



Submission to the Victorian Royal Commission into Mental Health

July 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 examine existing strategies for reducing the rate of suicide; 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

The relationship between mental ill health and suicide is complex: not all who suicide have experienced mental ill health, nor do all who experience mental ill health suicide.

Any comprehensive model of suicide prevention must adopt a wider perspective than the typical disease/mental health/clinical model. Rather, suicide prevention must take a prominent place *alongside* mental health service provision.

Australia's suicide rate represents an increasingly tragic national statistic. Since 2008, the rate rose by 15%.

Although rates in Victoria did not rise, they are still far too high.

Here, with an overarching theme of the interdependence of local and national aspects of service delivery, Lifeline articulates a suite of 14 recommendations designed to support and further enhance suicide prevention in Victoria.

Lifeline submits that benefits realised via adoption of local, relatable, relevant service delivery must in Victoria – as elsewhere - be considered in the broader context of the benefits of adopting a scalable national approach.

Royal Commission Questions	Lifeline Recommendations
1. Stigma reduction?	1. Adoption of stigma-reduction initiatives (training programs, peer-to-peer support, media or other initiatives) that are locally relevant but have national scalability.
3. Suicide prevention: What is working and what can be done better?	2. Victorian Government supports the commissioning and funding of systematic gatekeeper training on a national level 3. Victorian Government supports the delivery of a universal suicide bereavement support service that is funded consistently on a national scale 4. Increase accessibility of crisis support services by extending availability of crisis chat and crisis text messaging. 5. Increased responsiveness and access by supporting increased cultural competency 6. Support increased responsiveness via the development of a streamlined or 'hot' referral process 7. Introduce specific and universal care and support services to ensure safe and appropriate discharge, referral pathways and treatment plans for suicide survivors 8. Fund development of a nationally-available program to support proactive post suicide-attempt follow up. 9. Enhancement of a portal that provides timely, geographically-specific, accurate and sufficiently detailed information for users to quickly and easily identify fit-for-purpose services
4. Barriers and solutions to obtaining services	10. Adoption of a collaborative, sector-wide exercise of service mapping through which opportunities for direct transfers can be identified, and implementation of mechanisms for achieving those transfers
5. Community-specific disadvantage	11. Victorian Government supports the provision of a range of clinical and non-clinical service offerings for multi-modal delivery into rural and metropolitan regions.
6. Family and carer needs?	12. Victorian Government supports the introduction of NDIS-supported services for carers of those experiencing suicidality.
7. Attraction, retention, support of workforce?	13. Adoption of funding models that incorporate capacity for longer term appointments, particularly in non-metropolitan areas, in addition to enhancing perceived value of crisis support workers.
8. Improvements in social and economic participation?	Refer to recommendations arising in relation to Question 3
9. Ideal vision of Victorian system?	
10. Actions in preparation for change?	14. Government structures and processes, both State and Federal, be adopted as a key lever to reduce fragmentation and enhance sustainability to achieve optimal outcomes in Australia's suicide prevention efforts

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 22 member organisations; 18 Affiliate (operational) Members and 4 Non-Affiliate Members. 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.

Our ties to local communities run deep and wide.

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

Lifeline is served by 11,000 volunteers. 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.

The Lifeline brand is well recognised: polling research by Roy Morgan on behalf of Lifeline in November 2016, found 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 leader in the area of suicide prevention. We regularly contribute to the national discussion, most recently by making submissions to the Senate Community Affairs

Inquiry, the Fifth National Mental Health Plan, and Suicide Prevention Australia's position statement on Mental Illness and Suicide.



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.

However, 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.

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 played in the lead-up to engaging in suicidal behaviours by age, gender, genetics, cultural background; family dynamics; geographical isolation; financial situation; education levels; social and employment status, along with traumatic life events. 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.

