

Children talking to ChildLine about suicide

"I feel sad and tearful all the time but I don't know why. I don't think that anyone else has noticed. No one can help me anyway, nothing is going to change. I'm thinking about killing myself." (Teenage girl)

"I feel like killing myself. My mum and dad beat me and I'm getting bullied at school. I don't have anyone else to turn to except ChildLine. No one else would be able to help me. I'm scared of telling anyone." (Boy, aged 13)

"Young death is especially painful. Young suicide is the most painful of all, because it is preventable." (Esther Rantzen, founder, ChildLine)

Key findings

- Every day, on average eight children and young people talk to ChildLine specifically about suicide.
- In 2007/08, ChildLine counselled 2,925 children and young people about suicide. This represents two per cent of all children who rang and were counselled by ChildLine (176,185 in total) during that time.
- The number of children telling ChildLine that feeling suicidal is their main reason for calling has tripled in the last five years from 909 in 2003/04 to 2,925 in 2007/08.
- In addition, 3,003 children and young people rang and were counselled about another problem, but also said that they felt suicidal during the course of the call.
- In total, 5,928 children and young people spoke to ChildLine about suicide (either specifically or among other subjects) in 2007/08.
- The top three additional problems mentioned by children and young people who called ChildLine about feeling suicidal were family relationship problems, depression/mental health and self-harm.
- Children and young people told ChildLine that their concerns were not taken seriously by parents or by health professionals.
- Children and young people who call ChildLine about feeling suicidal can be very lonely and often do not believe that there is anyone they can talk to about their problems. For many, ChildLine is literally a lifeline.

1. Evidence: what children and young people tell ChildLine

1.1 Introduction

In 2001, ChildLine published its report *Saving young lives: calls to ChildLine about suicide*. This report analysed the 701 first-time calls made to ChildLine between April 1998 and March 1999 where suicide was recorded as the main problem. *Saving young lives* reported that “young suicide is on the increase” and movingly described the feelings of intense loneliness, the strong sense that no one is listening, and the array of problems and abuse experienced by the children and young people who phoned ChildLine. Many called ChildLine because they felt there was no one else they could turn to.

Sadly, this casenote reports that, nine years on from the publication of *Saving Young Lives*, the number of calls answered by ChildLine has grown significantly to 5,928. This is a major cause for concern. Writing in the foreword to *Saving young lives*, Esther Rantzen, founder of ChildLine, commented: “Young death is especially painful. Young suicide is the most painful of all, because it is preventable.” That remains the case today.

1.2 Methodology

This casenote reports on what children and young people said to ChildLine about suicide in 2007/08. In some cases, these children had got to a point where they were so unhappy that they just could not see any other way out and were seriously considering taking their own lives. Indeed, a small proportion had already harmed themselves and were in urgent need of medical attention. Other children and young people however, were having suicidal thoughts but may not have been seriously considering attempting suicide.

Regardless of the counsellor’s judgement as to the young person’s level of risk, all calls to ChildLine where suicide is mentioned are taken extremely seriously and will be logged as “suicide”. Counsellors also note down other problems that the child or young person mentions.

A summary of the discussion that has taken place is written up by the counsellor and entered into the database – these are called case records. From these case records, ChildLine’s information team can provide “snapshots” or summaries of the case record.

For the purposes of this casenote, 1,000 snapshots of calls to ChildLine about suicide were analysed using qualitative thematic analysis. The findings provide a picture of how children and young people who call ChildLine about suicide are feeling and what types of problems they are facing in their lives. In addition, two focus groups with a total of 10 counsellors were conducted in order to supplement the data with their unique insights into children and young people’s experiences.

Where direct quotes from children and young people have been used in this casenote, identifying details have been changed to protect the identities of callers.

2. Statistics

2.1 Calls to ChildLine in 2007/08 about suicide

In 2007/08, a total of 2,925 callers (2,282 girls and 643 boys) rang ChildLine and were counselled specifically about suicide. This represents two per cent of all children and young people counselled on a first-time basis during that time.

In addition, 3,003 children and young people rang and were counselled about another problem but also talked about suicide during the course of the call.

This means that the total number of children and young people who talked to ChildLine about suicide in 2007/08 was 5,928 (2.5 per cent of all children and young people counselled on a first time basis).

2.2 Trends in numbers of children and young people calling ChildLine to talk about suicide between 2003/04 and 2007/08

Figure 1

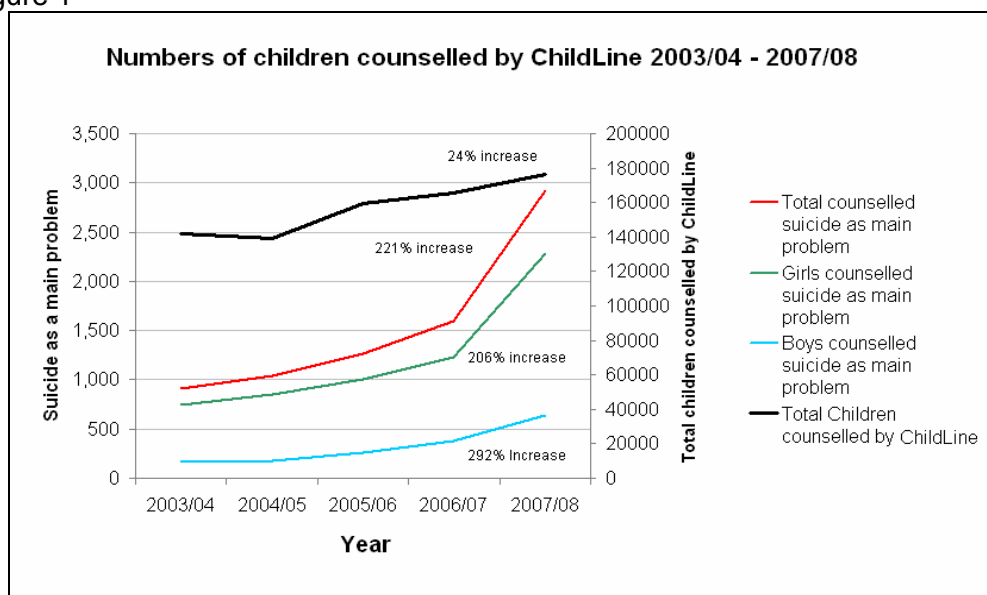


Figure 1 presents the trends:

