Inquiry by the National Children's Commissioner into Intentional Self-harm and Suicidal Behaviour in Children

Prepared by BoysTown

BoysTown

Fresh start.
New hope.

Authorised By:

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2 June 2014

Overview

Suicide, self-injury and self-harm are critical issues impacting on the wellbeing of Australian children. From 2011, Kids Helpline has experienced a 20% increase in contacts concerning suicide, self-injury and self-harm and mental health issues from children and young people under 25. Given the importance of these issues to Australian children, this organisation has prepared a detailed analysis of its experiences in supporting children to both inform the National Children's Commission's deliberations and to ensure that the voice of young people is heard in this Inquiry.

This analysis is based on the following data:

1. An examination of the 6,703 contacts from young people under 18 in relation to suicide as a main concern and the 4,380 contacts about self-injury and self-harm as a main concern received by Kids Helpline during 2012 and 2013

2. A qualitative analysis of contact notes for 50 young people receiving support from Kids Helpline in relation to suicide issues

3. A further qualitative exploration of 84 contact notes of young people receiving counselling for self-injury and self-harm issues

4. A study of the data (N=1,134 contacts) previously collected between 1998 and 2007 under the auspice of the National Youth Suicide Prevention Strategy. Information from a part of this database has been analysed for the years 2003-2006 and is included in this submission to assist the National Children's Commissioner in understanding the range of risk and protective factors for suicide present in young people's lives.

5. Consultations with Kids Helpline practitioners concerning their experiences with young people

This paper commences with an overview of the Kids Helpline service to provide a context for the interpretation of this evidence. It then provides a specific response to two issues raised by the National Children's Commission specifically why children engage in suicide, self-injury and self-harm and the programs required to reduce the incidence of this behaviour. Following this analysis we present five recommendations as to actions that need to be taken by Government and the Australian community to support our children in regard to these concerns.

About BoysTown & Kids Helpline

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

BoysTown provides a range of youth counselling, family support and employment support services across Australia. Our services are located in some of the most disadvantaged Australian communities including Logan City and Goodna near Brisbane, Western Sydney, North Adelaide, Port Pirie and Balgo Hills, Western

Australia. In 2012-13 we provided services to over 275,000 kids, young people and families.[1]

A service of BoysTown, 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. 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 self-harm and suicide.

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

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

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.

Kids Helpline has an extensive referral database of more than 9,500 support services that is used to refer young people to local sources of support. The Kids Helpline website contains a range of self-help resources and mental health information.

In recognition of our organisation's work with children and young people BoysTown was awarded in 2009, a Life Award by Suicide Prevention Australia.

Kids Helpline Data Collection System

Kids Helpline gathers information on a range of issues directly stated by children and young people to the service. Counsellors record non-identifying demographic data and classify contacts according to a defined set of problem types. In some instances, counsellors may also collect qualitative information from children and young people in order to provide case management assistance and to give voice to their concerns.

BoysTown through its Kids Helpline database holds a unique dataset on suicide. The data is derived from young people who are seeking help or are concerned about their own or others' suicidal thoughts or behaviours. This includes clients with general suicidal thoughts, specific plans, immediate intentions and those young people who are in the process of a suicide attempt at the time of contacting Kids Helpline. This differs from other studies which predominantly rely on data about people who are in recovery or who have completed suicide.

[1] BoysTown (2013) Annual Report 2013: 8

The Kids Helpline database also holds information from children and young people who are seeking help about their own or another person's deliberate self-injury and self-harming thoughts and behaviours. This includes any deliberate, non-life threatening, self-effected bodily harm with the intent to cause physical harm to self. Clients may also discuss their concerns about urges to self-injure and self-harm. This classification does not include any deliberate self-injury and self-harm with suicidal intent.

Given the source for our data is from those young people actively seeking help, it is likely that our analysis of risk and protective factors in relation to suicide, self-injury and self-harm will be more immediate. However it should also be pointed out that this group of young people may differ to those youth who do not seek help about these issues. Consequently there may exist possible respondent bias in the data set.

However it is our belief that the following analysis does reflect the 'voice' of a considerable number of children and young people who are experiencing the impact of suicidality, self-injury and self-harm and will assist in providing an evidence base for the development of strategies to respond to these issues.

Contacts with Children and Youth About Suicide, Self-Injury and Self-Harm

The following analysis is provided to inform the National Children's Commissioner of the direct experiences of the many young people seeking assistance with Kids Helpline about suicide, self-injury and self-harm. This evidence will assist in informing the development of strategies to support young people in relation to these issues as well as providing their voice.

During 2012 and 2013, Kids Helpline responded to 510,790 telephone and online contacts from children and youth aged **5 to 25** years, where 145,120 of these contacts involved the provision of counselling. Of these contacts, 19,011 were assessed by counsellors as having current thoughts of suicide. In addition, counsellors assessed 31,878 of the contacts as involving a client who self-injures and self-harms. In other words, 13.10% of counselling contacts were with young people assessed as having current thoughts of suicide and 21.97% were assessed as partaking in self-injury and self-harm.

Over the same period counsellors responded to 80,142 counselling contacts from children and young people who were **under 18 years** of age. Of these contacts, 11,180 were assessed as having current thoughts of suicide. The number of contacts assessed as having current thoughts of suicide increased from 5,451 in 2012 to 5,729 in 2013. In 18,737 contacts, the children and young people were assessed as self-injuring and self-harming. Very little change occurred during this time in terms of numbers for self-injury and self-harm where 9,451 contacts in 2012 and 9,286 contacts in 2013 were assessed.

'Suicide' and 'Self-injury and Self-harm' as Main Concerns

As well as recording the assessment by counsellors about suicide, self-injury and self-harm, our data system also records the issues directly stated by young people at the point of contact. During 2012 and 2013, Kids Helpline responded to 10,033 contacts where suicide was directly stated as one of the concerns by children and young people aged under 18 years when contacting Kids Helpline. Suicide was the main concern directly stated by under 18 year olds in 6,703

contacts during this time. Specifically, 3,190 contacts were made in 2012 where suicide was the main concern which amounted to 8.03% of counselling contacts from young people aged under 18 years. The proportion of contacts from young people aged under 18 years where suicide was the main concern increased significantly in 2013 to 8.69% (n = 3,513), $p < .05$. In 2012, suicide was the fifth most common focal concern for children and young people aged under 18 years who contacted Kids Helpline. In 2013, suicide became the third most common focal concern directly stated by children and young people aged under 18 years.

In 2012 and 2013, Kids Helpline responded to 8,117 contacts by children and young people aged under 18 years where self-injury and self-harm was one of the concerns directly raised by them. Self-injury and self-harm was the focal concern in 4,380 of these contacts. In 2012, 2,112 contacts were made about self-injury and self-harm as a main concern, accounting for 5.32% of counselling contacts from children and young people aged under 18 years. In 2013, Kids Helpline responded to 2,268 contacts about self-injury and self-harm as a main concern, accounting for 5.61% of counselling contacts from children and young people aged below 18 years. Self-injury and self-harm was the seventh most common concern directly stated by children and young people under 18 years during 2012 and 2013.

Reasons for Contact

Based on contemporary research evidence and operational experience these broad problem types are further deconstructed into a number of different sub-categories. The problem type of suicide includes five sub-categories which include seeking information, concern about another person, suicidal thoughts or fears, immediate intention and current attempt at the time of contact.

Similarly the problem category of self-injury and self-harm includes seeking information, concern for another, seeking help to resist thoughts and urges to injure, talking through consequences and/or alternative coping strategies, concern by others about the young person's self-injuring and self-harming behaviour and concern that an injury at the time of contact requires medical assistance.

The most common reason for children and young people aged under 18 years contacting about suicide was suicidal thoughts and fears. The proportion of contacts regarding concerns about another person and immediate intention decreased significantly from 2012 to 2013, $p < .05$. Meanwhile, the proportion of contacts about a current attempt at the time of contact increased significantly from 2.38% in 2012 to 3.95% in 2013, $p < .05$. The reasons for children and young people aged under 18 years contacting Kids Helpline about suicide are shown in Table 1.

Table 1. Reasons for children and young people aged under 18 years contacting about suicide as their main concern in 2012 and 2013.

Reason for Contact	2012		2013	
	Number	%	Number	%
Seeking information	22	0.69%	28	0.79%
Concerned about another person	497	15.58%	479	13.64%
Suicidal thoughts or fears	2,342	73.42%	2,635	75.01%
Immediate intention	253	7.93%	232	6.60%
Current attempt at the time of contact	76	2.38%	139	3.96%
Total	**3,190**	**100%**	**3,513**	**100%**

The most common reason that children and young people aged under 18 years contact Kids Helpline about self-injury and self-harm was to talk through the consequences of their self-injuring and self-harming behaviour and to discuss alternative ways of coping with their distress. Contacts from children and young people who are concerned about another person self-injuring and self-harming increased significantly from 12.45% in 2012 to 15.12% in 2013, p .<05. The reasons for children and young people aged under 18 years contacting Kids Helpline about self-injury and self-harm are shown in Table 2.

Table 2. Reasons for children and young people aged under 18 years contacting about self-injury and self-harm in 2012 and 2013.

Reason for Contact	2012		2013	
	Number	%	Number	%
Seeking information	58	2.75%	43	1.90%
Concerned about another person	263	12.45%	343	15.12%
Contacting to help resist thoughts and urges to injure	761	36.03%	741	32.67%
Talking through consequences and/or alternative coping strategies	827	39.16%	914	40.30%
Others are concerned about client's self-injuring and self-harming behaviour	131	6.20%	136	6.00%
Concerned that injury at the time of contact requires medical assistance	72	3.41%	91	4.01%
Total	**2,112**	**100%**	**2,268**	**100%**

Kids Helpline counsellors also have the ability to record if there is a cyber (i.e. online or texting) aspect with regards to the nature of the concern. This includes use of the internet or social networking sites as well use of mobile phones to text words, images or to send video clips.

During 2012 and 2013, 1.54% (n = 105) of the 6,703 contacts from young people aged under 18 years where suicide was the main concern were recorded as having a cyber aspect in nature. While the majority (74.25%) of the 6,703 contacts where suicide was the main concern were in relation to suicidal thoughts and fears, 73.79% of the 105 contacts with a cyber aspect were regarding concerns about another person. Of the 4,380 contacts from young people aged under 18 years where self-injury and self-harm was their main concern, 0.78% (n = 34) were recorded by Counsellors as having a cyber aspect regarding the reason for contact. Of these 34 contacts with a cyber aspect, the most common (61.67%) reason for contact was concern about another person. The data suggests that when there is a cyber aspect to contacts primarily focused on suicide and self-injury and self-harm, the young people who contacted Kids Helpline were mostly concerned about another person after viewing worrying information from them on the internet, social networking sites and mobile phone messages.

This form of help seeking by children is most likely a protective factor preventing contagion in relation to suicide, self-injuring and self-harming behaviour.

In summary, suicidal thoughts and fears remained the most common reason that children and young people under 18 years contacted Kids Helpline about suicide. Talking through the consequences of their self-injuring and self-harming behaviour and discussing alternative ways of coping with their distress was the most common reason for contacting about self-injury and self-harm.

In addition, contacts from children and young people who were concerned about other people's self-injuring and self-harming behaviour is increasing. When the reason for contact involves a cyber aspect, it is in relation to concerns about another person.

Gender and Age

Gender was recorded for 6,600 contacts from children and young people aged under 18 years where suicide was the main concern during 2012 and 2013. Of these contacts, 87.32% (*n* = 5,763) were from females and 12.68% (*n* = 837) were from males. The ages of the female group ranged from seven to 17 years, with an average age of 14.97 years. The majority (93.86%) were aged between 13 and 17 years. The average age of the male group was also 14.97 years, with an age range of six to 17 years. The number of contacts from males increased with the age of clients.

The breakdown of age and gender of children and young people contacting about suicide as the main concern is displayed in Figure 1.

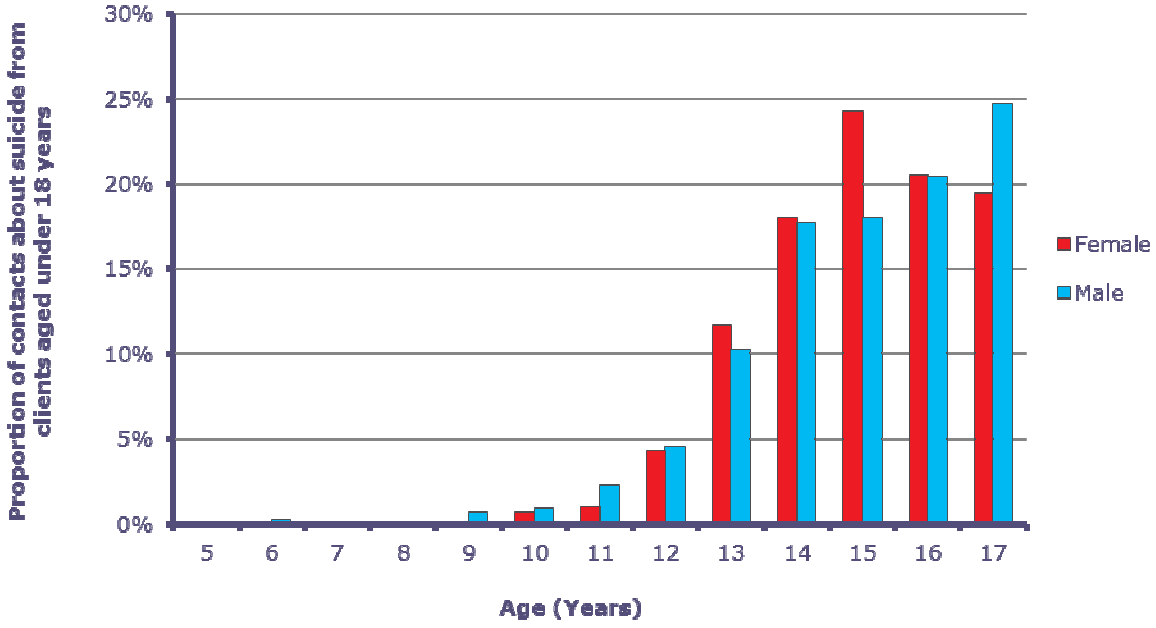

Figure 1. Breakdown of gender and age of contacts from children and young people under 18 years where suicide is the main concern.

Significant differences were seen in the mode of contact by females and males under 18 years contacting about suicide as their main concern. The proportion of online contacts from females (52.87%) in comparison to the proportion of online contacts from males (33.09%) was significantly higher, $p < .05$. Meanwhile, the proportion of phone calls from males (66.91%) was significantly higher than the proportion of calls from females (47.13%), $p < .05$. This is similar to the gender and mode of contact breakdown for all counselling contacts by males and females under 18 years. Specifically, 47.78% of contacts from females and 68.33% of contacts from males under 18 years were by phone, while 52.22% of contacts from females and 31.67% of contacts from males under 18 years were from online modes.

The proportions of contacts from males and females under 18 years contacting about suicide as the main concern by phone and online modes are shown in Figure 2.

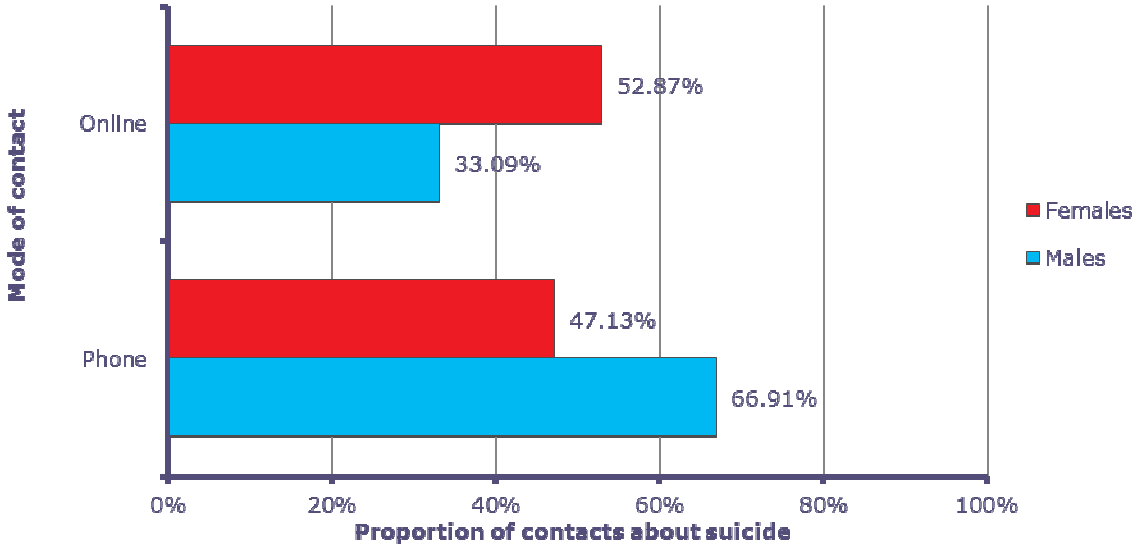

Figure 2. Proportion of online and phone contacts from males and females under 18 years where suicide is the main concern.

