



Submission to the Productivity Commission of Inquiry into Mental Health

2 April 2019

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Please note: There is sensitive discussion of suicide and its impacts within this document that may have a triggering effect on some readers. Should you or anyone you know experience emotional distress, please phone Lifeline on 13 11 14 at any time.

~ Yesterday in Australia, roughly eight people deliberately ended their own lives.

Today, another eight will do the same.....

But tomorrow, we have the chance to make a difference ~

“His suicide has been the most profound single event in my life.... Four years later there are no answers for me and the guilt and sadness are overwhelming.”

Personal story, shared with Lifeline by a person bereaved by suicide.

“Almost straight away I started to regret my decision; What had I done? I hadn't even said goodbye to my family... I think most suicidal people do not want to die.

They just don't want to be living their life.”

Personal story, shared with Lifeline by a person who attempted suicide.

1. Context

Of all human behaviours, one of the most perplexing is also by its nature one of the most final. Suicide – deliberately self-harming with the expectation it will be fatal – raises deeply troubling questions about fundamental aspects of the human condition.

It forces us to acknowledge limits to the strength of the human life force. And to question the level of protection usually afforded by our innate sociability. Tragically, for some individuals the social fabric is gossamer thin.

Suicide does not discriminate. The devastating impacts can be felt in any home, school, workplace or neighbourhood.

But by taking steps to address the national rate of suicide we have the chance to reduce its burden on suicidal individuals, as well as their families, friends, colleagues, and the wider community.

The purpose of this submission is to articulate the costs of suicide; to examine existing strategies for reducing the rate of suicide in Australia; to identify gaps in existing systems; and to propose new ways forward.

Lifeline Australia offers its unique perspective as Australia's most experienced frontline service provider with the vision of an Australia free of suicide.

Our goal is to meet people who reach out to us during the most difficult of times to enable them to realise their unique potential, to live with purpose and meaning, and to contribute to the lives of others.

We help people choose life.

2. Executive Summary

When considering the social and economic *benefits* of improving mental health, it is impossible not to reflect on the social and economic *costs* of suicide.

Suicide prevention must take a prominent place *alongside* mental health service provision in the National Mental Health and Suicide Prevention plan to ensure that suicide rates are reduced. It is on these grounds that Lifeline Australia submits that any discussion of mental health-related productivity should include a specific, focused consideration of the cost of our rising rates of suicidal behaviours, and the cost of not acting now to reduce the numbers of deaths by suicide in the future.

Despite an increase in funding of around 21% to improve mental health in Australia from 2007 to 2015, the number of suicide cases is increasing. Based on data published by the Australian Bureau of Statistics, in the ten-year period from 2008, the rate of suicide in this country has risen by 15%.

Estimates of the financial cost of suicide vary to some degree, but in 2014, the burden on the Australian economy was somewhere in the vicinity of \$6.73 billion. This amount is, staggeringly, over 10% of the annual economic cost of \$60 billion attributed to the full spectrum of mental illnesses that year (National Mental Health Commission, 2016).

The social cost of suicide is arguably even more shocking, as the devastating effects are estimated to extend to 135 people for each life taken (Cerel 2016).

Lifeline's work in suicide prevention and support over decades, our de-centralised operations model – we have 40 centres across Australia with over half of these located in regional areas – and the embeddedness of our people in the communities we serve offer us a unique and expert perspective on the challenge of reducing suicide rates.

Targeted, complementary programs augmenting our current services and those of organisations partnering with us to reduce suicide rates are required. In this context, Lifeline identifies remaining gaps and provides a suite of seven key recommendations (see Table 1 below) as they relate to:

1. Suicide Prevention
2. Crisis Support
3. Suicide Postvention

The goal of each and every recommendation is **to build and enhance resilience at a whole of population level**. This will be achieved by strengthening the capacity of communities to recognise and respond appropriately to a person in distress and by ensuring individuals can access the support they need.

A willingness to innovate, to expand and to better connect offerings within the existing mental health care framework is essential to improving outcomes. With increased resourcing, Lifeline can offer an enhanced, evidence-based, trusted pathway to reducing the great burden suicide places on our country's people and the economy.

Lifeline looks forward to continuing and extending our work with Government; the health system; organisations that partner with us in our efforts to prevent suicide; and members of the community to bring about the reduction in suicide rates we so desperately need.

REMAINING GAPS	ASSOCIATED RECOMMENDATIONS
<p>Suicide Prevention:</p> <p>Currently, the service model for increasing community-level mental health resilience and supports for those bereaved by suicide lacks geographical reach. Service provision through a national provider with maximal geographical reach is required.</p>	<p>Recommendation 1: Commission and fund systematic gatekeeper training on a national level for community leaders and front-line workers to be suicide intervention first responders.</p>
	<p>Recommendation 2: Deliver a universal suicide bereavement support service that is funded consistently on a national scale.</p>
<p>Crisis Support:</p> <p>The largest national provider of crisis support services is not yet accessed by people from all demographic groups, and is not yet maximally responsive. There remains the need to improve accessibility, responsiveness, and to streamline the experience of those who seek help during a crisis.</p>	<p>Recommendation 3: Increase accessibility through funding the development of short form and crisis text messaging into core Lifeline services.</p>
	<p>Recommendation 4: Increase responsiveness and accessibility of the largest national crisis support provider by supporting cultural competency training.</p>
	<p>Recommendation 5: Support increased responsiveness of Lifeline’s crisis support services via funding the development of a streamlined referral process.</p>
<p>Suicide Postvention:</p> <p>There remains a need for continuity of care plans to include supported transport from hospitals after discharge from a suicide attempt-related admission, and for the provision of evidence-based, post-attempt support groups operating across a wide geographical network of Australian sites.</p>	<p>Recommendation 6: Introduce specific and universal care and support services to ensure safe and appropriate discharge, referral pathways and treatment plans for suicide survivors.</p>
	<p>Recommendation 7: Fund the development of a nationally-available program for post suicide-attempt proactive follow up.</p>

Table 1: Remaining gaps in the suicide prevention space, and seven associated recommendations

3. About Lifeline

Lifeline is a national charity with a vision of an Australia free of suicide.

Lifeline Australia has 23 member organisations. Together, these organisations form a network of 40 Lifeline Centres operating in all states and territories as a nationally cohesive organisation. Lifeline is therefore uniquely placed to offer a coordinated, pan-Australia approach whilst also offering a local presence and responsiveness.

Our network delivers digital services to Australian people in crisis wherever they might be. Examples include: Lifeline's 13 11 14 crisis line; a nightly online Crisis Support Chat service; a suicide Hot Spot Service targeting known suicide locations; and a range of online self-help and referral resources. Lifeline Centres also deliver accredited education and training programs focussing on suicide awareness and prevention; and community-based suicide prevention initiatives, including support services (for example counselling and bereavement groups) for those impacted by suicide.

Lifeline's unique perspective.

A non-Government organisation, Lifeline's core purpose is the pursuit of personal and social outcomes without regard for politics or profit.

Moreover, we are an organisation with ties to local communities that run deep and wide. Lifeline's 40 centres are dotted across the nation, with over half of these located in regional Australia. This distributed model ensures that our organisation is embedded within the communities we serve, that our programs are relevant, and that our people are from diverse backgrounds with wide-ranging experience (for an overview, see Figure 1 below).

Lifeline is served by a corpus of 11, 000 people who regularly donate their time to help prevent lives being taken by suicide. These people form the backbone of all our services, including Lifeline's flagship 13 11 14 telephone support service. Our service model is one of people-helping-people, and because of this, the level of community buy-in our organisation enjoys is unsurpassed in the sector.

Given our embeddedness in communities across Australia, it is unsurprising that the Lifeline brand is well recognised: Polling research by Roy Morgan on behalf of Lifeline in November 2016, found that 91% of Australians surveyed connected our brand with crisis support and suicide prevention. This polling also reflected very high levels of community trust in our work and services.

Lifeline's focus is connection. We know all too well that there are 1 in 4 Australians experiencing isolation and loneliness today, and that limited social connectedness is associated with increased suicidal ideation (Fassberg et al 2012). By listening, we help to reconnect.

Lifeline Australia is also a thought leader in the area of suicide prevention. We regularly contribute to the national discussion, most recently by making submissions to the Senate



Lifeline has a national approach with a local delivery. Our centres sit within the **community** to meet specific needs.

- 40 Lifeline centres Australia-wide
- 60 locations
- 11,000 volunteers across Australia
- More than 250 retail locations nationwide
- **More than 50% of Lifeline's centres are located in regional Australia**

Figure 1: Lifeline centre locations, plus a brief snapshot of key organisational statistics.

