Peer Group Support Weekends

Evaluation Report
(14-18 year olds)

Prepared by
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The University of Western Australia
17 December 2007

Dear Reader/Supporter

After nearly 2 years the Peer Support Evaluation is now completed with results that have been positive and very rewarding for all those who have been involved.

Peer Group Support Weekend or more affectionately referred to as ‘Camp’ was the initial Youth Focus programme. Since conception, hundreds of young people, staff and volunteers have attended, each relaying their stories and comments as to what they thought was effective and what wasn’t. Over the years staff have meticulously listened and absorbed this feedback and endeavoured to appropriately respond by implementing suggested changes. The model has evolved to integrate lessons learned, emerging evidence and examples of good practice. Young people, their families, our staff, volunteers and referrers all felt that Camp was an effective therapeutic tool yet credible empirical evidence was lacking.

The Evaluation project has given us the opportunity to address this short fall and begin to articulate and demonstrate the therapeutic benefit that the Peer Group Support Weekend plays in the prevention of youth suicide, depression and self harm. The report outlines those findings and demonstrates the strengths of the project. The programme has proven to be a dynamic and attractive way of engaging with youth whilst providing therapeutic support and assistance.

The Evaluation project has been a long and challenging journey which would not have happened without the support and generosity of many. We would like to thank Lotterywest and the Youth Focus Ride for Youth, who without their generous financial backing the project would not have proceeded. We would also like to thank the University of Western Australia and particularly Dr Mark Sachman who repeatedly gave over and above his contracted obligations and commitment.

Although the Evaluation project took two years to complete, an equal amount of time was spent scoping the project and securing funding. We would like to acknowledge the support of the Reference Group in Dr Maria Harries, Ministerial Council of Suicide Prevention, Mr Stephen Edwards and Mr Geoff Rasmussen.

Dr Mark Sachman has especially offered praise and thanks to the Youth Focus Staff for their commitment, patience and enthusiasm in accomplishing this project. It goes without saying that both the Chairman and CEO can only echo the same praise for what has been a very educational and beneficial project for Youth Focus.

Sincerely

Gus Irdi
Chairman

Jenny Allen
Chief Executive Officer
Executive Summary

Youth Focus provides a comprehensive counselling and community based youth suicide intervention service. The action research project was initiated to optimally determine what was working or in need of changing as viewed from a number of perspectives namely: the young person, their families, Youth Focus Staff (counsellors, business services staff, and volunteers) and referrers.

Qualitative data was compiled and subject to thematic analysis. Nine core psychosocial themes were identified and articulated by the research participants. The themes were (i) Safe and nurturing environment, (ii) Peer support, (iii) Programme content, (iv) Planning of programme, (v) Care and commitment from the counsellors, (vi) Corrective emotional experiences, (vii) Stable and predictable boundaries, (viii) Understanding the young persons life context, and (ix) Organisational data.

Within the nine core themes both process and content issues were identified and these formed the basis of a change strategy for the Youth Focus Life Group Camp. These changes were implemented and subject to a feedback review by the camp participants.

The Youth Focus Action Research Project has resulted in significant positive changes to both the process and content of camp based activities.
Dedication

This project is dedicated to all those individuals who graciously participated and contributed to the project. However, special mention needs to be made of the many young people, and their families, who have been involved in the Youth Focus LIFE Group Support Programme and as a result of this project have helped shape the programme’s process and content and ultimately its success.
Acknowledgements

A number of individuals and groups need to be acknowledged for their significant contributions to the Youth Focus Action Research Project. They are as follows:

- Ms Jane Forward for her support and guidance throughout the action research process. The relationship with Ms Forward enabled the research process to be characterised by open and clear communication between all of the relevant parties.

- Ms Carolyn Johnson for her involvement in the interviewing of research participants and the data analysis.

- The Youth Focus counselling staff for their involvement in conducting interviews and with the data analysis.

- Ms Alana Thompson for her compilation of the literature review.

Thank you all for your time, effort and dedication to the project’s objectives.
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Chapter One

Introduction

1.1 Introduction:

In early 2003, Youth Focus management developed an initiative to undertake a research project to examine what it was that ‘worked’ for the camp participants. The intention was that a project plan and grant request would be developed to enable Youth Focus to undertake an evaluation of the group support youth suicide prevention programme. It was hoped that the evaluation would result in changes to the group support programme. This process would be overseen by the Youth Focus Action Reference Committee (see appendix No 1 for the project's history, rationale, and both content and process issues).

It was acknowledged that Youth Focus needed to be able to address a number of important requirements for the successful and appropriate delivery of counselling and camp based interventions to young people with suicidal and self harming behaviours. These were identified as follows:

- Clinical interventions needed to be effective
- Clinical interventions needed to be based on a sound theoretical framework
- Youth Focus as an organisation need to be able to identify and articulate its rational for its adopted treatment initiatives
- To develop and maintain an appropriate clinical operations manual incorporating all of the above.
The University of Western Australia was approached to see if it could offer research experience to assist in developing and managing the project. Negotiations resulted in The Centre for Vulnerable Children taking on the project. It was decided that UWA chief research investigator, Dr Mark Sachmann, would manage an action research process, engaging Youth Focus staff (counselling, business services and volunteers), clients, clients’ parents and the Youth Focus Action Research Reference Group in an interactive process for the specific purpose of: collecting data; adequately describing the Youth Focus Life Group Support Programme; identifying, developing and applying programme improvements; and reviewing these for suitability within the context of the programme goals.

1.2 Action research objectives

The Youth Focus Action Research Project has the following four objectives:

1. Systematic evaluation and development of the current group support programme, based on research participant experience
2. Qualitative study of what participants have deemed effective and the underlying reasons
3. Contributing to the body of evidence-informed knowledge in order to inform and guide future service delivery
4. Provision of a real example of how community based youth organisations can involve the community, clients, carers and experts in the evaluation and development of programmes against the LIFE and Community LIFE principles.

The data to be collected is highly variable and will include: a review of the literature on suicide (conceptualisation of the issue together with an examination of treatment initiatives), and interviews with research participants. It is intended that this data will be subject to qualitative analysis for the purpose of satisfying the four research objectives.
1.3 Research design and methodology

The research adopts an action research design, employing qualitative design characteristics. An action research approach is necessary in order to capture the multidimensional nature of the human experience. An action research design provides more perspectives on the phenomena being studied; in this case, the subjective impressions of the research participants.

The research method involves approaching a predetermined number of programme participants, their families, volunteers, referrers, and Youth Focus staff members, and inquiring as to whether they would participate in the research. If agreeing, the participants would be required to be involved in a semi-structured interview process. The interview will inquire into the participants’ subjective impressions and opinions as to their motivation for attending camp and the effectiveness, or otherwise, of the Youth Focus group support programme.

The data analyses will incorporate the application of thematic analytic procedures. The dominant themes emerging out of the research participants verbal responses will be identified and subsequently micro-analysed to determine important specific process and content issues that will ultimately inform a change strategy.

The Youth Focus action research project is an important undertaking because by adhering to the principles of action research, it will involve the entire organisation and the people it helps in the research process. The programme is designed to profile what the research participants believe to be effective, and not effective, and to determine a possible change strategy.

1.4 Difficulties in evaluating programmes from a qualitative approach

The following points identify important issues that need to be pointed out in relation to the application of action research methodologies in an effort to determine programme evaluations and identify ‘what works’ in psychosocial treatment/support initiatives:

- Since the adopted research has not been subject to a rigorous scientific methodology employing randomisation, between group comparisons and statistical analyses demonstrating significant mathematical superiority to
alternative treatments, the results cannot be generalised to other client populations.

- It must be acknowledged from the outset that data obtained from clients, family and clinical staff do not necessarily successfully identify the strategies of the Youth Focus intervention protocols that account for the positive therapeutic change process.

- As a result, programme changes initiated simply from the data obtained from the sources cited above may be misguided. Caution needs to be exercised in the interpretation and practical i.e. clinical application of the findings.

The American Psychological Association (1998) has identified a number of fundamental standards for empirically supported therapies. Well-established treatments have the following methodological characteristics:

1. Have at least two good between-group design experiments demonstrating efficacy in at least one of the following ways: (a) superior (statistically significantly so) to placebo or to another treatment or (b) equivalent to an already established treatment in experiments with adequate statistical power (about 30 per group).

2. Must be conducted with treatment manuals.

3. Must specify the characteristics of the client sample.

4. Must have demonstrated effects by at least two different investigators or investigating teams.

The criteria for probably efficacious treatments should include the following:

1. Two experiments showing the treatment is superior (statistically significantly so) to a waiting-list control group; or

2. One or more experiments meeting the well-established treatment criteria 1a or 1b, 2, and 3 but not 4 as set out above.
As detailed in Chapter Three on methodology, this research has not adopted these characteristics and hence can not lay claim to identifying empirically derived data that demonstrates what actually accounts for the therapeutic change in individuals. However, the research participants’ individual subjective accounts of what works is a valid qualitative data set that seeks to understand personal perceptions and opinions. Such perceptions can not be ignored and dismissed as unimportant or inaccurate.

1.5 Overview of Chapters:

Chapter One provides an outline of the overall structure of the research. Incorporated into the chapter are: (i) the profiling of the research objectives, (ii) justification for the research, (iii) a brief description of the research design and methodology, (iv) limitations of the research, and (v) a descriptive outline of the research process.

Chapter Two provides a detailed examination of the scientific research literature. The review commences with a broad overview of the pertinent research literature examining issues such as the epidemiological incidence of suicide, conceptual models of suicide and treatment initiatives. The literature review is an extensive exploration of previous work in the field and this approach is in keeping with the complex nature of the subject matter and with the traditions of social science inquiry.

Chapter Three describes the research design and methodology adopted to collect the data which was used to fulfil the research objectives. The choice of research design and methodology is identified, described and justified together with the research instrument employed in the study. The application of the research instrument i.e. the semi-structured interview schedule is detailed together with important ethical considerations.

Chapter Four presents the results obtained from the analysis of the data. Firstly, patterns of data were identified and profiled into nine core themes. Secondly, specific comments relating to these core themes were presented.
Chapter Five discusses the results and profiles the recommendations for a change strategy in relation to both the content and process of the Youth Focus Life Group Support Programme.

Chapter Six examines the application of the change strategies together with a discussion of the theoretical models informing Youth Focus intervention strategies. Furthermore, staff observations and reactions to the application of the change strategy will be identified and articulated, together with evaluative feedback on the impact of the change strategy.

Chapter Seven concludes with a brief overview and commentary on the Youth Focus Action Research Project.

1.6 Conclusion

Chapter One has provided the broad organisational structure for the research. It introduced the four research objectives, the research was justified, the research design and method were briefly described, difficulties in evaluating programmes with non-experimental qualitative designs were outlined, and the seven chapters comprising the action research project were systematically descriptively outlined.
Chapter Two

Literature review

2.1 Introduction

The literature review will seek to provide background information on: epidemiological data on suicide; conceptual frameworks for understanding suicide; models of suicide prevention, specifically a youth work model of peer support and self-help. The literature review will identify youth group support programmes utilised by organisations and agencies within Australia and abroad, and will consider published and unpublished good practice programmes that have been in use or are in use by relevant agencies.

A literature search was conducted on youth suicide and self-harm, including treatment approaches and preventative intervention programmes.

The electronic databases MEDLINE, PsycINFO, OVID, AMED, CINAHL, CRiSE, AFSP, IASR and IASP, SIEC, Proquest, Informit Online, including Digital Dissertations and the Cochrane Library were searched. Search terms included combinations of the following concepts: youth, suicide, prevention, interventions, camps, peer support, evidence based, school-based, treatment programmes, evaluation, and therapy.
2.2 Epidemiological data

Western Australia has one of the highest rates of youth suicide in Australia. The Western Australian Auditor–General reported in 2001 that “youth suicide has been identified as one of the major problems over the next decade and unless appropriate prevention strategies are put in place, the cost of youth suicide to the community in human and financial terms will continue to be significant” (O’Neil p10).

According to the Ministerial Council of Suicide Prevention in Western Australia, in 2002, 2320 suicide deaths were registered, representing an overall suicide rate of 11.8 per 100,000. This was a decrease on the 2,454 suicides registered in 2001.

Men of all age groups in Australia are far more likely than women to die from suicide, with the 2002 rates at 20.1 per 100,000 (1,935 deaths) and 5.1 (519 deaths) respectively. Rates for men have been consistently higher than for women throughout the time Australian data have been collected.

The highest age-specific suicide death rate for males in 2002 was observed in the 25-29 year age group (31.1 per 100,000). For females the highest rate occurred in the 40-44 year age group (9.7 per 100,000). The lowest age-specific suicide death rate for both males and females in 2002 was observed in the 15-19 year age group (13.1 per 100,000 for males and 4.1 per 100,000 for females) (MCSP, 2004).

All efforts in the biopsychosocial treatment of suicidal behaviour are guided, explicitly or implicitly, by a view of the risk factors for suicide. These aetiological frameworks can be conceptualised as those which focus on the individual, the social-environmental milieu, or those which consider both within an integrated or pathways framework. An emphasis on risk factors is common to all approaches, and only the salience of factors is disputed, with the relative importance of various factors varying culturally and over time. While there has been much research into the identified risk factors, the focus of many treatment programmes has been on developing strengths to counter suicidal tendencies i.e. protective resilience factors.

The literature reviewed will examine the extent of the problem, methods of conceptualising it and the different ways it has been addressed, evidence for specific therapeutic approaches and programmes is reviewed. This includes therapeutic modalities, and evidence for school-based peer programmes and residential support-
group camps. Camps have been used as a method for preventative activities but the
evidence-base for their effectiveness is limited, although research indicates that they
may have a useful role in the promotion of protective factors such as connectiveness
and the development of self-esteem.

While short suicide information programmes are not effective and may in fact
promote suicide in vulnerable young people, there is evidence to support the
effectiveness of school-based peer support programmes, which seek to increase the
protective factors against suicide by developing skills and providing support.

This review provides a review of studies in the areas of youth suicide and self-harm,
and preventative interventions for suicide. The report outlines the extent of the
problem within Western Australia and at the national level. Models of suicidal
behaviour are described in order to better understand youth suicide, and risk factors
for youth suicide are identified. The report outlines common treatment approaches to
youth suicide and presents the evidence base for various therapeutic approaches to
treatment, drawing specifically on Peer Education and Support Interventions
including School-Based Peer Support Programmes and Youth Group Support
Residential Camps.

2.3 Suicide prevention

Suicide prevention can refer to a range of approaches designed to reduce the risk
factors associated with suicide, and increase the protective factors such as mental
health and resilience within the community. An overall approach to suicide prevention
requires prevention, early intervention and treatment as well as supporting those who
are bereaved (Commonwealth Department of Health and Aged Care, 2001).

Preventing suicide is complex and there is no empirical evidence to suggest that one
model or strategy will prevent suicide. Both published and unpublished literature
reviewed, identified that a multi-factorial approach to the prevention of suicide is
required (New South Wales Department of Health, 2003).

It has been suggested that suicide prevention programmes be based on an
understanding of all the factors associated with suicidal behaviour (Roach, 2005).
However, given the complexity of known risk factors associated with suicidal
behaviour, this can be a very difficult task. Risk factors can vary from genetic and biological factors, social and demographic factors, family background and early childhood experiences, personality and beliefs, environmental factors and mental health issues (Queensland Government, 2003).

There is limited research in Australia on the effectiveness of suicide prevention programmes. Furthermore, from the literature reviewed there is no strong evidence for the efficacy of any particular Australian prevention strategy. The relative absence of empirical research demonstrating the effectiveness of suicide prevention interventions has been reported as compromising the development of strategies for suicide prevention (NHMRC, 1999).

In Australia there has been a focus on traditional approaches to prevention strategies that have focused on high risk groups. More recently in Australia and overseas there has been interest in the development of innovative youth suicide prevention strategies including programmes of youth group support and Life Skills programmes. It is reported by Roach (2005) that Life Skills programmes including suicide education have been shown to be more effective than school based education and telephone hotlines, however the efficacy of the suicide specific element remains uncertain.

2.4 Understanding youth suicide: models of suicide behaviour

A starting point for research into and treatment of suicidal behaviour is understanding what causes and what protects against suicide. While some concept of this underlies all treatment efforts, the model is not always made explicit. Models of suicide causation which have been identified include:

- psychological (based in the individual)
- biological (based in the individual)
- social structural (based in the social environment)
- integrated and pathways models (Braucht, 1979)

Each of these separate models will now be examined in detail:
2.4.1 Psychological Models

Psychological models look for the risk factors of suicide within the individual. Research based on these models focus on the personal characteristics, motives and underlying psychological and physiological characteristics which differentiate suicidal from non-suicidal individuals. Variants of this model include Psychoanalytic (Perelberg, 1995), the Depression Model and closely related approaches which focus on cognitive/problem solving deficit or low self esteem as the cause.

An example of this approach is a study by Rutter & Behrendt (2002) which examined suicidal ideation, behaviour, and attempt history of 100 youth aged seventeen to nineteen and identified four primary risk factors important for overall suicide risk. These factors were hopelessness, hostility, negative self-concept, and isolation. The authors suggest that focusing on these four factors would enhance suicide assessment and prevention efforts with youth.

Some models focus on personal motive. For example, a working model of adolescent suicide taken from Western Australian Ministry of Education (1993), Youth Suicide Prevention: Resource Package for Student Services lists the following possible motives for suicide: revenge-anger and hostility, social isolation, hopelessness, history of abuse, self perceived failure and loss. This model identifies loss as the most important risk factor of suicide. The loss may be real (for example, a relationship, a person who dies or leaves); more obtuse (for example self-worth or a goal in life) or it can be imagined.

2.4.2 Biological Models

Biological models look for the physiological correlates of suicidal behaviour in order to explain it and/or find pharmacological treatments. An example of this approach is Fawcett, Busch, Jacobs, Kravitz & Fogg’s (1997) four-pathway clinical-biochemical model. The four pathways posited incorporate severe anxiety/agitation associated with high brain corticotrophin-releasing factor (CRF or CRH) levels, trait baseline and reactivity hopelessness and trait impulsiveness associated with low brain serotonin turnover and low total cholesterol as a possible peripheral correlate.
2.4.3 Social Structural Models

According to the Social Structural perspective (also known as the stress model), suicide is the result of social determinants. The research based on this model focuses on environmental factors which distinguish suicidal from non-suicidal subjects (Zhang, 1996). Variants of this approach include geographic models (Congdon, 2001) and population health models which attempt to deal with social structural risk factors such as poverty and unemployment (Ausinet, 2004).

The use of the stress model in schools has been criticised on the grounds that it normalises suicide (i.e. anyone can commit suicide if circumstances are difficult enough) whereas emphasising the psychiatric component of suicide makes it less glamorous and therefore less likely to be copied (Shaffer 1990).

2.4.4 Integrated and Pathways Models

Most theorists and practitioners would acknowledge that there are multiple pathways to most psychosocial disorders. Different combinations of risk factors may lead to the same disorder and no single cause may be sufficient to produce a specific negative outcome (Greenberg, Speltz, & DeKlyen, 1993). Because of this, more sophisticated models tend to be integrated, and emphasise ecological factors (Kellam, 1990) and developmental pathways.

The complexity of developmental pathways is clear from research relating risk factors to disorders. However, there appears to be a non-linear relationship between risk factors and specific psychosocial outcomes such as suicide. Although one or two risk factors may show little prediction to poor outcomes, there are rapidly increasing rates of disorders with additional risk factors (Rutter, 1979; Sameroff, Seifer, Barocas, Zax, & Greenspan, 1987). However, not all children who experience such risk factors develop psychosocial difficulties (e.g., Cowen et al., 1992), and no one factor alone accounts for children’s adjustment problems (Sameroff & Seifer, 1990).

Recent findings in behavioural epidemiology indicate that mental health problems, social problems, and health-risk behaviours often co-occur as an organised pattern of adolescent risk behaviours (Donovan, Jessar, & Costa, 1988; Dryfoos, 1990; Elliott, Huizinga, & Menard, 1989; Jessar, Donovan, & Costa, 1991; Jessar & Jessar, 1977). Thus, because risk factors may predict multiple outcomes and there is great overlap
among problem behaviours, prevention efforts that focus on risk reduction of interacting risk factors may have direct effects on diverse outcomes (Coie et al, 1993; Dryfoos, 1990).

2.5 Risk Factors

Common to most models of suicide prevention and intervention is identification and articulation of risk factors. Unfortunately the presence of risk factors is not enough to predict suicide in individual cases. Differences occur in which factors are considered most salient and how the relevant factors dynamically interact.

Fahy, Mannion, Leonard, & Prescott (2004) conducted a study in which seven skilled clinicians attempted to identify suicides blind, based on psychiatric case records. Psychiatric patients reveal an excess of risk factors and psychiatric illness is itself a factor in many suicides. The records of 39 suicides of psychiatric patients and their matched controls (N=78) were rated blind and dichotomously rated for suicide by the raters. The researchers found that success in identification of cases only approximated to chance expectation. Fahy et al (2004) suggest that pending replication, these disappointing findings call into question the clinical utility of risk factor findings to date, their validity as a basis for significant change in service provision and the medico-legal significance of records in suicide-related civil law suits.

The relative importance of specific risk factors varies culturally. For example in the United States and Australia, males complete suicide at a significantly higher rate than females, however this is reversed in China (Yang 1990). Religion has been identified as a protective factor in the United States but the opposite was found to be true in a study of a Chinese population (Yang 1990). Patton and Burns (1999) commented that the lack of research into Australian risk factors is striking.

For young Western Australians the most significant risk factors have been identified as (MCSP, 2004):

- A history of mental illness (particularly depression) in self, parents or carers
- Harmful use of alcohol or other drugs
Severe difficulties in the family, e.g. relationship breakdown, divorce, reduced access to children and domestic violence

History of child abuse - sexual, physical and emotional

A family history of suicide or suicidal behaviour

The availability of lethal methods of suicide, particularly easy access to guns

Losses, including death and loss of physical health

Socio-economic disadvantage, including low educational achievement and unemployment, economic depression and sudden economic change

Legal problems, imprisonment or behaviour that brings the person into conflict with the law or society

Conflict over sexual identity or other sexual issues

Patterns of poor communication with others, especially family or friends

Financial problems

Work-related stresses

The following section discusses these factors in greater depth.

2.5.1 A History of Mental Illness

A history of mental illness is the strongest predictor of suicidal behaviour (Beautrais 1998, Carlson & Cantwell, 1982; Crumley, 1979 Allebeck and Allgulander 1990, Silburn at al 1991, Shaffer and Piacentini 1994). Research indicates that up to 90% of people who commit suicide have a psychiatric illness (Zubrick et al.1995). Depressive symptoms are the strongest predictors of suicide (Maris et al., 1991; Sherer, 1985; Kandel, Raveis, & Davies, 1991) and are also highly correlated with suicide ideation.

A Western Australian study found that over two thirds of the males who completed suicide were reported by family and friends to have shown signs of depression in the three months before their suicide. “Around half (52.8%) of all male suicides had sought some form of help in the preceding 12 months. Most commonly this help was sought from a General Practioner (34.2%), a psychiatrist (22.5%) or some other health worker or counsellor (14.7%)”. In the 12 months prior to completed suicide, one third of the males (32%) and almost two thirds (57%) of the female suicides suffered from a diagnosed psychiatric disorder including depressive
disorders, schizophrenia, substance misuse, personality disorder, and adjustment disorders.

The period following psychiatric treatment in hospital has been identified as a particularly vulnerable time with approximately one in ten males having completed suicide within a month of their psychiatric treatment in hospital. This statistic highlights the increased risk of suicide both during hospitalisation and in the immediate period post discharge.

### 2.5.2 Previous Suicide Attempts

A previous attempt at committing suicide is a strong predictor of suicide (Martin et al., 1997; Shaffer, Gould, Fisher et al. 1996, Shaffer, D., Gould, M. S., Fisher, P., Trautment, P., Moreau, D., Kleinman, M., & Flory, M. 1996). While numbers are difficult to estimate, attempted suicide is conservatively reported to be 30-50 times more common than completed suicides (Martin et al., 1997). Male youth who have previously attempted suicide are up to thirty times more likely than other youths to attempt suicide again. Female youth who have previously attempted suicide have about three times the risk. Approximately a third of youth suicide victims have made a previous suicide attempt (Shaffer, Gould, Fisher et al. 1996).

Attempted suicide is defined by Farmer (1982) as intentional self-inflicted injury not resulting in death. Farmer believes that both suicide and attempted suicide involve intent to cause death, and this view is shared by other researchers (Booth, 1999; Fabian, 1986; Farmer, 1982). However, this view is highly contentious. Some researchers argue that suicide attempts may not intend to die and the behaviour serves other needs such as a cry for help, or to manipulate others (Gregory, 1987, Beck, Schuyler & Herman, 1974; Martin et al. (1997); Parker, 1981, Hassan, 1995).

It seems likely that there are a number of categories of those individuals who attempt suicide. Tiller et al. (1997) identified two groups: (i) those who want to die but survive; and (ii) those who respond to circumstances with a suicide gesture, and Goldney (1981) identified a third group with the characteristics of a high degree of suicidal intent and hopelessness. Taylor (1982, p. 140) asserts that all suicidal acts are a 'gamble with death' and that differentiation between 'genuine' and 'other suicidal acts' is not a valid conceptualisation.
There is also disagreement about the relationship between the lethality of method chosen and intent to die. Lethality of means may reflect seriousness of intent (Hassan, 1995; Ruzicka & Choi, 1999) but choice of means may also represent complex cultural and gender differences (Gregory, 1987; Hassan, 1995; Ruzicka & Choi, 1999).

2.5.3 Self Harm

Self-harm is a direct and deliberate physically damaging form of bodily harm which is intentionally not life-threatening, often repetitive in nature and socially unacceptable (MCSP, 2004). The first year following an episode of self-harm is a period of high risk, and this risk is greatest in the first few months (Hawton and Fagg 1988). According to the NHS Centre for Reviews and Dissemination (1998) 37 studies report a one year repetition rate for deliberate self-harm.

Reasons for self-harm include:

- to ease tension and anxiety
- to escape feelings of depression and emptiness
- to escape feelings of numbness to relieve anger and frustration
- to relieve intense emotional pain to regain control over one’s body
- to maintain a sense of security or feeling of uniqueness as a continuation of previous abusive patterns to obtain feeling of euphoria
- to express coping with feelings of alienation as a response to self-hatred or guilt as a symptom of a more severe mental disorder, e.g. borderline personality disorder” (see SIEC alert #43 [www.suicideinfo.ca/csp/assets/alert43.pdf] MCSP

2.5.4 Alcohol and Drug Abuse

While alcohol and other drugs are frequently associated with suicidal behaviour, the relationship between substance use and suicide is a complex one. Alcohol is a central nervous system depressant and has a disinhibiting effect and therefore can increase impulsive decisions to suicide. It can also be used to bolster courage to go through with a decision to suicide.
Problems associated with alcohol and drug abuse or dependencies may lead people to suicide, but also the use of drugs and alcohol may be a symptom of underlying problems which need to be addressed in order to reduce both the substance abuse and the propensity to self-harm. The ingestion of drugs has also been implicated as a precipitating factor in suicidal actions (Hayward et al, 1992).

The extent of the correlation between substance abuse and suicide is dependant on the method of estimating the problem. Using data reflecting an identified substance abuse problem, Silburn et al (1990) estimated that substance abuse and suicide was correlated in 31 per cent of total suicide deaths among 15 to 24 year-olds. However, an estimate of over 50 per cent was made by researchers (Rich et al, 1988) using structured interviewing of associates of the suicide victim.

Fernquist (2000) examined the relationship between problematic drinking in the home and suicide rates in 10-14 year olds, based on surveys in the United States from 1947-1994. The results supported the hypothesis that chronic stress, as measured by problem drinking in the home, is related to youth suicide.

### 2.5.5 Social and Family Connectiveness

According to Hawton, O'Grady, Osborn and Cole (1982) family problems are one of the most important contributory factors in youth suicide. Family problems include poor communication, family breakdown, lack of cohesion, value conflicts with parents, alienation of the adolescent from the family and lack of affection and love (Yang, 1990).

Some studies have shown higher rates of parental divorce or separation among adolescents who have attempted suicide compared with non-suicidal community control groups (Spirito et al, 1989). However, other studies have found no differences between suicide attempters and non-suicidal psychiatric control subjects (Spirito et al, 1989). Two large-scale controlled studies (Brent et al, 1993a, 1994; Gould et al, 1996) found that suicide victims were more likely to come from a non-intact family of origin.

