

# Increasing the resilience of young people at risk: A literature review



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CENTRE FOR CLINICAL  
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Increasing the resilience of young people at risk: A literature review

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# 1. Introduction

This report provides an analysis of a literature review focussing on what works to increase resilience for at-risk and marginalised young people. The purpose of the review is to inform the development of a NSW Health Youth Health policy. It forms part of a larger body of work that the NSW Centre for the Advancement of Adolescent Health (NSW CAAH) is undertaking, in partnership with NSW Health, towards developing a new Youth Health Policy for NSW.

The report uses a model of literature review developed by the Centre for Clinical Governance Research (Travaglia and Braithwaite, 2007; Travaglia, Braithwaite and Debono, 2008). The literature has been examined in two ways: firstly, at a broad level, using content analysis to identify the concepts, their relationships and overarching themes; secondly, a targeted selection of literature has been systematically reviewed to identify and analyse the key published articles, reports and documents concerned with promoting resilience in at risk young people. The report also considers the role of evidence in informing policy and our changing conceptualisation of what kinds of evidence contributes to our understanding, in this case of the relationship between youth, resilience and risk.

This review was undertaken as an independent study project for the Master of Public Health, University of New South Wales. Supervisory support was provided by the Centre for Clinical Governance Research. In particular, Ms Joanne Travaglia and Professor Jeffrey Braithwaite provided valuable supervision and guidance.

NSW Health endorsed the literature review being undertaken as part of NSW CAAH's work towards developing a new youth health policy for NSW and provided input on the scope and themes for the review.

## 2. Evidence-informed health policy

There are increasing calls for policy to be evidence-based (Dobrow et al, 2004). In policy making, evidence is now something we build on, not add on. Evidence helps us answer the questions: "What is the problem?", "What will work to do something about it?" and "How can we do it better?"

Bowen and Zwi (2005) state that, in the policy making process, evidence is usually sought to show the need for policy action, guide effective policy implementation and

show cost effectiveness: it solves a particular problem and is feasible to implement. For policy makers, 'evidence' includes relevant knowledge about 'what works' and 'what should be done'. This means that the context has a large impact on what we call evidence (Dobrow et al, 2004). Evidence is best when it is timely, has good political fit and points to action (Nutbeam, 2003; Whitehead et al, 2004).

Policy makers are more likely than researchers to have a broader view of what constitutes evidence (Tenbensen, 2006). Evidence-based medicine looks to what is objectively true using the established hierarchies of evidence. Policy makers are keen to consider not only this evidence, but also the broader context of what works in practice to solve a particular problem and what the community values in terms of what should be done.

Currently services collect a lot of data. This varies from service to service, without a consistent measurement process. The difficulty is a lack of relevant data collected. "A common characteristic of health care systems is that they are data rich, but information deserts." (Maynard, Health Policy Roundtable, 2002). Of particular relevance to the current review is the additional fact that data collected is often more focused on illness than on resilience or protective factors.

Better measurement of health system performance would give decision makers information on which to base their decisions and provide accountability to the public, as currently evidence is limited and mixed (WHO, 2006). The Australian Productivity Commission (SCRGSP, 2006) suggests that any measurement of health services needs to allow for a comparison between the costs and benefits of prevention and early detection and treatment approaches, as well as a mix of service delivery types, including hospital and community based. This approach is particularly important in providing any rationale for the reallocation of resources.

The current youth health policy for NSW, *Young People's Health: Our Future* (NSW Health, 1989) is now ten years old. Since it was released, there has been significant research undertaken that can now inform practice. This review is an opportunity to consider new evidence about "What do we know works?", "What approaches are currently considered worthy of investment?" and "What are the hoped for outcomes and program goals?"

### 3. Defining the scope of the review

This review is concerned with approaches to increasing the resilience of young people at risk. Guidance regarding the overall thematic focus for the targeted review was provided by Mr Carmine Di Campli, Policy Officer, Primary Care and Community Partnerships Branch, NSW Health and Clinical Professor David Bennett AO, Head, NSW Centre for the Advancement of Adolescent Health.

Young people are defined here by the age range 12-24 years. The terms 'adolescence', 'adolescent', 'young people' and 'youth' are used interchangeably.

The WHO (1946) definition of health is adopted where "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." Further, a whole of community view of health is adopted: "Health is not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community" (National Aboriginal Health Strategy Working Party 1989).

Resilience is most commonly known as 'a pattern of positive adaptation in the context of past or present adversity' (O'Dougherty Wright and Masten, 2005). Individual resilience is inextricably related to concepts of family resilience, community resilience, community connectedness, social capital and social support. Resilience helps us to understand why experiencing earlier difficulties does not necessarily lead to longer term problems.

Risk is understood as 'a characteristic in a group of individuals or their situation that is associated with a negative outcome' (O'Dougherty Wright and Masten, 2005). In this review, risk is conceptualised as relating to a broad range of health issues such as mental health, sexual health and drug and alcohol abuse. A range of programs and approaches, including prevention and treatment, and a range of settings, including community and hospital-based, are considered.

## 4. The literature review process

The literature review process involved searching multiple databases, refining the identified literature and then analysing selected publications. A similar process has been used in reviews undertaken by the Centre for Clinical Governance Research (e.g. Travaglia and Braithwaite 2007; Travaglia, Braithwaite and Debono, 2008). The review was conducted between January and April 2008.

### 4.1 Search strategy

The search terms were informed through consultation with NSW Health and the Head, NSW CAAH. Literature on research relating to youth health is potentially very broad. The current search included terms relating to developing resilience in the context of supporting young people who are at risk and marginalised. A complete list of the search terms used for this review is provided in Table 1.

**Table 1: Search terms**

Search Terms for Developing Resilience in at risk youth
1. Youth or Adolescent or Young people
2. Vulnerable
3. At risk
4. Marginal/marginalised
5. Resilient/resilience
6. Youth development
7. Community connectedness
8. Social capital
9. Social support

The search terms 'youth', 'adolescent' and 'young people' were executed and combined to form a set of terms. A search was independently conducted for each of the other search terms in Table 1. These were then intersected with the youth/adolescent/young people set to narrow the search to articles on that topic relating specifically to young people. This search strategy was executed in three databases: Medline (medicine), CINAHL (nursing and allied health) and PsycINFO (psychology) because they were considered to cover a range of medical, psychological and other allied health themes.

A keyword search, mapping to subject headings, was conducted using the filters and limits: English-only articles, published in the last 5 years, only human subjects and complete records. There was some variation in the functionality of the filters, limits for each of the three databases used. Truncation was used to broaden the search

by picking up word derivations. For example, truncation was used to include the alternative endings for the search terms 'Marginal/Marginalised' and 'Resilient/Resilience'. All titles and abstracts were exported to Endnote X1, a bibliographic database package.

