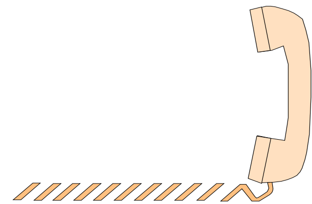
LiVeS oN ThE LiNE…



Youth suicide as told by the young Australians who have contacted Kids Help Line.

Produced under the National Youth Suicide Prevention Project

June 1999

Thanks must be extended to the competent and dedicated work of KHL counsellors in gathering and recording the anonymous information contained in this report, and to the young people throughout Australia who bravely sought out help when experiencing the depths of despair.

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Produced under the National Youth Suicide Prevention Project

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Executive Summary

This report presents the details of 6,429 suicide-related calls made to Kids Help Line (KHL) between March 1991 and August 1997. The experience of the young people who have contacted the service about suicide is presented in terms of:

- gender;
- age;
- severity;
- ethnicity;
- living arrangements;
- time of day;
- call duration;
- geographical breakdown;
- causal and contributing factors;
- referrals to other agencies and support services.

Throughout the report, other research is cited in order to place KHL findings into the broader context of the issue of youth suicide in contemporary Australia. In summary, the main findings from KHL data on suicide calls include:

- Although Kids Help Line counsellors responded to 6,429 suicide-related calls, these calls accounted for only 1% of all problem calls made to the service across the time period covered in this report;
- The proportion of suicide-related calls tripled from .6% of all calls in 1993 to almost 2% in 1997;
- Just over a quarter of callers had called Kids Help Line previously;
- Females made the majority (72%) of the suicide-related calls, and were more likely to have attempted suicide previously. Male callers were more likely to ring KHL with an immediate suicide intent;
- Almost a quarter of suicide-related calls were made by children younger than 15. Three-quarters of callers were aged between 15 and 18;
- Indigenous callers were almost twice as likely to ring KHL with an immediate suicide intent than their non-indigenous counterparts;
- Young people who were living alone, with a partner or who were homeless represented the largest proportion of those who contacted the service with an immediate suicide intent;
- While two-thirds of suicide-related calls are made between 3pm and 3am, half of the callers with an immediate suicide intent phoned the service between 6pm and 3am;

- The average duration of suicide calls is 31 minutes as compared to 11 minutes across all other KHL problem categories/calls;
- Young people in Victoria and Queensland made a higher proportion of suicide-related calls than their peers in other States;
- Young people who were living in the most remote and sparsely populated communities were more likely to call Kids Help Line about suicide-related issues than their peers in more populated regions of Australia;
- Males from rural and remote areas made a greater proportion of calls and were more likely to have previously attempted suicide than their urban counterparts;
- The two most common problems or experiences associated with suicidal thoughts or attempts were child abuse and family relationship difficulties;
- Those who had made one or more previous suicide attempts received the greatest proportion of referrals;
- As may be expected, the largest concentration of support services on the KHL referral database were located in capital cities and metropolitan areas; and
- Limited referral options available in rural and remote areas included (a) the majority of agencies not open 7 days a week, and (b) only one-third operated specifically for young people.

A discussion of the findings and recommendations for future research and service delivery for young people who are at risk or have attempted suicide is presented in the final section. In brief, these are:

- Normalising and encouraging help-seeking behaviours for males;
- A concerted effort to address inequalities and social injustice for indigenous Australians;
- The need to address and enhance coping skills and resilience in pre-adolescent and adolescent children;
- Increased resourcing of the community's capacity to respond to child protection issues; and
- Increased resourcing to rural and remote communities for child-centred services.

Child abuse and family breakdown are key areas to be addressed by both government and the community, in future programs and policies aimed at reducing the level of distress that lead many young Australians to consider and complete suicide.

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Appendix 1. Kids Help Line Record-A-Call Information

Appendix 2. Referrals by Geographical Location

1. Introduction

Kids Help Line (KHL) is a national telephone counselling service for young Australians aged 5 to 18 years. On average, 30,000 calls from children and young people are made to the service each week, of which approximately 1 in 2 are able to be answered. The service began in Queensland in March 1991 and progressively expanded into the other States and Territories, becoming a national service in May 1993. KHL is a non-denominational service funded by Boystown Family Care, an initiative of the De La Salle Brothers. The service has also received funding through the National Youth Suicide Prevention Strategy and corporate sponsorship through Kellogg's.

KHL has a strong value base which underpins and influences how it operates. The articulation and understanding of the implications of the value base have become increasingly sophisticated over the period of operation.

(i) Child Centred Practice

The key ethics and considerations of child centred practice involve:

- Listening to and respecting what children have to say;
- Focussing on their needs;
- Seeing the world from the caller's perspective;
- Acknowledging and believing that the child is the primary client;
- Seeing the child as an individual as well as a member of a class or group; and
- Respecting the child.

(ii) Confidentiality and Duty of Care

KHL has identified that confidentiality is a critical consideration for it's client group. Young people can ensure confidentiality by choosing to remain anonymous, and 60% of callers decline to provide information such as their name and location. The service seeks to balance the obligations of law, morality and ethics in the way anonymity and confidentiality are managed. The imperative of anonymity and confidentiality is even more strongly highlighted where the issues raised by young people are seen by them as highly sensitive, for example sexual identity, sexual abuse and suicide. However KHL also believes that it has a shared responsibility with all members of the community to exercise a "duty of care" where immediate or

untenable risk exists for young people. Situations which may require breaching of confidentiality because of duty of care considerations can include suicide risk, serious physical abuse, sexual abuse and threat to members of the community. Any decision at KHL to exercise duty of care that involves a breach of confidentiality is considered exceptional and a cause for serious consideration and review. Consideration is always given to the positive and potentially adverse outcomes such a decision may generate (Clark, 1998).

(iii) Empowerment

Empowerment at KHL involves the development of personal competence and resilience and enabling young people to influence their world in a positive manner.

Operational Principles

KHL has five principles that allow counsellors to operationalise the above organisational values. These principles are:

- Calls are confidential and anonymous*;
- All callers are treated with respect;
- Callers are free to choose the gender of the counsellor to whom they speak;
- Callers are able to access the same counsellor if they wish to call back; and
- Callers are encouraged to give feedback about Kids Help Line and the service they receive.

* Duty of Care considerations are acknowledged.

Data Collection and Limitations

Kids Help Line counsellors record non-identifying information about all counselling calls on a computerised database. While the amount of information collected after each call varies, counsellors must record the date and time of the call, the length of the call, problem type and problem severity. Where possible, counsellors also log other information including age and gender, postcode, school status, family structure, living arrangements and ethnicity (See Appendix 1 for a comprehensive listing of the fields collected).

The following factors may make it difficult for counsellors to record the above information:

- Anonymity – Clients frequently choose not to reveal details about themselves, particularly information that in their view might lead to identification. KHL markets itself as an anonymous service, therefore the process of data collection reflects this core organisational principle.
- Some contacts are such that direct information gathering is either contraindicated or proves difficult in the context of the call.

The recognition of these problems and their capacity for compromising our data has meant that KHL has adopted a policy of recording data in each field in such a way as to clearly identify the blank or incomplete responses. All statistical information reported is therefore based only on instances in which the field has been completed.

Counsellors are also able to record qualitative data about calls. The qualitative data provides a rich source of information that creates a clearer context for situations experienced by the children and young people who phone the service. This data also captures secondary or contributing factors to the problems discussed during the calls.

Callers are free to use the service as often as they wish. It is unrealistic to assume that all problems can be solved in one call. Indeed, for many callers who are suicidal, the sense of connectedness Kids Help Line provides is a key preventative tool. Therefore, data reported may include repeat calls made by individuals across a period of time.*

*Of the 6,429 callers who phoned about suicide between March 1991 and August 1997, 56% did not indicate whether they had contacted the service on a previous occasion. Seventeen per cent of the callers stated they had not called the service before, with the remaining 27% of callers stating they were calling back.

Regardless of the above limitations, the information collected provides a unique pool of valuable data on the issues of concern to young people who contact the service.

2. Overview of Youth Suicide

Suicide behaviours are a serious problem for Australia (Martin, 1996). Suicide is now the leading cause of death among young people under the age of 30 in Australia (AISRAP, 1998). Compared with other countries Australia has particularly high rates of suicide among young males aged 15-24 years (AISRAP, 1998). In 1996, 2,387 people died from suicide. Of these, 15% or 351 were males aged between 15-24 years (ABS, 1996). In particular, the rate of completed suicides for young men doubled between 1970 and 1995, with suicide representing the main cause of death in males aged 15-24 years. These findings are more confronting when considered against the fact that deaths by suicide are generally underreported (The Commonwealth Department of Health and Family Services, 1997).

Youth suicide is undeniably complex. National and international research continues to grapple with the task of detecting and confirming the possible risk factors, causal factors, vulnerabilities and stressors that correlate to the relatively high occurrence of youth suicide in Australia. Research to date has examined the relationship between psychosocial factors including isolation, alienation and hopelessness upon youth suicide rates. The body of wider research has also examined the rates of suicidal ideation, suicide attempts and completed suicide in relation to;

- the impact of child abuse;
- family functioning;
- unemployment;
- substance abuse;
- violence, including bullying;
- psychiatric disorders;
- low self-esteem;
- academic problems/pressure;
- media images of young people;
- gender roles;
- geographical location;
- sexuality, and
- the recent loss of a significant person.

(Beitchman, 1992; Brent, 1993; Commonwealth Department of Human Services and Health, 1997; Deykin cited in de Ananda, 1993; Here for Life, 1997; Rotheram-Borus, 1994; Silburn, 1991.)

The previous list is by no means comprehensive but is intended to highlight the scope of research and the multi-faceted nature of youth suicide.

Arising out of this body of research is the view that suicide attempts and completed suicides cannot be explained in terms of a singular or immediate cause (Watts, 1997). Watts argues that understanding youth suicide is further complicated by the fact that individuals who endure certain experiences will attempt or complete suicide while others with similar experiences may not.

Between March 1991 and August 1997, 6,429 children and young people phoned Kids Help Line specifically about suicide, accounting for 1% of all counselling calls received by the service. From the time the service became national in May 1993 through to December 1998, the proportion of suicide-related calls has tripled (see Figure 1).

Figure 1.