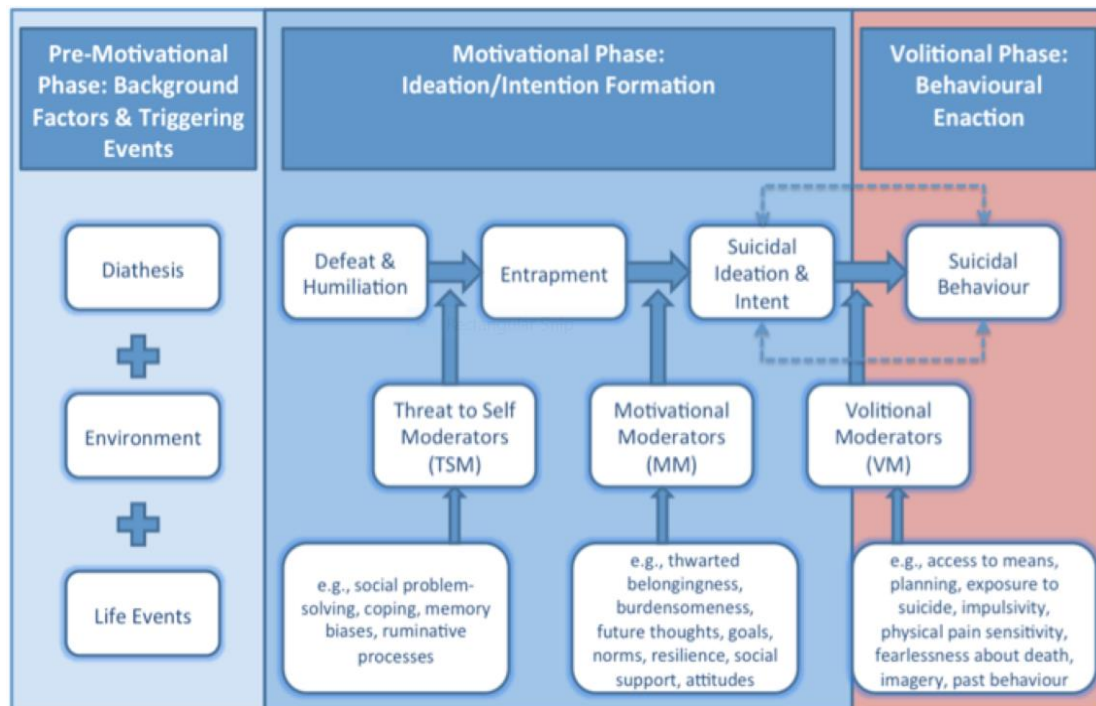


Figure 2: A widely accepted model of the precipitants of suicidal ideation, intentional formation, and behaviour (O'Connor & Kirtley 2018)

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 tragic epidemic.

Suicide prevention must take a prominent place *alongside* mental health service provision to ensure that suicide rates are reduced.

It is on these grounds that Lifeline Australia submits that any discussion of measures to improve mental health should include a specific, focused consideration of suicide prevention.

Suicide prevention in the Victorian context:

Australian suicide rates over the past ten years have recorded a net increase in every state and territory except Victoria (see Figure 3 below). Though it is important to note the trend for decline in Victoria is almost negligible, the very fact that rates are *not increasing* is in itself a distinguishing feature.

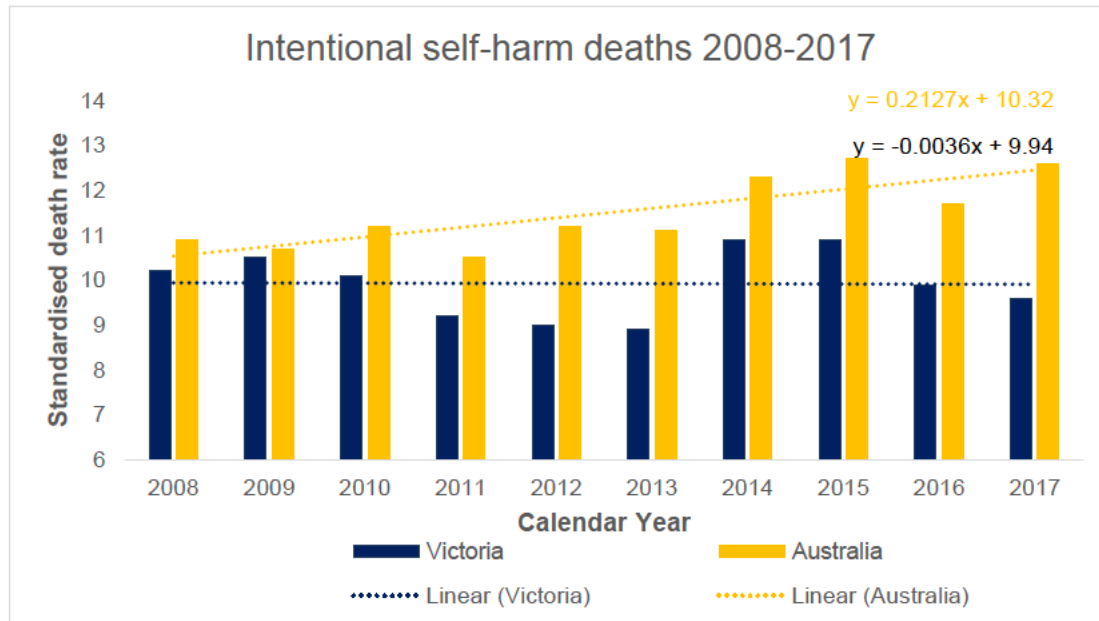


Figure 3: Rates of death by intentional self-harm from 2008-2017 for Victoria and all Australia

