Inquiry into Suicide in Australia

Prepared by the Strategy and Research Division, BoysTown

A Submission to the

Australian Senate
Community Affairs References Committee

Authorised By:

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Overview

BoysTown provides face to face services to over 6,000 children and young people across Australia. At any one time up to 20% of these young people are Aboriginal or Torres Strait Islander descent. Furthermore Kids Helpline, a service of BoysTown, responds to 11 contacts a day concerning suicidality. In recognition of our organisation's work with children and young people BoysTown was recently awarded a Life Award from Suicide Prevention Australia. This submission to the Senate Inquiry into Suicide in Australia provides an overview based on our work with young people into the nature of youth suicide in Australia. Recommendations are subsequently made in relation to prevention and intervention strategies. In view of the over representation of Indigenous youth in Australia's suicide statistical information is offered in relation to the specific factors that appear to be associated with suicide amongst Indigenous young people.

Qualitative data on suicide among Aboriginal and Torres Strait Islanders helped us gain better understanding of the issue. We utilised five different focus group discussions, conducted for the purpose of this submission to the Inquiry. These focus group discussions were participated by Kids Helpline Counsellors, Counselling Centre Supervisors, Clinical Practice Supervisors, Aboriginal and Torres Strait Islanders' Programs and Project Managers, Social Workers, Indigenous Youth Suicide experts and youth trainers.

The following are the highlights of the report:

Recommendations to the Australian Senate Community Affairs References Committee

Recommendation 1:

That Government enter into collaborative relationships with community organisations providing support to young people at risk of suicide, to develop and test strategies to increase young male help seeking behaviour in relation to this issue.

Recommendation 2:

That Government recognise the continued risk to young people aged 15-25 years from suicide and provide funding to implement targeted suicide prevention strategies for this age group.

Recommendation 3:

That COAG ensure that adequate funds are provided for the delivery of specialised counselling services to children and young people who are residents in crisis and/or transitional housing.

Recommendation 4:

That Government work with the medical profession to develop and implement strategies to raise community awareness concerning the potential threat to young people from being able to access prescription and non-prescription drugs and the need for control strategies.

Recommendation 5:

That Government funding be provided to research the impact of Antipsychotic and Antidepressant medication on suicidality amongst young people.

Recommendation 6:

That Government enter collaborative partnerships with organisations working in Indigenous communities and with Indigenous community leaders to resource and implement local service planning activities concerning the identification of predisposing and situational risk factors for suicide particularly in relation to youth and to fund initiatives to reduce these risks.

Recommendation 7:

That Government fund a training strategy to be delivered to Indigenous people living in communities to inform the development of community based suicide prevention strategies

Recommendation 8:

That the recruitment and training of Indigenous people in health services be accelerated to increase the availability of trained Indigenous workers in communities.

Recommendation 9:

That the Select Committee notes the need for the provision of quality professional supervision for workers delivering health and social services in remote communities.

Recommendation 10:

That all Government and community organisations providing services to regional and remote Indigenous communities implement organisational development strategies designed to enhance their cultural competence in working with Indigenous communities.

Recommendation 11:

That research be undertaken in relation to the needs of Indigenous children under State protection orders and their carers, to inform support strategies.

Recommendation 12:

That COAG explore the option of implementing multi-disciplinary response teams as the first line of intervention for children and young people at risk of suicide. These response teams could include police, medical and other health professionals and counsellors.

Recommendation 13:

That COAG investigate alternative programs that complement Hospital psychiatric units for the assessment, containment and the delivery of initial crisis intervention with children and young people at risk of suicide.

Recommendation 14:

That the availability of therapeutic services be increased for children and young people in recovery following a suicidal incident.

Recommendation 15:

That Government establish collaborative partnerships with service providers currently using online modalities to research, develop and implement strategies that will increase help seeking and the availability of online counselling to children and young people at risk of suicide.

Recommendation 16:

That the Commonwealth Government negotiate with telecommunication providers to provide free access to telephone and online counselling services.

Recommendation 17:

That the Commonwealth Government work with Telstra to ensure that there is adequate public telephone coverage across Australia particularly in rural and remote areas.

Recommendation 18:

That Government at both a State and Federal level enter into collaborative partnerships with community organisations to assess the effectiveness of 'wrap-around' case management models involving health, mental health and telephone and online counselling services.

Recommendation 19:

That Government fund research into community engagement models of intervention for children and young people at risk of suicide.

Recommendation 20:

That Government funding be enhanced for research into the influence of alcohol abuse and Fetal Alcohol Spectrum Disorders on suicidality amongst indigenous youth.

Definition of Terms

For clarification purposes, the following terms are presented with their operational definition and explanation on how they were used in this report:

'*Indigenous people'* - as used in this report, 'Indigenous people' refers to Aboriginal and Torres Strait Islanders. These words were used interchangeably in the report.

'Youth' – refers to children and young people from both Indigenous and non-Indigenous backgrounds, unless specified otherwise.

'Suicide' - is the deliberate taking of one's own life through the use of one or more means, due to a number of risk factors

'Risk factors' – people, things or situations that increase the likelihood that a person will commit suicide or self-harm; these factors can be classified into two: predisposing or precipitating

'Predisposing risk factors'- these factors can be present in the family or environment even before a person is born and are often long term and can increase vulnerability and suicide risk of the person (i.e. family history of mental illness or suicidality, discrimination, background of adversity)

'Precipitating risk factors' – (often called situational risk factors) - more closely related to the event of suicide itself and can hasten suicidal behaviour (i.e. intoxication, substance abuse, bullying, major disappointments, arguments, recent assault). In this report, these are the immediate concerns of contacts with current thoughts of suicide

'Protective factors' –these factors reduce the likelihood that a person may self-harm or complete suicide (i.e. supportive family and friends, responsibility to partner and/or children, sound employment, future dreams, regular counselling)

'Self- Injury' - this term was used in the report to mean self-harm. Unless specified otherwise, it means deliberate hurting of one's self without the intent of suicide; can be both life-threatening and non-life threatening

'*Suicide Strategies'* – refers to programs and services for suicide prevention, early intervention, intervention and post-vention

'Gender' – in this report, gender refers to sex (i.e. male or female)

'Means' – refers to methods for self-harming and suicide (i.e. means of self-harming – use of lethal drugs)

'Quantitative method' – analysis of statistically treated and validated data

'*Qualitative method'* – analysis of insights and perception of people through understanding the real meaning of their words, without resorting to statistical means

About BoysTown

BoysTown is a national organisation and registered charity which specialises in helping disadvantaged young people who are at risk of social exclusion. Established in 1961, BoysTown's mission *is to enable young people, especially those who are marginalised and without voice, to improve their quality of life.* BoysTown believes that all young people in Australia should be able to lead hope-filled lives, and have the capacity to participate fully in the society in which they live.

BoysTown currently provides a range of services to young people and families seeking one-off and more intensive support including:

- Kids Helpline, a national 24/7 telephone and on-line counselling and support service for five to 25 year olds with special capacity for young people with mental health issues;
- Accommodation responses to homeless families and women and children seeking refuge from Domestic/Family Violence;
- Parenting Programs offering case work, individual and group work support and child development programs for young mothers and their children;
- Parentline, a telephone counselling service for parents and carers in Queensland and the Northern Territory;
- Paid employment to more than 300 young people each year in supported enterprises as they transition to the mainstream workforce;
- Training and employment programs that skill approximately 6,000 young people each year, allowing them to re-engage with education and/or employment, and
- Response to the needs of the peoples of the remote Indigenous communities of the Tjurabalan in Western Australia.

Some of the most serious issues facing the young people who access BoysTown's services are mental health, self-injury and thoughts of suicide. BoysTown is able to support these young people through our mix of early intervention and crisis services that can be tailored to best suit each individual's needs.

Kids Helpline

Kids Helpline is Australia's only national 24/7, confidential support and counselling service specifically for children and young people aged 5 to 25 years. Since March 1991, young Australians have been contacting Kids Helpline about a wide range of issues: from everyday topics such as family, friends and school to more serious issues of child abuse, bullying, mental health issues, drug and alcohol use, self-injury and suicide.

Children and young people have direct access to a counsellor and can choose to speak with either a male or female counsellor. They are also able to arrange to speak again with the same counsellor to work through their issues. No other organisation speaks with as many young Australians.

Kids Helpline has a unique capacity to act as a safety net for vulnerable children and young people at risk of suicide. These young people often reach out when other services are closed or when suicidal thoughts become too much for them during the isolation of the midnight 'til dawn hours. For this reason, other agencies often include Kids Helpline in their safety plans for their young clients experiencing suicidality.

Case 1

> *Not that long ago I ran away from home in the night and was going to commit suicide. There were all these people walking past me and looking at me funny. This was a regular situation for me... I was really distressed and freaked out. I often deal with things like this because I am chronically suicidal but it's still really horrifying every time it happens. I rung Kids Helpline and we spoke for a while and eventually I agreed for them to ring the police to come and fetch me and take me to hospital. I believe that was the only thing to do in that situation because I was unable to keep myself safe. I find it helpful to speak to the counsellors at Kids Helpline because they seem confident in difficult situations and try and help me as best as possible.* **14 year-old Kids Helpline caller**

Case 2

> *I was planning on killing myself tomorrow at 2pm. I felt hurt that my male friend had used me for sex. I had been attacked on a beach in the past and thought maybe I had not gotten over it and it was affecting how I am feeling now. I wrote goodbye notes to family and friends. Writing the letters was my way of trying not to feel guilty but I knew that they would be devastated anyway. I agreed to talk to another friend and promised him that I would not hurt myself tomorrow. I also told the KHL Counsellor that I would call her back on her next shift and that I would phone Kids Helpline whenever I feel unsafe and suicidal.* **16 year old Kids Helpline contact**

Terms of Reference a:

The personal and social costs of suicide in Australia (focus on young Australians and young Aboriginal and Torres Strait Islanders);

To better understand the personal and social cost of youth suicide in Australia, it is wise to comprehend its true nature in terms of a number of significant variables:

Kids Helpline gathers information on the range of issues presented by children and young people to the service. Counsellors record demographic data as well as classifying contacts according to a defined set of problem types. In some instances, counsellors may also collect qualitative information from children and young people in order to provide further assistance to them and to give voice to their concerns with the Australian community.

It is our intent to provide reliable and valid data; thus, we have combined qualitative and quantitative research methods and data from different sources to present a cohesive picture of children and young people that have contacted Kids Helpline about suicide. In relation to this report the following data was analysed:

- 12,351 contacts to Kids Helpline from 2005 to 2008 who reported having current thoughts of suicide.
- A random sample of 861 sets of case notes taken by counsellors in respect to their contact with young people regarding suicidality from 2005 to 2008,
- From 2003 to 2006 Kids Helpline systematically collected additional information from children and young people reporting thoughts of suicide. This additional data included protective factors and information concerning the intended means of suicide. Consequently a further 11,034 male and female contacts from 2003 to

2006 who reported having current thoughts of suicide were analysed to inform this report.

- Focus groups were also conducted with BoysTown staff engaged in the delivery of services to children and young people as well as our Indigenous community partners who work with Indigenous young people in our programs.

BoysTown holds a unique data set on suicidality amongst youth. Our data is mostly derived from young people who are contemplating suicide but have not yet committed an attempt. This differs to other studies which predominantly rely on data from people who are in recovery or who have completed suicide. Consequently our analysis of risk and protective factors will be more immediate. However it should also be pointed out that this data originates from young people who are actively seeking help through their contact with Kids Helpline. Consequently there exists possible respondent bias in the data set. In view of the complexity of youth suicide as a phenomenon and indications that it is under-reported in Australia we believe that the findings of our study provides a valuable source of information for this Inquiry and will deepen our community understanding of this issue.

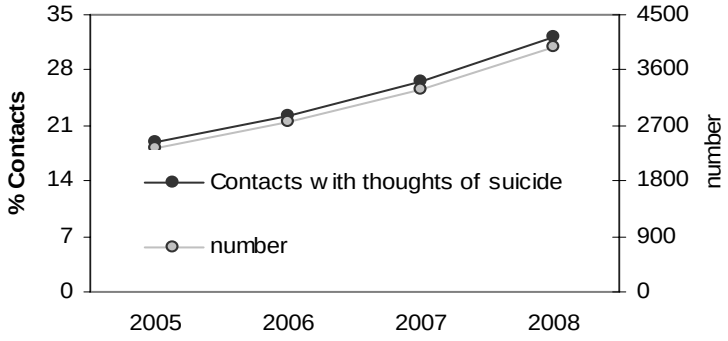
Definition of Suicide and Suicidality

For the KHL Counsellor to consider a caller at risk of suicide or suicidal, the caller should be contemplating suicide and/or has previously attempted suicide. Being suicidal also means the caller is having suicidal thoughts with general or specific plans and has suicidal thoughts or fears, immediate intention to suicide and is currently attempting suicide at the time of the call.

Number of Contacts:

From 2005 to 2008 Kids Helpline responded to 12,351 contacts where thoughts of suicide were presented. In 2008 alone, current thoughts of suicide were reported during 4,000 counselling sessions. This equates to approximately 11 counselling sessions each day. This represents about a 50% increase since 2005. This is an indicator that young people are increasingly seeking help in relation to their distress. This increase is graphically displayed in the graph below:

Number & Proportion of Contacts Reporting Current Thoughts of Suicide Over Time



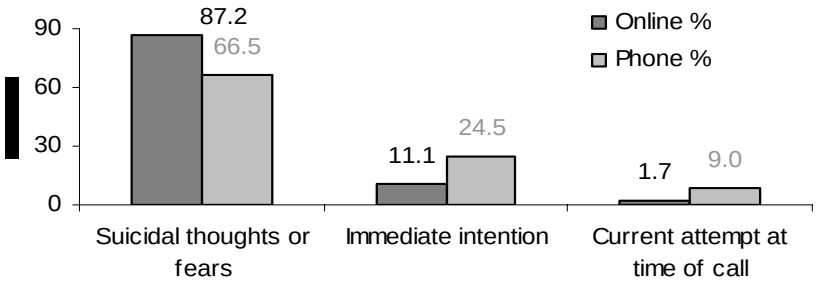
Suicide as a Primary Problem Type: 2005-08

As stated Kids Helpline counsellors assess and record the primary problem type presented to them in their contact with young people. Since 2005 suicide was

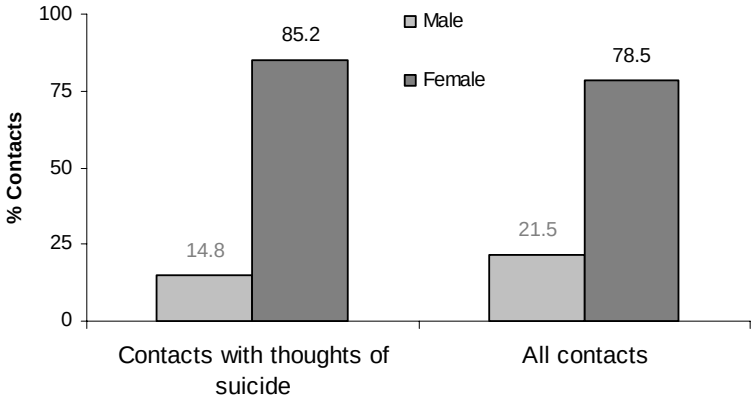
recorded as a primary problem type in 8,806 contacts. The nature of these contacts is outlined in the table below:

Suicidal Thoughts and Gender

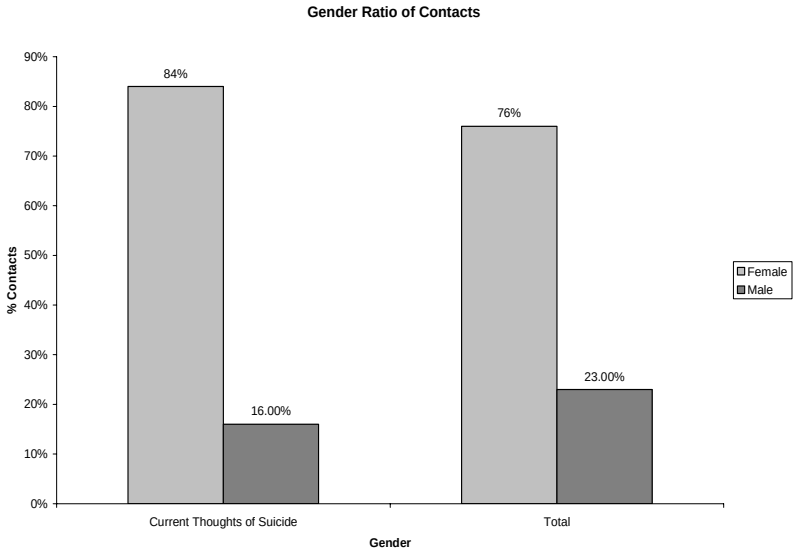
Severities for Phone & Online Contacts Reporting Suicide as the Primary Problem Type



Gender Distribution of Contacts Reporting Current Thoughts of Suicide & Overall Contacts



In 2005-2008, contacts presenting with suicidal thoughts are more frequently from females than males (1.08 times more so than all female residents calling KHL). This trend has been consistent over time. In the 2003-2006 data *(please see the following graph)*, 84% of females and 16% of males who contacted KHL within this period reported suicidal thoughts.



The data above also confirms findings from other research. ABS statistics indicates that women have greater rates of thoughts of suicide and suicide attempts.[1] Consequently it would be expected that there would be a high contact rate from young women to Kids Helpline in relation to suicidality.

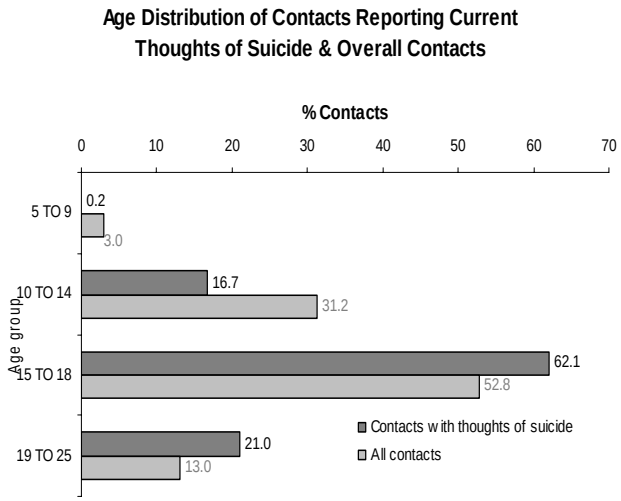
However these figures also indicate the difficulty in engaging young men in help seeking behaviour. Young men are less inclined to contact support services for assistance. This behaviour is consistent with international trends. However in relation to suicidality the numbers of young men seeking assistance appears to be even lower. This is despite the fact that Australian male suicide outnumbers female suicide by a ratio of 4:1. Consequently while thoughts of suicide may be at a higher level amongst women they will also be more inclined to seek help than men. This demonstrates the need for increased research into engagement strategies for young men to increase help seeking behaviour regarding suicidality.

Recommendation 1:

That Government enter collaborative relationships with community organisations providing support to young people at risk of suicide, to develop and test strategies to increase young male help seeking behaviour in relation to this issue.

Suicidal Thoughts and Age

Contacts with thoughts of suicide are predominantly in the older age group: especially between 19 to 25 years age group (ratio of 1.6 compared to all contacts), followed by the 15 to 18 year olds (ratio=1.2).



ABS statistics indicates that for both genders the suicide rate has significantly fallen for 19-25 year olds since 1997. Furthermore the official suicide rate amongst the 15 to 19 year age group has more than halved since 1997. However BoysTown's figures indicate there continues to be high rates of suicidality in the 15- 25 year age group. Consequently Government needs to have a policy and funding focus on remedying the risk factors that leads to suicidality amongst the 15-25 year age cohort.

Recommendation 2:

That Government recognise the continued risk to young people aged 15-25 years from suicide and provide funding to implement targeted suicide prevention strategies for this age group.

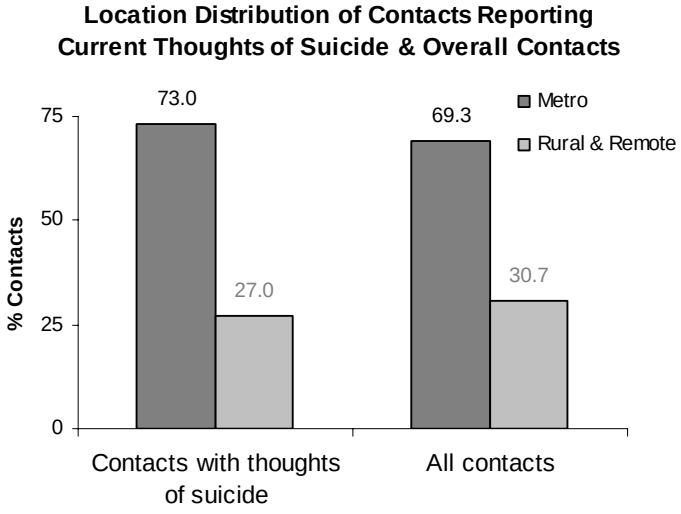
Contacts from Indigenous Youth: Suicidality

Indigenous youth are more likely to contact Kids Helpline with thoughts of suicide than non-Indigenous young people. This is shown in the graph below:

The issue of suicidality amongst indigenous young people is examined in detail in a later section.

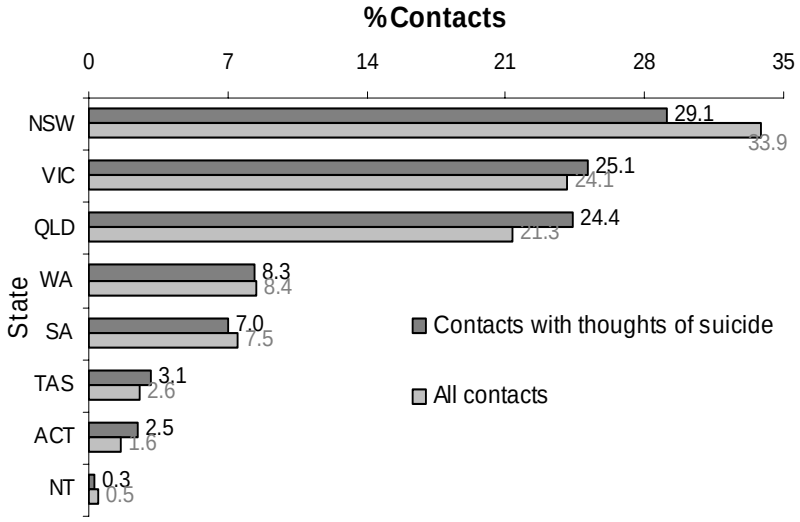
Distribution of Suicidality Contacts Across Regions and States

Contacts to Kids Helpline associated with suicidality were slightly more likely to be from metro residents (1.05 times more so than all contacts from metropolitan areas).



In relation to Australian States, contacts with current thoughts of suicide from QLD were 3% higher in proportion than all contacts from QLD; ACT and TAS showed a slightly elevated proportion of contacts with thoughts of suicide compared with the proportion of all contacts from these States, but the numbers were small. Rates of contacts involving suicidality from the remaining States were lower than the total from those States, especially from NSW. This is outlined below:

State Distribution Comparing Contacts With Current Thoughts of Suicide & Overall Contacts



Accommodation

Kids Helpline data suggest that young people living in residential and crisis emergency shelters are particularly vulnerable to thoughts of suicide. From data collected in 2005-08 young people are about three times more likely to contact Kids Helpline with issues involving suicidality if living in Mental Health Units, alternate care residential programs and crisis accommodation. Similarly young people who are living alone are more than twice as likely to present with thoughts of suicide. This situation has been consistent over time as data collected from 2003 to 2006 shows a similar pattern (refer to Appendix 3).

The living circumstances of young people contacting Kids Helpline with suicidality issues from 2005-08 is outlined in the following table:

LIVING WITH detail

		Thoughts of Suicide contacts	Valid Percent	TOTAL All KHL Contacts	Valid Percent
Valid					
	Alone	643	8.6	4255	4.2
	Boarding school	51	0.7	637	0.6
	Child Protect Facility ResCare	153	2.1	582	0.6
	Other extended family inc siblings	333	4.5	4092	4.0
	Foster parents	175	2.4	1709	1.7
	Friends/flatmates	593	8.0	4739	4.7
	General Hospital	2	0.0	11	0.01
	With Grandparents	110	1.5	1307	1.3
	Mental Health Unit	53	0.7	340	0.3
	Nowhere	82	1.1	914	0.9
	With Other Adult or Carer	80	1.1	399	0.4
	With own partner	201	2.7	3425	3.4
	With Partner and Children	42	0.6	956	0.9
	Shared custody two homes	17	0.2	766	0.8
	Shelter Hostel Supported accommodation	427	5.7	2845	2.8
	Single parent	1410	19.0	23183	22.9
	Two parents	2615	35.2	43335	42.8
	Two parents blended family	423	5.7	7549	7.5
	Own children - no partner	24	0.3	253	0.2
	Total	7178		101297	100.0

Although the National Affordable Housing Agreement (NAHA) and the National Partnership Agreement on Homelessness make provision for case management services it is unclear whether this will include and to what extent funding for specialised counselling services for young people with mental health and other risks associated with suicidal behaviour. It is our experience that there is a general scarcity of Government funding to support the provision of these much needed services to vulnerable groups.

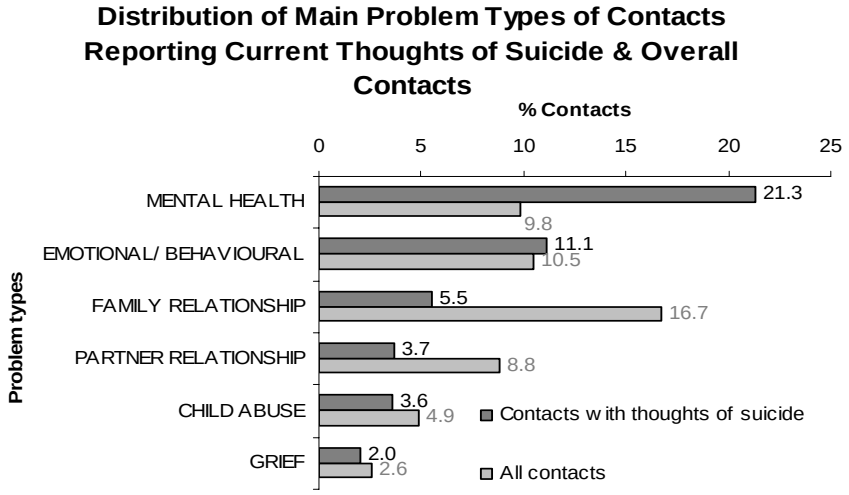
Recommendation 3:

That COAG ensure that adequate funds are provided for the delivery of specialised counselling services to children and young people who are residents in crisis and/or transitional housing.

Problems associated with Suicidality Contacts

As previously stated Kids Helpline counsellors record the primary problem type dealt with in the counselling contact. In relation to counselling contacts where thoughts of suicide are disclosed the associated primary problems with this issue, apart from suicide, are mental health which includes anxiety, depression and clinically diagnosed mental health problems and emotional and behavioural issues which can involve young people's reactions to traumatic experiences and anger management.

Primary Problem Types associated with Contacts Reporting Current Thoughts of Suicide: 2005-08



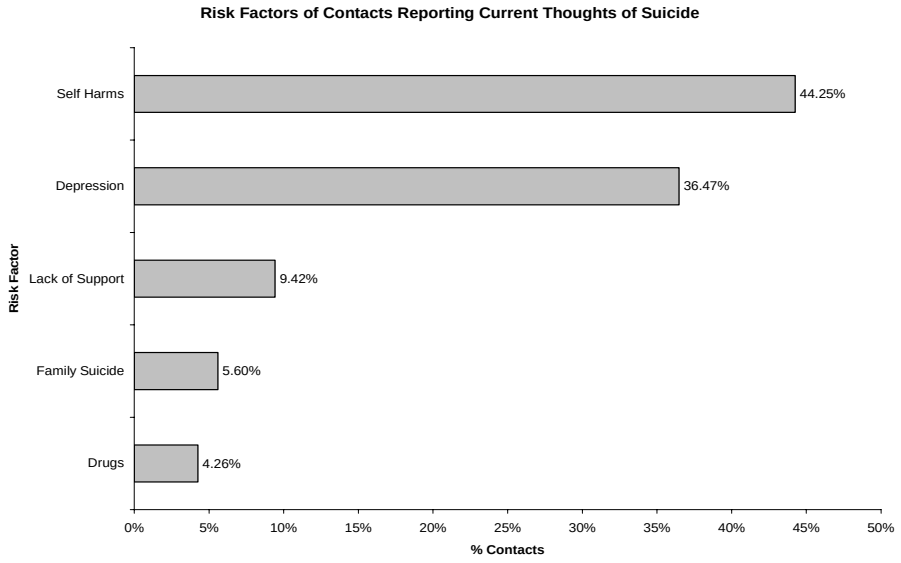
The table above shows that problems relating to mental health and emotional and behavioural management were the top two main problem types of contacts with thoughts of suicide. Gender differences were also found in the presenting problems associated with suicidality. Young women were more likely to disclose suicidality in relation to psychological/ emotional and sexual abuse/assault problems than males but males were more likely to report suicidality issues in relation to partner relationship problems and bullying compared to females. This pattern has been consistent over time as shown by the 2003-06 data analysis (Please see Appendix 4 for 2003-2006 statistical data).

