an increase in distress that are relevant to the person
- who and how to contact others for help regardless of the time of day
- how to safely and effectively respond when a person is distressed
- their role in providing treatment and supporting implementation of a safety plan (including reducing access to lethal means).

Summary

An SPP is a structured intervention designed to ensure people in suicidal distress receive a minimum set of interventions. It moves away from the stratification process of assessing suicide risk, which provides suicide prevention interventions only to those considered to be at high risk or with a specific psychiatric diagnosis. Instead, it follows the principle of delivering high-quality, evidence-based care to everyone who presents to health services with suicide or self-harm related distress and is undertaken in partnership with the person in distress and their support person/s. Development of an SPP in services ensures there is consistent, high-quality care provided by a health service to a person experiencing suicide or self-harm related distress.

Regrettably, both historical data and evidence suggest that incidents will arise, and deaths by suicide will occur, even with the best intentions from all parties involved.

Therefore, the creation of a Restorative and Just Learning Culture (RJLC) is a crucial component of the TZS initiative, aiming to transform our approach to responding to such incidents. It also provides opportunities of engagement for all those involved in incidents, to ensure that the provision of compassion is central to organisational responses to deaths by suicide.

Understanding a Restorative Just and Learning Culture

Organisational culture is the set of shared values, beliefs, practices, and behaviours that shape how employees interact, make decisions, and work together within an organisation. It influences the overall work environment, employee satisfaction, and organisational performance.

Everyday healthcare professionals apply their knowledge and practise their skills within excessively complex situations. At times, this results in unintended outcomes for the patient. All those involved are impacted by these unintentional errors – the person, their supports, healthcare professionals and the organisation.

A restorative just and learning culture (RJLC) is one built on trust, is forward looking in its

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accountability and seeks to learn from adverse incidents.

Developing RJLC requires leadership. Leaders who embrace recovery, healing, learning and improvement for all who have been impacted by an adverse event, such as suicide. Leaders who role-model the desired organisational culture.

Why is this important?

Many who are exposed to adverse events within the healthcare systems can experience traditional responses as punitive.

A retributive, or punitive approach, creates anxiety and distress among healthcare workers by focusing on the individual. A restorative just and learning culture is system oriented and asks three very different questions:

Retributive justice	Restorative just & learning culture
What rule is broken?	Who is hurt?
How bad is the breach?	What do they need?
What should consequences be?	Whose obligation is it to meet those needs?

Applying organisational health concepts to address risks to safety are proven to improve outcomes for patients, lower levels of turnover and increase levels of wellbeing and commitment within the workforce.

Applying the principles of RJLC

Psychological safety is at the heart of a RJLC. It is underpinned by a comprehensive programme of engagement that facilitates a continuous process of listening and dialogue that challenges thinking, provides the reality check, informs strategic priorities, and reinforces shared accountability for quality and organisational culture. To mobilise everyone in the health system to transform care for people, it is essential to create the conditions where:

- speaking up is encouraged and celebrated
- ideas for improvement are welcomed
- there is mutual respect among all team members
- mistakes were reported and openly discussed.

But real and lasting culture change needs leadership not just buy in but also action to “walk the talk”. Leaders need to:

- acknowledge: recognise the uncertainties and potential that can be expected to occur when things are changing, and complex challenges are being solved
- listen: create opportunities to listen, discuss and reflect without judgement
- be curious: ask questions which invite people to speak up
- be self-aware: be humble and admit that you might miss things and make mistakes and make it safe for others to do the same.

Senior leaders need honest, objective feedback and critique. When people come forward with bad news or mistakes, leaders need to respond in an appreciative and forward looking way. Practice a growth mindset - “Let’s see how we can fix this together”.

Organisational considerations

Professor Sidney Dekker is an internationally recognised leader in strengthening a restorative just & learning culture. He poses the following questions for policy makers:

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- Does your organisation:
- understand the difference between work as imagined and frontline work as actually done
- avoid firing or sanctioning workers
- ask what was responsible, not who was responsible
- perform new learning review instead of investigation
- acknowledge its role in creating goal conflicts and production demands
- collaboratively identify pathways to improvement?

Does your organisation encourage workers to:

- give their account
- recognise the needs of others
- show remorse and open to various ways of putting things right
- help identify pathways to prevention?

Does your organisation's just culture:

- address harms, needs and obligations
- identify and support first and second victims
- encourage accounts from all about how they were affected
- invite contributions from all involved about how to go forward
- drive dialogue, participation and collaborative decision making
- identify deeper systemic issues behind the incident
- respect all parties?

South Australian considerations

The need for culture shift in SA has been reinforced through feedback from LHN staff involved in the Towards Zero Suicide implementation. Staff workforce surveys and conversations indicate there is a desire to be involved in incident reviews and the development of recommendations for improvement.

An approach of 'not closing the loop' with frontline staff, can perpetuate apathy, and psychologically unsafe environments for staff whereby they are fearful of unknown outcomes, which may lead to experiences of blame and retribution. The consequences can be poor attitudes and indifference towards reporting incidents if the person reporting is not encouraged to be included in the incident reviews.

A consistent message at Towards Zero Suicide workshops] was in relation to the results of LHN workforce survey data that was undertaken in 2024, showing that 35% of mental health staff had no training in direct suicide prevention, which emphasised the value of providing workshops.