Suicidal thoughts and fears was the most common reason for males and females under 18 years to contact Kids Helpline about suicide during 2012 and 2013. The proportion of contacts from males (17.08%) discussing concerns about another person was significantly higher than the proportion of contacts from females (14.21%), $p < .05$. However the proportion of contacts from females (3.44%) making contact during a current attempt at suicide was significantly higher than the proportion of contacts from males (1.55%), $p < .05$.

The reasons for females and males under 18 years contacting Kids Helpline with suicide as the main concern are shown in Figure 3.

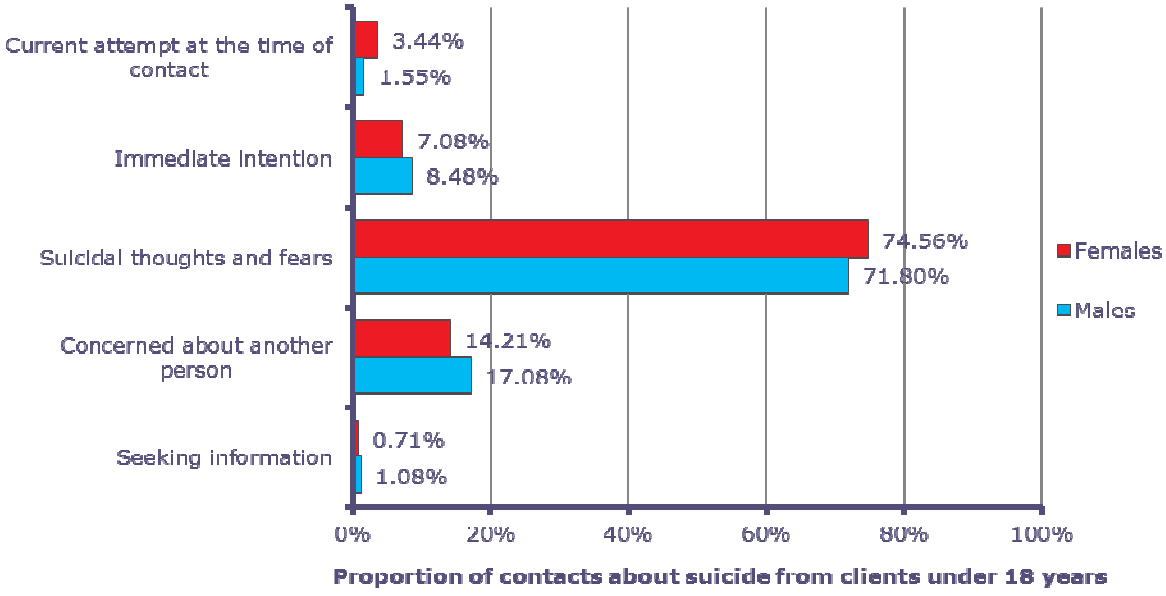

Figure 3. Reasons for males and females aged under 18 years contacting about suicide as the main concern.

The gender was recorded for 4,288 contacts from children and young people aged under 18 years where self-injury and self-harm was the main concern during 2012 and 2013. Of these contacts, 92.98% (*n* = 3,987) were from females and 7.02% (*n* = 301) were from males. The ages of the female group and male group ranged from nine to 17 years. The majority of contacts from females (92.78%) and contacts from males (94.35%) were aged between 13 and 17 years. The average age was 14.73 years for contacts from females and 15.06 years for contacts from males.

The breakdown of age and gender of children and young people contacting about self-injury and self-harm as the main concern is displayed in Figure 4.

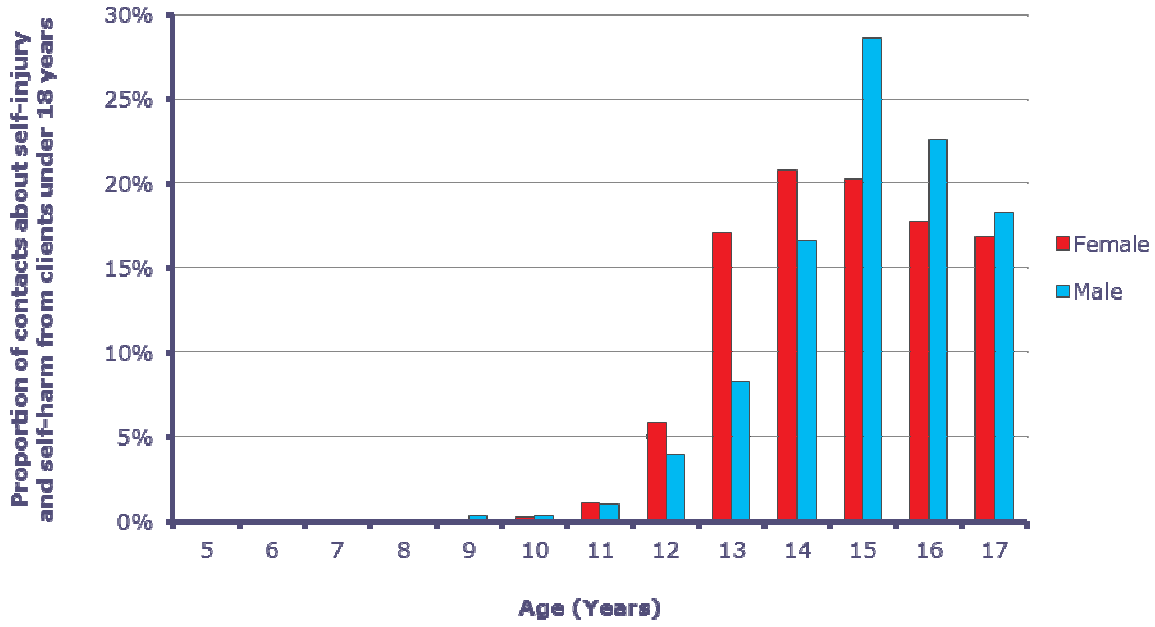

Figure 4. Breakdown of gender and age of contacts from children and young people under 18 years where self-injury and self-harm is the main concern.

Significant differences were seen in the proportions of online contacts and phone calls by females and males under 18 years discussing self-injury and self-harm as the main concern during 2012 and 2013. The proportion of online contacts from females (59.22%) was significantly higher than the proportion of males (44.85%), $p < .05$. However the proportion of males (55.15%) was significantly higher than the proportion of females (40.78%) contacting Kids Helpline by phone to discuss their concerns about self-injury and self-harm, $p < 05$.

The proportions of males and females under 18 years contacting about self-injury and self-harm as the main concern by phone and online modes are shown in Figure 5.

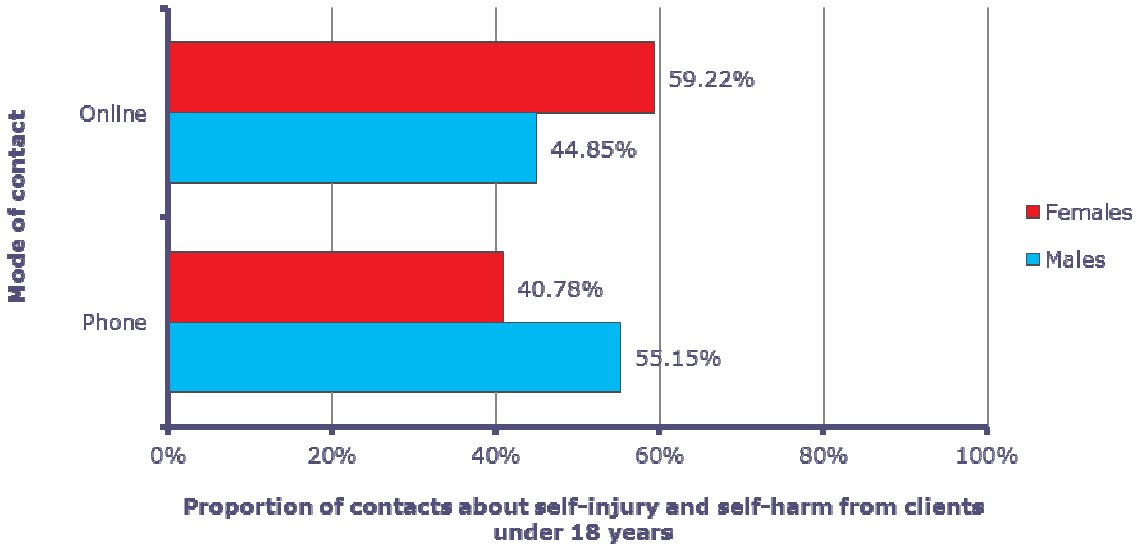

Figure 5. Proportion of phone and online contacts from males and females under 18 years where self-injury and self-harm is the main concern.

In 2012 and 2013, talking through the consequences was the most common reason for females under 18 years contacting Kids Helpline about self-injury and self-harm as their main concern. The proportion of females (40.63%) was significantly higher than the proportion of males (30.90%) under 18 years who contacted to talk through the consequences of self-injury and self-harm and discuss better coping strategies with their distress, $p < .05$. During this time, the most common reason for males under 18 years contacting about self-injury and self-harm was to get assistance with resisting the thoughts and urges to injure and harm. The proportion of males was significantly higher than the proportion of females under 18 years who contacted about self-injury and self-harm in relation to seeking information (4.65% versus 2.08%) and concerns about another person (23.92% versus 12.89%), $p < .05$. The reasons females and males under 18 years contacted Kids Helpline about self-injury and self-harm as the main concern are shown in Figure 6.

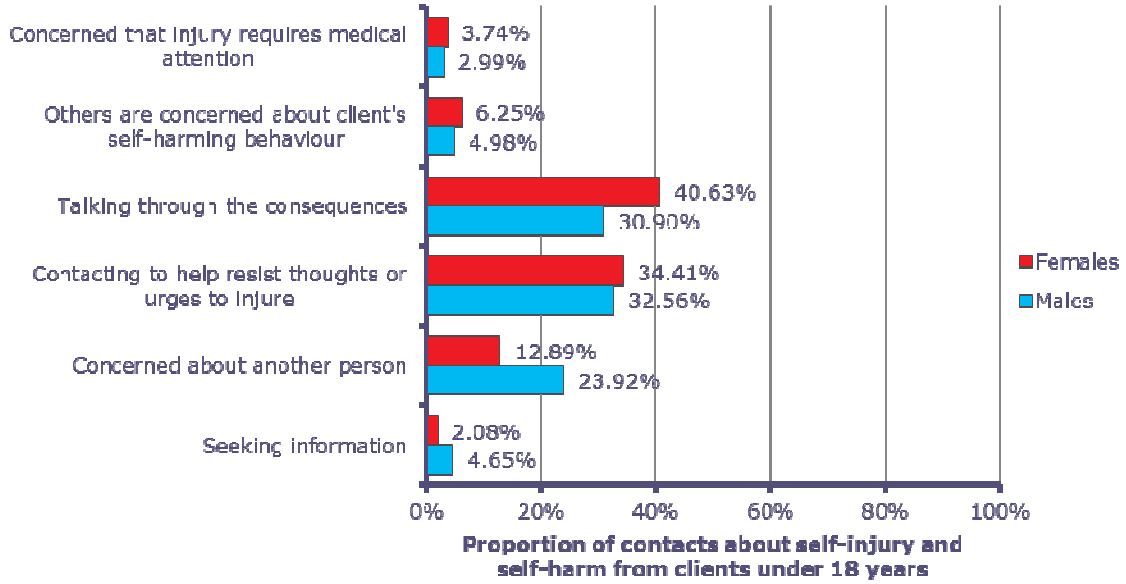

Figure 6. Reasons for males and females aged under 18 years contacting about self-injury and self-harm as their main concern.

In summary, the majority of contacts from males and females under 18 years about suicide and self-injury and self-harm were aged from 13 to 17 years. The number of contacts from males increased as the age of the young people making contact increased. Females were proportionally more likely at a significant level to make contact online about suicide and self-injury and self-harm while males were proportionally more likely at a significant level to make contact by phone about these two issues as main concerns.

A significant difference was seen in the higher proportion of females compared to males who contacted during a current suicide attempt. However males were proportionally more likely at a significant level to make contact when concerned about another person. In relation to self-injury and self-harm, females were significantly and proportionally more likely to contact to discuss the consequences of the harming behaviour and possible alternatives to cope with their distress. Males were proportionally more likely to seek information and to discuss their concerns about another person.

Key findings in this analysis that may inform the development of strategies to engender help seeking behaviours about suicide, self-injury and self-harm from children under 18 are:

- The importance of online methods of engagement such as web and email counselling for females under 18 both in general and in particular for those young women impacted by suicidality, self-injury and self-harm. Phone counselling is a critical engagement strategy for young men in relation to suicide, self-injury and self-harm. This issue will also be further developed in our response to Issue 7.

- The underrepresentation of young males in help seeking activities concerning suicide. This is consistent with other contemporary research. A focus needs to be placed on connecting with this group about suicide, self-injury and self-harm particularly given their risk profile.

- The different issues raised by young women and men when seeking help. Young women are more likely to engage in counselling about their own suicidality, self-injuring and self-harming behaviour than young men who tend to be contacting about their concerns regarding another person or seeking information.

Location

Counsellors also collect data on the location of the client making the contact about suicide and self-injury and self-harm. A regional classification system driven by postcode location is used to code data in the following classes:

- Capital city
    - State and territory statistical divisions
- Other metropolitan areas
    - Urban centres with a population greater than or equal to 100,000
- Large rural large centres
    - Populations between 25,000 and 99,000
    - Non-metropolitan Statistical Local Area (SLA) with an index of remoteness less than or equal to 10.5
- Small rural centres
    - Populations between 10,000 and 24,999

    - Non-metropolitan SLA with an index of remoteness less than or equal to 10.5
- Other rural areas
    - Populations less than 10,000
    - Non-metropolitan SLA with an index of remoteness less than or equal to 10.5
- Remote centres
    - Populations less than or equal to 5,000
    - Non-metropolitan SLA with an index of remoteness greater than 10.5
- Other remote areas
    - Populations less than or equal to 5,000
    - Non-metropolitan SLA with an index of remoteness greater than 10.5

In 2012 and 2013, Kids Helpline collected location data in 3,174 contacts from children and young people under 18 years when suicide was the main concern. Of these contacts, 62.73% (*n* = 1,991) were from a capital city and 8.76% (*n* = 278) from other metropolitan areas, 27.25% (*n* = 865) were from rural centres and areas and 1.26% (*n* = 40) were from remote centres and areas. Although the number of contacts is small, a significant increase was seen in the proportion of contacts originating in remote areas from 2012 (0.58%) to 2013 (1.92%), $p < .05$. The number and proportion of contacts about suicide from capital and metropolitan, rural and remote areas during 2012 and 2013 is shown in Table 3.

Table 3. Number and proportion of contacts about suicide from young people under 18 years in capital and metropolitan, rural and remote areas.

Regional classification	2012		2013	
	Number	%	Number	%
Capital city and other metropolitan areas	1,116	71.58%	1,153	71.39%
Rural centres and areas	434	27.84%	431	26.69%
Remote centres and areas	9	0.58%	31	1.92%
Total	**1,559**	**100%**	**1,614**	**100%**

The ages ranged from nine to 17 years (*M* = 15.04) for contacts about suicide from capital cities and other metropolitan areas, eight to 17 years for contacts from rural centres and areas (*M* = 15.42), and 13 to 17 years (*M* = 15.13) for contacts from remote centres and areas. The proportion of contacts from rural centres and areas increased with the age of the young people making contact. The breakdown of age and location of contacts from children and young people contacting about suicide as the main concern is displayed in Figure 7.