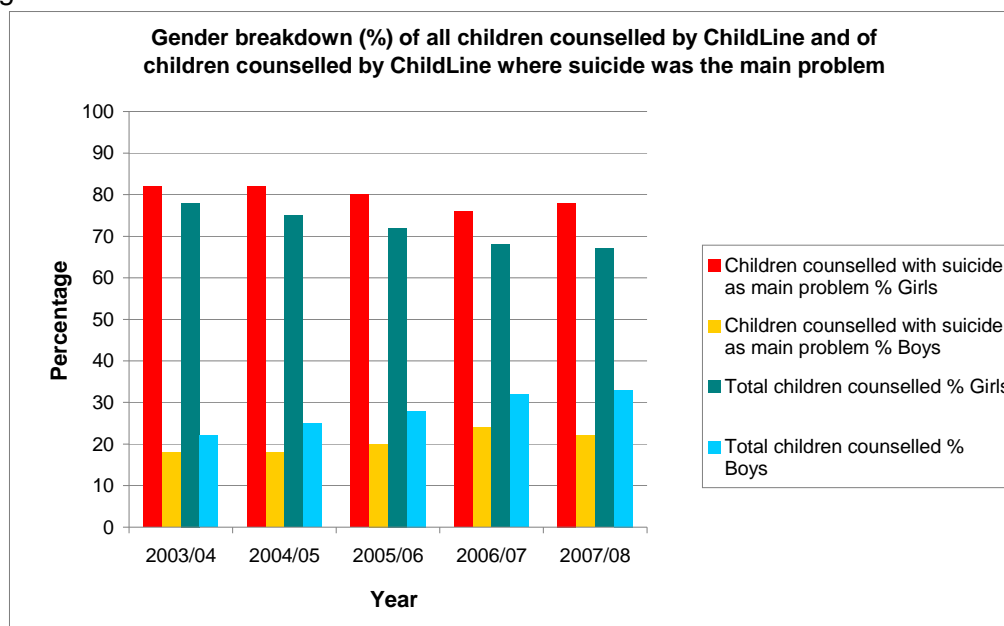
- The number of children telling ChildLine that suicide is their main reason for calling has tripled in the last five years, from 909 in 2003/04 to 2,925 in 2007/08. This is an increase of 221 per cent.
- The number of children who talked to ChildLine about another problem but also mentioned suicide as an additional problem has also increased in the last five years, from 1,557 in 2003/04 to 3,003 in 2007/08. This is an increase of 92.8 per cent.
- In total, the number of children and young people who talked to ChildLine about suicide (either as their main problem or as an additional problem) has increased in the last five years, from 2,466 in 2003/04 to 5,928 in 2007/08. This is an increase of 140 per cent.

2.3 The gender difference of children and young people counselled by ChildLine about suicide

Figure 1 also shows that the number of girls counselled where suicide was the main problem has increased by 206 per cent in the last five years, from 745 in 2003/04 to 2,282 in 2007/08. Similarly, the number of boys counselled about suicide has increased by 292 per cent, from 164 in 2003/04 to 643 in 2007/08. Therefore, proportionately, calls from boys about suicide have increased more than calls from girls.

This increase may indicate that more children and young people feel able to contact ChildLine to express a wide range of emotions, including suicidal thoughts and feelings, than they did five years ago. Some of these will be expressions of despair, powerlessness or desperation, while others will be in the form of more concrete plans to end their lives. In the ChildLine counsellors' view, it is a positive trend that more young people are talking to ChildLine openly about these thoughts and feelings at an early stage before they have actually formulated a suicide plan. This gives us a much greater opportunity for change, whether by listening to children and young people so that they feel understood, or by assisting them in accessing appropriate help.

Figure 2



As can be seen from Figure 2, the overall percentage of callers counselled who are boys has increased year on year. Between 2003/04 and 2007/08, the ratio of boys to girls counselled has increased from one boy to every four girls to one boy to every two girls. There has also been an increase in the proportion of male callers counselled about suicide. However, this has not been a significant increase in comparison to the overall children counselled. Between 2003/04 and 2007/08, the ratio of boys to girls being counselled about suicide has increased from one boy to every five girls, to one boy to every four girls.

2.4 Age breakdown of children and young people calling ChildLine in 2007/08 with suicide as a main problem

Figure 3

Age (yrs)	Girls (numbers)	% of known ages	Boys (numbers)	% of known ages	Total (numbers)	% of known ages
5 and under	4	0	0	0	4	0
6–11	102	6	33	7	135	6
12–15	931	56	180	41	1,111	52
16–18	640	38	228	52	868	41
Age unknown	605	n/a	202	n/a	807	n/a
Total	2,282		643		2,925	

Where their age was known, over half (52 per cent) of callers counselled about suicide were aged from 12–15 years. This reflects the fact that children and young people in this age group account for 54 per cent of all callers counselled by ChildLine overall.

Callers counselled about suicide who were aged from 16–18 years represented a larger proportion of callers (41 per cent) than all callers of this age group overall (23 per cent).

Only six per cent of children counselled about suicide were aged 11 or under, as compared to 23 per cent of children counselled by ChildLine overall. Only a small number of callers counselled about suicide were very young children (aged five or under).

2.5 What children and young people say to ChildLine about feeling suicidal

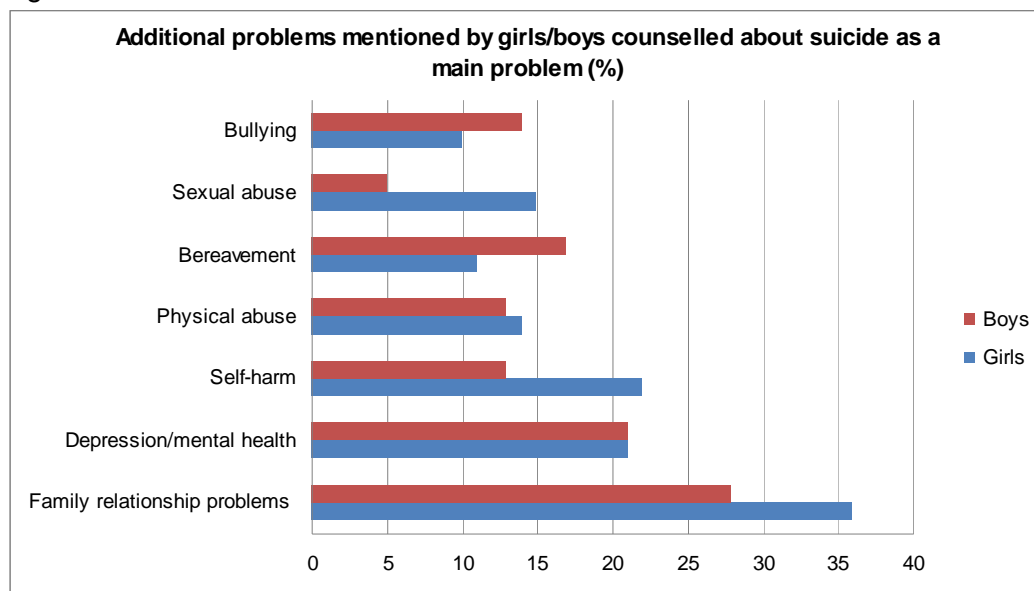
It is clear from the accounts of the children and young people who called ChildLine that thoughts of suicide are rarely a reaction to an isolated incident. Often these children talk about struggling to deal with a range of complex problems, and about finding it difficult to articulate how they are feeling and what the reasons for it are.

One ChildLine counsellor commented: “Young people have such limited language to describe how they are feeling. They have a tendency to say that they are feeling crap, and it’s very difficult to get a sense of what the issues are.”

Girls tend to talk more about their reasons for feeling suicidal. This may be partly due to the fact that they often call at an earlier stage, that is to say when they are feeling suicidal but have not formulated a plan, whereas boys tend to wait until they are more desperate and have actually started thinking about how they are going to harm themselves.

2.6 Additional problems mentioned by children and young people who called ChildLine to talk about suicide

Figure 4



2.6.1 Family relationship problems

A number of children (36 per cent girls and 28 per cent boys) who called ChildLine because they felt suicidal talked about very chaotic family lives, where there were a lot of arguments and where they did not feel that they were listened to. Often they talked about parents being separated or divorced; in particular callers talked about the difficulties of adapting to life with new step-parents or step-siblings and of not feeling that they had control over what was happening in their lives.

