YOUTH INSEARCH FOUNDATION (Aust) Inc.

Submission

to the

Examination of intentional self-harm and suicidal behaviour in children

by the

National Children's Commissioner

Australian Human Rights Commission

May 2014

Youth Insearch Foundation (YIF or the Foundation) is an independent non-government, not-for-profit organisation, whose aim since 1985 has been *'to empower young people to take control of their lives, by giving them the opportunity and skills to develop their self-esteem and play a positive role in society'*. Our stated objectives are:

- to reduce the incidence of crime, drug and alcohol abuse and suicide in young people
- to enhance young people's self esteem and productivity through empowering them to take control of their lives
- to break the cycle of family breakdown by giving young people some of the skills essential to being a successful parent
- to relieve the suffering and helplessness of young people affected by distressing issues
- to teach young people the positive values of life
- to teach young people the value of a good education in an effort to increase school retention and ability to secure employment

YIF lives out its mission and objectives primarily through the therapeutic milieu of its weekend peer-to-peer empowerment programs, targeted at young people who have experienced trauma and loss (such as abuse, death of a family member or family breakdown), and young people who misuse drugs and alcohol.

Over the last 30 years, the Foundation has sought to be a collaborative, complementary service, working at the nexus of the existing range of government agencies and third sector organisations involved in the provision of health, welfare, education and juvenile justice services for young people at-risk. During this time, we have worked hard to develop a clear articulation and documentation of our program's theoretical framework, to assist in continual improvement of our services, to increase transparency and to provide a clear evidence base for the benefit of external parties (e.g. Support Adults, potential funding agencies).

This submission is designed to present the theoretical framework and evidence base that underpins the Youth Insearch Program and, in so doing, to respond specifically to the issues raised by the National Children's Commissioner in her examination of how children and young people under 18 years can be better protected from intentional self-harm and suicidal behaviour. We present our submission in two parts. The first (*Examining Specific Aspects of Intentional Self-Harm and Suicidal Behaviour in Children*) is a series of responses to those of the nine issues the Commissioner has listed in her call for submissions on which the Foundation feels competent to comment. The second part (*Interventions for Young People "At-Risk": The Unique Role of Youth Insearch*) is an integrated statement of our program logic, together with evidence of the success of our approach, particularly with reference to its effectiveness with young people at risk of suicide and self-harm.

We would be pleased to support our submission in person if that would be helpful to the Commissioner.

Examining Specific Aspects of Intentional Self-Harm and Suicidal Behaviour in Children

1. Why children and young people engage in intentional self-harm and suicidal behaviour.

Being an adolescent is tough, with the experience of mental health problems being significant (AIHW, 2007). A World Health Organisation (WHO) study of 120,000 students in 28 countries has reported significant numbers experiencing depressive affect ("feeling low") on a weekly basis (average 25%), often feeling lonely (average more than 10%), and feeling tired most days of the week (average 22%) (Scheidt, et al, 2000:25-28). In Australia, 15% to 20% of adolescents report experiencing significant levels of psychological distress (NSW Health, 2004:31) or "mental health problems" (Sawyer, *et al*, 2000; ABS, 2007). A recent study of children and young people who have suicided in Queensland showed that arguments and relationship breakdowns (78%), and behaviour and disciplinary problems (63%) were among the most common associated factors (McNamara, 2014:358).

In a summary of the research literature to that point, the CAAAP (2000) provided a list of the identifying the characteristics of adolescents at risk of suicidal behaviour, *viz*: a history of depression; a previous suicide attempt; a family history of psychiatric disorders (especially depression and suicidal behaviour); family disruption; certain chronic or debilitating physical disorders or psychiatric illness; alcohol use and alcoholism; living out of the home (in a correctional facility or group home); a history of physical or sexual abuse; and psychosocial problems and stresses, such as conflicts with parents, break-up of a relationship, school difficulties or failure, legal difficulties, social isolation, and physical ailments (including hypochondriacal preoccupation). The Committee (2000) also reported that gay and bisexual adolescents exhibit high rates of depression, with rates of suicidal ideation and attempts, while the broader context within which adolescents are embedded also is involved, where long-term high levels of community violence contribute to emotional and conduct problems and add to the risk of suicide for exposed youth (see also, Boardman's and Saint Onge's (2005) findings regarding the influence of neighbourhoods on risk behaviours, educational outcomes, and adolescents' integration within their families, schools, and churches).

In Australia, a similar set of factors - a socio-economically disadvantaged background, childhood physical or sexual abuse, poor parent-child relationships, loss of a parent through separation or divorce, suicide or violence in the family, or experience in the family of imprisonment, mental health problems or harmful drug use – are recognised as placing young people at risk (Commonwealth Department of Health and Aged Care, 2000: 8; see also Queensland Commission for Children and Young People and Child Guardian, 2005:101). An analysis of situational circumstances and risk factors for identified suicides of children and young people by the Queensland Commission for Children and Young People and Child Guardian (2005:105—7) reaffirms the wider research evidence, as does a more recent evidence review of depression in adolescents and young adults by the Adelaide Health Technology Assessment (AHTA, 2010), on behalf of *beyondblue*.

On the other hand, such factors as strong connections to family and school; good mental and physical health; personal skills such as relationship and problem-solving ability, coping skills, a sense of hopefulness and an internal locus of control; social support and community connectedness; and the absence of guns in the house have been shown to protect young people against suicidal behaviours (Commonwealth Department of Health and Aged Care, 2000: 8; see also Queensland Commission for Children and Young People and Child Guardian, 2005:108; AHTA, 2010).

The research to date has been most instructive in identifying both risk and protective factors, but without the context of an explanatory framework that informs us of the reasons *why* it is so. The question of the underlying, interacting dynamics remains largely unanswered. We believe that our efforts to develop a program logic for the work we do with young people at risk, together with the evidence of success of our approach, suggests an answer, or at least a collection of answers to this critical question.

The disruptive behaviour, low self-esteem, low quality relationships, and stressful negative life events identified as "good" predictors of adolescent depression and suicide (AHTA, 2010:33-36) are also the key elements that bring young people to YIF. The core of the YIF program – empowering young people to take responsibility for their lives – is informed by an integrated approach to understanding and responding to the adolescent's experience of helplessness and hopelessness, which draws on the theoretical frameworks of Seligman's (1975) learned helplessness and Bandura's (1997) self-efficacy in the context of an appreciation of the variant clinical features of emotional disturbance in adolescence, in particular, the experience of depression. This set of dynamics is explored in the following sections.

1.1. Depression in Adolescence

The debate as to whether adolescent depressive symptoms are similar to those of adults or whether other adolescent behaviours are "masks" for depression, found its voice in the 1960s, when Toolan (1962a,b) argued that the clinical presentation of adult depression is rarely seen in young people, who manifest their depressed feelings by way of depressive equivalents – boredom, restlessness, somatic complaints and acting-out behaviours such as delinquency. This view was shared with Glaser (1967:565) who asserted that, in children and adolescents "depression is often not recognized because it may be hidden by symptoms not readily identified with this condition", and described behavioural problems and delinquent behaviour as examples of masked depression. Support for this view was provided, *inter alia*, by the research results of Cytryn and McKnew (1972), Inamdar, *et al* (1979) and Carlson and Cantwell (1980).

On the basis of clinical features, precipitating causes, family history and premorbid adjustment, Cytryn and McKnew (1972) were able to identify three distinct categories in the group of neurotically depressed children they studied, *viz*:

- masked depressive reaction of childhood
- acute depressive reaction of childhood
- chronic depressive reaction of childhood

Those children who were diagnosed as having a masked depressive reaction comprised by far the largest subgroup and Cytryn and McKnew (1972) concluded that depressive mood and behaviour are rare in childhood depressions.

Inamdar and his colleagues found Toolan's (1962a) "smiling depression" to be characteristic of the majority of their group of clinically depressed adolescents, insofar as these youngsters only looked sad when talking about their sad mood (Inamdar, *et al*, 1979). In addition, the symptoms of apathy, boredom, loss of interest and diminished school performance were much more prevalent than the more traditional symptoms of weight loss, slowed thoughts, memory disturbance, diminished libido and subjective anergia (Inamdar, *et al*, 1979). From their results, Inamdar, *et al*, (1979) suggested that, although there are a number of similarities between the features of adolescent depression and depression in adults, there are also many differences that might contribute to clinicians' under-recognition of depression in young people.

Carlson and Cantwell (1980) examined depressive symptoms and conduct problems in youngsters between the ages of seven and seventeen. They found that behaviour disturbances may overshadow a co-existing depression and that, while adult diagnostic criteria could be used to diagnose major affective disorder in youngsters over the age of seven, traditional evaluation methods overlooked the diagnosis of depression in 60% of the cases (Carlson and Cantwell, 1980).

While views on adolescent depression have changed significantly since the 1970s, Nunley (2001) notes that the debate continues as to whether, except for some development-specific differences, the symptomatology of childhood and early adolescent depression is similar to adult depressive features or whether youngsters tend to express their depression in behaviours which mask the underlying feelings, such that an adult-oriented diagnostic approach will often overlook the depressive underlay.

For example, in a survey of adolescents in a suburban high school, Blatt*, et al* (1993) established that dysphoria as a result of disruptions of interpersonal relatedness (e.g., feelings of loss or abandonment) were significantly related to internalising disorders, while dysphoria associated with diminished self-esteem (e.g., feelings of self-criticism, failure, or guilt) added significantly to the explained variance of both internalizing and externalizing disorders, specifically delinquency and aggression in both males and females. Similarly, Diclemente, *et al* (2005) found that a sample of depressed black female adolescents were nearly twice as likely to report engaging in antisocial behaviours and concluded that depression among black female adolescents may be accompanied by a broad range of adverse health consequences.