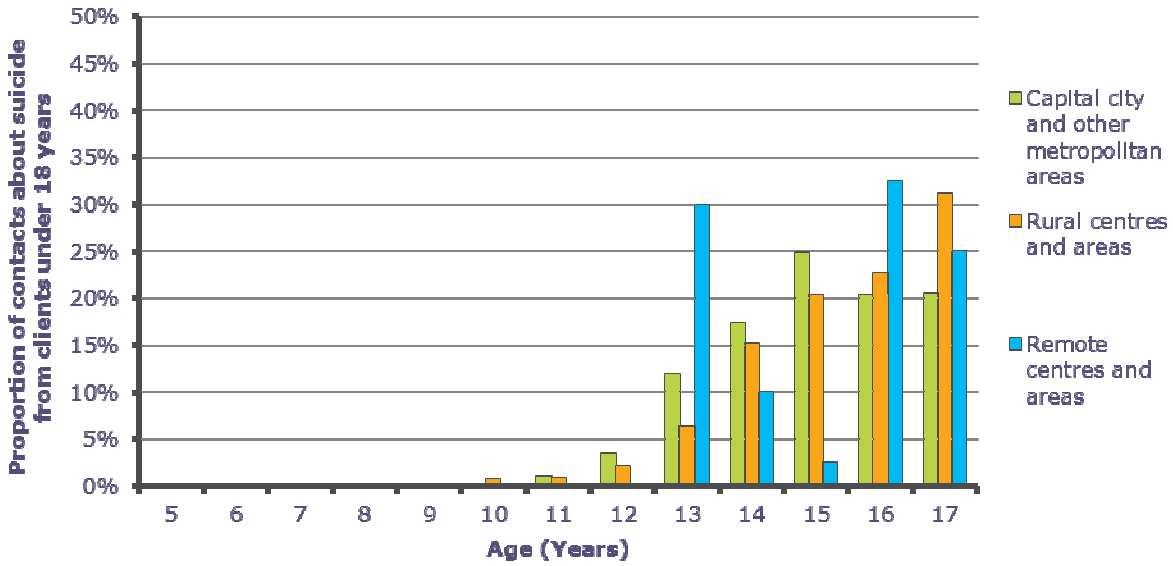

Figure 7. Breakdown of age and location of contacts from children and young people under 18 years where suicide is the main concern.

Significant differences were seen in the location data for females and males under 18 years where suicide was the main concern. The proportion of contacts from females in rural centres and areas (93.48%) was significantly higher than the proportion of contacts from females in capital cities and other metropolitan areas (89.35%), $p < .05$. Also, the proportion of contacts from males in capital cities and other metropolitan areas (10.65%) was significantly higher than the proportion of contacts from males in rural centres and areas (6.52%), $p < .05$. The proportions of contacts from males and females under 18 years contacting about suicide as their main concern from different locations is shown in Figure 8.

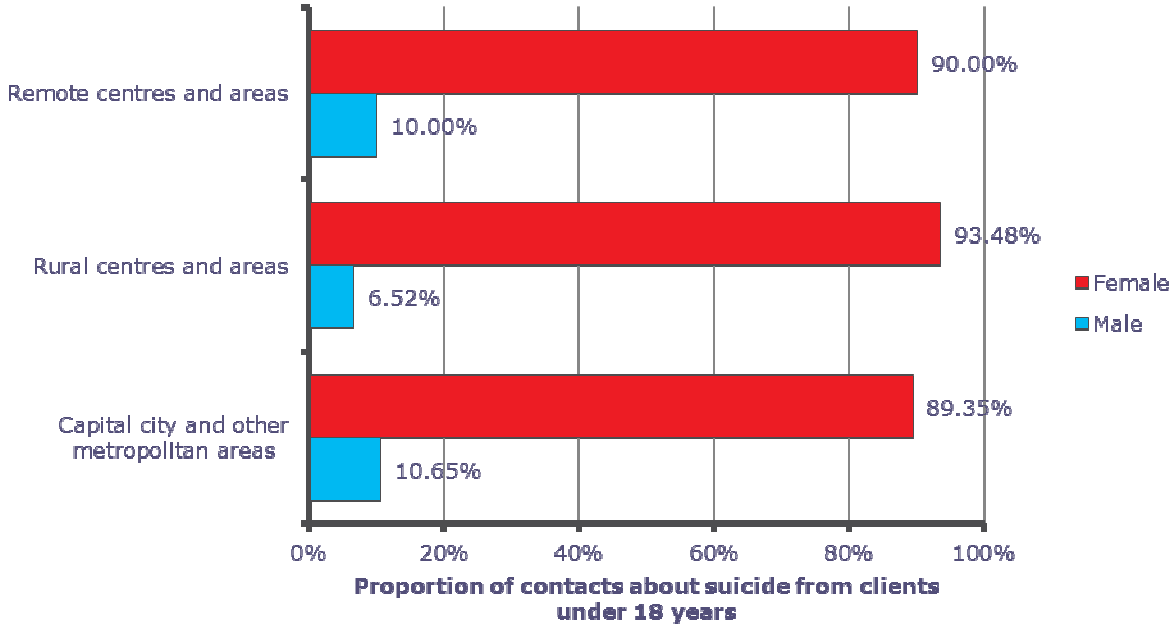

Figure 8. Proportions of contacts from males and females under 18 years from different locations contacting about suicide as their main concern

Significant differences were also seen in the mode of contact from young people under 18 years in different areas about suicide as a main concern. The proportion of contacts by phone from rural centres and areas (42.08%) was significantly higher than the proportion of phone contacts from capital cities and other metropolitan areas (37.42%), $p < .05$. Meanwhile, the proportion of online contacts from capital cities and other metropolitan areas (62.58%) was significantly higher than that from rural centres and areas (57.92%), $p < .05$. The proportion of phone and online contacts from young people under 18 years in different locations about suicide as a main concern is displayed in Figure 9.

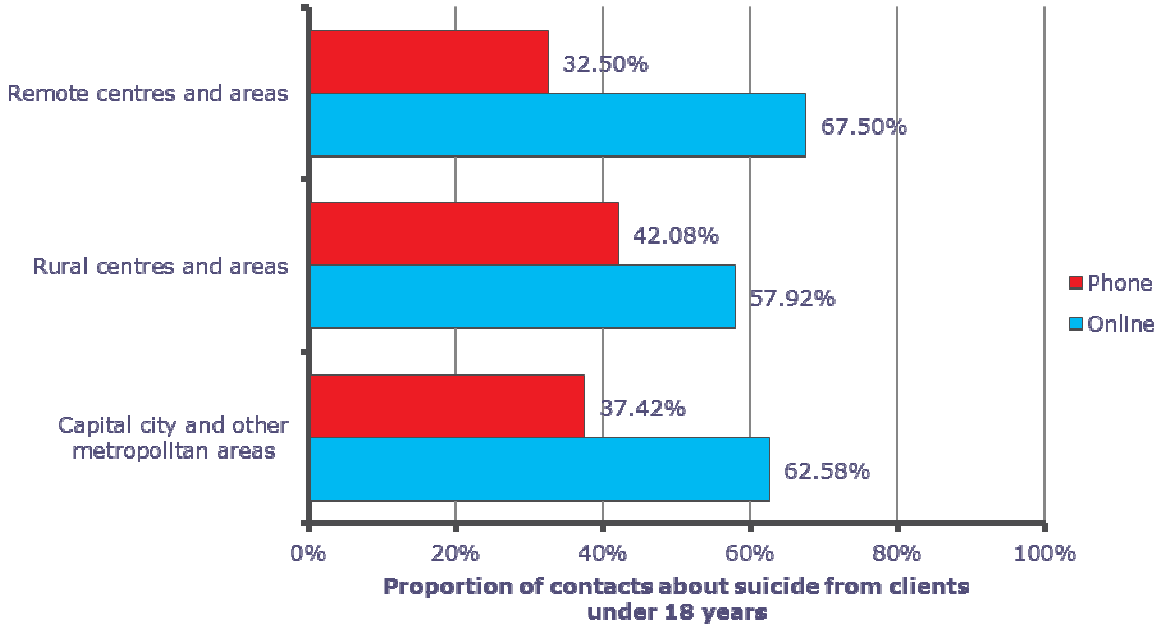

Figure 9. Proportions of phone and online contacts from young people under 18 years in different locations about suicide as a main concern.

In 2012 and 2013, Kids Helpline collected location data in 2,100 contacts from children and young people under 18 years when self-injury and self-harm was the main concern. Of these contacts, 62.86% (n = 1,320) were from a capital city and 6.62% (n = 139) from other metropolitan areas, 29.86% (n = 627) were from rural centres and areas, and 0.67% (n = 14) were from remote centres and areas. A significant decrease in the proportion of contacts from capital cities and other metropolitan areas was seen from 72.60% (n = 779) in 2012 to 66.21% (n = 680) in 2013, $p < .05$. Meanwhile, the proportion of contacts about self-injury and self-harm from young people under 18 years in rural centres and areas significantly increased from 27.12% (n = 291) in 2012 to 32.72% (n = 336) in 2013, $p < .05$. Although the number of contacts is small, a significant increase was seen in the proportion of contacts originating in remote areas from 0.28% (n = 3) in 2012 to 1.07 (n = 11) in 2013, $p < .05$. The number and proportion of contacts about suicide from capital and metropolitan, rural and remote areas during 2012 and 2013 is shown in Table 4.

Table 4. Number and proportion of contacts about self-injury and self-harm from young people under 18 years in capital and metropolitan, rural and remote areas.

Regional classification	2012		2013	
	Number	%	Number	%
Capital city and other metropolitan areas	779	72.60%	680	66.21%
Rural centres and areas	291	27.12%	336	32.72%
Remote centres and areas	3	0.28%	11	1.07%
Total	**1,073**	**100%**	**1,027**	**100%**

The most common reason across the geographic spread for contacting about suicide was suicidal thoughts and fears. The reasons for contacting about suicide regarding contacts from different locations are shown in Figure 10.

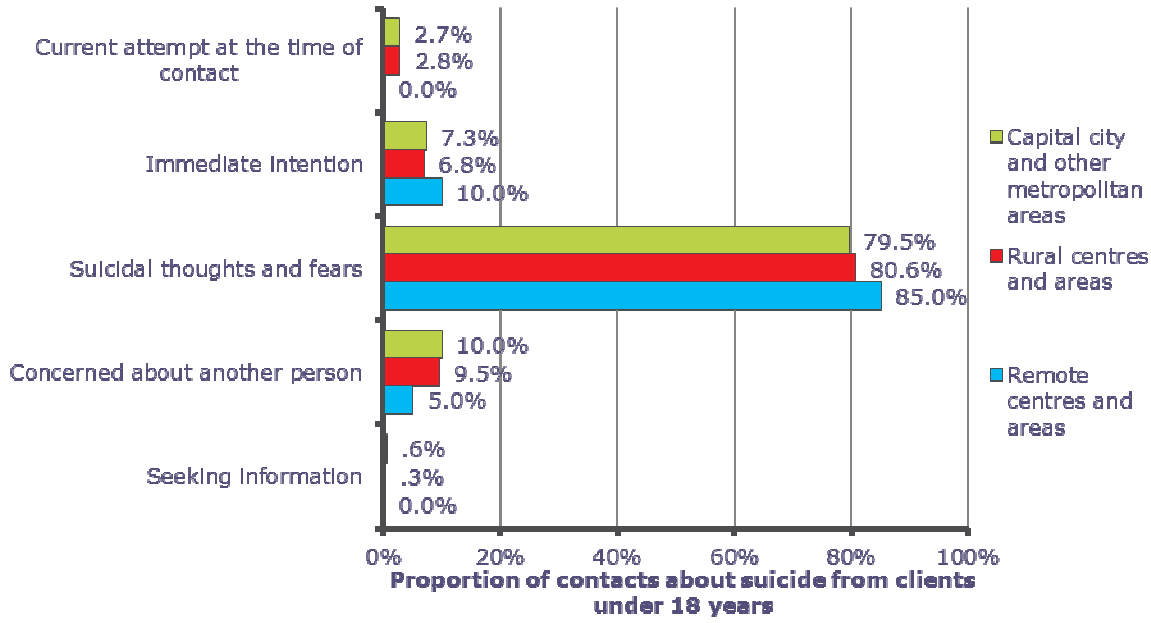

Figure 10. Reasons for contacting about suicide regarding contacts from different locations.

The ages ranged from nine to 17 years (*M* = 14.81) for contacts about self-injury and self-harm from capital cities and other metropolitan areas, nine to 17 years for contacts from rural centres and areas (*M* = 15.57), and 13 to 17 years (*M* = 14.79) for contacts from remote centres and areas. The majority (79.51%) of contacts from capital cities and other metropolitan areas were from young people aged between 14 and 17 years. In relation to contacts about self-injury and self-harm from rural centres and areas, 88.36% were aged between 14 and 17 years. The breakdown of age and location of contacts from children and young people contacting about self-injury and self-harm as the main concern is displayed in Figure 11.

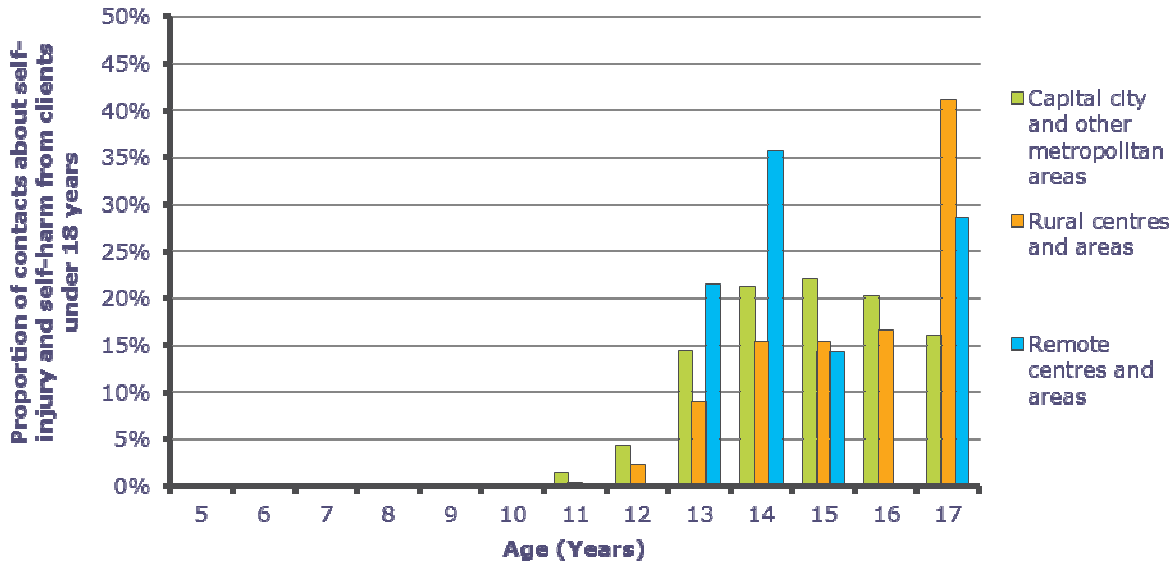

Figure 11. Breakdown of age and location of contacts from children and young people under 18 years where self-injury and self-harm is the main concern.

Significant differences were seen in the location of contact by females and males under 18 years where self-injury and self-harm was the main concern. The proportion of contacts from females in rural centres and areas (96.94%) was significantly higher than the proportion of contacts from females in capital cities and other metropolitan areas (91.86%), $p < .05$. Also, the proportion of contacts from males in capital cities and other metropolitan areas (8.14%) was significantly higher than the proportion of contacts from males in rural centres and areas (3.06%), $p < .05$. The proportions of contacts from males and females under 18 years contacting about self-injury and self-harm as the main concern from different locations are shown in Figure 12.

