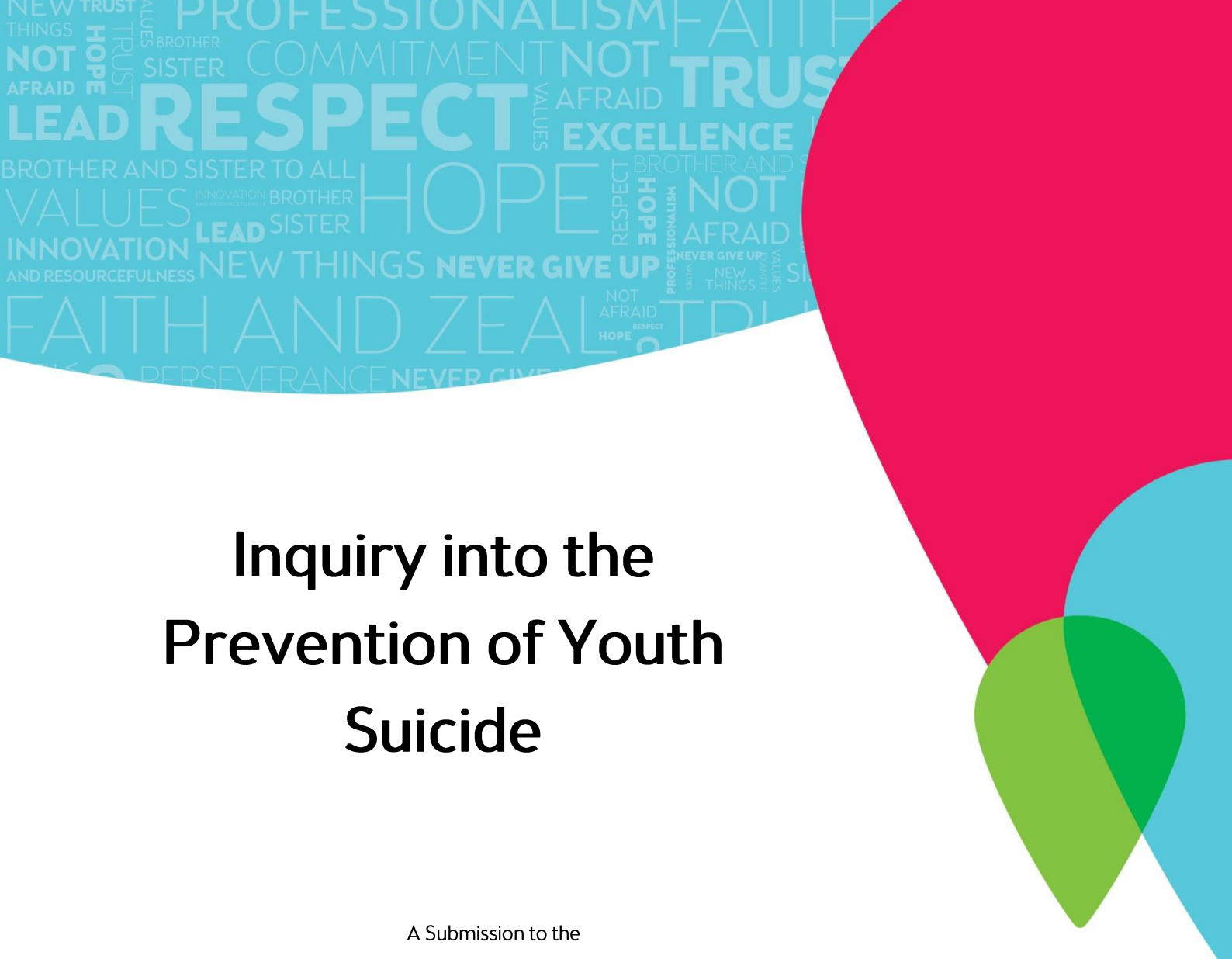


## **PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES**

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**Date Received:** 31 August 2017



# Inquiry into the Prevention of Youth Suicide

A Submission to the

**NSW Parliament Committee on Children  
and Young People**

Prepared by **yourtown**  
August 2017

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## Introduction

**yourtown** welcomes the opportunity to make this submission to the NSW Parliament Committee on Children and Young People's Inquiry into the Prevention of Youth Suicide.

The Australian Bureau of Statistics reports that there were 96 suicide deaths of young people aged 15-24 years in NSW in 2015 (Australian Bureau of Statistics, 2016). According to the NSW Child Death Review Team, five of these deaths involved a child aged 14 years or younger and 21 involved a young person aged between 15 and 17 years (NSW Child Death Review Team, 2016). Data obtained through national surveys, as well as our own records of help-seeking through Kids Helpline, show that many more children and young people think about, plan and attempt suicide (e.g., Zubrick et al., 2016).

Suicide has immense effects on the families, friends, and communities of people who die by suicide, causing long lasting grief and guilt. Arguably, these effects are even greater when the person who died by suicide is young. It is estimated that suicide costs the Australian economy more than \$17 billion per year (Mendoza & Rosenberg, 2010). Researchers and policy makers recognise that suicide is preventable, yet suicide rates have changed little in the past 10 years, suggesting that something needs to change.

We do not present a comprehensive review of the literature on this issue here; numerous reports and discussion papers doing this already exist. Rather, our submission highlights knowledge gained through our experience working with young people and the views they have shared with us in our own research.

Our submission focuses on point (d) in the Committee's Terms of Reference, *the provision of services for vulnerable and at risk groups*. We also touch more briefly on point (e), *data collection about the incidence of youth suicide and attempted suicide* and point (f), *provision of high quality information and training to service providers*, and provide some additional information under point (h), *other related matters*.

## About yourtown and Kids Helpline

**yourtown** (formally BoysTown) is a national organisation and registered charity that aims to tackle the issues affecting the lives of young people. Established in 1961, **yourtown's** Mission is *to enable young people, especially those who are marginalised and without voice, to improve their quality of life*.

**yourtown** provides a range of face to face and virtual services to young people and families seeking support. These services include:

- 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 and family violence
- Parenting programs offering case work, individual and group work support and child development programs for young parents and their children
- Parentline, a telephone counselling service for parents and carers in Queensland and the Northern Territory
- Employment programs and social enterprises, which support young people to re-engage with education and/or employment.

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. It offers counselling support via telephone, email and a real-time web platform. Kids Helpline is staffed by a professional workforce, with all counsellors holding a tertiary qualification. Since March 1991, young Australians have been contacting Kids Helpline about a

diverse group of issues ranging 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.

Detailed information about the service provided by Kids Helpline is presented later in this submission (p. 16).

### The nature of Kids Helpline data

Throughout this report we refer to data derived from Kids Helpline records of contacts with children and young people. This type of data is rare because it is designed to give young people in Australia a voice. The data provide ongoing insight into the issues that have been concerning young people for more than 25 years, as well as important information about their help-seeking preferences.

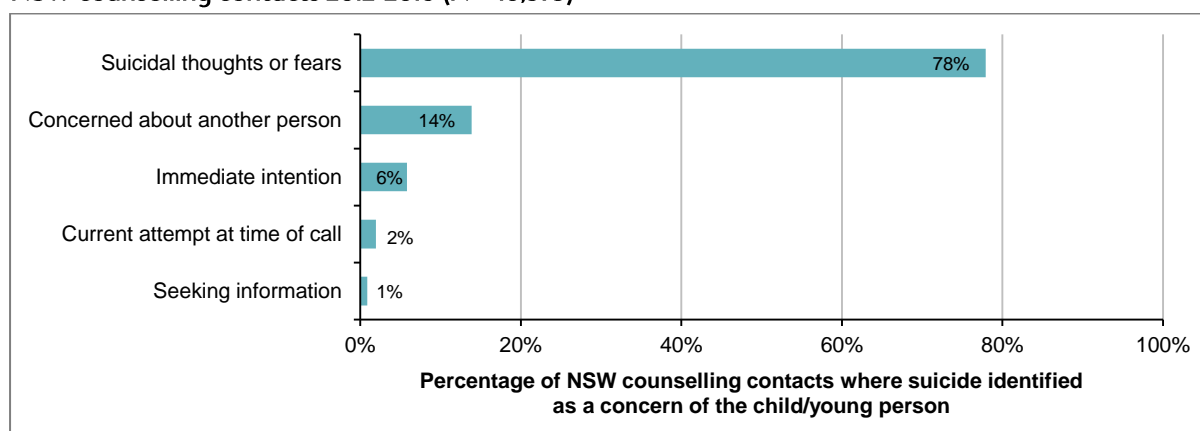
Nevertheless, it is important to note some limitations of the data. Kids Helpline data provide a snapshot of information that children and young people chose to disclose to counsellors. The number of contacts coded as 'suicide' is a measure of how often children and young people contacting the service disclosed this issue to counsellors - and counsellors saw it relevant to capture in case notes. It is not a measure of how often young people experience this issue.

That is, Kids Helpline data cannot be used as an indication of the prevalence of a problem in the community. It is self-evident that the data set only includes contact by young people who actively seek help; there are likely to be many more young people who do not seek help. Similarly, we report demographic characteristics such as age and gender to describe the nature of the group of children who have provided the data; however, these data cannot be used to compare prevalence between different groups. Figures reported are often numbers of contacts, not numbers of individuals.

### Kids Helpline support for children and young people experiencing suicidality in NSW

Between 2012 and 2016, more than one in three contacts (37%), or a total of 373,404 contacts with Kids Helpline came from NSW. Just over one quarter of contacts from NSW (26%, n=96,209) resulted in counselling sessions where the child or young person was seeking help with particular issues or concerns. In about one in ten (11%, n=10,375) of these counselling sessions, the child or young person contacted to discuss suicide-related concerns. Most of these sessions were about the child or young person's own suicidal thoughts, feelings or actions (86%), but one in seven (14%) was about the client's concern for someone else (see Figure 1). An additional 3527 contacts were received from young people who were seeking help about another issue, but disclosed current thoughts of suicide during the contact.

**Figure 1. Subcategory of concern where suicide identified as concern of the child or young person – NSW counselling contacts 2012-2016 (N= 10,375)**



The number of attempted contacts to Kids Helpline continues to exceed the capacity of the service. In 2016, young people in NSW made 99 894 attempts to contact by phone, of which approximately 49% were able to be answered. A further 21 412 attempts were made through webchat, of which 48% were answered.

## yourtown response to Terms of Reference

### Summary of key points

#### Term of reference (d): Provision of services for vulnerable and at-risk groups

- It is not membership of a vulnerable group per se that increases the risk of suicide and identification of high risk groups does not enable identification of individuals at risk. Suicide does not discriminate.
- Evidence of 'what works' is limited. We do know that no single intervention is sufficient. Effective suicide prevention requires a combination of activities to address a range of factors across the spectrum from universal prevention to continuing care.

#### *Key elements of effective services*

- **Dedicated to youth.** Services need to be tailored to the developmental stage of the individual, be staffed by youth specialists, and include a focus on peers, schools and parents/carers.
- **Recognise and respond to diversity both between and within vulnerable groups.** While specialist services for a particular group are welcome, they are not always feasible or appropriate. Mainstream need to welcome and respond effectively to a diverse range of young people.
- **Involve young people in design and implementation.** Young people value opportunities to be heard and involved and have unique insights. They should be involved in service design, implementation and evaluation.
- **Recognise and address modifiable risk factors, including disadvantage, marginalisation and discrimination.** Higher rates of suicide amongst many groups are associated with the disadvantage, discrimination and marginalisation experienced by members of those groups. To achieve long term sustained change, strategies need to increase social inclusion and reduce the marginalisation of vulnerable young people.
- **Recognise and target families as a source of both risk and protection.** Suicidality in young people is associated with child abuse, family violence, family conflict and parenting more broadly. Moreover, parents are one of the most important sources of support for young people. However, many parents struggle to know how to respond effectively when faced with a child or young person in distress.
- **Provide interventions that increase young people's resilience.** Evidence supports a need for two approaches to increasing resilience: skills training to increase young people's capacity to manage challenges and maintain wellbeing, and strategies to enhance supportive relationships with others.
- **Provide holistic support from youth specialist practitioners in non-clinical youth-friendly environments.** Young people need support, for example from a social worker, to address contextual issues contributing to suicidality, as well as mental health support. They also highlight a desire for services to be 'less clinical', and for practitioners to show more empathy and spend more time listening, because a trusting relationship is as important to them as an effective 'treatment'.
- **Ensure services are accessible and affordable for young people.** Governments need to provide a range of services that are easy to find, easy to access, available at the times when young people need them, and a sufficient dose must be affordable for children and young people. In particular, more outreach services that can see young people in their home, for example, would be beneficial.
- **Provide high quality compassionate crisis care and aftercare.** Young people continue to share stories about less than optimal care following a suicide attempt. Keeping a young person physically safe should be a bare minimum; health services should also aim to reduce distress and enhance emotional wellbeing by seeking the person not just the patient.
- **Use technology as a gateway to services, not a replacement for services.** Our experience and research suggest that young people desire contact with a 'real person', particularly when seeking help for complex issues such as suicide and mental ill health. A key role for the internet is as a means to connect vulnerable young people with that real person. More research is needed to investigate the

nature of effective online and app-based interventions before they can be recommended as an effective strategy for suicide prevention.

- **Include community education to reduce stigma and encourage help-seeking.** Most young people experiencing suicidal ideation do not seek help due to concerns associated with stigma, specifically fear of 'being judged', labelled an 'attention-seeker' or not being taken seriously. Campaigns to reduce stigma and provide practical information about supporting a person in distress should be a priority.

### **The role of teleweb services such as Kids Helpline**

We believe that confidential telephone and web-based counselling available 24/7 is a critical part of the service system and offers unique benefits. It can help to overcome barriers to help-seeking, act as a soft entry opportunity and pathway to more intensive services, is accessible to high risk groups, and can provide both ongoing counselling and crisis support.

Kids Helpline provides a unique safety net for vulnerable children and young people. By promoting itself as 'there for anyone at any time about anything', and offering the option to remain anonymous, Kids Helpline casts a wide net and seeks to reduce the effect of stigma on help-seeking. Being a virtual service, it is accessible from any geographical location, by any young person with access to a phone or internet connection. Being 24/7, it enables young people to seek help at a time and from a place that suits them. Professional counsellors use a child-centred and relationship-based approach to increase children's sense of safety and encourage them to name, define and explore their concerns and identify the help they need.

Kids Helpline is not a specialist services itself, but acts as a portal to specialist services by actively facilitating young people's access to support systems that may be confusing, alienating or even frightening to them. Kids Helpline counsellors are able to do this by spending whatever time is necessary to build the trust of reluctant services users, and gently, over time, encourage them to access specialist face-to-face services.

Through its youth-friendly no wrong door approach, Kids Helpline routinely fills service system gaps including a chronic lack of after-hours support, difficulty fitting emerging symptoms into mental health service eligibility criteria, fragmented pathways from child to adult mental health services, a lack of face-to-face services in some areas, and the high cost of much mental health care. Often Kids Helpline is the *only* mental health service that children and young people will reach out to.

### **Term of reference (e): Data collection about the incidence of youth suicide and attempted suicide**

The collection and reporting of data about suicidal behaviour in Australia, including NSW, is largely limited to data about suicide deaths. National surveys that provide information about suicidal ideation and attempts are conducted infrequently and to no regular schedule. Successful suicide prevention requires intervention earlier in the pathway, and effective targeting of early intervention requires accurate data about suicidal ideation and attempts, including if possible, information about demographic and other characteristics of young people. Ideally, collection and reporting of this data should be conducted nationally, but there is scope for NSW to lobby for and/or lead the way in this regard.

### **Term of reference (f): Provision of high quality information and training to service providers**

Findings from our consultation with young people suggest a need for youth specific training and a role for greater inclusion of lived experience as a means to increase awareness and understanding of suicidality in young people, particularly children and adolescents. When we asked young people what message they would like to give to service providers, their responses were overwhelmingly similar and can be summed up by one in particular:

"Stop judging. Listen. Don't assume. Care more."

Consequently, we suggest a need to increase service providers' understanding that a caring relationship is a crucial foundation for successful work with young people.

## **Term of reference (d): Provision of services for vulnerable and at-risk groups**

### **Who are the vulnerable and at-risk groups of young people?**

It is well known that a number of groups defined by demographic characteristics are especially vulnerable or at risk for suicide, including Aboriginal and Torres Strait Islander people, young people who identify as LGBTIQ, young people in rural and remote areas, young people living in or who have left out of home care and young people involved with the juvenile justice system. Young people who have been exposed to suicide are also more vulnerable than others.

While awareness of these vulnerable groups can support effective targeting of services, it is important to remember that it is not membership of the group per se that increases the risk of suicide, and identification of high risk groups does not enable identification of individuals at risk. Suicide does not discriminate. Young people of any gender, sexuality, cultural background or socioeconomic status can be vulnerable.

We also note two additional high risk groups. The biggest risk factor for death by suicide is a previous suicide attempt. That is, young people who have attempted suicide in the past form one of the most vulnerable groups. In addition, suicide by young people is more likely to be part of a cluster than suicide by adults (Robinson, Bailey, Browne, Cox, & Hooper, 2016). That is, exposure to suicide by others is an important risk factor for young people, but one that cannot be identified in advance.

### **What works for vulnerable and at risk groups of young people?**

Unfortunately, evidence of 'what works' in this area is limited. While there is evidence of effectiveness for large scale strategies such as restriction of access to means and responsible media reporting, evaluations of previous government strategies have failed to demonstrate clear benefits from any particular intervention for young people (Page et al., 2011; Robinson et al., 2016) and results of evaluations of specific interventions are mixed. When we limit 'young people' to members of vulnerable and at-risk groups, we know even less about effective strategies and interventions.

What we do know is that no single intervention is sufficient to prevent suicide. An effective strategy must include a combination of activities designed to address a range of factors across the spectrum from universal prevention to continuing care. In addition, it is important to be aware that local factors such as population characteristics, culture and socioeconomic context may influence whether a given intervention is effective.