In a study by Rubenstein et al (1989) it was found that youth in high schools who are integrated into their families and characterised by a high degree of mutual involvement, shared interests, and emotional support were 3.5 to 5.5 times less likely
to be suicidal than adolescents from families demonstrating less cohesion, even though they had the same levels of depression or life stress.

Divorce may have an effect on increasing suicide risk by increasing the youth’s vulnerability to psychopathology, such as depression (Amato and Keith, 1991; Aro and Palosaari, 1992; Aseltine, 1996). Depression is a established risk factor for suicide (Marttunen et al., 1991; Shaffer et al., 1996). Alternatively, the association may arise from social and environmental factors which are associated with both increased risk of divorce and increased risk of suicidal behaviour, e.g., parental psychopathology (Beautrais et al, 1996; Brent et al, 1994). Divorce may have an indirect effect on suicide through increasing the risk of disruptive, substance, and mood disorders, all of which are established risk factors for suicide (Marttunen et al, 1991; Shaffer et al, 1996).

Recent research has demonstrated that in Australia, men are more likely to successfully complete suicide while women are more likely to make unsuccessful attempts. Across all age groups in Australia, men are more likely than women to die from suicide, with the 2002 rates at 20.1 per 100,000 (1,935 deaths) and 5.1 (519 deaths) respectively. This pattern holds true throughout the time Australian data has been collected.

Some research indicates that the incidence of suicide ideation is higher for females (Simons & Murphy, 1985; Saxon, Aldrich, & Kuncel, 1978; Salmons & Harrington, 1984), but others have found no difference between genders (Harlow, Newcomb, & Bentler, 1986; Rudd, 1990; Sherer, 1985).

In terms of gender and suicide rate, research has found that although depressed women attempt suicide more often, depressed men are at higher risk for completed suicide. Many of the risk factors for depression that have been identified occur more frequently in females than males. However, when such risk factors are present they can lead to depression in both sexes (Nolen-Hoeksema & Girgus, 1994). Prevention programmes that include boys and girls (or men and women) and that focus on common risk factors are likely to be effective and are an important part of national depression prevention strategies (e.g., Clarke et al, 1995; Muñoz et al, 1995).

The most vulnerable period for male suicide in Australia appears to the 25-29 year age group (31.1 per 100,000). For females, the most vulnerable period is the 40-44
year age group (9.7 per 100,000). The lowest suicide death rate for both males and females in 2002 occurred in the 15-19 year age group (13.1 per 100,000 for males and 4.1 per 100,000 for females). The increasing number of suicide prevention and support services specifically designed to target this cohort of youth (aged 15-19) can perhaps be attributed to the relatively low suicide rate reported above.

In order to explain the gender difference in suicide attempts and completed suicides, researchers have considered the actual method of the act. Males have been found to use more lethal methods such as hanging and firearms, and females use less violent means, such as overdosing. Despite these differences in means, it is interesting to note that gender differences in successful suicide might be a cultural artifact since a study of Chinese adolescent suicides found that among the 1,299 recorded suicide cases between 1979 and 1989, males accounted for 31.9% (Yang, 1990).

### 2.5.6 Gender and Depression

Research into the association between gender and depression in the United States has found that starting sometime during adolescence, females are more than twice as likely as males to suffer from clinical depression. This research also found that approximately one in every 4–5 women will become depressed at some point during her lifetime, and many, or perhaps most of these women will suffer from recurrent episodes.

Furthermore, there is a large amount of research into post-natal depression. Maternal depression can interfere profoundly with care-giving and can be associated with impaired cognitive and emotional development in young children (e.g., Field, 1995). Interestingly, Downey & Coyne (1990) found that older children and adolescents whose mothers are depressed are 5 to 6 times more likely to develop depression than their peers. Such findings indicate a cross-generational pattern of depression in women.

Given these findings, the prevention of depression in women should become a national priority, as Le, Muñoz, Ghosh Ippen, and Stoddard (2003) have suggested. If effective prevention programmes can be developed and implemented, it may be possible to disrupt the transmission of depression from one generation to the next, and to prevent much of the depression that occurs today. Early adolescence is a
particularly relevant time to intervene, as it is during this time that the gender difference in depression emerges and depression rates rise dramatically.

As depression is a known risk factor for suicide, many programmes attempt to target several risk factors that have been identified in young women. Some programmes seek to incorporate ruminative response styles (Nolen-Hoeksema, 1990) and negative feelings about body image and pubertal changes (Petersen, Sarigiani, & Kennedy, 1991). Universal interventions might teach strategies for coping with difficult interpersonal events, and might also focus on the body image ideals that are portrayed by the media and the internalisation of these ideals by girls and young women.

Interventions reported in the literature have recently begun to target the youth mentioned above and are producing promising results (Beardslee et al., 1997; Clarke et al., 2001). Other high-risk groups that could be targeted include children with anxiety disorders, individuals with eating disorders, women with young children at home and with little social support, parents who have lost a child and children and adults who are living in poverty. Specifically, targeted prevention efforts could focus on subgroups of girls and women (and of boys and men) whose risk for depression is several times higher than average (Gilham, 2003).

### 2.5.7 Child Abuse

There are mixed findings to date on the association between child abuse and suicide. Rogers (2003) reviewed the research on the relationship between a reported history of sexual abuse and subsequent suicidal behaviour and concluded that it is premature to say that childhood sexual abuse (CSA) is a significant risk factor for subsequent suicidal ideation, attempts, and completed suicide. This is based on a lack of consistency in definitions of CSA and suicidality, issues related to sample selection and causality interpretations, and the absence of theoretical grounding.

However, a vast array of studies has demonstrated an association between a history of childhood abuse and the subsequent development of adult psychopathology: sexual dysfunction, borderline personality disorder (BPD), dissociative identity disorder, depression, anxiety disorders, impulse control disorder, and post traumatic stress disorder (PTSD) to name a few of the diagnoses that have been associated with early childhood trauma (Bryer et al, 1987; Brown and Anderson, 1991; Burgess

Whilst the direct link between suicidal ideation and childhood abuse may yet to be determined. Many of these diagnoses have suicidal and self-harm behaviours significantly correlation with suicides and self harm. Briere (1992) reports that there are seven primary forms of psychological disturbances to be found in adolescents and adults with abuse histories: (i) posttraumatic stress, (ii) cognitive distortions, (iii) altered emotionality, (iv) dissociation, (v) impaired self-reference (vi) disturbed relatedness and (vii) avoidance behaviours.

2.5.8 Conflict over sexual identity or other sexual issues

Studies in the United States have found risk of suicide attempt ranging from rates of 3.5 to nearly 14 times that experienced by heterosexual young people (Bagley & Tremblay 1997; Bell & Weinberg 1978; Hoogland & Peterse, 1997). Similarly, other alarming research by Bagley & Tremblay (1997) found that the group most at risk in terms of actual suicidal behaviours, suicidal ideation in the past six months, and for depression in the previous two weeks were celibate self-identifying homosexual males.

Studying an Australian population, Nicholas & Howard (1998) have found that gay-identified young men (aged 18 - 24) were 3.7 times more likely to attempt suicide, reflecting similar rates to that seen in the United States. Most of these attempts occurred after the person had identified themselves as gay, but before having a homosexual experience and before publicly identifying themselves as gay. Such findings demonstrate the necessity of support services to reach out to this target group of young men aged 18 – 24 years. Opportunities to reach this cohort of young men may be in a high school context, vocational education settings such as TAFE and tertiary institutions.

Studies on the association between conflict over sexual identity and suicide have been criticised (Remafedi, 1999) on the grounds of unrepresentative samples. Studies in the literature have focused on special populations defined by military service or birth place such as Christchurch, New Zealand, which can limit the ability
to infer a general principle from the findings to other places and types of persons. However, “taken together with earlier studies, there can be little doubt about the conclusion that homosexual orientation is associated with suicidality, at least among young men” (Remafedi, 1999). Some researchers (Remafedi, 1994; Tremblay, 1995) have argued that despite suggestive evidence of homosexual youth being at high risk of suicide, homosexuality issues have been largely ignored in suicide intervention and prevention programmes to date, and in youth suicide research.

2.5.9 Socio Economic Status

The relationship between socio-economic status and suicide is unclear. The Ministerial Council for Suicide Prevention (MCSP, 2004) in Western Australia reports that suicide occurs more often among males in the highest and lowest groups of socio-economic disadvantage. For females, significantly higher rates of suicide occur in the group least socio-economically disadvantaged (MCSP, 2004). Given the lack of evidence presented, socio economic status does not appear to be as significant a risk factor to suicide as other factors such as depression and conflict over sexual identity.

2.5.10 Aboriginal Suicides

The suicide rate for Indigenous males in Western Australia between 1986 and 2002 was 39.3 per 100,000, which is almost double the non-Indigenous male suicide rate (Hillman et al, 2000). Even more alarming is the rate of suicide by Aboriginal males in Australia which is even higher, averaging 47.8 per 100,000 population during 1986-2000 (ABS, 1999).

Approximately 86% of all Indigenous suicides are carried out by males. Aboriginal male suicides are almost twice that of Aboriginal female suicides with the male to female ratio of 7.8:1 in comparison to the state average of 4.2:1 (ABS, 1999). These figures further demonstrate the need for services that are designed specifically to target Aboriginal males who are at risk for suicide and self-harm.

According to Tatz (1999) and Dobson et al (1994) this high rate of Aboriginal suicide is however, a relatively new phenomenon. Studies conducted in the 1960’s did not find such high levels of suicide or mental illness (Cawte, 1968; Kidson and Jones,
The incidence of suicide among Aboriginal people is reported to have increased markedly in the 1980s, accompanied by declining traditional values (Thomson, 1991).

Causes for the higher rate of suicide in Aboriginal communities include family breakdown and separation of children from their parents, alcoholism, a large burden of grief, legal problems (Adin, 1991), social disadvantage Raphael and Martinek (1994) and Radford et al (1990) and lack of services. Services have not been culturally sensitive to Aboriginal concepts of holistic physical, emotional, spiritual and mental health and the importance of connections to family, community and the land.

2.6 Treatment intervention strategies

Prevention strategies have been conceptualised as occurring at three levels: (i) universal strategies are those strategies that include whole population groups or the general public, (ii) selective strategies focus on high risk groups, and (iii) indicated (or targeted) strategies focus on those who are clinically disturbed (Patton and Burns 1998).

Many investigators, including Le et al (1994), recommend that prevention research focus primarily on indicated (or targeted) interventions, particularly interventions that focus on individuals at imminent risk. There are several reasons for this recommendation. Indicated (or targeted) programmes may provide enormous benefit to participants. They have larger effect sizes, on average, than universal interventions and so require smaller samples to evaluate. When the risk is imminent, it is easy to tell when these programmes succeed or fail.

The various prevention strategies that will be outlined in the following sections include examples of Universal, Selective and Indicated approaches.

2.6.1 Treatment Approaches

The problem of youth suicide has been tackled in a range of ways, including:

- Policy and planning
- Community development and support
- Population health approaches

Public health approaches are population and risk-factor oriented, rather than symptom or disease oriented as in traditional approaches. Physicians have typically treated signs of illness, but not the risk. Providing treatment to suicidal persons is extremely important, however reduction of risk factors in the community at large may have more far-reaching and longer-term beneficial effects.

There has been concerted effort to advocate the public health approach to suicide prevention. For instance, the public health approach has been endorsed by both the World Health Organisation (WHO) and the International Association of Suicide Prevention (IASP). Moreover, an increasing number of countries, for example, Australia, New Zealand, the United States, England, Scotland, Finland, and Norway, are developing national strategies that combine various population-based and high-risk strategies. This indicates that the public health approach to suicide prevention is replacing the traditional medical model focusing solely on emergency treatment.

The Community Life programme, managed by a consortium led by the Institute and Curtin University of Technology’s Centre for Developmental Health successfully completed its first phase in September 2005. This programme used a community-wide approach to strengthen factors known to protect against suicide, to improve public understanding of suicide and its causes, and to reduce risk factors. The Community LIFE website (http://www.community-life.org.au/) includes a database of suicide prevention projects, briefing papers and bulletin board facilities.

The Institute mentioned above also houses the Western Australian Ministerial Council for Suicide Prevention (MCSP). This Council advises government and coordinates a range of statewide activities aimed at reducing the morbidity and mortality associated with suicidal behaviour. The Council also advances community and scientific understanding of suicide and its prevention. The Australian Suicide Prevention information and Resource Exchange (ASPiRE) website, sponsored by Woodside Energy Limited, is widely acknowledged as one of Australia’s leading sources of information and community resources for suicide prevention. (http://www.mcsp.org.au/)
2.6.2 Gatekeeper Training

Gatekeeper Training is designed to train people in how to identify and refer people at-risk of suicide. Gatekeeper programmes have been offered to staff in schools, and people in the general community. Although some evidence suggests increased knowledge and improved attitudes toward helping suicidal youth following gatekeeper training programmes, there is limited evidence for systematic evaluations to determine if more youth at-risk are receiving treatment as a result of these programmes or if the programmes are preventing suicidal behaviour.

2.6.3 General Suicide Education

A general suicide education approach includes school-based programmes that provide students with facts about suicide, alerts them to suicide warning signs, and provides them with information about how to seek help for themselves or for others. These programmes often incorporate a variety of self-esteem or social competency development activities. According to Burns et al (121, 2005) "judging from the evidence on the level of intervention required to bring about behavioural change in areas such as adolescent substance use and abuse, it seems unlikely that educational interventions are likely to be effective. There is scope for considering their incorporation into more comprehensive programmes addressing emotional health and social well-being”.

In the past decade, there have been several studies that evaluated school-based suicide awareness programmes (Ciffone, 1993; Kalafat and Elias, 1994; Kalafat and Gagliano, 1996; Shaffer et al., 1991; Silbert and Berry, 1991; Vieland et al., 1991). While improvements in knowledge (Kalafat and Elias, 1994; Silbert and Berry, 1991), attitudes (Ciffone, 1993; Kalafat and Elias, 1994; Kalafat and Gagliano, 1996), and help-seeking behaviour (Ciffone, 1993) have been found, other studies reported either no benefits (Shaffer et al., 1990, 1991; Vieland et al., 1991) or detrimental effects of suicide prevention education programmes (Overholser et al., 1989; Shaffer et al., 1991).

Detrimental effects included a decrease in desirable attitudes (Shaffer et al., 1991); a reduction in the likelihood of recommending mental health evaluations to a suicidal friend (Kalafat and Elias, 1994); more hopelessness and maladaptive coping responses among boys after exposure to the curriculum (Overholser et al., 1989); and
negative reactions among students with a history of suicidal behaviour, including their
not recommending the programmes to other students and feeling that talking about
suicide in the classroom "makes some kids more likely to try to kill themselves" (Shaffer et al., 1990). Other limitations of this strategy are that baseline knowledge
and attitudes of students are generally sound (Kalafat and Elias, 1994; Shaffer et al.,
1991), changes in attitudes and knowledge are not necessarily highly correlated with
behavioural change (Kirby, 1985; McCormick et al., 1985), and the format and
content of some programmes might inadvertently stimulate imitation (Gould, 2001).

To date there is insufficient evidence to either support or oppose curriculum-based
suicide awareness programmes in schools (Guo and Harstall, 2002). Accordingly,
emphasis has shifted toward alternative school-based strategies that will be
presented further below.

2.6.4 Screening Programmes

Evidence of screening programmes suggests that suicidal youth are not likely to self-
refer or seek help from school staff, and nor do knowledgeable peers request adult help (Kalafat & Elias, 1995). For this reason, screening procedures have
increasingly been used to identify youth at risk. Screening involves the administration
of a self-report instrument to identify those at risk and to provide targeted
assessment and treatment (Shaffer and Craft, 1999). Studies that have examined the
efficacy of school-based screening (Reynolds, 1991; Shaffer and Craft, 1999;
Thompson and Eggert, 1999) have found that while screening results in few false-
negatives, there were many false-positives. For this reason, screening is often
followed up by a second-stage assessment consisting of systematic clinical
evaluations, including interviews such as the Suicidal Behaviours Interview
(Reynolds, 1990) or the Diagnostic Interview Schedule for Children (DISC) in order to
identify those youth most at-risk.

2.6.5 Telephone Hotlines

Telephone Hotlines provide emergency counselling for people at-risk of suicide and
are usually staffed by trained volunteers. While there is evidence that such helplines
reach a large target audience, for example, Jones (2003) reports that in 2002,
Lifeline answered 1200 suicide calls, and Toumbourou (2000) (found that calls to
suicide hotlines increased after media reporting of suicide), young males are less
likely to use them than females. There is mixed consensus regarding the efficacy of the telephone hotline approach. According to Burns et al (2005) there is no available evidence to show that telephone hotlines actually decrease the incidence of suicide.

### 2.6.6 Improving Follow-Up Treatment from Emergency Departments

Most people do not seek follow-up treatment after attempting suicide (Piacentini et al., 1995). Interventions to increase the rate of follow-up have been trialled. One such approach being taken to reduce repeat suicide attempts is to refer individuals to treatment after they have been seen in the emergency department (ED) at the hospital in which they are admitted.

One study compared standard care to an intervention in which emergency department staff were taught to recognise the seriousness of suicide attempts, to reinforce the importance of outpatient treatment and to provide for an ED-based initial family education/therapy session. When compared to standard care, this enhanced ED intervention was shown to increase treatment attendance and decrease depression among adolescent Latino suicide attempters (Rotheram-Borus et al, 2000). However, the sample size used in this evaluation was too small to determine whether the intervention had an effect on the number of future suicide attempts.

### 2.6.7 Means Restriction

Restricting access to the means of suicide such as firearms and drugs has been shown to be an effective strategy for suicide reduction. Tightening of firearm legislation in Queensland, Australia has been correlated with a substantial fall in suicide by firearm in metropolitan regions although not in rural areas (Cantor and Slater, 1995). The introduction of automobile emission controls in the United States was also correlated with a decline in the rate of suicide by car exhaust (Clarke and Lester, 1998). There is also evidence to suggest that the use of smaller packs of panadol is associated with lower overdose rates (Gunnel et al, 1997).

### 2.6.8 Postvention

Postvention is the provision of services following an incident of suicide attempt or completed suicide. Postvention strategies involve the provision of crisis intervention,
support and assistance for people affected by a completed suicide. These services are designed to minimise the risk of further suicides and to assist those grieving for the loss of the suicide victim. There is limited evidence for effectiveness of such services.

2.6.9 Addressing Risk Factors including Mental Health and Resilience Promotion

Initiatives that have addressed risk factors such as depression and substance abuse in youth include a randomised controlled trial by Clarke et al (1995) targeting high school students at high risk of depression. The subjects in the study were provided with 15 after-school sessions of coping skills training. Results indicated reduced depression shortly after the intervention which had disappeared at the one-year follow-up. There was however a lower incidence of depression in the intervention group after one year. Similarly, Tobler (1992) reviewed 143 life-skills training programmes based in schools and concluded that they were also effective in reducing substance use in youth.

2.7 Evidence for Therapeutic Approaches to Treatment

This review covers evidence for the effectiveness of therapeutic approaches to youth suicide prevention, including peer support programmes and therapeutic camps for youth at risk of suicide.

2.7.1 Cognitive Behavioural Therapy

Cognitive-behavioural therapy is an action-oriented form of psychosocial therapy that assumes that maladaptive, or faulty, thinking patterns cause maladaptive behaviour and ‘negative’ emotions. The treatment focuses on changing an individual's thoughts (or cognitive patterns) in order to change his or her behaviour and emotional state.

Three models of treatment for treating suicidal ideation and depression were compared by Brent et al (1997) and the first treatment involved individual cognitive behavioural therapy (CBT). In order to make the treatment more suitable to youth, concrete examples were used exploring autonomy and trust, highlighting cognitive distortions and the affective shifts that occur during sessions. Sessions also involved
problem solving, affect regulation and social skills (Brent and Poling, 1997). The second treatment condition involved systemic behaviour family therapy and the third condition was non-directive supportive counselling. Researchers found that while all three treatments reduced suicidal thinking over the 3 to 4 months of treatment, cognitive behavioural therapy was the most effective at reducing depression.

An evaluation of the National Youth Suicide Prevention Strategy in Australia conducted by Mitchell (2000) reports that recent data indicates CBT is effective for depression of mild to moderate severity, however it is not effective in the treatment of severe depression. Martin and Wright (1999) make particular note of the lack of published research that has examined interventions into the family environment of depressed adolescents.

An additional study demonstrating support for cognitive behavioural therapy is the randomised controlled study by Salkovskis, Atha & Storer (1990) that investigated cognitive behavioural problem solving versus treatment as usual. Subjects included 920 patients at high risk of repeated suicide attempts. Subjects were allocated to either cognitive-behavioural problem solving or a "treatment-as-usual" control condition. Results indicated that the problem solving group improved significantly more than controls on ratings of depression, hopelessness, suicidal ideation and target problems at the end of treatment and results were maintained at one year follow-up.

Cognitive behavioural therapy has been found to be effective in treating individuals with borderline personality disorders. Brown et al (2004) conducted an uncontrolled clinical trial using a sample of 32 patients with Borderline Personality Disorder who reported suicide ideation or who engaged in self-injury behaviour. The subjects received weekly cognitive therapy sessions over a 1 year period as described by Layden et al (1993). Results demonstrated that subjects found significant decreases on measures of suicide ideation, hopelessness, depression, number of borderline symptoms and dysfunctional beliefs at termination. This improvement was sustained at 18 months follow-up, and rates of repetition also declined over the six months post treatment.

As indicated above, there is mounting evidence for the effectiveness of this approach which has been evaluated explicitly as cognitive behavioural therapy or indirectly as the basis of other youth suicide programmes.
2.7.2 Dialectic Behaviour Therapy

Dialectical Behaviour Therapy is a variant of Cognitive Behavioural Therapy, specifically designed as treatment for individuals with Borderline Personality Disorder. This form of therapy involves learning specific behavioural skills with the goal of improving impulse control, interpersonal skills and emotional regulation.

Focusing on suicidal youth with borderline personality features, Rathus and Miller (2002) evaluated the use of Dialectical Behaviour Therapy (DBT) in a general child and adolescent psychiatric inpatient unit by comparing DBT with treatment as usual (TAU). 62 youth who had attempted or had suicidal ideation were admitted to one of two psychiatric inpatient units. One unit used a DBT protocol of twice weekly therapy sessions, consisting of individual therapy and a multifamily skills training group (n = 29) for 12 weeks. The other unit relied on treatment as usual. Assessments were made of depressive symptoms, suicidal ideation, para-suicidal behaviours, hopelessness, hospitalisations, emergency room visits, and adherence to follow-up recommendations before and after treatment and at 1 year follow-up for both groups. Behavioural incidents on the units were also evaluated.

Results from the study indicated that Dialectical Behavioural Therapy significantly reduced behavioural incidents during admission, when compared with treatment as usual and both groups demonstrated highly significant reductions in symptoms of depression, para-suicidal behaviour, and suicidal ideation at 1 year follow-up.

2.7.3 Family and Social Network Support Therapies

Therapy with families may be based on a specific systemic approach such as Multisystemic Therapy. A systems approach is based on the premise that within any given social unit, relatively autonomous subsystems are formed to enhance the adaptive capacity of a larger system (Minuchin, 1974; Minuchin & Fishman, 1981). Therapy with families may also involve other models of therapy such as skills training, problem solving and counselling.

Family therapy-based interventions have shown significant success in treating youth with high levels of suicide risk factors such as violent and chronic juvenile offending, and drug abuse (Henry, Stephenson, Hanson & Hargett, 1993). These interventions
include Multisystemic Therapy (Henggeler et al, 1997), Functional Family Therapy (Barton et al, 1985), and Structural Family Therapy (Santisteban, 1996).

Parenting and family interventions have been found to be effective strategies for reducing risk factors for harmful youth substance use, at the universal, selective and indicated levels (Tombourou, 2000). Parenting training programmes typically include modules on communication, conflict resolution and effective child management. Results have shown reductions in conflict and a trend towards increased satisfaction and confidence in parenting (Jenkinc and Bretherton, 1994).

Some research however has suggested that Family Intervention Therapy does not reduce suicidal ideation in depressed youth (Brent et al’ 1997; Harrington et al, 1998). The reason suggested as to this lack of success is the insufficient time to implement this form of intervention.

### 2.7.4 Developmental Group Therapy

Group Therapy is commonly used in conjunction with other forms of therapeutic interventions or on its own as an effective form of Supportive Therapy. There is limited empirical evidence for the efficacy of Group Therapy as a primary therapeutic intervention.

The use of Developmental Group Psychotherapy was assessed by Wood et al (1996) who compared Group Therapy and routine care, with routine care alone. Treatment involved assessment and six ‘acute’ group sessions, covering issues such as school problems, family, relationships, anger management, self-harm, depression and hopelessness. The six ‘acute’ group sessions were followed by weekly ‘long-term’ groups of approximately 8 sessions. Results indicated that at the 7th month interview, youth who participated in the Group Therapy where less likely to have attempted suicide twice or more times than those in routine care alone. Results also found that the youth were less likely to need routine care, had improved school attendance and their rate of behavioural problems had reduced. The group intervention did not reduce depression or suicidal thinking but youth who attended more sessions of Group Therapy were less likely to attempt further self-harm.
2.7.5 Narrative Therapy

No studies of the effectiveness of Narrative Therapy in reducing suicidal behaviour or self-harm were identified in the literature search.

2.7.6 Life Skills Development

Life Skills Development covers a range of issues and topics for adolescents who are transitioning into adulthood. Life Skills Development curriculums commonly include topics such as relationships, sexual health, early parenting, budgeting, housing, employment and vocational training. Life Skills Development programmes can be designed to assist youth who have limited family support networks, and who may need help and support in navigating the challenges that independent living can bring.

In contrast to suicide awareness curriculums in schools, skills training programmes emphasise the development of problem-solving, coping and cognitive skills. There is some research that supports the notion that suicidal youths have deficits in these areas (e.g., Asarnow et al., 1987; Cole, 1989; Rotheram-Borus et al., 1990). It is hoped that through skills training programmes, an "immunisation" effect can be produced against suicidal feelings and behaviours. The reduction of suicide risk factors (e.g., depression, hopelessness, and drug abuse) is also a targeted outcome of these programmes.

Several evaluation studies of Life Skills Development programmes have shown promising results, with some evidence for reductions in completed and attempted suicides (Zenere and Lazarus, 1997) and improvements in attitudes, emotions, and distress coping skills (Klingman and Hochdorf, 1993; Orbach and Bar-Joseph, 1993). Research by Eggert et al (1995) found that Life Skills programmes targeting students at risk for school failure or dropping out of school showed significantly lower levels of suicide risk behaviours, depression, hopelessness and displayed higher levels of problem-solving skills.

Peer-led Life Skills training has been found to be more effective than teacher-led programmes with students in years 7/8, in both substance abuse and cognitive, attitudinal and personality mediating variables (Botvin et al 1990). These positive effects were reportedly strengthened by incorporating booster sessions into later years.
2.8 Peer Education and Support

In terms of resilience promotion, there is evidence that peer support programmes help reduce other factors associated with suicide such as antisocial behaviour and substance abuse (Dryfoos, 1990). In a meta-analysis of 143 peer support adolescent drug prevention programmes, Tobler (1986) found that, although programmes had a greater impact on knowledge than on attitudes, they did appear to reduce the frequency of substance abuse (the reduction being much greater for cigarette smoking than for the use of other substances).

Of particular interest is the finding that peer-influence programmes which focus on areas such as developing refusal skills and enhancing interpersonal competency, are more effective than other programme models (such as knowledge-oriented programmes and affective-education programmes that focused on building self-esteem). Results of a meta-analysis of data from 14 studies of school-based drug education programmes showed that programmes taught by peers were more successful than those taught by adults (Bangert-Downs, 1988).

Peer Education Support programmes which can be conducted in either school or non-school settings, are designed to foster peer relationships, competency development, and social skills as a method to prevent suicide among high-risk youth. An evidence base supporting the efficacy of School Based Peer Support Programmes has developed in recent years. The following section will outline evaluation findings of 8 School Based Peer Support Programmes.

2.8.1 School-Based Peer Support Programmes

1. CAST (Coping and Support Training)

The CAST school-based intervention was designed to build the personal and family strengths that influence suicide-risk behaviours (Eggert, 2001). The theoretical basis for the programme was the social support literature, social learning theory, and social influence models.