	1993	1994	1995	1996	1997	1998
Number	690	1033	997	1034	1734	2053
% of calls	0.6%	0.8%	1.0%	1.1%	1.9%	2%

Calls that are logged as a suicide call must conform to the following definition used by Kids Help Line:

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

The severity of suicide calls are recorded under the following categories:

1 = Seeking information
2 = Suicidal thoughts or fears
3 = Attempted suicide once previously
4 = Previous suicide attempts (more than once)
5 = Immediate intention

When combined with other data fields collected, this information enables KHL to gain an in-depth understanding about the severity of suicide-related calls and each caller's circumstances. The system of data collection used by KHL also distinguishes the service in that official statistics on suicide are usually limited to the number of deaths, not attempts or suicidal thoughts or ideation.

3. Gender

Females made 72% of the 6,429 calls concerning suicide and males 28%. This ratio is consistent with the gender breakdown across all calls to the service. The proportion of male and female callers parallels wider trends in gender and help-seeking behaviours across human service organisations in that females are more likely to seek help than males.

Overholser (1990) comments that societal norms influence the gender difference in help-seeking behaviours. Socialization traditionally dictates that males repress their inner emotions whilst it is considered more acceptable for females to access and utilise social supports in dealing with their problems. Given the disproportionate rate of young males who complete suicide, it could be argued that the societal norms of help-seeking behaviour need to be challenged. Overholser further argues that facilitating basic communication skills in males, with the clear message that it is acceptable to discuss problems, should help reduce their risk of completing suicide.

4. Age

Figure 2 displays the age and gender breakdown of the children and young people who called KHL with suicide-related issues.

Figure 2. Age of Suicide Callers

N=5,129	Males		Females	
	N	%	N	%
5-9	5	0.1	11	0.2
10-14	223	4.3	1014	19.8
15-18	1087	21.2	2789	54.4

NOTE: The discrepancy between the N presented in this table and the total N is due to the fact that not all calls had gender and/or age recorded.

A quarter of callers were younger than 15. Females tend to seek help about suicide-related issues at an earlier age than males.

When discussing suicide, and particularly when focussing upon the age of suicide callers, it is important to keep the issue in context. Accordingly, the tables displayed in Figure 3 highlight the eight main issues in rank order broken down by age and gender.

Figure 3. Rank Order Of Problems By Age Group And Gender

(Male Callers)

Rank Order	5-9 years	10-14 years	15-18 years
1	**Family Relationships**	**Family Relationships**	**Sexual Activity**
2	Bullying	Bullying	Partner Relationships
3	Physical Abuse	Sexual Activity	Family Relationships
4	Peer Relationships	Peer Relationships	Leaving Home/Homeless
5	Sexual Activity	Partner relationships	Drug Use
6	Grief	Physical Abuse	Peer Relationships
7	Loneliness	Drug Use	Sexual Orientation
8	Sexual Abuse	Development	Pregnancy
Other	**Suicide (25th)**	**Suicide (29th)**	**Suicide (19th)**

(Female Callers)

Rank Order	5-9 years	10-14 years	15-18 years
1	**Family Relationships**	**Family Relationships**	**Partner Relationships**
2	Peer Relationships	Peer Relationships	Family Relationships
3	Bullying	Partner Relationships	Peer Relationships
4	Development	Development	Pregnancy
5	Grief	Bullying	Leaving Home/Homeless
6	Loneliness	Pregnancy	Sexual Abuse
7	Physical Abuse	Sexual Activity	Self Image
8	Sexual Activity	Physical Abuse	Sexual Activity
Other	**Suicide (35th)**	**Suicide (27th)**	**Suicide (13th)**

The table indicates that suicide-related calls are ranked between 13th and 35th depending on age and gender. While the issues of concern for children and young people vary between age and gender, much of the counselling is in the area of early intervention highlighting the preventative nature of the work undertaken by Kids Help Line counsellors.

5. Severity of Calls

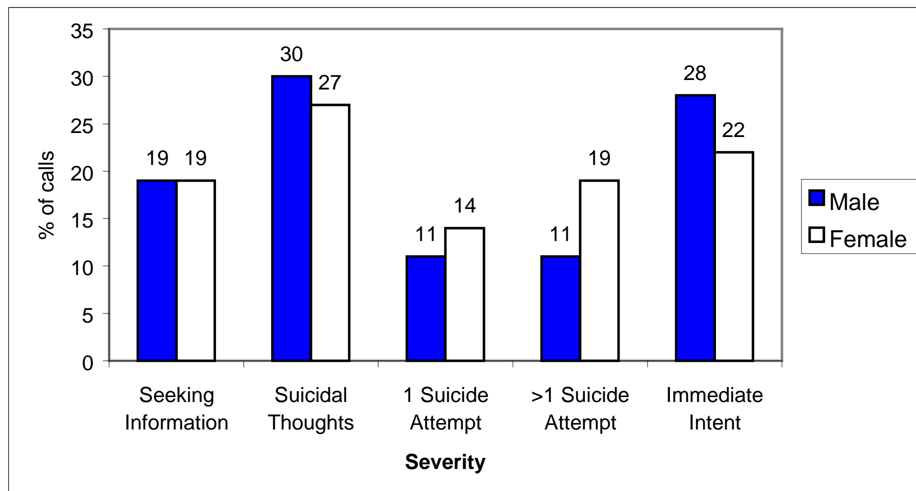
As mentioned previously, calls to the service are logged in terms of problem type, and problem 'severity'. The 'severity' definitions for suicide-related calls are as follows:

1 = Seeking information
2 = Suicidal thoughts or fears
3 = Attempted suicide once previously
4 = Previous suicide attempts (more than once)
5 = Immediate intention

5.1 Severity by Gender

Significant differences are evident between genders in relation to the severity of suicide calls. Figure 4 highlights that whilst males and females make similar proportions of calls seeking suicide-related information and to discuss their suicidal thoughts or fears, differences are apparent in other suicide related behaviours.

Figure 4. Severity of Calls by Gender



A greater proportion of female callers indicated they had attempted suicide on at least one occasion. In contrast, the proportion of males who rang with an immediate suicide intent was 38% higher than that of the female callers.

These findings are consistent with wider research in which it has been found that females attempt suicide more often than males. Kosky (1997) states there are possibly between 30 to 50 suicide attempts for every completed male suicide and between 150 to 300 attempts for every completed female suicide (cited in Baume, 1997). The higher ratio of suicide attempts amongst females has been linked to sex role socialisation (Triolo, 1984). As previously noted, it is argued that males are conditioned to repress some of their emotions at times, and thus "tend to be less communicative, give little if any warning, and adopt more lethal means of suicide" (Here for Life, 1997).

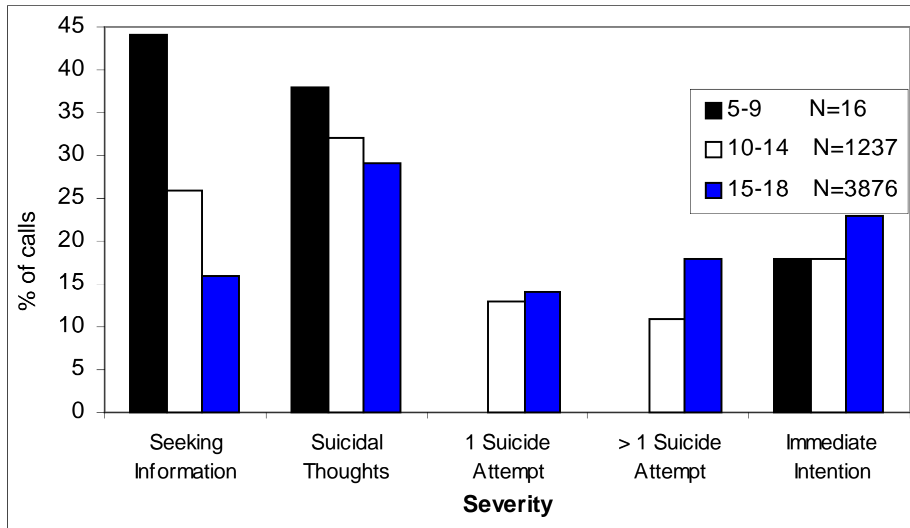
By contrast, it is argued that females "tend to prefer less violent and less lethal methods, such as drug overdoses. The chances for discovery and recovery from the more passive methods used by females is greater than from the violent methods used by males" (Overholser, 1990). The findings from the research are again linked to vulnerabilities stemming from differing gender trends in help-seeking behaviours.

Whilst research efforts to ascertain the ratio of male and female suicide attempts continues, perhaps the overriding consideration should be findings which indicate that previous suicide attempts are predictive factors of future suicide (Petrie, Chamberlain & Clarke, 1988 cited in Lennings, 1994). Particularly confronting findings include that 25-40 percent of people who complete suicide had made at least one previous attempt (Baume, 1997). It has also been found that the most significant risk factor for death by suicide in teenage males is a previous attempt (Shaffer cited in Commonwealth Department of Health and Family Services, 1997).

5.2 Severity by Age

Figure 5 highlights differing trends in the severity of suicide calls according to the age of KHL callers. Callers aged 5-9 years account for 0.3% of suicide related calls, compared with 24.1% for 10-14 year olds and 75.6% for 15-18 year olds.

Figure 5. Severity of Suicide Calls by Age.



All but three of the 16 callers aged between 5-9 rang seeking information (7) or to discuss their suicidal thoughts or fears (3). The remaining 3 rang with an immediate suicide intent. Of callers aged 10-14 years, 32% discussed having suicidal thoughts and 25% stated they had attempted suicide on a previous occasion. Young people aged 15-18 were more likely to have attempted suicide previously (32%) or had an immediate suicidal intent (23%).

The findings indicate there may be a continuum of suicidal behaviours. The continuum refers to the onset of suicidal thoughts and fears (ideation), the action phase of suicide attempts, and in too many cases completed suicide (Beck & Greenberg, 1971; Bedrosian & Beck, 1979; Paykel, 1974 cited in Simons, 1985).

Greene (1994) argues that although society denies the possibility of suicide in pre-adolescent's, suicide risk actually increases with the age of the child until it reaches a peak in adolescence. Greene further argues that suicidal thoughts and the risk of attempting and completing suicide steadily increases from the ages of 8 to 14 years.

Furthermore, developmental theories propose that middle adolescence brings changes in cognitive functioning which represent periods of heightened vulnerability toward suicidal thoughts and attempts (Inhelder & Piaget cited in Lennings, 1994).

