STEP Manual

An Educational Resource for those working with Indigenous, Refugee and Same Sex Attracted Young People

Written by

The Victorian Child and Adolescent Mental Health Promotion Officers

and

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STEP Project Co-ordinator

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As part of the National Youth Suicide Prevention Strategy

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Aboriginal Working Group

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Rozie Schultz	Mungabareena Aboriginal Co-op
Karin McMillan	Mungabareena Aboriginal Co-op
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Petah Atkinson	Rumbalara Aboriginal Co-op
Jo Harrison	Ballarat and District Aboriginal Co-op
Sue Humphreys	Ballarat and District Aboriginal Co-op
Glen Howard	Ngwala Willumbong Aboriginal Co-op
Stuart Harridine	Goolum Goolum Aboriginal Co-op
Lindy Muller	Goolum Goolum Co-op

Jason Misfud	Gunditjamara Aboriginal Co-op
Kaye Netherway	Gunditjamara Aboriginal Co-op
Marlin Parsons	Murray Valley Aboriginal Co-op
Rose Gilbey	Murray Valley Aboriginal Co-op
Len Slabb	Murray Valley Aboriginal Co-op
Lil Pettit	Murray Valley Aboriginal Co-op
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Staff from	Corranderk Aboriginal Co-op

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FOREWORD

In 1997, the Commonwealth Department of Health and Aged Care approved a grant to the Victorian Department of Human Services (under the National Youth Suicide Prevention Strategy) for education and training in youth suicide prevention for professionals. The grant was to assist the Mental Health Promotion Officers (MHPOs) in Child and Adolescent Mental Health Services (CAMHS) across Victoria to educate and train professionals working with three high-risk groups: indigenous, refugee and same sex attracted young people.

The MHPOs endorsed the employment of a STEP project co-ordinator to work in partnership with the MHPOs to develop and deliver statewide training to workers with young people from the three groups. A senior project officer from DHS Mental Health Branch worked in an advisory and supportive capacity. The project evaluator John McLeod provided the reference group with invaluable perspectives through his constructive questioning and observations.

Who Are the Mental Health Promotion Officers?

The Mental Health Branch created the Mental Health Promotion Program in 1997 as one of a number of suicide prevention strategies. The primary objectives include:

- Improving the community's awareness of mental health issues and services for children and adolescents,
- Enhancing the capacity of health, welfare and educational services to respond to the needs of young people at risk of suicide or at risk of developing mental health problems
- Facilitating opportunities for early intervention with mental health problems through collaboration with primary care services.

There is one Mental Health Promotion Officer (MHPO) position for each Mental Health Region in Victoria. The workers are employed in the Child and Adolescent Mental Health Services (CAMHS).

What is the MHPO role?

The Mental Health Promotion Program has a focus on the mental health needs of children and adolescents, and operates from a community development model to create frameworks, structures and policy to facilitate lasting change.

Mental Health Promotion Officers work in partnership with a range of health, welfare and education services in order to develop strategies for improving awareness of and responsiveness to mental health issues in children and adolescents. Such responses might range from improved understanding of when and how to access clinical services, through to encouraging health promoting cultures within which children and adolescents can grow and develop.

A primary role of the MHPO is to develop and implement strategies that promote young people's mental health and wellbeing including the improvement of early identification and early intervention. The role includes working with issues relating to depression and youth suicide and

has a strong focus on marginalised young people. The emphasis of the MHPO role is an intersectoral approach that aims to support and bring together mental health and other community sectors such as schools and community health centres. The aim in making these links is to:

- Increase professional and community knowledge and understanding of mental health issues for children and young people
- Improve understanding of and responsiveness to children's and young people's mental health needs including the development of environments which promote resilience and enhance wellbeing
- Improve awareness of and appropriate access to mental health services
- Facilitate community feedback to inform CAMHS quality improvement processes
- Facilitate collaborative practice.

Specific activities of the MHPO's include:

- Education and training
- Consultation
- Service development
- Joint program development (such as STEP)

Why was the Mental Health Promotion Program Developed?

World wide there is a recognition that the number of people with depression is increasing. In Australia it is estimated that one in five people have a mental illness.

Tertiary mental health services are not staffed to treat this level of need, nor is it appropriate for them to do so. Mental health problems affect families, communities and a much wider circle of people than the identified patient. Accordingly there is a need to work collaboratively with a range of sectors and service types in a way that facilitates the participation of young people, families and communities. (Refer Chapter 2, the Promoting Mental health and Wellbeing Model for a description of this continuum.)

What is Mental Health Promotion?

In the STEP manual, mental health promotion is defined in general terms, and is broader than the specific role of the mental health promotion officers. It is understood as:

> *A holistic approach that focuses on both individual and populations based approaches (commonly referred to as Public Health Approach). It takes an integrated approach towards promoting well being by improving or enhancing the social, emotional and physical environments through a range of strategies that are intended to change individual behaviour, as well as, create change of the social and environmental factors affecting health. The aim is to enable people to make the healthy choice the easy choice.*

How to contact the MHPO's

For information about activities being conducted by the MHPOs or to contact them visit their website at www.youthmentalhealth.org. They are available to:

- Provide consultation
- Facilitate the provision of professional development
- Assist in developing policy and/ or programs relating to the groups identified in this publication or more broadly to the mental health of children and young people.

Mental Health Promotion Officers can be contacted through local CAMHS.

Southern Metropolitan Region
Monash Medical Centre
Phone: (03) 9594 1300

Western Metropolitan Region
MH SKY
Phone: (03) 9342 2800

Eastern Metropolitan Region
Maroondah Hospital
Phone: (03) 9870 9788

Northern Metropolitan Region
Austin Hospital Campus
Phone: (03)9496 5108

Gippsland Region
Latrobe Regional Hospital
Phone: (03) 5171 1389

Hume Region
Wodonga District Hospital

Hume Region
Goulburn Valley Area Mental Health Service

Loddon Mallee Region
Mildura Base Hospital

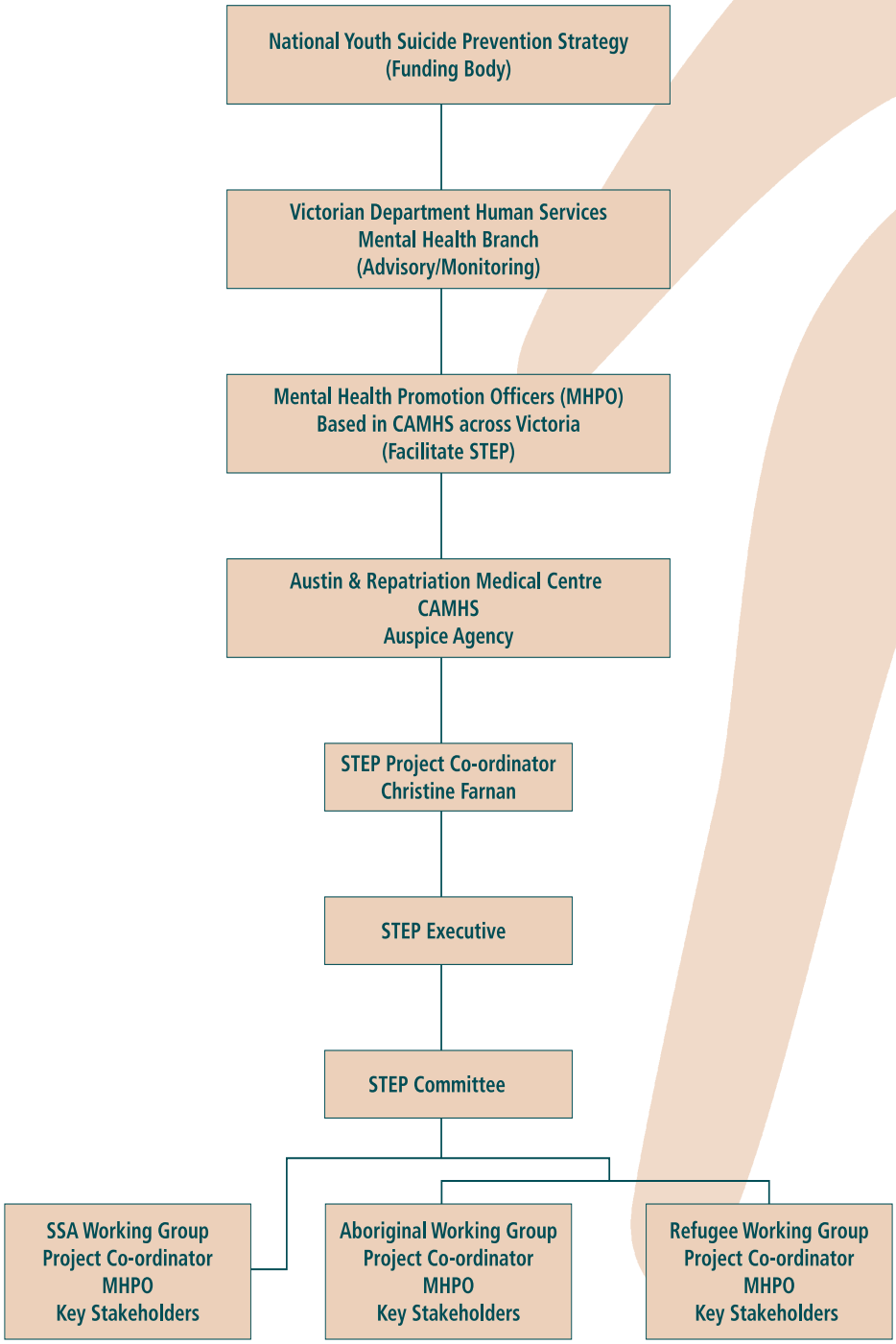
Loddon Mallee Region
Bendigo Health Care Group
Phone: (03) 5440 6500

Grampians Region
Grampians Psychiatric Services
Phone: (03) 5320 4100

Barwon Region
Barwon Health
Phone: (03) 5226 7159

STEP Management and Structure

The STEP Project has been developed and implemented in a mental health promotion framework that entailed commitment to collaborative partnerships. The figure below sets out the management structure.



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"An important lesson of my life has been to derive from discrimination against particular groups, the general lesson of the need to avoid discrimination upon any irrational ground. To discriminate against people on such a basis (whether it be race, skin, colour, gender, homosexual orientation, handicap, age or any other indelible feature of humanity) is not only irrational. It is immoral."

Justice Michael Kirby (1997)

CHAPTER 1

Introduction

1.1 Purpose of Manual

1.2 Target Audience

1.3 References

1 INTRODUCTION

The theoretical framework upon which STEP has been based supports the view that a person who has a positive level of mental health and wellbeing will have a greatly reduced risk for suicide. This manual is intended to assist professionals to promote the mental health and well being of marginalised young people, as a means of reducing their potential risk for suicide. Labonte's model for health advancement *(refer chapter 4)* has provided the underpinning of the STEP Project's approach to promoting the mental health and wellbeing of young people from the project's identified groups.

Suicide is a complex problem. It requires a range of responses that address the determinants of health (the social, emotional and environmental factors). The manual and associated training has been developed under a holistic public health model that ensured a multifaceted approach. The project was not seeking to replicate existing training materials relating to suicide intervention.

Rather the training and manual focused on specific issues pertinent to the young people from the project's identified groups which included young people who identify as being indigenous, same sex attracted or refugee. Evaluation was an integral aspect of the planning stages of the project and feedback from the pilot training informed the final design of the training and resource guide.

The STEP Project was directed across the spectrum for intervention as set out in the Commonwealth's 1999 "Mental Health Promotion and Prevention Action Plan". Based on an understanding of the needs of the young people from STEP's three identified groups there was an emphasis on the prevention and early intervention end of the spectrum (refer Appendix 1 Focus Group Results and Methodology). Blackmore (1999) made the recommendation that "key areas where further work could be done in producing high quality resources for use within communities that do more than teach warning signs and responses, and which emphasise and explore primary prevention". The STEP reference group felt that prevention and early intervention are more appropriate long-term strategies than CRISIS OR TREATMENT intervention, if inroads into reducing the three identified groups risk for suicide are to be achieved.

STEP has used Labontes model for health promotion (see chapter 4) as a working model for mental health promotion. This model identifies that an individual has a degree of control over their health. However, there are many hidden determinants of health that an individual cannot control. The STEP training and manual are intended to deal with problems at both levels. Education and training of professionals alone will have limited impact on the causes of risk for these young people. There is also a need to work with communities to develop mental health promotion strategies. The training was regarded as an opportunity to promote development of strategies at the local level, particularly given the presence of regionally based Mental Health Promotion Officers.

1.1 Purpose of Manual

The STEP Project has primarily been concerned with training health, welfare and educational professionals who form the project's target audience. The manual is intended to promote professional competence in working with young people from the identified groups who are at high

risk for suicide. These population groups are indigenous, refugee and same sex attracted (SSA) young people.

The manual addresses issues relating to suicide prevention and early intervention while taking a broad view across the mental health spectrum. It is intended to develop an extensive understanding of:

- The experiences and needs of young people from the identified groups.
- Cultural diversity.
- Good practice strategies for professionals.
- Mental health promotion strategies at the organisational, intersectoral or community levels.

The manual intends to demonstrate that it is not the individual, genetic or physiological reasons that put the STEP population groups at high risk of suicide. Rather, that social and environmental factors highlight their 'differences' and serve to marginalise and set them outside the socially accepted norms. Throughout the manual case examples are located in the margin directly beside relevant contextual material. These case examples are intended to provide professionals with a working illustration of the information being discussed.

Chapter 2 sets out the conceptual frameworks that gives professionals structural boundaries for applying the ideas presented in the manual. The STEP Model contends that care given to any young person should not be based on a narrow, illness model. Instead, the Model encourages workers to broaden their frameworks to embrace a holistic approach. Erikson's eight stages of development model outlines psychosocial development through the life span. This model has been used to contrast the impact of 'difference' on the each of the young people from the identified groups.

Australian society is becoming increasingly multicultural. Chapter 3 explores diversity, and whilst supporting the need for engagement with diversity, outlines the challenges for professionals and organisations to appreciate and work with difference. It provides strategies that can improve capacity to respond to the needs of people from diverse backgrounds.

Chapter 4 introduces the concept of mental health promotion. It provides an understanding of the processes involved so professionals and organisations will receive a practical guide to promotion strategies and methods, and move toward a holistic approach to health that incorporates all the factors influencing and creating health.

As there are a range of excellent training manuals available relating to suicide intervention, chapter 5 does not seek to replicate this material and, instead, makes recommendations about these resources. It also provides a broad overview of effective interventions that include understanding youth suicide and more specific knowledge and skills related to suicide intervention.

The remainder of the manual deals specifically with each of the identified youth populations. It provides an understanding of the needs of these young people and how they have come to be at higher risk for suicide. Erikson's (1963) model of development has been used with each

group to give some insight into the impact of their experiences on their identity development. Case examples are used throughout each chapter as a means of framing a concept for workers. Each chapter also profiles ideas, activities and practice strategies that are designed to create a supportive environment and more sensitive service provision.

A primary planning tool in mental health promotion is to assess the needs of people who are representative of the group for whom strategies are being implemented. A series of focus groups were conducted to assess the needs of young people from the project's identified groups. Throughout the manual the richness of these discussions has been cited or paraphrased. Refer also to Appendix 1 for a full report of the focus groups.

A series of summary sheets accompany the manual. They provide professionals with quick reference guides that are supported by the broader contextual information contained in the STEP manual.

1.2 Target Audience

The STEP Project's target audience was professionals whose work brings them into contact with the three groups of young people regarded as having a higher risk of suicide. The STEP Project has followed the Blackmore (1999) definition of a professional target audience:

> *Professionals are defined as those individuals or groups whose education, training and working environments brings them into contact with youth, particularly at-risk youth. It includes those working in a clinical capacity, such as general practitioners, nurses, psychologists, psychiatrists, and accident and emergency staff. It also includes, but is not limited to professionals such as teachers, welfare-guidance officers, police, juvenile justice workers, social service workers, youth and community workers, social workers, institutional staff, legal and drugl alcohol workers.*

The broad definition of STEP's identified groups has been adolescents and young adults which has been the project's focus of attention for consultation and training. Amongst the professionals targeted for training there is a difference in age groups of young people they target. For example the school system age group includes 5 years to 18 years and CAMHS age group is 0 years to 18 years. While the youth sector would normally describe young people as aged between 12 to 25 years. This manual would be relevant for professionals working with adolescents and young adults.

1.3 References

Blackmore, K. (1999) *Resource Guide on Education and Training. National Youth Suicide Prevention Strategy,* University of Wollongong and Commonwealth Department of Health and Aged Care. The resource guide is available on the internet at: http//www.ysp.medeserv.com.au/

Erikson, E. 1963, *Childhood and Society,* W. W. Norton and Company, New York.

CHAPTER 2

2. Conceptual Frameworks

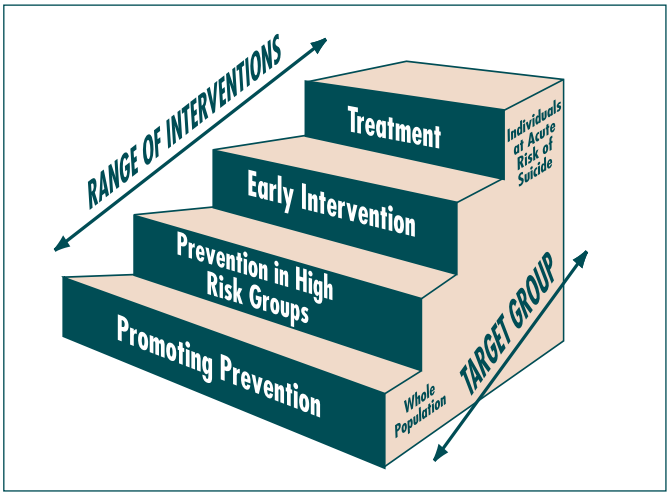
2.1 Project Model
2.2 Adolescent Development
2.3 References

2 CONCEPTUAL FRAMEWORKS

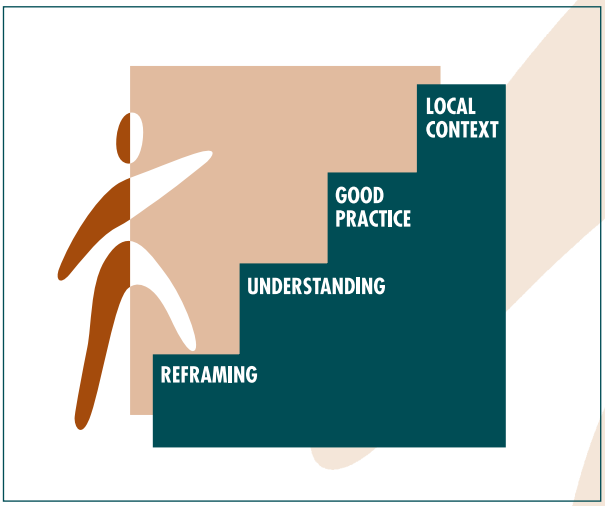
2.1 Project Model

The following section sets out the principles underlying the STEP goals. It was felt that if a suicide risk is to be reduced, prevention and early intervention are more appropriate long-term strategies than crisis or treatment intervention.

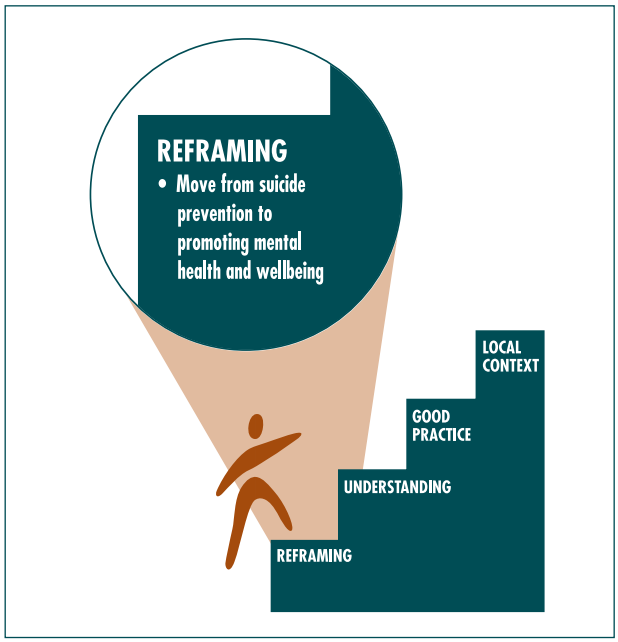
Promoting Mental Health and Well Being: The environmental context, as well as an individual's attitudes and behaviour, impact on health. The STEP Model assumes that as a complex range of causes can place marginalised young people at greater risk for suicide, solutions need to be multifaceted. Taking into account the determinants of health (physical and psychological well-being, individual attitudes and behaviour, genetic, social and the environmental context) the STEP Model is intended to target problems across the health spectrum and include all aspects of the continuum from prevention, early intervention and intervention. As one moves from the primary prevention end of the continuum towards the treatment end of the continuum the strategies will become more narrowed as one moves from a whole population focus through to individuals.