The CAST programme was evaluated using groups of 6-7 students who were provided with twice weekly sessions made up of support-building activities, problem-solving, anger management, self-esteem building and activities designed to
strengthen students’ ability to recognise their own progress. The groups were conducted for 12 weeks and the average age of student subjects was between 15 and 16 years old. A sample of 341 students was used for the evaluation and a control group was used.

The intervention provided evidence of significant reductions in students’ depression. The CAST programme contributed specifically to improvements in self-efficacy (personal control & problem-solving) and perceived family support. Eggert (2001) cautions though that the findings should be interpreted cautiously given the short-term nature of the follow-up, and that all of the outcome measures were self-report.

2. SOS

The SOS school-based prevention programme consisted of two suicide prevention strategies; (i) screening and (ii) a curriculum designed to raise awareness of suicide and related issues which features discussion in classroom settings.

The SOS programme was evaluated by Aseltine (2003) using a random controlled trial. The sample included 2100 students from 5 high schools in the United States. Subjects were randomly assigned to intervention and control groups. Self-administered questionnaires were completed by students in both groups approximately 3 months after programme implementation.

Aseltine (2003) found significantly lower rates of suicide attempts, greater knowledge and more adaptive attitudes about depression and suicide among students in the intervention group and small changes in knowledge and attitudes. Following programme implementation there was a 150% increase in youth seeking counselling for depression and suicide concerns. This was determined by comparing rates post implementation with the comparable month in the previous year. It should be noted that in this evaluation of the SOS programme, outcome measures were of a self-report nature which can be seen as a potential limitation to the findings.

3. RAP (The Resourceful Adolescent Programme)

RAP is a universal school-based programme designed to prevent depression in youth, developed by Griffith University in Queensland, Australia in 1996. This programme was evaluated by Schochet, Dadds, Holland, Whitefield, Harnett and
Osgarby (2001) from Griffith University, in order to assess the efficacy of the universal school-based programme.

In this evaluation a sample of 260 Year 9 secondary school students completed measures of depressive symptoms and hopelessness prior to being assigned to 1 of 3 groups. The first group was (a) the Resourceful Adolescent Programme-Adolescents (RAP-A) an 11-session school-based resilience building programme, as part of the school curriculum; the second group was (b) Resourceful Adolescent Programme-Family (RAP-F) the same programme as in RAP-A, but in which each student's parents were also invited to participate in a 3-session parent programme; and (c) Adolescent Watch, a comparison group in which adolescents simply completed the measures.

Results indicated that adolescents in either of the RAP programmes reported significantly lower levels of depressive symptomatology and hopelessness at post-intervention and 10-month follow-up, compared with those in the comparison group. Adolescents also reported high satisfaction with the programme. The study provides evidence for the efficacy of school-based universal programmes designed to prevent depression in adolescence.

4. ACE (Adolescents Coping with Emotions)

The ACE programme is an indicated school-based depression prevention programme for at-risk students and was developed by the New South Wales Health Department in 1998. The goal of the ACE programme is to build resilience, enhance coping skills and teach positive thinking styles in young people using group skills, psycho-educational and cognitive-behavioural practice. The programme sessions involve interactive education, discussion, structured group activities and practice of new skills through role-plays and exercises. The programme is conducted in schools over an 8-week period.

The ACE programme was evaluated using a controlled trial, and involved screening 882 students and offering ACE to 144 students. Results from the evaluation demonstrated a significant reduction in depression symptoms. The trial Researchers received NHMRC funding (2001 & 2002) to further evaluate ACE in conjunction with the universal programme Problem Solving for Life, conducted by the University of Queensland (Kowalenko, Rapee & Ann Wignall, 2001).
5. Problem Solving for Life

Problem Solving for Life is a universal school-based depression prevention programme developed in Queensland, Australia. The programme is delivered by teachers to young people who are taught to identify thoughts, feelings and problem situations. The programme teaches problem-solving skills including positive problem solving orientation and optimistic thinking styles, using didactic sessions, cartoons, individual small group and class exercises, homework and diary keeping.

Problem Solving for Life was evaluated using a randomised controlled trial, with allocation by school unit (Spence, Sheffield & Donovan, 2003). Schools were matched in pairs on the basis of State versus Private funding and number of students enrolled. After paired matching, one school from each pair was assigned to the intervention group and the other to the control group.

Teachers in the intervention group attended 6 hours of training on the theory and implementation of the programme consisting of 8 weekly self-contained sessions, lasting one class period of 45–50 minutes. Students and teachers at control schools received no intervention. The trial involved 1,500 students aged 12–14 years (mean 13 years). Students with scores of 13 or above on the Beck Depression Inventory at baseline were categorised as being at high risk of developing depression, and students with scores of 13 and less were categorised as low risk.

Results indicated that at the end of the intervention period high risk students who received the programme had a greater decrease in depressive symptoms and increase in problem-solving scores, compared with high risk controls. Among low risk students, depression scores were slightly reduced and problem-solving skills increased over the intervention period, compared with low risk controls. Benefits of this programme however, were not maintained at 12-month follow up.

6. Peer Gatekeeper Training Programme

The Peer Gatekeeper Training Programme began in 1999. The programme is a skills based training programme, delivered in two 4-hour sessions at least one week apart. At the end of the training programme participants are expected to demonstrate a greater understanding of the nature and causes of youth suicide, and are expected to
be able to identify the warning signals of suicide. It is expected that participants will also be able to ask if a peer is feeling suicidal, be able to assess risk for suicide and demonstrate an increase in active listening skills.

There are advantages of Peer Gatekeeper Training programmes including the fact that as peer helpers, youth will likely encounter peers at risk for suicide. This type of programme provides youth with an opportunity to build on the listening skills they learn in peer helper training through the school. The wide variety of teaching techniques employed enables the programme to be interesting, fun, and engaging for youth.

Waalen and Haelsrom (2003) evaluated the efficacy of such Peer Gatekeeper Training programmes using a repeated measures design (with no control group). The researchers found there were significant gains in knowledge about suicide and skills for responding to suicidal peers immediately after training and 3 months later. They also found a significant improvement in positive attitudes toward suicide intervention following training.

7. FRIENDS

FRIENDS is a universal evidence–based resilience-building, anxiety prevention and treatment programme used in schools and health clinics throughout Australia, the United Kingdom, Germany, Canada, the US, the Netherlands, Sweden, Portugal and Denmark. Within Western Australia the FRIENDS programmes is offered in Albany.

A random controlled longitudinal study was conducted to evaluate the effects of the FRIENDS programme at two developmental stages. The study involved 733 children enrolled in grade 6 (aged between 9 and 10 years) and grade 9 (aged between 14 and 16 years). Subjects were allocated to either a school-based cognitive-behavioural intervention or to a monitoring group, and all completed standardised measures of anxiety, depression and coping style. Those identified as at risk of an anxiety disorder were assessed for a clinical diagnosis with a structured diagnostic interview.

The results from the evaluation indicate that the universal intervention is effective in reducing symptoms of anxiety and increasing coping skills in children. Because the greatest reduction in anxiety symptoms occurred in primary school children, Lock and
Barrett (2003) suggest that earlier preventive intervention is potentially more advantageous than later intervention.

8. Circle of Support

Circle of Support is a school-based prevention and intervention programme addressing adolescent depression and self-destructive behaviour. The programme features policy implementation and gatekeeper training delivered in the following six programmes 1) Building A Circle of Support: A Model for the Intervention and Prevention of Adolescent Mental Health Problems 2) Adults Who Care: Education for Parents and School Staff 3) Tackling Tough Stuff, Adolescent Skills to Understand Depression 4) Reaching In/Reaching Out: Topics for Counselling Support Groups 5) Teens Helping Teens: Peer Helper Training on Depression and Suicide Attempts and 6) Teen Teachers: Cross-Age Education to Build Friendship Skills. No evaluation studies of the effectiveness of the Circle of Support programme were identified in the literature search.

2.8.2 Youth Group Support Programmes

Not only are high levels of support and connection related to positive mental health (Resnick et al, 1997), but who provides that support is also crucial. Youth service providers that include schools, youth agencies, family support agencies etc have a significant role in providing information and support to young people.

The group support model aims to provide peer support to assist young people to see that they are not alone in experiencing difficulties and begin to recognise that support is available and that change is possible. This model aims to strengthen protective factors in order to develop robust, resilient adolescents with the skills, attitudes and behaviours necessary to function as positive, successful members of their community.

Youth group support residential camps have been used as a site for preventative activities but the evidence-base for their effectiveness is limited. Preliminary evaluations do indicate that they may have a useful role in the promotion of protective factors such as connectiveness and the development of self-esteem. While there is limited empirical evidence for youth group support residential camps, the literature on youth suicide prevention indicates that promoting protective factors are
of vital importance, and as such these themes are central to the model of youth group support work.

The past decade has seen an increase in the availability of youth group support residential camps for young people both within Australia and abroad. In the United States for example, there is a range of camps with differing objectives, all of which are dependent on the target group of participants. It is proposed that the lack of empirical evidence for the efficacy of such youth group support residential camps is due to the fact that very few formal evaluations of camps have been conducted to date.

The following section will outline seven youth group support residential camp initiatives operating in Australia and abroad.

1. **Youth Insearch**

Youth Insearch is an Australian peer support programme that maintains the peer focus of young people supporting young people. Youth Insearch was founded in 1985 and operates across Australia, running weekend residential camps and conducting follow-up support groups for at-risk young people. The Youth Insearch programme conducts weekend residential camps for youth aged 12-18 years, in which approximately 65 people attend.

The emphasis of the camps is on young people helping young people, and the overarching goal is 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. Participants on the camps are encouraged to talk about their concerns and learn ways to handle them. A safe and trusting environment is intended to be created allowing young people to feel comfortable to discuss issues of an emotional nature. These issues may be related to family breakdown, bullying, drug and alcohol abuse, domestic violence, sexual abuse, suicide and grief. Issues such as communication, trust and self-esteem are also explored.

The weekend camps are run by Youth Leaders who have also completed the programme. A total of 18 sessions are run over the weekend course, and the same sessions are run over each camp. The camps incorporate a Support Adult who accompanies the young person to the camp and assists with the support groups. The
Support Adult can be family members, youth workers, school teachers, counsellors, nurses and other people.

After the camp has finished, young people are encouraged to attend support groups where they can discuss how things are going for them since the camp. Youth Insearch sees this as an opportunity to set new goals and directions with the support from those that attended the camp.

Youth Insearch does restrict some youth from attending camps, including young people who are in an acute stage of mental illness and those who are unable to cope without non-prescribed drugs or alcohol for a weekend. The camps also exclude sexual offenders.

2. **SAIL (Self Acceptance is Life)**

SAIL is a camp-based youth suicide prevention programme run by Camp Fire USA, a National youth development organisation based in Kansas City with chapters in 40 states. Camp Fire USA offers outcome-based programmes in the areas of youth leadership, self-reliance, after school groups, camping and environmental education and child care. It services 735,000 participants a year.

The SAIL camps target students in the 8th to 12th grade (13 to 17yrs) who are worried about their peers, and may have been personally affected by suicide. SAIL presentations focus on education, warning signs, and how to assist a friend who might be suicidal.

According to camp personnel, “the presentations are particularly effective because of the impact that peer education can bring. Youth are more receptive to presenters who are peers of, or close in age to, themselves. Because there are fewer barriers, participants remain interested in the subject matter.”

http://www.campfireinc.org/teens/sail.html

3. **R.M Pyles Boys Camp**

The R.M Pyles Boys Camp based in California, USA is a Wilderness Therapy Camp that provides a camp programme to at risk adolescent boys aged 12-16. This programme is geared toward increasing self-confidence and instilling the values of
hard work, goal setting, teamwork and problem solving. Camps are run by former campers and graduates of Pyles Boys Camp Leadership Programme that act as role models to the youth. Positive peer groups and the guidance of successful former campers provide a sound environment for this change. The positive peer group association provides a strong incentive and reminds participants of the choices they make.

Follow-up sessions after the initial camp experience are conducted including reunions, field trips, home visits, camp outs, letters and the development of a yearbook, to help reinforce positive behavioural changes achieved at camp. The follow-up group support has the goal of supporting the continued positive behavioural changes these young men are making. The longer term lasting effect is accomplished with reunions, field trips, leadership training and college scholarships.

The Pyles Boys Camp was evaluated to investigate the impact of the camp programme on changes in self-esteem, locus of control and relationship to group affiliation. The sample group of 223 boys were administered a pre-test and post-test and were followed up after 9 months. The Rosenberg Self-esteem Scale (Rosenberg, 1979) and the Nowicki-Strictland Locus of Control Scale (Nowicki-Strictland, 1973) was administered during each period of testing, and at the second testing the Group Climate Questionnaire (McKenzie, 1981) was administered.

Results indicated significant increases in self-esteem over time (from pre-test to post test, and from pre-test to 9 month follow-up), and a significant change towards an internal locus of control. The change was significant for self-esteem and locus of control across the three ethnic groups of Caucasians, Latinos and African Americans and across three local geographic regions.

4. New Horizons Wilderness Camp for Young Women

The New Horizons Wilderness Camp for Young Women was established in Oregon USA and is a peer support camp for troubled girls. This camp is a therapeutic self-empowerment intervention programme that focuses on the needs of young women aged between 13 and 17, and is run for 6-9 weeks and combines clinical therapy and outdoor adventure.
The programme is designed for girls who are depressed, mildly self-abusive, have poor body image or are bipolar (who are stabilised on medication). Unlike other youth support camps reviewed, the Horizons Wilderness Camp accepts girls who are suicidal and self-harming. For suicidal young women, it is a requirement that contracts are drawn up between the young woman and camp staff at the beginning of the programme. The ratio is 4-5 staff to 7 girls, with two therapists to supervise.

Therapeutic intervention incorporates a bio-psycho-social model with concentration on the family, the individual and the socio-cultural context. Individual Therapy, Family Therapy, Psycho-Education, Group Therapy, Cognitive Behaviour Techniques and Experiential Education that is solution-focused are all provided on these therapeutic camps.

Camp activities incorporate group discussions that are interwoven throughout the day and may last 1-3 hours depending on the needs of the girls. The programme is designed to work on different values each week including values such as Truth (what is the truth about you?), friendship, forgiveness, transition and acceptance. Each phase deals with the young woman, their families and peers. Self reflection, journal writing and reading is also encouraged on the camp.

This programme offers clinical tools that young women and their families can use long after the programme has finished. Parents and legal guardians are given ongoing written assignments that correlate with their daughters. Through such journal entries, letter writing and reading assignments, the goal is for the parent and daughter to gain the essential tools needed for effective, respectful communication.

For follow-up support, camp staff maintain contact with the girls for four years after they leave the programme, which serves as ongoing informal support.

5. **Blackwater Outdoor Experience**

The Blackwater Outdoor Experience is a Wilderness based Therapeutic Camp. The camp is a 21-day wilderness based therapeutic course that incorporates group counselling sessions (at least one per day) and formal individual sessions (at least 3 per course). Client specific treatment plans are developed, daily recording of client’s experiences are noted, and a thorough discharge summary is required. Aftercare recommendation services are considered closely by the youth and their family.
6. Nurturing Youth Aspirations

The Shire of Halls Creek in Western Australia conducted the Nurturing Youth Aspirations programme that consisted of two Cultural Camps. The Young Men’s Camp took place in October 2002 and was designed specifically for Indigenous males aged 16-25. The camp included presentations on services and programmes run by Garnduwa Youth Sports and Recreation Centre and Kununurra Youth Services. Elders from the community attended the camps and presented on topics such as Aboriginal heritage and culture.

7. Bush Babies Camp

The Bush Babies Camp conducted in Fitzroy region of Western Australia was designed specifically for young Indigenous females and included among other things, discussions on issues facing young women including early pregnancy, parenting, substance abuse and suicidal behaviours. The camp incorporated female elders for support and allowed for discussion in a safe environment. Elders from Fitzroy, Bidyadanga and Jalmadanga attended both camps and spoke about their past and cultural law.

As stated previously, within the literature there is limited empirical evidence for the efficacy of youth group support residential camps in the prevention of youth suicide. It is suggested that this may be due to the fact that very few formal evaluations of camps have been conducted to date.

In reviewing the various forms and styles of youth group support work, common themes and rationales can be identified in the stated programme objectives. The programmes reviewed above demonstrate a consistent focus on promoting protective factors such as connectiveness and developing one’s self-esteem, both factors are known to be of vital importance and central to the model of youth group support work.

Of the programmes reviewed, common components were identified including aftercare services such as follow-up group support counselling, the camps are often Youth Leader Led and have a strong Peer Focus. In terms of aftercare services, support after a camp is considered to be essential for the welfare of all young participants in order to reinforce new directions embarked on during the camp. Formal support groups and networking with peers in their area are ways that the
Youth Insearch programme sees the provision of such support. Formal support groups can also be a forum in which professional counselling may be identified as being required. Other common programme objectives identified include a non-specific orientation to ‘suicide prevention’. This is however seen as a by-product of programme goals including empowerment, building of self-esteem, communication and resiliency.

2.9 Conclusion

Chapter Two has presented a detailed review of the pertinent literature contributing to the understanding of youth self-harm, suicidality, and management and treatment intervention strategies. The areas covered have included: (i) a review of the epidemiological data concerning self-harm and suicide, (ii) psychosocial models of suicidal behaviour, (iii) biopsychosocial risk factors for self harm and suicidality, and (iv) the evidence for therapeutic treatment initiatives. These thematic foci were fundamentally relevant to the research questions, aims and hypotheses.

Cognitive behavioural therapy (CBT) has been recommended as the treatment of choice for depression among young people (NH &MRC, 1997). A literature review by Martin and Wright (1999) identified CBT as the most well studied psychological therapy and one that continues to have strong research support. Other forms of psychological therapy have not been as well studied or tested for empirical validity.

Psychological therapies or treatment methods for depression often include Individual Psychotherapy. Commonly used styles of therapy include Cognitive Behavioural Therapy, ‘Supportive’ Therapy, Individual Psychodynamic Therapy, Narrative Therapy, Family Therapy, Crisis Intervention and Relaxation Therapy.

A review of youth suicide prevention programmes in the Australian literature indicates that treatment methods are often multidimensional and multifaceted, and incorporate a range of services that may include individual therapy, as well as case management services, group work and life skills education. Programmes which involve such multiple strategies are hence more likely to be effective.

There is limited research in Australia on the effectiveness of suicide prevention interventions and programmes. Further, from the research that has been conducted,
there appears to be no strong evidence for the efficacy of any particular Australian prevention strategy.

Programmes of Peer Education and Support Interventions including School-Based Peer Support Programmes and Youth Group Support Residential Camps have a limited evidence-base for their effectiveness, although they can be used as a setting for preventative activities. Preliminary evaluations do indicate that they may have a useful role in the promotion of protective factors such as connectiveness and the development of self-esteem. While there is limited empirical evidence for such residential camps, the literature on youth suicide prevention indicates that promoting protective factors are of vital importance, and as such these themes are central to the model of youth group support work.

This group support model aims to provide peer support to assist young people to see that they are not alone in experiencing difficulties and begin to recognise that support is available and that change is possible. This model aims to strengthen protective factors in order to develop robust, resilient adolescents with the skills, attitudes and behaviours necessary to function as positive, successful members of their community.

In examining these topics, it is clear that significant deficits exist in our knowledge of what constitutes appropriate and effective treatment recommendations for the complexities of youth suicide and self-harm. Chapter Three will outline and discuss the design and methodological procedures adopted and applied in order to compile the data necessary to address the research objectives.
Chapter Three

Methodology

3.1 Introduction:

The Youth Focus Action Research Steering Committee stipulated that an action research methodology be adopted to address the project objectives as outlined in Chapter One. Action research is not easy to define. It was developed in the US in 1946 by social scientist Kurt Lewin. Its capacity is to bridge the gap between research, theory and practice, and to do research with people, rather than on them, which has resulted in its increasing popularity across a wide variety of disciplines.

Action research has changed substantially since its inception and there are a number of definitions, uses and theories relating to its epistemology and methodology. Most incorporate three key characteristics of action research: (i) it is participatory; (ii) democratic in intent and (iii) contributes both to the social science knowledge base and to social change.

Action research is used in real social situations. As opposed to engineered experimental or even quasi-experimental studies. This is a function of the primary focus of action research being developed and applied to resolving real i.e. social problems. Action research has in part been chosen in this context because the circumstances require flexibility, it involves young people in the research, and the desired change process is required to happen relatively quickly and holistically.

The action research process requires continual negotiation with all participants around purpose, process and outcomes (see figure 1). Action research
fundamentally depends on the building of trusting interpersonal relationships. It is anticipated that whilst the research will be led and mentored by UWA, ownership will clearly remain with Youth Focus. In its simplest terms action research is research by doing. A problem is identified; a group of people seek to understand and resolve the problem, and evaluate the effectiveness of the change strategy. Action research may be succinctly outlined as follows (Gilmore et al, 1986, 161):

“Action research…aims to contribute both to the practical concerns of people in an immediate problematic situation and to further goals of social science simultaneously. Thus, there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is regarded as a desirable direction. Accomplishing this twin goal requires the active collaboration of researcher and client, and thus it stresses the importance of co-learning as a primary aspect of the research process”.

Figure 1: Detailed action research model (Adapted from Susman 1993)
3.2 Principles of Action Research

What gives action research its unique flavour is the set of principles that guide the research process. Winter (1989) provides a comprehensive overview of six key principles:

1) Reflexive critique

An account of a situation, such as notes, transcripts or official documents, will make implicit claims to be authoritative, i.e., it implies that it is factual and true. Truth in a social setting, however, is relative to the teller. The principle of reflective critique ensures people reflect on issues and processes and make explicit the interpretations, biases, assumptions and concerns upon which judgments are made. In this way, practical accounts can give rise to theoretical considerations.

2) Dialectical critique

Reality, particularly social reality, is consensually validated, which is to say it is shared through language. Phenomena are conceptualised in dialogue, therefore a dialectical critique is required to understand the set of relationships both between the phenomenon and its context, and between the elements constituting the phenomenon. The key elements to focus attention on are those constituent elements that are unstable, or in opposition to one another. These are the ones that are most likely to create changes.

3) Collaborative Resource

Participants in an action research project are co-researchers. The principle of collaborative resource presupposes that each person’s ideas are equally significant as potential resources for creating interpretative categories of analysis, negotiated among the participants. It strives to avoid the skewing of credibility stemming from the prior status of an idea-holder. It especially makes possible the insights gleaned from noting the contradictions both between many viewpoints and within a single viewpoint.
4) **Risk**

The change process potentially threatens all previously established ways of doing things, thus creating psychic fears among the practitioners. One of the more prominent fears comes from the risk to ego stemming from open discussion of one’s interpretations, ideas and judgments. Initiators of action research will use this principle to allay others’ fears and invite participation by pointing out that they, too, will be subject to the same process, and that whatever the outcome, learning will take place.

5) **Plural Structure**

The nature of the research embodies a multiplicity of views, commentaries and critiques, leading to multiple possible actions and interpretations. This plural structure of inquiry requires a plural text for reporting. This means that there will be many accounts made explicit, with commentaries on their contradictions, and a range of options for action presented. A report, therefore, acts as a support for ongoing discussion among collaborators, rather than a final conclusion of fact.

6) **Theory, Practice, Transformation**

For action researchers, theory informs practice, practice refines theory, in a continuous transformation. In any setting, people’s actions are based on implicitly held assumptions, theories and hypotheses, and with every observed result, theoretical knowledge is enhanced. The two are intertwined aspects of a single change process. It is up to the researchers to make explicit the theoretical justifications for the actions, and to question the bases of those justifications. The ensuing practical applications that follow are subjected to further analysis, in a transformative cycle that continuously alternates emphasis between theory and practice.

3.3 **Locating action research in a research paradigm:**

Although sharing a number of perspectives with an interpretative research paradigm, and clearly utilising many qualitative methodologies, some researchers that are of the
opinion that qualitative epistemological structures do not adequately articulate action research (Lather, 1986; Morley, 1991).

A ‘praxis’ paradigm has been identified and presented as the most appropriate epistemological structure under which to place action research. Praxis as developed and articulated by Aristotle is the art of acting upon the conditions one faces in order to change them. It is focussed upon, and deals with, the disciplines and activities predominant in the ethical and political lives of people. Aristotle contrasted this position with Theoria – those sciences and activities that are concerned with knowing for its own sake. That knowledge is derived from practice, and practice informed by knowledge, in an ongoing process is a cornerstone of action research.

3.4 Methodology:

For ease of understanding, the research project will be described in relatively discrete phases with participatory process to suit the activity of the different phases.

i. Phase 1
The foundations of this project will be built on a review of the literature, a review of programmes which are similar to the Youth Focus group support programme; a secondary analysis of existing Youth Focus data (including post-camp survey data) and of agency documentation on the purpose and programme framework of the group support programme including detail of the Camp programme and the rationale for that. A preliminary report will incorporate an analysis and conceptualisation of the issues arising from this data.

Relationship building with the agency, including an iterative process arising from the sharing of existing knowledge and emerging themes, and the negotiation of ongoing process, will be undertaken during this phase.

The University of Western Australia Ethics Committee approval process will also be negotiated during this phase with an exemption from formal ethical review being sought on the grounds that this research is a low risk study essentially for the purpose of monitoring, evaluating and improving a service delivered by a provider.
ii. Phase 2
This phase will commence with the completion of Phase 1, and with meeting the requirements of the UWA Human Research and Ethics Committee. The first task in this phase, will be development of the interview and focus group schedules. These schedules will be informed by the findings from Phase 1 and ongoing discussion with the agency and participants; and may be further developed following commencement of focus groups and interviews. The identification of participants for interviews and focus groups will be finalised. Facilitation assistants (agency-based researchers) will be recruited, selected, and assisted in developing the necessary skills. The interview schedule already developed by Youth Focus will form the starting point for planning the numbers of interviews and focus groups to be undertaken.

iii. Phase 3
The interviews will be undertaken. The interviews will be undertaken by a UWA appointed research assistant and Youth Focus counselling staff. The interview data will be continuously reviewed, if at any stage it appears that saturation has been reached in the data being generated then the interviewing phase will be terminated. Data collection in the interviews and focus groups will be carried out using a semi-structured interview schedule incorporating open ended questions (see appendixes 2 and 3).

iv. Phase 4
Phase 4 is a consolidation and development phase commencing with the final analysis and write-up of the data collected in Phases 1 and 3. Understandings arising from Phases 1 and 3 will be articulated in a summary document and this will inform articulation of a new and evolved programme for Youth Focus.

It is proposed that a draft or interim report be produced at this stage, with the expectation that it will be amended prior to the completion of the research to accommodate the implementation of the change process. The format of the draft report will be negotiated with the stakeholders and is expected to be informed by such things as anticipated audience, future uses and authorship of various parts.
v. Phase 5

Phase 5 will focus on developing a change process to manage the shift from current practice to new practice within the agency. New practice and an associated evaluation mechanism will be incorporated into the group programme manual. This stage will be intensively negotiated with agency staff and it is anticipated that the agency will undertake the re-writing of the programme manual as a strategy for reinforcing agency ownership of the changes.

The education of Youth Focus staff will reaffirm their research journey, from evidence to change strategies, and equip them to implement new ways of working in the agency.

vi. Phase 6

It is proposed that education of the Youth Focus camp staff be jointly undertaken by the research team and the Youth Focus staff responsible for implementation, as this will provide an opportunity for Youth Focus staff to pass on knowledge obtained in the previous phase.

vii. Phase 7

Ongoing review and adaptation of the programme led by Youth Focus staff for the purpose of ownership, with the research team providing consultancy, advice and mentoring. This may work best if a series of formal meetings for 'review and evaluation' are diarised, with an additional capacity for ad hoc support.

viii. Phase 8

Final report generated.
3.5 Description of qualitative research methodologies:

In general, action research qualitative methodologies demonstrate the following characteristic elements:

- It assumes the social world is always a human creation and as a result, interpretative science always tries to capture reality, as it is, namely as perceived and experienced by the respondents
- It attempts to capture reality as human interaction
- It tends to study a small number of respondents
- It does not employ random sampling techniques
- It attempts to present the information gathered verbally, in a detailed and complete form not in numbers or formulas (no complex statistical analysis)
- It tries to approach reality without any preconceived ideas and pre-constructed models and patterns
- It perceives the researcher and the research as two equally important elements of the same situation. Respondents are not reduced to variables, units, or hypotheses, but are seen as parts of the whole. Reducing people into numerical symbols and statistical figures results in a loss of perception of the subjective nature of human behaviour
- Its purpose is to interpret meaningful human actions and the interpretations that people give of themselves and others
- It aims to understand people, not measure them
- It employs research procedures that produce descriptive data, presenting in the respondents’ own words their views and experiences.
- Qualitative methods aim to identify new meaning and increased understanding of an issue via the application of inductive reasoning.