Similarly, Triolo (1984) argues that as children move into middle and late adolescence, the risk of suicide increases by a factor of 10, however, Wagner (1997) states there is a lack of information on this subject and that future research efforts need to focus upon the link between developmental factors and suicide behaviours.

The importance of early intervention with the aim of preventing suicidal thoughts resulting in suicide attempts is reinforced by KHL data.

6. Ethnicity

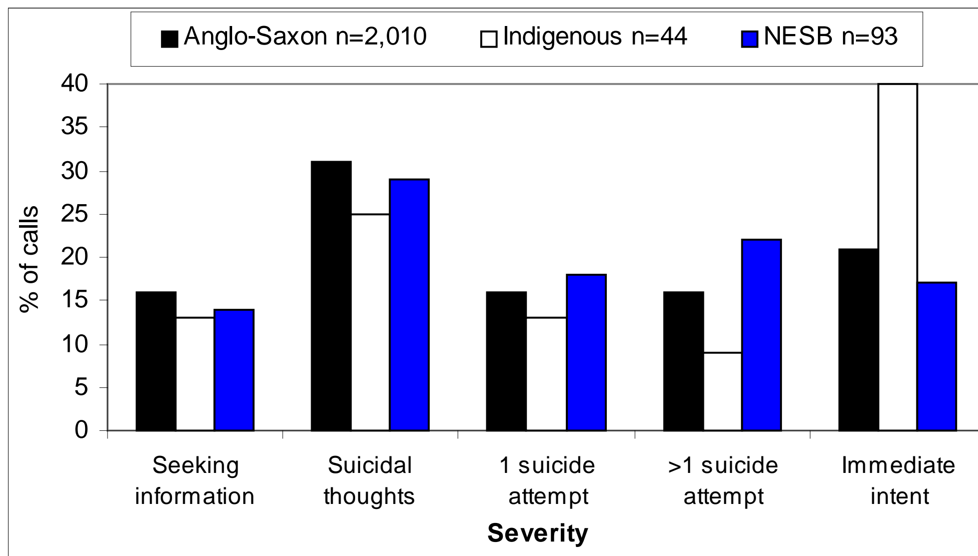
The ethnicity of callers was recorded for one-third of the 6,429 calls. Of the 2,189 calls in which ethnicity was noted, 94% were recorded as being from non-indigenous (or Anglo-Saxon) backgrounds. An additional 4% (94) of callers were from a non-English speaking background (NESB). The remaining 2% (44) were from an Aboriginal or Torres Strait Islander background (Indigenous).

Of calls made by 5 to 9 year olds, none were recorded as being from indigenous or non-English speaking backgrounds. Otherwise, no age or gender differences are evident across ethnic groups. Clearer differences are noticeable in the severity of suicide calls by the ethnicity of callers.

6.1 Ethnicity by Severity

Figure 6 (below) highlights significant differences between ethnic groups in terms of the 'severity' of suicide-related calls.

Figure 6. Severity of Suicide Calls by the Caller's Ethnicity.



A larger proportion of indigenous callers phone with an immediate suicide intent. Despite only representing 19 callers, the proportion of indigenous callers who rang with an immediate suicide intent is 90% greater than the corresponding figure for non-indigenous callers and more than double the corresponding figure for callers from a non-English speaking background. Callers from non-English speaking backgrounds were more likely to have attempted suicide previously (37.5%).

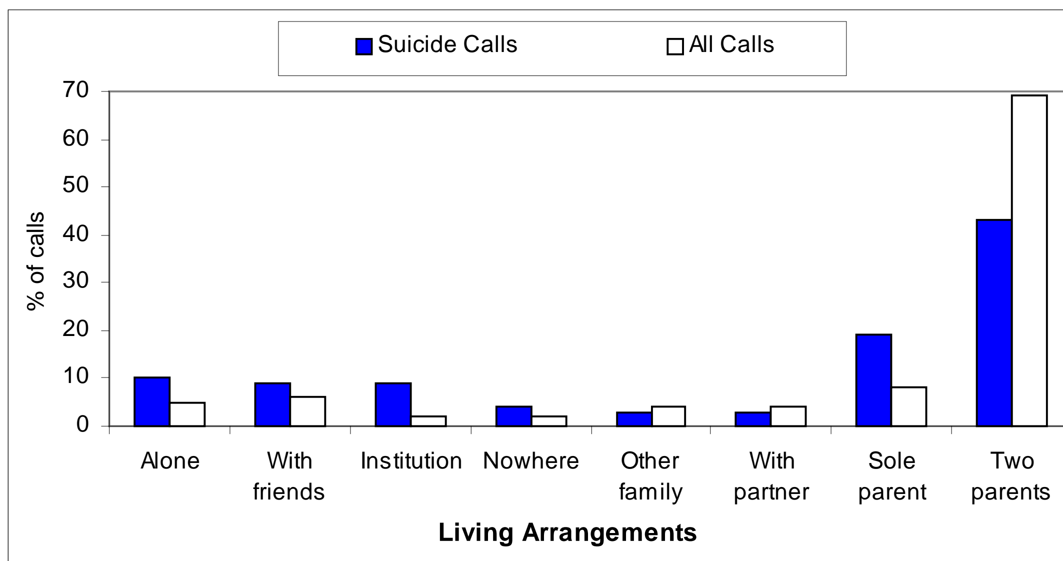
These findings concur with wider research which states that young people from an Aboriginal or Torres Strait Islander background are particularly at risk of suicide. Queensland data from 1990-1992 found that young people aged 15-29 years from an indigenous background completed suicide at a rate of 39.4 per 100,000. This figure is almost double the corresponding rate of 20.9 completed suicides per 100,000 amongst those aged 15-29 years in the total population. Furthermore, the rates of Aboriginal deaths by suicide have dramatically increased over the past decade. (Department of Health and Family Services, 1997)

Professor Ernest Hunter (cited in Donaghy, 1997, p134) cautions that the issue of youth suicide amongst indigenous young people is complex and multifaceted. He notes that a key factor is the perpetuation of racism, which can involve being caught in a set of social circumstances that continue to entrap indigenous young people who are not able to use the political system to their advantage. Donaghy also notes that by contrast, indigenous communities that are based upon traditional ways appear to have very few suicides. Therefore dispossession from one's heritage and the prevalence of multiple forms of disadvantage in the past and current social context may be key stressors which place indigenous young people particularly at risk of suicide.

7. Living Arrangements

The living arrangements of children and young people were recorded for 61% (3,905) of the 6,429 suicide calls (see Figure 7).

Figure 7. Living Arrangements of Callers.

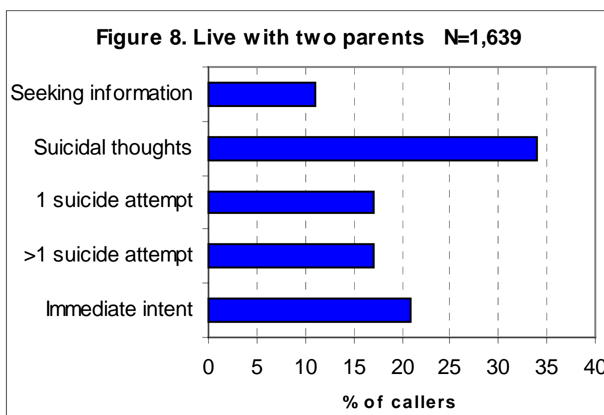


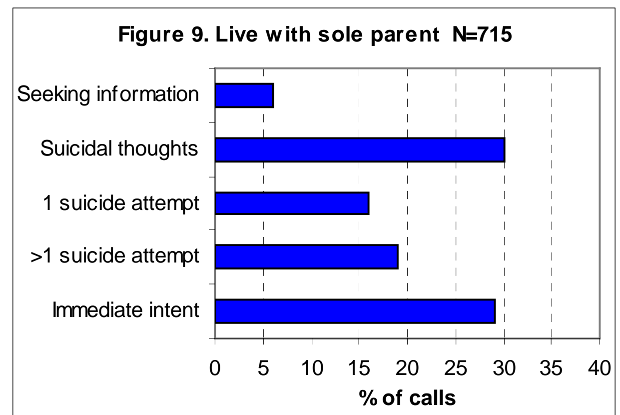
The largest proportion of callers stated they lived with two parents or in single parent families, reflecting Australian population demographics.

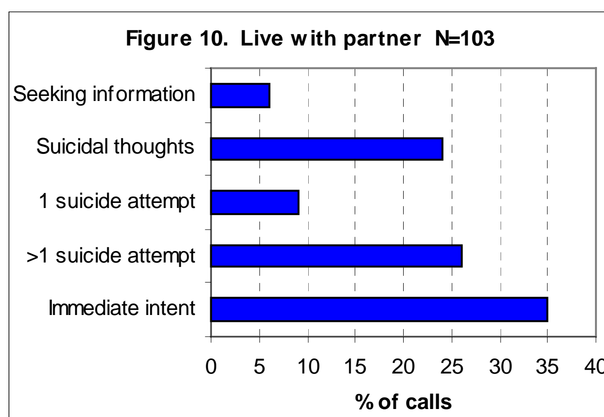
When comparing suicide calls against all calls, differences are apparent in terms of the living arrangements of callers. Higher proportions of suicide-related calls were made by those who were:

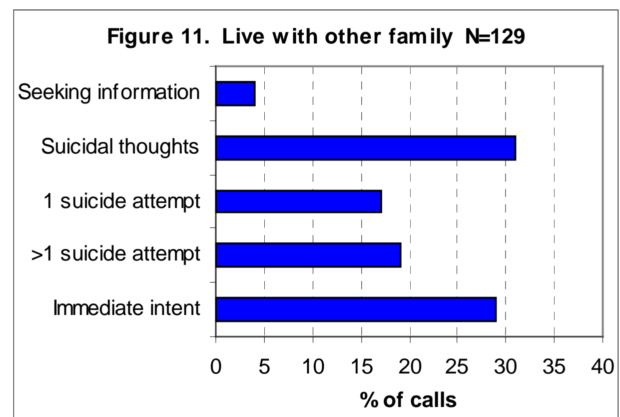
- living with a sole parent;
- homeless;
- living in an institution (includes boarding school, detention centre, hospital);
- living with friends; or
- living alone.

