



Submission to the COVID-19 Senate Committee Inquiry

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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.

Executive summary

Sadly, COVID-19 is set to have a devastating impact on the health and wellbeing of Australians.

Fear and anxiety around contracting the virus, combined with pressures on employment, finances, housing security, relationships, and physical health, will cumulatively impose a negative impact upon mental health and suicide in the national context.

Lifeline submits that the virus and associated countermeasures deal the nation a double blow: For the same reasons that demand for mental health and suicide prevention services have increased, so too has ability to seamlessly deliver those services been challenged.

Using scientific literature as a basis, overlaid with our experience as Australia's leading national suicide prevention service, Lifeline offers its perspective on the national response to COVID-19 across phases of recovery. Specifically:

Section 1 identifies, in the specific context of not-for-profit enterprises, challenges and protective factors with respect to service provision continuity in the COVID-19 era.

Section 2 addresses the impact of COVID-19 on the Australian public's mental health and suicidality across ongoing virus response and recovery phases including 1) *current arrangements of quarantine and isolation*, 2) *easing of current restrictions*, 3) *occurrence of surges and potential impact of re-imposition of local restrictions*, and 4) *long term recovery*.

Lifeline Australia's recommendations to support Australian's mental health and suicidality across pandemic response and recovery are summarised below in Table 1.

Table 1. Summary of Lifeline Australia’s recommendations to support Australian’s mental health and suicidality across pandemic response and recovery

Section 1	<p>Not-for-profit business continuity during COVID-2019</p> <p>1. Funding to ensure service continuity of mental health not-for-profits is critical.</p> <p><i>a) Based on our experience of the challenges and protective factors experienced by not-for-profit businesses, Lifeline Australia endorses the provision of funding to ensure the continuity of essential mental health services during disasters and pandemics.</i></p>
Section 2	<p>Current arrangements of quarantine and physical isolation</p> <p>1. Implementation of a national communication framework with a clear, nationally coordinated approach to public messaging around mental health is required.</p> <p><i>a) Adoption of basic public health messaging principles in relation to the mental health and suicide prevention context (as per WHO guidelines)</i></p> <p><i>b) Evidence-based approach to identifying appropriate individual communication objectives, taking into account stressors and protective factors</i></p> <p><i>c) Identification of a single or small number of key credible figureheads to deliver the national mental health and suicide prevention message/s</i></p> <p>Easing of current restrictions – Implications for suicide prevention</p> <p>1. Uplifting capacity for universal access to social connectivity and support - with zero barriers to entry.</p> <p><i>a) Government financial support for population-wide digital services access.</i></p> <p><i>b) Ongoing Federal and State financial support for helplines to future-proof service provision with regards to pandemics and natural disasters.</i></p> <p>2. Commissioning, and funding nationally accessible gatekeeper training for a diverse a group of community leaders and front-line workers.</p> <p><i>a) Upskill frontline staff in the welfare services in gatekeeper training to provide novel opportunities for intervention.</i></p> <p><i>b) Ensuring gatekeeper training is readily available to those living in remote, rural and regional areas is a priority.</i></p> <p><i>c) Training for providers of clinical and non-clinical services in identifying and responding to suicide in the online environment.</i></p> <p><i>d) Collective identification of appropriate and proportionate risk mitigation procedures in relation to delivering services online to at-risk groups</i></p> <p>3. Ensuring peer advice and support is embedded into new approaches to service delivery.</p> <p><i>a) The rapid development of lived experience-led, national ‘best practice’ materials regarding migrating suicide prevention services online.</i></p> <p><i>b) Wherever possible, incentivising and otherwise supporting the embedding of peer support offerings into the provision of services</i></p> <p>Occurrence of surges and the potential impact of re-imposition of local restrictions</p> <p>1. Implementation of data collection and sharing strategies to monitor the impact of COVID-19 hotspots on mental health and suicidality across geographic catchments.</p> <p><i>a) Increase the frequency of the National Mental Health and Wellbeing Survey.</i></p> <p><i>b) Providing ongoing support for, and indeed fast-tracking wherever possible, the National Suicide Information Initiative.</i></p> <p>2. Development and implementation of a region-specific public communications strategy at emerging COVID-19 hotspots.</p> <p><i>a) Roll out of campaigns led by local figureheads to emphasise the importance of social connectivity and identify and promote use of regionally-specific services.</i></p> <p><i>b) Development of a service portal with the capacity to provide clear points of entry to national and regional mental health services.</i></p> <p>Long-term recovery</p> <p>1. Development of an inter-agency disaster response and recovery framework as it pertains to suicide prevention through response stages.</p> <p><i>a) The framework should recognise and adapt to the rolling phases of psychological response and thus risk, over a prolonged period of community recovery.</i></p> <p><i>b) Such a framework is enabled by a focus at the individual agency level on offerings that address the core elements identified in item (a).</i></p> <p><i>c) The framework will enable coordination across governments as well as trusted non-profit and for-profit organisations, in delivering against all the core elements.</i></p>

About Lifeline

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

Our network of 41 national centres are embedded in their local communities and deliver services to Australian people in crisis wherever they might be. Lifeline's services include: Lifeline's 13 11 14 crisis line; a nightly online crisis support chat and text service; a suicide intervention service targeting sites people use to take their lives (formerly known as suicide hotspots); 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 face to face counselling and therapeutic groups for people at-risk, or bereaved, by suicide. Our centres are directly supporting thousands of people in the community every day.

As such, Lifeline's suicide prevention services can be conceptualised as falling into two key areas: The first is **digital** crisis support services (phone, chat and text). The second is our range of **in-community** programs and initiatives. Those latter are designed to help prevent suicide by embedding protective mechanisms at the individual and community level both prior to, and subsequent to, suicidal crises.

In that context, Lifeline's digital and in-community offerings are of direct relevance to the COVID-19 response and recovery.

Context

The COVID-19 pandemic is set to have a profound impact on mental health and suicidality in Australia.