Why focus on suicide prevention?

The relationship between mental ill health and suicide is a complex one.

Not all those who die by suicide have experienced mental illness, but Robert Goldney at Flinders University in South Australia estimates that two thirds of those who die by suicide have symptoms consistent with major depression.

But it is not the case that all those who experience mental illness die by suicide. Data reported by Washington University in the United States suggest that approximately 2-15% of those diagnosed with major depression go on to take their own lives. Up to 20% of those diagnosed with bipolar disorder deliberately take their own lives.

It is most accurate to say that suicidal behaviours are widely accepted as arising through a unique, interacting subset of psycho-social factors combined with other background elements and triggering events. The Australian LIFE (Living is for Everyone) framework identifies strong evidence of the role age; gender; genetics; cultural background; family dynamics; geographical isolation; financial situation; education levels; social and employment status; along with traumatic life events play in the leadup to engaging in suicidal behaviours. Similarly, a widely accepted model of suicidal behaviours (the integrated motivation-volitional or IMV model, see Figure 2 below) identifies a range of background factors and triggering events that in various combinations can precipitate suicidal ideation.

Put simply, diagnosable mental illness can - but does not always - play a part in the development of suicidal ideation and behaviours.

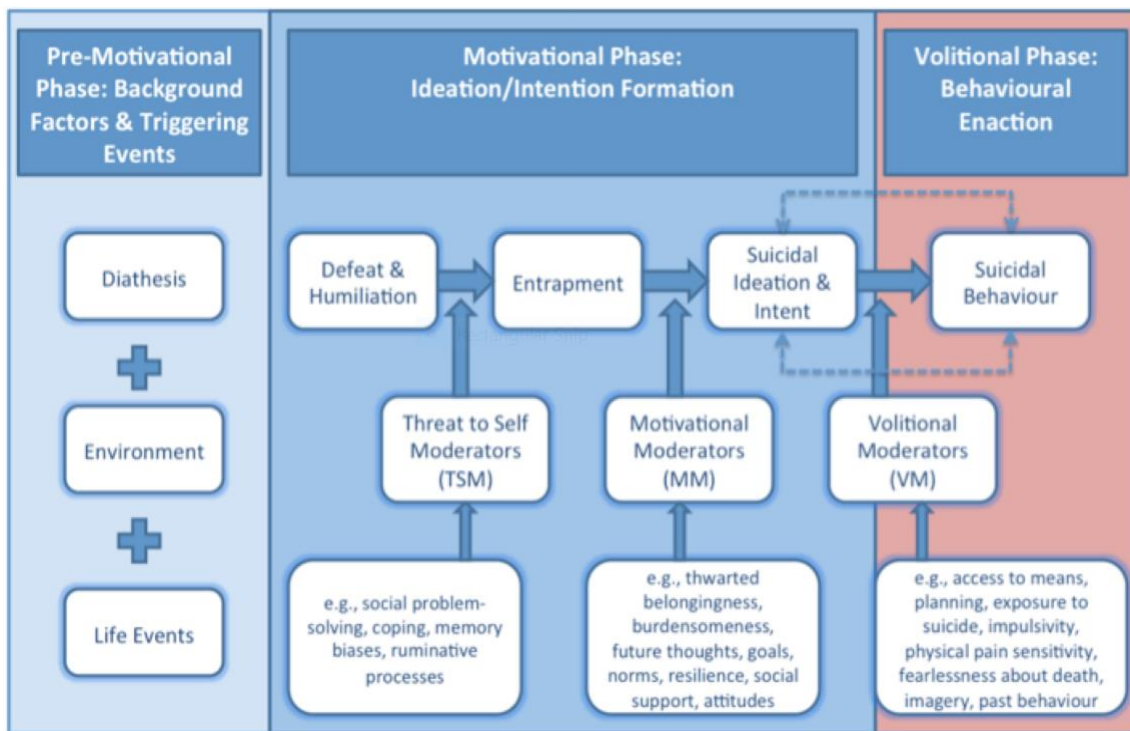


Figure 2: A widely accepted model of the precipitants of suicidal ideation, intentional formation, and behaviour (O'Connor & Kirtley 2018)

The knowledge that unique sets of precipitating factors lead to suicidal behaviour makes clear the need for the implementation of tailored solutions to prevent suicide.

It is not enough to adopt a typical disease/mental health/clinical model when designing a national response to this costly and tragic epidemic.

Suicide prevention must take a prominent place *alongside* mental health service provision in the National Mental Health and Suicide Prevention plan to ensure that suicide rates are reduced. It is on these grounds that Lifeline Australia submits that any discussion of mental health-related productivity should include a specific, focused consideration of the cost of our rising rates of suicidal behaviours, and the cost of not acting now to reduce the numbers of deaths by suicide in the future.

4. Consequences of Suicide

“A lady whose son had died by suicide told me that the light had gone out in her world. She felt she had failed him because she didn’t know how he felt and blamed herself. She was now considering suicide herself as she saw no reason to live.”

Consequence of suicide discussed by a Volunteer Telephone Crisis Supporter.

Societal costs.

Any death by suicide is a tragedy. Yet each day in Australia, roughly eight people die in this way.

Australian Bureau of Statistics (ABS) data show that in 2017 a total of 3,124 individuals deliberately took their own lives.

Of those who die by suicide, the data consistently show that most are males: The rate of death by intentional self-harm amongst men is approximately three times that observed in women. Suicide is the leading cause of death amongst individuals aged 15 to 44 years. Shockingly, according to 2017 estimates, approximately 1,582 individuals in that age group deliberately ended their own lives (ABS data 2017).

Aboriginal and Torres Strait Islander people are disproportionately impacted by suicide. In the age-standardised data relating to the year 2016, Indigenous people took their own lives at twice the rate of non-Indigenous members of the community.

Notably, too, suicide is also the fourth leading cause of death amongst the youngest cohort reported by the Australian Bureau of Statistics. In a 2017 statistic of breathtaking poignancy, *24 children aged between 1 and 14 years ended their lives in this way.*

Suicide has a ripple effect. Internationally, it has been reported that every life that ends by suicide impacts upon 135 people left behind (Cerel 2016). Of those left behind, six people are profoundly affected (Maple 2005). In a recent nationwide survey of 3,220 Australians, a staggering 85% of respondents indicated that they had exposure to at least one suicide death. That rate is even more alarming when considered in the context of the known consequences of such exposure. As reported by Pitman and colleagues in 2014, these impacts include increased risk of suicide (bereaved partners and bereaved mothers); the need for psychiatric care (bereaved parents); and increased rates of depression (bereaved children).

“The longing to still want to talk in a natural way about the person who suicided, for example including using their name but finding that some friends and family members just cannot do so. The parents of a child who suicides often each grieve differently. Stigma around suicide can contribute to loved ones left behind reeling and feeling utterly isolated and saying that yes, since ...took his life, I feel that doing the same may be an option for me, where prior to this, I’ve never contemplated suicide.”

Consequence of suicide discussed by a Volunteer Telephone Crisis Supporter.

When considered in isolation, the number of suicide deaths each year is a tragic statistic. But when considered across time, a tragic trend becomes clear. Tracked across a 10-year period from 2008, data show a rise from 10.9 to 12.6 suicides per 100,000 people. That uplift of approximately 15% is even more concerning when considered in the context of trends in mental health funding over a similar period.

Estimates of mental health expenditure (Australian Institute of Health and Welfare, 2014) are consistent with an increase of almost 21% from \$308 per person in the 2007/2008 financial year to \$373.14 in 2015/2016. Figure 3 (see below) illustrates the positive relationship between rates of suicide (scatter plots with trendline in orange) and per capita expenditure on mental health (columns with trendline in blue) over time. Supporting the data on the increased rate of expenditure in mental health services, Australian Government investment in the National Suicide Prevention Strategy (NSPS) has increased from \$1.9 million in 1995-96 to \$49.1 million in 2015/2016. In summary, despite increased funding over time, Australian suicide rates reflect an upwards trend.