Risk Factors

An analysis of KHL data has also been undertaken to assess risk factors associated with suicidal thoughts and behaviour of young people. Since a complex range of factors contribute to suicide, it cannot easily be predicted. A combination of underlying risk factors and recent events increase the likelihood of a suicide attempt. At Kids Helpline, many young people's issues are multi-faceted, spanning across more than one of the 35 problems types. Counsellors record the one problem type on which most of the counselling time was spent. Then, on the case notes field, they indicate other risk factors that may contribute to the disclosure of suicidality in counselling contacts.

For the purpose of this report, the immediate (problems) or concerns of contacts were presented as 'Situational Risk Factors'[2]. They are the immediate factors deemed to cause at risk people to complete suicide. Other underlying problems that contribute to the suicidality of contacts were presented as 'Predisposing Risk Factors'[3], these definitions are in line with contemporary research literature.

Risk factors identified generally in our 2003-06 data is diagrammatically presented in the graph below:



Counsellors identified a strong association between self harming behaviour and suicidality. This will be discussed further in a later section of the report. The second highest risk identified was depression. This is consistent with the earlier observation that suicidality is highly correlated with mental health issues. The lack of personal support networks, a history of family suicide and drug abuse were also found by counsellors to be associated with suicidality.

Qualitative Analysis of Online and Telephone Case Notes

To get a more in-depth picture of suicidality amongst children and young people, an analysis of the reasons and concerns, presented by young people with suicidal thoughts, were conducted through a review of case notes taken by KHL counsellors from 2005-2008. A random sample of 871 case notes from a possible total of approximately 1,200 online and telephone case notes were retrieved. To get a good representation of total KHL contacts with suicidal thoughts, 230 individual online case notes and 641 individual telephone case notes were included in the final analysis. It should be noted that more than one risk factor was identified in some individual contacts. Consequently the totals in these Tables vary.

Situational Risk Factors

This analysis is presented in the Table below:

Situational Risk Factors (immediate concerns of contacts)	Online Contacts	%	Telephone Contacts	%
1. Distress and feelings of helplessness and frustrations (family problems, school or work problems, being in a controlling and abusive manner physical, emotional and verbal abuse)/domestic violence, bullying, etc.)	89	38.69	168	26.2
2. Low self-esteem, guilt feelings, shame and self-loathing (illicit affairs, prostitution, teen or unwanted pregnancy, etc.)	50	21.73	57	8.9
3. Traumatic experience or unresolved trauma (sexual assault or abuse, loss	39	16.95	209	32.6
4. Isolation (no real friends, living alone) and disconnected from family and friends, etc.	35	15.2	67	10.5
5. Grief and loss (life transitions, loss of family member(s) or a loved one, relationship break down)	30	13.04	92	14.3
6. Others (frustrated/fear of statutory actions, having a court case/ criminal conviction religious fanatic/radical political and social ideation included, medication not working or having negative, made a suicide pact with someone, etc.)	14	6	14	2.18
7. Poverty (unemployment, homelessness, incurring large debts, etc.)	6	2.6	26	4.1
8. School expulsion/ not accepted into a school, etc.	6	2.6	8	1.25
TOTAL	**230**		**641**	

Situational Risk Factors (Immediate Concerns of Online and Telephone Contacts)

Based on the case notes analysed, distress and feelings of helplessness and frustrations ranked first amongst the reasons for having suicidal thoughts, with 89 or 38.69%. This was followed by low self-esteem, guilt feelings, shame and self-loathing with 50 or 21.73%. Ranked third was traumatic experience and unresolved traumas with 39 or 16.95%. Fourth in rank was isolation and disconnectedness with 35 or 15.2%. Grief and loss ranked fifth with 30 or 13.04% of all the notes sampled.

Based on the telephone notes analysed, traumatic experience or unresolved trauma (sexual assault or abuse, loss ranked first among the reasons for having suicidal thoughts, with 209 or 32.6% of all the sampled notes. Distress and feelings of helplessness and frustrations ranked second with 168 or 26.2%. This was followed grief and loss with 92 or 14.3%. Ranked fourth was isolation and disconnectedness with 67 or 10.5%. Fifth in rank was Low self-esteem and feelings of helplessness and frustrations with 57 or 8.9% of all the telephone notes sampled.

Predisposing Risk Factors

The qualitative analysis of case notes in respect to predisposing factors is contained in the Table below:

Predisposing Risk Factors	Online Contacts	%	Telephone Contacts	%
1. Family conflicts (tension with parents, not getting along well with siblings, argument with partner, etc.) and family breakdown (kicked out of the house, children taken away, etc.)	36	22.8	138	18.7
2. Previous suicide attempts	31	19.65	101	13.69
3. Exposure to motivators for self-harm (on prescription drugs, knife, guns, rope, drugs, literature on suicide, friends and/or family members who have committed suicide and/or are suicidal, etc.)	20	12.66	95	12.87
4. History of depression and mental health problems	18	11.4	164	22.22
5. Physically sick/with disease, etc. (overweight and not eating included) and not getting enough sleep	12	7.6	54	7.32
6. Poor communication/ having arguments	12	7.6	26	3.52
7. Isolation and anger management problems	11	6.9	87	11.79
8. Alcoholic/Abusing substances	7	4.43	32	4.34
9. Socially and economically disadvantaged (homelessness, poverty, etc.)	5	3.16	11	1.5
11.No medication/no intervention/stopped medication/stopped counselling	4	2.5	22	2.98
12. Physical disability (and/or mental disability)	2	1.3	8	1.08
TOTAL	**158**		**738**	

Predisposing Risk Factors (Other Problems Which Increase the Vulnerability to Suicide of Online and Telephone Contacts)

Among the most common predisposing risk factors presented by KHL contacts online, 'family conflicts' ranked first with 36 or 22.8%. Second was 'previous suicide attempts' with 31 or 19.65%. Exposure to motivators for self-harm ranked third with 20 or 12.66% and ranked fourth was 'history of depression and mental health problems' with 18 or 11.4%.

Among the most common predisposing risk factors presented by KHL telephone contacts, 'history of depression and mental health problems' ranked first with 164 or 22.22%. 'Family conflicts' ranked second with 138 or 18.7%. Third was 'previous suicide attempts' with 101 or 13.69% and exposure to motivators for self-harm ranked fourth with 95 or 12.87%.

Self harm (Self-Injury) Vs Suicide

Self-harm is a direct, deliberate and often repetitive destruction or alteration of one's own body tissue (e.g., head banging, self-biting, skin cutting and burning, self-amputation of body parts) without conscious suicidal intent. Self-harm is synonymous to "self-mutilation", "self-injury", "auto-aggression", and "para-suicide".[4]

Based on our 2005-2008 KHL data, there is a correlation between self harm (self-injury) and suicidal thoughts among KHL contacts:

Among all contacts to KHL, there was one contact reporting self injury for every 2.6 contacts reporting 'no' to self-injury. Among the two suicide categories however, the

situation is reversed: the majority of the contacts were reporting 'yes' to self-injury. Among those with thoughts of suicide there were three contacts reporting 'yes' to self-injury for every contact that reported 'no' (1/ 0.3). Similarly for contacts whose main problem was suicide, it was five contacts reporting 'yes' for every contact reporting 'no' to self-injury (1/ 0.2).

Contacts to KHL with suicide concerns (both thoughts of suicide and suicide as a primary problem) and contacts that self-injure were generally four to five times more likely to be over 15 years of age compared to all contacts to KHL.

Although the acts of self-harm are usually distinguished from non-fatal suicidal acts, some individuals engage in both types of behaviours.[5]

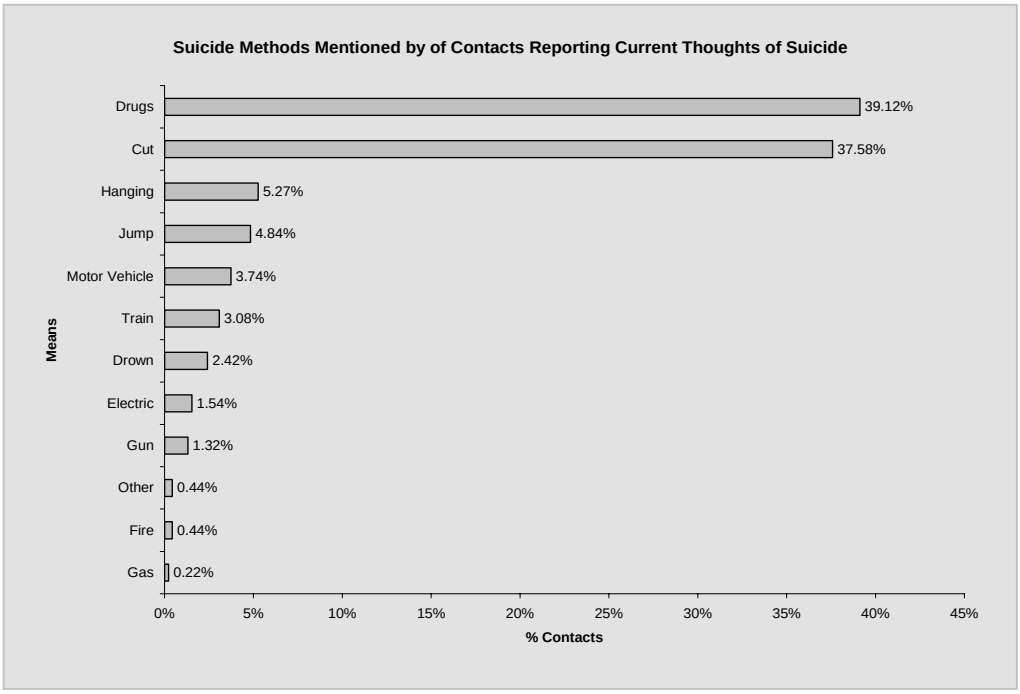
Link between self injury and suicide – is self injury a protective factor?

It is hypothesised that self-injury would be a risk factor for contacts reporting current thoughts of suicide. Although some counsellors have said that self-injuring could be a protection against actually attempting suicide, it is an unhealthy and dysfunctional coping mechanism.

Potential implications regarding self- injury and suicidal thoughts: Self-injury appears higher in those reporting current suicidal thoughts (not suicide attempts). This could be a way to deal with emotional distress because young people cannot use more functional methods of communicating their needs. In the short term, this is a protective factor against suicide attempts. But for some young people who engage in self injury, since they are unable to use functional means to resolve their distress, there will come a time when their self injuring no longer alleviates this distress and they feel they have no option other than to attempt suicide. Having said this, self-injury can be defined as a dysfunctional and unhealthy coping mechanism and must never be considered a protective factor.

Suicidal Contacts and their Means of Suicide

Children and young people's expressed means of suicide differ to that of the general population. Since 1997 the most frequently used methods of suicide in Australia were hanging, followed by poisoning, use of drugs and firearms.[6] However amongst children and young people drugs and cutting are consistently stated to be the preferred method. This is outlined in the following Tables:



Means of Suicide from Online and Telephone Case Notes

Means or Methods of Suicide (Case Notes)	Online and Telephone Contacts	%
1. Drugs and poisons	293	38.6
2. Cutting wrists, legs and other parts of the body; slitting throat	136	17.9
3. Hanging in a public place (or in private)	81	10.65
4. Running into the middle of the road to be hit by a car; crashing the car (motorbike in some cases); jumping out of a car or any moving vehicle; lying in the middle of the railway tracks	68	8.9
5. No definite plan or method	62	8.2
6. Jumping off a bridge or a cliff/roof/window/balcony	45	5.92
7. Burning and using explosives	23	3.02
8. Stabbing with a knife or other blunt objects	17	2.24
9. Hurting and/or hitting self- sticking things in throat to stop breathing/choking; hurting self with a metal bar or pulling something heavy on top of self/bashing self	13	1.71
10. Shooting self with a gun	11	1.45
11. Others (suffocation or use of plastic bag, pillow, etc.)	6	.79
12. Drowning	5	.66
TOTAL	**760**	

The following drugs are commonly identified by children and young people as ones that they would use in any suicide attempt:

Drug Class	Drug Names	Notes	Availability
Simple Analgesic	Panadol, Panamax		OTC
Anti Inflammatory	Neurofen (OTC), Voltaren (Script)		OTC/Script
Hypolipidaemic agents	Jezil	May cause depressive symptoms.	Script
Antideppressants	Sertraline, Prozac, Movox, Roboxetine, Fluoxetine, Efexor, Zoloft, Cipramil	Linked to higher rates of suicide risk	Script
Anti-anxiety agents	Diazepam, Valium, Xanax	May cause depressive symptoms.	Script
Antipsychotics	Lithium, Seroquel, Abilify, Risperdal, Zyprexa	Some drugs may increase suicidal ideation	Script
Sedative	Temazepam	Can increase depression and suicidal risk in some depressed patients	Script

Anticonvulsants	Topamax, Valpro, Epilim	Linked to increase in suicidal behaviour. Used in treating mania.	Script
Narcotic Analgesic	Morphine		Script
Antihistamine	Phenergan		Script
Drug Dependence agent	Zyban	May cause increase in suicidal ideation.	Script

This information is provided to the Inquiry to raise awareness of the current availability of these drugs to children. There is an urgent need to educate the public regarding the potential lethal effects of these drugs. Furthermore as many of these drugs are only available on prescription, medical professionals need to work with their patients and parents/carers to make certain that strategies are in place to ensure their proper use and that children are protected.

Recommendation 4:

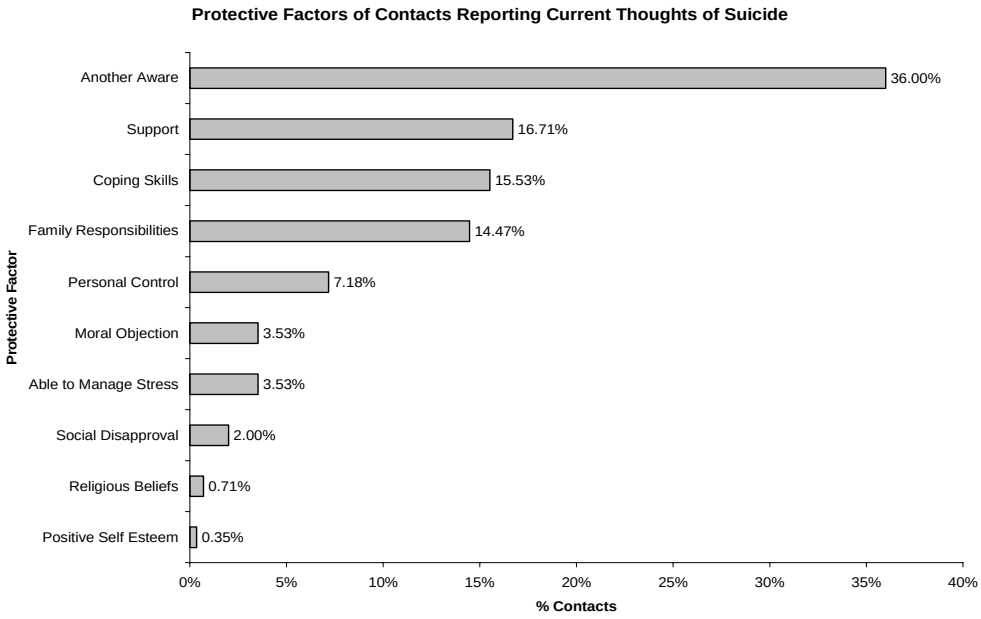
That Government work with the medical profession to develop and implement strategies to raise community awareness concerning the potential threat to young people from being able to access prescription and non-prescription drugs and the need for control strategies.

Recommendation 5:

That Government funding be provided to research the impact of Antipsychotic and Antidepressant medication on suicidality amongst young people.

Contacts with Current Thoughts of Suicide and their Protective Factors

Based on 2003-06 data, counsellors identified that the following factors reduced the risk of suicide amongst children and young people. These factors were: ability to manage stress/anxiety, another being aware of the situation, coping/problem solving skills, moral objections to suicide, personal control/competence, positive self-esteem, religious beliefs, responsibility to family, fear of social disapproval, and accessible support system. This is outlined in the table below:



Further analysis of the data revealed that females were more likely to report than males that there was another person aware of their situation that they had an accessible support system or that they had coping skills. This indicates that young men are particularly vulnerable to suicidal behaviour given that they lack the presence of protective factors in their environment.

A further analysis was undertaken of counsellor case notes from 2005-08. This is outlined below:

Protective factor(s)	Online Contacts	%	Telephone Contacts	%
1. Personal control (agreed to be taken to a hospital, see a counsellor, etc.)	24	23.3	145	23.39
2. Moral objections to suicide	1	1.06	8	1.29
3. Currently sees a counsellor/ psychiatrist/psychologist	11	10.67	67	10.81
4. Knowledge and willingness to implement some safety strategies	15	14.5	133	21.45
5. Caring and supportive family, foster carers, friends, etc.	20	19.4	77	12.42
6. Sense of connection and responsibility to family, friends and other people (even with pest in some cases)	14	13.59	88	14.2
7. Medical/ psychological/ psychiatric intervention (hospital visit, GP, nurse, paramedics, etc.)	6	5.8	80	12.9
8. Economic security/ employment	2	1.92	12	1.94
9. Future plans/dreams	9	8.7	10	1.6
10. Others	1	1.06	0	0
TOTAL	**103**		**620**	

Protective Factors of Online and Telephone Contacts Based on 2005-08 Case Notes

Based on the table above, 'Personal control' 'Caring and supportive family, foster carers, friends, etc.', 'Knowledge and willingness to implement some safety strategies' and 'Sense of connection and responsibility to family, friends and other people' were the top four protective factors identified amongst online contacts with current thoughts of suicide. As for the telephone contacts with current thoughts of suicide, 'Personal control', 'Knowledge and willingness to implement some safety strategies', 'Sense of connection and responsibility to family, friends and other people' and 'Medical/ psychological/ psychiatric intervention' were their top four protective factors.

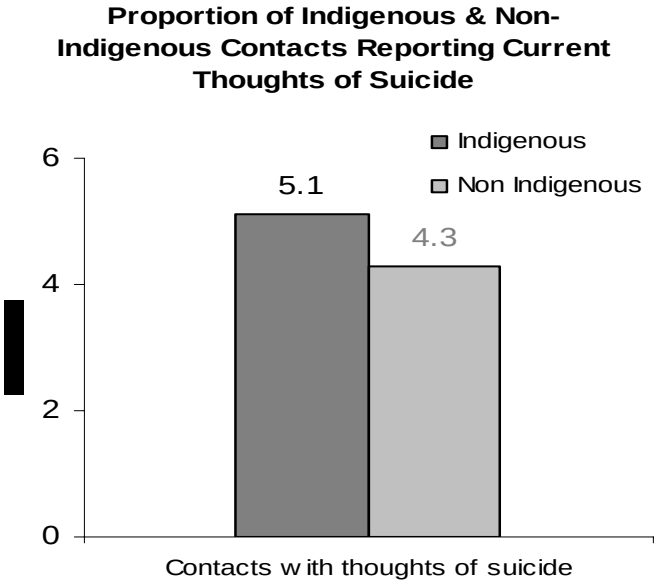
Suicide amongst Young Aboriginal and Torres Strait Islanders

Both quantitative and qualitative data were used to assess the issue of suicidality amongst Aboriginal and Torres Strait Islander youth. KHL Data, results of the five focus group discussions conducted and related literature and studies were all put together to create a clear picture of Indigenous suicide and how it impacts on the lives of Indigenous people. Furthermore, a comparative analysis between Indigenous and non-Indigenous suicide and suicidality is presented.

Suicide and self-harm cause great grief in many Aboriginal and Torres Strait Island communities. It is believed that the actual Aboriginal rate of suicide may be as much as two to three times higher than figures indicate. This may be due to the under-reporting of suicide as cause of death[7], the general lack of data on suicide attempts and self-harming behaviour[8] and the misclassification of Indigenous status on death certificates and other data systems. [9]

There has been little research conducted into Aboriginal understandings and definitions of suicide and self-harm behaviour. There are significant differences in suicidal behaviour not only between Indigenous and non-Indigenous populations, but also between different Indigenous communities. Suicide is often impulsive, and may be preceded by interpersonal conflicts. But suicide frequently occurs in communities that have experienced similar losses in the past, and where 'lifestyles of risk' are common.

The following are the statistical analysis and presentation of KHL data gathered for the purpose of this submission to the Inquiry:



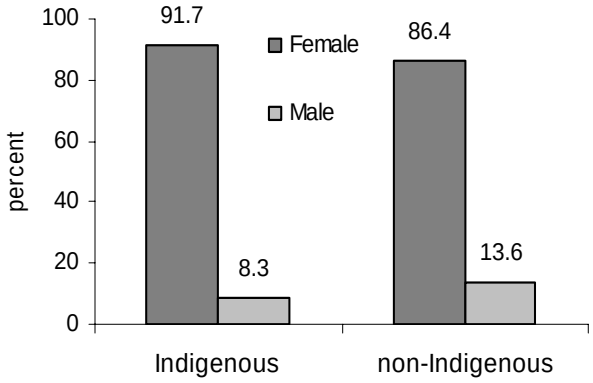
As stated the proportion of Indigenous contacts with current thoughts of suicide to all Indigenous contacts is greater than the proportion of non-Indigenous contacts with current thoughts of suicide to all non-Indigenous contacts. The above graph has been duplicated and placed here for the reader's convenience.

Gender Distribution of Indigenous and Non-Indigenous Contacts involving Suicide

Research suggests that Aboriginal and Torres Strait Islander suicide is most common among young men (although suicide attempts seem to be more common for Aboriginal and Torres Strait Islander women).

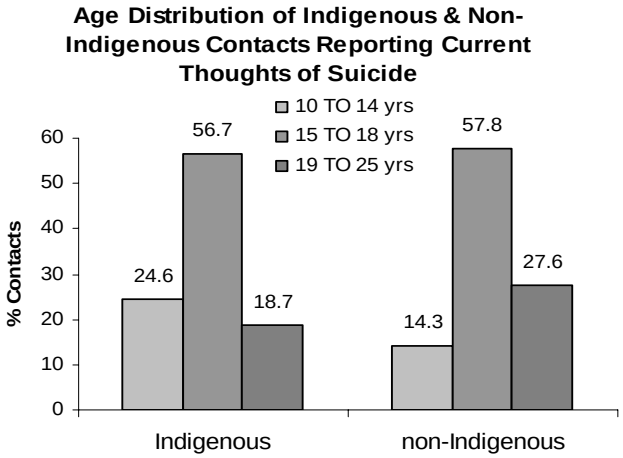
In contacts from Indigenous young people to Kids Helpline from 2005-08, it is evident that young women are more likely to be seeking help with suicide issues than young Indigenous men. This indicates that for young men generally and in particular Indigenous young men are less likely to engage in help seeking behaviour. This is another indicator that these young men are at high risk and require specialised engagement strategies. The supporting data is outlined below:

Gender Distribution of Indigenous & Non-Indigenous Contacts Reporting Current Thoughts of Suicide



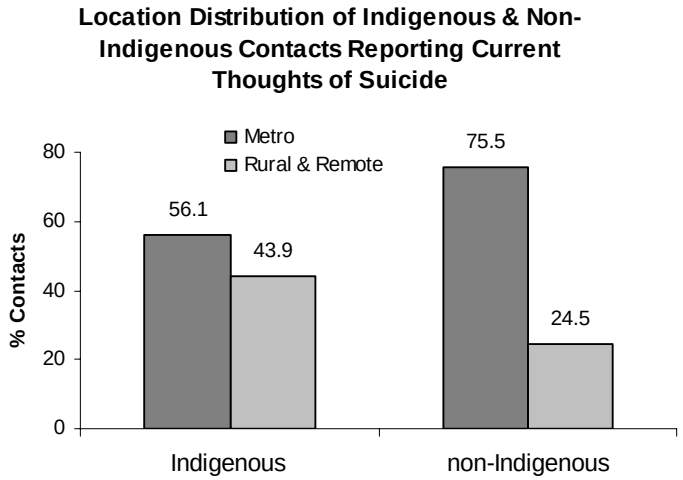
Contacts with 'current thoughts of suicide & suicidality' are more frequently from females than males (1.08 times more so than all female residents calling KHL.

Age Distribution of Suicidal Indigenous and Non-Indigenous Contacts



The age distribution of Indigenous and non-Indigenous contacts with 'thoughts of suicide & suicidality' shows that younger (10 to 14 year olds) Indigenous contacts were more represented (24.6%) than non-Indigenous contacts (14.3%). Consequently for Indigenous young people the younger age group of 10-14 years is vulnerable to risks from suicide. Aboriginal informants from the focus group suggest that this increased vulnerability may be due to the fact that this age group is transitioning to adulthood and find difficulty in responding to the increased expectations and responsibilities from their community.

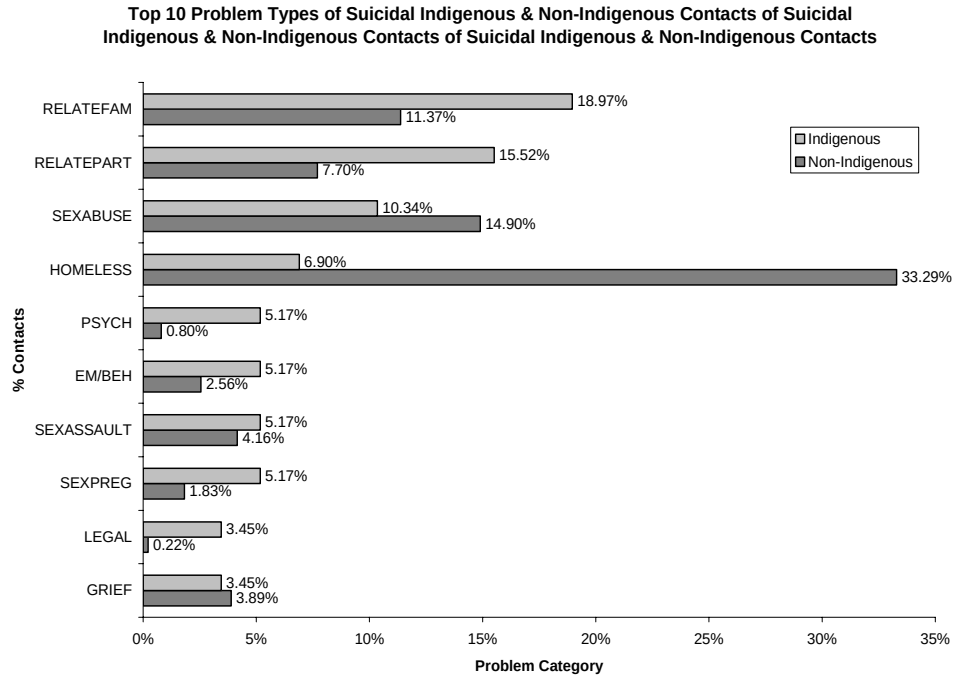
Location Distribution of Suicidal Indigenous and Non-Indigenous



Contacts

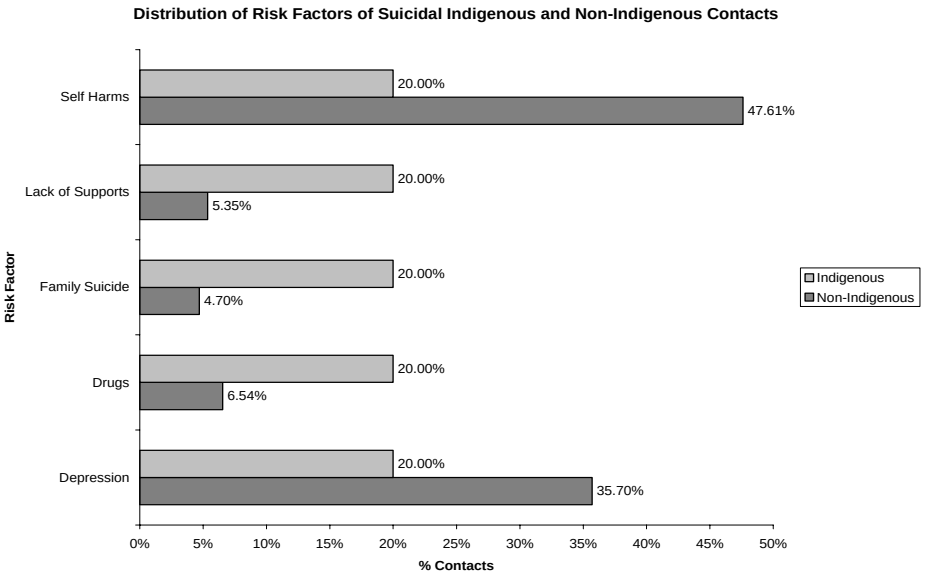
The location distribution of Indigenous contacts are different to those of the non-Indigenous contacts whereby there's significantly more representation from rural and remote areas (43.9% Vs 24.5%).