Articles for the targeted in-depth review were identified including a limited number of key articles from the database searches and from a hand search. Independently, the EMBASE, ProQuest databases and Google were interrogated. Specific journals, including the International Journal of Adolescent Medicine and Health, were hand searched. Other articles were obtained by searching government websites, WHO website and research centre websites. The same limits were used: English, last 5 years, human and complete records. Some international articles were included, but the majority were from Australia. As before, all titles and abstracts were entered into Endnote.

The Endnote files containing the titles and abstracts for both the database searches and hand searches were combined and duplicates removed. The content of the data was analysed using Leximancer software to provide a content analysis report for the literature as a whole and the subset that contained the word resilience in the title or abstract. A separate content analysis using Leximancer was performed with the whole content of the hand selected articles to provide a separate content analysis report for the hand selected literature.

### 4.2 Limitations of the review

This review covers a vast scope and as such, prioritises breadth over depth. The review does not consider the major health concerns and prevalence of health issues, instead focusing more on strategies to reduce health issues and the program goals. There are also some more specific areas of focus that the review does not cover; some of these include: the school curriculum, the influence of the media or media advocacy, and nutrition. There was a lack of information about some programs due to limited evaluation and publication of evaluation; this included the *beyondblue* schools program, *Mindmatters* and the NSW *School-Link* program. Further, education databases were not included in the review limiting the findings for school based settings. The programs considered worthy of investment in the literature are listed: the review does not include an in-depth analysis of what specific aspects make these programs successful.

### 4.3 Analysis and findings

Table 2 presents the numeric results of the searches. The keyword searches of the three databases produced a variation in the number of references identified: CINAHL made up the majority (46%) of the articles, followed by Medline (37%) and PsycINFO (13%).

Articles relating to concepts of young people being at risk or vulnerable made up 60% of the literature. The remaining search terms made up 40% of the results. This means that the literature focuses more strongly on risk than on resilience.

The initial total figure of 28,961 resulted from combining the searches across the three databases. The hand search revealed a further 76 articles. Removing duplicates reduced the final search result by 1,852. The final total for the search, N(S), was 27,185 references, where N is the number of references and S refers to the final search result.

**Table 2: Search findings**

SEARCH TERMS	DATABASE RESULTS: NUMBER OF ARTICLES			
	MEDLINE	CINAHL	PsycINFO	TOTAL
1. Youth/ Adolescent/young people	80,611	31,630	26,931	n/a
2. Vulnerable*	1,596	396	28	2,020
3. At risk*	4,638	8,026	2,891	15,555
4. Marginal/Marginalised*	1,531	195	19	1,745
5. Resilient/Resilience*	421	170	552	1,143
6. Youth development*	187	3,858	961	5,006
7. Community Connectedness*	1	1	3	5
8. Social Capital*	124	57	46	238
9. Social Support*	2,330	447	483	3,499
<b>Total</b>	10,828	13,150	4,983	28,961
Search of Google and Google Scholar				76
Removal of duplicates and irrelevant references				1,852
Selected literature [N(S)]				<b>27,185</b>

\* The results reflect the intersection of these terms with search terms 1.



**Table 3: Ranked list and thematic analysis of concepts associated with the broader literature about resilience and at risk young people**

THEME	CONCEPT	ABSOLUTE COUNT	RELATIVE COUNT	THEME	CONCEPT	ABSOLUTE COUNT	RELATIVE COUNT
<b>Risk</b>	<b>risk</b>	<b>16759</b>	<b>100%</b>	<b>Research</b>	<b>years</b>	<b>7810</b>	<b>46.6%</b>
	women	4803	28.6%		age	7722	46%
	activity	4311	25.7%		research	4905	29.2%
	girls	3235	19.3%		body	3495	20.8%
	sex	3043	18.1%		levels	3169	18.9%
	prevalence	2925	17.4%		community	2858	17%
	infection	2177	12.9%		glucose	2772	16.5%
	exposure	2135	12.7%		program	2230	13.3%
<b>Sexual</b>	<b>sexual</b>	<b>5977</b>	<b>35.6%</b>	<b>Study</b>	<b>study</b>	<b>14067</b>	<b>83.9%</b>
	behavior	4472	26.6%		group	4427	26.4%
	alcohol	4392	26.2%		sample	4055	24.1%
	behaviors	4267	25.4%		symptoms	3470	20.7%
	students	3766	22.4%	Health	health	10128	60.4%
	HIV	3544	21.1%		people	6377	38%
	smoking	3125	18.6%		development	6184	36.8%
	drug	2957	17.6%		intervention	3272	19.5%
<b>Adolescents</b>	<b>adolescents</b>	<b>10601</b>	<b>63.2%</b>	<b>Patients</b>	<b>patients</b>	<b>4868</b>	<b>29%</b>
	youth	7372	43.9%		disease	2946	17.5%
	social	5971	35.6%		hospital	1597	9.5%
	school	4887	29.1%		death	1168	6.9%
	support	4540	27%	<b>Cancer</b>	<b>cancer</b>	<b>1739</b>	<b>10.3%</b>
	prevention	3520	21%	<b>Therapy</b>	<b>therapy</b>	<b>1595</b>	<b>9.5%</b>
	suicide	2892	17.2%		syndrome	1173	6.9%
<b>Children</b>	<b>children</b>	<b>9871</b>	<b>58.8%</b>		<b>pain</b>	<b>1130</b>	<b>6.7%</b>
	care	5048	30.1%		asthma	1124	6.7%
	treatment	4594	27.4%	Rights	rights	4650	27.7%
	clinical	2842	16.9%				

While this broader analysis does include the hand selected articles, the numbers are so small in comparison with the database searches that they are unlikely to make any material impact.

Three overarching themes emerge from an analysis of the Leximancer concept map and ranked list. They centre on risk, the clinical orientation of the literature, and human rights, and can be summarised as follows:

1. Risk is a dominating theme in the literature: Table 3 indicates that 100% of articles related to the concept of risk. Other key concepts relating to specific areas of risk included *women, activity/behaviours, sexual, alcohol, HIV, smoking, drug, suicide*. In contrast, resilience did not rate highly enough as a concept to be included on the concept map or the ranked list even though it was a search term, indicating that research is more focussed on problem areas rather than on resilience.