One review of the literature related to the risk factors, clinical characteristics, and course of illness of adolescent depression concluded that, for adolescents, the clinical features of melancholic depression are rare, while the "irritable hostile" pattern is distinctly increased, and that "for the majority who develop adolescent depression, its expression and outcome appear more a reflection of the propagating determinants, most commonly anxiety and personality style" (Parker and Roy, 2001:572). The AHTA (2010:33-36) review similarly identified disruptive behaviour, including conduct problems, disruptive behaviour disorders, rebelliousness,

oppositional disorders, being under-controlled and showing antisocial behaviour, as closely connected to depression in this age group. Nevertheless, it would appear that, at least to the extent that these other behaviours are now better recognized, adolescent depression has been *un*masked as a variably manifest disorder.

1.2. Depression as Learned Helplessness

Overmier and Seligman (1967) coined the term "learned helplessness" to describe the interference in acquisition of escape-avoidance responses of dogs which had been exposed previously to uncontrollable electric shock. When these dogs were placed in controllable-shock conditions, they acted as if the shock was still uncontrollable. It was argued that the deficits in response initiation and response-reinforcement associations resulted from the dogs learning that responding and reinforcement were independent, that is, that their behaviour was not effective in controlling the aversive stimuli and they were "helpless" in that situation (Seligman, Maier and Solomon, 1971). Subsequent laboratory studies demonstrated that "helplessness" could be reliably induced in both animals and humans who are subjected to a variety of forms of uncontrollability (Miller and Seligman, 1975; Seligman, 1975).

Learned helplessness theory claims that the helplessness produced in the laboratory is a model for naturally occurring depression in humans and that the characteristic features of depression result from learning that outcomes are independent of the individual's actions (Abramson, Seligman and Teasdale, 1978; Seligman, 1975). In this framework, a perception of no control is no longer seen as a symptom of depression but, rather, as its most fundamental cause (Watson, 1977).

Learning that outcomes are uncontrollable is said to result in motivational, cognitive and emotional deficits – retarded initiation of voluntary responses (passivity), later difficulty in learning that responses will produce the outcome currently seen as uncontrollable (negative cognitive set), and depressed affect (Abramson, Seligman and Teasdale, 1978). Such a description is very similar to the cognitive triad Beck (1967, 1976) described as characteristic of depression in adults and to the negative cognitive biases which have been shown to be prominent in depressed adolescents (see, for example, Gencoez, *et* al, 2001; Marcotte, 1996; Marton, *et* al, 1993; Neshat-Doost, *et al*, 1998).

Dweck (1977) argued that the learned helplessness model of adult depression is also applicable to children and adolescents. She noted that adolescence is a period of increasing pressure to take responsibility for outcomes and suggests that, with the accompanying cognitive development, once helplessness cognitions are triggered, they may lead to a perception of generalized helplessness.

1.3. The Experience of Helplessness and Attempts to Reassert Control

At the same time, helplessness is not the inevitable result of being exposed to uncontrollable situations. Indeed, behaviour quite the opposite from helplessness has been observed. Roth and Bootzin (1974) found that subjects exposed to a laboratory situation designed to induce helplessness made more attempts to control a subsequent aversive stimulus than control subjects. Similarly, Roth and Kubal (1975) demonstrated that both facilitation and helplessness effects occur as a

function of amount of exposure to helplessness conditions. It was argued that when people's expectations of control are threatened, they may be motivated to re-establish control, so that an initial reaction to no control is to behave assertively to regain control (Roth and Bootzin, 1974). Thus individuals' generalized expectancies of control may interact with situationally determined expectancies to determine their responses to uncontrollable situations (Roth and Bootzin, 1974; Roth and Kubal, 1975).

Pittman and Pittman (1979) showed that, in mild helplessness conditions, internals' task performances were much improved while the performance of externally oriented subjects deteriorated. On the other hand, internals reported themselves as being significantly more depressed at high levels of helplessness than externals in the same situation. Pittman and Pittman (1979) concluded that individuals who initially expect control will attempt to reassert control after mild experiences of uncontrollability, but will eventually evince helplessness when exposed to extensive uncontrollability.

Dweck and Repucci (1973) studied children's differing reactions to failure experiences as a function of their general control expectations. They found that, while the youngsters designated as internals persisted with the problem-solving task, external children became passive, demoralized and effectively incapable. Dweck (1977) suggests that the "non-helpless" children saw their failures as owing to some easily modifiable self-aspect and used failure as a cue to use other strategies to solve the problem.

A study by Lamond (1982) is most instructive in this regard. The study was designed to investigate the concept of masked depression as it related to delinquent acting-out behaviour in early adolescence. A sample of 64 delinquent and 29 clinically depressed female and male adolescents aged 12 to 16 completed the Children's Depression Scale (CDS) (Lang and Tisher, 1978) and the Nowicki-Strickland Locus of Control Scale for Children (Nowicki and Strickland, 1973). In addition, 169 high school students aged 12 to 16 completed the locus of control scale as a control group.

Scores on the CDS showed that the delinquent males and females were as depressed as their clinically depressed counterparts, but differed in their experiences of depression – the delinquent youngsters reported themselves as being significantly more able to experience pleasure and likely to have more positive feelings of self-worth, while they experienced more intense feelings of guilt.

Clinically depressed males were significantly more external in their locus of control orientation than both delinquent and control males, while clinically depressed, delinquent and control females shared similar, more external control expectancies. A significant positive relationship between externality and level of depression was found for males but not for females.

The findings were interpreted as providing support for the proposition that clinical depression and delinquent behaviour are variable manifestations of a depressive underlay, representing alternative responses to similar underlying causes, with expectancies of control over the environment appearing to play a role in the choice of behavioural adaptation (Lamond, 1982).

The theme of the perceived inability to influence events and social conditions that significantly affect one's life, is picked up by Bandura (1997:153*ff*), when he seeks to explain people's sadness and despondency as a function, at least in part, of their "perceived inefficacy to gain highly valued outcomes".

Bandura (1997:160) goes on to observe that adolescence is a critical period of development placing simultaneous heavy demands on the management of stressful biological, educational and social changes, and reports that those who believe they cannot manage scholastic demands and form and maintain satisfying peer relationships suffer frequent bouts of depression. Other researchers highlight that subsequent depression appears to be the result of a significant interaction between this kind of negative cognitive set and negative life experiences of adolescents (see, for example, Gladstone and Kaslow, 1995; Joiner, 2000; Joiner and Wagner, 1995; Robinson, Garber, and Hilsman, 1995). The AHTA (2010:46) evidence review also reports on demonstrated links between self-esteem "involv[ing] beliefs about ones' abilities and values … [and] … themes of self concept, shame, self criticism and worthlessness" (2010:46), such that "[a]dolescents and young adults with low self esteem are at an increased risk for developing depression, depressive symptoms or suicide attempts compared to their peers with high self esteem … [while] … [h]igh self esteem is a protective factor for depression, depressive symptoms or suicide attempts" (2010:48).

1.4. Intentional self-harm and suicidal behaviour as attempts to reassert control in the face of perceived helplessness and inefficacy

As noted above, the disruptive behaviour, low self-esteem, low quality relationships, and stressful negative life events, identified as "good" predictors of adolescent depression and suicide (AHTA, 2010:33-36), are also the key elements that bring young people to YIF. We understand and respond to the adolescent's experience of helplessness and inefficacy in the context of an appreciation of the variant experience of depression in adolescence. In other words, we understand intentional self-harm and suicidal behaviour as attempts, albeit dysfunctional ones, on the part of these young people, to reassert control over their lives. This view, which informs the logic of our program of supported peer-to-peer empowerment, has been arrived at via an evidence based, theoretically informed interpretation of our engaged experience with young people over the last 30 years. The *gestalt* of understanding we have developed during this time is reflected in the efficacy of the therapeutic intervention, which we discuss in regard to issue 7.

3. The barriers that prevent children and young people from seeking help.

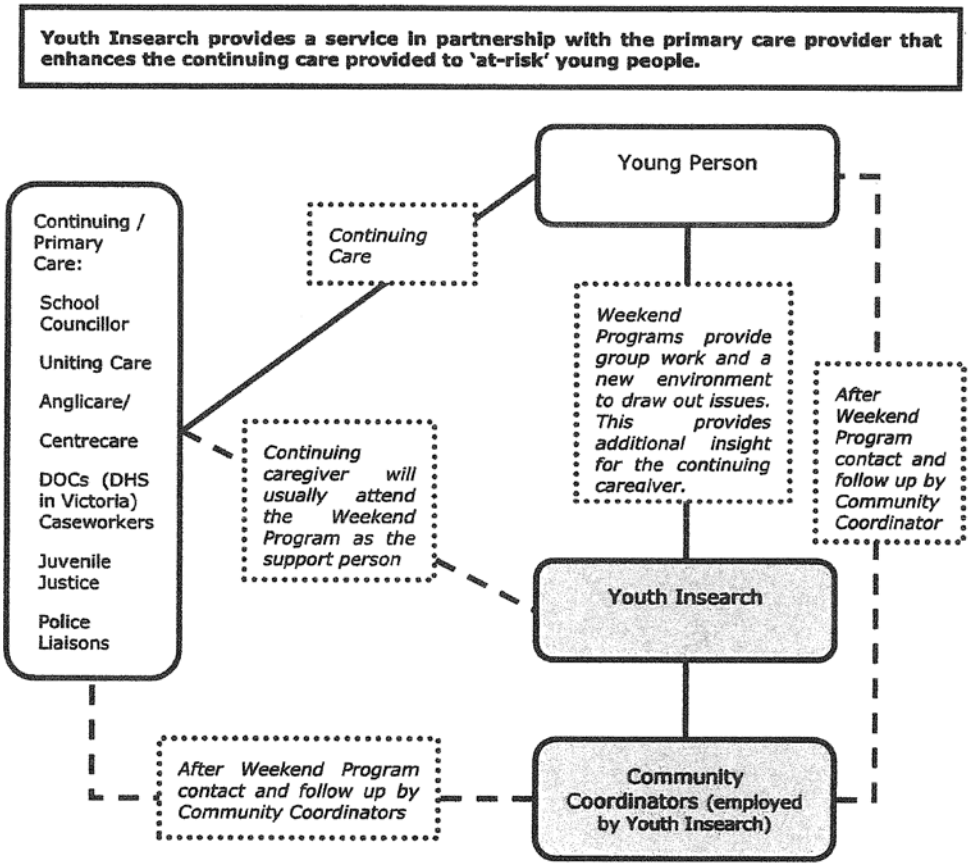
There will be many submissions discussing the psychological and social barriers to children and young people accessing supportive services in a timely manner. Accordingly we would like to focus on two others from our experience – the bureaucratic and budgetary.

