Talk Suicide Support

Evaluating the outcomes of a community-based suicide prevention model

In partnership with

Suicide Prevention Pathways

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Talk Suicide Support: Evaluating the outcomes of a community-based suicide prevention model

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ACKNOWLEDGMENT OF COUNTRY

In recognising Aboriginal and Torres Strait Islander peoples' spiritual and cultural connection to Country and in continuing ACU's commitment to Reconciliation, the authors acknowledge the First Peoples and the Traditional Owners and custodians of the Country where ACU campuses are located.

We respectfully acknowledge Elders past and present and remember that they have passed on their wisdom to us in various ways. Let us hold this in trust as we work and serve our communities.

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1. Executive summary

Guided by lived experience, Suicide Prevention Pathways (SPP), Talk Suicide Support (TSS) service delivers a non-clinical, community-based outreach model of care focused on safety, self-awareness, and capacity building. TSS is a free self-referral service available to individuals contemplating suicide, and families and friends of those at risk of suicide. TSS provides outreach throughout South East Queensland to people aged 15 years and over and extends its geographical reach through telephone and digital platforms. SPP accepts referrals from all channels, including individual self-referral, hospitals and other health and community-based services.[1]

This evaluation set out to examine the SPP's TSS effectiveness in achieving its short- and longer-term goals to help participants prevent suicide by enhancing their self-awareness and increasing their resilience to manage future crises. It also examined the key principles of the service model as operationalised by the service staff.

AIMS OF THE EVALUATION

1. Determine if the support SPP provides to clients through their TSS Service has a positive impact on those who engage
2. Determine if the TSS model helps those who engage stay safe through increasing knowledge, self-awareness, and resilience
3. Identify both gaps and strengths of the model, and provide recommendations for future service development that will enhance the service delivery model
4. Build an evidence base demonstrating the model's effectiveness to inform the sector on best practices in suicide prevention support.

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FINDINGS

SPP is unique among existing suicide prevention services within Queensland.

This evaluation found that the TSS model offers people experiencing suicidality an effective non-clinical, community-based, flexible service that supports them in planning for increased mental wellbeing and suicide prevention, driven by the values of compassion, non-judgement and 'vicarious resilience'.

TSS has several strengths in providing effective suicide prevention support. TSS has:

- **A high level of satisfaction amongst service users.** Overall, clients feel their needs are being met, feel more equipped to manage future issues and seek assistance from the service.
- **Referrers who are satisfied with the support that TSS provides to their clients.** The referrers find TSS easy to refer to and a valuable service for their clients. They appreciate the comprehensive safety planning, collaborative approach to care, and free-to-access nature of the service: filling a gap in service for people who experience suicidality.
- **A non-clinical setting, allowing for client-centric comprehensive safety planning.** Current and past clients find planning for suicide prevention helpful during and after periods of risk. Safety planning is comprehensive, connecting clients with community supports.
- **A culture and practice that supports staff wellbeing, which in turn helps them engage meaningfully with clients.** Staff operationalise a shared and clear understanding of the TSS model and feel supported to use professional discretion during the safety planning process.
- **Funding that does not drive service principles or set restrictions on the model.** While funding is secured annually through philanthropic streams, this allows for a service model that is responsive and flexible to client needs.[2]

RECOMMENDATIONS

While in general, the findings of this evaluation highlight the strengths of the TSS service, there are some recommendations embedded in this report, which indicate further areas of development for SPP. These recommendations centre on who is accessing the service, with potential to expand to broader populations, as well as what data is collected to evidence the program.

2. Background

Suicide is a multifaceted issue that often results from complex social, psychological, and biological factors.[3] Suicide is one of the most preventable public health issues in Australia and around the world. It remains the leading cause of death for Australians aged between 14 and 44 years and the leading cause of premature death in Australia. In 2019, 3,318 men, women, youth, and children died by suicide, an average of nine lives lost each day in Australia. Moreover, for every life lost, over 65,000 Australians attempt to end their life. It is important to remember that each suicide statistic represents a person with a family and a community grieving for their loss.[4]

2.1. Suicide in Australia

According to Suicide Prevention Australia (SPA), some of the social determinants of an increased risk of suicide include social isolation and loneliness, unemployment and job security, family and relationship breakdowns, the cost of living and personal debt, housing access and affordability, alcohol, and other drugs, ageing and retirement, environment and climate change, gender roles, health and fitness and new technology and social change.[5] These issues must be addressed through suicide prevention activities.

Males are three to four times more likely to die by suicide than females. However, females are more likely to attempt suicide or be hospitalised for intentional self-harm than males. Furthermore, suicide occurs more often in Australia's Aboriginal and Torres Strait Islander populations than in non-Indigenous populations. This has been linked to ongoing interconnected issues of cultural dislocation, trauma, disadvantage, racism, exclusion, and alienation that impact Aboriginal and Torres Strait Islander peoples.[6] Further to this, Australia's population of Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ+) people are also at an increased risk of suicide than the rest of the population. This has been linked with minority stress, stigma, violence and abuse, and structural and systemic inequalities that LGBTIQ+ people face. It should also be noted here that sexual orientation is often omitted from key suicide data collection activities, resulting in inaccurate reporting of LGBTIQ+ deaths by suicide in Australia. This, in turn, impacts LGBTIQ+ inclusion in mental health and suicide prevention policies and programs.[7]

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There has been a significant increase in help-seeking by people experiencing psychological distress in Australia during the COVID-19 pandemic.[8] A broader population of Australians have also experienced social determinants of suicide – job loss, financial instability, and social isolation – impacting services that aim to prevent suicide. Despite this, there was no increase in suspected suicide deaths in 2020.[9]

Looking more closely at suicide in Queensland through the Suicide in Queensland Annual Report 2020, suicide is a significant issue. In 2018, Queensland accounted for a quarter of all suicide deaths in Australia. A considerable majority of suspected suicide deaths were males (75.3%), and suicide deaths were most frequently reported in males aged 40-49 and women aged 45-49. Approximately 20% of those who died by suicide in Queensland were Aboriginal and Torres Strait Islanders. Over half of those who died by suicide in Queensland reportedly had a diagnosed mental health condition. Many people experience the social determinants of suicide, including being unemployed, facing financial difficulties or facing a relationship separation.[10] This highlights that some specific target populations require suicide prevention support in Queensland.

2.2. Approaches to suicide prevention

Suicide rates in Australia have increased over the last decade, leading to the significant challenge of ensuring that effective suicide prevention services and activities are employed to reduce the number of lives lost to suicide. Extensive efforts have been made across the suicide prevention sector to implement initiatives, policies, and programs to prevent and respond to suicide, to expand our knowledge of suicide, to meet the needs of those experiencing suicidal distress or crisis, to change the impact of social determinants of suicide and raise awareness of suicide in the community.[11]

The demand for suicide prevention services has increased over the past 12 months, and the sector has had to adapt to the changing landscape of the world. This includes changing service capacity, adapting to online technologies, especially in the realm of COVID-19 and lockdowns, and developing new services. Several key population groups require further support for suicide prevention, including Aboriginal and Torres Strait Islander peoples, Culturally and Linguistically Diverse (CALD) communities and LGBTIQ+ communities. The suicide prevention sector must adapt to the needs of these priority groups to reduce the number of lives lost to suicide.[12]

Evidence-based suicide prevention requires a systems approach to reduce the impact of suicide. According to the Black Dog Institute's paper on evidence-based systems approaches to suicide prevention, nine strategies should be implemented simultaneously, reducing suicidal behaviour. These include: aftercare and crisis care; psychosocial and pharmacotherapy treatments; GP capacity building and support; frontline staff and gatekeeper training; school programs; community campaigns; media guidelines; and means restriction.[13]

The World Health Organization (WHO) is a major advocate for countries to take action to prevent suicide through national suicide prevention strategies. The WHO Live Life Suicide Prevention Guide outlines the key effective interventions and

strategies that all countries should use to reduce the number of lives lost to suicide.[14] This document guides many of Australia's suicide prevention services, strategies, policies, and plans.

CONSIDERATIONS FOR SPECIFIC POPULATIONS

While this report does not focus specifically on culturally responsive and inclusive suicide support services, suicide prevention services must understand how to best support culturally and sexually diverse people. These populations have been highlighted as priority populations in the suicide prevention space.

Suicide support services must acknowledge and understand the cultural differences in communication, understanding of health and how Indigenous peoples interact with support services to provide effective and appropriate support. Some Indigenous people will not discuss personal issues with a non-Indigenous person or a person of the opposite gender. Thus, suicide prevention services should ensure that Indigenous people of both genders and culturally competent staff are employed to develop culturally safe and appropriate services. Furthermore, coordinated services must be provided to combat the range of social issues that impact Australia's Indigenous peoples and the location and cultural context of service delivery must be considered.[15] Suicide prevention in Indigenous communities should be structured on the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, which outlines the goals and actions required to reduce the rates and impact of suicide in Aboriginal and Torres Strait Islander peoples.[16]

Australia has one of the largest multicultural populations of the world. For CALD communities, suicide prevention data collection is often inconsistent and unreliable. Stigma plays a huge role in these reporting inconsistencies, which results in some suicides being reported as unintentional or accidental deaths.[17] Many CALD people do not seek support for their mental health. Often, information for CALD people is unavailable in their language, or there is no culturally appropriate service. However, people from CALD backgrounds are a priority population for suicide prevention in Australia and suicide prevention services and activities must understand the unique identities and understandings of mental health and suicide that many CALD people have to effectively reduce suicidal behaviour in this population.[18]

Further to our Indigenous and CALD communities, suicide prevention services must remain responsive to LGBTIQ+ people, who are another priority population at an increased risk of suicidal behaviour in Australia. When people die, their sexual orientation is rarely recorded in Australia, which leads to underreporting of LGBTIQ+ suicidal behaviour.[19] LGBTIQ+ people are at a much higher risk of suicide than the general population, due to the impacts of stress, stigma, violence, and abuse, coupled with structural and systemic inequalities that LGBTIQ+ people experience. As a result of the National Suicide Prevention Trial, some recommendations for suicide prevention services were developed to better support LGBTIQ+ people. This includes providing ongoing funding for suicide prevention coordinator roles and developing and embedding an LGBTIQ+ lived experience workforce.[20]

A review of community-based suicide prevention services in Queensland was undertaken for this study. The full review is available in Appendix B. This section of the report will outline some of these suicide prevention services specific to Queensland and highlight the suicide prevention plans, initiatives and strategies in the broader Australian context. A summary of the findings is given in 2.6 at the end of this chapter.

2.3. Talk Suicide Support service

Guided by lived experience, SPP's TSS service delivers a non-clinical, community-based outreach model of care focused on safety, self-awareness, and capacity building. TSS is a free self-referral service available to individuals contemplating suicide and families and friends of those at risk of suicide. TSS provides outreach throughout South East Queensland to people aged 15 years and over and extends its geographical reach through telephone and digital platforms. SPP accepts referrals from all channels, including individual self-referral, hospitals and other health and community-based services.[21]

The primary goal of the TSS service is to fill a gap between crisis response, clinical and brief interventions. Its outreach model of care focuses on safety, individual needs and strengths and building capacity, working with people to forge resilience to manage their suicidality and foster hope for their future. After appropriate safety planning, the service's primary goal is to begin people on their journey of self-awareness and resilience so that they leave the service with the goal of commitment to continue their own personal development.[22]

The key activities of the service involve support coaches guiding and encouraging service users to develop internal awareness and skills to manage suicidal thoughts and future challenges. The service activities aim to increase service users' resilience and hope by developing self-awareness and fostering stronger community linkages.

THE TSS OUTREACH MODEL OF CARE

SPP seeks to collaborate with other healthcare professionals and organisations to provide integrated rather than isolated support. SPP works with clinical and other community-based services, including GPs, psychologists, psychiatrists, community health workers, and other community support organisations to create wrap-around support for individuals within their communities.[23]

The primary goals of the TSS outreach model of care are to:

- Fill a service delivery gap between crisis response, clinical interventions and brief interventions focused on de-escalating the immediate crisis
- Improve the short-term wellbeing of participants previously at risk of suicide and enhance their self-awareness of their suicide signs and symptoms
- Be effective in achieving the longer-term goals of increasing participants' hope for their future and engagement in life and providing them with the tools to build resilience to manage future crises
- Be effective in reducing the participants' number of hospital visits.

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FLOWCHART 2.1

SPP TALK SUICIDE ACCESS AND SUPPORT PATHWAY

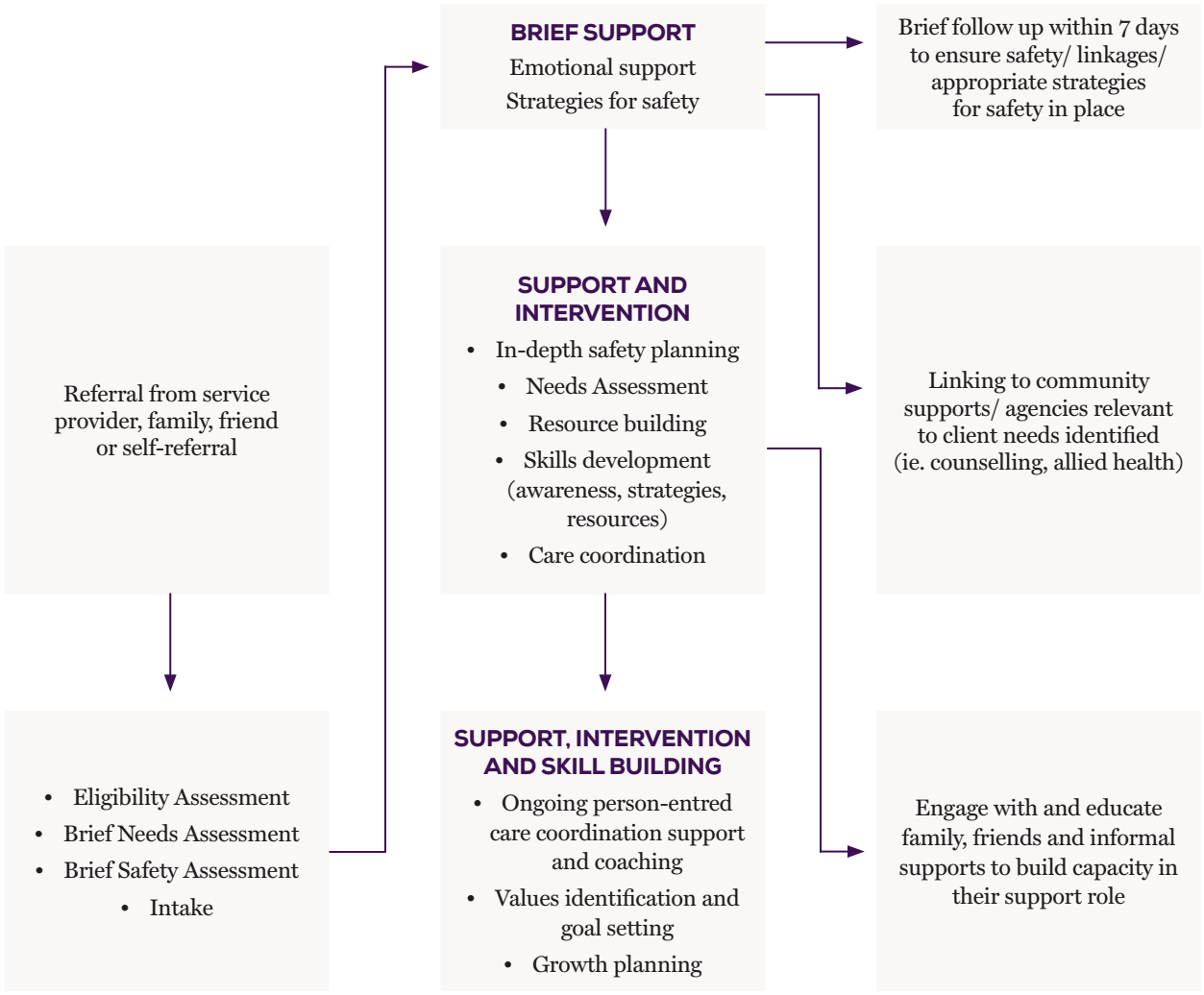

Image provided by Unsplash/ Joshua Lanzarini.

2.4. SPP – TSS service program logic

The TSS service has several intended program outcomes for service users outlined in the program logic (Appendix A), which was previously developed by the service. The key service activities of intake, coaching and linking and referral to other community supports aim to deliver the following outcomes for service users to address their suicidality:

- Reduced psychological distress
- Reduced distress, suicidal thinking and behaviour
- Reduced hopelessness and worthlessness
- Increased understanding and awareness of suicide and self
- Improved strategies for safety, self-care, and resilience

2.5. Evaluating the TSS service

Amongst community-based suicide prevention services in Brisbane that provide face-to-face support, SPP is unique in various ways. SPP appears to be one of the only suicide-specific prevention services offering face-to-face support that focuses on suicide prevention (supporting those contemplating suicide prior to an attempt, aftercare and ongoing support) rather than primarily aftercare (following an attempt) or postvention. SPP targets people at risk of or contemplating suicide.

SPP's service offering is also unique in its targeted length and scope of intervention. SPP provides brief to longer-term intervention, depending on individual needs, and coordinates a 'wrap-around continuum of care response' for individuals they work with and link them back to their support networks.[24] While there are many services available that provide short-term crisis intervention either via phone or online chat (Lifeline, Suicide Call Back Service, Beyond Blue Support Service) or in-person by Acute Care (or crisis assessment) teams, there are fewer support services in the Brisbane region that offer face-to-face suicide prevention interventions beyond the short-term.

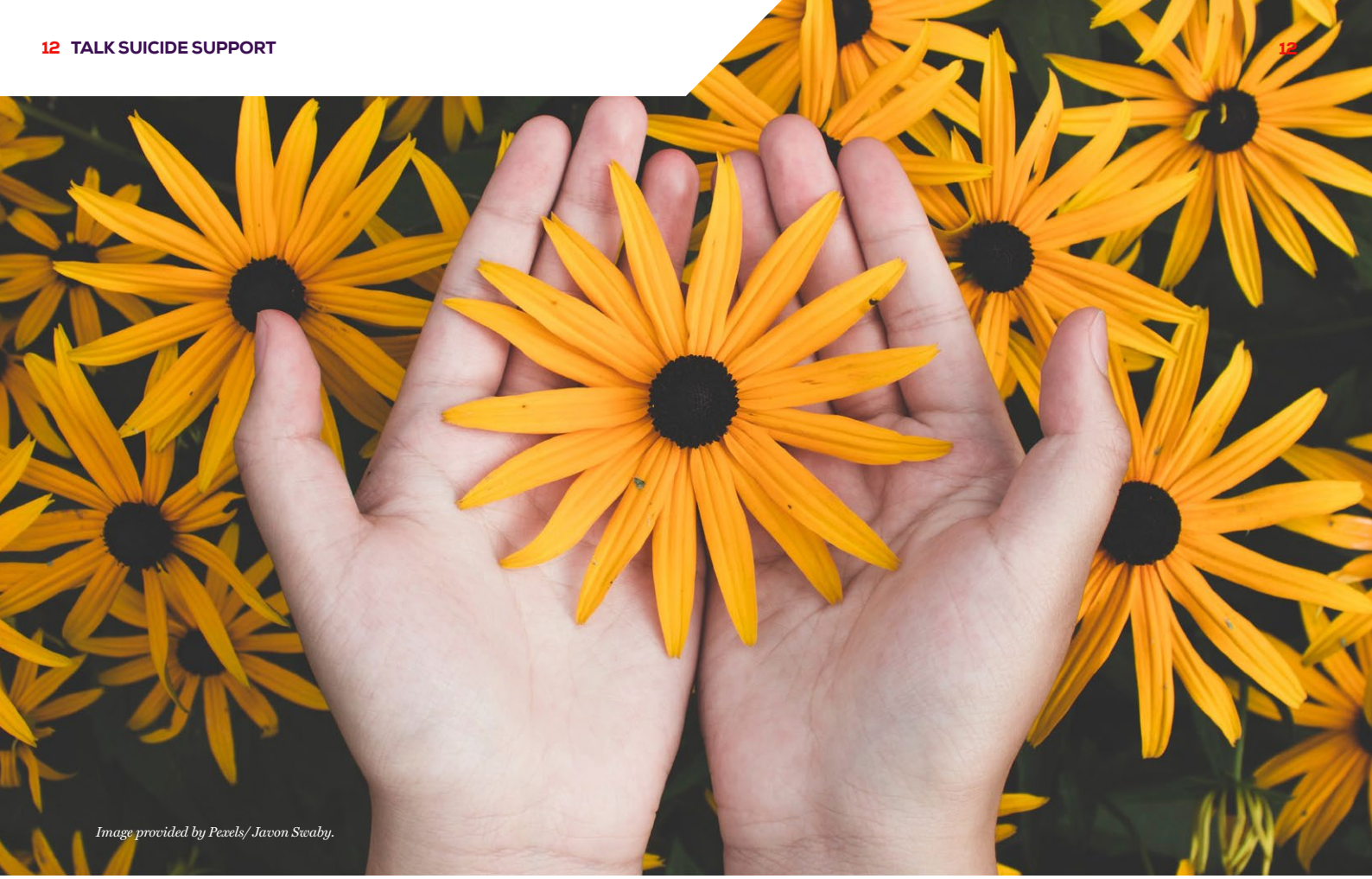

Image provided by Pexels/ Javon Swaby.

- Increased connectedness, participation, and wellbeing.

While SPP collected pre- and post-intervention service use data, no formal evaluation had previously been undertaken to measure the effectiveness of the TSS Service and model.

This evaluation aimed to demonstrate the TSS Service's effectiveness in achieving its short and longer-term goals to help service users prevent suicide by enhancing their self-awareness and increasing their resilience to manage future crises.

Specifically, this evaluation sought to:

1. Determine if the support SPP provides to clients through their TSS Service has a positive impact on those who engage
2. Determine if the TSS model helps those who engage stay safe through increasing knowledge, self-awareness, and resilience
3. Identify both gaps and strengths of the model, and provide recommendations for future service development that will enhance the service delivery model
4. Build an evidence base demonstrating the model's effectiveness to inform the sector on best practices in suicide prevention support.

EVALUATION DATA SETS AND SOURCES

The evaluation utilised several data sources, with some existing data collected by SPP and new data generated by ACU with SPP. A combination of qualitative and quantitative data was collected and analysed during the evaluation. The data sets and sources were:

- Existing data collected by SPP at the service entry and exit
- Client satisfaction, an existing data set generated by SPP
- SPP collected referrer feedback with ACU during the evaluation period
- Past client surveys and interviews completed by ACU with SPP
- ACU conducted staff interviews with SPP.

Each section of the report highlights the source of the data analysed, formats and specific procedures.