Lifeline's physical footprint in Victoria comprises seven sites in Ballarat, Central Victoria and Mallee, Geelong Barwon, Gippsland, Melbourne, Albury Wodonga and South Western Victoria. Some of these centres benefit from varying individual funding arrangements with the Victorian Government which contribute to a range of Lifeline initiatives within their local communities.

Notably and in contrast with NSW and the Northern Territory, Lifeline Australia receives *no Victorian state-based funding to support crisis service offerings*.

One consequence is Victoria's negative net contribution to Lifeline's national crisis support service capacity. That is, whilst 27% of crisis calls originate in Victoria, only 15% are answered in that state, yielding a national net contribution of -12%. By contrast in NSW, where the state Government contributes \$3.2 million annually to crisis support services (and in 2019 has announced an additional \$6 million to support the recruitment and training of crisis supporters to facilitate the increase in capacity of the Lifeline Text national service) the net contribution to national call answering capacity is currently in the order of +20%.

Net contributions to national call answer capacity from those two states are represented graphically in Figure 4 below, in which the green region represents *positive* net contribution of the state to national call capacity, and the *red* region represents a negative net contribution. It is worth noting that the two states generate the highest call volumes of any states and territories in Australia.

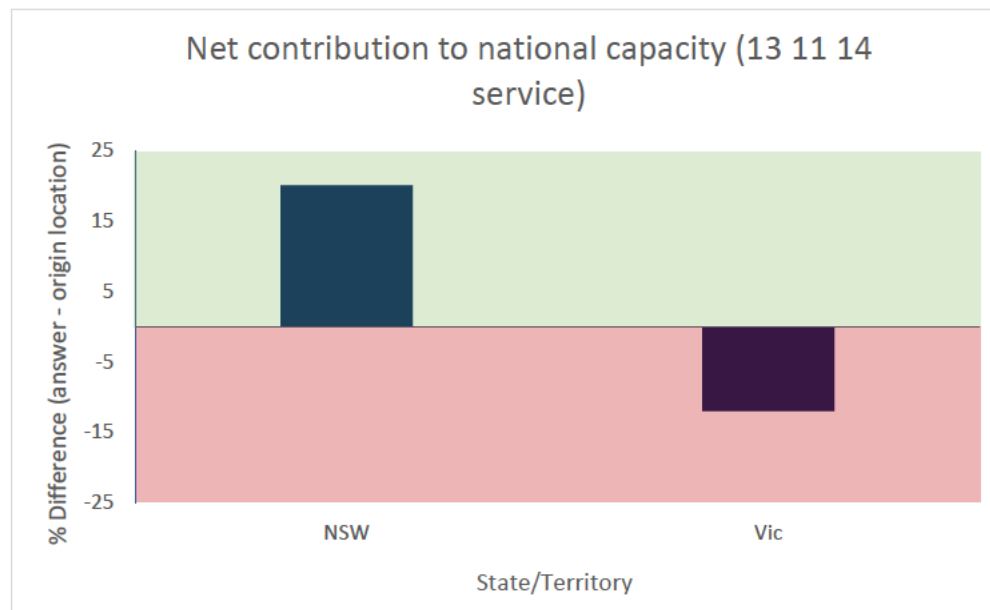


Figure 4: Net contribution to national capacity (13 11 14 service)

It is important to note that the lack of state-based funding for Lifeline's core crisis support services in Victoria has a range of flow-on effects on aspects such as number of volunteers trained, and capacity of centres to deliver community offerings. The lack of crisis service funding poses challenges to the very sustainability of Lifeline centres in Victoria.

Despite this, and as noted earlier, the rate of suicide per capita in Victoria over the past ten years has been relatively static. That observation may at least in part speak to the efficacy of the national call-routing model (amongst other suicide prevention initiatives offered by Lifeline and others). Over the longer term however, deleterious flow-on effects are likely to pose serious challenges to maintaining the negative trajectory of Victoria's suicide rates.