Many have tried to put our program into a variety of pre-determined treatment/intervention modality boxes, and it is tempting to allow that to happen, as it saves the effort of developing an exposition of what we do and how/why we do it. It also affords us a place in the 'mainstream' according to those same boxes. We have resisted doing so, however, primarily because we do not fit neatly into one of those

boxes. We eschew a "one best way" approach to working with young people. Rather, we define our program as a "peer-to-peer empowerment" model of intervention, which has its own legitimate theoretical underpinnings, drawing on an eclectic but nonetheless internally consistent and integrated set of associated therapeutic intervention modalities (see the exposition in relation to Issue 1).

As we noted in our introduction, over the last 30 years, the Foundation has sought to be a collaborative, complementary service, working at the nexus of the existing range of government agencies and third sector organisations involved in the provision of health, welfare, education and juvenile justice services for young people at-risk (see Figure 1). Indeed, when our program was first evaluated in 2003, the report was commissioned by the Crime Prevention Division of the NSW Attorney General's Department, with funding provided by the NSW Attorney General's Department, NSW Premier's Department, Office of Children and Young People, The Cabinet Office (NSW), NSW Department of Health, NSW Department of Education and Training (DET), NSW Department of Community Services (DoCS), NSW Department of Juvenile Justice (DJJ). The Steering Committee formed to oversee the evaluation, included representatives of each of these agencies, as well as the Commission for Children and Young People (Rintoul and Wilczynski, 2003:1).

Figure 1: Youth Insearch in Context (adapted from Walter Turnbull, 2009:12)



Notwithstanding strong endorsement from the evaluators, there was no funding forthcoming from any of the NSW government departments, presumably on the basis

that, on the one hand, YIF did not fit neatly into one of the Departments' funding program. On the other hand, Youth Insearch also provides its services interstate, with our program extending to Victoria and Queensland, and it would not be reasonable for NSW funding to be funnelled interstate.

We were pleased to begin receiving Commonwealth government funding in 2004 and, by the end of June 2015, YIF will have successfully acquitted nearly $3.7m. The two main sources of funds have been the *Stronger Families – Local Solutions* and the *Community Investment – Youth Support* programs.

In 2004, YIF received from the Commonwealth Government, through its *Stronger Families* initiative, $1 million over four years to employ eight (8) Community Coordinators (four (4) in NSW, three (3) in Queensland, and one (1) in Victoria) each on a 20 hour per week basis). Notwithstanding the success of the Community Coordinator positions over the life of the initial funding (see here particularly the evidence from the Urbis review of 2008), a combination of the Global Financial Crisis (GFC) (with the attendant reduction in corporate and private sponsorship), and subsequent "maintenance" funding from the *Youth Support* fund, has meant that only 3 Community Coordinators (one in each of Queensland, NSW and Victoria) have been employed as part of the current funding round. As the Urbis Report (2008) anticipated, one impact of this has been the significant reduction in the number of Weekend Programs that have been possible.

The Australian Government is investing over $100 million over the next decade to 2022 in the *Youth in Communities Program*, a major youth initiative that is helping thousands of young Indigenous people in the Northern Territory become more engaged with school, work and community life (Department of Social Services (DSS), 2013a). In its 2012 evaluation of the *Youth in Communities* (YIC) program, Courage Partners (2012:3) reported "good" outcomes for YIC participants, supporting improvements in well-being and positive life choices. Even a cursory examination of the findings of the Youth Insearch evaluations outlined above shows that Youth Insearch has consistently produced "good" and better outcomes for its participants over several decades. As such, reinvestment in our programs would represent good value for money, yet, one year from the end of the current funding round, it is still unclear what, if any funding program will replace the *Youth Support Fund*.

Ideally, an inter-governmental task force, bringing state and federal agencies together would be formed to determine a comprehensive, multifaceted and integrated approach to supporting agencies and strategies that don't fit neatly into one or another bureaucratic box or funding bucket.

4. The conditions necessary to collect comprehensive information that can be reported in a regular and timely way and used to inform policy, programs and practice.

At the moment, various amounts of service provider budgets are tied to securing evaluations on a consultancy basis. While that part of the process is (more or less) funded, depending on the economies of scale and scope of the individual service providers, the resources necessary for collecting, storing and analysing relevant client and intervention data are not. This raises then, the possible roles of Australian Government agencies, such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

It appears to us that, on a value for money basis, a coordinated approach to evaluating the range of service providers, and the services they provide, would be a significant improvement on what, at the moment, appears to be a largely uncoordinated and "patchy" (in quality terms) approach to the collection of information. Notwithstanding the impediments to the accurate identification and recording of intentional self-harm and suicide in children and young people, it is vital that valid and reliable data are collected, aggregated and analysed in order for a deeper understanding of the problems we are seeking to address to be derived, and a more accurate and consistent evaluation of the subsequent intervention strategies to be established.

5. The impediments to the accurate identification and recording of intentional self-harm and suicide in children and young people, the consequences of this, and suggestions for reform.

Again we anticipate there will be many submissions concerning the psychological and social impediments to accurately identifying and recording intentional self-harm and suicide in children and young people. Accordingly we would like to highlight administrative and resource-linked issues, tying in with our commentary in 4. above, that we have identified.

First, and so far as we are aware, there is no nation-wide approach to a classification-based data collection system that would assist in accurate identification and recording. Developed in connection with the data gathering in 4., a common intake/reporting form (preferably in electronic/soft copy version) would significantly improve the capacity to validly and reliably identify and record incidents and incidence of intentional self-harm and suicide, in a timely, efficient and sustainable manner.

The gathering, storing and analysis of this information need to be resourced and so an appropriate budget line item needs to be identified. Given that funds are made available for contracting out evaluation requirements, an aggregation and reallocation of those funds, such they are shared between the service providers (for data gathering) and the relevant Australian Government agencies, such as the Australian Bureau of Statistics and the Australian Institute of Health and Welfare (for data analysis and aggregated reporting purposes), would appear to be a more effective and efficient way of gaining access to the required knowledge and information.

6. The benefit of a national child death and injury database, and a national reporting function.

In their *National Action Plan for Child Injury Prevention* (CDCP, 2012:11-13), the U.S. Centers for Disease Control and Prevention identified six domains that constitute their blueprint for action – data and surveillance, research, communication, education and training, health systems and health care, and policy.

It is no accident that the data and surveillance domain is listed first, highlighting as it does the foundational importance of a national reporting function and database to the other domains, in particular the research, intervention and education activities such information informs. As the report states:

> **Systematic surveillance is essential for accurate needs assessment. Only with good data can one estimate the relative magnitude of problems in order to set**

priorities. Current data collection systems are imperfect and incomplete. Better data can lead to better decisions, increased effectiveness (doing what works) and efficiency (avoiding waste). This plan calls for better data standardization (so that it is comparable across geography and time), better data quality (so that it is reliable and believable), and filling gaps (information about circumstances of injury events, outcomes, costs, and information that is local and community-specific). Information systems must allow for making existing data more available to those who can use and share it to design and implement interventions.

Some of the actions include developing an online access to key databases, collecting better data on the costs of injury, improving links between police, hospital, and emergency department data, and standardizing data collection and reporting.

(CDCP, 2012:11)

We leave for others more expert to comment on the quality of the current data, although noting our earlier comments on the apparent absence of a systematic approach to evaluation of current interventions. Rather we affirm our support for the importance of better data and their impact on better decisions.

7. The types of programs and practices that effectively target and support children and young people who are engaging in the range of intentional self-harm and suicidal behaviours.

In response to issue 1., we sought to explain our understanding of why children and young people engage in intentional self-harm and suicidal behaviour. We noted that the disruptive behaviour, low self-esteem, low quality relationships, and stressful negative life events, identified as "good" predictors of adolescent depression and suicide (AHTA, 2010:33-36), are also the key elements that bring young people to YIF. We understand intentional self-harm and suicidal behaviour as attempts, albeit dysfunctional ones, on the part of these young people, to reassert control over their lives. This view informs the logic of our program of supported peer-to-peer empowerment. We take the opportunity here to highlight the success of our programs, based on external evaluations of our interventions.

2003 Urbis Keys Young Report

Commissioned by the Crime Prevention Division of the NSW Attorney General's Department, the Urbis Keys Young evaluation was designed to answer four questions:

(a) Were the participants "at-risk" (did they meet the target group criteria)?

(b) Did the program have a positive impact on behaviours such as suicide, interpersonal violence, criminal activity, and drug abuse?

(c) Did the program have a positive impact on mental health measures such as self-esteem, hopelessness, anxiety, depression and stress?

(d) Was there evidence that any improvements were sustained over time?