Many others have summarised this literature and we will not duplicate their work here, as we are confident the Committee would be aware of publications such as Orygen's *Raising the bar for youth suicide prevention* (2016) as well as reports resulting from a number of previous state and federal government and other inquiries (e.g., the National Children's Commissioner's *Inquiry into intentional self-harm and suicidal behaviour in children*). We also recommend the National LGBTI Health Alliance's *National lesbian, gay, bisexual, transgender and intersex mental health and suicide prevention strategy* (Jacobs & Morris, 2016) and the ATSIPEP report, *Solutions that work: What the evidence and our people tell us* (Dudgeon et al., 2016), about preventing suicide by Aboriginal and Torres Strait Islander people.

We will, however, highlight a number of elements we believe to be key to any effective response to preventing suicide by children and young people.

## **Key elements of effective responses to prevent youth suicide**

### ***Dedicated to youth***

Dedicated youth strategies, services and interventions are needed because the nature of strategies and interventions that are effective for children, adolescents and young adults is likely to be very different to those that are effective for adults. Suicide prevention activities need to be tailored to the developmental stage of the individual as pathways to suicide may have different characteristics across the lifespan. Moreover, the lives of children and adolescents take place in different contexts to adults, with parents, peers and school being particularly influential for children and young people.

Like any suicide prevention strategy, a dedicated youth strategy needs to be multi-level and comprehensive. In addition, activities targeting youth need to work specifically with parents/carers, peers and schools to enhance their capacity to support vulnerable young people. Regardless of the particular intervention, dedicated youth services need to be staffed by practitioners who are youth specialists, as particular skills are needed to successfully engage and build trust with children and young people.

### ***Recognise and respond to diversity both between and within vulnerable groups***

In addition to noting that children and adolescents are different to adults, it is important not to assume that there is a one size fits all approach to suicide prevention with children and adolescents. This does not mean that specific services are required for each different risk group. While services targeting a particular group (e.g., LGBTIQ or Aboriginal and Torres Strait Islander young people) are welcome, they are not always appropriate or feasible. Mainstream services need to be welcoming to all and flexible enough to meet the diverse needs, characteristics and preferences of young people outlined below.

For example, research suggests at least two subtypes of suicidal adolescents: those who are impulsive and demonstrate externalising behaviour problems (e.g., alcohol misuse, aggression), and those who are not impulsive and exhibit internalising behaviour problems (e.g., depression, anxiety) (Posner, Brodsky, Yershova, Buchanan, & Mann, 2014). Each will need a different response.

It is also likely that male and female young people follow different pathways to suicide. Young males are at greater risk of death by suicide than young females, but females are much more likely to attempt suicide than males. Female young people are also more likely to seek help (81% of KHL contacts from NSW young people disclosing thoughts of suicide were with females) and are more likely than males to engage in non-suicidal self-injury (55% vs 29% of KHL contacts). Research indicates that females benefit more from existing interventions than males.

There is also great diversity within the 12 to 25 years age range relevant to this submission. Even within the adolescent period, a 13 year old is very different to an 18 year old in their social and cognitive maturity and the types of stressors affecting their lives. For example, for children aged 12 to 14 years who disclose current thoughts of suicide to Kids Helpline, the most common concerns they wish to discuss are family relationship issues, child abuse and bullying (in that order). For those aged 15 years and older, family relationship issues and child abuse remain of concern, but bullying is replaced by dating and partner relationships.

There is also diversity within the high risk groups mentioned above. For example, some LGBTIQ young people have 'come out', while others have not; some experience family support while others experience rejection; some know other LGBTIQ young people while others do not. Hence, some may feel comfortable using LGBTIQ-specific services, while others will not.

### ***Involve young people in design and implementation***

Young people are the experts in their own lives and have important insights into the types of interventions and the nature of services needed to successfully engage and work with them. They need to be involved in the design, implementation and evaluation of responses to suicide prevention. Our experience with an online consultation survey demonstrated that children, adolescents and young adults want and value opportunities to share their thoughts and experiences, and that they think about services differently to service providers.

For example, while service providers tend to focus on treatments or interventions, young people focus on people and relationships. While service providers often describe young people as difficult to engage, young people describe services as difficult to engage with. This point is raised further on p. 10 where we discuss provision of holistic support in non-clinical environments.

Involvement of young people needs to be more than a token reference group. Those included need to have lived experience of suicide because we know that it is extremely difficult for those who have not experienced thoughts of suicide to comprehend being in the type of emotional pain that leads to suicide. Those included also need to represent the range of vulnerable young people from different risk groups to ensure their varied experiences are heard and used to inform strategies and services that affect them.

In support of this point we have attached a copy of findings from our consultation with young people, *Preventing suicide: The voice of children and young people, Insights part 4, Implications for policy and practice*, which shares young people's views, largely in their own words.

### ***Recognise and address modifiable risk factors, including disadvantage, marginalisation and discrimination***

Prevention of suicide amongst vulnerable groups requires understanding of the factors contributing to their risk in order to develop interventions that target modifiable risks. In particular, higher rates of suicide amongst certain groups are associated with the marginalisation experienced by members of those groups. For example, higher rates of suicide amongst LGBTIQ young people are associated with the discrimination, bullying and isolation they may experience as a result of other's responses to their sexuality or gender identity.

According to recent research with LGBTIQ young people, a supportive community environment characterised by indicators such as a higher proportion of same sex couples and the existence of specific school policies protecting LGBTI young people from discrimination and bullying, acts as a protective factor. Residing in an unsupportive social environment increased suicide risk for LGBTIQ young people by 20% over and above individual risk factors (Hatzenbuehler, 2011). Similarly, LGBTIQ students in Australian schools are more likely to feel safe at school, are more comfortable with their sexuality or gender, and are less likely to self-harm or attempt suicide if they perceive their school to be supportive of same-sex attraction and gender diversity (Hillier et al., 2010).

Aboriginal and Torres Strait Islander young people are more likely than others to experience socio-economic disadvantage, to have limited education, to misuse alcohol and drugs, to be involved in the child protection system, to be exposed to suicide, and to experience racism and discrimination. We have little understanding of whether the higher rate of suicide amongst Indigenous Australians is attributable (in whole or in part) to these risk factors, or whether it is due to other factors that are unique to that population (e.g., cultural, political and historical issues). More research is needed to understand this issue, and if we are to prevent suicide by Aboriginal and Torres Strait Islander young people, services that support healing and

empowerment among Indigenous Australians more broadly are needed to support services with a focus on suicide.

To achieve long term sustained change, effective suicide prevention strategies for high risk groups need to increase social inclusion and reduce the marginalisation of vulnerable young people.

### ***Recognise and target families as a source of both risk and protection***

Kids Helpline data and academic research demonstrate the importance of family functioning and parent-child relationships as both risk and protective factors for suicide by young people. Regardless of their age, young people contacting Kids Helpline about suicide are more likely to talk about family relationships than any other external issue. We also know that suicidality in young people is associated with child abuse, family violence, family conflict and parenting more broadly (e.g., Cero & Sifers, 2013; McNamara, 2013; Zubrick et al., 2016), and that the most common antecedent of suicide for children is relationship problems, particularly with parents (Holland, Vivolo-Kantor, Logan, & Leemis, 2017).

Strong relationships with parents/carers and other family members are protective for all groups of young people, regardless of the specific difficulties they face. For example, family support is linked to lower rates of suicidality in LGBTIQ young people and buffers the negative effects of verbal and physical abuse outside the home (Hillier et al., 2010).

Consistent with other research (Lawrence et al., 2015), **yourtown's** consultation with young people found that parents and friends were the most common sources of support for young people thinking about suicide. However, 44% of the 116 young people who had sought help from a parent reported the parent to have been 'not at all' helpful. Young people's comments highlighted a tendency for some parents to trivialise their child's concerns, or in some cases dismiss them entirely. We believe that most parents mean well, but lack of understanding of mental health issues and suicide limits their ability to respond appropriately. For children and adolescents, parents/carers are crucial both for their own sake and because they are the gateway to accessing professional support.

Based on our consultation with young people, we suggest a need for family (and community) education that includes the following messages. Young people with lived experience of suicide told us they want their families to:

- Be proactive – if at all concerned, ask their child if they're okay and offer to help. Understand how difficult it is for a young person to disclose thoughts of suicide.
- Learn about mental health and suicide. Understand depression is an illness and feeling suicidal is not a choice.
- Take children and young people seriously. Understand that they are not attention-seeking and thoughts of suicide can affect anyone.
- Know that it's okay not to have all the answers:
  - listen, be patient, show them you care, and
  - help them get professional support.

Research also suggests that suicide prevention interventions for young people may be more effective when they provide a complementary intervention for parents. For example, C-CARE is a brief computerised intervention for young people that uses motivational counselling to address suicide risk factors and to improve individual and social resources. P-CARE is specifically designed to complement C-CARE by providing parents with skills training that targets family processes such as conflict and lack of support. C-CARE alone has been shown to reduce a range of risk factors for suicide including suicidal



ideation, but its effects were greater when provided in conjunction with P-CARE (Hooven, Walsh, Pike, & Herting, 2012).

In addition, families of young people experiencing suicidal thoughts and/or behaviours may need significant professional support themselves. Families of a child who has attempted or died by suicide experience loss of hope, blame, guilt, sense of failure, isolation, hopelessness and powerlessness (Lachal, Orri, Sibeoni, Moro, & Revah-Levy, 2015), which affects both their own wellbeing and their capacity to effectively support their child.

### ***Provide interventions that increase young people's resilience***

Suicide is the result of complex interactions between multiple individual, social and contextual risk and protective factors which lead to a level of emotional distress that feels unbearable and appears inescapable. Consequently, building young people's resilience or capacity to cope with and bounce back from challenges is an important strategy to prevent suicide (Pisani et al., 2013). A range of interventions that build resilience is needed, with a dual focus on building the skills of young people experiencing suicidal thoughts so they can better manage adversity, and building the skills of others so they are better able to recognise and provide support to those in need.

Evidence supports the efficacy of training in skills such as coping, problem solving, and emotion regulation as a means to reduce risk factors such as depression, stress, hopelessness and anger, and enhance protective factors such as personal control, self-efficacy and problem solving (Scott & Guo, 2012). A further benefit of skills training is that it can be offered universally through schools or other organisations to avoid stigma and is potentially useful for all young people.

It is important that funding for such interventions provides for ongoing delivery. As with any skill, competencies build up incrementally so knowledge and skills need to continue being taught; one-off programs are unlikely to have sustained effects (House of Representatives Standing Committee on Health and Ageing, 2011).

Resilience is not only a result of internal capacities; supportive relationships with others also contribute to resilience. While parents/carers are an obvious source of supportive relationships, a caring relationship with a romantic partner, close friend or adult outside the family can also enhance resilience (Pisani et al., 2013; Wright, Masten, & Narayan, 2013). As highlighted in the previous section, our experience indicates that many people need education and support to know how to respond appropriately and effectively when someone close to them appears distressed or discloses thoughts of suicide.

### ***Provide holistic support from youth specialist practitioners in non-clinical youth-friendly environments***

Services that provide non-clinical holistic support are needed at all stages of a young person's journey, from early intervention for initial thoughts of suicide, to treatment, and recovery. These services need to include non-clinical professionals such as social workers, in addition to mental health professionals, all of whom need to be trained to effectively engage and work with children and young people. In addition, services need to be provided in youth-friendly environments that are welcoming and non-threatening.

While there is significant overlap between mental health problems and suicide, suicidality is not a mental illness and it has been argued that suicidality is often linked to situational distress rather than mental illness (Ashfield, Macdonald, & Smith, 2017). While clinical mental health services are important, services for young people experiencing suicidality also need to offer non-clinical holistic support that addresses the specific contextual issues contributing to an individual's distress. While these issues may be different for each young

person, examples are bullying, family dysfunction, problems with school, unemployment, grief, and homelessness.

In our experience, young people often find it difficult to connect with services they perceive as 'too clinical' and place great importance on a genuine caring relationship with a service provider. For example, when asked, 'What advice would you give to service providers?', respondents to our consultation typically referred to a desire for practitioners to show more empathy, spend more time listening, and demonstrate that they really care for and value the young person. When discussing how services helped them, very few young people referred to 'treatment'; instead they highlighted trusting relationships as key to their recovery.

For any treatment to be effective, the young person requires an adequate dose. While research often focuses on characteristics of the patient associated with drop out from therapy, the capacity of mental health and other professionals to connect with young people is an equally important influence on failure to complete treatment. Young people and those with more severe suicidal symptoms are most at risk of dropping out of treatment, as are those experiencing high levels of distress and feelings of hopelessness. Some studies of psychotherapy report drop-out rates as high as 50%, with drop out typically occurring within the first couple of sessions (Crane & Williams, 2010; Hom & Joiner, 2017; Landes, Chalker, & Comtois, 2016). Consequently, the ability of a service or treatment approach to keep a young person engaged for as long as necessary is as important as its ability to treat the problem.

In addition, the experience of Kids Helpline counsellors suggests that young people may need education about the nature of treatment, and additional support and encouragement when engaged in treatment. Many express frustration that treatment is too hard, takes too long, and doesn't work. We are unable to say whether young people don't understand that recovery can be a long, difficult process, or whether they are aware, but struggle with the reality of treatment and want a "quick fix". In either case, the result may be early disengagement from treatment, a disinclination to try again, and increased feelings of being somehow different or 'broken' for being unable to get better. We also suggest that parents, or other personal support persons, also need to understand the likely time frame for treatment so they are able to support and encourage the young person to continue.

### ***Ensure services are accessible and affordable for young people***

In addition to being youth-friendly and engaging, services must be easily accessible, available at the times when young people need them, and a sufficient 'dose' must be affordable for children and young people.

The ten sessions of therapy currently funded under the Australian Government's Better Access scheme is considered inadequate for anyone with more than mild depression or anxiety. In addition, young people contacting Kids Helpline highlight waiting lists for face to face services as a problem in some areas and others struggle to locate the most appropriate service. Inadequate service provision has the potential to do harm, over and above that occurring as a result of lack of treatment, and may exacerbate feelings that no one cares and nothing can be done.

For example, one young person told us that after 'jumping through so many hoops' to see an on-campus psychologist at a university, she was told the service was 'not for serious problems' and that she should 'research and look online.' Consequently, she 'felt so distraught that after an enormous amount of effort I was too messed up for the system, walking home I very nearly deliberately walked into traffic.'

As mentioned previously, many respondents to our consultation found parents unhelpful, and a number reported parents actively discouraging the use of professional services. Young people who lack the support

of parents face additional difficulties and need pathways to access services that are free, in easily accessible locations, and don't require a Medicare card.

Outreach services that can visit a young person in their home, school or other convenient location are also needed. For young people experiencing depression, anxiety or suicidality, building up the courage to attend a service in the community can be extremely difficult. Our consultation showed that stigma and fear mean that many young people don't seek help until they are in crisis, and our face-to-face services describe instances of young people agreeing to attend a service such as headspace, but being overwhelmed by feelings of shame or fear and refusing to leave the car when they arrive. Consequently, we suggest that service providers need to be more proactive in taking the service to the young person, rather than expecting the young person to come to them.

Finally, accessibility also means that services need to be available at times when young people wish to seek help. For young people with thoughts of suicide, this often means evening and night, when face-to-face services are closed. As shown in Figure 2 and Figure 3, the peak time of contact with Kids Helpline for 14-18 year old young people contacting about suicide is between 6pm and 7pm, while for 19 to 24 year olds, the peak is slightly later, between 8pm and 9pm. Approximately 12% of contacts from 14-18 year olds and 16% of contacts from 19-24 year olds are received between 10pm and 6am.

