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Suicidality in Primary Care, Youth Mental Health Services: Prevalence, Risk Factors and Implications for Practice

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ABSTRACT

Introduction: Youth suicide is a concern worldwide, and suicidality—the presence of suicidal ideation or intent—is a critical risk for youth mental health services. This study aimed to determine the prevalence of suicidality in primary care, youth mental health services, along with its correlates and the course of treatment offered to clients.

Methods: Routinely collected data from Australia's *headspace* National Youth Mental Health Foundation, which has over 160 centres across Australia providing mental health care to young people aged 12–25 years, were analysed for new clients who started and completed their first episode of care between 1 July 2022 and 30 June 2023. This included 30 437 young people/episodes of care and 74 393 occasions of service.

Results: Results showed that suicidality was evident in almost one-quarter of young people, although it was rarely reported as a primary presenting issue. When present, it was usually identified at first visit. Those most at risk were young people in unstable accommodation, who identified as LGBTIQ+ or who were indigenous.

Conclusions: The findings show that suicidality should be anticipated in young people presenting to primary care mental health settings, and youth services need to be able to competently deal with suicide risk rather than using this as exclusion criteria.

1 | Introduction

Youth suicide is a critical concern worldwide, particularly so in Australia where suicide is the leading cause of death in young people aged 15–24 years and the second leading cause of death in children aged 5–17 years (Australian Institute of Health and Welfare (AIHW) 2023). In Australia in 2021, deaths by suicide represented 34% of all deaths in those aged 15–17 years and 35% of all deaths in the 18–24-year group, up from 17% and 24%, respectively, of all deaths in these age groups in 2001 (Australian Bureau of Statistics 2023).

Although the risk of suicide affects people of all ages globally (World Health Organization (WHO) 2021), it is especially

concerning for young people in their teen and early adult years. Untimely deaths by suicide at this life-stage not only result in the devastating direct impact on family, friends and community but also have a major impact on society in general through the loss of young people on the verge of becoming contributing adult members of society. Consequently, preventing youth suicide is a critical focus of the Australian Government (Australian Government Department of Health and Ageing 2023), as it is for many governments worldwide.

Suicidality is ‘the risk of suicide, usually indicated by suicidal ideation or intent, especially as evident in the presence of a well-elaborated suicidal plan’ (American Psychological Association (APA) 2023). It incorporates suicidal thoughts, plans, gestures

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or attempts. Suicidal ideation, comprising suicidal thoughts or ideas, describes a range of contemplations, wishes and preoccupations with death and suicide (Harmer et al. 2023). Suicidal ideation is quite common among young people; the Longitudinal Study of Australian Children, which is a nationally representative cohort study that has followed over 10000 children since birth, reported that 17% of adolescents aged 14–17 years had thought about taking their own life in the past year (Terhaag 2020). Suicidal ideation is a key component of suicidality and a risk factor for suicide.

One of the main risks for suicidality is mental ill-health (Brådvik 2018), although many suicides occur impulsively in moments of crisis or during periods of life stress, such as financial problems, isolation, chronic illness and relationship problems (World Health Organization 2023). Suicidal ideation is a presenting issue of itself and a symptom and common co-morbidity of mental disorders such as depression, anxiety, mood and substance use disorders (Nock et al. 2010). Accordingly, it is a key concern for mental health services. Given the vulnerability of young people to suicidality, it is a particular concern for youth mental health services and a key risk to be assessed for all young people presenting for mental health care.

headspace is Australia's nation-wide primary mental healthcare service platform for young people who are at risk of, or experiencing, early stages of a mental health disorder and common co-occurring difficulties. It was initiated by the Australian Government in 2006 (McGorry et al. 2007) in recognition of the urgent need for health system reform to respond more effectively to the high incidence and prevalence of mental health problems among young people, and their low level of mental health service use (Rickwood et al. 2019). *headspace* provides early intervention mental health care (as well as a range of related health and support services, including work and study support, physical and sexual health services and alcohol and other drug services) to young people aged 12–25 years. *headspace* operates through over 160 centres across the country (supported by phone and web-based services), offering a safe and confidential space for young people to seek help for any mental health issue.