Commencing at the individual young person's point of referral, the Urbis Keys Young evaluation examined the characteristics of participants in two YIF programs, assessed their progress during and at the completion of the programs, and assessed their progress in a six-month follow up. In summary, the Urbis Keys Young evaluation:

(a) confirmed that young people involved in YIF activities meet the target criteria of being "at-risk" (Rintoul and Wilczynski, 2003:65-66). The percentages below indicate the incidence of each risk factor among the young people in the sample:

- living with extended family, in a blended family, with adoptive/foster/step parent(s), with one natural parent only, or in a refuge, shelter or hostel (70%)
- having a bad relationship with their family (25%)
- having a bad relationship with their friends (3%)
- not currently undertaking any education (26%)
- having left school before completing Year 10 (25%)
- thinking that they will not undertake any further/non-school education (11%)
- drinking alcohol a few times a week or every day (30%)
- getting drunk once a week or more frequently (34%)
- taking drugs once a month or more frequently (30%)
- getting drunk/taking drugs in order to not feel so bad about problems in their life, to escape reality, to forget, or because they feel empty and lonely (33%)
- having been in trouble with the police (64%)
- having low self esteem (Rosenburg score of 15 or below) (41%)
- having physically hurt themselves (58%)
- having had suicidal thoughts (60%)
- having tried to end their life (44%)
- receiving counselling for problems in their life, or feeling that counselling would help them (43%)
- being in contact with their school/TAFE counsellor (38%)
- being in contact with a DJJ worker (16%)
- being in contact with a DoCS worker (22%)
- being in contact with a social worker from elsewhere (i.e. not DoCS, DJJ, school or TAFE) (27%)

(b) Identified the elements of the YIF activities that decrease risk and build resilience of "at-risk" young people, as identified in the *Better Futures* framework (Rintoul and Wilczynski, 2003:69-71) :

- *Focus on well being*: Youth Insearch takes a holistic approach to working with young people, accepting a wide range of at-risk young people onto the programs, and encourages participation in every session at the program, not just those that appear to be most immediately relevant. The atmosphere of the program has as much influence as the content of the sessions. Further, the sessions that encourage communication and a safe family-like

environment are seen as equally as effective as some of the more serious sessions.

- *Prevention*: In many cases, young people are reported to become more receptive to offers or sources of assistance, friendship and support after their involvement in Youth Insearch, both from people who were on the program and also others in their community or family.
- *Accessibility*: Young people reported the 'look and feel' of Youth Insearch as very much youth-focused and youth-friendly. The programs are also very inclusive, with considerable efforts made to provide access to young people with physical disabilities, to those who would not be able to afford the program, those who are otherwise socially isolated, and so on.
- *Participation*: Youth Insearch is based on a very high degree of youth participation in all aspects of their activities (e.g. internal administration, program organisation, session facilitation). Indeed, Leaders and Support Adults indicated that youth involvement is one of the elements that set Youth Insearch apart from other programs for at-risk young people.
- *Quality*: While this was the first external evaluation of Youth Insearch's core program, young people at the end of each program complete evaluation questionnaires, and an annual review of activities is carried out with all Youth Leaders.
- *Minimal disruption*: Youth Insearch specifically aims to embed young people in local supports and to engage fully with their existing supports. The requirement for young people to be accompanied by a Support Adult is evidence of this, and is unusual for youth programs.
- *Early intervention*: Some of the difficulties faced by young people on Youth Insearch programs are in their 'early days'. Young people in these situations often report being strongly effected by seeing '*what might happen to me down the track*' and are motivated to divert themselves from that course. Those with more deeply entrenched problems, however, tend to use Youth Insearch programs in other ways – as an anchor, or a turning point.
- *Supporting service providers*: Youth Insearch provides a one-year training program for new Youth Leaders and ongoing training for existing Youth Leaders.
- *Collaboration and partnership*: Youth Insearch is in regular dialogue with a range of agencies that work with young people (government and non-government), particularly as sources of referral *into* the programs. Referral *from* the programs to external agencies is more limited, as Support Adults who attend with young people are typically responsible for such matters.

(c) Participation in YIF programs and follow up groups has a positive impact on young people's social behaviour and well-being over time (Rintoul and Wilczynski, 2003:67). The follow-up surveys of young people and Support Adults clearly suggest that, both immediately after the program and six months later, this group of young people:

- had higher self esteem

- had improved relationships with family
- had stable relationships with friends and were still in close contact with friends from program
- had stable educational attendance
- had more positive attitudes to current education and to future education
- were drinking alcohol less often, getting drunk less often and taking drugs less often
- were less violent and less involved in illegal behaviour.

In summary, then, the Urbis Keys Young evaluation concluded that the YIF program experiences provided to "at-risk" young people, were, *prima facie*, designed to decrease risk and build the resilience of those young people and, more importantly, had a positive impact on young people's social behaviour and well-being over time.

Urbis Report 2008

Under the *Stronger Families, Local Answers* funding program of the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA; previously the Department of Family and Community Services). Youth Insearch Foundation set aside a budget for external evaluation of the Program, with particular focus on the impact of the funding. The aims of the evaluation were to:

- collect new information and evidence that is not already gathered by Youth Insearch Foundation as part of its internal evaluation routine
- analyse this new data alongside results from Youth Insearch Foundation's internal evaluation activities
- make an independent assessment of:
  - the extent to which Youth Insearch Foundation is meeting its intended outcomes with at-risk young people
  - which elements of the program have delivered the best return on investment
  - the impact of FaHCSIA's funding (i.e. the Youth Liaisons) on Youth Insearch Foundation's operations
- articulate lessons that have been learned by Youth Insearch Foundation and the Youth Liaisons over the funding period
- identify possible future directions for Youth Insearch Foundation, particularly with regard to the role of Youth Liaisons.

Based on self-report surveys of program attendees for 2005, 2006 and 2007, the evaluation established that:

- Youth Insearch Foundation continues to target young people aged twelve to eighteen, who have experienced, or are experiencing, problems stemming from issues such as experimentation with drugs and alcohol, broken or dysfunctional homes, sexual or physical abuse, grief or other traumatic events.

- Those attending the programs have been a similar mix of gender, age, cultural background, education status and employment status (55% female, 23% ATSI, 81% attending school, 9% unemployed) 18% living with both natural parents).
- One in two (50%) young people reported experiencing physical abuse before their first program, and three in ten (30%) reported experiencing sexual abuse.
- The programs are attended by young people who are dealing with a wide range of issues, from anger (61%) and depression (41%) to drug and alcohol abuse (27%), violence (28%) and homelessness (4%).
- There is a relatively high prevalence of drug use (16% at least once a week) and alcohol use (56% at least once a month) and of a perpetration of violent behaviour (62%) and crime (egg theft 43%, vandalism 33%) among young people attending the programs.
- One in two (50%) of the program attendees reported having suicidal thoughts prior to their first program, and one in three (32%) reported having attempted suicide.

At the end of each program the young people are asked how Youth Insearch Foundation has helped them. The responses indicate a broad range of positive immediate outcomes from the programs, in particular making new friends (88%) and meeting others with similar problems (69%), feeling loved (66%) and respected (64%) as well as feeling respect for others (64%) and having support (63%). A small number (less than 5%) of young people, however, report negative outcomes.

In addition to these immediate outcomes, the results also show:

- 22% of young people had committed a crime prior to participating in the program. Following the program, only 7% stated that they would commit another crime.
- with regard to increased school and university attendance after program attendance, 25%-30% decided to stop 'wagging' school, 13%-18% decided to go back to school, and 12%-17% decided to go to TAFE or university.
- of those attending a subsequent program who had acknowledged that they had been physically violent before their first program, only between one-third and half of these (34%-48%) claimed they were still physically violent.
- there were reductions in the use of non-prescribed drugs, in alcohol consumption and cigarette consumption among those who used these substances prior to attending program
- whereas at the end of their first program, between 29% and 37% of young people had reported having attempted suicide prior to coming to program, at the end of *subsequent* programs, only 10%-14% of young people reported that they had attempted suicide in the time since their previous program.

Australian Institute for Family Studies 2012

The Australian Institute for Family Studies, through the Child Family Community Australia (CFCA), has listed Youth Insearch programs in its *Promising Practice*

Profiles (PPP) as examples of best practice or "what works" to improve outcomes for children and their families. PPP was implemented a part of a national evaluation of the Stronger Families and Communities Strategy 2004-2009, which provided funding for YIF's programs. The aim of the profiles is to identify, document and disseminate descriptions of effective practices in early childhood, early intervention and community development.

The PPP describes the Youth Insearch Program and Youth Insearch Leadership as "positive example[s] of an early intervention practice targeting 'at risk' young people through peer support, mentoring and leadership opportunities" (CFCA, 2012a:7-8; 2012b:9).

8. The feasibility and effectiveness of conducting public education campaigns aimed at reducing the number of children who engage in intentional self-harm and suicidal behaviour.

In responding to this issue, we note that, as Suicide Prevention Australia's (SPA, 2010:9) position statement on youth suicide prevention observes, empirical evidence regarding the effectiveness of particular youth suicide prevention programs remains largely absent. The statement goes on to say that, while many studies have been undertaken, methodological and evaluation techniques have not always been sophisticated. The recent House of Representatives Standing Committee on Health and Aging (2011) *Before it's too late* report on early intervention programs aimed at reducing youth suicide made similar observations. The report included a series of recommendations seeking to improve the quality of data available and the consistency of evaluations undertaken.

That being said, as we noted in response to the previous issue, our Youth Insearch Leadership has been described as a "positive example of an early intervention practice targeting 'at risk' young people through peer support, mentoring and leadership opportunities" (CFCA, 2012b:9). A similar program to our leadership program is the *Alive and kicking goals!* Project, based in the Kimberley, Western Australia, that aims to reduce the high suicide rate among Aboriginal and Torres Strait Islander youth through peer education workshops, one-on-one mentoring, and counselling (AIHIN, 2013). Like the Youth Insearch programs, the Kimberley project:

> **involves a range of activities delivered by staff and volunteer youth leaders to their peers. Young people are educated about suicide prevention, positive lifestyle choices, and hope about the future. *Alive and kicking goals!* delivers its peer education program at community events, schools, and in community settings. Training, education, and support are offered to young men and women who volunteer to be peer educators for the project. Many of the projects clients are now non-Aboriginal students in the school and counselling settings.**
>
> AIHIN, 2013

We strongly support the development and expansion of programs similar to those of the Foundation and the Kimberley project, along with the range of universal prevention measures identified by SPA (2010:9-12) – school-based programs, anti-bullying programs, physical health promotion, online and new media information and education programs, tertiary education, apprentice and early career-based programs, socio-economic programs, media education and restricting access to means.