The disease and its countermeasures have wrought havoc on daily life: Changes to the way we work, learn, eat, shop, recreate and socialise have unfolded almost simultaneously.

Knock-on consequences for people's employment, finances, housing security, relationships, and physical health are inevitable. Importantly and tragically, the cumulative impact of those stressors is likely to negatively affect mental health and suicidality, especially for society's most vulnerable.

Previous pandemics point to the effects likely to be observed in relation to mental health. Consequences ranging from distress (Taylor et al, 2008), to anger and anxiety (Jeong et al, 2016), to symptoms of post-traumatic stress disorder and depression (Hawryluck et al, 2004; Liu et al, 2012) have all been reported. Particularly, periods of quarantine have been associated with marked increases in symptoms of post-traumatic stress disorder and depression (Hawryluck et al, 2004; Mihashi et al, 2009).

Suicidality is also - tragically - likely to be affected. Again, based on data from previous pandemics, it is likely Australia will observe an uplift in severity and rates of suicidality. Metrics of the 2002-2004 SARS epidemic in Hong Kong showed increased suicides amongst older adults (Cheung et al, 2008).

The relationship between pandemics and suicidality is grounded in a broader understanding of the suicidology. Leading theories of suicidal behaviour such as the Integrated-Motivational (IMV) model identify as precipitants a range of background factors and triggering events - including social-economic factors and rapid social change (O'Connor & Kirtley, 2018).

Notably in an additional and troubling observation, society's most vulnerable are likely to be disproportionately affected: The IMV model predicts that the effects of the stressors particular to COVID-19 will only be magnified for people already facing existing situational stressors, suicidal ideation, and mental illness.

Further complexity in predicting the effects of COVID-19 on mental health and suicidality is imposed by the likely trajectory of virus mitigation measures.

It is widely accepted that psychological impacts of disaster typically follow a years-long time course characterised by fluctuations in the scale and nature of those impacts (Substance Abuse and Mental Health Services Administration, 2020). In the case of COVID-19, fluctuations in response are likely to be compounded by uncertainty stress associated with the ongoing need to more locally implement virus-mitigation measures. This is particularly important when considered in the context that compared to general life stress, uncertainty stress is more strongly associated with suicidal ideation (Wu et al, 2018).

Against a COVID-19-rendered backdrop of economic, social, and political upheaval, mental health and suicidality represent a key national risk. Public health policy must have a sharp

focus on supporting mental health and preventing suicide in the context of a complex and fluctuating set of circumstances.

This submission will outline that not only do the impacts of COVID-19 place significant additional stressors on individuals, there are significant implications for mental health service provisions. The experience of Lifeline demonstrates how the virus and associated countermeasures essentially deliver a double blow: For the same reasons the need for mental health and suicide prevention services increases, so too is the ability to deliver those services challenged. To highlight this dual impact, **Section 1** will address the impact of COVID-19 on mental health service continuity, and **Section 2** will address the impact of COVID-19 on the Australian public's mental health and suicidality across the pandemic response and recovery timeline.

Section 1: COVID-19 impacts on mental health service continuity

‘What my concern is – a lot of mental health and disability supports closed their doors... A lot of the support services were reaching out to me... wanting to put Lifeline down as a support for people they can no longer support. With support services closing their doors... it leaves such a huge gap in an already hard system’

Lifeline Centre Practice Lead

Lifeline has, due to COVID19, experienced an unprecedented and sustained increase in calls.

Twelve months ago, Lifeline averaged approximately 2,500 calls a day. From December 2019 to date, Lifeline recorded a sustained 10-15% increase in requests for support from the community. Lifeline often receives over 3,000 calls per day, equating to a call every 30 seconds.

Since the start of the COVID-19 pandemic, more than 50% of callers to Lifeline have expressed significant concern about the effects of the Coronavirus and anxiety about the future.

Lifeline’s national suicide prevention and crisis support services are delivered by thousands of highly trained volunteers and augmented by paid staff. Crisis supporters are recruited, trained and professionally developed nationally by our network of 41 Centres in over 60 locations across Australia.

Lifeline Centres usually maintain financial viability through a range of revenue generating activities such as our Lifeline retail stores, community fundraising events and book fairs. COVID-19 simultaneously increased the demand for our services and adversely impacted Lifeline Centres’ ability to raise revenue through traditional channels.

The Commonwealth as well as Victoria, QLD and NSW State Governments provided vital financial support for Lifeline to overcome the challenges associated with COVID-19 and ensure service continuity. That context is described in detail below, in addition to a case study of the impact of COVID-19 on Lifeline’s DV-Alert program.

1.1 Not-for-Profit business continuity during COVID-19

Challenges

Most of Lifeline’s 41 national centres are small businesses run solely for charitable purposes. For revenue, those centres rely heavily on donations and fundraising activities.

Since the introduction of social distancing measures approximately 250 charitable retail stores have been forced to close nationally. In addition, mental health community training programs,

bookfairs, community fundraising activities and corporate events have been cancelled or postponed.

The magnitude of the impact can be illustrated by some key examples:

- For many Lifeline centres, retail contributes approximately 85% of total revenue. The effect of the abrupt and indefinite closure of stores nationally was a devastating blow.
- The cancellation of a single bookfair can result in a loss of income of approximately \$150k, equating for some centres to 10% of total annual revenue.

In addition to the significant loss in revenue across Lifeline centres, COVID – 19 has brought an increase in costs relating to the ongoing training, recruitment and retention of volunteers within this period and to moving and supporting workers to work from home. Some of the additional costs include:

- The pausing of face-to-face crisis support volunteer training and subsequent migration of training online to smaller virtual groups which are delivered at a higher cost to the centres.
- Greater need to engage and stay connected with volunteers who have paused during this time to ensure retention.
- Greater need for support and supervision of paid staff due to remote working and greater demand and complexity from help seekers.
- Ongoing requirement for greater investment in workforce development e.g. crisis supporter training at a time of financial uncertainty.