“I’m having problems at home. I’m always arguing with my stepdad and I feel like my mum takes his side all the time. In the past it has made me feel suicidal and today I don’t want to go home in case there is an argument. I’ve been drinking a lot. I think it’s because it helps me forget my problems.” (Teenage girl)

Some callers (specifically four per cent and two per cent respectively of callers who rang about suicide) also said that their parents had problems with alcohol or drug abuse and talked about the impact that this had on them.

“I hate my life because, now Dad’s gone, I get blamed for everything and Mum is in the pub every day. I feel I have to look after her and the house because she gets drunk and acts stupid. We never have any money because of the drinking and I’ve got no friends now. I just want to die.” (Girl, aged 10, who had taken an overdose)

In some cases, children described very serious conflict between their parents where domestic violence was taking place, which they found very distressing.

“I want to die. A few weeks ago my mum and her boyfriend were arguing and I saw him punch her. I feel like I should be protecting her.” (Teenage girl)

Others talked about parents having mental health problems, which some young people found difficult to deal with. In some cases this also meant that they had to take on additional responsibilities, such as caring for their parent or for younger siblings.

The family-related risk factors for suicidal phenomena in adolescents that have been identified in research (Hawton et al, 2006) very much reflect what children and young people have said to ChildLine. These include:

- having parents who are divorced or separated
- conflict and arguments within the home
- living apart from both parents
- having a parent with mental health difficulties.

Several studies have found that good communication with family members and feeling understood by them is associated with a lower prevalence of suicidal thoughts and behaviours in adolescents (Evans et al, 2004).

2.6.2 Depression/mental health

A number of children who called ChildLine said they felt suicidal because they were depressed, with the emotions they described ranging from feeling “really down” to clinical depression.

“I feel sad and tearful all the time but I don’t know why. I don’t think that anyone else has noticed. No one can help me anyway – nothing is going to change. I’m thinking about killing myself.” (Teenage girl)

Callers also talked about a range of other mental health problems, such as suffering from schizophrenia, obsessional behaviour, anxiety and panic attacks, and eating disorders.

We know from research that mental health difficulties are generally associated with suicidal phenomena and there is strong evidence for a direct association between suicidal phenomena and depression, particularly among females (Hawton et al, 2003).

2.6.3 Self-harm

Many children and young people who called ChildLine about suicide also said that they had self-harmed in the past. In the majority of cases, children (both boys and girls) had been cutting themselves or had taken an overdose. This is consistent with research that suggests that self-cutting and self-poisoning are the two most commonly reported single methods of deliberate self-harm (Hawton et al, 2006).

Many callers said that this was a way of releasing tension and that they felt temporarily better afterwards.

“My girlfriend has split with me. I feel suicidal. Life is not worth living. When I feel suicidal I self-harm. It takes the pain away. I’m happy when I’m relieved of pain. We got on so well and it is hard without her. I am going to do it [kill himself] but I care about my family and it’s making me think about not doing it.” (Teenage boy)

ChildLine counsellors consider self-harm to be quite different from a suicide attempt, since self-harm may be the means by which a child tries to survive emotional pain, rather than being inspired by a desire to end life. However, in some cases, it can be

part of the same continuum, since they are both symptoms of acute distress, and there is evidence that people who self-harm are at an increased risk of suicide.

2.6.4 Bereavement

Children who talked about bereavement missed the person that they had lost and many said that they wanted to die as well so that they could be with them. In many cases, they did not feel that they had anyone to talk to about the person who had died because other family members were also grieving.

“My brother committed suicide. I feel angry, lonely and depressed. I can’t talk to my parents as they are grieving for him as well. I feel like committing suicide myself so that I can be with my brother.” (Girl, aged 15)

Often it was a parent who had died, and for some children this meant that they had lost their main caregiver and were now in care, while others were living with their other parent or another family member but had a difficult relationship with them.

Many felt guilty and that the death was somehow their fault or that they should have been the one to die. This was especially pronounced where the person who had died had committed suicide. In these cases, young people often felt that they should have taken action to prevent the person killing themselves.

“I want to commit suicide. I don’t want to live any more, I’m in pain and I feel sick. I don’t want to be here. It’s my fault my mum died.” (Boy, age unknown). The caller went on to say that he had felt like that ever since his mum had died.

In 2007/08, 58 children (two per cent) who called ChildLine about feeling suicidal specifically mentioned that a significant other had committed suicide, usually a parent.

Several studies have found that an increased risk of suicide and of deliberate self-harm are associated with a family history of suicidal behaviour. It may be that where someone in the family has attempted or committed suicide, other family members may feel more comfortable with the idea of suicide or are more likely to think of it in times of severe distress (Hawton et al, 2006).

2.6.5 Sexual abuse

Of the children and young people who were counselled about suicide, 15 per cent of girls and five per cent of boys said that they had experienced sexual abuse.

One 15-year-old told ChildLine: “I wanted to kill myself because of years of sexual abuse by a member of my family.”

Similarly, a 14-year-old told ChildLine: “I wanted to die because my dad has sexually abused me and I was also raped by someone I knew.”

Research shows that girls are more likely to experience sexual abuse than boys. A retrospective study that asked 2,869 young adults about their childhood experiences found that overall 11 per cent of boys aged under 16 and 21 per cent of girls aged under 16 experienced sexual abuse during childhood. Perpetrators of sexual abuse were more likely to be someone known to the child or young person, such as a relative, family friend or person in a position of trust, rather than a stranger (Cawson, 2002).

ChildLine data in 2007/08 indicates that 59 per cent of the perpetrators were family members, 29 per cent were known to the children and only four per cent were strangers (eight per cent of children did not give any information about the perpetrator). Children who rang ChildLine about suicide and talked about sexual abuse felt guilty and frightened, and were concerned that the abuse may be their fault.

2.6.6 Physical abuse

Fourteen per cent of girls and 13 per cent of boys who called ChildLine about suicide said that they had been physically abused.

One 11-year-old boy told ChildLine: "I want to kill myself. I feel so alone. My dad had been drinking and he hit me."

Research indicates that a quarter (25 per cent) of children experience one or more forms of physical violence during childhood, and that for the majority this violence happens at home (Cawson, 2002).

There is considerable evidence for a strong and direct association between both sexual and physical abuse and suicidal phenomena in adolescents (Hawton et al, 2006). Some studies have also found evidence to suggest that adolescents with a more severe history of sexual abuse (such as involving intercourse) and physical abuse (such as being hit more often) are more likely to self-harm than adolescents with a less serious abuse history (Evans et al, 2005).

2.6.7 Bullying

Some children who rang ChildLine because they were feeling suicidal said that they were being bullied and just could not cope with it any more. Fourteen per cent of boys and 10 per cent of girls calling about suicide said that they had been bullied. The types of bullying described included: verbal bullying, such as name calling; physical bullying, such as being hit or kicked; and in some cases cyber-bullying, such as being bullied via email or text. Among the children and young people who rang ChildLine with suicidal feelings, more boys mentioned bullying as their additional concern than girls.

One 14-year-old boy told ChildLine: "I am being bullied at school and feel no one likes me. I am always running to hide and cry on my own because I'm called names and am pulled at. I feel suicidal but I won't do it."

There is some evidence that being bullied or being a bully is a sign that an adolescent is at increased risk of depression and suicidal behaviour (Kaltiala-Heino et al, 1999, cited in Hawton et al, 2006).

Research also shows that being bullied is associated with deliberate self-harm in young people. One study found that males who had been bullied were three times more likely to have engaged in self-harm, and similarly females were twice as likely to have engaged in self-harm (Hawton et al, 2006).