The survey also indicated that 1 in 5 staff felt blame was levelled at staff closest to an incident, and 2 in 5 feared disciplinary reprisal following an adverse incident such as suicide. This supports the need for leadership within the health services to shift the culture from one of punitive approaches to suicide to one that adopts healing, recovery and learning for improvement.

Linking RJLC and staff training

A key outcome of the Zero Suicide Healthcare framework is to ensure that health services are confident and competent in working with people who present with suicidal behaviours. This provides an opportunity to strengthen the capability of the workforce to engage compassionately, confidently and collaboratively, whilst also ensuring an improved quality of care and outcomes for persons who experience suicide or self-harm related distress and their support persons.

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Implementing approaches, such as the TZS initiative, will provide a framework for all health services to review, identify and improve areas of practice, design systems that prevent harm for staff and persons who encounter services and develop strategies for continuously improving processes for consumer care.

In relation to these elements, key training of staff will include:

- working in partnership with people in distress, and their support people with the understanding that not all suicidal and self-harm distress is based upon a mental health diagnosis or severity of risk
- establishing a connection with all involved through a respectful, hopeful, and collaborative approach
- skills in providing contemporary practices in assessment and clinical formulation
- confidently discussing safety planning and lethal means counselling
- understanding suicide treatment options that are available to meet the varying needs of people in distress
- how to provide appropriate warm handovers to other services involved in that person's care, especially where they may be engaged in organisations that are relevant to the priority population groups
- conducting follow-up within 48-72 hours of leaving the service to ensure the person has connected with the aftercare provider and that the person and support person/s are managing the distress, as well as the safety and care plans
- most importantly, that they are all aware of how to recontact the service or what to do in the event that there is an increase in distress out of business hours
- setting up a plan with the person on who and how to contact someone else if they cannot be reached within the 48–72-hour timeframe.

In a broader context, beyond the direct delivery of care services, public sector health staff also face both direct and indirect experiences of trauma. They may encounter individuals who are in distress due to suicidal thoughts or self-harm.

While these staff members do not need the extensive skill set of clinicians and frontline workers, it is essential for them to engage in a non-judgmental and culturally sensitive way, listen attentively, offer compassion and provide appropriate respectful support. Encouraging individuals to accept the assistance available to them is also crucial. Training programs such as [Compassionate Foundations](#) serve as an ideal introduction to the necessary approaches and skills in this area.

Staff Wellbeing

The concepts of healing, recovery, and learning extend into the realm of staff wellbeing. It is acknowledged that health professionals, including first responders, mental health practitioners, and crisis workers, administrative staff and peer workers, frequently encounter suicide as part of their job responsibilities. Research indicates that such exposure has a profound effect on mental health, particularly leading to symptoms of depression, anxiety, and Post Traumatic Stress Disorder (PTSD) among those impacted.

Further studies reveal that these workers often experience emotional and cognitive responses akin to those felt by friends and family members of individuals who have died by suicide. Affected employees have expressed the necessity for organisational support after experiencing a suicide in the workplace, highlighting systemic shortcomings and insufficient resources that contribute to suicide in certain communities.

The *UK NHS Postvention guidance: Supporting NHS staff after the death by suicide of a colleague* ¹⁰ outlines the necessary support mechanisms and processes for employees following a colleague's suicide. This document was created in response to the NHS's recognition of the absence of postvention guidelines for its staff in such tragic circumstances.

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Postvention refers to the interventions implemented after a suicide, aimed at assisting those who may be grieving or affected by the loss. These measures are designed to help individuals cope with stressors and navigate the challenges of loss and grief.

The guidance also points out that nurses face a 24% higher risk of suicide compared to the general population. This finding is supported by the research conducted by [De Lyra et al](#)¹¹, in 2021, which showed that the age-standardised suicide rates among female nurses and physicians surpassed those of the general population.

This NHS guideline, along with other research, acknowledges the significant vulnerability among staff particularly in relation to the suicide of a colleague.

It was observed that there were considerable deficiencies in support at a systemic level, leading workers to rely on their personal resources to address these shortcomings, often to their own detriment. Effective postvention support necessitates evidence-based care approaches tailored to the specific culture of the health service. This is particularly critical in the context of responding to a colleague's suicide, requiring a swift and comprehensive response that addresses the immediate needs of all staff and management. Furthermore, postvention can be regarded as a vital component of suicide prevention, benefitting not only individuals experiencing suicidal distress but also healthcare professionals and others in the community impacted by suicide.

The guideline also acknowledges that employees require assistance, including time and motivation, to utilise the available services effectively. Organisations and their leaders must prioritise and foster a healthy work-life balance for their staff by offering flexible working hours and locations, ensuring regular breaks, and encouraging the use of annual leave. Coupled with open communication channels that enable employees to express their opinions, this approach can cultivate a positive workplace atmosphere, enhancing overall quality of life and supporting sustainable change.

When reflecting upon the effect of suicide upon healthcare and front-line staff, Zamir et al (2022)¹² identified that fear, stigma, exclusion and discrimination, all of which are tied to negative career implications, play a significant part in non-disclosure of mental health professionals who experience psychological distress.

Participants who have experienced psychological distress, with self-perceptions of embarrassment, shame, and of being seen as "weak", were factors that hindered their willingness to disclose. Similar to the wider data related to suicide, this stoic attitude towards non-disclosure greatly impacts an individual's capacity to manage distress in their life. This may ultimately lead to feelings of isolation, disconnection, and hopelessness each of which are significant contributors to someone who may be contemplating suicide.