**Figure 2. NSW Kids Helpline contacts where suicide was the main concern by time of day received: 14-18 year olds**

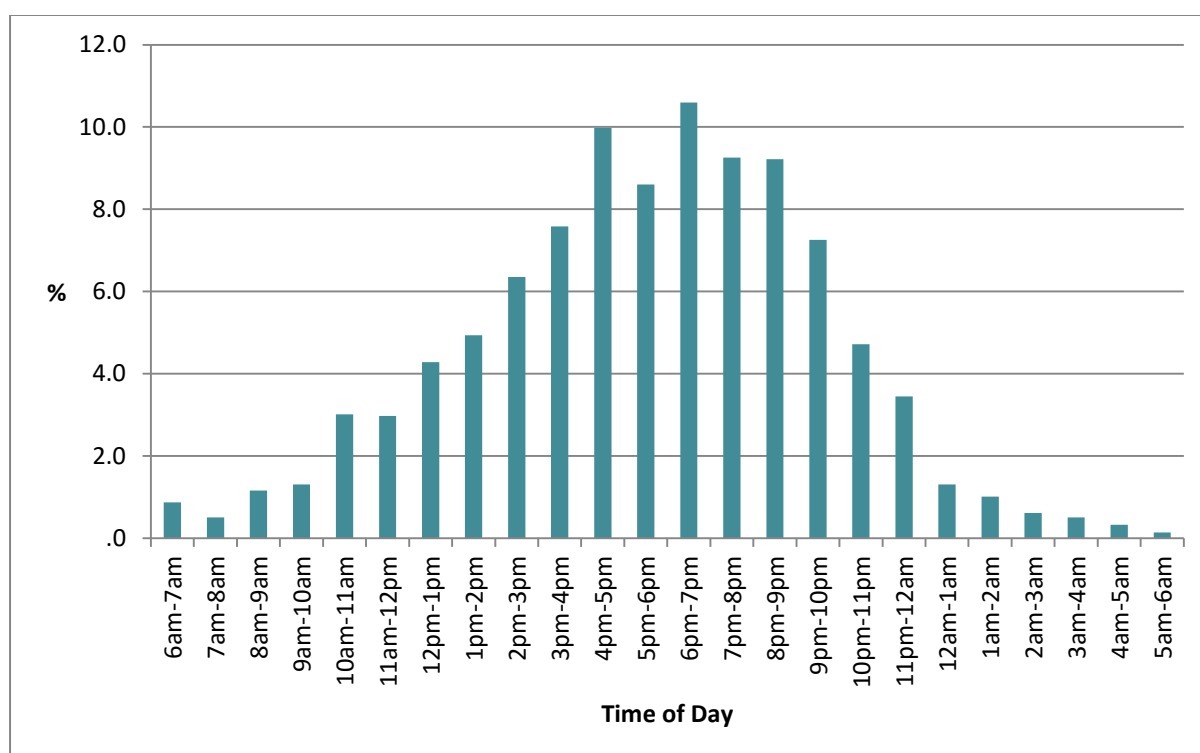
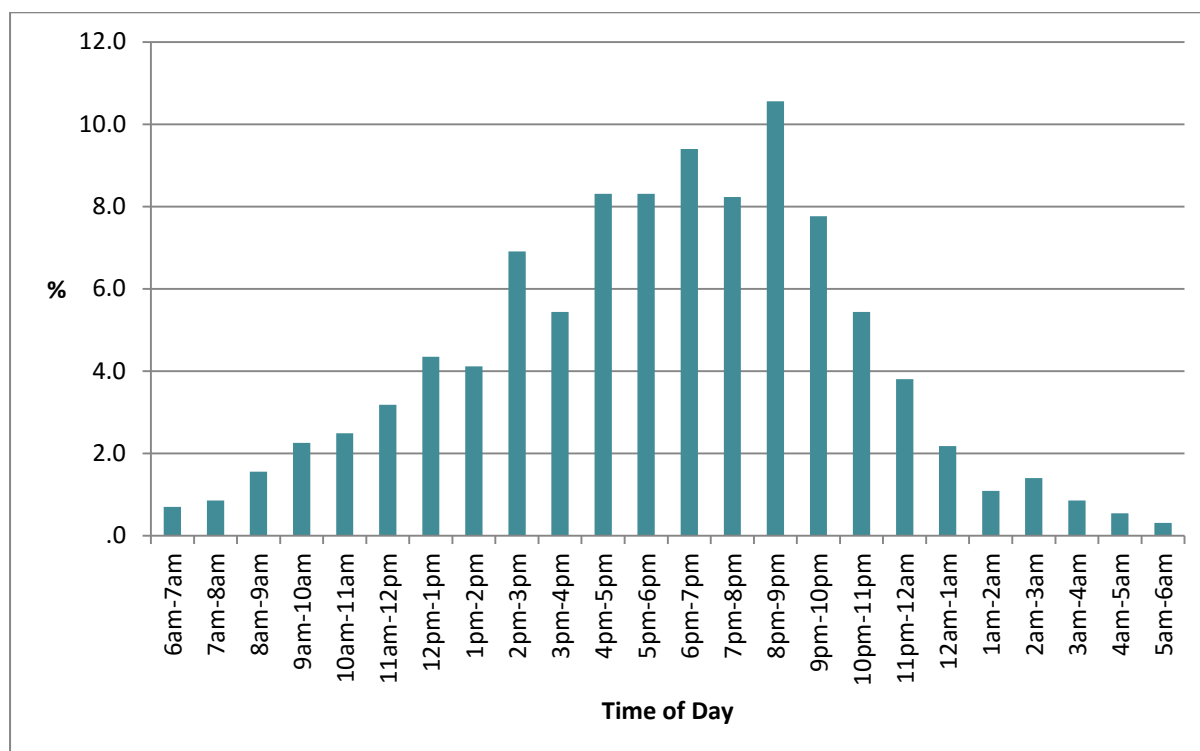


Figure 3. NSW Kids Helpline contacts where suicide was the main concern by time of day received: 19-24 year olds



### ***Provide high quality compassionate crisis care and aftercare***

Young people continue to share stories about less than optimal care following a suicide attempt. Their stories include negative experiences with nurses, doctors, paramedics, police and others, which result in the young person feeling ashamed, devalued and scared at a time when they are most in need of compassionate support. These experiences have both immediate and long term consequences, and create barriers to seeking help in the future. Many young people have told us they do not disclose suicidality, even to a counsellor, because they are scared of emergency services and/or hospitalisation.

One young person described their experience as follows:

*Cops travelled with me like I was a criminal ..... Got to the hospital had a mental health worker who was scary and strict ..... I felt unsafe ..... I tried to leave the hospital .... Ended up star-fished to the bed in restraints. I'd never tell anyone if I was truly at risk as I never want to be in hospital or have the police called on me. The day it happened I died, I will never be the same person ..... I attempted suicide soon after.*

The current NSW Health Framework for Suicide Risk Assessment and Management provides detailed guidelines for staff in the public health system to keep people at risk for suicide physically safe. We suggest that keeping an at-risk person physically safe should be considered a bare minimum. To contribute to suicide prevention in the long term, a service received in the public health system should also aim to reduce distress, support emotional wellbeing, and leave the young person with the view that a hospital is a safe and helpful place to be.

Education to increase understanding of suicide and self-harm is needed, but there is limited evidence for any particular program. We suggest that the effectiveness of education may be enhanced by including the voice of lived experience as a means to enable practitioners to see the person, not just the patient, and contribute to more compassionate responses.

We also note the need to ensure effective follow-up care following discharge from hospital. The potential to improve coordination and continuity of care for young people who have self-harmed or attempted suicide is well known, including within the NSW health system; the 2015 NSW Child Death Review Team report notes this point, and quality aftercare is one of the nine strategies included in the Lifespan trials being evaluated in NSW. We wish to point out that quality follow-up care needs to be holistic and youth-friendly, as outlined in the previous section about providing holistic support (p. 10).

### ***Use technology as a gateway to services, not a replacement for services***

There is a plethora of evidence that young people find useful information about mental health and wellbeing from the internet (e.g., Lawrence et al., 2015), but limited evidence for the effectiveness of interventions provided exclusively online or through apps. Our experience suggests that young people experiencing thoughts of suicide desire contact with a 'real person' and that a key role for the internet is as a means to connect vulnerable young people with that real person.

There is currently significant interest in activities that make use of the internet to deliver services, because online or app-based services/interventions are easily accessible, may reduce barriers to help-seeking and are cost-effective in comparison to face-to-face services. Evidence of the effectiveness of activities that deliver a mental health or suicide-focused intervention online is very limited, however. Hence, we suggest that more research is needed to investigate the nature of effective online and app-based interventions before they can be recommended as an effective strategy for suicide prevention.

There is stronger evidence for the effectiveness of the internet as a means to engage groups who can be difficult to reach, including Aboriginal and Torres Strait Islander young people, LGBTIQ young people, young people in rural and remote areas, and young people experiencing suicidality more generally (Robinson et al., 2016). Australian research with young people who self-harm reported that the internet was often endorsed as a step towards offline help-seeking, with 60% of young people wanting either online information that would help them talk to family, friends or a professional or online support that would be followed by offline support. When asked, 'What is most important to you in an online support service for self-harm?', contact with a professional through instant messaging was the most common theme (Frost & Casey, 2015)

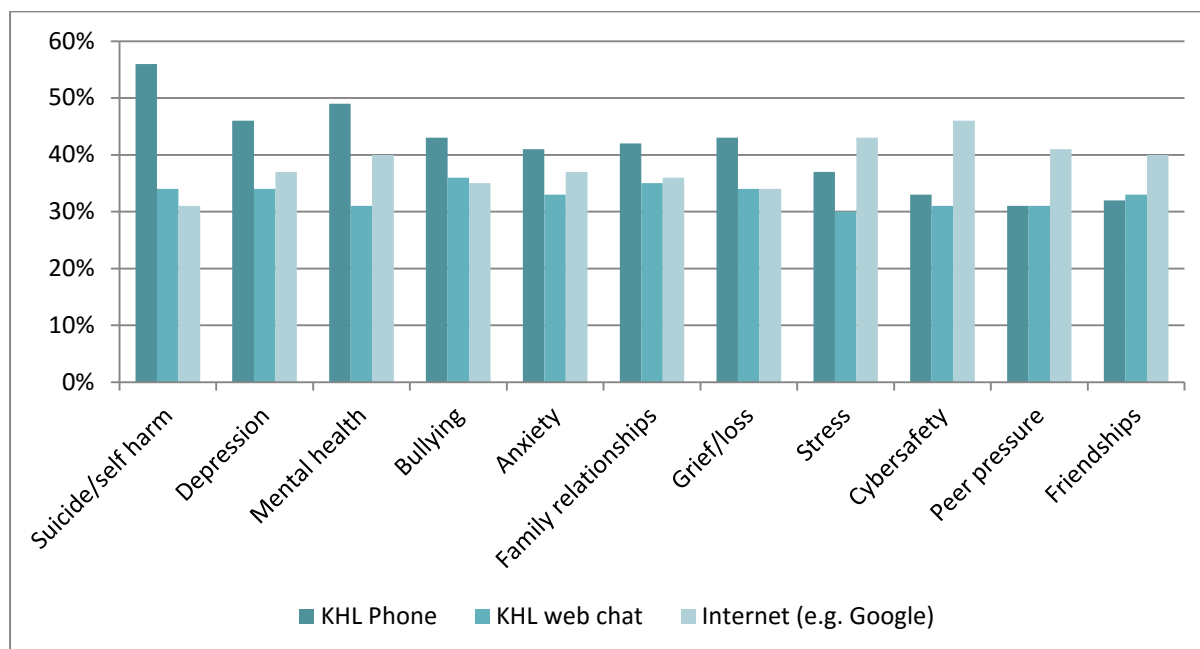
Consistent with a desire for personal contact, as shown in Table 1, Kids Helpline data show that while counselling provided through webchat or email is attractive to some young people, phone counselling remains the more popular option with 65% of NSW contacts from young people disclosing thoughts of suicide received by phone.

**Table 1. Medium of contact used in NSW Kids Helpline contacts experiencing current thoughts of suicide from 2012-2016**

Medium of contact	N	%
Phone	7353	65
Webchat	2624	23
Email	1316	12
Total	11,293	100

Recent national market research by Kids Helpline is consistent with this. We asked young people where they would be most likely to seek support for a range of issues, including suicide and self-harm. As shown in Figure 4, respondents demonstrated a significant preference for phone counselling rather than webchat or a google search when the issue was complex or serious.

**Figure 4. Stated preference for medium of support by issue of concern, 13-25 year old young people (n= 879)**



#### ***Include community education to reduce stigma and encourage help-seeking***

We note that the need to reduce stigma is well known. Nevertheless, this point bears repeating because it was clear from our consultation that stigma remains a significant barrier to help-seeking.

Most young people experiencing suicidal ideation do not seek help. Concerns associated with stigma, specifically fear of 'being judged', labelled an 'attention-seeker' or not being taken seriously, were the key reasons young people responding to our consultation did not seek help. Of 472 respondents with lived experience of suicidal thoughts and/or behaviours, only 26% of children 14 years and younger, 42% of those aged 15-19 years and 61% of those aged 20 years or older had ever received support for their suicidality. Our findings also showed that receiving help was associated with better outcomes, and more than 80% of young people who had received professional support found that support to be helpful. That is, increasing help-seeking, particularly by children and adolescents, should be a key strategy to prevent youth suicide.

The purpose of community education needs to be more than simply raising awareness of suicide. Families, peers and other community members need practical information about how to respond appropriately and where to go for professional support.

In regards to dissemination of information, education needs to go beyond merely making information available and relying on people to seek out the information. Information needs to be proactively disseminated in ways that ensure it reaches the target audience, and gains and holds their interest, for example, through a social marketing campaign.

### **The role of teleweb services such as Kids Helpline**

The term teleweb services is used to refer to services providing telephone or online counselling. In Australia, this includes services such as Kids Helpline, eheadspace, Lifeline and beyondblue, as well as specialist services for specific groups (e.g., QLife for LGBTIQ people).

In the past, mental health and suicide prevention strategies have typically made little, if any, reference to the place of teleweb services, beyond their role in crisis intervention. More recently, there has been recognition that teleweb services play a part in early intervention and continuing care, and there have been calls for increased access to telephone and online counselling services and greater integration of teleweb services and face-to-face services (House of Representatives Standing Committee on Health and Ageing, 2011; Robinson et al., 2016).

We believe that confidential telephone and web-based counselling available 24/7 is a critical part of the service system and offers unique benefits. It can help to overcome barriers to help-seeking, act as a soft entry opportunity and pathway to more intensive services, is accessible to high risk groups, and can provide both ongoing counselling and crisis support. That is, teleweb services act as a safety net for children and young people regardless of their particular circumstances and needs.

Specific benefits include:

- young people can remain anonymous if they wish
- they have choice in the method of contact (phone, webchat or email)
- they can contact without disclosing to anyone they know, including family
- support can be accessed at night, which is often a time of vulnerability
- support can be accessed from any location
- a prior appointment is not needed
- services are typically free.

We are aware that our sample may be biased, but amongst respondents to our consultation survey, of 102 who had used a telephone counselling service (including, but not limited to Kids Helpline), 52% found it 'very helpful', 33% found it 'fairly helpful' and only 15% found it 'not at all' helpful. In addition, consultation with young people by Orygen, the National Centre of Excellence in Youth Mental Health, found that Kids Helpline, Lifeline and beyondblue were all considered to provide a critical national service for young people at risk of suicide and that ensuring that online youth mental health counselling is 'resourced to respond to demand should be a priority' (Robinson et al., 2016).

### ***About the Kids Helpline service***

Kids Helpline is a free, confidential counselling and support service for children and young people across Australia aged 5-25 years. The objective of the service is *to listen and respond to the needs of children and young people anytime and for any reason, and where appropriate support children and young people to develop strategies and skills to better manage their lives*. To achieve this end, counselling and support services are provided by tertiary-qualified counsellors via telephone, web chat and email. Telephone and email counselling is provided 24/7 while counselling via web chat is currently available from 8am to midnight (AEST) seven days a week. In addition to the counselling and support service, Kids Helpline operates a substantial website with a diverse range of resources for self-directed help-seeking by children, young people and parents/carers. In partnership with Optus, Kids Helpline also delivers an early intervention and prevention program in primary schools called *Kids Helpline @ School* (KAS).

The Kids Helpline service is approximately 80% funded by the community through **yourtown's** Art Union ticket sales, donations and corporate support, which includes a partnership with Optus. The remaining 20% is funded through State and Commonwealth Government grants.

### ***The Kids Helpline service model***

Kids Helpline has developed what is sometimes referred to as a *public health model*, or a *stepped intervention framework*, where a continuum of services and interventions are matched to the individual child or young person's level of need. Support provided to children and young people at risk of or experiencing suicidal thoughts and behaviours ranges from early intervention when risk first emerges, to ongoing counselling for suicidal thoughts, crisis intervention and continuing support during recovery.

At the level of primary or universal prevention, the Kids Helpline service aims to build young people's resilience through:

- promoting knowledge and behaviours to support mental, emotional and physical health
- fostering a sense of belonging
- teaching social, emotional and general life skills and knowledge, and
- encouraging help-seeking and awareness of support options.

For young people demonstrating additional vulnerability or risk, Kids Helpline counsellors assess need and deliver support that aims to build resilience, prevent increased vulnerability, and reduce the risk of an escalation in symptoms. These aims are achieved through:

- information, referral and other non-counselling support (via phone, email or web chat)
- intermittent general counselling support (via phone, email or web chat)
- short-term case management (via phone, email or web chat)
- self-help resources on the Kids Helpline website, and
- links to relevant e-mental-health and electronic self-care resources.

At the level of tertiary or indicated intervention, Kids Helpline also supports young people with complex needs including mental illness, suicidality, child abuse and more. While this group makes up a small proportion of all Kids Helpline contacts, responding to their needs is a major part of the work of the service. At this level of need, the focus of intervention continues to be building resilience, preventing increased vulnerability to harm and/or reducing the risk of developing long term problematic symptoms; however, in light of their more complex presentations, young people are typically engaged in ongoing case management (via phone, web chat or email) to achieve these objectives.

In addition to case-management, the following services and interventions are provided to these children and young people:

- crisis responses (via phone, email and web chat), including decisions to act protectively arising from Kids Helpline's duty-of-care, such as external contact with police and emergency services where immediate safety concerns exist
- general counselling (via phone, email and web chat)
- targeted psychotherapeutic interventions (e.g. cognitive behavioural therapy, narrative therapy, mindfulness, etc.)
- wrap-around care with allied support systems (e.g. child and youth mental health services, crisis assessment treatment teams, schools, child protection services, etc.), and
- Kids Helpline Circles (our counsellor-facilitated social networking group for young people with anxiety or depression offered as an adjunct to individual counselling or case management).



When contacting Kids Helpline, children and young people can choose to speak with either a male or female counsellor and are able to arrange to call back and speak with the same counsellor to work through their issues.

Professionally trained counsellors respond to the concerns of children and young people by gently building trusting relationships, conducting risk assessments, identifying existing supports, discussing possible referrals and liaising with those referral agencies on behalf of clients, offering ongoing counselling relationships with the same counsellor and conducting 'wrap-around care' in conjunction with other agencies in the young person's life. Often, extensive advocacy is carried out on behalf of young clients to ensure specialist mental health services become/ remain involved when it is clear either a mental illness exists or symptoms are emerging.

### ***The role of Kids Helpline as a safety net for children and young people***

Kids Helpline provides a safety net for vulnerable children and young people in three main ways:

- A national service with no wrong door
- A portal into specialist support systems
- A provider of child/youth specialist support to mainstream services.

#### *National, easily accessible service with 'no wrong door'*

Kids Helpline provides a safety-net for children and young people in a broader social support system that often overlooks the particular developmental and structural vulnerabilities and needs of children. Kids Helpline promotes itself as 'there for anyone at any time about anything', and without a requirement for young people to disclose their identities. In this way Kids Helpline casts a very wide net and seeks to reduce the effect of stigma on help-seeking.

Kids Helpline is one of the most accessible services for young people in Australia. Being a virtual service, it is accessible from any geographical location, by any young person with access to a phone or internet connection. Being 24/7, it enables young people to seek help at a time and from a place that suits them, whether that is from the privacy of their bedroom at midnight or from the office of a school counsellor.