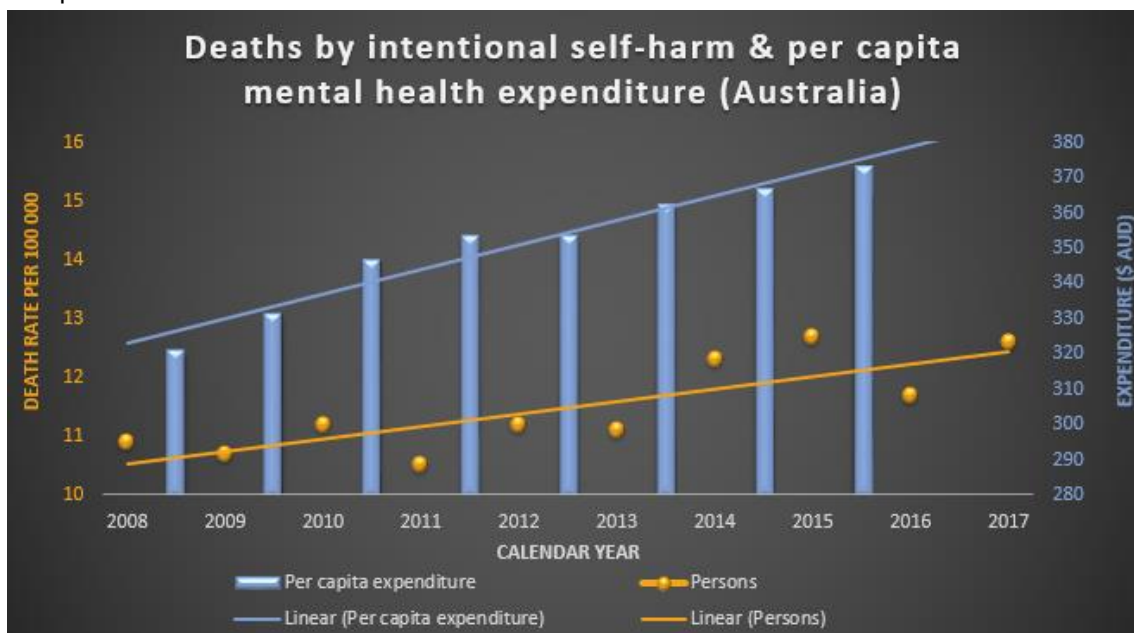


Figure 3: Visual representation of the rate of suicide deaths, juxtaposed with expenditure per capita on mental health, 2008-2017 (AIHW, 2016-17)

Non-fatal attempts to die by one's own hand must also be weighed in any consideration of the health, societal and financial burden imposed by suicide-related behaviours in Australia. The rate of hospitalisation due to non-fatal suicide behaviours (NFSB) runs at about 20 times that of deaths due to suicide (AIHW). Non-fatal suicide behaviours *not* resulting in hospitalisation are estimated to occur at an even higher rate: In total, non-fatal suicide behaviours have been estimated to occur at a rate 50 times that of the rate of deaths by suicide (Schwartz-Lifshitz et al 2012). As is the case with suicide itself, non-fatal suicide behaviours have ripple effects. Of the 3,220 Australians who responded to the survey mentioned above, fully 89% indicated they'd been exposed to at least one suicide attempt.

Economic costs.

Whilst the person-centred perspective should underpin any discussion of suicide and its consequences, articulating the economic cost can assist in decisions relating to resource allocation. Such is the value of estimating economic costs of suicidality in shaping effective suicide prevention strategies, the ethics of *not* engaging in the exercise has been questioned (McDaid, 2016).

The approaches and parameters used to estimate the economic cost of suicide and non-fatal suicide behaviours are diverse and there is a general lack of consensus regarding the optimal approach (The hidden toll: Suicide in Australia, 2010). David McDaid, an Associate Professor and thought leader in health economics at the London School of Economics, notes that there are still "relatively few cost estimates for suicide compared with those for other causes of premature death.... [and] available estimates can vary considerably depending on methodology used and the target population covered" (McDaid, 2016, p.778).

In the Australian context, various estimates of the cost of suicidality have been put forward. In a study based on 2012 data relating to suicide deaths, KPMG reported a total cost of \$1.657 billion dollars to the Australian economy. Notably, that total encompasses both direct (e.g. coronial, ambulance, police and grieving costs, including counselling support to the bereaved), and indirect costs relating to lost economic contributions from those who have engaged in suicidal behaviour.

In a more recent study conducted by researchers at Central Queensland University, Australia's 2014 suicide statistics were used to model the economic cost. Those researchers reported the annual economic cost of suicide to be approximately \$1.523 billion. Within this total was captured production disturbance, human capital, medical, administrative, transfer and other costs.

Notably though, in a highly informative additional costing exercise, those same researchers estimated the economic impact of non-fatal suicide behaviours. Their total cost estimate for non-fatal suicide behaviours resulting in short absences from the workforce was \$13.311 million. But by far the largest estimated cost arose with respect to non-fatal suicide behaviours resulting in full incapacity. Again, taking into account production disturbance, human capital, medical, administrative, transfer and other costs, the total financial impact was estimated to be \$5.195 billion.

Taken together then, the economic costs of suicide and non-fatal suicide behaviours to the Australian economy in 2014 was estimated at \$6.73 billion (see Figure 4 below). To put this in context, this amount represents more than 10% of the \$60 billion annual economic cost attributed to *the entire range of mental illnesses* in Australia (National Mental Health Commission, 2016).

At the higher end of available estimates are those published by ConNetica Consulting in 2009. In that report, ABS and AIHW data formed the basis for estimates of an annual cost of suicide and non-fatal suicide behaviours between \$10.9 billion and \$16.02 billion.

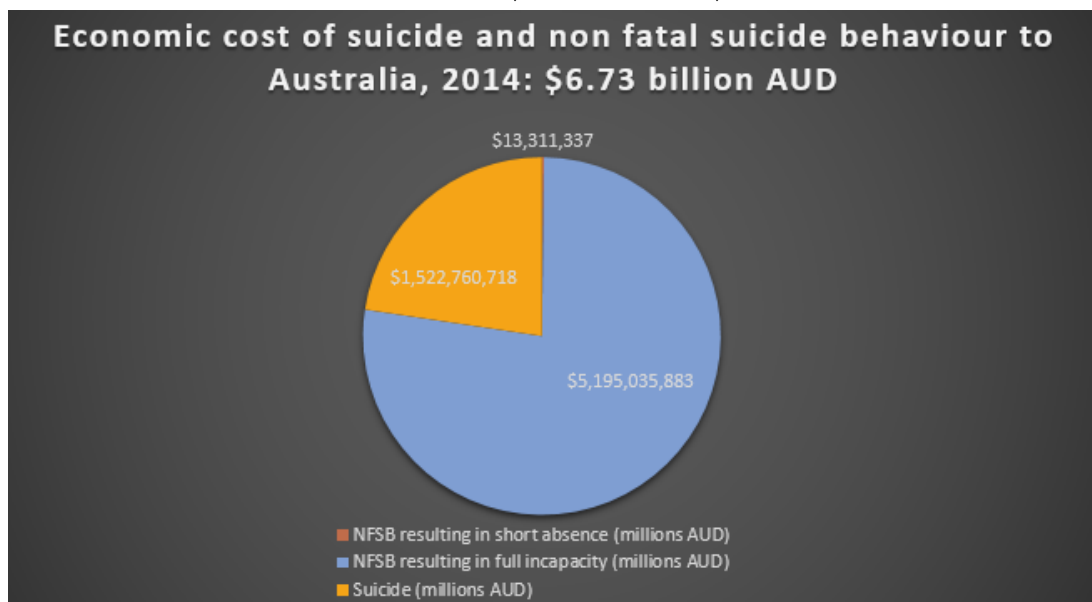


Figure 4: Total economic cost of suicide, non fatal suicide behaviour resulting in a short absence, and non fatal suicide behaviour resulting in full incapacity to Australia in 2014

The high proportional economic cost imposed by suicidality on the national economy is in large part due to its demographic signature. As noted earlier, suicide is the leading cause of death amongst those aged 15-44. In other words, those who die by suicide are typically from a younger demographic and the impact on the economy is commensurately higher.

Another index of this demographic impact is known as years of potential life lost, or YPLL. Suicide has a significant financial impact on productivity largely due to the disproportionate impact upon people early in their working lives. Based on 2017 data, **108,081** years of life were lost in Australia to intentional self-harm. This places suicidality above heart disease, cancer, transport accidents and indeed all other causes of death as the number one cause of premature death (see Figure 5 below).



Figure 5: Index of the ten top causes of years of potential life lost in Australia in 2017

Summary

Suicide imposes devastating personal and societal costs. It has a ripple effect that extends far beyond the individual who deliberately ends their own life. Evidence suggests that the causes of suicidality are complex and include a range of psycho-social and background factors that can, combined with triggering events, precipitate suicide. Despite increased funding for mental health in Australia in recent years, overall rates of suicide have remained 'sticky' at best and have even shown slight uplift. Due to the demographic characteristics of suicidality, within the broader context of mental illness it has a disproportionately deleterious effect on the Australian economy.