9. **The role, management and utilisation of digital technologies and media in preventing and responding to intentional self-harm and suicidal behaviour among children and young people.**

As information and communications technologies (ICTs) have continued to develop, their engagement in the provision of a range of health services, including mental health services has grown significantly. In its *E-Mental Health Strategy for Australia* (Department of Health and Ageing, 2012:12), the Federal Government identifies as a key area for action a "youth-focused telephone and online counselling service … intended to enable young people aged 12-25 to access e-mental health services that are specifically designed for their needs and ways of communicating". The following are some of the websites to which young people, and those concerned about young people, can access:

http://www.headspace.org.au/
http://www.youth.gov.au/sites/youth/ayf
http://www.familyrelationships.gov.au/Services/FRAL/Pages/default.aspx
http://education.gov.au/youth
http://www.youth.gov.au/sites/youth
http://www.youthbeyondblue.com/
http://australia.gov.au/people/youth

We see great value in these services in the same way as highlighted in the e-mental health strategy and by SPA (2010:11). Further though, we think added value could be brought to these services in the role of referral/brokerage, identifying local services based, say on the young person's postcode, so that there is a useful interlinking between these and the face-to-face services that are available.

We also share SPA's (2010:11) concern that increased youth e-literacy can create knowledge and understanding gaps between young people and adults. Accordingly, wider availability of training/awareness programs for relevant adults would also be a valuable addition to the strategy.

Thank you for the opportunity to make our contributions to this vital conversation. We do hope they are seen as positive and useful, and we look forward to further interaction as required.

In the meantime, in the following section, *Interventions for Young People "At-Risk": The Unique Role of Youth Insearch*, we provide an overview of the role that Youth Insearch has played in working with at-risk young people over the last three decades.

Interventions for Young People "At-Risk": The Unique Role of Youth Insearch

Over the last 30 years, the Youth Insearch Foundation (YIF) has sought to be a collaborative, complementary service, working at the nexus of the existing range of government agencies and third sector organisations involved in the provision of health, welfare, education and juvenile justice services for young people at-risk. During this time, we have worked hard to develop a clear articulation and documentation of our program's theoretical framework, to assist in continual improvement of our services, to increase transparency and to provide a clear evidence base for the benefit of external parties (e.g. Support Adults, potential funding agencies).

This submission is designed to present the theoretical framework and evidence base that underpins the Youth Insearch Program and, in so doing, to respond specifically to the issues raised by the National Children's Commissioner in her examination of how children and young people under 18 years can be better protected from intentional self-harm and suicidal behaviour. The evidence presented here is taken from earlier and concurrent research results concerning intervention programs for vulnerable young people, and evaluations of the Youth Insearch Foundation carried out by Urbis Keys Young, designed to investigate the efficacy of the Youth Insearch Program in meeting its stated objectives for at-risk young people. We present some wider research results first in order to provide a context within which to read and appreciate the findings for YIF.

2. "At Risk" Adolescents – At risk of what?

Being an adolescent is tough, with the experience of mental health problems being significant (AIHW, 2007). A World Health Organisation (WHO) study of 120,000 students in 28 countries has reported significant numbers experiencing depressive affect ("feeling low") on a weekly basis (average 25%), often feeling lonely (average more than 10%), and feeling tired most days of the week (average 22%) (Scheidt, et al, 2000:25-28). In Australia, 15% to 20% of adolescents report experiencing significant levels of psychological distress (NSW Health, 2004:31) or "mental health problems" (Sawyer, *et al*, 2000; ABS, 2007). The NSW Department of Health (1999:16) points out that young people with psychological or emotional difficulties may also have other issues – alcohol and drug use, homelessness, a history of physical or emotional abuse, a history of mental illness, recent loss – which impact on their mental health and may place a young person at increased risk of suicide.

At the same time, as the Urbis Keys Young evaluation report for YIF points out, the widespread use of the term *at-risk* is somewhat problematic, because it is not always immediately apparent as to what the young person might be at-risk *of* (Rintoul and Wilczynski, 2003:65). The report makes reference to the fact that each of the NSW government agencies involved in the evaluation had its own implicit definition, shaped by the scope of its mandate, noting that the NSW Commission for Children and Young People, for example, takes a broad definition:

> *'Risk factors act alone or in combination to undermine a young person's connection to family, school or community. For example, factors such as depression or anxiety, disrupted family circumstances, learning difficulties*

and being unwelcome at home can work against successful connections with the family, school and community.'

In light of such a definition, the ultimate disconnection from family, school and the community must surely be found in the death of the young person. Indeed, suicidal behaviour in adolescence is a major worldwide problem. In Australia, in 2003, death by suicide accounted for 19.9% of total male deaths and 13.1% of total female deaths registered in this age group (Australian Bureau of Statistics (ABS), 2004). In the United States, the number of adolescent deaths from suicide has increased dramatically during the past few decades such that suicide is now the third leading cause of death for adolescents 15 to 19 years old (Committee on Adolescence of the American Academy of Pediatrics (CAAAP), 2000).

The "good news" on adolescent suicide in Australia is that the suicide rate for persons aged 15-19 was lower in 2003 than for any year in the previous decade, 1993-2002 (ABS, 2004). This reflected a continuing overall decrease in suicide rates since the peak in 1997. Indeed, over the 10 years from 2001 to 2010 the crude rate of suicide for males 15-24 years of age decreased from 20.4 to 13.4 deaths per 100,000 population (ABS, 2012). At the same time, suicide remains a major problem for this age group. More generally, suicide continues to be a major public health issue, involving substantial human and economic costs (ABS, 2004). Meanwhile, recent Australian hospital statistics (AIHW, 2012) reported just over 10,000 incidents involving 14-24 year olds (at a ratio of 7 male to 3 female). Similar data are not available for males aged 5 to 14, but there were 690 incidents involving females in the 5 to 14 year age group.

2.1. "At Risk" Adolescents – The warning signs

In a summary of the research literature to that point, the CAAAP (2000) provided a list of the identifying the characteristics of adolescents at risk of suicidal behaviour, *viz*: a history of depression; a previous suicide attempt; a family history of psychiatric disorders (especially depression and suicidal behaviour); family disruption; certain chronic or debilitating physical disorders or psychiatric illness; alcohol use and alcoholism; living out of the home (in a correctional facility or group home); a history of physical or sexual abuse; and psychosocial problems and stresses, such as conflicts with parents, break-up of a relationship, school difficulties or failure, legal difficulties, social isolation, and physical ailments (including hypochondriacal preoccupation). The Committee (2000) also reported that gay and bisexual adolescents exhibit high rates of depression, with rates of suicidal ideation and attempts, while the broader context within which adolescents are embedded also is involved, where long-term high levels of community violence contribute to emotional and conduct problems and add to the risk of suicide for exposed youth (see also, Boardman's and Saint Onge's (2005) findings regarding the influence of neighbourhoods on risk behaviours, educational outcomes, and adolescents' integration within their families, schools, and churches).

In Australia, a similar set of factors - a socio-economically disadvantaged background, childhood physical or sexual abuse, poor parent-child relationships, loss of a parent through separation or divorce, suicide or violence in the family, or experience in the family of imprisonment, mental health problems or harmful drug use – are recognised as placing young people at risk (Commonwealth Department of

Health and Aged Care, 2000: 8; see also Queensland Commission for Children and Young People and Child Guardian, 2005:101). An analysis of situational circumstances and risk factors of identified suicides of children and young people by the Queensland Commission for Children and Young People and Child Guardian (2005:105—7) reaffirms the wider research evidence, as does a more recent evidence review of depression in adolescents and young adults by the Adelaide Health Technology Assessment (AHTA, 2010), on behalf of *beyondblue*.

On the other hand, such factors as strong connections to family and school; good mental and physical health; personal skills such as relationship and problem-solving ability, coping skills, a sense of hopefulness and an internal locus of control; social support and community connectedness; and the absence of guns in the house have been shown to protect young people against suicidal behaviours (Commonwealth Department of Health and Aged Care, 2000: 8; see also Queensland Commission for Children and Young People and Child Guardian, 2005:108; AHTA, 2010).

3. State and Federal Government Programs

The tough life of an adolescent is compounded by the fact that young people tend to be poorly informed about mental illness such that, when they have a mental health problem they seek assistance from family and friends or try to sort things out themselves, rather than seek professional help from mental health services (NSW Health Department, 2001:3). As the *Getting in Early* report from the NSW Department of Health (2001:4), pointed out, collaborative links between mental health services and the other services which young people access have long needed to be strengthened to improve their access to mental health services. Indeed, recognising the need for integrated service provision, the health and education agencies in NSW developed a "strong and effective partnership" (NSW Department of Health, 2003:i), while several States adopted an explicit "whole of government" approach, (see, for example, NSW Health, 1999; Queensland Government, 2003a,b; Success Works, 2003).

Efforts to address the problem of youth suicide on a national level began during the 1990s and, in 1995, these efforts were amalgamated into the *National Youth Suicide Prevention Strategy*, with the long-term twin aims of reducing rates of suicide and self-harming behaviours among young people and increasing the resilience and connectedness of young people (Commonwealth Department of Health and Aged Care, 2000:9). The importance of addressing these issues is underpinned by the recognition that mental health problems not only cause substantial distress to young people, their families and carers, but also that, when mental health problems are left untreated, there are increased demands on welfare, education and juvenile justice resources (NSW Department of Health, 1999:16).

Noting that the World Health Organisation had contemporaneously predicted that depression, with its effect on quality of life, relationships, personal function and health services utilization, would constitute the largest burden by 2020, Scanlon, Williams and Raphael (1997:17) argued for the incorporation of prevention and health promotion approaches in mental health and presented a conceptual framework to guide the development of relevant initiatives in NSW. In doing so, they pointed to the evidence suggesting that, in developing interventions to target the key mental health problems and disorders affecting children and young people, targeting generic risk

factors common to many mental health problems may be more beneficial than targeting specific risk factors alone. Based on the generic risk factors, Scanlon, *et al* (1997:28) thought that the following issues could be targeted:

- Key support people
- Parenting skills
- Resilience and competence
- Psychosocial development
- Parental discord
- Loss in childhood
- Child abuse and violence
- Stressful life events, including injury or chronic physical illness, hospitalisation, witness to violence and transition periods
- Substance use and abuse
- Children of parents with a mental illness
- Early identification of and intervention in, particularly, conduct disorders, depression/anxiety and early psychosis.