The STEP Model: The care given to any young person should be not be restricted to an illness model, but rather should be informed by a holistic approach. The STEP Model promotes this through the four key stages outlined below.



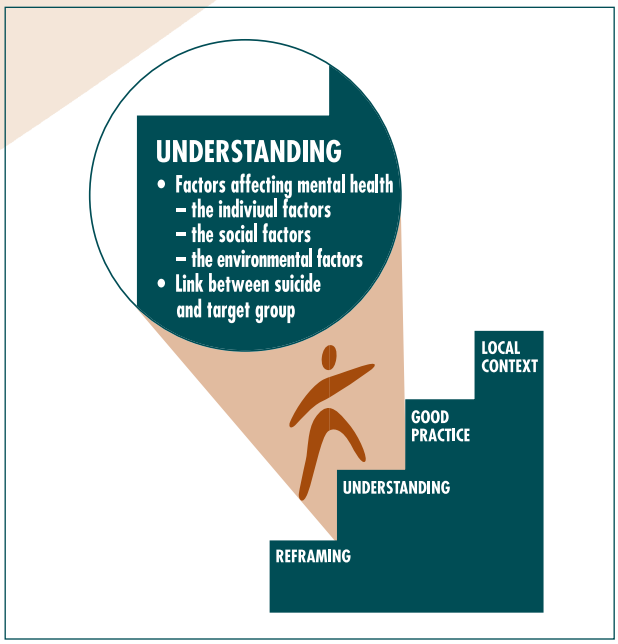
1. Reframing: There is a movement from suicide prevention or crisis intervention toward mental health promotion activity that targets populations across the spectrum for intervention and provides multifaceted solutions.



2. Understanding: The impact of health determinants suggests there are many factors at work that influence a person's health. These include:

- Individual.
- Social.
- Environmental.

The STEP program and manual sets out to identify the link between suicide and identified population groups. Understanding causes will assist the implementation of effective intervention strategies.



3. Good practice: When interacting with a client, professional skills are used to build a therapeutic relationship to enable the person to obtain assistance. These four key skills include:

- Competence.
- Knowledge, skills, resources and strategies.
- Listening, engagement and intervention.
- Enhancement of protective factors.

4. Local context: Working at a local level provides an appropriate use of resources that will empower the community to take control of their issues and priorities for better health. This includes:

- Local responses and support for young people.
- Meeting the local needs of young people.
- Intersectorial collaboration.

2.2 Adolescent Development

The public health approach has advanced the understanding of the underlying causes of illness. This understanding recognises that while health is affected by physical factors, pathogens and genetics, social and environmental factors (such as politics, economic circumstances and the physical surrounds) also have a powerful influence. This understanding now directs activities in the prevention, early intervention and treatment of illness. Psychiatry has long considered the relevance of social factors in the development of mental illness; however, the application of health promotion to address mental health at a population level is still in its infancy.

It is important for professionals to recognise and understand the impact of childhood events on a developing personality, as well as current factors. It is essential to realise that the mental health and wellbeing of the project's identified groups are affected by external factors. These include discrimination and ongoing transgenerational grief. Lack of understanding about the issues and needs of these young people can, and should, be addressed as part of service delivery. The balance between attention to individual care and support and broader population approaches will vary across the service system, but all professionals need to bear a level responsibility.

The environmental factors have a heightened significance in a context of child and adolescent development. The manual uses Erikson's (1963) developmental model as a vehicle to reflect on the influence of these environment factors at the different stages of development. While there are many models used to explain child and adolescent development, it was felt that Erikson's model was useful for contrasting the detrimental impact to development that negative environmental factors can have on indigenous, refugee and same sex attracted young people. Other authors have also used the model to illustrate the impact of damaging experiences on childhood development *(refer refugee chapter).*

Child and Adolescent Development

Erikson (1963, pp. 247–74; also in Slee 1993) provides a useful overview of psychosocial development in childhood. Erikson proposed eight ages of psychosocial development. His theory emphasises that development is a lifelong process and he focused on the development of identity. For the purpose of the manual, the model will be used to consider the early stages of development through to adolescence.

Erikson's model emphasises the parental influence on the child's development. The psychosocial development of a child is a two-way process and the infant plays an active role modulating their interaction with the social world. Development generally takes place within the family, and within the larger domain of culture and society in which the family lives. Therefore, the broader community has an important influence on development. If a young person has negative experiences, lacks appropriate role models, is viewed as different or has the pattern of 'normal' development interrupted, there will be implications for their growth and sense of self-esteem.

2 CONCEPTUAL FRAMEWORKS

Erikson's model has been used as a reference point for each of the project's identified groups of young people to emphasise the link between events occurring during childhood and adolescence that can impact on a developing personality. The first and second columns outline Erikson's stages of development. In other chapters, this model is repeated and a third column is added that emphasises some of the negative experiences that can be encountered by young people from the identified groups.

Table 1: Erikson's Stages of Development

Ages	Developmental Process
Basic Trust vs Mistrust (Birth to 1 year)	An infant is developing a sense of trust. This is influenced by the consistency, continuity and quality of care (such as feeding and nurturing). A sense of trust helps an infant to form the early stages of a sense of ego. If a baby experiences inconsistent and unpredictable care, a sense of mistrust can result.
Autonomy vs Shame and Doubt (18 months to 3.5 years)	Toddlers are developing a sense of physical independence and free choice or thinking skills. They are developing physical skills, walking, grasping and are beginning to explore their environment. All this can be a source of pride, but also shame and doubt if difficulties are mishandled. A parent should be firmly reassuring, but allow their child to experience choice. In experimenting with their autonomy, the toddler should 'be protected against meaningless or arbitrary experiences of shame and doubt'.
Initiative vs Guilt (3.5 to 5.5 years)	The child is discovering behavioural limits and continuing to become more assertive and take the initiative. Expressions of initiative may be accompanied by guilt if the child is uncertain what the bounds are, if they exceed the bounds, or are in fear of retribution for expressing initiative. 'Initiative is a necessary part of every act, and man needs a sense of initiative for whatever he learns and does, from fruit-gathering to a system of enterprise'.
Industry vs Inferiority (5.5 to 12 years)	The child deals with productivity and mastery and should 'expect that life must be school life, whether school is field or jungle or classroom and the child is set to win recognition by producing things'. There is potential for successes and failures, and potential to develop confidence or a sense of inferiority and incompetence depending on the child's experiences.
Identity vs Role Confusion (12 to 18 years)	The adolescent is developing a sense of identity in terms of what they are good at, sexual identity and peers, what they believe to be important and their values. This involves an intense exploration of personal values, beliefs and goals.

Ages	Developmental Process
	The sense of identity, then, is the accrued confidence that the inner sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others, as evidenced in the tangible promise of a career. The danger of this stage is ROLE CONFUSION. Where this is based on a strong previous doubt as to one's sexual identity, delinquent and outright psychotic episodes are not uncommon' (p. 262). Erikson suggests that if diagnosed and treated properly, these will not have detrimental impact.
Intimacy vs Isolation (19 to 40 years)	The young adult must develop intimate relationships with a partner as well as with a wider group of friends and peers. If a person faces difficulties with this task, they may withdraw and become isolated.
Generativity vs Stagnation (40 to 65 years)	Each adult must find a way to satisfy and support the next generation and to avoid stagnation.
Ego Integrity vs Despair (65 years to death)	There is a need to develop a sense of contentment in who you are as opposed to a sense of disappointment and regret about wasted chances and unfortunate choices.

2.3 References

Erikson, E. 1963, *Childhood and Society,* W. W. Norton and Company, New York.

Slee, P. 1993, *Child, Adolescent and Family Development,* Harcourt Brace Jovanovich Publishers, Sydney.

CHAPTER 3

Affirming Diversity

3.1 Introduction
3.2 Cultural Diversity and Identity
3.3 Cultural Diversity and Mental Health
3.4 Implications for Workers
3.5 Cultural Diversity—Some Snapshots
3.6 Resources
3.7 Reference

3 AFFIRMING DIVERSITY

"As our society becomes increasingly pluralist so that we are all exposed to a myriad of cultures, religions, traditions and lifestyle options, we need to develop in ourselves and in students skills of perception, critical thinking, the negotiation of differences, the passion for social justice, that engage with diversity rather than reconstruct it as homogeneity."

M. Pallota-Chiarolli (1996, p. 64)

3.1 Introduction

This section is intended to provide a practical understanding of issues concerning cultural diversity and identity. It includes frameworks to assist professionals when assessing young people's needs in a way that deals sensitively with cultural identity.

This section consists of formal discussions, an assessment tool and feedback from young people and case scenarios.

What do we mean by the term 'cultural diversity'?

Culture diversity can mean many things to different people. In this manual, cultural diversity is used in a broad sense; it not only refers to differences in ethnicity and language. Diversity can be based on differences in gender, age, nationality, race, ethnicity, culture, socioeconomic status, language, sexual preference, an individual's physical and/ or mental ability/ disability. It includes differences in perspective and expressions.

Race, ethnicity and culture have distinct meanings, even though they are often used interchangeably. Hays (1996, p. 333) uses the following definitions:

- *Race* refers to a person's race-specific physical characteristics, such as skin colour.
- *Ethnicity* commonly refers to socially constructed elements such as language, beliefs, norms, values, behaviours and institutions that are shared by members of an ethnic group. It is important for counsellors to understand the meaning a client attaches to their ethnic identity.
- *Culture* refers to all the learned behaviours, beliefs, norms and values that are held by a group of people and passed on from older members to newer members. The purpose is, at least in part, to preserve the group.

Gucciardo-Masci (1994, pp. 8–9) proposes that culture determines all human behaviour; it is not only related to those people who, for example, may have an accent. Culture teaches how to interact, coping skills, and how to individually and collectively interact with the world around us. Cultural diversity exists because individuals acquire their cultural development in different ways. Gucciardo-Masci (1994, p. 8–9) suggest the following core factors influence our cultural development:

- Values and norms.
- Beliefs and attitudes.
- Mental processes and learning styles.
- Sense of self and space.

- Communication styles and languages.
- Work habits and practices.
- Relationships, family and friends.
- Time and time consciousness.
- Food and eating habits.
- Dress and appearance.

Maslow (1987, p. 28) suggests that there is basic unity behind the apparent diversity from culture to culture. Although the superficial desires or behaviours may differ, the basic needs are common among humanity.

Everyone, particularly young people, benefit from an environment where diversity is valued and there is acceptance, inclusion and equality. Australian society has changed, and these changes have meant new challenges in meeting the needs of culturally diverse groups. Professionals must confront their individual perceptions, biases, ethnocentric judgements and opinions. By doing so, they can provide services in a relevant, meaningful and appropriate way to young people and communities of any background.

3.2 Cultural Diversity and Identity

Valuing cultural diversity acknowledges and respects aspects of a socialisation experience or cultural development. A person's race, ethnicity and culture informs the development of their value and belief systems which, in turn, impact on the way they interact within the broader community. However, we do not want to pigeonhole young people because of an identifiable cultural feature. It is important to gain an understanding of young people's different cultural orientations but there must be an acknowledgment of diversity within any cultural group. There is diversity within a culture, and each person will bring their own interpretations, understandings and experiences that will deviate from the cultural norm.

In Western culture, adolescence is a protracted and confused process; in other cultures, the change from child to adult can be more dramatic. When considering aspects of cultural diversity, the most significant developmental task facing a young person is establishing an identity. Cultural identity is acquired during childhood development. The way a young person experiences race, ethnicity and other cultural variables will influence this development.

Pigeonholing involves simplistic assumptions about beliefs and attitudes without having established the client's perspective. Visual cues can be misleading. They can lead to assumptions about vulnerability in particular areas that may preclude a careful and full assessment *(see also the Iceberg Model in section 4.4).*

CASE EXAMPLE

A young woman from Somalia presented to a youth worker wearing a scarf and it was assumed that she was a practising Muslim. Further assessment identified that she did not wear the scarf for religious reasons. She had taken to wearing it during her time in a refugee camp because of the common incidence of the raping of young women in the camp. It was a safety measure.

CAMHS Forum (1998)

3.3 Cultural Diversity and Mental Health

One of the most important protective factors for good mental health is connectedness to family, friends and the community. In Fuller et al. (1998) the work of Michael Resnick and colleagues is highlighted for its findings in large-scale surveys of young people in Minnesota. The factors that contributed to wellbeing in these young people were:

- Family connectedness.
- School connectedness.
- Church attendance.
- Belief in society.
- Parent-family connectedness

All of the above factors were found to be protective against emotional distress, suicidal thoughts and actions, violent acts and the use of cigarettes, alcohol and marijuana.

Fuller et al. (1998) then found similar results in their research of Australian young people. The four most significant factors that Australian young people saw as being positive protective factors against emotional distress included:

- Family connectedness.
- Peer connectedness.
- Feeling your family respects your decisions.
- Fitting in at school.

In youth suicide prevention literature, connectedness is listed as perhaps the most significant single protective factor explaining why some people, even though having strong suicidal ideation, decide not to take their own lives.

Connectedness is used to describe and understand a person's social environment; that is, the situation in which they live and interact. The underlying concept of connectedness is the sense of belonging and being valued by at least one significant other.

A young person living at home who does not go to school, has little or no social interaction with the broader community (such as through sporting or recreational groups), and who does not have any significant friendships or relationships is an example of someone who is disconnected and hence 'at risk'. Being disconnected from these major social groups can lead young people to feel they are not valued or important. This, in turn, may precipitate feelings of isolation and hopelessness.

Many young people may experience periods of hopelessness and loneliness, particularly during adolescence when they are seeking to understand who they are and to establish their place in the world. This can be compounded for young people who are part of a minority culture. 'Minority' or 'marginalised group' are used here to refer to groups that have experienced systematic marginalisation by the dominant culture, regardless of their numerical size.

Research conducted through the STEP Project (Farnan 1999) indicated that as a consequence of being marginalised, young people could encounter social avoidance, rejection and harassment at school and within the broader community. For some young people, their marginalised status can alienate them from their families; for example, young people who are same sex attracted (SSA) or young refugees who move away from family values in an attempt to connect with their Australian peers. Others, may well become distanced from the broader community through their loyalty to families that remain within a minority culture. Many of these young people are in a limbo; they are unsure where they belong and are afraid to seek help in clarifying their feelings and needs because they fear rejection. This level of alienation places these young people at increased risk for depression and suicide.

The following comments made by young people during focus groups (Farnan 1999) held for the purposes of gaining an increased understanding of the experiences of these young people. The comments substantiate the claim that marginality can increase a young person's sense of difference and with this, their sense of disconnection and isolation.

Indigenous Young People

The young participants in the rural focus group identified that the biggest issue for indigenous young people was the breakdown of parental relationships. Parental discord causes the children to feel powerless. There is no opportunity for the children to talk about their own problems. The sense of security and connection is lost, the young person feels isolated and powerless.

The young people discussed the sporting activity organised by the regional Aboriginal Co-op:

> *'The sport provides us with a worthwhile activity. You are mixing with older community members. It is a good thing to be around the elders, they are older and wiser.'*

An opportunity to be more visible or more included in associated club events was regarded as important by these young people. Overall, they wanted further opportunities to have more interaction with adults, as they considered this contact allowed them to receive positive encouragement and support.

Refugee Young People

> *'The cultural divide between the old country and the new creates friction between parents and children.'*

> *'I have difficulties making friends at school. I came to Australia with high expectations, often under pressure to succeed.'*

SSA Young People

One young woman talked about the fact that she had not "come out" to her family, as they were overtly heterosexual and she was not sure how they would respond, especially as she was low status in the family. She was worried that they would reject her and ask her to leave. She did not have a good emotional relationship with her family. She said,

"They might know and pretend to be naive and ignore the fact that I am gay. If they accept that I am gay, then my family have to react or deal with this so they do not make any response".

'One young person suggested that when they are stressed about being homosexual, they talk at school to friends who they have told about their homosexuality, as well as, the student welfare coordinator. The support from Family Planning Victoria is helpful.'

One young woman, who had attended a state school in a country town, said:

'During sex education, homosexuality was talked about as being abnormal and that there was a need to help homosexual people to get back on track, to become straight'. She stated that, as a result, she could not come out, was depressed and wanting to kill herself.

Promoting Acceptance and Understanding of Difference

A primary means of supporting these marginalised young people is to promote acceptance and understanding of difference. This issue has been highlighted in the Joint Commonwealth, State and Territory Initiative (1999) Mental Health Promotion and Prevention Plan. One of the priority mental health targets identified for people from diverse backgrounds is to 'promote community capacity building to address mental health promotion and prevention for people from diverse backgrounds'.

3.4 Implications for Workers

In supporting young people who may experience the alienation of minority cultural status, it is important to be aware of the:

- Range of cultural variables that may shape their experience and develop their cultural development.
- Potential for cultural identity to change over time.
- Cultural identity that you, as a professional, bring to an encounter with a young person as:
  - Individuals.
  - Members of an occupational group (for example, youth worker, teacher, social worker).
  - Representatives of an organisation (for example, a particular school, community health centre, housing service).
  - Representatives of a service system (for example, mental health, welfare, education, youth services).

Our professional identity will affect the way we understand and approach things, in terms of attitudes and values developed through training, or the policies and procedures that bind us as employees.

Our professional identity will also affect the way we are perceived by a young person, perhaps even before they meet with us.

Acceptance of another's difference is a vital ability for all professionals. Professionals also need a capacity for cultural self-assessment.

Opportunities for cultural self-assessment should be an integral part of a culturally competent system of care. It is not possible to erase our cultural orientation and approach a young person as a blank sheet. However, we can become more aware of how we are positioned, and of our underlying assumptions and values at an individual and organisational level. Where appropriate, this can help reduce overt value-laden attitudes that affect our interaction with, and assessments of, young people. Developing and modelling attitudes that demonstrate that we value and embrace diversity can go a step further in facilitating engagement with young people and shaping a different approach. This level of self-reflection and culturally sensitive practice will also provide a base from which we can promote cultural changes at an organisational level and with the broader community where negative attitudes may be the generators of minority status.

Strategies for workers

Achieving cultural competence will require commitment and an active process that needs to occur at a professional, service provider and systems level. Acceptance of diversity and valuing difference can be developed through training, experience, supervision and self-evaluation. It is important that initiatives occur across sectors in collaboration with a range of sectors. By negotiating with other partners who have responsibility for different areas of the intervention spectrum, it is possible to develop programs that operate across the spectrum. This needs to be mutually respectful and productive for children, young people and their families.

Hays (1996) has developed a model to alert us to a range of variables that may influence a cultural profile. All of these variables will be part of our make up and that of our clients. One or more may be contributing to an experience of personal distress. This framework is referred to as the ADDRESSING Model. It organises and systematically considers nine complex and overlapping cultural influences that counsellors need to tackle in their work. The model is particularly useful in helping professionals to examine their own biases and areas of inexperience regarding cultural minority groups, and in considering the salience of multiple cultural influences on clients. The ADDRESSING Model includes:

- **A**ge and generational influences.
- **D**isability-acquired.
- **D**isability-developmental.
- **R**eligion.
- **E**thnicity.
- **S**exual preference.
- **S**ocioeconomic status, including income, living arrangements, education, urban-rural origins, family name and other factors.
- **I**ndigenous status.
- **N**ationality.
- **G**ender.

3 AFFIRMING DIVERSITY

ADDRESSING Professional Bias

The first step in multicultural training is always considering one's own biases and areas of inexperience. The model provides a framework for this ongoing work.

In a classroom setting, the challenge can begin simply by asking students to think about their identities in relation to the ADDRESSING factors. A key question is 'How does my age and generation-specific experiences, my disability (or lack of experience with disability), my religion or religious upbringing (and so on) affect my view of people, my beliefs about the world, where I live, who my friends are, and the kind of work I do?'

The ADDRESSING Model does not assume that membership within, or understanding of, one minority culture automatically leads to understanding of other minority groups. For example, a Euro-Australian lesbian professional may be very aware of the subtle sexist and heterosexist biases against lesbian and gay clients, but relatively unaware of her own ethnocentric attitudes toward (heterosexual and gay) ethnic minority men. The ADDRESSING Model can be used to counteract the compartmentalisation of awareness by reminding professionals that everyone has biases and areas of inexperience and ignorance. The model provides an opportunity to frame the task of challenging one's own biases.

Another means of using the model to challenge one's biases is through consideration of a particular ethnic identity in relation to all the other ADDRESSING influences. By looking at the differences within a group that correspond to each of the ADDRESSING factors, the tendency to make inaccurate generalisations is reduced. For example, on meeting an Asian Australian client, the worker could remind themselves to consider the influence of, and differences related to, the client's age, including a range of historical events and contexts, generational influences, cultural norms about aging and development experiences, and so on through the model.