Kids Helpline is staffed by professional counsellors with specialist training to engage and work with children and young people. A child-centred and relationship-based intervention style is used to increase children's sense of safety and encourage them to name, define and explore their concerns and identify the help they need.

#### *Portal into specialist support systems*

Kids Helpline also serves as a safety net by actively connecting children and young people to the specialist services they require. In 2016, 36% of counselling contacts were identified as in need of a generalist or specialist referral. Like other child helplines around the world, Kids Helpline is not itself a specialist service but plays a critical role in facilitating children and young people's access to specialist services and support systems that may be confusing, alienating or even frightening for them to find, navigate and use alone. Counsellors help children and young people explore their needs, identify the right services for them using an extensive service provider database, and then actively connect them to those services where this is what the child or young person wants. Kids Helpline is effectively a *portal* for children and young people into mental health, child protection, homelessness and other key social support systems.

Kids Helpline counsellors will often spend weeks building the trust of reluctant services users, and gently, over time, encourage them to access specialist face-to-face services. When they are ready to take this step, counsellors actively facilitate and support their access to relevant local services and offer to support their treatment plans wherever appropriate.

In addition to actively facilitating children's access to specialist support, Kids Helpline helps ensure young people's needs are met by providing individual advocacy and liaison with other service providers when a young person has concerns about the service they are receiving.

#### *Child/youth specialist support to mainstream services*

Referrals are not a one-way street from Kids Helpline to broader support systems. Many community and government agencies across Australia refer children and young people to Kids Helpline's counselling and support service or website for age-specific information, referral, support and counselling, recognising that children and young people have unique needs and require specialist support. As most face-to-face services operate limited hours, many include Kids Helpline as an after-hours support in the case plans they develop with their clients. It is also not uncommon for non-clinical professionals such as school counsellors to support a young person to call Kids Helpline when the complexity of their need is beyond the scope of that professional's role.

#### ***System functions of Kids Helpline: Filling the gaps***

Kids Helpline also performs a range of *system functions* that again serve to build and maintain a safety net for highly vulnerable young people who might otherwise fall through gaps in the mental health system. These gaps include such things as:

- a chronic and widespread lack of after-hours support targeting young people's needs
- a fragmented pathway between youth and adult mental health services
- difficulty fitting children and young people's early symptom presentations into the diagnostic and service eligibility criteria of mainstream mental health services
- a lack of face-to-face services in many geographical areas, and
- the high cost of receiving certain forms of mental health care.

Kids Helpline routinely fills these gaps for children and young people through its youth-friendly no wrong door approach. Often Kids Helpline is the *only* mental health service that children and young people will reach out to. Research conducted for Kids Helpline in the mid-2000s found, for instance, that many of those who contact the service for support with mental health issues, particularly those who seek assistance through web chat, do not seek help from face-to-face services, finding the relative anonymity and privacy of a virtual service a more comfortable pathway into mental health care (King *et al.*, 2006).

### **Term of reference (e): Data collection about the incidence of youth suicide and attempted suicide**

The collection and reporting of data about suicidal behaviour in Australia, including NSW, is largely limited to data about suicide deaths, which is reported annually by the Australian Bureau of Statistics and reports of the NSW Child Death Review Team.

Knowledge of the prevalence of suicidal ideation and suicide attempts by children and young people comes from national surveys such as the Australian Child and Adolescent Survey of Mental Health and Wellbeing (Young Minds Matter; YMM). The most recent survey, conducted in 2013-14, found that in any 12 month period, approximately 2.4% of young people aged 12-17 years would have attempted suicide, 5.2% report making a plan, and 7.5% report suicidal ideation (Lawrence *et al.*, 2015). This was the first time such data had been collected since 1998 and there appears to be no schedule for future surveys.

A recent report from the Longitudinal Study of Australian Children (LSAC) provides prevalence estimates for 14-15 year olds: 4.6% reported a suicide attempt in the past 12 months, 7.2% reported having made a suicide plan, and 8.8% reported suicidal ideation (Daraganova, 2017). These figures are somewhat higher

than those reported by YMM; the LSAC estimate of attempts is almost twice that reported by YMM. This is probably because YMM included children as young as twelve, and highlights the need for regular collection of consistent data.

Effective decision-making requires regularly collected and accurate data that enables analysis of trends over time and provides an accurate baseline for evaluation of change. Data on deaths is not sufficient for this purpose. Successful suicide prevention requires intervention earlier in the pathway, and effective targeting of early intervention requires accurate data about suicidal ideation and attempts, including if possible, information about demographic and other characteristics of young people.

We also suggest that safe methods to collect data about the incidence of suicidal thoughts and attempts in younger children should be investigated. Kids Helpline data show that children as young as ten contacting our service disclose thoughts of suicide. Between 2012 and 2016, Kids Helpline counsellors responded to almost 12 500 suicide-related contacts from children 14 years or younger, but there is little other data and little research on this age group.

Ideally, collection and reporting of this data should be conducted nationally, but there is scope for NSW to lobby for and/or lead the way in this regard.

### **Term of reference (f): Provision of high quality information and training to service providers**

The provision of information and training to service providers is not an area in which we have direct experience; hence we will not make a comprehensive submission on this point. We will, however, highlight findings from our consultation with young people that suggest a need for youth specific training and a role for greater inclusion of lived experience as a means to increase awareness and understanding of suicidality in young people, particularly children and adolescents.

Young people responding to the **yourtown** survey reported that psychologists and counsellors were usually helpful, but a significant number (17%) were not. Medical professionals, including GPs and psychiatrists were less helpful; in each case, 32% were described as 'not at all helpful'. Comments suggested a lack of understanding of suicidality in young people, a tendency to downplay young people's concerns, and a lack of skill in connecting with young people, even amongst some school counsellors and mental health professionals. Young people's comments included:

"I met with a psychiatrist who told me I wasn't very self-aware because I couldn't answer some of his questions. He made me feel dumb and very anxious."

"I saw a psychologist, the first one ever and she blamed my mood swings on my period????"

"I went to a GP who would not give me a mental health care plan because I would not show her my self-harming ..... She implied that I was making everything up. I felt stupid and small and ashamed."

When we asked young people what message they would like to give to service providers, their responses were overwhelmingly similar and can be summed up by one in particular:

"Stop judging. Listen. Don't assume. Care more."

While this message may seem simplistic, it was clear that young people valued their relationship with a service provider more than any type of treatment. We also refer here to our earlier comments about high quality and compassionate crisis care and after care (p. 13). Consequently, we suggest a need to increase

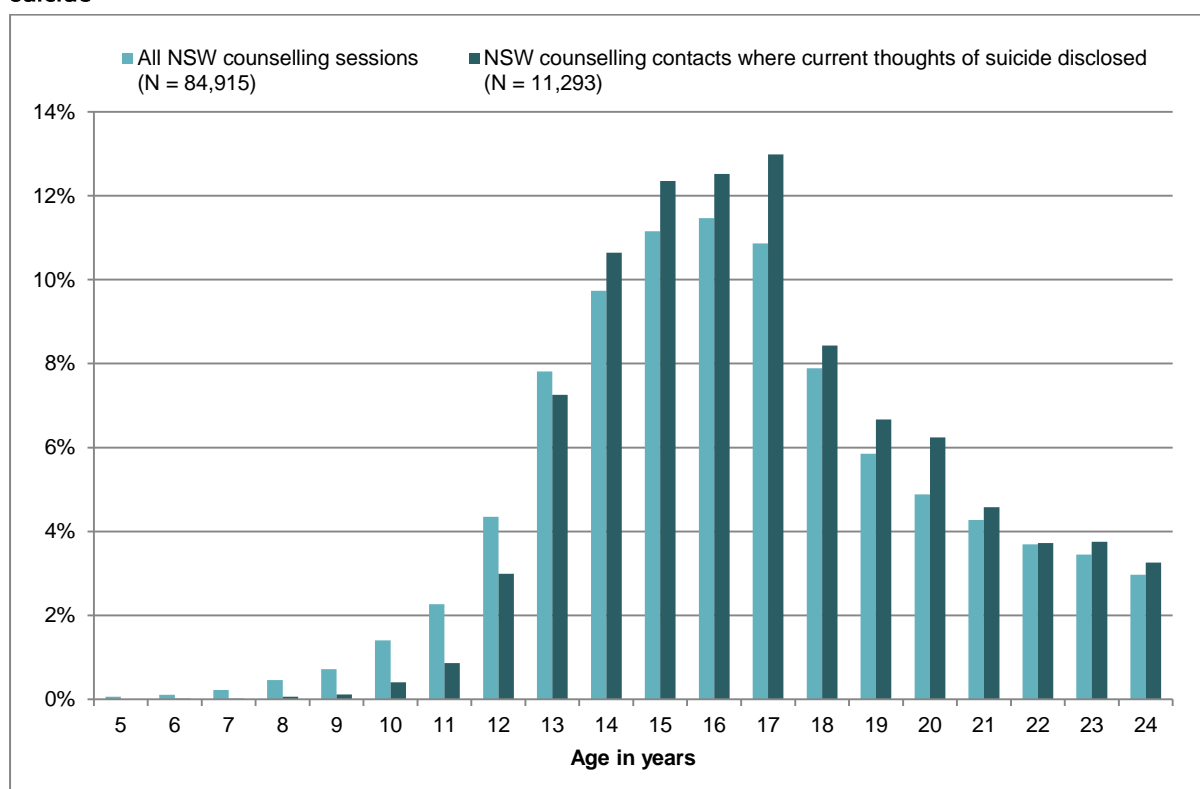
service providers' understanding that a caring relationship is a crucial foundation for successful work with young people experiencing suicidality, and again highlight the importance of including the voice of lived experience in education and training for service providers and communities.

## Term of reference (h): Other related matters

### Age of young people relevant to this inquiry

While this inquiry into the prevention of suicide focuses on young people aged 12 to 24 years, Kids Helpline receives contacts from children less than 12 years of age disclosing current thoughts of suicide, as shown in Figure 5. While the age distribution for counselling sessions where suicidal thoughts are disclosed is skewed upwards compared with the age distribution of all counselling sessions, there is a small but constant proportion of contacts received from children younger than 12 years who are struggling with suicidal thoughts. Between 2012 and 2016, Kids Helpline responded to 168 contacts from children aged less than 12 years in NSW where the child disclosed having current thoughts of suicide. Consequently, we suggest a need to consider early intervention services for younger children, for example, services in primary schools.

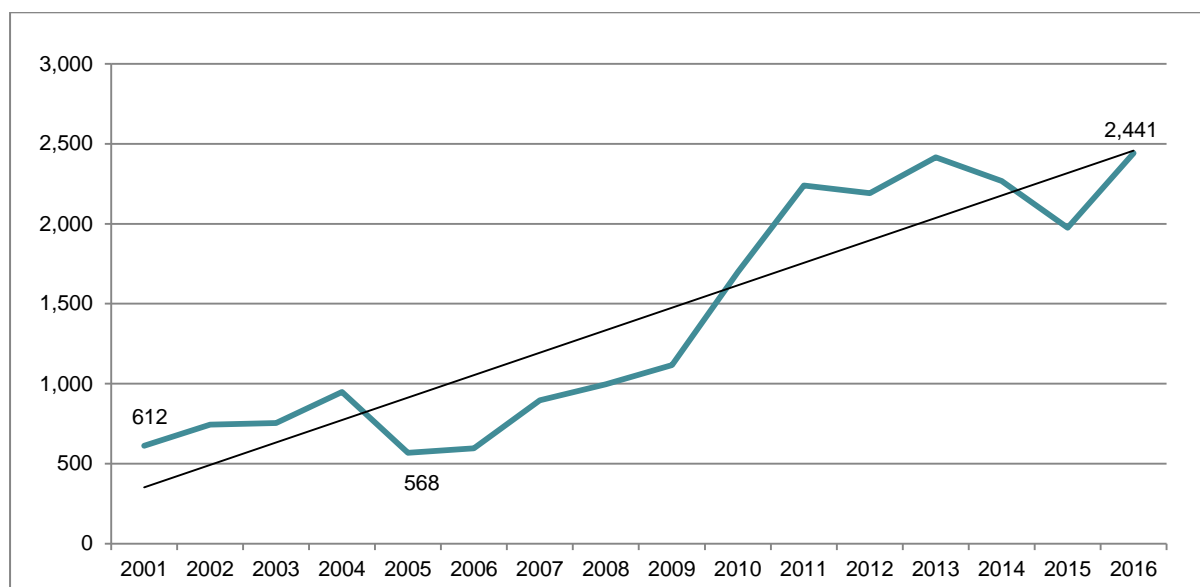
**Figure 5. Age of NSW Kids Helpline clients 2012-2016 by whether client disclosed current thoughts of suicide**



### Trends in contacts to Kids Helpline over time

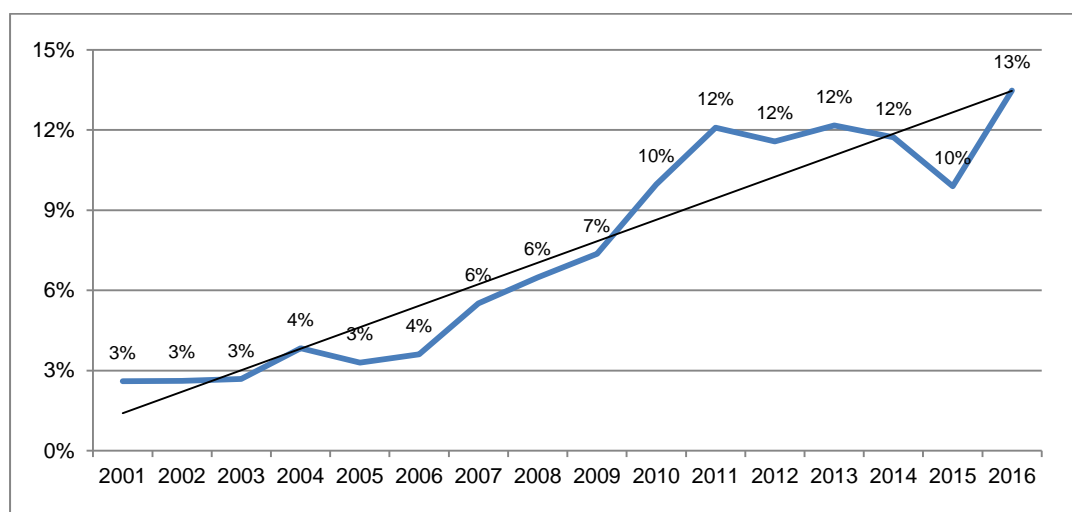
The number of counselling sessions conducted by Kids Helpline counsellors in NSW in which a child or young person disclosed thoughts of suicide has steadily increased since Kids Helpline started collecting data on this in 2001. As shown in Figure 6, in 2001 Kids Helpline conducted 612 counselling sessions with NSW children and young people who disclosed current thoughts of suicide. In 2016, 2441 sessions involved a child or young person disclosing suicidal thoughts. This is an increase of 299% over 15 years.

**Figure 6. Number of Kids Helpline counselling sessions with NSW children and young people who disclosed current thoughts of suicide 2001-2016**



As shown in Figure 7, counselling sessions with children and young people where current thoughts of suicide are disclosed have also increased as a proportion of all NSW counselling sessions. In 2001, only 3% of counselling sessions involved client disclosure of current suicidal thoughts. In 2016, 13% of sessions involved disclosure of suicidal thoughts.

**Figure 7. Percentage of NSW Kids Helpline counselling sessions where current thoughts of suicide were disclosed by the client 2001-2016**



It is important to note that this increase should not be interpreted to indicate an increase in the prevalence of suicidal thoughts amongst NSW children and young people over this period of time. It is likely that increases were at least partially a result of the 2005 expansion of the service to 19-25 year olds, and an intentional expansion of case management and ongoing support for young people with complex issues during the mid-2000s. Between 2012 and 2016, 29% of contacts related to suicide were from young people aged 19-25 years, while in 2005 there were no contacts from this age group. In 2005, approximately 20% of contacts were from young people receiving ongoing support, while in 2016 more than 40% of contacts

involved ongoing support. That is, the increase in the number and proportion of contacts about suicide suggests that Kids Helpline has been effective in engaging vulnerable young people.

### **Demographic characteristics of NSW contacts with Kids Helpline**

The following section highlights some key points of interest relevant to the demographic characteristics of young people in NSW who contacted Kids Helpline between 2012 and 2016. Detail of these characteristics, by whether the young person disclosed current thoughts of suicide or not, is presented in Table 2.

We note the following:

- Approximately 80% of Kids Helpline contacts are with females, regardless of the issue of concern, highlighting the need to encourage help-seeking by males.
- Almost half the contacts in which a young person discloses thoughts of suicide also involve disclosure of non-suicidal self-injury.
- In almost 70% of contacts in which a young person discloses thoughts of suicide, the counsellor assesses that young person to be experiencing a mental health disorder.
- Overall, young people who disclose thoughts of suicide and young people who do not are very similar in terms of demographic characteristics, apart from the following exceptions -
  - Those who disclose thoughts of suicide are less likely to be in the 5-12 years age group
  - Those who disclose thoughts of suicide are more likely to be receiving ongoing support.

Further detail about contacts to Kids Helpline by children and young people in NSW, including those not concerned about suicide, are provided in the attached report, *Kids Helpline Insights 2016, Statistical Summary New South Wales*.

### **Concluding remarks**

Developing a culture in which young people seek help when difficulties first arise, rather than waiting until they have reached a crisis point and their distress has become overwhelming, appears key to preventing suicide. Identifying young people at risk of suicide is exceptionally difficult; many demonstrate no risk factors and are adept at concealing their feelings. Hence, strategies to de-stigmatise suicide and encourage help-seeking are crucial.

At the same time, convincing young people to seek help and then not providing them with a quality and timely service can do more harm than good. Young people need access to a choice of services that are tailored to their developmental stage, gender, cultural background, and other preferences. Services must be youth-friendly and engaging for young people in order to avoid early drop out from a program.

Schools present an excellent opportunity for intervention with young people. However, many of the most marginalised and potentially at risk adolescents and young adults are not attending school and are not in employment. Other avenues to outreach to this group need to be developed.