Taking into account all these factors, a suicide prevention-focused consideration of the economic costs of mental illness and new ways forward in the prevention of suicide is clearly warranted.

5. Effectiveness of Current Programs and Supports

Lifeline Value

Every day, around eight Australian families lose someone they love to suicide. Lifeline's vision is for an Australia free of suicide. Our movement of 11,000 Australians, many of them volunteers, works to ensure that no person in Australia, if they reach out to us, has to face their darkest moments alone.

Lifeline keeps people safe by providing crisis support to people in need, enabling them to hold on to hope.

Each year, Lifeline responds to almost one million contacts from people around the country. A call to our flagship suicide prevention hotline is received every 32 seconds. In 2018, the 13 11 14 phone-line answered 739,481 calls, with calls typically lasting 14.66 minutes. The average quantifiable value of each of these calls was \$39 (including the hourly value of contributions of volunteer time), meaning the total value of this service was \$28,839,759 over the year. In addition, Lifeline's webchat service responded to 40,800 requests for contact and engagement.

Across these two services, our crisis supporters assisted 42,340 individuals to create safety plans to prevent suicidal behaviours for 24 hours allowing time for follow-up to occur. Crisis Supporters also initiated 5,840 emergency interventions, contacting emergency services and ensuring the safety of those assisted by remaining connected wherever possible until emergency services arrived to offer care.

Lifeline is more than a phone line.

Thanks to our de-centralised model of service delivery, Lifeline has made a significant contribution to the resilience of communities across a broad geographical reach.

Each year, our organisation trains well over 1,000 new volunteer crisis supporters, equipping them with mental health first aid skills that will stay with them for life. It is estimated that since its inception in 1963, Lifeline has provided Lifeline Mental Health First Aid Crisis Supporter Training to over 100,000 members of the Australian community.

13 11 14 Crisis support line

In 2018, Lifeline trained 1,372 crisis supporters. Facilitator costs alone exceeded \$6,773,000, while the number of volunteer hours contributed to training exceeded 233,240. The Australian Bureau of Statistics values a volunteer hour at \$41.72. The total value of hours contributed by volunteers in training to become crisis supporters in 2018, therefore exceeded \$9,730,772.

The Federal Government contributes **\$15,500,000** per year to run the 13 11 14 phonenumber. With the quantifiable value of our service to the community reaching an estimated **\$45,343,531** and not including the benefit gained in productivity of the caller and those that would have been impacted by an attempt, the **immediate return on investment is already at \$2.92** for every dollar provided in funding.

Crisis Support Offering (13 11 14)	Quantity	Quantifiable value to the community	R.O.I
Calls answered	739,481	\$28,839,759	
1372 volunteer crisis supporters trained	233,240 hours	\$9,730,772	
Facilitator costs		\$6,773,000	
Total		\$45,343,531	\$2.92

Short form messaging crisis support

In 2018, Lifeline provided a webchat service from 7pm – midnight every night. This service achieved around 40,800 web conversations in 2018. Estimated social return on investment for that service was \$8.40.

Crisis Support Offering (Webchat)	Quantifiable value to the community	S.R.O.I
netbalance estimated Social Benefit	\$7,210,273	\$8.40

A pilot trial of a national text messaging service (Crisis Text) was also conducted. The University of Wollongong has projected an annual cost to deliver this service 24 hours a day to be \$19,875,366. They estimate the benefit of service delivery to the Australian community to be \$51,644,942 with a return on investment of \$2.60.

Crisis Support Offering (Crisis Text 24 hrs)	Quantifiable value to the community	R.O.I
Wollongong University estimated benefit	\$51,644,942	\$2.60

Lifeline also significantly contributes to the mental health resilience of communities through our corporate, school and community training programs. In 2018, there were 12,452 participants in our training programs across the nation. Programs include, but are not limited to: SafeTALK in schools, Accidental Counsellor, Mental Health First Aid, DaretoAsk, ASIST, Domestic Violence Alert, Stress Management and Self-care.

The important role of non-clinical service delivery

Research reported by Alan Woodward and Claire Wyllie (2016) shows that crisis lines assist to identify and engage suicidal individuals. Around 50% of those who take their own life do not approach clinical services prior to attempting to end their life. Crisis lines, therefore, act as an important safety net for those who do not seek the assistance of clinical services. Crucially, they enable disclosures of suicidality which may not otherwise occur. Every day in 2018, Lifeline created over 116 safety plans and instigated an average of 16 emergency interventions.

“We support people to see their strengths and the worth they hold as fellow human beings. We support them through the darkest moments in their lives.”
Volunteer Crisis Supporter, Lifeline

The evidence based non-clinical support provided by Lifeline plays an obvious and important complementary role to that of clinical support. Last year's ABS data, for the first time, looked at comorbidity factors with suicide. It found that 43% of those who took their lives in 2018 were clinically diagnosed with depression, while 17% were clinically diagnosed with anxiety.

The availability of a 24-hour service for people with clinical diagnoses is obviously imperative. Recent evaluations conducted by Lifeline, found that of all callers to the service, 30% indicated that they were accessing clinical support on a regular basis. This information reflects that callers are seeking additional support from Lifeline to complement their clinical care.

The available data and our own feedback from callers make it clear that increased funding would enable Lifeline to increase access to our services. This ability would expand our capacity to provide our invaluable service, one that dramatically improves the impact of clinical care.

6. Gaps in Services

Overview

In the 2014 report *Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services*, The National Mental Health Commission (NMHC) described the response to suicide in Australia as being historically fragmented. This fragmentation has arguably been exacerbated by a lack of clarity around the specific roles and responsibilities of suicide prevention organisations and programs across Governments.

A legacy of systems-level inefficiencies has contributed to gaps that impact negatively on the quality of mental health generally and on suicide rates.

One example relates to the model for accessing clinical psychological services. A medical referral is required for a maximum of ten Medicare rebate-supported sessions per annum and regardless of need, any treatment in addition to those ten sessions occurs at the user's expense. Particularly for those living in Primary Health Network (PHN) catchment areas in rural and regional Australia, accessing clinicians can be difficult. Assuming a clinician is available to take appointments, that person is typically only available upon booking an appointment and only during business hours. Mental health crises including suicidal behaviours occur at all hours of the day.

Due to the often siloed nature of suicide prevention mechanisms; the prohibitive cost of seeking psychological care when not covered by the Medicare rebate; and the difficulties many face in accessing clinical care; it is unsurprising that, as their needs are not being adequately met, of those who do reach out to Lifeline at a time of crisis, at least one third are actively engaged with clinical mental health services (Lifeline caller profile report 2009).

Notably too, a large proportion of the Lifeline call volume arises from those who frequently rely upon our service. Many of these repeat callers report having been diagnosed with mental ill health (Pirkis and colleagues, 2016). As such, Lifeline's service metrics of approximately one million contacts per annum is one index of the scale of the remaining gaps in those systems traditionally considered to contribute to suicide prevention.

The profile of community groups that do *not* typically call Lifeline also demarcate remaining system gaps. Typically, Lifeline caller data show that males, Aboriginal and Torres Strait Islander people, members of the LGBTI community, and those from a CALD (culturally and

linguistically diverse) background are under-represented in our caller profile (see for example Waling et al 2019).

To address such gaps, Action 5 of the Fifth National Mental Health and Suicide Prevention Plan (2017) states that “Governments will support PHNs and LHNs (Local Hospital Networks) to develop integrated, whole-of-community approaches to suicide prevention” (pg 25). Entire communities should become engaged in forming a collective safety net using evidence-based approaches to suicide prevention.

What is being done right now:

Implementation of Action 5 has taken the form of four sets of local trials currently running in 29 sites around Australia. Those trials are respectively being funded by the Australian Government (12 sites), the Victorian Government (12 sites), the Paul Ramsay Foundation (four sites) and the Queensland Mental Health Commission (one site).

Notably, across those sites a range of integrated suicide prevention approaches is being tested. Each has multiple focus areas, as indicated by Table 2 below (arranged in groups as per the National Mental Health Commission Report Card 2018). Importantly, the broader intent of this rollout of integrated approaches is to develop an evidence base that will “inform future approaches to suicide prevention across Australia” (pg 27).