Assessing the Salience of the ADDRESSING Factors

A central task for professionals working with clients of minority cultures is to determine what cultural factors are more significant in a client's life. The model can help increase workers' awareness of specific cultural influences and minority identities that they might otherwise overlook. For example, a heterosexual counsellor may fail to consider the possibility that a client is lesbian, gay, bisexual or transgendered. The salience of each cultural factor is specific to the individual, the counselling situation, and the larger cultural context. The model is helpful in assessing the importance of diverse cultural influences.

The Client's Self-Identification

The starting point in many counselling situations will be some sort of self-description by the client. This information could be elicited by a simple question such as: 'Would you describe yourself for me—both how you see yourself and how you think others see you?'

Then by silently reviewing which of the ADDRESSING factors the client included in their self-description (either directly or implied), the professional can mentally organise those factors the client considered important enough to mention. The professional could ask the client to reflect back on those identifications they have mentioned. By encouraging a focus on the meaning of cultural influences and identities, the worker can gain an understanding of the person-specific and culture-specific aspects of the client's identity.

Considering Information Omitted by the Client

The degree to which a professional should ask directly about a cultural identity depends on the particular situation. If the worker senses that omissions represent a lack of trust on the client's part, it may be important to develop rapport and trust before proceeding. Having gained the client's confidence, the worker may then encourage the client to consider unacknowledged cultural influences, assuming that this fits with the client's presenting problem and goals.

A client may include or omit certain types of culture-specific information because they assume the counsellor shares the prejudices of the dominant culture. The potential biases and areas of inexperience that require the counsellor's most careful consideration are those that correspond to the client's salient identity.

It is important to be sensitive to the unique cultural identity and experience of each individual and family, and the changes that may occur over time at an individual, family and environmental level. As discussed above, workers' use of language and self-awareness have a strong influence on how well they connect with young people, what clients will be prepared to share with them, and how well they understand what clients do share.

Bazon et al. (1989) suggest that services should be adapted to fit the needs of the group and the individual client based on identity, degree of assimilation and subcultural grouping. It would be useful for services to include a regular case assessment that includes evaluation of cultural information such as that developed by LeVine & Matsuda (1999).

LeVine & Matsuda's Cultural Information Survey (table 2) has been designed as a tool to try and reduce assumptions about such cultural factors as ethnicity, nationality and sexual preference.

3 AFFIRMING DIVERSITY

Table 2: The Cultural Information Survey

Please tick items or write answers in space provided.

Omit answering question(s) if you have any concerns.

A) Personal Information

1) Name(s) given at birth (underline family or surname):

2) Preferred name (name(s) you want me/us to use in our sessions?

3) If you require an interpreter, what do you prefer regarding their details (such as political preference, religion, male or female, and so on)?

4) Language(s) of comfort and ease:
❑ Reading ❑ Writing
❑ Speaking

5) Date of birth: day/month/year: (If unknown, approximate date)

6) Sexual identity:
❑ Female ❑ Male

7) Do you have any religious affiliation(s):
❑ No
❑ Yes (please indicate)

8) Partner status(es) you identify with most (you may select more than one):
❑ Single ❑ Separated
❑ Divorced ❑ Married
❑ Widowed ❑ With lover
❑ Partnered ❑ Defacto
❑ Other (please indicate)

9) Current source of income:

10) Main occupation (including student):

11) Education, training/ apprenticeship(s):

12) Limitations and/ or restrictions (that is, physical, learning etc.) if any:

B) Place Information

1) Place of birth (town, village, country, camps):

2) Birth order (first born son etc.):

3) Nationality(ies) and residency(ies) held:

4) Place of father's birth (indicate if biological, adoptive/foster/step parent status):

5) Place of mother's birth (indicate if biological, adoptive/foster/step parent status):

6) Grandparents' places of birth (if known):

7) Place you have lived for more than one year (list places and dates):

8) Indigenous heritage, place(s), and/or language group (if any); that is, indigenous, Grampians, Australia or Ainu, Hokkaido, Japan, or Khmer, Takeo, Cambodia:

9) Ethnic identity (if any):

10) Region(s) in which you prefer to live (you may select more than one):
❑ Urban ❑ Suburban
❑ Rural ❑ Village
❑ Remote ❑ Other
❑ Low, rolling hills ❑ Flat grass or bush
❑ Desert region ❑ Mountain region
❑ Sea region ❑ Lake/ river region
❑ Other (specify)

11) Climate(s) in which you prefer to live:
❑ Temperate mild ❑ Moist, tropic
❑ Dry, desert ❑ Temperate cold
❑ Semi-tropic ❑ Other (specify)

12) Places you choose for recreation (that is, bar/pub, cafe, theatre, street, friend's place, mountains etc.):

13) Current type of shelter/ dwelling (that is, apartment, dormitory, shared house, tent etc.):

14) Place(s) in which you work (that is, home, taxi, office, market, street, ship, rice field etc.):

Source: LeVine and Matsuda (1999)

3.5 Cultural Diversity—Some Snapshots

CASE EXAMPLE

Tony an 18-year-old student who approaches the student welfare co-ordinator. He asks the counsellor for information about tertiary programs. The co-ordinator senses there are other issues Tony wishes to discuss.

The welfare co-ordinator interviews the young man to clarify his needs.

Tony is an 18-year-old Italian gay male whose parents are devout Catholics. His father runs a mechanic's workshop and has 'traditional values'. He hopes Tony will follow in his footsteps and join the family business when he leaves school. Tony has a lot of potential to be an excellent mechanic and already works for his father on the weekends. However, Tony has also excelled at art and hopes to attend university and complete a graphic design course. He needs the financial support of his family to do this. When Tony mentioned this, his father responded that he should get a real job in a trade, not a job that is only for girls. He wants to be proud of his son not ashamed, and he says that Tony should follow the family tradition of working in the business with the father, marrying a 'good Italian girl' and having lots of children.

The worker spends more time exploring ways for Tony to approach his family, especially his father about his future aspirations. Tony then explains his deeper concerns.

Tony feels that he will not be able to pursue his dreams or tell his family that he is gay. He feels cornered and his parents are putting pressure on him to go out with some of their friends' daughters. Tony feels it is perhaps wrong to feel the way he does; it goes against the church's teachings and the religion he has grown up with.

Tony has been increasingly feeling depressed and tearful. His sleep and appetite have been disturbed and he has become more accident-prone. His behaviour is becoming reckless and this is leading to many arguments with his family.

The worker is concerned about Tony's welfare and feels it is important to explore the issue of suicide with Tony. The worker asks Tony directly if he has thoughts about harming himself or killing himself.

Tony discloses that recently he told a friend that he feels his situation is hopeless and had thought of taking his life. He felt he could not continue to lead a double life, but believed that if he announced he was gay he would be disowned by his family.

By reflecting on the factors that the client included in their self-description (either directly or implied), further areas for consideration were identified. Tony's current distress stems from the pressure created through his sense of guilt about his sexuality given his family attitudes and values, and his religious background.

Given Tony's pervasive level of distress and hopelessness the worker's first concern is to have Tony's level of depression assessed to ensure short-term safety. Contact is made with the regional CAMHS to organise between the client and the service a mutually convenient appointment. The worker reflects positively on Tony's thoughts about his sexuality and reminds him that if he needs to speak to anyone not to hesitate to contact them. A time is then arranged to meet with Tony again to discuss the issue. Tony is given a book that explores sexuality and some flyers about services that provide support for gay and lesbian people.

CASE EXAMPLES

Refugee Young People

'The nuances in difference between cultures can create problems between teacher and student; for example, people from the Horn of Africa do not make eye contact with teachers and elders, as this is considered a sign of disrespect.'

(Farnan 1999)

'You can't generalise about each ethnic group. Workers should never assume that because they come from, for example, Somalia, that all Somalians are the same. There is enormous diversity with residents from one country of origin. Workers need to ask clients their wishes and beliefs.'

(Farnan 1999)

'In Australia there is a diagnosis of trauma and torture for refugees, but in the Horn of Africa there is no such thing. It is described as "still memorising what happens in war".'

(Farnan 1999)

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CASE EXAMPLE

SSA Young People

One young man told a few friends he was gay. He said:

'Their reaction was so terrible that I regretted telling them. Now people are leaving him alone and it is okay.' He feels there was a real shift in people's feelings because sexuality was being taught as a curriculum subject and homosexuality was explored. He felt comfortable enough to be able to share his experiences of being gay with the class when the teacher was talking in a positive and open sense about homosexuality. Since discussing his sexuality with fellow students in class, it is better for him at school. There is acceptance and understanding about homosexuality because he was able to break down the myths and stereotypes by providing his personal experience, making it much more of a reality for other young people.

CASE EXAMPLE

A 15-year-old Vietnamese girl presents to a youth resource centre. She asks the youth worker for information about employment programs. She appears quite distressed.

The worker interviews the young woman to clarify her needs. Asking her to 'Describe yourself for me—both how you see yourself and how you think others see you?'

The young woman replies that she is currently using drugs and has recently dropped out of school because it was a waste of time. She also explains that her family is Vietnamese and they came to Australia as refugees. Her family want her to do well in this new country and have put a lot of pressure on her, but she says they just don't understand.

Further discussion identifies that she has been unemployed since leaving school six months ago. She says she has no friends or social interests, and often feels down in the dumps. She does not sleep very well and appears quite thin. She presents as flat and lacking in energy or enthusiasm. She is reluctant to talk about her refugee experience.

The worker concludes that she may be depressed and is probably affected by her past trauma relating to her refugee experience. A referral is made for the young woman and the family to a Child and Adolescent Mental Health Service.

The young woman re-presents to the service and informs you that neither she nor her family attended the appointment with the mental health service.

The worker is concerned about her welfare and spends more time talking with her and trying to build a relationship.

By reflecting on the factors that the client included in her self-description (either directly or implied), further areas for consideration were identified. A sense of the young woman having been very disillusioned with school becomes apparent with further exploration. It is revealed that the school counsellor assessed her as having learning and reading difficulties but her family refused to acknowledge this assessment. Her current distress stems from the pressure created through her developmental disabilities, no doubt exacerbated in the context of her family's refugee background. At school she felt ashamed for constantly being teased as 'dumb', and is now frustrated about not being able to find a satisfying job.

Summary

There are some clear indicators and strategies that can improve professionals' capacity to respond to the needs of children, adolescents and their families who are from culturally diverse backgrounds. It is important to remember that culture is multifaceted. Culturally sensitive and competent practice requires professionals to mediate their knowledge of cultural profiles with an awareness of the nuances of personal presentation.

3.6 Resources

Victorian Co-op of Children's Services for Ethnic Groups (VIC SEG)
VIC SEG is a statewide ethno-generic service that focuses on children and their families. It uses a community development approach in resourcing members to provide leadership. The aim is to facilitate the development of structures that support community members within a host culture that has very different values and structures.

Contact: 11 Munro Street Coburg. Phone 9383 2533

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CHAPTER 4

Promoting Mental Health and Wellbeing

4.1 Introduction

4.2 Mental Health Promotion Defined

4.3 The Determinants of Health

4.5 Understanding Mental Health Promotion

4.6 Working Models of Mental Health Promotion

4.7 References

4 PROMOTING MENTAL HEALTH AND WELLBEING

LIFE

Life is up and down
Like mountains and valleys
When you're up you feel happy
You have no problems
Everything is good and you feel strong
You feel you are all right
But you can't stay on top forever especially the young.

You fall down
Because people aren't careful
They don't have the control
They fall right down like it's under the sea
They feel they have problems and they feel life is bad.

Before you were up and now you are down
If you want to get back up
You have to be careful
You have to go slowly
You have to get enough sleep
If you're tired life's too hard
Move steadily up, don't go too fast
Move and then rest
Take small steps to move your life forward
Go outside, go for a walk
Get out of the house, get some exercise
Talk to some friends
They may be able to help you
Take a hot shower or a long bath
You can start to feel better
Eat some fruit and drink clear water
Some people eat chocolate it makes them feel happy
Some people cry.

Young Adult Migrant English Course (YAMEC) students 2000.

The poem was developed by refugee students at North Metropolitan Institute of Technical and Further Education, as a contribution to STEP mental health promotion initiative.

4.1 Introduction

Health promotion and mental health promotion are comparatively new to the field of health. There has been a growing realisation that a broad range of determinants influence population health. As the medical model does not comprehensively address these broad determinants, the new public health or health promotion evolved. The discipline of health promotion is based on the assumption that improvements in health will occur by providing individual health services *and* investing in programs that target the broad determinants of health.

The World Health Organisation (WHO) defines health promotion (1986) as:

> *Health Promotion is the process of **enabling** individuals and communities to **increase control** over the determinants of health and thereby **improve** their health. To reach a state of complete physical, mental and social well-being, an individual or a group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective for living. Health is a positive concept emphasising social and personal resources, as well as, physical capacities. Therefore, health promotion is not just the responsibility of the heath sector, but goes beyond healthy life styles to well being.*

In the broadest use of the term, mental health promotion includes all actions aimed at improving people's health. These actions can occur along a continuum from prevention through to treatment or rehabilitation or, as it is otherwise referred to, as primary, secondary or tertiary intervention. *No matter where the activity is located on the continuum, the purpose is to enable people to improve their health.* Therapeutic approaches which emphasise good engagement with a client and a sound psychosocial framework for assessment and intervention are in fact using a mental health promotion approach, at the level of individual empowerment.

Health should be understood as a concept that has dual meanings. It can be used in a positive sense to mean a person is not considered to be ill; rather, they are being proactive in preventing illness or enhancing their health. Alternatively, health can refer to a person with an illness and the measures and activities they undertake to improve the outcome or reduce the impact of the disease.

Health professionals are realising that many factors affecting health are beyond their sphere of influence (for example, reducing the impact of bullying on mental health at school). If there is a serious commitment to prevention, early intervention and improving the outcomes for those who have an illness, then organisations and workers need to change their way of thinking and functioning. With the growing emphasis on promotion and prevention, it is time to expand beyond the medical model focus, toward a public health model or approach. Mental health promotion has developed as an interdisciplinary practice involving such disciplines as public health, medicine, health education, epidemiology, sociology, social work and so on.

Effective prevention of mental health problems and development of mental health promotion activities can be achieved by using affordable and simple methods. The intention in this chapter is to provide professionals with knowledge and a practical guide to health promotion strategies and methods. This will assist professionals to select, plan and implement effective programs for the promotion of better health across a diverse range of settings, population groups and health issues. Clearly, agencies will select settings, population groups and strategies relevant to their focus. Interagency collaboration will be important.

4.2 Mental Health Promotion Defined

There is still a degree of confusion about what is meant by health promotion. Health promotion needs to be acknowledged as a discipline in its own right with a sound theoretical base and principles which underlie the achievement of a state of complete physical, mental, social and emotional wellbeing.

In the health promotion field, phrases and words can have different meanings and understandings attached them. It is important to clarify the intended meaning when these phrases are being used within the context of the STEP manual. *Health promotion, mental health* and *mental health promotion* have been used extensively throughout the manual and their intended meanings are set out below.

Health Promotion

*Health Promotion is the process of **enabling** individuals and communities to **increase control** over the determinants of health and thereby **improve** their health. It has come to represent a unifying concept for those who recognise the basic need for change in both ways and conditions of living in order to promote health. Health Promotion represents a mediating strategy between people, their environments, combining personal choice with social responsibility for health to create a healthier future.*

World Health Organisation (1990)

Mental Health

In the health promotion context Mental Health is not viewed as simply the absence of a mental disorder. Rather as the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice.

Australian Health Ministers quoted in Raphael and Lange (1999, p. 3)

Mental Health Promotion

In the STEP manual, mental health promotion is defined as:

A holistic in its approach that focuses on both individual and populations based approaches (commonly referred to as Public Health Approach). It takes an integrated approach towards promoting well being by improving or enhancing the social, emotional and physical environments through a range of strategies that are intended to change individual behaviour, as well as, create change of the social and environmental factors affecting health. The aim is to enable people to make the healthy choice the easy choice.

4.3 The Determinants of Health

The field of mental health promotion recognises that a range of determinants influence an individual's health so programs are concerned with changing or influencing individual behaviour, as well as the social and environmental factors or determinants of health. These determinants are widely recognised as including:

- Human biological factors.
- Behavioural factors and lifestyle.
- Environmental influences such as the physical (natural and artificial) social, cultural, political and economic factors.
- Healthcare system.

Green and Kreuter (1999, p. 10) refer to the determinants of health as 'risk factors and risk conditions, together with factors predisposing, enabling and reinforcing them. These factors include adequate housing; secure income; healthful and safe community and work environments; enforcement of policies and regulations controlling the manufacture, marketing, labelling and sale of potentially harmful products; and the use of these products where they can harm others'.

4.4 Understanding Mental Health Promotion

The discipline of mental health promotion is steadily gaining credibility and acceptance within the health profession. Mental health promotion does not start with the illness. Instead, it commences with seeking answers to the questions such as 'What are the determinants of mental health?' Once the factors influencing illness and/ or positive mental health are understood, then a range of strategies can be employed to enable people to increase control over and to improve or enhance their mental health. Mental health promotion works with people in the settings of their everyday lives such as schools, workplaces, hospitals, local communities and so on.

Mental health promotion draws on many disciplines including medicine, biology, psychology, education, business management, marketing, sociology, ecology, political science, the law and anthropology. This results in informed, creative and innovative activities to enhance health.

Mental health promotion programs can function on a range of levels. They may include:

- Focus on improving mental health through improving lifestyles and behaviours and/ or environmental changes.
- Operate at the individual or the population level.
- Operate at a local or society-wide level.
- Education or training programs.

4 PROMOTING MENTAL HEALTH AND WELLBEING

CASE EXAMPLE

A worker assesses a young person after they have attempted suicide. The primary reason for the young person's suicide attempt is depression resulting from confusion and shame about their sexuality. The worker spends time with the young person and, over a number of visits, talks to them about ways to cope if they feel depressed or distressed. Yet the same sex attracted young person is still being bullied and harassed at school. They still require information and role models to assist them to explore their sexuality, and they live in terror of their family finding out about their homosexuality.

While it is important to continue working with the young person on an individual basis, it is imperative to explore and comprehend the variety of factors influencing how people live their lives and the choices that they make.

Stages of Mental Health Promotion

Prior to commencing mental health promotion activities, it is important to base strategies on an understanding of the determinants of health. Uncovering the factors that are influencing mental health is the first task in developing mental health promotion strategies. This is achieved by *assessing* needs. This will then inform health advancement interventions. It may entail such activities as conducting focus groups with people from the target group or community consultation. The intervention phase includes *methods* or the ways that change is brought about within a target group (such as community development, mass media, advocacy, and legislation). As well as *activities* or the particular processes used to create change (such as teaching individual coping skills, conducting community organised and lead activities, advocacy through the media).

Intersectoral collaboration will need to occur across sectors, as many fundamental factors influencing mental health are beyond the immediate influence of the health sector. Intervention or action warrants a range of strategies across sectors. For example a mental health service dealing with a child who has been subject to bullying at school. Successful intervention requires the working together of the mental health system and school sector and broader support at a departmental level with policies about bullying and a school's responsibilities in this area.

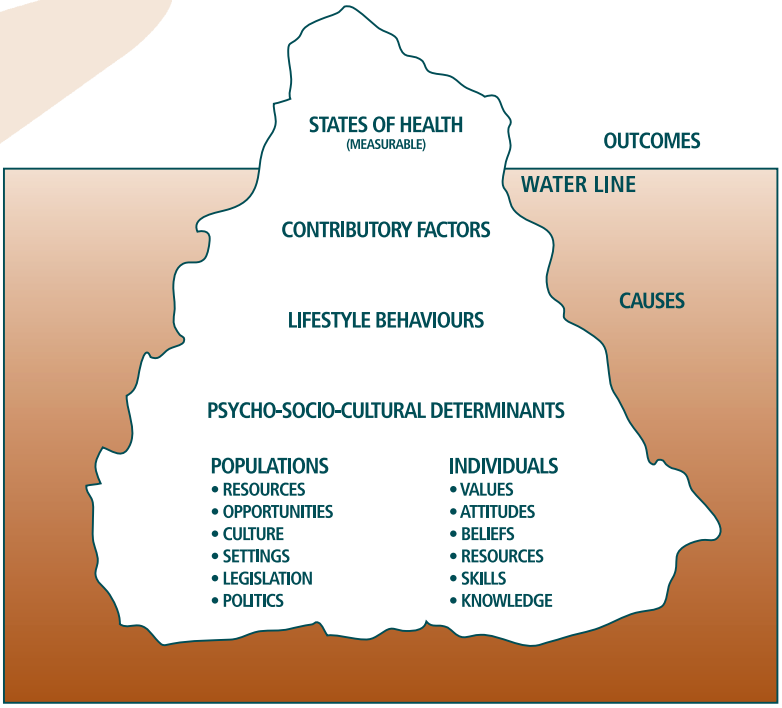
The Iceberg Model

Using the Iceberg Model (Travis and Ryan 1988), we can examine how various health determinants impact on a person to influence their health. The Iceberg Model is based on the assumption that visible health or illness is only the tip of the iceberg. To understand the multiple influences on health, one must look below the surface.