We suggest that educating and working with families is critical for a range of reasons:

- Family relationships are both a key risk and key protective factor.
- Parents and friends are the most common sources of support for children and young people. For children and adolescents, there is a limit to how much same-age friends can do. Young people

Table 2. NSW Kids Helpline counselling sessions 2012-2016: Client characteristics by whether or not the client disclosed having current thoughts of suicide during the session.

Client characteristics	Sessions where client disclosed current thoughts of suicide (n= 11,293)		Sessions where client <u>did not</u> disclose current thoughts of suicide (n= 84,915)		All NSW counselling sessions (n = 96,208)	
	n	%	n	%	n	%
<b>Gender</b>						
Female	8,997	81%	65,044	78%	74,041	79%
Male	2,086	19%	17,637	21%	19,723	21%
Intersex, trans & gender-diverse	57	1%	299	0%	356	0%
<b>Total</b>	<b>11,140</b>	<b>100%</b>	<b>82,980</b>	<b>100%</b>	<b>94,120</b>	<b>100%</b>
Unknown	153		1,935		2,088	
<b>Age group</b>						
5-12 years	506	5%	8,738	11%	9,244	10%
13-18 years	7,248	66%	49,424	62%	56,672	63%
19-25 years	3,188	29%	20,982	27%	24,170	27%
<b>Total</b>	<b>10,942</b>	<b>100%</b>	<b>79,144</b>	<b>100%</b>	<b>90,086</b>	<b>100%</b>
<26 but age unknown	351		5,771		6,122	
<b>Cultural background<sup>2</sup></b>						
Aboriginal &/or TSI	215	5%	1,063	3%	1,278	3%
CALD	1,546	34%	12,778	37%	14,324	36%
Neither ATSI nor CALD	2,812	61%	21,045	60%	23,857	60%
<b>Total</b>	<b>4,573</b>	<b>100%</b>	<b>34,886</b>	<b>100%</b>	<b>39,459</b>	<b>100%</b>
Unknown	6,720		50,029		56,749	
<b>Remoteness</b>						
Major Cities	4,897	72%	33,674	76%	38,571	76%
Inner Regional	1,504	22%	8,252	19%	9,756	19%
Outer Regional/Remote	423	6%	2,165	5%	2,588	5%
<b>Total</b>	<b>6,824</b>	<b>100%</b>	<b>44,091</b>	<b>100%</b>	<b>50,915</b>	<b>100%</b>
Unknown	4,469		40,824		45,293	
<b>Medium of contact</b>						
Phone	7,353	65%	57,308	67%	64,661	67%
Web chat	2,624	23%	19,467	23%	22,091	23%
Email	1,316	12%	8,140	10%	9,456	10%
<b>Total</b>	<b>11,293</b>	<b>100%</b>	<b>84,915</b>	<b>100%</b>	<b>96,208</b>	<b>100%</b>
<b>Relationship with Kids Helpline</b>						
First contact	2,732	25%	29,253	38%	31,985	36%
Occasional/Ongoing support	8,149	75%	48,614	62%	56,763	64%
<b>Total</b>	<b>10,881</b>	<b>100%</b>	<b>77,867</b>	<b>100%</b>	<b>88,748</b>	<b>100%</b>
Unknown	412		7,048		7,460	
<b>Presenting client issues</b>						
Disclosed current self-injury issues	5,291	47%	10,941	13%	16,232	17%
Has mental health disorder	7,826	69%	25,304	30%	33,130	34%

- should be able to trust that their parents will listen, try to understand, and help them to access whatever support they need, but it seems this is not the case for all.
- Young people need ongoing support for the duration of treatment.

Multi-faceted, community wide approaches, which feature a range of evidence-informed activities and are consistent with the key elements described in this submission, appear likely to be most effective in reducing deaths by suicide at the population level. It is important that these strategies clearly recognise that children, adolescents and young adults are distinct groups, who need a range of effective interventions that target their particular needs in ways that are age appropriate and engaging.



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# **Kids Helpline Insights 2016**

Statistical Summary  
New South Wales

# Introduction

## What is Kids Helpline?

Kids Helpline has been operating for 26 years and is Australia's only 24/7 counselling and support service for children and young people aged between 5 and 25 years.

Tertiary qualified counsellors provide free, private and confidential support via telephone, web chat and email. Telephone and email counselling is offered 24/7 and web counselling is available from 8am to midnight (AEST) seven days a week.

The service operates a substantial website with a diverse range of resources for self-directed help-seeking by children, young people and adults. In addition, support from Optus enables Kids Helpline to deliver an early intervention and prevention program in primary schools called *Kids Helpline @ School*.

Kids Helpline is a service of **yourtown** and is 70% funded by the community through **yourtown** Art Union ticket sales, donations and corporate support. The remaining 30% is funded through State and Commonwealth Government grants.

## What this report is about and who it is for

This report is an appendix to *Kids Helpline Insights 2016: National Statistical Overview*. It provides summary data on Kids Helpline service demand and client concerns and characteristics for New South Wales in relation to the 2016 calendar year. It will be of value to people working in social policy and research roles, journalists and others in the community who need to understand the current and changing help-seeking needs of children and young people in Australia today.

The *Kids Helpline Insights 2016: National Statistical Overview* and other related reports can be accessed at [www.kidshelpline.com.au/reports](http://www.kidshelpline.com.au/reports).

## Notes on data collection, analysis and interpretation

Substantial missing data in relation to a number of data collection fields, most notably remoteness and cultural background, undermine the reliability of data presented in a number of tables and figures in this report. Please consult the Appendix of the *National Statistical Overview* for more detailed information on data collection, analysis and interpretation.

## Where to get more information

This report has been compiled by **yourtown** Strategy and Research. For further information, please contact

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# Service demand

## Attempted and answered contacts

- In 2016, 124,960 of the 356,595 attempts made to contact Kids Helpline counselling service (or 35%) came from New South Wales (NSW).
- Most of these attempts were made by phone (99,894) but also by web chat (21,412) and email (3,655).
- 63,012 of these attempts were answered by counsellors, corresponding to a response rate of 50%. This compares with a response rate of 51% across Australia.
- Note that when phone attempts are adjusted to exclude callers who dropped out before the 21 second mandatory wait message, the response rate for NSW phone contacts in 2016 was 66%.

## Trends over time

- From 2014 to 2016 there was an overall decrease of 8% in attempted contacts from NSW across all media. Phone attempts decreased by 11% and email by 31%, while web chat attempts increased by 21%.
- Across all media, response rates for NSW have decreased from 57% in 2014 to 50% in 2016.

**Table 1. NSW attempted and answered contacts – by medium and year of contact, with comparison to all states<sup>1</sup>**

Medium of contact	2014			2015			2016			% change in attempts 2014-2016
	Attempts	Answered	Response rate	Attempts	Answered	Response rate	Attempts	Answered	Response rate	
<b>Phone</b>										
NSW	112,118	63,796	57%	113,447	65,281	58%	99,894	49,003	49%	-11%
All States	300,200	173,752	58%	290,767	169,802	58%	276,960	135,719	49%	-8%
<b>Web chat</b>										
NSW	17,748	7,735	44%	15,078	8,363	55%	21,412	10,355	48%	21%
All States	49,429	21,082	43%	43,464	24,115	55%	65,954	31,765	48%	33%
<b>Email</b>										
NSW	5,306	5,306	100%	4,500	4,500	100%	3,655	3,655	100%	-31%
All States	18,832	18,832 <sup>2</sup>	100%	15,886 <sup>3</sup>	15,886	100%	13,681 <sup>4</sup>	13,681	100%	-27%
<b>All media</b>										
NSW	135,172	76,837	57%	133,026	78,145	59%	124,960	63,012	50%	-8%
All States	368,461	213,666	58%	350,117	209,803	60%	356,595	181,165	51%	-3%

1. The data presented in this table are sourced from KHL phone, web chat and email systems databases.

2. In addition to 18,832 emails received and responded to in 2014, 544 outreach emails were sent.

3. In addition to 15,886 emails received and responded to in 2015, 535 outreach emails were sent.

4. In addition to 13,681 emails received and responded to in 2016, 413 outreach emails were sent.

# Who contacted the service

## Demographic characteristics

- Kids Helpline counsellors recorded data in relation to 177,591 contacts from children and young people across Australia who were aged 5-25 years. State or territory information was available for 163,323 of these contacts, and of this subset 56,905 (or 35%) were known to be from NSW.
- Table 2 shows the demographic characteristics of these contacts from NSW and compares them with the characteristics of contacts from the rest of Australia where the contact's state or territory was known.
- Seven out of 10 (69%) contacts from NSW were female and three out of five (59%) were aged 13-18 years. Two out of five (39%) were known to be from culturally and linguistically diverse (CALD) backgrounds.
- Compared with contacts from the rest of Australia, NSW contacts were:
  - slightly more likely to be male and slightly less likely to be female
  - more likely to be aged 13-18 years, and
  - more likely to be from CALD backgrounds and less likely to be from a Caucasian Australian background.
- Other characteristics of Kids Helpline contacts in NSW are similar to those of contacts from the rest of Australia.

**Table 2. Characteristics of Kids Helpline contacts 2016 aged 5-25 years – NSW and rest of Australia<sup>1</sup>**

Contact characteristics		NSW (N = 56,905)		Rest of Australia (N = 106,418)	
		n	%	n	%
<b>Gender</b>					
	Female	23,646	69%	51,125	74%
	Male	10,461	30%	17,672	25%
	Intersex, Trans & Gender Diverse	346	1%	718	1%
	<b>Total</b>	<b>34,453</b>	<b>100%</b>	<b>69,515</b>	<b>100%</b>
	Unknown	22,452		36,903	
<b>Age group</b>					
	5-12 years	3,543	12%	8,629	14%
	13-18 years	17,465	59%	32,719	53%
	19-25 years	8,539	29%	20,546	33%
	<b>Total</b>	<b>29,547</b>	<b>100%</b>	<b>61,894</b>	<b>100%</b>
	<26 but age unknown	27,358		44,524	
<b>Cultural background<sup>2</sup></b>					
	Aboriginal &/or TSI	651	5%	965	4%
	CALD	5,179	39%	8,385	32%
	Neither ATSI nor CALD	7,595	57%	16,558	64%
	<b>Total</b>	<b>13,425</b>	<b>100%</b>	<b>25,908</b>	<b>100%</b>
	Unknown	43,480		80,510	
<b>Remoteness<sup>3</sup></b>					
	Major Cities	14,645	75%	29,396	71%
	Inner Regional	3,841	20%	8,085	20%
	Outer Regional/Remote	1,167	6%	3,897	9%
	<b>Total</b>	<b>19,653</b>	<b>100%</b>	<b>41,378</b>	<b>100%</b>
	Unknown	37,252		65,040	
<b>Medium</b>					
	Phone	46,476	82%	83,889	79%
	Web chat	9,083	16%	18,820	18%
	Email	1,346	2%	3,709	3%
	<b>Total</b>	<b>56,905</b>	<b>100%</b>	<b>106,418</b>	<b>100%</b>
<b>Type of help-seeking</b>					
	Counselling contact	18,407	32%	40,258	38%
	Information/Referral/Other contact	38,498	68%	66,160	62%
	<b>Total</b>	<b>56,905</b>	<b>100%</b>	<b>106,418</b>	<b>100%</b>

1. Where column percentages sum to more or less than 100%, this is due to rounding.

2. TSI = Torres Strait Islander. CALD = Culturally and linguistically diverse. ATSI = Aboriginal and/or Torres Strait Islander

3. Remoteness classifications are adapted from the Australian Statistical Geography Standard (ASGS) used by the Australian Bureau of Statistics. See *Kids Helpline Insights 2016: National Statistical Overview* for more information.

## **Types of help-seeking**

The Kids Helpline counselling and support service responds to two broad categories of help-seeking: those children and young people seeking counsellor assistance for a particular concern or problem (*counselling contacts*), and those seeking information, referral to other services, or some other form of non-counselling support, like general conversation or playful engagement (*non-counselling contacts*, also called *information, referral and other contacts*).

As shown in Table 2, 32% of contacts from NSW in 2016 were seeking counselling support while 68% were seeking information/referral or other forms of non-counselling support. NSW contacts were more likely to be seeking non-counselling support than contacts from the rest of Australia (68% c.f. 62%).

## Demographic trends over time

Table 3 presents the characteristics of NSW contacts over the last three years to consider whether there have been noteworthy variations in the client group over the short term.

Key observations from the data in Table 3 include the following:

- There would appear to be little change in the demographic profile of NSW contacts over the last three years.
- The one exception is an increase in the proportion of contacts engaging with the service by web chat and a corresponding decrease in those engaging by phone.

**Table 3. Characteristics of NSW Kids Helpline contacts aged 5-25 years – by year<sup>1</sup>**

Contact characteristics	2014 (N = 68,674)		2015 (N = 70,977)		2016 (N = 56,905)	
	n	%	n	%	%	n
<b>Gender<sup>2</sup></b>						
Female	27,024	67%	26,198	66%	23,646	69%
Male	13,336	33%	13,324	34%	10,461	30%
Intersex, Trans & Gender Diverse	-	-	153	0%	346	1%
<b>Total</b>	<b>40,360</b>	<b>100%</b>	<b>39,675</b>	<b>100%</b>	<b>34,453</b>	<b>100%</b>
Unknown	28,314		31,302		22,452	
<b>Age group</b>						
5-12 years	3,122	10%	3,826	12%	3,543	12%
13-18 years	18,045	57%	18,110	57%	17,465	59%
19-25 years	10,333	33%	10,039	31%	8,539	29%
<b>Total</b>	<b>31,500</b>	<b>100%</b>	<b>31,975</b>	<b>100%</b>	<b>29,547</b>	<b>100%</b>
<26 but age unknown	37,174		39,002		27,358	
<b>Cultural background<sup>3</sup></b>						
Aboriginal &/or TSI	528	3%	496	3%	651	5%
CALD	5,745	37%	6,561	43%	5,179	39%
Neither ATSI nor CALD	9,293	60%	8,052	53%	7,595	57%
<b>Total</b>	<b>15,566</b>	<b>100%</b>	<b>15,109</b>	<b>100%</b>	<b>13,425</b>	<b>100%</b>
Unknown	53,108		55,868		43,480	
<b>Remoteness<sup>4</sup></b>						
Major Cities	13,403	72%	13,424	69%	14,645	75%
Inner Regional	4,522	24%	4,871	25%	3,841	20%
Outer Regional/Remote	817	4%	1,050	5%	1,167	6%
<b>Total</b>	<b>18,742</b>	<b>100%</b>	<b>19,345</b>	<b>100%</b>	<b>19,653</b>	<b>100%</b>
Unknown	49,932		51,632		37,252	
<b>Medium</b>						
Phone	59,896	87%	61,498	87%	46,476	82%
Web chat	6,391	9%	7,319	10%	9,083	16%
Email	2,387	3%	2,160	3%	1,346	2%
<b>Total</b>	<b>68,674</b>	<b>100%</b>	<b>70,977</b>	<b>100%</b>	<b>56,905</b>	<b>100%</b>
<b>Type of help-seeking</b>						
Counselling contact	19,574	29%	20,269	29%	18,407	32%
Information/Referral/Other contact	49,100	71%	50,708	71%	38,498	68%
<b>Total</b>	<b>68,674</b>	<b>100%</b>	<b>70,977</b>	<b>100%</b>	<b>56,905</b>	<b>100%</b>

1. Where column percentages sum to more or less than 100%, this is due to rounding.

2. A new gender category was introduced into Kids Helpline data collection from January 2015.

3. TSI = Torres Strait Islander. CALD = Culturally and linguistically diverse. ATSI = Aboriginal and/or Torres Strait Islander

4. Remoteness classifications are adapted from the Australian Statistical Geography Standard (ASGS) used by the Australian Bureau of Statistics. See *Kids Helpline Insights 2016: National Statistical Overview* for more information.



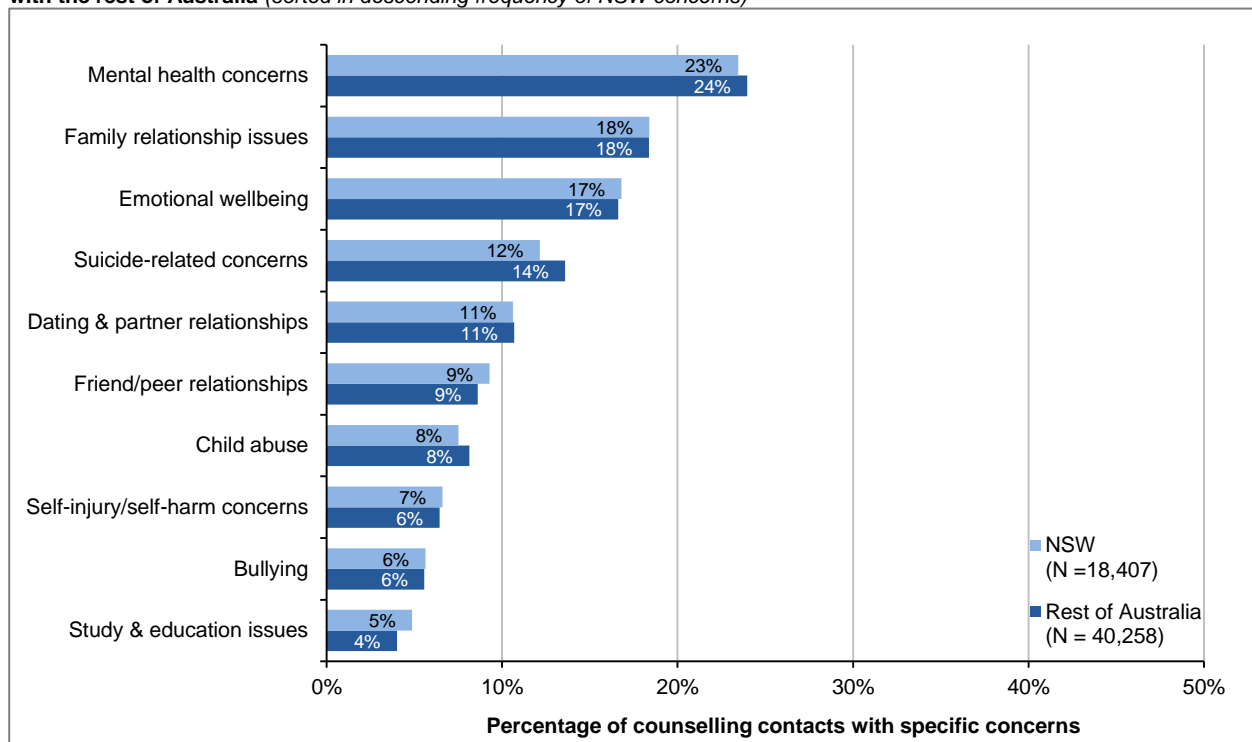
## Most common concerns of children and young people who received counselling

During 2016, Kids Helpline counsellors responded to 66,963 contacts from children and young people who were seeking help about specific problems or concerns (i.e. counselling contacts). Analysis of the types of issues and concerns raised by children and young people in these sessions provide a valuable insight into the help-seeking concerns of young Australians today.