The Commonwealth Government (2000) attempted to provide a description of the many programs, organisations and governments with an interest in or a potential overlap with suicide prevention activities. The range of Australia-wide programs that it brought under this rubric in addition to the National Youth Suicide Prevention Strategy, the National Suicide Prevention Strategy and the National Mental Health Strategy – drugs and alcohol, public health, sexuality and sexual health, health and well-being of Aboriginal and Torres Strait Islander peoples, people in rural and remote areas, health services and primary health care, older Australians, culturally and linguistically diverse people, families and social well-being, homelessness, child abuse and accommodation support, family law, crime prevention and firearms reform, young people and education, income support, employment programs, Vietnam veterans – shows not only the range of resources that touch on intervention in suicidal behaviour, but also the range of risk factors that are recognised and being addressed.

The Commonwealth Government was given direction for its interventions into the 21st century through the *Living Is For Everyone (LIFE): a framework for prevention of suicide and self-harm in Australia* document (Commonwealth Department of Health and Aged Care, 2000), which provided a four-year strategic framework for national action "to alleviate suicide and promote mental health and resilience across the Australian population. It was concerned with suicide in all age groups, with a particular focus on young people and young adults, for whom the loss of life years and potential is so great" (Commonwealth Department of Health and Aged Care, 2000:1).

The LIFE Framework provided a set of principles for effective suicide prevention that informed its development:

- Suicide prevention is a shared responsibility across the community, professional groups, non-government agencies and the government sectors.
- It requires a diversity of approach, targeting the whole population, specific population subgroups and individuals at risk.
- It must be evidence-based and outcome-focused.

- It must incorporate community and carer involvement and expert input.
- Activities must be accessible to those who need them, and appropriate and responsive to the social and cultural needs of the groups or populations they serve.
- They must be sustainable, to ensure continuity and consistency of service for communities, and evaluation must be an integral part.

(Commonwealth Department of Health and Aged Care, 2000:17)

With these principles in mind, the LIFE Framework identified six areas for action:

1. Promoting well-being, resilience and community capacity across Australia.
2. Enhancing protective factors and reducing risk factors for suicide and self-harm across the Australian community.
3. Services and support within the community for groups at increased risk.
4. Services for individuals at high risk.
5. Partnerships with Aboriginal and Torres Strait Islander peoples.
6. Progressing the evidence base for suicide prevention and good practice.

(Commonwealth Department of Health and Aged Care, 2000:21)

The NSW Department of Health (2000), in turn, provided a comprehensive review of a spectrum of evidence-based intervention programs for child and adolescent mental health, with the aim of identifying those programs shown to be effective in dealing with what are described, quite properly, as "complex, multivariate, social and health problems" (NSW Department of Health, 2000:3), and the multiple components of these programs. In doing so, it draws the distinction between universal, selective and indicated preventive interventions in child and adolescent mental health.

For our purposes, the definition of selective preventive interventions, as "targeted to individuals or a subgroup of the population whose risk of developing mental disorders is significantly higher than average" (NSW Department of Health, 2000:7), is worthy of note. The document (NSW Department of Health, 2000:8) also notes the argument by Offord, *et al* (1998) for the importance of an optimal mix of universal, targeted and clinical programs, where, first, effective universal programs are put in place, targeted programs are provided for those not helped sufficiently by the universal programs, and clinical services are available for those who have greater needs than can be met by the targeted programs.

A subsequent discussion paper by the National Mental Health Working Group (Department of Health and Ageing, 2004: 19) identified a series of principles for service provision for young people, *viz*:

1. Accessibility and engagement: Services should be accessible to all young people who need them, across cultures, language groups, communities of place and interest, abilities and socioeconomic groups. Similarly, mental health services should actively engage relevant groups of young people within the community.
2. Consumer and carer involvement: The involvement of young people and their families should occur in all aspects of service policy, planning, delivery and evaluation.

3. A preventative approach with a recovery focus: Expertise should be developed in these areas using a sound evidence base, to provide new opportunities for preventing mental illness and/or minimising or containing its effects in the short term and throughout adult life.
4. Continuity of care: A continuum of service provision should occur across the service system, and through young people's developmental transitions.
5. Workforce and workforce performance: A suitable range of workers needs to be available, with an appropriate range of professional expertise, an understanding of the issues facing young people, and the ability to exchange skills and expertise across a team.
6. Quality and performance: The provision of care of assured quality is required of all health services

A more recent examination of models of collaborative care for young people (National Advisory Council on Mental Health (NACMH), 2011:31-32) reaffirmed a similar set of principles, based on existing evidence of effectiveness, models described in the literature and consultations with experts in the field. It placed particular emphasis on the importance of partnerships, referral pathways and ongoing follow-up. One might note, *en passant*, that these principles included the establishment of "[s]ecure and ongoing funding structures … in order to support collaborative care arrangements" (NACMH, 2011:32).

3.1. Supported Peer-to-Peer Empowerment Program: From Theory to Practice

The disruptive behaviour, low self-esteem, low quality relationships, and stressful negative life events identified as "good" predictors of adolescent depression and suicide (AHTA, 2010:33-36) are also the key elements that bring young people to YIF. The core of the YIF program – empowering young people to take responsibility for their lives – is informed by an integrated approach to understanding and responding to the adolescent's experience of helplessness and hopelessness, which draws on the theoretical frameworks of Seligman's (1975) learned helplessness and Bandura's (1997) self-efficacy in the context of an appreciation of the variant clinical features of emotional disturbance in adolescence, in particular, the experience of depression.

3.1.1. Depression in Adolescence

The debate as to whether adolescent depressive symptoms are similar to those of adults or whether other adolescent behaviours are "masks" for depression, found its voice in the 1960s, when Toolan (1962a,b) argued that the clinical presentation of adult depression is rarely seen in young people, who manifest their depressed feelings by way of depressive equivalents – boredom, restlessness, somatic complaints and acting-out behaviours such as delinquency. This view was shared with Glaser (1967:565) who asserted that, in children and adolescents "depression is often not recognized because it may be hidden by symptoms not readily identified with this condition", and described behavioural problems and delinquent behaviour as examples of masked depression. Support for this view was provided, *inter alia*, by the research results of Cytryn and McKnew (1972), Inamdar, *et al* (1979) and Carlson and Cantwell (1980).

On the basis of clinical features, precipitating causes, family history and premorbid adjustment, Cytryn and McKnew (1972) were able to identify three distinct categories in the group of neurotically depressed children they studied, *viz*:

(i) masked depressive reaction of childhood

(ii) acute depressive reaction of childhood

(iii) chronic depressive reaction of childhood

Those children who were diagnosed as having a masked depressive reaction comprised by far the largest subgroup and Cytryn and McKnew (1972) concluded that depressive mood and behaviour are rare in childhood depressions.

Inamdar and his colleagues found Toolan's (1962a) "smiling depression" to be characteristic of the majority of their group of clinically depressed adolescents, insofar as these youngsters only looked sad when talking about their sad mood (Inamdar, *et al*, 1979). In addition, the symptoms of apathy, boredom, loss of interest and diminished school performance were much more prevalent than the more traditional symptoms of weight loss, slowed thoughts, memory disturbance, diminished libido and subjective anergia (Inamdar, *et al*, 1979). From their results, Inamdar, *et al*, (1979) suggested that, although there are a number of similarities between the features of adolescent depression and depression in adults, there are also many differences that might contribute to clinicians' under-recognition of depression in young people.

Carlson and Cantwell (1980) examined depressive symptoms and conduct problems in youngsters between the ages of seven and seventeen. They found that behaviour disturbances may overshadow a co-existing depression and that, while adult diagnostic criteria could be used to diagnose major affective disorder in youngsters over the age of seven, traditional evaluation methods overlooked the diagnosis of depression in 60% of the cases (Carlson and Cantwell, 1980).

While views on adolescent depression have changed significantly since the 1970s, Nunley (2001) notes that the debate continues as to whether, except for some development-specific differences, the symptomatology of childhood and early adolescent depression is similar to adult depressive features or whether youngsters tend to express their depression in behaviours which mask the underlying feelings, such that an adult-oriented diagnostic approach will often overlook the depressive underlay.

For example, in a survey of adolescents in a suburban high school, Blatt*, et al* (1993) established that dysphoria as a result of disruptions of interpersonal relatedness (e.g., feelings of loss or abandonment) were significantly related to internalising disorders, while dysphoria associated with diminished self-esteem (e.g., feelings of self-criticism, failure, or guilt) added significantly to the explained variance of both internalizing and externalizing disorders, specifically delinquency and aggression in both males and females. Similarly, Diclemente, *et al* (2005) found that a sample of depressed black female adolescents were nearly twice as likely to report engaging in antisocial behaviours and concluded that depression among black female adolescents may be accompanied by a broad range of adverse health consequences.

One review of the literature related to the risk factors, clinical characteristics, and course of illness of adolescent depression concluded that, for adolescents, the clinical features of melancholic depression are rare, while the "irritable hostile" pattern is distinctly increased, and that "for the majority who develop adolescent depression, its expression and outcome appear more a reflection of the propagating determinants, most commonly anxiety and personality style" (Parker and Roy, 2001:572). The AHTA (2010:33-36) review similarly identified disruptive behaviour, including conduct problems, disruptive behaviour disorders, rebelliousness, oppositional disorders, being under-controlled and showing antisocial behaviour, as closely connected to depression in this age group. Nevertheless, it would appear that, at least to the extent that these other behaviours are now better recognized, adolescent depression has been *un*masked as a variably manifest disorder.

3.1.2. Depression as Learned Helplessness

Overmier and Seligman (1967) coined the term "learned helplessness" to describe the interference in acquisition of escape-avoidance responses of dogs which had been exposed previously to uncontrollable electric shock. When these dogs were placed in controllable-shock conditions, they acted as if the shock was still uncontrollable. It was argued that the deficits in response initiation and response-reinforcement associations resulted from the dogs learning that responding and reinforcement were independent, that is, that their behaviour was not effective in controlling the aversive stimuli and they were "helpless" in that situation (Seligman, Maier and Solomon, 1971). Subsequent laboratory studies demonstrated that "helplessness" could be reliably induced in both animals and humans who are subjected to a variety of forms of uncontrollability (Miller and Seligman, 1975; Seligman, 1975).