The Iceberg Model is a useful analogy for recognising the broad range of factors that influence our health, mental health and wellbeing. The traditional Western medical model focuses predominantly on the 'illness' and fails to consider the multifaceted influences that create health. The idea that you *get sick, you go to a doctor, you get fixed* fails to take account of the factors occurring in your life before the illness, and the factors that will be present once you have left the doctor or health service. Many of these factors are beyond the individual's control.

If intended changes are to be made programs to enhance a person's mental health need to deal with all the determinants of health. The following example illustrates some of the limitations of confining ones understanding solely with a medical model.

Social and environmental factors can be understood to have significant impact on the mental health problems experienced by indigenous, refugee and same sex attracted young people from STEP's identified group. Many of the factors are beyond the individual's control. Adopting a mental health promotion framework is one appropriate strategy for improving the mental health and wellbeing of these young people. It requires a range of service providers working together across a number of sectors to bring about changes in the social and environmental determinants.



The iceberg suggests:

- *Above the waterline or the tip of the iceberg:* identifies *contributing factors* or the state of health that is visible (such as depression or stress).
- *Immediately below the waterline: lifestyle factors* easily identifiable as linked to illness or positive health (such as the link between cancer and smoking, recreation pursuits and increased physical or mental wellbeing). This level reflects such things as what you eat, how you relax, and generally how you behave in response to the various hazards in your life.
- *Well below the waterline: psycho-socio-cultural-political-economic-beliefs* are hidden determinants impacting on illness, good health, wellbeing and quality of life such as psychological, social, cultural, environmental and political factors. This level identifies the subtle, insidious elements that are a significant influence our health.

Many factors influence how people live their lives and the choices they make or are forced to make. If health is to be enhanced, those factors below the waterline or the *hidden determinants* need to be uncovered and dealt with.

4.5 Working Models of Mental Health Promotion

Mental health promotion activities are intended to favourably influence the determinants of health at two levels:

- individual
- population

4 PROMOTING MENTAL HEALTH AND WELLBEING

The determinants of health are created at two levels:

- Individual health choices and behaviour.
- Factors beyond the control of the individual: the broader context of the social, physical, economic, political environmental elements that impact on health.

Mental health promotion activities occur at three stages:

- Primary/prevention/promotion.
- Secondary/early intervention.
- Tertiary/intervention/treatment/rehabilitation.

Mental health promotion programs can intervene at the individual and/or the behavioural level, or at the broader social and environmental level. In many instances health promotion strategies focus on individual and broader environmental determinants. The assessment phase should inform this decision making and planning stage.

Effective approaches to mental health promotion use a broad base of action to address the determinants of health at the point where health is shaped. Today, a range of health promotion practice models are used to guide the development of approaches to improving health.

Three Commonly Recognised Mental Health Promotion Models are Outlined Below

1. The Ottawa Charter for Health Promotion (WHO 1986)

The Ottawa Charter nominates five action areas for intervention. It is important to understand that the charter concentrates on *strategic action areas.* Therefore, unlike the other two models, it is not suited to comprehensive planning for targeting individual or environmental determinants.

The Ottawa Charter is best used as a tool for planning comprehensive health development strategies using the five action areas for response at a national, state, regional or organisational level rather than for targeted or local responses. Responding to individual or environmental determinants should be based on a careful and through assessment of the local population and Green and Kreuter's (1999) PRECEDE/PROCEED model or Labonte's (1993) model are better suited to this task.

The five action domains of the charter are:

1. **Building healthy public policy** by advocating and promoting legislation or rules that enhance and promote health by improving structures and processes of society. Examples include legislation to enforce the wearing of seat belts or anti-discrimination legislation. Public health policy should attempt to deal with the inequalities between the disadvantaged and more advantaged that are due to social and educational gaps. This is linked to equal access to service and reducing barriers to services (such as recognising and attending to cultural diversity).

2. **Creating supportive environments** by developing socially cohesive groups and by linking community groups with their environments to enhance health. Examples include a support group for gay and lesbian young people run by a local community health centre, a local government encouraging a community group to set up a social group for migrants from the same country of origin, and a local service club funding recreational activities for young people.

3. **Strengthening community action** so community groups can advocate effectively on their own behalf to improve their environments, their structures for living, and the social structures that support people to enhance health. Examples include schools creating student representative councils and government funding of the Victorian AIDS council.

4. **Developing personal skills** so each individual has the skills and the knowledge to improve their lifestyle, eliminate risky behaviours, and enhance personal health. Examples include schools introducing stop, do, think to encourage school children to reduce the incidence of bullying, teaching young people help-seeking behaviour, and Child & Adolescent Mental Health Services (CAMHS) conducting outdoor education camps for young people.

5. **Reorientating health services** from the current exclusive focus on care and cure of illness to include a major focus on the promotion and enhancement of good health. Examples include Commonwealth funding of STEP Project and government funding of QUIT.

To address the factors influencing health many models exist that set out comprehensive planning frameworks. Labonte's model (1993) and Green and Kreuter's (1999) PRECEDE/PROCEED model provide useful examples. They are briefly explained below.

2. Labonte's Model of Health Advancement (1993)

Labonte's community health promotion model incorporates an extensive planning and implementation framework. Community development is a critical component. The four components of the model are:

- Community development and involvement is utilised at the planning stages. To assess needs and ensure action strategies meet the target groups needs. Labonte's model stresses the importance of community development to empower people to take control over their issues and priorities for better health.
- Media promotion is used as a tool for health awareness raising.
- Health education is directed at changing lifestyle behaviours through development of personal skills.
- Worker advocacy is suggested as a tool for improving behaviours at the individual level and to change attitudes and social structures at the community/societal levels. The model advises that for professionals working with people, it is important to develop advocacy skills. Change is not just dependent on individual abilities or motivations; the socio-political realities influence a person's life. An individual has limited control over these spheres. It is fundamental to speak out on community issues related to mental health and justice.

By using all components of the model in planning a program, workers have the opportunity to deal with the individual factors and environmental determinants of health. The complex web of factors influencing health is addressed. The notion behind the model is to enhance personal lifestyles while challenging the hidden determinants of health.

3. Green's PRECEDE/PROCEED model (Green and Kreuter 1999)

The Green and Kreuter model is another model that can be useful for planning mental health promotion programs. This model provides a detailed account for the planning and assessment stages of a program, it is less comprehensive about the implementation and evaluation phases. The model incorporates exhaustive phases that address the range of environmental determinants that impact on people's health. These assessment, or PRECEDE, phases incorporate social diagnosis, epidemiological diagnosis, behavioural and environmental diagnosis, and educational and organisational diagnosis. Information from the PRECEDE phase forms the basis for the PROCEED or implementation phase that entails developing the mental health promotion program. For professionals interested in using the model it is quite complex and would require reasonable knowledge about the field of mental health promotion.

SUMMARY SHEET

Summary of Phases of Mental Health Promotion

1. Initially focus to determine the population at risk.
2. Ensure the planning cycle includes assessment to uncover determinants of health.
3. Ensure planning approach is developed based on consideration and knowledge of identified causes or determinants of health for the target population. These factors will affect strategies or programs designed to influence change. At the planning stage consult with all groups and key stakeholders who have an interest in the issue.
4. Develop a detailed plan for implementation.
5. Incorporate evaluation in the planning stages and as an integral part of the implementation to measure how efficient, effective and equitable the activities are. Planning needs to incorporate sustainability of a program.
6. Set parameters during the planning process. It is not possible to change or control everything; therefore, develop activities based on the premise that what is going to be done will make a difference while being manageable.
7. Plan to work intersectorally. The complex web of mental health determinants requires interventions that involve a range of sectors and disciplines.
8. Implement the program.
9. Evaluate the program.

Tools for Action

Health promotion uses a variety of methods to achieve its goals including:

- Education and information to alter a person's behaviour by giving them information intended to influence their attitude and skills.
- Advocacy to promote change or get issues of concern on the public agenda.
- Social marketing, which encompasses strategies such as public relations, awareness raising, use of a range of communication channels and media briefings.
- Legislation and economic regulation.
- Mediation, which means balancing and reconciling competing interests in society for the pursuit of health.
- Intersectoral collaboration.
- Community development and community organisation.
- Preventive health services.
- Monitoring research and evaluation.
- Organisational and workforce capacity building.

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CHAPTER 5

Suicide Intervention

5.1 Introduction
5.2 Suicide Myths, Facts and Figures
5.3 Estimating the Level of Risk
5.4 Maintaining Engagement
5.5 Responding and Referring
5.6 Referral Pathways for CAMHS
5.7 Confidentiality
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5 SUICIDE INTERVENTION

5.1 Introduction

Youth suicide and attempted suicide is a major cause of preventable deaths and a significant health issue in our society. In Australia, it is second only to motor vehicle accidents as a cause of death for young people aged 15-19 years. Consequently, a wide variety of resources including information packages, training materials and courses have been developed. This chapter deals specifically with the issue of youth suicide.

In existence are several training programs that competently provide adequate suicide intervention training. The STEP manual is therefore not seeking to replicate them. Instead, workers dealing with the issue of youth suicide are encouraged to seek further information from the resources listed and/or attend suicide intervention training program such as the ASIST (Living Works) training. The Mental Health Promotion Officers based regionally in Child and Adolescent Mental Health Services can be of assistance. If you would like to receive information or suicide intervention training, visit the website at http://www.youthmentalhealth.org

This chapter provides an overview and summary of information considered useful in suicide intervention. A resource guide for some of these materials is provided at the end of this chapter; however, it is not comprehensive for all aspects of suicide intervention.

5.2 Suicide Myths, Facts and Figures

Over time a number of incorrect beliefs and myths have developed around the issue of suicide. This is unfortunate since inaccurate or misleading information can hamper people's efforts at providing assistance to young people at risk of suicide. For example, there is a commonly held myth that young people who talk a lot about suicide rarely attempt or complete suicide. If this is believed, the clear and obvious warning signs of stated intent to commit suicide could be ignored.

Many other such myths are described in more detail in the DHS Youth Suicide Prevention Information Kit (1996).

Myths that are commonly held about suicide include:

☒ Attempted or completed suicides happen without warning.

☒ If a person attempts suicide and survives, they will never make a further attempt.

☒ Once a person is intent on suicide, there is no way of stopping them.

☒ People who threaten suicide are just seeking attention.

☒ Talking about suicide or asking someone if they feel suicidal will encourage suicide attempts.

☒ Marked and sudden improvement in the mental state of an attempter following a suicidal crisis or depressive period signifies that the suicide risk is over.

Fortunately, there are now numerous sources of detailed and accurate data related to suicide in Australia *(listed in the resource guide at the end of this chapter).* Many identify trends and risks related to suicide using broad demographic data. This information is useful for health promotion and preventive work, but can be more difficult to utilise effectively in specific clinical situations where you may have a person at risk that requires immediate help. Some of this data is explored below.

Overall trends

- The overall suicide rate in Australia has remained relatively constant over the past 100 years,
- There has *not* been a huge increase in the *overall* rate of suicide. Suicide rates for all ages have remained between 12 and 16 per 100,000 in Australia.
- The rate of youth suicide has increased over the past 30 years. Since the 1960s, rates for male youth suicide have tripled, and rates for young women have also increased but to a lesser extent.
- In the mid-1990s, it appeared that the rate of youth suicide was levelling off; however, more recent data indicate that this is not the case. Youth suicide rates continue to increase.

Age

- Suicide rates are relatively lower in children under 15 years, although numbers appear to be increasing.
- Young men and women (15-24 years) have significantly higher rates of suicide and self-harm than the general population.

Gender

- Young women have higher levels of attempted suicide and deliberate self-harm than young men (around four to five times the rate).
- Young males (15-24 years) have completed suicide at rates that are at least four times higher than that of young females. A factor accounting for the difference in the rates between males and females is that males use more violent means such as firearms

Geography

- Australia has a high rate of youth suicide compared with other industrialised nations, and is generally ranked in the 'top 10' among Western developed countries.
- Data suggests that suicide rates in more remote rural areas are significantly higher than in metropolitan and large regional centres, although further research is required.

5 SUICIDE INTERVENTION

High Risk Groups

Among young people, there are a number of more marginalised groups that have a higher risks of suicide than the general population:

- Indigenous/Torres Strait Islander young people.
- Same-sex attracted young people.
- Young people from a refugee background.

Issues related to these higher risk groups are outlined in chapters 6, 7 and 8.

Within the suicide research literature, a number of additional social and environmental indicators are mentioned. They include marital status, employment and education, homelessness, family breakdown, mental and physical health status, drug use/substance abuse, past history of abuse, financial hardship, and so on. Further research is continuing in many of these areas and we will also consider them as we examine risk factors in more detail.

Resilience

Glover et al. (1998) has identified a number of key elements that contribute to the resilience and emotional well-being of young people. In summary, these comprise:

- The need for young people to feel safe and secure in their home, school and overall environment.
- The ability to communicate openly and honestly with at least some people in their lives.
- Positive regard from others—person/s who express a level of care and respect for them.
- The opportunity to develop new skills, abilities and to make some mistakes as they learn.

5.3 Estimating the Level of Risk

Estimating the level of risk a young person is experiencing remains a key element of suicide intervention and an area of concern for many workers. Cases involving the risk of suicide often create a high level of emotion and considerable anxiety in workers. The possibility that a young person we are working with could kill themselves would understandably make most of us quite anxious. Yet, despite this natural anxiety and concern we are able to intervene effectively. *If we know what to look for, it is possible to get a clear sense of risk in the context of a trusting relationship with the young person.*

To avoid fear and anxiety clouding our professional judgement, it is important to use an objective measure of risk based on sound information and knowledge of risk factors. A number of risk assessment frameworks currently exist *(see resource list)* that describe similar risk factors. Risk assessment can be seen as having three main elements:

- **Broad risk factors:** What does demographic and population data tell us about the possible risk?
- **Warning signs/risk indicators:** What tells us that a young person might be contemplating suicide?
- **Immediate risk estimators:** If a person is considering suicide, how immediate is the level of risk?

Broad Risk Factors

We have already looked briefly at some of the data on age, gender and other population and demographic data. While this information can give us some idea about general trends, it is not very useful in understanding the individual risk for a young person. For example, we may know that unemployed rural males aged 15-24 years have a statistically higher risk of suicide, yet this does not mean every unemployed rural young male that we see will be suicidal. Broad risk factors and demographic information only give us information about general trends. We require far more specific information.

Warning Signs and Risk Indicators

Here we begin to focus on the individual young person. What thoughts, feelings, or behaviours are they showing that may indicate they are considering suicide? Some of the more common warning signs include:

- Sudden and marked changes in behaviour, including changes in eating and sleep patterns.
- Withdrawal from family, friends, and school; loss of interest in social activities previously enjoyed.
- Changes in mood including irritability, agitation, ongoing sadness and unexplained crying.
- Persistent sense of failure or unworthiness, and/or a sense of hopelessness and feeling helpless.
- Preoccupation with themes of death (can be evident in conversation or art, poetry and music).
- Increased levels of risk-taking behaviour, such as drug/alcohol/substance abuse.
- Giving away possessions and tidying up affairs (sometimes a sudden lifting in spirits).

While many of these warning signs are fairly clear and obvious, others are subtler and less easily seen. If we work with young people, we already know many exhibit some of these signs as part of the normal stresses of adolescence, and this adds to the challenge of determining whether something is a risk factor or not. Therefore, it is important to look at the context in which the signs are occurring. Factors to consider include:

- What is 'normal' behaviour for this young person? Be alert for marked changes in behaviour and for recurring patterns rather than isolated one-off events.

- What kinds of stress have they been experiencing in their lives recently? Look for recent losses such as deaths and relationship breakdowns, as well as other possible stressors such as school, family, peers, even things like pending court appearances and so on.

These warning signs/risk indicators do not tell us exactly if a young person is suicidal or not; instead, they are a starting point. They alert us to the possibility that this person may be contemplating suicide, and should prompt us to get more detailed information about risk.

If we have some concerns about the young person based on warning signs/risk indicators being evident, the next key element in establishing suicidal risk is to *ask directly if the young person is considering suicide.*

Asking the young person directly about suicidal thoughts will not encourage them to suicide. Rather, it indicates to the young person that you are comfortable and prepared to talk about suicide, and this generally encourages them to begin talking more openly about the issue. There are many ways to ask a young person about suicide, such as:

- 'Are you thinking of killing yourself?' (Very direct.)
- 'Do you ever feel so down that you feel like harming or killing yourself? What about right now?'
- 'Sometimes when people have lots of hassles like you're having, they think about suicide. Have you been thinking about this?'

Whatever approach we choose, if we are specific and open in our questions and have engaged properly with the young person, they will generally answer honestly. Once we know a young person is thinking of suicide, we can estimate how severe or immediate the risk.

Immediate Risk Estimators

When we get a 'yes' response to a question about suicide, clearly we know we are dealing with a young person at risk. Then it is vital to estimate how immediate the level of risk is. Therefore, we need to obtain further details about the:

- **Current plan:** Has the young person planned how they would suicide? How prepared and detailed are their plans? Have they determined how, where and, most importantly, when they intend to suicide? What method have they chosen and do they have access to the means such as firearms or medication? A more detailed specific plan generally indicates a higher level of risk.
- **Previous attempts:** Prior suicidal behaviour greatly increases risk. Have they made previous suicide attempts? Have family members, friends or other people they know attempted or completed suicide? A history of previous attempts or exposure to suicidal behaviour of others can indicate increased risk.
- **Resources available:** Again, we need to examine the context in which the behaviour is occurring. How alone does the person at risk feel? Do they feel the situation is hopeless and no one can help? What supports/resources are available that they can identify? A young person who feels alone and believes nobody or nothing will help is at greater risk.

By obtaining information about these areas, we are now able to make a more accurate risk estimation and let the young person know of our concerns. We have also begun to gather information about resources that will be useful in developing an effective intervention strategy.

5.4 Maintaining Engagement

The first step in the counselling process is difficult. How do you encourage young people to seek help and continue to want to return? Establishing and maintaining engagement is a crucial part of providing support for a young person. Fuller (1998, p. 31) describes a familiar scenario where 'adolescents start any interview with their favourite words "dunno" and "what?". More often than not this is accompanied by a well-practised shrug of the shoulders and a gaze that would seem to indicate a fascination with the colour of the carpet. For the counsellor, a perplexing challenge has just begun: how to engage this young person.'

Engagement involves understanding what is needed to have a young person want to talk to you. As a worker, it is important to consider the significance of your own values and judgements in the process of accommodating the young person. Such adjustments may relate to getting the right mix for each young person in how you 'are' with them, how you can convey a capacity to listen, be open, flexible and curious without sounding like an adult offering the same old judgements and advice.

These adjustments may also relate to the environment. The traditional office setting needs to be user friendly for young people who may have real difficulties with formal, structured arrangements. Being prepared to meet in other locations, outside the confines of an office, may assist a young person to relax and have a greater sense of control over their situation *(see also chapter 3).*

When dealing with young people who are suicidal, the issue of engagement is clearly a central concern. However, the situation becomes potentially more complex as issues of how best to maintain a young person's physical safety also come into play. The process of carrying out a risk assessment should not compromise the engagement process.

5.5 Responding and Referring

Client Confidentiality

When working with young people who may be suicidal, the initial primary focus is to ensure their physical safety to prevent the suicide or deliberate self-harm. This may present a dilemma for us in terms of our professional responsibility in maintaining client confidentiality. For instance, to ensure the physical safety of a young person, there may be occasions when other services need to be brought in, which means the normal boundaries of confidentiality need to be breached. It may be difficult to gain permission from the client to share information and to engage the other service. It is important to understand what your organisation's policy is concerning confidentiality and informed consent. The development of inter-agency protocols may be helpful.

5 SUICIDE INTERVENTION

Duty of Care

The concept of duty of care may provide us with a framework within which to make difficult decisions. Duty of care describes our responsibility toward our clients. We have a professional responsibility to ensure the physical and psychological well-being of people under our care. In a situation where a young person is contemplating suicide, this duty of care may override confidentiality.

Working within this framework may be difficult and the situation is far from black and white. One way of dealing with the conflicting demands of client safety versus client confidentiality is to declare at the outset of involvement with the young person that there are some definite boundaries or limitations to the matter of confidentiality. This may involve a clear and concise statement to the effect that others will be brought in to assist in the event of some risk of deliberate harm to self or others.