Existing action plans such the [Every Doctor, Every Setting](#) Framework, which was developed with Life in Mind, brings together the best available evidence in a strategic and integrated approach on what works to prevent and respond to mental ill-health and suicide and applies it to the medical profession. Such frameworks, which are relevant across the workforce, can be useful in their entirety or when considered alongside approaches such as RJLC.

Pitman et al, 2018¹³ identified an association between suicide bereavement and occupational dropout and the work of [Padmanathan et al](#) (2023)¹⁴, found that occupational factors, such as exposure to potentially morally injurious events and the provision of a reduced standard of care, contribute to staff distress and could increase the likelihood of suicidal thoughts developing. The findings of the study suggested that improvements in mental health support and psychosocial risks may reduce suicidal thoughts and behaviour among healthcare workers.

Providing compassionate, focused, and prompt support is essential for safeguarding staff members who may experience mental health difficulties and suicidal thoughts after a colleague's suicide. A strong postvention strategy not only aids and shields employees but also safeguards the individuals in their care.

The NHS Guidance identified that by implementing effective, evidence-based postvention

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practices, NHS workplaces can ensure a compassionate response that fosters recovery and reduces the risk of additional harm.

Local Health Network (LHN) workforce surveys undertaken as a part of the Restorative, Just and Learning Culture within the TZS initiative reflected these issues, where staff in an LHN reported that they were regularly subjected to traumatic incidents. However, the workers did not report the incident within the regulated reporting system, and they were not asked about the traumatic incident by their line manager.

Appendix C – Means Restriction

Addressing Means of Suicide

The Suicide Prevention Act 2021 allows the Minister, the Chief Public Health Officer, or the Chief Psychiatrist to make recommendations relating to suicide prevention. Objects of the Suicide Prevention Act include reducing the incidence of suicide in the State and promoting best practice suicide prevention policies across the State.

The Act supports site visits to be undertaken in response to deaths by suicide and/or related areas of concern to better understand the context of suicide risk at public locations. This in turn enables suggestions to be made for future mitigation and prevention efforts.

Site visits are supported by multi-agency engagement and sharing of relevant data, and of information shared by respective organisations.

As a part of the OCP and statewide Suicide Prevention Strategy, inspections occur to review any aspects of recommended sites and surrounding infrastructures which may present a significant risk, as well as to make recommendations that would assist with increased safety for the public.

People who die by suicide are known to take steps to prevent their actions from being interrupted. This means searching for locations with limited potential for rescue, including public places.

Suicidal thoughts are often brief and fluctuating. When considering suicide prevention in public places, the priority is to interrupt the trajectory towards acting on suicidal thoughts. Research indicates that there are 4 types of interventions that are used and that can have benefit (Pirkis et al 2015)¹⁵, these are:

- restricting access to lethal means
- encouraging help-seeking (e.g. by installing phones, buzzers, speakers that link directly to crisis lines and/or by erecting signs with messages of hope and crisis line numbers that are staffed by experienced crisis counsellors).
- increasing the likelihood of intervention by a third party
- encouraging responsible media reporting of suicides at these sites.

Assistance is offered from the combined offices of the OCP and Chief Public Health Officer, and from the South Australian Suicide Prevention Council on suicide prevention measures that may be appropriately undertaken at the site. Key personnel and external expert advisors are invited to be part of the inspection team.

After site visits are completed and key informant interviews are undertaken, best evidence interventions are used to determine what may help at the time of final moments of a suicide act. A written report is generated considering cost, practical implementation, effectiveness, and possible unintended consequences or effects of targeted interventions.

In an example of a site visit, between an initial visit to an anonymised site and an arranged follow up visit one year later, there was a preliminary indication of the increased likelihood of intervention for multiple persons experiencing suicide related distress. This provided opportunities for interruption and for help seeking, whilst also supporting on-site staff to feel enabled to engage with a person who maybe experiencing suicide related distress.

In addition to the above, the reporting of suicide related events by media outlets can be of concern. If not conveyed within MINDFRAME Guidelines, this can raise visibility to those who may be considering ending their life by suicide and therefore may be suggestible to means and methods they had not previously considered. The specific naming of places can also attract attention or curiosity and raise awareness of frequently used locations.

Articles may inadvertently describe interventions and preventive actions that have been undertaken or implemented, raising awareness to those who may take steps to prevent their

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actions from being thwarted, and ultimately reduce the potential for interruption.

More broadly, responsible reporting of suicide is specifically acknowledged as a suicide prevention strategy on a worldwide basis. Although steps have been consistently taken to improve the quality reporting of deaths by suicide, it remains an area of improvement in society overall. Therefore, SA Health will continue to support the responsible reporting of suicide in conjunction with key partners. This will include the reporting and prevention of suicide amongst priority populations, occupational and societal groups, whilst also providing support and advice regarding reporting in the media and because of its obligations under the Suicide Prevention Act 2021, the Mental Health Act 2009 and its statutory office responsibilities.