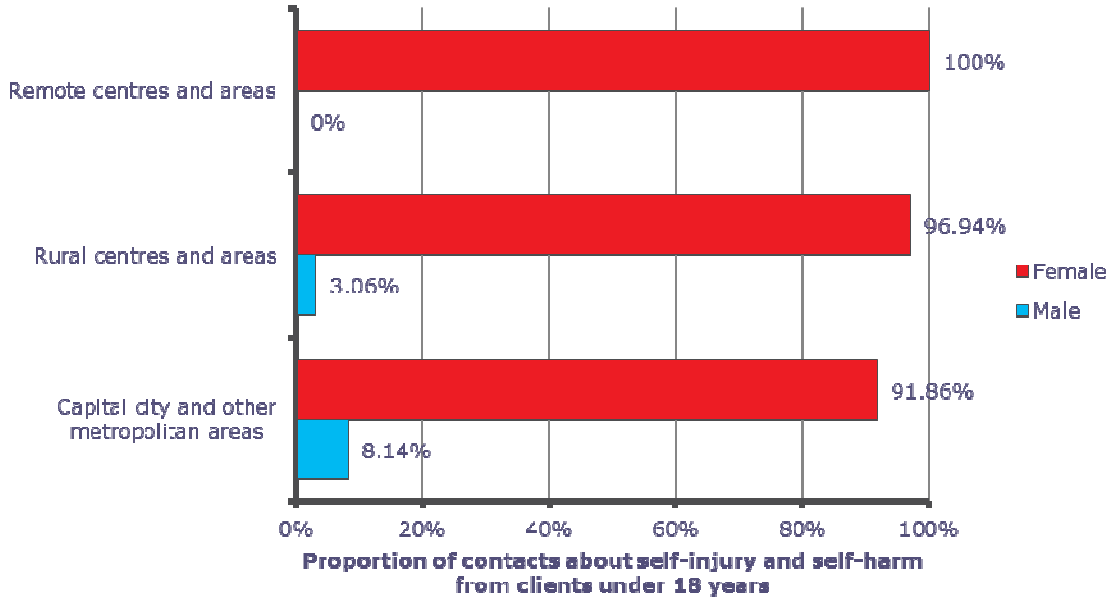

Figure 12. Proportions of contacts from males and females under 18 years in different locations contacting about self-injury and self-harm as the main concern.

Significant differences were also seen in the mode of contact from young people under 18 years in different areas about self-injury and self-harm as a main concern. The proportion of contacts by phone from rural centres and areas (36.04%) was significantly higher than the proportion of phone contacts from capital cities and other metropolitan areas (29.61%), $p < .05$. Meanwhile, the proportion of online contacts from capital cities and other metropolitan areas (70.39%) was significantly higher than that from rural centres and areas (63.96%), $p < .05$. The proportion of phone and online contacts from young people under 18 years in different locations about self-injury and self-harm as a main concern is displayed in Figure 13.

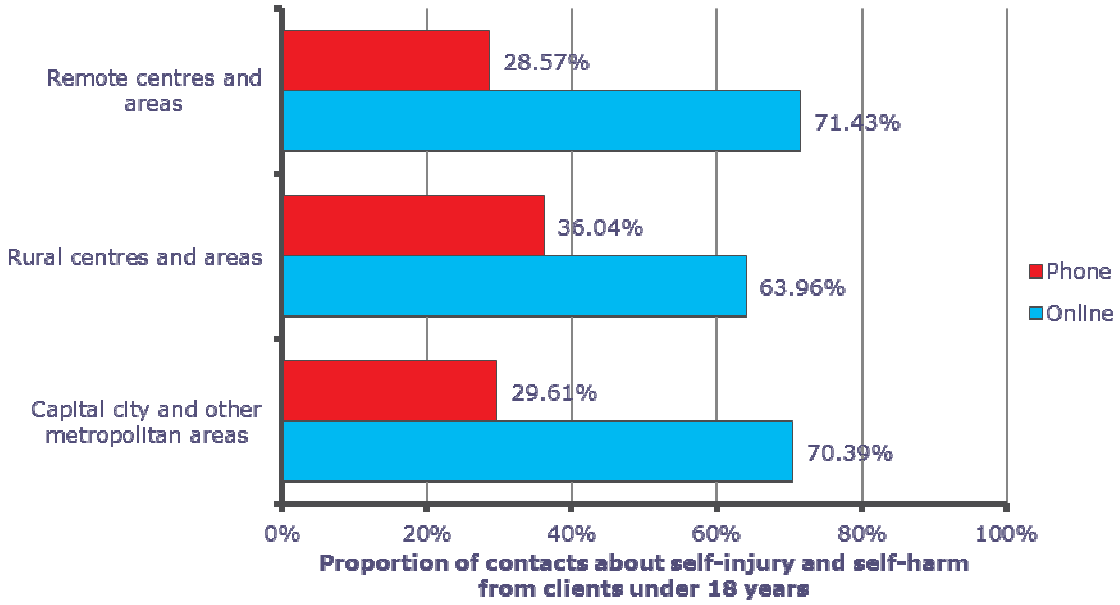

Figure 13. Proportions of phone and online contacts from young people under 18 years in different locations about self-injury and self-harm as a main concern.

The most common reason for children and young people under 18 years in capital cities and other metropolitan areas to contact about self-injury and self-harm was talking through the consequences of self-injury and self-harm and discussing alternative options to dealing with their distress. Specifically, 39.75% (n = 580) of contacts under 18 years from capital cities and other metropolitan areas were in relation to this reason, while 38.18% (n = 557) were contacting to get help in resisting the thoughts and urges to injure or harm.

The most common reason for children and young people under 18 years in rural centres and areas to contact about self-injury and self-harm was to access help in resisting the thoughts and urges to injure or harm. Specifically, 46.25% (n = 290) of contacts were in relation to this reason, while 39.07% (n = 245) were about talking through the consequences of self-injury and self-harm.

Significant differences were also seen between these two location groups regarding their reasons for calling. The number of contacts from remote areas was too low to be included in the significance testing. The proportion of contacts from young people under 18 years in capital cities and other metropolitan areas (10.83%) was significantly higher than the proportion of contacts from young people under 18 years in rural centres and areas (4.15%) regarding concerns about another person, $p < .05$. Meanwhile, the proportion of contacts from young

people under 18 years in capital cities and other metropolitan areas (39.75%) was significantly lower than the proportion of contacts from young people under 18 years in rural centres and areas (46.25%) with regards to talking through the consequences, $p < .05$. The reasons for contacting about self-injury and self-harm regarding contacts from different locations are shown in Figure 14.

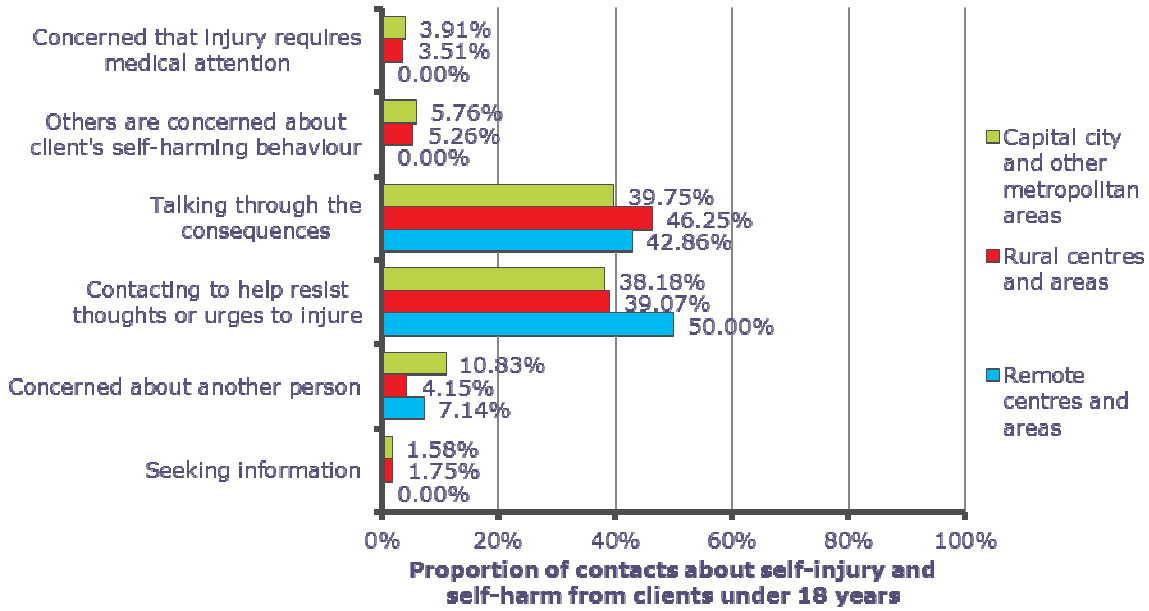

Figure 14. Reasons for contacting about self-injury and self-harm regarding contacts from different locations.

In summary, more contacts from young people under 18 years about suicide, self-injury and self-harm come from capital cities and other metropolitan areas. The average age of the young people making the contacts across these areas was between 14 and 15 years. The proportion of contacts from females in rural areas was significantly higher than the proportion of contacts from females in capital cities and other metropolitan areas for both suicide and self-injury and self-harm.

Meanwhile, the proportion of contacts from males from capital cities and other metropolitan areas was significantly higher than the proportion of contacts from males in rural areas for both suicide, self-injury and self-harm.

The proportion of online contacts from capital cities and other metropolitan areas was significantly higher than the proportion of online contacts from rural areas for both suicide and self-injury and self-harm concerns. However the proportion of phone calls from rural areas was significantly higher than the proportion of phone calls from capital cities and other metropolitan areas for suicide and also self-injury and self-harm. For self-injury and self-harm, the proportion of contacts from rural centres and areas significantly increased from 2012 to 2013, while the proportion of contacts from capital cities and other metropolitan areas significantly decreased during this time.

The reasons for contacting about suicide followed a similar pattern to all contacts from young people aged under 18 years. For self-injury and self-harm, the proportion of contacts from capital cities and metropolitan areas were significantly higher than contacts from rural areas regarding concerns about another person. However, the proportion of contacts from rural areas was significantly higher than the contacts from young people in capital cities and other metropolitan areas

about talking through the consequences of self-injuring and self-harming behaviour.

Key findings in this analysis that may inform the development of strategies to engender help seeking behaviours about suicide, self-injury and self-harm from young people under 18 years are:

- The need to build engagement strategies with young men from rural and remote areas concerning suicide, self-injury and self-harm. As previously noted young men are underrepresented in Kids Helpline data in relation to help seeking. This is consistent with contemporary research about help seeking which indicates that young men will generally not engage in seeking assistance for issues of concern. This data also suggest that young men in rural and remote areas are particularly resistant in engaging with services regarding these issues.

- The importance of online and telephone counselling for young people living in rural and remote areas as an engagement strategy.

- The critical value of online counselling options for youth populations in metropolitan areas, particularly for young female children.

Indigeneity

During 2012 and 2013, Kids Helpline responded to 978 counselling contacts from children and young people aged under 18 years who identified as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. Of these contacts, 13.60% (*n* = 133) were from children and young people aged under 18 years who identified as Aboriginal (*n* = 129) or both Aboriginal and Torres Strait Islander (*n* = 4) when they contacted Kids Helpline about suicide as a main concern.

Of the 130 contacts where information about gender was collected, 97.69% (*n* = 127) were female and 2.31% (*n* = 3) were male. For this cohort, the average age was 15.11 years and the age range was 12 to 17 years. The majority (90.55%) of contacts were from young people aged between 14 and 16 years. The age distribution of Indigenous children and young people under 18 years contacting about suicide as their main concern is shown in Figure 15.

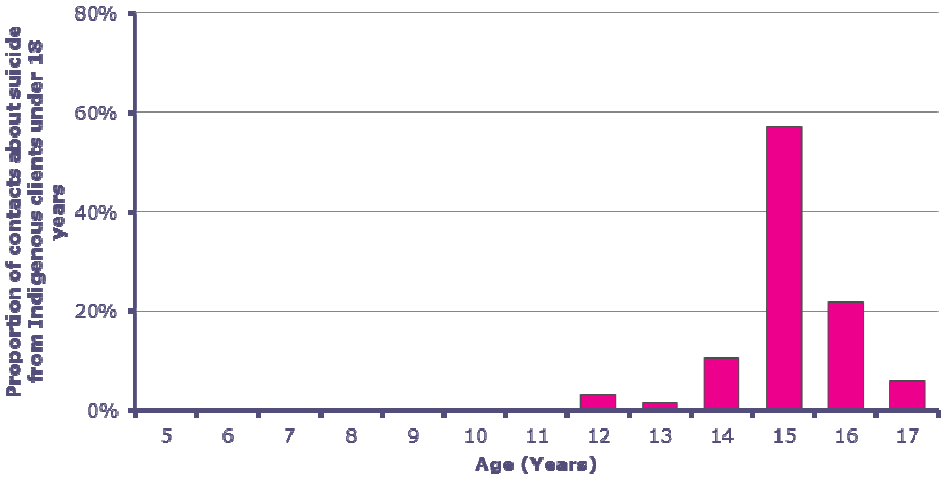

Figure 15. Age distribution of Indigenous children and young people under 18 years contacting about suicide as their main concern.

Of the 133 contacts from Indigenous children and young people under 18 years during 2012 and 2013 where suicide was the main concern, 71.43% (*n* = 95) contacted by phone and 28.57% (*n* = 38) contacted by online modes of web or email. Indigenous children and young people under 18 years were proportionally more like than all young people under 18 years to contact Kids Helpline by phone when suicide was their main concern. This comparison is shown in Figure 16.

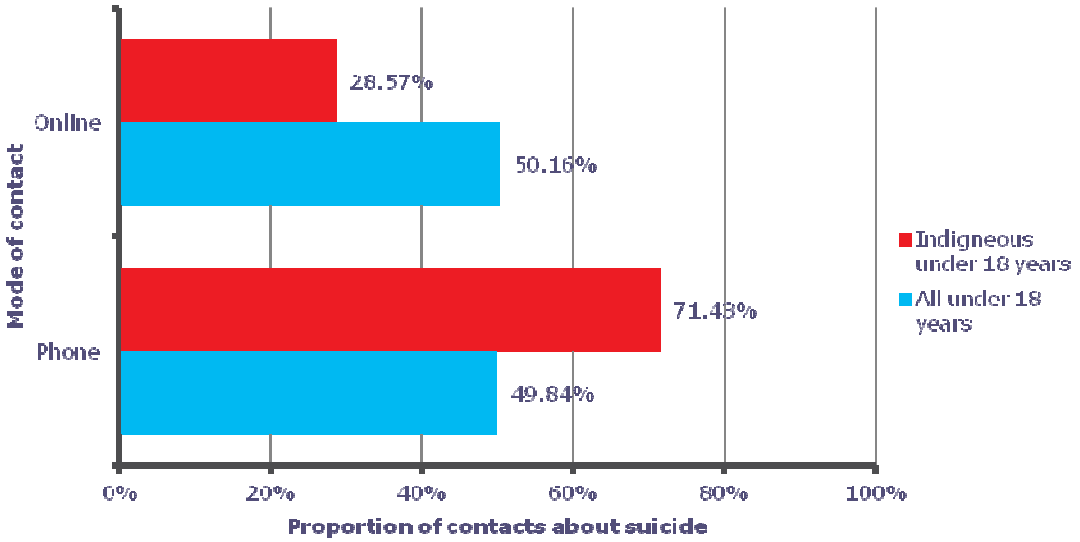

Figure 16. Proportion of phone and online contacts from Indigenous young people and all young people under 18 years where suicide is the main concern.

In 89 of these contacts, data was also collected about whether the client was in a metropolitan, rural or remote area. In 2012 and 2013, 77.53% (*n* = 69) of these contacts were in a capital or other metropolitan city, 21.35% (*n* = 19) were in a rural town, and 1.12% (*n* = 1) were in a remote area.

Suicidal thoughts and fears was the most common reason for Indigenous children and young people under 18 years to contact about suicide. In 2012 and 2013, this reason made up 83.46% of contacts about suicide from Indigenous young people under 18 years. This proportion is higher than that for all young people under 18 years contacting about suicidal thoughts and fears. The comparison of contacts from Indigenous young people and from all young people under 18 years and their reason for contacting about suicide is shown in Table 5.

Table 5. Comparison of contacts from Indigenous young people and from all young people under 18 years and their reason for contacting about suicide.

Reason for Contact	Indigenous under 18 years		All under 18 years	
	Number	%	Number	%
Seeking information	1	0.75%	50	0.74%
Concerned about another person	7	5.26%	976	14.56%
Suicidal thoughts or fears	111	83.46%	4,977	74.25%
Immediate intention	10	7.52%	485	7.24%
Current attempt at the time of contact	4	3.01%	215	3.21%
Total	**133**	**100%**	**6,703**	**100%**

During 2012 and 2013, 45 contacts were from children and young people aged under 18 years who identified as Aboriginal (*n* = 41) or both Aboriginal and Torres Strait Islander (*n* = 4) when they contacted Kids Helpline about self-injury and self-harm as a main concern. Of the 44 contacts where information about gender was collected, 95.45% (*n* = 42) were female and 4.55% (*n* = 2) were male. The age range of this cohort was 12 to 17 years (*M* = 14.27). The age distribution of Indigenous children and young people under 18 years contacting about self-injury and self-harm as their main concern is shown in Figure 17.