Learned helplessness theory claims that the helplessness produced in the laboratory is a model for naturally occurring depression in humans and that the characteristic features of depression result from learning that outcomes are independent of the individual's actions (Abramson, Seligman and Teasdale, 1978; Seligman, 1975). In this framework, a perception of no control is no longer seen as a symptom of depression but, rather, as its most fundamental cause (Watson, 1977).

Learning that outcomes are uncontrollable is said to result in motivational, cognitive and emotional deficits – retarded initiation of voluntary responses (passivity), later difficulty in learning that responses will produce the outcome currently seen as uncontrollable (negative cognitive set), and depressed affect (Abramson, Seligman and Teasdale, 1978). Such a description is very similar to the cognitive triad Beck (1967, 1976) described as characteristic of depression in adults and to the negative cognitive biases which have been shown to be prominent in depressed adolescents (see, for example, Gencoez, *et* al, 2001; Marcotte, 1996; Marton, *et* al, 1993; Neshat-Doost, *et al*, 1998).

Dweck (1977) argued that the learned helplessness model of adult depression is also applicable to children and adolescents. She noted that adolescence is a period of increasing pressure to take responsibility for outcomes and suggests that, with the accompanying cognitive development, once helplessness cognitions are triggered, they may lead to a perception of generalized helplessness. This theme, of the perceived inability to influence events and social conditions that significantly affect

one's life, is picked up by Bandura (1997:153*ff*), when he seeks to explain people's sadness and despondency as a function, at least in part, of their "perceived inefficacy to gain highly valued outcomes".

Bandura (1997:160) goes on to observe that adolescence is a critical period of development placing simultaneous heavy demands on the management of stressful biological, educational and social changes, and reports that those who believe they cannot manage scholastic demands and form and maintain satisfying peer relationships suffer frequent bouts of depression. Other researchers have also reported that subsequent depression appears to be the result of a significant interaction between this kind of negative cognitive set and negative life experiences of adolescents (see, for example, Gladstone and Kaslow, 1995; Joiner, 2000; Joiner and Wagner, 1995; Robinson, Garber, and Hilsman, 1995). The AHTA (2010:46) evidence review also reports on demonstrated links between self-esteem "involv[ing] beliefs about ones' abilities and values … [and] … themes of self concept, shame, self criticism and worthlessness" (2010:46), such that "[a]dolescents and young adults with low self esteem are at an increased risk for developing depression, depressive symptoms or suicide attempts compared to their peers with high self esteem … [while] … [h]igh self esteem is a protective factor for depression, depressive symptoms or suicide attempts" (2010:48).

3.1.3. The Experience of Helplessness and Attempts to Reassert Control

At the same time, helplessness is not the inevitable result of being exposed to uncontrollable situations. Indeed, behaviour quite the opposite from helplessness has been observed. Roth and Bootzin (1974) found that subjects exposed to a laboratory situation designed to induce helplessness made more attempts to control a subsequent aversive stimulus than control subjects. Similarly, Roth and Kubal (1975) demonstrated that both facilitation and helplessness effects occur as a function of amount of exposure to helplessness conditions. It was argued that when people's expectations of control are threatened, they may be motivated to re-establish control, so that an initial reaction to no control is to behave assertively to regain control (Roth and Bootzin, 1974). Thus individuals' generalized expectancies of control may interact with situationally determined expectancies to determine their responses to uncontrollable situations (Roth and Bootzin, 1974; Roth and Kubal, 1975).

Pittman and Pittman (1979) showed that, in mild helplessness conditions, internals' task performances were much improved while the performance of externally oriented subjects deteriorated. On the other hand, internals reported themselves as being significantly more depressed at high levels of helplessness than externals in the same situation. Pittman and Pittman (1979) concluded that individuals who initially expect control will attempt to reassert control after mild experiences of uncontrollability, but will eventually evince helplessness when exposed to extensive uncontrollability.

Dweck and Repucci (1973) studied children's differing reactions to failure experiences as a function of their general control expectations. They found that, while the youngsters designated as internals persisted with the problem-solving task, external children became passive, demoralized and effectively incapable. Dweck (1977) suggests that the "non-helpless" children saw their failures as owing to some

easily modifiable self-aspect and used failure as a cue to use other strategies to solve the problem.

3.2. Youth Insearch: Contributing to the Solution

The LIFE Framework proposed that suicide prevention should encompass a wide range of activities across a number of programs and sectors, according to following considerations:

- the purpose of the suicide prevention activity, which may range from responding to crisis or risk, through to health promotion;
- the target group, which may range from the whole population, through high-risk groups, to individuals;
- the evidence base for the effectiveness of many activities including where this is limited, to at least demonstrate a change in the estimated level of risk;
- the likely costs and benefits of a proposed strategy;
- its place and role in the overall field of suicide prevention including its nature, potential scope, boundaries and limitations; and
- a collaborative approach including relating to others to provide a more integrated and effective approach.

(Commonwealth Department of Health and Aged Care, 2000:21)

Informed in part by the LIFE Framework, the *Better Futures* (2001/2003) document was an action framework for working with vulnerable young people that arose out of the NSW Drug Summit, held in 2001. Among other things, it identified twelve principles for working effectively with young people. One of these is that the approaches utilised are evidence based, i.e. approaches that are supported by research and promote proven and innovative approaches in service delivery.

3.2.1. Peer-to-Peer Empowerment: A Program Logic

The findings regarding the variable manifestations of depression/dysphoria in adolescence, and the understanding of depression as one response to experiences of helplessness, taken together provide a series of critical insights that underpin and inform the YIF approach to dealing with “at risk” adolescents. The key elements are as follows:

- A combination of negative cognitive set (individual) interacting with negative life experiences (context) is likely to be a significant contributor to young people’s dysphoria
- This dysphoria may or may not be at levels sufficient to warrant a diagnosis of clinical depression, but is nonetheless real
- The behaviours that bring young people to the attention of health, welfare and other service providers reflect this experience of dysphoria, but also represent a series of attempts to reassert control, albeit not always in socially acceptable ways
- Supported peer-to-peer empowerment is an intervention approach which incorporates modelling alternative behaviours and cognitions as strategies to solve the problems, for example, through the use of Youth Leaders who have been through the program model successful behaviours

- Post-program sessions back in young people's local contexts provide opportunities for ongoing support and direct reinforcement of successful cognitions and behaviours
- Through this process, young people are taken from learned helplessness to learned (and supported) strength, to the experience of self-efficacy rather than inefficacy.

3.2.2. Program Objectives

We have already noted that, as an organisation, Youth Insearch Foundation aims to empower young people to take responsibility for their lives, by giving them the opportunity and skills to develop their self esteem and play a positive role in society. More specifically, its stated objectives are:

- to reduce the incidence of crime, drug and alcohol abuse and suicide in young people
- to enhance young people's self esteem and productivity through empowering them to take control of their lives
- to break the cycle of divorce and family breakdown by giving young people some of the skills essential to being a loving and successful parent
- to be accessible to all young Australians and to ensure that through their own efforts young Australians have a productive future.

At the program level, this is translated into the aim of working with young people "at risk" in order to have a sustained positive impact on

(i) behaviours such as suicide attempts, interpersonal violence, criminal activity, and drug abuse and

(ii) the well-being of those young people, as measured by mental health measures such as self-esteem, hopelessness, anxiety, depression and stress.

3.2.3. Program Strategies

We seek to achieve this aim thorough our supported peer-to-peer empowerment weekend programs by

- providing a supportive environment for young people to think about their lives
- showing young people in difficult situations that they are not alone and that there is hope
- exposing young people to positive role models and lifestyle choices
- encouraging young people to take control of, and responsibility for, their own lives
- motivating young people to make positive changes in their lives and assume positive roles in society – to 'get back on track'
- empowering young people and giving them skills to address their social and emotional problems
- providing a forum for young people to receive practical advice from their peers
- building young people's self esteem and reducing the likelihood of suicide
- improving emotional communication skills.

3.2.4. Outcomes

The results in this section, on the outcomes of the supported peer-to-peer empowerment interventions, are samples from the independent evaluations of our programs. The follow-up surveys of young people and Support Adults reported by Urbis Keys Young (2003) clearly suggest that, both immediately after the program and six months later, the young people who participated in our programs:

- had higher self esteem
- had improved relationships with family
- had stable relationships with friends and were still in close contact with friends from program
- had stable educational attendance
- had more positive attitudes to current education and to future education
- were drinking alcohol less often, getting drunk less often and taking drugs less often
- were less violent and less involved in illegal behaviour.

Summary results of program attendee responses during 2005-2007 (Urbis 2008) showed similar evidence of success, *viz*

- 22% of young people had committed a crime prior to participating in the program. Following the program, only 7% stated that they would commit another crime.
- with regard to increased school and university attendance after program attendance, 25%-30% decided to stop 'wagging' school, 13%-18% decided to go back to school, and 12%-17% decided to go to TAFE or university.
- of those attending a subsequent program who had acknowledged that they had been physically violent before their first program, only between one-third and half of these (34%-48%) claimed they were still physically violent.
- there were reductions in the use of non-prescribed drugs, in alcohol consumption and cigarette consumption among those who used these substances prior to attending program
- whereas at the end of their first program, between 29% and 37% of young people had reported having attempted suicide prior to coming to program, at the end of *subsequent* programs, only 10%-14% of young people reported that they had attempted suicide in the time since their previous program.

These findings, further reviewed and evaluated by the Australian Institute for Family Studies, through the Child Family Community Australia (CFCA), gave cause for the Institute to include the Youth Insearch programs in its *Promising Practice Profiles* (PPP) as "positive example[s] of an early intervention practice targeting 'at risk' young people through peer support, mentoring and leadership opportunities" (CFCA, 2012a:7-8; 2012b:9).