**Table 4: Ranked list of concepts in the broader literature on resilience and young people**

THEME	CONCEPT	ABSOLUTE COUNT	RELATIVE COUNT	THEME	CONCEPT	ABSOLUTE COUNT	RELATIVE COUNT	
<b>Resilience</b>	resilience	1155	100%	<b>Rights</b>	rights	545	47.1%	
	social	305	26.4%		<b>Health</b>	health	320	27.7%
	role	103	8.9%			mental	310	26.8%
<b>Adolescent</b>	adolescents	633	54.8%	stress		156	13.5%	
	children	435	37.6%	problems	150	12.9%		
	adolescent	396	34.2%	years	118	10.2%		
	youth	361	31.2%	<b>School</b>	school	259	22.4%	
	young	255	22%		high	160	13.8%	
	adolescence	188	16.2%		group	131	11.3%	
	people	147	12.7%	groups	99	8.5%		
	age	138	11.9%	students	126	10.9%		
	childhood	126	10.9%	<b>Community</b>	community	164	14.1%	
	parents	123	10.6%		intervention	137	11.8%	
	families	113	9.7%		violence	130	11.2%	
mothers	103	8.9%	academic	110	9.5%			
women	77	6.6%	<b>Research</b>	study	500	43.2%		
<b>Development</b>	development	392		33.9%	research	337	29.1%	
	developmental	158		13.6%	model	152	13.1%	
<b>Life experience</b>	life	183	15.8%	analysis	122	10.5%		
	experience	81	7%	studies	131	11.3%		
<b>Girls</b>	girls	155	13.4%	data	129	11.1%		

Table 4 provides more detailed conceptual information, extending the Figure 2 references. As described previously, the concepts have been grouped into themes.

The subset of literature that included the word *resilience* in the title or abstract differed in important ways from the literature that also included concepts of risk. In contrast it focussed on social roles, including families and parents, settings and contexts and positive youth development approaches. In particular, some of the notable features included:

1. *Resilience* is an overarching theme with 100% of the literature selected having concepts related to resilience. *Resilience* was associated with the words *social* and *role*, implying that social roles are important to resilience.
2. Social roles and family units: *Parents*, *families* and *mothers* are grouped with *adolescents* and *children*.

3. School and community are important settings. *Community* was associated with the themes *intervention*, *violence* and *academic*.
4. Young people's development is a key theme, with just over a third of articles relating to this subject.
5. *Women*, *mothers* and *girls* were commonly occurring themes within the articles. *Men*, *boys* or *fathers* did not appear as a common theme apart from them being included under the more general terms of *parents*, *families* and *adolescents*.
6. As with the broader literature for both risk and resilience *research* continued to be a theme but in contrast, was less clinical.
7. As with the broader literature, *rights* continued as a theme. Again this is likely to be a combination of concepts relating to *copyright* and *human rights*.

## 6. Content analysis of the selected literature

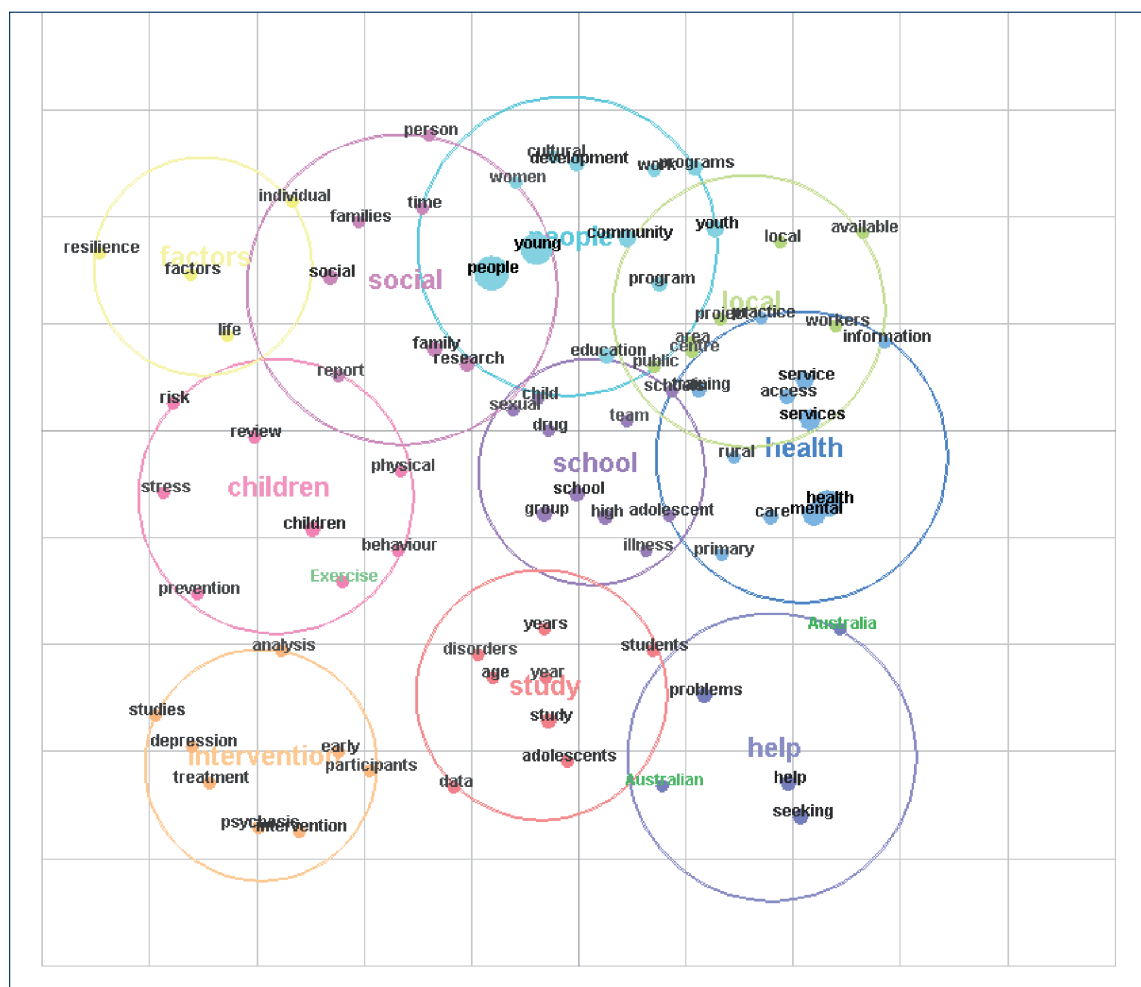
Further work was conducted to refine the literature search in order to identify those with most significance to the core question “What works to increase the resilience of at risk and marginalised young people?” The articles represented the areas of young people at risk as well as resilience building approaches. They were considered to be more relevant than the broader search outcomes to the key interests of the paper.

The hand selected articles covered a broad range of settings, target groups and program approaches. Preference was given to well known Australian researchers. The literature included a range of research types relevant to

the policy setting context, including systematic reviews of program effectiveness and policy arguments about what should be done. While the majority of published research focuses on medical settings and issues, the hand search allowed for more relevant literature, including grey literature such as reports from NGOs and grass-roots organisations, to have a voice.

