Suicide

11

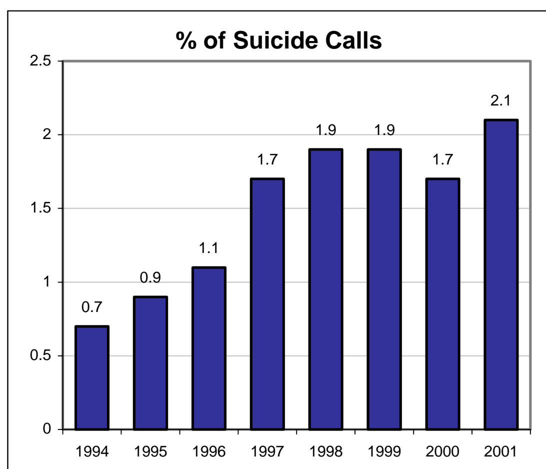
KIDS HELP LINE

Definition

Callers who are contemplating suicide and/or have previously attempted suicide. Suicidal thoughts with general or specific plans.

Suicide became a matter of national public concern in Australia during the 1990s. A focus on youth suicide was prompted by the observation that the rate for young males (i.e. 15-24 years) had risen about threefold during the 30 years to 1990, whereas the rates at older ages had tended to decline. During the 1990s, the rate for males aged 15-24 did not rise further and have declined each year after 1997 to 2000 (AIHW, 2002).

Kids Help Line (KHL) counsellors answer almost 1,800 calls each year from young people who call because of suicidal thoughts, intentions or behaviours. The number and proportion of suicide-related calls has doubled between 1994 and 2001, now accounting for 2% of calls made to the service.



Each year, an additional 1,800 children and young people mention suicidal thoughts to their counsellor while discussing other concerns including child abuse, drug use and mental health issues.

Given the reduction in suicide completion rates across the country, these figures represent an increasing preparedness by young Australians to acknowledge their concerns and to seek professional help.

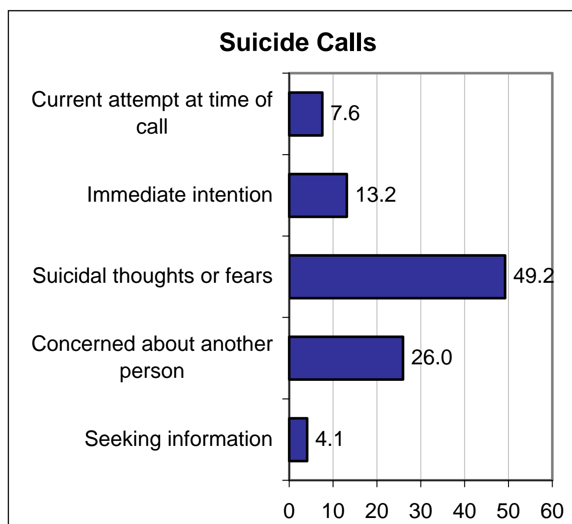
In addition to responding to 5 to 18 year olds, KHL counsellors respond to around 180 suicide-related calls from adults each year - mostly 19 to 25 year olds. This report is based on 5,064 suicide-related calls made by 5 to 18 year olds (between 1999 and 2001).

References

Australian Institute of Health and Welfare (2002). Australia's Health. http://www.aihw.gov.au/publications.

Level of Distress

Almost half the suicide-related calls were from young people experiencing suicidal thoughts or fears. A further 13% had an immediate intention of attempting suicide and 8% were making a suicide attempt at the time of their call.



The remaining young people were seeking information (4%) or had concerns about another person (26%).

Client Profile

Females made 84% of suicide-related calls and males made 16% - significantly less than the proportion of male callers across all other problem types (28%).

N = 4,739	*MALES*	*FEMALES*
5 - 9	0.2%	0.3%
10 - 14	3.8%	22.8%
15 - 18	12.1%	60.6%

Rounding errors of no more than .01 may be present.

The majority (73%) of those who phoned KHL about suicide were aged between 15 and 18 years, which is almost double the representation for this age group across all calls (41%).