2.6.8 Relationships with boyfriends/girlfriends

Both girls and boys who called ChildLine about feeling suicidal mentioned problems with their boyfriends/girlfriends. As would be expected, this was more common among young people as opposed to younger children. In the majority of cases, their boyfriend/girlfriend had ended the relationship or had been unfaithful and they were struggling to cope.

“I don’t want to live any more. My girlfriend left me last year and it made me feel horrible. I feel like ending my life now. I can’t deal with the pain. It feels like I’m being stabbed, it’s in my heart. I want it to stop. I hate what she has done to me.” (Boy, age unknown)

In cases where young people had minimal support from their families, they tended to rely heavily on their boyfriends/girlfriends and when these relationships broke down, they were devastated. Some girls also talked about other types of relationship problems, such as experiencing violence and abuse at the hands of their partners.

“I want to kill myself. I feel so depressed – I don’t know what to do. My boyfriend is really violent towards me.” (Girl, aged 16)

“I’m fed up and I want to die. My boyfriend sexually abuses me and I think I’m pregnant. It’s all my fault.” (Girl, aged 16)

A small number of girls who told ChildLine that they felt suicidal also said that they were afraid that they might be pregnant. In some cases they were concerned what the reactions of their friends, partners or their parents would be when they found out.

2.6.9 Those in care

During 2007/08, 3.5 per cent of children and young people who called ChildLine about suicide said that they were currently in residential care, while another one per cent had been in residential care in the past or thought that they were likely to go into it in the future. Another two per cent said that they were either currently being fostered or had been in the past. In many cases, they were, or had been, very unhappy with these living arrangements.

“I had a very bad early childhood and I’ve been in care for years. I’m 17 now and in my own flat but I feel really isolated. I’ve thought about all the ways that I could kill myself but I want it to be painless. When I think about the past I don’t want to live. I haven’t got any friends and I haven’t got a job or a college course or anything.” (Girl, aged 17)

Supporting this, two studies have found that living apart from both parents is associated with an increased prevalence of suicidal phenomena (Kaltiala-Heino et al, 1999; Rey Gey et al, 1998 cited in Hawton et al, 2006).

2.6.10 Exam stress

A small number of children and young people who spoke to ChildLine about suicide said that they were stressed about exams and were struggling to cope.

“I feel really stressed about my GCSE exams. I keep having panic attacks. I’ve been thinking about killing myself. I have had suicidal thoughts and feel very isolated.” (Girl, aged 15)

3. The policy context

3.1 England

In 1999, the Department of Health (DH) published *Saving lives: Our Healthier Nation* (DH, 1999), which set a national target to reduce suicide by 20 per cent by 2010, and was underpinned by the *National service framework for mental health: modern standards and service models* (DH, 1999). There then followed the publication of a *National suicide prevention strategy for England* (DH, 2002), informed by *Safety First: Five-Year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* (DH, 2001). Both the inquiry and the subsequent strategy were predominantly focused on the prevention of adult suicide.

Subsequently, the *National service framework for children, young people and maternity services* (DH, DfES, 2004) identified a need for services to address targets for, among other things, a reduction in rates of suicide in children and young people through the provision of targeted and/or specialist services. Additionally, the framework identified the vulnerability of particular groups, such as children and young people in care and young people in the secure estate. However, despite this, and the brief inclusion of children and young people's mental wellbeing in the suicide prevention strategy, children and young people were not identified as being at high risk of suicide.

More recently, the Child and Adolescent Mental Health Services (CAMHS) review (DCSF, 2008) urged service managers, providers and commissioners to ensure they consider and plan for children and young people at risk of suicide. In addition, the introduction and continuing roll-out of the Department of Health's predominantly adult-focused Improving Access to Psychological Therapies (IAPT) programme* includes guidance to commissioners to ensure that appropriate CAMHS are available and accessible to all young people up to the age of 18. The Department for Children, Schools and Families (DCSF) has introduced the Social and Emotional Aspects of Learning (SEAL) (DCSF, 2005) programme to promote children's social and emotional skills.

Although the issue of suicide as a cause of death in children and young people is acknowledged in England, there is no specific plan to address it.

3.2 Scotland

Choose life: A National Strategy and Action Plan to Prevent Suicide in Scotland (Scottish Executive, 2002) was launched in December 2002, and identifies the main suicide prevention actions that are required at both national and local levels. In each of Scotland's 32 local authority areas, *Choose Life* action plans have been developed by community planning partnerships (CPPs). These CPPs comprise representatives of the local council operating along with partners, such as the local health board. A key coordinator has also been identified with responsibility for liaising with the National Implementation Support Team (NIST) and sharing information with other planning partnerships and stakeholders.

* Improving Access to Psychological Therapies (IAPT) programme, a joint Department of Health (DH) and Care Services Improvement Partnership (CSIP) pilot project, which was launched by the Health Secretary Patricia Hewitt on 12 May 06. For further information, visit: www.mhchoice.csip.org.uk/psychological-therapies.html [13/03/09]

The main target is to reduce suicides across the population by 20 per cent by 2013. Among the priority groups for preventive action are children (particularly looked after children) and young people (particularly young men).

The Mental Health of Children and Young People: A Framework for Promotion, Prevention and Care (Scottish Executive, 2005); *Delivering for Mental Health* (NHS Scotland, 2006); and *Delivering a Healthy Future: An Action Framework for Children and Young People's Health in Scotland* (Scottish Executive, 2007) provide a combined focus for improving CAMHS in Scotland.

The Health and Sport Committee of the Scottish Parliament has recently launched an enquiry into CAMHS in Scotland and will report later in 2009. The committee is particularly interested in how children and adolescents at risk of developing mental health problems are identified by medical and other professions. It is keen to learn more about access to services and ongoing support for this group of children and any improvements that could be made in the transition from CAMHS to adult mental health services.

3.3 Wales

In November 2008, the Welsh Assembly Government published *Talk to me – A National Action Plan to Reduce Suicide and Self Harm in Wales 2008-2013* (Welsh Assembly Government, 2008) for consultation. The publication of this action plan brought Wales into line with the other countries in the UK that had already published various strategies and action plans in relation to suicide and self-harm. Alongside this, a single All Wales Child Death Review procedure is being piloted, which will be taking cases of suicide as its primary focus.

The Welsh Assembly Government has also consulted on a mental health promotion action plan, which aims to provide a framework for the promotion of emotional health and wellbeing across Wales. A strategy has also been published relating to school-based counselling, along with a specific chapter in the *National Service Framework for Children, Young People and Maternity Services in Wales* (Welsh Assembly Government, 2006) on the provision of mental health services to children and young people. The Welsh Assembly Government's Child and Adolescent Mental Health Services strategy, *Everybody's Business* (National Assembly for Wales, 2001), has also been reviewed jointly by the Welsh Audit Office and Healthcare Inspectorate Wales.

3.4 Northern Ireland

The increased levels of suicide in Northern Ireland, particularly among young males, have been a great cause of concern to both Direct Rule and Northern Ireland (NI) Executive Ministers. This has led to a developing strategic and cross-departmental focus on the prevention of suicide. First, Northern Ireland's Health, Social Services and Public Safety (DHSSPS) department's *Investing for Health* strategy in 2002 (DHSSPS, 2002), then the *Promoting Mental Health: Strategy & Action Plan* in 2003 (DHSSPS, 2003) and finally, and more specifically, the *Protect Life: a Shared Vision – The Northern Ireland Suicide Prevention Strategy and Action Plan 2006–11* (DHSSPS, 2006). *Protect Life* cuts across a range of government departments, health and social care and voluntary agencies and its aim is to "reduce the level of suicide in Northern Ireland". The strategy's implementation is overseen by a cross-sectoral Implementation Body and Ministerial Group on Public Health.