The content analysis outcomes of the hand selected articles can be found in Figure 3 and Table 5. Figure 3 is a concept map highlighting themes and concepts associated with the hand selected literature about resilience and at risk young people (Leximancer output).

**Figure 3: Concept map highlighting themes and concepts associated with targeted review literature about resilience and at risk young people**



**Table 5: Ranked list of concepts in the targeted review literature on resilience and at risk young people**

THEME	CONCEPT	ABSOLUTE COUNT	RELATIVE COUNT	THEME	CONCEPT	ABSOLUTE COUNT	RELATIVE COUNT
<b>Client group</b>	people	4156	100%		psychosis	300	7.2%
	young	3822	91.9%		behaviour	217	5.2%
	youth	1090	26.2%	<b>Help- seeking</b>	help	922	22.1%
	children	598	14.3%		seeking	792	19%
	family	565	13.5%		access	485	11.6%
	adolescents	481	11.5%	<b>Services</b>	services	1138	27.3%
	cultural	225	5.4%		care	653	15.7%
<b>Resilience factors</b>	factors	399	9.6%		intervention	470	11.3%
	resilience	301	7.2%		programs	452	10.8%
	life	275	6.6%		information	410	9.8%
<b>Health issues</b>	health	2430	58.4%		early	403	9.6%
	mental	2082	50%		treatment	380	9.1%
	social	737	17.7%		prevention	268	6.4%
	development	702	16.8%		primary	228	5.4%
	problems	531	12.7%	<b>Setting</b>	community	820	19.7%
	risk	423	10.1%		school	632	15.2%
	depression	396	9.5%		local	294	7%
	drug	316	7.6%		rural	236	5.6%

Table 5 describes the same output as Figure 3, presented as a ranked list of concepts. As described previously the concepts have been grouped into themes.

In comparison with the broader search, the literature reflects themes that are more relevant to public health and policy. The findings show that the selected literature is different in key ways:

1. Resilience is a key theme.
2. Risk behaviours are related to health issues, including mental health and drugs.
3. Help-seeking and young people's access emerge as a grouping of themes.
4. Relating to service provision, early intervention and prevention are important, particularly in relation to mental health, including depression and psychosis.
5. Community based settings are important as indicated by the terms *school*, *local* and *rural*.

## 7. Targeted analysis of the literature

We turn to a different type of analysis. Having mapped the lie of the land and examined the broad overview of the landscape of the literature, we can now consider the targeted literature in more depth.

### 7.1 Types of research

The types of research articles included in the review ranged from program reports published on the internet to peer reviewed journal articles. They included:

- Cluster random control trials
- Cross-sectional health surveys
- Longitudinal studies
- Qualitative research with service providers and young people
- Literature reviews including concept analysis, targeted reviews, and Cochrane Collaboration reviews
- Descriptions of health care programs and program evaluation reports
- Good practice guides
- Position statements from peak and professional bodies
- Theoretical analysis journal articles
- Policy advocacy journal articles including the viewpoints of prominent thinkers
- Survey of young people's views
- Call to action conference statement

### 7.2 Geographical scope

For relevance, articles included in the targeted review were mainly Australian. Others included articles from New Zealand, United Kingdom, United States, Canada, and Sweden as well as several comparative international studies.

### 7.3 Focus areas

The first point to emerge from the systematic analysis is that concepts of risk and resilience are concepts across the spectrum of programs, approaches and settings in youth health. An exemplar list of the topics and associated authors from the hand selected literature is presented in Table 6. The selection aimed to redress the imbalance where literature is mainly hospital-based and clinical research oriented while there is a relative lack of literature focussing on community-based approaches. The following ideas or frameworks influenced the choice of articles for the targeted review:

1. Described service models and program approaches, including promoting young people's access to services.
2. Represented the work of respected experts in the field.
3. Concentrated on youth health advocacy and policy development.
4. Included emerging issues of importance (for example, transition care, the use of technology to engage young people).
5. Focussed on enhancing individual, family or community resilience rather than only individual resilience.

**Table 6: Exemplar list of focus areas included in the selected review**

HEALTH AREA	AUTHOR(S)
Access and help seeking	Kang et al (2005); Jorm (2007)
Advocacy and policy	Burt (2002); McGorry (2007); Kelly (2007)
Better practice models	NSW CAAH (2005)
Care and protection system	Schmeid, Tully & Brownhill (2006)
Chronic Illness – service responses	Sawyer et al (2007)
Coordinated care/complex needs	Lee et al (2004)
Community resilience	Davis, Cook, Cohen (2005)
Drug and alcohol determinants	Spooner, Hetherington (2004)
Family resilience	Patterson (2002)
High risk adolescents	Ungar (2004)
Indigenous young people	Blair, Zubrick, Cox (2005); Scougall et al (2008)
Information & communication technology	Burns, et al (2007)
Juvenile justice	Lynch et al (2007); Dept of Juvenile Justice (2003)
Medical care and hospitals	Towns et al (2007)
Mental health services	Patel et al (2007); Hickie (2007); McGorry & Jung (2003)
Obesity	Denney-Wilson, Baur (2007)
Primary care models	Tylee, et al (2007); Kang and Sanci (2007)
Psychological resilience	Olsson et al (2003); Harvey, Delfabbro (2004)
Rural and remote young people	Bourke (2003); Hodges et al (2007)
School-based early intervention	Neil and Christensen (2007); Patton (2006); Barnes et al (2004); WHO (2006)
Sexual health services	Skinner et al (2007)
Transition care	Steinbeck et al (2007)
Young males	Barwick (2004)
Young refugees	The Royal Australasian College of Physicians (2007)
Youth development	Resnick (2005)
Youth health services	Patton et al (2007); McGorry (2007)
Youth participation	James (2007)
Young people's views	Mission Australia (2007)

## 7.4 Priority Groups

With a view to increasing equity, key priority groups and areas were identified in many of the articles. These included:

- Young people at risk, including but not limited to at risk of not completing school
- Young people in custody
- Indigenous young people
- Homeless young people
- Geographically and socially isolated young people living in remote and rural areas
- Culturally and linguistically diverse young people, particularly those who are newly arrived or from a refugee background
- Pregnant and parenting young people
- Young people who are same-sex attracted or questioning their sexuality
- Male-focussed approaches and separate programs for young men
- Young people with a chronic illness or disability
- Transition periods: Assistance during challenging transitions (for example, from high school to the workforce and from prison to the community), particularly for those who are not doing well
- For school based programs, young people early in their high school experience

## 7.5 Risk and resilience

Resilience was found to be described as both an outcome and a process. “Resilience is both an outcome of interactions between individuals and their environments, and the processes which contribute to these outcomes” (Ungar, 2007, p.288). Resilience is the process whereby young people modify the impact of a risk setting, by developmentally adapting, and the outcome of coping with a challenging situation.