Top 10 Problems Presented by Suicidal Indigenous and Non-Indigenous Contacts



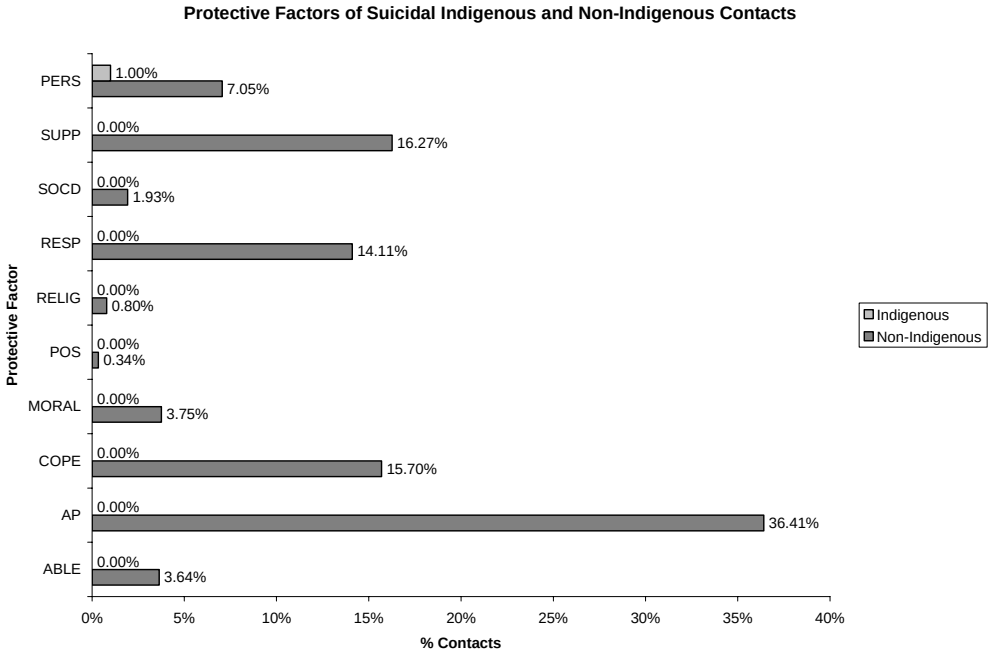
In 2003-2006, 'Family relationship' was the number one problem presented by Indigenous suicidal contacts, as compared to 'Homelessness' among non-Indigenous suicidal contacts. The second problem mostly represented by Indigenous suicidal contacts was partner relationships. Other problems more common to Indigenous suicidal contacts were mental health, emotional and behavioural management, sexual assault, pregnancy and legal matters such as court representation and other related forms of legal interventions.

Risk Factors of Suicidal Indigenous and Non-Indigenous Contacts



Risk factors more represented among Indigenous contacts with current thoughts of suicide as compared with non-Indigenous contacts are lack of support, history of family suicide and drugs.

However, counsellors were unable to identify significant data on the protective factors *(please see graph below)* among Indigenous contacts with current thoughts of suicide. This reflects the lack of protective factors among these young Indigenous people, making them a very vulnerable group when it comes to suicidality.



As noted BoysTown Indigenous staff and external partners were consulted in relation to the key issues concerning suicide amongst indigenous youth. The following points are considered to be key issues that our Indigenous staff and partners suggest needs to be acknowledged in any strategy to respond to Indigenous youth suicide:

Suicide and the Aboriginal and Torres Strait Islanders' Culture

During the 1950s and 1960 greater numbers of Indigenous children were removed from their families to advance the cause of assimilation. Not only were they removed for alleged neglect, they were removed to attend school in distant places, to receive medical treatment and to be adopted out at birth.[10]

1. Aboriginal contacts link the increased frequency of suicidality in their community with the associated traumas caused by the 'stolen generation'.

2. 'Indigenous Parenting' for the children of the 'stolen generation' has been compromised. Many of the stolen generation were placed in institutions and subsequently their knowledge and ability to provide parenting was negatively impacted by this experience.

3. In some communities Aboriginal boys at an early age are initiated into manhood and are expected to reason and act like men afterwards. These

young men feel greatly pressured at this transition point in their lives.

4. The strong community links and strong family ties among Aboriginal and Torres Strait Islanders may partially cause clustered suicidal behaviour. Having strong community and family ties, young Aboriginal and Torres Strait Islanders tend to feel strongly for their departed loved ones, and often feel too lonely and unable to cope with their loss. There may be a tendency to model a family member's problem-solving 'tools' and means *(in this case suicide and suicide means or methods)* because of exposure to them, but this should not be associated with Indigenous people alone, as this is also prevalent within the non-Indigenous communities, as exposure to suicide motivators is a risk factor common to all at risk people, both Indigenous and non-Indigenous.

5. The high death rates in some indigenous communities mean that children from a young age are exposed to constant loss and grief.

6. Suicide deaths, particularly by hanging, are frequently witnessed by many members of the community, who experience first hand the impact such deaths have on the community. Such deaths often spark a cluster of suicides in Aboriginal communities, of similar methods, gender and age groups, suggesting an observational learning, modelling, imitative, catalytic role.[11]

Indigenous Suicide Vs Non-Indigenous Suicide

1. Indigenous young people attempt suicide for reasons different from those of non-indigenous young people. For young Aboriginal and Torres Strait Islanders, it is mostly to do with culture and shame.

2. Aboriginal suicide is currently being addressed under the same framework as the general population by different national and state-based suicide prevention strategies. This should not be the case as this general framework is based on non-Aboriginal understandings of suicide, mental health and health care.[12]

Mental Health Vs Cultural and Spiritual Beliefs

1. Aboriginal people believe that there is an over diagnosis of depression and other psychiatric illnesses within communities due to a misunderstanding of Indigenous behaviour. Some behaviour considered to be reflective of mental illness may be ways of coping derived from local culture. This is supported by Tatz[13] who found that suicidality among Aboriginal youth should not always be looked at as precipitated by psychiatric illness. There was little evidence of clinical depression in the Aboriginal suicide cases he investigated.

Indigenous Suicide in Metro and Urban Areas Vs Indigenous Suicide in Rural and Remote Areas

1. Aboriginal people are distinct from Torres Strait Islanders, particularly those living in remote and rural areas. Between these groups, the government should have different ways to address the issue of suicide.

2. Aboriginal people believe that their youth have a crisis of self identity. Young people do not have a real sense of self-identity as they have lost their 'real' culture. Their rituals and spirituality *(which play a big part in the*

Aboriginal and Torres Strait Islanders' cultures) have been lost. Being caught in the middle of two cultures means that many youth are experiencing confusion concerning self-identity.

Young Indigenous People in Custody and Foster Care

1. There is an over-representation of young Aboriginal and Torres Strait Islanders in custody and foster care. Most of them are into self-medicating and are manifesting depression-like behaviour.

2. Feelings of disconnect and a lack of meaningful support networks are prevalent among Aboriginal and Torres Strait Island young people (18 years and over) who were previously in custody or foster care. Programs and services that can address their needs such as employment and training, dwelling, health and education are lacking.

3. Too many predisposing factors are present among this group of young people such as drug abuse, sexual abuse, loneliness and depression, lack of self-identity, lack of role models, lack of meaningful support networks sexuality or sexual preference. The last one is considered a taboo within the Indigenous communities; thus, no young people will come out in the open and reveal his or her true sexuality for fear of humiliation and further isolation. This issue should be further explored.

BoysTown Initiatives with Indigenous Communities:

As noted in our submission to the Senate Inquiry into Remote Indigenous Communities, BoysTown is currently working with Elders of the Balgo community in the Southern Kimberley in relation to a community development strategy.

The aim of the project is to improve the health and well-being of young people through the delivery of community wide initiatives such as employment, vocational training, micro-business development and at an individual level counselling and personal development.

As a component of this project, local service planning between Government, community organisations and the community is being undertaken within a Service Alliance model. This community governance model involves:

1. The development of a Service Alliance Agreement between local services and the Community Council specifying expected outcomes and performance standards. Local services are accountable to the local community through the Community Council for meeting these performance standards.

2. Joint local planning and the delivery of services to respond to 'joined–up' complex community issues

3. Review and evaluation of the Service Alliance Agreement against performance standards on a yearly basis by all signatories.

The Service Alliance Agreement is a mechanism to ensure the direct accountability of services to the local community. This model could be applicable to the development of local community based suicide prevention strategies given that the risk factors are complex and interdependent. The

Select Committee may wish to consider the applicability of this model for the development of suicide prevention plans in other Indigenous communities.

A further strategy the Select Committee may wish to consider improving the quality of service delivery to Indigenous youth in remote and rural communities, and to assist in staff retention is the provision of professional supervision to front line staff. Professional supervision within the disciplines of social work and psychology is an accepted strategy to support the knowledge and skill development as well as the effective use of these skills in the duties performed by front line staff.[14] Workers in remote Indigenous communities are on a daily basis confronted with complex issues at both an individual, family and community level.

The nature of these issues over time usually causes significant stress for both Indigenous and non-Indigenous workers. The ability of these workers to effectively intervene in these situations will be severely restricted if they are working in isolation without professional mentoring and support. Professional supervision can also relieve premature worker burnout. For these reasons, BoysTown ensures that all staff in contact with young people receive professional supervision. BoysTown staff located within the Balgo community have an allocated Clinical Supervisor who delivers professional supervision via phone and video link.

The other critical factor in providing quality responses consistent with the needs of regional and remote Indigenous communities is enhancing the cultural competence of service providers. In 2006 BoysTown initiated a strategy to increase help seeking behaviour by Indigenous youth with Kids Helpline. This strategy entailed:

a) The training of counsellors to raise their awareness of Indigenous culture and appropriate communication strategies with Indigenous people

b) The development of culturally appropriate marketing collateral with Indigenous people and communities and

c) The strengthening of relationships with indigenous communities through the employment of Indigenous staff, community visits and the establishment of an Indigenous Reference Group to inform the engagement strategies with indigenous youth

This strategy has seen a 46% increase in contacts since 2005 in contacts by Indigenous youth with the Kids Helpline service.

Recommendation 6:

That Government enter collaborative partnerships with organisations working in Indigenous communities and with indigenous community leaders to resource and implement local service planning activities concerning the identification of predisposing and situational risk factors for suicide particularly in relation to youth and to fund initiatives to reduce these risks.

Recommendation 7:

That Government fund a training strategy to be delivered to Indigenous people living in communities to inform the development of community based suicide prevention strategies

Recommendation 8:

That the recruitment and training of Indigenous people in health services be accelerated to increase the availability of trained Indigenous workers in communities.

Recommendation 9:

That the Select Committee notes the need for the provision of quality professional supervision for workers delivering health and social services in remote communities.

Recommendation 10:

That all Government and community organisations providing services to regional and remote Indigenous communities implement organisational development strategies designed to enhance their cultural competence in working with indigenous communities.

Recommendation 11:

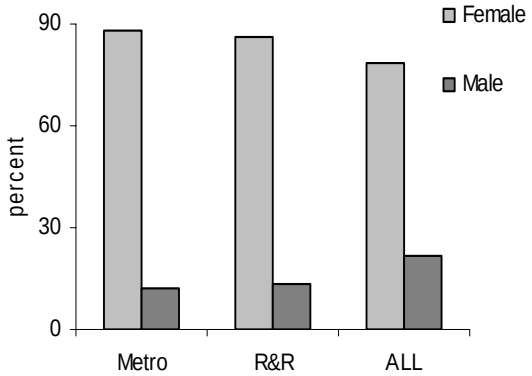
That research be undertaken in relation to the needs of Indigenous children under State protection orders and their carers, to inform support strategies.

Metro Vs Regional and Remote Suicidality

An analysis is provided to the Inquiry of contacts from rural and remote areas to Kids Helpline to identify the particular nature of suicidality amongst young people in these locations. All data is from the period 2005-08 unless otherwise stated.

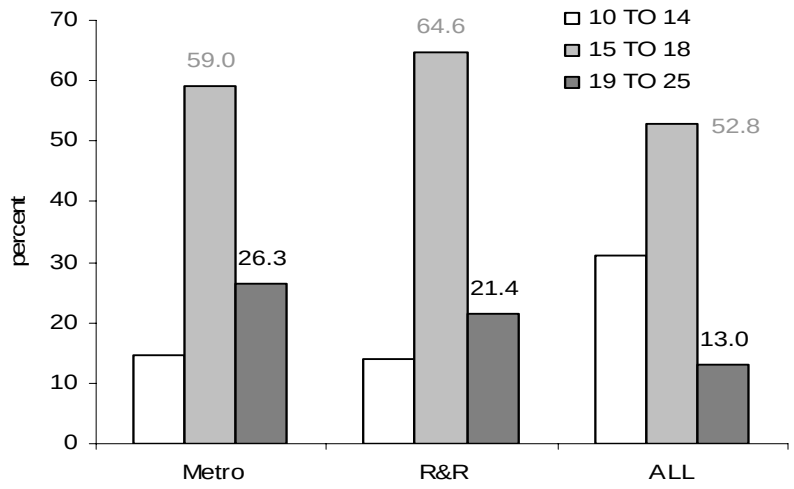
Gender

The gender distribution amongst contacts involving suicide to Kids Helpline is similar to that of all contacts. This is shown in the graph below:



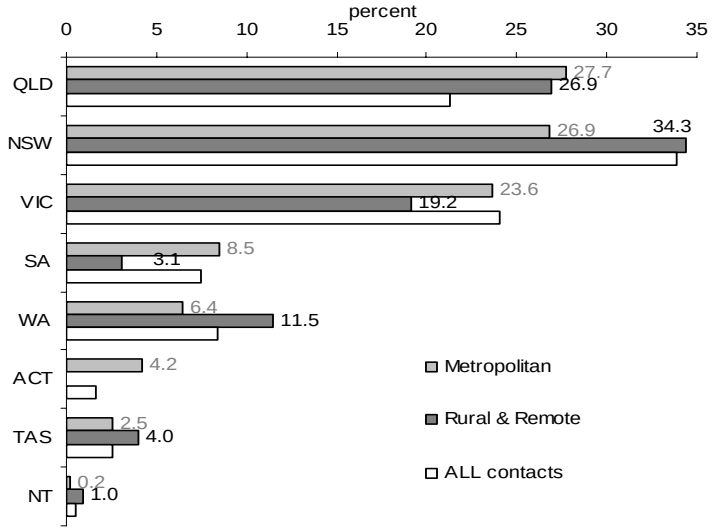
Age

There appears to be a higher proportion of contacts from young people aged 15 to 18 years living in rural and remote areas compared to metropolitan and all contacts. This is demonstrated below:



State Distribution

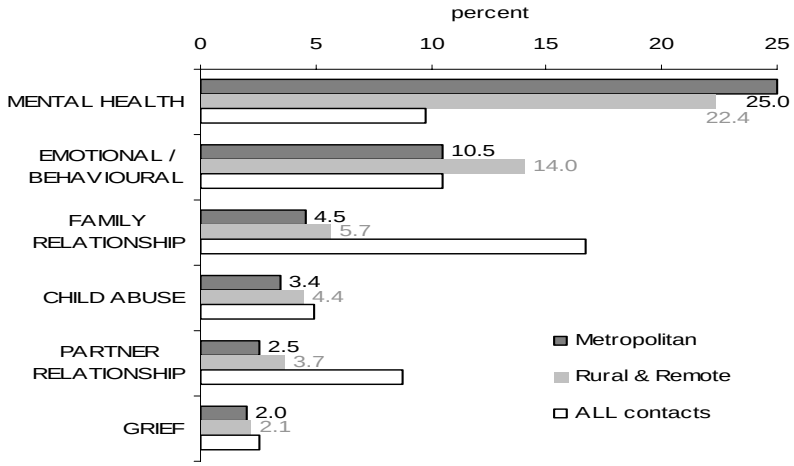
The State distribution of these Regional contacts with 'thoughts of suicide' show that Qld has the highest proportion from metropolitan areas (27.7%) followed by NSW (26.9%). NSW has the highest proportion of contacts from the rural and remote areas (34.3%) followed by QLD (26.9%). This is outlined in the following graph:



Problem Types associated with Suicidality

The top six problem types among the metropolitan and 'rural and remote' contacts was fairly similar: the Emotional / Behavioural proportion among the rural and remote contacts was higher than all the other groups (14%) and Mental Health among the metropolitan and rural/remote groups was much higher (25% and 22.4%) than the proportion among all contacts to KHL (9.8%). Similarly Family relationship was high on the priority among all contacts to KHL (16.7%) but not with these regional contacts with 'current

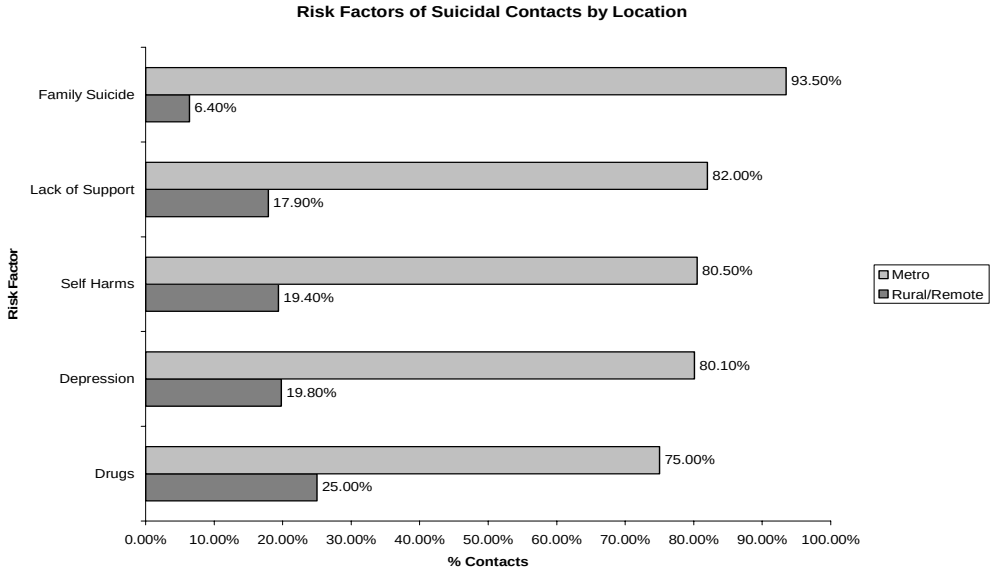
thoughts of suicide'. This is supportive of the finding that positive family relationships are a protective factor for young people in relation to suicidality. This is graphically displayed below:



Risk Factors

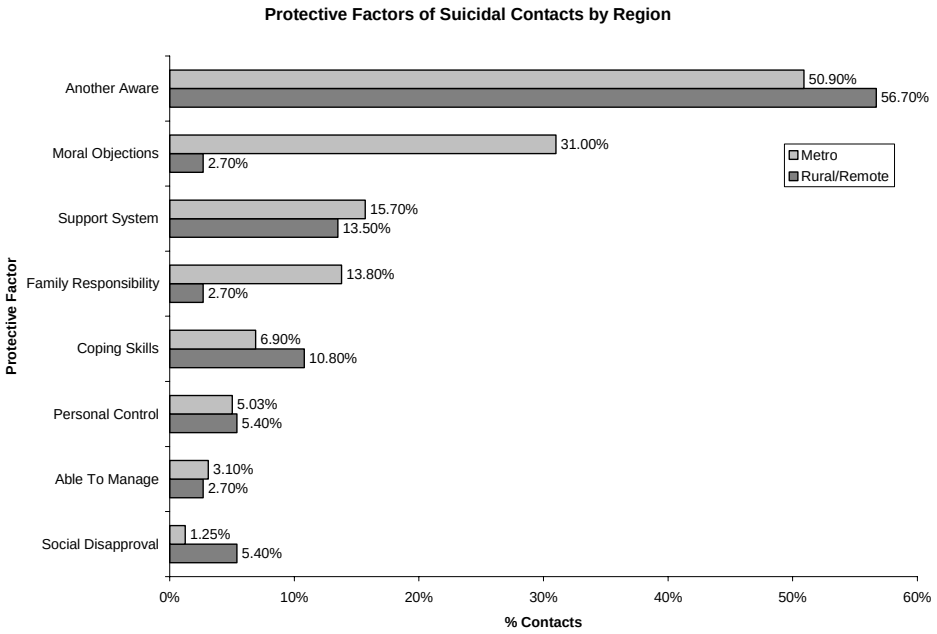
Data sourced from 2003-06 is used in the following sections to analyse risk and protective factors as well as means of suicide.

In relation to risk factors, all of the top five risk factors were over-represented among suicidal contacts in metropolitan areas: history of family suicide, lack of support, self-harm, depression and drugs – refer to following graph.



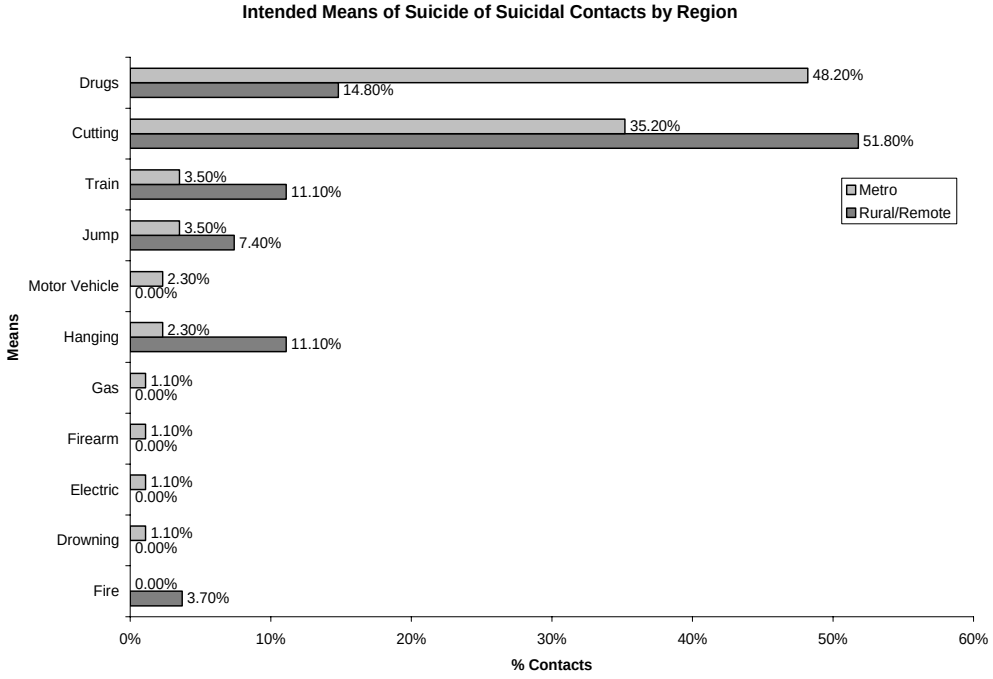
Protective Factors

The protective factors against suicide which were more represented among suicidal contacts in metropolitan areas than rural/remote areas were moral objections to suicide, support system, family responsibility and ability to manage. Those protective factors more represented among suicidal contacts in rural/remote areas than metro were another person being aware of the situation, coping skills, personal control and social disapproval – refer to graph.



Means of Suicide

Among suicidal contacts in metropolitan areas, the most common means of suicide are drugs/overdosing, motor vehicles, gas poisoning, the use of firearms, electrocution and drowning. Among suicidal contacts in rural/remote areas, more represented means of suicide were cutting, jumping off a train or lying on the railway tracks, jumping off a bridge or any high place, hanging and fire/burning.



Terms of Reference c:

The appropriate role and effectiveness of agencies such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

Note: Results of in-depth interviews with the KHL Counselling Centre Manager and BoysTown Clinical Practice Supervisors are presented below in response to the terms of reference c:

The response of statutory agencies has improved immeasurably since the mid-1990's assisted by reforms to Mental Health Acts and the development of mental health facilities across the states and territories. However distance to those facilities in times of crisis remains a difficult issue for suicidal people, police and families in rural and remote areas.

Police are no longer forced to hold persons deemed at risk to themselves in the watch house as the Mental Health Act/s require them to transport the person to the "nearest point of medical safety". Police are to remain at the Emergency Dept of the hospital until a Psychiatric Assessment has occurred and the delays that result has been a concern for police.

Furthermore although it has been KHL counsellors experience that Australian police are generally sympathetic to the needs of at risk young people, police intervention may inadvertently increase the tension and stress on the young person at risk of suicide.

Tensions can also exist between police and mental health staff, and family members and mental health staff when the suicidal person is assessed but then immediately discharged without admission to a psychiatric ward. Kids HelpLine has also encountered this when the Counselling Centre Supervisors have secured a Mental State Examination and Suicide Risk Assessment at a mental health service for a client only to have them telephone us again hours later saying they were discharged.

Thus, while the pathways of referral now exist, are commonly understood and procedures followed, the end point of referral is the acute mental health service where the patient will be assessed but may or may not be admitted into the psychiatric ward.

So while staff within these statutory agencies carry out their roles in the case of a suicidal person, the diagnostic psychiatric model together with demand for psychiatric beds, does limit the number of persons being admitted to wards on the basis of harm prevention when assessed as suicidal. This occurs for a number of reasons:

- 'Suicidality' is not a mental illness/disorder diagnosis. It does not come under the DSM-IV as a diagnosis so unless there is co-morbidity, securing a bed in a children's or adult mental health ward is unlikely.

- Like any statutory service carrying waiting lists with limited numbers of resources (beds in this case), 'gate-keeping' occurs. Patients, particularly those seen as chronic self-harmers, are so numerous and often seen as disruptive on wards and for whom there is no effective medication regime, tend to be 'gate-kept' out of wards.

- To argue that the person is currently suicidal means arguing the case of suicidality versus self-harm (no lethal intent) is often ineffectual. It should be remembered that patients in these situations often with lengthy waits involving transport, legal and triage processing when faced with incarceration under an Involuntary Treatment Order (ITO) exhibit resistant behaviour.

For young people, the federal and state governments answered various calls of inadequate responses to youth suicide by creating adolescent psychiatric units. While many in the health and welfare sectors questioned the fit of the model for the needs of these young people, the money was not in child protection and at least there was somewhere to house the young person for a short period.

The composition of suicidality in a person is known to be an accumulation of negative experiences over time. While there may often be a precipitating factor/situation which has moved the person closer to a suicidal act, the predisposing factors will inevitably have been present for some time.

When one assesses suicidal young people, an examination of the predisposing and precipitating factors expose common themes: child physical and emotional abuse, child neglect, sexual abuse and exposure to violence in families-of-origin. Rejection by families and failure of child protection agencies to effectively protect, often result in homelessness and hopelessness where suicide seems a viable solution.

The annual statistics published by The Children's Commission QLD documenting death by suicide of children currently under the care of the Department of Child Safety in Queensland bears witness to the stress being placed on State child protection systems. Kids Helpline encounters a common theme of child protection departments around the country being reluctant, or even refusing to take referrals for children over the age of 14 years despite being mandated in legislation to do so.

Consequently in summary there is a need for greater coordination between emergency, mental health and child protection services to ensure the safety of young people at risk of suicide.