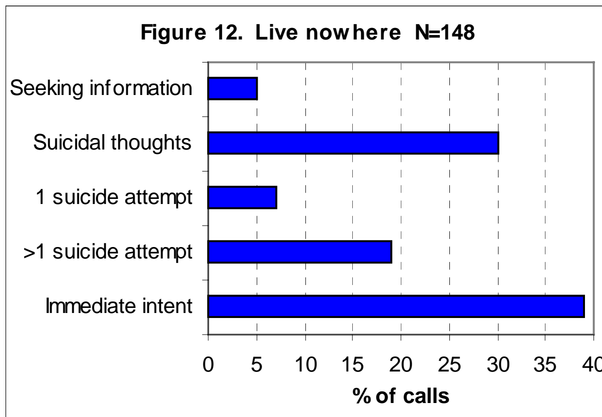
Figures 8 - 15 (detailed on the following pages) display the living arrangements of callers by the severity of the suicide call.

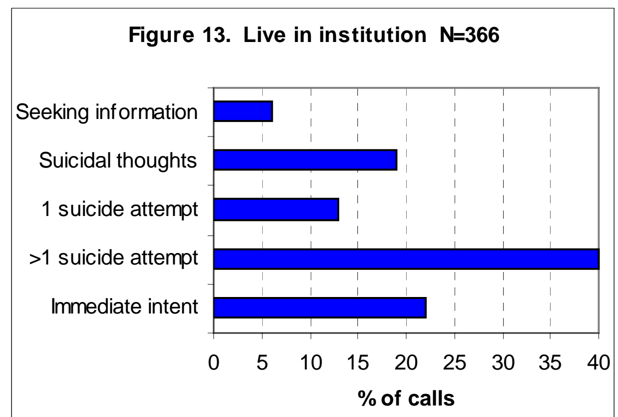


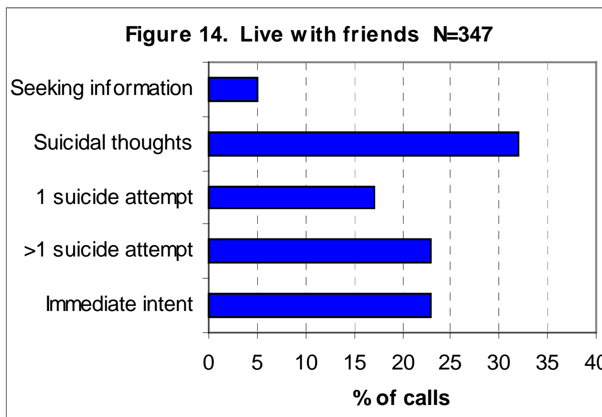


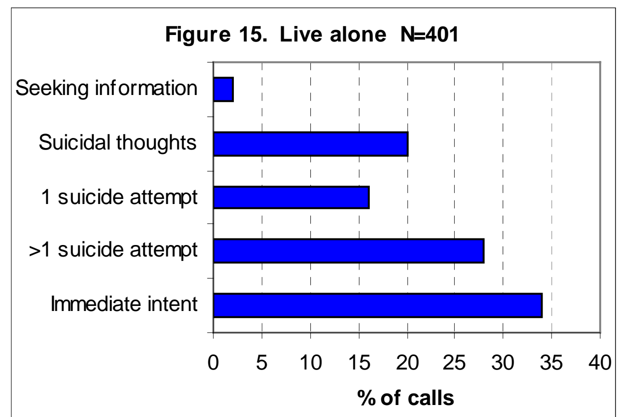












These figures highlight that callers who phone Kids Help Line with an immediate suicide intent are more likely to be homeless, live alone, live with a partner or live in a single parent family.

The highest proportions of callers with more than one previous suicide attempt were more likely to be living in an institution of some kind or to live alone.

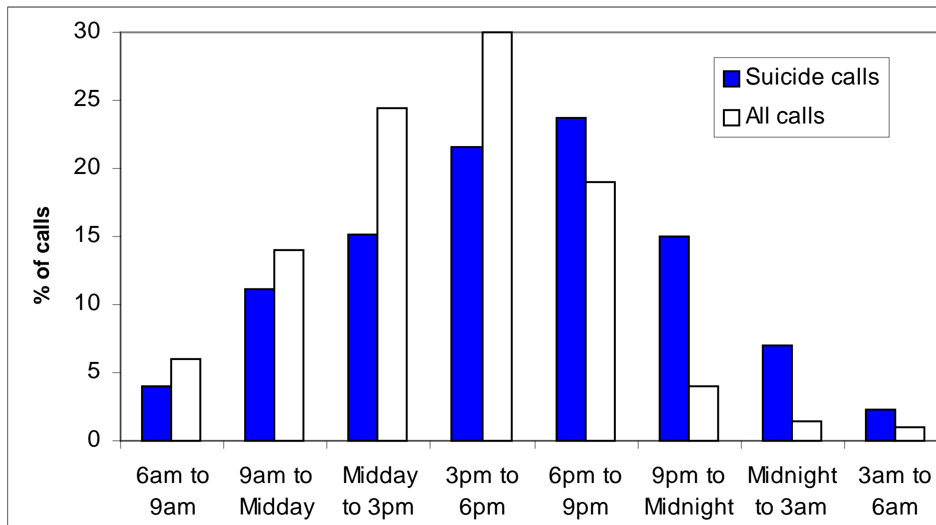
Homelessness can be a significant risk-factor for young people. This is supported by the Victorian Suicide Prevention Task Force report which identified the homeless as one of the groups "vulnerable to suicide at higher than average rates" (1997).

It is interesting to note that the lowest proportion of those who rang with an immediate suicide intent (21%) were those who lived with both parents. Intact two-parent families may be an important protective factor for young people.

8. Time of Day

Figure 16 provides a summary of the time of day that suicide-related calls are made to Kids Help Line compared with other counselling calls.

Figure 16. Proportion of Calls by the Time of Day.



Whereas almost three-quarters of all calls to KHL are made between 9am and 9pm, the graph shows that two-thirds of suicide-related calls are made between 3pm and 6am.

Gender differences are evident with the time of day that the call is made.

Figure 17. Time of Day of Suicide-Related Calls by Gender.

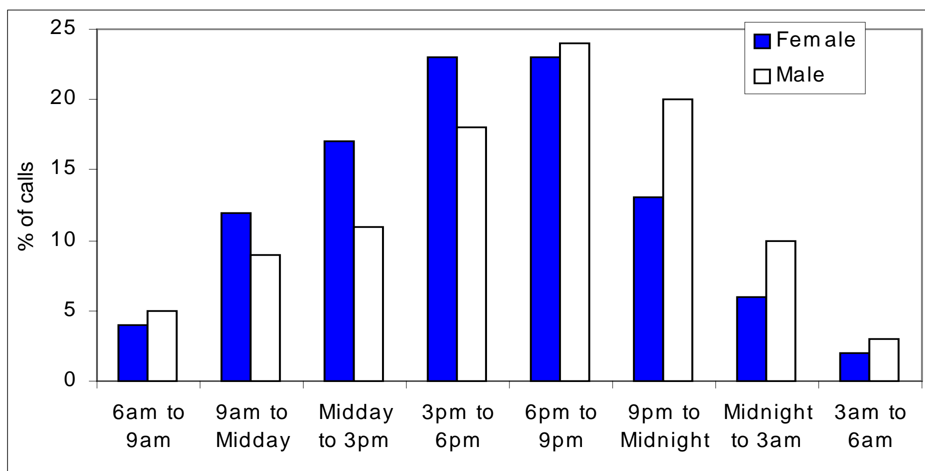


Figure 17 indicates the highest proportion of suicide-related calls made by males are made between 6pm and midnight (44%). Equivalent proportions of females (46%) phone with suicide-related issues between 3pm and 9pm.

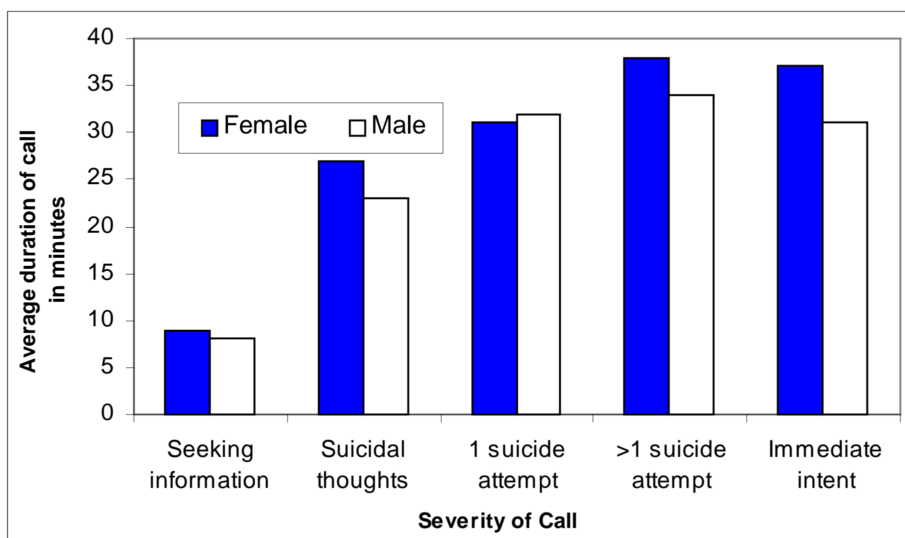
KHL has found that during the hours of 6am to 9pm a higher proportion of young people ring to seek information or discuss their suicidal thoughts or fears. As the evening progresses so does the severity of suicide calls. Approximately half of all callers with an immediate suicide intent (52%) phone between the hours of 6pm to 3am.

Therefore, suicide calls of potentially the greatest severity are most commonly made during the evening or early hours of the morning. These findings have implications for service delivery in the field of suicide prevention, in that services need to be accessible and responsive 24 hours a day.

9. Call Duration

Figure 18 displays the average duration of calls according to the severity of the suicide call and gender of the caller.

Figure 18. Duration of Calls by the Severity of the Call and Gender of the Caller.