The magnitude of the impacts of COVID-19 on Lifeline is perhaps best illustrated by the observation that a number of centres were placed in a position of becoming economically unviable.

In the broad, Lifeline's experience makes it clear that organisations not operating on a fee-for-service basis, but relying on donations and community fundraising activities for revenue, experience unique and potentially devastating challenges in the COVID-19 context. Specifically, in addition to the practical challenges associated with migrating service online faced by all service providers during COVID-19, NFPs face simultaneous significant challenges on the revenue side.

Protective factors

Government and community responses have safeguarded Lifeline's ability to provide service and ensure the ongoing viability of centres during COVID-19.

Government responses include:

- *Recognition of Lifeline as an essential service.*
- *Introduction of the JobKeeper payment scheme.* This initiative was welcomed by Lifeline Centres nationally. Lifeline acknowledges and commends the decision to lower the JobKeeper payment eligibility threshold for charities to 15% decline in turnover and the more recent confirmation allowing charities to elect to exclude government revenue from the JobKeeper turnover test.
- *Timely injection of funds by Federal and State/Territory Governments:* Recognition by various tiers of Government of the central importance of mental health and suicide

prevention, as embodied by a funding injection has been welcomed by Lifeline. The funding has had a deep impact on capabilities including:

- Allowing our services to continue providing service to the most vulnerable in our community, ensuring no Australian has to face their darkest moments alone during the COVID-19 pandemic.
- Allowing Lifeline to retain and deploy the expertise of highly trained Crisis Supporters, thus helping close the mental health service accessibility gap created by COVID-19.
- Allowing Lifeline to increase capacity to respond to Australians in crisis and ease the burden of unemployment by offering temporary employment opportunities.

Community responses include:

- *Increased interest in becoming a volunteer crisis supporter:* Lifeline Centres have reported an increase in people returning to the phones or becoming a new volunteer.
- *Dedication of current volunteers:* The existing volunteer group have provided greater hours and support to 13 11 14 service by coming in for additional shifts. The concern is that this is not be sustainable over the long-term as people return to work or need to take a break.

Recommendations

1. Funding to ensure service continuity of mental health not-for-profits is critical.

Based on our experience of the challenges and protective factors experienced by not-for-profit businesses, Lifeline Australia endorses the provision of funding to ensure the continuity of essential mental health services during disasters and pandemics.

1.2 Impact of COVID-19 on service provision: A Case Study of DV-Alert

Lifeline is a partner in the National Plan to Reduce Violence Against Women and their Children, delivering the DV-alert program on behalf of the Commonwealth Department of Social Services. DV-alert is a national program that targets prevention of, and early intervention in addressing Domestic and Family Violence (DFV).

DV-alert aims to upskill Australian front line workers in recognising, responding to, and referring within the context of DFV. Frontline workers may choose to complete accredited coursework via self-paced e-Learning online, or alternately may enrol in face to face workshops. Workshops are offered nationally and are delivered by Lifeline Centres within their local community.

DV-alert offers training for front line workers in the core skills required to respond to DFV via a 2-day workshop, and then students can choose to go on and complete a range of specialised courses for frontline workers within specific contexts including:

- Working with women with a disability;
- Working with people from a CALD background;
- Working in contexts where culture and complex forms of violence may intersect;
- Working with refugee communities; and

- Working with people via interpreter.

COVID-19 Impact on DV-alert service provision

In FY20 DV-alert was funded to deliver over 550 face to face workshops nationally. Before the COVID-19 pandemic related shut-down the program was on track to deliver all workshops, and associated benefit to front line workers. The shut-down however precluded face to face workshops and these were ceased in early March.

Students enrolled in future scheduled workshops were advised that courses had been suspended. Students were encouraged to consider self-paced e-Learning online as an option in place of the face to face workshops. DV-alert marketing and website were amended to reflect the changes and to further focus front line workers on the e-Learning option accessible via dvalert.org.au.

DV-alert e-Learning experienced a material uplift in enrolment rates with a doubling of enrolments during the month of March.

Development of virtual DV-alert workshops

Lifeline and the broader DFV sector held concerns regarding the increased risk of DFV during pandemic shut-down conditions. Research has shown that community crisis and natural disasters are linked to increases in DFV. Furthermore, the specific shut-down and isolation arrangements presented increased risk of DFV being unchecked, with reduced opportunity for victims to access external sources of support and assistance. Concomitant factors including job loss, anxiety, increased use of alcohol and disempowerment represent further stressors within this context.

These increased risks highlight the need for ongoing front-line worker capacity building. To meet this need Lifeline is working with our DFV specialist trainers and subject matter expert partners to transition face to face workshop content into a format suitable for virtual delivery. DV-alert Trainers have received specialist training in managing workshop delivery via video platform. Pilot video workshops are scheduled to commence in mid-May 2020.

Impacts on Lifeline Centres

DV-alert is delivered by Lifeline's national network of Centres. Centres are remunerated for each workshop delivered. The cessation of workshop delivery in response to shut-down measures presented a severe financial risk for all Lifeline Centres contracted to deliver DV-alert. Lifeline Centres rely on DV-alert funding and for some Centres this revenue forms a material component of annual revenues. In addition to this risk Lifeline Centres other revenue channels had also been severely impacted with Lifeline retail shops, community fundraising events, book fairs being closed and or cancelled.

Centres were facing the prospect of needing to cut costs by terminating the employment of skilled and experienced DV-alert Trainers. These measures were going to be impactful for the many trainers themselves and would also leave the DV-alert program significantly un-prepared to recommence service delivery once pandemic shut-down provisions were lifted.

The program funder, the Commonwealth Department of Social Services, acknowledged the risks to program viability and agreed to allow budgeted funds to be distributed to DV-alert

training partners, notwithstanding delivery of face to face workshops. This flexible measure has ensured DV-alert will be able to transition to virtual workshop delivery, whilst also supporting the viability of the program through until the post-pandemic period.