Recommendation 12:

That COAG explore the option of implementing multi-disciplinary response teams as the first line of intervention for children and young people at risk of suicide. These response teams could include police, medical and other health professionals and counsellors.

Recommendation 13:

That COAG investigate alternative programs that complement Hospital psychiatric units for the assessment, containment and the delivery of initial crisis intervention with children and young people at risk of suicide.

Recommendation 14:

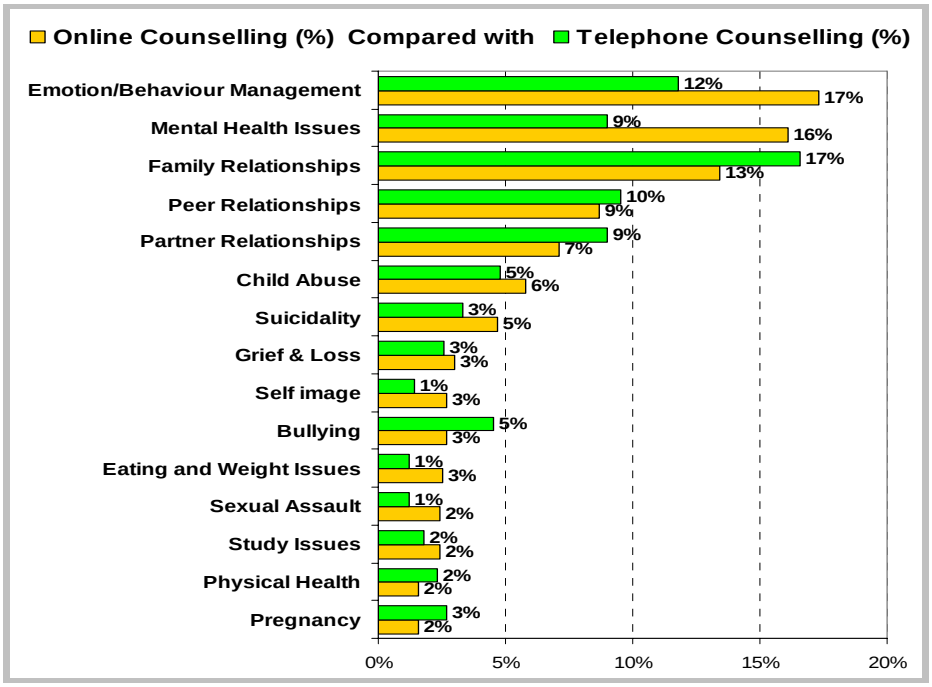
That the availability of therapeutic services be increased for children and young people in recovery following a suicidal incident.

Terms of Reference f:

The role of targeted programmes and services that address the particular circumstances of high-risk groups;

Contemporary communicative behaviour of children and young people needs to be considered in developing any preventative and intervention strategies in response to youth suicide. Australian children and young people have embraced internet and mobile phone technology. A 2009 survey undertaken by the ABS indicates that an estimated 96% of children aged 12-14 regularly accesses the internet and 33% have a mobile phone.[15] [16] [17]Similarly 93% of those aged 15-17 and 85% of the 18-24 year old group are internet users. Data from the Australian Communications and Media Authority (ACMA) show that 92% of young people aged 18-24 years use mobile phones.

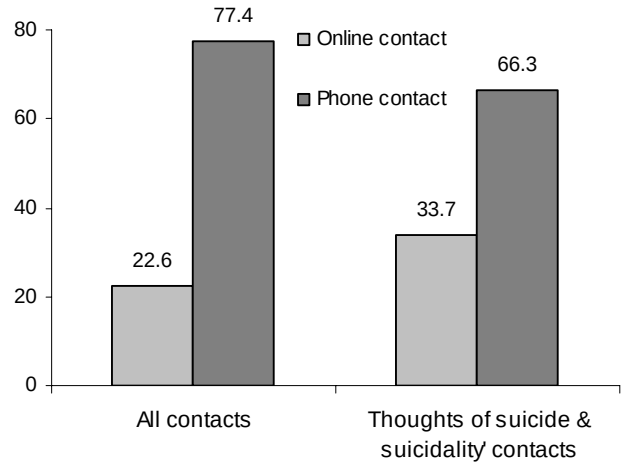
In the nine years Kids Helpline has offered web and email counselling, greater proportions of young people have consistently sought help online for some of the more severe concerns. This trend continued in 2008. Deliberate self-injury, suicide, emotional and/or behavioural management, mental health issues, self-image and eating and weight issues continued to be presented online at much greater rates than via telephone counselling (see following bar graph).



(Please refer to Appendices 5, 5.2 and 5.3 for 2005-2007 bar graphs)

In relation to counselling contacts involving thoughts of suicide, web and email counselling modalities are 1.5 times more frequently used than in other counselling sessions (33.7 / 22.6). This is graphically displayed in the graph below:

Analysis of Modality for Counselling Contacts: Suicidality v All Contacts



Contemporary research involving international child helplines suggests that children with complex issues such as thoughts of suicide feel more comfortable in using online modalities for help seeking as it provides them with a feeling of greater anonymity and control over the communication. In terms of counsellors experience with online counselling modalities we find that web and email appear to be providing a door through which highly marginalized young people can have access to counselling.

Many clients initially access the service by sending an email to a counsellor due to the increased emotional distance that they feel in writing emails. Through the emails, counsellors begin to build a therapeutic relationship and assess risk. As this relationship develops young people often take the next step in accessing the same counsellor through web counselling services where they experience real time communication with a counsellor which further reduces the client's anxiety about help seeking, then the next step is to work with clients on the phone. Often clients may continue to share many of their issues through email whilst also accessing phone counselling, when they do not feel that they can discuss a particular issue directly with their counsellor on the phone. Some clients also use email as an emotional outlet during times of distress between phone counselling sessions.

BoysTown's research indicates that telephone and online counselling are effective in assisting young people to overcome their issues. In the 2008 client outcomes survey of Kids Helpline users of the 77 clients surveyed, 95.6% reported having gained some ideas on how to deal with their problem, thus increasing their confidence in handling the issue(s). Indeed, almost half (44.6%) expressed they 'strongly agreed' that they'd gained ideas on dealing with things.

Additionally, 92.7% of clients surveyed reported feeling at least somewhat able to deal with their problem(s) following their call, of whom 17.2% expressed being 'very able'. A copy of the report is in Appendix 6 (BoysTown 2008 Evaluation of Kids Helpline Counselling Effectiveness and Client Satisfaction)

These results concerning the effectiveness of online counselling is supported by contemporary research literature.[18] There are a number of reasons why people choose to have counselling online. Some people prefer online counselling because they feel more comfortable with writing, and so they can be more honest and open about their problems. This is because writing things down

often enables clients to focus on what is troubling them, and that can bring emotional relief. If the client has not talked to anyone before, this way of working can sometimes feel less frightening, and so safer. The client may also feel more comfortable in an anonymous environment.[19]

Young men can prefer the anonymity that online counselling offers. Many people also find e-mail counselling preferable because it gives them time to think through what they need to say, and there is always an opportunity to read and re-read their counsellor's responses.[20]

Consequently any successful engagement strategy with young people in relation to suicide issues must involve the encouragement of help seeking behaviour and the delivery of counselling and support through online modalities.

Recommendation 15:

That Government establish collaborative partnerships with service providers currently using online modalities to research, develop and implement strategies that will increase help seeking and the availability of online counselling to children and young people at risk of suicide.

Upsurge in the use of Mobile Phones

Young people's use of mobile phone technology as a medium for help seeking behaviour is demonstrated in the changing nature of telephone contacts to Kids Helpline. In recent times there has been an upsurge in the number of children and young people using a mobile phone to contact the service. In 2008, 161,851 calls were made from mobile phones, accounting for 59% of all telephone calls. This is a 2% increase on 2007 mobile contacts (158,550) and a 64% increase since 2003 (98,624).

However the cost of using mobile phones may be an inhibitor for children and young people in accessing assistance. Calls through the Optus and Vodafone networks are the only mobile phone contacts that are free to children and young people. It is imperative that vulnerable children and young people are able to seek appropriate assistance via free mobile phone contacts to authorised services.

Recommendation 16:

That the Commonwealth Government negotiate with telecommunication providers to provide free access to telephone and online counselling services.

Public phones in regional and remote areas are still relevant

Public phones are still relevant to children and young people, particularly the Aboriginal and Torres Strait Islanders. Despite the enormous growth in mobile phone use, payphones still play a significant role in children and young people accessing Kids Helpline. In 2008, 2,690 of all telephone counselling sessions with children and young people were made from payphones. (refer to Appendix 7 - KHL Overview 2008)

Access to payphones is particularly important for Indigenous children and those young people located in regional and remote areas of Australia. One-in-five calls to Kids Helpline from Indigenous children and young people and one-in-ten calls from regional and remote areas were made from payphones.

Ensuring easy and free access to telephone services is more critical for these two groups because they are often disadvantaged by a lack of local services and rely heavily on communication technologies to seek help via telephone and internet-based services.

However in recent times the number of pay phones that children can access to seek assistance has been reduced. It is critical that Government work with telecommunication providers to ensure an adequate coverage of public telephones across rural and remote Australia and within indigenous communities.

Recommendation 17:

That the Commonwealth Government work with Telstra to ensure that there is adequate public telephone coverage across Australia particularly in rural and remote areas.

Wrap Around Care

There is a need to coordinate face to face, telephone and online counselling services to ensure continual and instantaneous services are available to vulnerable children and young people contemplating suicide. Kids Helpline is frequently used in the safety plans developed for vulnerable young people as we provide 24/7 service coverage and access to professionally trained counsellors. Furthermore a wrap around case management model of care is used where a number of face to face, medical and other specialist services coordinate their services to an individual within an agreed case plan to ensure effective intervention. To date this year 880 young people are involved in a case management process by Kids Helpline. This is a 400% increase in the numbers of case managed young people from 2007 (N=222). We believe that this is an innovative service strategy that is effective in protecting vulnerable children and young people. Consideration should be given to extending this type of service nationally.

Recommendation 18:

That Government at both a State and Federal level enter into collaborative partnerships with community organisations to assess the effectiveness of 'wrap-around' case management models involving health, mental health and telephone and online counselling services.

Community Engagement Models involving Mentoring and Employment Initiatives

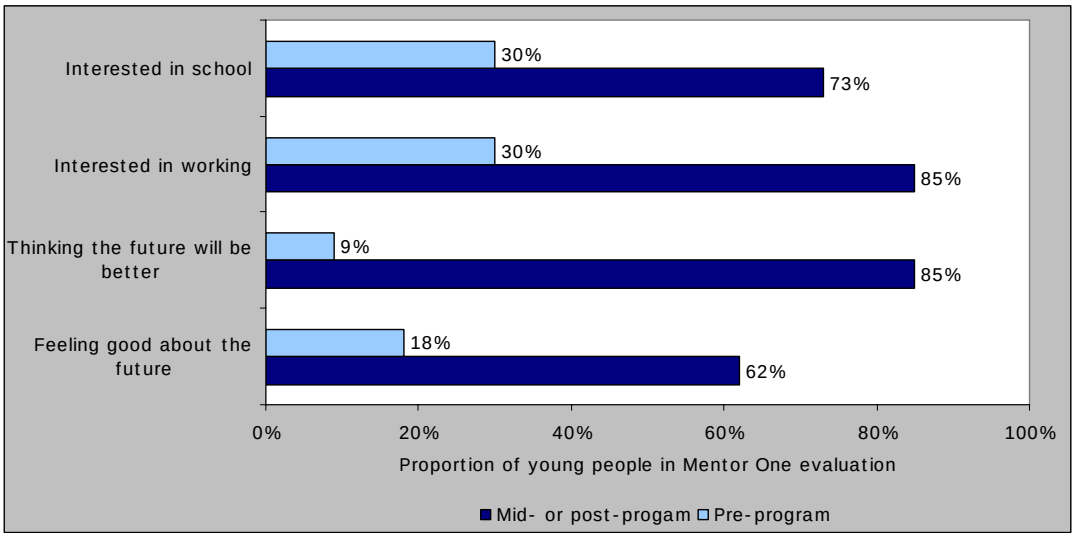
Currently intervention responses to young people at risk of suicide are dominated by the medical model framework. In our earlier overview of risk and protective factors for young people it is evident that a lack of social connection is a serious risk factor and conversely social networks protects and lessens the risk of suicide amongst young people. The experiences of many young people as related to our counsellors suggest that in the recovery period young people

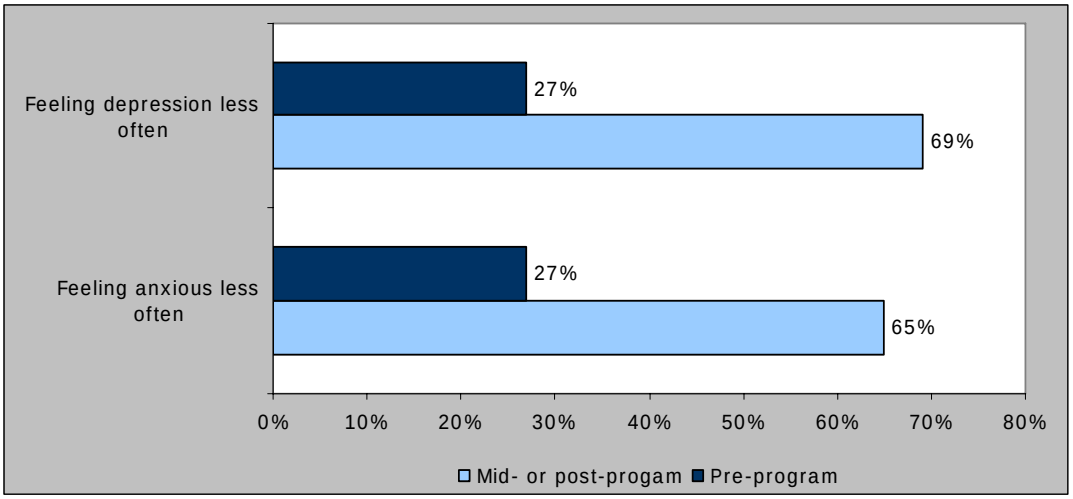
can fall through the cracks following discharge from hospitals with little follow-up services provided. Little research has been undertaken on the effectiveness of suicide intervention models that integrate community engagement strategies such as employment and mentoring strategies with case management and counselling.

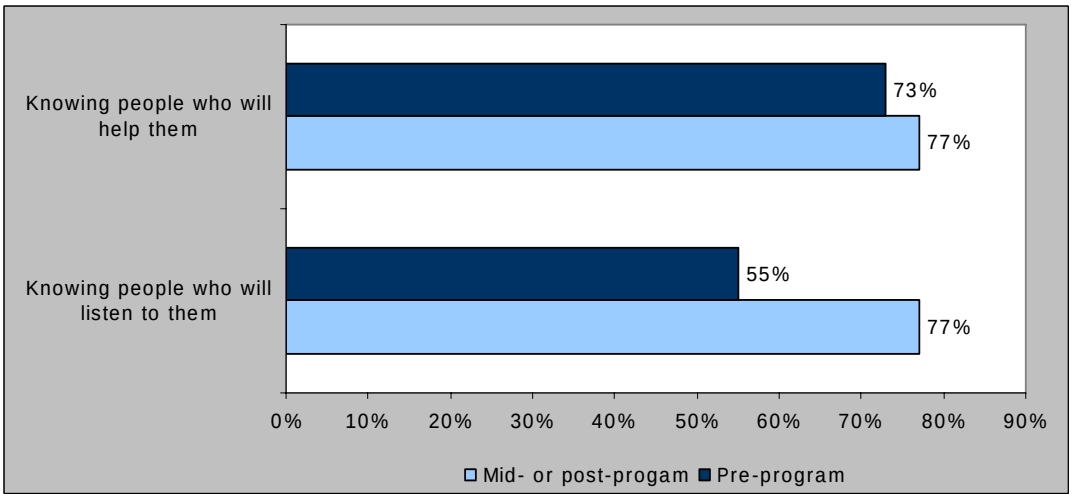
However BoysTown's research indicates that mentoring and employment initiatives are effective strategies in mitigating risks that lead to suicide behaviour amongst youth.

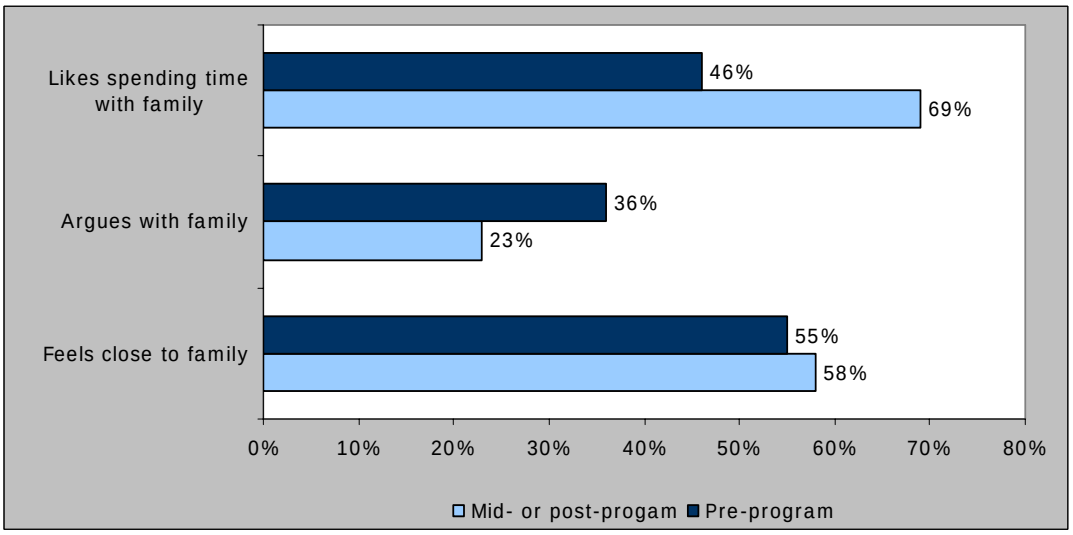
BoysTown delivers a mentoring program for children at risk of early disengagement from schools and education. Part of the self development focus of this mentoring program involved addressing self esteem, resilience and coping ability. A recent evaluation demonstrated that young people (Sample Group = 79) who had progressed through or were in engaged with the 'Mentor One' program were more likely to be optimistic about the future, resilient, able to cope when encountering obstacles, participating in more social networks and took better care of their physical and mental health. Specifically, mentees were more likely to think positively about their future and feel good about their future and where they were going in life. Furthermore, young people were more likely to try their best in everything they do, persisted if they did not succeed the first time, and coped well when they experienced difficulties. In relation to health, young people were more likely to have good physical health, feel depressed or anxious less often and stay away from cigarettes, drugs and alcohol.

This is outlined in the following graphs. An Executive Summary of the report on the evaluation findings is attached as an Appendix 7.




Feeling depression less often
27%
69%
Feeling anxious less often
27%
65%
0%
10%
20%
30%
40%
50%
60%
70%
80%
Mid- or post-progam
Pre-program


Knowing people who will help them
73%
77%
Knowing people who will listen to them
55%
77%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
Mid- or post-progam
Pre-program


Likes spending time with family
46%
69%
Argues with family
36%
23%
Feels close to family
55%
58%
0%
10%
20%
30%
40%
50%
60%
70%
80%
Mid- or post-progam
Pre-program

Furthermore BoysTown is partnering with Griffith University Queensland in an Australian Research Council sponsored project that is investigating the most effective strategies to reengage marginalised young people with employment and further education. Young people who are participating in BoysTown's social enterprise programs that provide real work experiences in a supported environment are being monitored as part of this research project. These young people also are offered services consistent with the BoysTown Social Inclusion Model – refer to Appendix 8.

Preliminary findings to date indicate that these young people's sense of optimism about their future prospects is significantly enhanced through their participation in social enterprises. The summarised findings from preliminary data are outlined in the following tables:

Social Inclusion Barriers	**Before BoysTown (n=99)**	**Benefits from Participation in BoysTown (n=122)**
No work experience	46%	27%
Main source of income		
- Work	24%	50%
- Government income support payment	37%	35%
- Nil income	39%	15%
Offending behaviour		
- Time in detention	17%	3%
- Trouble with the police	39%	33%
- Difficulties with controlling anger	40%	13%
- Getting into physical fights	48%	13%
Regular substance abuse	29%	17%

Social Inclusion Barriers	**Before BoysTown (n=99)**	**Benefits from Participation in BoysTown (n=122)**
Lack of accredited qualifications	84%	58%
Literacy		
- Poor writing skills	35%	29%
- Poor reading skills	33%	21%
- Difficulties with daily tasks	43%	35%
Numeracy		
- Poor numeracy skills	52%	46%
- Difficulties with daily tasks	68%	45%
Lack of future aspirations	41%	7%
Poor wellbeing	32%	8%
Low self esteem	19%	7%

The clear conclusion from these preliminary research findings is that if young people can be supported to overcome their feelings of hopelessness and

isolation that lead to suicidal and other adverse behaviours, that their potential to contribute to the community is huge.

Consequently based on this research data we advocate for the development and evaluation of trial community engagement projects involving mentoring and employment initiatives with highly vulnerable young people at risk of suicide to assess whether these models can be effective contributors to reducing risk of suicide amongst young people. These models may lead to a reduction in the work demands of hospitals and could compliment the work of mental health practitioners.

Recommendation 19:

That Government fund research into community engagement models of intervention for children and young people at risk of suicide.

The Impacts of Alcohol Abuse within the Indigenous Community

BoysTown's Aboriginal staff and partners strongly advocate that the impact of alcohol abuse among young Aboriginal and Torres Strait Islanders must be explored further. There are current research studies being conducted on the effects of alcohol and binge drinking. A most poignant one was about suicidality of Indigenous adolescents and adults with Fetal Alcohol Spectrum Disorders (FASD).

FASD is proof that alcohol and its use and abuse among Indigenous and non-Indigenous people have short-term and long-term negative effects on people. In the short-term, alcohol can cause impulsive people with emotional and mental problems to attempt suicide. In the long-term, alcohol can cause generations of children with growth deficiency, facial dysmorphia and central nervous system impairment or damage as a result of prenatal alcohol exposure. It should be noted that case studies have proven that suicidality among people with FASD is very high; thus, FASD is considered a predisposing cause of suicide, as it increases vulnerability and suicide risk. (*Please see Appendix - Fetal Alcohol Spectrum Disorders [FASD]).*

These studies consequently support the need to implement preventative health strategies to counter the impacts of FASD amongst Aboriginal and Torres Strait communities.

Recommendation 20

That Government funding be enhanced for research into the influence of alcohol abuse and Fetal Alcohol Spectrum Disorders on suicidality amongst Indigenous youth.

APPENDICES

Appendix 1

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Appendix 2

Article

Binge Drinking During Pregnancy as a Predictor of Psychiatric Disorders on the Structured Clinical Interview for DSM-IV in Young Adult Offspring

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Objective: This study explored the extent to which the high frequency of psychiatric problems reported in clinical groups with fetal alcohol spectrum disorders might also be observed in a nonclinical group of young adults and the psychiatric conditions that are related to prenatal alcohol exposure in this group.

Method: From a longitudinal prospective study beginning with interviews of 1,529 pregnant women, a birth cohort of about 500 newborns was chosen to include all of the most heavily alcohol exposed plus a sampling of the continuum of alcohol exposures from total abstinence through heavy drinking. At an average age of 25.7 years, 400 members of this birth cohort were administered valid Structured Clinical Interviews for DSM-IV (SCID), including both the SCID for axis I disorders and the SCID for axis II personality disorders.

Results: The odds of the appearance of six psychiatric disorders and traits were more than double in adults exposed to one or more binge alcohol episodes in utero. Three of these six odds ratios were uniformly stable against confounding: axis I substance dependence or abuse disorders and axis II passive-aggressive and antisocial personality disorders or traits.

Conclusions: Prenatal exposure to alcohol may be a risk factor for specific psychiatric disorders and traits in early adulthood, even in a nonclinical group.

(Am J Psychiatry 2006; 163:1061–1065)

Prenatal exposure to alcohol causes birth defects, including fetal alcohol syndrome, fetal alcohol effects, and alcohol-related neurodevelopmental disorder, collectively referred to as fetal alcohol spectrum disorders (1). These involve abnormal development in various domains, including attention and memory, executive functioning, motor skills, learning, and judgment.

The brain is the organ most vulnerable to prenatal alcohol damage across a wide range of regions (2–13), and alcohol-related brain pathologies affect specific domains of neuropsychological and neuromotor functions (14, 15). Although mental health conditions are not a criterion for any of the fetal alcohol-related diagnoses, they have been identified in 87% and over 90% of the subjects in two independent studies of people with fetal alcohol spectrum disorders, although the subjects were not recruited into these studies specifically because of these conditions (16, 17).

Here we used the Structured Clinical Interview for DSM-IV (SCID) to quantify the psychiatric disorders and traits that exist in a nonclinical group of adults with known levels of prenatal exposure to alcohol. This work is intended as a contribution to developmental neuropsychiatry (18–20) and neurodevelopmental psychiatry (21, 22), which acknowledge the importance of early biological development in adult psychiatric etiologies.

Method

Acquisition of Study Group

In 1974–1975, 1,529 pregnant women were interviewed in mid-pregnancy regarding their prenatal use of alcohol, cigarettes, caffeine, recreational drugs, and medications. Based on a hierarchical listing of 19 alcohol use patterns and cigarette use and without the knowledge of newborn status or functioning, approximately 500 singleton children were chosen at birth for a longitudinal prospective study. The group was stratified for cigarette use across levels of alcohol use and oversampled for heavier drinkers. These women were generally at low risk of adverse pregnancy outcome; street drug use was rare except for marijuana. All mothers were in prenatal care by mid-pregnancy but were otherwise representative of the Seattle area in terms of sociodemographic characteristics (23). Eighty-eight percent of the mothers were married, 13% had not graduated from high school, and 88% reported white ethnicity; the mean maternal age was 26.5 years (range=14–45) (9% were teenagers). The children had previously provided developmental data at birth, 8 and 18 months, and 4, 7, 11, 14, 21, and 25 years.

A 25-Year Follow-Up

Across a 3-year period, 431 members of this birth cohort participated in an extended clinical research assessment that included the SCID and the Structured Clinical Interview for DSM-IV Personality Disorders (SCID-II) (24). SCID data were not collected from 29 subjects who participated by only telephone or mail, one who refused, and one whose IQ was 69. The average age of the 400 subjects who provided valid SCID data was 25.7 years (range=24.8–27.4); 53% were men; 83% reported white ethnicity, 4% were black, 2% were Asian, and 12% were of other or mixed races. IQs at age 21 years ranged from 70 to 144 with a mean of 103.

Appendix 2.2

TABLE 1. Frequencies of Psychiatric Disorders and Traits in a Follow-Up of 25-Year-Olds, by Prenatal Alcohol Binge Exposure

	Total (N=400)		Subjects Not Exposed to Binge Drinking (N=329)		Subjects Exposed to Binge Drinking (N=71)			
Disorder or Trait[a]	N	%	N	%	N	%	Odds Ratio[b]	95% CI
Axis I disorders (one or more)								
Somatoform	5	1.3	2	0.6	3	4.2	7.21	1.18–44.00
Substance abuse or dependence	140	35.0	102	31.0	38	53.5	2.56	1.52–4.32
Manic	7	1.8	5	1.5	2	2.8	1.88	0.36–9.88
Dysthymia or mood	30	7.5	22	6.7	8	11.3	1.77	0.75–4.16
Depressive	154	38.5	120	36.5	34	47.9	1.60	0.95–2.68
Anxiety	117	29.3	93	28.3	24	33.8	1.30	0.75–2.24
Eating	14	3.5	11	3.3	3	4.2	1.28	0.35–4.69
Adjustment	15	3.8	12	3.6	3	4.2	1.17	0.32–4.24
Psychotic	5	1.3	4	1.2	1	1.4	1.16	0.13–10.54
Axis II disorder or trait (personality disorder)								
Paranoid	9	2.3	5	1.5	4	5.6	3.87	1.01–14.79
Passive-aggressive	23	5.8	14	4.3	9	12.7	3.27	1.35–7.88
Antisocial	27	6.8	17	5.2	10	14.1	3.01	1.31–6.89
Other	19	4.8	13	4.0	6	8.5	2.24	0.82–6.12
Depressive	32	8.0	24	7.3	8	11.3	1.61	0.69–3.76
Schizoid	24	6.0	18	5.5	6	8.5	1.59	0.61–4.17
Schizotypal	8	2.0	6	1.8	2	2.8	1.56	0.31–7.90
Avoidant	39	9.8	30	9.1	9	12.7	1.45	0.65–3.20
Mixed	26	6.5	20	6.1	6	8.5	1.43	0.55–3.69
Histrionic	10	2.5	8	2.4	2	2.8	1.16	0.24–5.60
Dependent	6	1.5	5	1.5	1	1.4	0.93	0.11–8.05
Narcissistic	12	3.0	10	3.0	2	2.8	0.92	0.20–4.31
Borderline	13	3.3	11	3.3	2	2.8	0.84	0.18–3.87
Obsessive-compulsive	65	16.3	55	16.7	10	14.1	0.82	0.39–1.69

[a] Ordered by odds ratio for alcohol exposure within axis.
[b] Odds ratios greater than 1 indicate prenatal alcohol risk. A two-tailed log-symmetric 95% CI is next to each odds ratio. Lower CI limits above 1.0 correspond to conventional significance levels of p≤0.05.