	LifeSpan	Victorian Place Based Trial Network	European Alliance Against Depression
1.	Improving emergency and follow-up care for suicidal crisis	Appropriate and continuing care once people leave emergency departments and hospitals	‘Emergency cards’ that guarantee direct access to professionals during crisis, distributed to high-risk groups
2.	Using evidence-based treatment for suicidality	High-quality treatment for people with mental health problem	
3.	Equipping primary care to identify and support people in distress	Training general practitioners to assess depression and other mental illnesses, and support people at risk of suicide	Equipping general practitioners to identify and treat suicidality and depression
4.	Improving the competency and confidence of frontline workers to deal with suicidal crisis	Suicide prevention training for frontline staff every three years, including police, ambulance and other first responders	
5.	Promoting help-seeking, mental health and resilience in schools	School-based peer support and mental health literacy programs	
6.	Training the community to recognise and respond to suicidality	Gatekeeper training for people likely to come into contact with at-risk individuals	Educational workshops for community facilitators and stakeholders, including media
7.	Engaging the community and providing opportunities to be part of the change	Community suicide prevention awareness programs	General public depression awareness campaign
8.	Encouraging safe and purposeful media reporting	Responsible suicide reporting by media	
9.	Improving safety and reducing access to means of suicide	Reducing access to lethal means of suicide	

Table 2: Overview of the key focus areas of the models currently under trial. As per the NMHC report, focus areas have been grouped for similarity

Strengths of the models under trial:

One strength is that the multi-faceted nature of each of the models effectively recognises the evidence of the complex web of causal factors associated with suicidality. In the Black Dog Institute’s LifeSpan model for example, doctors, specialists, families, and teachers all form part

of both a preventative framework and a safety network when individuals within the community are in crisis. Another is that by running as a multi-site trial, the results of which will eventually be used to inform the broader national approach, the importance of evidence-informed practice is recognised.

Remaining gaps overview

Despite this, and the considerable ongoing investment in the models being deployed at trial sites dotted across Australia, gaps remain. Specifically, in its 2018 report card, the Commission iterated unresolved issues relating to the limited geographic reach of the models being tested, insufficient suicide prevention training for those working within the health, allied health and community sectors, as well as a “lack of appropriate care and support for people in crisis” (pg 29).

As a leading national service provider, Lifeline is uniquely positioned to offer additional insight around gaps as they pertain to the prevention, crisis support, and post-vention phases of suicidality.

Remaining gaps - Suicide Prevention:

As recognised in the IMV model proposed by Rory O'Connor and Kirtley (2018) a wide range of life factors contribute to the development of suicidal behaviour. The nature of the crisis calls made to Lifeline on a regular basis bears this out. Family and parenting issues, relationship breakdown, employment instability/stress, financial and housing instability, as well as alcohol and drug abuse, gambling problems, and domestic violence are commonly cited precipitants of crisis. For these reasons, intervening in people's lives 'upstream' of a potential personal crisis, by way of taking steps that help mitigate the risk of the individual experiencing potential triggers, can be effective in reducing rates of suicide.

Of those measures most likely to capture individuals before they become suicidal, gatekeeper training has been identified as having a strong evidence-base (Kysinska et al 2016). There are multiple programs explicitly designed to assist those working with the health, allied health and community sectors identified by the NMHC to be more alert to signs of personal distress and thus intervene at an earlier stage. When combined with additional measures such as suicide prevention training in schools and suicide bereavement support groups (for example, the StandBy service which is unfortunately, not universally accessible and inconsistently supported by PHNs) the overall effect is to improve the resilience and mental health literacy of a wide range of people embedded in local communities.

The expected outcome of a more engaged, mental health literate populace is that local communities are trained to serve as their own safety net.

Whilst a number of the focus areas of the models currently under trial go some way to addressing these aspects of enhancing suicide prevention efforts, one of the key gaps identified by the NMHC remains: that of geographic reach.

Remaining Gaps, Suicide Prevention:

Currently, the service model for increasing community-level mental health resilience and supports for those bereaved by suicide lacks geographical reach. Service provision through a national provider with maximal geographical reach is required.

Remaining Gaps - Crisis Support

Lifeline's flagship crisis support service forms the backbone of the response to personal crises in Australia. 24 hours per day, 7 days per week, people in crisis are helped by Lifeline. That help comes in the form of having someone who will listen without judgement, who can develop a safety plan, and who provides critical referrals to additional (often clinical) services.

Put simply, our service is one of the foundation stones upon which the national response to suicidal crisis is built.

But more can be done. Lifeline faces the challenge of increasing the number of calls we answer each day (call answer rate) so that more people can quickly and more reliably receive the help they need. Presently, challenges associated with increasing the call answer rate represents a gap in the crisis support system. That gap can be addressed with increased funding. In addition, Lifeline has identified 'hot' referrals as an important new area for capacity building. Transferring a person seeking help directly from the Lifeline service to additional services from which they can receive clinical support will directly enhance the user experience and promote positive outcomes.

Extending the reach of the Lifeline service to all Australians also represents a significant gap in suicide prevention mechanisms. Indigenous Australians, men, members of the LGBTI community (Waling et al 2019), young people, and members of the CALD community all under-utilise the Lifeline crisis support service. With respect to young people as one example, there is evidence that alternative forms of communication ('chat' or short form messaging) would improve service uptake (Williams et al., 2018). Platform-independent digital service delivery has the potential to support real time language translation, thus improving accessibility for those whose first language is not English.

Remaining Gaps, Crisis Support:

The largest national provider of crisis support services is not yet accessed by people from all demographic groups, and is not yet maximally responsive. There remains the need to improve accessibility, responsiveness, and to streamline the user-experience of those who seek help during a crisis.

Remaining Gaps - Suicide Postvention:

The biggest predictor of suicide is a previous attempt (Christianson et al 2007). For this reason, concerted efforts are being made to improve services for those who have attempted suicide. All three of the models represented in Table 2 above have identified aftercare as an area of focus.

Whilst the strategies currently under trial have continuity of care incorporated into patient discharge plans, the physical aspect of sending individuals home from a hospital has not been adequately addressed.

Similarly, whilst one-on-one non-clinical supports are offered via The Way Back service, the service is not nationally available. Appropriate group therapy supports are also not in place for people who have attempted suicide, despite evidence internationally of the efficacy of such programs. The Survivors of Suicide Attempts support group run by Didi Hirsch Mental Health Services in California USA, which is supported by an emerging evidence base, (Hom et al 2018)

serves as one example. Lifeline is currently trialling an Australian context-specific adaptation of the Didi Hirsch model under the banner of Eclipse Groups.

Remaining Gaps, Suicide Postvention:

There remains a need for continuity of care plans to include supported transport from hospitals after discharge from a suicide attempt-related admission, and for the provision of evidence-based, post-attempt support groups operating across a wide geographical network of Australian sites.

7. Likely Effectiveness of Alternative Programs and Supports

As per the gaps identified above, Lifeline puts forward the following recommendations that will enhance resilience at a whole of population level. This will be achieved by strengthening the capacity of communities to recognise and respond appropriately to a person in distress and by ensuring individuals can access the support they need. A visual representation of the closed gaps model that appears below (see Figure 7) will be discussed in the text that follows.