Informed Consent

In most cases, the concept of informed consent can be used to involve other services. This entails negotiating and obtaining agreement from the client before referring to and utilising other services. For instance, a worker may reach agreement with a young person for the need to involve an appropriate counsellor where drug and alcohol issues are seen as a part of the presenting problem. Informed consent may also need to be negotiated when involving parents and family, particularly if the young person is living independently. This may also apply to involving other services.

In some cases, to ensure a young person's immediate safety, it may be necessary to involve other services without the consent of the person at risk. This may be in the case of a more disturbed young person who requires admission to a mental health service where police are used to transport them.

Ultimately, decisions about involving other services or people with or without the consent of the young person at risk depend on an accurate assessment of the level of suicide risk. It is important to keep the young person informed about decisions made to ensure their safety, even though there may be continuing concerns about compromising engagement.

It is important that workers remain aware of the distinction between *different levels of involvement* such as suicide intervention, psychological counselling and treatment. Although it is not always possible to entirely separate these three, they do both conceptually and practically represent different levels of involvement.

- Suicide intervention refers to the crisis level of involvement where the worker believes a significant possibility of life-threatening behaviour exists. The focus is on evaluating the risk of suicidal behaviour in the young person, and on deciding what needs to be done to save the person's life.
- Counselling and treatment refer to a longer-term process where the issues underlying the suicidal behaviour are focused on.

SUMMARY SHEET

Suicide Intervention

The worker needs to bear in mind assumptions that are specific to the work of adolescent suicide intervention. These include:

- Suicidal behaviour may be 'a cry for help' or 'a scream for change' rather than a desire to die.
- Suicide intervention (assessment and action) may make a difference as to whether or not a young person lives or dies.
- Children and adolescents can feel as much pain, anguish, sadness and despair as adults.
- Suicidal young people almost always have some degree of ambivalence about taking their own life: one part of them wants to live, the other part wants to die or end their emotional pain.
- The part of the young person that wants to live can provide the therapeutic opportunity upon which to base suicide intervention work.
- Accurate assessment is necessary, but it is also important that the worker respects their hunches, gut feelings, and intuition. If you 'feel' a client is at risk, then they probably are.

It is useful to remember that:

- Adolescents are a distinct group in respect to their developmental stages. They are vulnerable to the psychological, emotional and physical changes occurring over which they may feel they have little control.
- Many young people lack experience and confidence in dealing with the world and may need help to access services.
- Families play a crucial role in adolescent development and may need support; however, workers need to be mindful of the medico-legal issues related to confidentiality and consent.
- A range of health and welfare services work with young people at risk of suicide. Some of these include general practitioners, community health centres and youth services. It is important to know what services exist in your area, who they work with and how to access them. It is not always essential that the mental health services become involved. However, in those cases where the risk of suicide is immediate or the sense of hopelessness pervasive, it may be appropriate for a referral to a CAMHS to be made.

5.6 Were to From Here—Referral Pathways for Child and Adolescent Mental Health Services (CAMHS)

The Child and Adolescent Mental Health Services (CAMHS) client group includes children and adolescents under 18 years of age and their families/carers who are experiencing serious social, emotional, psychological and psychiatric problems. CAMHS provide assessment, treatment and prompt crisis response. Treatment may include family therapy, parent counselling, individual therapy, group therapy and medication, if required. Referrals to the service can be arranged through:

- General enquires through the intake team or triage service in the region. In some areas, this may be a Monday to Friday service only.
- After-hours emergency referrals through accident and emergency departments, psychiatric registrars and community teams.

If necessary, a crisis appointment will be made. Otherwise one of the intake teams will consider the issues of the case, there will be a decision made about the priority of the intake. There is generally a waiting period. At the arranged appointment, the young person will have a case manager allocated and then there will be an assessment and formulation of a management plan.

The case manager will conduct a psychiatric assessment and coordinate a range of therapies to care for the young person. This generally entails:

- Interviews with the young person, parents/carers, family and other relevant persons.
- Diagnosis and formulation of a management plan
- Management that may include general support, individual therapy, family therapy or group therapy, medication, behavioural therapy and so on.

Secondary Consultation

There may be occasions when the use of secondary consultation is deemed helpful. Secondary consultation occurs when a worker needs to seek the advice of another worker to bring additional expertise to the case management. This may reduce the need for referral and allow the primary worker to maintain continuity of contact with the young person. Secondary consultation may assist the primary worker to feel more competent to manage the situation or provide information and support to ensure appropriate referral occurs. In the case of rural workers, secondary consultation is often the only option. If specialist services are appropriate and available, then referral should be made. It may involve seeking advice from more experienced staff from within a service or from an external agency with particular expertise.

Facilitating Access

If the decision is made to refer the young person to another worker for ongoing counselling or medical care, it is crucial this is done with the knowledge that young people are vulnerable to not accessing services. Many services report low attendances of voluntary clients in the 15-24 age group, as well as poor attendances at follow-up appointments. Referral pathways need to be in place and the young person may require support in a number of ways to take up and engage with another service.

Facilitating access is an essential component of the worker's role when working with vulnerable young people. Workers will benefit from knowing about available referral services when working with young people in crisis. A young person is likely to be far more confident making contact with the name of another worker who is known and recommended than if only a telephone number and agency name is given.

Adopting an advocacy role may also support a young person who is fearful and lacking confidence and information. To advocate does not mean to take charge but rather sensitively clarify degrees of self-reliance, confidence or anxiety that the young person may be feeling and then offer appropriate levels of support. This may take the form of offering to stay in the office while the person telephones the new agency, or telephoning the new agency in the presence of the young person on their behalf. Advocacy may also mean offering to go with the young person on the initial contact and arranging a meeting that is as comfortable as possible with the other worker.

Following through is important. Often, young people at risk simply do not go back to a service with which they feel uncomfortable. The crisis/advocate worker needs to ask the young person how the contact went and continue to sensitively promote the engagement process as appropriate. The role of support may need to continue for awhile (for example, if counselling sessions are too infrequent to meet the immediate needs of a young person in crisis).

5.7 Confidentiality

The CAMHS worker obtains information about others in many ways including observation, public records, disclosure by individuals or people associated with clients, and from other service providers and health professionals. It is essential to be aware of the legislation and principles around how this information is shared.

Confidentiality, and thus control over the flow of information, belongs to the person receiving the services. They should decide who can be given information about their situation, although this may occur in collaboration with the mental health worker. Where the person is a child or a very young person, this collaboration may be with the parents or guardian. Deciding how much information is given to the family requires taking into account the age and wishes of the child or young person, what is in their best interests, privacy and duty of care. However, the law does not compel confidential information to be given to the family.

5 SUICIDE INTERVENTION

CAMHS staff have legal, professional and ethical obligations in relation to confidentiality. The legal frameworks most relevant to child and adolescent services are the *Mental Health Act 1986* and the *Children and Young Persons Act 1989.*

Section 120(a) of the Mental Health Act prohibits any member of a mental health service from disclosing information in relation to people who are, or have been, receiving mental health services, except in some specific situations. These include when the information is given:

- With the client's consent.
- In general terms.
- To a primary carer because the information is reasonably required for the care of the person to whom it relates.
- In connection with further treatment of the person.
- To a court in the course of criminal proceedings.
- Under prescribed circumstances to the Secretary of the Department of Human Services.

The Children and Young Persons Act specifies that in instances of child abuse, notifications to Protective Services or giving them information in the course of an investigation do *not* constitute a breach of section 120A or of professional ethics. In addition, this Act protects the notifier from being identified (sections 64 and 67). Indeed, under section 64 (1A) it is mandatory for specified professionals to report such abuse.

It is also important to realise that information can be shared to facilitate better treatment. Mental health workers hold the view that confidentiality should not obstruct effective cooperation between a range of professional staff providing services to children and their families. Where safety is an issue, mandatory reporting requirements or duty of care may take precedence over confidentiality. This point has special importance where there is a risk of harm to others or self (for example, suicidality).

The young person receiving mental health services should always be informed about confidentiality and how it applies to them using terminology that is easily understood. Consent to sharing information should always be obtained where appropriate. This process is intrinsic to a trusting relationship between the mental health professional and the client. (Source for above information Mental Health Branch (1998), Aged, Community and Mental Health Division and Youth and Family Services Division (1998).

SUMMARY SHEET

Some General Risk Factors for Youth Suicide

- Youth suicide is a significant health issue and is likely to remain so in the future. With appropriate information and training, we *can* identify and assist young people at risk of suicide.
- Demographic information informs us that certain groups are more vulnerable to suicide. By understanding this, we can routinely consider, 'Is this young person at risk of suicide?'
- Young people at risk of suicide generally give clear warning signs. Information about warning signs/risk indicators helps us determine if a risk of suicide may be present.
- If warning signs/risk factors are evident, we *ask the young person directly if they are having thoughts of suicide.* We then estimate the level of risk by asking about current plan, prior behaviour and resources.
- When we identify risk of suicide, it is important to develop a clear action plan to ensure the immediate safety of the person at risk. Where possible, we do this with the person at risk and may involve other people and services as resources and supports.

Possible Risk Factors for Youth Suicide

- Mental illness (depression).
- Prior attempts (self or significant other).
- Family stressors.
- Social and cultural factors.
- Biochemical and genetic factors.
- Risk-taking behaviour (drug and alcohol).
- Individual skills (hopelessness, lack of coping skills and isolation).

Possible Precipitating Factors for Youth Suicide

- Recent loss of significant other.
- Major disappointment.
- Suppression of emotions.
- Lack of resolution of psychological crisis.
- Unable to be self (peer pressure).
- Fear of rejection or prediction of punishment.
- Sexual identity conflict.
- Experience of injustice.
- Negative experience of education (leaving system or failure).
- Negative media coverage of suicide. This can include film, television, radio or print.

5.8 Loss, Grief and Bereavement

Grief is a significant issue for the young people especially those from STEP's identified group. Throughout the manual there is constant reference to grief and loss, it is important to recognise the significance of grief for young people. Bereavement is loss of someone or something loved and cared for, and grief is the resulting emotional experience of being bereaved. Grief is a natural response to death.

Loss as Part of the Transition from Adolescence to Adulthood

For some young people, leaving the protected and dependent phase of childhood may be experienced as loss, although for others this may be a relief. Moving through adolescence to adulthood involves meeting community expectations about new roles and responsibilities. For some young people this transition can have significant emotional and psychological effects. These effects can at times impact so negatively on a young person that suicide is contemplated.

For young people, there are some specific experiences of loss that may relate to their developmental experiences such as:

- Parents or other important people separating or getting divorced.
- Moving away from home.
- Leaving school or university.

Loss accompanied by grief can be experienced following a number of life events, including suicide. There are many types of loss:

- Losing a loved one through death.
- Ending a relationship.
- Losing a job.
- Losing a home through disaster, such as bushfire.
- Having an abortion.
- Being forced to give up something you want to keep, such as a child, home or job.
- Having a miscarriage.
- Separating from friends or community.
- Being unable to have children.
- Losing the ability to do some things through disability.
- Becoming very sick, or seeing someone else become very sick.

Loss Experienced by Indigenous, Refugee and Same Sex Attracted Young People

These young people may experience any of the losses described above, but their diversity puts them at risk of specific grief experiences.

- **Indigenous young people:** Young people who identify as indigenous may experience the inheritance of loss of land and culture, the formally sanctioned removal of children from their families in previous generations, and the breakdown of the tribal culture.
- **Refugee young people:** Refugee young people experience loss of home, community, lifestyle and, possibly their family. They may lose a sense of feeling safe and secure. The may also experience a loss of identity, psychologically and in a practical sense, as with no papers it is difficult to access services.
- **Same sex attracted young people:** The experience of loss for same sex attracted young people arises from community attitudes toward people who are not heterosexual. This may involve loss of self-esteem, friends, family relationships, the capacity to openly identify as same sex attracted, and education due to prematurely leaving school. SSA young people may also experience the loss of feeling safe and secure due to the violence sometimes perpetrated on people identified as not heterosexual.

Reactions to Death—Stages

Loss as a result of death can be an extremely emotional and psychologically painful experience. Vulnerable young people who experience such a loss may be at heightened risk of suicide or deliberate self-harm.

Anniversaries can also be very painful times when the memories of the person, and the loss experienced, can come flooding back. It is important to recognise these times, prepare for them, and accept them.

Dr Elisabeth Kübler-Ross (1970) first defined stages of grief for people who were dying. The Community Mental Health Centre, Bendigo (1985) outlined the following stages for those left after the death of a loved one:

- **Loss:** Encompasses feelings of emptiness.
- **Numbness:** A protective mechanism that shuts down emotions and stops any more feelings of hurt.
- **Anger:** Feelings of indignation, rebellion and resentment that a person who was cherished has been taken away. People may feel self-pity and wonder why it has happened to them, what they have done to deserve this, why have they been singled out. They may want someone to blame.
- **Denial:** Refusing to believe that the person is dead, hoping that their death has not happened, and that they will return.
- **Acceptance:** When the anger burns out and the denial fades, acceptance begins and reality prevails.

- **Letting go:** With acceptance, the bereaved person can begin go let go and look to the future.
- **Regrowth:** May take a long while to complete. Sometimes people continue to look back or return to previous stages. Eventually, life returns to normal. This is not to say that a gap will not remain that represents the person who has died.

The stages set out above are not separate and distinct in real life—they overlap. Each individual or stage will take varying amounts of time, depending on a variety of factors such as the amount of support available.

5.9 Reactions to the Death of Someone by Suicide—Specific Issues

This section uses material from New South Wales Health Department (1998).

If a family member has died from suicide, the family may:

- Be embarrassed and fear they will be judged negatively.
- Feel guilty about not being able to prevent the death.
- Feel inadequate that the person who died did not ask for help.
- Feel any signals of distress from the person should have been noticed.
- Have personal fears of also committing suicide.
- Feel abandoned by the person who died.
- Constantly ask 'why'.
- Blame someone within the family (that the behaviour of a family member provoked the suicide).

Postvention

Postvention is a purposeful response following a critical and/or traumatic incident. Critical Incident Stress Debriefing is intended to take place immediately following the traumatic incident such as a suicide and may be seen as the first stage of postvention. Grief and bereavement counselling may be seen as the second stage of postvention where the longer-term effects of trauma and loss may be dealt with.

In connection with youth suicide, postvention work focuses on the prevention of imitative suicidal behaviour, and the emotional consequences of those bereaved. Shneidman (1973, p. 385) refers to postvention as 'those things done after the dire event has occurred that serve to mollify the after-effects of the event in a person who has attempted suicide, or to deal with the adverse effects as the survivor-victims of a person who has committed suicide'.

While critical incident debriefing often utilises the support available from working within a group context, there is evidence to suggest young people may be more vulnerable to imitative behaviour than the general community. Therefore, group suicide postvention strategies specifically

designed for young people are discouraged. Young people who have been exposed to the death of a peer by suicide are in the high-risk category for suicidal behaviour. The most helpful setting is one-to-one opportunities where the worker is mindful of these facts.

Appropriate staff should commence procedures for dealing with the effects of a fatal incident on young people by identifying those affected. Immediate counselling and support should be offered within 24 hours. This may include attention to 'the facts' as perceived by different individuals and allowing space for them to tell how they experienced the events. It is essential that people be encouraged to express their feelings and be reassured that grief reactions are natural and normal. People need to explore and observe any changes such as self-destructive thoughts or residual grief reactions from past unresolved matters, as well as noting changes in behaviour within significant relationships. Opportunities for ongoing and longer term counselling and treatment should also be available. Identification of support networks may be important, as are self-care strategies. When appropriate, procedures should be in place to ensure workers responsible for ongoing care of young people associated with the incident be made aware of young person's at-risk history.

Media portrayal can be a significant factor that may influence copycat suicides. Imitative behaviour can be a consequence of sensationalised media coverage where young people are vulnerable to 'taking on' certain types of portrayals of completed suicide, such as the death of Kurt Cobain. Those young people that are peripheral to the suicide can be at increased risk for suicide as they do not observe the devastating emotional trauma associated with a suicide, only the more 'sensational' aspects. The Federal Government has produced 'a resource kit for Australian media professionals for the reporting and portrayal of suicide and mental illness'. The document is available via the Internet at http://www.health.gov.au/hsdd/mentalhe

School Response to Youth Suicide—Postvention

Leenaars and Wenckstern (1973) set out the principles of postvention in schools. These include:

- It is important the school community acknowledge the suicide of a school member.
- In working with survivor victims of suicide, it is best to begin as soon as possible after the tragedy with children at the school.
- Resistance may be met from some survivors; some will be willing to have the opportunity to talk to professionally trained people.
- Negative emotions about the deceased person, or about the death itself, need to be explored such as irritation, anger, envy, shame or guilt.
- The person intervening should play the important role of reality tester: remembering the person as having strengths and weaknesses, openly acknowledging the suicide, but arranging a ceremony of commemoration.

- Referrals should be made to community services where required.
- It is important to be acutely observant of the students' mental health.
- Where post-traumatic stress disorder (PTSD) is an outcome for a young survivor, recovery from the disorder may take a long time.

Cobb (1990) developed guidelines for dealing with death or traumatic events in the school community after an incident at a school in Michigan USA:

- To provide support to those of the educational community when one of ours is lost.
- To acknowledge the death and affirm the life of the survivors.
- To provide an organised, systematic, but flexible approach to dealing with tragedy.
- To demonstrate that the grieving process is a natural part of the chain of events following any loss.
- To reflect on the significance of that member to the school.
- To allow the school to make a tangible response to defined immediate survivors on behalf of the school.
- To bring consolation and comfort to the group.
- To provide follow-up resources for survivors.

The postvention response is critical for reducing the risk for suicide amongst fellow students and to ensure young people have an opportunity to learn to deal with their grief appropriately. It is important to take care the response does not to 'glorify' the death or 'normalise' the suicide.

5.10 Resources

The Compassionate Friends Victoria Inc. is part of a worldwide organisation of bereaved parents caring for one another. The Compassionate Friends seek to help through understanding and supporting one another. The organisation provides support to parents and surviving brothers and sisters through 24-hour telephone access grief support groups, newsletter, library and literature. Information is available from:
267 Canterbury Road
Canterbury 3126
Tel: (03) 9888 4944
Fax: (03) 9888 4900.

Lifeline: 24-hour crisis counselling service.
Tel: 13 11 14.
Applied Suicide Intervention Skills Training (ASSIST) is widely available. Contact Lifeline for information on who runs the training in your area.

Victorian State Coroners Office, Grief Counselling and Support Service provides bereavement support following a suicide.
Tel: (03) 9684 4444
Rural Victoria: 1800 136 852

National Association for Loss and Grief. (NALAG)
Tel: (03) 9331 3555

The Canadian **Suicide Information and Education Centre** (SIEC) provides an extensive database of over 21,000 references on suicide. Many resources on bereavement after suicide may be located through keyword or author searches within this database. The database is available on CD-ROM but may also be accessed on the World Wide Web at http://www.siec.ca

South Australian Department of Human Services, Youth Health Information/Child and Youth Health/Healthy Mind at http://www.cyh.sa.gov.au/

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CHAPTER 6

Indigenous and Torres Strait Islander Young People

6.1 Introduction

6.2 The Stories

6.3 Adolescent Development

6.4 What Research Has Taught Us

6.5 Cross-Cultural Issues for Consideration When Working with Indigenous Communities and Young People

6.6 Recommendations

6.7 Resources

6.8 References

6 INDIGENOUS AND TORRES STRAIT ISLANDER YOUNG PEOPLE

While data was generally inadequate, available evidence of a systematic kind indicated that indigenous people suffered mental health problems such as depression at a very high rate, compared to non-indigenous people, that rates of self-harm and suicide are higher, and that substance abuse, domestic violence, child abuse and disadvantage contribute additional risk factors. Trauma and grief were seen as overwhelming problems, both related to past history of loss and traumatisation and current frequent losses with excess mortality in family and kinship network. Indigenous people perceived mainstream mental health services as failing them, both in terms of cultural understanding and response, and repeatedly identified the need for indigenous mental health services, which took into account their concepts of the holistic value of health and their spiritual and cultural beliefs, as well as the contexts of their lives.

Swan and Raphael (1995, p. 1)

6.1 Introduction

The reasons for poor mental health status and high rates of suicide among indigenous young people are well established. These reasons fit within the Iceberg Model's determinants of health and need to be understood within the context of loss of social identity, culture and self-esteem, and lack of opportunities. In general, non-indigenous people's understanding of the determinants of mental health and well-being of indigenous people have become more widely established. However, responses to influence these determinants have been largely unsuccessful. Consideration of indigenous self-determination in a supportive social environment is primary to success of any program. During strategic planning stages, collaboration and consultation with peak indigenous groups needs to occur prior to any allocation of funding.

During the development of the STEP Project, there was considerable liaison and negotiation with peak bodies concerned with indigenous health and well-being. In respect of the indigenous communities and co-operatives differing cultural beliefs and practices, developing a singular view on what constitutes appropriate training of professionals working with indigenous young people appeared inappropriate. Rather, it became apparent through consultations with various co-operatives that a collaborative approach requires the privileging of their own stories.