“The continuity of funding provided us with sustainability by enabling us to maintain minimal staff levels, covered the expenses that had already been committed through flights, accommodation and venue hire. It reduced the over-all impact which has us better positioned to continue providing DV-alert into the future. We would’ve had to draw on funds that are intended for suicide prevention programs, so the over-all impact would have had created serious risks to our communities.”

Scott Hammond Chief Executive Officer Lifeline Broken Hill

“We are committed to DV-alert and look forward to delivering via virtual workshop soon, but understand that we have a skill and experience gap. The continuity of funding allows us to deliver virtual workshop training into the community providing the team with the opportunity to develop their skills and experience so that when we are delivering DV-alert we are doing so effectively, professionally and meaningfully.”

Lorna MacGregor Chief Executive Officer Lifeline WA

Section 2: The impact of COVID-19 on the Australian public's mental health and suicidality

In shaping the ongoing national response to COVID-19, and thus also writing a playbook for mental health and suicide prevention responses to future pandemics, it is vitally important to recognise the full range of stressors placed, nation-wide, on mental health and suicidality.

In this context it is vitally important to consider the impact of additional life stressors placed on individuals across the pandemic response and recovery timeline, in addition to the impact on service provision. The following section combines scientific literature with Lifeline's experience as Australia's leading national suicide prevention service to provide specific recommendations for supporting the mental health of Australians across the fluctuating disaster response.

2.1 Current arrangements of quarantine and physical isolation

On the 25th March 2020 the Federal Government implemented advice that overnight effectively isolated millions of Australians to their homes.

The impact of such COVID-19 countermeasures on mental health is continuing to be quantified. Recent data from a nationally representative survey (see Liddy, Hanrahan & Bird, 2020) identified that, compared to pre-pandemic levels, Australians experienced increased feelings of despair (2% to 9%), loneliness (6% to 20%) and stress (14% to 29%).

Increased despair is related to suicidality: Appraisals of defeat and/or humiliation from which there is no perceived escape (i.e. the sense of despair and entrapment) have been identified in the IMV model referred to above as key proximal predictors of the emergence of suicidal ideation (O'Connor & Kirtley, 2018).

In keeping with this, there is evidence that deaths by suicide increased during the 1918-19 influenza pandemic across the USA (Wasserman, 1992), and as previously mentioned, among elders during the 2003 severe acute respiratory syndrome (SARS) outbreak in Hong Kong (Cheung et al., 2008).

Of particular relevance in the Australian context, a history of consecutive traumatic community events also plays a damaging role. The long-term psychological impacts of an epidemic *are exacerbated by exposure to traumatic events prior to the outbreak* (Liu et al., 2012).

Alarming, Australia's very recent history of drought and bushfire devastation leaves us particularly vulnerable to negative mental health outcomes in this time of COVID-19.

With that in mind, a national disaster response and recovery framework as it pertains to community mental health and suicidality is required.

Supporting mental health: Learnings from previous health crises

An important finding from the SARS epidemic in Hong Kong was that despite the associated spike in suicides, the population exhibited a remarkable degree of resilience. While sense of wellbeing did show an overall decline, it nonetheless remained *within normative range* (Lau et al., 2008). This was despite high levels of everyday disruption, including physical distancing measures.

A plausible account of those findings is that deeply embedded cultural factors played a protective role. Particularly amongst the aged cohort, a strong emphasis on neighbourhood bonding likely buffered the negative mental health impacts (Lau et al., 2008). That is to say, it is likely that a *strong sense of community connection* afforded protection against the worst impacts of the epidemic on mental health.

Underlying mechanisms

Neuroscience offers insight into the fundamental importance of social connection.

Data has emerged that threats to social connectivity are - in terms of patterns of neural processing - handled similarly to threats to physical survival (Eisenberger & Cole, 2012). Specifically, the threat of social isolation triggers a fight-or-flight response with flow on effects to the immune system that can cumulatively impact upon physical health.

Conversely, strong social connectivity is processed in a similar way to physical safety. For example, empathetic connection has been found to significantly decrease the perception of pain intensity, and was associated with the activation of brain regions implicated in the subjective experience of 'relief' or 'safety' (Eisenberger, 2013; Fauchon et al., 2019).

For an organism to maintain a healthy homeostasis, social connectivity is not only an important but also likely a *necessary* condition.

Limited access to sources of support and social connectivity, combined with restricted access to mental health services, means that people in suicidal crisis may not receive adequate support during periods of physical distancing and quarantine.

Conclusions

With the significant impacts of physical distancing on mental health and suicidality in mind, Lifeline submits that decisive action is required. In addition to countermeasures to protect us from the worst physical impacts of the disease, a coordinated approach to protecting the nation from the mental health impacts during Australia's current and potential ongoing periods of quarantine and isolation must be applied. Lifeline recommends in particular:

Recommendations

1. Implementation of a national communication framework with a clear, nationally coordinated approach to public messaging around mental health.

A clear, nationally coordinated approach to public messaging around mental health is needed to ensure Australians can access mental health support when needed. In times of natural disaster or pandemic, an individual's cognitive capacity is often overwhelmed. Consequently, clear messaging is a vital help-seeking enabler. This is particularly the case in the data-rich

modern digital environment, where information of varying quality is readily available to anyone with a digital device.

In that context, Lifeline Australia recommends a strong emphasis be placed on developing a communications strategy directing help seekers to a single, tailored, crisis support service offering. Such a strategy should reduce cognitive load and provide a clear pathway for people negatively impacted by the disaster or pandemic resulting in better service uptake and improved outcomes. Clear public mental health messaging should focus on fostering social connectivity: A sense of connection is a known protective factor at times of natural disaster or pandemic. In that context, terminology that fosters connection (physical distancing rather than social distancing terminology) is absolutely vital.