Adolescence and young adulthood represent a critical period of life transition and identity formation, accompanied by increased vulnerability to mental health challenges. Suicide rates peak among young people aged 15–24 years in Australia, emphasising the importance of targeting this age group with prevention efforts. Young people from some population groups are at even higher risk of suicide. Notably, there are significant gender differences, with young women and trans young people more likely to attempt suicide than young men (Tsirigotis et al. 2011); recent studies indicate an alarming rise in female youth suicide rates (Stefanac et al. 2019). Yet, young men are three times more likely to die by suicide (Australian Institute of Health and Welfare (AIHW) 2023), as they often use more fatal means and are less likely to seek help (Chatmon 2020).

Ethnicity and cultural factors also influence youth suicide rates. Indigenous youth in Australia have disproportionately high suicide rates compared to their non-indigenous counterparts

(Australian Institute of Health and Welfare (AIHW) 2022). Data from 2017 to 2021 shows that suicide rates among indigenous Australians are twice the rate of non-indigenous Australians (24.9 per 100000 and 12.7 per 100000, respectively). This highlights the importance of addressing historical and systemic factors, including intergenerational trauma and cultural disconnection, while working towards culturally appropriate prevention strategies. Young people living in rural areas are also at greater risk for suicidality. Remote and rural areas can experience higher suicide rates due to limited access to mental health services, social isolation and economic challenges (Pridmore 2018). Bridging the urban–rural divide by improving mental health services in regional areas is crucial to reducing youth suicide rates.

Typically, for people experiencing an acute mental health issue, such as high-risk suicidality, access to mental healthcare is through the emergency department or crisis tertiary health services (Orygen 2021). As an early intervention service, *headspace* was designed to provide services to young people with experiences of mild to moderate mental ill-health, which usually rules out acute issues such as suicidality. Yet, *headspace* centres across the country report an increasing proportion of high-risk and complex presentations, likely related to the severe pressure on the mental healthcare sector as a whole and the *headspace* ‘no wrong door’ policy, which maintains that each young person should receive appropriate and adequate support for their needs regardless of severity (Gao et al. 2024). Added to this is the high level of suicidal ideation commonly present for young people (Scott et al. 2012). Given these circumstances, it is likely that *headspace* staff and staff in similar primary care youth services are regularly a first point of contact for young people with suicidal ideation. It is, therefore, paramount that primary youth mental healthcare services, including those that focus on early intervention, are well-equipped to recognise and respond to suicidality in their clients and not to exclude them.

Little is known, however, about the prevalence of suicidality in primary care youth mental health services. The purpose of this study is, therefore, to examine the suicidality risk prevalence in primary care, early intervention focused, youth mental health services, its correlates and the course of treatment offered to clients. We use data from *headspace* to determine suicidality in young people accessing youth mental healthcare and investigate demographic differences across *headspace* priority groups expected to be more vulnerable to suicidality due to gender, being LGBTIQ+, indigenous or living in a rural area. Understanding the suicidality of youth who attend primary care mental health services is crucial for developing effective prevention strategies, inform clinician training and resource management and provide targeted support to more vulnerable population groups.

2 | Method

2.1 | Participants

Participant data come from the *headspace* minimum data set (MDS), which comprises routinely collected data from young people accessing all the *headspace* centres across Australia. The

data used in the current study are for new *headspace* clients who started and completed their first episode of care between 1 July 2022 and 30 June 2023. This included 30 437 young people/episodes of care and 74 393 occasions of service. Excluded are 'group services' where the suicidality question and primary/other issue are not recorded, as well as occasions of service where the service provider did not complete any information on primary/other issue or suicidality ($n = 2097$).

2.2 | Procedure

When young people present at a *headspace* centre, they are provided with an electronic device on which they answer a series of questions. Different question sets are presented depending on the visit number. The first visit in each episode of care has the longest questionnaire, including demographic and other background information. Service providers also input information at every visit.

Young people are asked for consent not only for the use of their data for the primary purpose of service provision and outcome monitoring but also for research purposes. Ethics approval comprised initial approval through the *headspace* Board Research subcommittee. The consent processes were reviewed and endorsed by an independent body, the Australasian Human Research Ethics Consultancy Services. The data are collected primarily for service provision and quality improvement purposes, and parental consent is not routinely sought for those under 18 years, who are assessed as mature minors unless otherwise indicated. Young people can opt out of data collection if they choose or at the discretion of their parents.

2.3 | Measures

Demographic characteristics were client-reported as shown in Table 1.