### NSW compared with rest of Australia

- State or territory information was available for 58,665 of these 66,963 counselling contacts and of this subset 18,407 (or 31%) were known to be from NSW.
- Figure 1 shows the 10 most common concerns of NSW counselling contacts in 2016 and compares this with the frequency with which these concerns were raised by counselling contacts from the rest of Australia where state or territory information was known.
- The key observation to be noted from the data is that the frequency with which children and young people in NSW sought help from Kids Helpline for all of these issues is consistent with the frequency with which children and young people elsewhere in Australia sought help for these issues.

**Figure 1. Most frequently recorded concerns of Kids Helpline counselling contacts 2016 aged 5-25 years – NSW compared with the rest of Australia** (sorted in descending frequency of NSW concerns)<sup>1</sup>



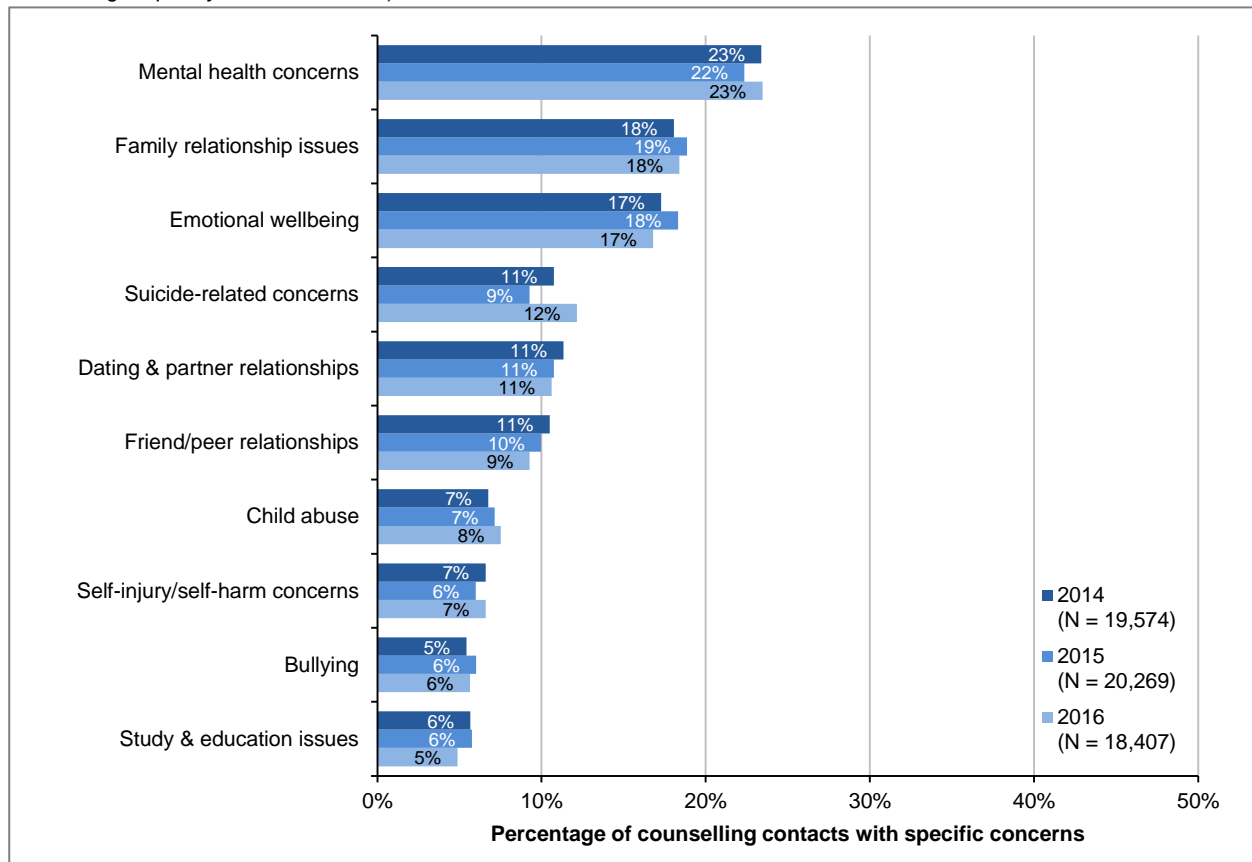
1. Up to four concerns per contact may be recorded. Accordingly, percentages may sum to more than 100%.

## Trends over time

Figure 2 shows the 10 most common concerns of NSW counselling contacts in 2016 and compares this with the frequency with which these concerns were raised by NSW contacts in 2014 and 2015.

- The key observation to note from the data is that the frequency with which children and young people in NSW are contacting Kids Helpline about these various concerns has remained very consistent over the short-term.

**Figure 2. Most frequently recorded concerns of NSW Kids Helpline counselling contacts aged 5-25 years – by year** (sorted in descending frequency of 2016 concerns)<sup>1</sup>



1. Up to four concerns per contact may be recorded. Accordingly, percentages may sum to more than 100%.

## All concerns of children and young people who received counselling

Children and young people contact Kids Helpline about a very wide range of concerns, and focusing on the 10 most common concerns can obscure that diversity and the emergence of trends in other areas of less common client concern.

To address this issue, Table 4 reports the frequency with which *every concern* in the Kids Helpline's concern classification system was raised by counselling contacts from NSW in 2016 and compares this with the frequency with which the concern was raised in 2014 and 2015. Table 4 groups individual concerns under eleven 'concern classes' which aggregate frequencies across conceptual clusters of client concern.

- The key observation to be noted from the data in Table 4 is that the frequency with which children and young people in NSW are contacting Kids Helpline about all these different concerns and classes of concern is quite consistent over the short-term.

**Table 4. Number and proportion of Kids Helpline counselling contacts 5-25 years with particular concerns and classes of concern – NSW by year<sup>1</sup>**

Concern and concern class	2014 (N = 19,574)		2015 (N = 20,269)		2016 (N = 18,407)	
	n	%	n	%	n	%
<b>Mental health &amp; emotional wellbeing</b>	<b>10,224</b>	<b>52.2%</b>	<b>10,362</b>	<b>51.1%</b>	<b>9,703</b>	<b>52.7%</b>
Mental health concerns	4,580	23.4%	4,532	22.4%	4,319	23.5%
Emotional wellbeing	3,382	17.3%	3,711	18.3%	3,092	16.8%
Suicide-related concerns	2,106	10.8%	1,877	9.3%	2,237	12.2%
Self-injury/self-harm concerns	1,290	6.6%	1,213	6.0%	1,215	6.6%
Loss and grief	781	4.0%	723	3.6%	574	3.1%
<b>Friends, peers, partners &amp; dating</b>	<b>4,162</b>	<b>21.3%</b>	<b>4,096</b>	<b>20.2%</b>	<b>3,580</b>	<b>19.4%</b>
Dating and partner relationships	2,219	11.3%	2,180	10.8%	1,953	10.6%
Friends/peer relationships	2,056	10.5%	2,023	10.0%	1,708	9.3%
<b>Family relationships</b>	<b>3,536</b>	<b>18.1%</b>	<b>3,825</b>	<b>18.9%</b>	<b>3,386</b>	<b>18.4%</b>
Child-parent relationships	2,516	12.9%	2,699	13.3%	2,400	13.0%
Other family relationships	767	3.9%	834	4.1%	726	3.9%
Changing family structures	396	2.0%	448	2.2%	421	2.3%
Parenting own children	72	0.4%	75	0.4%	51	0.3%
<b>Identity &amp; self-concept</b>	<b>1,675</b>	<b>8.6%</b>	<b>1,498</b>	<b>7.4%</b>	<b>1,401</b>	<b>7.6%</b>
Self-concept (global)	991	5.1%	806	4.0%	739	4.0%
Body image	313	1.6%	250	1.2%	182	1.0%
Sexual orientation	255	1.3%	236	1.2%	230	1.2%
Gender/sex identification	62	0.3%	107	0.5%	184	1.0%
Disability-related concerns	65	0.3%	95	0.5%	75	0.4%
Cultural identity	52	0.3%	54	0.3%	50	0.3%
<b>Violence &amp; abuse (non-family)</b>	<b>1,619</b>	<b>8.3%</b>	<b>1,730</b>	<b>8.5%</b>	<b>1,646</b>	<b>8.9%</b>
Bullying - school related	904	4.6%	1,051	5.2%	882	4.8%
Bullying - other	170	0.9%	175	0.9%	162	0.9%
Sexual assault or abuse (non-family)	280	1.4%	242	1.2%	329	1.8%
Dating and partner violence	138	0.7%	146	0.7%	138	0.7%
Harassment and assault (non-sexual)	82	0.4%	79	0.4%	93	0.5%
Sexual harassment	76	0.4%	65	0.3%	72	0.4%
<b>Child abuse &amp; family violence</b>	<b>1,322</b>	<b>6.8%</b>	<b>1,449</b>	<b>7.1%</b>	<b>1,384</b>	<b>7.5%</b>
Physical abuse	611	3.1%	735	3.6%	720	3.9%
Sexual abuse	315	1.6%	274	1.4%	243	1.3%
Emotional abuse	304	1.6%	330	1.6%	355	1.9%
Neglect of child	64	0.3%	81	0.4%	73	0.4%
Exploitation by family member	0	0.0%	1	0.0%	3	0.0%
Exposure to family violence	141	0.7%	152	0.7%	153	0.8%
Living-in-care issues	86	0.4%	92	0.5%	59	0.3%
<b>School, education &amp; work</b>	<b>1,419</b>	<b>7.2%</b>	<b>1,588</b>	<b>7.8%</b>	<b>1,283</b>	<b>7.0%</b>
Study and education issues	1,108	5.7%	1,166	5.8%	897	4.9%
Employment issues	210	1.1%	266	1.3%	306	1.7%
School authority issues	127	0.6%	179	0.9%	105	0.6%
<b>Physical or sexual health &amp; development</b>	<b>1,137</b>	<b>5.8%</b>	<b>1,063</b>	<b>5.2%</b>	<b>914</b>	<b>5.0%</b>
Physical health concerns	585	3.0%	469	2.3%	433	2.4%
Pregnancy-related concerns	254	1.3%	242	1.2%	228	1.2%
Sexual activity	232	1.2%	282	1.4%	213	1.2%
Physical/sexual development	43	0.2%	49	0.2%	28	0.2%
Contraception/safe sex	46	0.2%	48	0.2%	35	0.2%
<b>Homelessness &amp; basic needs assistance</b>	<b>458</b>	<b>2.3%</b>	<b>530</b>	<b>2.6%</b>	<b>530</b>	<b>2.9%</b>
Homelessness	245	1.3%	309	1.5%	286	1.6%
Practical/material assistance	164	0.8%	182	0.9%	203	1.1%
Financial assistance/concerns	61	0.3%	54	0.3%	57	0.3%
<b>Substance use, addictions &amp; risk-taking</b>	<b>471</b>	<b>2.4%</b>	<b>422</b>	<b>2.1%</b>	<b>426</b>	<b>2.3%</b>
Drug use	321	1.6%	262	1.3%	242	1.3%
Alcohol use	122	0.6%	101	0.5%	116	0.6%
Addictive behaviours (not drugs/alcohol)	43	0.2%	51	0.3%	65	0.4%
Physical risk-taking	9	0.0%	10	0.0%	5	0.0%
Gang/cult involvement	6	0.0%	13	0.1%	14	0.1%
<b>Offending, abusive or violent actions</b>	<b>179</b>	<b>0.9%</b>	<b>243</b>	<b>1.2%</b>	<b>177</b>	<b>1.0%</b>
Illegal/offending behaviour	101	0.5%	128	0.6%	93	0.5%
Abusive or violent actions	59	0.3%	102	0.5%	77	0.4%
Sexual violence/offending actions	21	0.1%	18	0.1%	12	0.1%

1. Up to four concerns per contact may be recorded. Totals provided for class of concern will be less than the sum of the individual concerns that make up that class due to the fact that multiple concerns within the class may have been identified in a single contact.





# Preventing suicide:

THE VOICE OF CHILDREN  
AND YOUNG PEOPLE

**Insights Part 4**  
Implications for  
policy and practice



KidsHelpline is a service of **yourtown**



yourtown

## BACKGROUND

Between October 2015 and February 2016, **yourtown** invited children and young people who had lived experience of thinking about, planning or attempting suicide to share their experiences of seeking and getting support. The results of this consultation have been published in five papers, which are available on the **yourtown** website:

- Insights Part 1: Seeking and getting help
- Insights Part 2: Young people's experience – What helps and what doesn't
- Insights Part 3: Messages for parents and carers
- Insights Part 4: Implications for policy and practice
- Background, method and description of respondents

**This is Insights Part 4: Implications for policy and practice.** These papers have been written for a general audience. We also hope to publish one or more academic papers in the future.

Thank you to all the young people who took the time to share their thoughts with us. Your insights were invaluable and are being shared with experts and decision-makers around Australia.

Some people may find the content of these papers distressing. If you start to feel distressed while reading, or you have been thinking about suicide, please talk to someone you trust or call a helpline.

- **Kids Helpline – for ages 5-25 to talk about anything at all**  
24/7 phone counselling on 1800 55 1800 or WebChat between 8am and midnight at **[kidshelpline.com.au](http://kidshelpline.com.au)**
- **Lifeline – all ages, for support in a personal crisis**  
24/7 phone counselling on 13 11 14 or web chat between 7pm and 4am at **[lifeline.org.au](http://lifeline.org.au)**
- **Suicide Call Back Service – for 15 years and over, support when you or someone you know is feeling suicidal**  
24/7 phone counselling on 1300 659 467 or see **[suicidecallbackservice.org.au](http://suicidecallbackservice.org.au)**

### Where to find more information:

- **Young people:** **[kidshelpline.com.au](http://kidshelpline.com.au)**, **[ReachOut.com](http://ReachOut.com)** and **[Youthbeyondblue.com](http://Youthbeyondblue.com)** have some great resources and information for young people who are going through tough times or feeling suicidal, and for young people concerned about a friend.
- **Adults:** You can read 'Suicide – The Facts' at **[kidshelpline.com.au](http://kidshelpline.com.au)**. **[beyondblue.org.au](http://beyondblue.org.au)** provide lots of information about anxiety, depression and suicide at any age. If you are a concerned

If you or someone you know is in immediate danger, call 000 for an ambulance.

parent, they have a family guide to youth suicide prevention. **[ReachOut.com](http://ReachOut.com)** also has a parent site with information to help parents support their teenagers.

**[Conversationsmatter.com.au](http://Conversationsmatter.com.au)** has tips for safe suicide discussions and other resources for both the general public and professionals.

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## INTRODUCTION

**A wide-ranging analysis of current policy and practice is beyond the scope of this paper and our aim in writing it is not to provide comprehensive advice to policy makers or service providers. In most cases, results of our consultation with young people are consistent with existing research and practice. Our aim in this paper is to highlight the issues that young people told us are important to them, and to draw particular attention to those that we believe warrant increased consideration in the current policy and practice arena.**

This paper focuses on the following topics:

- Consultation with young people
- The centrality of relationships
- Connecting young people to professional counselling and psychological services
- Duty of care, emergency services and hospitalisation
- Whole of community education
- Gatekeeper training
- Holistic responses, including support for families
- School based programs
- Technology and the internet.

## CONSULTATION WITH YOUNG PEOPLE

The consultation on which this paper is based was undertaken by placing an online survey on the Kids Helpline website. The only promotion of the survey was an advertisement on Facebook, which targeted 15 to 25 year olds. No incentive was offered for survey completion. The survey generated more than 750 click-throughs and was at least partially completed by 472 young people. The number of responses and significant time spent by many young people clearly indicate that young people want and value opportunities to share their thoughts and experiences.

Current suicide prevention and mental health policy in Australia recognises the importance of incorporating insights from those with lived experience of suicide.<sup>1</sup> Nevertheless, consulting with young people can be challenging. Hence, the views of children and adolescents are often missing from discussion.

Greater efforts need to be made to consult and collaborate with young people, particularly those who are marginalised and at-risk. Consultation is often undertaken with small groups of people with lived experience, for example, through representation in advisory mechanisms or focus groups. It is important to investigate a range of consultation methods to ensure that marginalised young people, who may lack the capacity to engage in advisory groups, also have a voice.


Our experience with an online survey suggests that this method has potential to be used more often, due to its ability to reach a broad cross-section of young people, including those from at-risk groups such as Aboriginal and Torres Strait Islander young people, young people from culturally and linguistically diverse backgrounds, and young people from rural and remote areas. Respondents to our survey ranged in age from children under 13 years to young adults, and comprised 22% young people who identified as LGBTIQ, 5% who identified as neither male nor female, 7% who identified as Aboriginal and/or Torres Strait Islander, and 6% from outer regional and remote areas.

Given the high-risk nature of these groups, our sample probably under-represents them as a proportion of suicidal young people. We also note the disadvantages of online survey methods in regards to the depth and quality of data collected, and potential ethical issues for researchers. Nevertheless, the results indicate that high-risk groups can be reached in this way, and an approach that specifically targets these groups is likely to have greater reach than that achieved by our efforts.