The chapter sets out the stories of the indigenous groups that participated in discussions with the STEP Project Coordinator and the regional Mental Health Promotion Officer (MHPOs). The stories are told by members of various indigenous community controlled health organisations. It was intended that the information gathered would inform development of training to meet the needs of indigenous young people at risk of suicide. Instead the information gathered has been set out below to provide some insight into the views of community members from a range of Victorian indigenous communities.

The remainder of the chapter attempts to bring together a framework to illustrate some understandings of indigenous young people's experiences. Erikson's model has been used to explore the information from the consultations and broader research material. Some cross-cultural information is presented to assist professionals. A series of recommendations are also set out.

6.2 The Stories

The purpose of the STEP consultations was to consult with indigenous workers and community members from community controlled health organisations to discuss the issue of youth suicide. The next step was to plan a local training day about indigenous youth suicide based on the local information. It was intended that the local training would be community driven and facilitated. The STEP Project Coordinator and the regional MHPO would be available for support and would use project funds to cover the cost of the training sessions. From the perspective of the indigenous workers and the young people, there was constructive debate and discussion about the issue of indigenous youth suicide. The consultations did not evolve into training sessions during the life of the STEP project. However, there are prospects of training developing in some communities following on from the project.

The consultations involved:

- Explaining the STEP Project.
- Exploring key issues in indigenous youth suicide.
- Gaining a clear understanding of the current local response.
- Determining indigenous workers' concerns.
- Planning the regional training sessions together.

Youth suicide in indigenous communities was acknowledged as being of grave concern. Indigenous workers and communities members felt the most appropriate strategy was to educate the community and family members about suicide intervention so they could identify, know how to intervene, and be informed about suitable contacts for dealing with youth at risk of suicide. As the high risk for suicide arises, in part, from a lack of control and self-esteem, the difficulty lies in meeting the community's need for self-determination.

The following consultations are the stories as discussed by each community consulted in the course of the STEP Project. The information is set out under regions that took part in the process. The information provided by indigenous workers remains their 'property'. It has been reproduced as a way of acknowledging indigenous workers and communities' concerns, and to assist in reducing the incidence of suicide among their young people.

Robinvale

Present:
Mildura Base Aboriginal Liaison Officer
Manager Indigenous Unit—TAFE
Chairperson Aboriginal Education Consultation Group
NSW Aboriginal Police Liaison Officer
Family and Community Services (FACS)

- Workers within the cooperative skill themselves with suicide intervention skills to permit greater opportunity for Aboriginal Co-operative involvement in future funding opportunities. If the training meant workers received certificates, their skills are formalised and 'recognised' by external service providers in addition to permitting help to be available within the Indigenous community.

- The issue of youth suicide is so urgent in the community that immediate work will need to focus on intervention before it can move to prevention.

Wodonga

Over the past few months, meetings took place and culminated in a proposal for a series of forums. The meetings were generated through the STEP Project. Prior meetings were directed at developing training in conjunction with key indigenous workers from Wodonga. There was a degree of concern about the process and the expectations on local indigenous workers. It was determined that a better process would be to take a collective approach that entailed a general consensus. The forums were suggested as the most suitable way to support this course of action.

The forums were proposed following a meeting between members of the Mungabareena Aboriginal Co-operative, the regional Mental Health Promotion Officer (MHPO) based at North Eastern Child and Adolescent Mental Health Service (NECAMHS), and the STEP Project Coordinator (Statewide Training and Education in Youth Suicide Prevention Project).

The forums were intended to encourage participants to share knowledge and beliefs about a range of issues relating to reducing the risk of suicide of local indigenous young people. Each forum had a nominated facilitator. The information gained was meant to lead to a training session for the local community. It was agreed that any process instigated as a result of the forums would occur in collaboration with the forum participants, the MHPO for NECAMHS and the STEP Project Coordinator.

Information and issues discussed during each forum where be put together into notes for distribution to participants.

There were to be six forums based on the information first proposed for the training session. These topics included:

- Historical context.
- Worker issues.
- Working day.

Forum One: Historical Context

At the beginning of the forum, the facilitator assured participants that the discussion was intended to be relaxed and people were not expected to talk about personal or sensitive issues. There were a small number of participants at the forum; however, the discussion was constructive and meaningful.

The facilitator began with a teaching tool he had devised. It was a map of Australia pinned to a polystyrene box. Everyone was asked to use a pin to indicate where their family came from originally. The purpose of the exercise was to contemplate the notion of diversity of origin, and provide people with an opportunity to talk about ways of dealing with particular situations.

There was a general discussion and explanation about the origins of families shown on the map. The conversation brought to light a range of experiences shared by most indigenous families. The strength, importance

and meaning of extended kinship were quite evident, as was the enormous impact of transgenerational loss and shared grief. People described a lot of movement from their place of origin.

The stories about indigenous families illustrated the dramatic change indigenous people were forced to make when moving from a traditional to European lifestyle. Many families were forced to make these changes instantaneously, under circumstances that worked against them succeeding. Indigenous people seemed to find ways to manage living between the cultural divides.

The enormity of grief for indigenous people was discussed. A few resources concerned with the history of indigenous grief were mentioned such as *The Seven Stages of Grieving.* It is a play written by an indigenous person. It is about the seven phases of indigenous history and may be used as part of the curriculum by some schools in NSW. Another relevant resource is *The Little Red, Yellow and Black (green and blue and white) Book. A Cultural History of Australia* was a handed out and discussed.

It was pointed out that when indigenous people discuss the issue of pain and loss, they expose themselves to more hurt and pain from people who do not understand. It was suggested that this has implications for training because people will be exposing themselves to more grief.

Forum Two: Worker Issues

The session commenced with a 'brainstorm' about worker issues that were then elaborated on by the group. The following points outline the discussion and the issues of concern to indigenous workers.

The discussion mostly centred on the issues; possible solutions were only touched upon. However, everyone felt comfortable about raising issues without reaching firm solutions to reduce the overwhelming burden for indigenous workers.

Confidentiality

- As an indigenous worker, you are not only working with your local community, but also your own family (family for indigenous people means well beyond the nuclear family).
- As a worker, you work and live in the indigenous community.
- There is a fine line between what is work and being a member of the community.
- As a worker, it is frustrating to observe misunderstanding/minimising of an issue as it exists in the community.
- As an indigenous worker, you cannot just go home and switch off. It is difficult to get the community to understand that you're off duty.
- Indigenous people see you as a person, not a professional or worker. This creates a difficult situation when you are bound by your professional codes and your community does not understand these. This has implications for being called upon by the community seven days a week.

- There is a lack of resources
- Inflexible schedules are not appropriate when working with indigenous clients.

Language

- The indigenous language is similar to English so teachers accuse indigenous students of using slang, and they are reprimanded and told not to do it again.
- Indigenous students using Aboriginal English are regarded as having poor language and writing skills.
- There is an urgent need for the wider community to accept or recognise the bilingual ability of indigenous young people.

Difficulties indigenous workers encounter when working with mainstream workers

- When an indigenous worker takes an indigenous family to a mainstream service provider, often the workers will be condescending toward the family. The mainstream workers often hold the perception that indigenous people do not speak English, or know how to read or write.
- In these circumstances, the indigenous worker becomes the 'meat in the sandwich' and is caught between the cultural divides.
- Most schools teach through verbal instruction. This is not necessarily the learning style of the indigenous people. There is a need for teachers to use aids and hands-on approaches or demonstration.
- There is a need to recognise and attend to differences in learning styles.
- The issues being raised should be understood within the context of the broader sociological processes at work.
- There is a need to have service providers accept reality; that is, to accept who indigenous people are and how they live.
- Performance indicators are an unrealistic means of evaluating and measuring the worth of an indigenous program/worker. There needs to be re-evaluation of assessment methods. They need to be more in tune with holistic approaches. 'Attendance is one thing, all the other aspects of the service provided are important too, but not measured.'

Burnout

- Indigenous workers generally have to deal with three levels of expectations: from management, fellow workers and the indigenous community. The expectation is that because you are an indigenous person, you should understand and know how to handle particular issues.
- As an indigenous worker, there is a large degree of feeling personally responsible for any indigenous people who are not well looked after by your service.
- People from minority groups face so many difficulties that they need to prioritise which issues they will battle or they will only burn out.
- Burnout becomes a problem at home and your children suffer by feeling the brunt of your stress.

- A consequence of burnout is that some workers will opt out, and the rate is higher for workers from minority groups. As an indigenous worker, there is less opportunity to escape from an issue when you go home because you are confronted by the issue when you go out into the community.

Debriefing

- As an indigenous worker, you prefer to approach someone from the community to debrief with because you feel you relate better and they will understand.
- When debriefing with a non-indigenous worker, they often do not understand your perspective, and time is spent explaining. This adds to your stress and frustration.
- Management perceives that when you are catching up with an indigenous worker you're wasting time. This meeting is an important opportunity to debrief. It was suggested that if this process was more formalised, management might be more supportive of it.
- A decision was made to pursue setting up a local peer support group of indigenous workers to meet regularly, at a neutral venue. It was decided that one of the indigenous workers would a proposal that will be reviewed by fellow workers for ratification, then be given to management. This particular group may present an opportunity for dealing with confidentiality.
- Another suggestion included developing a local critical incident management plan with a database of workers to call on when the need arises.
- Assertiveness training may assist indigenous worker with some of the difficulties.
- There was a suggestion that indigenous workers would benefit from information about the grief process and understanding how grief affects people.

Forum Three:

The session focused on statistical information about youth suicide. It has been removed as it was felt that the material did not communicate the groups personalised understanding of contributing factors for suicide amongst indigenous young people.

Forum Four: Working Day

The purpose of the forum was to shape the information discussed in previous forums so it would be suitable for use as a training tool.

The initial discussion deemed that it would be most suitable to develop training that was directed at two distinct groups:

- The indigenous community.
- Mainstream service providers from the local region.

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The suggested process for developing training was to commence with the indigenous community and eventually move to cross-cultural training of broader community.

The process for developing training aimed at promoting indigenous young people's mental health would occur in three broad steps:

- A group of indigenous workers would formalise information for a community discussion group. To guide the process, Rumbalara indicators and CHC indicators would be used. There would need to be a practice session for people facilitating community groups.
- Indigenous community discussion groups would be conducted. The community groups would be drawn from existing groups.
- Cross-cultural training would take place with mainstream service providers. The intention was that the cross-cultural training could become part of an orientation program for workers across the local region.

The objective of the indigenous community training was to promote prevention of suicide or development of mental health problems by providing information though discussion groups. The community group would be conducted as a relaxed discussion that gave participants an opportunity to talk about issues with their kids, and help them to identify when their child may be at risk, and then move on to discussion strategies that may help.

The facilitators would need some frameworks and may use Erikson or Peterson (1989) to develop an outline of stages of development. They may also discuss transgenerational grief and its impact using *The Seven Stages of Grieving.* The important consideration for indigenous young people is that often intervention does not happen early enough. There is denial that a problem exists. Accessing services generally occurs when the young person is at their most extreme stage. Managing risk can lead t into a discussion about how people have coped: 'What has worked for people in the past?'

If the group gets stuck, facilitators may use case scenarios that presenters to promote discussion.

The following table outlines the proposed topics for the workshops.

Community Training	Mainstream Training
How main stream services operate	Cultural historical context. Link issues back to historical issues
Identifying at-risk young people (informal information)	General information specific to indigenous people; that is, usually indigenous people coming to a service will bring a friend or someone they trust.
Managing at-risk young people (How have other people coped successfully?)	Differences in risk factors for indigenous young people
	Language: Aboriginal English
	Video

Ballarat/Horsham

Present:
Youth Suicide and Natural Carers Project Officers from Ballarat
Administrator Goolum Goolum Aboriginal Co-op
Health worker Goolum Goolum Co-op
Psychiatric Nurse Horsham Psychiatric Services
Manager Centracare Ballarat
Project Officer DHS Grampians region

The conversation involved issues that impact on indigenous young people. These incorporated:

- Two tribes in the region.
- For most young people, the problem comes back to poor self-esteem.
- Cultural breakdown. Young people need opportunities to develop cultural pride.
- Peer support/pressure/need for acceptance lead many indigenous young people to risk-taking behaviour.
- Young people in trouble have nowhere to go; they need a safe house.
- Young people are looking to kill the pain of daily life.

It was intended that training would be developed for the region based on a training model at one of the larger Aboriginal Co-operatives.

Warrnambool

Present:
Coordinator at Gunditjamara Aboriginal Co-op
Health Educator at Gunditjamara Aboriginal Co-op
Mental Well-being Worker at Gunditjamara Aboriginal Co-op
Manager, Warrnambool CAMHS
Psychologist, Warrnambool CAMHS

There was discussion about local activities being conducted jointly through Co-op and Warrnambool CAMHS. A group, PATHWAYS, exists to oversee/decide on local projects for the southwest region. The Young Indigenous Support Team has come about through PATHWAYS. The team was picked from leaders among indigenous youth in region with the intention of giving them training and skills. It is hoped they, in turn, will use this knowledge to assist other indigenous young people. To date, there have been monthly meetings and a three-day camp to promote cultural, language and reduce barriers.

A regional meeting was organised to promote local discussion with members from the regional Aboriginal Co-operatives. A senior Project Worker from the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) supported this meeting; however, disappointingly, no local members came to the meeting.

Rumbalara

There was approximately 20 staff present from Rumbalara Aboriginal Co-operative.

The agenda for the day included agreement with people at commencement of the session about times for smokes and breaks.

1. Overview—aim of training.

2. General discussion with all participants.
   Ask participants if there are any particular issues that they would like discussed.

3. Overview of 'normal' adolescent development using Erikson's model to promote discussion.

4. Intervention process—dealing with a suicidal crisis. There was a general group discussion about the difficulties of the working relationship with the regional CAMHS. It was intended to actively seek the input of participants about their current practice, and negative and positive experiences in working with the service, especially with high-risk indigenous young people. This session looked at risk factors, assessment of risk, issues for management, referral and ongoing management (including joint management and partnerships).

5. Conclusion and general summary
   Overview of discussion about intervention and future directions. The afternoon session was for indigenous workers only. It was conducted by Shaun Coade from VACCHO and the spiritual and well-being worker from Rumbalara. Rumbalara reviewed the material prepared following the training session. It was decided not to allow the material to be used by STEP.

   It is important to thank Rumbalara staff for allowing us to assist with the training.

Victorian Aboriginal Health Service (VAHS)

Present:
Chief Executive Officer VAHS
VAHS Adolescent Coordinator
VAHS Child Coordinator
Resource Unit for Indigenous Mental Health Education and Research (RUIMHER) staff.
Austin CAMHS Representative for Koori Kids Mental Health Network
MHPO Austin and Repatriation Medical Centre

The STEP Project Coordinator provided an overview of the project, the conceptual framework and STEP training model. Then there was a general discussion about the potential to work collaboratively with the VAHS and RUIMHER. In recognition of existing good practice, it was intended to build on their current collaboration with the CAMHS through the Koori Kids Mental Health Network. Such collaboration was crucial for ensuring training was sustained the beyond the life of the project.

The MHPO network indicated that some of the STEP Project funding was available to develop training in partnership with pertinent organisations. The funding would be used to pay for costs of training sessions (such as catering, venue hire and facilitator's fees).

The STEP Project Coordinator outlined the training activities that occurred at Rumbalara Co-operative. This training included the MHPO from Shepparton CAMHS presenting the morning session on adolescent development, and conducting an open discussion about suicide intervention and local service provision. The afternoon session was for indigenous workers only. It was conducted by a Senior Project Officer from VACCHO and the spiritual and well-being worker from Rumbalara. Rumbalara decided not make the material available to STEP for broader use in developing a training format.

It was agreed that VAHS, RUIMHER staff, the STEP Project Coordinator and some of the MHPOs would work in partnership to deliver training to a range of indigenous workers at a metropolitan level. The training would be for indigenous workers across a variety of services such as education, accommodation, youth services, health, welfare, sport and recreation. The training was planned for some time in June or July. The training did not eventuate within the timeframe of the project. This related in part to difficulty in achieving a consensus view among the key stakeholders involved.. It had been intended that training for non-indigenous service providers would be considered at a later date.

6.3 Adolescent Development

Erikson's model (1963, pp. 247-74) provides one useful overview of psychosocial development in childhood and adolescence. Erikson theorised that there are eight stages of psychosocial development. This theory emphasised that development was a lifelong process and emphasised the development of the ego. He recognised the impact of society, history and culture on an individual's development, and emphasised the parental influence on the child's development.

Erikson's model has been used as a reference point for considering the experiences of indigenous young people, and to emphasise the link between events occurring during childhood and adolescence that can impact on a developing personality. Erikson's stages of development are outlined in the first and second columns while the third column emphasises some of the negative experiences that have been encountered by Indigenous young people. (The material in the third column was found in Beresford and Omaji (1996), Groome (1995) and Peterson, C (1996).)

The model, while not the only point of reference for understanding childhood development, is regarded as providing a useful framework to emphasise the impact of a range of factors on a young person's identity development. It shows how these factors may be detrimental to a young person's mental health and well-being, as well as placing them at greater risk for suicide.

Table 3: The Eight Ages of Development and the Indigenous Perspective

Stages	Developmental Process	Indigenous
Basic Trust vs Mistrust (Birth to 1 year)	An infant is developing a sense of trust. The consistency, continuity, and quality of care (such as feeding and nurturing) influence this. A sense of trust helps an infant form the early stages of a sense of ego. If a baby experiences inconsistent and unpredictable care, a sense of mistrust can results.	The experience of the Stolen Generation disrupted for many the most basic development of trust. The effect on today's parents of institutionalisation, and the experience of an uncaring social environment, have meant disrupted attachment bonds for their children and today's indigenous young people.
Autonomy vs Shame and Doubt (18 months to 3.5 years)	Toddlers are developing a sense of physical independence and free choice or thinking skills. They are developing physical skills, walking, grasping and are beginning to explore their environment. All this can be a source of pride, but also shame and doubt if difficulties are mishandled. A parent should be firmly reassuring, but allow their child to experience choice. In experimenting with their autonomy, the toddler should 'be protected against meaningless or arbitrary experiences of shame and doubt'	An indigenous mother's traditional care of her children enhances their mastery of cognitive and problem-solving skills as they are given more autonomy and encouragement in decision making. Institutionalisation from an early age is likely to have caused emotional scarring and led to a sense of growing up without love. Indigenous children were moved from one foster home to another and this created an unstable environment. They where not told about their true origins or made to feel ashamed of being Aboriginal and were therefore 'de-Aboriginalised'.
Initiative vs Guilt (3.5 to 5.5 years)	The child is discovering behavioural limits and continuing to become more assertive and take the initiative. Expressions of initiative may be accompanied by guilt if the child is uncertain what the bounds are, if they exceed the bounds, or are in fear of retribution for expressing initiative. 'Initiative is a necessary part of every act, and man needs a sense of initiative for whatever he learns and does, from fruit-gathering to a system of enterprise'.	There has been consistent devaluing of indigenous culture, and a culture imposed by the broader non-indigenous community. Many indigenous children, traditional and non-traditional, are more socially skilled, more independent, and better and earlier judges of their physical capacities. This is a consequence of being treated as autonomous and competent decision-makers from infancy. Indigenous children have more freedom to learn for themselves. This may help to explain the greater use of visual learning strategies by many indigenous people.

Stages	Development Process	Indigenous
Industry vs Inferiority (5.5 to 12 years)	The child deals with productivity and mastery and should 'expect that life must be school life, whether school is field or jungle or classroom and the child is set to win recognition by producing things'. There is potential for successes and failures, and potential to develop confidence or a sense of inferiority and incompetence depending on the child's experiences.	In indigenous communities, the traditional parenting style allows children more freedom and independence. Ridicule and teasing are used to discipline children. This results in a sense of 'shame' that the community regards as an important social regulator. Children learn a strong sense of allegiance to kin and the extended family. Traditional indigenous society evolved informal and non-verbal means of parenting such as real-life performance, persistence, repetition and context-specific activities for transmitting culture and skills. Institutionalisation disrupted this. The indigenous egalitarian manner of relating to their parents can be at loggerheads with Anglo-Australian teachers so the social approach of indigenous children is likely to be regarded as negative and disrespectful. There is a high rate of irregular or non-attenders at school. The school system is failing indigenous children.
Identity vs Role Confusion (Adolescence 12 to 18 years)	The adolescent is developing a sense of identity in terms of they are good at, sexual identity and peers, what they believe to be important and their values. This involves an intense exploration of personal values, beliefs and goals. 'The sense of identity, then, is the accrued confidence that the inner sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others, as evidenced in the tangible promise of a career. The danger of this stage is role confusion'. If diagnosed and treated properly, these will not have detrimental impact.	In traditional indigenous communities, adolescence is not a protracted process as it is in Western adolescence. At puberty, the process of initiation and change in status begins. The rites of passage mark clear boundaries between childish freedom and the power and responsibility of adult life. Cultural dislocation has disrupted this process and identity crisis is complicated by need to integrate traditional and Western cultural patterns. Erikson believed that experimentation with negative identities increases when a young person in a rapidly changing culture strives to integrate two essentially incompatible sets of ideals ('traditional' vs 'modern'). The past negative parental experience of formal education reduces their children's opportunities for parental help and encouragement. Ethnographic works have shown that the 'authoritative structure' of schools is at odds with indigenous children. For example, leaving class without permission may carry no message for indigenous children other than exercising their accustomed independence and freedom. Indigenous culture is more concerned with relating to the world and valuing harmony within human relationships compared to the Western transactional view of changing the world and progress. Lack of employment and recreational activities often mean indigenous young people have nothing to do. The negative imagery that surrounds indigenous people has a significant influence on the formation of young people's identities. Many indigenous young people grow up between two worlds, and many lack knowledge about their culture and history. As they mature, they experience racism, which can be traumatising, and may lead them to deny their heritage or be wary of contact with non-indigenous people. There is growing number of positive indigenous role models, yet there are still many negative portrayals of indigenous people that can directly challenge a young person's positive sense of identity.