Suicidality was reported by service providers at each occasion of service (including presentation), indicating whether suicidality was present via three items: (1) the service provider records 'suicidal thoughts/behaviour' as primary presenting issue, (2) as other presenting issue or (3) answers positively to the question 'Was there indication that suicidality is a concern for this young person today?'. A positive response to any item indicates suicidality. Note that these are subjective measures, as perceived by the service provider. *headspace* services are expected, however, to undertake standardised risk assessment, including of suicide risk, at presentation (and throughout the episode of care), and there are recommended assessment processes for doing this. Nevertheless, despite the recommendations from *headspace* National Youth Mental Health Foundation, individual centres are governed by Lead Agencies and their clinical and operational processes prevail (although these are assessed through the *headspace* Model Integrity Framework assessment process).

Mental health indicators and service characteristics are indicated in Table 2. These included the following.

- *Psychological distress* measured using the 10-item self-report Kessler Psychological Distress Scale (K10) (Kessler et al. 2002).
- *Quality of life* measured using the five-item, self-report MyLifeTracker (MLT) (Kwan et al. 2018).
- *Functioning* assessed by service providers via the single-item Social Occupational Functional Assessment Scale (SOFAS) (Goldman et al. 1992).
- *Stage of illness* assessed using a single item based on Shah et al. (2020).

3 | Results

3.1 | Prevalence and Demographic Profile of Suicidality Among Headspace Clients

Of the 30 437 new *headspace* clients, 19.4% ($n = 5900$) were assessed with suicidality at presentation. A further 4.9% ($n = 1483$) were assessed with suicidality at a later point in their episode of care, raising the total number of young people who were suicidal at any time during their first episode of care to almost one-quarter (24.3%, $n = 7383$).

Table 1 shows the prevalence of suicidality at presentation and at any time during the first episode of care for different demographic groups. Since many of the individual characteristics associated with suicidality are correlated, odds ratios from logistic regressions that control for these characteristics simultaneously are reported alongside the base rate of suicidality for each demographic.

Young people 15–17 years of age have a higher suicidality rate than other age groups, with a base rate of 21.0% at presentation and 26.4% at any time. Relative to the youngest age group (12–14), their odds of being assessed as suicidal are 16.0% higher at presentation and 18.9% higher at any time during their first episode of care. The lowest chance of being suicidal is recorded at ages 22–25.

Female and gender diverse young people have higher suicidality rates than males. Compared to male young people, females have 16.7% higher odds of being suicidal at any time in their episode of care, and gender diverse young people have 28.5% higher odds. LGBTIQ+ young people in general (which includes gender diverse young people) present substantially more often with suicidality than others, with a base rate of 26.8% at presentation and 35.1% at any time. Compared to other core demographic factors, identifying as LGBTIQ+ has the strongest association with suicidality; a young LGBTIQ+ person has 65.5% higher odds of being suicidal at presentation and 71.8% higher odds of being suicidal any time during their care than a non-LGBTIQ+ young person. Indigenous young people are also more likely to present with suicidality, showing 29.2% higher odds of suicidality at presentation and 25.5% higher odds of suicidality at any time than non-indigenous young people. There is no difference in suicidality rates and odds between young people with a CALD background and others, conditional on other characteristics. However, having a CALD background is the only characteristic that emerges as significantly related to being assessed

TABLE 1 | Suicidality rates and odds ratios of suicidality by demographic characteristics.