The *Protect Life* publication was influenced by a review of the evidence base around suicide and a number of policy, training and service development issues. The strategy's first action plan sets out a range of implementation areas with actions targeted at a community level, the family, and children and young people. Key measures for children and young people include developing the curriculum and school-based approaches to promote coping with life skills, emotional literacy and positive mental health. Additional resourcing has seen the establishment of a regional suicide helpline called Lifeline, ministerial involvement with internet service providers on the dangers of suicide websites and the development of a five-nations suicide prevention group to share best practice.

The issue of suicide has also been a concern to the NI Assembly. Suicide prevention has featured in a number of debates and the Health, Social Services and Public Safety Committee conducted an inquiry into the matter in 2008 (DHSSPS, 2008). The recommendations from this assembly review are being considered by the Minister for Health, Social Services and Public Safety and will assist in the development of further *Protect Life* action plans.

4. Key issues facing children and young people who called ChildLine about feeling suicidal

4.1 Feeling lonely, not having anyone to turn to and not being listened to

The children and young people who talked to ChildLine about feeling suicidal were usually in turmoil and were facing a range of problems in their lives, the combination of which had left them feeling desperate and unable to cope. What many of these children and young people had in common was that they had very low self-esteem and they thought that no one cared about how they were feeling.

"I want to die. Everything's just crap. There is no point talking to anyone as no one will give a shit if I die." (Boy, age unknown)

Many of these children felt very lonely and isolated and did not feel that there was anyone who they could turn to for help or support. Often callers said that they did not have any support from their families and that they did not have any friends.

"I've run away from home. I don't want to go back. I want to kill myself because I can't carry on any more. My mum doesn't want me; she never shows me any affection. I don't want to live any more because I've got no one to be happy with. My teachers have a go at me as well. I've been thinking about different ways that I could kill myself." (Boy, age unknown)

"I feel like killing myself, my mum and dad beat me and I'm getting bullied at school. I don't have anyone else to turn to except ChildLine. No one else would be able to help me. I'm scared of telling anyone." (Boy, aged 13)

"I feel like committing suicide. I'm thinking about going to buy some pills. I've felt like this for years but I don't get any support from anyone, not even my parents. I have been self-harming as well. I'm going to college soon and I feel really worried about it." (Girl, aged 17)

It is known that a substantial proportion of adolescents who deliberately self-harm or who have suicidal thoughts do not receive help (Kann, 2000, cited in Hawton et al, 2006). A recent school-based survey of 6,020 adolescents (Hawton et al, 2006) found that those who said that they had self-harmed* or who had had thoughts about self-harming mentioned fewer categories of people who they felt able to talk to about their problems. Of those who had engaged in self-harm, 53 per cent had not tried to seek help beforehand, with boys being less likely to have sought help than girls.

Other studies have also found that young men are less likely to seek some form of help when in mental distress than young women (Biddle et al, 2004).

Those children and young people who had sought help were most likely to have talked to friends, followed by a family member. Very few reported that they had sought help from a teacher or other professional.

Of those respondents who had not sought help, a small proportion said that this was because “they wanted to die”. By far, the most common reason cited for not seeking help, however, was that they had not wanted or needed help.

For example, one respondent to Hawton’s survey said: “I didn’t need it. I could get through it on my own and I did better than if anyone had helped me.” (Unknown)

Other reasons included:

- Not thinking that their problem was serious enough for them to seek help
- Thinking that they should deal with their problems themselves
- Feeling ashamed of the way they were feeling and not wanting others to know
- Fear of how others would react, especially of being seen as an attention seeker
- Thinking that no one could help, or that no one would want to help.

4.2 Talking to parents about their problems

It seems that children and young people’s fears that their problems may not be taken seriously may be well founded. Some children and young people told ChildLine that they had tried to talk to someone (usually their parents) about the way that they were feeling, but felt that their concerns were not understood and were trivialised.

In some cases it seems that parents find it difficult to accept that their child is feeling suicidal or has mental health problems. In other cases it may be that they are struggling to juggle work with other responsibilities and are not finding the time to listen to what their child is saying.

4.3 Talking to health professionals

Some children who called ChildLine about feeling suicidal had had some contact with either their GP or mental health services, but in many cases they did not feel that this had been helpful. Reasons for this included: not feeling able to talk to the professional

* The definition of deliberate self-harm in this study includes any intentional act of self-injury or self-poisoning, irrespective of the apparent motivation or intention. The purpose of such acts includes actual suicide attempts, a means of altering a distressing state of mind, a way of showing other people how bad a person is feeling and an attempt to change the dynamics of an interpersonal relationship (Hawton et al, 2006).

that they had seen, feeling that their concerns had not been taken seriously, or finding that the length of time that they had to wait for appointments was too great.

Many also expressed a reluctance to talk to health professionals because of a fear that they would breach confidentiality. Research shows that confidentiality is the prime concern affecting young people's use of health services (Finlay, 1998, cited in Hawton et al, 2006).

"I'm feeling really low. I'm going to kill myself. I've seen my GP and I've been prescribed anti-depressants. I've attempted suicide before. I don't want to talk to my GP because it wouldn't be confidential. I can talk to ChildLine because I know it is." (Unknown)

5. Help for children and young people who call ChildLine about suicide from ChildLine counsellors

For children and young people who make suicidal calls, it is crucial that a very careful risk assessment is made by the ChildLine counsellor who receives the call, and for this reason the counsellors receive special training on ways to assess and support suicidal children.

The main distinction they have to draw in making their assessment is between the children and young people who say they have had suicidal thoughts and those who say they have either made suicide plans or have actually taken action to end their own lives.

5.1 Children and young people whose lives are in immediate danger

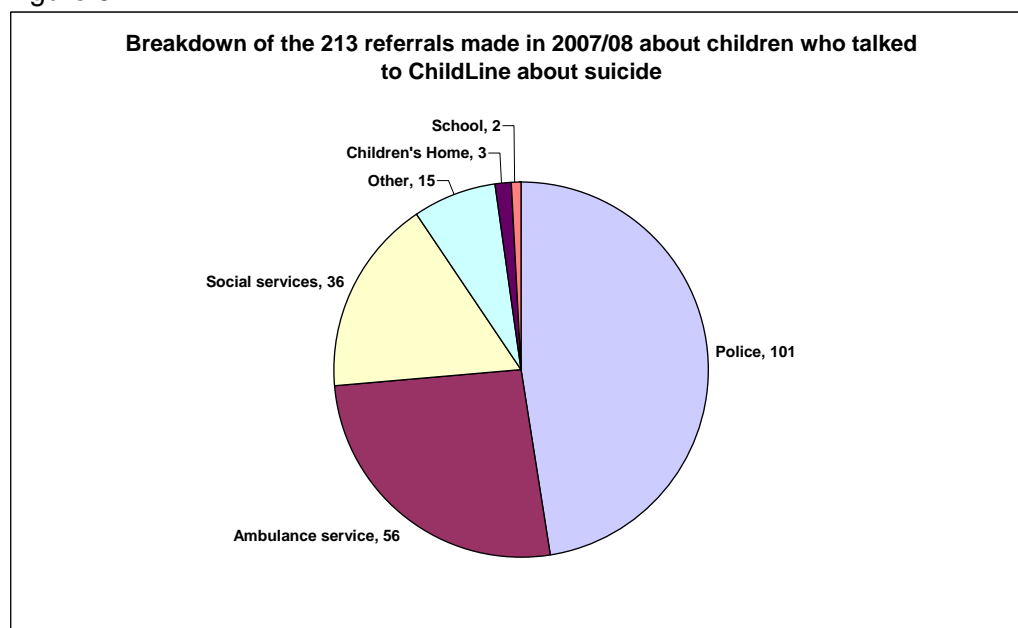
Some children and young people say that they have already taken action to harm themselves. In these cases, the counsellors assess as quickly as possible how dangerous the action has been, for example, by contacting the local poisons unit to discover if an overdose of a particular drug is life-threatening.