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As professionals, it is important to understand and acknowledge the potential for impaired parenting skills. When a generation of parents was forcibly removed from their families and spent their childhood in institutions or being passed around foster families, they lacked the opportunity to learn parenting skills. During the course of STEP Project consultations with indigenous communities the ongoing effects of the Stolen Generation was repeatedly raised. With impairment of the Stolen Generation's parenting skills being suggested as a reason for the concern about the current generation of young people.

The Human Rights and Equal Opportunity Commission National Inquiry into the separation of Aboriginal and Torres Strait Islander children from their families (1997, p. 18) findings also highlight this view. The Commission stated that:

> *It is difficult to capture the complexity of effects for each person. For the majority of witnesses to the Inquiry, the effects have been multiple, continuing and profoundly disabling. The trauma of separation and attempts at 'assimilation' have damaged their self-esteem and well being, and impaired their parenting and relationships. In turn, their children suffer. There is a cycle of damage and people find it difficult to escape unaided.*

Bowlby (1979) states that one of the deepest blows to the human spirit is the loss of the individual. He believes we have exceptional 'affectional bonds' with people such as our parents. Bowlby also states that unwilling separation and loss can give rise to many forms of emotional distress and personality disturbances including anxiety, anger, depression and emotional detachment. He suggests that when working with an individual who has had these experiences, it is important to assist them to understand how their past experiences of disrupted affectional bonds have influenced their present mode of perceiving and dealing with emotionally significant people in their lives.

6.4 What Research Has Taught Us

When considering the specific issue of youth suicide amongst indigenous young people there are some important considerations for professionals.

As part of the Federal and State Governments' youth suicide prevention strategies, access to means has frequently been cited as an important prevention strategy. Hunter (1997) who has considerable experience working with remote indigenous communities makes an important point about the relationship between alcohol and access to means of suicide. Hunter observes that 93 per cent of indigenous suicides (in remote communities) resulted from hanging or firearms. Therefore, it is important that professionals working with indigenous young people consider access to means, the simplicity of execution, and the connection between alcohol, intoxication and impulsivity.

Hunter (1996, p. 197) vividly describes the social and environmental factors that precipitate suicide among indigenous young people. The information conveyed by indigenous young people during focus groups supports the view that Hunter's case study (see below) is not an indictment of the indigenous family, but rather is an example of the need for broader social change in the Australian community.

CASE EXAMPLE (HUNTER 1997)

A young man was raised in a home in which there may have been chronic instability, often associated with drinking and violence. There may have been a history of sexual abuse. Schooling may have been irregular or failed to adequately educate the young person with a likelihood of him leaving early. He enrols for social security or may find himself in an unrewarding and unstimulating job with poor prospects. Through this time, the young person is growing and developing an identity, yet he would be confronted with diminution of his culture by the broader society. The alluring benefits that surround the young person would probably remain elusive. During adolescence, he begins drinking. The young man has few recreational opportunities. His experience of role models may have demonstrated violence with little chance of learning skills for containing intense emotion. He is likely to have lived in substandard housing that was overcrowded.

Given the prevalence of these circumstances for many indigenous young people, they face adolescence with many real and substantial problems, often with few sources of strength or resilience, and extremely limited personal reserves or coping mechanisms.

Risk Factors for Suicide Amongst Indigenous Young People

It is important to know the identifiable risk factors among indigenous young people when conducting a risk assessment for suicide. These include:

- Intoxication, with vulnerability being increased if they have a recent history of loss or relationship disruption.
- Mental health problems or evidence of a mental health disorder with symptoms such as depression, hallucinatory experiences or paranoid ideation.
- The first few hours of being taken into custody, particularly those under the influence of alcohol or drugs and when incarcerated alone.
- A history of previous attempts.
- Recent death by suicide of other friends or family
- The young person's social context, which can create a sense of lack of control of one's life and anger.
- The likelihood that you will be dealing with a young person with multiple disabilities such as drugs, alcohol and mental illness.
- The likelihood that the young person's first contact with the health system will only occur when they have reached crisis stage. Mainstream service providers can learn from this by reflecting on the accessibility and responsiveness of their service in meeting the needs of indigenous young people.
- Serious regard must be given to expressions of suicidal intent by an indigenous young person, their family or friends.

6.5 Cross-Cultural Issues for Consideration When Working with Indigenous Communities and Young People

Ignorance about cross-cultural issues can be damaging when trying to build a working or counselling relationship with indigenous young people. Being cross-culturally aware prior to consultation and working with indigenous people is important. It is possible to contact one of the Aboriginal co-operatives and ask them to provide cross-cultural awareness training for an organisation.

The following material has been developed from information gathered during focus groups with indigenous young people and consultations with Aboriginal co-operatives. The information may not be relevant to all indigenous young people.

- The term Koori refers to the indigenous people who are the traditional owners of the lands of southeastern Australia. Many indigenous people have been displaced from their traditional lands since the arrival of Europeans in Australia.

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- The term Aboriginal includes Aboriginal and Torres Strait Islander peoples.
- If a family member commits suicide, the family does not talk with outsiders about it.
- Some indigenous people consider it culturally unacceptable to look others directly in the eye. They consider it acceptable to listen without making eye contact.
- Brief replies to questions are preferred to detailed elaboration.
- Non-verbal communication is valued more highly than words.
- Many indigenous people speak Aboriginal English. This is a complete and complex language that is different to standard English. This language has been misunderstood as young people using slang. It needs to be seen in parallel to the language used by young people from non-English speaking backgrounds.
- An indigenous person should only be touched if you know them very well, and if you have their consent to do so.
- Request, rather than instruct, indigenous clients. Orders can be associated with past experiences of authority, police, prisons and welfare intervention.
- The word 'no' does not exist in indigenous languages. You are likely to receive a 'yes' or a 'maybe' to most questions, but this does not mean affirmation or acceptance.
- Indigenous people feel intimidated by those who speak loudly. Speaking loudly indicates hostility.
- In traditional society, mortuary rites are an obligation for the entire community. In urban society, indigenous people give priority to attending the funerals of members in their communities. Failure to attend such a funeral causes loss of face.
- Family matters are given priority above all else.
- It is not unusual for children to be cared for among the extended family.
- Some indigenous people may not read or write English. This could explain why they have not completed a form correctly.
- Answering correspondence, filling out forms and attending interviews at a specific time is far removed from the usual lifestyle of indigenous people, so emphasising deadlines is essential.
- Indigenous culture cannot be separated from the land. They believe the land, its features and all life upon it were created by Ancestral Beings during the Dreaming or creation era.
- Indigenous people will avoid using public transport. They tend to rely on rides with friends/relatives to appointments or will use a taxi if they have money.
- Deafness is common in indigenous people so check this by asking for feedback.
- Many indigenous children are brought up in the traditional way and are taught to be group-sensitive and group-oriented rather than independent and self-seeking.

- Indigenous people are group-sensitive. Parents do not chastise their children; instead, they show their disapproval of behaviour by withholding expressions of interest in their children. In this way, the children learn their behaviour is unsatisfactory, but they do so without condemnation. Consequently, indigenous children have few inhibitions. As they are brought up to rely on intuitive feelings, their response to a given situation is largely determined upon interpreting it in relation to past experiences.
- Agencies should always question the cultural appropriateness of their rules; for example, examining the appropriateness of school rules in the light of a young indigenous person's 'disobedience' at school.

6.6 Recommendations

The following recommendations are based on reflects from the STEP Project. They are intended to reflect an understanding for promoting the mental health and well-being of indigenous young people.

- To provide equal access to services for indigenous young people, the first step is understanding their needs and reduce barriers to service use. Indigenous people place enormous importance on family and kinship. Services might consider allowing family involvement in an indigenous young person's care and management.
- Mainstream service providers need to rethink how information for the indigenous community is presented to ensure community members understand it. For example, given the low literacy rate among indigenous people try employing an indigenous artist to design posters, or work directly with the community to develop flyers in Aboriginal English or to visually represent a message.
- It is extremely important to conduct negotiations with indigenous organisations or communities at a local level.
- A fundamental reason for the inability of STEP to progress has been the sense among the indigenous community that the allocation of funding denied them the opportunity to exercise control over decision making. Therefore, the Royal Commission's recommendation should be heeded. A basic principle of any proposed program for Indigenous communities should be that it is developed, implemented, managed and evaluated by or in conjunction with indigenous communities:

It is a recommendation of this report that Aboriginal communities and organisations should not be crowded with programs but allowed time to think their position through and formulate the order in which they want to attend to things-then come back to the broader society to discuss decisions that they have made. It some cases, perhaps in all, they will need some advice-technical, professional-in coming to those decisions. That advice should be provided at their request.

Johnston (1991, p. 22)

- A primary means of demonstrating self-determination is to employ indigenous workers to liaise and negotiate with the various indigenous communities. Employing indigenous workers allows for a strong indigenous voice in development of health programs.

- Professionals whose work brings them into contact with indigenous people should consider receiving training in cross-cultural communication that includes an understanding of the history and circumstances of indigenous people. This would reduce the chance of unwittingly asking insensitive questions that are likely to intimidate and/or antagonise indigenous clients.
- Provide training programs in a safe and nurturing environment that is culturally specific. By adopting a train-the-trainer approach a few key indigenous workers could undergo training such as suicide intervention. In turn these workers can train other community members.
- The broad social and environmental factors have a significant effect on the level of suicide. Indigenous young people have the added challenge of low self-esteem, limited opportunities and racism. Indigenous communities consider that health and well-being should be understood as holistic.
- The consultations identified the high incidence of early school leavers amongst indigenous young people. As a consequence illiteracy should be a key consideration when interacting with indigenous workers and clients. It is also important to keep this in mind when developing training, information and resources for indigenous people.

6.7 Resources

Victorian Aboriginal Health Service (VAHS)
186 Nicholson Street, Fitzroy
Tel: (03) 9419 3000
Fax: (03) 9417 3897

VAHS provides:

- Adult mental health network.
- Koori Kids Mental Health Service.

The VAHS funded a study of indigenous young people's health and well-being. The study was carried out by the Health Promotion and Research Unit of the VAHS. The information gathered in the study will help trigger ideas and help with planning. The evaluation will be used for lobbying and preparing submissions. The study outlines information provided by indigenous young people. It was carried out under indigenous community control by VAHS. Further information about the study is available from VAHS.

Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and community controlled Aboriginal Co-operatives that function at a regional level.
PO Box 1328
Collingwood 3066
Tel: (03) 9419 3350
Fax: (03) 9417 3871

The Little Red, Yellow and Black (and green and blue and white) Book (1994). This book provides a cultural history of indigenous people going back to 60,000 BP (Before Present) through to today. It provides an outline of key events in the history of indigenous Australia. It is published by the Australian Institute for Aboriginal and Torres Strait Islander Studies.

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CHAPTER 7

Refugee Young People

7.1 Introduction

7.2 Who Are Refugees?

7.3 Australia's Humanitarian Program

7.4 Child and Adolescent Development

7.5 Framework for Understanding the Impact of Torture and Trauma

7.6 Implications for Settlement

7.7 Assessment

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7 REFUGEE YOUNG PEOPLE

7.1 Introduction

> *The socio-political situations and events of this century have led to human rights violations on a massive scale. Torture, extrajudicial detention, mass killings, the destruction of homes and other forms of state sanctioned violence have been perpetrated by oppressive regimes to destroy both the mind and body of the individual; and the spirit and fabric of the community of which they are part.*
>
> *(Victorian Foundation for Survivors of Torture and Trauma 1998, p. 9)*

This chapter focuses on the experiences of refugee young people, the majority of whom have experienced severe traumatic events. Trauma and torture have no political, religious, cultural, gender, class or age boundaries. Children, women and men can all be targets and the impact on families can be transgenerational (van der Veer 1998). Inevitably, the experiences include profound, multiple losses in a context where one's survival is at risk and support systems are fragmented. Unlike other forms of trauma, torture is a deliberate fundamental assault on the individual's self and assumptive world (Genefke and Vesti 1998). Although relatively few young people have been systematically tortured, violence (through the experiences of their parents) is certainly part of their every day experience.

Settlement in a new country does not automatically mean refugees move on to recovery and a new life. As Eitinger and Weisaeth (1998, p. 10) detail:

> *"A tortured refugee has lost not only his or her country and health, security and self-esteem, but also family and social contacts and his or her role in society and working life. When the reaction is a depressed state, neither antidepressant drugs and psychological understanding of depression background will be of little importance as long as the young person has no proper place to live, no source of income, and no one who cares about them."*

The settlement process needs to be holistic in its approach and account for physical, psychological, social, economic and environmental factors.

For young people, the reaction to trauma is further compounded by the added challenges of development. Identity formation in the early years is a time when young people learn to make sense of the world and become socially competent. Ideally, it is a time for emerging from the safety of family supports to explore and experiment with different worldviews and values. During civil unrest and war, the threat of violence, family separation and neglect are everyday realities for young refugees and these intensify the challenges to their development.

7.2 Who Are Refugees?

A refugee is a person who has left their homeland by force (not by choice), generally in an attempt to survive. This is the important distinction between refugees and the general immigrant population.

A refugee is likely to have been subjected to torture. The perpetration of torture is intended to crush a person's psychological resistance and thus destroy their personality (Eitinger & Weisaeth 1998). A recent disturbing development is the torture of individuals or groups as a means of exerting pressure on a third party.

The Refugee Experience

Conditions in the Country of Origin

Prior to arrival in the country of settlement, the refugee is likely to have been subjected to longstanding persecution or oppression. They may have been living in a state of constant fear, and hearing rumours about family members being killed. They may have been raped, beaten up in front of other family members, abducted or a witness to violence. Individual and family functioning is likely to be severely disrupted as a result of such experiences.

Fleeing the Country of Origin

As the political climate and social turmoil in their homeland continue to decline, individuals and families decide that their only chance of survival is to leave. Often this journey is fraught with as many dangers and traumas as the refugees have left behind. Families can become separated or are at the mercy of ruthless pirates and profiteers. Many people perish or are murdered.

Refugee Camps

Before fleeing their homeland, they may have spent months (or, in most cases, years) in a refugee camp with little or no access to adequate health services, and generally no educational facilities for children. Most are grieving the loss of family members, friends and their home. Their future is uncertain. They can no longer control their destiny. Conditions can be extremely overcrowded and daily essentials, such as food and water, can be in limited supply. For many young people, growing up in a refugee camp means they are denied the basic human rights of secure, safe accommodation and safety from abuse.

Arrival in the Country of Settlement

After arriving in the country of settlement, the customs and social systems are often unfamiliar and their own customs are no longer dominant. Inhabitants of the country of settlement may have different understandings about the refugees' circumstances. Consequently, refugees' opportunities for gaining work and participating in educational and recreational activities may be limited.

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THE REFUGEE EXPERIENCE

Summary of the Refugee Experience

Although every person's experience is different, there are common threads to the refugee experience:

- Deteriorating political climate and social turmoil in their homeland.
- Experiencing or having witnessed violence.
- Escaping from their homeland.
- Undertaking a treacherous journey fleeing their homeland.
- Spending time in a refugee camp.
- Searching for permanent settlement.
- Experiencing an alien culture and social systems in the country of settlement. This can cause confusion and distress.

PERSONAL PERSPECTIVE FROM A YOUNG ASYLUM SEEKER

Being an asylum seeker means Mohammed has permission to stay in Australia while he applies for recognition by the Australian Government as a refugee and for permanent residence.

Mohammed describes his experience:

I am 15 years old and I have eight brothers and sisters. I am from Somalia.

I have been is Australia for one year. I used to live in Mogadishu. When I was growing up I lived in a big house in a nice neighbourhood. My dad worked for the government. He was very important. In my country, women are responsible for making sure that the house runs well, and to raise the children. Somali children must show respect to grown-ups and speak to children in certain ways. My mum taught me all about my culture and my people.

School is very important in Somalia. My school was just round the corner. I used to walk to school each morning with my brothers and sisters, but when I got to school I would go and play with my friends Abdi and Mohamud.

War started in 1991, when I was 8 years old. When I was 9 years old my school closed down, as it was too dangerous. One day some men from my dad's work came to our house. They told my mum that my dad had been killed and that my family was not safe. Mum told all of us to follow her. We did not have time to bring any of our things or to say goodbye to our friends.

We walked for many weeks. There were lots of other people walking too. I got very tired and hungry. I missed my friends. Eventually we got to a refugee camp in Kenya. There were no houses like our old one, just lots of tents and some huts made out of scrap mental and wood. We stayed there for eight months before we moved to another refugee camp. Over the next four years I lived in lots of different camps. I did not like living in a camp, they are very dangerous places and there is never enough food or water for everyone. Also some of the different groups who are fighting would attack the camps and people would run everywhere. I lost my mum and most of my brothers and sisters one day when this happened. I was very sad, but I still had my older sister Nasra. Nasra told me that I must go to another country and make a safe home for us.

It took me one year to get to Australia. I was very happy to get here. I hoped to get a job and find my family and then help them to come and live with me here. I have not been able to find a job as I have no Australian experience and my schooling was stopped too early. Also I do not know yet if I am allowed to stay in Australia. I hope to go back to school next year, but I will be in a class with children much younger than me. I am not sure I will fit in.

I miss my family. I write to Nasra often, but neither of us knows where our mother or brothers and sisters are. The Red Cross is helping me to find them. Every day I wait for news. I also miss my home. My family was rich in Somalia, but in Australia I am poor. I am thankful that people help to support me, but I want to look after myself.

(De Silva and Fiske 1998)

Definitions used by Department of Immigration and Multicultural Affairs (1997)

It is important to be aware that there are many people who do not meet the United Nations High Commission for Refugees (UNHCR) definition (see below), but have suffered gross violation of human rights. Australia, among a small number of countries, have responded to their plight and provided a resident visa on 'humanitarian' grounds.

Refugee

In international law, the UNHCR defines a refugee as:

> *People outside their country of nationality who are unable or unwilling to return because of a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion.*

Asylum Seekers

Asylum seekers in Australia are also referred to as refugees; however, they are a distinct group in that they do not have formal refugee status. Asylum seekers are people who apply to the government of a country for recognition as a refugee, and for permission to stay, because they claim to fear persecution in their own country on the grounds of race, religion, political beliefs or nationality, or because they belong to a particular social group.

Until the government has considered their applications against the UN Convention definition, they will not be formally recognised as refugees. In Western countries, the proportion of asylum seekers who achieve formal recognition as refugees is about 10 per cent.

Unauthorised Arrivals in Detention

It is a requirement under Australian law that people who arrive unauthorised, whether by sea or air, are held in detention until they are granted a visa to remain in Australia or they leave the country. People who arrive in Australia unauthorised and apply for a protection visa must meet the UN criteria of having a well-founded fear of persecution in their own country.

7.3 Australia's Humanitarian Program

The Australian Government Department of Immigration and Multicultural Affairs (DIMA) has a policy that outlines its response to refugee and humanitarian issues.

The Humanitarian Program caters for refugees and other people who have left their homes and countries because of war or civil strife, or who have experienced human rights abuses. In common usage, humanitarian entrants are called refugees.

The following information was obtained through the DIMA's website. As government policy and immigration figures are dynamic and subject to change, it is advisable to obtain current facts and figures from DIMA's website at http://www.immi.gov.au

In 1998-99, the Humanitarian Program intake comprised 12,000 places: 10,000 places for people overseas in humanitarian need and 2000 for people already in Australia. The main focus during this time was people from the countries of the former Yugoslavia, Iraq and Horn of Africa. Some visas were issued to people from other areas such as Asia and Central America.