Research has attempted to compare resilient and non resilient young people, however they found that young people initially labelled as resilient and non resilient only differed in how they achieved health and the degree of social acceptance for their choices – young people differ in how they survive the risks they face (Ungar, 2004).

Olsson et al (2002) undertook a concept analysis of the literature from 1990 to 2000 focussing on resilience in young people aged 12-18. They found that the resilience

literature fell into two main types based on whether it was measured as a *process* or an *outcome*:

1. The investigation of protective mechanisms is important in the *process* of successful adaptation;
2. Psychological *outcomes* in young people defined by a particular risk setting.

Similarly, programs can broadly be divided into those which enhance resilience and those that focus on reducing risk. Resilience based approaches emphasise the building of skills and capacities that help young people negotiate high risk environments, while a risk reduction approach emphasises removing or avoiding factors implicated in the development of problematic outcomes, such as drug experimentation.

Our understanding of resilience has continued to grow and develop over time, moving from being understood as an individual ability to act positively under adverse circumstances to a focus on exploring protective factors within individuals and their lives. Aronwitz (2005) found that the key factors enhancing resilience in at risk young people included ‘feeling competent’ and ‘elevating expectations’ facilitated in the context of a reliable, caring and competent adult.

Strength-based treatment approaches are increasingly referenced as a model for engaging, looking forward, gaining the young person’s perspective and involvement, setting achievable goals and reviewing progress, looking for resources and supports, and facilitating access to those supports (Schmeid et al, 2006), particularly for young males (Barwick, 2004). Strength-based approaches are also increasingly being applied to organisational settings (Williams, 2007).

This focus has broadened to identifying access to health resources and assets and the overall community environment, particularly with a view to decreasing health inequalities and building community capacity (Davis et al, 2003). Youth development approaches focus on enhancing the resilience of individuals, families and communities (Ausyouth, 2002). Zubrick and Robson (2003) consider both proximal and distal factors contributing to Indigenous young people’s outcomes, suggesting that resilience building needs to focus on individual as well as whole of community approaches.

More recently, researchers have become more sensitive to culturally embedded definitions of resilience. “Resilience is not only an individual’s capacity to overcome adversity,

but the capacity of the individual's environment to provide access to health-enhancing resources in culturally relevant ways" (Ungar et al, 2007, p288). Ungar et al (2007) found seven tensions that young people negotiate from different cultural perspectives: access to material resources; relationships; identity; cohesion; power and control; social justice and cultural adherence.

Many studies advocated for more subjective measures enabling young people to assess their own resilience, and flexible notions of what constitutes success based on culturally and contextually appropriate measures.

## 7.6 Program approaches

### *What approaches are currently considered worthy of investment?*

The types of programs are described according to their prevention or treatment focus and their setting/scope, including individual, family, social/educational (school/peer) and community. These are summarised in Table 7. Targeted strategies aim to improve the health outcomes of young people with additional needs while universal strategies aim to lift the health of the entire population of young people. Transition points were considered to be key opportunities for supportive interventions to maintain resilience (Alperstein and Raman, 2003; Lynch et al, 2007).

Prevention programs tend to focus on enhancing resilience while treatment programs tend to focus on risk reduction. The exception to these is strengths-based treatment approaches.

#### **Individual**

Young people's access to primary care services, including youth health services, community health services, General Practice and hospital based services, is important for both preventative care and treatment (Tylee et al, 2007; Kang et al, 2003).

The *youth health model* has gained further support in recent years as an accessible youth friendly model of service provision where there is a right to access irrespective of severity level, as well as recognition of the need for better integration with broader youth health services and GPs (McGorry and Yung, 2003; McGorry 2007; McGorry et al, 2007; Hickie et al, 2007). Examples include both *headspace* and the NSW Youth Mental Health Service Model.

Preventative approaches include arts based story telling (Nettles and Mason, 2004), participation in youth development activities (Resnick, 2005) and social networking offered by information and communication technology (Wyn et al, 2005).

#### **Family**

Parents and other caregivers play an important role for young people, including those at risk, enabling them, through interactions with these adults, to develop constructions of themselves as resilient (Ungar, 2004). There is an increasing recognition of the need to enhance parenting skills and supports as well as include families in treatment services (Patterson, 2002).

#### **School and peer-based interventions**

Universal and whole-of-school approaches can promote changes to the school environment, school ethos and personal skills development (Stewart-Brown, 2006). Resilience based approaches that enhance the whole-of-school environment have been shown to increase young people's connection with school (Patton et al 2006), while other programs increase family connectedness with the school (Lennox Terrion, 2006). Transition-to-school programs include both less intensive universal programs and more intense targeted programs.

School nurses present an opportunity to provide clinical services, screening and health promotion in schools (Barns et al, 2004). GPs-in-schools programs also promote access to health care (Kefford et al, 2005), as do teacher training programs. There are also varying models of peer support, particularly for chronic illness.

#### **Community-based interventions**

Youth development approaches are an important way of enhancing young people's resilience before problems develop as well as giving skills to young people who are already facing challenges (Resnick, 2005). Youth development programs create contexts in which young people can thrive incorporating proactive processes such as caring relationships, high expectations and opportunities for meaningful participation (Australian Government, Dept of Family and Community Services, 2005).

Young people can benefit from increased opportunities to participate and contribute to society (Evans, 2007). Media advocacy to promote more positive representation of young people in the media may also help to change the perceptions of young people.

## **Access**

The promotion of access to services was a theme across all program approaches. In particular, parents, teachers, youth workers, refugee workers who can facilitate services access were considered important in addition to strategies targeting young people (Deane et al, 2002; Rickwood et al, 2007). Jorm et al (2005) contend that we can increase help-seeking by raising community awareness, as well as parents' knowledge and skills, and increase the attractiveness of services through youth participation. Other approaches looked at increasing the acceptability of services through youth participation. James (2007) has examined the range of successful Australian models that support youth participation.

Patton et al (2007) state that research in the last five years has clarified further what is most likely to lead to success in engaging adolescents. For example, young people prefer youth specific services when they are available. The barriers to young people's access to services (Booth et al, 2004) and what constitutes better practice (Kang et al, 2005) are well known and provide a useful framework to guide future policy directions in youth health.

## **Information and communication technology**

There is an increasing appreciation that health reforms must be inter-sectoral to achieve success (Galbally, 2000), including the need to look outside of health services themselves (Patel et al, 2007). New technologies have opened up possibilities for engaging with young people (Rickwood et al, 2007). Websites such as Reach Out! offer new ways of promoting access to help (Burns et al, 2007, Wyn et al, 2005), especially as young people state they are more likely to access help via the internet than from professionals or community agencies (Mission Australia, 2007).