If the child's life is at risk, the counsellor will explain that, because ChildLine cares about the caller's safety and believes that the caller's life is precious, the counsellor will take action to save the child. The action is fully explained to the child, and if possible the child's permission and location details are obtained. However, even if permission is refused, because the child's safety is paramount, this is one of the few circumstances in which confidentiality is breached and medical or other help is urgently sought. For these children, ChildLine is literally a lifeline.

In one case, a teenage boy rang from the back of a classroom during a history lesson, having attempted to take his life. An ambulance was called to the school.

In another, a teenager rang from a place of great danger. The police had seen him, and were trying to persuade him to return to safety. Frightened and confused, he told the police if they attempted to intervene, he would take his life. He then rang ChildLine. ChildLine's counsellor was able to persuade him to hand the mobile phone to the police, asked them to withdraw to give him space, and persuaded him to move to safety.

Figure 5



As demonstrated in Figure 5, in 2007/08 there were a total of 213 referrals about children and young people who had made suicidal calls to ChildLine. Almost half of these referrals were made to the police, a quarter to the ambulance service and a sixth to social services. All of these children and young people were told they could and should ring ChildLine for help and support if they ever needed it again in the future.

5.2 Children and young people who have made plans to die

If a child or young person has made a suicide plan but is not deemed to be in immediate danger, the counsellor will ask if the child has the means to put the plan into action, for instance, has obtained enough tablets for an overdose. If so, the counsellor will attempt to persuade the child for the duration of the call to separate themselves from the means of taking their own lives, for instance, by putting the pills in another room or stepping back from the edge of a building. Counsellors will then make it clear that they want to listen to the child's thoughts and feelings, trying to connect with the part of the child that wants to live, while acknowledging the part that wants to die.

The crucial task of the counsellor in these cases is to assure children that they are being heard and taken seriously. Such children ring ChildLine as their last resort, believing that no one else in their lives cares whether they live or die. It is the counsellors' role to assure them that ChildLine cares. Survivors frequently tell ChildLine that these are the only conversations that have given them hope.

5.3 Suicidal children and young people who feel their lives are hopeless and that death would be preferable

If a child or young person reports that they are having suicidal thoughts, but have not yet put them into action, ChildLine counsellors always take them seriously, ensuring that the child understands that ChildLine exists for them, cares about them, and that they feel properly heard. Counsellors will explore with the child what makes them feel so hopeless, and why they feel that death is preferable.

Provided that the child is not at immediate risk, the counsellors will make it clear that they want to listen, and will explore with them the negative and the positive aspects of their lives, focusing on the positives, exploring options and, where possible, finding solutions and discovering what support networks are available to them. For example, a child who is in despair because of bullying may ask ChildLine to make a call to the school. Or a child whose life is being wrecked by parental drug or alcohol abuse may wish to be referred to a relevant support group, or to social services. These referrals would be made with the consent of the child, and full information offered to the child, sometimes by means of a conference call with the agency or team involved.

6. Why suicidal children and young people choose to ring ChildLine

6.1 Loneliness

Counsellors report that a common factor for these children and young people is that they feel utterly lonely, and that nobody apart from ChildLine cares or notices whether they live or die.

“They feel as if no one would notice if they killed themselves and that everyone would be better off if they just took themselves out of the equation.” (A ChildLine counsellor)

6.2 No time in today’s family life for suicidal children and young people to reveal feelings of despair to their parents

One ChildLine counsellor says: “Family life is so hectic these days. Mum and Dad often come home from work really late so there isn’t time to ask how a young person is getting on and how they are feeling. Parents really have to make time to talk to them and find out what went on in their lives that day.”

Another counsellor reports: “Sometimes busy parents will say to their children, ‘but you’ve got everything, what more do you want?’ They don’t recognise that their child has mental health problems. They think that they are just being difficult.”

6.3 Parents need more help to identify danger signals

A ChildLine counsellor says: “Parents need to be aware that this can happen to your child. It’s easy to think when they come home in a strop that they’re in a mood, and that it’s nothing too serious. Parents aren’t always aware of the danger signs. I, as a parent, certainly never saw anything that said, ‘Watch out for this’.”

6.4 Other agencies are not child-centred, sufficiently resourced, or trusted by children and young people

One ChildLine counsellor reports: “Some children say that they are on a waiting list for mental health services but they are suspicious because they don’t feel that they can speak openly and honestly because the information will be passed on.”

Another says: “Because the service is rationed, children don’t feel free to talk as long as they need to, or that the person has enough time to listen. Or they feel that the person is telling them to do something, rather than listening to them.”

Another counsellor added: “The majority of young people who call saying they feel suicidal have such shattered backgrounds that the input they get from other agencies isn’t sustained long enough. They really need supporting. They may like their counsellor and be able to talk to her, but they won’t see her often enough. Sometimes they can’t wait nine months until the appointment arrives.”

7. Conclusions

- The number of children and young people calling ChildLine about suicidal feelings has increased in the last five years.
- On average, every day around eight children and young people talk to ChildLine specifically about suicide.
- Children and young people with suicidal feelings mentioned family relationships, depression/mental health and self-harm as their top three additional problems.
- Children and young people who are counselled by ChildLine with suicidal feelings mentioned that they do not feel that they are understood and listened to when they need help. They seem to feel that there is no one to turn to for help.
- Children and young people say that health professionals do not understand their needs and feel that the health professionals need to communicate with them at their level. Children also worry about confidentiality.
- In ChildLine counsellors’ view, parents need help to identify danger signs. Health professionals should give clear guidance to children about future appointments and assessments.
- There needs to be more appropriate services focusing on children’s needs. There also should be more research to understand suicide in children and young people.

8. Recommendations

8.1 Advice to parents and carers: what the warning signs are

Parents and carers should be provided with guidance on ways to identify the warning signs that a child is feeling suicidal, and possibly planning suicide. Such advice should be provided by primary health care professionals and parenting organisations. Abuse, bullying, bereavement, family upheaval and exam stress are among the most common cases of suicidal feelings, according to children who ring ChildLine.

The calls received by ChildLine indicate that many of the children and young people feeling suicidal are deeply affected by family breakdown and relationship problems. Sometimes they feel they cannot talk to their parents, carers and other members of the family. Many feel that their needs are not understood or are ignored. In some cases the suicidal child may have become so detached that they conceal their feelings and take on a happier disposition.

In order to prevent suicide and suicidal feelings, parents and carers need to be alert to the possible signs that something may be wrong and what they can do in response. Appendix 1 outlines a checklist of possible signs and responses.

8.2 Advice to parents and carers: give children and young people time to talk about their feelings

Children and young people calling ChildLine about suicide often describe feelings of not being understood by anyone, including parents and carers, and describe the seemingly insurmountable difficulties they face in talking to someone. As a result of increasingly busy working lives and long working hours, children can become marginalised. This places children at risk when they feel that they are not given the time or opportunity to discuss their suicidal feelings. Appendix 1 contains advice on how parents and carers can really listen to their children.