<sup>1</sup> 'The Roadmap for National Mental Health Reform 2012-2022' (Council of Australian Governments, 2012).

Children and  
young people  
want to have a  
voice: 472 took  
the time to share  
their thoughts  
and experiences  
with us.





“Just be there to listen to them. Nurture them, support them and just care for them. We just want to feel like we are wanted.”

## THE CENTRALITY OF RELATIONSHIPS: IMPLICATIONS FOR SERVICE PROVIDERS

The importance of providing a youth-friendly service and building a strong therapeutic relationship to engage and work effectively with young people is well-known. Nevertheless, research and policy often focus on the importance of developing evidence-based strategies and treatments. Young people's responses to the question, 'What advice would you give to service providers?', highlighted relationships as being key to recovery from their perspective. In particular, young people suggested that service providers need to be non-judgemental, more understanding and show that they care. Correspondingly, some asked that service providers be less clinical and spend more time listening.

“Don't just tell them how their brain works or that puberty is messing them up. Sympathise with them, be empathic, cry with them, make them feel important and make them feel like their problems are worth being like that.”

“LISTEN! Try to actually understand what's going on. Stop jumping to medications and diagnosing everything.”

When young people wrote about helpful experiences with a counsellor or psychologist, their stories were most often about feeling valued and cared for by the counsellor or psychologist. They wrote about the benefits of a trusting relationship with a reliable counsellor much more often than they wrote about the benefits of 'treatment'. This is

consistent with previous research, which reported that the most important characteristics of mental health professionals identified by suicidal young people were positive personality traits (e.g., friendly, patient), being understanding, active listening and being non-judgemental, while 'competence' was ranked as the least important trait.<sup>2</sup>

Young people's comments highlight the importance of youth specialist services, which can provide counsellors who are expressly trained and experienced to interact and connect with young people.

<sup>2</sup> Sophie Isabelle Hyman et al., “Youth-Friendly” Characteristics of Professionals in Mental Health Settings, *Vulnerable Children and Youth Studies* 2, no. 3 (23 November 2007): 261–72, doi:10.1080/17450120701660594.

Young people told us they feel alone, view themselves as worthless, and believe they are a burden on others who would be better off without them. Their survey responses suggested they are looking for 'evidence' they are wrong in the behaviour of others, including mental health professionals.

Young people also highlighted that it takes time to build a trusting relationship. They wanted service providers to realise that they often find it difficult to open up, and hide their true feelings. They expected that a good counsellor should realise this and persevere, but not pressure them to share personal thoughts and feelings before they are ready.

"Please be patient. We're not being stubborn. We're just scared. Try to understand."

"Be patient with young people that call and seek help. Don't judge a book by its cover because I was one that was able to mask myself very well... My counsellor didn't know about the severity of my feelings. My recovery was aided with her staying in my life and walking with me regardless."

"My worker was a god send. Even when I didn't say anything because I was so scared she stayed and didn't give up on me."

They told us that relatively simple actions such as a follow-up phone call after a counselling session can make a significant difference, because actions that appear to go beyond 'duty' demonstrate to a young person that they matter and that the service provider genuinely cares about them. Conversely, even a small action can have significant negative consequences when a young person interprets it as evidence they are not valued as a person.

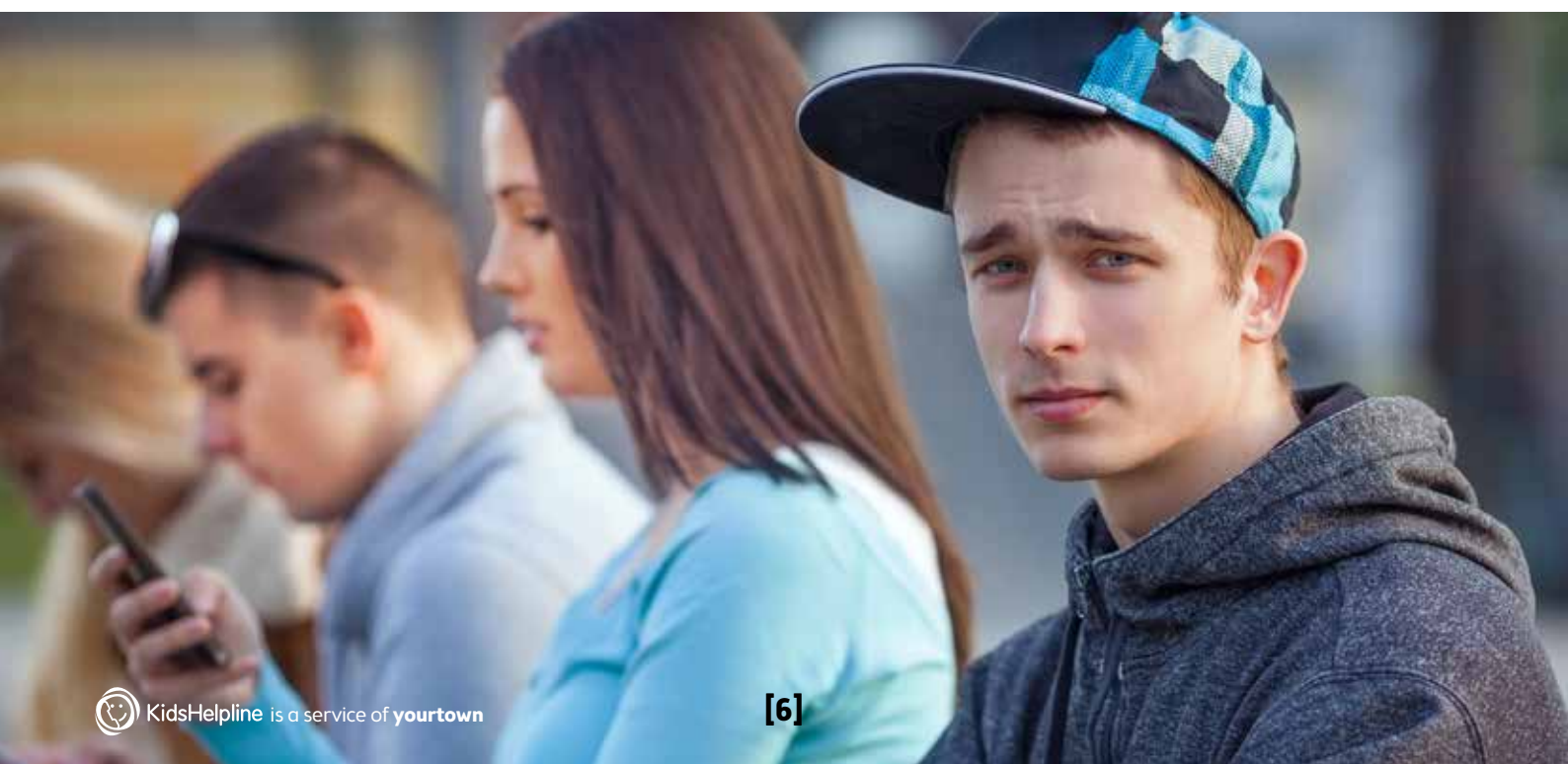
"Please be open minded, patient and understanding. We are not just cases but people."

"One face to face counsellor I had always used to call to check up on me the next day. That made me feel important and valuable."

Of course, this focus on relationships does not mean that evidence-based treatments are not important. It does, however, highlight differences in the way young people think about treatment, and what they consider important, in comparison to policy makers and service providers. Young people are sometimes considered difficult to engage in treatment, and understanding what matters to them may provide useful insights into how best to engage them.

"I like it when the counsellors are interested in me as a person and my life and not just my symptoms cause it makes me trust them and I feel comfortable to share more about the darker thoughts."

"Don't be distant. Offer advice and comfort. Please don't just nod your head, I want input. I want it to be a two way conversation. I don't want you to feel sorry for me. I just need support and some love."



# CONNECTING YOUNG PEOPLE TO PROFESSIONAL COUNSELLING AND PSYCHOLOGICAL SERVICES

Young people clearly identified counsellors and psychologists as the most helpful form of support for suicidal thoughts and behaviours. Of 115 respondents who had seen a counsellor or psychologist, 44% reported the experience to be 'very helpful', 39% reported it to be 'fairly helpful' and only 17% reported it to be 'not at all helpful'.

However, many young people do not access these services. Results of the consultation suggested three main issues that need to be addressed:

1. Barriers to seeking help
2. Taking young people's concerns seriously
3. Access to services.

## Barriers to seeking help

Most participants in the consultation had not sought support, and those around them either did not notice or did not respond to the seriousness of the situation. Overall about 40% of respondents had received help. Of those who had received help, 20% did not receive it until after a suicide attempt. The main barriers to seeking help were stigma, feelings of worthlessness, and concern not to hurt or burden others. "Insights Part 1: Seeking and getting help" provides a detailed description of these issues.

Young people do want help, including professional counselling and psychological services. Nevertheless, they may intentionally hide their feelings due to a fear of 'being judged' or called an 'attention-seeker'. Although feelings of fear and

shame may prevent active help-seeking, young people told us they often hint at their feelings and are hoping someone will notice.

"If people saw through my smile and realized it was fake a lot of the time ... if professionals picked up the vibe more often then maybe I'd be in a better place ... often I may be trying to hint towards how I'm feeling without actually saying it as I may be too embarrassed or worried about being judged."

Consequently, connecting young people to services requires more than simply encouraging help-seeking. For some young people fear is paralysing; they want to ask for help, but simply can't get the words out. Two young people said that they would never have told anyone, but when directly asked, they couldn't lie. Many young people clearly indicated that they want those around them to be proactive, that is, to directly ask how they are, offer to help and follow-through with that help. A number of respondents specifically asked that adults, particularly parents, help them to gain access to professional services.

## Taking young people's concerns seriously

For a significant number of young people, their first experience of seeking support served to demonstrate that their fear was not unfounded. As outlined in "Insights Part 2: What helps and what doesn't", some young people described having their feelings trivialised or minimised, while others described building up the courage to speak to someone, only to have their concerns

"I just want someone to ask me if I ever had suicidal thoughts, my reply will be yes. No one really knows how sad I am."



dismissed completely. That is, seeking help did not always result in receiving help. Concerningly, these experiences occurred with professionals such as school staff, GPs, and even counsellors, as well as with family and friends.

In addition to having a significant negative effect on a young person's immediate wellbeing, negative responses to help-seeking sometimes lead to the young person isolating themselves further and had the potential to delay future help-seeking by years. Consequently, ensuring that every young person receives a helpful response every time they ask for help, regardless of who they approach, is crucial.

As one young person said,

"And even if you believe that the young person is 'making it up' or 'just doing it for the attention', you have to take them seriously. Because you could be wrong ... The amount of workers and services that I have slipped through the cracks over the years, simply because they thought I was faking it. If just one of them had learnt a little about young people feeling suicidal and used some of that to connect with me, I would have been able to connect with one of them sooner and told them what was going on ... You might be their 'I'll try one last time then I'm done', you need to always take them seriously."

## Access to services

Young people's responses highlighted a number of well-known barriers to accessing services, including waiting times, location, cost and difficulty finding the right service.

When some young people sought help from a service that was not equipped to work with them, they were simply turned away. As highlighted previously, for a young person who already feels worthless, this type of response can have significant negative consequences. Services that are unable to work with suicidal young people may need education or training to actively help young people find a more appropriate service.

"I went to see a psychologist on campus, after jumping through so many hoops to see her, [she] said the service was not for serious problems, but I should research and look online. I felt so distraught that after an enormous amount of effort I was too messed up for the system, walking home I very nearly deliberately walked into traffic."

"[service] made me feel very very worse. They literally just abandoned me as soon as I was 'weight restored' from my eating disorder. They did not address my suicidal thoughts, or even let me bring it up with them, and also didn't address any of my other issues. It makes me feel pathetic and abandoned."

Lack of parental support was an issue for some young people. In addition to the need for parents to provide transport, a Medicare card and the financial resources to meet gap payments, some parents were described as actively discouraging access to professional support.

"I think it'd be cool for some programs where people with depression could go to for free, because I have no money and my parents don't do nothing so it'd be cool to go out and do something to help yourself instead of staying in your room on Netflix all day."

"[What else would have helped?] Family actually being there for me and supporting me rather than discouraging me from accessing support."

One young person reminded us that some of the most high risk young people may not be in school, and that it's important that easily accessible pathways to support are provided for those young people.

"I came from a very disadvantaged background (missed a lot of school) so I feel that services, the government, etc should remember that some of the young people needing their services the most, go forgotten. For example the children of parents too drunk to remember to take them to school or the home-schooled whose parents may control every bit of information they had access to."

These experiences suggest a need for more services that can be accessed without parental support, that is, free services that do not require a Medicare card, in easily accessible locations. Telephone and web-based counselling services are an obvious way to address this need. We are aware that our sample may be biased; nevertheless, it is worth noting that of 102 young people who had used a telephone counselling service, 52% found it 'very helpful', 33% found it 'fairly helpful' and only 15% found it 'not at all helpful'.

"I called [service] when I was in my room and couldn't stop crying. I had my antidepressants and pills and a knife and I was getting ready

to kill myself but then I decided to call [service] because they've always helped me. I felt very alone but talking to someone helps. Even though my regular counsellor wasn't on it helps to talk because they never judge or freak out at me if I say I'm feeling suicidal. They helped me to put away the pills and work on my safety plan. Sometimes the feelings get so dark and scary and I get terrified but knowing I can talk to a professional is really comforting and they make me feel safe and they make me believe in myself that I can get through the urges."

Moreover, tele web services were attractive to young people because they are available 24/7

and allow young people to remain anonymous. The assurance of confidentiality was an important characteristic for many young people.

It is important that helplines are not seen as a crisis service only; young people described using telephone and web counselling as early intervention, during crisis, and through recovery. A number of young people described an ongoing association with a telephone counsellor as an important relationship in their life, which helped them feel valued and important. Responses to the question, "What helped?" included:

"Finding a counsellor that I connected with and actually having a place to go where I feel safe. Having access to online support literally saved my life."

"The fact that she [counsellor] has always been there for me whenever I called was very powerful. It demonstrated to me that I am important and that the person I was talking to cares about me."

"The trust and rapport I have built with my counsellors has helped me to talk openly and honestly about what is going on and trust what

they have to say. My counsellors have really helped me not to give up when I have really felt like the only thing that would be best is to end my life."

"Calling [service] a lot was the best thing I ever did to overcome suicide ... the counsellor made me think about practical ways of feeling safe which is not something I thought of on my own ... Explaining my story really helped clarify my feelings for myself and took a terrific weight off my shoulders. Finally through the counsellor's support and the relationship I began to experience different parts of life and learn and practice new skills ... Since the counselling I hardly even think of suicide due to applying and reapplying the skills I learned and trying new experiences as much as I can."



## DUTY OF CARE, EMERGENCY SERVICES AND HOSPITALISATION

A number of young people's responses demonstrated knowledge that services have a duty of care, which limits confidentiality when a young person is considered at serious risk of harming themselves, someone else, or when there is a concern about child protection. Consistent with other research, comments indicated that duty of care obligations and associated limits to confidentiality present a challenge to help-seeking that warrants consideration.

A fear that emergency services would be called or parents would be contacted created a barrier to disclosing suicidality after having sought help for some young people.

"I've always been very careful to not disclose for fear that I would be intervened and that she would enact her duty of care."

"There have been times where I purposely haven't reached out and told ANYONE that I am feeling highly suicidal because I feared that I would end up back in the hospital involuntarily. Luckily I was able to get through those times by myself and nothing really bad happened to me."

In some cases, concerns about duty of care had long term negative consequences for help-seeking and young people suggested that the concept of duty of care needs to be explained more clearly.

"I didn't get help for my self-harm and suicidal thoughts for 6 years cause I was too scared about who the counsellors would tell. Explaining confidentiality and duty

of care more clearly can help to ease the anxiety around telling someone for the first time."

"Being upfront and honest I feel is the best way to do things instead of 'surprise the cops are at your door' (this has happened to me) ... Health professionals not being upfront and honest has left me with even bigger trust issues, I do not trust health professionals lightly now. I am frightened they'll call the cops on me."

A number of young people who had experienced a duty of care response believed that the decision was not the best response to the situation. Consistent with other research<sup>3</sup>, respondents to the survey often found their experience with emergency services and hospitals unhelpful and reported that the duty of care response had done more harm than good.

"Don't immediately call the cops if someone says they want to die. Listen to them first and see why they feel that way. There's a good chance you could talk them out of it. I've been taken to hospital numerous times for suicidal thoughts and none of them were helpful. It would have been much more helpful for someone to just show me I'm not alone and listen to how I feel."

"Just being taken to the hospital by police, ambulance, psychiatrists etc. under the law and actually being at the hospital. It doesn't help me at all, in fact it makes me worse. I get distressed and try to hurt myself in the hospital whether it is banging my head repeatedly against the wall or punching the wall over and over again until I bruise. I just want to get out of there because you are treated like a prisoner in a jail. It may keep me safe in the sense that I can't kill myself, but mentally it destroys me."

Young people's comments suggest an urgent need to investigate alternative emergency care responses, in particular, responses that do not involve police and avoid hospitalisation as much as possible. Current guidelines in regards to appropriate terminology when talking about suicide state that the phrase 'commit suicide' should not be used, because the word 'commit' implies a crime or a sin. Yet, a service response to a person at imminent risk of suicide is likely to involve the person being forcibly transported to hospital by police, leaving them feeling as if they had committed a crime.

"[I] showed up at my private psychologists clinic, sat with her, then next thing I knew the cops were in the room. The very place I felt safe in was no longer. Put in an ambulance by the very psychologist/help person I trusted, cops travelled with me like I was a criminal ... Got to the hospital had a mental health worker who was scary and strict. Asking for my next of kin, I felt unsafe, I refused to give. I tried to leave the hospital ... Ended up star fished to the bed in restraints. I'd never tell anyone if I was truly at risk as I never want to be in hospital or have the police called on me. The day it happened I died, I will never be the same person ... I attempted suicide soon after."