SERVICE MAPPING REVIEW

In addition to the evaluation data, ACU conducted a service mapping review to ascertain the TSS model's distinctiveness. For a consistent approach, the review focused on retrieving information from two primary sources, Queensland-based member organisations of SPA and organisations and services commissioned by Brisbane's two Primary Health Networks (PHNs).

2.6. Key findings and recommendations from reviewing Suicide Prevention Support services

In summary, the key findings from the service and literature review are:

- National and state government reform has been underway since 2021 for the national mental health and suicide prevention system in Australia and is focused on early intervention and on developing integrated, better-coordinated whole-of-government and whole-of-community responses.
- Following the example of numerous community-based services, there is an increasing move to include people with lived experience of suicide in the planning and delivery of government suicide prevention and postvention services.
- There is increased state and federal policy and service investment for vulnerable populations, in particular Aboriginal and Torres Strait Islander communities, to prevent suicide and provide greater postvention support.
- A large proportion of Queensland-based Suicide Prevention Australia member organisations focus instead on community awareness-raising through the provision of training for community members and professionals and the collation of online resources and service contacts, rather than direct intervention.
- While suicide-prevention-specific support is needed as distinct from mental health support, there are few Brisbane-based suicide-prevention-specific organisations that provide a direct intervention service to individuals contemplating suicide other than SPP.
- SPP is unique among existing suicide prevention services within Queensland in providing a direct intervention service to all persons aged 15 and above (rather than being cohort-specific or needing to meet other criteria); in being a suicide prevention-focused organisation that provides intervention to individuals contemplating suicide (as opposed to primarily aftercare); in providing wrap-around support that is not time-limited (rather than being funded to provide support within specific timeframes); in offering face-to-face outreach (in addition to telephone or online support); and in accepting referrals from all pathways (rather than only from hospitals or health care professionals).
- SPP is one of the only purely philanthropically-funded suicide prevention services that operate in the South East Queensland region. Findings indicate that they are one of the only purely philanthropically-funded suicide prevention services operating in Australia.
- It would benefit further service evaluations and local efforts to plan a coordinated suicide prevention service response if clear definitions or shared understandings of 'situational distress,' 'suicidal distress' and 'suicidal crises' were provided, with clear inclusion and exclusion criteria for each point of intervention.

TABLE 2.1

MAPPING TSS AND OTHER QLD BASED SUICIDE PREVENTION SERVICES

SERVICE ACTIVITIES	TALK SUICIDE SUPPORT – SUICIDE PREVENTION PATHWAYS	NORTHERN GC SUICIDE PREVENTION – WESLEY MISSION	WAY BACK/ BEYOND BLUE/ WESLEY MISSION
REFERRAL	Accepts referrals from all pathways	GPs and organisations only	Hospital after suicide or suicide crisis presentation
MODALITY	Online, telephone and face to face	Online, telephone or face to face	Face to face
AGE RANGE	15 and over	18 and over	15 and over
TIMEFRAME FOR SUPPORT	No fixed timeframe	6 weeks	12 weeks
REFERRAL POINT	Suicide prevention via wrap-around community linkage and individual support	At point of situational distress, coaching and practical support/ linkage	At point of crisis – for those who have presented to hospital with suicide attempt/intent
OTHER ELIGIBILITY	South East Queensland but extended due to online, telephone contact	For people living in the northern Gold Coast region	Geographical boundaries depending on gazetted hospital

3. Outcome evaluation: Data collected by SPP

The following section of this report outlines findings from three sources of data collected by SPP, which are mapped to the expected program outcomes below:

- Client Satisfaction Survey (CSS)
- Client Pre- and Post-Outcomes Survey (The SPP Support Progress Tool – OS) and
- Survey of the Referral Network of SPP/TSS.[25]

Though the focus is on program outcomes, there are implications for service delivery in the data set and subsequent reporting. This section of the report outlines the findings from each source and a set of recommendations, with implications for future data collection and broader service delivery. Table 3.1 maps Outcomes Survey Questions against responses from the Client Satisfaction Survey.

3.1. Client satisfaction

Findings from the CSS indicate that SPP clients have a high level of satisfaction with the services rendered by TSS.

The Client Satisfaction Survey (Appendix C) is administered via the online Survey Monkey platform by SPP. It poses ten fixed and open text questions to clients at the end of their service journey with TSS, along with a unique code to differentiate respondents. Questions range from the client's level of satisfaction with service delivery, the client's needs, expectations, and whether the client would feel equipped at the point of exit to self-manage future issues related to suicidality.

The data that is included in this report was collected from August 2018 to April 2021. Thirty-four responses were collected; however, two have been omitted as the code entered is void.[26] Twenty-eight surveys were completed in full, and therefore responses are reported in percentages. The response rate for this survey cannot be calculated as the number of clients it was sent to is unknown.

A summary of the findings from the CSS can be found in Table 3.2, SPP Client Satisfaction Survey summary.

Overall, findings from the CSS indicate that SPP clients have a high level of satisfaction with the services rendered by TSS.

Clients felt that they gained problem-solving skills during their engagement with the service. 97% of respondents stated that the service 'helped' or 'helped a lot' in their effectiveness in problem-solving. Key aspects of the service delivery were identified in open text responses. The service offers authentic engagement in a non-clinical context:

> *'The personable human-to-human connection was critical. This service wasn't focused on the systemic psychologically structured therapy being peddled by 10,000 psychology Uni graduates every year – this was a real and candid discussion between two people with like life experiences who could mutually benefit from such an engagement.'*

Image provided by Unsplash/ Max Saeling.

The written or planned nature of strategies developed during the engagement with the service was also highlighted by two respondents: 'the majority of what was discussed I already knew but it was very helpful to have it on paper' and 'the safety plan helps me during my dark days'.

The survey is completed with an open text question inviting clients to offer 'other comments'. Twelve respondents offered their comments which were predominantly heartfelt notes of thanks and gratitude to particular workers of the service. An example of these is:

> *'Being connected in with SPP has changed my life for the better. I feel that I am linked in with those crucial services now because of being connected with SPP. I now recognised my emotions for what they are and can respond to my needs well. I do have ongoing suicidal thoughts but I believe that these thoughts, not urges, are well managed. Overall, I couldn't be happier that I was referred to your services. It's not often you get a mental health service that sincerely delivers. I've felt very cared for and understood'.*

Only two of the 12 comments related or contained a suggested service improvement. One client noted that staffing levels of the service required modification so that the frequency of staff contact could be increased: 'more staff to help more often than just once a fortnight.'

From these findings, we can state that there is a high level of satisfaction amongst service users. Overall, they feel their needs are being met, they feel more equipped to manage future issues and feel that they can seek future assistance if needed from the service. These areas of satisfaction all align with the service goals to improve resilience and manage future suicidal distress.

However, it is important to note that there are limited responses to this survey overall. Ways to increase response rates or enable other forms of client feedback mechanisms would be helpful for future program development and evaluation. It is unclear what the response rate relates to as there may be a valid reason such as that clients have not exited from the service in order to complete the satisfaction survey. Another approach to the timing of the survey could be useful, such as a yearly survey of all clients rather than at the point of exit. There is also scope for refinement of the survey questions, as there are currently only two sub-questions that ask what a client felt could be improved or that they found unhelpful. These sub-questions are constructed as open text comments when asking about the client's development of their problem-solving skills and improvements to skill and knowledge building. A stand-alone question that asks clients their suggested improvements in broader areas could assist in further service quality improvement.

3.2. The SPP Support Progress Tool (OS)

The SPP Support Tool outcomes indicate a significant improvement in the severity, frequency, and awareness of suicidal thoughts, behaviours and risks for service users.

Table 3.3 summarises general findings and recommendations from this OS data.

The SPP Support Progress Tool (Appendix D) is administered via the online Survey Monkey platform by SPP. It poses 37 fixed (Likert scaling) and open-text questions, including a unique code to differentiate clients' responses at two points of service engagement – at intake and exit. While there are open-text questions, no narrative text comments are collected.[27] The Support Progress Tool was created by and for SPP and is administered by workers during contact with the client at the service intake and when clients exit the service at a minimum.[28] These two points will be interpreted as pre- and post-interventions for this evaluation.

The data included in this report was collected between October 2018 and April 2021 from over 200 clients of the service.[29] The findings are reported in rounded percentages or weighted averages for numerical scaling questions. The survey remains open as new service users are engaged and existing ones exited at appropriate points of their recovery journey. Exit surveys commenced at the service in April 2019, and a peak of exit data (Exit and Exit without tool being completed) was entered in January 2021 (n=149). For this report, 204 clients pre- and post-questionnaires were matched for comparison, though there were 240 exit surveys completed during this period.

The Intake and Exit survey entries were compared to measure the 'distance travelled' concerning each inquiry area. These areas include but are not limited to the program's expected outcomes. Other questions within the survey relate to the demographics of service users and the nature of the service delivered by SPP (duration and intervention type).

THE DEMOGRAPHICS OF SERVICE USERS

A summary of the user demographics for TSS can be found in Table 3.4, Demographics of Service Users.

For the purposes of this evaluation, service users under the age of 18 were excluded from the data set when analysing outcomes.

SUPPORT SUMMARY

The duration and nature of the support offered by SPP are defined into three categories, 'Brief Support', 'Brief Intervention', and 'Support, Intervention and Education'. These levels of support are further illustrated in Table 3.5, Duration and Nature of Support Offered by SPP.

At exit, 50% of service users engaged in a 'Brief Intervention', defined by SPP as between one and six sessions. There were 34% that selected 'Support, Intervention and Education', which ranged from one to 12 weeks in duration, and 16% had 'Brief Support', which was for 1–2 sessions only. Although there is overlapping of the period of the support, making it difficult to distinguish the exact nature of the support offered, at least half of the service users had a maximum number of six sessions. The least offered service was 'Brief Support' of 1–2 sessions.

SELF-REPORTED SERVICE USER PROGRESS

Though the SPP worker administers the survey tool with the client, the progress noted is self-assessed by the service user.

Themes from the survey tool include: accessing services for suicidal thoughts and/or behaviours, mood and behaviours, suicidal thoughts, behaviours, and self-awareness, and social and participation markers.

Accessing services for suicidal thoughts and/or behaviours

Questions eight through to 12 of the SPP Support Progress Tool ask the service user if they have accessed specific services for suicidal thoughts and/or behaviour for the month prior (four weeks).

Mood and behaviours

Several SPP Support Progress Tool questions request a self-assessment of mood and behaviour using a Likert scale over four weeks prior. The scale ranges from 'All of the Time', 'Most of the Time', 'Some of the Time', 'A Little of the Time' and, 'None of the Time'. While there are no narrative responses that could provide qualifiers or context to service users' self-assessments, there are significant changes service users noted in the areas of sadness, nervousness, hopefulness, and worthiness.

To summarise, the distribution of responses was reversed for all indicators, including restless and fidgety behaviour, worthiness, and feelings of effort, with movement pointing to an apparent reduction of the phenomena experienced by service users at Exit from the service.

Suicidal thoughts, behaviours, and self-awareness

Questions 21 to 27 of the SPP Support Progress Tool specifically focus on the thoughts and nature of suicidal thoughts experienced by service users. The questions use a range of numerical scales from zero to ten, asking service users to describe the experience in the corresponding scaling. Each of the questions 21 to 27 uses different scaling descriptors, as outlined in Table 3.6.

Social and participation markers

Questions 29 to 33 relate to social and community connections and activities during the previous one week for service users.

Contextually, a large proportion of Exit data was collected during the COVID-19 restrictions and could have impacted responses to this question. When asked about face-to-face or online, or telephone social connection, there were slight increases from Intake to Exit, but more markedly for online or phone socialising. However, the responses to this question did not dramatically increase from Intake to Exit overall.

There was, however, an increase in participation in activities when alone in social or recreational settings at Exit. When asked if they went out on their own (to see a movie, have dinner, go shopping, or go to a sports game) at Intake, 37% stated that they did, which increased to 62% at Exit. This finding, again, can be partly related to COVID-19 restrictions. However, when contextualised with others, such as reduced

Image provided by Pexels/ Valeria Boltneva.

suicidality and increased self-awareness, this finding could be related to an increased sense of service users' mental wellbeing.

Overall, the SPP Support Tool outcomes indicate a significant improvement in the severity, frequency, and awareness of suicidal thoughts, behaviours and risks for service users. Table 3.3 summarises general findings and recommendations from this OS data. These themes and findings are also further illustrated in Table 3.6 Self Reported User Progress Findings.

3.3. Survey of Referral Network

Referrers to the TSS service were surveyed by SPP using a series of nine fixed and open-text questions (Appendix E) to determine the referrer's experiences of the effectiveness of the TSS service via a Survey Monkey link. Questions range from information about the referrers, the referrers' level of satisfaction with the service, and whether the referrers believed that their clients had benefited from the TSS service. The data included in this report was gathered between 25 August 2021 and 1 September 2021. There were twelve respondents to the survey[30], all of whom responded in full. Thus, the responses are reported as rounded percentages.

The final question allowed respondents to provide an open-ended answer to the question: 'Is there anything else you would like to share with us?' Of the 12 respondents, five did not provide any further feedback, 17% of respondents reiterated that they would continue to refer their clients to the TSS service. One of these respondents indicated that they would share TSS's details with other organisations. Other responses included gratitude for the service, such as:

'Thank you for your amazing work!'

'Thank you for this very valuable service'.

One respondent praised TSS for their quick response to referrals. Another answer suggested that TSS's support was a great way to complement the work the referrer did with clients with alcohol and other drug (AOD) issues. Furthermore, another respondent reiterated the importance of 'normalising suicidal thoughts' and 'peer support and those who have experienced suicide is extremely important'. Importantly, none of the final written responses suggested the need for service improvement.

These results show that the referrers are satisfied with the support TSS provides to their clients. The referrers find TSS easy to refer to and a valuable service for their clients. They appreciate the comprehensive safety planning, collaborative approach to care, and free-to-access nature of the service. Most of the respondents also agree that TSS fills a gap that exists between other services that support people contemplating suicide. All the respondents agreed that they would recommend the TSS service to other organisations and individuals. It should be noted that the results from this survey represent a small sample of referrers and the survey response rate is not available as part of this analysis. However, the results from this feedback survey align with the TSS service model that strives to fill a gap between crisis response and clinical intervention by providing in-depth safety planning.

Greater detail on these findings can be found in Table 3.7, Referral Network Survey Findings and Discussion.

3.4. Key findings and recommendations from client and referrer feedback

The key findings of SPP collected data from service users via staff, and the referral network indicates that the service successfully supports people with suicidality in a non-clinical setting. In summary:

CLIENT FEEDBACK

- There is a high level of satisfaction amongst service users. Overall, they feel their needs are being met, feel more equipped to manage future issues and seek future assistance from the service. These areas of satisfaction all align with the service goals to improve resilience and manage future suicidal distress.
- Several significant client outcomes can be inferred from the provision of the SPP service, which fulfills the specified program aims and logic. At Exit, service users report increased self-awareness about their suicidal thoughts and behaviours, present less to hospital emergency departments and their GP, and generally experience reduced suicidality.

REFERRER FEEDBACK

- Referrers are overall satisfied with the support that TSS provides to their clients. The referrers find TSS easy to refer to and a valuable service for their clients. They appreciate the comprehensive safety planning, collaborative approach to care, and free-to-access nature of the service. Most respondents also agree that TSS fills a gap between other services that support people contemplating suicide. All the respondents agreed that they would recommend the TSS service to other organisations and individuals.
- Ways to increase response rates or enable other forms of client feedback mechanisms would be helpful for future program development and evaluation.

TABLE 3.1

EXPECTED PROGRAM OUTCOMES MAPPED AGAINST QUESTIONS FROM OUTCOMES SURVEY (OS) & CLIENT SATISFACTION SURVEY (CSS)

EXPECTED PROGRAM OUTCOMES	MAPPED SURVEY QUESTIONS – CSS	MAPPED SURVEY QUESTIONS – OS
REDUCED PSYCHOLOGICAL DISTRESS		Q13-18
REDUCED DISTRESS, SUICIDAL THINKING AND BEHAVIOUR		Q15; Q21-25
REDUCED HOPELESSNESS AND WORTHLESSNESS		Q14; Q19-20
INCREASED AWARENESS AND UNDERSTANDING OF SUICIDE AND SELF	Q8	Q16; Q26-27
INCREASED STRATEGIES FOR SAFETY, SELF-CARE, AND RESILIENCE	Q7; Q8	Q8–12; Q17; Q18; Q28
INCREASED CONNECTEDNESS, PARTICIPATION, AND WELLBEING	Q10	Q6; Q19-20; Q29-35

TABLE 3.2

SPP CLIENT SATISFACTION SURVEY SUMMARY	
SURVEY QUESTIONS	**SURVEY RESPONSES**
HOW WOULD YOU RATE THE QUALITY OF SERVICE YOU HAVE RECEIVED?	Respondents rated the quality of the service as: • 'excellent' (73%) • 'good' (27%) • 'fair' (0%) • 'poor' (0%)
TO WHAT EXTENT HAS OUR PROGRAM MET YOUR NEEDS?	Respondents felt that the service met: • 'most' or 'almost all' of their needs (93%) • 'only a few' needs (7%)
DID THE SUPPORT YOU RECEIVED MEET YOUR EXPECTATIONS?	• The majority (90%) of clients felt that the support the service offered met their expectations • Open text responses also indicated that it was the 'care and support' of service staff that helped meet their service expectations
HOW SATISFIED ARE YOU WITH THE AMOUNT OF HELP YOU RECEIVED?	Respondents felt that they were: • 'mostly' or 'very' satisfied with the amount of help they received (97%) • When a similar question rated satisfaction more generally of the service the respondent received overall, 100% noted that they were 'mostly' or 'very' satisfied
HAVE THE SERVICES YOU RECEIVED HELPED YOU TO DEAL MORE EFFECTIVELY WITH YOUR PROBLEMS?	Respondents felt that, 'yes', the service: • 'helped' or 'helped a great deal' in managing their problems more effectively (97%)
IF YOU WERE TO SEEK HELP AGAIN, WOULD YOU COME BACK TO OUR PROGRAM?	• Respondents were more likely than not to return to TSS if required (97%)
DO YOU FEEL MORE KNOWLEDGEABLE AND EQUIPPED TO MANAGE FUTURE STRESSORS AS A RESULT OF THE SUPPORT PROVIDED BY OUR SERVICE?	• Most respondents noted that they felt more knowledgeable and equipped to manage future stressors due to the service provided by TSS (96%), with only 4% stating that they did 'not really' feel they were
IF A FRIEND WERE IN NEED OF SIMILAR HELP, WOULD YOU RECOMMEND OUR PROGRAM TO HIM OR HER?	• All respondents (100%) would recommend the service to a friend if they too presented with a similar need for help
IN AN OVERALL, GENERAL SENSE, HOW SATISFIED ARE YOU WITH THE SERVICE YOU HAVE RECEIVED?	Respondents felt that they were: • 'mostly' or 'very' satisfied with the service they received (100%)

TABLE 3.3

GENERAL FINDINGS AND RECOMMENDATIONS FROM SPP SUPPORT PROGRESS TOOL	
EXPECTED PROGRAM OUTCOMES	**FINDINGS**
REDUCED PSYCHOLOGICAL DISTRESS	Overall, psychological distress was reduced. At Intake 69% of participants stated they felt sad that nothing could cheer them up which saw a reduction to 15% at Exit. Likewise, there was a reduction in nervousness upon Exit to only 3 % from 31% at Intake for those who initially stated that felt nervus 'all the time'. There were fewer ED and GP presentations. Hospital attendance decreased after participation in TSS. In the four weeks prior to Intake, 34% of service users had attended hospital for suicidality. At Exit, only 9% had. A similar shift was noticeable in presentations to GPs. In the four weeks prior to Intake, 63% participants accessed their GP. At Exit, 29% had.
REDUCED DISTRESS, SUICIDAL THINKING AND BEHAVIOUR	Clients were able to actively addressthoughts of suicide. When comparing Intake and Exit data, there was a noticeable decline in how often participants said they felt suicidal. The average weighted score dropped from 6.5 to 4 (where 0= 'never' and 10= 'always' felt suicidal). At Exit, participants indicated they felt they had more control over their suicidal thoughts. The average weighted score increased from 5.74 to 6.37 (where 0= 'no control' and 10= 'full control'). Additionally, there was a reduction in the number of suicide attempts in the last four weeks (from 21% at Intake to 5% at Exit).
REDUCED HOPELESSNESS AND WORTHLESSNESS	There was a reduction feelings of hopelessness and worthlessness at Exit compared with Intake. At Exit, only 3% still felt hopeless all of the time and 17% most of the time compared with 30% and 39% respectively upon Intake.
INCREASED AWARENESS AND UNDERSTANDING OF SUICIDE AND SELF	Suicidal thoughts were reduced, increased self-awareness developed. At Exit, there was a 20% increase in participants awareness of situations and people that increased their risk of suicide and a 26% increase in having a deeper understanding of their signs of risk.
INCREASED STRATEGIES FOR SAFETY, SELF-CARE AND RESILIENCE	At Exit, there was an increase from 60% to nearly 100% of participants indicating they were aware of healthy coping strategies.
INCREASED CONNECTEDNESS, PARTICIPATION AND WELLBEING	Linkage to community/social participation does not indicate a significant increase. For example, 67% of users socialised away from home at Exit, but almost half were already participating in that way prior to becoming involved in TSS. This question may be better linked to the nature of the support given by SPP. If this is one of the program's aims (as per the Program Logic), look to ways to measure this more accurately or how the program addresses this linkage for clients. The timeframe associated with the questions could be rethought, or attribution to the SPP intervention could be directly questioned.

GENERAL FINDINGS AND RECOMMENDATIONS FROM SPP SUPPORT PROGRESS TOOL CONTINUED	
RECOMMENDATIONS	
CONTENT OF SUPPORT SESSIONS NOT TRACKED	Though the support type is tracked in the survey tool, the content is not. This can be added to the survey to better understand critical aspects of intervention and education that impact service users. Brief Intervention of a maximum of six sessions is the most common nature for service user involvement. Returning service users are not tracked in the survey, so this could be a feature to add to the SPP Progress Tool more explicitly (not just user ID).
FURTHER IMPROVEMENTS TO DATA COLLECTION	The OS could be self-administered for unfiltered feedback using the survey link rather than paper to online transcription, have open text responses to provide context, and use fixed fields for questions such as age to make analysis easier. This can still be used as a progress tool (as it is currently being used) and can improve the capacity to measure program outcomes. While the Progress Support Tool developed by SPP relies on several validated measurement tools, further use of the following validated tools could be incorporated: Kessler Psychological Distress Scale (K10), Suicidal Intent Scale, Adult Hope Scale (AHS), InterSePT Scale for Suicidal Thinking- Plus, the Sheehan-Suicidality Tracking Scale General Health Questionnaire Suicide Scale (GHQ-28 SS).
INVESTIGATE STRATEGIES TO INCREASE ENGAGEMENT WITH AT-RISK POPULATION GROUPS, INCLUDING MEN, ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLE, PEOPLE FROM CALD BACKGROUNDS, AND LGBTIQ+ PEOPLE	Although other services in the area/context have service-specific population and community groups that they serve, a review of inclusiveness strategies could take place to extend the reach of SPP with regards to the below at-risk groups: • Gender: SPP client group is currently female-dominated. SPP could investigate ways to be more inclusive if aiming to service a broader population, or look to specific ways to specifically support men (a noted at-risk group in Queensland) • Cultural diversity: SPP can include more culturally responsive and inclusive language and information on the service website to connect with population groups such as Aboriginal and/or Torres Strait Islander people, and people from CALD backgrounds. SPP could also employ Aboriginal and Torres Strait Islander peoples and culturally responsive staff to develop culturally appropriate services • Sexual and gender diversity: SPP can include more inclusive language and information on the service website to connect with LGBTIQ+ people, and employ LGBTIQ+ staff with lived experience.