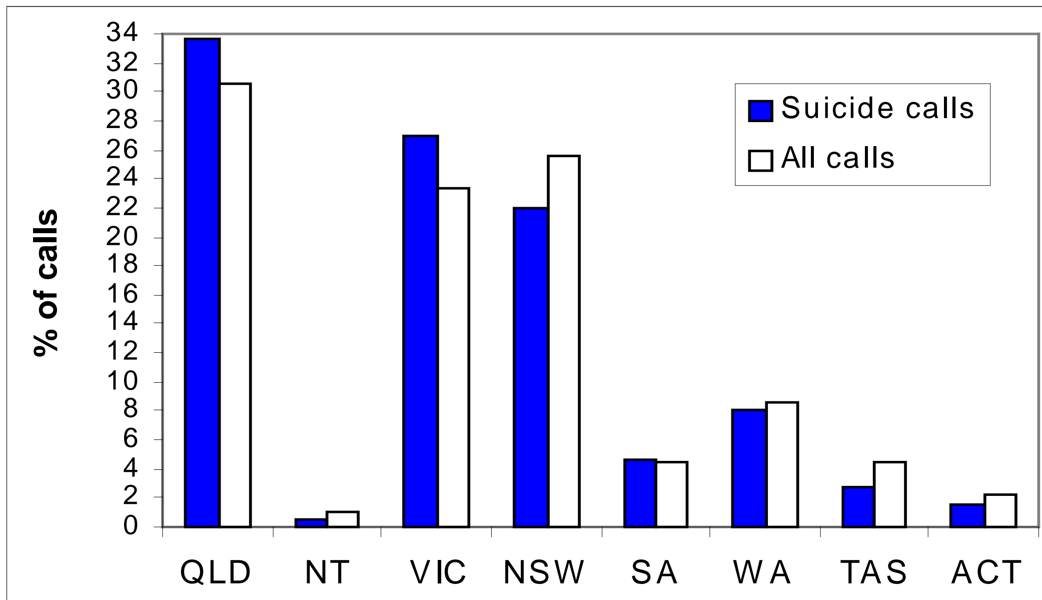
While the average duration of suicide calls is twenty-seven minutes, three-quarters of the calls take 31 minutes or longer. Suicide calls of the longest duration were those in which the callers stated having attempted suicide on more than one occasion (average duration for both genders = 36 minutes).

10. Geographic Location of Callers

10.1 Suicide Calls by State

The graph below shows the proportion of suicide-related calls from each State compared to the proportion of all calls.

Figure 19. Suicide Calls by State.



NB. The graph only includes those callers who nominated their location. Approximately 60% of callers prefer not to reveal their location to counsellors.

The graph highlights that the highest proportions of calls were received from the largest States, Queensland, Victoria and New South Wales. Higher proportions of suicide calls, as compared to all counselling calls, were made by callers from Queensland and Victoria.

10.2 Regional Breakdown of Suicide-Related Calls

Despite the rising rate of suicide in young males, it is only recently that interest has been shown in the relationship between suicide and geographic location. As a result, a higher suicide rate among young rural males has been demonstrated with a five-fold increase in suicide in this group (Baume & Clinton, 1997).

Suicide incidence data has found that males living in rural communities have a consistently higher rate of suicide than their urban counterparts. This is particularly the case for males aged between 15-24 years, with 38 suicide deaths per 100,000 recorded in rural areas (1992) compared with 25 per 100,000 recorded in urban areas. It has also been found that the rate of suicide among young males in rural areas has increased by more than 50% since 1986 (Department of Human Services and Health, 1995). Considerable debate surrounds the issue of higher rural youth suicide rates. Researchers have argued that inconsistent, and in some cases, improper methods have been used to classify rural and remote regions, thereby compromising data analysis of suicide rates.

The research conducted to date has linked disproportionately high suicide rates in rural and remote communities to the 'rural crisis.' Graham (1994) argues that the historical view, in which rural Australia represents health and freedom from stress, is eroding.

Factors that have been identified as being particularly stressful or which place young people who are living in rural and remote communities at risk of suicide include:

- A lack of youth specific and youth friendly community/welfare resources;
- Geographic isolation from social supports;
- Loneliness;
- Transport difficulties;
- High rates of unemployment;
- Lack of advanced education opportunities;
- A prevailing ideology of self reliance;
- Greater access to lethal means of suicide;
- Financial strain imbued in the pastoral existence with increased family stress; and
- Increasing rates of family breakdown (Forrest, 1988; Baume & Clinton, 1997).

It is argued that for young people living in rural and remote communities, the process of seeking help is further complicated by a number of barriers. These barriers include a lack of independent finances, difficulty negotiating and differentiating between helping agencies and the perception that anonymity and privacy will be compromised by seeking help from within the local community (Forrest, 1988). It is also a widely held belief among service providers, community leaders and researchers that the provision of community services is sparse in rural and remote communities compared to the level of service delivery in urban communities (Croce, 1994).

As previously stated, KHL counsellors record the caller's postcode of residence on the database if the caller is willing to reveal their whereabouts. Between March 1991 and August 1997 individual postcodes were recorded for 52% of suicide callers, allowing an analysis of 3,373 calls by geographical location. To establish whether different issues exist between rural and metropolitan suicide callers to Kids Help Line, each caller's postcode was assigned a corresponding geographical classification. The classifications of geographical location that were applied to KHL data are as follows:

- *CAPITAL CITIES*: State and territory capital city statistical divisions.
- *METROPOLITAN AREAS*: Urban centres of population 100,000 or more in size.
- *LARGE RURAL CENTRES*: Populations ranging from 25,000 to 99,000 in size.
- *SMALL RURAL CENTRES*: Populations ranging from 10,000 to 24,999 in size.
- *OTHER RURAL AREAS*: Populations ranging from 5,000 to 10,000 in size.
- *OTHER REMOTE AREAS*: Populations less than 5,000 in size

(Department of Primary Industries and Energy & Department of Human Services and Health, 1994).

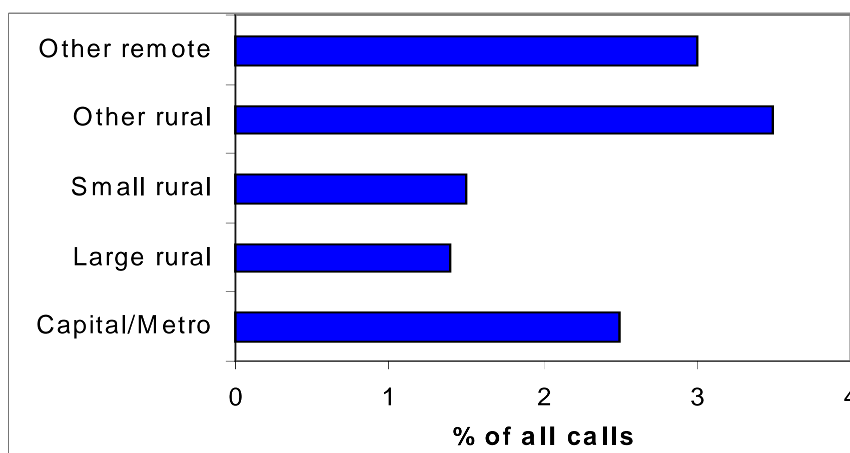
The post-codes of KHL suicide callers were then grouped according to the corresponding classifications of location (above) and analysed. As previously stated, the key aim of the analysis was to detect any differences in the

proportions of calls, concerns and referrals of suicide callers from metropolitan and rural/remote areas.

Three-quarters of suicide-related calls to KHL were made from capital cities and metropolitan areas (2511), with the remaining one-quarter of calls made from rural and remote centres (862). This breakdown is largely consistent with the nationwide distribution in which 80% of the population is estimated to live in metropolitan areas with the remaining 20% living in rural and remote communities.

The graph below shows the proportion of suicide-related calls (as a percentage of all calls) from each geographical location.

Figure 20. Proportion of Suicide Calls by Location.



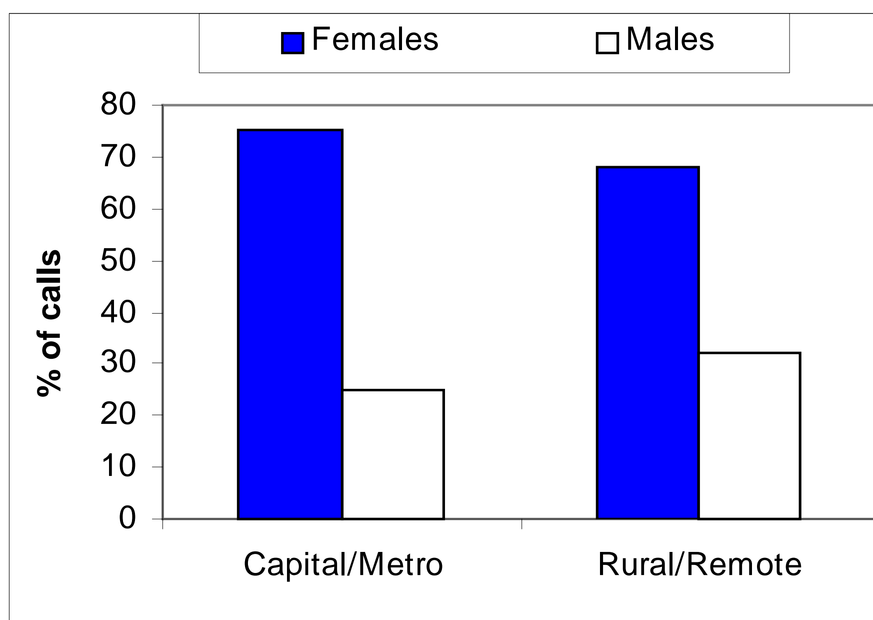
Differences are apparent in the proportion of suicide-related calls received from each geographical location. It can be seen (in the graph above) that the proportion of calls about suicide from capital cities and metropolitan areas represented 2.5% of all the calls received from these areas. Large and small rural areas reported lower proportions of calls about suicide (1.4%). By contrast the proportion of calls received from "other rural" and "other remote" areas was 30% higher than the corresponding proportion from capital cities and metropolitan areas, accounting for over 3% of all calls.

Therefore children and young people who live in the least populated areas of Australia make a higher proportion of calls about suicide than their counterparts in capital cities and metropolitan areas.

10.3 Gender, Age and Severity by Region

The graph below shows the gender breakdown of callers from capital/metro areas compared with callers from rural and remote regions of Australia.