Subgroup	N	Suicidality at presentation			Suicidality any time		
		Suicidality rate	Odds ratio	95% CI	Suicidality rate	Odds ratio	95% CI
Full sample	30437	19.4%			24.3%		
Core demographics							
Age at first service							
12–14	10383	18.4%		(ref.)	23.0%		(ref.)
15–17	9265	21.0%	1.160**	[1.062, 1.267]	26.4%	1.189***	[1.097, 1.289]
18–21	6809	20.0%	1.084	[0.983, 1.196]	24.9%	1.112*	[1.016, 1.216]
22–25	3925	17.1%	0.839**	[0.740, 0.952]	21.5%	0.857**	[0.765, 0.960]
Gender							
Male	8653	17.2%		(ref.)	22.0%		(ref.)
Female	14859	20.2%	1.147***	[1.059, 1.242]	26.1%	1.167***	[1.085, 1.255]
Gender diverse	1078	28.2%	1.203*	[1.017, 1.424]	37.5%	1.285**	[1.100, 1.502]
LGBTIQ+ status							
Is not LGBTIQ+	14151	17.6%		(ref.)	23.0%		(ref.)
Is LGBTIQ+	4919	26.8%	1.655***	[1.519, 1.803]	35.1%	1.718***	[1.588, 1.859]
Indigenous background							
Is not indigenous	20488	19.1%		(ref.)	25.0%		(ref.)
Is indigenous	2515	22.3%	1.292***	[1.153, 1.448]	27.9%	1.255***	[1.130, 1.395]
CALD background							
Is not CALD	19234	19.7%		(ref.)	25.6%		(ref.)
Is CALD	2639	19.3%	1.015	[0.907, 1.137]	27.0%	1.096	[0.990, 1.213]
Additional demographics							
Work and study							
Neither work nor study	2509	23.8%		(ref.)	31.5%		(ref.)
Study	8636	20.3%	0.841**	[0.738, 0.959]	26.8%	0.831**	[0.735, 0.938]
Work	3091	20.0%	0.986	[0.844, 1.151]	26.9%	0.973	[0.843, 1.123]
Study and work	4886	18.7%	0.770***	[0.667, 0.888]	25.2%	0.771***	[0.676, 0.879]
Looking for work							
No	13284	18.8%		(ref.)	25.2%		(ref.)
Yes	5838	23.6%	1.206***	[1.101, 1.321]	31.2%	1.214***	[1.116, 1.321]
Living situation							
Stable accommodation	15290	20.1%		(ref.)	26.4%		(ref.)
Unstable accommodation	1298	32.0%	1.663***	[1.453, 1.902]	40.8%	1.727***	[1.519, 1.962]
Rurality							
Metropolitan	18395	20.0%		(ref.)	25.2%		(ref.)
Non-metropolitan	12011	18.4%	0.843***	[0.772, 0.920]	22.8%	0.788***	[0.727, 0.854]

(Continues)

TABLE 1 | (Continued)

Subgroup	N	Suicidality at presentation			Suicidality any time		
		Suicidality rate	Odds ratio	95% CI	Suicidality rate	Odds ratio	95% CI
State							
ACT	627	23.0%		(ref.)	23.4%		(ref.)
NSW	8619	19.7%	0.789	[0.596, 1.045]	24.7%	1.167	[0.884, 1.541]
NT	506	15.8%	0.844	[0.547, 1.301]	18.4%	0.993	[0.651, 1.517]
QLD	6079	24.2%	1.072	[0.808, 1.421]	28.3%	1.328*	[1.004, 1.757]
SA	2291	17.6%	0.753	[0.555, 1.022]	20.9%	0.966	[0.716, 1.303]
TAS	856	12.7%	0.618*	[0.417, 0.917]	17.3%	1.07	[0.742, 1.542]
VIC	8247	17.1%	0.782	[0.588, 1.041]	22.3%	1.212	[0.915, 1.606]
WA	3212	18.2%	0.725*	[0.538, 0.977]	25.8%	1.275	[0.954, 1.704]

Note: Suicidality rate refers to prevalence of suicidality in a particular sub-group in the raw data. Odds ratios and 95% confidence intervals are from logistic regressions, clustering standard errors at the young-person level and adjusted for covariates. In panel Core demographics, all core demographic variables are covariates in the regressions. In panel Additional demographics, all core demographic and additional demographic variables are covariates in the regressions.

* $p < 0.5$, ** $p < 0.01$, *** $p < 0.001$.

with suicidality later on in their episode of care (compared with determination at presentation) (not in table; CALD young people approximately 5% more likely to be assessed as suicidal later on, p -value = 0.001).

Looking beyond core demographics, young people who are neither studying nor working, as well as those who are looking for work, have higher base rates of suicidality (23.8% (23.6%) at presentation, 31.5% (31.2%) at any time), whereas those who are currently studying *and* working are at lower risk of suicidality. Being engaged in study alone, or in study and work, reduces the odds of suicidality by 16%–23%. Young people who live in unstable conditions (which includes homelessness, short-term or other unstable accommodation and having somewhere to live but experiencing issues with accommodation) experience the highest base rates of suicidality, both at presentation (32.0%) and at any time (40.8%) in their episode of care. Conditional on other factors, unstable living conditions are associated with 66.3% higher odds of suicidality at presentation and 72.7% higher odds at any time. Contrary to expectation, young people in metropolitan areas more often present with suicidality than those in non-metropolitan areas. Across the Australian jurisdictions, Queensland has the highest (24.2% at presentation, 28.3% at any time) and Tasmania the lowest suicidality rates (12.7% at presentation, 17.3% at any time).