**Table 7: Program Approaches**

	Community	School/Peers	Family	Individual
Prevention	<ul style="list-style-type: none"> <li>• Help communities identify and foster elements in the community environment that promote positive health and safety</li> <li>• Encouraging communities to value and engage young people</li> <li>• Young people are invited to join in community as full and active participants</li> <li>• Provide opportunities for meaningful service to the community</li> <li>• Innovative approaches developed with communities</li> <li>• Create positive images of young people</li> <li>• Community-based youth development and adventure based programs</li> </ul>	<ul style="list-style-type: none"> <li>• Promoting positive social environments and peer supports</li> <li>• School-based programs (e.g. Gatehouse) that aim to build connectedness</li> <li>• Maximising formal and community recognition of learning outcomes</li> <li>• Involvement of parents in schools</li> <li>• Support for young people to achieving success in education</li> <li>• A whole of school approach including the local community</li> <li>• School-based health education programs, including peer led programs</li> <li>• Curriculum/teaching and learning programs</li> <li>• Transition to school programs</li> </ul>	<ul style="list-style-type: none"> <li>• Relationships with caring, competent and responsible adults that enhance feeling confident and elevate expectations</li> <li>• Support for families in parenting</li> <li>• Programs promoting positive family relationships, improving communication and conflict resolution</li> <li>• Involvement of parents in schools</li> <li>• Prevention of obesity: increasing physical activity, reducing sedentary activity, behaviour modification and family involvement</li> </ul>	<ul style="list-style-type: none"> <li>• A range of interactive, structured and supervised youth development activities</li> <li>• Creative arts programs that involve story telling</li> <li>• Promotion of healthy youth development through teamwork and leadership</li> <li>• Use of information and communication technology to foster identity exploration, belonging, engagement, sense of community</li> </ul>
Treatment	<ul style="list-style-type: none"> <li>• Mentoring programs</li> <li>• Community-based supports such as youth services, refuges, transition to employment programs</li> <li>• Community education specifically addressing help seeking attitudes and beliefs</li> <li>• Promote awareness of services and facilitate access to services</li> <li>• Better access to primary health care including youth health services, DGP youth health programs and GPs</li> <li>• Vocational and educational supports</li> <li>• Vaccination and STI screening</li> </ul>	<ul style="list-style-type: none"> <li>• Teacher training to increase schools identifying mental health problems</li> <li>• Promote awareness and access by health literacy programs such as the GPs in schools programs and school visits to community facilities</li> <li>• Clinical care focussing on physical and psychosocial concerns, health education, health surveillance by school nurses and school counsellors</li> <li>• Personal skills development such as healthy eating and physical activity, mental health &amp; well being, conflict resolution and self esteem</li> <li>• Face-to-face peer support, either disease-specific (eg. Triple-A Asthma) or community-based and generic (eg. ChIPS - Chronic Illness Peer Support Programme)</li> </ul>	<ul style="list-style-type: none"> <li>• Enable parents to recognise mental health problems and facilitate help seeking</li> <li>• Family supports, particularly for those experiencing challenges</li> <li>• Strengths-based approach to clinical work</li> <li>• Family based interventions</li> <li>• Services engage families</li> <li>• Family approaches to managing a young person's issues</li> </ul>	<ul style="list-style-type: none"> <li>• 'Safety nets' or early intervention for those who are beginning a potentially negative pathway</li> <li>• Individual practical support and advocacy</li> <li>• Internet based promotion of help seeking</li> <li>• Strength-based holistic approaches</li> <li>• Comprehensive community based primary care services including counselling, group work, mental health services and GPs</li> <li>• Developmentally appropriate settings and approaches including specialist youth specific services aged 12-25</li> <li>• Screening, assessment and management of risk</li> <li>• Access to comprehensive expert assessment and intervention when required</li> </ul>

## 7.7 Program goals

### *What are the hoped for outcomes and program goals?*

The program goals described in Table 8 are the stated program aims. They are grouped separately for individual, family, social/educational (school/peer) and community-based programs and for the varying levels the goals targeted. Because promoting connection and facilitating access to services are overarching themes, there is considerable overlap. There is also a symmetry that occurs. For example, school based programs have individual goals and individuals have educational goals.

Resnick (2005) suggests that we need clear goals that drive our actions and priorities, asking the question “What are the fundamentals that young people need to survive and thrive in this dynamic time of change?” (p.399). In answering this question, Resnick reminds us to consider young people’s healthy development rather than viewing young people as a set of risk factors.

The program goals found throughout the literature were largely consistent with the findings of the Australian Temperament Project, a longitudinal study that identified protective factors for young people (Smart et al, 2007) as well as Silburn’s (2003) model of pathways to resilience. While the program goals are not necessarily indicative of evidence-based outcomes, nor outcome measures, they could inform the development of performance indicators.

## 7.8 Programs with evidence of effectiveness

### *What do we know works?*

Evidence of program effectiveness was limited due to the small number of evaluation studies.

Evaluation is not common among services, making it difficult to determine if many programs are meeting their goals and what benefits are achieved (Kang et al, 2005). The *Youth Health Better Practice Framework* (CAAH, 2005) therefore advocates to enhance the capacity of services to undertake evaluation through strengthening program management and investment in evaluation skills. At the present time it is not possible to implement this recommendation. Evaluation is needed to determine the difference between what was originally intended and the end results. Many evaluations are initiated at the end of a program, making this difference difficult to discern.

Petticrew et al (2004) state that we need evidence that is evaluative, not just explanatory, and points to what are the ‘best buys’ for the investment of our health dollars. Evaluation also needs to consider the multiple health system goals: efficiency (cost benefit), appropriateness, effectiveness, equity (Duckett, 2004).

### **Primary care services**

An international review of youth friendly primary care services (Tylee et al, 2007) found that young people access care for physical health problems more readily than for mental health problems. Research on young people’s access to services has provided a clear indication of the barriers young people face in accessing primary health care services, findings that need to be translated into practice. Research from NSW on this subject (Booth et al, 2004; Kang et al 2005) has been translated into a user-friendly planning tool, the *Youth Health Better Practice Framework* (CAAH, 2005). The World Health Organisation (2005) has also developed a framework for youth friendly health service provision that is equitable, accessible, acceptable, appropriate and effective.

Two Cochrane Collaboration reviews looking at mental health found supportive evidence for the use of exercise for both prevention and treatment of anxiety and depression (Larun, 2006) and support for early intervention into psychosis (Marshal and Lockwood, 2006). Patel (2007) advocated for mental health services where mental health expertise is integrated with youth health and welfare expertise, with the aim of promoting access to appropriate mental health services.