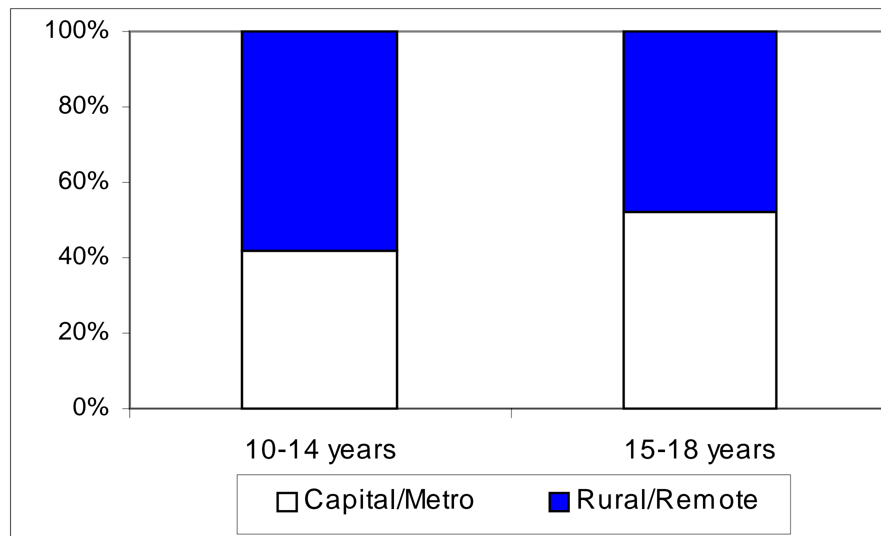
Figure 21. Gender of Suicide Callers by Location.



The graph indicates that the proportion of male callers from rural and remote communities (32%) is 28% greater than the corresponding rate for males in capital cities and metropolitan areas (25%).

Figure 22 compares the age breakdowns of callers from capital/metro regions with callers from rural and remote areas. A higher proportion of suicide-related calls were made by those aged 10-14 years living in rural and remote regions than their urban counterparts.

Figure 22. Calls by Age and Location.

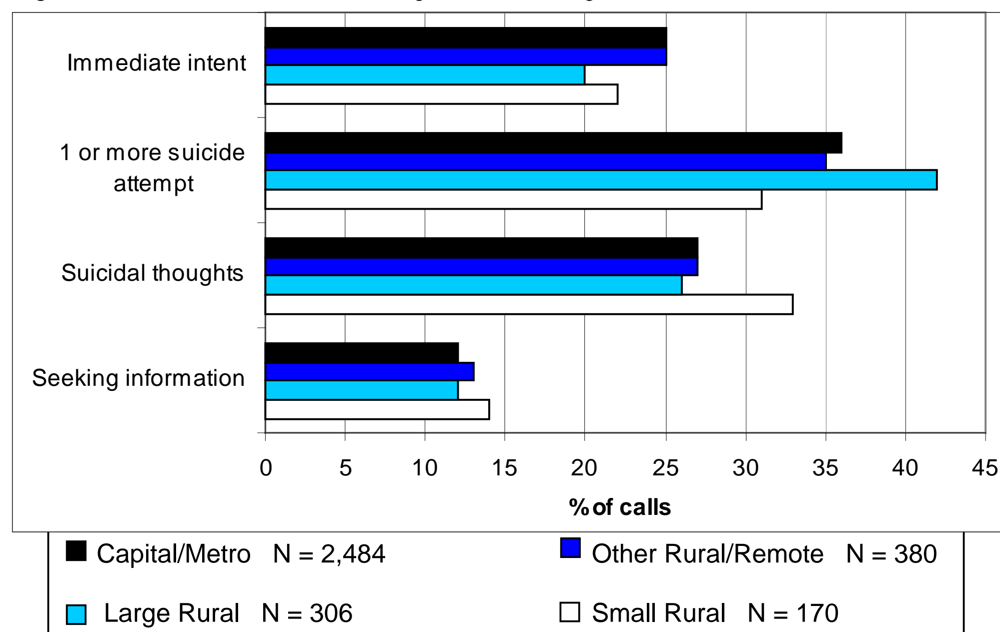


Analysis across the six location types reveals that young people aged between 10 and 14 living in "other rural areas" made the highest proportion of suicide calls of the 6 location types, making 61% more calls than their counterparts in capital cities and metropolitan areas.

The findings suggest that young people from rural and remote communities may begin to experience suicidal thoughts or intentions at an earlier age. Alternatively, they may seek help in higher proportions than their urban counterparts. The lack of other services, and the anonymity associated with using the telephone to seek help may also make KHL attractive to children and young people living in these communities.

Figure 23 displays the severity of suicide-related calls by the geographical location of the callers.

Figure 23. Location of Callers by the Severity of the Call.



The severity of calls received from differing geographic locations reveals interesting differences. These include:

- The proportion of suicide callers from "large rural centres" who indicated they had attempted suicide once is 43% higher than the corresponding figure for capital cities and metropolitan areas.
- The proportion of callers from "small rural centres" who rang in regard to their suicidal thoughts or fears was 22% higher than their counterparts from capital cities and metropolitan areas.
- Callers from "other rural and remote areas" and callers from "capital/metro regions" were most likely to call with an immediate suicide intent.

It thus appears that higher proportions of callers from a range of rural areas (compared to their urban counterparts) experience suicidal thoughts, have previously attempted suicide or ring the service with an immediate suicide intent.

Overall, male callers from rural and remote areas report a higher incidence of previous suicide attempt/s than male callers from capital cities and metropolitan areas. These findings support wider research that suggests males who live in rural and remote communities are particularly vulnerable to suicidal thoughts, suicide attempts and to the completion of suicide (King, 1994).

11. Contributing and Causal Factors

The KHL data logging system provides counsellors the opportunity to document qualitative data. This information proves valuable in highlighting issues associated with the main problems discussed during counselling calls.

Due to the small proportion of suicide calls received from children aged 5-9 no qualitative data was recorded. However a significant amount of qualitative data was recorded for callers aged between 10-18 years.

11.1 Callers Aged 10 to 14

Of the 261 statements of qualitative data recorded for callers aged between 10-14 years (see Figure 24), child abuse was identified by 27% of callers as the main issue associated with thoughts of suicide and/or suicide attempts, with sexual abuse most frequently mentioned. It is important to note that approximately half of these callers stated they were the victims of both sexual and physical abuse.

A further 14% of 10-14 year old callers related family relationship problems to their suicidal thoughts or attempts. The problems with family relationships identified by callers included distress over parents who were arguing, family separation, conflict with siblings and conflict with one or more parents or step-parents.

Figure 24. Causal factors for 10 - 14 year olds.

N=261

Suicide-Related Problem Type	Percentage of Qualitative Text
Child Abuse	27%
Concern for Suicidal Friend	18%
Family Relationships	14%
Problems at School (includes bullying)	8%
Suicide of Family Member/Friend	5%
Relationship Breakdown	4%
Rape/Sexual Assault	4%
Pregnancy	4%
Self-esteem	3%
Other includes: Domestic Violence, Depression, Mental Health Problems, Homelessness, Substance Abuse by Family Member	13%
Total	**100%**

It is also interesting to note that 18% (44 callers) aged between 10 to 14 years rang KHL out of concern for a friend who was suspected or had expressed having suicidal thoughts or had attempted suicide. The majority of these callers phoned the service seeking strategies on how to best support their friend(s) to prevent them from further suicide attempts.

Problems at school accounted for 8% of the qualitative data recorded under suicide calls made by children in the age group of 10-14 years. Problems managing school work loads, academic pressure and difficulty understanding subject content accounted for 3% of the suicide-related qualitative data. Bullying from peers at school accounted for 5% of the calls from this age group; the majority of whom stated being the victims of frequent bullying which involved emotional and physical abuse.

Whilst the main issues identified by callers aged between 10 and 14 years have been documented separately, approximately three-quarters of the callers identified that multiple problems were associated with their suicidal thoughts or suicide attempts.

11.2 Callers Aged 15 to 18

Figure 25. Causal factors for 15 - 18 year olds.

N=649

Suicide-Related Problem Type	Percentage of Qualitative Text
Child Abuse	18%
Family Relationships	13%
Concern for Suicidal Friend	9%
Relationship Breakdown	8%
Substance Abuse	6%
Problems at School (includes bullying)	6%
Rape/Sexual Assault	5%
Mental Health	4%
Self-esteem	4%
Loss of Parents/Family Member	4%
Pregnancy	3%
Loneliness	3%
Depression	3%
Homelessness	3%
Unemployment	2%
Suicide Pact with friend/partner	1%
Other includes: Sexuality Issues, Eating Behaviours, HIV/AIDS.	8%
Total	**100%**

Of the 649 statements of qualitative data recorded for callers aged between 15 and 18 years (see Figure 25), sexual, physical and emotional abuse were the most commonly mentioned issues associated with thoughts of suicide and/or suicide attempts. Similar to those aged between 10 and 14, approximately half of the callers who were aged 15-18 years stated they were the victims of multiple forms of child abuse.

Furthermore, a similar proportion of older callers related family relationship problems to their suicidal thoughts or attempts as those aged 10-14. The themes of these calls included distress over family breakdown, ongoing conflict, or feelings of rejection from one or both parents.

The proportion of 15-18 year old callers who phoned out of concern for a suicidal friend (9%) was 50% lower than the corresponding figure for those aged 10-14. Similar to those aged 10-14, the majority of these callers phoned to seek strategies on how to best support their friend(s) and prevent them from completing suicide. However an additional 3% of callers (25) rang to discuss their experience of grief after the suicide of a family member or friend. According to the qualitative data, 8 callers rang the service to discuss the suicide plans or pacts they had formulated with their friends or partners.

Problems at school accounted for 6% (54) of the qualitative data recorded under suicide-related calls made by young people aged 15 to 18. Family pressure to achieve, uncertainty about future study or employment opportunities and difficulty coping with school workloads represented common themes from this age group.

The proportion of suicide-related calls received from those aged between 15-18 years about the issue of bullying was 40% lower than those aged 10-14, accounting for 3% of the qualitative data. The majority of these callers reported being bullied on a frequent basis with some callers stating the bullying ranged from taunts to physical and sexual intimidation.

A further 8% (69 callers) related their suicidal thoughts or attempts to the breakdown of an intimate relationship. Common themes of these calls included feeling unable to cope with the relationship breakdown, distress over an ex-partner beginning a new relationship, and feelings of loneliness and rejection after the breakdown of an intimate relationship.

Self-esteem issues accounted for 4% of the qualitative data from callers aged 15 to 18 (37 calls). Common themes of these calls included feelings of low self-worth, feeling of "no use to anyone" and persistent or chronic feelings of inadequacy.