Consequently, Lifeline recommends that consistent, universally embedded public messaging to meet the specific challenges associated with COVID-19 requires:

- a) Adoption of basic public health messaging principles in relation to the mental health and suicide prevention context (as per WHO guidelines),*
- b) Evidence-based approach to identifying appropriate individual communication objectives, taking into account stressors and protective factors in regards to mental health in the context of pandemic, and*
- c) Identification of a single or small number of key credible figureheads to deliver the national mental health and suicide prevention message/s.*

2.2 Easing of current restrictions – Implications for suicide prevention

Easing of restrictions will allow a large cohort of Australians to return to a life more closely resembling their pre COVID-19 existence.

Importantly though, such changes will not be equally experienced.

For many the changes will create a divide: Individuals with chronic conditions that make them particularly vulnerable to COVID-19 (Department of Health, 2020) are one example. Already there are reports of individuals with pre-existing medical conditions voluntarily extending their personal stay-at-home measures until a vaccine is developed (Wong & Ferguson, 2020).

This is troubling news, as functional limitations that impact a person's ability to carry out a life considered 'normal' is a significant predictor of suicide (Kaplan et al, 2007). Individuals with chronic conditions who are unable to re-enter society are likely to experience significant difficulties in accessing mental health support without adequate digital provisions.

Further, from an economic perspective, despite easing of restrictions, individuals will feel the impact of COVID-19 for years to come.

Recent estimates suggest that between 14 and 26% of Australian workers are out of work due to the coronavirus shut down, with the impact disproportionately felt by low income workers, young Australians and women (Grattan Institute, 2020). The longer the downturn goes, the more challenging it will be for these individuals to re-enter the workforce. It is of concern that the 2008 economic recession was associated with an increase in suicide rates in the USA

(Reeves et al, 2012), Greece (Kentikelenis et al, 2012), Italy (De Volgi et al, 2012) and England (Barr et al, 2012).

In this context, ensuring that priority groups, as well as the general community, can access appropriate and effective help on an ongoing basis is pivotal to supporting Australians during the easing of pandemic restrictions. Once face-to-face options become a reality again, it is important that firstly, Australians know where to access the mental health support they need, and secondly, that there are a wide range of frontline staff who are trained gatekeepers to support individuals to seek help who have not otherwise done so.

Recommendations

1. Uplifting capacity for universal access to social connectivity and support - with zero barriers to entry.

The recently released draft Productivity Commission Mental Health Report (2019) highlights some of the difficulties faced by consumers when seeking support. Even before the pandemic, pathways into mental health services were challenging to navigate, and those challenges were amplified by the distress, confusion, and generally increased cognitive load associated with crisis.

Based on the evidence, suicidal states are underpinned by neurological and cognitive changes that contribute to deficits in attentional control, decision making, and working memory (Kelip et al, 2013; Richard-Devantoy et al, 2014). Consequently, in suicidal and crisis states the individual's capacity to resolve problems, identify solutions, and seek help from appropriate sources are often highly compromised.

Although in the initial stages of physical distancing there is anecdotal evidence that some hospitals have reported a reduction in patients with mental health symptoms accessing emergency services and mental health professionals (Turner, 2020; Hayne, 2020), this is likely to change. As restrictions on physical distancing and isolation are eased, the social and economic stressors associated with COVID-19 are set to contribute to an influx of demand for mental health services. Now more than ever, Australians need to have access to timely and appropriate mental health care.

To ensure Australians have access to appropriate and accessible mental health care Lifeline offers the following recommendations.

- a) Government financial support for population-wide digital services access: Digital access is an enabler for physical and mental health, as well as education and other services directly relevant to social justice.*
- b) Ongoing Federal and State financial support for helplines to embed safe remote work practices into service provision as a current measure and to future-proof service provision with regards to pandemics and natural disasters.*

2. Commissioning and funding a nationally accessible gatekeeper training for a diverse a group of community leaders and front-line workers to be suicide intervention first responders will enable the shift towards zero suicides.

Gatekeeper training for frontline staff has a strong evidence base to identify and respond to individuals experiencing potential triggers who are at risk of becoming suicidal (Krysinska et al, 2016). A major systematic international review of suicide prevention strategies concluded that gatekeeper education was – in combination with means restriction and general practitioner (GP) education - one of the three most promising interventions for reducing suicide (Mann et al 2005). More recently, dynamic systems modelling has predicted that the most effective intervention in reducing suicide in Australia over the next 10 years from 2015-2025 would be general practitioner (GP) training (6%) (Page et al, 2017).

With that in mind, identifying a wide and diverse group of key touchpoints for gatekeeper training will maximise demographic reach. In the Black Dog Institute's LifeSpan model for example, GPs, specialists, families, and teachers all form part of both a preventative framework and a safety network when individuals within the community are in crisis (Black Dog Institute, 2018). In the current pandemic crisis where estimates suggest at least 1 million Australians will lose their jobs (Bankwest Curtin Economics Centre Research Brief, 2020), additional touchpoints for gatekeeper training could be extended to include frontline staff in the welfare system. Financial instability is a known risk factor for suicidality, and millions of people engaging in the welfare system creates novel opportunities for intervention.

Simultaneously, it is worth noting that current gatekeeper training largely focuses on suicide intervention in a face-to-face context. Since the COVID-19 outbreak physical distancing measures have forced many health services to migrate online, consideration must be given to best practice in the new delivery platforms in the digital environment.