Staff Considerations

Health Professionals may be particularly sensitive to media coverage and portrayals of suicide within healthcare settings, as the suicide of persons involved with mental health services frequently leads to scrutiny of staff practices and conduct, including the identification of staff members by the media. Indeed, studies have shown that mental health professionals often experience fear (Murphy et al. 2019)¹⁶ and distress (Sherba et al., 2019)¹⁷ associated with adverse media attention concerning death by suicide of persons involved in care, a circumstance that may be exacerbated if colleagues who have died by suicide are part of their caseloads.

Therefore, the development of frameworks within the workplace, along with policies and procedures to manage media enquiries, respond to articles of a negative nature, and to minimise sensationalist and inaccurate, stigmatising language and messaging can help to ensure that colleagues or affected individuals are able obtain sufficient support. Simultaneously this can reduce harmful speculation about work-related factors or events that could contribute to suicide. This is especially important considering the sometimes-negative stereotypes and reporting about health services that the media perpetuate. (Garcia & Qureshi 2022)¹⁸ Groves et al (2022)¹⁹

Service responses to mental health issues, suicide and other elements mentioned above, have typically been focused on an individual level and not at the systemic or organisational approach to the work environment. There is existing best practice, which is isolated and not organisationally available, SA Health will therefore strive to provide support to develop these approaches more broadly.

Inclusive of this is the approach of reporting and monitoring staff access to means of suicide. In 2022, WorkSafe New Zealand undertook a project to collect data and increase understanding of work-related suicide. Over a four-year period, they found that 12% of all suicides met the criteria of being work related. This reflects international research which showed similar results, they found that:

- approximately 12% of suicides were work-related
- 86% of work-related suicides involved stressors related to work
- 22% of work-related suicides used means related to work
- 10% of work-related suicides occurred in the deceased person's workplace.

These findings reflect the linkages available to monitor work related deaths, not just for SA Health Services but across all of SA, which fits across many aspects of this Action Plan. Elements such as site visits under the Suicide Prevention Act, use of the South Australian Suicide Register (SASR), consideration of reducing access to means for suicide and Restorative Just and Learning Culture to name but a few. When considered alongside literature reviews of healthcare staff and access to means of suicide, this can drive further considerations of staff wellbeing and organisational responses to ensure safety and support across all aspects of SA Health services.

Appendix D: Priority Populations

Tailored Approaches for Priority Populations

There is clear evidence for the need to tailor approaches to the needs of certain population groups that are over-represented in current suicide rates.

Consideration of a person's cultural context and identity, and how this may influence suicidality and pathways to recovery, should be routine for any interaction regarding interventions and care planning.

This extends to understanding the importance that should also be given to matching any recommended interventions with the flexibility required to engage in collaborative care and meet the person's needs and circumstances.

The use of data to identify key groups within a given community or area of service provision may also be useful.

Examples of people who have been shown to be over-represented in current suicide rates can be seen in the Table on the following page.

It is therefore essential that people with lived experience of suicide and/or self-harm distress, and with the understanding of the needs of priority population groups, be involved in the following ways:

- approaches to care will be informed by and include, the specific needs of priority population groups utilising the various resources and plans, which have been developed in conjunction with lived experience
- lived experience representatives will have a role in partnering with organisations and services from a governance, safety, quality, and improvement perspective
- drawing on the strengths of communities, including expertise held in community organisations and within SA Health.

Priority Populations

**in no order of priority and as examples of many more	
Children and young people including those in out-of-home care; those in youth justice system and those who fit several of the other categories below	Aboriginal and Torres Strait Islander people
Care leavers (people who spent time in out-of-home care as a child)	LGBTQIA++SB (Lesbian, gay, bi-sexual, transgender, query, intersex, asexual, sistergirl and brotherboy
People who have experienced bullying and victimisation	People with severe mental health conditions
Survivors of abuse or violence, including sexual abuse and domestic violence	Certain occupational groups with increased knowledge of, and ready access to the means to attempt suicide, such as, doctors, nurses, vets, farmers and other agricultural workers
People who use or experience domestic violence	Some male-dominated industries, such as construction and mining
People living with long-term physical health	Some culturally and linguistically

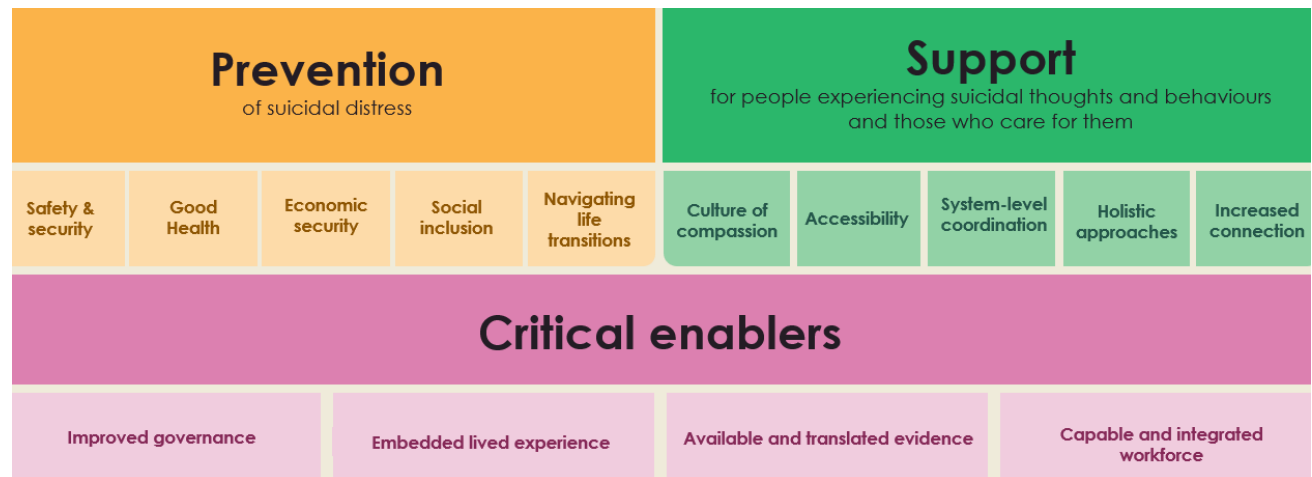
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conditions	diverse (CALD) communities – especially recognising that suicide may still be illegal in their homelands
People with untreated depression	Asylum seekers and refugees
People who are neurodivergent	Prisoners and others in contact with the criminal justice system
People who are socioeconomically disadvantaged	Rough sleepers, the homeless and those at risk of homelessness
People who misuse drugs or alcohol	Older people, especially men
People bereaved or affected by suicide	Residents of aged care facilities
People who do not have strong connections to their culture or identity	People experiencing significant gambling harm
People who have been placed on a Mental Act Legal Order or who have appealed their status under the MH Act and been unsuccessful in that appeal.	People with disability
Populations at higher risk of suicide and suicidal behaviour	Serving and ex-serving Defence Force members and their families (see Royal Commission report)