Marston and King (2007) reviewed programs relating to sexual health and identified seven common themes which they suggest can be used as a checklist to guide program development. Skinner et al (2007) advocated for primary prevention, health education in schools and peer led education programs, broader programs looking to increase school connectedness, teacher training, vaccination and Chlamydia screening.

### School based programs

A recent WHO review (Stewart-Brown, 2006) of health promotion in schools and health promoting schools revealed that the most successful programs were resilience based programs: those that adopted a universal and whole-of-school approach including the local community; those that promoted changes to the school environment, school ethos and personal skills development as well as those programs that were of longer duration and greater intensity. The most effective programs were those that promoted healthy eating and physical activity, mental health & well being and conflict resolution. Moderately effective programs included those aiming to improve self esteem. Ineffective programs were those with a risk focus: suicide prevention (potential harm); prevention of depression and self harm; prevention of substance abuse (including tobacco smoking); sexual health programs and driver education.

An Australian review of nine school-based prevention and early intervention programs to reduce depression and anxiety have shown small to moderate reductions in depression and anxiety for both indicated and universal approaches (Neil and Christensen, 2007). The review did not include programs with a lack of outcome data including the *beyondblue* schools program, *Mindmatters* and the NSW *School-Link* program. These findings were consistent with those of a Cochrane Collaboration review (Merry, McDowell and Hetrick, 2004).

Some of the best Australian evidence relating to enhancing connectedness to family and school includes the Gatehouse Project (Patton et al, 2006). The study showed a reduction in health risk behaviours and improved emotional well-being, including recent substance use, antisocial behaviour, initiation of sexual intercourse, and depressive symptoms. The study provides support for prevention strategies in schools that move beyond health education to promoting positive social environments.

### Young people with complex issues

Schmeid, Tully and Brownhill (2006) reviewed the literature relating to effective strategies for case management of young people within a child protection context. They advocated for a strengths-based approach to working with young people, particularly opportunities for workers to develop relationships with young people, as well as engaging families and working collaboratively. Individual therapeutic approaches, group programs and parent education (long term multi modal programs) were also supported by Schmeid et al (2006). A review of mentoring programs found that these programs work best for young people at risk and when programs are longer term (DuBois, Hallaway, Valentine and Cooper, 2002).

### Hospital Based Services

Steinbeck et al (2007) advocate for transition care planning and coordination for the wellbeing of young people with chronic illness and support to lead a normal life, particularly in the form of peer support. Likewise, Sawyer et al's (2007) review suggests we need better strategies to facilitate the transition of responsibility for self-care during adolescence through a comprehensive approach that includes the community, the health-care system and its design, support for family and self-management, decision making support, and clinical information systems.

**Table 8: Program Goals**

	Community-based programs	School/peers programs	Family-based programs	Individually targeted programs
Individual Goals	<ul style="list-style-type: none"> <li>Better health and safety outcomes, reduced inequalities</li> <li>Young people are responsible, contributing members of their community</li> <li>Young people learn about their own strengths and skills</li> <li>Positive social values</li> <li>Young people's identity formation and social relations, citizenship and civic engagement</li> <li>Young people are optimistic about society's future</li> <li>A sense of belonging</li> <li>Gatekeepers, such as youth services and refugees, are able to facilitate service access</li> </ul>	<ul style="list-style-type: none"> <li>Good relationships with peers, fewer anti-social-peer relations</li> <li>Young people to develop a sense of identity</li> <li>Protection of vulnerable members</li> <li>Early intervention and prevention of health issues broadly in a school setting</li> <li>Participation in employment and education</li> <li>Positive values: empathy, helpfulness, caring towards others</li> <li>Curiosity about the environment and support for cognitive development</li> <li>More attachment and positive attitudes to school</li> <li>Young people are engaged and take responsibility</li> </ul>	<ul style="list-style-type: none"> <li>Supportive caring parents</li> <li>Positive parent-child relationships</li> <li>A sense of connectedness with caring, competent adults</li> <li>Good preparation for adult life and adult roles to enter the workforce, and learning to be a caring responsible friend, partner, and spouse</li> <li>Families provide structure</li> <li>Families help young people develop social constructions and being competent</li> <li>Taking responsibility</li> </ul>	<ul style="list-style-type: none"> <li>Developing self-worth, self-esteem and self-image</li> <li>A sense of competence and confidence</li> <li>The capacity to enjoy life</li> <li>Coping with multiple issues</li> <li>The capacity to make effective choices</li> <li>Good mental and physical health</li> <li>The knowledge and skills to promote health</li> <li>Healthy lifestyle behaviours such as healthy eating and physical activity</li> <li>Reducing health risk behaviours (such as drug and alcohol use)</li> <li>Better recovery outcomes for mental illness</li> <li>Moral beliefs and values</li> </ul>
Family Goals	<ul style="list-style-type: none"> <li>Better connections between families</li> <li>Strong cultural identity and a respect for diversity</li> </ul>	<ul style="list-style-type: none"> <li>Schools build a community for parents and family</li> <li>Schools promote better personal development for families and young people</li> <li>School has better relationships with parents</li> </ul>	<ul style="list-style-type: none"> <li>Family approaches to managing a young person's issues</li> <li>Secure and stable family</li> <li>Family belonging: membership and family formation</li> <li>Family's subjective appraisal of their sources of stress and ability to manage them</li> <li>Closer (but not harsh) parental supervision</li> <li>Positive family relationships, improving communication and conflict resolution</li> </ul>	<ul style="list-style-type: none"> <li>Strong attachments, connectedness to family</li> <li>The transition of responsibility for self-care during adolescence</li> </ul>
School/Peer Goals	<ul style="list-style-type: none"> <li>Strengthened connection with community through relationships, participation and contribution to the community</li> </ul>	<ul style="list-style-type: none"> <li>Strong relationships, ability to make and keep friends</li> <li>School attendance</li> <li>Opportunities for success and recognition of achievement</li> <li>Connectedness to vocational and educational activities</li> <li>Positive school climate and ethos</li> </ul>	<ul style="list-style-type: none"> <li>Better parent relationships with the school</li> </ul>	<ul style="list-style-type: none"> <li>Skill development through activities that are structured and sequenced to build on previous learning outcomes</li> <li>Level of interpersonal skill and social impact on others, empathy</li> </ul>
Community Goals	<ul style="list-style-type: none"> <li>Community networking</li> <li>Positive representation of young people in the media</li> <li>Social inclusion, freedom from discrimination</li> <li>access to resources</li> <li>A more caring and inclusive society</li> <li>Greater awareness of youth health in the community</li> </ul>	<ul style="list-style-type: none"> <li>School facilitate access to health services</li> <li>A sense of community in schools and a sense of belonging</li> </ul>	<ul style="list-style-type: none"> <li>Parents are able to facilitate access to services</li> </ul>	<ul style="list-style-type: none"> <li>Access to Medicare and/or access to bulkbilling services</li> <li>Help seeking and ability to access health care services that are relevant</li> <li>Online help seeking and awareness of online resources</li> </ul>

## 7.9 Better Practice Principles

### *How can we improve our practice?*

The literature reviewed advocated for a range of better practice principles that fitted well with the seven principles from the *Youth Health Better Practice Framework* (CAAH, 2005). This framework is based on research into young people's access to health services (Kang et al, 2005). Key themes from the articles relating to each of the seven *Youth Health Better Practice Principles* are described in Table 9.

