lifeline International

The Benefits of Investment in Crisis Support Services

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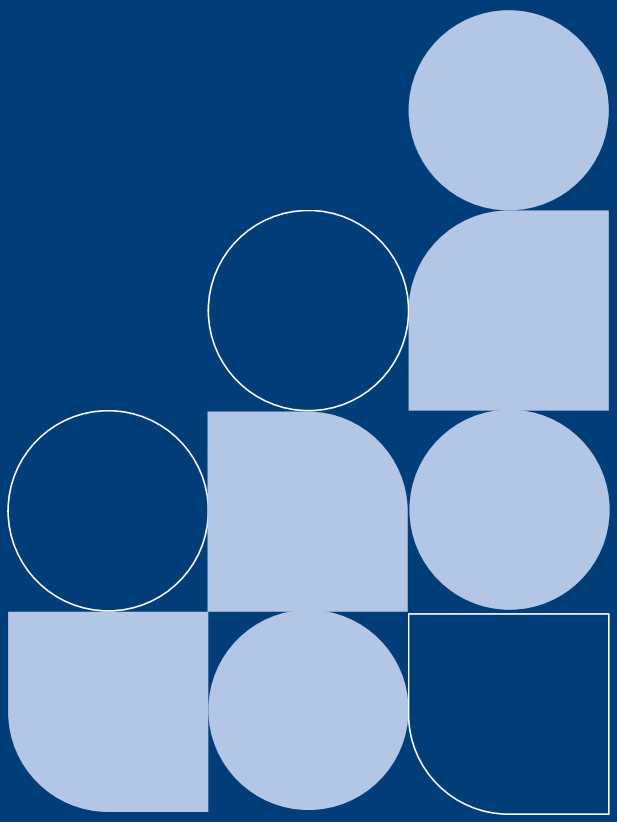

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SUMMARY

Telephone crisis helplines and more recently online chat and crisis text or messaging services are found throughout the world. They operate in an estimated 138 countries, meaning that for almost two-thirds of the world's population there is a service in their country. These services emerged in the 1950's and have grown in reach, geographic spread, and technological capability. They are now known as digital crisis support services, operating within the broader digital ecosystem which includes AI and social media platforms.

Digital crisis support services are effective in two key ways as universal health services: they reach people experiencing elevated distress and provide rapid relief to reduce the risk of mental health problems, such as anxiety or depressive conditions; they attract people considering suicide and enable crisis intervention to de-escalate the suicidal urge and prevent a death.[1] In doing so, digital crisis support services contribute to the prevention and moderation of two public health concerns: mental health and suicide.

Mental ill-health and suicide and self-harm have economic impacts as well as social impacts. Both generate direct costs in the usage and overall demand for health services, and direct costs in the provision of non-health services including transport, emergency services, childcare. In addition, mental health and suicide/self-harm generate indirect costs through productivity losses. Intangible economic impact can also be estimated when a monetary value is applied to the population health measure Disability Adjusted Life Years (DALYs) which measures losses due to people experiencing disabling effects of a health condition, as well as premature deaths. To illustrate, a global study of the economic impact of mental health disorders including suicide and self-harm, chronic pain, alcohol and drug use and neurological disorders, reported these disorders combined accounted for 16% of the global (DALYs) or 418 million DALYs in 2019, at an estimated economic value of USD$5 trillion, equivalent to 4% of gross domestic product in Eastern sub-Saharan Africa and 8% in High-income North America.[2]

To minimise the economic impacts of mental ill-health and suicide/suicide-harm public health strategies are required to address earlier prevention as well as the provision of effective services to provide support, healthcare and treatments for individuals.

Digital crisis support services provide this. They are available to anyone with a mobile phone or computer. They operate as a safety net to reach people, address immediate needs, and link people to other services. They are private and easy to use, lessening the barriers to seeking help that stigma and discrimination can generate. They are an essential service in any health system for mental health and suicide prevention.

Despite the vital function that digital crisis support services perform, there are few services worldwide that receive ongoing and sufficient funding for their operations. Accordingly, a significant gap exists in service capacity to meet demand. The economic and societal benefits of these services are constrained when this occurs. There is a strong case for investment in these services, at scale, to realise their potential impact.