With that in mind, Lifeline submits that:

- a) *In the context of the COVID-19 pandemic, there is the opportunity to upskill frontline staff in the welfare services in gatekeeper training to provide novel opportunities for intervention within a newly unemployed, high-risk cohort of our community.*
- b) *Ensuring gatekeeper training is readily available to those living in remote, rural and regional areas is a priority (National Mental Health Commission, 2018). Gatekeeper training should be nationally accessible, via digital access or through a service provider with an extensive geographic reach.*
- c) *Training for providers of clinical and non-clinical services in identifying and responding to suicide in the online environment, where there are a paucity cues from which to identify potential suicide risk.*
- d) *Collective identification of appropriate and proportionate risk mitigation procedures in relation to delivering services online to at-risk groups.*

3. Ensuring peer advice and support is embedded into new approaches to service delivery.

People with lived experience of crisis and suicide have invaluable knowledge of the needs of people in crisis and are ideally positioned to provide expert advice on the development of appropriate and accessible disaster-proof services. From a rights-based perspective, individuals with experience of mental health issues and suicide need to be recognised as those

who mental health organisations are serving by being involved in service development in relevant and meaningful ways (Ball et al, 2019). Further, lived experience involvement in project planning and design has been found to enhance the design, uptake, and use of services (Leviton et al, 2018; Mann et al, 2018).

In the COVID-19 context where new services are being quickly migrated online, or developed, to meet demand Lifeline recommends:

- a) *The rapid development of lived experience-led, national ‘best practice’ materials regarding migrating mental health and suicide prevention services online, and*
- b) *Wherever possible, incentivising and otherwise supporting the embedding of peer support offerings into the provision of services*

2.3 Occurrence of surges and the potential impact of re-imposition of local restrictions

The psychological stressors associated with ongoing virus surges, emergence of hotspots, and reimposition of restrictions on a rolling and localised basis will likely present unique mental health challenges.

During the initial wave of COVID-19 countermeasures, almost every aspect of daily life - including how we shop, eat, exercise, work and educate - was impacted.

Whilst shocking, the new reality was at least a collective one. Once the full raft of virus counter-measures was in place, a level of certainty was conferred by the simple need to ‘stay home’.

The future state of virus containment measures is qualitatively different in at least two ways: One is that restrictions will be imposed depending on a rolling set of circumstances, effectively heightening uncertainty for individuals as to what the future holds. Two is that those restrictions will likely be locally applied, and as such the protective factor of feeling part of a broad collective will be diminished.

It is of concern that uncertainty stress, compared to general life stress, is more strongly and uniquely associated with suicidal ideation than general life stress (Wu et al, 2018).

Recommendations

In this context, Lifeline recommends the following actions are taken:

1. **Implementation of data collection and sharing strategies to monitor the impact of COVID-19 hotspots on mental health and suicidality across geographic catchments.**

Currently there is a paucity of regionally- and demographically-specific data on Australians’ mental health and suicidality (Law, 2018). This impacts governments’ and service providers’ ability to monitor and efficiently and effectively respond to emerging regional crises. As such, increasing the collection of mental health data is vital by:

- a. *Increasing the frequency of the National Mental Health and Wellbeing Survey to gather information about changes in mental health status over time, and how these relate to factors including disaster and disease hotspots.*
- b. *Providing ongoing support for, and indeed fast-tracking wherever possible, the National Suicide Information Initiative. The Suicide Information Initiative would provide accurate and timely regional and demographic suicide information to assist governments and service providers in improving responsiveness to emerging clusters or sites people use to take their lives (formerly known as suicide hotspots), and more. With regards to the latter, Lifeline already has hard stand telephones in situ so people in distress can quickly access a crisis supporter. Increased sensitivity afforded by the new national system will facilitate Lifeline's ability to rapidly offer appropriate interventions at identified sites.*

2. Development and implementation of a region-specific public communications strategy at emerging COVID-19 hotspots to counteract the impact of fear and uncertainty on individuals' risk of serious mental health conditions and suicidality.

As previously stated, consumers can have difficulties in accessing mental health services that will likely be magnified during the COVID-19 crisis. To assist in fulfilling the recommendation presented in Section 4.2 to uplift capacity for universal access to social connectivity and support the following steps are recommended:

- a. *Roll out of campaigns led by local figureheads to emphasise the importance of social connectivity and identify and promote use of regionally-specific services.*
- b. *Development of a service portal with the capacity to provide clear points of entry to national and regional mental health services, including geographic location, service availability, accessibility, appropriateness, and steps to engage. Such a step would importantly outline the role of digital services in the context of the overall mix of service options, and empower consumers in their mental health care. For example, the Pandemic Response Crisis Coalition in the United States has created a helpline specific portal, but the concept could be extended to both digital and community mental health services (<https://www.covidmentalhealthsupport.org/get-help-now>).*

2.4 Long term recovery

The impact of the COVID-19 pandemic is set to be dynamic and enduring.

Recovery from the COVID-19 pandemic has been compared with natural disasters, such as bushfires, tsunamis or earthquakes. In this context it is likely that psychological responses to COVID-19 will involve a series of phases, reflecting an approximation of the fluctuating emotional highs and lows commonly associated with disasters (see for example Substance Abuse and Mental Health Services Administration, 2020). Those phases can unfold over timeframes measured not in weeks or months but years. For instance, the negative mental

health consequences of the Black Saturday fires were measurable even five years post-disaster (Bryant et al, 2017).

It is for this reason that not only must any long-term pandemic response and recovery framework make provision for suicide prevention offerings, but it must also respond to the fluctuating mental health needs of communities over timeframes that can be measured in years.

Recommendations

2. Development of an inter-agency disaster response and recovery framework as it pertains to mental health and suicide prevention through the various stages of psychosocial response to a pandemic will maximise protective benefits.