8.3 Adequate and accessible provision of information for children and young people

The child health strategy, *Healthy lives, brighter futures – The strategy for children and young people's health* (DCSF & DH, 2009) reported: "...confusion among parents and children about the support they can expect to get." (para. 1.17). We therefore recommend that:

8.3.1 Information about help and support should be widely available to all children and young people in an accessible and acceptable form.

Information about ChildLine should be available, particularly on school premises, but also in a wide cross-section of public spaces including those related to information and communications technology.

8.3.2 Information should be provided in a wide range of formats and languages.

Children and young people are not a homogenous group with easily identifiable, common needs. For example:

- Boys and young men are significantly *more* likely to commit suicide than girls and young women. However, the proportion of boys and young men contacting ChildLine about suicide is significantly *less* than the proportion of girls and young women. This imbalance is indicative of the need to identify the barriers felt by boys and young men in seeking counselling and support. This will enable national, regional and local agencies to develop information that is more accessible and acceptable to boys and young men, and/or inform the provision of gender-specific information.
- Children and young people with disabilities may have specific communication needs, particularly if they have learning or sensory disabilities. Information on where to go for help should be available in a variety of accessible formats.

- English may not be the first language of some children and young people. Information should be readily available in a variety of languages, reflecting the diverse nature of contemporary society.

8.4 Counselling services

Healthy lives, brighter futures – The strategy for children and young people’s health (DCSF & DH, 2009) recognises the importance of young people’s mental health and psychological wellbeing and acknowledges that: “[E]arly intervention, when young people first experience mental distress...is [therefore] crucial.” (para. 5.4).

In addition, the strategy goes on to acknowledge the need to take forward improvements in access “...to mental health support through universal services...” and to ensure “...that parents and carers have access to high quality advice and support when they are concerned about their children’s mental health...” (para. 6.23). We therefore recommend that:

8.4.1 Counselling services should be provided confidentially.

Such services, both the confidential helpline and face-to-face support, give children and young people an opportunity to talk to someone before problems escalate and counsellors can support children in developing the tools to help themselves and build their resilience.

8.4.2 Counsellors must be alert to the risk factors associated with suicide.

Furthermore, if it becomes clear that primary preventive services are unable to provide the level of support required, those working with children should be familiar with the procedures for escalating concerns, in line with the requirements of *Healthy lives, brighter futures – The strategy for children and young people’s health* (DCSF & DH, 2009).

8.5 Training

The Government has recognised the need for a “...flexible, skilled and specialist adolescent health and wellbeing workforce offering a range of health and social care in a variety of settings ... focused on early intervention ... [and with] a strong emphasis on mental health and psychological wellbeing.” (DCSF & DH, 2009, para. 5.42). We recommend that:

8.5.1 Training in suicide awareness and prevention should form part of the competencies of professionals who deal with or work with children and young people.

Suicide is a particular risk for children and young people in transition, especially where neglect or abuse have been a feature of their lives, while experiences of bullying or being bullied are strongly associated with attempted and completed suicides (Brandon et al, 2008). In addition, research has shown that children in care and in youth offending institutions are disproportionately likely to attempt suicide (Social Work Inspection Agency, 2006 and Mesie et al, 2007).

Training on suicide awareness and prevention, including identification of early risk and high risk groups, should be part of the competencies of all key professionals, including teachers, school nurses, counsellors and general practitioners, and should ideally include input on suicide prevention to all professional training and post-qualification courses.

8.5.2 A model of suicide prevention in children and young people should be used to develop appropriate multi-agency and single agency training.

The NSPCC's model of suicide prevention (Colquhoun and NSPCC, 2007) could usefully inform appropriate training modules for use by local safeguarding children boards (LSCBs) and other organisations.

8.6 The internet

8.6.1 All internet services geared toward children should have clear links to sources of help and support.

The growth in children and young people's use of multiple forms of mobile and internet information and communications technology means that it is important to ensure that there is information about readily available sources of support, such as ChildLine, on all the major social networking sites and other online services that children use.

In addition, we recommend ensuring that those providing services for children online should have a policy on how to deal with potentially harmful information relating to suicide that may not meet the threshold of illegality. **We recommend that internet services have clear policies on such content, which include review and removal of content where appropriate, as well as proactively offering support to users who have shown an interest in seemingly harmful suicidal content.**

8.6.2 Under the Suicide Act 1961, the promotion of suicide is illegal. Websites should not be exempt from this. The definitions governing the promotion of suicide should be revised to include internet-based materials, and we urge that greater clarity is provided concerning what type of website content is pro-suicide and thus illegal. Enforcement should be on the basis of a policy of "no tolerance" of illegal material. This would require internet companies hosting illegal content on the internet to locate and remove it or to remove it within 24 hours once notified of its presence.

8.6.3 All professionals working with children and young people should be aware of the issue of pro-suicide information that is distributed through internet sites and chatrooms that may be dedicated to the promotion of suicide.

It is important that parents, carers and those working with children are encouraged to communicate with children about what they are doing online and feel able to offer them help.

8.6.4 Further consideration needs to be given to how to tackle the difficulties of monitoring and controlling internet sites that are hosted in countries outside the UK.

This should explore solutions for blocking illegal suicide material.

8.7 Learning from what we know to inform a strategic approach

8.7.1 An informed strategic approach to preventing suicide in children and young people must be developed.

This should utilise information already available, and highlighted in this casenote, and be supplemented with the provision of more robust statistical data as outlined below:

- Current guidance concerning case review arrangements is inconsistent across the UK. However, in those cases where abuse or neglect are known or

suspected to have contributed to the suicide of a child or young person it is mandatory to undertake a Serious Case Review (SCR) (HM Government, 2006), or in Northern Ireland, a Case Management Review (DHSSPS, 2003). In Wales, a Serious Case Review is mandatory in all cases of suicide, regardless of the circumstances (Welsh Assembly Government, 2006), and in Scotland every child death is automatically followed by a case review by the Child Protection Committee.

- The implementation of child death overview arrangements is not yet consistent across the UK. However, when the systematic collection and analysis of data from this process is in place, it will provide considerably more detailed information about the extent and circumstances of suicides.
- The information derived from the child death overview process and the SCR/Case Management Review process should be brought together and used to provide an in-depth understanding across the UK of the causes of child deaths through suicide. This information must then be used to promote preventive, rather than reactive, work and, taken together with the findings of individual SCRs, contribute to the understanding of child suicide and the development of a strategic multi-agency approach to its prevention.

8.8 A consistent approach to the recording of child suicides across the UK

8.8.1 The extent and nature of suicide among children and young people must be consistently recorded across the UK.

This will provide robust information about causal factors, provide for cross-jurisdictional comparisons and enable agencies to implement appropriate preventive measures.

8.8.2 Official statistics should be refined to include data about the extent and nature of completed suicides in children and young people under the age of 15 years.

Child death overview processes will go some way towards revealing a more comprehensive and accurate record of the incidence, methods and underpinning causes of suicide or probable suicide in children and young people and to better ensuring more effective identification of deaths with suicidal intent.

8.8.3 Information about death by suicide should be aggregated at regional and national level.

The information should then be disaggregated to reveal:

- the extent and nature of suicide among children and young people overall;
- the extent and nature of suicide by gender and age categories;
- the identification of general risk factors; and
- the identification of particular risk factors associated with gender and age.