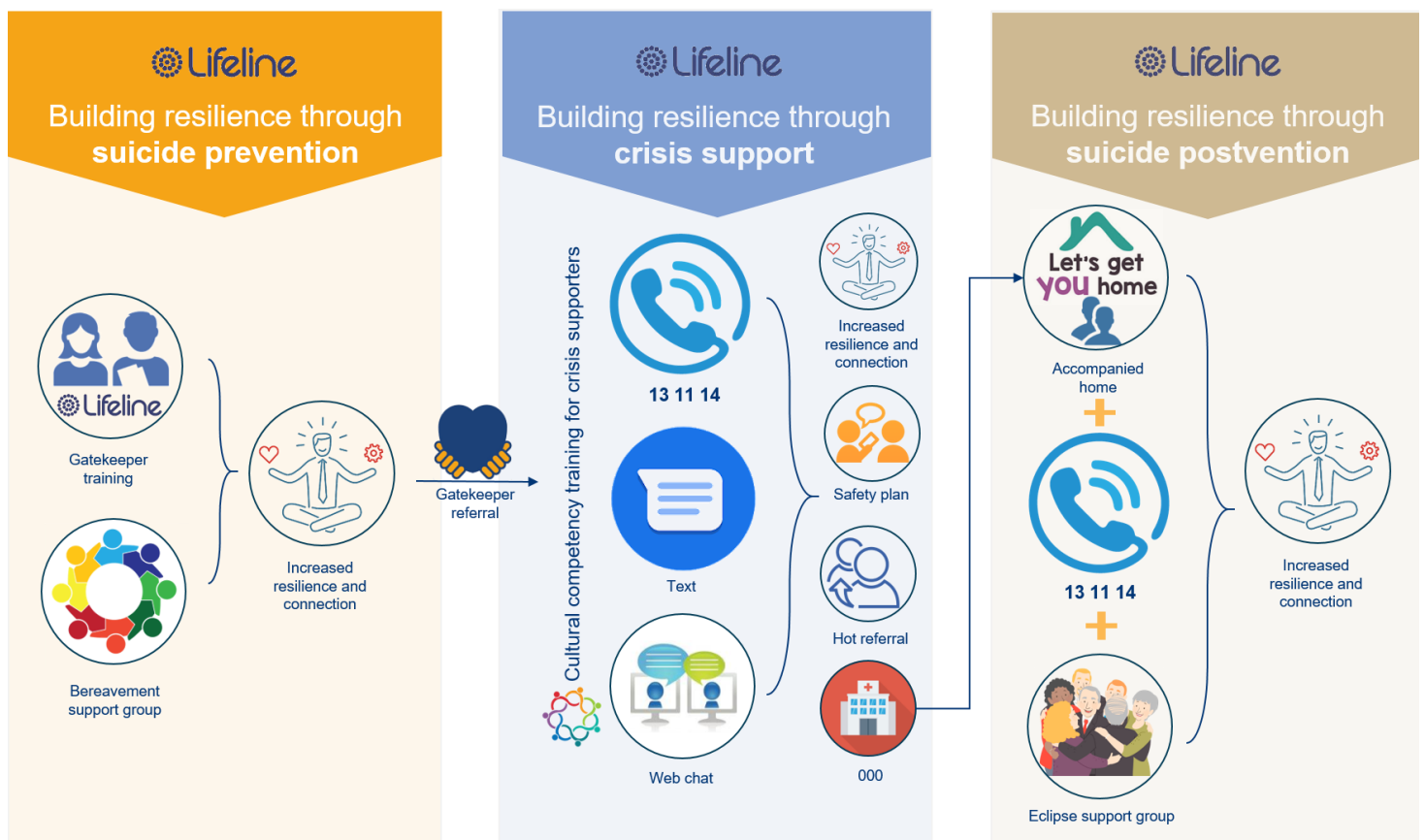


Figure 7: Model of Resilience-Building in Suicide Prevention

Likely Effectiveness - Suicide Prevention

Recommendation 1: Commission and fund systematic gatekeeper training on a national level for community leaders and front-line workers to be suicide intervention first responders

“I can’t stress enough the importance of educating community members to watch out for change in behaviour. After facilitating Gatekeeper training for a drought-stricken community near Dubbo, a participant came up to me at the end. She said she was ticking off the signs of potential suicidality that she had noticed in one of her friends, and that now she knew them, she would check on her on her way home. Unfortunately, she was too late, her friend had taken her own life. In another community, a publican who had attended our training, was instrumental in an intervention that saved the life of one of her regular customers. This awareness saves lives, we must do what we can to educate the community.”

Stephanie Robinson, CEO, Lifeline Central West.

A major systematic international review of suicide prevention strategies concluded that gatekeeper education was one of the three most promising interventions identified as likely to impact national suicide rates, alongside means restriction and physician education (Mann et al 2005).

All levels of the population are serviced by ensuring we have resilient communities that are educated in mental health. Suicide intervention training for community gatekeepers and front-line workers has considerable promise as part of a wider suicide prevention strategy. While results of studies are mixed, there is sufficient and growing evidence of benefit to support a more systematic application of this training that includes follow-up to evaluate efficacy over the longer term.

A more systematic approach to suicide intervention training will significantly increase the chance of intervening in the progressions of suicidal ideation if family, friends, colleagues and other ‘gate-keepers’ in the community are able to recognise instances of social, situational, emotional or interpersonal precipitating risk factors, and then act to refer to more formal support mechanisms.

Lifeline specifically recommends:

- Encouraging and enabling systematic development of role-appropriate suicide intervention training within professional groups and front-line workers using high quality programs such as LivingWorks ASIST and SafeTALK.
- Exploring strategies to embed suicide intervention training within organisational and workplace settings as part of multi-faceted strategies such as those applied by the US airforce which achieved a 33% reduction in risk for suicide;
- Embedding SafeTALK training in schools for students and parents nationally;
- Establishing accessible gate-keeper training to build long-term mental health resilience for community members in rural and regional areas where catastrophic climate events are expected to increase in severity and duration contributing to poorer mental health outcomes for those directly affected.
- Identifying programs that already have some positive evaluation history as a starting point, while also encouraging evaluation of new initiatives;
- Building best practice in suicide intervention training and informing consumer choice for this training through an Australian based registry that develops evidence-based programs.

“There needs to be more funding put into keeping people supported in the community, and building fences to stop people falling off the cliff, rather than paying so much for all the ambulances at the bottom!”

Personal story submitted to Lifeline.

In a survey of volunteer Lifeline Telephone Crisis Supporters, 91% of respondents indicated that they believe training communities to be suicide safe is extremely important. A further 9% of respondents indicated it is moderately important.

An appropriately resourced, strategic national mandate to implement such training at organisational and regional levels is required and would lead to a reduction in suicide rates. Lifeline can offer its historical experience with suicide intervention training and access to internationally recognised suicide intervention training resources to any Australian initiatives in this arena. Prioritised roll-out could include first-responders and tertiary education institutions.

Suicide can be prevented. The following is an excerpt from a letter received from a participant in a two-day suicide prevention training course. Her husband and son had died by suicide within a decade of each other:

“I am astounded at how easy it would be for all of us to recognise early warning signs of suicide. If only I had been given this knowledge nine years ago, how different my life would have been.”

Recommendation 2: Deliver a universal suicide bereavement support service that is funded consistently on a national scale.

Bereavement by suicide places people at greater risk of suicide and suicidal ideation. Those who are bereaved by suicide need to be supported differently from those bereaved for other reasons. A UK Study by Pitman, et al (2010) found that bereavement by suicide is a specific risk factor for suicide attempt when compared with bereavement due to sudden natural causes, regardless of the relationship to the deceased. Furthermore, a study by Bolton, et al (2013) found that parents bereaved by the suicide of a child experience increased rates of suicidal ideation, relationship breakdown, adverse mental illness and poor social outcomes.

The importance of such bereavement intervention came through strongly in a recent survey of Lifeline volunteer telephone crisis supporters. When asked about the consequence of suicide, 65% of respondents mentioned the devastation caused by grief, loss and guilt on the loss of a loved one. Of those who responded to this survey, 22% specifically identified the suicidal ideation by those left behind when previously they had never contemplated suicide.

Lifeline, with its de-centralised model of 40 centres, is well placed to assist with the consistent roll-out of support programs for people bereaved by suicide. For example, a number of Lifeline centres currently offer the StandBy service, a coordinated response offering support and assistance for people who have been exposed to or bereaved by suicide. Currently, this important service is not universally accessible and while funding for a national rollout is available, PHNs are not required to fund suicide bereavement services consistently.

Likely Effectiveness - Crisis Support

There is a need to elevate resources for crisis support services to ensure maximum responsiveness and accessibility for all ages and demographics. This can be achieved via three specific recommendations appearing below.

Lifeline currently achieves an 83% Call Answer Rate. This rate is high by international crisis line standards, but to achieve a significant reduction in the rate of suicide, each and every call must be answered. To that end, Lifeline is requesting additional funding to pursue essential changes to its service delivery model that will ensure accessibility and responsiveness. Expanding the variety of channels for contact will increase the likelihood that people in crisis will feel comfortable reaching out.

13 11 14 Crisis Hotline

In the long term, advances in communication technology and the way we communicate mean we are likely to see a drop in universal access to the 13 11 14 crisis line. Due to population ageing, however (see Figure 8 below), we anticipate that call numbers will remain at current rates for some time yet. Sadly, with age comes increased isolation and quite often, resistance to adopting new technology. It is therefore important that the 13 11 14 service be fortified to respond to the needs of our ageing population.

Correspondingly, new technologies provide an important opportunity to increase call answer rates and to reduce suicide numbers by diverting one third of callers who would prefer contact via short form messaging to a service more suited to their needs (ARTD, 2011).