The impact of this methodological and philosophical positioning is that action research can be appropriately applied in the following contexts:

- Research that cannot be done experimentally for practical or ethical reasons
- Research that delves in-depth into complexities and processes
- Research for which the relevant variables have yet to be identified
- Research that seeks to explore where and why policy, folk wisdom and practice do not work
- Research on innovative systems
- Research on informal and unstructured linkages and processes in organisation
- Research on real as opposed to stated organisational goals

3.6 Sampling procedures

Sampling was conducted on the basis of a purposive sampling method. This was adopted because of the ease of this process and the deliberate identification of those participants who may provide useful data.

Since an action research project does not attempt to denote scientific empirically validated data but rather the subjective ‘lived experience’ of the participants, random sampling was deemed unnecessary given that generalisation of the findings is not intended.

3.6.1 Sample size:

The sample size in qualitative research is not governed by requirements such as statistical power, as such, the sample was determined by two fundamental research parameters namely (i) keeping the research manageable and (ii) exhaustible until the material gathered was no longer providing new information that contributed to the research objectives.

The sample size was determined primarily on the basis of what was practical in term of time and resources. Whilst the projected sample size was 60 participants, the investigator remained conscious of the need to collect useful data and retained the discretion to cease collection, if and when, saturation occurred.

3.7 Analysis of the qualitative data:

The essential idea in discovering grounded theory is to find a core category at a high level of abstraction but grounded in the data. Grounded theory achieves this in three ways:
• The first is to identify and articulate conceptual themes within the data
• The second is to identify relationships between the categories
• The third is to conceptualise and account for these relationships

This approach will be useful in this research project, as the research is attempting to identify what the participants deem therapeutically effective in the Youth Focus programmes. It would be an added benefit if the data could assist in formulating early theoretical constructs that will inform clinical intervention procedures. Moreover, this data may form the foundations for a more quantitatively informed research project at a later date.

Theme interviews will be recorded manually by hand at the time by the interviewer. Whilst this does not capture the responses in a verbatim form as would be possible with recording, it was considered an appropriate method to capture the data.

The analytical process is in keeping with Miles and Huberman’s (1994) *transcendental realism* approach. The authors identify three concurrent activities that dynamically interact throughout the analytical process. Diagrammatically it may be represented as shown in Figure 2:

**Figure 2:** Components of data analysis: interactive model (Miles and Huberman, 1994).
3.8 Data management and analysis:

The data analysis was undertaken by Youth Focus counselling staff, Ms Carolyn Johnson and Dr Mark Sachmann over a four day period. The verbal responses of the research participants were electronically recorded and then transcribed into written form to facilitate thematic analysis. All of the verbal responses were subject to thematic analysis and six primary themes were identified. These themes would form the basis of the qualitative data analysis.

Data interpretation will be based upon noting patterns and themes. This method is identified by Miles and Huberman (1994) as a valid mechanism for strengthening qualitative interpretations.

3.8.1 Thematic analysis

The text will be coded and subsequently categorised. The coding will be identified on the basis of emerging patterns. The pattern codes will be used to identify emerging themes and assist in data reduction. The process of coding will develop around four points, namely (i) themes, (ii) causes/explanations, (iii) relationships and (iv) theoretical constructs.

Four fundamental steps will be employed in the analysis of the qualitative interview data. The four steps are as outlined by Lamnek (1989):

Step 1: Transcription

Transcribing the verbal interview data in manuscript form.

Step 2: Individual analysis

The thematic analysis of individual transcripts: integration and evaluation of the data.

Step 3: Generalisation

The findings of the individual interviews are generalised, and differences and similarities are identified, this allows for the development of categories.
Step 4: Control

Going back over transcripts and comparing transcripts. This allows for the identified themes to be verified or modified.

3.9 Rationale for this method of analytical technique

Such an approach allows for the subjective meaning presented by the research participants to be successfully identified and articulated so as to be readily used in assisting with the research projects objectives.

3.10 Research instrumentation:

The research instrumentation was a semi-structured interview schedule enquiring into the experiential and perceptual opinions of the research participants (see appendixes 2 and 3). However, the interview was not always strictly adhered to, if the interviewer was of the opinion that alternative forms of questioning would illicit important data then the interview was allowed to proceed along an unintended tangent that was deemed necessary at that point in time.

Such an open ended approach is in keeping with the action research approach in assisting in promoting the research participant to lead the discussion along the lines that they see as indicated.

3.11 Ethical considerations:

Ethical considerations are of fundamental importance in qualitative research. In this case the issue of confidentiality is an important consideration as the participants are those young people who are utilising the programme and hence may feel compromised if their observations and perceptions were linked to them personally.

Since action research is carried out in the social world, and is characterised by close and open communication involving observation, perceptions and potential criticism and difference of opinion, the researcher must pay close attention to the many ethical
considerations implicit in the research process. Richard Winter (1996), identifies and articulates a number of fundamental ethical issues in action research:

- Make sure that the relevant persons, committees and authorities have been consulted, and that the principles guiding the work are accepted in advance by all.
- All participants must be allowed to influence the work, and the wishes of those who do not wish to participate must be respected.
- The development of the work must remain visible and open to suggestions from others.
- Permission must be obtained before making observations or examining documents produced for other purposes.
- Descriptions of others’ work and points of view must be negotiated with those concerned before being published.
- The researcher must accept responsibility for maintaining confidentiality.

However, since the interviews did not focus upon the life experiences of the participants for example, abuse related issues or ask the participants to identify and divulge emotional material. Concern did not exist over adverse emotional reactions to the interview content and process. Consequently, the University of Western Australia Ethics Committee exempted the research from the need for ethical application.

However, the research process highlighted a number of important ethical considerations. All components of the research design, methodology, ethical considerations and overall philosophical framework was in accordance with The University of Western Australia Ethics Committee guidelines. The following discussion addresses the ethical concerns inherent in the research process and content of the subject arena.

Secondly, participants may inadvertently divulge and discuss sensitive personal information that could have resulted in emotional discomfort. Whilst this was not a part of the research methodology, nonetheless it may have occurred and protocols needed to be in place. The research instrumentation design and application were of assistance in this regard.
A matter-of-fact interviewing approach was helpful (Jacobson and Richardson, 1987). No attempt was made to challenge the participants’ defences, perceptions or behaviours. Terminology such as abuse, neglect, trauma were specifically not referred to (Fink, 1993). Additionally, participants were routinely asked how they were coping with both the process and content of the interview.

A final ethical issue concerned developing protocols for clinical intervention if a participant’s mental state deteriorates during the research and specifically, deterioration which could be imputed to be related to the research process or content. The method of dealing with such an event involved immediately notifying a counsellor for follow up clinical consultation and assessment. The protocol included either a Youth Focus counsellor or the interviewer being involved in a debriefing session with the participant. Fortunately, this situation never eventuated and the researcher is of the opinion that this was due to the protective measures outlined and discussed above.

3.12 Conclusion:

In Chapter Three, the seven primary themes related to research design and methodology have been discussed: (i) description of the research design, strategy, and methodology, (ii) the rationale for this approach, (iii) research instrumentation, (iv) administration of the research instrumentation, (v) data analyses, and (vi) ethical considerations. Chapter Four will present the results of the analyses of the data.
Chapter Four

Analysis of data

4.1 Introduction:

Chapter Four presents the results of the thematic analysis of the verbal responses collected from the research participants. The aim of this chapter is to present patterns of results and qualitatively analyse them for their relevance to the research objectives outlined in 1.2 of Chapter 1. The discussion of the results and their relationship to the wider body of knowledge outlined in Chapter Two is presented in Chapter Five the discussion of the results.

This chapter is organised along the following lines. Firstly, it presents the qualitative data as collected from each of the participant groups namely (i) clients, (ii) volunteers, (iii) business services staff, (iv) clinical staff (v) families and (vi) referrers. Secondly, this data is subject to a thematic analysis and the themes are in turn analysed to identify both positive and negative perceptions of the Youth Focus camp experiences and perceptions.

The thematic analysis was jointly undertaken by UWA research staff and Youth Focus counsellors. This was in keeping with the action research process requiring that Youth Focus be actively involved in all aspects of the research process.
4.2 Analysis of post camp data:

Ms Carolyn Johnson examined the post camp data in order to identify any data that may be of use in satisfying the research objectives. However, upon examination she was of the opinion that the respondent comments did not provide any useful data in relation to: (ii) understanding the effectiveness of the camp programme and (ii) informing a change strategy (see appendix 3).

4.3 Descriptive characteristics of the data

In total 38 individuals (this includes two families) agreed to participate in the research. Despite all attempts, it was not possible to generate 10 participants in each of the six-targeted groups. Table 1 outlines a profile of the break down of both the type and number of research participants.

Table 1: Research participant profiles

<table>
<thead>
<tr>
<th>Participant type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients</td>
<td>10</td>
</tr>
<tr>
<td>Business Services Staff</td>
<td>4</td>
</tr>
<tr>
<td>Counsellors</td>
<td>9</td>
</tr>
<tr>
<td>Families</td>
<td>2</td>
</tr>
<tr>
<td>Referrers</td>
<td>4</td>
</tr>
<tr>
<td>Volunteers</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total number</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>


4.4 Data Analysis:

In examining the overall data, it was evident that a number of core themes were clearly emerging. It is necessary, to identify and articulate the themes that emerged out of the verbal responses provided by the research participants. In all, nine core themes emerged from the data, they were as follows:

- Safe and nurturing environment
- Peer relationships and support
- Programme content
- Planning of programme
- Care and commitment from the counsellors
- Corrective emotional experiences
- Stable and predictable boundaries
- Understanding the young person’s life context
- Organisational data

4.5 Results of the thematic analysis of the data

Each one of the identified themes will now be individually examined in greater detail. For ease of understanding, the themes were subdivided into both ‘positive’ and ‘negative’ responses, together with examples of verbal responses from the participants. Positive responses were those that supported the current content and process of the camp, whilst negative responses were those that identified problems or concerns. It should not be inferred that this categorisation, implies that there were ‘good’ or ‘bad’ responses. This method was chosen to highlight differences of opinion and to clearly identify that which is seen to work, from that which is in need of change.

The verbal responses profiled below, are presented as they were recorded at the time of interview. In order to present the data in its original form, no attempt has been made to correct errors in spelling, syntax or grammar.
4.5.1 Safe and nurturing environment

Positive responses relating to the importance of a safe and nurturing environment were frequently reported. Common sub-themes included the following:

- Trust
- Removal of dysfunctional influences of family
- A non pathologising environment
- Physical location of the camp
- The presence of medical kits
- Being able to contain cognitions and affects
- Being encouraged to reflect on alternatives to current life circumstances

Examples of verbal responses:

- The way there was no putting down and people picking on each other. That everyone was cool and could talk about problems with each other to help resolve them.

- The most important outcome is YP spend time together in an environment that is supportive and embrace and respectful.

- Bring them into a safe, friendly environment

- I think primarily the most important thing is the safe and trusting environment

- They feel safe and comfortable enough to be open to have the discussion we have facilitated

- I’d say the bonding and the safe environment getting to know new people often gaining a peer group. Being understood, and feeling acceptance, reduction in isolation and alienation due to an alternative experience.

No negative responses were reported.
4.5.2 Peer relationships and support

Positive responses relating to the importance of peer relationships and support were frequently reported.

Common sub-themes included the following:

- Connecting with people with similar backgrounds
- Bonding with peers
- Listening to others tell their stories
- To develop new peer relationships

Examples of verbal responses:

- To meet a new group of people.

- Peer function is very strong for young people. Many are socially isolated and don’t fit in. When they meet others there is a feeling that they’re not the only ones. They are not as badly off. There is a bonding It’s very strong for YP. It's also therapeutic.

- Peer group support To understand other yP with the same problwms More experienced kids will tell their story You see the penny drop

- To form positive friendships.

Negative responses relating to the importance of peer relationships and support.

- The impact of peers who have had experience with a number of camps may not be positive.

4.5.3 Programme content

Positive responses relating to the importance of programme content were frequently reported. Common sub-themes included the following:

- Education
- Life skills
• Conflict resolution
• Positive communication
• Candle circle
• Opportunity for young person to identify what the family means to them
• Time to talk about successes
• Role playing

Examples of verbal responses:

• The people. The entertainment night. It was fun, it was funny. Everyone got to be themselves and have fun. Lots of happy moments.

• Everything. It’s a safe place to be. It’s a really good environment to be in. Just the people. Everyone are good people.

• The entertainment night – keeps my mind off heaps of things from camp and home. The food – has a good variety, is the only time that eat three meals and morning and afternoon tea

• Probably the fact that they said they could help me with my anger. To have the experience. They said that it was all friendly and nice. They had strict rules on things, especially the no put-downs.

• Probably the bush walk – you’re able to get out in the open and talk to people while you’re walking, you can away from the hall and the classroom activities.

Negative responses relating to the importance of programme content were reported. Common sub-themes included the following:

• Educational material not always understood
• Outdated material
• Absence of spare time
• Not enough unstructured activities
• Not enough transition time between activities
• How deep can you go in two days
• Getting the balance between process and content
• Need for increased physical activities
• Identify more clearly what the goals of the camp are
• Need for gender specific groups
• More craft activities
• Good sessions to be followed by bad sessions
• Too much cramming of material in two days
• Too much emphasis on content and not enough on process issues
• Not integrating persons growth derived from activities into the individuals camp experience

Examples of verbal responses:

• The ones I didn’t participate in, the falling and massage. (What was it about those activities that you didn’t like?) I didn’t want other people touching me.
• The food. They didn’t have enough to cater for vegetarians. It was based for meat eaters. For vegetarians it was like those frozen packet meals.
• Groups were too short. We just got comfortable talking and then it was time to stop. I know our group had trouble in the grief and loss group, but for the other groups maybe 10-15 minutes longer.
• More recreational based activities More structured recreational based activities. Less talking

4.5.4 Planning of camp/programme

Positive responses relating to the importance of Planning of camp/programme were frequently reported. Common sub-themes included the following:

• Organised
• Importance of the geographical location and setting of the camp
• The mix of young people in the camp

Examples of verbal responses:

• We should have good, bad, good, bad sessions (eg. Families & relationships, triumphs, grief and loss, goal setting), then be less likely to be in tears for one day
and happy the other. Need to break it up and mellow. People should be free to leave at any time, but at least to turn up to group.

- Wanted Camp to go for longer. Maybe over school holidays for a week. Would be able to open up better. Didn’t start to open up until third day.

- We have moved into the position of screening. Some people are just not ready for camp.

Negative responses relating to the importance of programme planning were recorded. Common sub-themes included the following:

- Volunteers not feeling prepared for camp
- Volunteers having little input into programme content
- Should camp have a singular focus rather than being characterised by multiple themes?
- What would constitute the make up of the camp? Should assessment seek to exclude more people with specific problems?
- Consideration for a new venue
- Should be a pre-camp group
- Camp should be longer
- Transport issues
- Gender balance in camp participants

Examples of negative verbal responses:

- Getting there after school transport etc may be difficult for them.

- Maybe one more day. A long weekend. A week is too much, not like what the others were saying. By the last day everyone feels they know everyone and then it’s time to go home.

- The way it is, is kind of OK. Maybe do the walk after the hard groups to clear your head, and have a way of releasing things. Maybe having the hard groups on the second day, because on the first day you feel too awkward to say too much about yourself.
• Not long enough, maybe one more day longer. At first you get a bit homesick but at the end you don’t want to leave.

• Open environment – if you’re upset the other kids support you and I can support them.

• Breaks a little bit longer – more time to talk outside the room. Just chat about normal things, getting to know people in other ways, have normal conversations.

• Breaks longer. Another bush walk – it’s nice to be outside.

• One more day. Can have more conversations, don’t get much time to talk.

• That we all need a break sometimes and sometimes we need to be together. Camp pretty much helped in that

• Felt uncomfortable with leaders in the same dorms. Said people liked to talk about problems in the dorms and it was hard to talk about how we feel with leaders in the room. Also wanted more “me” time, time to self without leaders being around.

• It’s difficult to do it in 2 days. I wonder how much more movement we may have achieved if we had one more day. If I could have slept it would be OK. You have to interact. You have no time to yourself.

4.5.5 Care and commitment from the counsellors

Positive responses relating to the importance of care and commitment from the counsellors were frequently reported. Common sub-themes included the following:

• Giving up own time to be involved in the camp (volunteers)
• Giving back to the community
• Acceptance
• Gentle limit setting
• Non-judgemental
• Supportive
• Very professional
• Good role models
• Honest
• Counsellors were being themselves

Examples of verbal responses

• My main concern is it's exhausting for workers. They need regular time out.

• I was very impressed with the volunteers. They were fantastic.

• One YP noted that the staff looked stressed. I reassured him but we were stressed. We are human. It worried me that we were anxious. It's a huge burden of responsibility for that we have for YP on camp.

• They feel listened to. Feel supported both by staff and each other and they learn to support themselves.

• Some counsellors get calls because the YP is so dislocated. They may get the first call after an OD. There needs to be recognition, that it is a difficult area of work and that support is needed.

Negative responses relating to the importance of care and commitment of counsellors were reported:

• Very challenging for the counsellors to go to the camp

• Leaders need to be more laid back. Some seemed worried. If leaders relax we relax. This would help me open up more. Thought that it was a bit strict on swearing. Hard to say what really feel if not allowed to swear.

4.5.6 Corrective emotional experiences

Positive responses relating to the importance of a corrective emotional experience were frequently reported. Common sub-themes included the following:

• Normalising experiences and responses
• Providing hope
• I'm not to blame for my experiences of abuse etc
• Being aware of issues
• Being aware of appropriate community standards
• Insight into family
• Increase in self esteem
• Opportunity to reflect
• Decreased social isolation
• Learning not to feel out of control when someone is distressed
• Validation of young person’s experience
• Validation of young person as a ‘person of worth’

Examples of verbal responses:

• That there are other people who have problems same as me and that I’m not alone.

• To have self-confidence and not to let anyone else get you down. Lots of groups helped out, the self esteem one

• Lots of things. On the last camp I learned that I can support others, while still taking care of myself. I learned to trust a bit more and that’s a big thing for me. I learned to give people a chance to be trusted straight up. I learned to open up a bit more.

• They suck. They’re not nice people. Some of the stuff they do is wrong. I used to blame myself, because I didn’t know that what they were doing is wrong. Things are clearer in a way.

• Everything about it

• Even the hard stuff (groups)
• It’s the only place I feel safe and whole

• I feel comfortable because I can go there and others have been through similar stuff that I have.

• I get to open up more each time.

• Good way to get away from my nephews.

• Comfortable environment – you don’t give people putdowns, and they don’t putdown me.

• At my first few camps I realised that my grandmother was dead and will never come back. It has taken so long to get over but camp helped.
• Can easily make friends if I tried. (Asked how this makes him/her feel) Feels good, that I can do it, that's the reason that I lost so much weight

• Knowing some people from other camps. Can talk about stuff that won't be able to talk about outside camp. Remembering the fun times, a lot of us usually have fun on camps

• I learnt to control myself way easier – I use to have a temper. I would be pout down, and I would turn my back on my friends. Learnt to brush them off and ignore them (groups who picked on the young person)

• The way there was no putting down and people picking on each other. That everyone was cool and could talk about problems with each other to help resolve them.

• That there are other people who have problems same as me and that I'm not alone.

• That Mother’s side of the family is “crazy” and needs help. Need to give people in family a go. Learned to try and trust Stepmum more. Realised that I don't tell family how I really feel.

• Their communication sessions seem to go very well. It’s a huge area communication, they learn more about themselves

• Some YP have been thru horrendous experiences. They can gain strength thru this.

• The opportunity to put words to thoughts.

• One said I don’t like it when you do this not just at camp but outside. It takes a lot of courage to do this. It was great to see the second girl, she could handle the criticism and change her behaviour.

• The experience of witnessing self disclosure and their own reaction to it makes them realise they will not be judged or criticised for who they are eg If a boy cries when talking about an issue and in social time no-one ridicules him, they treat him normally then that person knows they will also be accepted.

• One YP always showed me the sheet of positive comments that she got from camp. She had it on her wall. It meant a lot to her. It acted as a reminder of relationships and the feedback given from them. You should see the kids when they come off camp they are so hyped they feel so good it is uplifting for them.
Negative responses relating to the importance of corrective emotional experience were reported. Common sub-themes included the following:

- I didn’t enjoy the camp. I find interacting with other people difficult. (Is this something that happened just on camp?) No. I have found this difficult for a long time. (What do you think may have made your time on camp more enjoyable?) Going with someone I knew and meeting everyone before camp.

4.5.7 Stable and predictable boundaries

Positive responses relating to the importance of stable and predictable boundaries were frequently reported. Common sub-themes included the following:

- Appropriate rules
- Structured programme
- Consistent rules
- Stability of staff and volunteers
- Boundaries clearly identified and verbalised
- Good limit setting

Examples of verbal responses:

- Having something on listening skills as a way of reinforcing how they should treat others.

- Time out

- No gossip

- Life can be bad but your life is important Plant the seeds of an idea of appropriate self disclosure

- YP need clear boundaries It’s what we try to do with YP We teach them it’s Ok to have boundaries. We are quite comfortable talking about them. Experience a safe place.

- Should be about YP having space where they can learn to support each other but also recognise when it is beyond them Feel OK sitting with someone’s distress.
• **Being in an environment where it’s OK to talk about that stuff.**

Negative responses relating to the importance of stable and predictable boundaries were reported.

**Examples of verbal responses:**

• **Rules concerning swearing are too rigid as they are a valid form of self-expression for some.**

4.5.8 **Understanding the young person’s life context**

Positive responses relating to the importance of understanding the young person’s life were frequently reported. Common sub-themes included the following:

• Single parent families
• ‘Parentification’
• Fractured/blended families
• Impact of abuse experiences
• Realising that family is sometimes ‘good’
• Realising that family is sometimes ‘not good’
• Realising that I was not the cause or problem
• Grief and loss issues
• Food
• Issues of abandonment and rejection
• The complexity and severity of the various life issues that young people face

**Examples of verbal responses:**

• **Usually every camp I feel better about myself, think more about what I should do and how to get that done. Usually each camp I try to work on different sections of camp**

• **One young person through talking in family and relationship sessions she started to realise she is quite happy with her relationship with her step father.**

• **These YP have multiple losses.**
Things I heard shocked me

But families focus group stood out YP don’t often have the opportunity to look at their families. Need to look at both positive and negative aspects of their families.

Not bad but I do think it continually reminds me that you need to take time to consider from that person’s experience and perspective.

In the main they are quite emotionally barren families, where the skills of showing affection, having boundaries are poor. Parenting is authoritative and is not based on relationship or sharing of responsibilities.

It is so entrenched in themselves how they have interacted their families it affects their other relationships. Some kept their cards pretty close to their chest. They knew the reason for the camp. Campers who had been doing workshop on grief and loss did not find it easy.

Many of the YP we see have severe attachment disorder

Negative responses relating to the importance of understanding the young person’s life context were reported. Common sub-themes included the following:

- Camp experience may alter the young person’s family dynamics for the worse
- Apathy of some parents concerning the camp
- Understanding the parents negative reactions to the camp

Examples of verbal responses:

- Very fraught, difficult I’m appalled at the apathy of parents.

- A large percentage have troubled families, backgrounds of drugs and alcohol. One boy, the last thing he said to his mother was “go and kill yourself” She went and did it. Left him with it, at 16.
4.5.9 Organisational data:

Positive and negative responses relating to organisational data were frequently reported. Common sub-themes included the following:

- The clinical staff appear to be some what estranged from the management committee.
- Liaison between Youth Focus and referrer organisations needs to be clearly identified and not personality
- Management doesn’t know what we are doing
- Invitations are not extended to clinical staff to attend functions
- No feedback from Youth Focus to referral agent in relation to young person’s progress
- Relationships with referral agencies too personality based
- Increased realisation on behalf of management of the stress of clinical positions

Examples of verbal responses:

- Camp organisation is very good and the referral system works very well. We are advised of when the camps are coming up. I don’t have a negative word to say about Youth Focus.

- I have nothing but absolute praise for the organisation

- At first YF representative came out and spoke to us about the camp programme, that was about 2 years ago.(school counsellor and dean of students) It would be good if that happened again, maybe on a regular basis once a year.

- The difficulties I’ve had in referring is that many YP are afraid of their first contact, of getting on the bus with kids they don’t know. It is a huge thing for them.

- Perth is so spread out It is a shame YF is so central. It would be good if they could operate satellite services at youth centres like Clarkson or Wanneroo youth centres.

- In the counseling area at YF the staff turnover may have an impact on clients. Staff care is really important in this industry.
• From a referrer’s point of view, YF are always accessible. They always notify us of the camps. They are always pro active, always ready to discuss referrals. They always send us a fax.

• I would like for YF to talk to our team, to re-energise our staff. It’s been a long time since we had a conversation about camp. It would be good to increase awareness of how we work. To have face to face contact and to talk through who is an appropriate referral.

• In YF there was consistency of staff for a while. About 2 years ago there were some staff changes and this did impact on us. We had good relationships. It would be good to revisit our relationship with YF.

• Don’t know much about youth focus would like a presentation to staff at our professional development day. We do have their brochures. Duty intake has got brochures, a presentation would flesh it out, let us know what the exclusion criteria might be.

• Vicarious trauma after camp with workers. Can’t expect people to last in this field. They should be pro-active should be talked about. There is no recognition of why people leave.

4.6 Conclusion:

Chapter Four has profiled the results of the qualitative thematic analysis of the data. Nine core themes were identified incorporating verbal comments from the research participants to enrich the data presentation. Chapter Five will discuss the results and articulate recommendations for a change strategy for the Youth Focus Life Group Programme.
Chapter Five

Discussion of the results

5.1 Introduction:

Chapter Four compiled the qualitative data necessary to address the four research objectives presented in section 1.1 of Chapter One. The aim of Chapter Five is to critically analyse the qualitative data within the context of fulfilling the research objectives.

Chapter Five is organised along three primary lines. Firstly, discussion of the data in relation to research objective number two will be discussed. Secondly, discussion of the general exploratory findings of the data is also presented. Finally, theoretical and practical i.e. clinical conclusions concerning research objective one will be presented and discussed.

At this juncture, it is important to reorientate the discussion within the context of the aims and outcomes of the research. As outlined in section 1.1 of Chapter One, the action research has four clearly stated objectives:

1. Systematic evaluation and development of the current group support programme, based on participant experience

2. Qualitative study of what participants have deemed effective and the underlying reasons
3. Contributing to the body of evidence-informed knowledge in order to inform and guide future service delivery

4. Provision of a real example of how community based youth organisations can involve the community, clients, carers and experts in the evaluation and development of programmes against the LIFE and Community LIFE principles.

Chapter Five will now examine the data and provided the necessary data to satisfy the research objectives. In order to provide adequate data to satisfy objective number one, two and three, a detailed discussion of the nature and potential implications of the data is indicated. As outlined above, the data is optimally condensed into the nine core themes and in keeping with this decision the discussion will focus on a better understanding these themes, in particular to inform a change strategy. This will be achieved by referring to the existing literature, and extrapolating the data from a psychosocial perspective, and how this may better inform, and ultimately improve upon, the youth focus camp programme.

5.2 Discussion of the results:

As identified in the previous chapter on data analysis, the result of the feedback from the various respondents may be optimally condensed into nine primary themes. They are identified as follows:

- Safe and nurturing environment
- Peer relationships and support
- Programme content
- Planning of programme
- Care and commitment from the counsellors
- Corrective emotional experiences
- Stable and predictable boundaries
- Understanding the young persons life context
- Organisational
At the most fundamental level, this research has identified these core themes as the primary reasons for the Youth Focus Life Group camp programmes having the success it has enjoyed to date.

5.2.1 A safe and nurturing environment:

This is an extremely important aspect of the camp organisation, content and process. The literature is very clear in terms of the importance of a safe environment in relation to assisting people to be able to feel safe and hence become open to the activities and therapeutic processes being offered. Without a sense of safety, individuals are too defensive to engage in new learning. Moreover, children who may have experienced abuse experiences are typical hypervigilant about their environment and will take time for them to feel safe and secure and to engage in the activities camp offers.