<sup>3</sup> 'Lessons for Life. The Experiences of People Who Attempt Suicide: A Qualitative Research Report.' (SANE Australia and University of New England, 2015).





## WHOLE OF COMMUNITY EDUCATION

Programs are urgently needed to increase understanding of mental health problems and suicidality amongst children and young people. In particular, young people told us that they want others to learn to:

- Pay attention if a young person seems to be going through a tough time, ask if they're okay, offer to help, and follow through with the offer.
- Understand that depression is an illness, feeling suicidal is not a choice, and recovery takes a long time.
- Take children and young people seriously when they share their feelings and voice their concerns
  - they are not attention-seeking
  - it can happen to anyone – suicide does not discriminate.

- Know that it's okay not to have all the answers:

- just listen, be patient, show them you care, and
- help them get professional support.

*"I think maybe if people were more educated on mental illness, it may help to explain why I feel certain ways. It's also good to teach people that all some people need is someone they can talk to."*

*"My family is very supportive in their own way. But if they had been able to learn more about how to communicate with family members that are experiencing feelings of self harm or suicide, I feel it would have enabled them to connect with me more. Some of the things they did over the years that they thought helped had actually done the opposite."*

A whole of community approach is needed because young people seek support from parents, siblings, friends, teachers, youth workers, medical professionals, counsellors,

psychologists, and others. Young people's survey responses highlighted that judgemental attitudes can be found amongst all these groups. Hence, anti-stigma campaigns and community education programs that target all members of the community are needed.

*"I wish I could walk up the driveway of my psychologist office and not look around at who might see me entering, I wish I didn't have to be afraid that the wrong person might find out and judge me for being unwell."*

*"I suffered a long time before seeking help, I think deeper education needs to be taught in mental illness including where to access help and warning signs so friends can help friends AS WELL AS STIGMA ISSUES!!! I thought (and I thought right) that people would make fun of me if I told them what I was thinking so I hid!!! I think so much needs to be changed!!!"*

"Many times it has been emergency department doctors/ ambulance officers making comments about how suicidal people are wasting the time of medical personnel and are simply attention seeking/manipulative. I have been called a waste of time and a waste of a hospital bed. I have been called a burden on the health system."

"When I picked up a food package I was lectured about budgeting. I hadn't eaten for a long time. I was in a really bad place. I felt ashamed."

As highlighted previously, it is crucial to ensure that every young person receives an appropriate response every time they seek help, regardless of who they choose as a source of support. The experiences shared by young people clearly demonstrated significant negative effects on wellbeing and future help-seeking when an attempt to seek help received an inadequate or inappropriate response.

"I saw a psychologist who laughed at me because I was 13 and experiencing crippling anxiety and depression. 'you're gonna be a fun one.' I never went back and I'm still completely scarred."

"I went to a GP who would not give me a mental health care plan because I would not show her my self-harming. She was rude and patronizing and put me off seeking professional help for a couple of years. She implied that I was making everything up. I felt stupid and small and ashamed."

The significance of stigma as a barrier to help-seeking is well known, but young people highlighted an issue that may not be recognised; some adults simply don't believe children and young people when they say they are feeling depressed or suicidal. This issue was described in more detail in "Insights Part 2: What helps and what doesn't." Our data do not explain this, but responses suggested beliefs that suicidality needs a clear cause, and a tendency to assume that a young person with no obvious problems could not be truly suicidal. Education needs to highlight the fact that suicide can happen to anyone, that suicidal thoughts can start young, that it takes courage to seek help, and that every young person should be taken seriously.

"[What was unhelpful?] Telling me to stop being sad, or that I can't feel sad because my life is 'okay'."

"I talked to my mum and the school counsellor and the counsellor just told me it was puberty and made me read a book about puberty which made me feel like my problems weren't real. My mum told me it was just a phase."

"When I first told my mum I was depressed she said I was too young and that I was being stupid."

"One time a doctor told me that my life is fine and that he had gone through harder stuff and I should just be happier."

"[What else would have helped?] Being taken seriously when I said I wanted to die, I didn't want to be here. I was told to get over it and that everyone has bad days."

**"I was young and felt like nobody would think that I felt like that because of my age and because nothing "bad" had happened in my life to make me feel that way."**



## GATEKEEPER TRAINING

Gatekeeper training is considered one of the most promising suicide prevention strategies, and programs typically focus on training professionals who work with young people to identify and respond to young people at risk. Results of the consultation confirmed the importance of gatekeeper training for school staff and GPs. Of those respondents who had sought help, 52% had sought it from a GP, but almost a third reported the experience to have been 'not at all helpful'. Similarly, 48% had sought help from school staff, including both school counsellors and teachers, but one in four found the experience 'not at all helpful'.

"While I was at school I was receiving 'support' from the Year 10 Coordinator. After a few months, because I was still depressed, he blamed me for 'not doing anything to help myself recover'."

"Counsellor from school, tried to get it in my head that my friends helped me self harm cause its 'trendy'."

"GP – was very insensitive and not confidential which put me off seeing a psychologist later on and gave me a bad view on professional help."

"The first GP I ever told about the family violence I have/was experiencing at the time didn't bring up mental health so I felt like I couldn't bring it up either."

Young people's stories also confirmed that school staff and GPs can be extremely useful sources of support if trained to respond appropriately. "Insights Part 2: What helps and what doesn't?" provided more detail in this regard.

Parents are often missing from discussions of gatekeeper training, but our results indicated that educating parents is crucial. Parents are a primary source of emotional support for children and young people; as outlined in "Insights Part 3: Messages for parents and carers", respondents to the survey wrote about experiences with parents more than anyone else. Moreover, for children and adolescents, parents hold the keys to accessing professional services.

Concerningly, young people's survey responses showed that many parents struggle to support their children appropriately and effectively. Some may feel they are to blame, others that the disclosure of suicidality is a deliberate attack on their parenting skills, or that suicide is something that 'only happens to other people'. Hence, ensuring that parents have the knowledge and skills to effectively support their children needs to be a key part of youth suicide prevention policy.

## SCHOOL-BASED PROGRAMS

### Programs promoting mental health and resilience

Evidence suggests that suicide education and awareness programs in schools are potentially effective, but our consultation results suggest that programs currently delivered in Australian schools may not be effective in engaging and supporting students experiencing suicidal thoughts. The Australian Government has committed to an end-to-end school-based mental health program, which will build on the existing KidsMatter and MindMatters programs, as part of its suicide prevention strategy. KidsMatter and MindMatters have traditionally focused on promoting mental health and resilience, and have not included specific education about suicide.

Only one respondent to our survey mentioned any kind of school-based program for students. It may be that survey respondents had not participated in a school-based program, but alternative explanations are that they did not find the focus on mental health and resilience relevant to their needs, or that the programs failed to inspire a response, either positive or negative.

Emerging evidence suggests that school-based programs that specifically target suicidality can be delivered safely in schools. Nevertheless, we note that the lone comment we received about a school-based program suggested potential negative consequences for some students that need to be considered.

“When we were at school this year, we had to do a unit on mental health and all that, I got all choked up and everyone looked at me and I had to leave the room and I cried and I was really embarrassed.”

The characteristics of our sample and their comments highlight the need for school-based support to start early and continue into tertiary education. One in five (21%) of the survey respondents was aged 13 years or younger, and two young people specifically suggested that education about self-harm should start in primary school.

“I think more education on these sorts of things needs to be done and we should be starting early in primary school. It’s unlikely but people do cut in primary school. I would know because I did in Year 6 and nobody understood which made it so hard.”

Two comments identified a need for a school-based program to include tertiary education settings. In particular, these young people clearly felt the lack of pastoral care in the tertiary setting in comparison to high school. Given the known risk of young people falling through the cracks as they transition from child to adult mental health services, programs to support tertiary students to access appropriate assistance would be beneficial.

“Actual services at university, really anything, but even an auto generated email when you miss class would have made a huge difference to me.”

## “I didn’t have many friends because ‘no one likes a guy that self harms’.”

### **Programs to reduce stigma, increase understanding and encourage supportive relationships**

Some young people wrote about experiencing stigma amongst peers at school, for example, peers making inappropriate jokes about mental illness or victimising the young person. Hence, anti-stigma programs are important.

“Sometimes at school people make jokes about depression and stuff.”

“Some people started to tell me I was better off dead and all those types of phrases.”

“Had my friend screenshot messages of me talking about my self-harm and sending them to my enemy and getting them spread around my school and losing all my friends because they thought I was an attention seeker.”

However, young people’s experiences with peers and friends suggested that providing specific education/training regarding how to respond when a friend or peer discloses suicidality or a mental health problem is at least as important.

A number of young people referred to losing their friends because of their mental health problems. This sometimes appeared to be linked to stigma, but other responses suggested that friends felt uncomfortable, didn’t know how to respond, and may not have recognised the young person’s need.

“Overall, I’ve found that most people just avert their eyes when I mention my anxiety, depression and issues. Metaphorically, I mean. They just look the other way, change the topic as fast as they can and try to pretend they didn’t hear what they heard.”

“My friends said yeah I think I’m depressed too, then went on to say some random things that happen to anyone, depressed or not. That did not help at all because she just passed it off like yeah, it’s just nothing, along with my anxiety.”

“They will start asking questions like ‘Why did you do it?’ ‘Did it hurt?’ ‘What did it feel like?’. Those questions made me feel unsafe and depressed.”

“I spoke to a friend about it and it didn’t help at all! They just said, ‘oh ... maybe like call a helpline or something ... yeah ...’ And never discussed the subject with me again.”

## TECHNOLOGY, THE INTERNET AND SOCIAL MEDIA

The internet provides an unprecedented opportunity to disseminate educational messages to young people and the community more broadly. Responses to the 2015 Child and Adolescent Survey of Mental Health and Wellbeing showed that around 40% of young people with a major depressive disorder had accessed information about mental health online, 13% had accessed information about services in the community, and almost 30% had used an online assessment tool to determine whether they needed professional support.<sup>4</sup> Of those respondents to our consultation who had sought help, 50% (n=95) had sought it online. Of those, 36% found it 'very helpful' while only 19% found it 'not at all helpful'.

The internet also has potential as a medium to deliver suicide prevention interventions. Evaluation of the effectiveness of online and app-based interventions is limited at this stage, but they show promise because they are easily accessible, may reduce barriers to help-seeking, can be widely disseminated, and are potentially cost-effective in comparison to face-to-face services. The Australian Government's response to the Review of Mental Health Programmes and Services<sup>5</sup> includes a number of references to steering people towards digital and self-help resources if they are considered to have low level needs.

Young people's comments in our consultation showed that many are distressed that their concerns are trivialised or not taken seriously, even by mental health

professionals. It is important to ensure that encouraging referral to less intensive digital services in the first instance does not exacerbate this problem by suggesting to young people that their problems don't warrant the support of a real person. Young people told us they intentionally hide their feelings due to stigma, and downplay the severity of their suicidality due to fear of being hospitalised. Consequently, there is a real risk of mistakenly assessing suicidal young people as low needs.

"Even though I have (and still do) reach out for help, I sometimes underplay my feelings. I still inherently feel that I am not as important as other people and tend to act less needy/desperate."

Whether online interventions need to be accompanied by personal support (that is, therapist-guided care programs) is an issue needing further investigation<sup>6</sup>, but results of the consultation suggest that this may be the case for suicidal young people. As outlined previously, young people clearly identified relationships with others as key to recovery, and wrote about the value of a caring, trusting relationship with a mental health professional more than the value of 'treatment'.

In contrast to the policy and research focus on the potential of online technologies, and the multitude of apps targeting young people experiencing mental health difficulties, few respondents referred to technology or apps as a form of support. Only one wrote about the hazards of social media (e.g., cyberbullying, trolling), which are often mentioned in the mainstream media.

A small number reported information found on social media as a positive influence, and used social media as a way to overcome

isolation. Comments supported the potential of online peer-support groups, or other uses of social media to connect young people to others with similar experience.

"Honestly the best thing for me was when one day I was reading all these positive quotes on Tumblr about how you only get one life to live, so why waste it being sad?"

"The internet. Tumblr, blogs. Whether they be true or not, many of the tips did help. And there was some comfort that these people may have been there and know more than someone who's just read about it in a textbook."

"Honestly, me joining a fandom has helped immensely. The reason many join one is to escape reality of everyday life. I have made friends because of it, and without them I know I wouldn't have made it this far."

"I think finding an online community of people similar to me really helped. I felt like there were people I could trust."

"Maybe start an online group where you could get kids any age just to join in talk about what's bothering them with other people that are feeling the same way they are."

<sup>4</sup> David Lawrence et al., The Mental Health of Children and Adolescents Report on the Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Canberra: Department of Health, 2015).

<sup>5</sup> Australian Government Department of Health, 'Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services' (Commonwealth of Australia, 2015).

<sup>6</sup> Azy Barak and John M. Grohol, 'Current and Future Trends in Internet-Supported Mental Health Interventions', Journal of Technology in Human Services 29, no. 3 (July 2011): 155–96

## HOLISTIC, INTEGRATED RESPONSES, INCLUDING SUPPORT FOR FAMILIES

The Australian response to suicide has traditionally been biased towards a mental health perspective, but recognition of the need for holistic responses across a range of areas including homelessness, drug and alcohol, domestic and family violence, family and relationships, employment, and more, is increasing<sup>7</sup>. While young people did not speak directly to this issue, a number of responses highlighted the need for an approach that considers suicidal behaviour in context. For example:

“After spending a week the first time in hospital with amphetamine withdrawals I had to go back to my GP and get a referral to a psychologist, unfortunately the second day I was out I used again because I was suicidal and using was keeping me sane and I was honest to this GP who then judged me rudely and asked me what I expected her to do and that I was stupid.”

“[What else would have helped?] Somewhere to shower, store my bag of clothes when I went to school, wash my clothes.”

“Listen to us. Try to get an understanding about what’s happening in all different parts of our lives.”

Consistent with research that demonstrates the benefits of integrated services, a number of young people described the value of having a team of people providing support in different ways.

“The ongoing support from my team at [service]. My psychologist helped me realise my thought processes and helped me challenge them and a counsellor continued that when he left. An exercise physiologist helped kick start my reliance on staying active to become more mentally well. As well as this, the support I’ve gotten from an external psychiatrist has been good and well.”

“Having an experienced group of health professionals (GP, psychologist, psychiatrist) who could collaborate with each other to provide me with the help I needed.”

“Having regular and constant support/access to proven genuine and caring professionals like my GP, psychologist and counsellor. I had a team of people.”

As highlighted in “Insights Part 3: Messages for parents and carers”, young people who participated in our consultation emphasised the crucial role of parents and carers as sources of support. Beyond this, family functioning is fundamentally important for children’s social-emotional wellbeing and resilience. A number of young people described problems in the family environment as a significant source of stress that contributed to their suicidality. Consequently, suicidal children and adolescents need a holistic response that takes the home environment into account and includes family counselling and support where appropriate.

“If my parents/family were a lot more understandable or persuadable instead of always screaming and fighting. I would of found that a lot better.”

“I always try to forget about [suicide] through singing, playing the piano, reading, listening to music, or just hanging out with

friends. Yes it does help but when each day you wake up in the morning and your mum and dad are fighting and your brother and dad are fighting it doesn’t help.”

“I think if my family life were a little more stable and if my parents were in a position to support me, it would have helped. Alas this is not the case. My father is an alcoholic who spends the better part of everyday drunk ... My mother has enough to deal with without me adding more to the issues.”

“I honestly think going to a hospital will help, because I live in a house with lots of stress. And people at a hospital are there to help you and they can be better than parents. Taking a break from my house and family.”

Moreover, even when families appear to be functioning well, parents need support to cope effectively with their own emotions. Learning that your child is considering ending his/her own life is distressing for any parent. Young people described parental anger and distress, and we know from other research that parents of children who self-harm may experience anxiety, depression and social isolation<sup>8</sup>, which affects their capacity to provide effective support to their child and adds to the child’s distress.

“Probably just with the distress of mum really brought me down, I felt guilty for making her worry and concerned for my welfare – sometimes she got so distressed she would yell and it wasn’t exactly what I needed at that moment.”

<sup>7</sup> Suicide Prevention Australia, ‘Discussion Paper. One World Connected: An Assessment of Australia’s Progress in Suicide Prevention’, 2014.

<sup>8</sup> Anne E. Ferrey et al., ‘The Impact of Self-Harm by Young People on Parents and Families: A Qualitative Study’, *BMJ Open* 6, no. 1 (1 January 2016): e009631, doi:10.1136/bmjopen-2015-009631.

# YOUNG PEOPLE'S MESSAGES FOR SERVICE PROVIDERS

"Take each person that reaches out seriously. Be true. Be genuine. Be caring. Be honest. Be understanding. Be non-judging. Be there for them."

"Always be there even if they push you away."

"Be non-judgemental – really. And treat them like a valued person, not a patient. Treat them like you are really glad they are talking to you and let them know that."

"I think that sometimes counsellors have to know that we lie about our suicidal thoughts sometimes cause we are scared that the police will be called or our parents will be told."

"Often young people are just looking for someone to talk to and not necessarily looking for extensive treatment."

"Don't judge, be kind, let them know you care and help them to understand that things can be different and they won't always feel the same way. But mostly be kind, one nice person can make a difference."

"Don't be forceful or overly clinical, be gentle, understanding and simply listen to what they have to say."

"Don't focus so much on the negative side to it. Yes, it's important to confirm safety and immediate risk to self but it's also important for the young person to be heard and to be able to have their story told without feeling like they'll get put into a hospital if they talk about their thoughts."

"Don't interrogate, support. Young people are like flowers – we're shut tight as a bud and it takes careful nurturing, love, and sunshine to make us open ourselves to the world."

"Please be open minded, patient and understanding. We are not just cases but people. Don't send us away when we try to ask for help because that might be our last. If you can't help, find us who can."

"Listen to the young person, they know a lot more than you think."

## "Stop judging. Listen. Don't assume. Care more."