Image provided by Unsplash/ Nati Melnychuk.

TABLE 3.4

DEMOGRAPHICS OF SERVICE USERS	
SPT QUESTIONS	**SERVICE USER RESPONSES**
GENDER (AT EXIT)	• Female (69%) • Male (29%) • Transgender (1%) • Other 1% • There was a slight shift in the demographics from pre- and post-data, with a 1% increase in service users identifying as male after initially identifying as transgender • Regarding sexuality and gender identity, a small number of service users (8%) stated they were LGBTIQ+
NATIONALITY AND BACKGROUND	• Aboriginal and/or Torres Strait Islander (3%) • CALD (2%) • Other (2%) • None of the above applies (86%)
AGE	• The ages of service users varied, reflecting the eligibility of service users the program is designed for: from 15 to 68 years of age • The median age of service users was 47 years old
DIAGNOSED MENTAL ILLNESS	• The majority stated they had a diagnosed mental illness (90%) at the point of intake, with a minor increase at exit (91%)

TABLE 3.5

DURATION AND NATURE OF SUPPORT OFFERED BY SPP		
BRIEF SUPPORT	**BRIEF INTERVENTION**	**SUPPORT, INTERVENTION AND EDUCATION**
• 1–2 Sessions • May be phone only • Initial conversation and compassionate support provided • Intake is generally complete	• 1–6 Sessions • Intake (via phone) • Face-to-face caring conversations • Safety planning • Building internal and external resources • Suicide awareness and education • Self-awareness/exploration of perspective • Introduction (in some cases) to values and goal setting • Follow-up phone support	• 1–12 Sessions (though may be longer) • As per Brief Intervention • More in-depth education and skills development to increase resilience and ability to manage future crisis, that is, developing self-agency, self-determination, values identification, and goal setting

TABLE 3.6

SELF REPORTED USER PROGRESS FINDINGS

ACCESSING SERVICES FOR SUICIDAL THOUGHTS AND/OR BEHAVIOURS

INDEPENDENTLY ACCESSING GP SERVICES

- 63% of service users at the point of Intake had accessed a general practitioner the four weeks prior
- 29% of service users had accessed a general practitioner at Exit to the service (a significant decrease from Intake)

HOSPITAL ATTENDANCE

- 34% of service users indicated they had attended a hospital for suicidality in the four weeks before Intake
- 9% of users noted they had attended hospital for suicidality at Exit (a significant decrease from Intake)

HOSPITAL ADMISSION

- Admission rates for the 34% of hospital presentations were 55% at Intake
- Less than half of those who presented to the hospital at Exit (9%) were admitted (47%)

MOOD AND BEHAVIOURS

SADNESS

- At Intake 69% stated they felt sad that nothing could cheer them up, most or all of the time (55% and 14%, respectively); reduced to 15% at Exit, with only 2% stating they felt sad to the point that nothing could cheer them up all of the time and 13% most of the time

NERVOUSNESS

- 31% of service users stated they felt nervous 'all of the time' in the four weeks prior to Intake. However, this was reduced distinctively at Exit to only 3%
- The most common response was that service users felt nervous 'most of the time' (36%) in the four weeks prior to Intake. At Exit, this dropped by 11%, to a total of 25% who indicated they were feeling nervous most of the time

HOPELESSNESS

- There was a significant reduction in service users' feelings of hopelessness at Exit compared to Intake. 30% of service users experienced hopelessness 'all of the time', 39% 'most of the time' and 22% 'Some of the Time' at Intake. 3% still felt hopeless 'all of the time' and 17% 'most of the time' at Exit. Most responses were 'Some of the Time' at 47%, 23% at 'A Little of the Time' and 10% 'None of the Time', which was 2% only at Intake

SUICIDAL THOUGHTS, BEHAVIOURS, AND SELF-AWARENESS

SUICIDAL THOUGHTS

- At Intake and Exit, users were asked to rate how often they felt suicidal on a scale of 0 -10 (0= they 'never' felt suicidal to 10= they 'always' felt suicidal) in the past month
- At Intake, the weighted average score was 6.5, with most responses between 5 through to 10
- This was reduced at Exit, to a weighted average score of 4
- Notably, 10 in the scale (they 'always' felt suicidal) was selected by 13% at Intake, but at Exit this had dropped to 1%

EXTERNAL LOCUS OF CONTROL AND SUICIDAL THOUGHTS

- Users noted a weighted average score of 5.74 to indicate their feelings of control over suicidal thoughts (0= 'no control' to 10= 'full control'). At Exit, this weighted average shifted to 6.37, indicating that service users felt they were more in control of their suicidal thoughts

INTERFERENCE WITH DAILY CHORES AND TASKS

- There was also a reduction in how suicidal thoughts interfered with daily chores and tasks (weighted averages Intake = 5 and Exit = 3)

SUICIDE ATTEMPTS

- At Exit, there was a reduction in the number of suicide attempts in the last four weeks (5% at Exit, compared with 21% at Intake
- 52% had scaled themselves at 0, indicating they had not made or felt the need to make an attempt of suicide in the previous four weeks at Exit
- Weighted averages went from 6.0 at Intake to 2.0 at Exit, signifying a reduction of feelings of closeness to making a suicide attempt

AWARENESS OF SUICIDAL TRIGGERS

- Participants were asked about their awareness of situations or people that increased thoughts of suicide. At Exit, just over half of service users 'Absolutely Agreed' they were aware of these (this was an increase of 20% from Intake)
- Self-awareness of mood, behaviours and suicidal thoughts increased from Intake to Exit with 98% of service users stating that they 'Absolutely' or 'Somewhat' agreed that they had a deeper awareness of their signs of risk. (This shifted 26% from Intake for these two scaled responses)

HEALTHY COPING STRATEGIES AND SAFETY

- Approximately 60% of users 'absolutely' or 'somewhat' agreed, at Intake, that they were 'aware of healthy coping strategies to keep [themselves] safe'
- Almost 100% of users noted awareness of healthy coping strategies at Exit
- 0% of users expressed no awareness of healthy coping strategies at Exit

SOCIAL AND PARTICIPATION MARKERS

FACE-TO-FACE SOCIALISING

- 63% of users stated that they partook in face to face connections or activities during the previous week at Intake
- 78% indicated that they partook in face to face socialising at Exit

ONLINE OR TELEPHONE INTERACTIONS

- 69% of users noted online or phone connections in the week prior to intake
- 85% of users at Exit were engaging in online or phone interactions

SOCIAL ACTIVITIES OUTSIDE OF HOME

- 48% of users participated in social activities outside of home at Intake
- 67% of users socialised away from home at Exit. However, almost half were already participating in this way

TABLE 3.7

REFERRAL NETWORK SURVEY FINDINGS AND DISCUSSION	
REFERRAL NETWORK SURVEY QUESTION	**FINDINGS AND DISCUSSION**
WHICH BEST DESCRIBES THE ORGANISATION YOU WORK FOR?	• Community organisations (92%) • Psychologists (8%)
ON AVERAGE HOW OFTEN DO YOU REFER PEOPLE TO TALK SUICIDE SUPPORT SERVICE?	• Less than once a month (67%) • Once a month (25%) • A few times a week (8%) • This data did not indicate how frequently individual referrers referred people to the service. Therefore it is unclear, whether the psychologist (who made up 8% of the sample size) referred people more or less regularly to TSS than community organisations
HOW EASY IS IT TO REFER TO TALK SUICIDE SUPPORT SERVICE?	• Very easy (67%) • Easy (33%)
HOW WOULD YOU RATE THE SUPPORT THAT TALK SUICIDE PROVIDES YOUR MUTUAL CLIENTS?	• Very valuable (50%) • Extremely valuable (33%) • Unsure (17%). While there is no clear answer as to why this response was selected, this result may indicate that those referrers were provided with no feedback from either the TSS service or their client to be able to give an informed response to this question
WHAT DO YOU SEE AS THE BEST FEATURE OF THE SUPPORT PROVIDED BY TALK SUICIDE SUPPORT SERVICE?	• There was a mixed response to the question: 'What do you see as the best feature of the support provided by TSS service?'. The respondents were able to provide multiple responses to this question, with 41 responses given to the seven answer choices • Comprehensive safety planning (83%) • Free to access nature of the service (50%) • Collaborative approach to care (50%) • Flexibility of the service (42%) • Client skill building (33%) • Non-clinical nature of the service (25%) • Other (17%). Written responses included: 'The quick response to referrals' and 'Everything. The support is excellent and the care for clients is outstanding' • These results reflect the goals and purpose of the TSS service as outlined in their program logic and highlight the importance of the comprehensive safety planning provided by the TSS service
MY CLIENTS APPEAR SATISFIED WITH THE SUPPORT THEY RECEIVE FROM TALK SUICIDE SUPPORT	• Strongly agreed (58%) • Agreed (25%) • Unsure (17%). It is unclear why the referrers were unsure whether their clients were satisfied with the support, they received from TSS. However, this result may indicate that the referrers had not received any feedback from their clients about the efficacy of the service and were unable to provide an informed response to this question
DO YOU BELIEVE THAT TALK SUICIDE SUPPORT FILLS A GAP THAT EXISTS BETWEEN OTHER SERVICES AVAILABLE TO SUPPORT PEOPLE CONTEMPLATING SUICIDE?	• Yes (92%) • Unsure (8%). It is again unclear why the referrer was unsure about this question. This result may indicate that this referrer lacked knowledge about the other services available to support people contemplating suicide or they were not fully aware of the support that TSS provides and whether it does fill a gap
WOULD I RECOMMEND TALK SUICIDE SUPPORT TO OTHER ORGANISATIONS AND INDIVIDUALS?	• Yes (100%). This indicates that TSS service works effectively from the perspective of referrers and that they are satisfied with the service
IS THERE ANYTHING ELSE YOU WOULD LIKE TO SHARE WITH US?	• Indicated they would continue to refer clients to TSS service (17%) • One respondent indicated they would share TSS' details with other organisations

Image provided by Unsplash/ Lilartsy.

4. Past service user experiences

To further explore the experiences of clients of the TSS service, an ACU-initiated survey and interview invitations (an opt-in question in the survey) were sent to former service users via SPP staff.

As the survey asked about engagement with the TSS, SPP staff distributed the secure Qualtrics survey link and Participant Information Sheet to past service users after a brief assessment of the client's exit (e.g. when and under what circumstances the client exited the service to ensure that the survey was appropriate to send). Working with SPP staff, the survey was sent to a small cohort of past clients, along with the Participant Information Sheet, which highlighted support for anyone that the survey questions about past engagement with the SPP may trigger.

Ten respondents completed the survey, and three expressed their interest in interviews. After some attempts to arrange an interview with three potential participants expressing interest, only one past client participated in an interview. All three were contacted using the contact details they provided. However, after two attempts, the two respondents who expressed initial interest were not followed up further.

One interview participant offered rich insights into the experience of working with SPP staff. As this was the sole interview, to offer further anonymity to this participant, data has not been analysed into themes but used to provide further example to questions posed in the survey.

4.1. Survey and interview of past client experiences

The nine-question survey focused on past clients' experiences and feedback of TSS. Open-ended and some fixed-response questions asked what past clients liked, found useful at the time and since their involvement with TSS, and what areas they suggested the service could improve. An opt-in question, with a separate link, was posed at the end of the survey for anyone wanting to express interest in an interview.

The survey was available to past clients from May 2022 to November 2022. One semi-structured interview was completed in July 2022.

POSITIVE EXPERIENCES

Survey respondents and the interview participant (hereby referred to as respondents unless the interview participant is specified) stated that at the core, the staff member they worked with shaped their positive experience of the service, despite the circumstances that brought them to seek assistance from TSS. Respondents offered specific factors or qualities of the staff interaction that made the service experience positive:

Image provided by Unsplash/ Ian Schneider.

'The staff member made me feel at ease. I appreciated being able to openly talk about suicide without judgement. Suggestions to improve my mental state were helpful and tailored to my needs'.

'Excellent practical and individualised suggestions and follow-up support'.

'They listened & were empathetic. Pointed me in the right direction'.

Respondents described that staff helped them to access other services, be aware of their own triggers for suicidal thoughts, reinforced their sense of resilience, and helped them to gain a different perspective on their suicidal thoughts:

'At the point of crisis it gave me something to be looking forward to, it helped me look at my life in a different perspective'.

'I could discuss my concerns and also received great questions that facilitated conversations and reminded me how many important factors I had/could turn to'.

Having one worker was also highlighted as important, so that there was one person that the respondents worked with rather than different workers of the service:

'We don't want to go through that [the circumstances around their suicidality] every other week with a different person. We really don't'.

However, the TSS Safety Plan was mentioned several times in open-text comments. It was regarded as one of the most beneficial aspects of the TSS, along with supportive counselling (which is used to formulate the Safety Plan). Table 4.1 outlines the options respondents could choose from in the survey, which came from earlier findings of SPP-generated data. Respondents were able to select more than one option.

The TSS Safety Plan created with clients offered a tool respondents could also refer to after their involvement ended with the service: 'I still think about suicide yes there's some days I feel like dying but then I put in practices I get my safety plan out which I don't think I'd had a safety plan until I went to SPP'. The Safety Plan was a critical tool for the interview participant who found the process that led to the creation of their plan integral to its usefulness. The interview participant outlined that the planning process included supportive counselling, but more importantly that through multiple sessions, they were able to increase their own self-awareness about what surrounded their suicidal thoughts:

Image provided by Unsplash/ Nathan Dumlao.

> *'It [the Safety Plan] started off with my triggers … not seeing my [family members] and my domestic violence past. They're my main things. So that's what we sat down and we worked on those. We had open and honest discussions about each of those pretty much. And then my warning signs, we put them into place, what I was feeling internally, and how it affected me. I was feeling external thoughts, like behaviours and things I do to notice the things that I'm doing to say, "Oh, you're heading down this track" '.*

The SPP worker's capacity to follow up on previous sessions and discussion points was also noted by respondents as supporting recovery. Several respondents mentioned that this helped focus on any actions from each session with their worker. The interview participant offered a deeper insight into why this element of the model was critical to them:

> *'After each visit, each appointment, they would also send a text, remember this is what we've talked about today. Remember, next time, I'm going to check with you this, this and this. And [the SPP worker] would always check. That's what I liked about it; she was always following up with discussions'.*

Follow-up also featured after exit from the program in the form of a phone call. The interview participant noted that this was unique to SPP as they had been involved with several other services, and none offered this kind of support:

> *'I'm having a follow-up call in [month]. Who does that? No one does that and I think that's wonderful. I think it's three months after you go off out of the thing, they ring you in three months to see how you're going. I think that's awesome…nobody does that'.*

AREAS FOR IMPROVEMENT

There were only two suggestions for consideration by past clients. One client suggested that home visits would improve access while the other suggested that they would have liked if their support coach could have joined them in social activities such as social groups or classes as they relate to their support plans. One of the comments was about being aware of the environment in which the client is met (e.g. reducing background noise).

While the ability of SPP workers to meet clients in public non-clinical spaces was appreciated (parks and cafes were mentioned), the suggestion of a home visit (currently unavailable) was viewed as a way to improve the service further.

There was also one suggestion: SPP could join the client to complete some action tasks on their Safety Plan to assist with anxiety about the new strategy, such as attending a social group or class.

In an open text comment, one former client said they would like to see the service in NSW.

4.2. Key findings and recommendations from past service user experiences

ACU collected data from past service users suggests that SPP offers people experiencing suicidality a relational, consistent model of support, which aligns with the TSS service model.

In summary:

- Past clients found TSS helpful because of the consistent, individualised support and care from the one member of the SPP staff they worked with. Safety Plans (and the planning process itself) allowed past clients to increase their awareness and understanding of their suicidal thoughts and behaviours to increase preventative strategies unique to them. In this way, TSS has long-term benefits for preventing suicide.
- The only suggested improvements from past clients are related to extending the service to include the possibility of home visits and opportunities to work on goals together. However, these suggestions would change the nature of the service concerning the risk to staff and outputs or activities of the TSS. This sits outside the SPP model of care and the service's resource capacity. Referral to other community organisations that offer such services could then be offered.
- A deeper review into the use and impact of safety planning could be further investigated.

TABLE 4.1

RESPONSES TO WHAT WAS FOUND HELPFUL ABOUT TSS BY RESPONDENTS*		
RESPONSE	**%**	**COUNT**
THE REFERRAL PROCESS	3.03%	1
SUPPORTIVE COUNSELLING	18.18%	6
SAFETY PLANNING	18.18%	6
EDUCATION	9.09%	3
FOCUS ON BUILDING MY RESILIENCE	12.12%	4
GOAL SETTING	12.12%	4
MY WORKER	12.12%	4
LINKS TO OTHER SERVICES	9.09%	3
FOCUS ON MY HOPES	6.06%	2
OTHER – PLEASE PROVIDE A FURTHER EXAMPLE	0.00%	0
TOTAL	100%	33

** Client respondents could select multiple options out of the 10 response options provided as listed in Table 4.1*

5. Staff perspectives

There was a decentralised notion of where support could be offered, allowing each client and worker to formulate this as part of their individualised support. The strategies in place helped staff feel well supported in the challenging work they engaged in, where they held the inherent risks of the work in the context of the relationships with their peers and clients.

Given the service's relational emphasis, the SPP staff were invited to participate in interviews to explore their understanding and practice of the TSS model. Their insights give further depth to the description of TSS, as practiced by staff who operationalise the model. Four semi-structured staff interviews were completed from July 2022 to September 2022 over Zoom after an open invitation was sent to SPP staff. Interviews were then transcribed for analysis.

An applied thematic analysis[31] method was used to segment, code and theme the interview transcriptions.

Staff who participated all had a current role with SPP agency at the time of the interview; therefore, demographic or other features of each participant that may identify them, including years of experience in the field or background qualifications, have been omitted from this report to maintain confidentiality.

5.1. Staff understanding of their role

Staff named and described their role at SPP as that of a support coach.

All staff spoke about how they used the coaching relationship to support clients through their experience of suicidality, to increase the client's self-awareness, connection to the community and appropriate professional support. While staff came from different disciplinary backgrounds, they all used this joint approach, framed by the TSS service model, which was consistently understood by all staff participants to be individualised, relationship-based guidance and coaching. The core values of their practice that all staff participants spoke to were compassion, non-judgement, and 'vicarious resilience'[32], meaning that staff felt they gained valuable insights through the professional relationships formed with clients.

Once there was an initial intake assessment, interactions between the staff and client (and their identified community supports, or 'natural supports') centred on developing a bespoke, client-driven Safety Plan. The process, as described by staff, involves:

Image provided by Unsplash/ Priscilla Du Preez.

- Openly discussing the client's suicidal thoughts, beliefs and fears;
- Talking about confidentiality, its limits and the boundaries of the service and worker;
- Explaining the process of safety planning, the service offering and the need to share information;
- Helping clients identify triggers, causes and stressors that increase their suicidality;
- Supporting clients to set goals and incremental actions towards them;
- Assisting clients to identify and link in with their community/broader support network and actively engage with them (with the client's permission); and
- Working at the client's pace rather than being driven to complete any planning based on the service needs – knowing that clients may not need this level of support from SPP.

While all staff described this process in depth, the following staff participant, SI3, explained the significance of sharing the Safety Plan for clients' longer-term resilience:

> *'When we do the safety planning, obviously that's huge we then get the person's consent to share the safety plan with their natural and professional supports. And that's so that when we do step back there is a support system around the person that we're aware of, we've had conversations with, but they also have a copy of that safety plan. And that's so [because] sometimes we know individuals are unable to help themselves when they are in crisis. So having that support system around them of people that can kind of go, "Hey, John, I've noticed A, B, C and D have you looked at your safety plan? Have you tried one, two, three that you've put on your safety plan for coping strategies? Or have you called X, Y, Z?" '*

The Safety Plan was seen as a living document that the client could use past the point of SPP's involvement. However, while the intended outcome was to co-produce this document, there was no fixed point at which this planning needed to occur. In this way, staff felt they could use their professional discretion to introduce planning when the client was ready to take this work on, rather than imposing this process when the client may not be prepared for such a demand. This was viewed as a critical difference between TSS over clinical or other services that had a more fixed or rigid intervention model:

'[It] takes a lot of work to get to the point where you have direct conversations about suicide, what kind of risks people see themselves in, and then also what kind of growth they want to see in themselves. It just doesn't happen like wham, bam.' (SI3)

'We're there to guide and support, but we're not going to pretend to be this, like you must do this, and you must do that.' (SI2)

'No two people are the same and you absolutely cannot just use a flowchart to help both people say, "Well, this is how you're going to make it through this." ' (SI4)

'We absolutely work at the client's pace. And right from the beginning, I say, "As we go along, you might start to get overwhelmed or exhausted, because I know how exhausting it is to be in the headspace that you're in at the moment, so you just tell me if you feel we need to stop, and we'll pick it up at our next appointment. You let me know because that's what we're all about. We work at your pace. I'm not clock-watching at all, there's no time limits, so I want you to feel free to guide me for what's working for you." ' (SI4)

In the meantime, staff stated they spent time developing the client–worker relationship, listening deeply to help clients understand their feelings and thoughts about their suicidality. They also ensured clients knew who to call on for crisis support until such time that Safety Planning became appropriate or required. Yet, this type of referral or risk assessment was completed with the client–worker relationship at its core, not what the service needed from the client:

'I understand they go to the GP, they go to their psychologist, psychiatrist, community healthcare, whatever, and there are boxes to be ticked along the way. I completely understand that, but I feel that our service is so valuable in, we 100% are about holding space for this person. And it doesn't matter if it takes six sessions to fill out the initial intake form. Doesn't matter because to them, someone has 100% been there for them when nobody else has been, or they've had to go through the tick boxes with everyone else, so they feel that they're a number.' (SI4)

'What we're seeing is a whole bunch of boutique-type services for people which actually then means that it's actually more difficult to access services. You actually need to be a very specific pigeonhole type of person to access these services. "Oh, you're drunk? No, you can't go there. Oh, you are pregnant? You can't go there. Oh, you are under 18? You can't go there." All of those, those types of things. What is most important about what SPP does as well is that there isn't a go there […] because I see what SPP does, which is absolutely imperative, is go to where people are.' (SI1)

The flexible, non-clinical setting for the service was seen as a strength by all staff participants. Staff also acknowledged that having the flexibility to choose where to engage with a client in person in a public place rather than a central office facilitated client access to support.