The participants feedback is clear in stating that the Youth Focus Camps are well organised and that safety is a primary concern for the organisers and in particular the counsellors. One very telling comment came for a young person who interpreted that the presence of a first aid box was a very important message that the camper’s safety was paramount and had been planned for in advance.

Importance should clearly remain in identifying and articulating the campers’ safety issues and concerns. This should be clearly articulated to the young person, and not just inferred and/or taken for granted.

Abuse and or neglect may result in avoidant and ambivalent attachments patterns. However, the therapeutic process, be it individual or group, asks the client to go against life long adaptive attachment dynamics. The provision of a safe and supportive therapeutic context is crucial to positive therapeutic outcomes.

However, facilitating a safe and supportive environment is clearly a ongoing developing process, rather than a discrete event in time. Safety is primarily a result of the clinician’s attitude, behaviour, and efforts in communication. In this environment, the client is free from assaults, rejection, abandonment, and exploitation. An added dimension in relation to the camp process is the attention to safety as indicated and expressed by the provision of medical kits and firm rules and boundaries.
Trust as would be expected was identified a number of times by the participants. Trust is a complex and difficult process to promote in a short time frame as it is earned and not merely bestowed. However, trust can be seen to develop out of a safe and nurturing environment wherein the rules, boundaries and the attitude of counselling staff and volunteers is seen to be consistent, fair and stable. Trust is very capable of developing in a psychosocial environment characterised by these dynamics. The comments made by the young people would suggest that trust is developed and maintained on camp.

The importance of the camp being a non-pathologising environment that seeks to understand and support rather than diagnose and focus on dysfunction would appear to be a process that is valued highly by the participants. The importance of this approach probably cannot be over emphasized in terms of how it provides support and understanding to the client. This is a very clear application and manifestation of a strengths-based approach in the counsellors’ interactions with young people.

Offering an alternative experiential group dynamic to some of the dysfunctional family dynamics the young people have emerged from is an important facet of the camp process. This experience demonstrates that groups of individuals can, if not should be, invested in one another’s welfare and that communication, appropriate expression of emotions, appropriate boundaries, and behavioural limitations assist in fostering healthy relational dynamics.

This in turn arguably facilitates the likelihood of the young person engaging with their counsellors and fellow campers. Offering an alternative experience, to some of the dysfunctional family dynamics they may have been exposed to. This may promote the internal conversation and self-reflections so necessary for the young person to process their dynamics and to identify alternatives to their current life circumstances.

As has frequently been identified and articulated within the therapeutic literature safety, trust and stable boundaries have been viewed as fundamental prerequisites to a positive therapeutic success. This is a consistent theme and in independent of philosophical framework and theoretical intervention modality.
5.2.2 Peer relationships and support:

The importance of developing and maintaining healthy peer relationship in adolescence and throughout life has been well documented in the literature. The young people attending the camp have clearly identified the benefit of being able to make supportive connections with young people their own age. Developing relationships, even when they are relatively transient in nature such as the length of the camp weekend, is an important experience. Moreover, these relationships facilitate the opportunity to hear what others have experienced and this in turn frequently results in a strong sense of interpersonal support and in normalising the young person’s life.

Attachment theory asserts that the quality of early experiences with caregivers is seen to determine the quality of later adolescent and adult relationships (Bowlby, 1973). Early traumatic experiences characterised by issues such as neglect, separation, attack and anxiety result in individuals having similar perceptions of their current relationships in the form of fear of abandonment, rejection and high levels of anxiety (Benjamin, 1993; Dutton et al, 1994). Stable healthy peer relations and the support they provide may be highly useful therapeutic processes that demand attention as they may provide effective correctional relational experiences.

Abuse experiences may result in the individual having strong expectations about their interpersonal environment, of other people, and themselves. These expectations are frequently fragmented, contradictory and hence lack coherent stability. Interpersonal relationships characterised by these dynamics are inherently unstable and contribute to poor adaptive functioning in the form of personality development, emotional regulatory deficits, suicidality, drug and alcohol abuse and poor academic and employment performance. Given these problems attention to healthy peer relationships is paramount.

The importance of peer relationships in adolescence has always been acknowledged. Recently however, added significance to peer relationships has been bought about by the view that peers may influence our development more so than our parents. Harris (1989) states that the influence of our peer-groups, particularly throughout adolescence, is pivotal in terms of our development in language, social and academic areas. Peer relations are seen to be more significant in determining
outcomes in these areas than the influence of parents. These relationships are becoming increasingly important as fundamental to our development of identity.

The effects of abuse upon an individual’s cognitive processes is likely to be profound since abused individuals frequently have a strong sense of being unable to control or influence life events (Livesley, 2000). A pervasive cognitive set characterised by a belief that the individual is powerless, inept and incomplete without attachment to another. These thoughts may give rise to the marked feelings of dependency and associated fears of abandonment. These dynamics have a destructive impact on the quality of interpersonal relationships.

Research in identifying the biopsychosocial factors that contribute to resilience has repeatedly acknowledged the importance of relationships in being able to manage life’s traumas. Factors such as (i) secure attachment with at least one other person, (ii) Relational quality where warmth and low ambivalence are characteristic dynamics, and (iii) close relationships with competent others-available for role modelling and mentoring.

The respondents in identifying (i) connecting with people with similar backgrounds, (ii) bonding with peers, (iii) listening to others tell their stories and (iv), to develop new peer relationships have clearly stated the importance of peer-relationships in their personal development. The importance of interpersonal support, via the development and maintenance of stable relationships, validates the views expressed in the scientific literature.

**Process issues for consideration:** Early abuse/neglect frequently results in disturbances in the interpersonal realm. Since much of life unfolds in the context of interpersonal relationships, disturbances in these areas are important areas for therapeutic consideration. Moreover, suicidal ideation and self-harming behaviours are linked to interpersonal disturbances.

**Techniques:** The therapeutic relationship is crucial in this regard. This relationship is a powerful source of interpersonal trigger’s (perceived and actual abandonment), rejection and various affective states. How well these dynamics and issues are identified and worked through is fundamental in making sound clinical progress in this area of disturbance.
5.2.3 Programme content:

The comments compiled from the research participants were very positive concerning the content of the programme. Clearly, issues and interventions aimed at interpersonal functioning are highly appreciated and useful to young people. Educational input that normalises and challenges some of the young people’s thoughts about themselves and others, in particular family members and family life, have been identified as very useful interventions strategies.

Specific technique driven activities have been seen to be of significant therapeutic value and need to be maintained. The following activities were repeatedly identified as being well received:

- Education
- Life skills
- Conflict resolution
- Positive communication
- Candle circle
- Opportunity for young person to identify what the family means to them
- Time to talk about successes
- Role playing
- Entertainment night

As would be expected, interpersonal issues figure prominently in the young person’s psychosocial world. The efforts of Youth Focus to actively address issues and dynamics associated with interpersonal conflict, development, and maintenance of interpersonal relationships and interpersonal boundaries are highly appropriate and well received. The emphasis given to interpersonal relationships needs to be maintained and possibly augmented.

Additionally, studies conducted with children have also identified that abused children demonstrate a greater risk for impaired peer relations (Cicchetti and Carlson, 1989; Conaway and Hansen, 1989; Shields et al, 1994). Two important themes emerge out of the available literature as to how abuse experiences may adversely influence the development of personality: (a) deviations in the intrapsychic process of defining,
regulating, and integrating aspects of self and (b) deviations in the related ability to experience a sense of trust and confidence in relationships.

Additional support for this hypothesis may be found in attachment theory where the quality of early experiences with caregivers are seen to determine the quality of later adult relationships (Bowlby, 1973). Early traumatic experiences characterised by neglect, separation, attack and anxiety result in individuals having similar perceptions of their current relationships in the form of fear of abandonment and high levels of anxiety (Benjamin, 1993; Dutton et al, 1994).

The processes and activities devoted to the dynamics and issues associated with interpersonal relationships were appreciated by the participants. However, criticisms have been identified:

- Educational material not always easily understood
- Outdated material
- Absence of spare time
- Not enough unstructured activities
- Not enough transition time between activities
- How deep can you go in two days?
- Need for increased physical activities
- Identify more clearly the goals of the camp
- Need for gender specific groups
- More craft activities
- ‘Bad’ sessions’ to be followed by ‘good’ sessions
- Too much cramming of material into two days
- Too much emphasis on content and not enough on process issues
- Not enough emphasis on integrating the individuals growth derived from activities into the individuals camp overall camp experience

The recommendations for change for camp content based activities are important to examine in some detail. The educational content has been criticised by some for being outdate and hence not interesting enough for young people to hold their interest. If this is the case, then consideration needs to be given to updating camp activities. Activities clearly need to be interesting and informative and presented in a manner that appeals to a young person, otherwise maintaining their interest and motivation may be difficult.
Furthermore, it would also appear that many young people are of the opinion that not enough ‘transition time’ exists between activities. This is very important point, because it suggests that many young people are interested, consciously or otherwise, in understanding the meaning and potential impact of camp activities. This strikes at the heart of the delicate balance between camp content and process. The desire for more time between activities potentially implies that young people may need more time to:

- Process, cognitively and emotionally, the psychosocial implications of the activities
- Better understanding of the process of camp and how this relates to long term outcome goals i.e. ‘the big picture’
- To place a boundary around the different activities as to not contaminate each successive activity with the dynamics and emotional reaction to the previous activity.
- To simply provide an opportunity to ‘take a break’

The identification of more time between sessions may also be reinforced by the other requests for simply more time for self. Again this may be simply the need to have ones own personal space to be with your thoughts, a legitimate request in its own right. However, it may also be an expression for a similar need to have time to process the issues that arise out of the session and to better integrate and synthesis the personal meanings prompted by camp activities.

Additional support for the importance of what may be optimally described as ‘process issues’ may be found in the desire for increased understanding of the goals of camp i.e. outcomes of the camp based initiatives. Importantly counsellors have also commented upon this issue and were of the opinion that too much emphasis has been placed on content i.e. activities and not enough on process issues wherein the individual is not integrating the growth derived from activities into the individual’s camp experience and overall life experience.
5.2.4 Planning of camp/programme:

The following comments profiled are a synoptic restatement of some of the material profiled in section 4. The planning of the camp programme figures significantly in the respondents’ answers to the interview questions. It would appear that the participants value the thought in planning the programme and this demonstrates that Youth Focus staff value the camps and their importance to the young people.

The comments concerning the gender composition of the camps indicates that gender balance is an important issue for some respondents. This may represent concerns over safety, relationship issues, and family of origin dynamics.

- Very well organised
- Importance of the geographical location and setting of the camp
- The mix of young people in the camp

Some recorded suggestions from respondents in relation to changes in the planning of the programme are as follows:

- Volunteers not feeling prepared for camp
- Volunteers having little input into programme content
- Should camp have a singular focus rather then being characterised by multiple themes
- What would constitute the make up of the camp? Should assessment seek to exclude more people with specific problems?
- Consideration for a new venue
- Should be a pre-camp group
- Camp should be longer
- Transport issues
- Gender balance in camp participants
- Good sessions to be followed by bad sessions

These themes represent a variety opinion as to the optimal length, geographical location of the camp, and gender balance. It is difficult to determine how to accommodate these wishes and whether they would make a significant contribution to the outcome of Youth Focus camps. However, the issues of gender balance and
clinical assessment (attempts to identify and limit the presence of acutely behaviourally disturbed individuals) warrant attention as the literature has made important comments on the necessity of a gender balance and assessments that identify disturbed children so as to not disrupt the therapeutic process of camp based initiatives.

Transport issues were identified and primarily centred on the desire for everyone to be transported to the camp together on a bus in order to facilitate pre-camp bonding.

The importance of the volunteers in the camp programme is considerable. However, volunteers have expressed dissatisfaction with (i) not being adequately prepared for the camp experience, (ii) not having enough input into the camp process and activities and (iii) not being adequately debriefed and holding on to vicarious trauma.

Consideration needs to be given to being more inclusive of camp volunteers in camp planning and more sensitive identification and handling of their psychological reactions to being exposed to trauma histories.

5.2.5 Care and commitment from the counsellors:

The commitment and care demonstrated by the counsellors is clearly noted by the camp participants. The commitment is important as it demonstrates to the young person how important they are and that this inherent worth is openly acknowledged and supported by the counsellors.

This is not simply an intellectual acknowledgement by the camp participants, it is a very important relational precursor. Knowing that the counsellors are committed to the young person’s well-being is a very necessary first step in being able to trust and enter into a supportive therapeutic relationship. The care and commitment is necessary for people to feel safe and relatively secure that the individual will not abandon or reject you. For many young people abandonment dynamics have been acutely experienced before and they are well aware of the damage done by repeated failures in these areas.

This is important knowledge for the counsellors and is fundamental to the development of therapeutic relationships with a population, many of which arguably have significant attachment issues.
Secure attachment bonds are seen as a result of sound parental empathy (Sroufe, 1995) and these early bonds are the foundation for the development and maintenance of emotional regulation, self-confidence, and interpersonal trust. Affective dysregulation difficulties in childhood can impair important developmental tasks and result in long-term impairments in psychosocial functioning. These impairments may include anger control problems, self-esteem and interpersonal problems and problems in recognising and describing emotional experience (Paivio and Laurent, 2001).

5.2.6 Corrective emotional experiences:

The fundamental importance of corrective emotional experiences can not be overemphasized. Not simply in the form of ‘having a good time’, whilst this is clearly an inherently enjoyable process, but also in order to provide the young person with an awareness that life may provide multiple contrasting experiences some ‘good’ and some ‘bad’ and that all experiences need to be managed in an adaptive manner.

The opportunity to observe and participate in how other individuals negotiate interpersonal conflict, regulate their emotions and identify and articulate inner experience is fundamental in any therapeutic process particularly in the context of abuse related dynamics. The multiple opportunities for young people on camp to see life managed in more adaptive ways and the new learning that is derived from these experiences has been identified by many of the research participants. Feedback from parents would appear to support the view that many participants demonstrate a relative increase in healthy adaptive capacities following the peer support weekend experience.

It is important that the Youth Focus staff have an understanding of the psychosocial effects of abuse related experiences, as intervention strategies are optimally grounded in this knowledge. This is even more important given that a percentage of the young people referred to Youth Focus have abuse experiences characterised by acts of either commission or omission.

It has been repeatedly acknowledged within the literature that one of the primary areas adversely affected by abuse experiences is the development and maintenance of the self-system. Chronic disturbances in self-esteem and a perception of
incapacity to influence the environment have been frequently reported (Alexander and Lupfer, 1987; Finkelhor et al, 1990), as has generalised emotional confusion (Herman, 1981). Moreover, the destructive impact of the abusive families persistent and pervasive attitude that the child’s needs, desires and perceptions are irrelevant may lead to what Briere (1992) describes as a ‘dysfunction of the self’ wherein the child is unable to identify and define themselves separately from the needs of others.

The capacity to articulate internal states and feelings of self and other is an age appropriate development of childhood and adolescence and is considered to be evidence of the child’s emerging self-other differentiation and understanding and to be intimately linked to the regulation of social interaction (Bretherton, 1985; Cicchetti and Barnett, 1991; Dunn and Brown, 1991; Harris, 1989; Stern, 1985).

An emerging body of evidence suggests that childhood abuse has disruptive effects upon children’s early self-development and associated sociocommunicative abilities. Maltreated children’s use of language in describing self-feeling states are significantly delayed, impoverished, and pragmatically restricted in comparison to non-maltreated children (Beeghly and Cicchetti, 1994). These findings are important since language is crucial to the regulation of social interaction and an early index of self-other differentiation and understanding.

Deficits in self-functioning inevitably result in problems with interpersonal boundaries, fragmented representations of both self and others, and a relative incapacity for intimacy and mature attachment. Poor peer relations and social incompetence have been demonstrated to be predictive of adult psychopathology (Dodge, 1983; Dodge, 1986; Parker and Asher, 1987).

Specific self-regulatory deficits have been demonstrated in children who have been exposed to abuse experiences. These deficits have included behavioural dysregulation, in the form of internalising difficulties, and aggressive behaviours. Self-regulatory deficits also mediated the effects of the child’s social competence. Moreover, research has demonstrated that emotional regulatory dysfunction, derived via maltreatment experiences, predicted a decrease in the child’s peer competence (Shields et al, 1994).

Additional support for this hypothesis may be found in attachment theory where the quality of early experiences with caregivers is seen to determine the quality of later
adult relationships (Bowlby, 1973). Early traumatic experiences characterised by neglect, separation, attack and anxiety result in individuals having similar perceptions of their current relationships in the form of fear of abandonment and high levels of anxiety (Benjamin, 1993; Dutton et al, 1994).

The capacity to articulate internal states and feelings of self and other is an age-appropriate development of toddlerhood and is considered to be evidence of the child’s emerging self-other differentiation and understanding and to be intimately linked to the regulation of social interaction (Bretherton, 1985; Cicchetti and Barnett, 1991; Dunn and Brown, 1991; Harris, 1989; Stern, 1985).

5.2.7 Stable and predictable boundaries:

The boundary disturbances inherent in sexual abuse experiences would appear to be fertile ground for the development of disturbances in identity, interpersonal functioning and the capacity to relate to self. Psychological and interpersonal boundaries are fundamental in facilitating the child to develop a healthy sense of self and identity.

The boundary dynamics and issue identified by the young people would appear to validate the finding of the research that purports the important of boundaries in providing a coherent stable and safe social structure for the young person to engage with.

The boundary issues identified by the respondents were as follows:

- Appropriate rules
- Structured programme
- Consistent rules
- Stability of staff and volunteers
- Boundaries being clearly identified and verbalised
- Good limit setting

This data would appear to reinforce the self-acknowledged importance of healthy, stable and predictable boundaries.
**Process issues for consideration:** Problems with self-other differentiation, probably the result of early attachment disturbances and abuse related experiences. Internalisation of therapeutic relationship, peer-relationships and consistency of boundaries is crucial. The therapeutic process is fundamental in identifying and addressing boundary issues. The handling of transference and counter-transference dynamics is very important.

**Techniques:** The therapeutic process is fundamental in identifying and addressing boundary issues. The handling of transference and counter-transference dynamics is very important. Education in respect of identifying appropriate boundaries is highly valuable.

**5.2.8 Understanding the young person’s life context:**

Families from which intrafamilial abuse emerges have more rigid and conventional rules when compared to families without sexual abusive behaviours. Courtois (1988, 45) profiled six interpersonal standards commonly associated with sexually abusive families:

- Don’t feel. Keep your feelings in check. Do not show your feelings, especially anger.
- Be in control at all times. Do not show weakness. Do not ask for help.
- Deny what is really happening. Disbelieve your own senses/perceptions. Lie to yourself and others.
- Don’t trust yourself or anyone else. No one is trustworthy.
- Keep the secret. If you tell, you will not be believed and you will not get help.
- Be ashamed of yourself. You are to blame for everything.

Clearly the family rules and dynamics of abusive families, as outlined above, are characterised by marked levels of dysfunction that arguably have their own impact over and above the overt behavioural abuse. It remains to be determined as to what exerts the most destructive impact on the developing individual, the abuse experiences or the invalidating family dynamics in which the abuse takes place.

Understanding the young person’s life context is an essential factor in being able to intervene in their lives. The understanding is not simply related to an intellectual
appreciation of family dynamics, abuse related sequelae and the unique characteristic of the young person’s experience. It also involves the empathic understanding of the young person’s emotional experiences.

It must be acknowledged that not all of the young people participating in the camp process have been subject to abuse experiences. However, for those that have, an empathic understanding of their life context is crucial in developing trust. Similarly, for young people without such experiences this is important for positive self esteem and trust.

5.2.9 Organisational data:

Firstly, comments from the referrers profiling how Youth Focus is viewed from a referrer’s perspective is very positive. However, a couple of important issues necessitate attention. Notably, the issue of both referrers and Youth Focus contacts being too personality driven. Here the challenge is for Youth Focus to make what can arguably be described as agency to agency contact. When contacts are the result of individual personalities, the referral process becomes inherently vulnerable to personnel change: a reality all too present in the non-government sector.

Secondly, there were some comments that could be indicative of a management-counselling staff divide. This is particularly important in relatively small agencies, if such a divide were to exist, then this compromises the agencies functioning and mandate. The task here is to make tangible efforts to address any real, or perceived, division between management and counselling staff.

Thirdly, staff turn over has been acknowledged as one of the significant issues that potentially compromises service delivery. Stable and experienced counselling staff are a fundamental component in the provision of sound clinical intervention strategies. Persistent staff turn over may very well intensify rejection and abandonment issues for camp participants and hence compromise the development and maintenance of sound therapeutic relationships. The crucial importance of developing and maintaining, emotionally available interpersonal relationships for camp participants with counselling staff can not be over emphasized. Particularly since research over the last decade has determined that it is the quality of the relationship that most strongly correlated to positive therapeutic outcomes.
Youth Focus management needs to acknowledge and develop recruitment and retention strategies for counselling staff (The author acknowledges that this may already be an important issue for management).

5.3 Identification and articulation of suggested change activities:

Youth Focus Life Group Camp programmes should consider the nine identified core themes and give consideration to the identified recommendations for change. As previously outlined, the majority of change recommendations were related to the programme content issues. The important areas for consideration are as follows:

- **More physical activities:**
  - This appears to be particularly pertinent for young males who require more physically based activities. This is either as a distraction or as an alternative gender specific activity for inclusion in the programme.
  - Activities that promote physical expression and not merely emotional and cognitive processes.

- **Educational material not always easily comprehended by all participants:**
  - The varying intellectual, emotional and developmental capacities of the camp participants may result in some individuals not adequately comprehending the educational material being presented.

  Consideration needs to be given to providing material that is less intellectually demanding. For example, material could be presented in a variety of educational mediums such as visual, physical, verbal, experiential and written.

- **Outdated material:**
  - Material has been noted as outdated and not stimulating enough to maintain the interest for the participants. Material that reflects the
current interests and preoccupations of young people needs to be considered and delivered in an attractive developmentally appropriate manner.

• **Absence of spare time:**

  ▪ Participants have noted that a relative absence of spare time is a significant concern. Spare time affords the individual valuable and necessary time to process material and where required, take a break from the emotional demands of the camp activities.

    An increase in the free time available to camp participants should be considered to assist in the processes outlined above.

• **Not enough unstructured activities:**

  ▪ This issue is related to the relative absence of spare time. Participants would appear to require some activities that are merely enjoyable and not designed with a clear therapeutic purpose in mind.
  ▪ Unstructured activities may also provide the opportunity for the young person to reflect on their own psychosocial processes and assist in their cognitive and emotional processing.

• **Not enough transition time between activities to process experiences:**

  ▪ This request would appear to be relatively self-evident. Simply stated, participants would like more time between activities to both cognitively and affectively process the experiences prompted by the various activities. Furthermore, this time allows the individual to ‘take a breath’ between sessions.

• **Identify more clearly what the goals and the intended outcomes of the camp experience:**

  ▪ Some camp participants would appear not to adequately comprehend the intended outcomes of the camp experience. Whilst therapeutic
outcomes clearly vary between individuals, some educational clarification may be useful in identifying and articulating what the camp experience is intending to provide. Having an adequate, intellectual and emotional conceptualisation of the psychosocial processes on the camp is necessary for purposeful outcomes.

• **More craft activities:**

  - Again this request would appear to be self-evident. Whilst the interviewers did not seek to clarify the precise reasons for this request, it would seem possible that in part, it is a desire for activities that are merely pleasurable and turn attention away from intrapsychic and interpersonal reflection.

    This is allied to the need to ‘take a break’ from the therapeutic processes of the camp and indulge in creative self-expressive activities, that do not demand intense intellectual preoccupations and capacities.

• **Too much emphasis on content and not enough on process issues i.e. not integrating a person’s personal insight derived from activities into the individual’s overall camp experience:**

  - These comments appear to make reference to a need to acknowledge process dynamics and their contribution to personal growth, insight and an understanding of the overall camp experience. Furthermore, how precisely process issues relate to the young person’s overall developmental journey.

As is the case of any psychosocial treatment initiative, it is arguably what happens in any given session or activity that is more important than the specific content of what is said. An appropriate balance of both process and content is fundamental to any successful therapeutic outcome.
The areas of high process importance in relation to general therapeutic endeavours with young people with possible abuse related sequelae (although not exclusively), self-harming behaviours and suicidality have been identified as follows:

- The balance between exploration of potentially distressing material and the need to provide support and consolidation
- Intensity control
- The decision as to when to focus attention on the present concerns versus historical events
- The negotiation of client resistance
- The sequence in which problems are addressed in relation to self versus trauma
- Termination issues

Process issues are fundamentally important in the treatment of abuse related symptoms and dynamics. At the very least they are of equal importance to those more readily identifiable and enacted content based activities. In working with young people, such as those referred to Youth Focus, the balance is between the young person’s need for safety, support and stability and the therapeutic processes that bring cognitively and emotionally laden material into awareness for processing.

Therapeutic interventions that focus and promote too much emphasis on support and safety run the risk of stifling the therapeutic process by inhibiting the necessary psychological material for insight, desensitisation and affect regulation skills. Conversely, clinicians promoting too much process related dynamics at the very least may render the client very anxious and unwilling to investigate abuse related material and at worst may harm the client by destabilising and compromising their adaptive psychosocial capacities.

5.4 Psychotherapeutic (group/individual) treatment considerations:

Adaptive psychosocial outcomes are heavily dependent upon the young person having positive characteristics such as high self-esteem, positive social orientation, and environmental characteristics such as familial warmth and cohesion, and adequate positive social supports (Masten and Garmezy, 1985). These areas
require specific targeting in the camp based process, not just because they have been identified in the literature but also, and perhaps even more importantly that have been identified by the respondents in this research.

Children learn to identify, discriminate and exert control over their emotions by receiving familial (public) validation and feedback for their inner experiences (Kohlenberg and Tsai, 1991). Therefore, the adolescent’s inner experience may be defined and shaped by the emotional reactions of caregivers. Youth Focus staff, in assuming the role of caregivers, need to be cognisant of the impact they may have in shaping a young person’s inner experiences. This is not a result of technique based initiatives, but rather how effectively the staff can identify and manage the varying processes characterising this complex issue.

The nine identified themes are very similar to the themes identified in the treatment of individuals who have experienced early childhood trauma (suicidality and self-harming behaviours are common abuse related symptomatic sequelae). Briere (1992) has presented a theoretical paradigm that assists in focussing upon specific important areas of functioning that are important for an individual who is experiencing difficulties with abuse related symptoms. The areas are as follows:

- Safety and support
- Strategies to address self-harming behaviours
- The development of the capacity to affect regulation and tolerance
- Facilitating self-awareness and positive identity
- Interpersonal functioning (disturbed relatedness)
- Boundary issues (self-other differentiation)

Another treatment structure originally developed and articulated for personality based dysfunction that may have an application for young people with suicidal and self-harming behaviours (particularly since these symptoms are frequently associated with personality based dysfunction) is as follows:

- Stable treatment structure
- Increased activity on behalf of the clinician
- Tolerance of negative transference
• Pay careful attention to counter-transference reactions (withhold own acting out)
• Connect actions with feelings
• Provide hope, encouragement and praise
• Educating the patient
• Positive reframing
• Emphasising strengths/talents
• Validating feelings/thoughts/experiences
• Strategies to deal with acting out behaviours
• Permission for between session telephonic contact
• Contracting the treatment process

It is also important to profile the indications, as identified in the literature, for either supportive or insight orientated clinical interventions (Rockland, 1995).

**Indications for supportive treatment:**

• Severe external stress
• Excessive acting out: suicidality, substance abuse
• Depressive states
• Vulnerability for uncontrolled regression
• Reduced capacity for psychological mindedness
• Chronic lying-withholding of information (if any treatment is possible)
• Excessive prolonged silences

**Indications for more expressive forms of treatment:**

• Patient rejects or is threatened by support
• The treatment has become stilted/superficial and one or both participants appear to be losing interest and not valuing treatment
• Increased self awareness on behalf of the patient
• Decreased acting out in the patient
• An increasingly stable and clinically useful therapeutic alliance

The nine identified themes identified by this research provide an appropriate starting point for the Youth Focus team to better conceptualise the effectiveness of the
therapeutic interventions from the participants’ perspective. However, the scientific literature pertaining to suicidality and self-harming also needs to be factored into the complex psychosocial algorithm accounting for effective therapeutic interventions.