Appendix E: National Context

National Suicide Prevention Strategy

The Strategy provides a nationally consistent alignment of suicide prevention in Australia, driven by the recognition for high quality and effective supports, with social and emotional wellbeing concepts also at its core. The Strategy has two main domains of focus for suicide prevention.



The National Suicide Prevention Strategy model: National Suicide Prevention Office. The National Suicide Prevention Strategy 2025-2035. Canberra: 2025.

Prevention

This domain recognises the social determinants of suicide related distress that look to build wellbeing by addressing the drivers of distress. This approach recognises that the building of protective factors in the whole population can increase wellbeing by attending to inclusive approaches to reduce loneliness, and social exclusion, as well as other areas that can disproportionately affect persons in distress.

Support

This domain recognises that the connection to safe and effective supports are central to every service and system. They are key to reducing barriers to engagement. Services must be accessible, affordable, and timely, they must be safe and provide effective care that is responsive to priority populations such as Aboriginal and Torres Strait Islander, Culturally and Linguistically Diverse (CALD) and LGBTQIA+SB communities.

Supports provided must be effective, with peer workers and carer supports to help address the full range of needs across the holistic spectrum, not solely to focus upon mental health aspects of care.

Within each domain, there are recognised drivers for reducing suicide, and within each driver are critical enablers to balance interventions across all levels of Commonwealth and State governments. This ensures that the domains are actionable, to sustain and maintain the approaches to an effective level. This will reflect the need for service provision to reduce suicide in SA, in which:

- governments and portfolios think about suicide prevention and work together to sustain approaches nationally
- create cultures and organisational structures that support people with lived experience
- maintain data:
- where people live
- services they use

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- identify gaps
- provide a capable and integrated workforce to maintain the domains
- have a more extensive workforce strategy
- support and sustain formal and informal supports.

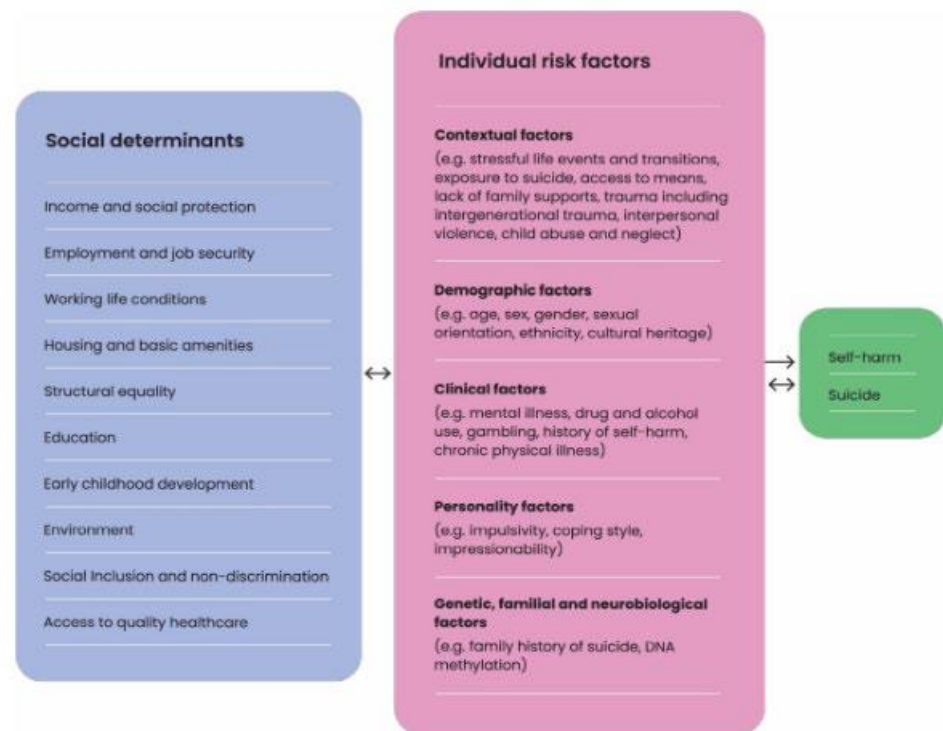
Within the National Strategy, there are (28) recommendations that are of relevance to jurisdictions and are linked to joint responsibility with the Commonwealth. The actions fall into three themes:

1. The continuation of joint Commonwealth and State and Territory commitments to address key social determinants of suicide, for example through education initiatives, responses to the *Disability Royal Commission* and implementation of the *National Preventative Health Strategy*.
2. Pursuing a more holistic support system that is better equipped to meet the needs of groups disproportionately impacted by suicide.
3. Building on the existing *National Mental Health and Suicide Prevention National Agreement* to strengthen ongoing ways of working between governments.