The decision on where to meet happens between the client and their coach to ensure the client feels comfortable in their surroundings. TSS sessions were held in public spaces such as libraries, parks and cafés. A focus of the SPP model includes an attempt to meet people outside in nature, to help individuals connect with their surroundings and find peace within it. Sessions were also held online using video conferencing or by phone. Text messages were also sent as reminders or prompts from sessions to and from clients. Overall, there was a decentralised notion of where support could be offered, allowing each client and worker to formulate this as part of their individualised support.

The TSS model of care was also acknowledged as having the potential to negatively impact them as workers, given the content of their conversations with clients. However, all staff participants spoke about a robust support system supporting their wellbeing within the team, the organisation, and themselves. Strategies included formal group supervision, individual supervision, team meetings, a culture of regular debriefing, and staff openly sharing successes, resources and practice strengths with each other. Staff also noted the part-time nature of their work, which helped them to balance their role supporting people who were experiencing suicidality and the rest of their lives. Several also spoke about a mindfulness approach to their self-care. Overall, the strategies in place helped staff feel well supported in the challenging work they engaged in, where they held the inherent risks of the work in the context of the relationships with their peers and clients.

When asked about ideas for future growth for SPP and the TSS service, all staff participants were grateful for the model that is currently in place, with philanthropic funding viewed to enable their holistic, relational approach to suicide prevention. Staff participants spoke about the risks of particular funding streams, where the nature of the TSS would change to suit a broader objective rather than being flexible to client-need. As staff participants saw them, the potential gains would be to have ongoing funding, but all highlighted that this would not be a worthwhile trade for a change to the current model. One suggestion to counter the risk of particular funding models which were output driven was to partner with other mental health providers to offer support for individual clients, such as through the NDIS, for people experiencing more prolonged suicidality.

Image provided by Unsplash/ Amy Humphries.

5.2. Key findings and recommendations from staff interviews

Interviews with staff suggest that a consistent practice model is operationalised across the TSS, which features a shared set of values and approaches.

In summary:

- Staff identified the flexible, relational coaching model as effective when working with clients of TSS.
- The non-clinical setting and context of their work were identified as a strength of service delivery.
- Staff appreciated that they could be client-centred rather than service-centred or excessively risk-averse when coaching clients through the TSS assessment and safety planning model.
- There is a culture and practice of supporting staff wellbeing, which helps them engage meaningfully with clients.
- While funding was acknowledged as an ongoing concern, maintaining the current model was seen as the priority rather than applying for more secure funding, which could fundamentally shift the service.

6. Conclusion

TSS is an effective suicide prevention service. The TSS model offers people experiencing suicidality a non-clinical, community-based, flexible service that supports them in planning for increased mental wellbeing and suicide prevention.

Several significant client outcomes can be inferred from the provision of the SPP service, which fulfills the specified program aims and logic. There is evidence that the model developed by SPP supports clients to increase their self-awareness about their suicidal thoughts and behaviours, present less often to hospital emergency departments and their GP, and experience reduced suicidality.

The TSS Safety Plan, as a process and tangible outcome developed with clients, successfully guides them and their natural and professional supports for possible experiences of future suicidality.

Several strengths and some areas for development have been identified from this program evaluation. Recommendations are presented in the body of the report for SPP's further consideration to improve the TSS service offering.

TABLE 6.1

SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS	
KEY FINDINGS	
SIGNIFICANT CLIENT OUTCOMES FROM SPP SERVICE, IN DIRECT RESPONSE TO PROGRAM AIMS AND LOGIC	At Exit, service users report increased self-awareness about their suicidal thoughts and behaviours, present less to hospital emergency departments and their GP, and generally experience reduced suicidality.
TSS PROVIDES CLIENTS WITH CONSISTENT, INDIVIDUALISED SUPPORT AND CARE	Safety Plans (and the planning process itself) allowed past clients to gain awareness and understanding of their suicidal thoughts and behaviours to increase preventative strategies unique to them. In this way, TSS has long-term benefits for preventing suicide.
HIGH LEVEL OF SATISFACTION AMONGST SERVICE USERS	Overall, service users feel their needs are being met, feel more equipped to manage future issues and seek future assistance from the service. These areas of satisfaction all align with the service goals to improve resilience and manage future suicidal distress.
EFFECTIVE RELATIONAL COACHING MODEL	Staff identified the flexible, relational coaching model as effective when working with clients of TSS.
CLIENT-CENTRED APPROACH	Staff appreciated that they could be client-centred rather than service-centred or excessively risk averse when coaching clients through the TSS assessment and safety planning model.
NON-CLINICAL SETTING	The non-clinical setting and context of their work were identified as a strength of service delivery by TSS staff.
REFERRERS ARE SATISFIED WITH THE SUPPORT THAT TSS PROVIDES TO THEIR CLIENTS	The referrers find TSS easy to refer to and a valuable service for their clients. They appreciate the comprehensive safety planning, collaborative approach to care, and free-to-access nature of the service. Most respondents also agree that TSS fills a gap between other services that support people contemplating suicide. All the respondents agreed that they would recommend the TSS service to other organisations and individuals.
STAFF WELLBEING	There is a culture and practice supporting staff wellbeing, which helps them engage meaningfully with clients.
PROVIDE HOME VISITS AND COLLABORATE ON GOAL-SETTING	Past clients suggested improvements could be made by extending the service to home visits and providing opportunities to work on goals together. However, it was noted earlier in the report that these past client suggestions would change the nature of the service concerning the risk to staff and outputs or activities of the TSS. TSS does not present itself as a case management or carer service where these suggested activities would align, so other types of services may need a referral for some service users rather than changing the unique support offered by SPP.
RECOMMENDATIONS	
SAFETY PLANNING	A deeper review into the use and impact of safety planning could be further investigated.
MAINTENANCE OF CURRENT FUNDING MODEL	While funding was acknowledged as an ongoing concern, maintaining the current model was seen as the priority rather than applying for more secure funding, which could fundamentally shift the service.
INVESTIGATE STRATEGIES TO INCREASE ENGAGEMENT WITH AT-RISK POPULATION GROUPS	Although other services in the area/context have service-specific population and community groups that they serve, a review of inclusiveness strategies could take place to extend the reach of SPP with regards to the below at-risk groups: • Gender: SPP client group is currently female-dominated. SPP could investigate ways to be more inclusive if aiming to service a broader population, or look to specific ways to specifically support men (a noted at-risk group in Queensland) • Cultural diversity: SPP can include more culturally responsive and inclusive language and information on the service website to connect with population groups such as Aboriginal and/or Torres Strait Islander people, and people from CALD backgrounds. SPP could also employ Aboriginal and Torres Strait Islander peoples and culturally responsive staff to develop culturally appropriate services • Sexual and gender diversity: SPP can include more inclusive language and information on the service website to connect with LGBTIQ+ people, and employ LGBTIQ+ staff with lived experience.

Endnotes

[1] 'Talk Suicide Support Service,' *Suicide Preventions Pathways*, 2021, retrieved 16 April 2021, https://suicidepreventionpathways.org.au/programs/talk-suicide-support-service/.

[2] While this evaluation did not aim to examine funding in depth, staff highlighted that the current funding model has allowed the TSS model to develop as it has. New funding streams would need to consider this.

[3] Kinchin, I., & Doran, C. M. (2018). The Cost of Youth Suicide in Australia. *International Journal of Environmental Research and Public Health*, 15 (672), 1–11.

[4] Australian Institute of Health and Welfare, *Suicide and Self-Harm Monitoring Data*, https://www.aihw.gov.au/suicide-self-harm-monitoring, retrieved 13 September 2021.

[5] Suicide Prevention Australia (2021). *State of the Nation in Suicide Prevention: A Survey of the suicide prevention sector*, https://www.suicidepreventionaust.org/wp-content/uploads/2021/09/State-of-the-Nation-in-Suicide-Prevention-2021-report.pdf, retrieved 14 September 2021.

[6] Australian Institute of Health and Welfare, *Suicide and Self-Harm Monitoring Data*.

[7] Black Dog Institute. (2021). *Suicide prevention for LGBTIQ+ communities: Learnings from the National Suicide Prevention Trial*. https://www.blackdoginstitute.org.au/wp-content/uploads/2021/04/BDI21_Suicide-prevention-for-LGBTIQ-communities.pdf, Retrieved 30 September 2021.

[8] Australian Institute of Health and Welfare, National Suicide and Self-Harm Monitoring System outlined in https://www.abc.net.au/news/2021-07-20/rise-of-self-harm-mental-health-services-covid-pandemic/100305640, retrieved 20 July 2021.

[9] Australian Institute of Health and Welfare, *Suicide and Self-Harm Monitoring Data*.

[10] Leske, S., Adam, G., Schrader, I., Catakovic, A., Weir, B., & Crompton, D. (2020). *Suicide in Queensland: Annual Report 2020*. Brisbane, Queensland, Australia: Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University, https://www.griffith.edu.au/__data/assets/pdf_file/0035/1196855/QSR_Annual_Report_2020.pdf, retrieved 30 September 2021.

[11] Black Dog Institute. *What can be done to decrease suicidal behaviour in Australia? A call to action*. Director, Black Dog Institute White Paper. 1 October, 2020. Sydney, AU: Black Dog Institute.

[12] Suicide Prevention Australia (2021). *State of the Nation in Suicide Prevention: A Survey of the suicide prevention sector*, retrieved 14 September 2021: https://www.suicidepreventionaust.org/wp-content/uploads/2021/09/State-of-the-Nation-in-Suicide-Prevention-2021-report.pdf

[13] Black Dog Institute. (2016). *An evidence-based systems approach to suicide prevention: guidance on planning, commissioning and monitoring*, retrieved 17 September 2021: http://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/an-evidence-based-systems-approach-to-suicide-prevention.pdf?sfvrsn=0

[14] World Health Organization (WHO). (2021). *Live Life: An Implementation Guide for Suicide Prevention in Countries*. Retrieved 28 September 2021, https://www.who.int/publications/i/item/9789240026629

[15] Department of Health and Ageing. (n.d.). *Fact Sheet 16: Suicide prevention in Indigenous communities*. Retrieved 20 September 2021: https://earlytraumagrief.anu.edu.au/files/Suicide-prevention-in-Indigenous-communities.pdf

[16] Department of Health and Ageing. (2013). *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, retrieved 20 September 2021: https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-natsisps-strat-toc/$FILE/National%20Aboriginal%20and%20Torres%20Strait%20Islander%20Suicide%20Prevention%20Strategy%20May%202013.pdf

[17] Suicide Prevention Australia. (2021). *Fact Sheet: Suicidality Among Culturally and Linguistically Diverse Communities*, retrieved 20 September 2021: https://www.suicidepreventionaust.org/wp-content/uploads/2021/06/CALD-Suicide-Prevention-Fact-Sheet.pdf

[18] Life in Mind. (2021). *Culturally and Linguistically Diverse Communities*. Retrieved 21 September 2021: https://lifeinmind.org.au/about-suicide/priority-populations/culturally-and-linguistically-diverse-communities

[19] Skerrett, S. M., Kolves, K., & De Leo, D. (2014). Suicides among lesbian, gay, bisexual, and transgender populations in Australia: An analysis of the Queensland Suicide Register, *Asia-Pacific Psychiatry*, 6, 440–446.

[20] Black Dog Institute. (2021). *Suicide prevention for LGBTIQ+ communities: Learnings from the National Suicide Prevention Trial*. Viewed 30 September 2021: https://www.blackdoginstitute.org.au/wp-content/uploads/2021/04/BDI21_Suicide-prevention-for-LGBTIQ-communities.pdf

[21] 'Talk Suicide Support Service,' *Suicide Prevention Pathways*, 2021, Retrieved 16 April 2021, https://suicidepreventionpathways.org.au/programs/talk-suicide-support-service/.

[22] 'Talk Suicide Support Service', 'Talk Suicide Support Evaluation Plan,' 2020, *Suicide Prevention Pathways* (internal document).

[23] 'Get Help,' *Suicide Prevention Pathways*, 2021, retrieved 16 April 2021, https://suicidepreventionpathways.org.au/get-help/#workers

[24] 'Talk Suicide Support Service,' *Suicide Prevention Pathways*.

[25] This survey was not mapped against the program outcomes as it involved outcomes as perceived by referrers who may not have had ongoing contact post-referral.

[26] The client code entered was 'test' in the two response and it is assumed this is not from a client of SPP.

[27] Open fields were for worker initials, age of service users, number of times a service was accessed and notes from workers if survey was incomplete.

[28] There is a category for Exit without Support Progress and at other points; however as this data was not consistently collected in the sample, only Intake and Exits have been included in the analysis.

[29] Exclusions and full details of respondent numbers are further explained and relate to age of participants which were manually removed from the data set.

[30] Survey response rate not able to be calculated as the survey administration was completed by SPP.

[31] Guest, G., MacQueen, K. M., & Namey, E. E. (2012). *Applied thematic analysis*. SAGE Publications, Inc., https://dx.doi.org/10.4135/9781483384436

[32] A term offered by SI1, describing the reciprocal nature of relational work with clients – as opposed to 'vicarious trauma' when working with people experiencing wide-ranging trauma

Appendix A.
TSS Program Logic

TALK SUICIDE SUPPORT SERVICE PROGRAM LOGIC PREPARED BY SPP				
OUTCOMES	**OUTPUTS**	**ACTIVITIES**	**INPUTS**	**STAKEHOLDERS**
• Reduced psychological distress • Reduced distress, suicidal thinking and behaviour • Reduced hopelessness and worthlessness • Increased awareness and understanding of suicide and self • Increased strategies for safety, self-care and resilience • Increased connectedness, participation and wellbeing	• Referrals received • Intake and brief interventions • Clients provided brief intervention and support • Provided intervention, support and education • Connections made • SPT scores pre/ post	• Provide callback within 24- 48 hours • Provide intake and Brief Risk Suicide Assessment • Provide face to face, online and telephone support • Provide emotional space to reduce pain • Identify and address practical needs through linking • Educate to increase knowledge and awareness of suicide, self and strategies for safety	• Develop MOU's and partnership agreements • Identify referral pathways both in and out • Ensure adequate staff, training and support • Establish linkages with clinicians and HHS • Regular team meetings, case review and staff supervision • Utilise appropriate process and systems for support and data collection	• SPP staff • Clients • Family and friends • GPs and private clinicians • Community referral pathways • Hospital and health services • Local networks • Funders

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Appendix B.
A review of community-based suicide prevention services in Queensland

While community-based suicide prevention organisations have long recognised the need for further investment, the need to bolster Australia's suicide prevention response is increasingly identified as a priority area for governments and the healthcare system at the state and federal levels. While the need for suicide prevention programs to be integrated and multi-modal is recognised, substantial gaps exist in the inclusion of non-clinical community-based programs whose focus extends beyond crisis mitigation and safety planning, toward creating future resilience.

1. Approach, limitations and structure of this review

The following service and literature review aimed to identify and evaluate suicide prevention services currently being offered in Australia, focusing on Queensland services, to determine points of similarity and difference to the TSS model of care. This review responds to the following questions:

- What other organisations and services offer a non-clinical face-to-face suicide prevention model similar to SPP's model?
- How are existing suicide prevention services similar or different to SPP's TSS Service?
- What makes the TSS Service distinct?

It is important to note that the review was undertaken on the basis of information that was available at the time of writing. Some community-based programs or services may no longer be in operation and there may now be newer services which are not featured.

Information regarding current services was retrieved from two primary sources, SPA and the Brisbane-based PHNs. With approximately 115 member organisations, SPA is the national peak body for the Australian suicide prevention sector, supporting the services of their members and acting as a key information channel connecting the sector with government. Members range from small and large organisations, community-based and government-based services, and include institutes and centres that are either connected to universities or privately run, and several private businesses.[1] This review did not include SPA member services that offer programs targeted towards specific cohorts, including military members and veterans, men, Indigenous persons, young people, LGBTIQ+ persons and rural and remote communities, for which there exist numerous SPA members across all states.[2] However, as both national and state-based suicide prevention strategies have been identified, strengthening suicide prevention efforts targeted at these cohorts is crucial (given many are identified as either vulnerable or hard-to-reach populations).

Brisbane North and Brisbane South PHNs and their relevant commissioned services were a second source for the review. Given that they provide a triage point for access to government-funded public mental health services and work with numerous community-based services, they were important sources to consult for the review. PHNs play an integral role in coordinating local suicide prevention services as they are government-funded, have extensive resources

and established networks, and are tasked with overseeing the development of Regional Suicide Prevention Action Plans. Provided in this review is an overview of the suicide prevention work being undertaken by both PHNs (and in some cases, the Gold Coast PHN, also an SPA member), in addition to overviews of some of their commissioned programs.

Programs have been reviewed based on the information available online via organisations' and government websites and other relevant sites in the form of program overviews and brochures, reports, media items and service evaluations. According to their point of intervention, programs have been assessed and compared to TSS, goals, funding source, referral pathways, model of care, participant outcomes, and community impact. However, significant gaps exist, particularly regarding the assessment of participant and service outcomes due to limited data being publicly available. Therefore, a limitation of the review is that its findings are primarily based on tertiary data that organisations have made available online rather than primary service efficiency data.[3]

After outlining the policy context to current suicide prevention initiatives in Australia and specifically Queensland, the remainder of this review will provide a brief map of Queensland's suicide prevention services sector, including a discussion of Brisbane-based suicide prevention services. The review will conclude by providing more in-depth information on services identified to be the most similar to SPP in various ways, including preventative and early intervention services targeting situational and suicidal distress, crisis support and aftercare services.

2. Current suicide prevention initiatives in Australia: A national and state priority

Strengthening and expanding Australia's suicide prevention response is a current priority of the Australian government, with the appointment of the First National Suicide Prevention Adviser and National Suicide Prevention Taskforce in 2019, the Productivity Commission (PC) Inquiry into the Mental Health System, completed in 2020, and increased funding commitments for 2021–22 focused on enacting major reform to the national mental health and suicide prevention system in Australia.

The Australian government 2021–22 national budget provides a $2.3 billion investment in the National Mental Health and Suicide Prevention Plan (the Plan) to lead new mental health and suicide prevention systems. The Plan marks a significant policy shift by focusing on coordinating and integrating whole-of-government and broader community changes, recognising that effective suicide prevention is a shared responsibility and cannot be addressed by a medical model alone.[4] The investment is the first phase of the response to the PC's Inquiry into Mental Health findings, released publicly in November 2020, and the National Suicide Prevention Adviser's (NSPA) Final Report, released in April 2021.[5] The Government accepted all 21 recommendations from the PC Report and the eight recommendations from the NSPA Final Report either in full, in part or in principle. Most of the recommendations will be enacted in phases through collaboration with state and territory governments. In contrast, several will be passed jointly through a new National Mental Health and Suicide Prevention Agreement, which was enacted via the signing of bilateral agreements with each State and Territory in March and April 2022.[6]

The Plan focuses on strengthening the involvement of consumers and carers. Targeted approaches for populations experiencing vulnerability aim to ensure access to the care they need, in particular, Aboriginal and Torres Strait Islander peoples, migrant and multicultural communities, LGBTIQ+ persons and young people. The Plan also embeds multidisciplinary teams, care coordination, consistent intake and assessment tools, and greater continuous evaluation into the system to ensure it is better coordinated, easy to navigate and delivers person-centred care.[7]

THE FUTURE OF NATIONAL SUICIDE PREVENTION: A FOCUS ON EARLY DISTRESS INTERVENTION, AFTERCARE, POSTVENTION AND LIVED EXPERIENCE

Based on five key pillars, the Plan's suicide prevention reform (Pillar Two) consists of a $298.1 million funding commitment that focuses on strengthening early distress intervention, aftercare and postvention services in addition to the establishment of a National Suicide Prevention Office to oversee the whole-of-government approach to suicide prevention, in partnership with states and territories. The central funding piece of the Plan's suicide prevention reform is universal aftercare, which, for the first time, will be funded to provide support to every Australian discharged from hospital following a suicide attempt.[8] Significantly, given referral pathways for provision of support are often limited to hospitals, as this review will note, this includes funding for trial aftercare services for persons who have attempted suicide or experienced suicidal distress that may not have presented to a hospital.[9]

In addition to increased funding for aftercare support, the Plan's suicide prevention reform includes continued delivery of local suicide prevention initiatives across Australia through the former National Suicide Prevention Trial sites – established in 2016 to implement local suicide prevention approaches for at-risk populations – and funding to pilot, in partnership with the states and territories, a national Distress Intervention program (based on the Distress Brief Intervention [DBI] model), which aims to provide earlier intervention and support to people in crisis or experiencing distress.[10]

While the most significant amount of suicide prevention funding in the federal 2021–22 Budget is allocated to expanding aftercare services, the federal government's commitment to implementing a National Distress Intervention program is significant in promising to expand community-based intervention services that are delivered before a suicide attempt. The Distress Intervention program comes out of a recommendation of the PC's Inquiry into Mental Health Final Report to ensure that mental health and suicide prevention services are accessible to individuals in the community and not just at emergency departments (EDs)

Image provided by Unsplash/ Priscilla Du Preez.

and health services (Recommendations 4 and 13)[11] and the recommendation of the National Suicide Prevention Adviser's Final Advice to respond earlier to distress (Recommendation 5).[12] The NSPA's Final Advice recognises that 'the service system in Australia is primarily focused on responding to a suicidal crisis or responding after a suicide attempt rather than addressing distress early,' a finding that this review of Queensland-based suicide prevention services has also replicated, particularly in regards to the service emphasis being on responding after a suicide attempt, or aftercare.[13] The planned Distress Intervention program is reviewed in more detail below.