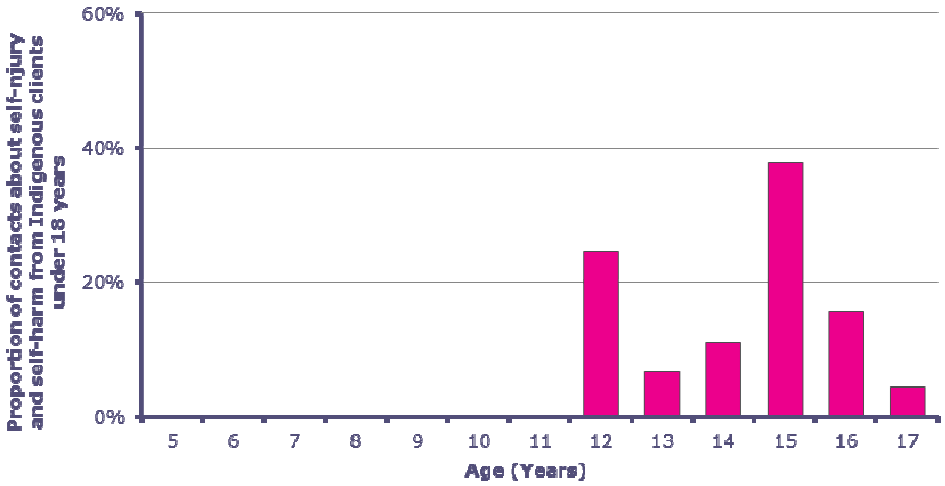

Figure 17. Age distribution of Indigenous children and young people under 18 years contacting about self-injury and self-harm as their main concern.

Of the 45 contacts from Indigenous children and young people under 18 years during 2012 and 2013 about self-injury and self-harm as the main concern, 64.44% (*n* = 29) contacted by phone and 35.56% (*n* = 16) contacted by online modes of web or email. In addition, Indigenous children and young people under 18 years were proportionally more like than all young people under 18 years to contact Kids Helpline by phone when self-injury and self-harm was their main concern. This comparison is shown in Figure 18.

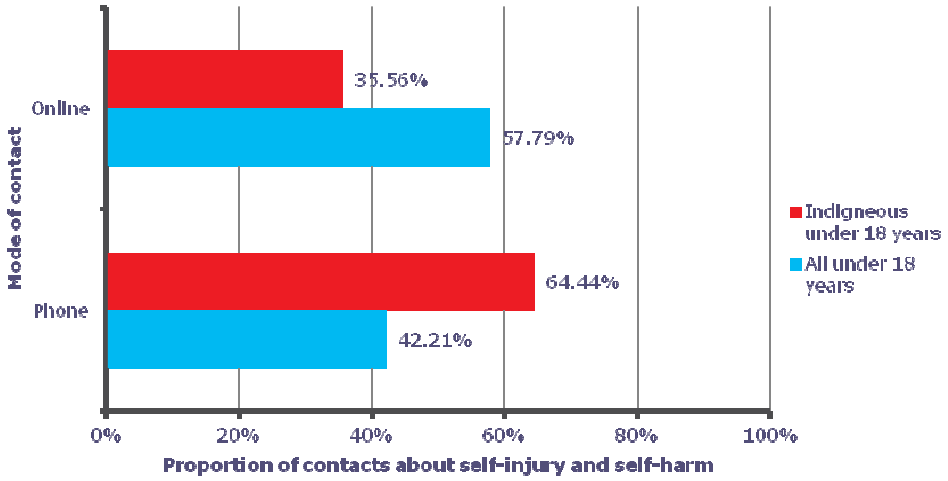

Figure 18. Proportion of phone and online contacts from Indigenous young people and all young people under 18 years where self-injury and self-harm is the main concern.

In 23 of these contacts, data was collected about whether the client was in a metropolitan, rural or remote area. In 2012 and 2013, 91.30% (*n* = 21) of these contacts were in a capital or other metropolitan city and 8.70% (*n* = 2) were in a rural town.

Contacting to help resist thoughts and urges to injure was the most common reason for contact from Indigenous young people under 18 years when presenting about self-injury and self-harm during 2012 and 2013. This was the second most common reason for all young people under 18 years contacting about self-injury and self-harm. The other common reason that Indigenous young people under 18 years contacted about self-injury and self-harm was to talk through the consequences of the self-injuring and self-harming behaviour and to discuss alternatives to that behaviour. The comparison between Indigenous young people and all those under 18 years and their reasons for contacting about self-injury and self-harm is displayed in Table 6.

Table 6. Comparison of contacts from Indigenous young people and from all young people under 18 years and their reason for contacting about self-injury and self-harm.

Reason for Contact	Indigenous under 18 years		All under 18 years	
	Number	%	Number	%
Seeking information	0	0%	101	2.31%
Concerned about another person	0	0%	606	13.84%
Contacting to help resist thoughts and urges to injure	21	46.67%	1,502	34.29%
Talking through consequences and/or alternative coping strategies	18	40.00%	1,741	39.75%
Others are concerned about client's self-injuring and self-harming behaviour	6	13.33%	267	6.09%
Concerned that injury at the time of contact requires medical assistance	0	0%	163	3.72%
Total	**45**	**100%**	**4,380**	**100%**

In summary, Kids Helpline responded to 133 contacts from Indigenous young people under 18 years in 2012 and 2013 about suicide as the main concern, and 45 contacts from Indigenous young people where self-injury and self-harm was the main concern. The majority (more than 90%) of this group of contacts were female. No contacts from Indigenous children under the age of 12 were identified as contacting about suicide or self-injury and self-harm as a main concern.

Indigenous young people were more likely to contact to discuss suicide, self-injury and self-harm by phone than by online modes of contact. In addition, Indigenous young people under 18 years were proportionally more likely to contact Kids Helpline by phone when suicide was their main concern, while all young people under 18 years with suicide and self-injury and self-harm as a main concern were more likely to contact Kids Helpline by web and email.

Indigenous young people were proportionally more likely than all young people under 18 years to make contact about suicidal thoughts and fears. In relation to self-injury and self-harm, Indigenous young people under 18 years were most concerned about discussing ways to resist thoughts and urges to self-injure and self-harm, talking through consequences of self-injuring and self-harming behaviour and speaking about how others are concerned about their self-injuring

and self-harming behaviour. No contacts from Indigenous young people under 18 years were recorded regarding concerns about another person or for the purpose of seeking information.

The key findings from this discussion indicate:

- An underrepresentation of contacts from aboriginal males. This reinforces earlier findings about the need to develop engagement strategies with young men to increase help seeking.

- Indigenous young people are more likely to contact by phone than online to discuss concerns about suicide, self-injury and self-harm. This highlights the importance of phone counselling in engaging Indigenous young people around issues of suicide, self-injury and self-harm.

- Overall Indigenous young people are underrepresented in data about help seeking with Kids Helpline. This confirms other current research indicating that Indigenous young people do not generally connect with mainstream services in seeking assistance. Serious consideration needs to be given to addressing this issue in light of the high risk levels in relation to suicide, self-injury and self-harm prevalent in this demographic group. A robust engagement strategy needs to be developed that may include enhancing the role and availability of Indigenous services and information campaigns specifically targeting Indigenous children and young people.

Children with a Culturally and Linguistically Diverse Background

During 2012 and 2013, Kids Helpline responded to 6,755 counselling contacts from children and young people aged under 18 years who identified as being from a Culturally and Linguistically Diverse (CALD) background. CALD refers to groups whose first language is not English or whose cultural background is derived from a non-English speaking tradition. Individuals from a CALD background are those who identify as having a specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, language(s) spoken at home or because of their parents' identification on a similar basis.

Of the 6,755 counselling contacts for CALD children and young people under 18 years, 5.23% (*n* = 353) were in relation to suicide as a main concern. Information about gender was collected in 350 of these contacts – 81.71% (*n* = 286) were from females and 18.29% (n = 64) were from males. The ages ranged from nine to 17 years (*M* = 14.97). Fourteen to 17 year olds made 80.45% of contacts. The age distribution of contacts from CALD children and young people under 18 years where suicide is the main concern is shown in Figure 19.

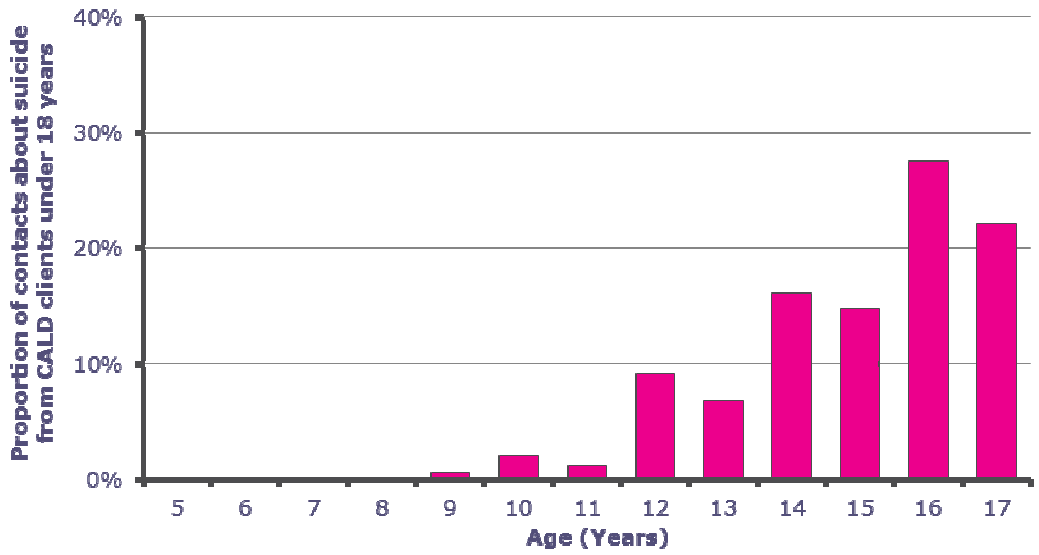

Figure 19. Age distribution of contacts from CALD children and young people under 18 years where suicide is the main concern.

Of the 353 contacts from CALD children and young people under 18 years where suicide was the main concern, 55.81% (*n* = 197) were made by phone and 44.19% (*n* = 156) were made by web or email. CALD children and young people under 18 years were proportionally more like than all young people under 18 years to contact Kids Helpline by phone when suicide was their main concern. This comparison is shown in Figure 20.

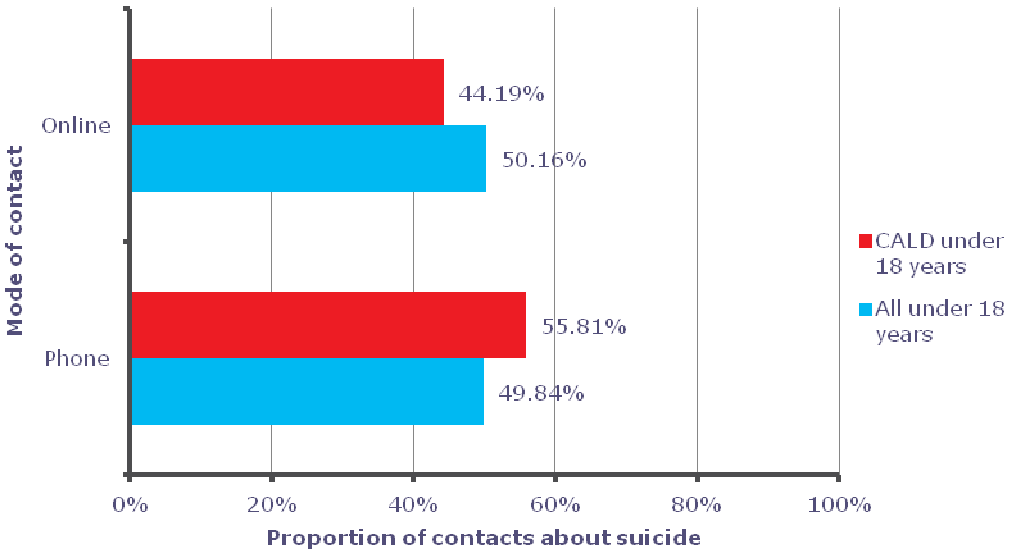

Figure 20. Proportion of phone and online contacts from CALD young people and all young people under 18 years where suicide is the main concern.

Location data about whether the client was in a metropolitan, rural or remote area was collected in 161 contacts. In 2012 and 2013, 79.50% (*n* = 128) of these contacts were in a capital or other metropolitan city, 14.29% (*n* = 23) were in a rural town, and 6.21% (*n* = 10) were in a remote area.

The reasons for CALD children and young people contacting about suicide followed a similar pattern to the reasons for all children and young people under 18 years. Of the 353 contacts from CALD children and young people under 18 years in 2012 and 2013, 76.20% (*n* = 269) were in relation to suicidal thoughts and fears. This was the most common reason to contact about suicide for CALD children and young people and all young people under 18 years. The comparison between CALD young people and all those under 18 years and their reasons for contacting about suicide is displayed in Table 7.

Table 7. Comparison of contacts from CALD young people and from all young people under 18 years and their reason for contacting about suicide.

Reason for Contact	CALD under 18 years		All under 18 years	
	Number	%	Number	%
Seeking information	4	1.13%	50	0.74%
Concerned about another person	40	11.33%	976	14.56%
Suicidal thoughts or fears	269	76.20%	4,977	74.25%
Immediate intention	31	8.78%	485	7.24%
Current attempt at the time of contact	9	2.55%	215	3.21%
Total	**353**	**99.99%**	**6,703**	**100%**

Please note that due to rounding, the total percentage may not add up to 100%

During 2012 and 2013, Kids Helpline responded to 200 contacts from CALD children and young people under 18 years where self-injury and self-harm was the main concern. Information was collected about gender in 198 of these contacts, where 89.90% (*n* = 178) were from females and 10.10% (*n* = 20) were from males. The age range of this cohort was from ten to 17 years (*M* = 15.10). The age distribution of contacts from CALD children and young people under 18 years where self-injury and self-harm is the main concern is shown in Figure 21.

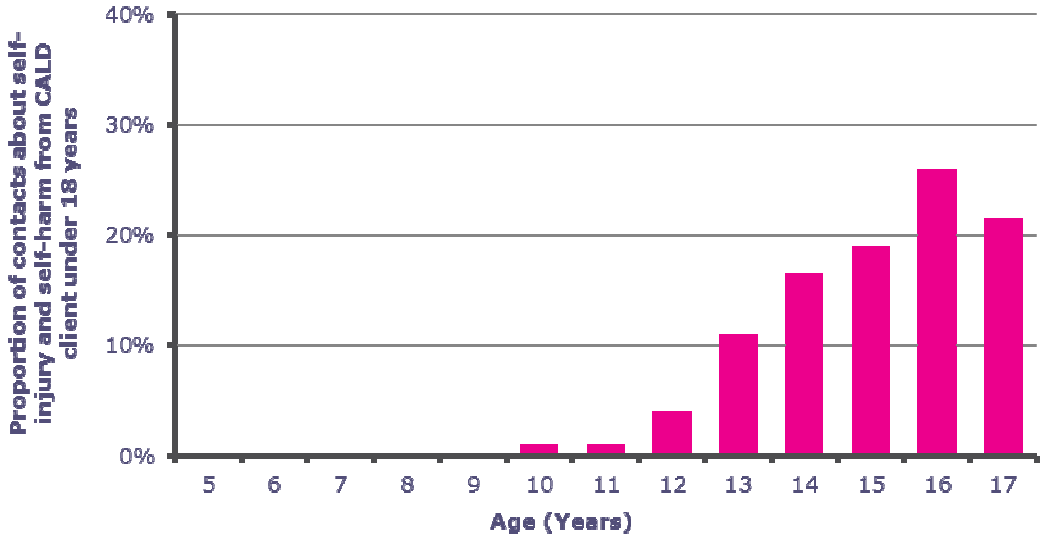

Figure 21. Age distribution of contacts from CALD children and young people under 18 years where self-injury and self-harm is the main concern.