Interdependence of the 'local' and 'national' aspects of service delivery is an overarching theme of the responses that follow. Lifeline submits that benefits realised via adoption of local, relatable, relevant service delivery in Victoria – as elsewhere – must be considered in the broader context of the benefits of adopting a scalable national approach.

1. What are your suggestions to improve the Victorian community's understanding of mental illness and reduce stigma and discrimination?

Context:

For some time, concerted and coordinated national efforts have been underway to reduce stigma and increase understanding of mental illness.

Within the specific context of suicide-related stigma, data from a 2017 survey conducted by Colmar Brunton indicate that roughly one third of respondents identified suicide as cowardly, irresponsible or stupid. That outcome underscores the central importance of ongoing action in this space.

Lifeline's contribution to the national effort operates at a range of levels.

Training Programs:

Nationally, and as outlined in Lifeline's recent submission to the Productivity Commission (https://www.pc.gov.au/data/assets/pdf_file/0011/239384/sub087-mental-health.pdf), Lifeline Centres deliver a range of training programs designed to improve mental health literacy and impart skills to recognise and appropriately refer those in suicidal distress.

In one example specific to the Victorian context, a program suitable for national delivery is being adapted to include video vignettes that are identifiably Victorian. Specifically, Lifeline and Orygen are implementing a large-scale evaluation of a stepped-care suicide prevention program delivered to Year 10 students in Victorian schools. The program's efficacy in reducing children's suicidal ideation, hopelessness and other key variables will be measured with a view to rolling the program out nationally through Lifeline's centres.

Further to the specific skill sets promoted by such programs, a broader and arguably more fundamental benefit is conferred: the education provided via such training replaces the vacuum of information that contributes to stigma.

Peer to peer support initiatives:

Lifeline is also overtly active in challenging suicide-related stigma.

There is an emerging evidence base to support the efficacy of peer-to-peer support mechanisms in suicide prevention.

Lifeline's recently launched podcast series, **Holding on to Hope** (www.lifeline.org.au/podcast), shares the experience of people who have come through the darkness of suicidality. Each participant shares the connection they made that gave them hope to continue living. The key goals of the initiative are to reduce the stigma of suicidality and encourage both help seeking and supporting behaviours.

Media initiatives:

Lifeline has partnered with the TrackSAFE Foundation to deliver nationally the 'Pause. Call. Be Heard' media campaign. Through engaging, positive and interactive billboard advertisements, the campaign reminds the public to take a moment and know they are never alone: Lifeline's crisis support services are available 24/7.

Specifically in relation to the Victorian roll-out, a University of Melbourne evaluation (San Too et al 2019) estimated that 27 000 commuters per day were exposed to the campaign messaging. Of those who noticed the campaign, close to 80% indicated that as a consequence, they were more likely to seek help from Lifeline themselves, or to suggest Lifeline as a source of help to others.

Victoria also served as the trial site for roll-out of a digital version of the campaign. Facebook/Instagram, Spotify and YouTube were selected as platforms across which to deliver a personalised mobile advertisement experience at specific stations and commuter train track routes. Data indicates that click through rates were above industry rates, with completion rates of above 89% on YouTube and above 99% on Spotify.

On the basis of the campaign's impact in Victoria, Lifeline Australia and TrackSAFE are working towards digital delivery into other states and territories: learnings arising from the local Victorian roll-out will inform the national approach.

Though the campaign was designed specifically to promote self-help behaviours, its focus on mental health behaviours and normalisation confers the additional benefit of challenging the conditions necessary for stigma to exist.

Recommendation 1:

Adoption of stigma-reduction initiatives (training programs, peer-to-peer support, media or other initiatives) that are locally relevant but have national scalability.

2. What is already working well and what can be done better to prevent mental illness and to support people to get early treatment and support?

Lifeline's focus on suicide prevention and what can be done in that space is addressed in our response to Question 3 below.

3. What is already working well and what can be done better to prevent suicide?

In a recent submission to the Productivity Commission, Lifeline Australia outlined a comprehensive overview of remaining gaps and solutions in Australia's suicide prevention efforts. As stated in that document, Lifeline has a crucial and specific role to play at both the state and national level in enhancing service offerings for suicide prevention, crisis support, and suicide postvention.

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 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 averaging 14.66 minutes. The quantifiable value of each call was \$39 (including the hourly value of contributions of volunteer time), meaning the total quantifiable 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 in the 2018 calendar year, 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.