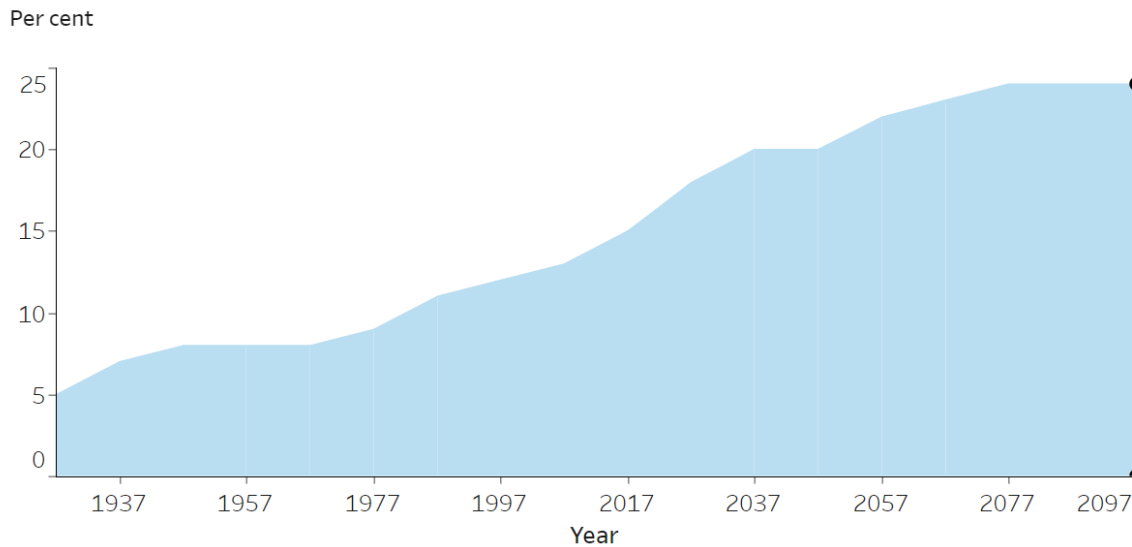


Figure 8: Projected proportion of Australian population aged 65 and over time (ABS, 2017)

Recommendation 3: Increase accessibility through funding the development of short form and Crisis Text messaging into core (24 hours/7days) services. These services cannot be extended without additional resourcing.

Lifeline Webchat

A survey of young people reported by Crosby and colleagues in 2015 found that while telephone is the preferred mode of support for most, over 59% of young people prefer to contact crisis services via short form messaging such as text (25.3%), online chat (18.7%) and social networking (15%).

With technological change and increased reliance on text and chat-based apps, this figure is predicted to grow rapidly into the future. Investments in new technology platforms and in increased technological capacity must be made in order for crisis support services to be responsive to people seeking help across various modes of communication. Furthermore, platform-independent digital service delivery has the potential to support real time language translation, thus improving accessibility for those whose first language is not English.

Lifeline currently offers Lifeline Crisis Chat online between the hours of 7pm and midnight (AEST). Throughout 2018, we held over 40,000 crisis conversations between these hours. A 2014 evaluation of the social return on investment forecast of the Lifeline Online Crisis Support Chat Service conducted by **netbalance**, found that for every dollar invested in the online crisis support service, the social return on investment was \$8.40. This report recommended that the service be recognised as a vital national infrastructure service in suicide prevention and crisis support. It also recommended that the social return on investment could be increased if the service was available for more hours each day by increasing access for people in crisis to seek appropriate help when needed.

Crisis Text Trial

Lifeline is also currently trialling a text-based service between the hours of 6pm and 10pm (AEST). A recent survey by Deloitte (Drumm and colleagues 2016) found that Australian mobile consumers interact with their smartphone 480 million times a day, an increase of 40 million interactions since the previous year's survey. The survey also found that nearly 30% of mobile consumers do not regularly use their phone to make voice calls but are communicating more than ever through the many data-based communication channels enabled by smartphones. The fact that mobile phones are generally kept on all the time and carried everywhere make them an ideal platform for the delivery of mHealth (mobile health) interventions. Such interventions can be highly effective as they can be personalised, tailored, interactive, and repeated at a relatively low cost. Mobile text messaging, in particular, has proven to be an effective form of psychiatric intervention (Berrouguet et al. 2018).

With very targeted and limited marketing to ensure numbers for the trial are maintained at a serviceable level, this trial is achieving an average of 30 approaches within operating hours and 30 approaches out of hours per evening. An extensive interim evaluation of Lifeline's Crisis Text trial has been conducted by Wollongong University. This evaluation has found that based on Lifeline Australia data for business-as-usual service delivery, the cost per text conversation has been estimated at \$177.16 and \$123.18 for a four-hour evening service or a 24-hour service respectively. The economic analysis has estimated an average \$320 in benefits for each text conversation. These benefits comprise reduced direct and indirect costs of suicidal behaviour (fatalities, serious injuries and short-term absence from work) and decreased health service and productivity impacts of psychological distress.

If Crisis Text were to run as a 24-hour service, 171,650 contacts to the service would be expected over the course of one year. Extrapolating from the trial data so far, 94,552 of these contacts would be expected to result in reduced distress, 12,585 would avert a non-fatal suicide attempt, and 968 would avert a suicide. The interim evaluation found that the projected benefits are substantial, given that the service itself is not providing extended therapy, but is a short-term crisis support intervention lasting around an hour, on average.

With adjustments for the volume of calls associated with each type of benefit, the overall return on investment for each dollar spent is \$1.81 for an evening service and \$2.60 for a 24-hour service. This return on investment is relatively modest compared with an earlier analysis of Lifeline's online chat service (netbalance 2014). One reason for this may be the higher cost of providing a service via SMS as the cost calculations have factored in salaries for paid staff. Feedback from the crisis supporters involved in the Crisis Text trial suggests that this method of crisis support is intensive and requires exceptionally high-level skills on top of those required for telephone crisis support.

Reasons for using Crisis Text from people who sought help through the service:

- "Because I am shy and would probably not call. So, therefore, I would not get any help. And I need to be somewhere where I'm alone to do it."
- "because I didn't want to cry on the phone the entire time"

- “Because I find text you can talk about anything and anywhere without others hearing what’s being said.
- “I’m not comfortable to talk to someone yet. This is the first time I’ve properly sought help and it’s so daunting accepting that you need to talk.”
- “I can’t talk out loud when I’m not coping. Plus, I’m hearing impaired and it’s hard sometimes to chat.”
- “The internet is unreliable in my region and I’m not in a situation where I can talk aloud without being overheard”

Recommendation 4: Increase responsiveness and access by supporting increased cultural competency.

There are a number of marginalised communities that Lifeline is aware are not accessing our crisis support services to the extent required. With resourcing to build cultural competency training into our volunteer crisis supporter training and subsequent target marketing to reach these communities, we will break down barriers and increase access to our service.

For example, recent research by La Trobe University, commissioned by Lifeline Australia, explored the needs of LGBTI+ people during times of personal or mental health crisis. The aim of the study was to inform the evidence base for Lifeline to design, resource and deliver services to meet the needs of LGBTI people in Australia during times of crisis.

The La Trobe study found that 71% of LGBTI+ Australians did not reach out to services such as Lifeline for help during their most recent personal or mental health crisis. Researchers found the main reason LGBTI+ people chose not to use crisis counselling was “an anticipation of discrimination”, even though most of those who did access services reported positive experiences. The findings of this study revealed a pressing need for mainstream crisis support services such as Lifeline to engage in LGBTI+ inclusive practice programs. Such programs would enable the development and support of cultural competency and safety in mainstream service use.

Similar findings regarding cultural competency were found in a 2017 study conducted in partnership with the Bridging Hope Charity Foundation and DiverseWerks. This study found that 38% of the Chinese Australian community have recently experienced a period of stress and that 36% of this group know someone who has recently experienced stress. Of particular concern was that 63% of those people did not seek support. Those members of the Chinese Australian community who did, usually sought the support of family or friends.

This study recommended culturally appropriate training for crisis supporters; mental health first aid and capacity building training for Chinese community members so they recognise the signs and assist others with seeking support; as well as promotional activities targeting both Mandarin and Cantonese speaking Chinese communities.

Similarly, Aboriginal and Torres Strait Islander populations make up 1.7% of all callers to Lifeline despite representing 3.3% of the population (ABS, 2016). Lifeline is currently embarking on a project in which Indigenous understandings of healing and wellbeing as they pertain to suicide

will be compiled, with a view to better informing Lifeline's capacity to deliver a culturally appropriate service to Aboriginal and Torres Strait Islanders.