Of the 200 contacts from CALD children and young people aged under 18 years about self-injury and self-harm as the main concern, 62.00% (*n* = 124) were via phone and 38.00% (*n* = 76) were by online modalities. In addition, CALD children and young people under 18 years were proportionally more likely than all young

people under 18 years to contact Kids Helpline by phone when self-injury and self-harm was their main concern. This comparison is shown in Figure 22.

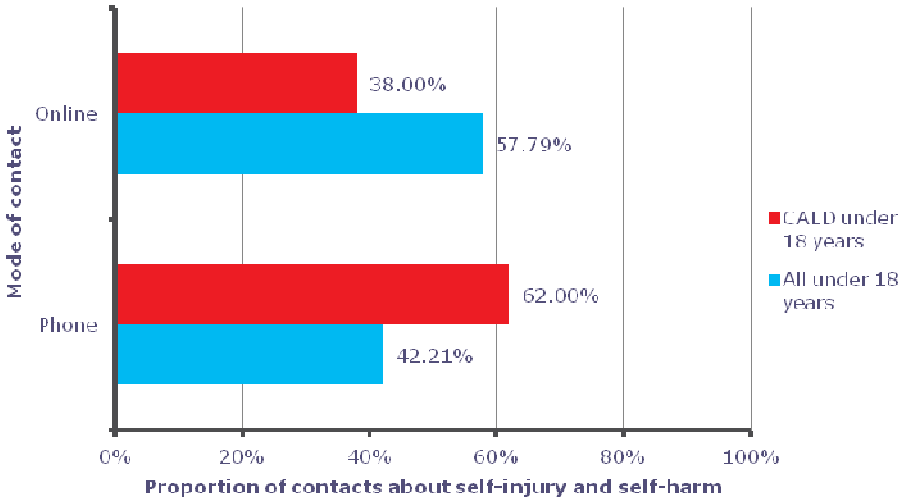

Figure 22. Proportion of phone and online contacts from CALD young people and all young people under 18 years where self-injury and self-harm is the main concern.

In 109 of these contacts, data was collected about the location of the client. In 2012 and 2013, 81.65% (*n* = 89) of these contacts were from a capital or another metropolitan city and 18.35% (*n* = 20) were from rural areas.

The reasons for contacting about self-injury and self-harm for CALD children and young people followed a similar pattern to the reasons for all those under 18 years contacting about the same concern. The majority (78.50%) of contacts about self-injury and self-harm from CALD young people under 18 years were in relation to accessing help to resist thoughts and urges to harm and to talk through the consequences of such behaviour and discussing alternative ways to deal with the distress. The comparison between CALD young people and all those under 18 years and their reasons for contacting about self-injury and self-harm is displayed in Table 8.

Table 8. Comparison of contacts from CALD young people and from all young people under 18 years and their reason for contacting about self-injury and self-harm.

Reason for contact	CALD under 18 years		All under 18 years	
	Number	%	Number	%
Seeking information	1	0.50%	101	2.31%
Concerned about another person	21	10.50%	606	13.84%
Contacting to help resist thoughts and urges to injure	84	42.00%	1,502	34.29%
Talking through consequences and/or alternative coping strategies	73	36.50%	1,741	39.75%
Others are concerned about client's self-injuring and self-harming behaviour	13	6.50%	267	6.09%
Concerned that injury at the time of contact requires medical assistance	8	4.00%	163	3.72%
Total	**200**	**100%**	**4,380**	**100%**

In summary, Kids Helpline responded to 353 contacts from CALD children and young people aged under 18 years in 2012 and 2013 where suicide was the main concern. In addition, 200 contacts came from this same cohort about self-injury and self-harm as the main concern. More than 80% of the contacts about these two issues came from females. In relation to suicide, 96.32% of contacts came from young people aged 12 to 17 years, while 94.00% of contacts about self-injury and self-harm came from young people aged between 13 and 17 years. The most common reason for CALD young people to contact about suicide was their suicidal thoughts and fears. In relation to self-injury and self-harm, the most common reason for CALD young people under the age of 18 years was to resist thoughts and urges to injure and harm.

The key findings from this discussion indicate:

- An under representation of young males with CALD backgrounds engaged in help seeking activities about suicide, self-injury and self-harm and

- The importance of phone counselling in supporting youth with CALD backgrounds

Means of Suicide, Self-injury & Self-harm

Children and young people's expressed means of suicide differ to that of the general population. In 2012 Australian Bureau of Statistics data indicates that hanging, strangulation and suffocation, poisoning by drugs, poisoning by other methods and firearms are the most prevalent methods of suicide.[2] However a qualitative analysis of contact notes for 50 randomly selected young people being supported by Kids Helpline in the past year in relation to suicide issues indicates that drugs and cutting closely followed by trains and jumping are consistently stated to be the preferred methods. This is outlined in the following table.

Table 9. Intended means of suicide 2013-14.

Suicide or suicide ideation - method	Number
Overdose	14
Cutting/slashing	6
Throwing self under traffic or train	5
Jumping off high buildings or bridges	5
Hanging	2

A study undertaken of data from contacts about suicide from 2003-06 by this research team suggest that these stated preferences by young people have remained consistent over recent years. This is outlined in Figure 23.

[2] ABS 2012 : Methods of suicide - table 5.5 for mechanisms of death
http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2012~Main%20Features~Method%20of%20Suicide~10011 visited 2 June 2014

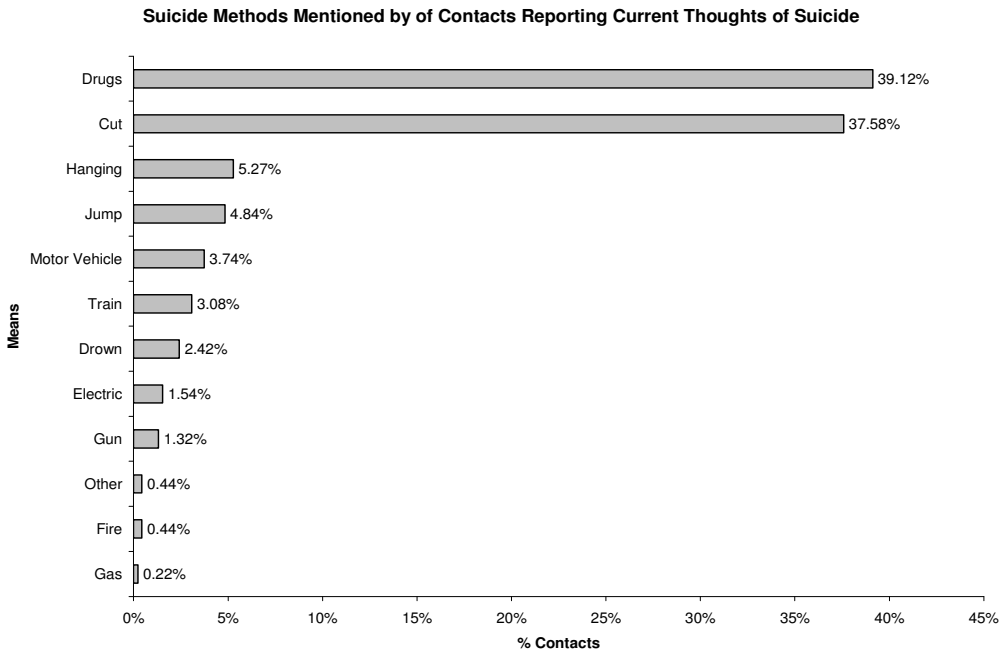

Figure 23. Suicide methods by contacts reporting current thoughts of suicide 2003-06.

In the self-injury and self-harm group the preferred method was cutting. "The predominant forms of self-injury and self-harm disclosed to Kids Helpline counsellors are cutting the skin of arms or legs and/or deliberate overdoses of both prescription and over-the-counter medications not designed to be fatal. Other behaviors such as burning or picking the skin or pulling out hair can also be termed self-injury and self-harm but are not nearly as common as the first two.[3]" Of the self-injury and self-harm group 76 of the young people disclosed their preferred method which is shown in Table 10.

Table 10. Methods of self-injury and self-harm reported in contacts to Kids Helpline 2013-14.

Current self-injury and self-harm	Number
Cutting	70
Burning	2
Jumping from heights	1
Stabbing	1
Overdosing	1
Excessive alcohol	1

[3] Kids Helpline Hot Topic, *Self-Injury* accessed on 23 May 2014 from http://www.kidshelp.com.au/grownups/news-research/hot-topics/self-injury.php

Specific Questions raised by the National Children's Commissioner

Attention will now be focused on responding to some of the specific issues being canvassed by the National Children's Commissioner.

Why Children and Young People engage in intentional self-harm and suicidal behaviour

Kids Helpline Counsellors can record if there was more than one concern discussed during a telephone call or online contact. Data can be recorded for up to four concerns. This information indicates the type of trigger issues that drive self-injury, self-harm and suicidal behaviour.

An examination of contact notes for 50 current children being supported for suicide issues and 84 children being counselled in relation to self-injury and self-harm issues was also undertaken to identify situational and pre-disposing risks as well as protective factors.

Self-injury and self-harm

Of the 4,380 contacts from young people aged under 18 years where self-injury and self-harm was the main concern in 2012 and 2013, 49.43% (n = 2,165) were recorded as having self-injury and self-harm as the only concern discussed, while the remaining 50.57% (n = 2,215) of contacts were recorded as having self-injury and self-harm as the main concern along with other issues as additional concerns.

When self-injury and self-harm was the main concern for young people under 18 years contacting Kids Helpline during 2012 and 2013, suicide was the most common concern discussed in the same contact. The other common concerns also discussed when self-injury and self-harm was the main concern included mental health, emotional wellbeing, child-parent relationships and relationships with friends and peers.

In 2013, the number of contacts increased where bullying was discussed when self-injury and self-harm was the main concern. Self-image was one of the common concerns discussed when suicide was a main concern and also when self-injury and self-harm was a main concern. This concern deals with clients seeking help or contacting about how they feel about themselves, their identity, self-concept, self-image or self-esteem. This may include shyness, embarrassment, and/or feelings of worthlessness. The concern of body image on the other hand was more prevalent together with contacts about self-injury and self-harm than with contacts about suicide. This type of concern deals with clients seeking help or concerned about their body or physical appearance and can relate to weight, size, shape, skin colour, skin appearance, hair style or hair colour.

The most common additional concerns discussed when self-injury and self-harm is the main concern are displayed in Table 11.

Table 11. Number and type of coexisting concerns discussed when self-injury and self-harm is the main concern for children and young people under 18 years.

2012		2013	
Additional Concern	**Number**	**Additional Concern**	**Number**
Suicide	275	Suicide	238
Mental health	258	Mental health	228
Child-parent relationships	205	Emotional wellbeing	186
Emotional wellbeing	192	Child-parent relationships	152
Relationships with friends and peers	116	Bullying	96
Self-image	82	Relationships with friends and peers	89
Bullying	73	Self-image	80
Grief	50	Body image	53
Other family relationships	47	Relationship with partner	43
Relationship with partner	43	Other family relationships	35

To gain a further in-depth picture of concerns expressed by young people when seeking assistance for self-injuring and self-harming, a qualitative analysis was conducted of randomly selected 84 online and phone contacts by young people under the age of 18 years who contacted KHL for assistance between May 2013 and May 2014. Of the 84 all had been coded as either engaging in current self-injury and self-harm or were wanting assistance with their self-injuring and self-harming behaviours and were selected for this study on that basis.

To understand the factors contributing directly to the young person's intentional self-injury and self-harm, case notes were analysed for themes. Some young people had more than one theme recorded and these themes are shown in Table 12 below.

Table 12. Thematic analysis of immediate concerns - current self-injury and self-harm in young people under 18 years of age May 2013 to May 2014.

Situational risk factors of young people who contact KHL for issues with issues of current self-injury and self-harm	Online contacts	Phone contacts
Emotional distress (overwhelmed, confusion, existential concerns, feeling unloved, lonely, not coping with change, anger issues, current suicidal thoughts, past suicide attempts, or past suicidal ideation)	46.5%	35%
Diagnosed mental and physical health concerns	22%	28%
Grief and loss (such as death of family member, end of a friendship or other relationship)	8%	14%
Physical/emotional abuse (including sexual abuse, child abuse, bullying)	12%	7%
Family conflict (including breakdown in relationship with parents/siblings, extended family, parents separating, father living away from home /country)	8%	10%
School pressures		3%
Body image issues (weight, weight gain)	2.5%	3%

The findings from the qualitative analysis are consistent with the analysis of coexisting concerns in self-injury and self-harm contacts to Kids Helpline. Overall

young people who self-injure and self-harm generally seem to have underdeveloped coping skills in responding to their suicidal feelings and thoughts as well as their mental health and for a very small number, the challenges of living with physical illness. The grief and loss associated with losing a close friend or family member was third, followed by physical, sexual and or emotional abuse which also included bullying.

Overall suicide was the most common additional issue for when self-injury and self-harm was the main concern discussed. This reinforces contemporary research that suggests self-injuring and self-harming behaviour may possibly be engaged in as a coping strategy to manage feelings and thoughts of suicidality. When suicide and self-injury and self-harm were the main concerns, the other common concerns discussed were mental health, emotional wellbeing, child-parent relationships, bullying, and relationships with friends and peers. Emotional wellbeing was increasingly being discussed in contacts where suicide is the main concern. The prevalence of bullying as an additional concern was increasing when self-injury and self-harm was the main concern.

As well as situational factors the contact notes were also analysed for other factors known as predisposing factors. These factors are those that may contribute to the current situation but are not the immediate reason for the young person's self-injuring and self-harming behaviour.

Table 13 sets out the predisposing factors for young people under 18 years of age engaged in current self-injury and self-harm.

Table 13. Predisposing risk factors-current self-injury and self-harm in young people under 18 years of age May 2013 to May 2014.

Predisposing risk factors of young people who contact KHL for issues with issues of current self-injury and self-harm	Online contacts	Phone Contacts
Family conflict or breakdown	30.5%	44%
Poor coping mechanisms (negativity, violence, self-injury and self-harm, attempted suicide, emotional, lonely, socially isolated, feeling unloved, uncared for and abandoned, school stress)	30.5%	15%
Mental and physical health issues	10%	21%
Physical and emotional abuse (sexual abuse, bullying, physical abuse)	12%	15%
Grief and loss (death of family member or partner, loss of friendship)	8%	4%
Body image concerns (weight)	8%	nil

For the group who are engaging in current self-injury and self-harm the main predisposing factor appears to be family breakdown including dysfunctional communication within the family. This is followed by poor coping mechanisms for dealing with strong emotional responses or stress and having a diagnosed mental health concern

Suicide

Of the 6,703 contacts from young people aged under 18 years where suicide was the main concern in 2012 and 2013, 54.44% (*n* = 3,649) of these were recorded as having suicide as the only concern discussed while the remaining 45.46% (*n* = 3,054) were recorded as having suicide as the main concern along with other issues as additional concerns.

In contacts when suicide was the main concern for young people under 18 years contacting Kids Helpline in 2012 and 2013, mental health was the most common concern discussed in the same contact. These mental health contacts dealt with children and young people who were concerned about their mental health or that of another. The discussion ranged from emerging symptoms to moderate or significant mental health issues that are diagnosed or undiagnosed.

The other common concerns also discussed when suicide was the main concern included self-injury and self-harm, child-parent relationships, emotional wellbeing and friend and peer relationships. In 2013, the number of calls increased where emotional wellbeing and self-image were discussed when suicide was the main concern. The top coexisting concerns discussed on 2012 and 2013 when suicide is the main concern of children and young people aged under 18 years are shown in Table 14.

Table 14. Number and type of coexisting concerns discussed when suicide is the main concern for children and young people under 18 years.

2012		2013	
Additional Concern	**Number**	**Additional Concern**	**Number**
Mental health	480	Mental health	409
Self-injury and self-harm	369	Self-injury and self-harm	396
Child-parent relationships	268	Child-parent relationships	240
Relationships with friends and peers	152	Emotional wellbeing	207
Emotional wellbeing	143	Bullying	116
Bullying	124	Relationships with friends and peers	92
Grief	96	Self-image	89
Relationship with partner	84	Grief	65
Physical abuse	79	Physical abuse	62
Other family relationships	76	Other family relationships	59

We have evidence suggesting that these presenting issues in contacts from young people concerning suicide have been reasonably consistent over time. In a study undertaken in 2009 for the Senate Inquiry into Suicide in Australia, Kids Helpline presented the following Graph (Figure 24) in relation to coexisting concerns discussed in contacts where suicide is the main concern.