This will enable the identification and implementation of an appropriate range of targeted preventative measures.

8.9 The evidence base

8.9.1 Further research into suicide by children and young people is required to develop a robust quantitative evidence base.

This would also include the explicit intention of using this to develop suicide prevention strategies in each of the UK jurisdictions, as well as facilitating cross-jurisdictional learning.

8.9.2 The evidence base should additionally be informed by qualitative information.

This would come from agencies like ChildLine and other relevant organisations.

8.9.3 Consideration should be given to a National Confidential Inquiry dedicated to children and young people and covering each of the countries in the UK.

Safety First: Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (DH, 2001) informed the subsequent publication in England of the Department of Health's *National suicide prevention strategy for England* (DH, 2002), but paid scant regard to children and young people.

In contrast, a recently commissioned literature review by the Scottish Government into risk factors for suicide and suicidal behaviour revealed gaps in the evidence available to the review on research on children, especially looked after children (The Scottish Government, 2008).

Appendix 1

ADVICE FOR PARENTS AND CARERS

How can you tell if a child or young person is suicidal?

There are no foolproof ways of telling if someone is suicidal, with friends, family and carers often reporting that they had no idea that a child or young person was suicidal. Nevertheless, there are some pointers that may help in building up a “suicide picture”.

The following signs may be present when a child or young person is thinking about taking their own life:

- Talking about methods of suicide
- Dwelling on insoluble problems
- Giving away possessions
- Hints that “I won’t be around” or “I won’t cause you any more trouble”
- Changes in sleeping or eating habits
- Withdrawal from friends, family and usual interests
- Violent or rebellious behaviour, or running away
- Drinking to excess or misusing drugs
- Feelings of boredom, restlessness or self-hatred
- Failing to take care of personal appearance
- Complaints about headaches, stomach aches, tiredness, or other physical symptoms
- Becoming over-cheerful after a time of depression
- Unresolved feelings of grief following the loss of an important person or pet (including idols, such as pop stars and other “heroes”).

Suicidal feelings and actions frequently involve a combination of several of the above and/or other factors. These signs are possible indicators and, if a child or young person is displaying one such sign, it does not necessarily mean he or she is feeling suicidal.

If you notice any of the above signs, let the person know you are concerned.

Children tell us that the most common causes for their suicidal feelings are abuse, bullying, family upheaval, relationship breakdowns, exam stress and mental health problems in themselves or in members of their family. In addition, research has shown that the following circumstances can put children and young people at greater risk of suicide:

- Loss, bereavement or the break-up of a relationship
- Living in an isolated rural area
- Going to prison
- The experience of racism or a culture clash
- Struggling with sexual identity
- A history of suicide in the family
- Illness or disablement
- Previous suicide attempts
- Stress and anxiety relating to work, school or home
- A combination of any of the above.

It is vital for parents and others to let children and young people know they are concerned, available and want to help. Above all, it is important not to ignore their distress.

If you suspect a child or young person is in difficulties but they are withdrawn or uncommunicative, try the direct approach:

- Ask “How do you feel?” or “How bad do you feel?”
- Say “Some people feel suicidal; do you ever feel like that?”

The child or young person may slam the door or ignore you, but you should ask anyway. It is better to give some reassurance that you are concerned than to give the impression that you do not care. If questions get you nowhere, try the following:

- Say “I’m concerned about you”
- Say “I know you are having a bad time at the moment”
- Let the child or young person set the agenda for discussion on their own terms
- Be patient and sympathetic; children and young people may not be able to articulate how they feel
- Help the child or young person discuss his or her options, offering solutions and alternatives
- Enable them to talk both about what led them to feel like this, and what they might look forward to in the future
- If they still will not communicate with you about how they feel, suggest they might talk in confidence to another person – a trusted family member, another trusted adult, such as a teacher, or a friend. You might say: “If you can’t or don’t want to talk to me, who do you think you might talk to? What about ChildLine, for instance?”

Difficult as it may seem for today’s hard-working parents, busy carers, teachers and friends, your time and patience are of the essence:

- Be available to listen and talk when you are needed
- Build up the child or young person’s confidence and self-esteem; do not judge or put them down
- If you are floundering, find help and support from others, such as Parentline Plus (www.parentlineplus.org.uk; 0808 800 2138); Young Minds Parents' Helpline (www.youngminds.org.uk; 0800 018 2138); Samaritans (www.samaritans.org; 08457 909090); Parentline Scotland (www.children1st.org.uk; 0808 800 2222); Parents Advice Centre (PAC) Northern Ireland (www.parentsadvicecentre.org; 0808 8010 722); and Lifeline Northern Ireland (www.contactyouth.org; 0808 808 8000). You could also talk to a GP, teachers, other parents and friends. Don't try to cope alone.

Think in practical terms about what kind of situation, or opportunity, might push your child over the edge and take avoiding action:

- Do not force a child or young person into an impossible situation, such as going to school when there is severe bullying.
- Remove potential means of suicide, such as paracetamol tablets.

This advice for parents and carers is based on *Saving young lives: calls to ChildLine about suicide*, Brigid McConville, ChildLine, 2001

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About the information in this casenote

The findings in this casenote are based on detailed analysis of calls to ChildLine from April 2007 to March 2008. Children and young people often talk to ChildLine because they know they will receive a confidential service and that what they say will not go any further unless they wish. ChildLine will always make an informed judgement as to whether the child can give realistic consent to act on his/her behalf. On rare occasions this contract of confidentiality can be broken if the child is assessed to be in a dangerous or life-threatening situation. The majority of children do not identify their whereabouts and maintain their own anonymity.

The counsellor will listen and take the child or young person seriously when they call. ChildLine will help the child to talk through their concerns, exploring what might make a difference, and whether there are supportive adults in their lives. Sometimes the child will practise what they would say to increase their confidence in speaking to such an adult. The counsellor will also give the child information on how other agencies can help. If the child wants ChildLine to make contact on their behalf, or this is assessed as necessary, ChildLine will mediate, advocate or refer the child to a relevant agency or person, such as social services, the police, the ambulance service, or a parent or teacher.

ChildLine's data is not comprehensive, as the main priority for helpline counsellors is to provide comfort, advice and protection to the caller, not to gather demographic or other information for research purposes.

The content of ChildLine counselling conversations is captured through written records. Every time a counsellor speaks to a young person, the counsellor notes the main reason the child called, any other concerns raised, and details of family and living circumstances revealed by the child, and a narrative of the discussion. Conversations are child-led and not conducted for the purposes of research; but it is for precisely these reasons that they often reveal information that formal research might not uncover.

ChildLine provides a confidential telephone counselling service for any child with any problem, 24 hours a day, every day. In February 2006, ChildLine joined the NSPCC as a dedicated service, in order to help, support and protect even more children. ChildLine continues to use its own name, and the 0800 1111 phone number remains unchanged. Volunteer counsellors continue to provide a free 24-hour service for any child or young person with a problem.

For more information, please contact the NSPCC Library and Information Service on: **020 7825 2775** or email: **info@nspcc.org.uk** or contact the NSPCC Media Team on: **020 7825 2500**, email: **media@childline.org.uk** or visit: **www.nspcc.org.uk/casenotes**

All names and potentially identifying details have been changed to protect the identity of callers.

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ChildLine is a service provided by the NSPCC. In Scotland the ChildLine service is delivered by CHILDREN 1st on behalf of the NSPCC.

NSPCC registered charity numbers 216401 and SC037717. CHILDREN 1st
Scottish registered charity number SC016092.