Outcomes

The SCID assesses 129 symptoms sorted into nine primary classes of axis I psychiatric disorders: depressive, manic, psychotic, anxiety, somatoform, mood, adjustment, eating, and substance (alcohol or drug) disorders. Questions are phrased in terms of "ever in your life."

The SCID-II (24) evaluates 14 personality disorders derived from responses to 107 3-point ratings for which a code of zero stands for the rating of "none," a code of 1 for "yes, subthreshold," and a code of 2 for "yes, suprathreshold." These are also evaluated for "ever in your life." The scoring software provides diagnoses, and for 12 of the 14 disorders, it also indicates maladaptation or traits that do not meet criteria for diagnosis but that are nevertheless serious enough to "interfere with life." Here we used the disorder or trait scores for each of the 12 classes of personality disorders for which they are available.

The 23 SCID classifications presented here cover all of the information available from the SCID. Each of the 23 summary scores (Table 1) is set to 1 if any disorder in the class is positive and to 0 otherwise. The general summary score is a simple count of the number of disorders and traits (from 0 to 23).

The SCID was administered privately face-to-face by one of two SCID-trained, licensed clinical psychologists (P.D.C. and J.E.H.): 394 at the University of Washington Fetal Alcohol and Drug Unit, four in private rooms reserved offsite, and two in prisons. After the procedures had been fully explained and informed consent had been obtained, SCID data were collected with software from Multi-Health Systems Inc. (North Tonawanda, N.Y.) and American Psychiatric Publishing, Inc. (Arlington, Va.). Interviewers were blind to maternal reports of prenatal alcohol use and to all previous developmental data. In a random subsample of five cases rated by both clinicians, interrater reliability was 100% agreement on the SCID diagnoses; axis II scores from the two examiners differed by two points on 2% of the reliability data and by one point on 8%.

Prenatal Alcohol Exposure

Alcohol exposure was assessed from maternal self-reports for two gestational periods: early pregnancy (before pregnancy recognition) and mid-pregnancy (around the time of the interview). The measures available included average ounces per day, monthly occasions of drinking, average drinks per drinking occasion, maximum number of drinks on any occasion, and binge episodes. The small numbers of psychiatric disorders and traits in this group precluded the dose-response explorations that would use continuous alcohol measures. For this report, alcohol is a simple dichotomy: one or more binge episodes during mid-pregnancy compared to none. A binge episode is defined as five or more drinks on at least one occasion. Seventy-one mothers of this group (17.8%) reported such binge drinking. In contrast were 150 mothers (37.5%) who abstained or drank only infrequently at low levels and 179 (44.8%) who reported light or moderate alcohol use patterns.

Other Predictors of Mental Health Problems

Of the potential predictors of mental health problems identified in a literature search (23, 25–27), 11 were available for this cohort. These included prenatal cigarette exposure, prenatal marijuana exposure, prenatal nutrition, breast-feeding, socioeconomic status, the Mother/Infant Interaction Scale (an ordinal maternal deviancy score) (28), surrogate parenting of the subject (e.g., foster care, adoption), biological family history of serious mental health problems (in first- and second-degree relatives), a history of alcohol problems in two parents and four grandparents, sex, and the subject's own cigarette smoking history. Each was used as a dichotomy in our analyses. Although current

Appendix 2.3

ORIGINAL ARTICLE

FETAL ALCOHOL SPECTRUM DISORDERS AND SUICIDALITY IN A HEALTHCARE SETTING

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Received 2 July 2007; Accepted 11 August 2007

ABSTRACT

Objectives. To present a clinical case report and provide a review of the available literature on fetal alcohol syndrome and the fetal alcohol spectrum disorders and suicidality to highlight important implications for providers.
Study design. A case report and literature review.
Results. Almost 6% of adolescents evaluated by the fetal alcohol spectrum disorders diagnostic clinic at the Alaska Native Medical Center had been seen for self-harm related consultation.
Conclusions. Persons with the fetal alcohol syndrome and the fetal alcohol spectrum disorders, as a result of their disability, demonstrate characteristics or features that are commonly thought to be risk factors for suicide—such as mental illness, alcohol and other drug abuse, impulsivity, history of trauma or abuse, and employment and relationship/social difficulties. These persons may experience mental health problems, including suicidal ideation and attempts, over the course of their life times. *(Int J Circumpolar Health 2007; 66(Suppl 1):54-60).*

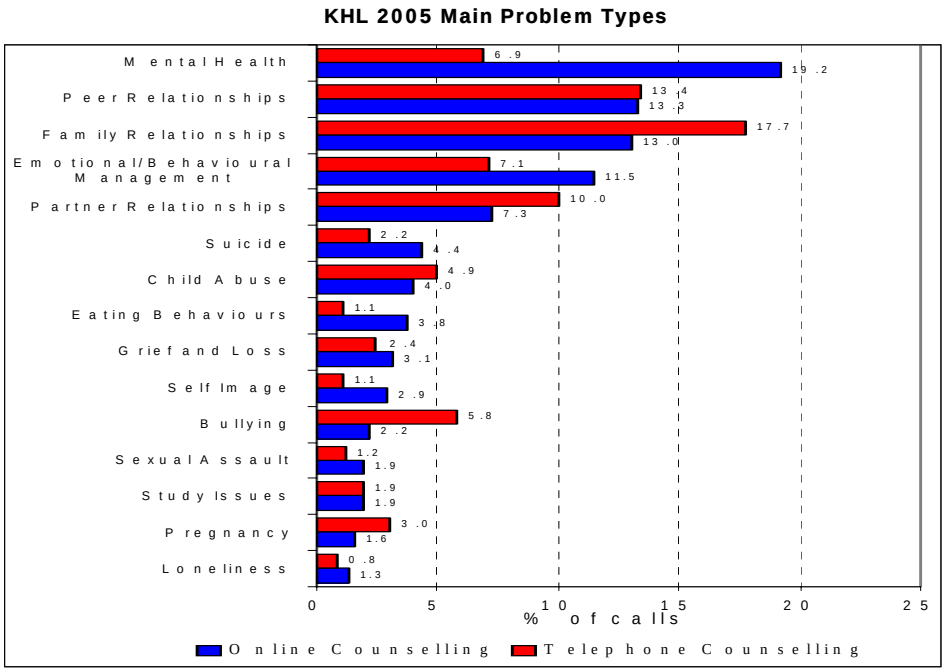
Appendix 3

Living With…	Total %	Suicidal Thoughts %
Alone	2.7	5.8
Boarding school	.9	.5
Extended family	4.3	5.6
Foster parents	1.7	2.6
Friends/flatmates	3.7	5.7
Institution	.3	.7
Nowhere/homeless	1.1	1.3
With partner	2.9	2.8
Shared custody	.3	.1
Shelter/hostel/supported accommodation	2.3	4.7
Single parent	26.2	21.4
Two parents (biological/adopted)	45.1	41.9
Two parents (blended)	7.6	6.7
With own child/children	.8	.3

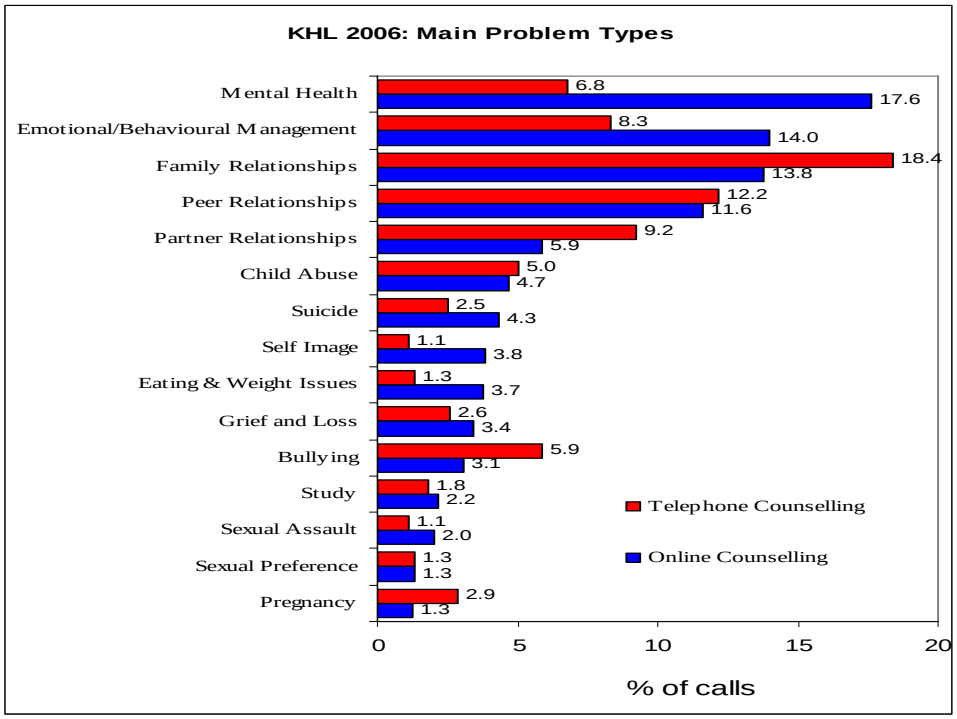
Appendix 4

Problem type	Total %	Females %	Males %
Suicide	46.9	46.8	47
Mental Health	17.6	18.5	12.7
Emotional and Behavioural management	7.9	8.1	6.5
Family Relationships	6.1	6.2	5.7
Partner Relationships	4.1	3.4	8.6
Sexual Abuse	2.2	2.5	0.6
Grief	2.1	2	2.4
Peers	1.9	1.8	2
Sexual Assault	1.4	1.6	0.3
Physical Abuse	1.3	1.4	1.1
Self-Image	1.2	1.2	1.5
Bullying	1.1	0.8	2.4
Homeless	1	0.9	1.5

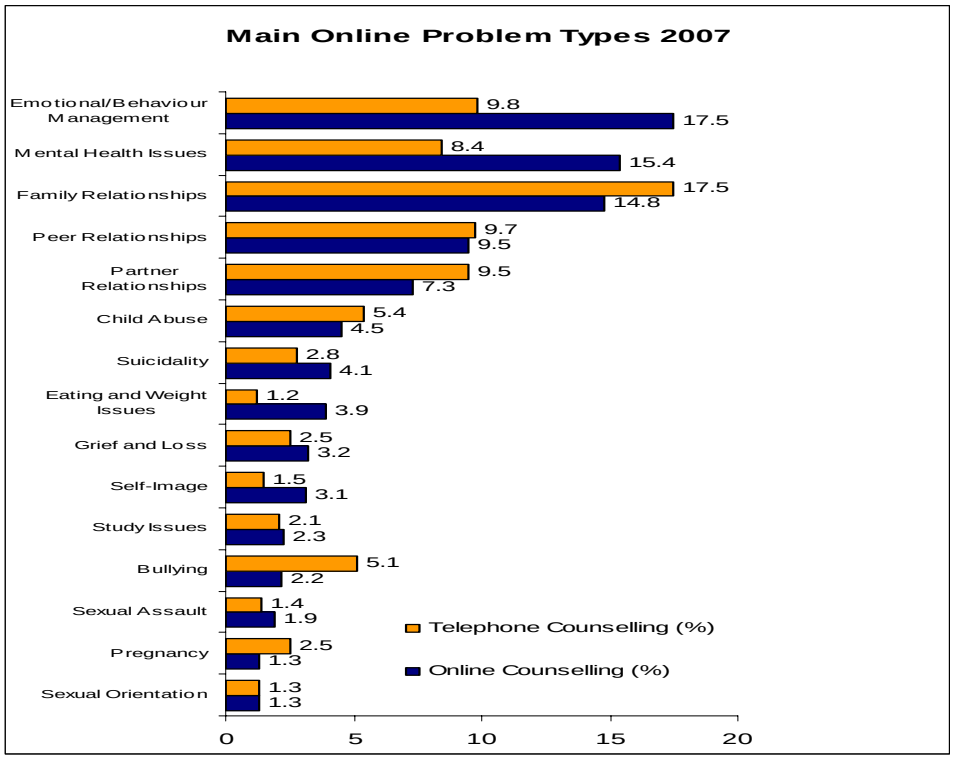
Appendix 5



Appendix 5.2



Appendix 5.3


Main Online Problem Types 2007
Emotional/Behaviour Management
9.8
17.5
Mental Health Issues
8.4
15.4
Family Relationships
17.5
14.8
Peer Relationships
9.7
9.5
Partner Relationships
9.5
7.3
Child Abuse
5.4
4.5
Suicidality
2.8
4.1
Eating and Weight Issues
1.2
3.9
Grief and Loss
2.5
3.2
Self-Image
1.5
3.1
Study Issues
2.1
2.3
Bullying
5.1
2.2
Sexual Assault
1.4
1.9
Pregnancy
2.5
1.3
Sexual Orientation
1.3
1.3
Telephone Counselling (%)
Online Counselling (%)
0
5
10
15
20

Appendix 6

Kids Helpline

Satisfaction & Efficacy Report 2008

Understanding Client Satisfaction and the Service's Efficacy in Increasing a Young Person's Ability to Cope

BACKGROUND TO THE SERVICE

What is Kids Helpline?

Kids Helpline is Australia's only 24/7 private and confidential counselling service providing education, guidance and support specifically for young people aged 5 to 25 years. The service is an initiative of BoysTown.

Kids Helpline offers counselling and support via phone, email and real-time web services. Each week counsellors respond to more than 5,000 phone and online contacts about a range of issues from everyday topics such as family, friends and school to more serious issues of abuse, bullying, mental health concerns, drug and alcohol use, homelessness and suicide.

Young people have direct access to counsellors and can choose to speak with either a male or female counsellor.

Who uses the service?

The age of clients range from 5 to 25 years, with two thirds of these being older adolescents and young adults. Consistent with national help-seeking trends, females make up the majority of Kids Helpline contacts (approximately 80% each year).

Counselling sessions are held with young people from all States and the Northern Territory. In 2008, client numbers were generally reflective of the youth population living in each area. Most clients came from NSW (33%), followed by Victoria (24%) and Queensland (22%), with 21% representing Australia's remaining States/Territory.

Clients come from a variety of cultural and linguistic backgrounds (CALD), although English-speaking backgrounds consistently dominate. In 2008, the proportion of clients identifying as Indigenous was 3.8%. Clients identifying as CALD increased to 17%.

Although phone remains the most common form of contact (94%), web and email counselling still provide an important role, particularly for some of the more sensitive topics. In 2008, frequency of contacts via these methods represented 4% and 2%, respectively.

The most frequent primary concerns reported by children and young people in 2008 were family relationships (16%), emotional/ behavioural management issues (13%), mental health issues (10%) and peer relationships (9%).

The majority of counselling sessions are with young people who are contacting Kids Helpline for the first time or who occasionally use the service (71% in 2008). The remaining are engaged in ongoing counselling sessions and case management.

WHY IS SUCH A SERVICE IMPORTANT?

Childhood, adolescents and young adulthood are all challenging and emotional stages in a person's life. Often the impact of distressing or difficult situations can be felt even more acutely by young people than by adults.

The need for a free, accessible and confidential counselling service for young people was first addressed by BoysTown in 1991. Since its establishment, Kids Helpline counsellors have responded to more than six million contacts from young people seeking assistance. With trends over the past five years showing an increase in the proportion of young people presenting with complex needs (e.g. mental health issues, suicidal ideation, emotional / behavioural management concerns), one could posit that a service offering qualified counselling is needed now more than ever.

Both anecdotal and empirical evidence tell us that if young people are able to receive emotional support and guidance from a qualified professional they will have greater opportunity

to fulfil their potential. Moreover, promoting skills and capacities have been shown to reduce risk factors and increase protective factors to achieve positive outcomes for individuals over the longer term[5]. Particularly through the practice of strength-based therapy approaches, counsellors can provide the support necessary for clients to achieve meaningful change by encouraging and restoring hope. Indeed there is much empirical research showing that strength-based interventions are an important method for building strengths and skills in young people to empower them to explore ways of changing and/or enhancing their behaviours.[1,3,4,5]

THE NEED FOR RESEARCH

BoysTown is committed to ensuring that all their services are evidence-based and effective in addressing client needs. Research enhances organisational accountability and procurement of funding, as well as providing valuable information to inform strategic planning and decision-making.

Research into Kids Helpline's efficacy is undertaken annually. The 2008 research assessed client outcomes and satisfaction levels through the following specific measures:

- number/percentage of clients surveyed who are satisfied with the quality of service provision
- number/percentage of clients surveyed reporting an increased ability to effectively manage their issues; and
- number/percentage of clients surveyed reporting increased confidence to effectively manage their issues.

RESEARCH METHODOLOGY

The research methodology involved short (two - five minute) telephone surveys. Due to the anonymous nature of the service, surveys were conducted by Kids Helpline counsellors. On calls where counsellors considered it appropriate to do so, the research project was introduced and explained at the end of the counselling session. Due to the sensitive nature of the service, Counsellors were advised to only approach clients who they considered not to be too distressed. Clients were informed that participation was voluntary.

A five-item oral self-report scale was developed to measure the child-centred outcome. Its design was based on learnings from previous evaluations of Kids Helpline and consultation with counselling supervisors. The works of Miller, Duncan, Brown, Sparks and Claud were considered in the validity, reliability, feasibility and design of the outcome rating scales[2].

Surveys were conducted with a total of 77 clients. Participants included a mix of genders, age and both first-time and repeat callers. Numbers for these were achieved through natural fall-out rather than set quotas. Consistent with national contact statistics, females made up the majority of participants.

Table 1: Breakdown of Final Sample

	Male	Female
5-9 yrs	0	3
10-14 yrs	5	14
15-18 yrs	4	29
19-25 yrs	3	18
Unspecified	0	1
Totals	**12**	**65**

All interviews were conducted between 9 and 31 October 2008.

FINDINGS

Overall, results suggest that most young people contacting Kids Helpline find the service effective. Such high levels of satisfaction and successful outcomes indicate a high quality counselling service.

Satisfaction & Efficacy Report

Client Satisfaction

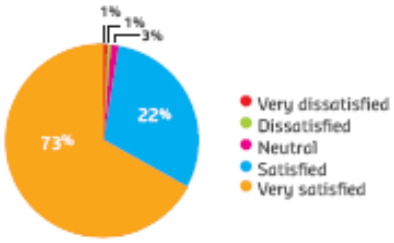
A very high proportion of the 77 clients surveyed reported satisfaction, including:

- 77% claiming to be 'very satisfied'; and
- 18% claiming to be 'satisfied'.

A position of neutrality (i.e. neither satisfied nor dissatisfied) was reported by 3% of clients, with 2% reporting dissatisfaction. Reasons for dissatisfaction related to not having received the advice they expected.

The following graph shows the full breakdown of responses. Participants for which the measure did not apply have been excluded.

Figure 1: Overall Client Satisfaction



Feedback offered by clients was typically positive, including statements such as:

"I never thought about using something like this before. It really does help"

"If you're feeling down and don't want to live you should call (Kids Helpline) because they can help"

"You've actually made me feel a whole lot better than I did before"

Perceived effectiveness in increasing confidence and ability

Participants were asked to rate their most recent call to Kids Helpline in terms of its ability to:

- give some practical ideas on how to deal with their problem; and
- increase their confidence in being able to deal with their problem.

Of the 77 clients surveyed, 95.6% reported having gained some ideas on how to deal with their problem. Indeed, almost half (44.6%) 'strongly agreed' that they'd gained ideas on how to deal with things.

With regard to confidence levels, 92.7% of clients reported feeling at least somewhat able to deal with their problem(s) following their call, of whom 17.2% expressed being 'very able'.

The following graphs show the full breakdown of responses. Participants for which the measure did not apply have been excluded.

Figure 2: Effectiveness in Increasing Ability

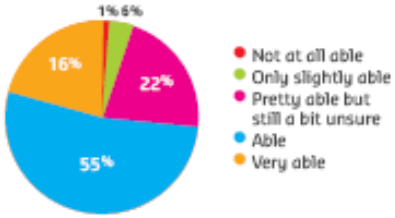
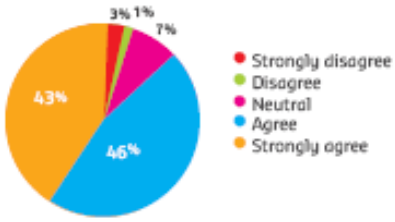


Figure 3: Effectiveness in Increasing Confidence



DISCUSSION

This research highlights Kids Helpline's efficacy in increasing a young person's ability and confidence to deal with their issue(s). The high level of client satisfaction suggests that the service model is inline with the needs and desires of callers. Moreover, it suggests a high level of expertise with the counselling.

The findings of this research echoes other contemporary research findings which suggest that providing counselling support for young people can have numerous benefits not only for them being able to cope with their presenting issue(s), but also cope with other issues that may arise later in life[4]. Having the skills, knowledge and attitude to deal with issues is the first step toward growth and confidence to change one's own situation.

The overwhelmingly positive feedback from clients also highlights the services' relevance to the needs of its clients.

The success of Kids Helpline, as evidenced by this research, supports the continued funding and quality assurance practice of the service.

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Appendix 7

BoysTown

Executive Summary: Mentor One Evaluation

1. Introduction

Mentoring relationships play an important role in young people's lives. Mentoring supports young people to build better relationships with family (King et al., 2002) and peers (Herrera, 2004), improve their participation in education, training and employment (Colley, 2003; Portwood et al., 2005), increase self esteem, communication and social skills (Karcher, 2005), and reduce substance misuse (Beier et al., 2000).

In January 2006, BoysTown received $435,050 in funding from the Federal Government after applying for funding in the Mentor Marketplace program which is managed by the Department of Education, Employment and Workplace Relations. From this funding, BoysTown developed and operated their Mentor One program to target young people aged 12 to 25 years at risk of disconnecting from their families, schools and communities. The first mentoring relationships in the program were established in September 2006. Many of the young people in the program were identified by schools as having emotional or behavioural problems, including truancy and disruptive classroom behaviour and aggressive behaviour in general.

Mentor One was developed to reach out to young people who were at risk of disengaging or who were already disengaging from their school, family, and community. An evaluation was conducted by BoysTown's Strategy and Research team in order to assess the effectiveness of Mentor One in addressing disengagement by its clients.

The purpose of this impact evaluation was to assess Mentor One against the program outcomes and performance indicators stated in the funding agreement. The specific program objectives were to:

1) Target young people aged 12-25 years who are disengaging from school
2) Provide mentoring support to young people aged 12-25 years who are disengaging from education
3) Provide comprehensive support for participants through engagement in other BoysTown programs
4) Increase opportunities for participation in work, education, training and community life
5) Increase levels of connection to family and peers
6) Increase skills in leadership and communication
7) Increase levels of self esteem, resilience and physical and mental health
8) Increase program sustainability

2. Methodology

Pre-program survey data was collected by researchers from 11 young people, otherwise known as mentees, in Mentor One. In addition, 27 mentees part-way through the program or finished with Mentor One were also surveyed and interviewed in relation to school, work and family engagement, leadership and communication skills, self esteem, resilience and physical and mental health.

Twenty-five mentors completed surveys while 14 mentors participated in one of three focus groups. Data was collected from mentors in relation to the benefits and disadvantages of volunteering in the program.

Twenty-two stakeholders were also surveyed about the effectiveness of mentoring relationships and the importance of Mentor One to the community.

3. Evaluation findings

3.1 Targeting young people aged 12-25 years who are disengaging from education

Mentor One received almost 600 enquiries from members of the local community, schools and chaplains in relation to becoming a mentor, the nature of mentoring and the services provided by Mentor One.

3.2 Providing mentoring support to young people aged 12-25 years who are disengaging from education

During the 2006-2007 period, there were 30 mentees and 32 mentors in Mentor One, 107 mentees and 103 mentors in the 2007-2008 period, and 70 mentees and 68 mentors in the 2008-2009 period thus far. There were 79 young people who completed Mentor One because they thought they had improved enough to cope on their own, while 16 young people left the program to relocate to another area or because they were not engaging in the program.

One common theme from the mentors was the feeling that they had made a valuable contribution to the community through Mentor One. The majority (92%) of mentors were either satisfied or very satisfied with the Mentor One program in general, their relationships with their mentees and their experience as mentors.

Mentees also displayed high level of satisfaction with the program. Specifically, 92% of the young people who had spent time in Mentor One indicated high or very high levels of satisfaction with the program, the mentoring they received and their mentor's ability to listen, understand and give advice. The majority (88%) Mentees also had high levels of satisfaction with the support they received from BoysTown.

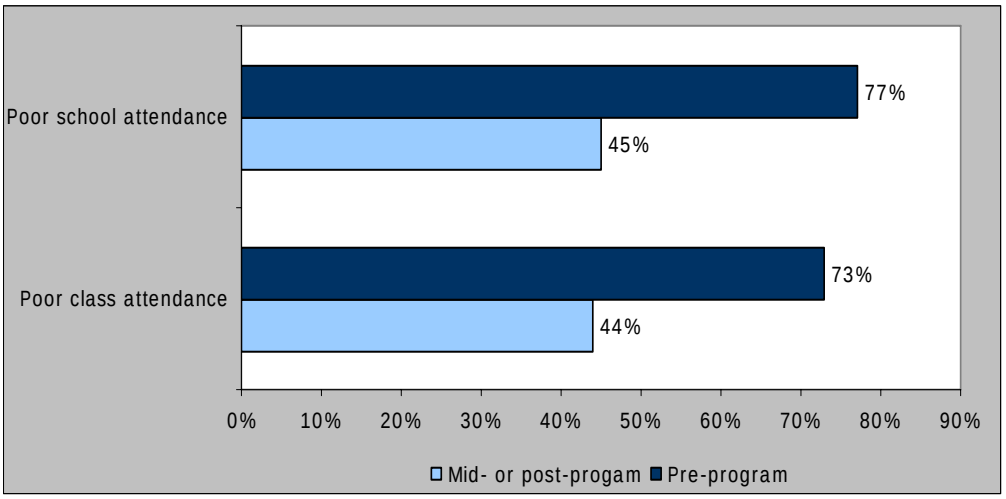
3.3 Providing comprehensive support for participants through engagement in other BoysTown programs

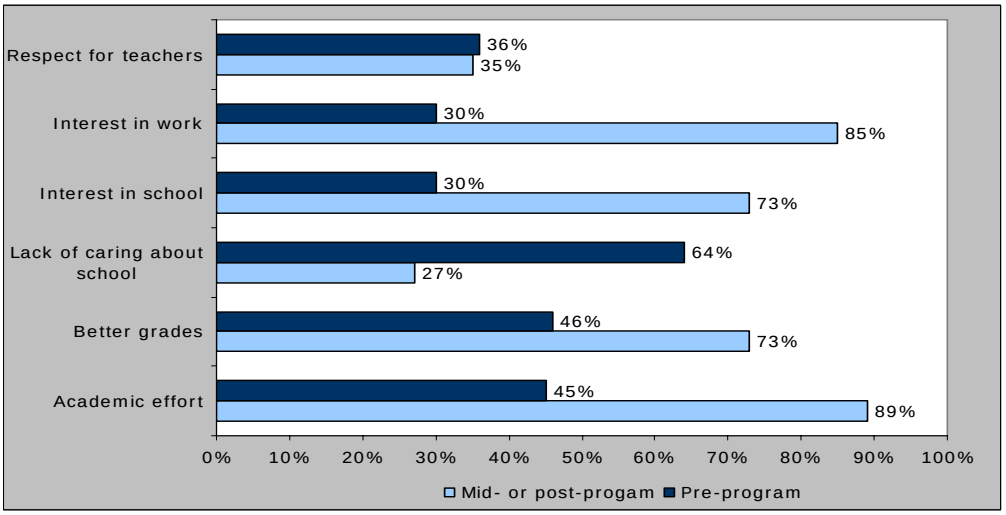
BoysTown has a range of other programs for young people in Mentor One to access. Five young people in Mentor One were also in Fresh Start, three young people participated in Get Set For Work, two young people were in Job Placement Employment and Training and one young person was in the Personal Support Program. Eight of these young people were surveyed for this

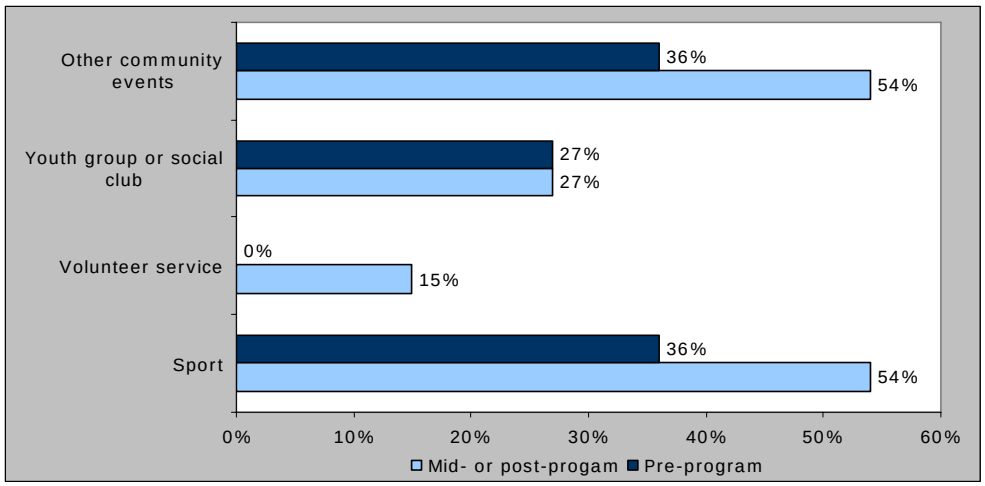
evaluation, with 88% indicating that they were very satisfied with the other BoysTown programs they were participating in.