Following the example of numerous community-based services such as Brook RED and Roses in the Ocean, there has been an increasing move to include people with lived experience of suicide in planning and delivering government-funded suicide prevention and postvention services. For example, StandBy Support After Suicide has established a National Lived Experience Advisory Group to guide their activities.[14] Further, the federal government's National Mental Health and Suicide Prevention Plan announced in the 2021–22 Budget was informed by the lived experiences of Australians and the National Suicide Prevention Adviser's Final Advice recommendation to invest more in lived experience knowledge and leadership (Recommendation 2).[15] Similarly, Brisbane North PHN's Wellbeing regional plan has prioritised collaboration with people with a lived experience and their families or carers in developing the Plan.[16]

Other national suicide prevention plans, strategies, and initiatives in Australia[17]

THE FIFTH NATIONAL MENTAL HEALTH AND SUICIDE PREVENTION PLAN (FIFTH PLAN)

The Fifth Plan (and the corresponding Implementation Plan) were endorsed by COAG Health Council in August 2017. It is a cross-jurisdictional plan that represents a commitment from all governments to work together to achieve integrated planning and service delivery of mental health and suicide prevention related service. The Fifth Plan aligns with mental health reforms in Australia and builds upon the foundations of state and territory mental health and suicide prevention plans. It sets out to achieve outcomes in eight priority areas, with priority area two looking at effective suicide prevention. The Fifth Plan aligns with the World Health Organization's (WHO) Preventing Suicide: A Global Imperative, that focuses on eleven elements: surveillance; means restriction; media; access to services; training and education; treatment; crisis intervention; postvention; awareness; stigma reduction; and oversight and coordination. Over the next five years, the Fifth Plan will build on the achievements that have been made over the previous 25 years of national mental health reform. Whilst the actions outlined in the Fifth Plan are not intended to solve all problems within the next five years, they will instead set the direction for change and provide a foundation for long-term system reform.[18]

LIVING IS FOR EVERYONE (LIFE): A FRAMEWORK FOR THE PREVENTION OF SUICIDE IN AUSTRALIA

The Living is for Everyone (LIFE) Framework is the overarching evidence-based strategic policy framework for Australia's suicide prevention sector which informed the development of the Talk Suicide Support Model of Care in 2007. It provides support for national action to prevent suicide and promote mental health and resilience in Australia, as well as providing a range of resources and research about how to address the issues of suicide and suicide prevention. The LIFE Framework document outlines the vision, purpose, principles, action areas and proposed outcomes for suicide prevention in Australia. The six action areas focus on: (1) improving the evidence base and understanding of suicide prevention; (2) building individual resilience and the capacity for self-help; (3) improving community strength, resilience, and capacity in suicide prevention; (4) taking a coordinated approach to suicide prevention; (5) providing targeted suicide prevention activities; and (6) implementing standards and quality in suicide prevention. The ultimate goal of this framework is to reduce suicide attempts and loss of life through suicide and the impact of suicidal behaviour in Australia.[19]

THE NATIONAL SUICIDE PREVENTION STRATEGY FOR AUSTRALIA'S HEALTH SYSTEM: 2020–2023 (THE STRATEGY)

The NSPS provides the foundation for Australia's national policy on suicide prevention with a focus on all suicidal behaviour. It is a three-year, whole-of-population strategy that is part of Australia's journey towards zero suicides and is the first national suicide prevention strategy endorsed by every Commonwealth and state and territory Health and Mental Health Minister. The strategy reaffirms the commitment by all governments to implement systems-based suicide prevention approaches. The priority domains of the strategy include supporting individuals and communities to seek help and to support others; building systems of care to change the trajectory of people in suicidal distress; enabling recovery through post-crisis aftercare and postvention; and community-driven Aboriginal and Torres Strait Islander suicide prevention. This strategy supports and furthers the existing achievements of governments, non-government organisations, PHNs, the private sector, research institutes and people with lived experience of suicidal behaviour.[20]

THE NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER SUICIDE PREVENTION STRATEGY (THE STRATEGY)

This is the first National Aboriginal and Torres Strait Islander Suicide Prevention Strategy and is focused on holistic, early interventions that build strong communities through community-focused and integrated approaches to suicide prevention. This strategy demonstrates the commitment of the government to reducing suicidal and self-harm behaviour among Aboriginal and Torres Strait Islander peoples. The Strategy is informed by extensive community consultation across Australia and by Aboriginal and Torres Strait Islander peoples' holistic view of health that includes mental health, physical, cultural, and spiritual health. The Strategy presents

Image provided by Pexels/ Gursharndeep Singh.

six action areas: building strengths and capacity in Aboriginal and Torres Strait Islander communities; building strengths and resilience in individuals and families; targeted suicide prevention services; coordinating approaches to prevention; building the evidence base and disseminating information; standards and quality in suicide prevention. These action areas align with the nine guiding principles for Aboriginal and Torres Strait Islander people outlined in The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023 and the priority areas of The Fifth National Mental Health and Suicide Prevention Plan 2017. Implementing the activities listed under each action area should provide benefit to Aboriginal and Torres Strait Islander peoples, particularly those at greater risk or disadvantage.[21]

THE NATIONAL LGBTI MENTAL HEALTH AND SUICIDE PREVENTION STRATEGY (THE STRATEGY)

The National Lesbian, Gay, Bisexual, Transgender, and Intersex (LGBTI) Mental Health and Suicide Prevention Strategy is a plan for strategic action to prevent mental ill health and suicide for LGBTIQ+ people and communities in Australia. In addition, it promotes good mental health and wellbeing for these populations. Historically, LGBTIQ+ people and communities have been excluded from mental health and suicide prevention strategies, policies, and frameworks. Therefore, this Strategy has been developed to provide strategies for action to ensure that targeted responses adequately and appropriately support the needs of LGBTIQ+ people and communities as a priority. This strategy includes recommendations for the promotion, prevention, intervention, treatment, and maintenance of mental health work in Australia. The purpose of the strategy is to respond to LGBTIQ+ people in current need, provide interventions to those at risk, and to limit the structural factors that lead to the overrepresentation of LGBTIQ+ people in mental health and suicide statistics. The Strategy clearly identifies effective mental health and suicide prevention strategies for LGBTIQ+ people and communities in Australia.[22]

THE QUEENSLAND GOVERNMENT'S RESPONSE TO SUICIDE PREVENTION

The federal commitment to suicide prevention reform is shared across the states. For example, the Royal Commission into Victoria's Mental Health System report, delivered in February 2021, recommended establishing the Suicide Prevention and Response Office and for peer-led safe spaces and gatekeeper training across communities and workplaces.[23] In the Queensland 2019–20 State Budget, the government allocated almost $62 million over four years for suicide prevention initiatives under their Shifting Minds Suicide Prevention Flagship, and the amount was matched in the 2020–21 budget to continue delivery of Flagship initiatives.[24] Their whole-of-government suicide prevention approach is guided by Every Life: The Queensland Suicide Prevention Plan 2019–2029, delivered in 2019 and backed by the 2019–20 State Budget funding for suicide prevention initiatives. The Every Life plan sits under the Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018–2023.[25]

Image provided by Unsplash/ Alexander Grey.

Key actions of the Every Life plan include the development of a business case for providing pathways to assertive follow-up based on the DBI and similar models, crisis service delivery reform, which provides for the implementation of eight safe spaces and the implementation and evaluation of the Way Back Support Service in seven Queensland sites, in partnership with Beyond Blue and PHNs.[26] Several of these initiatives and other programs commissioned by Brisbane's PHNs are further explored below.

3. Mapping the suicide prevention services sector in Queensland

Suicide prevention services exist as specific services offered within broader mental health support services or support services provided by stand-alone organisations specifically for suicide prevention support. Naturally, mental health support and suicide prevention support are linked, and many mental health support services provide resources and support relating to suicide prevention. As well, suicide prevention-specific services aim to address clients' suicidality within the context of helping persons to manage and improve their overall mental health. Given SPP's remit as a suicide prevention-specific service, this section of the review focuses chiefly on comparing similar organisations that provide suicide prevention support and has omitted mental health support services, except where they offer a suicide prevention program.

This review highlights the diversity of suicide prevention services. They can, however, be grouped according to several measures:

- To the targeted point (prevention, aftercare, postvention)
- To the length of intervention (crisis, short-term or medium- to long-term)
- Whether they are clinical or community-based services
- Whether they offer face-to-face support in addition to phone and online support
- To differences in services' target cohort (according to community, cultural background, age range, gender, and industry, for example).

Given the type of service SPP provides, this review focuses on identifying similar public community-based prevention services that provide face-to-face support in addition to phone and online support.

REVIEW OF BRISBANE-BASED SUICIDE PREVENTION SERVICES

SPP's service has been assessed in relation to other relevant services according to factors noted: according to the targeted point (prevention, aftercare or postvention services) and length of intervention (crisis, short-term or medium-to-long term), whether they are clinical or community-based services, and whether they offer face-to-face support in addition to phone and online support.

With the exception of SPP, the majority of SPA member organisations were included in the review. These include (but were not limited to): Calm Consulting Pty Ltd, Care for Life Suicide Prevention Network Inc., Gold Coast Mental Health and Specialist Services, Grapevine Group, Lifeline Queensland (UnitingCare Queensland), Mates in Construction AUST Ltd,

Mind Blank Ltd, Queensland Transcultural Mental Health Centre (QTMHC), Roses in the Ocean Ltd, Run For MI Life, Selectability, StandBy Support After Suicide, TUFMINDS Life Rescue, Whitsunday Suicide Prevention, Network and Yourtown).

This assessment has found that most Queensland-based SPA member organisations do not provide a direct intervention service but focus instead on community awareness-raising and education by offering training to community members and professionals, as well as online resources that link into existing, mostly non-suicide-prevention specific services.[27] While there is a need to deliver effective suicide prevention training to professionals, communities and organisations, including a requirement to extend training to overlooked cohorts, the balance towards the provision of training services among Queensland-based SPA members as opposed to direct intervention services is notable.[28]

Further, while suicide-prevention-specific support distinct from mental health support is needed, few Brisbane-based suicide-prevention-specific organisations provide a direct intervention service to individuals contemplating suicide other than SPP. Numerous intervention services offering face-to-face support exist in Queensland. However, many are not suicide-prevention services but rather mental health services (for example, Yourtown, Queensland Transcultural Mental Health Centre). Headspace's Brisbane (and Australia-wide) sites offer an early intervention community-based model with face-to-face support, but this is not a suicide prevention service, and it is also explicitly targeted at 12–25-year-olds. Wesley Mission Queensland also runs two Brisbane South PHN-commissioned programs for mild to moderate cases, the Psychological Therapies Program (existing alongside the Better Health Initiative Mental Health Plan, for people who cannot afford the latter and are experiencing financial disadvantage) and the Wellbeing Mental Health Service (providing free short-term face-to-face and telephone psychological interventions to ages 16 and above).[29]

Given the limitations to services identified above, amongst community-based suicide prevention services in Brisbane that provide face-to-face support, SPP is unique in various ways. SPP appears to be one of the only community-based suicide prevention services offering face-to-face support that focuses solely on suicide prevention (those contemplating suicide, having not yet made an attempt), in addition to direct aftercare and ongoing suicide specific support, as opposed to solely focusing on crisis response, brief aftercare or postvention. Other than SPP's TSS Service, suicide prevention-specific face-to-face support services available within north Brisbane include the Way Back service (though this is designed to provide support following a recent suicide attempt or 'suicidal crisis') and the Standby – Support After Suicide service (however, this is a postvention service). One of the three Brisbane South PHN-commissioned suicide prevention services, the PAUSE program delivered by Brook RED, provides an aftercare service. Thus, the existing government-funded services in the Brisbane region do not appear to include a community based suicide prevention-specific face-to-face support service for people at risk of suicide, which in addition provide ongoing support according to this understanding. There is a need for both 'before', and 'after' programs and provision for ongoing support in suicide prevention. Further resourcing of services like TSS would enable the gap to be better filled in community-based face-to-face preventive services and complement aftercare services.

SPP's service offering is also unique in its targeted length and scope of intervention. SPP provides brief to longer-term intervention, depending on individual needs, and coordinates a 'wrap-around continuum of care response' for individuals who work with and link them back to their support networks.[30] While there are many services available that provide short-term crisis intervention either via phone or online chat (Lifeline, Suicide Call Back Service, Beyond Blue Support Service) or in-person by Acute Care (or crisis assessment) teams, there are fewer support services in the Brisbane region that offer face-to-face suicide prevention interventions beyond the short-term.

Given that much mental health and suicide prevention support is provided digitally or over the phone, determining whether services also offer face-to-face support in their model of care is a significant factor to measure. For example, national organisations and services such as Suicide Call Back Service, Lifeline, Beyond Blue, and SANE offer free phone and/or online-based web chat support. Within Queensland, the 1300 MHCALL phone line provides the point of access to the public mental health service, providing immediate phone support and advice to individuals experiencing a mental health crisis.[31] Digital and phone support comprise an essential part of a suicide prevention response and appropriate first points of contact. The provision of scheduled or follow-up face-to-face support is also important in working with individuals beyond the short term, yet appears to be limited amongst suicide-prevention-specific Brisbane-based organisations, other than SPP. While SPP's TSS is a core suicide prevention service provided in the Brisbane North PHN catchment area,[32] other face-to-face suicide-prevention services offered in this area include the Brisbane MIND Suicide Prevention program (a clinical model providing short-term psychological therapy) and the Way Back Support Service (providing aftercare, as noted above).[33]

Of the Queensland-based SPA members listed that provide an intervention service beyond digital and phone support, unlike SPP, many are cohort-specific rather than offering services to the general adult population. For example, Mates in Construction AUST Ltd provides staff training and some direct support to individual workers (via a support line and case management). However, the support provided is limited to the construction industry and thus, unlike SPP, does not extend to anyone who reaches out (another example is the Queensland Transcultural Mental Health Centre).[34] Of the three Brisbane South PHN-commissioned suicide prevention services, two are cohort-specific. Brook RED delivers an LGBTIQ+ suicide-prevention program offering peer support, skills development, and psychoeducation in Redlands. The Queensland Program of Assistance to Survivors of Torture & Trauma (QPASTT) run the Nexus program, offering individual counselling for children and young people from refugee backgrounds who may be at risk of suicide.[35]

4. Deeper review of Queensland-based services

The following section provides an in-depth review of several key initiatives of suicide prevention services within Queensland that are similar to SPP's service in various ways. As established, this review could not identify any community-based suicide prevention service in Brisbane precisely identical to that provided by SPP. However, the following services are the most similar services identified to SPP in that they focus on assisting clients in developing their coping skills:

- Extending beyond safety planning (Northern Gold Coast Suicide Prevention Community Support Program)
- Providing community-based alternatives to the ED for individuals experiencing suicidal distress (safe spaces)
- Providing community-based or lived-experience-led care for individuals following a suicide attempt or experiencing a suicidal crisis, extending beyond crisis or short-term care (the Way Back Support Service and Brook RED PAUSE program).

Preventative services providing early intervention and targeting situational and suicidal distress

INTERVENTION PROGRAMS

As noted in their Mental Health and Suicide Prevention Plan, announced in May 2021, the federal government is committed to piloting a state-based Distress Intervention program, which aims to provide earlier intervention to people in crisis or experiencing distress. Although no specific services could be identified that have yet been implemented in this space, this service model has been included in the review as it forms a core part of the federal and state governments' planned suicide prevention strategies and signals a shift to an early intervention focus. The Distress Intervention program is not necessarily a suicide prevention service; instead, it is designed to provide support to prevent an individual's distress from escalating to suicidality, and thus it serves as a core strategy along a continuum of suicide-prevention interventions.

Based on a Scottish Distress Brief Intervention (DBI) Program that commenced in 2016, non-mental health frontline workers trained in DBI (including health workers, police and paramedics) provide presenting individuals with a rapid response and refer them, if agreed, to a DBI service that contacts the individual within 24 hours to arrange further support and link them in to further supports. The model targets people experiencing distress where emergency care is not required.[36] The Distress Intervention trial will include funding to implement national standards for Safe Spaces services and expand the Roses in the Ocean CARE connect service, a peer-led call-back service. While the support is short-term – provided over two weeks – like SPP, it focuses on equipping individuals with the skills they need to manage their own wellbeing and effectively prevent future crises.[37]

The program adopts a similar model to SPP in aiming to up-skill individuals to learn to self-manage their distress and develop future resilience, yet again, more limited in that it provides only short-term support. It seeks to prevent a person's distress from escalating to suicidality. It also differs from SPP because its point of intervention is prior to the individual contacting a suicide prevention service. Thus, the model targets an earlier invention point than SPP, as support is offered more broadly across the community when people are experiencing distress, without them having to present to dedicated mental health or suicide prevention services.[38]

The Northern Gold Coast Suicide Prevention Community Support Program, run by Wesley Mission Queensland, is a six-week program supporting individuals living on the Northern Gold Coast who are experiencing 'situational distress.' Accepting referrals from specified GPs and community groups and organisations for individuals residing in the Northern Gold Coast, support facilitators work with clients for up to six weeks providing practical support, coaching, and mentoring. They provide non-clinical support to individuals and their families either over the phone, face-to-face or online. Similarly, to SPP, they assist clients in finding services, creating a plan to stay safe in moments of distress and develop their coping skills.[39] The program is relatively new, having been established in late 2020.[40]

The program is one key outcome of the Gold Coast Suicide Prevention Community Action Plan and was developed in response to the Gold Coast PHN's previous health needs assessment, which identified the need for a local, community-based suicide prevention response for the Gold Coast. Based on the information provided by the consultants engaged by Gold Coast PHN and Wesley Mission Queensland to develop the service model, the program was created to provide preventative intervention and support to persons prior to reaching the stage of making a suicide attempt. It aims to provide tailored psychosocial support to people experiencing suicidal crisis or in situational distress within the community and primary care setting, and by doing so, preventing them from using acute and emergency services relating to a suicidal crisis. The program aims to identify people experiencing situational distress in the community and connect them with emotional, practical and coaching support, focusing on linking with a person's regular GP.[41] Although the target cohort mentioned includes people experiencing situational distress or suicidal crisis, the focus is on situational distress in the service descriptions.[42]

CRISIS SUPPORT SERVICES

Another recently introduced non-clinical service is a peer-support model, called safe spaces or Crisis Support Spaces, which focuses on crisis de-escalation. It functions as an alternative to the ED for people presenting to hospitals experiencing suicidal distress or mental health crisis. However, the service is not suicide-specific and is targeted towards people experiencing emotional distress or a mental health crisis, which may or may not include suicidal distress. Further, unlike SPP, this is a crisis response model.

The establishment of eight Crisis Support Spaces in Queensland hospitals forms a major part of the Queensland government's state-wide framework for mental health crisis service delivery. As noted earlier, this crisis system reform initiative was delivered in the 2019–20 State Budget, whereby Queensland Health was allocated almost $62 million over four years for suicide prevention initiatives under their Shifting Minds Suicide Prevention Flagship.[43] Crisis support spaces are being established in EDs at the Prince Charles Hospital, the Princess Alexandra Hospital and Cairns and Mackay hospitals, with a further four spaces having opened in the second half of 2021, based on findings gathered from the first four spaces.[44]

Based on the Safe Haven Café model implemented in the UK, a peer worker with lived experience of mental health or suicidal crisis works alongside ED and mental health staff to provide integrated care, so that the person presenting has a non-clinical point of contact to support them during their hospital visit. The peer worker also provides the client, family, and carers with options and referrals to explore after leaving the hospital to seek support within their community.[45]

A similar Crisis Support Space called Living EDge is located at Redland Hospital run by Brook RED, a lived experience managed and operated organisation, focused on supporting holistic recovery from a mental health concern. The service commenced as a trial program in mid-2019 and works in partnership with Redland Hospital ED. The Crisis Support Space is targeted at people who rely on hospital EDs in times of suicidal distress.[46] It consists of an alternative space at Redland Hospital located near the ED, which provides a calming space where people at risk of suicide can talk to peer support workers, be heard, enjoy relaxing activities, and arrange ongoing guidance and support.[47] A second component of the program is called Living EDge in the Community where, supported by peers, people can access help such as weekly group support, a self-management kit and access to individually tailored activities such as running groups, art classes, yoga and other activities.[48]

The program, funded by Queensland Health under the Suicide Prevention in Health Services Initiative, was developed and is co-managed by Enlightened Consultants and Brook RED, and is a lived-experience designed and delivered service.[49] According to Helen Glover from Enlightened Consultants, the design lead for the trial, a critical element of the program is helping people learn to self-manage their distress instead of removing their distress entirely.[50] People can self-refer to the program.[51] It is innovative in that it is a peer-led model and offers a non-clinical space in which to talk with people who have lived through similar situations. In a news report from January 2020, Brook RED Suicide prevention services manager Nick Moreau noted that approximately five to 10 people now accessed the room per night between Mondays and Thursdays, a significant increase since the program began.[52] The service launched in mid-2019 and its initial trial period ran until the end of September 2019.[53] At last report in January 2020, the trial was extended, and was due to close on 31 March 2020. Thus, it is unclear whether the program still exists.[54] The same report also notes that after March 2020 data collected throughout the trial would then be evaluated.[55] Another source from late 2019 notes that the program was due to be evaluated by Dr Kate (Katherine) Gill at the time. However, the evaluation could not be located online.[56]

Establishing safe spaces in the North Brisbane region is also one objective in the Brisbane North PHN's regional Suicide Prevention Action Plan, Planning for Wellbeing Across 2018–2023. During 2019, Aftercare, Richmond Fellowship Queensland, Wesley Mission Queensland and Encircle partnered to implement trial sites in Redcliffe and Caboolture. Findings from the trial suggested that the spaces were successful in decreasing distress levels for visitors, with 96% of visitors reporting that they found their visits to the Safe Space useful and over 72% reporting that they used strategies to learn to self-manage distress levels.[57] While they needed to close the sites after the trial period, they secured renewed funding from the Commonwealth Department of Health to continue the service, expected some time this year. Unlike the Crisis Support Spaces being established within Queensland hospital EDs, the safe spaces in Redcliffe and Caboolture are community-based rather than located within a hospital. It also appears that these safe spaces were not initially suicide-specific but targeted at people experiencing some level of psychological distress. The Safe Spaces Working Group later adapted the model to align with a suicide prevention approach, which then attracted Commonwealth Department of Health funding.[58]

TARGETING AFTERCARE

The Way Back Support Service is a program developed by Beyond Blue and administered by local community organisations in every state and territory other than Western Australia and South Australia.[59] It is a community-based aftercare service that supports people to link into existing health, clinical and community-based services to address their needs and support their safety. Support facilitators provide non-clinical care and practical support to individuals presenting to hospital EDs following a suicide attempt or experiencing a 'suicidal crisis.' The program aims to prevent repeat suicidal behaviour for people presenting to hospital following a suicide attempt by delivering person-centred, non-clinical care for three months after discharge, and is based on findings that this group are among the most at-risk of re-attempting suicide.

The intervention is similar to SPP's TSS in that they provide safety planning, linking to other relevant services and check-ins. However, a limitation to the service is that, unlike SPP, it provides a community-based response to hospital-treated self-harm only; referrals are only accepted from hospitals and support is capped.

Image provided by Unsplash/ Wout Vanacker.