THE IMPACT OF SUICIDE

Suicide is a global public health priority. The World Health Organisation reports that there are an estimated 720,000 deaths by suicide every year: this places suicide alongside malaria, HIV/AIDs, breast cancer, war and homicide. While suicide rates have declined worldwide over the past 20 years, this trend is not evenly spread with countries in the African and Southeast Asian regions experiencing rising suicide rates.[3] Health equity considerations also apply with low- and middle-income countries accounting for 73% of the deaths by suicide each year. There are also demographic considerations with suicide now the third leading cause of death for people aged under 29 years, and youth suicide rates are increasing in most regions around the world.[4, 5]

It is not just the deaths by suicide that create the public health imperative for prevention. For every death by suicide, it is estimated that up to 20 people make suicide attempts that are non-fatal. Although there are no global estimates or data reported on the prevalence of suicidal ideation and attempts, some insights may be gained from an Australian survey that revealed in 2020–2022 that in their lifetime 16.6% of adults had experienced suicidal ideation, 7.5% had made suicide plans 4.9% had attempted suicide.[6] For younger people, studies have revealed that between 14% and 23% of youth experience suicidal ideation, between 4% and 24% have made a plan to end their lives, and between 5% and 16% have experienced a suicide attempt.[7]

Suicide attempts can result in severe injury and ongoing disability, and related costs, for the person, with some estimates suggesting up to one fifth of those who are injured by a suicide attempt experience ongoing disability as a result.[8] Crucially, those who survive a suicide attempt are themselves of greater risk of death by suicide later in life if supports and recovery services are not provided.[9]

The impact of suicide is also found on those who are exposed to another's suicide and accordingly are themselves at higher risk of suicidal ideation - which could result in suicide attempts and deaths. A recent publication reported: "The lifetime prevalence of losing a family member to suicide is 4%, and the lifetime prevalence of losing a friend to suicide is 14.5%. The suicide of a relative triples an individual's odds of suicide or suicide attempt, and the suicide of a friend or acquaintance increases these odds by a factor of 2.5."[10] Around 135 people are exposed to each death by suicide[11]. One estimate is that almost half the US population has been exposed to suicide during their lifetime[12].

Suicide prevention therefore has a cumulative benefit in reducing exposures to suicides: reductions in people's exposure to suicide reduces their risk to suicide.

It is important to acknowledge that the research evidence described is mostly generated from higher income countries; for low- and middle-income countries the situation is likely to be similar or higher, and it is within those countries that most suicide deaths occur.

THE COST OF SUICIDE

VVarying methodologies are used to estimate the cost of suicide. Some examine direct costs, such as the cost of emergency and health services, or the loss of productivity through premature exit or absence from the workforce. Others examine public health and societal, or intangible costs, of suicide/self-harm – placing a value on retaining health and life.

A study in Aotearoa/New Zealand in 2005 illustrates how these two methodologies can be applied. First, the cost of suicide and self-harm was calculated in terms of services used and lost production, i.e. the direct costs. This cost was estimated to be $448,250 for each death by suicide and $6,350 for each attempt of suicide/injurious self-harm, making a total of $32.3 million in 2002. Second, the broader intangible costs were examined by applying the DALY to a Value of Statistical Life, set at $2.25 million. This cost was estimated to be $1.15 billion for the 19,218 life years lost in 2002.[13] The latter is much higher.