3.4 Increasing opportunities for participation in work, education, training and community life

Most young people referred to Mentor One were disengaging from school. Young people who were midway through or finished with Mentor One reported higher levels of engagement with school, work, and the community, in comparison to young people entering Mentor One (see following graphs).



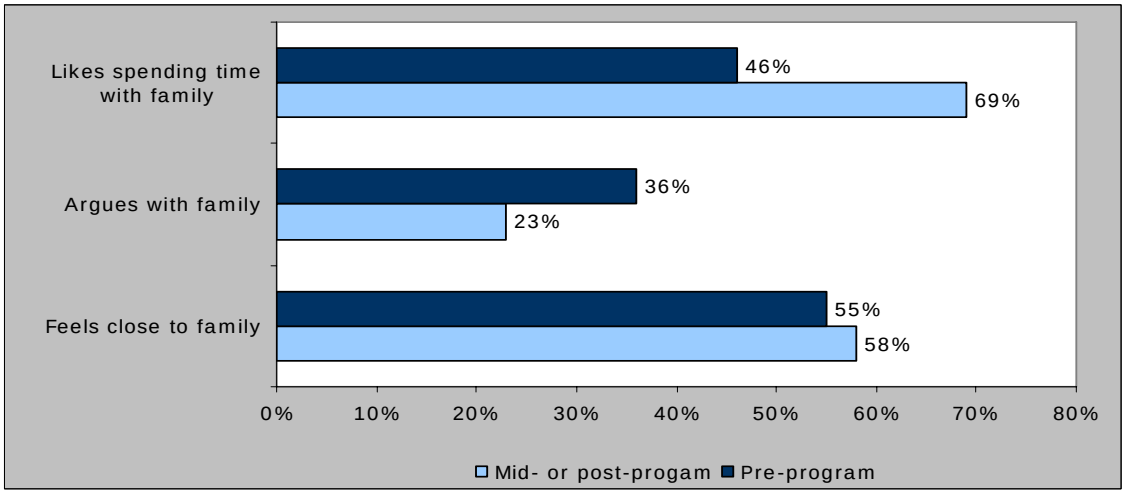


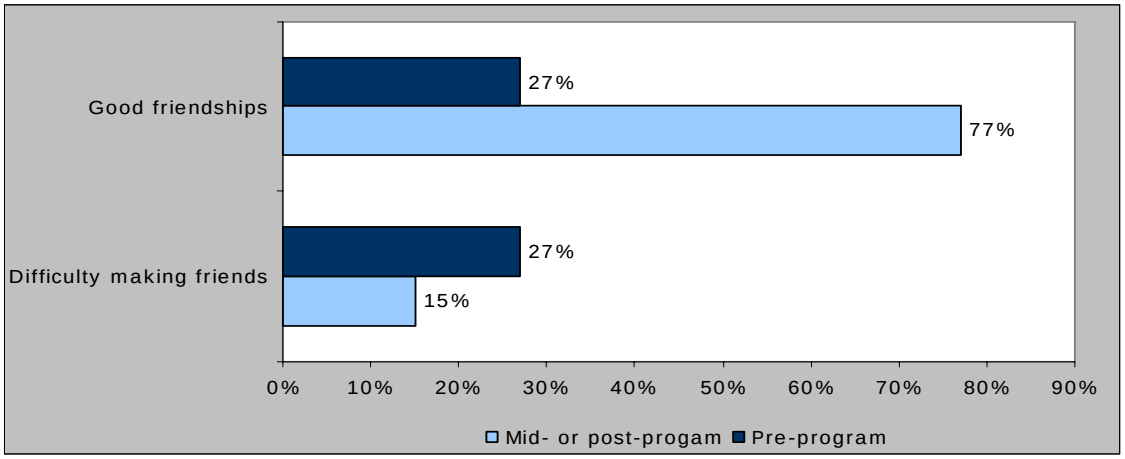


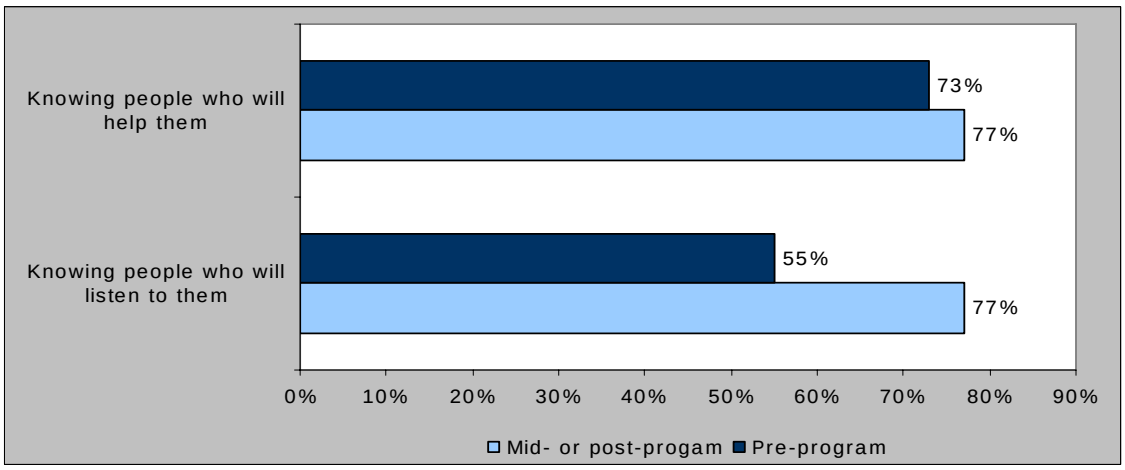
Specifically, mid-program and exit-program data in comparison to pre-program data showed higher levels of school and class attendance, interest in school and work, academic effort, and participation in sports, volunteering and community events. Along with school engagement, mentoring also focused on improving the personal relationships of young people.

3.5 Increasing levels of engagement to family and peers

There were improvements in the personal relationships for young people midway through or finished with Mentor One (see following graphs).



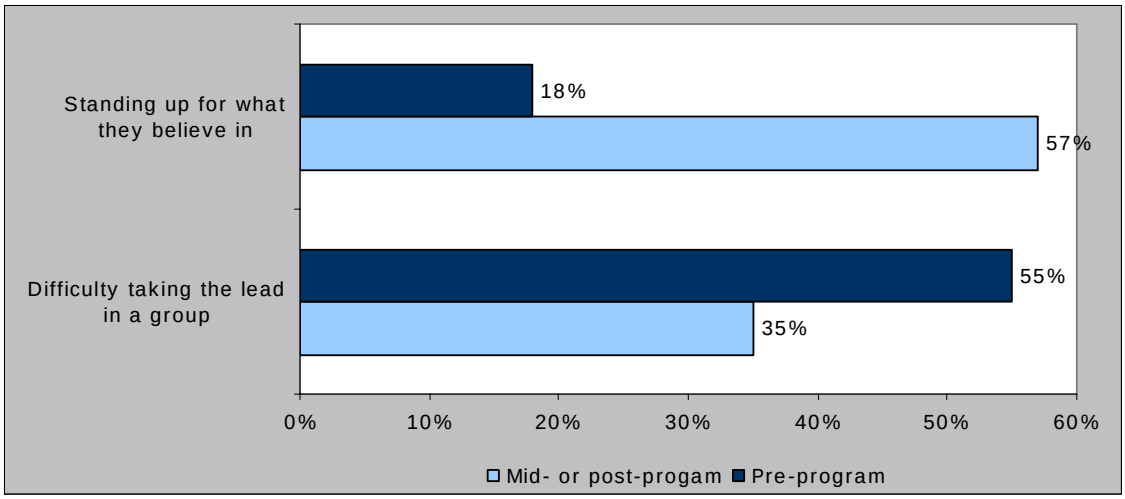


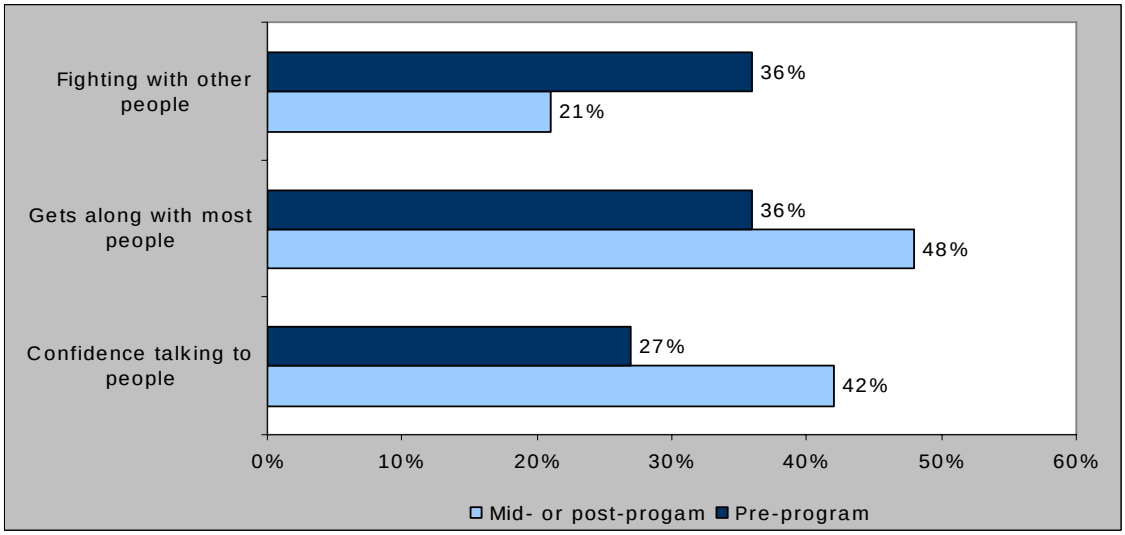


Specifically, young people were enjoying spending time with their families and arguing less with their families. In addition, more young people were forming better friendships and developing relationships with people who would listen to them. While mentoring addressed issues such as engagement with family, school and community, an emphasis was also placed on self development where skills such as leadership and communication could be improved.

3.6 Increasing skills in areas such as leadership and communication

Young people who had spent time in Mentor One developed better leadership and communication skills (see graphs below).

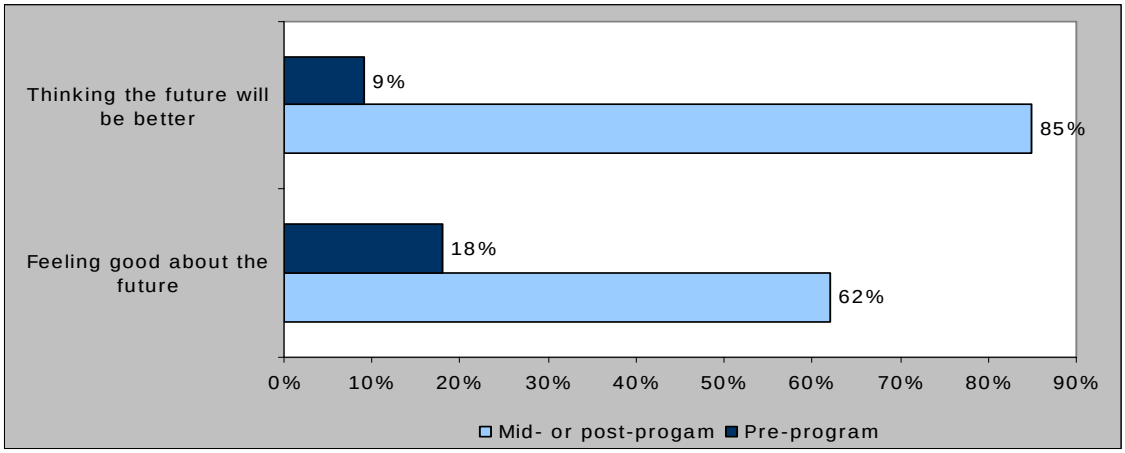




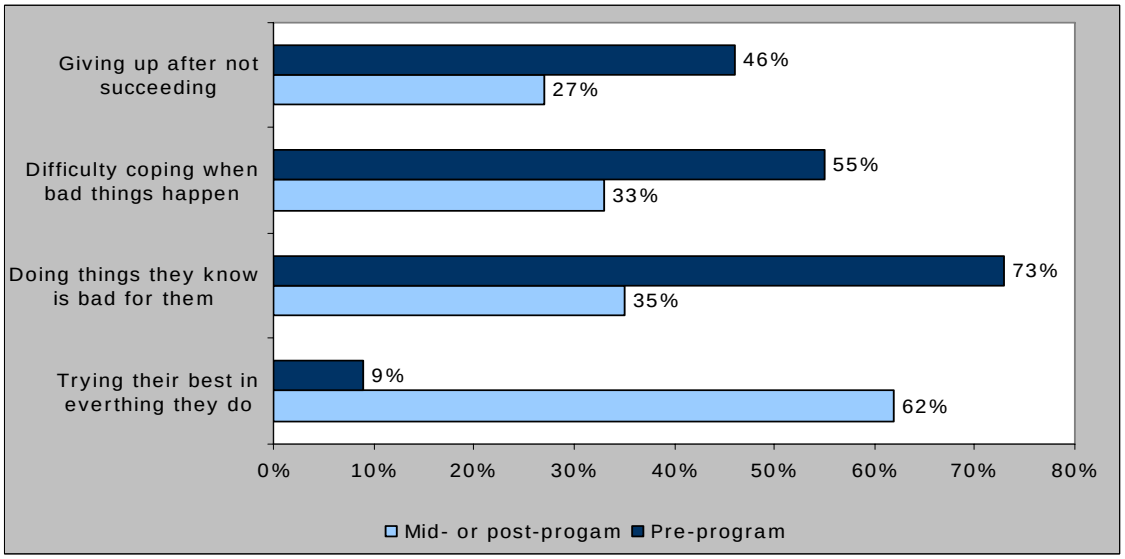
These young people were also more likely to stand up for what they believe in, take the lead in a group, get along with most people, feel confident talking to people and avoid fighting with people. Along with leadership and communications, mentoring also focused on improving self esteem, resilience and physical and mental health.

3.7 Increasing levels of self esteem, resilience and physical and mental health

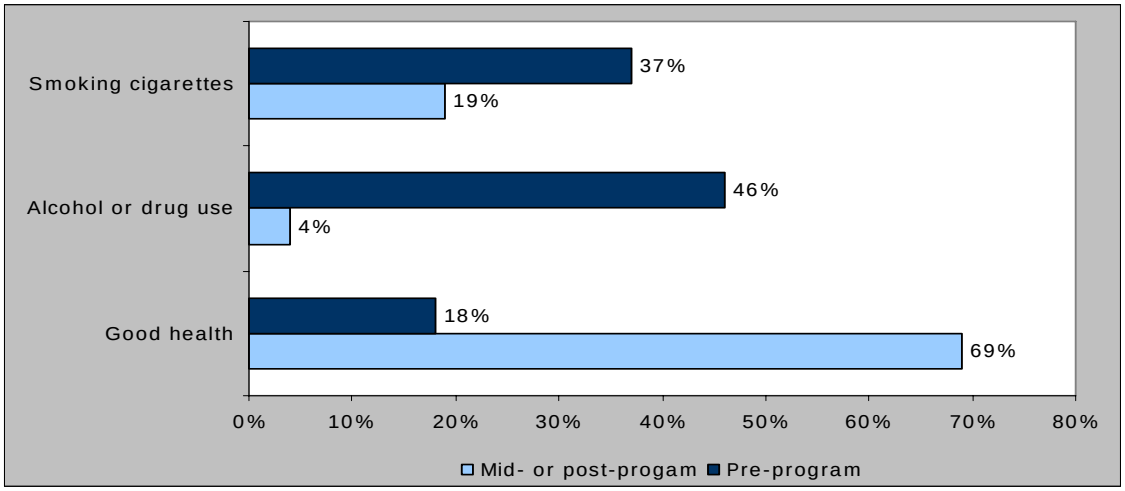
Part of the self development focus of mentoring involved addressing self esteem, resilience and coping ability. Young people in Mentor One were more likely to be optimistic about the future, resilient, able to cope when encountering obstacles and took better care of their physical and mental health. Specifically, mentees were more likely to think positively about their future and feel good about their future and where they were going in life (see graph below).

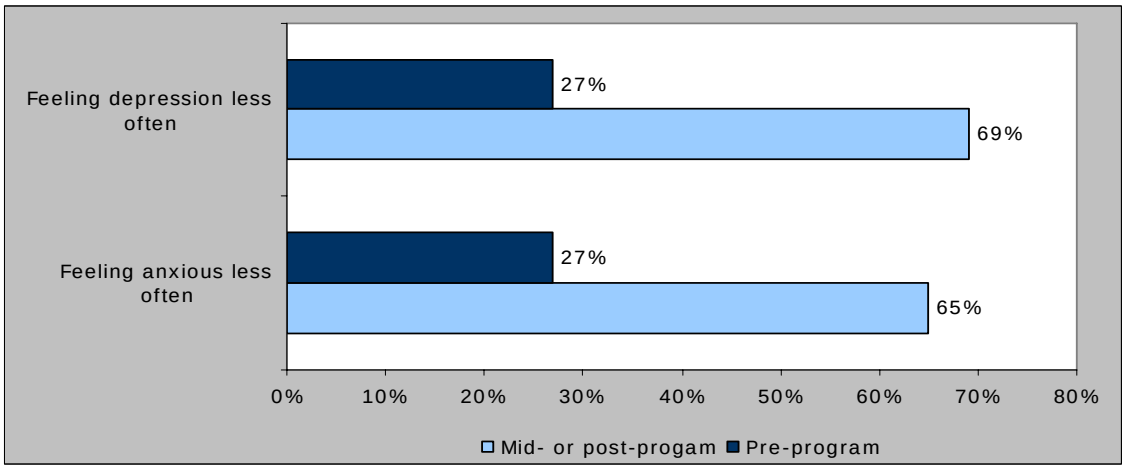


Furthermore, young people were more likely to try their best in everything they do, persisted if they did not succeed the first time, and coped well when they experienced difficulties. This is shown in the following graph



In relation to health, young people were more likely to have good physical health, feel depressed or anxious less often and stay away from cigarettes, drugs and alcohol, as shown in the graphs below.





3.8 Increasing program sustainability

Mentors and mentees have indicated that they are very satisfied with the Mentor One program. Stakeholders have also shown support for Mentor One. Three out of four stakeholders thought that the mentoring relationships were effective, while 91% of the stakeholders recognised the importance of the continuation of Mentor One to the community.

4. Recommendations

This evaluation shows the program's strengths lie in influencing the positive personal development of young people through mentoring. Furthermore, based on contemporary research and the findings of this evaluation, mentoring is an effective strategy in ending the social exclusion of disengaged young people. Meanwhile, one area for improvement is the targeted number of participants in the mentoring program. Recommendations have been made based on the evaluation findings.

Recommendation 1: That Government continues to fund and increase the allocation of funding to mentoring programs given their efficacy in enhancing the social inclusion of disengaged young people.

Recommendation 2: That Government recognise the need for rigorous screening and training of mentors and close supervision of mentoring relationships to ensure the safety of young people in mentoring programs, and subsequently one program staff member cannot provide support and supervision to more than 35 mentoring relationships.

5. Conclusion

A strong focus of the service model was to ensure the safety of young people in the program through supervision of mentoring sessions and screening processes for mentors. These conditions however, meant that the program spent many of its resources on managing the mentoring relationships and consequently did not meet the targeted level of participation.

Although the participant target was not reached, the findings of the evaluation suggested that Mentor One facilitated significant personal development in young people's relationships with school, family, peers and the community. Furthermore, improvements were also seen in young people's resiliency, self esteem, leadership, and health. These findings are consistent with contemporary research on how mentoring facilitates the social inclusion of young people who are disengaged from school, work, family and the community.

The high levels of satisfaction from mentors and young people in relation to Mentor One and the management of this program suggested advanced expertise in the development and implementation of the mentoring program. The combination of a strong service model and the strong knowledge and skills of the Mentor One staff have seen young people in the program move towards social inclusion.

Appendix 8

BoysTown Social Inclusion Model

Kids Helpline

We care.
We listen.

OVERVIEW 2008

Kids Helpline 2008 Overview

Kids Helpline is Australia's only 24/7, private and confidential counselling service specifically for children and young people aged 5 to 25 years.

Since March 1991, young Australians have been contacting Kids Helpline about a wide range of issues; from everyday topics such as family, friends and school to more serious issues of child abuse, bullying, mental health issues, drug and alcohol use, homelessness and suicide.

Counselling and support is provided via the phone, web and email. Email counselling began in 1996 and real-time web counselling commenced in 2000.

Children and young people have direct access to a counsellor and can choose to speak with either a male or female counsellor. They are also able to arrange to speak again with the same counsellor to work through their issues.

No other organisation speaks with as many young Australians. The Kids Helpline 2008 Overview offers unrivalled insight into key issues concerning children and young people in Australia.

Contents

Highlights from 2008

Help-seeking trends

- Children and young people continued to seek help in significant numbers during 2008, with 492,327 attempts to reach Kids Helpline. Counsellors responded to 60% of these contacts (an increase of 6% compared with 2007). **Almost 300,000 telephone and online interactions were provided**.

- During 50,979 of those interactions, children and young people presented with issues that required counselling: 38,703 telephone and 12,276 web and email sessions.

- Kids Helpline remained an extremely important service for children and young people living in regional and remote areas. While only one third of the population lives in these areas, they accounted for just under half of all contacts.

- There was a continuing upward trend in the number of children and young people using a mobile phone to contact the telephone service. Following a six-year trend, three-in-five callers used a mobile to contact Kids Helpline counsellors in 2008.

- One-in-three counselling sessions were with children and young people receiving either ongoing counselling or intensive support with a case management plan. Following a five-year trend, this type of counselling response was accessed 25% more often than in 2007 and at six-times the rate of 2003.

- Seventy percent of counselling sessions were with older adolescents and young adults, continuing a seven-year trend of increasing contact from older age groups.

- Kids Helpline has seen an increase in contacts from children and young people from culturally and linguistically diverse backgrounds (CALD). During the year there was a 37% increase in the number of counselling sessions with young people from CALD backgrounds.

Concerns of Australian children and young people

- The main reason for contacting Kids Helpline was family relationships. This has been consistent over the 17 years of operation.

- Interpersonal relationships were a significant issue - almost 17,000 counselling sessions related to family, friends and partners.

- Mental health contacts continued to rise – these issues were presented at almost triple the rate compared with 2003. When combined with counselling sessions regarding suicide, it was the second most common reason for contacting Kids Helpline. In addition, mental health was the top concern for females aged 19 to 25 years.

- Almost half of the young people presenting with mental health concerns were ongoing clients; 38% of these were also engaging in deliberate self-injury; and one-in-six reported current thoughts of suicide.

- Young people presenting concerns related to managing their emotional and behavioural responses to situations have more than doubled since 2003 and are the most common concern presented online. One-in-four of these contacts are with clients engaging in deliberate self-injury and close to half are engaged in ongoing counselling with a Kids Helpline counsellor.

- Current thoughts of suicide were reported during 3,991 counselling sessions. This equates to more than 11 counselling sessions each day and equates to a 45% increase over the past two years.

- Self-injury remained a serious concern with 15% of counselling sessions held with young people who had deliberately injured themselves or taken overdoses of substances they believed to be non-lethal.

- Responses required to protect children, such as contacting an emergency service or child protection agency, were actioned for 658 sessions, a 12% increase over the past two years and 80% higher than responses required in 2003.

- Child abuse, bullying, homelessness, grief and loss, study issues, pregnancy, self-image, drug and/or alcohol issues and physical health continued to be common reasons for seeking help in 2008.

- Young people continued to present different concerns through online counselling than telephone counselling. Deliberate self-injury, mental health issues, self-image, sexual assault, and eating behaviours and weight issues were presented online at almost double the rate of telephone counselling during 2008.

Concerns of Australian children and young people continued

- Two-in-five counselling sessions (19,300) were with children and young people who fell within the parameters of groups defined as the most marginalised and at-risk young people in our society. These groups include individuals experiencing homelessness, mental health issues, child abuse, bullying, domestic violence and contact with the criminal justice system.

- Males accounted for 22% of counselling sessions, consistent with the previous year. Males were proportionally more likely than females to seek help about bullying, drug and alcohol use, homelessness, partner relationships, sexual orientation, sexual activity, legal issues, loneliness, and employment or financial issues.

- Indigenous children and young people were proportionally more likely to seek help about homelessness, drug and/or alcohol use, violent assault, witnessing domestic violence and physical health issues compared with non-Indigenous clients.

- Children and young people of culturally and linguistically diverse backgrounds were more likely to seek help about family relationships, partner relationships, child abuse, study issues, and self-image when compared with other clients.

How they sought help

Total help-seeking

- Children and young people's rates of help-seeking remained high in 2008, with 492,327 attempts to reach Kids Helpline's telephone and online services. **Counsellors responded to 294,873 (60%) of these contacts**.

- Approximately 5,300 telephone calls were answered by counsellors each week, a total of 275,468 during 2008.

- More than 68,000 of those who called the service disconnected during the wait message. In an attempt to minimise this, a new means of communicating this mandatory privacy information has been implemented.

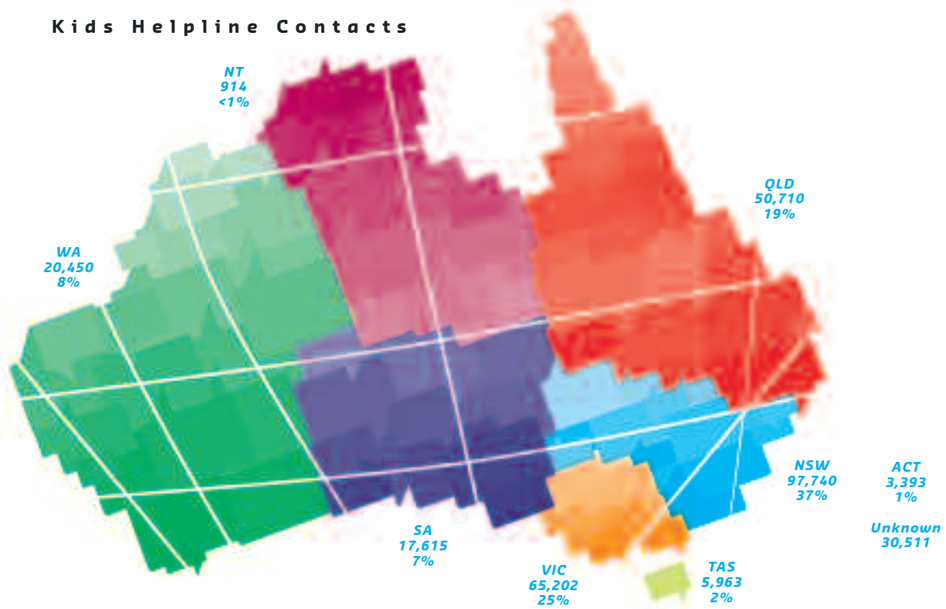
- Each week, counsellors engaged in approximately 370 online interactions. In total, **29,557 online contacts were received and 19,405 (66%) responded to**. A total of 10,255 real time web counselling sessions were provided and all of the 9,150 email contacts received a reply.