5.5 Resilience Theory

In order to address the challenge in synergistically combining participant feedback and scientific understanding, it is useful to examine the contributions from resilience theory. It is perhaps no coincidence that the identified themes resemble closely material sighted within the scientific literature in relation to suicidality, personality development, issues of abuse and resilience. Resilience is an important subject for the Youth Focus Team, an increased understanding of the importance of resilience factors and attempts to augment their presence in the young person’s life would be highly useful clinical endeavours.

Increasing a young person’s adaptability and resilience to life’s psychosocial challenges is an appropriate point of reference academically, but more importantly, to promote optimum development of self on behalf of the young person despite their exposure to psychosocial risk factors. Many of the respondents will continue to be exposed to significant psychosocial issues so increasing resilience factors is clearly indicated.

Resilience is a multidimensional process encompassing fundamental individual, social and cultural dimensions. Harms (2005) has cogently summarised these as follows:

**Individual dimensions of resilience:**

- Developed cognitive capacities
- Self-perceptions of competence, worth and confidence
- Adaptable and sociable temperament and personality
- Emotional regulation skills
- Positive appraisal (optimism, hopefulness)
- A sense of coherence or meaning
Relational dimensions of resilience:

- Secure attachment with at least one other
- Relational quality—high warm, low ambivalence
- Close relationships with competent others and availability of role models and mentors

Social dimensions of resilience:

- Safe neighbourhoods
- Perceived and received social support, via both formal and informal networks

Structural dimensions of resilience:

- Community resources and facilities
- High quality human services—including social and health services
- Adequate policies and resources for education, housing, financial, and employment needs

Cultural dimensions of resilience:

- Non-stigmatising, anti-discriminatory attitudes towards individual experience
- Traditions and worldviews that give a sense of coherence and meaning to life
- Participation in rituals and rites of passage

This important profile comprising the fundamental elements of resilience is presented as a potentially significant reference point for Youth Focus staff to consider when developing and revising intervention strategies. Knowledge of the known resilience factors is of crucial importance since these areas represent protective factors that may be augmented by appropriately developed and delivered programmes.

5.5.1 Resilience and suicidality

A fundamental component of any programme seeking to address a complex biopsychosocial phenomena like suicidality, is a comprehensive understanding of the
known risk factors. In order for Youth Focus to demonstrate competency in this area, risk factors must be adequately conceptualised and clinically targeted.

The risk factors for adolescent suicide are as follows:

- Living in rural or remote areas
- Being unemployed
- Having a mental illness
- Being indigenous
- Lacking a trusted adult
- Struggling with sexual identity
- Suffering a recent loss
- Previously attempting suicide
- Being depressed
- Being a survivor of physical or sexual abuse
- Having low self-esteem

In comparing the known factors contributing to resilience and the risk factors for suicide we are immediately confronted by the similarity in the form of psychosocial commonalities. Many of the factors contributing to resilience, in their opposite forms, constitute risk factors for suicidality for young people in Australia. This provides increased support for therapeutic initiatives that specifically focus on increasing a young person’s resilience to psychosocial trauma.

The understanding of suicidality and abuse related sequelae, derived from more quantitative research methodologies, combined with the qualitative data identified by this research, represent an appropriate foundation upon which Youth Focus may choose to base their therapeutic interventions.

Youth focus counselling and camp based interventions, both process and content, already target risk factors such as:

- Having a mental illness
- Lacking a trusted adult
- Struggling with sexual identity
- Suffering a recent loss
• Previously attempting suicide
• Being depressed
• Being a survivor of physical or sexual abuse
• Having low self-esteem

5.6 Comments on childhood abuse and the healthy development of self:

It is acknowledged that not all of the participants in Youth Focus camp based programmes have been exposed to childhood or adolescent abuse experiences. Feedback from counselling staff clearly states that abuse experiences are significant in the lives of many of the camp participants. If this is indeed the case, then an appropriate conceptualisation of how abuse related experiences and their sequelae may fundamentally compromise an individual's self-development is clearly indicated. Moreover, perhaps more importantly, how this may determine the individual's behavioural presentation and how this in turn will demand appropriately developed and focussed clinical intervention strategies.

It is believed that the development of a sense of self is one of the earliest and most fundamental of all psychological developmental phases (Alexander, 1992; Cole and Putnam, 1992; Kernberg, 1984; Mahler, 1971; Masterson, 1976). Most authors point to approximately 18 months of age when the infant begins to develop a sense of self (Cicchetti and Toth, 1994; Kernberg et al, 1989; Mahler, 1971; Rinsley, 1982).

The literature on the self emphasizes that the self is (i) a complex multifaceted cognitive structure; (ii) an active memory structure that functions to mediate and regulate behaviours; and (iii) a dynamic structure that is both highly stable and highly malleable (Markus and Wurf, 1987; Stein and Markus, 1996). The self system is usually considered to be a product of social interaction and as such the development of the self is seen in part to be a product of how the individual has been treated by significant others (Markus and Cross, 1990; Sullivan, 1953).

For Harter (1992) the self is a cognitive structure around which behaviour is organised. As the self construct is developed and maintained by biopsychosocial forces it is subject to change throughout the individual's life (Table 2). The self-structure serves to provide organisation to behaviour and stability over the
individual’s life. Emotions are believed to organise behaviour and shape personality through signalling self and others and through regulating perceptions and cognitions (Sroufe, 1989).

Healthy adaptive psychosocial functioning and personality development occurs when the individual stays within limits of emotional and psychological arousal (Table 3). This is facilitated by caretakers who also have the responsibility of maintaining the child’s arousal within optimal limits (Cohen, 1997). Therefore, caretaker dysfunction in the form of early childhood abusive behaviours will have a profound influence in determining pathological levels of emotional and psychological arousal.

Briere (1992) has demonstrated early childhood sexual abuse experiences exert a potentially destructive influence upon the child’s capacity to identify needs, desires and perceptions of both internal and external stimuli. Sexual abuse experiences render the child vulnerable to being unable to both identify and define themselves separately from the needs of others.

Moreover, early childhood sexual abuse experiences, in particular incestuous experiences, would appear to adversely influence three fundamentally important areas of development and functioning. These have been identified as (i) self-integrity, (ii) self-regulation, and (iii) social functioning (Cole and Putnam, 1992).
Table: 2   Aspects of the development of self in childhood

<table>
<thead>
<tr>
<th></th>
<th>Early childhood</th>
<th>Middle to late childhood</th>
<th>Early to middle adolescence</th>
<th>Late adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding of self (description)</td>
<td>Physical characteristics</td>
<td>Capabilities compared to others</td>
<td>Characteristics related to approval or disapproval</td>
<td>Personal values and beliefs</td>
</tr>
<tr>
<td>Valence of self</td>
<td>All positive, fusion of real and ideal</td>
<td>Positive and negative in different domains</td>
<td>Vacillation from positive to negative; conflict between contradictory abstractions</td>
<td>Self positive and negative in different situations appropriate</td>
</tr>
<tr>
<td>Self-criticism</td>
<td>Cannot criticise Self</td>
<td>Observes that others negatively evaluate</td>
<td>Preoccupation with others’ evaluations acceptance</td>
<td>Evaluation according to internalised standards</td>
</tr>
</tbody>
</table>

Source: Adapted from Harter, 1992.
### Table: 3  Emotional development in childhood

<table>
<thead>
<tr>
<th>Causes of negative Emotion</th>
<th>Early childhood</th>
<th>Middle to late childhood</th>
<th>Early to middle adolescence</th>
<th>Late adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotions control self: rage</td>
<td>Actions of others</td>
<td>Other people (actions not motives)</td>
<td>Motives, feelings or intentions of others</td>
<td>Interpersonal, intrapersonal</td>
</tr>
<tr>
<td>Ego development</td>
<td>Impulsive stage</td>
<td>Opportunistic, self-protective, avoid trouble</td>
<td>Conformist, obey rules avoid social condemnation</td>
<td>Conscientious, inner rules, moral imperatives</td>
</tr>
</tbody>
</table>

Source: Adapted from Harter, 1992.
A number of authors have commented that adult survivors of childhood abuse have marked difficulties in how they relate to self (Briere, 1992b; Briere and Runtz, 1986, 1988; Cole and Putnam, 1992; Courtois, 1988). Briere (1992b, 43) postulates that severe childhood abuse may interfere with the child’s capacity to access a sense of self and the child may not be able to: “refer to, and operate from, an internal awareness of personal existence that is stable across contexts, experiences, and affects”. The child’s pain and discomfort are continuously discounted by the perpetrator and simultaneously informed that the perpetrator’s needs and wants are all that is valid. This pathological interpersonal dynamic may result in a dysfunctional self-system where the child’s capacity for self-object differentiation is compromised (Briere, 1992).

The capacity to articulate internal states and feelings of self and other is an age appropriate development of both childhood and adolescence and is considered to be evidence of the child’s emerging self-other differentiation and understanding and to be intimately linked to the regulation of social interaction (Bretherton, 1985; Cicchetti and Barnett, 1991; Dunn and Brown, 1991; Harris, 1989; Stern, 1985).

This finding would appear to support the views of Linehan and Koerner (1993) who postulate that emotional regulatory dysfunction interferes with the development and maintenance of a sense of self. Moreover, emotional consistency and predictability are the foundations of a coherent identity development that in turn contributes to self-development. Research has demonstrated that emotional and behavioural dysregulation among maltreated children coincides with attenuated social competence and self-awareness (Cicchetti et al, 1992; Conaway and Hansen, 1989; Mueller and Silverman, 1989).

Affective instability may represent underlying trait vulnerability, or a direct response to early traumatic experiences (or what is more likely, a complex amalgam of the two). Difficulties in modulating anger, chronic self-destructive and suicidal behaviours, inappropriate sexual behaviours and impulsive risk-taking behaviours will promote disturbances in self-regulation, social functioning, and developmental arrest. This problem has been identified as being important for resilience and is commonly found to be related to a number of the risk factors for suicidality. Intervention strategies aimed at improving the young persons capacity to adaptively regulate their emotional world is clearly indicated.
The psychological consequences of incapacity to access a sense of self would appear to be profound. Various authors have stated that identity confusion, boundary issues, feelings of personal emptiness, hypersensitivity and over-reactiveness to stressors, incapacity for self-nurturing, problems in self-object differentiation are common self-deficit sequelae to childhood abuse experiences (Cicchetti and Tucker, 1994; Shields et al, 1994). Moreover, maltreated children have demonstrated a risk for a wide variety of self-regulatory problems such as anxiety, depression, aggression, impulsivity, inattentiveness, social withdrawal, non-compliance, and contextual inappropriate behaviour (Cicchetti et al, 1991; Erickson et al, 1989; Toth et al, 1992).

It is evident from the research discussed that the development and maintenance of the self-system may be compromised by early childhood trauma. The implications for Youth Focus counselling initiatives are that they need to: (i) understand the possible psychosocial sequelae to childhood abuse, and (ii) have a conceptual framework that informs both management and intervention strategies.

Common psychological and interpersonal issues manifesting themselves on camp, parallel the symptoms and dynamics outlined above, in particular: identity confusion, boundary issues and feelings of personal emptiness, interpersonal conflict, anxiety, impulsivity, hypersensitivity and over-reaction to stressors, incapacity for self-nurturing, problems in self-object differentiation. The nine core themes and their associated content and process change initiatives will provide an appropriate clinical foundation upon which to focus on these important issues.

A more sophisticated understanding of the impact of abuse experiences will result in better informed management and treatment modalities. Since theory should guide clinical practice, this would suggest that camp interventions should optimally focus, where possible, on alleviating the dynamics of early abuse experiences and their symptomatic sequelae.

The data emerging out of the action research project demonstrates that a single treatment and management strategy is unlikely to demonstrate strong clinical efficacy. A combined multimodal approach drawing from differing schools of thought, emphasising the various components of the biopsychosocial spectrum, is clearly indicated. Additionally, this treatment approach requires an understanding of the aetiological factors involved in childhood abuse, suicidality and self-harm as this knowledge should influence the therapeutic goals. The structure of individual and
group based therapy and the selection of appropriate intervention strategies must be firmly grounded in our understanding of the aetio logically significant variables.

5.7 Suggested therapeutic intervention strategies

It is crucially important that young people develop a sense of control over some of their more disabling symptoms. Symptomatic control contributes to self esteem, a positive view of abilities and an emerging, more adaptive, positive sense of self. For example, strategically targeted interventions aimed at ameliorating self-harming ideation and behaviours is clearly indicated.

There are a number of important areas of clinical concern in working with young people with suicidal behaviours. Since suicidal ideation and intent must not be conceptualised in isolation to the known co-morbidities and life events. The following are areas that necessitate strategies for intervention:

- Strategies to deal with self-harming behaviours
- Depression
- Substance abuse
- Current crises

Substance abuse should be identified and treated as early as possible. Besides the impact it has in its own right, substance abuse will fundamentally compromise all other treatment and management initiatives. Hence prompt referral to specialist services is indicated for the young person. Current situational crises need to be worked through in individual counselling: emphasising previous coping skills, increasing social support, challenging negative cognitions. Unresolved crises may result in the development of adjustment disorders, depression or anxiety. These diagnoses would significantly compromise the young person’s life and clinically complicate their management.

On the other hand, depression and self harming behaviours have established clinical intervention procedures that should be incorporated into the overall management strategy for the young person. They are as follows:
Strategies to address self-harming behaviours:

**Process:** Self-harming may be seen as a behavioural form of self-help. Self-harming may assist in the regulation and expression of affect.

**Techniques:** A broad array of strategies is available. A better understanding of the links between the behavioural action i.e. self-harming and the emotional and cognitive precursors is clearly required.

Practical strategies for dealing with self-harming behaviours.

- **Non harmful symbolic enactments:**
  Draw blood or marks on paper, draw marks with red crayon on your skin.

- **Physical awareness/sensation:**
  Stroke arm or leg, stomp feet, take a bath, snap a rubber band on your wrist.

- **Distraction:**
  Read a book, watch a video, run, jog, listen to your favourite music.

- **Interpersonal contact:**
  Contact a friend/family member/partner/therapist: discuss the impulse to self harm. Listen to tapes of friend (s) talking.

- **Imagery:**
  Imagine the self-injury, imagine (fantasise) directing the impulse elsewhere, create a safe place where you can go at times of stress eg special place at the beach, park or bush etc.

- **Physical activity/tension reduction:**
  Exercise, walk/run, shred paper.

- **Art and writing approaches:**
  Draw the feeling, need, memory. Write about your experiences, emotions, use a journal.

- **Expressive anger activities:**
  Pound pillows, scream, rip up old phone books, or a punching bag.
• **Grounding and reorienting:**
  Utilise self-soothing activities: wrapping self up in a blanket, sleeping, transitional objects e.g. teddy bears, associational cues, relaxation techniques.

**Comforting letter:**

Unfortunately, when we most need comfort it is often the time when it is most difficult to remember what would help. The comforting letter will help you to remember when you most need it. Since a letter is portable it has the advantage of being a source of comfort you can carry along with you to have available wherever you go. Here is how to create a comforting letter for yourself:

The **comforting letter** is a letter *from you to you*. It should be written at a time of relative calm and well being with the understanding that you will read it at a time when you are feeling upset, overwhelmed or distressed. The letter should contain, but is not limited to the following:

- A list of activities you find comforting
- Names and phone numbers of supportive family-friends
- Reminders of your strengths and virtues
- Reminders of your special talents, abilities, and interests
- Reminders of your hopes and dreams for the future
- Special advice or other reminders important to you
- Anything else that may be comforting

*(Yvonne Dolan Workshop Notes, 1996)*

**Depression:**

Depression is one of the most common psychological problems, affecting nearly everyone through either their own personal experience or via depression in a family member, friend or partner. Depression will significantly interfere with normal functioning, and frequently causes problems with work, social and family adjustment.
The general symptoms of depression are as follows:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyed, including sex
- Decreased energy, fatigue, being "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Depression may frequently result from the young person experiencing the following psychosocial issues:

**Grief and loss:** grief work plus enabling the patient to compensate for past losses by engaging in contemporary relationships.

**Role transitions:** Assisting the patient to develop a sense of mastery over new roles.

**Interpersonal disputes:** Strategies for conflict resolution and or promoting the development of new relationships and ending negative relationships.

**Interpersonal deficits:** Developing the necessary social skills to develop and maintain new healthier supportive relationships.

**Useful steps to address depression:**

- Depression diary/thought record.
- Increase the rewards in your life.
- Enable you basic needs to be regularly met:
  - To give and receive attention and intimacy
  - Developing and maintaining interpersonal relationships
A sense of control

- Improve self-esteem: what is it that you value in yourself and others and work towards maintaining developing these qualities.
- Focus on problem solving the main problems you have now, in particular interpersonal conflicts.
- Challenge the automatic negative thoughts.
- Expect to relapse, progress is rarely linear.

**Steps to altering negative thinking:**

- Get in touch with your feelings
- Accept that you can cope with bad feelings
- Reward your successes
- Try to identify your self-talk
- Test your self-talk
- Teach yourself to think rationally
- Establish the patient's sense of self-worth and meaning:
  - Discuss short term goals.
  - Identify and reinforce the patients previously demonstrated strengths and coping strategies.
- Introduce new coping strategies:
  - Relaxation
  - Meditation
  - Guided imagery
  - Self-hypnosis

**5.8 Conclusion:**

The results of this research have not been limited to simply compiling a descriptive profile of the important psychosocial factors identified as being effective from the participants' perspective. Rather, it has examined the nine core themes dynamic interaction and in doing so, presented a proposal outlining how they may combine with known resilience factors to result in the development of an effective therapeutic intervention. This research confirms that the problems confronted by young people, together with their solutions, are indeed a complex psychosocial process that defies simplistic one-dimensional explanations.
Chapter Five discussed the results of the thematic analysis specifically by addressing and applying the psychosocial literature on resilience theory. Furthermore, the chapter profiles the recommendations for a change strategy in relation to both the content and process for the Youth Focus Life Group Support Programme.

Chapter Six examines the application of the change strategies. Youth Focus counselling staff *in situ* observations and reactions to the application of the change strategy are identified and articulated, together with evaluative feedback on the impact of the change strategy.
Chapter Six

Application of the change strategies

6.1 Introduction

The recommendations as identified and articulated in chapter five were examined by a Youth Focus committee charged with the mandate for deciding what changes would be incorporated into the next Youth Focus camp.

6.2 Action research recommendations and changes

A meeting was conducted on the 29th of July 2006 where all counselling staff attended to discuss the action research findings. Staff defined the objective function and target demographics of the Peer Support Weekend (PSW). Mark Sachmann presented on resilience and attachment theories. Staff all agreed that these theories are suitable explanatory frameworks for the PSW. Staff agreed that the operational/therapeutic frameworks for the PSW also include Narrative, Brief Solution Focused and Strength Based therapies.

6.3 An overview of the philosophy and theoretical modalities informing Youth Focus clinical interventions

Whilst sound and appropriately applied clinical theory (both in terms of process and technique) is fundamental in any sound treatment approach in working with young
people with psychological difficulties, it is by no means the only facet. Equally important, is the overall philosophical orientation to working with young people (Briere, 1992).

A clinician well versed in technique and theory but nonetheless who pathologises and does not facilitate self-determination, strength, and resilience in the young person is unlikely to be very effective in dealing with this sensitive area.

A number of philosophical facets have been identified in the literature and these will be profiled below. These attitudes have demonstrated themselves to be of significant positive value in dealing with young people with psychosocial difficulties.

- Respect, positive regard and the assumption of growth
- The phenomenological perspective
- The functionality of symptoms and defenses
- Awareness and integration
- The therapeutic structure
- Therapy as reality based
- Social context

A distinction between explanatory theory and practice theory is clearly indicated, as confusion in this important conceptual arena may lead to clinical confusion and inappropriate interventions. Explanatory theories describe and explain behaviour and how problems develop, contribute to the development of practice models. Explanatory theories that now provide a thorough grounding for the rational for intervention for Youth Focus have been identified as follows:

- Resilience theory
- Attachment theory

Alternatively, practice theories explain and predict behaviour/problems and assist with guidance towards intervention. They are different from explanatory theories as they seek to inform and guide practice. The practice theories that have now clearly been identified and articulated in the Youth Focus management and intervention strategies are as follows:

- Narrative therapy
- Attachment theory (Psychodynamic)
• Brief solution focused therapy
• Strength based theory
• Cognitive behavioural therapy

The synergistic combination of appropriate applied explanatory and practice theories is a fundamental demonstration of clinical competence in treating and managing young people with suicidal and self-harming behaviours. The continued development of the Youth Focus Operational Manual that now reflects a more detailed conceptualisation of the various theoretical modalities that inform treatment intervention is a significant step forward in Youth Focus being seen as professionally competent, and capable of being able to meet the needs of young people with confronting complex psychosocial problems.

Plans to identify a young person’s resilience factors and to actively target and augment these factors is an important initiative in demonstrating that Youth Focus is familiar with the scientific literature and that its epistemological focus and clinical intervention and management strategies are clearly reflecting this knowledge and the experience that derives from application.

The clinical approach in dealing with young people with self-harm and suicidal issues is ultimately informed from a broad based biopsychosocial perspective that has demonstrated usefulness along the following lines:

• The importance and values of catharsis
• The importance of a sound therapeutic relationship
• Broad base psychosocial support
• Modelling adaptive behaviours
• Normalisation of experiences
• Cognitive behavioural strategies in assisting with anxiety and depressive reactions
• Psychodynamic methods that attempt to address developmental disruption, loss and abandonment

6.4 The Biopsychosocial Model:

Firstly, before any theoretical model(s) may be applied some form of overarching framework needs to be identified, articulated and applied. The most appropriate
framework for the work of Youth Focus is the biopsychosocial model. This framework will enable Youth Focus to optimally conceptualise the presenting issues of self-harm and suicidality and have appropriately informed intervention strategies.

Research demonstrates that human difficulties are the result of a complex dynamic interaction of the biological, psychological and sociological. The inclusion of all of these fundamental human dimensions is what is referred to as the 'biopsychosocial model'. In some professional contexts this is sometimes referred to as the predisposition–stress model. With predisposing factors reflecting varying degrees of biological vulnerability and environmental factors representing the type and severity of psychosocial stress.

The biopsychosocial model is based on the general systems theory of Von Bertalanffy (1968), which implies that all levels of an organisation or system, beginning from molecules and cells and ending up with society or biosphere, are linked to each other in a hierarchical relationship, so that a change in one effects changes in the others.

The biopsychosocial paradigm challenges the anachronistic ‘nature vs. nurture’ position that purports that the human condition is the result of a simplistic ‘either or’ scenario. This model incorporates the biologic aspects of a disorder, often in regards to predisposition vulnerabilities, with the unique psychosocial experiences of the individual. This inclusive framework assists in explaining the complex variation in symptomatic expression among individuals having the same condition.

There are significant individual variances in how individuals respond to life events and treatment. Disease models (i.e. purely biological) have always struggled with individual variances and outcomes in relation to signs and symptoms and response to treatment initiatives.

This reflected the difficulties inherent in a mind body dualist approach. This was primarily a consequence of the tension between the Platonic, disease-focused and Hippocratic, person-focused approaches within medicine, and these disputes often become polarised into black and white views. Because the biopsychosocial approach is inherently dynamically interactional it offers a way out of these polarities.
Not only does it focus on interactions between domains in a wide sense (for example, on how poverty or lifestyles affect rates of disorders) but also on the need for clinicians to be mindful of interactions within individuals.

The biopsychosocial model identifies and articulates a distinction between the actual pathological processes that cause disease, and the patient's perception of their health and the effects on it, called the illness. For Youth Focus this enables treating staff to have a broad spectrum approach understanding youth and their unique problems. Whilst Youth Focus clearly does not have a mandate for treating biological conditions, it does have a responsibility to factor into the complex algorithm that accounts for a young person's presentation the possibility of biological risk factors.

This may be in the form of appreciating the neurobiology of major depressive disorder and the possible clinical indication for antidepressant medication. The likelihood that temperamental traits, that are significantly hereditary, may play a significant role in a young person's presentation: particularly in personality disorders, anxiety disorders and obsessional compulsivity.

Such a well informed multifactorial framework will reduce the tendency to become conceptually reductionist (i.e. nature vs. nurture), open up the possibility of better treatment initiatives where indicated, improve treatment response on behalf of the young person and most importantly, improve life outcomes.

6.5 The explanatory and practice theories informing Youth Focus interventions:

Attachment theory

Attachment theory is a group of theories concerned with the psychological concept of attachment: the tendency to seek closeness to another person and feel secure when that person is present.

According to attachment theory, attachment is not just a consequence of the need to satisfy various drives, like Freud thought. For example, children are not just attached to their parents because they provide food; their attachment also involves behaviour that is independent of their direct needs. Attachment theory assumes that humans
are social beings; they do not just use other people to satisfy their drives. In this respect, attachment theory is similar to object relations theory. Affectional bonds are formed as a result of interactions with the attachment figure i.e. between child and parent.

Emotional life is seen as dependent on the formation, maintenance, disruption or renewal of attachment relationships. Consequently, the psychology and psychopathology of emotion is deemed to be largely the psychology and psychopathology of affectional bonds.

Psychopathology is regarded as due to a person having suffered or still suffering the consequences of disturbed patterns of attachment, leading the person to have followed a deviant pathway of development. Infancy, childhood and adolescence are seen as sensitive periods during which attachment behaviour develops, normally or abnormally, according to the experience the individual has with his attachment figures.

The basic premise of attachment theory is based on the primacy of early childhood relational experiences, and from these how people develop general expectations and beliefs about relationships. Then, once formalised into cognitive structures, these beliefs are resistant to change and have implications for the nature of one's relationships across the human life span.

**Psychodynamic theories**

These are developmentally based theories that explain individuals and their problems in the context of innate potentials and their interaction with the environment in early childhood experiences. These interactions result in internal processes, conscious and unconscious, which impact thinking, affect, and behaviour. Problems are understood as symptoms of underlying issues.

**Narrative therapy**

The primary focus of a narrative approach is people's expressions of their experiences of life. These are expressions of people's experiences of a world that is lived through, and all expressions of lived experience engage people in interpretive acts.
It is through these interpretive acts that people give meaning to their experiences of the world. These interpretive acts render people's experiences of life sensible to themselves and to others. Meaning does not pre-exist the interpretation of experience.

Expressions of experience are units of meaning and experience. In all considerations of people's expressions of life, meaning and experience are inseparable. Acts in the interpretation of experience are achievements that are dependent upon people's engagement with interpretive resources that provide frames of intelligibility.

Narrative therapy involves ways of understanding the stories of people's lives, and ways of re-authoring these stories in collaboration between the therapist / community worker and the people whose lives are being discussed.

It is a way of working that is interested in history, the broader context that is affecting people's lives and the ethics or politics of therapy. These are some of the themes which make up what has come to be known as 'narrative therapy', naturally, different people engage with these themes in their own unique ways.

**Cognitive Behavioural Therapy**

Focuses on the individual's thinking as the core determinants of behaviour and affect. There are reciprocal interactions between cognition, affect, behaviour and physiology, but problems are primarily driven and maintained by cognition. Problems arise as a result of errors in thinking, irrational thinking or beliefs, and unconscious cognitive schema which impact how we view the world and ourselves.

Cognitive behavioural therapy (CBT) helps the patient to uncover and alter distortions of thought or perceptions, which may be causing or prolonging psychological distress. The central insight of cognitive therapy as originally formulated over three decades ago is that thoughts mediate between stimuli, such as external events and emotions.

A stimulus elicits a thought - which might be an evaluative judgement of some kind - which in turn gives rise to an emotion. This in turn typically results in a behavioural response. In other words, it is not the stimulus *itself* which somehow elicits an emotional response directly, but *our evaluation of, or thought about* that stimulus.
Cognitive behaviour therapy aims to help the client to become aware of thought distortions which cause psychological distress, and of the behavioural patterns which are reinforcing it, and to correct them. Throughout this process of learning, exploring and testing, the client acquires coping strategies as well as improved skills of awareness, introspection and evaluation.

This enables the client to manage the process on their own in the future, reducing their reliance on the clinician and reducing the likelihood of experiencing a relapse.

**Strengths perspective**

The strengths perspective is embedded in an understanding of social, environmental, economic and cultural influences that impact on individuals.

This perspective challenges traditional models, which focus on problem identification and individual deficits, by instead identifying and building upon client strengths and resources that can be used to address personal concerns. The strengths perspective is not yet a theory—although developments are in the making.

It is a way of thinking about what you do and with whom you do it. It provides a distinctive lens for examining the world of experiences of practitioners and clients and is composed of assumptions, rhetoric, ethics, and a set of methods. At the very least, the strength perspective obligates workers to understand that, however down trodden or sick, individuals have survived (and in some cases thrived). They have taken steps, summoned up resources, and coped.