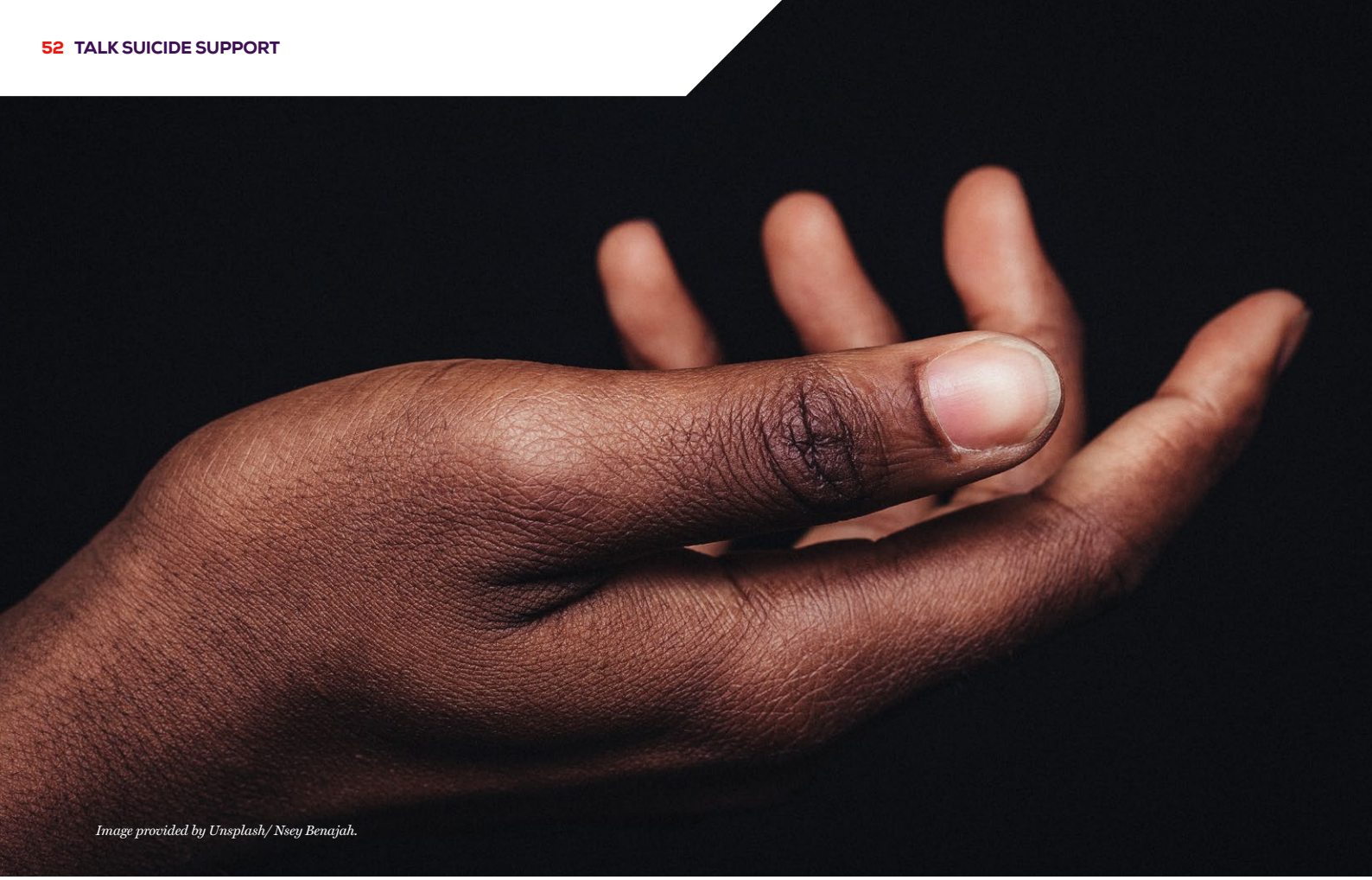

Image provided by Unsplash/ Nsey Benajah.

Beyond Blue commissioned an independent evaluation of the Way Back in the Hunter New England region of NSW, conducted by a consortium of Calvary Mater Hospital, the University of Newcastle, Hunter Primary Care and Everymind. The 2019 report found:

- 97% of people reported positive progress on their recovery plan
- Psychological distress scores dropped in key measures, on average, from severe to mild
- Participants reported less concern about the issues contributing to their attempt and fewer of those issues.[60]

A core element of Queensland Health's Shifting Minds Flagship in their 2019–20 budget was the provision of funding over four years to expand the Way Back service to all seven of Queensland's PHNs, matching Commonwealth funding.[61] The Way Back Support Service will be progressively expanded to 29 sites as part of the 2021–22 national budget.[62]

Wesley Mission Queensland runs the Way Back Support Service to eligible people living in the Gold Coast and Brisbane South regions, accepting referrals from Robina, Gold Coast University and Princess Alexandra Hospitals. Launched in October 2017 as a trial site, the Brisbane North PHN-commissioned site in Redcliffe is delivered by Richmond Fellowship Queensland and supports people who are 15 years of age or older, who reside in the Redcliffe-Caboolture region. A staff member from the Way Back Support Service contacts and checks in with clients within 24 hours of receiving a referral from Redcliffe or Caboolture Hospital. The Way Back team at the Redcliffe site consists of clinical and non-clinical staff who work together with clients to identify and link them to the personalised support they require. Similarly to SPP, the service also aims to support the families and carers of people at risk where possible. The service operates seven days per week, including after hours and on weekends.[63]

PAUSE (Peer, Acceptance, Support, Understanding, and Empathy) is a short-term non-clinical follow-up and support service delivered by Brook RED in partnership with Metro South Hospital and Health Service for people in the Logan Hospital catchment area following self-harm or a suicide attempt. It offers community-based peer support to people who have experienced suicidal distress or crisis while awaiting connection to appropriate mental health care and social services.[64] Though having a name different from Beyond Blue's Way Back Support Service, it provides a similar service in its point of intervention (providing an aftercare service), referral pathway (hospital ED only), and support offered. PAUSE has been running since 2018 and is reported to support approximately 90 to 100 people per year experiencing suicidal distress.[65] The program was evaluated by the Australian Institute for Suicide Research and Prevention[66] and found that though having a peer worker increased a sense of connection and engagement for people accessing the service, the peer workers illness, crisis, or recovery strategies were the least reported support offered. A key finding of the evaluation was that the peer service effectively reduced feelings of suicidal ideation and increased hope in service users. The service used validated tools: the Kessler Psychological Distress Scale (K10), the Adult Hope Scale and the General Health Questionnaire.

Image provided by Unsplash/ Marcus Wallis.

TARGETING HIGH-RISK POPULATION GROUPS: NATIONAL SUICIDE PREVENTION TRIAL

The National Suicide Prevention Trial was launched in 2016 by the Commonwealth Department of Health. This initiative was focused on trialling systems approaches to suicide prevention in 12 regions across Australia. The goal of the trial was to reduce suicide attempts and death in 12 trial sites, with each trial site tailored to the needs of those particular communities. Each trial site served a priority population within their region who were identified as being at risk of suicide. This included Aboriginal and Torres Strait Islander Peoples; LGBTIQ+ individuals; ex-Australian Defence Force personnel and their families; men; older people; youth (aged 16–35); and rural and remote communities.[67] As mentioned earlier, the present review does not include SPA member services that offer programs targeted towards specific cohorts, for which there exist numerous SPA members across all states.[68] However, given the high need for these priority populations to access suicide prevention services, it is important to identify what services are being provided for these groups in order to determine what further support SPP can provide to people in the cohorts who access their service.

For four years, the 12 communities in which the trial sites were located, were supported by the Black Dog Institute to design and deliver best-practice suicide prevention initiatives. The trial resulted in new services and resources being trialled and improved suicide prevention activities delivered in Australia. Although funding for the trial ended in June 2021, many of the sites continue to deliver their suicide prevention support beyond the trial environment.[69]

Table 1 gives an overview of key service activities for TSS and some of the other agencies that provide suicide prevention support to individuals and their families in the South East Queensland area.

5. Assessing targeted point of intervention: the need for clear language

Based on their target point, intervention services vary – from seeking to address persons' situational distress through clinical psychological therapy services or community-based counselling and support programs to prevent escalation to a suicide attempt. Mental health services include Wesley Mission Queensland's Psychological Therapies Program; Wellbeing Program (commissioned by Brisbane South PHN); Brisbane North PHN's Brisbane MIND.

State public mental health referral services including Brisbane South PHN's Mental Health Referral Service and Brisbane North PHN's My Mental Health Service Navigation team support people who are experiencing suicidal distress or contemplating suicide.

The Northern Gold Coast Suicide Prevention Community Support Program and potentially the Way Back Support Service help extends to persons experiencing distress and having thoughts of suicide as well as supporting people who are experiencing 'suicidal crisis'. Services also include 'aftercare' – providing community-based follow-up to prevent

further attempts by individuals who have presented to hospital after making a suicide attempt (the Way Back Support Service and Brooke RED PAUSE programs, for example).

However, the line between the former three categories – addressing persons' situational distress, suicidal distress, or a suicidal crisis – is blurred. It is at times unclear whether 'situational distress' also extends to suicidality, and if so, whether programs aimed at supporting persons' situational distress also provide support if this escalates to suicidal distress (for example, in the case of the Northern Gold Coast Suicide Prevention Community Support Program).

It is also unclear whether 'suicidal crisis' also refers to persons experiencing 'suicidal distress' who have not presented to an ED or made a suicide attempt, or only to those who have made a suicide attempt (as with the ambiguous description of the Way Back Support Service).

Furthermore, given that point-of-intervention describes the particular point at which a person presents along a spectrum of experiencing distress, experiencing a suicidal crisis, or having made a suicide attempt, the definitions will be, at least in part, subjective.

Based only on the service overview provided online, identifying the point of intervention and type of support suicide prevention programs provide is difficult without further information provided directly by the services. Assessing the impact of the services on clients and within the community is restricted without access to service evaluations and without consultation with their clients.

It would benefit local suicide prevention efforts to provide an integrated, coordinated service response if clear definitions of 'situational distress,' 'suicidal distress' and 'suicidal crisis' were provided, and clear inclusion and exclusion criteria for each type of intervention were provided to help ensure there is support provided across all points of intervention as described above (pre, during and 'after'). Such definitions would also assist services, professionals and researchers to evaluate services within the suicide prevention sector.

Given that extensive planning and consultation with stakeholders at all levels has already occurred across the regions focused on in this review, these definitions and service descriptors may already exist to create Brisbane North, South and other PHN's community action plans. For the purposes of this review, they could not be located by consulting each PHN's community action plans, though Brisbane South PHN's Mental Health, Suicide Prevention and Alcohol and Other Drug Strategy 2019–2022 does recognise the use of common language as a key driver in implementing an effective, coordinated model.[70]

Given the Queensland government's call for improvements into how the evaluation of suicide prevention initiatives is translated into targeted preventative action, clear definitions will help support suicide prevention evaluation efforts across the sector.[71]

6. Key findings and recommendations from reviewing suicide prevention support services

In summary, the key findings from the service and literature review are:

- National and state government reform has been underway since 2021 for the national mental health and suicide prevention system in Australia and is focused on early intervention and on developing integrated, better-coordinated whole-of-government and whole-of-community responses
- Following the example of numerous community-based services, there is an increasing move to include people with lived experience of suicide in the planning and delivery of government suicide prevention and postvention services
- There is increased state and federal policy and service investment for vulnerable populations, in particular Aboriginal and Torres Strait Islander communities, to prevent suicide and provide greater postvention support
- The majority of Queensland-based Suicide Prevention Australia member organisations do not offer a direct intervention service but are focused on community awareness-raising through the provision of training for community members and professionals and the collation of online resources and service contacts
- While suicide-prevention-specific support is needed as distinct from mental health support, there are few Brisbane-based suicide-prevention-specific organisations that provide a direct intervention service to individuals contemplating suicide other than SPP
- SPP is unique among existing suicide prevention services within Queensland in providing a direct intervention service to all persons aged 15 and above (rather than being cohort-specific or needing to meet other criteria); in being a suicide prevention-focused organisation that provides intervention to individuals contemplating suicide in addition to aftercare and ongoing support; in providing wrap-around support that is not time-limited (rather than being funded to provide support within specific timeframes); in offering face-to-face outreach (in addition to telephone or online support); and in accepting referrals from all pathways (rather than only from hospitals or health care professionals)
- SPP is one of the only philanthropically funded suicide prevention specific services operating in the South East Queensland region. Findings indicate that they are one of the only purely philanthropically funded suicide-prevention specific services operating in Australia.
- It would benefit further service evaluations and local efforts to plan a coordinated suicide prevention service response if clear definitions or shared understandings of 'situational distress,' 'suicidal distress' and 'suicidal crises' were provided, with clear inclusion and exclusion criteria for each point of intervention.

Image provided by Pexels/ Rahul Pandit.

TABLE 1

MAPPING TSS AND OTHER QLD BASED SUICIDE PREVENTION SERVICES			
SERVICE ACTIVITIES	**TALK SUICIDE SUPPORT – SUICIDE PREVENTION PATHWAYS**	**NORTHERN GC SUICIDE PREVENTION – WESLEY MISSION**	**WAY BACK/ BEYOND BLUE/ WESLEY MISSION**
REFERRAL	Accepts referrals from all pathways	GPs and organisations only	Hospital after suicide or suicide crisis presentation
MODALITY	Online, telephone and face to face	Online, telephone or face to face	Face to face
AGE RANGE	15 and over	18 and over	15 and over
TIMEFRAME FOR SUPPORT	No fixed timeframe	6 weeks	12 weeks
REFERRAL POINT	Suicide prevention via wrap-around community linkage and individual support	At point of situational distress, coaching and practical support/ linkage	At point of crisis – for those who have presented to hospital with suicide attempt/intent
OTHER ELIGIBILITY	South East Queensland but extended due to online, telephone contact	For people living in the northern Gold Coast region	Geographical boundaries depending on gazetted hospital

Appendix B endnotes

[1] SPA member institutes and centres connected to universities include University of the Sunshine Coast's Thompson Institute; Australian Institute for Suicide Research and Prevention housed at Griffith University, and Black Dog Institute, affiliated with UNSW Sydney. Privately run institutes and centres include Postvention Australia and Cairnmillar Institute. Private businesses include Red Point Psychology & Coaching Pty Ltd, and Morgan Campbell Health Consultants. *Suicide Prevention Australia*, 2021, retrieved 15 April 2021, https://www.suicidepreventionaust.org/ and https://www.suicidepreventionaust.org/support/our-members/

[2] For example, the Australian Defence Force Centre for Mental Health, Australian Men's Health Forum Incorporated, Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, Headspace National Youth Mental Health Foundation Ltd, LGBTIQ+Health Australia, Rural & Remote Mental Health Ltd, among others. See 'Our members,' *Suicide Prevention Australia*, 2021, retrieved 15 April 2021, https://www.suicidepreventionaust.org/support/our-members/.

[3] While the findings may later be expanded upon via direct follow-up with relevant services, they should be interpreted with this limitation in mind.

[4] 'Historic $2.3 Billion National Mental Health and Suicide Prevention Plan,' Media Release, *Prime Minister of Australia*, 11 May 2021, retrieved 20 May 2021, https://www.pm.gov.au/media/historic-2-3-billion-national-mental-health-and-suicide-prevention-plan; Fiona Shand, 'We know how to tackle Australia's suicide crisis, but success depends on swift government action,' ABC News, 24 April 2021, retrieved 20 May 2021, https://www.abc.net.au/news/2021-04-24/tackling-australias-suicide-crisis-success-government-action/100091882.

[5] 'Historic $2.3 Billion National Mental Health and Suicide Prevention Plan,' *Prime Minister of Australia*; 'Mental Health,' *Productivity Commission*, retrieved 19 May 2021, https://www.pc.gov.au/inquiries/completed/mental-health/report.

[6] 'Prevention Compassion Care: National Mental Health and Suicide Prevention Plan,' *Australian Government*, 2021, retrieved 20 May 2021, https://www.health.gov.au/resources/publications/the-australian-governments-national-mental-health-and-suicide-prevention-plan, 7; 'The National Mental Health and Suicide Prevention Agreement,' *Federal Financial Relations*, retrieved 23 February 2023, https://federalfinancialrelations.gov.au/agreements/mental-health-suicide-prevention-agreement.

[7] 'Historic $2.3 Billion National Mental Health and Suicide Prevention Plan,' *Prime Minister of Australia*.

[8] 'Prevention Compassion Care: National Mental Health and Suicide Prevention Plan,' 11. The recommendation to expand aftercare services came out of the 'Productivity Commission Inquiry into Mental Health Final Report,' *Australian Government*, retrieved 19 May 2021, https://www.pc.gov.au/inquiries/completed/mental-health/report/mental-health.pdf, 68 (Recommendation 9).

[9] 'Prevention Compassion Care: National Mental Health and Suicide Prevention Plan,' 11–12.

[10] Ibid., 13; 12.

[11] 'Productivity Commission Inquiry into Mental Health Final Report,' 63; 72.

[12] 'Connected and Compassionate: Implementing a national whole-of-governments approach to suicide prevention (Final Advice),' *National Suicide Prevention Adviser*, Canberra; December 2020, retrieved 19 May 2021, https://www.health.gov.au/sites/ default/files/documents/2021/05/national-suicide-prevention-adviser-final-advice-connected-and-compassionate.pdf, 40-41.

[13] 'Connected and Compassionate (Final Advice),' 37.

[14] 'About Us,' *StandBy Support After Suicide*, 2021, retrieved 19 May 2021, https://standbysupport.com.au/#About.

[15] 'Prevention Compassion Care: National Mental Health and Suicide Prevention Plan,' 7; 'Connected and Compassionate (Final Advice),' 23.

[16] 'Planning for Wellbeing,' *Brisbane North PHN*, retrieved 23 April 2021, https://planningforwellbeing.org.au/chapters/people-with-a-lived-experience-leading-change/.

[17] Life in Mind. (2021). *National Suicide Prevention Strategies in Australia*, https://lifeinmind.org.au/policies/national-policy, retrieved 21 October 2021

[18] Australian Government. (2021). *National Mental Health and Suicide Prevention Plan*, https://www.health.gov.au/sites/default/ files/documents/2021/05/the-australian-government-s-national-mental-health-and-suicide-prevention-plan-national-mental-health-and-suicide-prevention-plan.pdf, retrieved 21 September 2021.

[19] Department of Health and Ageing. (2007). *Living is For Everyone (LIFE): A Framework for prevention of suicide in Australia*. https://lifeinmind.org.au/splash-page/docs/LIFE-framework-web.pdf, retrieved 24 September 2021.

[20] *'National Suicide Prevention Strategy for Australia's Health System: 2020–2023'*, Victorian Government, 2020, retrieved 22 October 2021, http://www.coaghealthcouncil.gov.au/Portals/0/Reports/2001614_National%20Suicide%20Prevention%20Strategy-2020-2023%20FINAL.pdf

[21] *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy*, 2013, Australian Government, Department of Health and Ageing, retrieved 20 September 2021, https://www.health.gov.au/sites/default/files/documents/2021/05/national-aboriginal-and-torres-strait-islander-suicide-prevention-strategy.pdf

[22] *National Lesbian, Gay, Bisexual, Transgender and Intersex Mental Health & Suicide Prevention Strategy*, National LGBTI Health Alliance, retrieved 22 October 2021, https://d3n8a8pro7vhmx.cloudfront.net/ lgbtihealth/pages/409/attachments/ original/1585378577/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB-1.pdf?1585378577

[23] *Royal Commission into Victoria's Mental Health System, Final Report, Summary and recommendations*, State of Victoria, Parliamentary Paper No. 202, Session 2018–21, retrieved 20 May 2021, https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_ExecSummary_Accessible.pdf, 62; 45; 63.

[24] Budget 2019–20: *Suicide prevention initiatives*, Queensland Mental Health Commission, 2019, retrieved 18 May 2021, https://www.qmhc.qld.gov.au/sites/default/files/fact_sheet_80.1_million_suicide_prevention_budget_initiatives.pdf; 'Highlights,' Queensland Budget 2020–21, Queensland Government, 2020, retrieved 20 May 2021, https://budget.qld.gov.au/highlights/#safeguarding-our-health.

[25] 'Suicide prevention plan,' Queensland Mental Health Commission, 2021, retrieved 20 May 2021, https://www.qmhc.qld.gov.au/strategic-planning/action-plans/suicide-prevention.

[26] *Every life: The Queensland Suicide Prevention Plan 2019–2029 Phase One*, Queensland Mental Health Commission, Queensland government, 2019, retrieved 19 May 2021, https://www.qmhc.qld.gov.au/sites/default/files/every_life_the_queensland_suicide_prevention_plan_2019-2029_web.pdf, 24; 25.

[27] See for example, the extensive online contact lists for emergency, crisis and general counselling or support provided by Grapevine, Care for Life Suicide Prevention Network Inc and Whitsunday Suicide Prevention Network Inc, retrieved 6 April 2021.

[28] As an example of an overlooked cohort, a recent study supported the need for gatekeeper and other suicide prevention training for community pharmacists, as health professionals accessible to the community who have often interacted with someone who they perceived to be at risk of suicide. See Bridget Judd, 'Pharmacists are on the frontline of Australia's mental health battle, but they're often overlooked,' ABC News, retrieved 22 April 2021, https://www.abc.net.au/news/2021-04-22/australia-pharmacists-suicide-prevention-training/100029612.

[29] 'Brisbane South Psychological Therapies Program,' Wesley Mission Queensland, 2020, https://www.wmq.org.au/mental-health-services/brisbane-south-psychological-therapies-program; GCPHP, retrieved 19 May 2021, https://bsphn.org.au/wp-content/uploads/2020/10/2020_09_01_Final_Service-Compendium_Downloadable-PDF_MHAOD_Oct2020_SL_V6.pdf, 4, 5; Wellbeing Mental Health Service, *Wesley Mission Queensland*, 2020, retrieved 19 May 2021,https://www.wmq.org.au/mental-health-services/wellbeing-mental-health-service.

[30] 'Talk Suicide Support Service,' *Suicide Prevention Pathways*.

[31] '1300 MH CALL: Mental health access line,' Queensland Government, 2020, retrieved 16 April 2021, https://www.qld.gov.au/health/mental-health/help-lines/1300-mh-call.