- Overall, Kids Helpline improved its response to children and young people, increasing from 54% in 2007 to 60% of contacts answered in 2008.

- The demand for Kids Helpline from each State and Territory was generally reflective of the actual population of children and young people living in each area. (see Figure 1).

figure 1

Kids Helpline Contacts



Regional and remote access

Kids Helpline continued to provide strong support to children and young people living in regional and remote areas. These young people tend to have less access and choice in support services.

Despite the fact that only one-in-three young people in the general population live in regional and remote areas, almost half (47%) of all Kids Helpline contacts in 2008 were from these areas.

Regional children and young people contacted Kids Helpline mostly by phone, with only 22% of online contacts from these areas. This level of access by regional youth via the online mediums is consistent with previous years.

the issue...

Access to online assistance for young people in regional Australia

The facts:
- While almost half (47%) of all Kids Helpline contacts are from regional and remote areas, only 22% of online contacts are from these children and young people.

Our analysis:
- Kids Helpline provides strong support to children and young people living in regional and remote areas via our telephone service, demonstrated by the high percentage of phone users from these areas. The 22% uptake of online access is likely to reflect that regional areas can have limited access to emerging communication technologies.

Our response:
- Actively encouraging help-seeking of young people in Indigenous and regional communities
- Assisting with secure and safe access to telephone and online services through placement of telephones and computers in rural and remote Indigenous communities
- Targeting rural and remote Indigenous communities to promote and encourage open access to Kids Helpline for children and young people in a culturally sensitive manner
- Promoting Kids Helpline through community and education facilities

Upsurge in the use of mobiles

Kids Helpline continued to see an upsurge in the number of children and young people using a mobile phone to contact the service. In 2008, 161,851 calls were made from mobile phones, accounting for 59% of all telephone calls. This is a 2% increase on 2007 mobile phone contacts (158,550) and a 64% increase since 2003 (98,624).

It is important to note that not all phone calls made from mobile phones to Kids Helpline are free. Calls from the Optus network, including Virgin, are free. Normal mobile charges apply to calls from the other network providers.

the issue...

Increased access to Kids Helpline with mobile telephones: Not a free-service to all young Australians

The facts:
- In 2008, 161,851 calls were made from mobile phones, accounting for 59% of all telephone calls. In other words, more than half of all contacts to Kids Helpline counsellors were via a mobile phone.

Our analysis:
- Not all mobile phone carriers provide access to Kids Helpline free of charge. A substantial amount of access to Kids Helpline counselling is at a monetary cost to Australian children and young people. As a result, many vulnerable children and young people are being charged to access our service when they need it most.

Our response:
- We will advocate with the Australian Communications and Media Authority and all telecommunication carriers to provide free access to Kids Helpline.

Public phones still relevant

Despite the enormous growth in mobile phone use, payphones still play a significant role in children and young people accessing Kids Helpline. One-in-fifteen (2,690*) of all telephone counselling sessions with children and young people were made from payphones.

Access to payphones is particularly important for Indigenous children and those young people located in regional and remote areas of Australia. One-in-five calls to Kids Helpline from Indigenous children and young people and one-in-ten calls from regional and remote areas were made from payphones.

Ensuring easy and free access to telephone services is more critical for these two groups because they are often disadvantaged by a lack of local services and rely heavily on communication technologies to seek help via telephone and internet-based services.

It is important to note that not all phone calls made from payphones to Kids Helpline are free. Charges may apply to calls from private or non-Telstra phones.

*Where a young person phoned from is recorded in approximately 73% of all counselling calls. This figure has been extrapolated.

Types of help-seeking: counselling, support and connection

Children and young people contact Kids Helpline for a diverse range of reasons. Counsellors are trained to respond to each individual's needs - support, encouragement, counselling, assistance, information and connection are provided.

Just over half of all interactions (54%) are with children and young people who do not report any immediate problems, but have heard of Kids Helpline and want to "check out" the service to find out what counsellors actually do. At the time, these calls do not always have discernable outcomes. However, Kids Helpline has confidence that if young people test the service in this way and are responded to in a positive and respectful manner then they are likely to connect with a counsellor if more serious concerns arise.

Almost half (46%) of all interactions are with children and young people seeking counselling or support. Support provided is often low intensity communications from young people who want to build relationships with a safe adult. Some young people are in crisis and have heard of Kids Helpline's reputation for assisting in these kinds of situations. These young people often know what they want and are able to ask for what they need. Others may be facing less critical concerns and are seeking help to consider their options or simply want to talk things through.

The online medium attracts a far higher percentage of young people wanting counselling and support than telephone (87% compared with 43%).

The average time spent in phone counselling and web counselling remained constant when compared with average durations reported during 2007. Counsellors spent an average of 20 minutes with children and young people in telephone counselling sessions, and an average of 52 minutes in web counselling sessions.

the issue...

Communicating mandatory privacy information to children and young people

The facts:

- We rely on some recording and monitoring of calls to ensure the quality of our counselling.
- To comply with the Privacy Legislation Act, Kids Helpline's telephone service has a pre-recorded message or "announcement" that all callers listen to before speaking with a counsellor.
- More than 68,000 of those who called Kids Helpline in 2008 disconnected during this mandatory privacy wait message.

Our analysis:

- It is a difficult engagement challenge when young people report the mention of 'recording' and 'monitoring' as disruptive, aversive and, in many cases, anxiety provoking and likely to cause them to hang up. In other words, some kids told us they found the message scary.

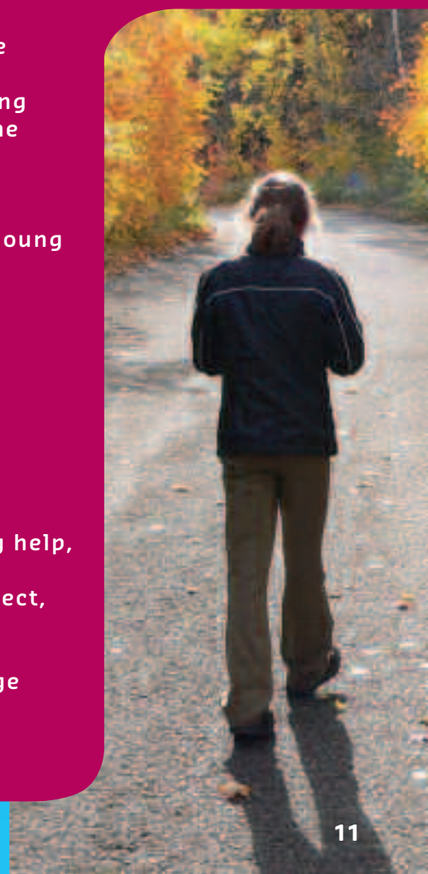
Our response:

- During 2008, Kids Helpline consulted with children and young people about how we could best communicate privacy information to callers. This research has assisted us to establish new messages and information that can be communicated alongside the monitoring information to reduce young people's anxiety levels and increase their comfort with seeking help.

We will implement a new wait message that:

- aims to effectively engage and encourage callers to wait on the line
- enhances trust in Kids Helpline and comfort with seeking help, and
- maximises the chances of communicating empathy, respect, and honesty.

We will closely monitor the impact of this new wait message on young people's help-seeking and amount that drop out during the new message.



Counselling assistance

The remainder of this Overview is based upon counsellor's reports on the **50,979** counselling sessions (38,703 telephone and 12,276 web and email sessions) held with children and young people aged 5 to 25 years.

Increase in ongoing counselling and intensive support

Young people with severe, complex and long-standing issues benefit from working with a service on a regular or ongoing basis (ongoing counselling). This usually includes speaking predominantly with one or two key counsellors who become familiar with their concerns. There was a 25% increase during 2008 in the number of counselling sessions provided to young people working with designated counsellors in an ongoing way.

Case management is a model of care that offers more intensive support, generally to ensure numerous different needs can each be considered and planned for. Sometimes this means linking the young person with other more specialised face-to-face services and developing joint or "wrap-around" case management plans. Kids Helpline has noted a 24% increase in the past year in the number of counselling sessions provided to case-managed clients.

The increased access to ongoing counselling and intensive support during 2008 (12,476 times) follows a five-year trend, with this type of counselling response now offered at six-times the rate it was during 2003 (2,186 times).

Of the 42,460 counselling sessions where counsellors recorded the frequency of contact and type of assistance the client was receiving, one-in-three (12,476) were with children and young people receiving either ongoing counselling (17%) or intensive support with a case management plan (12%). The other 71% of counselling sessions were with children and young people who were contacting Kids Helpline for the first time or who occasionally contacted the service.

Ongoing counselling was provided more frequently though our online services (20%) compared with telephone counselling (16%). However, intensive support through case management was provided more frequently through our telephone service (14%) than via online counselling (9%).

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the issue...

Increased demand for ongoing counselling and for assistance with serious and complex concerns

The facts:
The past five years has seen a steady and consistent increase in the complexity of issues presented to Kids Helpline. Presentations of complex needs by children and young people such as mental health issues, suicidality, self-harm and difficulties managing emotional and behavioural responses have been on the rise. At least one-in-four of all counselling sessions now involve these issues.

In response to these trends, Kids Helpline counsellors have increasingly offered more continuity of counselling response and greater amounts of intensive and planned counselling responses to young people presenting with these complex needs, immediate crises and those experiencing major effects on their well-being.

Our analysis:
Kids Helpline has become a key service provider for assisting children and young people in crisis, those with mental health issues, or those young Australian's at risk of developing a mental health problem.

The importance of a 24/7 telephone line offering the ability to reconnect with the same counsellor has been reinforced year after year. Many children choose Kids Helpline counsellors to be the first one they tell of abuse and adolescents and young adults consistently connect for help in times of crisis or times of significant need. These young people often reach out when other services are closed or when the suicidal thoughts become too much for them during the isolation of the midnight 'til dawn hours.

While the telephone service remains extremely important, young people are now consistently demonstrating a strong desire to disclose complex issues such as mental health over the online counselling modality. Mental health issues are presented at a significantly higher rate online than on the telephone service.

Our response:
We have enhanced our ability to ensure the quality of counselling response through expanding counsellor training in mental health, providing case management and the wrap-around care model, and using case notes, case planning, case review, and working with external agencies.

In all, our focus has been on ensuring young people gain the continuity of speaking with one or two key counsellors who become familiar with their concerns, strengths and goals. This enables counsellors to prepare and implement a plan for each individual that is responsive to their different needs. It also provides a more integrated and effective response by linking the young person with other more specialised face-to-face services and developing joint or "wrap-around" case management plans.

We also commenced the development of an enhanced Client Information and Case Management software to improve the quality of information recorded for each young person. We updated the Kids Helpline database of other service providers to ensure most mental health providers across Australia were included. This improved our ability to refer young people to appropriate face-to-face services in the local area.

With a focus on providing the highest quality and professional response to children and young people's needs, we improved our ability to supply sufficient and appropriate professional supervision to our counsellors through:

- Increasing the amount of supervision available
- Enhancing supervisor professional development to meet the increased demand for supervisory assistance with case planning, ongoing interventions, case reviews, crisis responses and protective actions
- Enhancing our management information system to monitor the amount and type of supervision undertaken

Referral to other support

Across all counselling sessions, counsellors were able to directly assist 35,448 (70%) of young people contacting the service without referring them on to another agency. For those counselling sessions in which a referral was required:

- 10% (5,256) resulted in the child or young person being referred to another service for ongoing support (including crisis response and three-way link-ups with both the client and another agency).
- In 2,248 sessions (4%), counsellors were unable to provide a referral because either no appropriate service was available or the young person finished the session before a referral could be discussed. This may have been because they did not want to engage in the process, were reluctant to disclose identifying information or were not ready to seek face-to-face help.
- 16% (8,027) were referred to their doctor, school/ guidance counsellor, mental health worker or other non-specific referrals.

Age, gender and background of clients

Females made up the majority of counselling sessions in 2008, with the proportion of males contacting Kids Helpline consistent with help-seeking trends for males in the majority of counselling services:

- 40,012 females (78%)
- 10,967 males (22%)

Note: these figures have been extrapolated based on gender known in 98% of counselling contacts.

The telephone service remained the preferred method for males seeking counselling, with 87% of their help-seeking via this medium. Boys and young men make almost one-in-four of all telephone counselling contacts and one-in-eight online counselling contacts.

Seventy percent of all counselling sessions were with older adolescents and young adults during 2008, continuing a seven-year trend of increasing contact from older age groups (see Table 1).

Online clients in particular tend to be older, with 15 to 25 year-olds involved in three-quarters of online counselling sessions (compared with two-thirds of telephone sessions).

table 1

Age	Number of Contacts	% of Contacts
5-9 years	1,178	3%
10-14 years	12,824	27%
15-18 years	22,045	47%
19-25 years	10,758	23%
Total	46,805	100%*

** These percentages were related to contacts where age was known. There were 4,174 contacts where age was not recorded*

During 2008, Kids Helpline saw a 31% increase in the level of cultural background reported by counsellors compared with the previous year. In line with this, there was also an increase in the number of telephone and online contacts where counsellors recorded backgrounds as being either Indigenous or culturally and linguistically diverse.

Despite the increase in reporting, the cultural background of clients was recorded in only 45% of counselling sessions. Therefore the following figures are likely to be a significant under-representation of the actual amount of counselling with culturally diverse clients. Overall:

- 869 counselling sessions were with Indigenous children and young people: consistent with the record high numbers reported in 2007.
- 3,895 counselling sessions were with children and young people from culturally and linguistically diverse backgrounds: a 37% increase from 2007.

table 2

Background	All (N=22,846)	Telephone (N=20,056)	Online (N=2,790)
Indigenous	4%	4%	2%
CALD	17%	16%	22%
Other	79%	80%	76%
Total	100%	100%	100%*

** Proportions based on counselling sessions in which background of client was known*

Indigenous clients predominantly phoned Kids Helpline while culturally and linguistically diverse children and young people were proportionally more likely to seek help online.

Contact from young males

Although young males make 22% of counselling contacts to Kids Helpline, they engage in a greater level of testing activity. When both counselling and non-counselling activity is considered, 100,588 (34%)* of contacts were with males. This greater chat and testing activity may be due to young males wanting to contact help services but requiring more time and practice than females at asking for what they need.

*Gender is only recorded in approximately 50% of all contacts. This figure has been extrapolated.

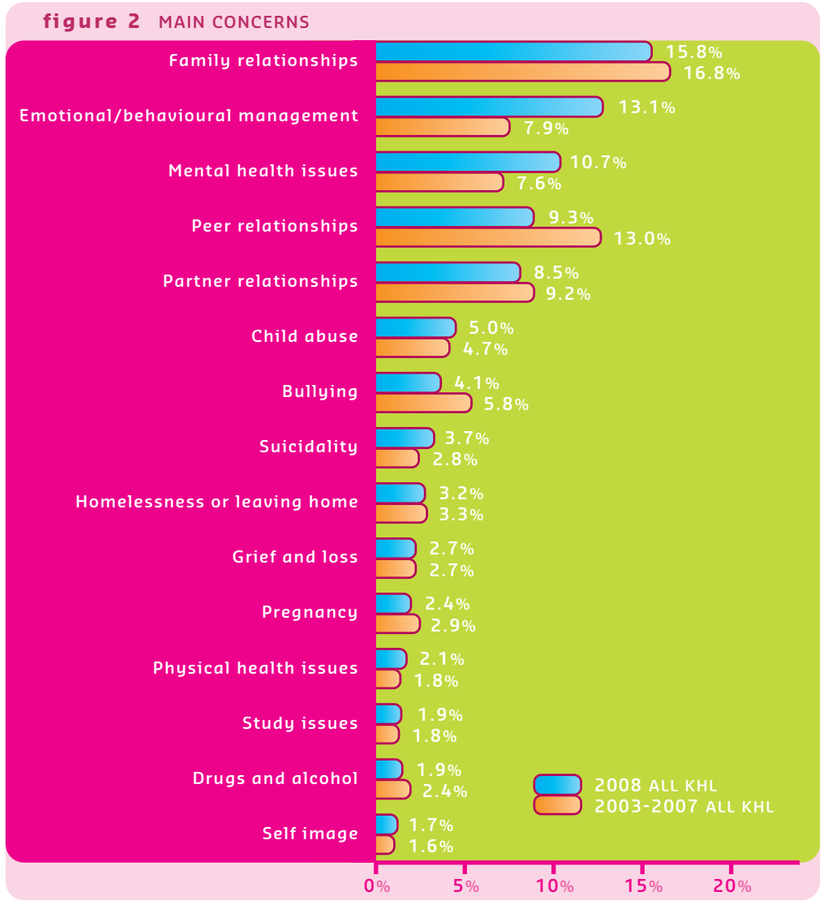
Concerns of Australian children and young people

Snapshot of concerns

The concerns of children and young people who contact Kids Helpline are often complex and relate to more than one issue, for instance both bullying and peer relationships. However, the primary topic discussed during each counselling session is always recorded in order to provide an indication of what is concerning young Australians.

The 15 most frequent primary concerns reported by children and young people in 2008 are shown in Figure 2 along with comparative data for the 2003 - 2007 period.

figure 2 MAIN CONCERNS



After 17 years of operation, the number one reason children and young people contact Kids Helpline remains concerns about family relationships. However, over the past six years the proportion of counselling sessions related to mental health issues, emotional and/or behavioural management, and thoughts of suicide have increased. There has been a substantial decrease in peer relationship and bullying concerns and smaller decreases in relation to drug and/or alcohol, pregnancy, sexual activity, sexual orientation, and school authority concerns across this period.

- Over 17,000 counselling sessions focussed on relationships.
- Family relationships remained the top concern for young people aged between 5 and 14 years, and for those from culturally and linguistically diverse backgrounds aged 5 to 25 years.
- Emotional and/or behavioural management concerns have more than doubled since 2003 and are the most common concern presented online. One-in-four of these clients are engaging in deliberate self-injury and close to half are receiving ongoing counselling or case management assistance from a Kids Helpline counsellor.
- Relationships with friends or peers were a key concern for children aged 10 to 14 years. Forty-one percent of the counselling sessions relating to friendships involved this age group.
- The top concern for males aged between 15 and 25 years was partner relationships, consistent with rankings in 2006 and 2007.
- Following a five-year trend, the rate of mental health concerns presented to Kids Helpline counsellors increased during 2008. These issues are now presented at almost triple the rate compared with 2003. The majority of these counselling sessions were provided to older adolescents and young adults, with these young people often reporting deliberate self-injury and/or thoughts of suicide. Kids Helpline provides ongoing counselling and case management to a high proportion of these young people.
- Bullying concerns were predominantly presented by children younger than 15 years and by first-time or occasional clients. The decrease in contacts about this issue since 2003 is in line with a decrease in the overall number of counselling sessions with 5 to 14 year olds.
- Almost half of child abuse contacts were from children and young people reporting a current abusive or neglectful situation. Reports of child abuse featured more prominently for Kids Helpline clients up to 14 years of age than for older adolescent and young adult clients.
- Concerns about homelessness or leaving home were most prominent with older adolescents with two-thirds of counselling sessions about this issue involving a young person aged between 15 and 18 years.
- Suicide concerns increased in 2008, with numbers up by 45% compared with 2006. Kids Helpline counsellors engaged in an average of eleven counselling sessions per day with young people expressing current thoughts of suicide: a total of 3,991 during 2008.

Social exclusion: the most marginalised and at-risk young people

We believe that all young people in Australia should be able to lead hope-filled lives, and have the capacity to participate fully in the society in which they live. However, many disadvantaged young people do not get this opportunity, but remain excluded or on the fringes of society such as those who become trapped in cycles of poverty, unemployment, homelessness, mental illness or experiencing difficulty believing in a future for themselves.

Of the 50,979 total counselling sessions, more than 19,350 (38%) were with children and young people 'at risk of social exclusion and disadvantage'. Kids Helpline believes experiences leading to social exclusion include homelessness, mental health issues, child abuse, bullying, domestic violence and contact with the criminal justice system.

When 14 yr old Margaret* first called she felt unsafe to disclose her real name and said she was calling for a friend. Margaret shared that 'her friend' was tired of her mother screaming abuse at her and wanted to know how to 'she' could help. Margaret eventually felt safe enough to disclose that she was actually calling about herself and shared she had a history of self-harm and said 'there wasn't a day when she did not want to die'.

Over several months, Margaret opened up and shared the violent abuse she had suffered at the hands of her father. Margaret also shared that her mother tells her on a regular basis that if the government finds out which country her father is from that they will lock her up in a camp. This has resulted in Margaret injuring herself in ways she believes to be non-lethal as well as attempting suicide. She is also agoraphobic and has panic attacks when leaving the house fearing her father will find her.

With ongoing support from Kids Helpline, Margaret has worked to reduce her panic attacks and her level of self-harming, and has had several days where she has had no suicidal thoughts. On her behalf, Kids Helpline has advocated and liaised with other services to establish ongoing face-to-face support. At Christmas, Margaret called excited to share that she had managed to open the metal security blind in her room and leave it open for two days - the security blind had been down for three years.

**names have been changed for privacy reasons*

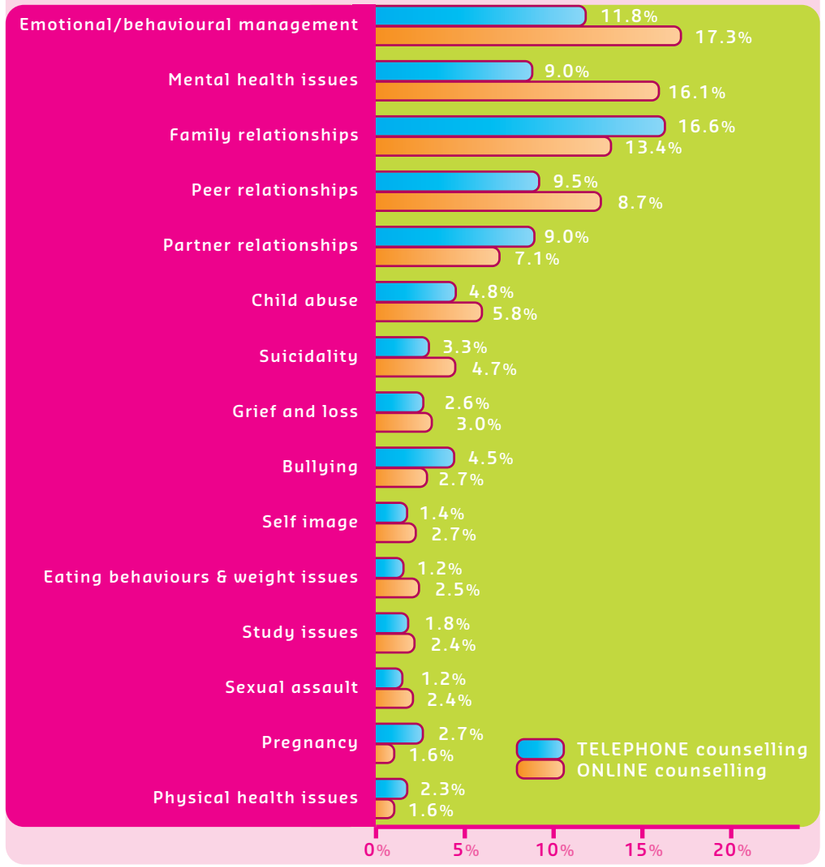
Online vs telephone counselling

During 2008, online counselling continued to be accessed for different concerns to telephone counselling. Online counselling appears to provide a greater degree of comfort to young people when disclosing issues that may feel shameful. This may be because there can be a greater level of anonymity in online communication.

In the nine years Kids Helpline has offered web and email counselling, greater proportions of young people have consistently sought help online for some of the more severe concerns.

The top 15 concerns about which young people contacted Kids Helpline online are shown in Figure 3. Telephone counselling figures are also given in order to provide a comparison.

figure 3 MAIN ONLINE CONCERNS



Deliberate self-injury, mental health issues, self-image, sexual assault, and eating behaviours and weight issues were presented online at almost double the rate of telephone counselling during 2008. In addition, suicidality, emotional and/or behavioural management concerns, child abuse, grief and loss, sexual orientation, and study issues were presented online at greater rates than presented on the telephone.

Conversely, more children and young people were likely to engage in telephone counselling rather than online counselling when needing to discuss concerns surrounding relationships, drugs and alcohol, bullying, pregnancy, and homelessness.

Top 10 concerns of young Australians

Relationships with family

Family relationships remained the most frequent concern for children and young people overall and presented as the primary concern for 16% of those seeking counselling. Table 3 shows the nature of counselling sessions about family relationships.

table 3

Family relationships	All (N=8,053)	Telephone (N=6,414)	Online (N=1,639)
Worry about a family member	13%	14%	9%
Occasional family conflict or disruption	25%	26%	20%
Frequent or major family conflict or disruption	51%	48%	61%
Family breakdown, separation or divorce	11%	12%	10%
Total	100%	100%	100%

Younger children along with young people from culturally and linguistically diverse backgrounds made proportionally more contacts about family relationships than older children and non-CALD young people respectively. Family concerns were often raised by first-time clients and more likely to be discussed via the telephone than online.

In particular:

- A third of counselling sessions with 5 to 9 year-olds and a quarter with 10 to 14 year-olds were about family relationships.
- More than one-in-four counselling sessions with young people from culturally and linguistically diverse backgrounds focused on their family.
- Half of family relationship contacts were from first-time clients compared with 39% on average for all counselling sessions.

Twelve-year-old Emily called in tears one morning because she had to visit her father soon, as part of a custody arrangement. She was refusing to see him because he frequently swore at her and told her he didn't love her. He was also excessively critical and often ignored her. These experiences had left Emily feeling inadequate and anxious and had damaged her self-confidence. She said she felt unsafe about visiting his home. With her counsellor's support, Emily devised ways to cope while at her father's house, and began to express and understand her thoughts and feelings surrounding the situation.*

Over a number of counselling sessions, Emily expressed the grief and sadness she felt as she considered how little her father cared for her, and that her love for him had waned. She reported a realisation that her father's treatment of her did not fit her own values and needs. She slowly gained the confidence to articulate her needs to him on several occasions; but as the situation worsened, Emily made the difficult decision to not see him anymore. Emily* is presently travelling through this difficult period with much support from her mother and step-father, as they work to gain sole custody of her.*

**names have been changed for privacy reasons*

Emotional and/or behavioural management

The proportion of children and young people seeking help about emotional and/or behavioural management increased significantly in 2008, continuing a six-year trend. It is the second most common concern, accounting for 13% of all counselling sessions.

The nature of concerns about managing emotional and behavioural responses are varied but include anger management, violent behaviour, self-injurious behaviour and coping with traumatic experiences. Table 4 shows the nature of these 6,683 counselling sessions.

Emotional and/or behavioural management features as a major concern for all our client groups. Of note, this was the top concern via online counselling, frequently with an ongoing client and often with a young person reporting deliberate self-injury.

table 4

Emotional and/or behavioural management	All (N=6,683)	Telephone (N=4,565)	Online (N=2,118)
Concerned about another person	1%	6%	1%
Needing to talk through emotions or behaviour	63%	37%	61%
Seeking management strategies	11%	33%	14%
Experiencing difficulty managing emotions or behaviours	22%	17%	21%
Extremely distressed at the time of contact	3%	7%	3%
Total	100%	100%	100%

Specifically:

- The proportion of contacts about emotional and/or behavioural management concerns via online (17%) was substantially higher than those via the telephone (12%).
- 44% of these sessions were with an ongoing or case managed client.
- 26% were with young people engaging in deliberate self-injury.

Deliberate self-injury

All children and young people contacting Kids Helpline are assessed in relation to recent incidences of deliberate self-injury. During 2008, 15% (7,710) of counselling sessions were with young people who had deliberately injured themselves or taken overdoses of substances they believed to be non-lethal.