Elements would include measures designed to address mental health needs in the immediate aftermath, through to longer term community recovery programs that support connectivity and recognise predictors of suicidality including unemployment and financial stress (Hawton & Haw, 2013). Specific inclusions endorsed by Lifeline Australia are:

- a. The framework should be designed to address the core elements of a successful Community Disaster Relief and Recovery program as it pertains to mental health and suicide prevention. Such a framework should recognise and adapt to the rolling phases of psychological response and thus risk, over a prolonged period of community recovery. There are local and national examples of how this has been implemented in other contexts.*
- b. Such a framework is enabled by a focus at the individual agency level on offerings that address the core elements identified in item (a).*
- c. Development of a framework that enables coordination at the level of State Government of the role of Government, as well as trusted non-profit and for-profit organisations, in delivering against all the core elements.*

References

- Ball, S., Harshfield, A., Carpenter, A., Bertscher, A., & Marjanovic, S. (2019). Patient and public involvement in research: Enabling meaningful contributions. *Patient and Public Involvement in Research: Enabling Meaningful Contributions*.
<https://doi.org/10.7249/rr2678>
- Barr, B., Taylor-Robinson, D., Scott-Samuel, A., McKee, M., & Stuckler, D. (2012). Suicides associated with the 2008–10 economic recession in England: A time-trend analysis. *BMJ*, 345.
- Black Dog Institute. (2018). *Training the community to recognise and respond to suicidality*.
https://www.blackdoginstitute.org.au/docs/default-source/lifespan/lifespan-strategy-summaries-research-summaries/lifespan_training_community_research_summary.pdf?sfvrsn=8
- Bryant, R. A., Gibbs, L., Gallagher, H. C., Pattison, P., Lusher, D., MacDougall, C., Harms, L., Block, K., Sinnott, V., Ireton, G., Richardson, J., & Forbes, D. (2018). Longitudinal study of changing psychological outcomes following the Victorian Black Saturday bushfires. *Australian and New Zealand Journal of Psychiatry*, 52(6), 542–551.
<https://doi.org/10.1177/0004867417714337>
- Cassells, R., Duncan, A., Dockery, M., Kiely, D., & Mavisakalyan, A. (2020). Potential Job Losses in the COVID-19 Pandemic. In *Bankwest Curtin Economics Centre Research Brief*.
https://bcec.edu.au/assets/2020/03/BCEC-COVID19-Brief-2_Potential-Job-losses_FINAL-2.pdf
- Cheung, Y. T., Chau, P. H., & Yip, P. S. F. (2008). A revisit on older adults suicides and Severe Acute Respiratory Syndrome (SARS) epidemic in Hong Kong. *International Journal of Geriatric Psychiatry*, 23, 1231–1238. <https://doi.org/10.1002/gps.2056>
- Coates, B., Cowgill, M., Chen, T., Mackey, W., Mackey, W., Davidson, P., & Holden, R. (2020). *Shutdown: Estimating the COVID-19 employment shock*.
- Connor, R. C. O., & Kirtley, O. (2018). The Integrated Motivational-Volitional Model of Suicidal Behaviour IMV Model of Suicidal Behaviour The Integrated Motivational-Volitional Model of Suicidal Behaviour Suicidal Behaviour Research Laboratory , Institute of Health & Wellbeing , University of . *Philosophical Transactions of The Royal Society B Biological Sciences*, March.
- De Volgi, R., Marmot, M., & Stuckler, D. (2012). Excess suicides and attempted suicides in Italy attributable to the Great Recession. *Journal of Epidemiological Community Health*, 67(4), 378–379. <https://doi.org/10.1136/jech-2012-201607>

- Department of Health. (2018). *Recommendations of the National Survey of Mental Health and Wellbeing 3: Technical advisory group*. <https://www.health.gov.au/sites/default/files/foi-1135-technical-specifications-national-survey-of-mental-health-and-wellbeing.pdf>
- Department of Health. (2020). *Coronavirus (COVID-19) advice for people with chronic health conditions*. Coronavirus (COVID-19) Health Alert. <https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/advice-for-people-at-risk-of-coronavirus-covid-19/coronavirus-covid-19-advice-for-people-with-chronic-health-conditions>
- Eisenberger, N. I. (2013). An empirical review of the neural underpinnings of receiving and giving social support: Implications for health. *Psychosomatic Medicine*, 75(6), 545–556. <https://doi.org/10.1097/PSY.0b013e31829de2e7>
- Eisenberger, N. I., & Cole, S. W. (2012). Social neuroscience and health: Neurophysiological mechanisms linking social ties with physical health. *Nature Neuroscience*, 15(5), 669–674. <https://doi.org/10.1038/nn.3086>
- Fauchon, C., Faillenot, I., Quesada, C., Meunier, D., Chouchou, F., Garcia-Larrea, L., & Peyron, R. (2019). Brain activity sustaining the modulation of pain by empathetic comments. *Nature - Scientific Reports*, 9(1), 1–10. <https://doi.org/10.1038/s41598-019-44879-9>
- Hawryluck, L., Gold, W. L., Robinson, S., Pogorski, S., Galea, S., & Styra, R. (2004). SARS control and psychological effects of quarantine, Toronto, Canada. *Emerging Infectious Diseases*, 10(7), 1206–1212. <https://doi.org/10.3201/eid1007.030703>
- Hawton, K., & Haw, C. (2013). Economic recession and suicide. *BMJ*, 347. <https://doi.org/doi.org/10.1136/bmj.f5612>
- Hayne, J. (2020, May 5). Mental health services are seeing a drop in usage amid coronavirus, despite increased anxiety. *ABC News*. <https://www.abc.net.au/news/2020-04-29/mental-health-coronavirus-impact-beyond-blue/12196922>
- Jeong, H., Yim, H. W., Song, Y. J., Ki, M., Min, J. A., Cho, J., & Chae, J. H. (2016). Mental health status of people isolated due to Middle East Respiratory Syndrome. *Epidemiology and Health*, 38, e2016048. <https://doi.org/10.4178/epih.e2016048>
- Kaplan, M. S., McFarland, B. H., Huguet, N., & Newsom, J. T. (2007). Physical illness, functional limitations, and suicide risk: A population-based study. *American Journal of Orthopsychiatry*, 77(1), 56–60. <https://doi.org/10.1037/0002-9432.77.1.56>
- Kelip, J. G., Gorlyn, M., Russell, M., Oquendo, M. A., Burke, A. K., Harkavy-Friedman, J., & Mann, J. J. (2013). Neuropsychological function and suicidal behavior: Attention control, memory and executive dysfunction in suicide attempt. *Psychological Medicine*, 43(3), 539–551. <https://doi.org/10.1017/S0033291712001419>
- Kentikelenis, A., Karanikolos, M., Papanicolas, I., Basu, S., McKee, M., & Stuckler, D. (2011). Health effects of financial crisis: Omens of a Greek tragedy. *Lancet*, 387, 1457–1458.
- Krysinska, K., Batterham, P. J., Tye, M., Shand, F., Caele, A. L., Cockayne, N., & Christensen, H.