"I dialled 13 11 14... A lovely woman picked up, I said 'I don't really know why I called', and she said 'That's alright [REDACTED], that's normally how the conversation begins'....That woman, God bless her, whoever she is, set into course a chain of events that ended up saving my life. That's why I'm here today." [REDACTED]

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.

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 postvention phases of suicidality.

Suicide Prevention:

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

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. Intervening in people's lives 'upstream' of a potential personal crisis, by 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 National Mental Health Commission (NMHC) to be more alert to signs of personal distress and thus intervene at an earlier stage. Adding 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 Primary Health Network [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.

“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, 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 of a Lifeline Centre.

Gatekeeper training:

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, they can 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.
- 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 2019 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 is often preventable. 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:

Victorian Government supports commissioning and funding systematic gatekeeper training on a national level for community leaders and front-line workers to be suicide intervention first responders.

Bereavement Support Service:

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 and colleagues (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 and colleagues (2013) provided evidence 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 community based 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. 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.

Recommendation 3:

Victorian Government supports the delivery of a universal suicide bereavement support service that is funded consistently on a national scale.

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.

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.

However, 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 represent a gap in the crisis support system.

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 would cover 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). Furthermore, accessibility for CALD communities can be increased by platform-independent digital service delivery which has the potential to support real time language translation, thus improving accessibility for those whose first language is not English.

Call answer rate:

13 11 14 Crisis Hotline

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, every call must be answered.

The positive impact of state Government funding that specifically supports the provision of Lifeline's flagship 13 11 14 service in NSW is reflected in the net contribution of that state to the national call answer capacity.

Expanding the variety of channels for contact will increase the likelihood that people in crisis will feel comfortable reaching out.

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 5 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. In any effort to reduce suicide, it is therefore critical 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).

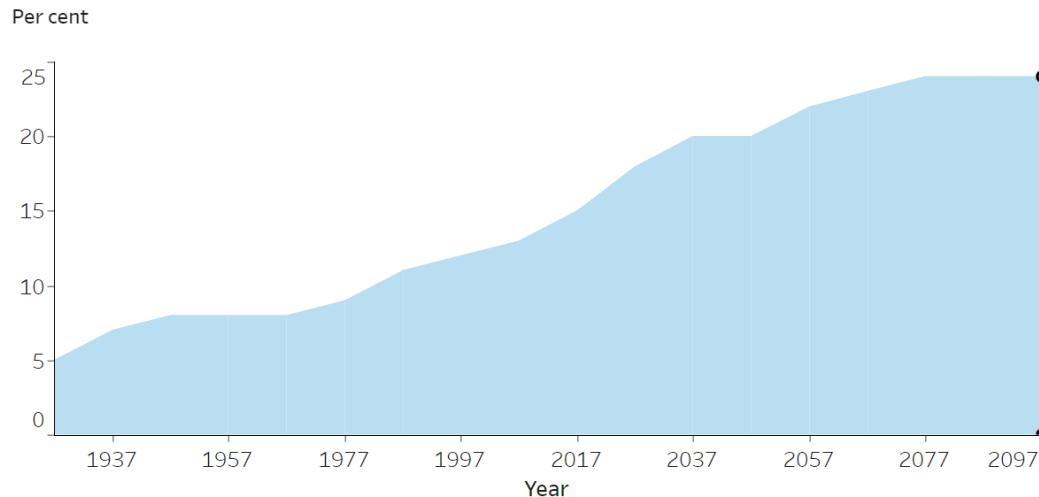


Figure 5: Projected proportion of Australian population aged 65 and over time (ABS, 2017)

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.

Mobile phones are generally kept on and carried everywhere making 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 (Berrouiguet 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 for a four-hour evening service and \$123.18 for a 24-hour service. 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 accessibility of crisis support services by extending availability of Crisis Chat and Crisis Text messaging.

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:

Increase responsiveness and access by supporting increased cultural competency.

Referral process:

Another opportunity to increase the responsiveness 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.

Recommendation 6:

Support increased responsiveness via the development of a streamlined or 'hot' referral process

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.

The biggest predictor of suicide is a previous attempt (Christianson et al 2007). Concerted efforts are being made to improve services for those who have attempted suicide. All three of the models represented in Figure 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'.

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 (Berrouguet 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:

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

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.

Recommendation 8:

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

4. What makes it hard for people to experience good mental health and what can be done to improve this? This may include how people find, access and experience mental health treatment and support and how services link with each other.