Of note:

- Self-injury was predominately reported by females (95%) and the vast majority (86%) of young people presenting with this behaviour were aged between 15 and 25 years. .
- Almost one-in-three reported thoughts of suicide at the time of their contact.
- Kids Helpline provides ongoing counselling and intensive support through case management to a high proportion (64%) of these young people.
- The proportion of young people presenting with self-injury behaviour via online contacts (21%) was substantially higher than those accessing the telephone service (12%).

Mental health issues

Mental health continues to emerge as a growing concern amongst young people contacting Kids Helpline, and was the third most frequent issue for children and young people in 2008.

Accounting for 11% (5,460) of counselling sessions, mental health issues were presented at almost triple the rate compared with 2003 (4% of counselling sessions).

The nature of mental health concerns presented included depression, anxiety, psychosis, personality disorders, Attention Deficit Hyperactivity Disorder (ADHD) and other childhood disorders. This is a significant under-representation of the total contacts related to mental health issues because specific or early stage mental health issues were also recorded in other Kids Helpline problem types. These problem types include suicide, eating behaviours and weight issues, substance use and emotional and/or behaviour management. Table 5 shows the nature of the telephone and online counselling sessions recorded under mental health issues during 2008.

table 5

Mental health issues	All (N=5,460)	Telephone (N=3,478)	Online (N=1,982)
Seeking information or concerned about a significant other	7%	7%	6%
Experiencing mild or occasional symptoms or concerns	31%	26%	41%
Severely distressed or experiencing major effects on their life	21%	21%	21%
Clinically diagnosed mental health issue	41%	46%	32%
Total	100%	100%	100%

Mental health concerns were presented in proportionally higher rates via the online medium, by females and by older adolescents and young adults. These counselling sessions were often with an ongoing or case-managed client and the young people were often engaging in deliberate self-injury and/or experiencing thoughts of suicide.

Specifically:

- The proportion of contacts about mental health concerns presented online (16%) was substantially higher than those via the telephone service (9%) and is the second most common problem presented for online counselling.
- 86% of all contacts regarding mental health were made by females and almost 90% were made by young people between 15 and 25 years of age.
- Almost half (47%) of these counselling sessions were with an ongoing or case-managed client.
- 38% of these counselling sessions were with young people engaging in deliberate self-injury.
- One-in-six reported current thoughts of suicide.

Sixteen year-old Louise* emailed Kids Helpline about her reaction to and struggles with a recent diagnosis of depression. She was having difficulty disclosing this to family and friends, and had not considered accessing face-to-face support for fear of the stigma attached to mental illness.

Louise and her counsellor exchanged several emails that covered information about depression and normalisation of reactions and fears. They also explored the consequences and possibilities that could come from disclosing her depression to friends and family, support options and barriers to accessing support. Finally, they developed step-by-step planning to enable Louise to best empower herself to seek further support.

These emails ended with Louise firstly talking to a peer about her depression and eventually approaching the school counsellor who she now sees on a regular basis. She was also able to speak to her GP. Louise advised she feels much more able to access and maintain support networks after experiencing counselling with Kids Helpline.

****names have been changed for privacy reasons***

Relationships with friends and peers

While the number and proportion of counselling sessions in relation to peer relationships has been decreasing since 2001, this issue remains an important concern. Table 6 shows the nature of the 4,721 counselling sessions regarding relationships with friends and peers in 2008.

table 6

Peer relationships	All (N=4,721)	Telephone (N=3,659)	Online (N=1,062)
Concern for a friend's well being	29%	30%	26%
Occasional or one-off friendship problems	35%	37%	29%
Significant relationship problems	22%	20%	29%
Difficulty making or maintaining friendships	14%	13%	16%
Total	100%	100%	100%

Almost half of all peer relationship concerns were presented by children aged between 10 and 14 years making it the second most common concern for children from this age group. The decrease in contacts about this issue is in line with a decrease in overall counselling sessions with 5 to 14 year olds.

Counselling sessions focused on peer relationships were predominantly with first-time or occasional callers with 84% of these sessions with a first-time or occasional Kids Helpline client.

Relationships with partners

Partner or intimate relationships continued to be a major concern for young people. Table 7 shows the nature of the 4,357 counselling sessions about partner relationships during 2008.

table 7

Partner relationships	All (N=4,357)	Telephone (N=3,491)	Online (N=866)
Wanting to establish a relationship	13%	13%	18%
Seeking help with negotiating a relationship	31%	29%	35%
Concern for partner's well-being	6%	6%	8%
Significant relationship difficulties or relationship breakdown	50%	52%	39%
Total	100%	100%	100%

Counselling sessions focused on intimate relationships were predominantly via the telephone service and with first-time or occasional callers. These concerns were also presented in proportionally higher rates by males, young people from culturally and linguistically diverse backgrounds and by older adolescents and young adults.

In particular:

- More than 80% were with a first-time or occasional Kids Helpline client.
- Males were proportionally more likely than females to seek help about partner relationships. It was the most common concern for 15 to 25 year-old males.
- For young people of culturally and linguistically diverse backgrounds, partner relationships ranked as the third most common concern.
- Almost 90% of all partner relationship concerns were presented by young people aged between 15 and 25 years.

Child abuse

Child abuse is the sixth most frequent concern for children and young people, accounting for 5% of all counselling sessions. The majority of these 2,547 contacts were in relation to physical abuse (46%) or sexual abuse (37%), with 13% related to emotional abuse and 4% concerning neglect.

Almost half of the child abuse counselling sessions were with children and young people reporting a current abusive or neglectful situation (see Table 8).

table 8

Child abuse	All (N=2,547)	Telephone (N=1,839)	Online (N=708)
Seeking information	10%	11%	6%
Currently at risk of abuse/neglect	10%	12%	5%
Current and/or ongoing abuse/neglect	47%	48%	46%
Abuse no longer current, seeking assistance with unresolved issues	33%	29%	43%
Total	100%	100%	100%

Younger children along with young people from culturally and linguistically diverse backgrounds (CALD) made proportionally more contacts about child abuse than older children and non-CALD young people respectively. Key points regarding child abuse counselling sessions include:

- Almost half of all child abuse concerns were presented by children younger than 15 years.
- 15% of these counselling sessions were with young people engaging in deliberate self-injury.
- 6% of these young people reported current thoughts of suicide.
- One-in-four were given a referral to another organisation or service (usually state child protection services or police), compared with one-in-ten for all other concerns.

Twenty year-old Jessie* is a long-term client of Kids Helpline, with a history of physical and sexual abuse resulting in significant physical injuries, foster care placements, and homelessness. Jessie has sought support from Kids Helpline throughout all of this. This ongoing support has involved providing emotional support, 'wrap-around-care' with other services also providing her with assistance, actioning protective interventions to ensure her safety and advocacy. Jessie is now in stable accommodation, receiving adequate medical care and is heavily involved as a volunteer worker and speaks publicly about transitioning from care and the foster care system from a consumer point of view. Jessie says that Kids Helpline has been her most consistent and reliable form of support during this journey.

**names have been changed for privacy reasons*

Bullying

School-related bullying accounted for more than 2,000 counselling sessions in 2008. Almost half of the bullying counselling sessions were with children and young people reporting frequent incidents of bullying or continual harassment (see Table 9).

table 9

Bullying	All (N=2,070)	Telephone (N=1,735)	Online (N=335)
Seeking information or concerned for a friend	4%	4%	3%
Reporting an isolated instance of bullying	16%	17%	7%
Experiencing episodic incidents of bullying	35%	37%	28%
Experiencing frequent incidents of bullying or continual harassment	45%	42%	62%
Total	100%	100%	100%

Bullying concerns were predominantly presented on the telephone by children younger than 15 years and by first-time or occasional callers. These concerns were also presented in proportionally higher rates by males.

In particular:

- 80% of these counselling sessions were with children younger than 15 years.
- 94% were with a first-time caller or occasional Kids Helpline client
- Boys were proportionally more likely than girls to seek help about this issue (7% of all counselling sessions with males compared with 3% of sessions with females).
- The proportion of contacts about bullying received by Kids Helpline via telephone (5%) was substantially higher than those via the online services (3%).

the issue... Cyberbullying and Cyber-harassment

The facts:
Cyberbullying or cyber-harassment is behaviour that is consistent with general bullying or harassment but is transmitted via communication technologies. It involves the deliberate and ongoing harassment of one person by another person or group such as the transmission of hurtful messages or images via SMS, email, in internet chat rooms or other internet communication mechanisms.

Our analysis:
Anecdotal reports from Kids Helpline counsellors indicated that cyberbullying was an emerging issue for children and young people.

Our response:
- The Kids Helpline data collection system was adjusted in July 2008 to enable monitoring and reporting on this issue more closely
- We developed and implemented an online survey for young people in January 2009 to better understand the behaviour and impact on young people including information about who is being bullied, how it's happening and what did or did not work to combat attacks. We will publish this research as a way of informing policy, prevention strategies and anti-bullying programs, along with informing intervention strategies for cyber-bulling.
- Raise awareness of the issue through participation in government inquiries, Kids Helpline publications and through encouraging appropriate media coverage. In addition to increasing awareness and understanding on the issue we will advocate for change through:
  - Implementing communication strategies that increase the help seeking behaviour of children and young people subject to bullying and cyberbullying by encouraging young people to speak out about bullying and giving them information about current sources of support and counselling – knowledge of who they can safely turn to for assistance.
  - Increasing availability of peer helper programs that positively influence the quality of peer to peer relationships and to improve the ability of peers to provide support.
- Foster partnerships with key organisations that can increase pathways to assistance, such as to Kids Helpline, for children and young people impacted by cyber harassment.
- Co-distribution of cyber-safety DVD to schools across Australia.

Suicidality

Suicidality was the eighth most common reason for contacting Kids Helpline during 2008, accounting for 1,869 or 4% of counselling sessions.

Table 10 shows the nature and severity of counselling sessions during 2008 where the majority of counselling work was related to suicide.

table 10

Suicide-related issues	All (N=1,869)	Telephone (N=1,291)	Online (N=578)
Seeking information or concerned about a friend	11%	14%	6%
Experiencing suicidal thoughts of fears	68%	61%	83%
Immediate intention or making an attempt whilst talking with a counsellor	21%	25%	11%
Total	100%	100%	100%

Suicide concerns were presented in proportionally higher rates by older adolescents and young adults and via the online medium. These counselling sessions were often with a young person also engaging in deliberate self-injury. Kids Helpline provides ongoing counselling and case management to a high proportion of these young people.

Specifically:

- 85% of these counselling sessions were with young people aged between 15 and 25 years.
- A larger proportion of suicide concerns were presented via online counselling (5%) than on the phone (3% of calls).
- Over half (51%) of these counselling sessions were with young people engaging in deliberate self-injury.
- 44% of sessions were with an ongoing or case managed client.

Current thoughts of suicide

Regardless of the main issue recorded, a more accurate reflection of the incidence of suicidal thinking in young people is demonstrated through counsellors also assessing children and young people in relation to current thoughts of suicide. In addition to the 1,869 counselling sessions provided where suicidality was the primary concern, thoughts of suicide were also recorded in a further 2,122 counselling sessions where young people were presenting other concerns. Subsequently, current thoughts of suicide were reported during 3,991 counselling sessions (2,684 telephone and 1,307 online). This equates to approximately eleven counselling sessions each day and represents a 45% increase over the past two years (2,750 reports of suicidal thoughts during 2006).

This finding is particularly important as whilst it is concerning that it appears young people are increasingly likely to have thoughts of suicide, it also suggests that they are more likely to contact Kids Helpline in times of extreme emotional stress.

Homelessness and leaving home

Kids Helpline counsellors responded to 1,654 young people facing homelessness or leaving home concerns. Table 11 shows the nature of these concerns.

table 11

Homelessness /leaving home	All (N=1,654)	Telephone (N=1,555)	Online (N=99)
Seeking information or contemplating leaving home	34%	31%	80%
Young person told to leave their home	17%	18%	6%
Left home with somewhere to stay	16%	16%	9%
Left home with nowhere to stay	31%	33%	3%
Severely distressed or at risk of harm	2%	2%	2%
Total	100%	100%	100%

Most counselling sessions that focused on homelessness were via the telephone, with first-time or occasional clients, and with young people aged between 15 and 18 years. Counsellors were able to provide more than half of all these callers with a referral to other services. Concerns about homelessness were also presented in proportionally higher rates by males and Indigenous young people.

Specifically:

- The proportion of contacts about homelessness via telephone (4%) was four times higher than the online service (1%).
- 87% were from a first-time caller or occasional Kids Helpline client.
- 67% of counselling sessions were with children and young people aged between 15 and 18 years.
- Although females made a greater number of contacts about homelessness than males, males were proportionally more likely to seek help about this issue (5% of all counselling sessions with males compared with 3% of sessions with females).
- Indigenous children and young people were proportionally more likely to seek help about homelessness when compared with non-Indigenous young people (6% of counselling sessions with Indigenous youth compared with 3% of sessions with non-Indigenous clients).

Grief and loss

Grief and loss concerns were the tenth most common reason for seeking help via both telephone and online counselling during 2008. These concerns include any kind of grief response to death or loss such as the death of a parent, pet, friend, grandparent or the loss of relationships or lifestyle such as moving interstate. Table 12 shows the nature of these 1,360 counselling sessions.

table 12

Grief and loss	All (N=1,360)	Telephone (N=987)	Online (N=373)
Seeking information	3%	3%	1%
Needing to talk through an experience of loss	53%	53%	54%
Suffered a recent loss and in acute distress	31%	32%	30%
Unable to resume usual lifestyle	6%	6%	8%
Experiencing extreme long-term distress	7%	6%	7%
Total	100%	100%	100%

Although older adolescents made a greater number of contacts about grief and loss issues than their younger counterparts, children aged up to 14 years were proportionally more likely (3.2%) to seek help about this issue than 15 to 25 year old clients (2.5% of contacts from this group).

It was not uncommon for children and young people seeking help about grief and loss to be engaging in deliberate self-injury (14% of these counselling sessions) or to be experiencing thoughts of suicide (6%).

Increase in protective actions

Counsellors exercise their duty of care obligations if they assess that a child is at risk of injury or harm at the time of their call or online contact. Responses required to protect children, such as contacting an emergency service or child protection agency, were actioned during or after 658 counselling sessions during 2008 (518 via the telephone service and 140 via online counselling). This was an increase of 12% on 2006 figures. Overall protective actions taken by counsellors have risen 80% since 2003.

Issues presented by ongoing counselling clients

Young people receiving ongoing counselling or intensive support through a case management model were predominately female (88%) and aged between 15 and 25 years of age (89%).

Issues discussed were proportionally more likely to about mental health problems, managing emotional and/or behavioural responses, eating behaviours and weight issues, suicidality, self-image, development issues, physical health, and employment or financial concerns (when compared with other clients). Additionally, these young people were significantly more likely to report engaging in deliberate self-injury (38%) and/or current thoughts of suicide (15%).

Top concerns of clients engaging in ongoing or intensive counselling support

1. Emotional and/or behavioural management
2. Mental health issues
3. Family relationships
4. Suicidality
5. Partner relationships
6. Child abuse
7. Relationships with peers and friends
8. Physical health
9. Development issues
10. Grief and loss
11. Eating behaviours or weight concerns
12. Self image
13. Drug and alcohol use
14. Study issues
15. Sexual assault

Are boys and young men's issues different?

While males account for only 22% of counselling sessions, they are proportionally more likely than females to seek help about bullying, drug and alcohol use, homelessness, partner relationships, sexual orientation, sexual activity, legal issues, loneliness, and employment or financial issues.

Top 10 concerns of male clients

1. Family relationships
2. Emotional and/or behavioural management
3. Partner relationships
4. Relationships with peers and friends
5. Mental health issues
6. Bullying
7. Homelessness or leaving home
8. Child abuse
9. Drug and alcohol use
10. Sexual orientation

What are the issues for Aboriginal and Torres Strait Islander clients?

The total number of all contacts from Indigenous and Torres Strait Islander children and young people remained steady from 2007 figures with 1,562 contacts during 2008. However this was an increase of 21% since 2006 and of 46% since 2005. Twenty percent of these young people were calling for the first time. In addition, contacts from Indigenous and Torres Strait Islander youth that required a counselling type response during 2008 were 61% greater than 2006 figures.

These findings are particularly important as it has been a key objective for Kids Helpline to improve and increase contact with Indigenous children and young people. The 2008 findings indicate they are continuing to reach out to Kids Helpline for contact and counselling needs. These children and young people are proportionally more likely to seek help about homelessness, drug and/or alcohol use, violent assault, witnessing domestic violence, and physical health issues compared with non-Indigenous clients.

Top concerns of Indigenous youth

1. Emotional and/or behavioural management
2. Family relationships
3. Mental health issues
4. Relationships with peers and friends
5. Homelessness or leaving home
6. Child abuse
7. Drugs and alcohol
8. Partner relationships
9. Bullying
10. Grief and loss

Indigenous children and young people contacting Kids Helpline in 2008 were twice as likely to talk with a counsellor about drug and alcohol issues (5.1%) and homelessness (6.0%) than non-Indigenous young people (1.9% and 3.0% respectively).

What are the issues for young people from culturally and linguistically diverse backgrounds?

Children and young people from culturally and linguistically diverse (CALD) backgrounds (not including Indigenous young people) are proportionally more likely to seek help about family relationships, partner relationships, child abuse, study issues, and self-image (when compared with other clients).

Top 10 concerns of CALD clients

1. Family relationships
2. Emotional and/or behavioural management
3. Partner relationships
4. Mental health issues
5. Relationships with friends and peers
6. Child abuse
7. Study issues
8. Bullying
9. Self image
10. Suicidality

Children and young people from culturally and linguistically diverse backgrounds (CALD) who contacted Kids Helpline in 2008 were twice as likely to talk with a counsellor about study issues (4.1% of counselling sessions compared with 1.6% for other clients). They were also 50% more likely to discuss self-image concerns (2.5% of counselling sessions) than other clients (1.7%).

Twenty-seven percent of CALD youth speaking to Kids Helpline counsellors in 2008 were contacting Kids Helpline for the first time.

What concerns children of different ages?

The following is a list of the top 10 concerns by age group and gender during 2008. Relationships with family along with managing emotional and/or behavioural responses feature as major concerns for children and young people of all ages. However, there were differences between specific age groups in relation to the issues for which children and young people sought help. Differences of particular note are:

- For children up to 14 years of age, peer relationships, bullying, child abuse and grief and loss feature more prominently than for older ages.
- Mental health issues, partner relationships and drug and/or alcohol use become increasingly more common concerns for older age groups.
- For adolescents between 15 and 18 years of age, homelessness, study issues, pregnancy and sexual orientation concerns feature more prominently.
- For older adolescents and young adults, mental health, suicide, partner relationships, eating behaviours and weight issues, and self-image issues feature more strongly than for younger clients.

Top 10 Concerns for each age group and gender

Female 5-9 years

1. Family relationships
2. Bullying
3. Relationships with friends and peers
4. Emotional and/or behavioural management
5. Child abuse
6. Grief and loss
7. Development issues
8. Loneliness
9. Witnessing domestic violence
10. Self image

Female 10-14 years

1. Family relationships
2. Relationships with friends and peers
3. Emotional and/or behavioural management
4. Bullying
5. Child abuse
6. Mental health issues
7. Partner relationships
8. Grief and loss
9. Pregnancy issues
10. Suicidality

Female 15-18 years

1. Emotional and/or behavioural management
2. Family relationships
3. Mental health issues
4. Partner relationships
5. Relationships with friends and peers
6. Suicidality
7. Child abuse
8. Homelessness or leaving home
9. Pregnancy issues
10. Grief and loss

Female 19-25 years

1. Mental health issues
2. Emotional and/or behavioural management
3. Partner relationships
4. Family relationships
5. Suicidality
6. Relationships with friends and peers
7. Child abuse
8. Eating behaviours or weight concerns
9. Physical health issues
10. Grief and loss

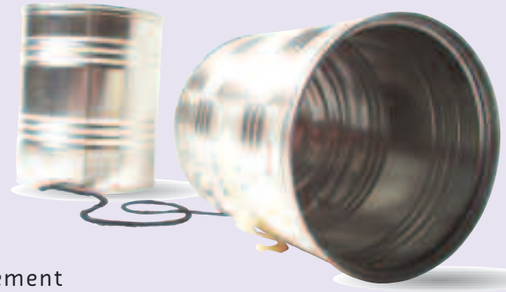
Top 10 Concerns for each age group and gender

Male 5-9 years

1. Family relationships
2. Emotional and/or behavioural management
3. Bullying
4. Child abuse
5. Grief and loss
6. Relationships with friends and peers
7. Physical health issues
8. School-related authority
9. Mental health issues
10. Loneliness

Male 10-14 years

1. Family relationships
2. Bullying
3. Emotional and/or behavioural management
4. Child abuse
5. Relationships with friends or peers
6. Homelessness or leaving home
7. Partner relationships
8. Sexual activity
9. School-related authority
10. Grief and loss



Male 15-18 years

1. Partner relationships
2. Family relationships
3. Emotional and/or behavioural management
4. Relationships with friends and peers
5. Mental health issues
6. Homelessness or leaving home
7. Sexual orientation
8. Drug and alcohol issues
9. Sexual activity
10. Suicidality

Male 19-25 years

1. Partner relationships
2. Emotional and/or behavioural management
3. Mental health issues
4. Family relationships
5. Drug and alcohol issues
6. Relationships with friends or peers
7. Homelessness
8. Suicide-related issues
9. Physical health issues
10. Loneliness

Problem Type Yearly Trends

Proportion of telephone and online counselling contacts by year

MAIN CONCERN	2003	2004	2005	2006	2007	2008
INTERPERSONAL RELATIONSHIPS	40.5%	40.2%	39.5%	38.0%	35.5%	33.6%
Family	16.6%	16.7%	16.7%	17.4%	16.9%	15.8%
Friends	14.4%	14.1%	13.4%	12.1%	9.6%	9.3%
Partners	9.5%	9.4%	9.4%	8.5%	9.0%	8.5%
EMOTIONAL	11.9%	12.9%	14.2%	16.2%	18.2%	20.3%
Emotional/Behavioural Management	5.7%	6.7%	8.1%	9.5%	11.6%	13.1%
Grief and Loss	2.7%	2.7%	2.5%	2.8%	2.7%	2.7%
Loneliness	0.8%	0.8%	0.9%	1.0%	0.8%	0.9%
Suicide-Related Issues	2.7%	2.8%	2.7%	2.9%	3.1%	3.7%
HEALTH	7.2%	10.3%	12.9%	12.8%	13.8%	14.4%
Eating Behaviours & Weight Concerns	1.0%	1.6%	1.7%	1.8%	1.8%	1.5%
Physical Health Issues	1.9%	1.8%	1.6%	1.8%	2.0%	2.1%
Mental Health Issues	4.3%	7.0%	9.6%	9.2%	10.0%	10.7%
SCHOOL	10.2%	8.7%	7.7%	7.9%	7.4%	6.7%
School Authority	1.2%	1.0%	0.8%	0.8%	0.8%	0.7%
Bullying	7.5%	5.9%	5.0%	5.3%	4.4%	4.1%
Study Issues	1.5%	1.9%	1.9%	1.9%	2.1%	1.9%
PRACTICAL	5.9%	5.8%	5.6%	5.4%	5.7%	5.8%
Employment/Financial Issues	0.6%	0.6%	0.6%	0.6%	0.7%	0.8%
Homelessness or Leaving Home	3.3%	3.3%	3.3%	3.2%	3.3%	3.2%
Legal Issues	1.0%	0.9%	0.9%	0.9%	0.9%	1.0%
Life Skills	1.0%	0.9%	0.8%	0.6%	0.8%	0.8%
CHILD ABUSE	4.5%	4.6%	4.7%	4.9%	5.2%	5.0%
Emotional Abuse	0.4%	0.5%	0.6%	0.6%	0.6%	0.7%
Neglect	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
Physical Abuse	2.0%	2.1%	2.2%	2.2%	2.4%	2.3%
Sexual Abuse	1.8%	1.8%	1.7%	2.0%	2.0%	1.9%
SELF CONCEPT	5.2%	5.1%	4.6%	4.9%	4.8%	4.6%
Developmental Issues	2.1%	1.8%	1.6%	1.6%	1.6%	1.7%
Self Image	1.4%	1.6%	1.5%	2.0%	1.8%	1.7%
Sexual Orientation	1.7%	1.6%	1.5%	1.3%	1.3%	1.2%
SEX RELATED	8.3%	6.7%	5.6%	4.9%	4.2%	4.5%
Sexual Activity	3.2%	2.3%	1.8%	1.5%	1.3%	1.5%
Contraception	1.0%	0.7%	0.7%	0.5%	0.4%	0.3%
Pregnancy	3.6%	3.2%	2.7%	2.6%	2.2%	2.4%
STIs	0.5%	0.4%	0.4%	0.4%	0.3%	0.3%
ALCOHOL/DRUGS	3.0%	2.4%	2.3%	2.1%	2.0%	1.9%
Alcohol Use	0.6%	0.5%	0.5%	0.4%	0.5%	0.6%
Drug Use	2.4%	1.9%	1.8%	1.7%	1.5%	1.3%
VIOLENCE	3.3%	3.2%	2.8%	2.8%	3.2%	3.0%
Cyberharassment or Bullying*						0.2%*
Physical Assault or Harassment	1.0%	0.9%	0.7%	0.7%	0.8%	0.7%
Witnessing Domestic Violence	0.4%	0.4%	0.4%	0.5%`	0.5%	0.5%
Sexual Harassment	0.5%	0.5%	0.3%	0.3%	0.3%	0.2%
Sexual Assault	1.3%	1.4%	1.3%	1.3%	1.5%	1.5%
OTHER	0.1%	0.1%	0.1%	0.1%	0.1%	0.1%
	100%	100%	100%	100%	100%	100%

**Cyber-bullying and harassment issues were separated from "Bullying" and "Assault or Harassment" problem types from 1 July 2008.*

Client satisfaction and client outcomes

Kids Tell Us that Counsellors Are Getting it Right

Children and young people are satisfied with Kids Helpline counselling and are reporting positive outcomes, demonstrating that the service is having an immediate and positive impact on young people's social and emotional well-being.

Based on the feedback of just under 100 children and young people who engaged in telephone counselling sessions during October 2008:

- Counselling was effective at increasing their self-reported confidence and ability to manage their issue of concern. Ninety-six percent reported an increase in ideas of how to deal with their problem and 93% reported feeling at least somewhat more able to deal with their problem following their call.

- The satisfaction with counselling provided was very high with 95% of participants reporting satisfaction with the Kids Helpline telephone counselling service.

Data collection and limitations

Kids Helpline counsellors record non-identifying information at the end of every telephone or online session. There are a maximum of 32 different fields where data may be logged. However, only 10 are mandatory (including date, time, length of session, cultural background, frequency of contact, main problem, problem severity, outcome, whether the session related to suicide in any way and whether the client engages in self-injury).

Ideally counsellors enter information for each field. In reality, however, the amount of information recorded about each session varies due to the following reasons:

Privacy and Confidentiality – Kids Helpline markets itself to young people as a private and confidential service – frequently clients choose not to reveal details of themselves, particularly those that might in their view lead to identification.

Sensitivity of information – the nature of some contacts is such that direct information gathering is either contraindicated or proves difficult.

The length or nature of the call – is such that even basic data collection is impossible or irrelevant.

Other issues that need to be considered in relation to the data within this report include:

Repeat contacts – children and young people are free to use the service as often as they need. Therefore, data reported may include repeat contacts made by individuals across a period of time. Indeed, for many young people, the sense of connectedness Kids Helpline provides is a key preventative tool for serious issues such as mental health and self-harm.

Multiple problems – many young people's issues are multifaceted, spanning across more than one of the 35 problem types. Counsellors record the one problem type on which most of the counselling time was spent.

Missing data – Kids Helpline has adopted a policy of recording data in each field in such a way as to identify incomplete, unknown or blank responses. All statistical information reported is therefore based on those instances where the information is known.

Statistical significance – all stated data comparisons have been assessed against a 95% confidence interval.

Notes

BoysTown

Fresh start.
New hope.

Kids Helpline

We care.
We listen.

BoysTown is a company limited by guarantee.

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Kids Helpline welcomes feedback about this Overview and would be pleased to hear of your ideas for useful information for inclusion in future editions.