All jurisdictions have been involved on the progress of the Strategy to date and will continue to be involved in the development of an Outcomes framework.

The Strategy also identifies suicide distress as a human response to overwhelming suffering. It is complex – typically, there are many factors at play rather than a single isolated cause. These factors include:

Social determinants and individual risk factors for suicide and self-harm: National Suicide Prevention Office. The National Suicide Prevention Strategy 2025-2035. Canberra: 2025.



Aboriginal and Torres Strait Islander People

The National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2025-2035, was developed in partnership with Gayaa Dhuwi (Proud Spirit) Australia, and sets a path for all governments to work in genuine partnership with Aboriginal and Torres Strait Islander people, organisations and communities to reduce the rates of suicide and self-harm amongst Aboriginal and Torres Strait Islander people, by driving culturally safe and responsive solutions

When working with Aboriginal and Torres Strait Islander people consider the impact of:

- racism
- colonisation

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- intergenerational trauma
- dispossession
- policies of exclusion and child removal
- social and economic disadvantage.

It is acknowledged that the ongoing impacts of colonisation result in Aboriginal and Torres Strait Islander people experiencing a deeply entrenched lack of trust in mainstream services, including health services. There may be a risk of harm resulting from culturally unsafe mainstream services and it is therefore important to engage others in planning the care for this person and their support persons. Health practitioners need to be aware that, wherever possible, a referral to an Aboriginal Community Controlled Organisation (ACCO) or similar service and effective transfer of care is likely to be in the best interests of an Aboriginal or Torres Strait Islander person experiencing suicide or self-harm related distress (and their families and communities). If there are Aboriginal Mental Health Consultants or Peer Workers available, it is advisable to discuss options and pathways for this person.

The SA Health banner story and why this is important.

- At the centre of the artwork is the Department for Health and Wellbeing / Aboriginal Health.
- It shows other organisations coming to the organisation for information and support in the Aboriginal health space.
- The wider illustration represents the communities and organisations who are impacted by the work and results-based outcomes spearheaded by our organisation.

The whole visual represents the wider network and partnerships forged, and the collaborations that are yet to come.

Artwork by Eastern Arrernte Artist Pat Caruso.



The South Australian Aboriginal Social and Emotional Wellbeing Centre (ASEWC) is due to open in the latter part of 2025.

The ASEWC will provide safe healing for First Nation peoples of all ages. The Centre will recognise cultural connections to family, land, lore and language. It will offer holistic healing practices, mental health assessments and referrals, which will be facilitated by mob with a First Nation focus and knowledge of customs, values and belonging.

ASEWC staff will also offer support to other LHN staff to provide advice on the most appropriate services and pathways for a person who presents in distress. The intent is not to control the services for that person who may present to an ED etc, but more about providing the support for staff to identify options for how that person in distress may be supported.

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It is important to engage with, and seek advice from, priority population organisations in the early stages of engagement.

From the National Suicide Prevention Advisor

While all suicide prevention programs and initiatives need to be culturally safe, Aboriginal and Torres Strait Islander people must lead and develop their own tailored approaches to suicide prevention. This ensures they are culturally appropriate, community connected, relevant, and safe.

Aboriginal and Torres Strait Islander communities have a unique emphasis on 'social and emotional wellbeing underpinned by cultural values and perspectives that support connection and belonging to family, community, culture, country, spirituality and ancestry within a collective context.' This conceptualisation of what health and wellbeing means and what sustains it, is fundamentally different from the individually oriented model upon which Australia's health and mental health systems are built.

Suicide within Aboriginal and Torres Strait Islander communities occurs within a broader context, which includes intergenerational trauma and disadvantage, together with ongoing experiences of racism and discrimination. Recognising these broader factors and how they shape both Indigenous wellbeing and engagement with mainstream services is essential to developing responses that meet the needs of Aboriginal and Torres Strait Islander people.



In practice, this means that systems and services that respond to Aboriginal and Torres Strait Islander suicide and self-harm need to be responsive to the needs of individuals, family, and community. This includes being accessible and easy to navigate, placing the individual at the centre of responses to suicide and self-harm. This also includes prioritising integration and collaboration of all aspects of the system to meet the needs of Aboriginal and Torres Strait Islander people accessing suicide and self-harm support.