In its recent report to the Productivity Commission into Mental Health, Lifeline submitted that a range of barriers still exist to the seamless provision of appropriate and fit-for-purpose services to those in significant emotional distress.

Lifeline noted that in the 2014 report *Contributing Lives, Thriving Communities: Review of Mental Health Programmes and Services*, The 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 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 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). 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.

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.

To that end and as noted in response to Question 3 above, Lifeline has developed a range of national offerings within the suicide prevention, crisis support, and suicide post-vention spaces and made specific recommendations for how to enhance user access and experience with regards to those services.

In relation to the additional issues of how people find services and how those services link together, gaps remain. Lifeline centres in Victoria have identified as an issue the lack of availability of timely and sufficiently detailed information about what services are available. In addition, in Victoria as in other states and territories, there is further scope to improve user experience through the development of better transfers between services: Lifeline submits that a proactive approach on the part of service providers to identify and develop pathways between services is required.

Recommendation 9:

Enhancement of a portal (such as the suicide prevention hub) that provides timely, geographically-specific, accurate and sufficiently detailed information for users to quickly and easily identify fit-for-purpose services.

Recommendation 10:

Adoption of a collaborative, sector-wide exercise of service mapping through which opportunities for direct transfers can be identified, and implementation of mechanisms for achieving those transfers.

5. What are the drivers behind some communities in Victoria experiencing poorer mental health outcomes and what needs to be done to address this?

The burden of suicide is not homogenously distributed across societal groups.

Australian Bureau of Statistics (ABS) data show that in 2017 a total of 3,128 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 in particular 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 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.*

In addition to those factors, geography plays a role. Specifically, those residing in rural communities are more likely to end their lives through suicide than their urban-dwelling counterparts (see for example Hirsch et al 2014).

The causal factors underlying this lack of homogeneity are complex and varied. As a consequence, one size does *not* fit all with respect to appropriate service offerings. Rather, a broad range of offerings delivered via multiple channels is required. Lifeline aims to offer services to those in need anytime, anywhere, and anyway the person seeking help requires.

Recommendation 11:

That the Victorian Government support provision of a range of clinical and non-clinical service offerings for multi-modal delivery into rural and metropolitan regions.

6. What are the needs of family members and carers and what can be done better to support them?

Lifeline has identified programs to support carers *bereaved* by suicide in its response to Question three.

With regards to carers *supporting a suicidal person*, Lifeline identifies that supporting a person experiencing suicidality can impose a significant burden upon family members and carers (see for example Morgan et al 2013). Despite this, few services are available to support those who support suicidal persons.

In Victoria as elsewhere, a barrier has been created by NDIS funding arrangements in which respite for carers is generally a non-funded service.

To address this need in NSW, Lifeline offers services for those supporting suicidal persons. The Life Matters program is one example. Via Lifeline's national network of centres, with funding, similar programs can be offered in the Victorian context.

Recommendation 12:

Victorian Government supports the introduction of NDIS-supported services for carers of those experiencing suicidality.

7. What can be done to attract, retain and better support the mental health workforce, including peer support workers?

Lifeline identifies existing funding models as a fundamental barrier to attracting, retaining and supporting a suicide prevention workforce.

Lifeline centres, including those located in Victoria, typically source funding for program delivery from Public Health and Local Hospital Networks. It is typically the case that those funding opportunities are for limited time periods. In the event an application is successful, potential staff can only be offered roles on a limited-time basis. Particularly in non-metropolitan areas, the offer of non-permanent employment can be a fundamental impediment to attracting a sufficiently skilled workforce.

Lifeline identifies a further issue related to building a high-quality workforce in non-clinical service provision. The value of the role played by crisis helplines and their often volunteer-based workforce in preventing suicide was recently endorsed by the World Health Organisation's publication of a resource for creating a helpline. Lifeline submits that steps must be taken to reinforce positive public perceptions of the value of such roles with the broader public.

Recommendation 13:

Adoption of funding models that incorporate capacity for longer term appointments, particularly in non-metropolitan areas, in addition to enhancing perceived value of crisis support workers both paid and volunteer.

8. What are the opportunities in the Victorian community for people living with mental illness to improve their social and economic participation, and what needs to be done to realise these opportunities?

In our recent submission to the Productivity Commission into Mental Health, Lifeline articulated the devastating personal and societal costs imposed by suicide. We noted that in addition to the ripple effects on those known to the person who deliberately takes their own life, the annual economic cost to the nation of suicide and non-fatal suicide behaviours sits between \$1.5 and \$5.2 billion. That high economic cost is largely driven by the demographic characteristics of suicide: The rate at which young people deliberately take their own lives means that suicide is the leading cause of years of potential life lost. Finally, rates of suicide are at best 'sticky' (as in Victoria) and increasing in all other states and territories. This is despite increased funding for mental health in Australia in recent years.