[32] See 'Suicide prevention services guide,' Brisbane North PHN, March 2018, retrieved 23 April 2021, https://d1jydvs1x4rbvt.cloudfront.net/downloads/WEB_MHAOD-SP-guide.pdf?mtime=20200303112206&focal=none, 9, 11, 16

[33] Provided by Health4Minds, the Brisbane MIND Suicide Prevention program provides free psychological therapy in a primary care setting to under-serviced groups experiencing financial hardship (similarly to Wesley Mission Queensland's Psychological Therapies Program), who are at risk of suicide, but not at immediate or acute risk. See 'Brisbane MIND – referral information,' Brisbane North PHN, retrieved 23 April 2021, https://d1jydvs1x4rbvt.cloudfront.net/downloads/Mental-health-services/WEB_MHAOD-Brisbane-MIND-Referral-Information-V3-Aug-2020.pdf?mtime=20200803143303&focal=none. As one of the 12 trial sites across Australia that took part in the National Suicide Prevention Trial, Brisbane North PHN also offers suicide prevention programs targeted towards Aboriginal and Torres Strait Islander people, LGBTIQ+ people and men aged 25–55, cohorts who are identified as being at increased risk of suicide due to higher-than-average rates of suicide in the Brisbane North and Moreton Bay region. See 'Suicide prevention services,' Brisbane North PHN, retrieved 20 May 2021, https://brisbanenorthphn.org.au/our-programs/mental-health-services/suicide-prevention-services.

[34] 'How Mates works,' *Mates in Construction AUST Ltd*, 2021, retrieved 19 May 2021, https://mates.org.au/how-mates-works.

[35] 'Mental Health, Suicide Prevention and Alcohol and Other Drug (MHSPAOD) Treatment Services in Brisbane South PHN region,' Brisbane South PHN, retrieved 26 April 2021, https://bsphn.org.au/wp-content/uploads/2020/10/2020_09_01_Final_Service-Compendium_Downloadable-PDF_MHAOD_Oct2020_SL_V6.pdf, p. 12. No information about Brook RED's LGBTIQ+ program could be located online outside of the Brisbane South PHN service directory cited at the beginning of this endnote.

[36] 'Connected and Compassionate (Final Advice),' 40.

[37] 'Prevention Compassion Care: National Mental Health and Suicide Prevention Plan,' 12.

[38] 'Connected and Compassionate (Final Advice),' 40.

[39] 'Northern Gold Coast Suicide Prevention Community Support Program,' *Wesley Mission Queensland*, 2020, retrieved 7 May 2021, https://www.wmq.org.au/mental-health-services/suicide-prevention-initiatives/northern-gold-coast-suicide-prevention.

[40] 'Suicide Prevention Co-Design: Gold Coast PHN,' *Beacon Strategies*, 2020, retrieved 7 May 2021, https://beaconstrategies.net/projects/2020/9/29/gold-coast-phn-suicide-prevention-co-design.

[41] 'Suicide Prevention Co-Design: Gold Coast PHN,' *Beacon Strategies*.

[42] Based on the program information and planning documents provided by Beacon Strategies (see endnotes above).

[43] 'Budget 2019–20: Suicide prevention initiatives,' *Queensland Mental Health Commission*.

[44] The sites were indicated in a communication from Clinical Excellence Queensland, part of Queensland Health. See 'New Crisis Support Spaces in QLD,' retrieved 18 May 2021, https://onwordswings.wordpress.com/2020/05/27/new-crisis-support-spaces-in-qld/. See also 'The Safe Space at TPCH,' 2023, Metro North Health, retrieved 24 February 2023, https://metronorth.health.qld.gov.au/tpch/healthcare-services/the-safe-space; and 'Supporting people in suicidal distress,' Brook RED, retrieved 24 February 2023, https://www.brookred.org.au/supporting-suicidality

[45] 'Budget 2019–20: Suicide prevention initiatives,' Queensland Mental Health Commission; 'New peer support model breaks down barriers,' Metro North Health, 17 December 2020, retrieved 16 May 2021, https://metronorth.health.qld.gov.au/qoc-2020/peer-support.

[46] 'ED alternative: trial underway,' Queensland Mental Health Commission, 2021, retrieved 16 May 2021, https://www.qmhc.qld.gov.au/media-events/news/ed-alternative-trial-underway; 'Living EDge: Ground-breaking suicide prevention space opens at Redland Hospital,' 27 August 2019, Clinical Excellence Queensland, 2020, retrieved 18 May 2021, https://clinicalexcellence.qld.gov.au/about-us/news/living-edge-ground-breaking-suicide-prevention-space-opens-redland-hospital. The information provided from the latter site is correct as at January 2020.

[47] 'Living EDge: Ground-breaking suicide prevention space opens at Redland Hospital,' Clinical Excellence Queensland.

[48] 'ED alternative: trial underway,' Queensland Mental Health Commission.

[49] 'Living EDge: Ground-breaking suicide prevention space opens at Redland Hospital,' Clinical Excellence Queensland; 'ED alternative: trial underway,' Queensland Mental Health Commission.

[50] 'ED alternative: trial underway,' Queensland Mental Health Commission.

[51] 'Living EDge: Ground-breaking suicide prevention space opens at Redland Hospital,' Clinical Excellence Queensland.

[52] Stacey Whitlock, 'Trial extended for Living EDge suicide prevention program at Redland Hospital,' *Redland City Bulletin*, 21 January 2020, retrieved 16 April 2021, https://www.redlandcitybulletin.com.au/story/6590544/redlands-trial-suicide-prevention-program-a-turning-point-hospital-visitors-say/.

[53] 'ED alternative: trial underway,' Queensland Mental Health Commission.

[54] Whitlock, 'Trial extended for Living EDge suicide prevention program.'

[55] Ibid.

[56] 'A moment to PAUSE at the Living EDGE,' Brook RED, World Suicide Prevention Day Community Forum, September 2019, retrieved 16 April 2021, https://www.griffith.edu.au/__data/assets/pdf_file/0028/771580/Final-program.pdf, 24. Further information on findings from the trial period can be found in the report 'Alternatives to Emergency Departments Project Report September 2019,' Consumers of Mental Health WA, 2019, retrieved 18 May 2021, https://www.mhc.wa.gov.au/media/2993/alt-to-ed-and-safe-havens-final-report-2019.pdf, 35–36.

[57] Planning for Wellbeing, Brisbane North PHN.

[58] Planning for Wellbeing, Brisbane North PHN; 'Brisbane North Safe Space Network,' Wesley Mission Queensland, 2020, retrieved 23 April 2021, https://www.wmq.org.au/news-and-events/news/brisbane-norths-safe-space-network.

[59] 'The Way Back Support Service,' Beyond Blue, retrieved 5 March 2021 at https://www.beyondblue.org.au/the-facts/suicide-prevention/after-a-suicide-attempt/the-way-back-support-service.

[60] Greg Carter, Katie McGill, Lisa Sawyer, Danielle Adams, Katrina Delamothe and Ian Whyte, 'The NSW Way Back Support Service (Hunter): Process & Effectiveness Outcomes Evaluation Report,' Version 4, 30 October 2019, retrieved 16 April 2021, https://www.beyondblue.org.au/docs/default-source/the-way-back-evaluation-docs/7-1-hunter-wbss_final-report_v4-4.pdf?sfvrsn=d9826deb_2, 50, 4, 61.

[61] 'Budget 2019–20: Suicide prevention initiatives,' Queensland Mental Health Commission.

[62] 'Prevention Compassion Care: National Mental Health and Suicide Prevention Plan,' 13.

[63] 'The Way Back Support Service,' Wesley Mission Queensland, 2020, https://www.wmq.org.au/mental-health-services/suicide-prevention-initiatives/the-way-back-support-service.

[64] 'Distress Support,' Brook RED, https://www.brookred.org.au/distress-support.

[65] Whitlock, 'Trial extended for Living EDge suicide prevention program.'

[66] Gibson, M. & Crompton, D. (2020). Peer support after suicide-related emergency presentation: Evaluation of the PAUSE pilot. Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane https://51889018-c1d2-4dd3-bafc-dba0c7d13f0c.usrfiles.com/ugd/518890_efbbac9c43734515a66255d5d7eeeec3.pdf

[67] Black Dog Institute. (2021). *The National Suicide Prevention Trial: Insights and Impact*, retrieved 30 September 2021. https://www.blackdoginstitute.org.au/wp-content/uploads/2021/05/The-National-Suicide-Prevention-Trials-Insights-and-Impact_Jan-2021-V3.pdf

[68] For example, the Australian Defence Force Centre for Mental Health, Australian Men's Health Forum Incorporated, Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention, Headspace National Youth Mental Health Foundation Ltd, LGBTIQ+Health Australia, Rural & Remote Mental Health Ltd, among others. See 'Our members,' *Suicide Prevention Australia*, 2021, retrieved 15 April 2021, https://www.suicidepreventionaust.org/support/our-members/.

[79] Black Dog Institute. (2021). *The National Suicide Prevention Trial: Insights and Impact*

[70] 'Brisbane South Mental Health, Suicide Prevention and Alcohol and Other Drug Strategy 2019-2022,' Brisbane South PHN, 2018, retrieved 19 May 2021, https://bsphn.org.au/wp-content/uploads/2019/03/Brisbane-South-Mental-Health-Suicide-Prevention-and-Alcohol-and-Other-Drug-MHSPAOD-Strategy-2019-2022.pdf

[71] This call is embedded in their suicide prevention plan 'Every life: The Queensland Suicide Prevention Plan 2019–2029 Phase One'.

Appendix C.
Client Satisfaction Survey administered by SPP

1. Please type in your unique 6 digit reference code:_____

2. How would you rate the quality of service you have received?
   a. Poor
   b. Fair
   c. Good
   d. Excellent

3. To what extent has our program met your needs?
   a. None of my needs have been met
   b. Only a few of my needs have been met
   c. Most of my needs have been met
   d. Almost all of my needs have been met

4. Did the support you received meet your expectations?
   a. No, definitely not
   b. No, not really
   c. Yes, generally
   d. Yes, definitely

5. If a friend were in need of similar help, would you recommend our program to him or her?
   a. No, definitely not
   b. No, I don't think so
   c. Yes, I think so
   d. Yes, definitely

6. How satisfied are you with the amount of help you received?
   a. Quite dissatisfied
   b. Indifferent or mildly dissatisfied
   c. Mostly satisfied
   d. Very satisfied

7. Have the services you received helped you to deal more effectively with your problems?
   a. No, they seemed to make things worse
   b. No, they didn't really help
   c. Yes, they helped
   d. Yes, they helped a great deal
   e. Please provide further information about what you fund most helpful or unhelpful [Open text response]

Image provided by Unsplash/ Julia Rudakova.

8. Do you feel more knowledgeable and equipped to manage future stressors as a result of the support provided by our service?
   a. Not at all
   b. No, not really
   c. Yes, generally
   d. Yes, definitely
   e. If yes, please provide information about the knowledge and skills you learnt to help you in the future. If no, please provide further information on how we might make improvements. [Open text response]

9. In an overall, general sense, how satisfied are you with the service you have received?
   a. Quite dissatisfied
   b. Indifferent or mildly dissatisfied
   c. Mostly satisfied
   d. Very satisfied

10. If you were to seek help again, would you come back to our program?
    a. No, definitely not
    b. No, I don't think so
    c. Yes, I think so
    d. Yes, definitely

Appendix D.
SPP Support Progress Tool utilised by SPP

1. Enter Your Unique ID:_____

2. Support progress:
   a. Intake
   b. Mid (6)
   c. Mid (12)
   d. Mid (26)
   e. Mid (52)
   f. Exit
   g. Exit – Exit SPT not available
   h. Follow-up

3. Summary Support:
   a. Brief Support (1-2 sessions)
   b. Brief Intervention (1-6 sessions)
   c. Support, Intervention & Education (1-12 sessions)

4. Age:_____

5. Gender:
   a. Male
   b. Female
   c. Transgender
   d. Intersex
   e. Other (please specify):_____

6. Do you identify with any of the following (mark any/all that apply):
   a. Aboriginal and/or Torres Strait Islander
   b. CALD
   c. LGBTIQ++
   d. None of the above
   e. Other (please specify):_____

7. Have you been diagnosed with a mental health issue or illness by a medical practitioner?
   a. Yes
   b. No
   c. N/A

8. In the past 4 weeks have you seen a GP for help in dealing with suicidal thoughts/behaviours?
   a. Yes
   b. No
   c. N/A

9. How many times? [Open text response]

10 In the past 4 weeks have you attended hospital with suicidal thoughts/behaviours?

a. Yes
b. No
c. N/A

11 How many times? [Open text response]

12 Were you admitted?

a. Yes
b. No
c. N/A

13 During the past 4 weeks, how much of the time did you feel so sad nothing could cheer you up?

a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

14 During the past 4 weeks, how much of the time did you feel nervous?

a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

15 During the past 4 weeks, how much of the time did you feel restless or fidgety?

a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

16 During the past 4 weeks, how much of the time did you feel hopeless?

a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

17 During the past 4 weeks, how much of the time did you feel that everything was an effort?

a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

18 During the past 4 weeks, how much of the time did you feel worthless?

a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

Tick the box you feel most relevant to you for the statements below.

19 The future seems to me to be hopeless and I can't see things are changing for the better:

a. Absolutely agree
b. Somewhat agree
c. Cannot say
d. Somewhat disagree
e. Absolutely disagree

20 I feel that it is impossible to reach the goals that I would like to strive for:

a. Absolutely agree
b. Somewhat agree
c. Cannot say
d. Somewhat disagree
e. Absolutely disagree

21 In the past month, how often had you had thoughts about suicide?
(0 = never; 10 = always)

22 In the past month, how much control have you had over these thoughts?
(0 = no control; 10= full control)

23 In the past month, how close have you come to making an attempt?
(0 = not close; 10 = made an attempt)

24 In the past month, to what extent have you felt tormented by your thoughts of suicide?
(0 = not at all; 10 = extremely)

25 In the past month, how much have thoughts of suicide interfered with your ability to carry out daily activities such as work, chores, social activities?
(0 = not at all; 10 = extremely)

26 I am aware of the situations and/or people that increase my thoughts of suicide:
a. Absolutely agree
b. Somewhat agree
c. Cannot say
d. Somewhat disagree
e. Absolutely disagree

27 I am aware of the changes that occur in my thinking, behaviours and moods when my risk is escalating:
a. Absolutely agree
b. Somewhat agree
c. Cannot say
d. Somewhat disagree
e. Absolutely disagree

28 I am aware of healthy coping strategies to keep myself safe:
a. Absolutely agree
b. Somewhat agree
c. Cannot say
d. Somewhat disagree
e. Absolutely disagree

29 In the last week, did you spend time socialising face to face?
a. Yes
b. No
c. Not yet

30 In the last week, did you spend time on the telephone or online with family and friends?
a. Yes
b. No
c. Not yet

31 In the last week, did you do activities away from home with friends or family (see a movie, have dinner, go shopping, see a sports game, have a chat)?
a. Yes
b. No
c. Not yet

32 In the last week, did you go out on your own (to see a movie, have dinner, go shopping, go to a sports game)?
a. Yes
b. No
c. Not yet

33 Are you interested in increasing your social and recreational activities?
a. Yes
b. No
c. Not yet

34 Are you interested in increasing employment?
a. Yes
b. No
c. Not yet

35 How satisfied are you with:
(0= no satisfaction at all; 10= completely satisfied)
a. How safe you feel?
b. What you are achieving in life?
c. Your personal relationships?
d. Feeling part of your community?

36 Have you reviewed your responses?
a. Yes
b. No

37 Please enter notes if survey incomplete. [Open text response]

Image provided by Pexels/ Ruvim.

Appendix E.
Survey for the Referral Network administered by SPP

1. Which best describes the organisation you work for?
   a. Community organisation
   b. Youth organisation
   c. Government
   d. Hospital and health service
   e. General practitioner
   f. Psychologist
   g. School
   h. Other (please specify):_____

2. On average how often do you refer people to Talk Suicide Support Service?
   a. A few times a week
   b. About once a week
   c. A few times a month
   d. Once a month
   e. Less than once a month
   f. Other (please specify):_____

3. How easy is it to refer to Talk Suicide Support Service?
   a. Very easy
   b. Easy
   c. Neither easy nor difficult
   d. Difficult
   e. Very difficult
   f. Other (please specify):_____

4. How would you rate the support that Talk Suicide provides your mutual clients?
   a. Extremely valuable
   b. Very valuable
   c. Somewhat valuable
   d. Not so valuable
   e. Not at all valuable
   f. Unsure

Image provided by Pexels/ Nsu Mon.

5 What do you see as the best feature of the support provided by Talk Suicide Support Service?

a. Free to access
b. Comprehensive safety planning
c. Flexibility
d. Non-clinical
e. Collaborative approach to care
f. Client skill building
g. Other (please specify):_____

6 My clients appear satisfied with the support they receive from Talk Suicide Support:

a. Strongly agree
b. Agree
c. Neither agree nor disagree
d. Disagree
e. Strongly disagree
f. Unsure

7 Do you believe that Talk Suicide Support fills a gap that exists between other services available to support people contemplating suicide?

a. Yes
b. No
c. Unsure

8 I would recommend Talk Suicide Support to other organisations and individuals:

a. Yes
b. No

9 Is there anything else you would like to share with us? [Open text response]

Appendix F.
Questions asked in the ACU-initiated online survey of past service user experiences

1. Can you please outline what kind of support you received from SPP?
   a. 1–2 sessions
   b. Between 2 to 6 sessions
   c. More than 6 sessions

2. How many times have you sought support from SPP?
   a. 1 time – I contacted them, got support and have not asked for support again
   b. I have contacted them for support after my initial involvement/support sessions

3. What do you like about the support offered by SPP? (select all that apply)
   a. Easy referral
   b. Flexibility of contact (phone and/or in-person)
   c. Different from other mental health services
   d. Flexible number of sessions
   e. The staff/workers
   f. Links to other supports
   g. I don't like any features of the support offered by SPP
   h. Other – please provide further information:
   _____

4. In what ways did you feel supported by SPP? [Open text response]

5. What did you find the most helpful about SPP?
   a. The referral process
   b. Supportive counselling
   c. Safety planning
   d. Education
   e. Focus on building my resilience
   f. Goal setting
   g. My worker
   h. Links to other services
   i. Focus on my hopes
   j. Other – please provide further example/s:
   _____

6. Thinking about your response to the previous question, can you tell us why you found it the most helpful? [Open text response]

Image provided by Unsplash/ Mink Mingle.

7 In what ways do you think SPP can do better?

a. Referral process

b. Number of support sessions

c. Location of service

d. Type of support offered

e. Other – please provide further information:

_____

8 Since the time you received support from SPP – are there things you still apply from the sessions now that you find helpful? Please let us know why you find these helpful. [Open text response]

9 Please tell us anything else related to SPP that you would like us to know. [Open text response]

Appendix G.
Prompt questions for interviews with past clients, developed by ACU

1. Can you describe your involvement with SPP/TSS?
2. Can you describe what TSS offered?
3. How did you find the process of safety planning? Can you describe it for me step by step?
4. Were you/How were you linked to any other agencies/ supports? What were they? Are you still using these supports?
5. Can you describe the journey from Intake to Exit?
6. Is there something different or unique about TSS?
7. Were there any barriers that stopped you from getting support from SPP?
8. What elements of the work you did with TSS do you still hold on to and why? Can you share examples?

Post interview – email with supports, voucher details

Appendix H.
Prompt questions for interviews with SPP staff, developed by ACU

1. Can you describe your role at SPP? (Prompts – background, previous work -a little bit about your experience as you came into this service? Years of service, nature of employment)

2. What do you see as really some of the special/unique factors or the unique aspects of SPP, and in particular the Talk Suicide Service?

3. Can you describe the activities of your role? (Prompts – typical day, tasks)

4. Can you tell me about the process of working with a client? (Prompts – client story examples, expand in any unique factors of TSS)
   a. Community connection – How is that process in terms of identifying those key supports with people, and what happens when they have none?
   b. Safety planning?
   c. Intake to Exit?

5. Is there anything that happens at SPP you don't think happens elsewhere (other services)?

6. What helps sustain you to work at SPP?

7. Are there any aspects of the funding of the service that impacts you or you have ideas about?

Post interview – transcript to be sent to staff to review and confirm.

Appendix I.
Research advertisements for past clients, developed by ACU

Text of the advertisement for the survey

HAVE YOU USED SUICIDE PREVENTION PATHWAYS' TALK SUICIDE SUPPORT SERVICE?

Hello,

Suicide Prevention Pathways (SPP) has partnered with Australian Catholic University to understand whether their Talk Suicide Support (TSS) Service is achieving its goal to help individuals who engage with the service stay safe by increasing their resilience to manage future challenges.

We are looking for people who have used the TSS Service to participate in our study. Your views and experiences of SPP's TSS Service will be very valuable and help enhance the service that SPP provides to individuals and the community.

What will I be asked to do?

- Complete a short survey of about 10 to 15 minutes
- Participation is voluntary. We won't ask for your name and your answers will be confidential.

You can withdraw from the study at any time before you submit your anonymous survey.

If you would like to join the study, please access the survey here [link provided]

If you would like more information, please contact:

Dr Sera Harris, Australian Catholic University

Text of the advertisement for interviews

HAVE YOU USED SUICIDE PREVENTION PATHWAYS' TALK SUICIDE SUPPORT SERVICE?

Hello,

Suicide Prevention Pathways (SPP) has partnered with Australian Catholic University to understand whether their Talk Suicide Support (TSS) Service is achieving its goal to help individuals who engage with the service stay safe by increasing their resilience to manage future challenges.

We are looking for people who have used the TSS Service to participate in our study. Your views and experiences of SPP's TSS Service will be very valuable and help enhance the service that SPP provides to individuals and the community.

What will I be asked to do?

Attend an interview with the researcher via Zoom or phone for 45 minutes to an hour, where you will have the chance to discuss your experiences of the TSS service.

- Participation is voluntary. Your answers will be confidential and will not be discussed in an identifiable way with SPP

You can withdraw from the study at any time before or during the interview.

As a token of our appreciation for your time, we are offering EFTPOS vouchers to all interviewees.

If you would like to join the study or would like more information, you can contact the researcher in charge of the study.

Dr Sera Harris, Australian Catholic University

Appendix J.
Text of the research advertisement for SPP staff, developed by ACU

WOULD YOU LIKE TO TAKE PART IN A STUDY ABOUT SUICIDE PREVENTION PATHWAYS' TALK SUICIDE SUPPORT SERVICE?

Hello,

Suicide Prevention Pathways (SPP) has partnered with Australian Catholic University to understand whether their Talk Suicide Support (TSS) Service is achieving its goals to help individuals who engage with the service stay safe by increasing their resilience to manage future challenges.

We are inviting SPP staff who have been involved in providing the TSS Service to participate in our study. Telling us about your experience of providing the TSS Service to clients will greatly assist SPP to enhance the service they provide to individuals contemplating suicide and the community. The study will focus on the SPP service and not on your performance as a staff member.

What will I be asked to do?