Three-quarters were located in capital cities and metropolitan areas (population > 100,000). Young people from rural and remote areas made 33% of calls, closely matching the population distribution.

The cultural/ethnic background of young people was recorded for 15% of suicide-related calls. Of these, 83% were Anglo-Australian, 8% of non-English speaking backgrounds, 5% Aboriginal and Torres Strait Islander youth and the remaining 4% from other backgrounds. These proportions match KHL national caller trends.

KIDS HELP LINE INFOSHEET

Underlying & Contributing Factors

Children and young people often disclose severe distress to their counsellor when seeking help about other concerns. Suicidal thoughts and behaviours are most commonly expressed when young people phone about:

- Mental Health Problems (18% of callers disclose suicidal thoughts or behaviours)
- Sexual Abuse (9%)
- Emotional Abuse (8%)
- Self Image (7%)
- Sexual Assault (6%)
- Grief and Loss (5%)
- Cult or Gangs (4%)
- Eating Behaviours (4%)
- Physical Abuse (4%)
- Loneliness (3%)

Suicidal thoughts and/or behaviours are even more prevalent for children and young people experiencing severe incidents of the above problems. Callers are at highest risk of suicide when experiencing:

- A clinically diagnosed mental health disorder (22%)
- Loneliness resulting in long-term social dislocation (18%)
- Regular sexual abuse (14%)
- Unresolved issues related to past sexual abuse (13%)
- Persistent low self-value or severe feelings of worthlessness (13%)
- Severe health problems from continued disordered eating behaviours (12%)
- Regular and/or severe emotional abuse (11%)
- Current risk of injury from physical abuse (10%)
- Social isolation (6%).

Table 1: Contributing Factors in Rank Order

Suicide Main Concern	*Other Main Concern*
Family Relationships	Family Relationships
Sexual Abuse	Self Image
Mental Health	Sexual Abuse
Grief & Loss	Mental Health
Partner Relationships	Grief & Loss
Physical Abuse	Peer Relationships
Self Image	Physical Abuse
Peer Relationships	Partner Relationships
Sexual Assault	Emotional Abuse
Loneliness	Sexual Assault
Drug use	Loneliness
Emotional Abuse	Study Issues
Homelessness	Bullying
Study Issues	Drug use
Bullying	Domestic Violence

In circumstances where suicidal thoughts or behaviours are disclosed to a KHL counsellor, additional data is recorded about the young person's suicidal risk including factors contributing to their level of distress. Table 1 shows these contributing factors in rank order.

In essence, young people's experiences of despair centre around physical and sexual violations, mental health conditions, destruction of their self worth, disruption to significant relationships, loss of significant people and lack of supportive relationships in their lives.

Differences in Severity & Distress

While males and females seek help about suicidal thoughts and behaviours in significantly different proportions, there is no difference in the severity of their calls.

The severity of suicidality expressed to KHL counsellors increases with age - 15 to 18 year olds are twice as likely to report an immediate intention or current attempt when compared to younger callers.

While there is little difference between callers located in metropolitan and remote (populations < 5,000) areas, young people calling from rural locations (populations 5,000-99,999) are nearly twice as likely to have an immediate intention or be attempting suicide at the time of their call. This is concerning given the limited access to services in rural and remote locations.

Outcome of Calls

On average counsellors spend 34 minutes talking to young people each time they phone about a suicide concern compared to an average of 17 minutes for all other issues.

Fifteen percent of callers who phone about suicide are referred to other support services (including crisis response and 3-way linkups). Duty-of-Care actions are required in 42% of suicide-related calls. These actions range from discussing confidentiality, ethical or legal responsibilities with callers to contacting an emergency service.

In 24% of calls, counsellors intend to offer a referral but are unable to because either no appropriate service is available or the caller finishes the call before a referral can be given. A further 23% of callers are given a non-specific referral such as to a local doctor or school/guidance counsellor. For the remaining 38% of callers, the nature of their issue does not require a referral.

In addition to offering referrals to relevant services and agencies, KHL counsellors make agreements with 72% of callers with suicide concerns to contact KHL again to speak with their counsellor on a specific date.

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For more information

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