We need to know what they have done, how they have done it, what they have learned from doing it, what resources (psychological and social) were available in their struggle to surmount their troubles.

A strengths perspective involves working with client’s strengths rather than their deficits. It is based on the belief that people learn more and progress better if their workers resist focussing on pathology and instead focus on the things their clients do well and on their achievements. This perspective is based on the belief that even the most problem-saturated person has inner resources which help him or her develop.
According to Saleebey (1997) five principles underlie the guiding assumptions of the strength perspective:

- Phenomenalism purposes accepting as knowledge only things which we can evidence through our own experience or observation.
- Nominalism purposes that any general notion must refer to and summarise matters for which we can adduce evidence through experience or observation.
- We best serve clients by collaborating with them.
- Every environment is full of resources.

**Brief solution focussed therapy (BSFT)**

One of the major differences between BSFT and more traditional approaches is that traditional approaches tend to examine and emphasize dysfunction, pathology and that which generally does not work. BSFT employs a strengths based approach emphasising and focussing upon strengths, the resourcefulness of the client and is generally more optimistic.

The interpersonal dynamics are more conversational process emphasising an equal relationship between the counsellor and client. The conversational process intentionally makes use of language e.g. externalising the problem and exaggerating consequences.

The counsellor’s task is to channel the flow of the conversation, identifying the client’s goals and identifying exceptions to the current difficulty, rather than focussing on the problem. Problems, rather than being seen as something that needs to be fixed, are seen as stories which can change and develop different meanings through a conversational process.

Analysing problems in the traditional sense is viewed as possibly making the individual overwhelmed and pessimistic about change. BSFT approach emphasizes a client’s resources and strengths.

A BSFT approach to counselling emphasizes:

- A respectful partnership between client and counsellor
- Strengths and resources of the client
6.6 Discussion of the Youth Focus Change Strategy

Staff discussed the ‘Action Research Evaluation Project: Feedback on Data Analysis’ document by Mark Sachmann. Included in this report were nine recommendations for possible changes to the PSW programme. Since the meeting Youth Focus clinical staff have implemented changes to meet each recommendation outlined in the 2006 report. These changes are outlined below (refer also to Table 4 on page 145).

Identification and articulation of possible change activities:

1. More Physical Activities

   • This appears to be particularly pertinent for young males who require physical based activities as either a distraction or as an alternate activity for inclusion in the programme:

   A low ropes course has been incorporated into the PSW programme. All feedback received by staff, volunteers and young people has been very positive.

2. Educational material not always easily comprehended by all participants.

   • The varying intellectual and developmental capacities may result in some individuals not adequately comprehending the educational material being presented.

   Staff agreed that this was an issue in earlier camps however the content has changed. Educational material is now presented in many ways to include visual, physical, verbal, experiential and written. Examples of this include the self esteem act/performance, the low ropes course, and caucusing sessions.

3. Outdated Material:

   • Material has been sighted as outdated and not simulating enough to maintain the interest for participants.
The PSW scripts were reviewed by staff and those considered to be outdated were updated or removed. The material/sessions updated include the self esteem, clearing house and expression sessions. The PSW scripts removed from the camp programme included the bed time story and the final hugs session.

4. Absence of spare time:

- Participants have sighted that a relative absence of spare time is a concern. Spare time allows the individual time to process material and where requires, take a break from the demands of camp activities.

Spare time is now incorporated into the camp programme. Meal breaks have been extended for this purpose. A camp journal has been developed as an option for young people to utilise during the spare time as a processing and reflection tool.

5. Not enough unstructured activities:

- This issue is related to the absence of spare time. Participants would appear to require some activities that are merely enjoyable and not designed with a clear therapeutic purpose in mind.

- Unstructured activities may also provide the opportunity for the young person to reflect on their own intrapsychic processes.

As mentioned above, spare time has been incorporated into the camp programme for the above purposes. Currently staff are exploring unstructured activities for young people to access/utilise during spare time e.g. football and four square.

6. Not enough transition time between activities to process experiences:

- This request would appear to be relatively self-evident. Simply stated participants would like more time between activities to both cognitively and affectively process the experiences prompted by the various activities.
The camp timetable has been altered to allow for processing time. A processing activity (e.g. a bush walk, expression session and entertainment night) is conducted following each focus session (e.g. family and relationship and grief and loss).

7. Identify more clearly what the goals and the intended outcomes of the camp experience:

- Some camp participants would appear not to adequately comprehend the intended outcomes of the camp experience. Whilst clearly these vary between individuals, some educational clarification may be useful in articulating what the camp experience is intending to provide.

Counsellors now incorporate the intended outcomes of the camp experiences (aims) into the client camp assessments and also explore the young person’s goals and expectations of camp. On the Friday night of camp the aims are clearly outlined by the Camp Coordinator to all participants. All young people who attend the camp receive an information form outlining the aims and objectives of the Peer Support Weekend as well as the sessions and activities that will be conducted over the duration of the PSW.

8. More Craft Activities:

- Again this request would appear to be self-evident. Whilst the interviewer did not seek to clarify the precise reasons for this request, it would seem possible that in part it is a desire for more activities that are merely pleasurable and turn attention away from intrapsychic and interpersonal reflection.

Craft activities are now incorporated into the expression session.

9. Too much emphasis on content and not enough on process issues i.e. not integrating a person’s personal insight derived from activities into the individuals overall camp experience.

- These comments appear to make reference to a need to acknowledge process dynamics and their contribution to
personal growth, insight and an understanding of the overall camp experience. Moreover, how process issues relate to the young persons overall developmental journey.

A caucusing session has been implemented into the PSW programme on the final day. The caucusing session provides an opportunity for participants to discuss and reflect on their experiences of the PSW without input from the staff. After the young people have shared their experiences, camp staff are invited to comment on their reflections of the camp process and the young peoples journey.

Feedback from young people and staff has proven to be very positive. Young people have stated that they enjoy the opportunity to reflect over the weekend without any input from staff.

A goodbye session has also been incorporated into the PSW programme as a processing and reflecting tool. Photographs are taken over the weekend and presented at the goodbye session via PowerPoint with music in the background. Feedback from this session has also been very positive.

Changes to the Youth Focus peer support weekend:

December 2005:

- Photo cards for the family and relationship session were introduced. The photo cards were spread out on the floor and young people were asked to select a photo that represented family and/or relationships. The young people were asked to share in small groups why they had chosen the photo. The photo cards were very useful in encouraging discussion in a less confronting way.

- Caucusing session introduced as a processing and reflection activity.

March 2006:

- The family and relationships, expression session and grief and loss focus sessions were extended to one hour each. The prompt card questions were also altered as complaints from the previous camp indicated the questions were monotonous and lengthy.
• There was concern that a few young people were not sharing in the smaller group due to not being interested in the therapeutic aspect of the PSW and as a result other young people did not feel safe and able to share. It is now incorporated into the camp guidelines that “if people do not wish to share in smaller groups it is ok but to it is important not to be disrespectful to other young people who may wish to share”.

• The “Camp Stuff” journal was introduced into the Peer Support Weekend (PSW) as a processing tool for young people.

• A post camp debriefing session was established for staff attending camp. This session was and will continue to be held Tuesday morning after the PSW (before any staff or volunteer meetings). This session allows staff an opportunity to process the weekend, raise any concerns, to debrief and to determine what feedback is necessary to relay to the counsellors regarding their clients.

• A goodbye session introduced to provide a reflection and processing opportunity. Photographs of participants and activities are taken over the weekend and presented at the final session of camp (with the calling song playing). This session has received very positive feedback.

• There were concerns that the self esteem session used for the December 2005 script was very outdated. An updated self esteem session was introduced. The updated self esteem script consisted of an acting segment presented by staff and a large group discussion.

• After the December 2005 PSW there were some concerns raised about the massages and final hugs session being outdated and overwhelming and unsafe for some participants (particularly those who may have experience abuse). Staff agreed that these sessions would be removed from the programme. Natural group hugs occurred (initiated by young people) on the camp after the caucusing session.
• The trust fall session was removed from the programme due to safety concerns. A volunteer hurt their back in this activity and a young person was nearly dropped in this activity at the December 2005 PSW.

• Counsellors were informed to clearly define PSW boundaries in relation to swapping counsellors. Moreover that young people can only access their allocated counsellors after camp due to policy and procedures. Often young people become attached to camp counsellors and at times have contacted them at the office post camp.

• Spare time was incorporated into the PSW programme to provide individuals with an opportunity to process material and to take a break from the demands of camp activities.

June 2006:

• A wellbeing medication form was developed which was designed to assist the wellbeing person with ensuring young people consumed medications.

• A buddy system was implemented whereby each new volunteer is paired with an experienced volunteer. The experienced volunteer would support the new volunteer throughout the camp. The new volunteer could assist the experienced volunteer in the preparation and facilitation of their scripts however the new volunteer's primary role on camp is to observe the process.

• Youth Focus hired the services of the Bickley Recreational Staff to facilitate a low ropes course.

• The timetable of camp was altered to ensure that there was a processing activity after each focus session. Staff stated that the processing time is now sufficient.

• The self-esteem session was further developed by incorporating a small group discussion on factors that increase and decrease self-
esteem and ways in which young people can protect themselves from negative factors that can contribute to low self esteem.

**September 2006:**

- Young people on previous camps often ask staff about the timetable of the camp. Staff stated that they believed that young people needed more clarity of what was occurring during each day. A timetable for young people was established as a result and timetables are now pinned at various locations on camp (including dorms, dining hall, main group room).

- The self esteem session was further developed. The acting segments were reduced in length and were separated into two segments. The first segment (on how self esteem can be reduced) is presented to introduce the session. Young people are asked to break into small groups after this activity and discuss their experiences of the presentation, what factors increase and decrease self esteem and how we protect ourselves against factors contributing to low self esteem.

- Had volunteer caterers for the first time which was a great success.

- Incorporated in the trust session script: “What is important when working in groups to provide a safe, trusting environment”. As a way of creating safety before the focus sessions.

- A post camp group was established to discuss what young people can take away from the camp experience and utilise in their daily lives with the aim of building resilience.

- More focus on resilience building and continuing the formation of attachments in the post camp groups.
Changes made prior to the December 2006 PSW:

- A camp clean up script was developed.
- A ‘Volunteer Roles on the PSW’ form was developed and will be distributed to volunteers prior to the PSW.
- Established a lost property box with distribution of its belongings on the final session on camp.
- Provided young people with water bottles on the Friday of camp. Wrote names on each bottle. This also assisted with the consuming of medications.

Will continue to explore in 2007:

- To explore updating icebreakers for the communication session as fruit salad was identified as dangerous.
- To explore altering the PSW timetable so that the trust session is before the self esteem sessions. It has been suggested that this would then increase young people’s sense of safety before discussing self esteem issues.
- To explore changing the relaxation session so that it can be more psycho-educational e.g. teaching relaxation and grounding techniques.
- To purchase sporting equipment to be utilised by young people between sessions.

December 2006 Youth Focus Caucusing session

As part of the Youth Focus peer support camp held at Bickley on the weekend of 2, 3 and 4 December, 2006, a caucusing session was held, where the youth were able to contribute answers to a set of nine focus questions, and the counsellors and volunteers were then able to reflect on these contributions. One of the volunteers acted as scribe so that the contributions could be recorded.

The first part of the caucusing session involved the youth breaking into small groups of three to four people to discuss the nine focus questions for twenty minutes. Most
of the questions related to the peer support camp, with a few questions relating to counselling in its broader sense, including the peer support camp. For the most part the youth were focussed and involved in discussing the questions, appearing to enjoy the freedom to say what they thought. There was lots of smiling and laughter as well as useful discussion in a relaxed small group atmosphere.

The second part of the caucusing involved the youth forming into a crescent so that everyone could see each other. The counsellors and volunteers formed a mirror crescent, separated from the youth but able to easily see and hear them talk as a larger group. The youth discussed the nine focus questions while the counsellors and volunteers listened carefully without making any contributions. The youth contributed in a very respectful way, with natural facilitators emerging from within the group that kept the process of contributing flowing, and allowed everyone to have their say. During the fourth question the youth noticed that the counsellors and volunteers were taking notes, but this was only a momentary distraction and did not adversely affect the contributions to the discussion of that or any subsequent question. At the end of the youth group discussion, the youth spontaneously engaged in a supportive and extended group hug, clearly demonstrating their enjoyment of the discussion and the contributions they could make freely and responsibly as a group of youth. The youth contributions to the focus questions were as follows.

Question 1: What do counsellors do that you find helpful?

- Counsellors listen, give good advice, crack jokes at the right moment, are easy going, help when you are upset, are supportive, give free help, give the right amount of support and assistance appropriate for your particular problem.

Question 2: What do you like about camp?

- Weather, people, the leaders, focus sessions as a relief to bottling things up, games in between, people are brave and supportive, supportive environment, meeting everyone, the young people are cool, counsellors are awesome, I am not considered a freak, presents (from Santa at the entertainment night), food, other people, helps express things particularly difficult things when you need to let emotions out, everybody is cool, everybody knows what space to give, counsellors are really organised, we have our moments but that is part of life, meeting new people, watching previous campers grow further, help with working through our problems in normal life, group sessions.
Question 3: What do you think of sharing time on camp with other young people?

- Helps with social skills, helps each other deal with similar problems, helps find a special confiding person who you can speak to out of camp, good for social skills, allows you to say what you want to say, helps you realise you are not alone, provides a chance to say what you have been holding in for years, allows people to listen to me, provides comfort in knowing others are there and going through the same things, the sessions are good even though they can get people down but they are good for helping with problems, it is good to listen to others, helps you get through things, love sharing, allow you to see how strong others are, helps me to push on.

Question 4: What is the best thing you can do to help other young people on camp?

- Give people space, comfort them when they need it, be there for them, for me to know other people can trust you, have the time, remembering the good times and the fun, trying your best to let them know you understand.

Question 5: Why do you come on camp?

- To catch up with old friends and to make new ones, to get help, to learn new things about myself and new ways of overcoming things, to jet away from negatives for a few days, to be open, to meet new people, it is a safe place, make friends and understand myself a little more, to escape life, to sort out some issues, for fun friends and food, to get away from (full on) families, to meet old friends, to watch people grow, to realise you are not alone in things, to escape life, a break from home, for more quiet time.

Question 6: Why do you talk to a counsellor?

- To make me feel better, to help work through problems, to help lift you up when you are feeling down, to express problems before you go insane, to get advice, to get help with problems and lifts the weight off problems, you can talk about family when talking to family yourself can make it worse, to work through things.

Question 7: Thinking about the sessions on camp – which ones did you like / get the most out of and why?

- (3 responses) Focus sessions – these can help, but mixed with games to relieve the intensity, they can make you down but can release tension
- (2 responses) Expression session – to allow you to express who you are
- (2 response) Massages – helps you relax
• (2 responses) Anything that is not a focus session – in these other sessions you get to be you
• (1 response) Entertainment night – laughs

Question 8: What kinds of things did you see other young people doing that inspired you?
• Talking about their problems up front and getting them off their chest, just going on camp – the courage of young people to come on camp, it takes courage to come and inspires you to start talking, some have issues but have the courage to talk about families trust and share, coming up and confronting problems, seeing people slowly start to work through things and get better slowly, being supportive and giving help to others, courage and strength to deal with issues.

Question 9: Anything really special that you want to say about someone here on camp?
• They are all wonderful people and a joy to catch up, (camper’s name) for talking to me, everyone especially (camper’s name) who is wonderful, everyone it is a pleasure and honour to be here and (camper’s name) is especially lovely, (camper’s name) for sharing in focus sessions as we have a lot in common, everyone – you are all an inspiration – love you all, all (camper’s name) included me in their group - (another camper’s name) for talking through problems - (another camper’s name) rocks my socks - (another camper’s name) for hugs within reach, all have courage to come back which is inspirational - (camper’s name) and (another camper’s name) who opened up over camp, all – great to see everyone again and to talk to them, great to see (new campers) getting involved and opening up.

The third part of the caucusing involved the counsellors and volunteers reflecting on the youth comments while the youth listened without commenting. The counsellor and volunteer comments were:
• Found it interesting and the youth, for the most part, seemed unaware of observers
• Ownership of the process, answers flowed, facilitators emerged, discussion methods varied, respectful sharing, natural leaders emerging, kept on track
• Great to hear quieter people talking and sharing, those that may have not been highly visible in other activities
• Support for new campers was encouraging, reminiscent of team support
• Focus sessions – although these were heavy there was deep sharing
• Diversity of needs and wants and this aspect was respected
• The value for young people of hearing others share – lets them watch how others have coped
• An interesting tension emerged related to focus sessions – the youth may not like them but they get a lot out of them
• Value of hearing the strength and courage shared in the focus sessions
• Hope that positive affirmations such as compliments and the pizza box comments can be remembered
• Good to hear the personal specifics included in the young people’s sharing
• Reflection on the mix of previous and new campers, and the opportunities for space to share
• The (extended) camp time allows time for young people to connect with the leaders, with everyone looking out for each other, and time to get to know and adjust to others
• Everyone had a chance to have a say in the caucusing
• Inspired by the repeated examples of strengths and courage
• Feel that Youth Focus counsellors are “on track” based on the feedback from the young people in the caucusing

As the final part of this third part of the caucusing, some personal triumphs by the young people were acknowledged by the counsellors and volunteers. These included:
• Taking a risk to be here and expected to share
• Courage to get involved, especially in the entertainment night
• (Camper’s name) supportive of new people
• (Camper’s name) open to say things in clearing house that sets an example for others
• (Camper’s name) handling things on camp and how more confident people become
• opportunities for young people to be themselves
• (Camper’s name) willingness to apologise
• supportive comments from (three camper’s names) in group sessions
• personal aspects of (camper’s name) emerging during activities and in interpersonal work, showing personal courage and growth
Part four of the caucusing involved the youth, counsellors and volunteers reflecting together on the caucusing process. This reflection indicated that it was good to get an opportunity to talk about things not brought up in other sessions, and that it was a good opportunity for young people to say what they wanted to say while running the discussion in their own way.

Scribing and transcription by Steve Brown, Youth Focus Volunteer.
### Table 4: Discussion of the action research change strategy

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Changes</th>
<th>Result/Feedback</th>
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<tbody>
<tr>
<td><strong>Volunteers</strong></td>
<td>1. An annual volunteer meeting is now held for volunteers to identify needs/wants for the year.</td>
<td>Volunteers identified that they wanted to feel more connected to the agency. Volunteers suggested monthly newsletters, training three times a year and three volunteer get-togethers a year as a solution.</td>
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<tr>
<td>1. Identified that they did not feel connected, integrated and involved in the agency.</td>
<td>Volunteer’s newsletters are developed and sent on a monthly basis. The newsletters consist of information on camps, mentoring, upcoming events, money raised from events, staff changes, useful resources and birthday wishes.</td>
<td>Feedback has been received verbally and numerous emails have been sent via volunteers commenting on feeling more connected, integrated and involved in the agency.</td>
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<tr>
<td>3. Volunteer get-togethers are held four times per year</td>
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<td>A volunteer nominated herself to organise the volunteer get-togethers. Four volunteer get-togethers have been held this year. Volunteer’s feedback that they enjoy the opportunity to meet with other volunteers and staff socially and as a result feel more connected and involved in the agency. Volunteers have also stated that it is beneficial to discuss with other volunteers their experience of Youth Focus and of their work with young people.</td>
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<tr>
<td>4.</td>
<td>Three volunteer training sessions are held per year.</td>
<td>The training held this year was on working with young people who self harm, understanding youth suicide and working with young people from sexually diverse backgrounds. Feedback has been very positive.</td>
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<tr>
<td>2. Vicarious trauma as a concern</td>
<td>1. Vicarious trauma training is being developed for volunteers.</td>
<td>Volunteers have been informed of the training and many stated that they would be very keen to attend.</td>
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<td></td>
<td>2. A debriefing meeting is now held after camp on the Tuesday.</td>
<td>Volunteers have provided feedback that debriefing is an essential process for volunteers attending camp. Volunteers state that they enjoy being able to discuss their experiences of camp and any concerns that may be lingering.</td>
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<tr>
<td>Explanatory Framework</td>
<td>As a result of the action research undertaken, staff identified resilience and attachment theories as appropriate explanatory frameworks for working with young people at risk of suicide, depression and self harm. The project identified that many young people will continue to be exposed to significant psychosocial issues that would contribute to suicide, depression and self harm. The Peer Support Weekend (PSW) provides a forum for young people to build appropriate attachments and</td>
<td>By identifying the explanatory frameworks Youth Focus is able to clearly articulate the purpose, aims and objectives of camp. Youth Focus is also to develop the camp programme in a therapeutic purposeful way.</td>
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</tbody>
</table>
resilience that will increase the likelihood of them coping with difficult life situations.

**Intervention Framework**

The practice model informs the process that staff, counsellor and peer support interventions are carried out on camp. Clients are already seeing a counsellor regularly on a one to one basis and are given the opportunity to practice new skills and coping strategies alongside other young people with a shared experience. The counsellors are present when clients are in the peer support setting to support and promote personal growth and healing.

The updated manual and scripts identify the peer support programme intervention framework which is based on a clearly specified model. All staff are able to access the manual and clearly identify goals and intervention objectives that are necessary before staffing on a camp.

**Updating Camp Manual and Operational Manual**

1. All scripts for camp have been updated so there is a consistent format, prompt cards for facilitators and resilience and attachment theory aims.
2. Flowcharts have been added into the operational manual.
3. Intervention frameworks will be added to the camp and operational manual.
4. The aims and objectives of camp have been updated by staff.

All changes have resulted in more user friendly documents and more clearly articulated therapeutic scripts and manuals.
**More Physical Activities**

This appears to be particularly pertinent for young males who require physical based activities as either a distraction or as an alternate activity for inclusion in the programme.

1. Two recreational activities have been introduced into the camp programme.

   Young people have provided feedback verbally and via camp evaluations that they love the new recreational activities. They state it provides them with an opportunity to have a break from the heavier sessions. They have also feedback that it brings them closer to other camp participants.

   Staff and volunteers have provided feedback that the activities provide the young people with team building opportunities, increase self esteem, courage and confidence, stress relief, increases team cohesion and strengthen peer attachments.

2. A volunteer developed a new music and dance session (as part of the expression session) as a way of allowing young people to express themselves.

   Feedback from the December camp was very positive. Staff informed me that young people enjoyed themselves. Staff also provided feedback that the session provided young people with fun, humour, a break and an opportunity to develop peer attachments.

**Educational material not always easily comprehended by all participants**

The varying intellectual and developmental capacities may result in some individuals not adequately comprehending the educational

1. Visual aids introduced into the camp programme e.g. new grief and loss cards, checking in cards, photos for families and relationships.

   Staff and volunteers have commented that as a result of the visual aids there has been increased discussion in the focus sessions.

2. An acting segment introduced into the self
<table>
<thead>
<tr>
<th>Outdated Material</th>
<th>esteem session.</th>
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<tbody>
<tr>
<td>Material has been sighted as outdated and not simulating enough to maintain the interest for participants.</td>
<td>The PSW scripts were reviewed by staff and those considered to be outdated were updated or removed. The material/sessions updated include the self esteem, families and relationships, grief and loss, clearing house and expression sessions. The PSW scripts removed from the camp programme included the bed time story, massages and the final hugs session.</td>
</tr>
<tr>
<td>All staff and experienced volunteers have commented on the improvements to the self esteem session. Comments have been made regarding the relevance of the skit for young people and the increased opportunity for discussion. The self esteem session is still being reviewed. The grief and loss and family and relationships now have visual aids added to assist discussion and questions regarding coping strategies and resilience. Staff and volunteers have raised concerns regarding the clearing house session. Concerns included that the session can be unsafe for some young people. The session was replaced with a checking in session which focuses on providing young people with the opportunity to reflect on their camp experience, regulate their emotions and ground themselves within the group. Conflict resolution strategies are outlined in the beginning of camp and prior to the checking in sessions.</td>
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</table>
The expression session has been updated and now includes a more structured art and dance/music session. Feedback from these sessions has been fantastic. Young people commented that the sessions have given them an opportunity to express themselves in a fun and creative way. The writing session is still being developed.

The final hugs and massage session were removed due to concerns regarding young people’s sense of safety and personal space. Hugs do occur naturally.

The bedtime story was identified by staff and volunteers as being outdated and were removed from the programme.

Absence of spare time
Participants have sighted that a relative absence of spare time is a concern. Spare time allows the individual time to process material and where requires, take a break from the demands of camp activities.

Spare time is now incorporated into the camp programme. Meal breaks have been extended for this purpose. A camp journal has been developed as an option for young people to utilise during the spare time as a processing and reflection tool. Staff and volunteers are available during these times to support young people in processing material if needed.

All feedback has been very positive. Young people utilise this time to access staff/volunteers/peers for support, to develop peer attachments, to simply have a break and to process the camp.
<table>
<thead>
<tr>
<th><strong>Not enough transition time between activities to process experiences</strong></th>
<th>The camp timetable has been altered to allow for processing time. A processing activity (e.g. a bush walk, expression session and entertainment night) is conducted following each focus session (e.g. family and relationship and grief and loss). The meal times have also been extended to provide young people with an opportunity to process sessions and material discussed on camp.</th>
<th>Young people often state how much they love the bush walk as it gives them a chance to process and let go of the issues discussed in the focus sessions. Staff and volunteers who attend camp have provided positive feedback on the mix of focus sessions and fun/process activities.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identify more clearly what the goals and the intended outcomes of the camp experience</strong></td>
<td>1. Staff meet to discuss the goals and intended outcomes of the camp experience.</td>
<td>Staff now have a shared understanding of the goals and intended outcomes of the camp experience.</td>
</tr>
<tr>
<td>Some camp participants would appear not to adequately comprehend the intended outcomes of the camp experience. Whilst clearly these vary between individuals, some educational clarification may be useful in articulating what the camp experience is intending to provide.</td>
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2. Counsellors now incorporate the intended outcomes of the camp experiences (aims) into the client camp assessments and also explore the young person’s goals and expectations of camp. On the Friday night of camp the aims are clearly outlined by the Camp Coordinator to all participants. All young people who attend the camp receive an information form outlining the aims and objectives of the Peer Support Weekend as well as the sessions and activities that will be conducted over the duration of the PSW. Copies of timetables, guidelines and aims are now put in all utilised rooms.

### Increased match of client need and therapeutic benefits which camp has to offer.

These more appropriately selected clients attend camp with a better understanding of the goals and intended outcomes of the camp experience.

<table>
<thead>
<tr>
<th><strong>More Craft Activities</strong></th>
<th>Craft activities are now incorporated into the expression session. The activity was designed by a volunteer and approved by staff.</th>
<th><strong>Processing time</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Staff and volunteers who attended the session stated that young people really enjoy the session.</strong></td>
<td>1. The camp programme was altered to allow for processing time.</td>
<td><strong>Young people, staff and volunteers have provided feedback that the additional time for processing has been beneficial. Young people in this time utilise and access the journal, peer support, counsellors and volunteers to assist them with processing and reflection.</strong></td>
</tr>
</tbody>
</table>

**Processing time**

Too much emphasis on content and not enough on process issues i.e. not integrating a person’s personal insight derived from activities into the individuals overall camp experience.
<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>A camp journal was introduced as a reflection and processing tool.</td>
<td>Young people are given a journal at the beginning of camp. Many young people utilise the journals during the spare time to reflect and process the camp material and relationships. Young people often present their journals in their post camp counselling sessions to process their camp experience.</td>
</tr>
<tr>
<td>3.</td>
<td>A caucusing session was introduced. The caucusing session provides young people with an opportunity to reflect and to discuss their experience of camp.</td>
<td>All feedback regarding this session has been very positive. Young people often state that they enjoy the time to talk about camp without the input from staff/volunteers. Staff and volunteers have provided feedback that the session is very helpful for young people in processing the camp content, relationships and the meaning of the camp experience in the broader context of the young people’s lives.</td>
</tr>
<tr>
<td>4.</td>
<td>A goodbye session was introduced to the camp programme. Photographs are taken of young people throughout camp and presented on the final session of camp. This provides young people with an opportunity to reflect on their journey and their accomplishments.</td>
<td>All feedback on this session has been extremely positive. The feedback from this session can also be witnessed visually. Young people often laugh and cry at achievements they have made over the weekend and the peer attachments developed.</td>
</tr>
</tbody>
</table>
6.7 Future areas for research and discussion:

Despite the significant change process that was identified and applied, the Youth Focus staff have identified a number of additional areas for consideration:

- Staff and volunteer self care on camp
- Increased time off for staff after camp to avoid burn out
- Another counsellor to attend camp due to the increasing amount of referrals. This would result in more time for staff to self care, less pressure on the female staff to provide counselling support to young people etc.
- To explore updating icebreakers for the communication session as fruit salad was identified as dangerous.
- To explore altering the PSW timetable so that the trust session is before the self esteem sessions. It has been suggested that this would then increase young people’s sense of safety before discussing self esteem issues.
- To explore changing the relaxation session so that it can be more psycho-educational e.g. teaching relaxation and grounding techniques.
- To purchase sporting equipment to be utilised by young people between sessions.
- Evaluations mechanisms for young people to be developed to include resilience measures.