There are no global estimates on the cost of suicide. Studies of selected populations, however, using loss of economic production, provide insight on what the levels may be. A European study in 2021 assessed the direct economic production losses attributable to suicide by calculating the average worker productivity for life expectancy, and the losses of this productivity associated with a gender-specific suicide death at a certain age. It estimated each suicide death resulted in a loss of €213,088 , amounting to €9.07 billion across the 28 European Union states, or 0.061% of the EU-28 GDP.[14] The economic impact of youth suicide in countries with a high human development index (generally higher income countries was estimated by determining that 6,912 young lives lost to suicide resulted in 406,730 years of life lost, (YLLs), which resulted in an economic loss of $5.53 billion, based on an average cost of $802,939 per death.[15] An indication of the cost of suicide in low-middle income countries emerged in 2024, with a systematic review of studies finding the economic burden of suicide based on Years of Life Lost (YLL) at between US$15,006 to US$621,166 per death by suicide, depending on the country.[16]

A more recent study in the US in 2024 combined direct and indirect methodologies to estimate the total economic cost of suicide and self-harm at US$510 billion per year, adding the measure of Value of Statistical Life (VSL) to count the cost of the 50,000 lives lost, as well as calculating direct medical and healthcare related costs, injury morbidity, and loss of employment (production) due to injury (for 12 months following the injury).[17] This is perhaps the closest estimate of the economic cost of suicide, but unfortunately is restricted only to a high income country and not generalisable globally.

Suicide: Contribution of Crisis Support Services

Crisis support services contribute to the prevention of suicide. They attract suicidal persons and are equipped to identify suicidal distress and respond appropriately. Crisis support services attract people in suicidal crisis and provide the opportunity for crisis intervention to prevent loss of life. Large volume services such as the US 988 service and Lifeline Australia have reported that around 35%-45% of all contacts are from people who are suicidal[18, 19] with 5% to 15% of calls/contacts are from people at imminent risk of death or injury.[20-22] Crisis support services create an opportunity for intervention to avert this death or injury.

The initial contact with a crisis support service can be lifesaving. A study of callers to the US national suicide prevention lifeline found suicidal desire reduced during the call with 12% of callers in this study reporting that the crisis line call prevented them from killing themselves.[23] A current study of US 988 found most of those Lifeline callers who were suicidal at the time thought their crisis call helped them (98%) and stopped them from killing themselves (88%).[24]

Provided adequate follow up support occurs, a person who has contemplated or attempted suicide is likely to recover and not re-attempt suicide. A Belgium study estimated that over 10 years people's use of the telephone and chat services meant that about 36% of suicides and first suicide attempts were avoided. The analysis found that at a population level, the investment of €218,899 in the operation of the Belgium crisis line and chat services saved €1,452,022 for the public health service. This translated into a return on investment of 6.6.[25]

THE COST OF PSYCHOLOGICAL DISTRESS

Psychological distress is associated with emotional distress (feelings of worry, sadness, stress, anger) and negative moods (such as sadness, anguish, restlessness). It is an indicator of declining mental health and often observed alongside a person's experience of difficulties and negative life events, or relationship difficulties. Individual and societal functionality is related to lower levels of psychological distress.

Critically, psychological distress is associated with destructive behaviours including violence, alcohol and substance abuse and suicide and self-harm. The association with suicide was documented in study on the use of the K10 measure (for clinical assessment of levels of psychological distress) in suicide prevention.[26] The association between higher K10 recordings and suicidality is shown in the following diagram:

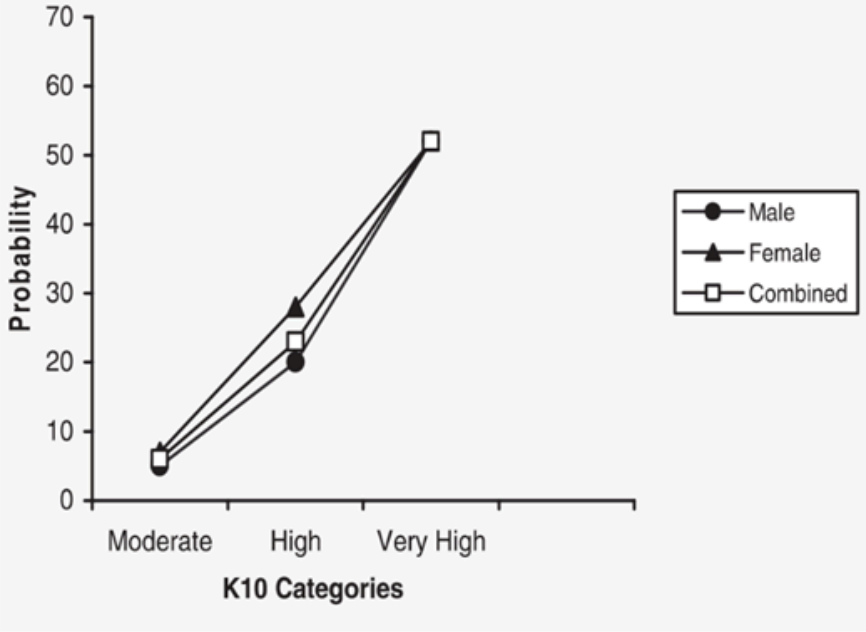

Figure 1. P (suicide ideation) for male, female, and overall sample as a function of K10 classification.

Reinforcing the public health value of addressing psychological distress, the seminal publication on social determinants of health, titled The Solid Facts (WHO 2003) stated that stress affected mental health (anxiety and depression) and physical health, the latter being through cardiovascular and immune systems. It recommended governments address both psychosocial and material needs of their people to reduce stress, support families, combat social isolation and promote coping skills.[27]

Levels of psychological distress are increasing. A global study across 113 countries using annual representative survey data from 1.53 million people from 2009 to 2021 found emotional distress (worry, sadness, stress, anger) had increased from 25% of the survey group to 31% in this period. Those with lower levels of education and income experienced the largest increases in this distress.[28]

These results were similar to those in a study across 149 countries from 2007 to 2021 found most (85%) of countries reported worse psychological stress in 2020 compared to 2008. This experience was spread across location and employment status; however, psychological wellbeing had declined most rapidly amongst younger people compared to older age groups. This study suggested widespread experiences of psychological distress across all countries, with 30%-50% of the populations in 77 countries experiencing psychological distress. The study authors noted that attention to physical pain and financial insecurity, as well as social safety nets and services to alleviate socio-economic pressures, were more important than health programs alone for decreasing this stress. [29]

Across OECD European countries, the prevalence of psychological distress in populations ranges from under 10% to 30%. This demonstrates that psychological distress is a predictable, measurable and preventable element of population health. Increasingly, psychological distress is being recognised as an important element of a public health strategy.

There are economic costs related to higher levels of psychological distress for individuals, families/households, employers/industries and national economies.

An Australian study found moderate to high psychological distress adversely affects people's job productivity through increased sickness absence, higher likelihood of presenteeism and greater levels of underemployment. The study estimated people with moderate and high psychological distress incur additional annual sickness costs of AUD$60.66 and AUD$99.26 annually respectively, compared to people with low psychological distress. Also, people with moderate and high psychological distress experience additional costs through presenteeism at AUD$1,166.30 and AUD$3,656.05 respectively, each year. The study concludes that addressing psychological distress should be prioritised as an employee wellbeing and workplace productivity policy.[30]

Another Australian study reported an association between moderate and high psychological distress and health state utility values to determine its influence on quality of life and daily functioning, such as hindered concentration, relationships and work or school performance, often presenting as anxiety or depressive symptoms. The study found that rising psychological distress has a negative effect on health state utility values and that high psychological distress led to a significant reduction in the health state utility values.[31] This has implications for population health, noting that there are economic and social impacts on declining health state utility values. Some researchers also contend that prolonged psychological distress is associated with chronic diseases such as depression, cardiovascular disease and HIV-AIDS[32].

A USA study on the economic impact of younger people's experience of elevated psychological distress found that a hypothetical policy that prevented 10% of youth developing clinically significant (high) levels of psychological distress could lead to USD$52 billion in federal budget benefit over 10 years in reduced labour support costs alone.[33]

Psychological Distress: Contribution of Crisis Support Services

Crisis support services are effective in attracting people experiencing elevated distress and de-escalating this distress level. They are somewhat uniquely placed as services to achieve this outcome; while other services may incidentally reduce psychological distress, crisis support services operate under a service model designed to address emotional distress, enable befriending and social connection interactions and develop the coping capabilities for a person through an empowerment-oriented approach. They are frontline, accessible and open services that can address psychological distress.