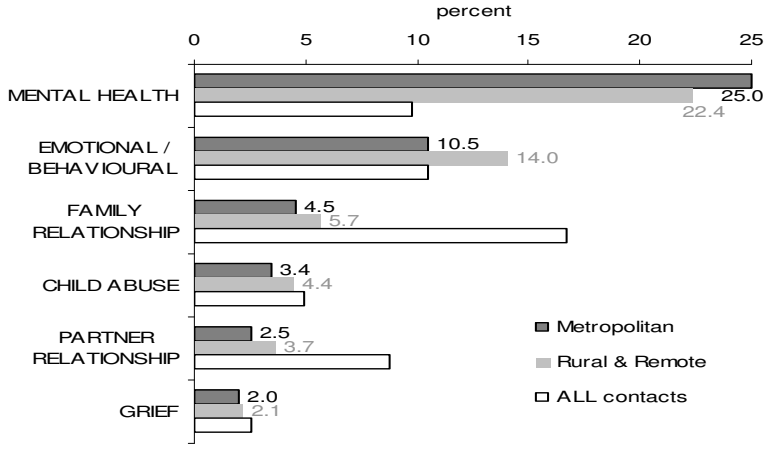

Figure 24. Coexisting concerns discussed in contacts where suicide is the main concern.

Although this needs to be cautiously assessed given that the 2009 analysis also included young people aged 18-25, it does indicate that mental health, unsatisfactory family relationships and abuse are consistent risks associated with youth suicide.

To gain a more in-depth picture of concerns expressed by young people seeking assistance for either a current suicide attempt or current suicide ideation, KHL contact case notes were reviewed. A qualitative analysis was conducted of 50 randomly selected online and phone contacts by young people under the age of 18 years who contacted KHL for assistance between May 2013 and May 2014. Of this group 26 are currently engaging in suicidal behaviour by either intending to suicide and thus have specific or general plans in place, or are currently engaging in suicidal behaviour as they make contact; and 16 are currently having suicidal thoughts (suicidal ideation). Of the online contacts 50% indicated that they are currently engaged in suicidal behaviour in that they have specific plans in place and the means for a suicide attempt. For those making contact by phone over a third are concerned with thoughts of suicide and almost a quarter have contacted KHL as they are currently engaged in or planning suicidal behaviour.

The contact notes describe the concerns raised by the young person when they make contact and some have more than one main concern. These were thematically analysed and the four main themes that emerged are shown in Table 15 below:

Table 15. Thematic analysis of situational risk factors - current suicidal behaviour and suicidal ideation in young people under 18 years of age May 2013 and May 2014.

Situational risk factors or immediate concerns for young people who contact KHL with issues of suicide or suicide ideation	Online contacts	Phone contacts
Emotional distress (fear of re-hospitalisation, anxiety about performance at school, self-punishment, self-loathing, mental health concerns, physical health, suicidal thoughts or behaviour)	38.5%	35%
Recent or past trauma (physical or emotional abuse, sexual abuse, bullying, death of family member, rape, abortion, sexual exploitation – sexting)	38.5%	30%
Family conflict (family misunderstanding, disconnection from family)	23%	25%
Relationship breakdown (grief and loss re breakup, friends no longer caring)	nil	7.5%

This indicates that young people's mental health concerns can originate in anxiety about school, physical health, unresolved feelings about past or recent trauma caused by abuse, bullying, sexual assault and sexual exploitation as well as family conflict and relationship breakdowns with significant others.

In relation to suicide we have also undertaken an analysis of the longer term pre-disposing risks in relation to suicide as they relate to children. This analysis was based on the before mentioned 50 suicide contacts and is based on counsellors' assessments. This examination is presented in Table 16 below.

Table 16. Predisposing risk factors-current suicide or suicidal ideation in young people under 18 years of age May 2013 to May 2014 (n=50).

Predisposing risk factors for young people who contact KHL with issues of suicide or suicide ideation	Online contacts	Phone contacts
Past self-injury and self-harm, past suicide attempt, past suicidal ideation, chronic suicidality	16.6%	39.5%
Emotional distress (such as helplessness, low self-worth, school pressures, lives alone, school absenteeism ,identity crisis (gender), grief and loss over suicide of friend, girlfriend or boyfriend relationship breakdown)	25%	12%
Past physical and/or emotional abuse (by parents, by step father, sexual grooming, verbal abuse, child abuse, past physical abuse, school bullying)	20.8%	15%
Family issues (including sickness at home, father's alcoholism, parent's separation, conflict in the family, sibling arguments, non-acceptance of new stepfather, conflict with mother)	16.6%	12%
Diagnosed mental or physical health issues (such as eating disorder, delusional, voices, anxiety attacks, physically unwell)l	12.5%	12%
Poor response to counselling	4%	6%
Alcohol and/or drug abuse	4%	3%

Overall, for young people seeking assistance because of current suicide behaviour or suicidal ideation the picture that emerges is that suicide or thoughts of suicide are more likely in those who have inadequate coping mechanisms for managing strong emotional responses, are experiencing current or past physical and/ or emotional abuse, and who have in the past attempted suicide, or have chronic suicidality, or had engaged in self-injury and self-harm.

The analysis presented in this section indicates the importance of having accessible mental health, counselling and family support services for young people to divert them from self-injury, self-harm and suicide.

Protective Factors

To assist the National Children's Commissioner in developing strategies to prevent self-injury and self-harm and suicide an analysis was also undertaken of protective factors identified by children.

For young people under 18 years who are being supported by KHL because of current self-injury and self-harm other protective factors are shown in Figure 25 below.

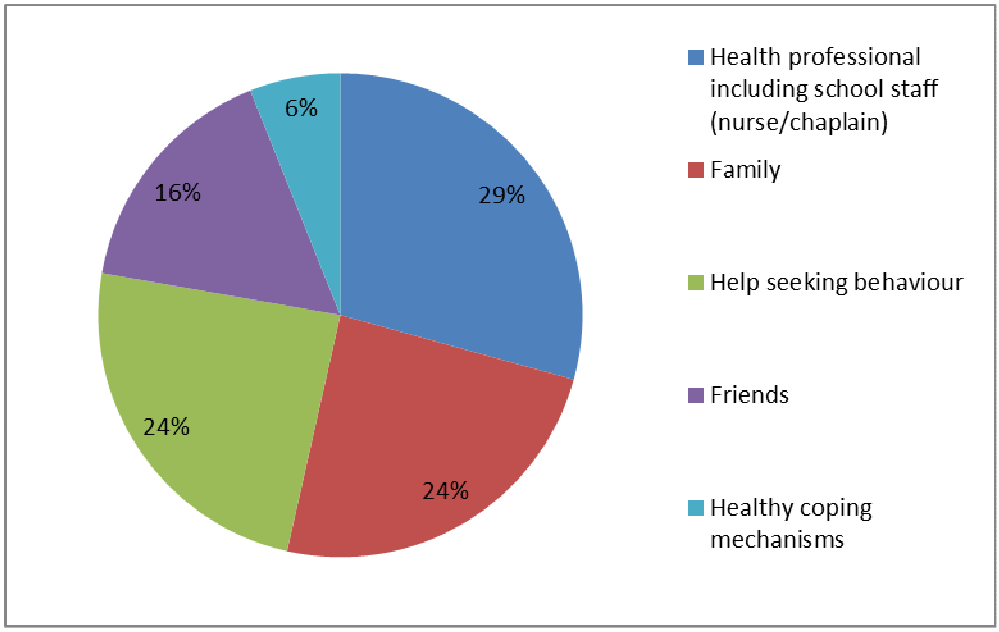

Figure 25. Other protective factors for young people under 18 years engaging in current self-injury and self-harm May 2013 to May 2014 being supported by Kids Helpline.

For this group the involvement of others in assisting the young person to manage their self-injury and self-harm is a significant protective factor. The least developed protective mechanism for this group is that of utilising healthy coping mechanisms with only 6% able to do so.

An evaluation of data collected for children and young people under 25 during 2003-06 indicates that the most significant protective factors against engaging in suicidal behaviour were having another person being aware of their suicidality, a personal value system that inhibited engaging in suicide and having a support system in place. This is outlined in Figure 26 below.

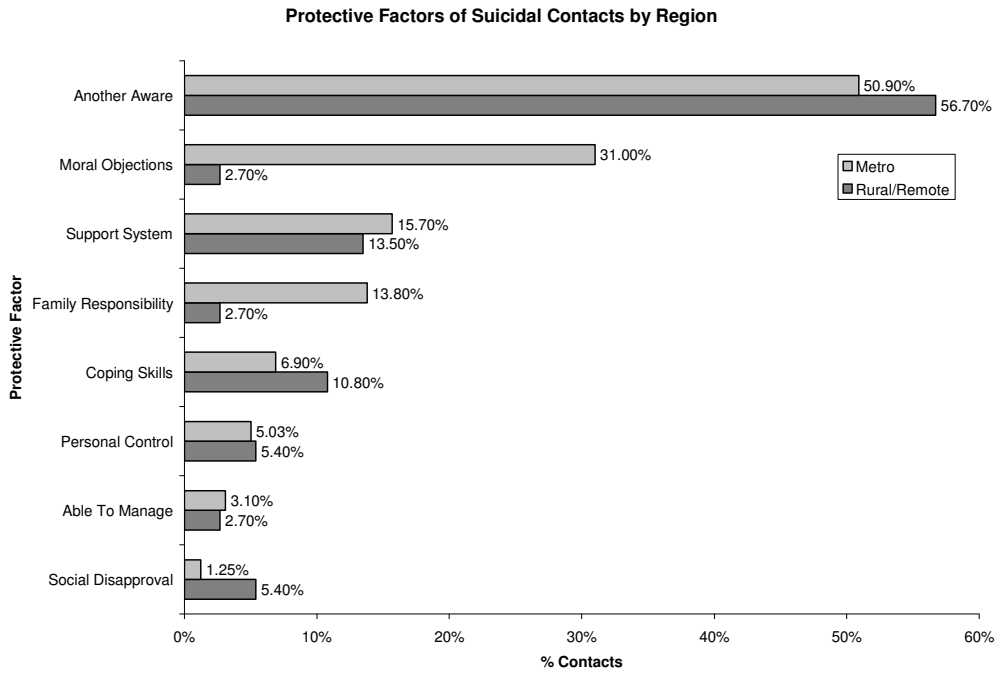

Figure 26. Protective factors for young people aged under 25 years 2003-06 against engaging in suicidal behaviour.

This analysis was updated for this report by investigating other sources of support being accessed by young people being supported by Kids Helpline for suicidality. The analysis shows that children's ability to initiate help seeking behaviours with others when required including at crisis points, the involvement of mental health professionals as well as support from family and friends are key protective supports. This analysis is outlined graphically below in Figure 27.

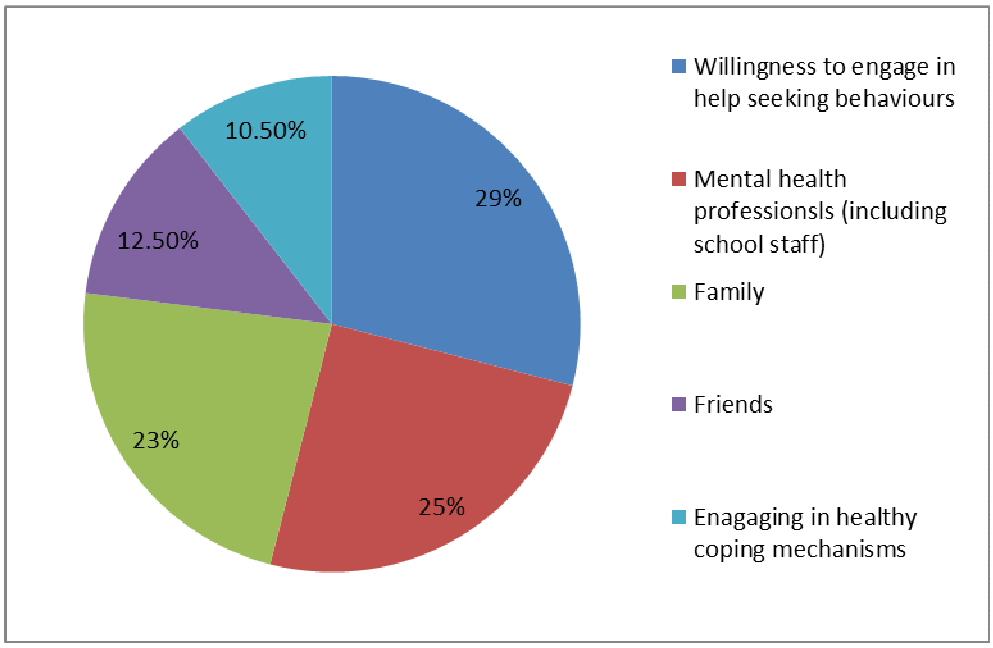

Figure 27. Other protective factors for young people under 18 years engaged in current suicidal behaviour or suicidal ideation May 2013 to May 2014 being supported by Kids Helpline.

This data indicates that an effective protective strategy for both self-injury and self-harm, and suicide prevention would be to increase the awareness and capability of adults in contact with children to intervene. This includes family, school and health professionals. This is often referred to in research literature as 'Gate Keeper' training. This data also suggest that peer to peer support methods of intervention could also be effective.

The Types of Programs and Practices that effectively target and support children and young people

Children under 18 have a strong preference to engage with counselling concerning self-injury and self-harm, and suicide behaviour through online modalities. This will be shown through an analysis of engagement behaviour with Kids Helpline.

Children and young people have the option of contacting Kids Helpline via telephone or online modes of email and web. Of the 6,703 contacts from children and young people aged under 18 years where suicide was the main concern in 2012 and 2013, 49.84% (*n* = 3,341) contacted via phone and 50.16% (*n* = 3,362) contacted through online modes. A similar trend was seen for all 80,142 counselling contacts from children and young people aged under 18 years where 51.53% (*n* = 41,297) were via phone and 48.47% (*n* = 38,845) were via web and email.

The young people under 18 years of age contacting online were proportionally more likely than those calling Kids Helpline to contact about suicidal thoughts and fears. In other words, a significant difference was found between the 83.14% of online contacts from clients contacting about suicidal thoughts and fears compared to the 65.1% of calls to Kids Helpline about the same reason for contact about suicide, $p < .05$.

In addition, the proportion of calls from children and young people aged under 18 years was significantly higher than the proportion of online contacts from the same age cohort with regards to their concerns for another person (17.96% versus 11.18%, $p < .05$), any immediate intention regarding suicide (10.75% versus 3.75%, $p < .05$), and current attempts at the time of contact (5.12% versus 1.31%, $p < .05$). The breakdown of contacts by phone and online methods and children's reasons for contacting about suicide are shown in Figure 28.

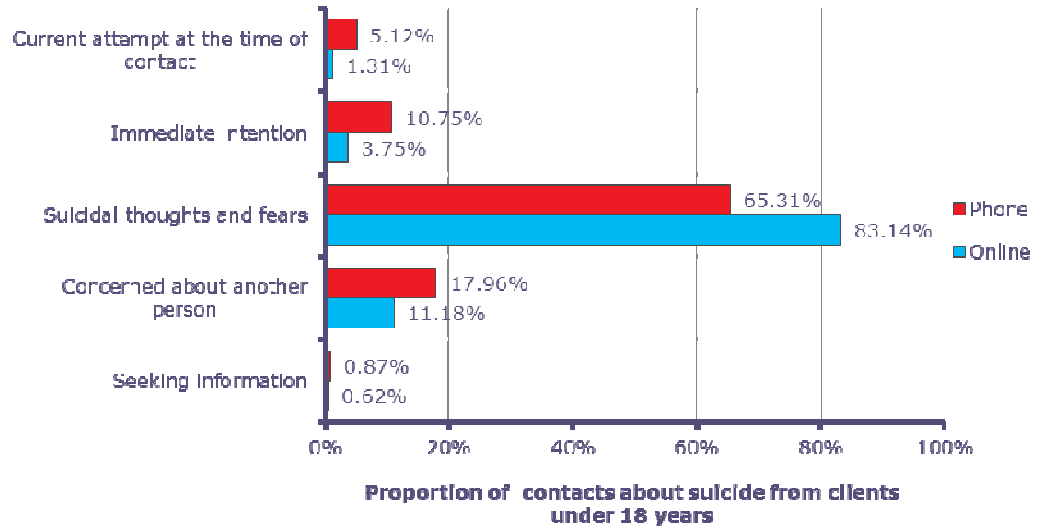

Figure 28. Reasons for children and young people aged under 18 years contacting about suicide by phone and online modes.