These proposed changes will be subject to the action research feedback cycle that has now come to characterise the Youth Focus approach to its camp based initiatives.

6.8 Conclusion:

The Youth Focus change strategy, as identified and articulated in the report, have had a very positive therapeutic impact on not only the individual’s camp experience but their life as a whole. The feedback cycle inherent in action research processes has made a very real impact on the provision of the camp experience. This positive change gives considerable support and validation to the fact that young people do know what is good for them and when asked can provide some very insightful and
useful directions for the psychosocial support and treatment of their complex life issues, such as suicide and self-harm.

Another result of the positive changes in the provision of Youth Focus camp based initiatives has been the compilation of relevant policies and procedures and the continued development of the operations manual. Here the rational and purpose of the various types of interventions and strategies employed by Youth Focus clinicians have been identified and described. This provides a very detailed overview of the unique Youth Focus approach to treating young people with self-harm and suicidal ideation and behaviours.

This understanding has made the Youth Focus camp process more accountable and open to critical evaluation and revision. It is crucial that Youth Focus at all times be able to identify and articulate the rational for its various intervention strategies. As a result of the compilation of these documents, Youth Focus can now be very clear about how and why it intervenes in a young person’s life and can provide very detailed theoretical and clinical descriptions of its activities.
Chapter Seven

Conclusion

7. Conclusion

The application of the identified changes as outlined in Chapter Six have resulted in a Youth Focus Peer Support Weekend programme that is more appropriately focussed, has a good balance between content and process issues, has an increased responsiveness to gender based differences in relation to preference for activities, and content based initiatives that are now more contemporary in nature and hence more appealing to young people.

The Youth Focus Action Research Project has assisted in altering the manner in which Youth Focus intervenes in young people’s lives. Whilst Youth Focus continues to apply its intervention strategies from an informed theoretical base as identified and articulated in the psychosocial literature, action research indicates that theory informs practice and that in turn, practice informs theory. This continuous feedback cycle is fundamental to the process of action research and has been applied and demonstrated in a highly successful manner in the Youth Focus Action Research Project.

The onus of responsibility is firmly upon Youth Focus to continue to identify, articulate and scientifically justify the theoretical and practice knowledge that informs service delivery to young people and their presenting psychosocial issues. The clinical interventions utilised by counselling staff, in individual counselling or Peer Support Weekends, will continue to be subject to ongoing professional critical analysis and where indicated, change in both content and process.
Not only has the change strategy successfully reshaped many of the Youth Focus Peer Support management and intervention strategies, but it has also provided an opportunity for Youth Focus to become significantly more able to theoretically justify its position in relation to conceptual models that inform clinical practice. The models profiled in Chapter Six form a solid theoretical foundation for Youth Focus to base its clinical intervention strategies upon. It is by no means suggested that these models were not being applied in an appropriate manner prior to the research, but rather now the synergistic combination of theoretical frameworks have been articulated and justified in a more clinically precise and transparent manner.

It has been a result of a combined effort of all concerned, staff, the young people, their families, volunteers and referrers that Youth Focus is now in a better position to offer management and treatment for young people who are experiencing suicidal ideation and its psychological and behavioural sequelae.

The Youth Focus Action Research Project has indeed been a graphic demonstration of the effectiveness of appropriately applied action research in motion. The knowledge gained from the research should now assist Youth Focus counselling staff in being able to apply action research methodologies in the future.
Appendixes:
Appendix 1:

ATTACHMENT C

SECTION 3.2: DETAILS OF THE REQUEST

GROUP SUPPORT
FOR YOUTH AT RISK OF SUICIDE

BACKGROUND

Youth Focus has been in operation for over ten years. The organisation was conceived out of a youth work model of peer support and self help. Since conception, the original model has evolved to integrate lessons learned, emerging evidence and examples of good practice. The current Group Support programme recognises adolescence as a period of transition from childhood and dependence on the family to independence and dependence away from the family. For some young people this transition is more problematic due to a range of environmental, social and biological factors. The Group Support programme aims to provide peer support to assist young people to see that they are not alone in experiencing these difficulties and begin to recognise that support is available and that change is possible (see Attachment D for further details). At the time of its conception, the programme moved outside the traditional medical model and suggested that an adult centred approach may not be the most effective way of supporting this target group, but instead great inroads could be made by adopting an approach led by youth. At the time this philosophy was exciting yet problematic as it proposed an element of risk, however years later it has gained recognition and support.

Youth Focus holds a reputation of providing innovative and cutting edge support services to young people. The organisation endeavours to provide professional and quality services yet at the same time is not afraid to enter into uncharted or unfamiliar territory. In a climate of ever increasing need and declining government funding it is suggested that for many youth services they are unable to venture out of traditional ways of operating, and despite legitimacy there is a culture of fear regarding research and evaluation. Consequently, it is suggested that multiple pockets of unevaluated
examples of good practice exist however, these examples only benefit their own target group and have yet to influence the way we assist youth at risk. This project aims to challenge this culture and demonstrate the enormous benefits of employing consumer led evaluation and how, when once recorded, these findings have the potential to aid the development of youth services and ultimately better serve youth at risk.

INTRODUCTION

The 2000 National Mental Health Strategy clearly spells out the enormous personal, social and economic impact of the occurrence of mental health disorders\(^1\). In 1996, Australian mental disorders accounted for nearly 30 per cent of the non-fatal disease burden. The direct cost of mental disorders and problems was estimated to be $2 billion. This does not take into account the indirect costs such as the impact on families and communities, the need for welfare response and coronial work in the case of suicides. Indicators reveal that the burden of mental health problems and mental disorders is high and rising. A twelve month survey conducted in 1998 estimated that one in five people in Australia were affected by a mental health problem; the survey also revealed that young adults aged 18 to 24yrs were most at risk\(^2\). By providing support and assistance at an early stage, Youth Focus aims to prevent suicide and deliberate self harm.

The World Health Organisation currently notes that depression is the fourth leading cause of disability and by 2020 this will have achieved second place\(^3\). Depression does not cause suicide but is viewed as a risk factor or warning sign. Risk factors increase the chance of problems arising or exacerbate the existence of current problems\(^4\). Youth Focus operates from a premise that these risks can be counteracted by the development of protective factors, defined as: *something in a young person’s life that may be a support in dealing with problems in a more positive*

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3 National Action Plan, op.cit

The current Group Support programme aims to strengthen protective factors, in order to develop robust, resilient adolescents with the skills, attitudes and behaviours necessary to function as positive, successful members of their community.

THE NEED FOR RESEARCH

Living Is For Everyone (LIFE): a framework developed by the National Advisory Council on Youth Suicide Prevention for prevention of youth suicide and self-harm in Australia, provides a four-year strategic framework for national action. The framework outlines several principles of effective suicide prevention:

- Suicide prevention is a shared responsibility involving families, communities, government and non-government agencies;
- It requires a diversity of approach, targeting the whole population, specific sub-groups 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, appropriate and responsive to the social and cultural needs of the groups or populations they serve;
- Prevention efforts must be sustainable, to ensure continuity and consistency of service for communities.

Across Australia a range of localised suicide prevention networks has evolved. Generally, these groups aim to promote the implementation of programmes proven to strengthen protective factors and promote resiliency. However, “the lack of outcome evaluation represents a large gap in current Australian suicide prevention initiatives”. Discussions with local and rural Western Australian suicide networking groups has seen a high level of interest and support for the development of evidence-based models for local implementation. Groups, organisations and governments want to be

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5 Bond et al., op.cit.


sure that service provision is beneficial, and confident that support and assistance is not going to cause more harm than good.

This project aims to evaluate, record and publicise a suicide prevention programme which is evidence-based, outcome-focused and incorporates client, carer, community and expert input. This project is outside the normal business of Youth Focus, however, as an established and credible service provider it is proposed that the organisation is well positioned to embark upon this challenge. Through adopting, implementing and promoting good practice principles outlined in the national LIFE framework this project aims to begin to address the clear need for increased knowledge and informed and evaluated practice. The project intends to undertake this research in a manner which motivates and encourages other community based organisations to follow suit with an ultimate benefit of adding to the body of evidence-based research which better informs and guides suicide prevention.

Benefits of the project are:

1. To contribute to present knowledge about group support programmes for the prevention of youth suicide, so that the current shortfall in evidence-based programmes can be effectively addressed.

2. To develop an effective, well-designed, Group Support Camp which can be applied to youth services, (in WA and elsewhere), which are working with young people in this age group aimed at the development and strengthening of protective factors.

3. To provide a ‘real’ example of how youth services can involve consumers in evaluation, development and service design.

**ISSUE WHICH THE PROJECT WISHES TO EXPLORE**

Youth Focus services are based on an assumption that Group Support Residential Camps are effective in motivating young people to bring about positive personal changes which increase their resilience and open doors to other opportunities for personal growth.
This assumption will be explored using an action research approach. For the purposes of this project, the following definition of action research has been adopted:

“Action research is a process by which change and understanding can be pursued at the one time. It is usually described as cyclic, with action and critical reflection taking place in turn. The reflection is used to review the previous action and plan the next one. It is commonly done by a group of people.”

There are several advantages of employing action research as the primary methodology:

- It utilises a research process which uses procedures, methods and techniques that have been tested for their validity and reliability;
- It actively seeks, records and incorporates input from those who have experienced camp;
- It enables an interactive process to occur in which the input from participants and providers (voluntary and paid) can generate new ideas and activities during the research cycle;
- It enables young people to share ownership of the programme;
- It maintains the focus on youth by involving youth participation;
- It validates young people’s opinions and views, as well as their families, referral sources, volunteers and Youth Focus counsellors.

**PROJECT PLAN**

Project objectives:

I. The systematic evaluation and development of the current group support programme, based on participant experience.

II. A qualitative study of what participants have deemed effective and the underlying reasons why.

III. To contribute to the body of evidence based knowledge so as to inform and guide future service delivery.

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IV. To provide a ‘real’ example of how community based youth organisations can involve the community, clients, carers and experts in the evaluation and development of programmes.

V. To motivate other community based youth services to adopt LIFE and Community LIFE principles.

PROJECT METHODOLOGY

The methodology employed in this project consists of three elements:

I. Convening a Project Reference Group

II. Conducting a secondary study of present literature and other unpublished works

III. Conducting a primary study to gain new information

It is proposed that this Project will be undertaken in three stages:

STAGE ONE

• Establishment of a Reference Group to guide and advise the project. (The Reference Group has already been established, and has endorsed this proposal.)

STAGE TWO

• Primary preparation of background information identifying evidence-based programmes of group support used by other service organisations with a similar target group, particularly in Australia, New Zealand and Canada.

• Exploration and identification of those elements of the current Youth Focus Group Support Programme that are working well.

• Information and progress presentations.

• Integration of consumer feedback and appropriate elements from these other group support programmes as determined by those who have experienced camp, to create a new (modified) programme.

• Ongoing circular process of assessment of the effectiveness of the new programme within the Youth Focus environment.
STAGE THREE
• Submission of the model, and the evidence on which it is based, for publication and distribution to other agencies and communities for local use.
• Conference presentation.

STAGE ONE
Establishment of a Reference Group
A Reference Group has been established to advise and guide the project. The tasks of the Reference Group are:
• Support and assist Youth Focus to scope and design the project
• Oversee the delivery and implementation of the project’s aims and objectives
• Ensure the credibility, relevance and quality of process
• Support and endorse this application for funding
• Ensure that all actions are efficacious, are based on best-practice principles and do not generate any risk of harm to clients

The Reference Group is comprised of 5 members, from each of the following groups of key stakeholders:
• Youth Focus
  o Member of the Board of Governors (Mr Geoff Rasmussen)
  o Youth and Family Services Manager (Ms Jane Forward)
• Ministerial Council for Suicide Prevention (Ms Jenny Cugley)
• University of Western Australia (Discipline of Social Work - Dr Maria Harries)
• Other service providers working with young people at risk (Mr Stephen Edwards, PhD candidate who has a long and contemporary history of providing services for youth including Youth link, Self Harming Social Worker at Sir Charles Gardiner and Royal Perth Hospital, YMCA)

(It is considered inappropriate to include a young person as a representative of the stakeholder client group, because members of the Reference Group have been selected on the basis of their experience in project design and supervision.)

The Reference Group has endorsed the scoping of the project, which involved:
• determining the essential guiding principles for this project, within the framework of Youth Focus’ organisational objectives
- identifying the tasks to be undertaken, and development of action plans and timelines
- development of indicators of achievement of tasks

Several external experts or experienced researchers have been consulted in order to ensure that project conceptualisation and proposed plan reflects best practice. Suggestions and feedback from the following individuals have been adopted with the opportunity for ongoing consultation and review. Researchers consulted thus far include:

- Janet Jones, Senior Research Officer, Community LIFE, Perth.
- Roger Vallance, Director, Centre for Research and Graduate Studies, University of Notre Dame, Australia.
- Dr Faline Howes, BMedSci, MBBS, Researcher, Victoria Health.
- Dr Ernie Stringer, Adjunct Professor of Education and Aboriginal Studies, Curtin University.

**PROJECT COORDINATION**

This role is an integral part of the research project and as such requires an experienced post holder who holds knowledge of research process, Youth Focus structures and systems. The post acts as a pivotal point bringing together reference group members, Youth Focus Board, staff, clients and volunteers. Given the level of experience and seniority required, it is appropriate for the Youth Focus Services Manager to accept responsibility for coordination of the project. In order to release the Services Manager from some of her current tasks so that she can coordinate the project, while at the same time ensuring that those tasks continue to be carried out, financial assistance is sought to extend the working hours of a youth counsellor who is currently working part-time.

Tasks of Project Coordinator:

- Convene and coordinate reference group meetings
- Chair and resource reference group
- Act as central point of communication for external experts
- Inform the research process
- Educate and inform Youth Focus staff and management about the Project Coordinator’s role, aims and processes. The reference group has identified
the crucial need for this role within the project; for without ongoing education and communication, the project’s aims will not be achieved and a model of action research will not be deployed

- Present model and six monthly updates at community information sessions (see Stage 2.c)
- Responsible for publication, promotion and conference presentation (see Stage 3).

STAGE TWO

a. Preparation and primary background

To identify successful evidence-based Group Programmes/Projects used by other organisations and agencies, it is proposed:

- To undertake a comprehensive literature review, and
- Using Community Life\(^9\) guidelines, consider some good practice programmes that have not been published, but which may be in use, or have been used, by other relevant agencies.

The purpose of the literature review is to provide primary background which will be used as a source of reference or ideas when implementing the model of action research. Programmes selected for consideration will meet the following essential criteria:

- Target young people in the age range between 12 and 18 years
- Target early signs associated with youth suicide and deliberate self-harm
- Based on a model of group support
- Are professionally facilitated
- Have similar goals or purpose, namely to increase resiliency and decrease suicidal ideation

The literature review will be conducted by researchers comprised of University of Western Australia (UWA) Post-Graduate Social Science students. 750 hours has been allocated to undertake this exercise. Youth Focus has no prior experience of undertaking a research project of this size; hence, external researchers will be employed to ensure that research principles are adhered to. Post-graduate students

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\(^9\) (Community LIFE: a federal initiative aimed at supporting the community to plan and develop suicide prevention activities and programmes)
will be utilised in an effort to reduce costs and also to provide the ability to work in partnership with academic supports and resources.

Based on findings from the literature review combined with data obtained about similar programmes which have been identified, but which have not been published, a report will be prepared which will include:

- A summary of relevant projects in the literature, as well as others which have been identified as best-practice yet unpublished, with their key characteristics. Patterns and common themes will be identified.

- A selection and critique of the projects which:
  - are the most similar to the Youth Focus’ programme,
  - have outstanding merit,
  - are culturally appropriate,
  - may be innovative, and
  - youth friendly.

**b. Exploration and identification of those elements of the current Group Support Programme that are ‘working well’**.

Evaluation mechanisms currently employed comprise of post camp questionnaires. These questionnaires ask participants to highlight what they feel has been of benefit to them and what has not. Feedback from this reporting mechanism and informal discussion suggests that the camp has many benefits however, under the current evaluation structure there is no capacity to establish which elements, from a consumer perspective, are deemed effective and why. In addition the structure does not allow consumer input into programme development in a systematic and reliable manner.

In order to identify and describe those elements of the current Group Support Programme which are considered to be useful as benchmarks for such services, a range of focus sessions and individual interviews will be conducted. In addition the consultation process aims to establish and clarify research questions, report mechanisms and development of assessment processors. Those who will be invited to provide feedback are those who have attended at least one camp:
• Youth Focus counsellors
• volunteers
• current clients
• previous clients
• families or carers of clients
• referrers who have provided post group support

Four, former Youth Focus clients aged 18 to 25yrs will be invited to assist with facilitation of the focus groups. Those who are selected will be trained beforehand by a member of the external research team and a part time Youth Focus Youth Counsellor. The involvement of the Youth Counsellor is to create a climate of familiarity and trust. This role does not fit within the existing tasks of the youth counsellor and as such they will be offered additional hours of employment to undertake this extended role. Having members of this group involved in this process aims to reduce barriers to client participation by:
• creating a safe and trusting environment
• creating an environment of shared memories and experience
• motivating younger clients to participate
• bridging the potential communication gap between the researcher and young person
• ensure what is recorded represents a youth perspective.

Utilising the same personnel as noted above, 850 hours has been awarded to undertake this component of the investigation. The appointment of external researchers aims to ensure appropriate application of an action research model. Youth Focus staff will play a role alongside clients and their families in providing input and perspective of their experience of group support and subsequent reflection. It is envisaged that these two elements will be undertaken concurrently utilising a team approach. In addition, a team approach will be adopted in order to ensure that project momentum is sustained and that tasks are concluded in a shorter time period. Given the project’s underlying philosophy of youth input and ownership, it is imperative that a shorter time frame be adopted to ensure that the interest and attention of these participants are maintained.

Research team tasks:
• Development of actual research methodology
• Review of literature
• Collection and collation of clients, their families or carers, staff, volunteers and referral sources data

While the reference group is currently exploring a research method that is most appropriate. The research team will not be appointed until funds become available. It is anticipated that the literature review will comprise secondary rather than primary analysis, and will begin as soon as practicable when funds are available.

Ethics approval will be sought from the Human Research Ethics Committee at the University of Western Australia.

c. Information circulation

The project aims to involve the wider youth sector by providing a range of information update and progress sessions. These sessions aim to tap into existing networks such as the East Metro Suicide Prevention network and other metro youth network forums. These sessions will be held six monthly, initially presenting the programme outline and then progress updates. These sessions aim to break down barriers surrounding the research process and demonstrate the importance and utility of evidence-based practice.

d. Implementation, review and evaluation.

The development of a new model of the Group Support Programme:

• Integration of feedback and appropriate elements from other group support programmes, (as determined by those who have experienced camp), to develop a modified group programme. Youth Focus Group Support Programme will be adapted to incorporate recommended elements.
• Ongoing circular process of assessment of the effectiveness of the new programme within the Youth Focus environment.
STAGE THREE
Publication and promotion of the group support programme and journey of discovery.

• Description of the new model of the group support programme, and submission for publication and distribution to other agencies and communities for their own use, as well as web based sites:-
  o Community Life
  o Australian Youth Studies Clearing House
  o Ausinet, and

• Presentation at a local and eastern states conference: e.g. Australian Suicide Prevention Association annual conference.

The specific tasks to be undertaken in Stage Three will depend on outcomes from Stage Two.

BUDGET
Preliminary discussions have already been held with Lotterywest about possible funding for the project. Stage One was financed by Youth Focus and is now complete. Stage Two and Three will not be undertaken until external financial support is secured.

External funding is needed primarily to finance the appointment of external researchers. Youth Focus has historically been focussed on service delivery and as such does not possess internal expertise in this area. Secondary costs surround the extension of tasks and hours of employment of current part time staff. Youth Focus and the reference group have endeavoured to provide a proposal which is based on value for money. In order to support this process a number of external experts have been consulted including Roger Vallance, Director, Centre for Research and Graduate Studies, University of Notre Dame.

Total project costs and timeline have been included (see pages 10 and 11), however, given the dependency of Stage Three upon the completion of Stage Two it is proposed that a review budget and progress report be submitted at the completion of Stage Two.
CONCLUSION

Youth Focus has had over ten years experience delivering Group Support Programmes to this target group, with informal evaluation and feedback being extremely positive. Our experience indicates that the current programme develops protective factors whilst promoting and strengthening resiliency.

The formative development of the project aims to systematically record successful elements of the programme whilst replacing those deemed ineffective or overly risky. The project will validate or disprove client and staff hunches whilst beginning to address the current shortfall of evidence-based programmes in this field. Successful completion of the project has the potential to benefit young people, their families and their communities, across Australia and beyond.
## PROPOSAL TO LOTTERYWEST

### BUDGET

<table>
<thead>
<tr>
<th>ACTION RESEARCH PROJECT</th>
<th>Stage 1</th>
<th>Stage 2</th>
<th>Stage 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Team</td>
<td></td>
<td></td>
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<tr>
<td>(based on a total equivalent salary of $50K, plus 20% on-costs)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Project coordinator*</td>
<td>5,000.00</td>
<td>7,500.00</td>
<td>5,000.00</td>
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<tr>
<td>Travel</td>
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<td></td>
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<tr>
<td>Administrative support</td>
<td>1,000.00</td>
<td>1,500.00</td>
<td>1,000.00</td>
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<tr>
<td>Office utilities (light, water, IT rental, internet access, phone etc.)</td>
<td>1,000.00</td>
<td>3,000.00</td>
<td>1,000.00</td>
</tr>
<tr>
<td>Articles / reprints**</td>
<td></td>
<td></td>
<td>500.00</td>
</tr>
<tr>
<td>Focus group sundries</td>
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<td></td>
<td></td>
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<tr>
<td>Youth research assistant plus training and support costs***</td>
<td></td>
<td>800.00</td>
<td>200.00</td>
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<tr>
<td>Printing, distribution and promotion</td>
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<tr>
<td>Conference presentation</td>
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<tr>
<td>• Local</td>
<td></td>
<td></td>
<td>500.00</td>
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<tr>
<td>• Eastern States (incl. travel &amp; accommodation)</td>
<td></td>
<td></td>
<td>3500.00</td>
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<tr>
<td>TOTAL</td>
<td>7,000.00</td>
<td>74,000.00</td>
<td>12,700.00</td>
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</table>

| Amount contributed by Youth Focus                           | 7,000.00| 10,000.00| 2,000.00|
| Amount requested from Lotterywest                           | 0       | 64,000.00| 10,700.00|

**TOTAL REQUESTED FROM LOTTERYWEST FOR STAGE TWO AND STAGE THREE** $74,700.00
*In order for the Services Manager to undertake coordination of the project, she is delegating some of her responsibilities to a senior youth counsellor. Costs are based on increased hours for the senior youth counsellor at a rate of $35 per hour (for an average of 4 hours per week in Stage 2). Change in costs from year to year reflect the time requirement of the project at each stage.

**It is anticipated that several articles will need to be purchased from overseas sources to complete the literature review.

***Costs are based on increased hours and associated on-costs of part time youth counsellor at a rate of $20 per hour.
# ACTION RESEARCH – GROUP SUPPORT PROGRAMME

## TIMELINE

<table>
<thead>
<tr>
<th>TASK</th>
<th>When</th>
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<tbody>
<tr>
<td><strong>Stage 1</strong></td>
<td></td>
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<tr>
<td>• Formation of Reference Group and description of the project</td>
<td>Aug 2003</td>
</tr>
<tr>
<td>• Funding application submitted to Lotterywest</td>
<td>April 2004</td>
</tr>
<tr>
<td><strong>Stage 2</strong></td>
<td></td>
</tr>
<tr>
<td>• Appointment of research personnel</td>
<td>July/August 2004</td>
</tr>
<tr>
<td>• Methodology defined</td>
<td>September</td>
</tr>
<tr>
<td>• Submission to Ethics Committee</td>
<td>September</td>
</tr>
<tr>
<td>• Commencement of literature review</td>
<td>October</td>
</tr>
<tr>
<td>• Appointment of facilitation assistants</td>
<td>Nov/Dec</td>
</tr>
<tr>
<td>• December Group Support weekend</td>
<td>December</td>
</tr>
<tr>
<td>• Identification of ‘working well’ elements of current Programme</td>
<td>Dec/Jan 2005</td>
</tr>
<tr>
<td>• First six monthly information presentation</td>
<td>Feb</td>
</tr>
<tr>
<td>• Literature review and scoping reports completed</td>
<td>Feb</td>
</tr>
<tr>
<td>• Design of new group programme</td>
<td>Feb</td>
</tr>
<tr>
<td>• Implementation of new programme (March camp)</td>
<td>March</td>
</tr>
<tr>
<td>• Cyclical process of review and adaptation (June Camp)</td>
<td>Ongoing</td>
</tr>
<tr>
<td>• Describe new model of group work programme</td>
<td>August</td>
</tr>
<tr>
<td><strong>Stage 3</strong></td>
<td></td>
</tr>
<tr>
<td>• Submit model for publication and distribute to interested agencies</td>
<td>Jan 2006</td>
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</tbody>
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Appendix 2:

Suggested interview schedule for counsellors, business services staff, referrers

1. What made you decide to go on camp
2. What do you think should happen at camp
3. What stood out for you from camp
4. What did you think went well at camp
5. What did you think did not go well at camp
6. What did you learn about working with at risk youth
7. What did you learn about client’s interface with their families
8. Is there anything else that would have been helpful
9. What do you think should be the process at camp
10. Is there anything you would like to change
11. What are your thoughts about the length of the camp
12. What do you think makes clients come back to camp
13. What did you hope clients would achieve at camp
14. Did you see evidence of this
15. Why do you think they come to post camp group
16. Why do you think they don’t come to post camp group
17. Is there anything else you think I should know about camp
Appendix 3:

Additional questions for family Interviews:

- I'm wondering what you noticed about the young person when he/she came home from attending camp?

- What about other camps, generally what have you noticed being different about the young person since he/she began going to Youth Focus camps?

- I'm wondering if you think his father has noticed any difference in how the young person has been or changed since attending camps?

- Anything else that you think the camps have helped with?
Appendix 4:

YOUTH FOCUS:

ACTION RESEARCH PROJECT FOR GROUP SUPPORT PROGRAMME

Documents read:

- Youth and family Service Operational Manual
- Peer Support Weekend Manual
- Pilot Programme Evaluation Report February 2001
- Participant
- Camp Co-ordinator’s Report
- Participants’ feedback evaluation sheets

It is clear after reading the documentation supplied by the agency that current programmes are very well planned with great attention to detail. Accountability, rules and procedures to maximise client safety and processes for dispute resolution are built into the programme and workers are provided with clear guidelines as to how to conduct sessions. Workers appear to have a high level of commitment to the work. Feedback from clients is overall very positive and points to the preparation being worthwhile in terms of meeting the needs of participants.

Client feedback sheets are useful in providing feedback on the camp experience and provide a chance for participants to begin to reflect on this, but are somewhat limited in providing information about how this experience may translate into a changed experience of self for the individual, and how this then translates into future behaviour, experience and meaning for the individual. The action research methodology planned for the research project will address this, and is highly appropriate for this client group and the agency serving it.

The collaboration required to begin this process and how this is undertaken is critical to the outcome. Whilst there is a need to embrace the current energy in the agency for the project, this need should be balanced with a commitment to ensuring the integrity of the process. Therefore, it should not be rushed and care should be taken
for the process to be as inclusive and as interactive as possible. As with any process of social change the best and most enduring results are achieved when time is taken to respectfully engage and dialogue with those whose lived experience is the focus of the work.

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RESEARCHER
6 May 2005
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The Centre for Suicide Prevention www.suicideinfo.ca/csp/assets/alert43.pdf Canadian Mental Health Association