A systematic review of research literature identified 33 studies and concluded that around half of these reported immediate proximal outcomes for service users, i.e. that during the call there were reductions in distress levels, and improvements in mood. Around 17 of these studies reported that in the period after contact with a crisis support service, the service users took steps to address issues in their lives, strengthened their coping capabilities and accessed other forms of support including mental health and community services.[33]

A study on befriending found it provided a less medicalised approach to emotional distress that could prevent individuals at risk of developing mental health problems.[34]

Crisis support services create a pathway for people to address the underlying stressors in their lives through accessing other social and health services. An early study found 64% of callers to a crisis line had taken action to access treatments within two weeks of contact with the service.[35] A later study of young people found 71% of those surveyed had taken specific action to follow up with other services after the call.[36] In a large study on the mental health care use of those who called the US national crisis line, Gould et al found that around 50% of those who received a referral to a mental health care service made use of those referrals and received that care.[37] Vulnerable groups benefit from this pathways function: 85% of callers to a veterans crisis line made contact with health care and 79% made contact with mental health services.[38]

A Social Return on Investment study of an online crisis support service considered the economic benefit of the service for users that were at high risk of suicide but also identified another cohort of service users that were less imminently at risk of suicide, for whom use of the service resulted in them taking earlier, preventative action and engaging with other health and social services to avert a suicidal crisis. This study concluded that at a population level the greatest economic benefit was for the second group. It concluded that an investment of AUD$860,517 to operate the generated a social return valued at AUD$7.642m; that is, a return valued at AUD$8.40.[39] These benefits were allocated across health, emergency services as well as wider community employment and social outcomes.

Importance of Investment in Crisis Support Services

Crisis support services are immediate, open and convenient services for people in distress. Crisis support services reach people who otherwise will be missed. They are confidential, safe environments for people to disclose their emotions, their thoughts and suicidal urges without judgement or fear of negative consequences for doing so. The provide pathways to other services and treatments for mental health conditions.

A recent position statement endorsed by all crisis support service networks globally summed up the description of these services as: *"universal, immediate support services for people experiencing elevated distress and emotions surrounding experiences or difficulties in their lives that they are struggling to cope with."* These services are widely known for being available for people 'in crisis' – a place to turn to.

Crisis support services are essential, infrastructure, services in any health system. They provide a safety net for mental health and suicide prevention.

Unfortunately, this safety net has too many holes to perform its purpose.

There are 63 countries which do not have a digital crisis support service. Over one billion people cannot connect to a service when they need to. Mostly it is low-middle income countries that are without a service, reinforcing existing inequities in mental health and psychosocial supports.

Furthermore, many services face funding and resource shortages. Few services receive ongoing and sufficient funding for their operations. Only a few of the wealthiest countries such as Australia and the United States of America provide substantial funding and integrate digital crisis support services in a broader service environment. Most crisis support services are operated by non-government organisations or charities that must compete with others and different funding causes in their attempts to generate sufficient resources to be able to match service demand.

Accordingly, a significant gap in funding exists, and there is a commensurate gap in service capacity. Many services struggle to answer all the calls/contacts that they receive. People, communities and nations are left without adequate cover against a predictable public health concern: periodic experiences of psychosocial distress which can progress to suicide and self-harm behaviour. The crisis support safety net as it exists cannot meet the goal of every person in crisis having someone to listen, care for them, check their safety and help them find ways to cope and improve their lives.

Glossary

Disability Adjusted Life Years (DALYs) measure the total burden of disease or health conditions, taking into account both fatal and non-fatal health losses, expressed as the number of years lost of full health, which for mental health and wellbeing represents years with full functionality, ability to cope with stresses of life, learn and work, and contribute to society, if the WHO definition of mental wellbeing is applied.