3.1.1 | Intersectionality

Recognising the mounting mental health difficulties and access barriers for LGBTIQ+, CALD and indigenous young people, *headspace* considers these demographics priority populations. Young people who fall into multiple *headspace* priority groups (intersectionality) do not experience significantly higher rates of suicidality than those who are part of only one priority group. As Figure 1 shows, there is a consistent jump in the estimated probability of suicidality at presentation between non-LGBTIQ+ and LGBTIQ+ young people, regardless of whether this is calculated for the average young person (turquoise line), an

indigenous or non-indigenous young person (light blue and red lines) or a young person with or without CALD background (black and grey lines). The apparent more pronounced difference between LGBTIQ+ and non-LGBTIQ+ young people with a CALD background is statistically non-significant.

3.1.2 | Mental Health Indicators of Suicidality

Table 2 shows psychosocial mental health indicators at the occasion of service when a young person is assessed with suicidality compared to other occasions of service and suicidality rates by stages of illness. In 16.3% ($n = 12\,108$) of the total 74 393 occasions of service, the service provider made a positive assessment of suicidality. This was predominantly expressed through the direct suicidality question (11.6%, $n = 8592$) and was recorded as 'other presenting issue' in 7.5% ($n = 5540$) of occasions of service and as 'primary presenting issue' in 2.6% ($n = 1904$) of occasions of service (note that overlap is possible).

When service providers indicate suicidality, the young people have a significantly higher level of psychological distress (K10), a lower level of social and occupational functioning (SOFAS) and a lower score on MLT. They have also been totally or partially unable to go about their day-to-day activities for more days in the last 4 weeks than at those occasions of service when the young person was not considered suicidal. From a clinical perspective, they are much more likely to receive an above or just below threshold diagnosis for a mental disorder (Stages 1b and 2–4).

A one-point higher K10 score is associated with 6.7% increased odds of suicidality, a one-point higher SOFAS score (higher level of SOFAS) is associated with 2.2% reduced odds of suicidality, and a one-point higher MLT score is associated with 1.5% reduced odds (*ceteris paribus*, controlling for visit number and core demographic variables in Table 1 and mental health variables in Table 2). Figure 2 shows the estimated probabilities of suicidality

TABLE 2 | Mental health indicators of suicidality.

	N	Suicidality at occasion of service		
		Suicidality rate (%)		p (t-test)
Full sample	74 393	16.3		
Mental health indicators (cont.)	N	Mean (SD) Suicidality	Mean (SD) No suicidality	p (t-test)
K10	34 171	34.02 (7.69)	27.00 (8.37)	<0.001
SOFAS	58 876	60.28 (12.57)	68.05 (12.11)	<0.001
MLT	42 137	42.16 (19.23)	58.55 (20.85)	<0.001
K11: Days totally unable	33 967	8.91 (8.44)	5.64 (7.27)	<0.001
K12: Days cut down	33 970	11.34 (8.96)	9.88 (9.3)	<0.001
Mental health indicators (cat.)	N	Suicidality rate (%)		
Stage of illness				
Not applicable or unable to assess	2956	12.5		
Stage 0: No symptoms of mental disorder	2815	3.3		
Stage 1a: Mild to moderate general symptoms	26 646	9.8		
Stage 1b: Sub-threshold diagnosis	14 562	21.6		
Stage 2: Threshold diagnosis	7955	25.2		
Stage 3: Periods of remission	1427	24.2		
Stage 4: Ongoing severe symptoms	3324	38.7		

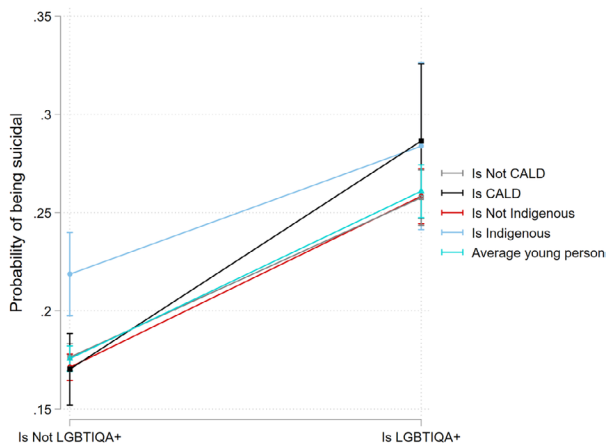


FIGURE 1 | Probability of suicidality at presentation by LGBTIQ+ status and CALD/indigenous background.

at different levels of psychological distress (K10), quality of life (MLT) and SOFAS. For a young person at the highest level of psychological distress, this probability is above 0.350, meaning that a young person in very high psychological distress has, on average, a 35% chance of suicidality, holding constant other factors such as demographics and mental health conditions.