- Attend an interview with the researcher via Zoom or phone for 45 minutes to an hour to discuss your views and experience of providing the TSS Service
- We will schedule the interview during your work hours so you can take part while at work

Participation is voluntary and confidential. While you have received this advertisement for the study from the CEO of SPP, the content of your interview will not be discussed in an identifiable way with SPP.

You can withdraw from the study at any time up until 6 weeks after your interview.

If you would like to join the study or would like more information, you can contact the researcher in charge of the study:

Dr Sera Harris, Australian Catholic University

Appendix K.
Participant information letter about the survey for past SPP clients, developed by ACU

PROJECT TITLE

Talk Suicide Support: Assessing the impact of a community-based suicide prevention model

CHIEF INVESTIGATOR

Dr Sera Harris (ACU)

CO-INVESTIGATORS

Vivien Cinque (ACU), Jillian Cox (ACU)

Dear Participant,

You are invited to be part of a research study by Australian Catholic University (ACU) with Suicide Prevention Pathways (SPP).

This letter explains what is involved in the study to ensure you can make an informed decision about participating. Please read it carefully and ask questions about any information in this document.

WHAT IS THE STUDY ABOUT?

The study will evaluate the effectiveness of the Talk Suicide Support (TSS) Service that SPP provides to the community. TSS is a service available to individuals contemplating suicide and their families and friends throughout South East Queensland.

The study aims to identify whether the TSS Service is achieving its goal to help individuals who engage with the service stay safe by enhancing their self-awareness and increasing their resilience to manage future challenges. Sharing your experience of using SPP's services will help enhance the service that SPP provides to individuals and the community.

WHO IS UNDERTAKING THE STUDY?

Dr Sera Harris, a Senior Lecturer in Social Work at ACU. Sera is a researcher and an experienced practitioner in the mental health and youth sectors. Sera's research interests are in mental health, young people and social work practice.

WHAT WILL I BE ASKED TO DO?

You will be asked to complete an online survey.

If you agree to take part in the survey, you can access the survey link at the end of this letter. The link works on computer, smart phone or tablet. The survey aims to collect information from individuals who have previously engaged with the TSS Service in order to understand their experience of the service provided.

While SPP staff will invite you to undertake the survey, the information you give will not be discussed with SPP in a way that identifies you. We will not ask for your name in the survey.

The survey should take 10 to 15 minutes to complete.

Before undertaking the survey, you will be asked to complete an online consent form, which asks whether you agree to your answers being included in the study.

ARE THERE ANY BENEFITS OF PARTICIPATING?

Telling us about your experience using SPP's services will help SPP improve the services they provide to people with suicidal thoughts, their support networks and the community. It's important that we hear from people who have used SPP's services so we can learn from your experience to help SPP better support those who contact them for help in the future.

You do not have to join the study just because you have used SPP's services – it is entirely your choice. Even if you change your mind later about being part of the study, it will not in any way affect your relationship with SPP – you are free to use their services again in the future if you need to.

IS THERE ANY HARM OR RISK IF I JOIN?

While all information collected for the study will be reported as de-identified data, we may use some of the answers you provided and note that they are from someone who participated in the Talk Suicide Prevention Program. If this happens, SPP staff or anyone else who knows you participated in Talk Suicide Support Program may recognise patterns of speech, which may increase the chance of someone knowing you were part of the evaluation. Whilst we will make every effort to ensure that this risk is minimised, this risk is worth considering.

Talking about your experiences with SPP's service may bring up uncomfortable feelings or memories of a difficult time in your life. If this happens, you can call or email Sera [contact details provided] – or speak with one of these organisations:

- 000 – call if you are in an emergency 24 hrs
- Lifeline – 24-hr counselling and crisis support – 13 11 14
- Crisis chat (8pm–12am only) – www.lifeline.org.au/Get-Help/Online-Services/crisis-chat
- Suicide Call Back Service – 24-hr telephone support – 1300 659 467
- 24-hr online chat support: https://www.suicidecallbackservice.org.au/
- Beyond Blue – 24-hr telephone support – 1300 22 4636
- Online support (1pm–12am only) – https://online.beyondblue.org.au/#/chat/start

CAN I WITHDRAW FROM THE STUDY?

It is completely your choice whether to join the study or not.

Before you do the survey, it is important that you think about whether you want to be part of the study. Once you submit your survey, you will not be able to change your mind. If you submit your answers, we cannot remove you from the study, because we will not know which answers you wrote.

If you would like to leave the study, please email or call Sera: [contact details provided]

HOW WILL THE INFORMATION I GIVE BE USED?

During the study, the information you give us will be stored securely in an anonymous format and accessible only by ACU staff. After the study, SPP will have access to the information that was collected but they will not know who participated or who gave which answers.

Any time the information you give us is used, your name will not appear so your answers cannot be linked to you. ACU or SPP may use your answers in reports, presentations, and other public documents and/or given to other researchers, but in a way that does not identify you.

The information you provide will be destroyed by ACU and SPP 15 years after the study is finished or after we publish what we learnt.

WILL I BE ABLE TO FIND OUT THE RESULTS OF THE STUDY?

If you would like to receive a summary of the findings at the end of the project, please email Sera: [contact details provided]

WHO DO I CONTACT IF I HAVE A COMPLAINT?

Please contact Ms Vivien Cinque, Manager, Stakeholder Engaged Scholarship Unit (SESU), ACU Engagement [contact details provided]. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

WHO DO I CONTACT IF I WANT TO JOIN OR HAVE ANY QUESTIONS ABOUT THE STUDY?

To undertake the survey, please use this link [link provided]

If you have any questions, please contact Sera on email or phone [contact details provided]

Yours sincerely

Sera Harris (on behalf of the research team).

Please keep a copy of this information letter for your records.

Appendix L.
Participant information letter about the interview for past SPP clients, developed by ACU

PROJECT TITLE

Talk Suicide Support: Assessing the impact of a community-based suicide prevention model

CHIEF INVESTIGATOR

Dr Sera Harris (ACU)

CO-INVESTIGATORS

Vivien Cinque (ACU), Jillian Cox (ACU)

Dear Participant,

You are invited to be part of a research study by Australian Catholic University (ACU) with Suicide Prevention Pathways (SPP).

This letter explains what is involved in the study to ensure you can make an informed decision about participating. Please read it carefully and ask questions about any information in this document.

WHAT IS THE STUDY ABOUT?

The study will evaluate the effectiveness of the Talk Suicide Support (TSS) Service that SPP provides to the community. TSS is a service available to individuals contemplating suicide and their families and friends throughout South East Queensland.

The study aims to identify whether the TSS Service is achieving its goal to help individuals who engage with the service stay safe by enhancing their self-awareness and increasing their resilience to manage future challenges. Sharing your experience of using SPP's services will help enhance the service that SPP provides to individuals and the community.

WHO IS UNDERTAKING THE STUDY?

Dr Sera Harris, a Senior Lecturer in Social Work at ACU. Sera is a researcher and an experienced practitioner in the mental health and youth sectors. Sera's research interests are in mental health, young people and social work practice.

WHAT WILL I BE ASKED TO DO?

You will be asked by SPP staff if you are interested in undertaking an interview with Sera to discuss your experiences with the SPP service. If you agree, you will attend a one-on-one interview with Sera for about 45 minutes to an hour via Zoom, which can be accessed by a computer or phone, depending on your preference. We will be interviewing up to five people who have previously used SPP's services. While SPP staff will invite you to undertake the interview, the information you give will not be discussed with SPP in a way that identifies you.

As a token of our appreciation for your time, we are offering $50 EFTPOS vouchers to all interviewees.

You will be asked to complete a consent form electronically before the day of your interview. The form confirms that you agree to the de-identified information you give to be included in the study (meaning that your name will be removed from the information you give during your interview so that your answers will not be linked to you). Before the interview begins,

Sera will check with you to make sure you are comfortable proceeding.

We would like to audio record your interview so we can prepare a transcript of the conversation that records what you have said for us to use later. The transcript will not include your name or contact details. Once we prepare the transcript, the recording will be deleted. However, you can tell us if you do not want your interview to be audio recorded by not ticking the question that asks about this when you complete the consent form.

You should ensure that you can choose a confidential setting for your interview to take place so you can talk freely and comfortably. If you experience any interruptions on your end during your interview, please let Sera know so that she can pause or postpone the interview to another suitable time.

If there are technical issues during your interview, such as poor or lost connection, please attempt to reconnect/redial. Sera will also attempt to reconnect or call you again. If this is not successful, Sera will contact you as soon as possible to arrange another time.

ARE THERE ANY BENEFITS OF PARTICIPATING?

Telling us about your experience using SPP's services will help SPP improve the services they provide to people with suicidal thoughts, their support networks and the community. It's important that we hear from people who have used SPP's services so we can learn from your experience to help SPP better support those who contact them for help in the future.

You do not have to join the study just because you have used SPP's services – it is entirely your choice. Even if you change your mind later about being part of the study, it will not in any way affect your relationship with SPP – you are free to use their services again in the future if you need to.

IS THERE ANY HARM OR RISK IF I JOIN?

While all information collected for the study will be reported as de-identified data, we may use some of the answers you provided and note that they are from someone who participated in the Talk Suicide Prevention Program. If this happens, SPP staff or anyone else who knows you participated in Talk Suicide Support Program may recognise patterns of speech, which may increase the chance of someone knowing you were part of the evaluation. Whilst we will make every effort to ensure that this risk is minimised, this risk is worth considering.

Talking about your experiences with SPP's service may bring up uncomfortable feelings or memories of a difficult time in your life. If this happens, you can call or email Sera [contact details provided] – or speak with one of these organisations:

- 000 – call if you are in an emergency 24-hrs
- Lifeline – 24-hr counselling and crisis support – 13 11 14
- Crisis chat (8pm-12am only) – www.lifeline.org.au/Get-Help/Online-Services/crisis-chat
- Suicide Call Back Service – 24-hr telephone support – 1300 659 467
- 24-hr online chat support: https://www.suicidecallbackservice.org.au/
- Beyond Blue – 24-hr telephone support – 1300 22 4636
- Online support (1pm-12am only) – https://online.beyondblue.org.au/#/chat/start

CAN I WITHDRAW FROM THE STUDY?

It is completely your choice whether to join the study or not.

If you choose to have an interview with Sera, you are free to leave the study at any time before or during the interview. The information you provide prior to leaving will be deleted, including the audio recording of your interview (if it has been recorded).

If you would like to leave the study, please email or call Sera: [contact details provided]

HOW WILL THE INFORMATION I GIVE BE USED?

During the study, the information you give us will be stored securely in a de-identified format and accessible only by ACU staff. After the study, SPP will have access to the information that was collected but they will not know who gave which answers.

Any time the information you give us is used, your name will not appear so your answers cannot be linked to you. ACU or SPP may use your answers in reports, presentations, and other public documents and/or given to other researchers, but in a way that does not identify you.

The information you provide will be destroyed by ACU and SPP 15 years after the study is finished or after we publish what we learnt.

WILL I BE ABLE TO FIND OUT THE RESULTS OF THE STUDY?

If you would like to receive a summary of the findings at the end of the project, please email Sera: [contact details provided]

WHO DO I CONTACT IF I HAVE A COMPLAINT?

Please contact or Ms Vivien Cinque, Manager, Stakeholder Engaged Scholarship Unit (SESU), ACU Engagement [contact details provided]. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

WHO DO I CONTACT IF I WANT TO JOIN OR HAVE ANY QUESTIONS ABOUT THE STUDY?

If you have any questions, please contact Sera on email or phone [contact details provided].

Yours sincerely,

Sera Harris (on behalf of the research team).

Please keep a copy of this information letter for your records

Appendix M.
Participant information letter about the research for SPP staff, developed by ACU

PROJECT TITLE

Talk Suicide Support: Assessing the impact of a community-based suicide prevention model

CHIEF INVESTIGATOR

Dr Sera Harris (ACU)

CO-INVESTIGATORS

Vivien Cinque (ACU), Jillian Cox (ACU)

Dear Participant,

You are invited to be part of a research study by Australian Catholic University (ACU) with Suicide Prevention Pathways (SPP).

This letter explains what is involved in the study to ensure you can make an informed decision about participating. Please read it carefully and ask questions about any information in this document.

WHAT IS THE STUDY ABOUT?

The study will evaluate the effectiveness of the Talk Suicide Support (TSS) Service that SPP provides to individuals contemplating suicide and their families and friends throughout South East Queensland.

The study aims to identify whether the TSS Service is achieving its goals to help individuals who engage with the service stay safe by enhancing their self-awareness and increasing their resilience to manage future challenges.

We are inviting individuals who have previously engaged with the TSS Service to complete an anonymous survey and (for up to five participants) to attend an interview, to understand their experience of the service provided.

As part of the study, we are also inviting SPP staff to attend an interview to help understand their experience of providing the TSS Service. Telling us about your experience of providing SPP's services as a staff member will help enhance the service that SPP provides to individuals and the community.

Who is undertaking the study?

Dr Sera Harris, Senior Lecturer in Social Work at ACU. Sera is a researcher and an experienced practitioner in the mental health and youth sectors. Sera's research interests are in mental health, young people and social work practice.

Image provided by Unsplash/ Krystal Ng.

WHAT WILL I BE ASKED TO DO?

If you agree, you will attend a one-on-one interview with Sera for about 45 minutes to an hour either via Zoom, which can be accessed by a computer or phone, depending on your preference. We are keen to gain your expertise and insights into providing SPP's services to individuals and the community and, as such, the interview questions will focus on the SPP service and not on your performance as a staff member.

While SPP staff will invite you to undertake the interview, the information you give will not be discussed with SPP in a way that identifies you.

You will be asked to complete a consent form electronically before the day of your interview. The form confirms that you agree to the de-identified information you give to be included in the study (meaning that your name and other identifying details will be removed from the information you give during your interview so that your answers will not be linked to you). Before the interview begins, Sera will check with you to make sure you are comfortable proceeding.

We would like to audio record your interview so we can prepare a transcript of the conversation that records what you have said for us to use later. The transcript will not include your name or contact details. Once we prepare the transcript, the recording will be deleted. However, you can tell us if you do not want your interview to be audio recorded by not ticking the question that asks about this when you complete the consent form.

As the interview relates to your work as an SPP employee, the interview will be undertaken during your work day. If attending your interview at the SPP office, we recommend you choose a private room to ensure your conversation is confidential. If attending your interview while working from home, you should ensure that you can choose a confidential setting so you can talk freely and comfortably. If you experience any interruptions on your end during your interview, please let Sera know so that she can pause or postpone the interview to another suitable time.

If there are technical issues during your interview, such as poor or lost connection, please attempt to reconnect/redial. Sera will also attempt to reconnect or call you again. If this is not successful, Sera will contact you as soon as possible to arrange another time.

After the interview, you will have a chance to review a transcript of the interview to add or correct any information. Any information you choose to remove will not be included in the study. You will have two weeks to return the transcript to us after it has been provided to you. If you do not return your transcript after two weeks you are confirming you are happy with the contents.

ARE THERE ANY BENEFITS OF PARTICIPATING?

Your contributions will help SPP improve the services they provide to people with suicidal thoughts, their support networks and the community. Hearing from SPP staff will help us identify gaps in SPP's service and/or ways SPP can review its service framework to better support individuals who ask for support and referrers to SPP in the community.

IS THERE ANY HARM OR RISK IF I JOIN?

We do not foresee any major risks from your involvement in the study, but wish to highlight that while all information collected for the study will be reported as de-identified data, we may note that the answers you provided are from someone who works at SPP when the findings are reported. As there are relatively few staff at SPP, if you are quoted, there is a chance that someone reading the findings could recognise familiar patterns of speech, which could increase the risk of your identity being known by others. Whilst we will make every effort to ensure that this risk is minimised, this risk is worth considering. You will also have the chance to review your interview transcript to ensure that nothing you have said identifies you personally.

Your decision to participate will not be known by other staff at SPP unless you tell them.

We wish to highlight that although the interview relates to your work as an SPP employee, your decision to participate or not will in no way affect your relationship with or employment at SPP. It is not a requirement of your role at SPP to join the study and your participation in the study will not be used to evaluate your individual or organisational performance in any way.

As participation in this research involves the topic of suicide, which people might find sensitive, if you feel discomfort or distress because of your involvement in the study, you are free to contact Sera [contact details provided] – or contact one of the following support services:

- Lifeline – 13 11 14 or www.lifeline.org.au/Get-Help/Online-Services/crisis-chat
- Beyond Blue – 1300 22 4636 or https://online.beyondblue.org.au/#/chat/start

CAN I WITHDRAW FROM THE STUDY?

It is completely your choice whether to join the study or not.

If you agree to participate in the interview, you are free to leave the study at any time before or during the interview, and up to six weeks after the interview. After this time your data will be de-identified and aggregated and we will not be able to tell which answers you provided. The information you provide prior to withdrawing will be deleted, including the audio recording of your interview (if it has been recorded).

If you would like to leave the study, please email or call Sera: [contact details provided]

HOW WILL THE INFORMATION I GIVE BE USED?

The answers you provide in your interview will be confidential and de-identified: that is, we will remove your name from your answers so that they will not be linked to you, but we may record that they were given by a staff member at SPP. ACU or SPP may use the information you provide in reports, presentations, and other public documents and/or given to other researchers.

During the study, the information you give us will be stored securely in a de-identified format and accessible only by ACU staff. If it was recorded, the recording of your interview will be deleted once the transcript is prepared. After the study, SPP will have access to the information that was collected but they will not know who gave which answers.

At the conclusion of the study, de-identified data will be stored securely by ACU and SPP and destroyed 15 years following publication or completion of this study.

WILL I BE ABLE TO FIND OUT THE RESULTS OF THE STUDY?

If you would like to receive a summary of the findings at the end of the project, please email Sera [contact details provided].

WHO DO I CONTACT IF I HAVE A COMPLAINT?

Please contact Ms Vivien Cinque, Manager, Stakeholder Engaged Scholarship Unit (SESU), ACU Engagement [contact details provided]. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

WHO DO I CONTACT IF I WANT TO JOIN OR HAVE ANY QUESTIONS ABOUT THE STUDY?

If you want to join the study or have any questions, please contact Sera on email or phone: [contact details provided].

Yours sincerely,

Sera Harris (on behalf of the research team).

Please keep a copy of this information letter for your records

Appendix N.
Text of the online consent form for past SPP clients participating in the survey, developed by ACU

PROJECT TITLE

Talk Suicide Support: Assessing the impact of a community-based suicide prevention model

CHIEF INVESTIGATOR

Dr Sera Harris (ACU)

CO-INVESTIGATORS

Vivien Cinque (ACU), Jillian Cox (ACU)

Your name: *[Free text field so name can be added]*

Tick ☐ if you agree:

☐ I understand the information in the Participant Information Letter and any questions I had have been answered to my satisfaction.

☐ I agree to participate in the anonymous survey.

☐ I understand I can withdraw from the study before or during the survey and if I choose to withdraw my information from the survey the responses will be deleted. I understand I cannot withdraw after I submit the survey responses.

☐ I agree to the information I give in the survey being published in reports, presentations, and other public documents and/or given to other researchers in a form that does not identify me in any way.

Please click **SUBMIT** to send your consent to the researchers.

Appendix O.
Text of the online consent form for past SPP clients participating in the interview, developed by ACU

PROJECT TITLE

Talk Suicide Support: Assessing the impact of a community-based suicide prevention model

CHIEF INVESTIGATOR

Dr Sera Harris (ACU)

CO-INVESTIGATORS

Vivien Cinque (ACU), Jillian Cox (ACU)

Your name: *[Free text field so name can be added]*

Tick ☐ if you agree:

☐ I understand the information in the Participant Information Letter and any questions I had have been answered to my satisfaction.

☐ I agree to participate in an interview with the researcher via Zoom or phone for about 45 minutes to 1 hour.

☐ I agree to my interview being audio-recorded. I understand that the researchers will use the recording to generate a transcript of the interview and that once they prepare the transcript, the recording will be deleted [please leave box un-ticked if you do not agree to your interview being recorded].

☐ I understand I can withdraw from the study before or during my interview and if I choose to withdraw, the information I provide prior to leaving will be deleted, including the recording of my interview (if I agreed that it could be recorded).

☐ I agree to the information I give in my interview being published in reports, presentations, and other public documents and/or given to other researchers in a de-identified format that does not identify me in any way.

Please click **SUBMIT** to send your consent to the researchers.

Appendix P.
Text of the online consent form for SPP staff participating in the interview, developed by ACU

PROJECT TITLE

Talk Suicide Support: Assessing the impact of a community-based suicide prevention model

CHIEF INVESTIGATOR

Dr Sera Harris (ACU)

CO-INVESTIGATORS

Vivien Cinque (ACU), Jillian Cox (ACU)

Your name: *[Free text field so name can be added]*

Tick ☐ if you agree:

☐ I understand the information in the Participant Information Letter and any questions I had have been answered to my satisfaction.

☐ I agree to participate in an interview with the researcher via Zoom or phone for about 45 minutes to 1 hour.

☐ I agree to my interview being audio-recorded. I understand that the researchers will use the recording to generate a transcript of the interview and that once they prepare the transcript, the recording will be deleted [please leave box un-ticked if you do not agree to your interview being recorded].

☐ I understand I can withdraw from the study before, during or up to six weeks after my interview and if I choose to withdraw, the information I provide prior to leaving will be deleted, including the recording of my interview (if I agreed that it could be recorded).

☐ I agree to the information I give in my interview being published in reports, presentations, and other public documents and/or given to other researchers in a de-identified format that does not identify me in any way.

Please click **SUBMIT** to send your consent to the researchers.

Appendix Q.
Debriefing statement provided to past SPP clients after participating in the survey or interview

DEBRIEFING STATEMENT

Thank you for participating in this study called: 'Talk Suicide Support: Assessing the impact of a community-based suicide prevention model'. We appreciate your time in participating in this study. Although participating in this study was time consuming, it is important for people providing community services to have reliable information to improve their service delivery.

We would like to acknowledge that this research has involved several topics that people might find sensitive. If you feel any level of discomfort or distress as a consequence of participating in this study, please feel free to contact the Chief Investigator via email [contact details provided] or the Suicide Prevention Pathways support team on 1800 008 255.

Other support services are available to you:

- 000 – call if you are in an emergency 24-hrs
- Lifeline – 24-hr counselling and crisis support – 13 11 14
- Crisis chat (8pm-12am only) – www.lifeline.org.au/Get-Help/Online-Services/crisis-chat
- Suicide Call Back Service – 24-hr telephone support – 1300 659 467
- 24-hr online chat support: https://www.suicidecallbackservice.org.au/
- Beyond Blue – 24-hr telephone support – 1300 22 4636
- Online support (1pm-12am only) – https://online.beyondblue.org.au/#/chat/start

We once again thank you for your time and involvement in this study. If you have any questions or would like to receive a summary of the findings from the study after it has been completed, please do not hesitate to contact the Chief Investigator via email (details above).