Consistent with the younger callers, approximately half of those aged 15-18 years identified that multiple problems were associated with their suicidal thoughts or suicide attempts. The KHL qualitative data concurs with wider research, which argues that a complex interplay of multiple stressors or traumatic life events precede and contribute to suicidal thoughts and attempts.

11.3 Callers from Rural and Remote Areas

Similar to all suicide calls received by the service, callers from rural and remote locations most commonly identified problems with family relationships and child abuse and concern for a friend as the main issues associated with their thoughts of suicide and/or suicide attempts (see Figure 26).

Figure 26. Issues Identified by Suicide Related Callers from Rural and Remote Areas

N=229

Suicide-Related Problem Type	Percentage of Qualitative Text
Family Relationships	15%
Child Abuse	12%
Concern for Suicidal Friend	10%
Substance Abuse	8%
Relationship Breakdown	7%
Self-esteem	6%
Grief over death of Family/Friend	5%
Depression	5%
Problems with Friends	5%
Rape/Sexual Assault	4%
Academic Problems/Pressure	3%
Homelessness	3%
Boredom	3%
Mental Health	3%
Loneliness	2%
Aggression/Anger	2%
Legal Problems	2%
Bullying	1%
Financial Problems	1%
Hopelessness	1%
Sexual Orientation	1%
Pregnancy	0.5%
Eating Behaviours	0.5%
Total	**100%**

Alcohol and drug abuse accounted for 8% of the qualitative text recorded under suicide calls from rural and remote areas.

12. Referrals

KHL counsellors are supported by a referral database which contains approximately 8,000 welfare and support services in all parts of Australia. Given that KHL is a single-site service with all calls being answered in Brisbane, counsellors must be skilled in searching the referral database to find appropriate local services for their clients. This can be done in a number of ways:

- by the name of the service;
- by keyword;
- by postcode;
- by both postcode and keyword.

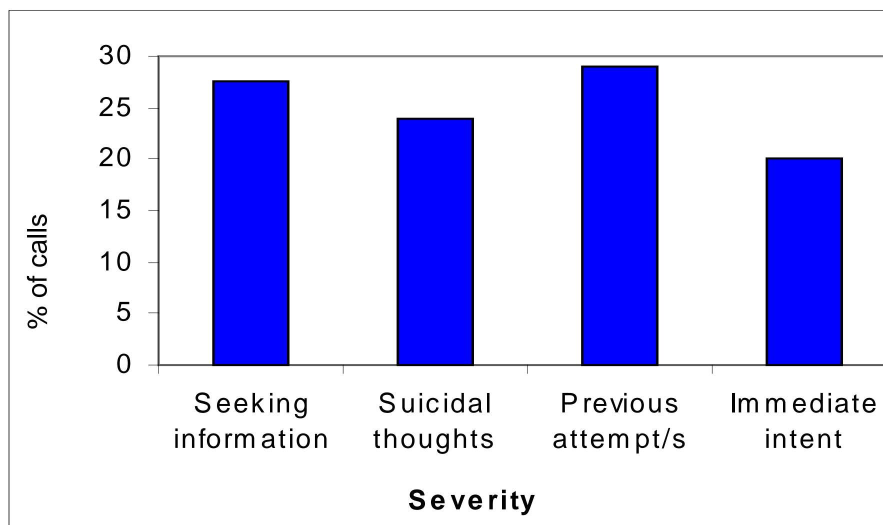
Each referral has a full description of services offered, referral criteria and names and contact numbers of staff. This referral database is constantly updated, and is also available on disk for purchase.

Overall, 8% (273) of those who contacted KHL about suicide were referred to other agencies. This figure is comparable to the 9% referral rate across all counselling calls received by KHL.

12.1 Referrals by Severity

The percentage of referrals for the different 'severity' of suicide-related calls are shown in Figure 27.

Figure 27. Referrals by Severity



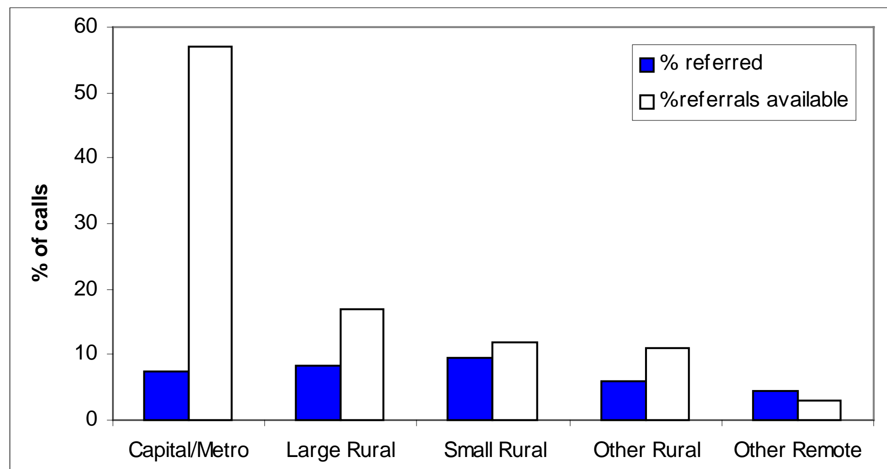
The graph indicates that callers who phoned with an immediate suicide intent received the fewest referrals to other agencies. Most referrals given to callers with an immediate suicide intent involve crisis intervention (eg contacting an ambulance or the police to intervene in a suicide in progress). Anecdotal information provided by KHL counsellors suggests that attempting a referral in this phase is frequently not appropriate and may increase the callers level of distress and lead to premature termination of the call. It is after the crisis has resolved or passed that referrals to other agencies for longer-term follow-up are more often made and accepted by the young person.

An assessment of the individual's level of suicidality is a vital part of the counselling intervention with suicidal callers. This includes assessing the individual's level of distress as well as the lethality of the method used in the proposed suicide attempt. It is in the assessment stage that existing support networks and the option of referral is canvassed with the caller and/or they are encouraged to contract with the counsellor to call back as many times as needed to work through the immediate crisis. As mentioned in the introduction, 27% of callers stated they were calling again. At a latter stage of the process it may be agreed that a referral to another agency is an acceptable option for the young person.

12.2 Referrals by Location

The rate of referrals varies according to the caller's geographical location. The graph below compares the proportion of agencies on the Kids Help Line database with the proportion of referrals made across geographical locations. Please note that the available referrals are those which are linked and able to be searched on the KHL database to the word "Suicide". Until 1997, 81 services on the database were linked to this keyword, leaving counsellors with few options for referring callers to other services. By 1998 this number had increased to 363 services.

Figure 28. Location of Callers by Referral Options



The above graph shows that three-quarters of agencies are located in capital cities, metropolitan areas and large rural centres. Services for those who phone about suicide are fewest in small rural and remote communities.

While the proportions of referrals from metropolitan and rural areas vary, differences are also apparent in the range of services that KHL suicide callers were referred to. Young people who phoned the service from capital cities and metropolitan areas were offered a broad range of referral options. The services included suicide prevention agencies, generic support services as well as specialised agencies such as sexual assault services. It may be assumed that referrals in capital cities and metropolitan areas included services that were open after business hours and were also youth specific. For a full listing of the referrals given to callers from metropolitan and rural/remote areas please see Appendix 2.

Eight percent of those who phoned about suicide from large rural areas were referred to other services. However, unlike the referrals from capital cities and metropolitan areas, no specific suicide prevention services were available on the KHL database. In addition, the services referred to had limited hours of accessibility (two-thirds only operated between 9am-5pm) and were not youth specific.

Ten percent of the 199 callers from small rural centres were referred to other agencies. Whilst this is a larger proportion of referrals than the callers from large rural centres, the range of services available was less extensive. The majority of referrals given were to generic services such as hospitals and three quarters of the services were listed as operating between 9am to 5pm. It can be argued that the limited range of referrals offered to callers from small rural centres is a reflection of the limited availability of services for young people in these communities.

There was a marked decrease in the proportion of referrals given to callers from 'other rural' and 'other remote' areas. On average, the proportion of referrals given to callers from the two areas was 31% lower than the corresponding figure for callers in capital cities and metropolitan areas. The majority of available services were not youth specific, were not open seven days a week and largely operated between the hours of 9am to 5pm. However three suicide prevention specific services were available in 'other rural' areas.

The above information on the proportion and range of referrals made to KHL callers by their location supports the following consensus among researchers, service providers and consumers:

> "the vast array of urban welfare services are generally unavailable in rural and remote areas or are so inaccessible as to be virtually non-existent" (Cheers 1991 cited in Croce).

13. Recommendations

The findings in this report have implications upon prevention and intervention efforts in regard to youth suicide. These implications are documented through the following series of recommendations.

1. Normalising Help-Seeking for Males

Kids Help Line data across suicide and all calls received, highlights that females constitute the majority of those who seek out help when experiencing a problem. This finding is consistent across human service organisations which have found that females are more likely to seek external help for their problems. The data has also shown that when males do call, they are more likely to phone when the issue has reached crisis point; i.e. they are more likely to phone with an immediate suicide intent.

Addressing this issue may involve two levels of advocacy. The initial level involves challenging the fact that society conditions males to view external help seeking as a weakness. The message to be communicated to males of all ages is that seeking out help when experiencing problems is acceptable and a positive step. A variety of mediums need to be utilised in promoting this message across the long-term, the education system being one key resource. Furthermore, agencies have a responsibility to ensure that their service meets the needs of males.

The secondary issue is that perhaps males do not view formal services as applicable to their particular needs or the culture of agencies may not be compatible with the help-seeking patterns of males. Preliminary research into programs such as the "Being There", Peer Skills Program has found that males (and females) are more likely to seek out help from their peers when experiencing a problem. Forrest (1988) has also found that programs of this nature have proven effective in the prevention of suicide. Essentially these programs aim to enhance the inherent skills of young people in dealing with their own and other's problems. This may in turn overcome some of the existing barriers to help-seeking. It must be noted that in the program young people are informed of wider resources that are available and are taught strategies which do not make them feel solely responsible for the emotional well being of others.