Mental Health Good mental health enables individuals to realise their own potential, cope with the stresses of life, work productively and make a positive contribution to their communities. (World Health Organisation 2019)

Psychological Distress refers to non-specific symptoms of negative affect (such as sadness, anguish, restlessness), often associated with emotional distress (feelings of worry, sadness, stress, anger). It is sometimes combined with somatic symptoms (such as inability to sleep or loss of appetite) that do not reach the clinical threshold of a diagnosis within psychiatric classification systems. Psychosocial factors such as personal meaning and optimism, personal relationships and sense of belonging, loneliness, social exclusion and discrimination, violence, financial hardship, are known to be associated with psychological distress levels.

Value of a Statistical Life (VSL) refers to an economic metric that estimates the value a society places on reducing the risk of a person dying. This ‘statistical life’ is not the life of a particular person but for the purposes of the value proposition is generally assumed to be a young adult with at least 40 years of life ahead. The VSL is calculated by measuring how much society is willing to pay to reduce the risk of death. This can be done by population surveys that generate responses on ‘acceptable’ expenditures to prevent loss of life. Other ways of measuring willingness to pay involve the use of indirect measures such as how much consumers pay for products that reduce the risk of death (such as safety devices in cars), or observations of how much workers are willing to pay (through reduced wages) for improvements in workplace safety.

Years of Life Lost (YLLs) measure the number of years of expected life that are lost because people have died earlier than a standard life expectancy would suggest.

References

1. Hvidt, H.A., T. Ploug, and S. Holm, The impact of telephone crisis services on suicidal users: A systematic review of the past 45 years. Mental Health Review Journal, 2016. 21(2): p. 141-160.
2. Arias, D., S. Saxena, and S. Verguet, Quantifying the global burden of mental disorders and their economic value. EClinicalMedicine, 2022. 54: p. 101675.
3. World Health Organization, Suicide worldwide in 2019: global health estimates. . 2021, World Health Organization.
4. McGorry, P.D., et al., The Lancet Psychiatry Commission on youth mental health. The Lancet Psychiatry, 2024. 11(9): p. 731-774.
5. Bertuccio, P., et al., Global trends in youth suicide from 1990 to 2020: an analysis of data from the WHO mortality database. EClinicalMedicine, 2024. 70: p. 102506.
6. Arya, V., et al., Suicidal ideation, suicide plans and suicide attempts among Australian adults: Findings from the 2020-2022 National Study of Mental Health and Wellbeing. Aust N Z J Psychiatry, 2025. 59(6): p. 500-509.
7. Van Meter, A.R., E.A. Knowles, and E.H. Mintz, Systematic Review and Meta-analysis: International Prevalence of Suicidal Ideation and Attempt in Youth. J Am Acad Child Adolesc Psychiatry, 2023. 62(9): p. 973-986.
8. Kinchin, I. and C.M. Doran, The Economic Cost of Suicide and Non-Fatal Suicide Behavior in the Australian Workforce and the Potential Impact of a Workplace Suicide Prevention Strategy. Int J Environ Res Public Health, 2017. 14(4).
9. Le, L.K., et al., Modelling the cost-effectiveness of brief aftercare interventions following hospital-treated self-harm. BJPsych Open, 2023. 9(5): p. e139.
10. Pirkis, J., et al., Addressing key risk factors for suicide at a societal level. Lancet Public Health, 2024.
11. Cerel, J., et al., How Many People Are Exposed to Suicide? Not Six. Suicide Life Threat Behav, 2019. 49(2): p. 529-534.
12. Cerel, J., et al., Suicide Exposure in the Population: Perceptions of Impact and Closeness. Suicide Life Threat Behav, 2017. 47(6): p. 696-708.

References

13. O'Dea, D. and S. Tucker, The Cost of Suicide to Society. 2005, Ministry of Health, New Zealand.

14. Lyszczarz, B., Production losses attributable to suicide deaths in European Union. BMC Public Health, 2021. 21(1): p. 950.

15. Doran, C.M. and I. Kinchin, Economic and epidemiological impact of youth suicide in countries with the highest human development index. PLoS One, 2020. 15(5): p. e0232940.

16. Jain, N., et al., Economic burden of suicides and suicide attempts in low- and middle-income countries: a systematic review of costing studies. Expert Rev Pharmacoecon Outcomes Res, 2024. 24(9): p. 1067-1079.