In addition to the general guidance provided for the engagement of any priority populations, these resources provide specific information about the contextual factors impacting suicidality among Aboriginal and Torres Strait Islander people. These resources also provide practical implications and guidance for clinical practice:

- [Guidelines for Best Practice Psychosocial Assessment of Aboriginal and Torres Strait Islander People Presenting to Hospital with Self-Harm and Suicidal Thoughts](#)⁸³
- [Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing](#)

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[Principles and Practice 2nd Ed](#) ⁸⁴

- [Wellbeing and Healing Through Connection and Culture](#) ⁸⁵
- [Solutions That Work: What the Evidence and our People Tell Us – Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report](#) ⁸⁶
- [The National Guide to Preventive Health Assessment for Aboriginal and Torres Strait Islander People \(RACGP/NACCHO\)](#) ¹⁰¹

An SPP is suitable for all population groups within the state. It provides the framework for LHNs to embed the essential components of suicide and self-harm care into any locally developed SPPs within their networks. LHNs may choose to develop an SPP to specifically meet the needs of people from the priority populations. For example, using the various guidelines referenced in the [Chief Psychiatrist SPP Guideline](#), and with input from those with lived experience in these areas, specific needs and care can be identified to assist staff in delivering informed and improved care to those from the priority populations,

Evidence shows specific populations are at higher risk of suicide and suicidal behaviour. Suicide rates amongst Aboriginal and Torres Strait Islander people are twice that of non- Indigenous people. As well, LGBTQIA+SB communities have the highest rate of suicide of any priority population in Australia.

The NATSISSP recognises that 'health should connect the physical health and wellbeing of an individual with the health of their family, kin, community, and connection to Country, culture, spirituality, and ancestry. Approaches to suicide and self-harm in services must encompass a holistic and integrated understanding of health and must follow a systems-based approach to suicide prevention. Services need to be responsive to the needs of individuals, family, and community. This includes being accessible and easy to navigate, placing the individual at the centre of responses to suicide and self-harm. This also includes prioritising integration and collaboration of all aspects of the system to meet the needs of Aboriginal and Torres Strait Islander peoples accessing suicide and self-harm support.'

Important links for staff working with Aboriginal and Torres Strait Islander people:

- [Yarning Contacts](#) [Yarning contacts | SA Health](#)
- [SA Social and Emotional Wellbeing Centre due to open in the latter part of 2025](#)
[Aboriginal Social and Emotional Wellbeing Centre | SA Health](#)
- [Culture, Care Connect](#)

In aligning these key documents, we acknowledge that we have an opportunity to support service change that provides an individualised approach to care for the person who is experiencing suicide or self-harm related distress, and their support persons. Even though this care is individual, we can drive service provision and care that is consistent state-wide, that directs culture change for services to be compassionate, collaborative, culturally responsive and focused on the person and their support persons, and not the service.

This approach is reinforced by the aims and goals of the *SA Health and Wellbeing Strategy 2020 – 2025*, which provides a focus to drive improvement efforts across the system and a structure to enable monitoring of outcomes, especially in the context of enhancing hospital care, reforming mental health care, improving the health of Aboriginal people, and commitment to a health system that produces positive health outcomes by focusing on health promotion, illness prevention and early intervention.

Appendix E

Development of the Suicide Prevention Action Plan

SA Health has utilised insights and feedback from ongoing Suicide Prevention initiatives that have been included in the current plan, as well as identifying priorities from this work. The draft plan is to be subject to broader consultation.

For instance, the consultation process for the Suicide Prevention Action Plan incorporated various feedback mechanisms, including the development of the Suicide Prevention Pathway Standard and Guideline.

The framework of the draft Suicide Prevention Action Plan is fundamentally integrated into the care provided to individuals facing suicide or self-harm related distress and who seek assistance from SA Health Services. It is also intended to integrate with Staff Wellbeing initiatives.

Consultation efforts were conducted to ensure a comprehensive approach, gathering feedback from a diverse array of groups and individuals who are invested in changing approaches to suicide prevention. Documents were extensively distributed to numerous internal, external, and interstate organisations, both governmental and non-governmental, soliciting their insights and recommendations.

The development of initiatives has also been a direct consequence of requests by LHNs for improvements in clinical care, electronic medical record development and specific training modules to meet the needs of service improvement.

Glossary and Definitions

Collaborative: We work with each other to achieve the best possible outcomes for our people presenting in distress who are at the centre of everything we do. In working collaboratively, we acknowledge that every person working in the health system plays a valuable role that contributes to achieving the best possible outcomes.

Comorbidity: refers to two or more conditions occurring in the same person, either simultaneously or sequentially. Comorbidity refers to interconnected conditions that influence each other, often requiring an integrated treatment approach.

Culturally safe: Cultural safety in healthcare means designing and providing services that meet the needs of people in suicide and/or self-harm distress through a process of self-reflection, awareness of cultural biases and processes to actively respond in a way that will benefit the person's health and wellbeing.

It requires healthcare organisations and individual staff to reflect on their own knowledge, skills attitudes and biases and the potential impact of their culture on interactions with others and service delivery. This requires ongoing self-reflection to acknowledge and address biases, attitudes, and assumptions, that may affect the quality of care provided.²

Staff and organisations should be aware of the power imbalance between themselves and the people they interact with in delivering services. The creation of a safer or safe enough space is vital, which is free of assault, challenge, or denial of that person's identity that addresses barriers to optimal health and wellbeing, such as racism, discrimination, and unconscious bias.

Inclusive: Aiming to provide equal access to opportunities, resources, and care for all people.