2. Indigenous Youth Suicide: The Quest for Social Justice

The fact that young indigenous males are almost twice as likely as non-indigenous males to ring the service with an immediate suicide intent is highly disturbing. It is widely recognised that disproportionate rates of youth suicide amongst indigenous young people is multi-faceted and complex, though largely relates to the wider social structure which continues to disadvantage indigenous people. Whilst reconciliation is an essential step in formally recognising the cultural genocide that has been inflicted through past policies such as those that produced the "stolen generation", it is argued that education is the most powerful tool against perpetuating past wrongs. Professor Ernest Hunter recommends that the "*most effective way to compensate indigenous Australians for all they have lost is an education system which would genuinely advantage the next generation of Aboriginal people ...Education is about providing the tools that enable real choices to be made*" (Donaghy, 1997, p140).

The education system must ensure that young people of all ethnic backgrounds receive a high quality curriculum in which their cultures are promoted, respected and valued. The promotion of positive role models from disadvantaged cultures is also a key component of reinforcing the options and successes that are achievable. These role models also play a key role in challenging negative stereotypes toward people from differing cultural backgrounds.

3. Formal Recognition of Suicidal Thoughts and Attempts in Pre-Adolescent Young People: The Need to Enhance Coping Skills

Over the six years of responding to young people who contact the service about suicide, it has become evident that there is a clear progression in the severity of suicide behaviors as the age range of caller's increases. Greene (1994) argues that while there is little information on suicide of 10-14 year olds, the myths by which youth is seen to be the happiest time of one's life needs to be redressed. Therefore it is recommended that further research efforts need to be focussed upon the possibility of a correlation between developmental factors and suicide behaviours.

Hart (1998) argues that suicide behaviours in young people can be prevented by enhancing their coping skills and by following the tested and true method of "focussing on the positives rather than the negatives." The "Aussie Optimism Program" follows this ethic by teaching cognitive and social skills to children as they enter puberty. The overall aim of the program is to prevent depression/suicide behaviours and assist the development of positive coping skills and resilience among young people. It is thus recommended that programs which enhance the positives in young people, aim to prevent depression and teach positive coping skills, which also contain an evaluation component, are supported and funded by Government.

4. The Need to more Adequately Resource the Community's Capacity to Respond to Child Protection Issues

The most striking information the KHL qualitative data presents is the impact of physical and sexual abuse in contributing to the suicidal feelings and behaviour of young people. Efforts to decrease suicide in young people could well be directed to improving under resourced statutory child protection systems and ensuring a significantly improved range and quality of treatment services for young people and their families. Treating the problem of child abuse may well prevent the escalation of Australia's rate of suicide.

In response to the apparent link between child abuse and youth suicide prevention KHL is keen to work collaboratively with researchers, practitioners and statutory child protection bodies to establish adequate funding levels and models of best practice.

5. Resourcing Rural and Remote Communities: Bridging the Rural and Urban Service Delivery Divide

KHL data on the referrals available to young people from rural and remote communities has reinforced the clear inequities between the availability of support services in capital cities and metropolitan areas as compared to rural and remote areas. It is acknowledged that Australia's population by the nature of its geography is sparse in rural and remote areas and as such equal

levels of service delivery are difficult to attain. Therefore it is recommended that existing methods of supports are better resourced and extended. One such resource may be the continuing education of General Practitioners to enable them to play a key role in suicide prevention, particularly in rural and remote areas. Research has found that between 60-80% of people who complete suicide have seen their General Practitioner in the month before their death. General Practitioners have also been nominated by young people as being the service provider they would be most likely to contact in the event of a mental health or suicide crisis (Moylan, 1996). Therefore it is recommended that funding be extended for programs such as the National General Practice Youth Suicide Prevention Project, which involves improving the skills of GP's in identifying, treating and referring young people who are at risk of suicide. The above component must also contain training on child centred practice by which young people are seen as the experts of their own lives and that their issues, opinions and choices are heard and respected. This approach must also recognise and enact the reality that young people are not a homogenous group but are individuals who have individual perspectives and needs.

KHL has found that suicide calls of potentially the greatest severity are made between the hours of 3pm to midnight. It is therefore recommended that G.P.'s and other services in rural and remote areas are resourced to be able to respond to crises which occur outside of traditional business hours.

The overriding consideration of all suicide prevention and intervention efforts must reflect what the young people of Australia who have contacted KHL over the past 6 years have consistently stated. This involves truly listening and valuing what young people have to say and viewing young people as competent and capable individuals who have expert knowledge about their own lives.

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LiVeS oN ThE LiNE
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Appendix 1. KHL Record-a-Call Information

Date & time of call	___/___/___ ___:___
Duration of call	____ minutes
Caller ID:-	
Name/alias	______________________________
City/town	______________________________
State	_______________
Location type	_______________
Sex	_____ M (Male), F (Female), Blank (Unknown)
Age (approximately)	__________
Phoning from	_____ H (Home), P (Public phone), F (Friend/Family)
How did you hear about KHL?	______________________________
School status	_____________________
Nationality/Ethnicity	_____________________
Living with	_____________________
How long	______ months
If ran from home, why	________
Marital status of parents	________
Source of income	________
Which service did you try	_________________
Rating	______
Is this your first call	____ Y (Yes), N (No)
This call referred to	______________
Accepted	____ Y (Yes), N (No)
Presenting problem	___________
Severity	___________

MAKE NOTES (TEXT) ON BACK

Appendix 2. Referrals By Location.

1. Callers from Capital Cities and Metropolitan Areas

A broad range of services were offered to the 7% of young people from capital cities and metropolitan areas, who phoned KHL about suicide and received referrals. The services these callers were most commonly referred to included the following:

- Family crisis/counselling services (n=33);
- Community health centres (n=28);
- Drug and alcohol services(n=12);
- Mental health emergency services (n=9);
- Refuges and supported accommodation (n=9);
- Child protection Departments(n=9);
- Hospitals (n=8);
- Sexual Assault counselling and support services (n=7); and
- Family planning (n=7).

The callers were also referred to services which offered telephone counselling as a component of their service delivery. These services included Lifeline (n=12), Parentline (n=4), the Samaritan Youth Line (n=4), Crisis Line (n=3) Salvo Care Line (n=2) and Grief Line (n=1).

Callers from capital cities and metropolitan areas were also referred to suicide prevention, specific agencies. These agencies included the following:

- Bereaved by Suicide Support Group (n=3);
- Suicide Prevention – We Care (n=3); and
- Survivors of Suicide (n=2).

Appendix 2. Referrals By Location.

2. Callers from Large Rural Centres

The 30 services that the 363 suicide callers from large rural centres were commonly referred to included the following:

- Family crisis/counselling centres (n=6);
- Child protection Departments (n=5);
- Psychiatric services (n=3);
- Community health centres (n=3);
- Refuges and supported accommodation (n=3);
- Lifeline (n=3); and
- Community mental health services (n=2).

Further examination of the operational aspects of the services that callers were referred to included:

- Only 4 of the 30 agencies were open 7 days a week;
- One-third of the agencies were available on a 24 hour basis, with the remaining two-thirds operating between the hours of 9am to 5pm;
- The majority of services (77%) offered face to face counselling; however
- only 26% of the services operated specifically for young people.

Appendix 2. Referrals By Location.

3. Callers from Small Rural Centres

Nineteen of the 199 suicide callers from small rural centres were referred to other agencies. While only representing 19 referrals, the proportion of those referred to other agencies is 29% greater than the corresponding figure from capital cities and metropolitan areas. Even though the proportion of referrals is greater from small rural centres, the range of support services appears to be less extensive than the referrals from large rural centres.

The majority of referrals from small rural centres were to community health centres (n=4) and community mental health services (n=3). The other agencies which callers were referred to for additional support included:

- Family crisis/counselling services (n=2);
- Hospitals (n=2);
- Refuges and supported accommodation (n=2); and
- Generic youth services (n=2).

The operational aspects of the services callers from small rural centres were referred to included:

- 5 of the 19 agencies were open 7 days a week, with the majority (74%) operating between Monday to Friday;
- The majority of the agencies (68%) operated between the hours of 9am to 5pm, with only 6 agencies open for 24 hours a day;
- Fifteen of the services offered face to face counselling; however similar to the agencies in large rural areas,
- only 26% of the services operated specifically for young people.

Appendix 2. Referrals By Location.

4. Callers from 'Other' Rural and 'Other' Remote Centres

Similar to the other regions, the majority of referrals made to callers from other rural areas were to family crisis/counselling services (n=5) and community health centres (n=3). Young people from other rural areas who contacted KHL about suicide were also referred to the following agencies:

- Sexual assault services (n=2);
- Community mental health services (n=2);
- A generic youth service (n=1);
- A child protection Department (n=1);
- A psychiatric service (n=1); and
- A child and youth mental health services (n=1).

Three callers from other rural areas were also referred to suicide prevention specific agencies. These agencies included:

- Living Hope (suicide prevention counselling for young people) (n=1);
- Samaritan Youthline (Telephone counselling service for suicidal youth) (n=1); and
- The Young People at Risk Program (Social and emotional support for young people at risk of suicide and other high-risk behaviours) (n=1).

The operational aspects of the services that callers from other rural areas were referred to included:

- Similar to the agencies within small rural centres, 5 of the 19 agencies the callers were referred to were open 7 days a week, with majority (74%) operating between Monday to Friday;
- Almost three-quarters of the agencies (74%) operated between the hours of 9am to 5 pm, with only 5 agencies open on a 24 hour basis;
- Fourteen of the services offered face to face counselling; and
- Approximately half of the services operated specifically for young people.

Only 3 or 4% of the 69 suicide callers from "other remote" areas were referred to support services. The referrals were to a community health centre, an accommodation service and a community based psychiatric service. None of these services were recorded on the KHL database as operating 7 days a week and none were open after 5pm.

Commonwealth Department of
Health and
Aged Care

Appendix 1. KHL Record-a-Call Information

Date & time of call	___/___/___ ___:___
Duration of call	____ minutes
Caller ID:-	
Name/alias	______________________________
City/town	______________________________
State	_______________
Location type	_______________
Sex	_____ M (Male), F (Female), Blank (Unknown)
Age (approximately)	__________
Phoning from	_____ H (Home), P (Public phone), F (Friend/Family)
How did you hear about KHL?	________________________________
School status	_____________________
Nationality/Ethnicity	_____________________
Living with	_____________________
How long	______ months
If ran from home, why	________
Marital status of parents	________
Source of income	________
Which service did you try	_________________
Rating	______
Is this your first call	____ Y (Yes), N (No)
This call referred to	______________
Accepted	____ Y (Yes), N (No)
Presenting problem	___________
Severity	___________

MAKE NOTES (TEXT) ON BACK