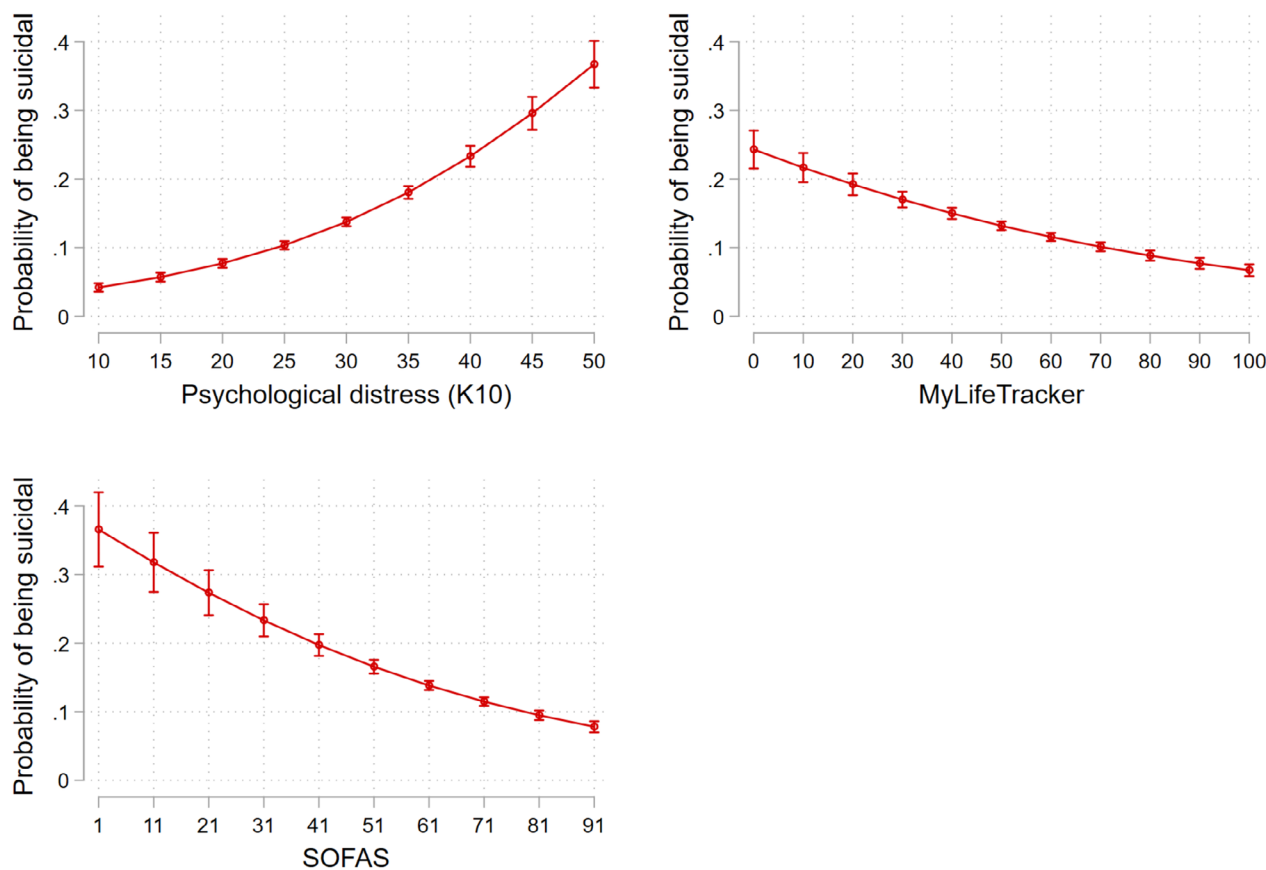
3.2 | Clinical Pathways and Outcomes

Young people with suicidality are more often influenced by a GP, school-based worker, friend or other person to seek support at

headspace; they are less often influenced by a family member or say it was their own idea to attend. Their main reason for attendance is feeling sad or depressed and they more often report that they have thoughts that bother them (not in table).