External Evaluations of the Youth Insearch Foundation Programs

1. Urbis Keys Young Report 2003

The 2003 Urbis Keys Young report was commissioned by the Crime Prevention Division of the NSW Attorney General's Department, with funding provided by the NSW Attorney General's Department, NSW Premier's Department, Office of Children and Young People, The Cabinet Office (NSW), NSW Department of Health, NSW Department of Education and Training (DET), NSW Department of Community Services (DoCS), NSW Department of Juvenile Justice (DJJ). The Steering Committee formed to oversee the evaluation, included representatives of each of these agencies, as well as the Commission for Children and Young People (Rintoul and Wilczynski, 2003:1)

The terms of reference and subsequent methodology of the Urbis Keys Young evaluation were informed by earlier research carried out by the Psychological Services Centre at Charles Sturt University (CSU) to evaluate the outcomes of a YIF five-day suicide prevention program involving 40 participants aged between 14 and 19 years and reported in *Leaps and Bounds* (2001, cited in Rintoul and Wilczynski, 2003). Utilising the self-report approach to measuring individuals' well-being in the CSU report, the Urbis Keys Young evaluation was designed to answer four questions:

(e) Were the participants "at-risk" (did they meet the target group criteria)?

(f) Did the program have a positive impact on behaviours such as suicide, interpersonal violence, criminal activity, and drug abuse?

(g) Did the program have a positive impact on mental health measures such as self-esteem, hopelessness, anxiety, depression and stress?

(h) Was there evidence that any improvements were sustained over time?

Commencing at the individual young person's point of referral, the Urbis Keys Young evaluation examined the characteristics of participants in two YIF programs, assessed their progress during and at the completion of the programs, and assessed their progress in a six-month follow up. In summary, the Urbis Keys Young evaluation confirmed that:

(d) Young people involved in YIF activities meet the target criteria of being "at-risk" (Rintoul and Wilczynski, 2003:65-66). The percentages below indicate the incidence of each risk factor among the young people in the sample:

- living with extended family, in a blended family, with adoptive/foster/step parent(s), with one natural parent only, or in a refuge, shelter or hostel (70%)
- having a bad relationship with their family (25%)
- having a bad relationship with their friends (3%)
- not currently undertaking any education (26%)
- having left school before completing Year 10 (25%)
- thinking that they will not undertake any further/non-school education (11%)

- drinking alcohol a few times a week or every day (30%)
- getting drunk once a week or more frequently (34%)
- taking drugs once a month or more frequently (30%)
- getting drunk/taking drugs in order to not feel so bad about problems in their life, to escape reality, to forget, or because they feel empty and lonely (33%)
- having been in trouble with the police (64%)
- having low self esteem (Rosenburg score of 15 or below) (41%)
- having physically hurt themselves (58%)
- having had suicidal thoughts (60%)
- having tried to end their life (44%)
- receiving counselling for problems in their life, or feeling that counselling would help them (43%)
- being in contact with their school/TAFE counsellor (38%)
- being in contact with a DJJ worker (16%)
- being in contact with a DoCS worker (22%)
- being in contact with a social worker from elsewhere (i.e. not DoCS, DJJ, school or TAFE) (27%)

(e) Identified the elements of the YIF activities that decrease risk and build resilience of "at-risk" young people, as identified in the *Better Futures* framework (Rintoul and Wilczynski, 2003:69-71) :

- *Focus on well being*: Youth Insearch takes a holistic approach to working with young people, accepting a wide range of at-risk young people onto the programs, and encourages participation in every session at the program, not just those that appear to be most immediately relevant. The atmosphere of the program has as much influence as the content of the sessions. Further, the sessions that encourage communication and a safe family-like environment are seen as equally as effective as some of the more serious sessions.
- *Prevention*: In many cases, young people are reported to become more receptive to offers or sources of assistance, friendship and support after their involvement in Youth Insearch, both from people who were on the program and also others in their community or family.
- *Accessibility*: Young people reported the 'look and feel' of Youth Insearch as very much youth-focused and youth-friendly. The programs are also very inclusive, with considerable efforts made to provide access to young people with physical disabilities, to those who would not be able to afford the program, those who are otherwise socially isolated, and so on.
- *Participation*: Youth Insearch is based on a very high degree of youth participation in all aspects of their activities (e.g. internal administration, program organisation, session facilitation). Indeed, Leaders and Support Adults indicated that youth involvement is one of the elements that set Youth Insearch apart from other programs for at-risk young people.

- *Quality*: While this was the first external evaluation of Youth Insearch's core program, young people at the end of each program complete evaluation questionnaires, and an annual review of activities is carried out with all Youth Leaders.
- *Minimal disruption*: Youth Insearch specifically aims to embed young people in local supports and to engage fully with their existing supports. The requirement for young people to be accompanied by a Support Adult is evidence of this, and is unusual for youth programs.
- *Early intervention*: Some of the difficulties faced by young people on Youth Insearch programs are in their 'early days'. Young people in these situations often report being strongly effected by seeing '*what might happen to me down the track*' and are motivated to divert themselves from that course. Those with more deeply entrenched problems, however, tend to use Youth Insearch programs in other ways – as an anchor, or a turning point.
- *Supporting service providers*: Youth Insearch provides a one-year training program for new Youth Leaders and ongoing training for existing Youth Leaders.
- *Collaboration and partnership*: Youth Insearch is in regular dialogue with a range of agencies that work with young people (government and non-government), particularly as sources of referral *into* the programs. Referral *from* the programs to external agencies is more limited, as Support Adults who attend with young people are typically responsible for such matters.

(f) Participation in YIF programs and follow up groups has a positive impact on young people's social behaviour and well-being over time (Rintoul and Wilczynski, 2003:67). The follow-up surveys of young people and Support Adults clearly suggest that, both immediately after the program and six months later, this group of young people:

- had higher self esteem
- had improved relationships with family
- had stable relationships with friends and were still in close contact with friends from program
- had stable educational attendance
- had more positive attitudes to current education and to future education
- were drinking alcohol less often, getting drunk less often and taking drugs less often
- were less violent and less involved in illegal behaviour.

In summary, then, the Urbis Keys Young evaluation concluded that the YIF program experiences provided to "at-risk" young people, were, *prima facie*, designed to decrease risk and build the resilience of those young people and, more importantly, had a positive impact on young people's social behaviour and well-being over time.

2. Urbis Report 2008

Youth Insearch Foundation secured Federal government funding ($1m over four years: October 2004 – June 2008) under the *Stronger Families, Local Answers* funding program of the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA; previously the Department of Family and Community Services).

Youth Insearch Foundation used this funding to employ Youth Liaisons in eight locations (in NSW, Queensland and Victoria). The role of these Youth Liaisons was to prepare young people and Support Adults for their first program and ensure adequate support for young people (by Support Adults) during and after the programs. As part of the funding agreement with FaHCSIA, Youth Insearch Foundation set aside a budget for external evaluation of the Program, with particular focus on the impact of the funding.

The aims of the evaluation were to:

- collect new information and evidence that is not already gathered by Youth Insearch Foundation as part of its internal evaluation routine
- analyse this new data alongside results from Youth Insearch Foundation's internal evaluation activities
- make an independent assessment of:
    - the extent to which Youth Insearch Foundation is meeting its intended outcomes with at-risk young people
    - which elements of the program have delivered the best return on investment
    - the impact of FaHCSIA's funding (i.e. the Youth Liaisons) on Youth Insearch Foundation's operations
- articulate lessons that have been learned by Youth Insearch Foundation and the Youth Liaisons over the funding period
- identify possible future directions for Youth Insearch Foundation, particularly with regard to the role of Youth Liaisons.

Based on self-report surveys of program attendees for 2005, 2006 and 2007, the evaluation established that:

- Youth Insearch Foundation continues to target young people aged twelve to eighteen, who have experienced, or are experiencing, problems stemming from issues such as experimentation with drugs and alcohol, broken or dysfunctional homes, sexual or physical abuse, grief or other traumatic events.
- Those attending the programs have been a similar mix of gender, age, cultural background, education status and employment status (55% female, 23% ATSI, 81% attending school, 9% unemployed) 18% living with both natural parents).
- One in two (50%) young people reported experiencing physical abuse before their first program, and three in ten (30%) reported experiencing sexual abuse.

- The programs are attended by young people who are dealing with a wide range of issues, from anger (61%) and depression (41%) to drug and alcohol abuse (27%), violence (28%) and homelessness (4%).
- There is a relatively high prevalence of drug use (16% at least once a week) and alcohol use (56% at least once a month) and of a perpetration of violent behaviour (62%) and crime (egg theft 43%, vandalism 33%) among young people attending the programs.
- One in two (50%) of the program attendees reported having suicidal thoughts prior to their first program, and one in three (32%) reported having attempted suicide.

At the end of each program the young people are asked how Youth Insearch Foundation has helped them. The responses indicate a broad range of positive immediate outcomes from the programs, in particular making new friends (88%) and meeting others with similar problems (69%), feeling loved (66%) and respected (64%) as well as feeling respect for others (64%) and having support (63%). A small number (less than 5%) of young people, however, report negative outcomes.

In addition to these immediate outcomes, the results also show:

- 22% of young people had committed a crime prior to participating in the program. Following the program, only 7% stated that they would commit another crime.
- with regard to increased school and university attendance after program attendance, 25%-30% decided to stop 'wagging' school, 13%-18% decided to go back to school, and 12%-17% decided to go to TAFE or university.
- of those attending a subsequent program who had acknowledged that they had been physically violent before their first program, only between one-third and half of these (34%-48%) claimed they were still physically violent.
- there were reductions in the use of non-prescribed drugs, in alcohol consumption and cigarette consumption among those who used these substances prior to attending program
- whereas at the end of their first program, between 29% and 37% of young people had reported having attempted suicide prior to coming to program, at the end of *subsequent* programs, only 10%-14% of young people reported that they had attempted suicide in the time since their previous program.

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