17. Peterson, C., T. Haileyesus, and D.M. Stone, Economic Cost of U.S. Suicide and Nonfatal Self-harm. American Journal of Preventive Medicine, 2024.

18. Mishara, B., et al., Comparing Models of Helper Behaviour to Actual Practice in Telephone Crisis Intervention: A Silent Monitoring Study of Calls to the US 1-800-SUICIDE Network. Suicide & Life-Threatening Behavior, 2007. 37(3).

19. University, N., Samaritans Service Evaluation. 2010.

20. Watson, R.J., J. McDonald, and D.C. Pearce, An exploration of national calls to Lifeline Australia: social support or urgent suicide intervention? British Journal of Guidance & Counselling, 2006. 34(4): p. 471-482.

21. Perkins, D. and M. Fanaian, Who calls Lifeline: Baseline study of callers and their needs. 2004, Centre for Equity and Primary Health Care Research in the Illawarra and Shoalhaven, University of New South Wales.

22. Ohtaki, Y., et al., Characteristics of telephone crisis hotline callers with suicidal ideation in Japan. Suicide and Life-Threatening Behavior, 2017. 47(1): p. 54-66.

23. Gould, M.S., et al., An evaluation of crisis hotline outcomes: Part 2: Suicidal callers. Suicide and Life-Threatening Behavior, 2007. 37(3): p. 338-352.

24. Gould, M.S., et al., National Suicide Prevention Lifeline (Now 988 Suicide and Crisis Lifeline): Evaluation of Crisis Call Outcomes for Suicidal Callers. Suicide Life Threat Behav, 2025. 55(3): p. e70020.

References

25. Pil, L., et al., Cost-effectiveness of a helpline for suicide prevention. J Telemed Telecare, 2013. 19(5): p. 273-81.

26. Chamberlain, P., et al., Suicidal ideation. The clinical utility of the K10. Crisis, 2009. 30(1): p. 39-42.

27. Social Determinants of Health - The Solid Facts. 2003, World Health Organisation.

28. Daly, M. and L. Macchia, Global trends in emotional distress. Proc Natl Acad Sci U S A, 2023. 120(14): p. e2216207120.

29. Piao, X., J. Xie, and S. Managi, Continuous worsening of population emotional stress globally: universality and variations. BMC Public Health, 2024. 24(1): p. 3576.

30. Keramat, S.A., et al., Psychological distress and productivity loss: a longitudinal analysis of Australian working adults. Eur J Health Econ, 2025. 26(8): p. 1503-1524.

31. Keramat, S.A., et al., The Estimation of Health State Utility Values for Psychological Distress in Australia: Implications for Future Economic Evaluations. Value Health, 2025. 28(3): p. 368-378.

32. Cohen, S., D. Janicki-Deverts, and G.E. Miller. Psychological Stress and Disease. 2007.

33. Counts, N.Z., et al., Psychological distress in adolescence and later economic and health outcomes in the United States population: A retrospective and modeling study. PLoS Med, 2025. 22(1): p. e1004506.

34. Hoffberg, A.S., K.A. Stearns-Yoder, and L.A. Brenner, The Effectiveness of Crisis Line Services: A Systematic Review. Front Public Health, 2019. 7: p. 399.

35. Mead, N., et al., Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. Br J Psychiatry, 2010. 196(2): p. 96-101.

36. Litman, R.E., Suicide Prevention Centre Patients: A follow up study. Bulletin of Suicidology, 1970. 6: p. 358-363.

References

37. Turley, B., S. Zubrick, and S. Silburn, Lifeline Youth Suicide Prevention Project Final Report. 2000.

38. Gould, M.S., et al., National suicide prevention lifeline: Enhancing mental health care for suicidal individuals and other people in crisis. Suicide and Life-Threatening Behavior, 2012. 42(1): p. 22-35.

39. Britton, P.C., et al., Veterans Crisis Line Call Outcomes: Treatment Contact and Utilization. Am J Prev Med, 2023.

40. Social Return on Investment forecast of the Lifeline Online Crisis Support Chat Service. 2014, Net Balance.

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