Young people presenting with suicidality receive a similar number of services as those without suicidality concern at *headspace*. They are, however, more likely to be referred to another service (28.2% vs. 12.5% for young people with suicidality vs. not, respectively, overall). In line with this, the stated reasons for the end of an episode of care (where a reason is given) are more often that ‘headspace is not/no longer the best care option for this young person; advised or referred to alternative care’ (38.5% for young people with suicidality on presentation vs. 21.0% for those without) and less often ‘Treatment goals have been met; no further treatment required at this time’ (15.2% for young people with suicidality on presentation vs. 26.1% for those without) and slightly less often ‘Young person has decided not to engage or not to continue with treatment’ (37.8% with suicidality; 44.2% with no suicidality).

Of the young people who continue at *headspace* for at least three sessions, the clinical outcomes of their care, as measured by a significant change in any of the three clinical outcome measures collected, are more positive for young people with suicidality concern. Table 3 shows that on all three measures, greater proportions of young people presenting with suicidality achieve significant improvement: 69.7% achieve significant improvement in at least one measure vs. 66.2% for non-suicidal young people. However, when controlling for young person characteristics (age, gender, rurality, state, indigenous status, CALD background, LGBTIQ+ status



Covariates at means.

FIGURE 2 | Estimated probability of suicidality at different levels of psychological distress (K10), quality-of-life (MLT) and social and occupational functioning (SOFAS).

TABLE 3 | Percentage with significant improvement in clinical outcomes for episodes of care of at least three sessions.

Significant improvement	In K10 (%)	In SOFAS (%)	In MLT (%)	On at least one measure (%)
Suicidality on presentation	41.1	43.5	59.9	69.7
Suicidality at anytime	39.5	41.6	57.6	68.4
Not suicidal	39.1	41.4	51.5	66.2

and number of sessions), the difference becomes statistically non-significant.

3.3 | Main Services Provided

Most of the services provided when young people are assessed with suicidality are initial screening or initial assessments (intake/access, 62%). Aside from intake/access services, in the session when young people are assessed by the service provider with suicidality, the young people receive either a psychological mental health intervention (44%), a low intensity mental health intervention (41%), general assistance (6.9%) or a medical

mental health intervention (5.4%) (other services occur at <1% frequency). In contrast, young people who are never assessed with suicidality most often receive a low intensity mental health intervention (51%) and less frequently a psychological mental health intervention (36%), general assistance (4.5%) or a medical intervention (3.1%).

4 | Discussion

This is the first study, to our knowledge, that investigates suicidality among young people presenting to primary care, early intervention focused, youth mental health services. Our aim was to determine the prevalence, correlates and general treatment pathways for clients experiencing suicidality compared with their non-suicidal peers.

The stand-out finding is that almost one-quarter of young people present with suicidality to the *headspace* youth mental healthcare services. This was somewhat unexpected for a service that is designed for young people with early and non-acute presentations. This result demonstrates that suicidality is common for help-seeking young people, regardless of severity, and needs to be routinely assessed and incorporated within the young person's treatment plan. It also means that service providers working in primary care youth mental healthcare need to be skilled and confident in dealing with suicide risk.

Suicidality was evident at first presentation for the vast majority of young people who were showing suicidality, with only another 4.9% identified later in their episode of care. Importantly, young people rarely present with suicidality as their primary issues (2.6%), with somewhat more presenting with suicidality as an ‘other’ presenting issue (7.5%). Most were identified in our study through a specific question asking their service provider whether there was any concern regarding suicidality for the young person at this occasion of service (11.6%). This reveals that a targeted question is needed to identify and estimate prevalence of suicidality among young people attending services and that considering only main presenting issue(s) significantly underestimates this prevalence. Presenting issues in *headspace* youth mental healthcare services are generally depression and anxiety symptoms, with suicidality a co-morbidity for many.

The demographic characteristics commonly reported in the literature to be associated with increased suicidality were generally supported. The highest probability of suicidality at any time in their episode of care was for young people in unstable accommodation (0.377), closely followed by those who were LGBTIQ+ (0.341). The next highest risk was for indigenous young people (0.298) and those living in metropolitan areas (0.290). Young people who were gender diverse (0.286) and those in mid-adolescence (0.280) also showed higher risk. Notably, these risks were uniquely relevant and intersectionality did not account for increased risk beyond the individual risk factors.