LGBTQIA+SB: - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, Sistergirl and Brotherboy communities

Lived experience: The [SA Suicide Prevention Act 2021](#) states:

lived experience of suicide - a person will be taken to have lived experience of suicide if the person:

- a) has attempted suicide; or
- b) has, or has had, suicidal thoughts; or
- c) cares, or has cared for, a person who has died by suicide, has attempted suicide or has, or has had, suicidal thoughts; or
- d) is bereaved by the suicide of a person; or
- e) is otherwise directly affected by the suicide of a person

It is equally important to remember people who have experienced a death by suicide, such as a work-related suicide or witnessing a suicide. This traumatic experience can also cause suicidal distress for that person.

Definition of Aboriginal and Torres Strait Islander Lived Experience (Black Dog Institute)

A lived experience recognises the effects of ongoing negative historical impacts and or specific events on the social and emotional wellbeing of Aboriginal and Torres Strait Islander people. It encompasses the cultural, spiritual, physical, emotional and mental wellbeing of the individual, family or community.

People with lived or living experience of suicide are those who have experienced suicidal thoughts, survived a suicide attempt, cared for someone through a suicidal crisis, been bereaved by suicide or having a loved one who has died by suicide, acknowledging that this experience is significantly different and takes into consideration Aboriginal and Torres Strait Islander people ways of understanding social and emotional wellbeing.

Mental health: A positive concept relating to resilience, enjoyment of life and social connection. This state of wellbeing increases the person's ability to realise their own abilities, cope with the normal stresses of life, work productively and contribute to their community.

Non-judgmental: Not judged or judging based on one's personal standards, experiences, or opinions.

NSQHSS: National Safety and Quality Health Service Standards (2nd edition, 2017) The standards of service expected to be delivered by health including mental health services across Australia.

Peer Worker: In this document, a peer worker is considered someone who provides social, emotional, and practical support to people in suicide or self-harm distress in need. This is enhanced by their personal experience of suicide or self-harm distress, enabling them to make a strong connection with those who are going through similar experiences. Other titles of a peer worker may be known as, but not limited to, consumer or carer consultant.

Person: The term "person" has been used throughout the document, following feedback from lived experience advisors, that using the terms client, consumer, patient etc is not contemporary language and may disempower someone in distress. It is important to ask the person how they would like to be addressed and then ensure that this is handed over to all staff.

Support Person/s: The term "support person" has been used to describe the person or persons who will be part of the ongoing journey and care of the person in distress. Lived experience advisors have stated this term provides respect and recognition to those who are family, partner, friends, co-workers, trusted others etc as identified by the person, and ensures the support persons are afforded recognition and support for the roles they play in the ongoing care and support they provide.

Person-centred: The person is placed at the centre of the service, and they are treated as a person first. The focus is on what the person can do rather than their condition or disability. Support focuses on achieving the person's aspirations and is tailored to their needs and circumstances.

Recovery: The person is able to create and live a meaningful life, contribute to the community that they choose with, or without, mental health issues.

Recovery-oriented: The principles of this approach include understanding that each person is different and should be supported to make their own choices. They should be listened to and treated with dignity and respect. They are the expert in their own life and support should assist them to achieve their hopes, goals and aspirations. Recovery will mean different things to different people.⁷

Recovery-oriented practice: The application of sets of capabilities that support people to recognise and take responsibility for their own recovery and wellbeing and to define their goals,

wishes and aspirations.

Respectful: Respecting the abilities, knowledge, skills and achievements of all people who work in the health system. It is coupled with a commitment to provide health services that acknowledge and respect the feelings, wishes and rights of the person and their carers.³

Self-harm: Any behaviour that involves the deliberate causing of pain or injury to oneself. Self-harm is usually a response to distress – often the distress associated with mental illness or trauma. In the short term, some people find that it provides temporary relief from the psychological distress they are experiencing.

While people who self-harm do not necessarily mean to kill themselves, it often becomes a compulsive and dangerous activity and requires careful professional help.

Suicide: An act of intentionally ending one's life.

Suicidal attempt: Self-initiated, potentially injurious behaviour with the intent to die but does not result in a fatal outcome.

Suicidal behaviours: Thinking or talking about suicide, planning a suicide, or taking actions related to ending one's own life.

Suicidal ideation: Thoughts about wanting to be dead or intentionally ending one's life.

Traditional Healer: An Aboriginal healer, also often referred to as a Ngangkari in local SA Aboriginal languages.

Trauma-informed care: Involves the re-conceptualisation of traditional approaches to healthcare that means all aspects of services acknowledge the high incidence of trauma within the community. Trauma-informed services are aware of, and sensitive to, the dynamics of trauma as distinct from directly treating trauma.

Treatment: Specific physical, psychological and social interventions provided by health professionals aimed at reducing impairment and disability and/or the maintenance of current levels of functioning.

Wellbeing: The state of complete physical, mental, and social satisfaction and not merely the absence or presence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic and social condition.

Workplace Wellbeing

A healthy workplace is one where employers and employees collaborate to continually protect and promote people's health, safety, and wellbeing and workplace sustainability.

It's important to recognise that an individual's experience and satisfaction at work is influenced by both [organisational](#) and [personal factors](#).

A healthy workplace considers the below factors and how they impact on workforce wellbeing:

- the physical work environment
- the [psychosocial work environment](#), including organisation of work and workplace culture; and;
- an [individual's physical and mental health](#) and how it is supported at work

Contact Details

email:

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