- (2016). Best strategies for reducing the suicide rate in Australia. *Australian and New Zealand Journal of Psychiatry*, 50(2), 115–118.
<https://doi.org/10.1177/0004867415620024>
- Lau, A. L. D., Chi, I., Cummins, R. A., Lee, T. M. C., Chou, K. L., & Chung, L. W. M. (2008). The SARS (Severe Acute Respiratory Syndrome) pandemic in Hong Kong: Effects on the subjective wellbeing of elderly and younger people. *Aging and Mental Health*, 12(6), 746–760. <https://doi.org/10.1080/13607860802380607>
- Levitan, B., Getz, K., Eisenstein, E. L., Goldberg, M., Harker, M., Hesterlee, S., Patrick-Lake, B., Roberts, J. N., & DiMasi, J. (2018). Assessing the Financial Value of Patient Engagement: A Quantitative Approach from CTTI's Patient Groups and Clinical Trials Project. *Therapeutic Innovation and Regulatory Science*, 52(2), 220–229.
<https://doi.org/10.1177/2168479017716715>
- Liddy, M., Hanrahan, C., & Byrd, J. (2020, April 28). How Australians feel about the coronavirus crisis and Scott Morrison's response. *ABC News*. <https://www.abc.net.au/news/2020-04-28/coronavirus-data-feelings-opinions-covid-survey-numbers/12188608>
- Liu, X., Kakade, M., Fuller, C. J., Fan, B., Fang, Y., Kong, J., Guan, Z., & Wu, P. (2012). Depression after exposure to stressful events: Lessons learned from the severe acute respiratory syndrome epidemic. *Comprehensive Psychiatry*, 53(1), 15–23.
<https://doi.org/10.1016/j.comppsy.2011.02.003>
- Mann, C., Chilcott, S., Plumb, K., Brooks, E., & Man, M. S. (2018). Reporting and appraising the context, process and impact of PPI on contributors, researchers and the trial during a randomised controlled trial - the 3d study. *Research Involvement and Engagement*, 4(1), 1–12. <https://doi.org/10.1186/s40900-018-0098-y>
- Mann, J. J., Haas, A., Mehlum, L., & Phillips, M. (2005). Suicide prevention strategies: A systematic review. *JAMA*, 294(16), 2064–2074.
<https://jamanetwork.com/journals/jama/fullarticle/201761>
- Mihashi, M., Otsubo, Y., Yinjuan, X., Nagatomi, K., Hoshiko, M., & Ishitake, T. (2009). Predictive Factors of Psychological Disorder Development During Recovery Following SARS Outbreak. *Health Psychology*, 28(1), 91–100. <https://doi.org/10.1037/a0013674>
- National Mental Health Commission. (2018). *Monitoring mental health and suicide prevention reform: National Report 2018*.
- Page, A., Atkinson, J. A., Heffernan, M., McDonnell, G., & Hickie, I. (2017). A decision-support tool to inform Australian strategies for preventing suicide and suicidal behaviour. *Public Health Research and Practice*, 27(2), 1–7. <https://doi.org/10.17061/phrp2721717>
- Productivity Commission. (2019). *Mental Health Draft Report Vol.2*.
<https://www.pc.gov.au/inquiries/current/mental-health/draft>
- Reeves, A., Stuckler, D., McKee, M., Gunnell, D., Chang, S. Sen, & Basu, S. (2012). Increase in state suicide rates in the USA during economic recession. *The Lancet*, 380(9856), 1813–1814. [https://doi.org/10.1016/S0140-6736\(12\)61910-2](https://doi.org/10.1016/S0140-6736(12)61910-2)

- Richard-Devantoy, S., Berlim, M. T., & Jollant, F. (2014). A meta-analysis of neuropsychological markers of vulnerability to suicidal behavior in mood disorders. *Psychological Medicine*, 44(8), 1663–1673. <https://doi.org/10.1017/S0033291713002304>
- Substance Abuse and Mental Health Services Administration. (2020). *Phases of Disaster. Recovering from Disasters*. <https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster>
- Taylor, M. R., Agho, K. E., Stevens, G. J., & Raphael, B. (2008). Factors influencing psychological distress during a disease epidemic: Data from Australia's first outbreak of equine influenza. *BMC Public Health*, 8, 1–13. <https://doi.org/10.1186/1471-2458-8-347>
- Turner, R. (2020, May 5). How mental health services are adapting to coronavirus restrictions. *ABC News*. <https://www.abc.net.au/news/2020-04-28/how-mental-health-services-adapting-to-coronavirus-restrictions/12189342>
- Wasserman, I. M. (1992). The impact of epidemic, war, prohibition and media on suicide: United States, 1910–1920. *Suicide and Life-Threatening Behavior*, 22, 240–254.
- WHO. (2000). Preventing suicide: A resource for media professionals. *Geneva: World Health Organization*, 18.
- Wong, L., & Ferguson, K. (2020, May 5). COVID-19 lockdown restrictions to continue for family with compromised immunity. *ABC News*. <https://www.abc.net.au/news/2020-04-29/covid-19-lockdown-for-immunocompromised-holmes-family/12196362>
- Wu, D., Yang, T., Rockett, I. R. H., Yu, L., Peng, S., & Jiang, S. (2018). Uncertainty stress, social capital, and suicidal ideation among Chinese medical students: Findings from a 22-university survey. *Journal of Health Psychology*. <https://doi.org/10.1177/1359105318805820>