Of interest, the proportion of contacts from young people aged under 18 years (50.16%) was significantly higher than the proportion of young people aged between 18 and 25 years (24.70%) with regards to contacting Kids Helpline online when suicide was the main concern, $p < .05$. The proportions of phone and online contacts from young people in the aforementioned age groups that contact Kids Helpline are shown in Figure 29.

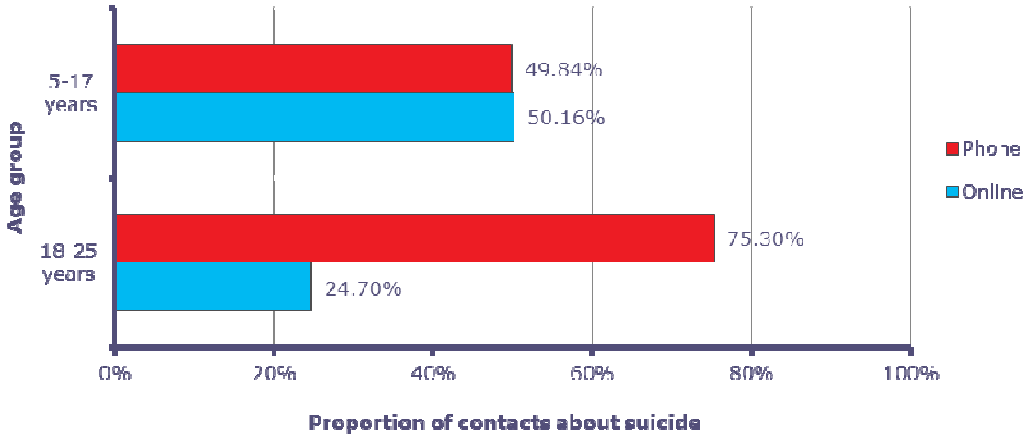

Figure 19. Proportion of online and phone contacts by age group where suicide is the main concern.

Of the 4,380 contacts from children and young people aged under 18 years where self-injury and self-harm was the main concern in 2012 and 2013, 42.21% (n = 1,849) contacted via phone and 57.79% (n = 2,531) contacted by online modes.

The most common reason for children and young people under 18 years to contact Kids Helpline online in relation to self-injury and self-harm was to talk through the consequences of their self-injuring and self-harming behaviour and to discuss alternative ways of coping with their distress. The proportion of online contacts (46.90%) to discuss the consequences of self-injuring and self-harming was significantly higher than the proportion of calls (29.96%), $p < .05$. Also, 18.77% of calls and 10.23% of online contacts were from young people aged under 18 years with concerns about others while 6.87% of calls and 1.42% of online contacts were in relation to concerns about injuries that required immediate attention. These differences between online and phone modes of contact were statistically significant at $p < .05$.

The most common reason for children and young people under 18 years calling Kids Helpline in relation to self-injury and self-harm was to access help to resist thoughts and urges to self-injure and self-harm. The proportion of children and young people calling (37.59%) about this reason was significantly higher than the proportion of those who were contacting online (31.88%), $p < .05$. The breakdown of contacts by phone and online methods and the reasons for contacting regarding self-injury and self-harm are shown in Figure 30.

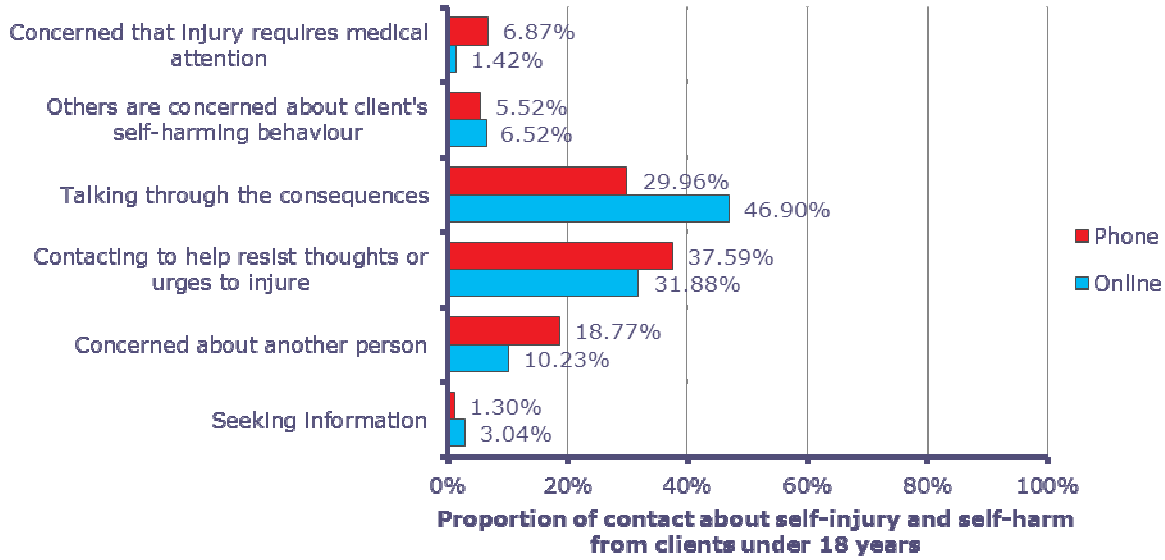

Figure 20. Reasons for children and young people aged under 18 years contacting about self-injury and self-harm by phone and online modes.

Young people aged under 18 years were proportionally more likely to contact Kids Helpline by web or email when self-injury and self-harm was the main concern compared to young people aged between 18 and 25 years. Specifically, when self-injury and self-harm was the main concern, 57.79% (n = 2,531) of contacts from children and young people aged under 18 years were via web and email, in comparison to the 27.43% (n = 1,196) of online contacts from young people aged between 18 and 25 years. The proportions of phone and online contacts from young people in the aforementioned age groups that contacted Kids Helpline are shown in Figure 31.

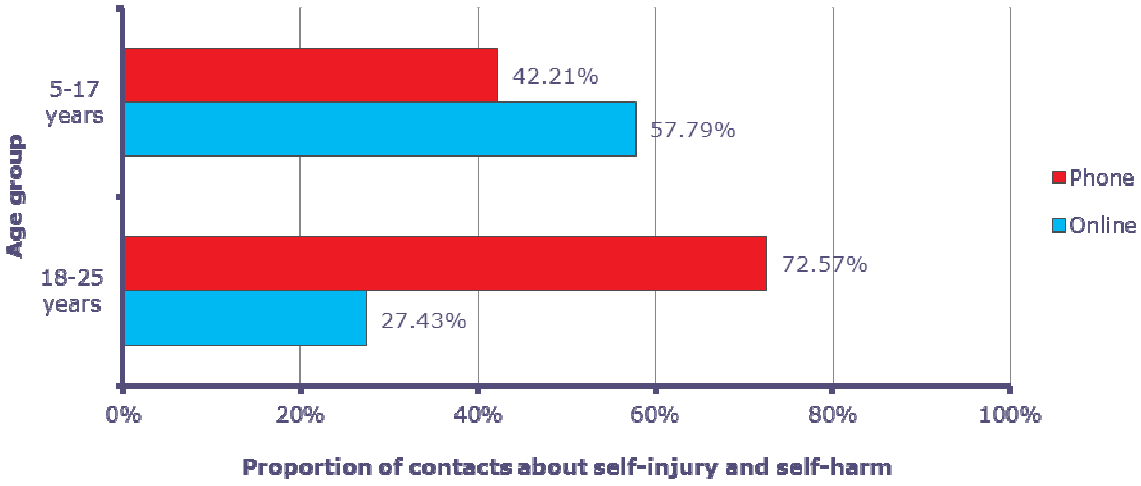

Figure 31. Proportion of online and phone contacts by age group where self-injury and self-harm is the main concern.

In summary, children and young people aged under 18 years contacted Kids Helpline more by online modes than by phone. In addition, the proportion of online contacts from children and young people aged under 18 years contacting about suicide or self-injury and self-harm as main concerns was significantly higher than the proportion of online contacts from young people aged between 18 and 25 years. The number of online contacts was higher than the number of phone calls from children and young people under 18 years discussing self-injury and self-harm as a main concern.

A higher proportion of online contacts, compared to the proportion of phone calls, was seen when children and young people aged under 18 years wanted to talk through the consequences of their self-injuring and self-harming behaviour and alternative ways to cope as well as to discuss suicidal thoughts and fears.

On the other hand, a higher proportion of phone calls, in comparison to online contacts, was seen when clients wanted to talk about an immediate intention to commit suicide, a current suicide attempt at the time of the call, ways to resist the thoughts and urges to injure, concerns that an injury requires medical assistance, and concerns about another person's issues with suicide and self-injury and self-harm.

As discussed children present their issues concerning self-injury, self-harm and suicide differently across online and phone counselling. For those under 18 years both telephone and online counselling are critical sources of support. Overall online counselling options are more often used than phone by under 18 year olds for these problems. However, it should be noted that for males, and children from Indigenous, CALD and rural areas phone counselling is preferred to online counselling when discussing concerns about suicide and self-injury and self-harm. Consequently any engagement and support strategy with children about suicide and self-injury and self-harm must include telephone as well as online counselling options.

Recommendations

Given this analysis a number of recommendations are made about effective strategies to work with children to reduce the incidence of suicidal behaviour and self-injury and self-harm.

1. **That recognition be given to the importance of youth specialist providers in implementing prevention strategies and delivering services to children experiencing thoughts of suicide, self-injury and self-harm**

Children and youth are more likely to seek assistance from services that are child/youth focused and conversant with contemporary youth culture, needs, and engagement preferences.

Statistics indicate that despite overall static levels of help seeking by children with formal mental health services, increasing numbers of young people are seeking assistance about mental health, suicide, self-injury and self-harm issues with Kids Helpline. As noted, Kids Helpline has seen a 20% increase in contacts about these issues since 2011. We believe that this growth in help seeking from children and young people is primarily driven by the fact that Kids Helpline is recognised as a trusted authentic youth specialist provider.

There have been inconsistent practices concerning the delivery of services in this area. For example: the initial funding associated with the former Commonwealth Government's 2010 *Mental health: taking action to tackle suicide* strategy was predominantly given to generalist services. This ignored the reality that young people are a high risk demographic in relation to suicide. Engagement of youth at risk of suicide, self-injury and self-harm is best facilitated through the development of a service network with a diverse range of providers to both increase access points into the mental health system and to enhance responsiveness to the special needs of particular vulnerable groups such as Aboriginal and Culturally and Linguistically Diverse (CALD) youth.

Suicide, self-injury and self-harm prevention strategies and services need to be delivered through a range of authentic youth specialist providers that know the needs of children and have been able through their specialised practice to develop focused responses. Currently, this is not always recognised in the roll-out of programs.

2. **That Government enter into collaborative relationships with community organisations providing support to young people at risk of suicide, self-injury and self-harm, to develop and test strategies to increase young male help seeking behaviour particularly for those living in rural areas or who are of Indigenous and of diverse cultural backgrounds.**

Kids Helpline data is consistent with other contemporary research indicating an underrepresentation of young men in help seeking activities about suicide, self-injury and self-harm. Our data suggests that this lack of connection by young men with services is particularly acute for those living in rural areas and/or are of CALD or indigenous backgrounds. Despite the lower level of help seeking by young men when compared to young women, it is generally recognised that young men are a high risk group in relation to suicide.

Further research is also required on the protective factors for young men in relation to self-injury and self-harm, and suicide. This will provide evidence to inform the development of preventative responses.

3. **That increased funding be provided to enhance the accessibility of mental health, counselling and family support services for young people with the purpose of diverting them from suicide, self-injuring and self-harming behaviour.**

In analysing the reasons as to why young people engage in suicide, self-injuring and self-harming behaviour it was evident that unresolved mental health concerns, conflictual and dysfunctional family relationships, inadequate personal coping skills and unresolved trauma from abuse and sexual violence were prominent risk issues. Young people require access to formal support services to assist them to overcome these risk factors associated with suicide, self-injury and self-harm issues.

4. **That a continued focus be placed on increasing the capacity of people such as educators, health professionals, families and peers to identify risks associated with suicide, self-injury and self-harm and to intervene and support those children at risk**

Young people being supported by Kids Helpline indicated that other protective factors included support received from health professionals, school staff, family and friends. Previous research undertaken by Kids Helpline indicated that for many young people having another person being aware of their distress about their thoughts of suicide was a protective factor. However based on operational experience and consultations it is known that due to the stigma and the general lack of knowledge about suicide, self-injury and self-harm, many people are not willing to intervene with at risk children on these issues. Contemporary research indicates that 'Gate Keeper' training strategies whereby frontline workers involved in the care of children i.e. emergency services staff and those in other public contact roles such as educators, receive instruction about risk assessment and intervention strategies in response to suicide are effective in protecting children. This strategy could be extended to include the education of parents and carers as well as peer to peer support.

The 'Conversation Matters' website sponsored by the New South Wales Department of Health is a good example of this strategy in action.

5. **That telephone and online counselling services be expanded given their criticality and effectiveness in delivering assistance to children concerning suicide, self-injury and self-harm**

As previously mentioned, Kids Helpline has seen a 20% increase in contacts involving mental health, suicide, self-injury and self-harm since 2011. Increasing numbers of children and young people are seeking assistance with Kids Helpline on these issues despite a generally static level of help seeking by young people.

We also have evidence demonstrating the effectiveness of Kids Helpline's telephone and online counselling. Each year we seek the views of children and young people about the quality and effectiveness of the service. In 2013, 778 children and young people participated in an online survey regarding their satisfaction and perceived effectiveness of Kids Helpline. Around 81% of respondents agreed that they had increased ideas about how to deal with their problems as a result of their contact to KHL. Around 65% (n=381) of all respondents felt more able to deal with their problems after the contact.

An overview of children's help seeking behaviour with Kids Helpline regarding suicide, self-injury and self-harm has been provided in this report. The analysis showed differences in the preferences of children in accessing support through telephone and online modalities. In summary these preferences are outlined in the Table below:

Table 17: Children's Help Seeking Preferences concerning Telephone and Online Counselling.

Demographic	Help Seeking Preference: Telephone V Online re Suicide, Self-Injury and Self-Harm
Young Male children (All)	Phone
Young Female children (All)	Online
Young People (Metropolitan areas)	Online
Young People (Rural and Remote)	Online
Indigenous children	Phone
CALD children	Phone

In summary, increasing numbers of children and youth are seeking assistance for suicide, self-injuring and self-harming issues through telephone and online counselling. Interventions delivered through these channels are effective in assisting children to manage these issues. Both telephone and online counselling options are critical in engaging children as there are a diverse range of preferences amongst children depending on their gender, where they live and cultural background. Unfortunately telephone and online counselling providers are unable to meet existing demand. In 2013 Kids Helpline had capacity to respond to only 60% of contacts. Additional financial support to increase the capability of telephone and online counselling services is required.

Conclusion

An examination of Kids Helpline data concerning contacts by children seeking support in relation to suicide, self-injury and self-harm has been presented. This evidence suggests that youth specialist service providers, further investment in research regarding help seeking by young males, an enhancement of accessibility for children to mental health, family support and counselling services, Gatekeeper training and the expansion of the existing capability of telephone and online counselling services would be effective strategies to reduce the incidence of suicide, self-injury and self-harm amongst children.

This organisation is well aware of the existing austerity policies being adopted by Australian Governments. It is recognised that some of these recommendations require additional investment to be achieved either through budget enhancements or reallocation.

We do however maintain that as a community a commitment to effective response as well as early intervention are critical if we are to divert children and young people from suicide, self-injury and self-harm.

We are confident that investment in prevention and rehabilitative services will provide significant long term benefit to not only children and young people but to the Australian community. Evidence of this is shown in a Social Return on Investment evaluation of the Kids Helpline service, which showed its efficacy in reducing impacts of mental health and other risk factors that contribute to suicide, self-injury and self-harm. Refer to Attachment 1 on the following page.