Taking into account all these factors, Lifeline submits that those means that effectively reduce suicidality and suicide will confer benefit to the social and economic participation of Victoria as a whole.

Recommendation:
See Recommendations 2-8

9. Thinking about what Victoria's mental health system should look like, tell us what areas and reform Ideas you would like the Royal Commission to prioritise for change?

Lifeline submits that an ideal mental health system should include clearly articulated and accessible pathways between a range of services designed to meet user need as defined over time, geography, and socio-demographics.

Such a model is particularly relevant to service provision in the suicide prevention space.

As evidenced by the high volume of contacts Lifeline receives per annum, and as endorsed by the World Health Organisation's recent release of the 'Preventing suicide, A Resource for establishing a crisis line' report, non-clinical approaches *must* form an integral part of that suite of services.

To that end, Lifeline has proposed a suite of recommendations designed to reduce suicide and suicidality. Those recommendations – articulated in response to Question three and represented as Figure 6 below, represent Lifeline's vision of an ideal and achievable approach to suicide prevention in the state and nationally.



Figure 6: A model for Lifeline services designed to prevent suicide via the lever of building community resilience

10. What can be done now to prepare for changes to Victoria's mental health system and support Improvements to last?

The NMHC described the response to suicide in Australia as being 'historically fragmented'. This fragmentation has been exacerbated by a lack of clarity around the specific roles and responsibilities of suicide prevention organisations and programs across governments.

One key initiative currently underway to address this approach is the development of a National Suicide Prevention Implementation Strategy.

In Lifeline's response to the draft national strategy, we endorsed the use of government leadership as a key lever to generate greater cohesion within the sector.

An important consequence of embedding information sharing and a collaborative approach into government structures is to set the tone for the entire sector. For service providers such as Lifeline, the advent of an embedded cross-sector approach that recognises the necessary role of round the clock services complimentary to clinical care will have a much-needed streamlining effect not only with respect to applications for funding, but also with respect to projecting influence and increasing efficacy: A more coherent, cross-sectoral government approach will improve the ability of all those working within the sector to contribute to thought-leadership activities in a more efficient, impactful way leading to optimal outcomes for people seeking help.

Recommendation 14:

Government structures and processes, both state and Federal, be adopted as a key lever to reduce fragmentation and enhance sustainability to achieve optimal outcomes in Australia's suicide prevention efforts.

Conclusion

Lifeline offers its sincere thanks to the Government of Victoria for providing a focus on mental health and suicide prevention through the Royal Commission into Victoria's Mental Health System. We are grateful for the opportunity to offer a detailed submission.

As Australia's largest service provider in suicide prevention Lifeline submits it has a vital role to play in shaping the future of Australia's approach to reducing deaths by suicide.

Lifeline stands ready, and willing, to offer further contributions to this important process in future.

References:

- ARTD Consultants (2011) Evaluation of Lifeline's crisis chat support service trial, ARTD Consultants: Sydney, Australia.
- Australian Bureau of Statistics. Average Weekly Earnings, Australia, Cat no. 6302.0. Canberra: ABS, May 2018
- Australian Bureau of Statistics. Causes of death, Australia, 2015. Cat no 3303.0. Canberra: ABS, 2016
- Australian Bureau of Statistics. Population Projections, Australia, 2017. Cat no 3303.0. Canberra: ABS, 2017
- Berrouiguet, S., E. Baca-Garcia, S. Brandt, M. Walter and P. Courtet (2016). "Fundamentals for Future Mobile-Health (mHealth): A Systematic Review of Mobile Phone and Web-Based Text Messaging in Mental Health." *J Med Internet Res* 18(6): e135.
- Bolton, J.M., Au, W., Leslie W.D., Martens, P.J., Enss, M.W., Roos, L.L., Katz, L.Y., Wilcox H.C., Erlangsen, A., Chateau, D., Walld, R., Spiwak, R., Seguin, M., Shear, K. & Sareen J. (2013) Parents bereaved by offspring suicide: a population-based longitudinal case-control study, *Journal of the American Medical Association*, 70(2): 158-167.
- Chen, H., Mishara, B.L. & Liu, X. X. (2010) A Pilot Study of Mobile Telephone Message Interventions with Suicide Attempters in China, *Crisis*, 31, pp. 109-112
- Christiansen, E. & Jensen, B.F. (2007) Risk of repetition of suicide attempt, suicide or all deaths after an episode of attempted suicide: a register-based survival analysis, *Australian & New Zealand Journal of Psychiatry*, 41(3): 257-265
- ConNetica Consulting (2009) The Estimation of the Economic Cost of Suicide to Australia; ConNetica Consulting: Caloundra, Australia.
- Crosby Budinger, M., Cwik M. F. & Riddle M. A. (2015). "Awareness, attitudes, and use of crisis hotlines among youth at-risk for suicide." *Suicide & Life-Threatening Behavior*, 45(2): 192-198.
- Fassberg, M.M., van Orden, K.A., Duberstein, P., Erlangsen, A., Lapierre, S., Bodner, E., Canetto, S.S., De Leo, D., Szanto, K., Waern, M. (2012) A systematic review of social factors and suicidal behavior in older adulthood, *International Journal of Environmental Research and Public Health*, 9(3): 722-745.
- Goldney, R. D. (2005) Suicide prevention: a pragmatic review of recent studies. *Crisis*, 26(3): 128-140.
- Hom, M. A., Davis, L., & Joiner, T. E. (2018). Survivors of suicide attempts (SOSA) support group: Preliminary findings from an open-label trial. *Psychological Services*, 15(3), 289-297.

Krysinska K, Batterham PJ, Tye M, Shand F, Caelear AL, Cockayne N. & Christensen, H. (2016) Best strategies for reducing the suicide rate in Australia. *Australia New Zealand Journal of Psychiatry*, 50(2):115–8.

Hirsch, J. K., & Cukrowicz, K. C. (2014). Suicide in rural areas: An updated review of the literature. *Journal of Rural Mental Health*, 38(2), 65-78

Hunt, I.M., Kapur, N., Webb, R., Robinson, J., Burns, J., Shaw, J. & Appleby, L. (2009) Suicide in recently discharged psychiatric patients: a case-control study. *Psychological Medicine*, 39(03): 443-449

Mann, J. J., Apter, A., Bertolote, J., Beautrais, A., Currier, D., Haas, A., ... Hendin, H. (2005) Suicide prevention strategies: a systematic review. *JAMA*, 294(16), 2064 - 2074. <https://doi.org/10.1001/jama.294.16.2064>

Meehan, J., et al., Suicide in mental health in-patients and within 3 months of discharge. National clinical survey British Journal of Psychiatry, 2006. 188: p. 129-134

Morgan, S., Rickard, E., Noone, M., Boylan, C., Carthy, A., Crowley, S., Butler, J., Guerin, S. & Fitzpatrick C. (2013) Parents of young people with self-harm or suicidal behaviour who seek help - a psychosocial profile. *Child and Adolescent Psychiatry and Mental Health*, 7 (1):13.

netbalance (2014) Social Return on Investment forecast of the Lifeline Online Crisis Support Chat Service, prepared for Lifeline Australia.

O'Connor R.C., Kirtley, O.J. (2018) The Integrated Motivational-Volitional Model of Suicidal Behaviour. *Philosophical Transactions of the Royal Society B*. 373:20170268 <https://doi.org/10.1098/rstb.2017.0268>

Pirkis J., Middleton A., Bassilios B., Harris M., Spittal M., Fedyszyn I., Chondros P., Gunn J. Frequent callers to Lifeline. Melbourne: University of Melbourne; 2015.

Preventing suicide: a resource for establishing a crisis line. Geneva: World Health Organization; 2018 (WHO/MSD/MER/18.4). Licence: CC BY-NC-SA 3.0 IGO.

San Too L., Ross A., Pirkis J., Reavley N., & Reifels L. (2019), Pause. Call. Be Heard campaign: the impact on help-seeking and suicidal behaviours within the rail environment, *submitted for publication*.

Waling, A., Lim, G., Dhalla, S., Lyons, A., & Bourne, A. (2019). Understanding LGBTI+ Lives in Crisis. Bundoora, VIC & Canberra, ACT: Australian Research Centre in Sex, Health and Society, La Trobe University & Lifeline.

Williams K., Fildes D., Kobel C., Grootemaat P., and Gordon R. (2018) *Evaluation of the Lifeline Text Pilot Trial Interim Formative and Economic Evaluation Report (Draft)*. Centre for Health Service Development, Australian Health Services Research Institute, University of Wollongong.