The finding that suicidality was more prevalent for young people in metropolitan than non-metropolitan areas was unexpected. Typically, rurality is a risk factor for suicide (Barry et al. 2020). However, our data measure suicidality not suicide, and it may be that suicidality is higher in urban populations, while suicide deaths are greater in rural areas. Armstrong et al. (2017) noted that there were a number of aetiological and methodological reasons why these two suicide indicators may not match. Foremost, suicide deaths and suicidal thoughts are related yet still quite different phenomena; although suicidal thoughts are likely to be an antecedent to a suicide death, not all those who have suicidal thoughts will attempt or die by suicide.

4.1 | Practice Implications

Understanding the suicidality of young people attending primary care youth mental health services is crucial for effective prevention and treatment. This is critical to inform clinician training and resource management and to provide targeted support to more vulnerable young people. Our findings show that suicidality must be routinely questioned. This is particularly the case for young people in unstable accommodation, who are LGBTIQ+ and of indigenous background, who should all be considered at increased risk. Nevertheless, with almost a quarter of young people presenting with suicidality when directly questioned, it is evident that *all* young people accessing youth mental healthcare need to be carefully and deliberately asked about suicidality—it is not sufficient to rely upon expressed presenting issues. It is also clinically relevant to note that young people from CALD backgrounds may take more time to disclose

suicidality, meaning that continued sensitive probing around this major risk may be indicated. Although ongoing assessment of suicide risk is an expected part of good quality clinical care, which we assume is occurring in practice throughout the *headspace* centre network, it is helpful for clinician support tools and data collection systems to ensure that this occurs through regular prompts and audits.

Our findings also underscore the essential inclusion of young people with suicidality in primary youth mental healthcare. Given the high prevalence, and even higher prevalence among young people from some groups that are less likely to seek help (i.e., indigenous youth), youth mental healthcare services must expect to be accessed by young people with suicidality and be able to appropriately question and respond to this risk, including incorporating addressing suicidality in treatment plans and having sound pathways to acute emergency services when required. Our study was not able to consider the referral pathways for young people identified with suicidality, beyond showing the main services provided while within the *headspace* service, and this is a clear direction for future research.

4.2 | Limitations

Finally, some limitations must be noted. In particular, our methods did not include a full suicide risk assessment measure and the data provide no indication of the severity, acuity or type of suicidality, which are important considerations for service providers. The measures in the current study are not necessarily based on the standardised risk assessment of suicide. Given that data were collected through routine data collection methods via the *headspace* MDS, full suicide risk assessments were not available (nor are they appropriate at every occasion of service). Instead, our measure of suicidality is based on the service provider’s assessment of whether suicidality is a presenting issue or clearly evident in the relevant occasion of service. This is obviously a limitation, relying on subjective service provider clinical determination, but given that a standardised assessment is not appropriate at every visit, we argue that this clinical impression provides a defensible indicator of suicidality based on the service provider’s assessment of the content of the occasion of service.

Nevertheless, our results show the importance of a clinical suicide risk assessment, especially at presentation, and future research should further investigate the nature of the suicidality, including how acute it is, using an appropriate design. Our findings are also limited to the Australian *headspace* primary care youth mental healthcare setting. Prevalence rates are likely to vary depending on the nature of the service setting.

4.3 | Conclusions

Suicidality is a common co-morbidity in primary care youth mental health services but rarely shows as a presenting issue of itself and needs to be specifically questioned. Service providers require competence and confidence in sensitively assessing for suicidality on presentation, as it is usually evident not only early on but also

throughout the episode of care as some young people may disclose later, particularly those from CALD backgrounds. It should be recognised that young people with unstable accommodation, who are LGBTIQ+ and who are indigenous are at substantially higher risk. Suicidality is a common need and necessary care component in primary care youth mental health services.

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Conflicts of Interest

The authors declare no conflicts of interest. Although all authors are employed by headspace National Youth Mental Health Foundation, this does not comprise a conflict for this paper.

Data Availability Statement

The data that support the findings of this study are available from headspace National Youth Mental Health Foundation. Restrictions apply to the availability of these data, which were used under license for this study. Data are available from the author(s) with the permission of headspace National Youth Mental Health Foundation.

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