**Table 9: Youth Health Better Practice Framework**

<b>Accessibility - Increasing the youth friendliness of services and promotion of services</b>
<ul style="list-style-type: none"> <li>• Increasing the acceptability and inclusiveness of services to young people and their families from a range of backgrounds</li> <li>• Better access, early detection and engagement</li> <li>• Barriers to young people's access to health services such as concerns about confidentiality, knowledge of services and discomfort in disclosing health concerns, and accessibility and characteristics of services are addressed</li> <li>• GPs are promoted as a source of help and GP practices are more youth friendly</li> <li>• A right to care, irrespective of perceived severity</li> <li>• Youth friendly, youth oriented models of care and dedicated adolescent services (12-24 years)</li> <li>• Program staff that are able to establish warm and friendly relationships while setting limits and enforcing rules</li> <li>• Encouraging and respecting choice</li> <li>• Address information-sharing barriers between services concerned with young people's health and well-being, particularly strategies to externally promote their service and programs</li> </ul>
<b>Evidence-based approach - The sources, quality and range of data used in service planning</b>
<ul style="list-style-type: none"> <li>• Using the evidence and looking to the future</li> <li>• Some examples of practice that is evidence-informed includes: Separate youth health models of care and early intervention approach; early intervention, early detection of psychosis and other mental health issues; prevention and management of harm caused by drug use</li> </ul>
<b>Youth participation - Young people's involvement in service planning, decision making, implementation and evaluation</b>
<ul style="list-style-type: none"> <li>• Participation of young people in all levels of planning and decision making</li> <li>• Services are more acceptable and access is promoted through youth participation</li> <li>• Commitment to sharing resources, power and ownership</li> <li>• Young people are consulted in meaningful ways</li> <li>• Offer challenge, creativity, reliability and caring</li> <li>• Set realistic expectations</li> <li>• Recognise young people are not a uniform group</li> <li>• Recognise duty of care especially for &lt;18 years and respect young peoples' other goals (i.e. recovery)</li> <li>• Participation requires commitment, but it also needs flexibility</li> <li>• Ensure participation is resourced and participation is recognised</li> </ul>

**Table 9: Youth Health Better Practice Framework continued.**

<b>Partnerships - Collaboration with other services and sectors</b>
• Developing better integrated and coordinated services
• Working together in partnerships – working collaboratively with other agencies
• Strengthening the interconnectedness of social networks and better information sharing between organisations
• System wide approaches to promoting competence and prevention of psychological difficulties, rather than individual treatment approaches
• Collaborative care models - Improve referral systems, increase organisations' opportunities to work cross-sectorally and identify new partnerships. Improved service coordination for those most at risk including multi-agency forums for case discussion for clients with chronic, complex presentations
• Better service integration through co-location and/or other strategies including linking to mainstream health services. For example, mental health services integrating mental health with youth health expertise and welfare expertise
• Whole-of-government systems can provide coordinated services, more cost-effective planning and harm prevention
<b>Professional development - Ensuring a skilled and confident workforce</b>
• Increased capacity of service providers to work with and engage young people
• Culturally acceptable, skilled aboriginal health workforce
• Youth friendly GPs - Increase GPs skills in working with young people
• Training for adolescent health care providers about adolescent development and health care
<b>Sustainability - Sustainable change and positive outcomes in the longer term</b>
• The number of quality programs available enhances the capacity of the sector as a whole
• Long term multi component interventions
• Making investment count through building capacity
• Working in partnership
• Strong organisational leadership, support for quality improvement, presence of adequate information technology, and external incentives are important
<b>Evaluation - Evaluation against aims and measurable objectives</b>
• Evaluation of what works focussing on health outcomes, engagement, satisfaction and access
• Reorienting the MH service system to a more youth friendly approach requires evaluation to see what works and to strengthen arguments for investment

Within the literature, the aims of health services were in line with those proposed by Duckett (2004): acceptability, quality, efficiency and equity. Given the significant barriers young people experience in accessing health care, there is a particularly strong emphasis in the youth health literature on enhancing acceptability.

Calls for greater investment in youth health, support of policy development, service improvement and delivery, youth participation, cross-sectoral coordination and collaboration have been strongly supported by service providers and young people (Chiang and Tyne, 2006; Chiang, Yap and Camilleri, 2007).

## 8. Conclusion

*Resilience is not only an individual's capacity to overcome adversity, but the capacity of the individual's environment to provide access to health-enhancing resources in culturally relevant ways (Ungar et al, 2007, p.288).*

### Summary of findings

1. Resilience enhancing programs include youth development approaches, whole of school programs, and holistic strength-based treatment models.
2. In addition to targeted treatment services, a population health approach with wide population coverage is needed. The full range of service systems including community, school based, family and individual approaches need to be considered.
3. Whole of government and community approaches where partnerships are fostered and responsibility is shared are advocated. To achieve this, better cross-governmental collaboration is needed.
4. Equity and social justice is an important goal with a focus on key priority groups of young people at risk including: young people in custody; indigenous young people; homeless young people; geographically and socially isolated young people; culturally and linguistically diverse young people; young people who are same-sex attracted or questioning their sexuality; young men; pregnant and parenting young people; young people with a chronic illness or disability.
5. The *Youth Health Better Practice Framework* provides a useful framework for guiding future evidence-informed policy to enhance young people's access to services.
6. Age-appropriate, evidence-based strategies that address multiple health issues and determinants and result in multiple outcomes should be promoted.
7. A focus on young people's access to services through a range of strategies, including making services more appropriate for this age group, is needed. In community and hospital settings, youth specific services are the most appealing for young people. There also needs to be an emphasis on reorienting mainstream services (including General Practice) to become more youth friendly. Greater involvement of young people and meaningful consultation are highly desirable.
8. Improved communication systems would allow for better information sharing and increase the sector's capacity to adopt better practice strategies.
9. Initiatives that are sustainable and have long-term commitment should be promoted.
10. Published literature focuses more on risk than on resilience factors. The literature is also predominantly hospital-based clinical research, with a relative lack of literature focussing on community-based approaches. There is a need for increased evidence to inform the development of positive youth development and community capacity development approaches. Further, increased service evaluation, particularly on what constitutes 'good practice', and on service outcomes, would be of benefit.

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