Recommendation 5: Support increased responsivity via the development of a streamlined or 'hot' referral process

Another opportunity to increase the responsivity and accessibility of Lifeline is by introducing a direct referral by call transfer from Lifeline to other services. Having the additional capacity to patch those seeking help through seamlessly to the most appropriate follow-up service will enhance the user experience.

For example, in 2018, at least 0.95% of Lifeline's calls (7,025) were placed by minors. With a direct referral process, these people seeking help could be directed to Kids Helpline to ensure they get the specialist support they require. With adequate resourcing, similar direct referral measures could be put in place to Suicide Call Back Service and other appropriate mental health services. This approach would prevent duplicate service provision, it would increase collaboration between services, reduce call wait times for individuals seeking help and increase beneficial outcomes for callers.

Likely Effectiveness - Suicide Postvention

Recommendation 6: Introduce specific and universal care and support services to ensure safe and appropriate discharge, referral pathways and treatment plans for suicide survivors.

Failure to provide outpatient follow-up care after suicide attempts is associated with increased risk of reattempt and death by suicide (Meehan et al 2006).

Lifeline is recommending resources be allocated to provide proactive services that take an assertive approach to providing support post-discharge from hospital. This includes, but is not limited to, introducing specific services to accompany a person as they are discharged from hospital and assisting them to settle once they're home. Ideally, this service would also include post discharge in-home follow-up in the 72 hours after discharge.

A 2014 study analysed the benefits of supportive text messages on hospital discharge. Researchers found that people who were discharged after a suicide attempt were willing to accept supportive text messages even after refusing hospitalisation (Berrouiguet et al 2014) and showed a desire to keep receiving messages (Chen et al 2010).

Lifeline is well placed to provide these services given our wide-ranging footprint across 40 locations around Australia, and the opportunity to offer referral pathways and additional support through our existing 13 11 14 service and Crisis Text. In a survey of Telephone Crisis Supporter volunteers at Lifeline, 92.54% believed providing a postvention service for people who have attempted suicide to be safely discharged and accompanied home was extremely important.

Recommendation 7: Fund the development of a nationally-available program to support proactive post suicide-attempt follow up.

Sadly, we know that the period immediately after discharge from psychiatric inpatient care is particularly dangerous for survivors, with a UK study identifying that 47% of suicide deaths occurred within the month after discharge and 43% of those occurring before the first follow-up appointment (Hunt and colleagues, 2009).

As mentioned, under the banner of the 'Eclipse' program, Lifeline is currently trialling an adaptation of the Didi Hirsch model of postvention Survivor Support Groups. Eclipse meetings are a lived-experience support for adults who have non-fatally self-harmed. The sessions complement clinical service provision and allow lived experience to be shared in a safe, non-judgemental, facilitated environment over an eight-week period. The primary objective of the Eclipse program is to keep people safe by equipping participants with tools and skills for coping and planning should suicidal impulses take hold in the future.

It is expected that formal evaluation of Lifeline's Eclipse groups will support the positive outcomes reported by Hom, Davis and Joiner (2018) in relation to survivors of suicide attempt support groups in the United States.

Participants in this study reported significant reductions in suicidal ideation, feelings of hopelessness, suicidal desire, and suicidal intent after completing the SOSA (Survivors of Suicide Attempts) program. Additionally, individuals reported significant increases in their capacity for resilience following SOSA group participation.

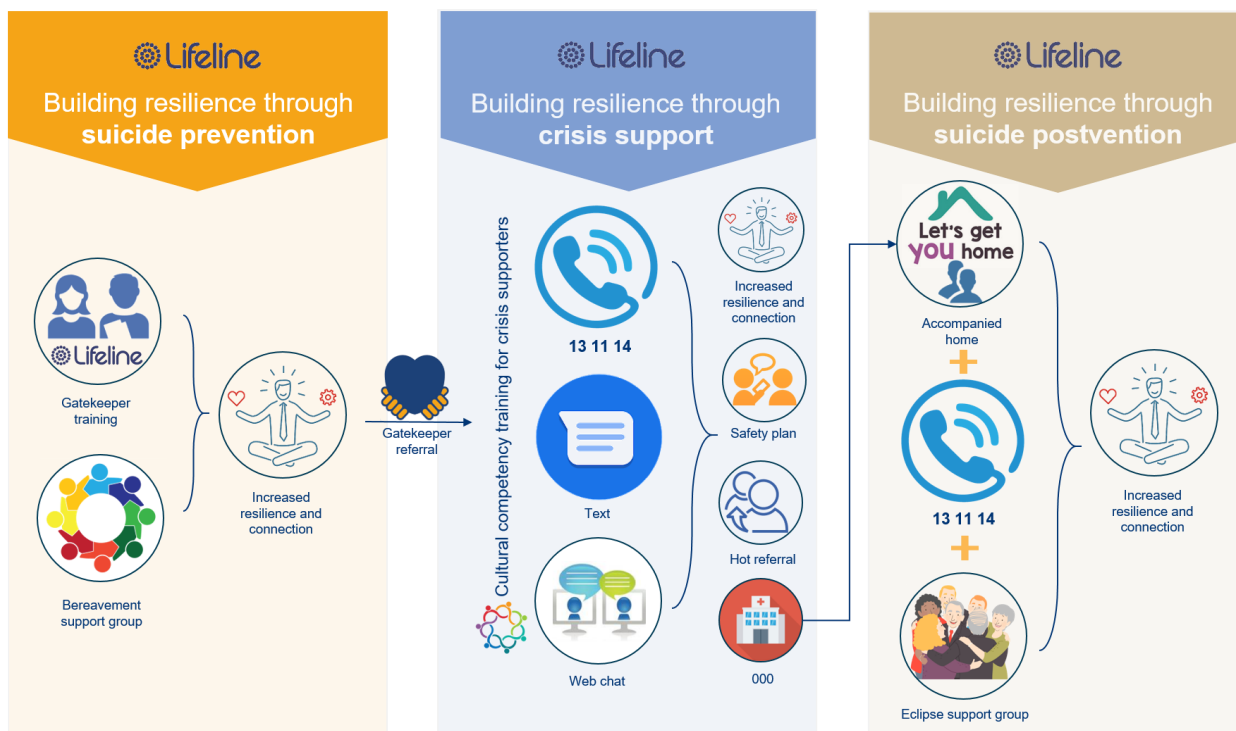
Notably, individuals engaged in additional mental health treatment whilst participating in the SOSA program did not demonstrate significantly greater reductions in suicidal symptoms than those participating in the group sessions only. This highlights the potential utility of interventions such as SOSA. In a survey of Lifeline volunteer Telephone Crisis Supporters, 90.5% believed postvention lived experience support groups are important interventions.

8. Recommendations

REMAINING GAPS	ASSOCIATED RECOMMENDATIONS
<p>Suicide Prevention:</p> <p>Currently, the service model for increasing community-level mental health resilience and supports for those bereaved by suicide lacks geographical reach. Service provision through a national provider with maximal geographical reach is required.</p>	<p>Recommendation 1: Commission and fund systematic gatekeeper training on a national level for community leaders and front-line workers to be suicide intervention first responders.</p> <p>Recommendation 2: Deliver a universal suicide bereavement support service that is funded consistently on a national scale.</p>
<p>Crisis Support:</p> <p>The largest national provider of crisis support services is not yet accessed by people from all demographic groups, and is not yet maximally responsive. There remains the need to improve accessibility, responsiveness, and to streamline the experience of those who seek help during a crisis.</p>	<p>Recommendation 3: Increase accessibility through funding the development of short form and crisis text messaging into core Lifeline services.</p> <p>Recommendation 4: Increase responsiveness and accessibility of the largest national crisis support provider by supporting cultural competency training.</p> <p>Recommendation 5: Support increased responsiveness of Lifeline's crisis support services via funding the development of a streamlined referral process.</p>
<p>Suicide Postvention:</p> <p>There remains a need for continuity of care plans to include supported transport from hospitals after discharge from a suicide attempt-related admission, and for the provision of evidence-based, post-attempt support groups operating across a wide geographical network of Australian sites.</p>	<p>Recommendation 6: Introduce specific and universal care and support services to ensure safe and appropriate discharge, referral pathways and treatment plans for suicide survivors.</p> <p>Recommendation 7: Fund the development of a nationally-available program for post suicide-attempt proactive follow up.</p>

9. MODEL OF RESILIENCE-BUILDING IN SUICIDE PREVENTION

If recommendations are implemented, the model below provides a visual representation of a closed gaps model of suicide prevention.



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