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The Humanitarian Program has five components:

1. **Refugee:** 4000 places allocated for people who meet the United Nations Convention definition of a refugee.
2. **Special Humanitarian Program (SHP):** 4250 places were allocated for those who have suffered discrimination amounting to gross violation of human rights, and who have strong support from an Australian citizen or resident or a community group.
3. **Special assistance category (SAC):** 1750 places were allocated for those who while not meeting the refugee or special humanitarian criteria, were nonetheless in situations of discrimination, displacement or hardship. Most applicants under the SAC required proposers of applicants to be close family members resident in Australia.
4. **Onshore protection visa grants:** 2000 places were allocated within the Humanitarian Program for refugees granted protection visas in Australia. If the number granted rose above 2000, the excess was to be drawn from the offshore element of the program.
5. **Placement visa:** visas that are numbered between 200-217 indicate that the person has a refugee experience. As of October 1999, a new visa category, temporary protection visa (three years duration), has been introduced for unauthorised arrivals who apply for refugee status in Australia.

Humanitarian Visas	UNHCR refugee Special humanitarian Special assistance category (SAC) – Permanent residence – Visa issued offshore
Permanent Protection Visa	Permanent protection visa – Permanent resident – Visa issued onshore to asylum seekers who were authorised arrivals
Temporary Protection Visa	Haven temporary protection visa – Very temporary residence – Visa issued offshore Temporary protection visa – Temporary residence (three years) – Visa issued onshore to asylum seekers who were unauthorised arrivals after October 1999

The Humanitarian Program: Implications for Workers

It is important that workers have a knowledge and understanding of the Humanitarian Program because:

- A knowledge of a client's migration status will impact on their sense of personal security through such issues as entitlement to access Australian services (for example, employment, social security benefits, medical services, housing and so on). If the visa is for a limited time, this has implications for their sense of the future and security. It is important to understand the visa categories that your client has been granted. This will help you to determine their eligibility for services, as well as ensuring a better understanding of their underlying anxieties.
- Knowledge of a refugee's country of origin under Australia's Humanitarian Program provides a strong indication that the person has been subject to trauma. As a worker, knowing a client's country of origin can provide an understanding of their past experiences without having to be unnecessarily intrusive when eliciting details.

Humanitarian Settler Arrivals by Country of Birth

The following table details the country of origin, in age groups, from which young people have entered Australia under the Australian Humanitarian Program at five-year intervals since 1985. The figures where derived from DIMA, statistical section, Canberra.

Table 4: People Who Have Entered Australia Under the Humanitarian Program

Year of arrival	Country of birth*	Ages 0-14	Ages 15-19	Ages 20-24	Total of arrivals‡	Grand total#
1998-99	Bosnia-Herzgovina	379	120	90	1,327	
	Croatia	221	93	89	983	
	Former Yugoslavia Republic of Serbia & Montenegro	549	225	139	2,286	
	Iran	76	46	33	286	
	Iraq	411	99	88	1,179	
	Sudan	183	64	43	583	
	Afghanistan	262	70	39	649	
	Somalia	150	53	50	404	
	Ethiopia	20	20	30	186	
	Eritrea	22	21	23	132	
Total						**8,790**
1997-98	Former Yugoslavia NFD	304	87	80	1,124	
	Bosnia-Herzegovina	549	208	150	2,064	
	Croatia	256	103	47	907	
	Iraq	501	134	108	1,393	
	Iran	89	45	31	309	
	Sudan	140	17	27	395	
	Vietnam	111	36	50	401	
	Afghanistan	176	73	20	439	
	Sri Lanka	56	26	27	220	
	Somalia	208	101	53	506	
Total						**8,779**
1996-97	Former Yugoslavia NFD	365	156	112	1,571	
	Bosnia-Herzegovina	523	174	149	1,993	
	Croatia	115	48	49	495	
	Iraq	495	138	135	1,599	
	Iran	109	21	23	315	
	Sudan	118	29	27	328	
	Cambodia	119	39	18	275	
	Burma (Myanmar)	48	11	27	264	
	Vietnam	291	57	138	1,042	
	Somalia	114	42	24	261	
Total						**9,886**
1995-96	Former Yugoslavia NFD	670	154	181	2,346	
	Bosnia-Herzegovina	901	241	273	3,318	
	Croatia	145	46	52	551	
	Iran	220	49	48	644	
	Iraq	695	188	229	2,170	
	Sudan	147	39	17	426	
	Cambodia	230	66	37	549	
	Afghanistan	186	51	41	499	
	Sri Lanka	125	32	37	379	
	Somalia	124	42	42	383	
Total						**13,824**

** Country of birth (10 listed with highest numbers of arrivals in Australia for the period). ‡ Total of arrivals all age groups by country of birth. # Grand total all humanitarian arrivals in Australia for period.*

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Year of arrival	Country of birth*	Ages 0-14	Ages 15-19	Ages 20-24	Total of arrivals‡	Grand total#
1994-95	Former Yugoslavia NFD	1,455	316	401	5,100	
	Former USSR/ Baltic states	86	25	24	507	
	Ukraine	57	30	35	407	
	Iran	100	26	39	394	
	Iraq	602	142	314	2,245	
	Cambodia	172	38	83	600	
	Burma (Myanmar)	123	34	59	500	
	Vietnam	349	116	205	1,509	
	Former Ethiopia	61	44	63	384	
	Somalia	102	29	29	330	
Total						**13,632**
1990-91	Romania				38	
	USSR				97	
	Iran				338	
	Iraq				98	
	Lebanon				1,147	
	Laos				301	
	Afghanistan				266	
	El Salvador				1,400	
	Ethiopia				111	
	Somalia				47	
Total						**7745**
1985-86	Poland				587	
	Iran				569	
	Lebanon				781	
	Chile				520	
	El Salvador				471	
	China				593	
	Kampuchea				704	
	Laos				477	
	Thailand				338	
	Vietnam				4,468	
Total						**11,840**

** Country of birth (10 listed with highest numbers of arrivals in Australia for the period). ‡ Total of arrivals all age groups by country of birth. # Grand total all humanitarian arrivals in Australia for period.*

Australia's Offshore and Onshore Humanitarian Program: Visa Types

Humanitarian Visas
UNHCR refugee
Special humanitarian
Special assistance category (SAC)
* Permanent residence
* Visa issued offshore
Permanent Protection Visa
Permanent protection visa
* Permanent resident
* Visa issued onshore to asylum seekers who were authorised arrivals
Temporary Protection Visa
Haven temporary protection visa
* Very temporary residence
* Visa issued offshore
Temporary protection visa
* Temporary residence (three years)
* Visa issued onshore to asylum seekers who were unauthorised arrivals after October 1999

7.4 Child and Adolescent Development

A recent study (Iredale et al. 1996) of refugees who entered Australia under the Humanitarian Program over the past decade found that 25 per cent had suffered extreme experiences of torture, and another 38 per cent reported less serve experiences of trauma. Young people are especially vulnerable to the effects of torture and trauma that occur during their development and identity formation. Torture and trauma can shatter their core assumptions of trust and emotional bonds with family, friends and community. Their dependency on adults can increase the impact of betrayal.

Refugee young people are confronted by an utterly cruel world where there is enormous social disruption. This is occurring at a time that is critical for personality development and before the developmental tasks of childhood have been completed. Moreover, the adults may not be able to meet their children's needs as they are often traumatised themselves.

Children are often seen as resilient and able to bounce back once circumstances settle. It is expected that on arrival in the country of settlement, the effects of the past will be left behind by the young person and will not be part of their new life. It is now recognised (Pynoos et al. 1995) that exposure(s) to trauma places the child at risk of developmental disturbances. Therefore, settlement strategies should give early assistance and support to assist children to resolve past traumatic experiences and enable them to resume development.

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Erikson's Model

Erikson (1963, pp. 247-74) proposed the theory that there are eight stages of psychosocial development. This theory emphasised that development was a lifelong process and was focused on the development of the ego, and recognised the impact of society, history and culture on an individual's development.

Erikson's model provides a useful outline of the stages of child development and emphasises the parental influence on this development. The psychosocial development of a child is a two-way process and the infant plays an active role in modulating their interaction with the social world. Development generally takes place within the family, and within the larger domain of culture and society in which the family lives.

Garbarino and Kostelny (1993) have developed a framework that expands on Erikson's life cycle development. This framework provides a description of the destructive effects of violence on a child's development and coping skills, and the surrounding influences that promote resilience. The challenges that children living amid war and communal violence face in meeting these life stages have been set out in the third column in table 5 below. Some of the material has been drawn from Pynoos et al. (1995, p. 76). The first and second columns outline Erikson's stages of development and the third column emphasises some of the negative experiences encountered by refugee young people.

Garbarino and Kostelny (1993, p. 49) believe an understanding of the effects of war on child development can create intervention opportunities. The framework identifies the potential negative impact on childhood development and 'it illuminates the many necessary elements of intervention to help children cope effectively'.

Table 5: The Eight Ages of Development and the Refugee Perspective

Stages of Life Cycle	Developmental Process	Challenges for Refugee Development
Basic Trust vs Mistrust (Birth to 1 year)	An infant is developing a sense of trust. The consistency, continuity, and quality of care (such as feeding and nurturing) influence this. A sense of trust helps the infant to form the early stages of a sense of ego. If a baby experiences inconsistent and unpredictable care, then a sense of mistrust can result.	Basic trust is difficult to achieve when family functioning is disrupted, or parents are psychologically unavailable. This can lead to neglect that can hinder brain development.

Please note table continued on next page.

Stages of LIfe Cycle	Developmental Process	Challenges for Refugee Development
Autonomy vs Shame and Doubt (18 months to 3.5 years)	Toddlers are developing a sense of physical independence and free choice or thinking skills. They are developing physical skills, walking, grasping and are beginning to explore their environment. All this can be a source of pride, but also shame and doubt if difficulties are mishandled. A parent should be firmly reassuring, but allow their child to experience choice. In experimenting with their autonomy, the toddler should 'be protected against meaningless or arbitrary experiences of shame and doubt'.	The trauma of life in a war zone may lead to regression among young children. Toileting and speech problems are common. Both are threats to the basic competence that underlies autonomy. Toddlers rely on social referencing to attachment figures to respond to situations of uncertainty regarding safety and risk, and initiate motoric and mental efforts aimed at searching for the protective figure.
Initiative vs Guilt (3.5 to 5.5 years)	The child is discovering behavioural limits and continuing to become more assertive and take the initiative. Expressions of initiative may be accompanied by guilt if the child is uncertain what the bounds are, if they exceed the bounds, or are in fear of retribution for expressing initiative. 'Initiative is a necessary part of every act, and man needs a sense of initiative for whatever he learns and does, from fruit-gathering to a system of enterprise'.	Initiative versus guilt depends in part on negotiating a settlement between fantasy and impulse. War and civil unrest undermines this process by releasing the negative behaviour such as aggression, by disrupting culturally normal relationships, and by overturning or disarming social structures, thus placing young children in jeopardy. In preschool children their experience of trauma can lead to a natural response being one of fear, and to diminish fearful apprehension they become dependent on attachment figures.
Industry vs Inferiority (5.5 years to 12 years)	The child deals with productivity and mastery and should 'expect that life must be school life, whether school is field or jungle or classroom and the child is set to win recognition by producing things'. There is potential for successes and failures, and potential to develop confidence or a sense of inferiority and incompetence depending on the child's experiences.	War disrupts schooling and ordinary vocational development for children. Often schools are closed. The psychological and physical effects of torture can mean children often have difficulty concentrating in school, and develop learning and behaviour problems in the classroom. In situations of potential threat, school-age children rely less on cues from caretakers and envision increasing self-efficacy in the face of danger. They experience a sense of ineffectualness or culpability when that fails.
Identity vs Role Confusion (Adolescence 12 to 18 years)	The adolescent is developing a sense of identity in terms of they are good at, sexual identity and peers, what they believe to be important and their values. This involves an intense exploration of personal values, beliefs and goals. 'The sense of identity, then, is the accrued confidence that the inner sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others, as evidenced in the tangible promise of a career. The danger of this stage is ROLE CONFUSION.' If diagnosed and treated properly, these will not have detrimental impact.	Moral development occurs during adolescence, and adolescents are very sensitive to issues of rights and injustice. Refugees can lose their sense of faith in justice. This sense of injustice can easily be triggered in the new country. Adolescents rely more readily on their own appraisals of threat and motivation. They more fully envision the threatened harm and its later consequences, and struggle with decisions over whether to intervene.

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When a child is faced with the chronic trauma that the horror of war presents, they need psychological assistance to help them redefine their sense of the world. If they do not receive this help, they may reasonably draw conclusions about the world that has negative consequences for their adult life and society.

In responding to the needs of refugee young people, it is critical that the response is holistic and meets not only their physical and psychological needs, but their social, emotional and environmental needs as well. The most important task for professionals is to undertake activities that will build a sense of trust and safety, and allow these young people to develop a positive sense of what their future can hold.

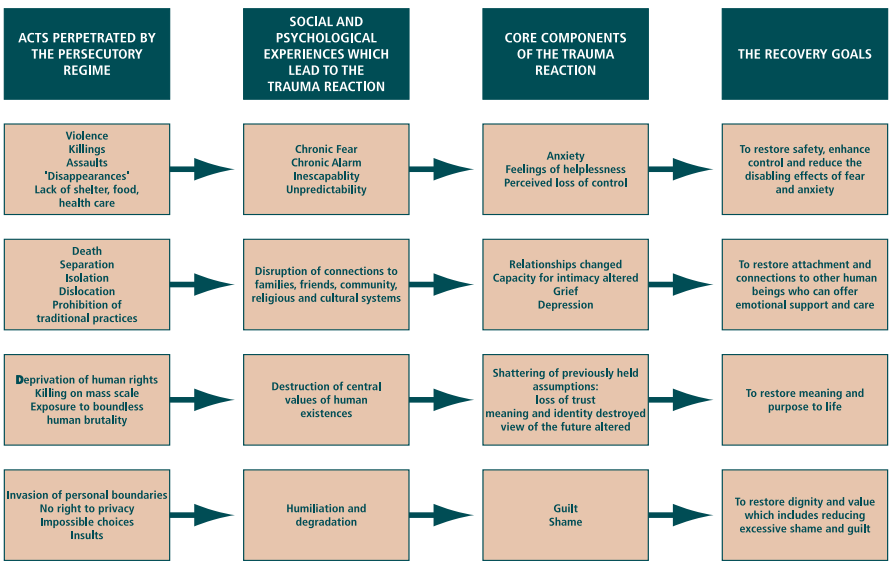
7.5 Framework for Understanding the Impact of Trauma and Torture

> *It is important to underline that the causes of trauma are to be seen in the systems that perpetrate them, not within the individuals who suffer the effects. But it is the psychological and social reality of survivors and their communities which are altered as a result of violations. It is the experience of terror which is internalised. Core attachments to others are disrupted and the integrity of self, family and their relationship to the community is fragmented. The most invasive of persecutory acts are used to create shame and guilt, condemning people to isolation and exile from their communities and from themselves.*
>
> *(VFST 1998, p. 9)*

The information contained in this section draws very strongly from Victorian Foundation for Survivors of Torture (VFST) publication *Rebuilding Shattered Lives* (1998). This publication is highly recommended for further reading on this subject *(see 7.10 Resources).*

The VFST has developed a conceptual framework that presents the causes and reactions to trauma and recovery goals.

Figure 3: Victorian Foundation for Survivors of Trauma and Torture Framework



The core causal components of the trauma reaction are analysed in terms of the main social and psychological experiences which impact on the individual and family to destroy the community of which they are part.

(VFST 1998)

It is important to understanding the meaning of events, from the survivors' perspective and from a broader socio-political perspective. The recovery goals need to be holistic and workers need to adopt a collaborative response and work with a range of services, not only those with a treatment or therapeutic focus.

The association of horrific events with multiple losses, and the challenging of basic assumptions about life and humanity, can generate complex and profound reactions. The impact of war and human rights violations are far reaching and can be conceptualised as affecting several core areas of psychological functioning. These are described below.

Anxiety, Helplessness and Loss of Control

Anxiety results from exposure to intolerable danger in a context that renders the victim helpless to act. This experience of helplessness is critical in determining the severity of the anxiety reaction.

Effects Associated with Anxiety

Effects associated with anxiety generated through torture and trauma may include:

- Intrusive and recurrent distressing recollections of traumatic event. This may be manifested as recurrent memories, images and nightmares of trauma.
- Impairment in ability to think, concentrate and remember.
- Conditioned fear response to reminders, places, things and people's behaviour, leading to:
  - Avoiding fearful situations.
  - Restriction of imaginative play.
  - Emotional withdrawal.
- Generalised fear not directly related to trauma including:
  - Fear of strangers.
  - Fear of being alone.
  - Fear of dark places.
- Hyper-vigilance or watchfulness. 'Being on guard for danger.'
- Startle response. Being startled by sudden changes in environment, such as noise.
- Reduced capacity to manage tension and frustration.
- Reduced control over impulsive behaviour
- Emotional numbing. Denial, detachment, reduced interest in activities and people.
- Re-enactment of traumatic events in play.
- Psychosomatic complaints; for example, headaches.
- Regressive behaviour; for example, tantrums.

CASE EXAMPLE

A young woman of 18 years was training to be a nurse when war broke out. She witnessed many atrocities as she was forced to tend to injured men who belonged to the opposition group. Once in Australia, she began to exhibit many distressing symptoms. She could not leave the house without experiencing panic attacks and broke into tears frequently. With counselling, she overcame many symptoms, but her persistently recurring nightmare related to an event she had witnessed of women and children being transported from their village. She believed she should have done something in the way of protest at the time but, in her own words, she had helplessly watched. She experienced her helplessness as a betrayal of her core value to assist innocent people.

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Loss, Grief and Depression

There are multiple losses that are experienced as a result of torture and trauma. These include loss of home, property, family, friends, community and opportunity. Not surprisingly, the grief process is complicated and prolonged and, in many cases, resolution of grief does not occur *(see chapter 5).* In these circumstances, the capacity to form new relationships can be affected. Distorted relationship patterns may include anxious attachment, compulsive self-reliance, compulsive caregiving, or fears about relationships. Overall, survivors of torture and trauma are at high risk for depression that may develop over time as the impact of losses is felt. Such depression presents a significant risk of suicide *(see chapter 5).*

- **Grief**
  - Numbness, denial
  - Pining, yearning
  - Preoccupation with lost person
  - Anxiety
  - Emptiness, apathy, despair
- **Attachment behaviour in relationships altered**
  - Increased dependency, clinging behaviour
  - Fierce self-sufficiency
  - Compulsive caregiving
  - Guardedness, suspiciousness
- **Depression**
  - Pessimism
  - Loss of interest
  - Sleep disturbance
  - Appetite disturbance
  - Poor concentration
  - Self-degradation
  - Self-blame
  - Hopelessness
  - Suicidal thoughts and plans

Shattering of Assumptions About Human Existence

Being subject to organised violence brings into question core human values, dignity and the value and meaning of life and death. As Anderson (1995) states:

The essence of psychological trauma is the loss of faith that there is order and continuity in life. Trauma occurs when one loses the sense of having a safe place to retreat within or outside oneself to deal with frightening emotions or experiences.

Particular issues for young people include the potential for truncation of their moral development, as concepts of good and bad are shattered by their experiences. Their additional vulnerability arises from the fact that, for them, the processes of identity development and achieving competence within their culture are incomplete.

- Loss of meaning and purpose.
- Capacity to trust damaged; sense of betrayal intense.
- Future outlook changed.
- Adolescents are particularly alert to issue of human accountability and very sensitive to injustice.
- Moral concepts affected. Behaviour is either overly regulated by considerations of what is good or bad or, alternatively, amoral.
- Loss of faith of adults' ability to protect.
- Loss of continuity of the self.

Guilt and Shame

A sense of guilt and shame often prevails for refugees who have been subject to torture. There may be guilt because they survived while family and friends may have died, or perhaps they gave information that harmed others. Torture and exposure to violence can be used to create the 'impossible choice' by deliberately placing victims in a situation that requires them to transgress their moral principles. For example, children may be asked to chose which of their siblings must die and, if they do not choose, all of their siblings will die.

Rape is another commonly used tool of torture. VFST clients with a history of rape commonly feel suicidal and young women, particularly, are concerned about their inability to prove virginity when they marry. Such experiences give rise to enduring guilt and shame that are associated with the maintenance of post-traumatic stress disorder. The inevitable and intended outcome of torture and witnessing of violence, irrespective of a victim's choice, is to cause the victim to feel responsible for the outcome.

Even when nothing could have been done to change a situation, people image that they should have been able to do something. This is preferable to facing sheer helplessness.

(VFST 1998)

- Preoccupation with feelings of having failed to do something more to avert violence.
- Use of fantasy to exact revenge and repair damage done during traumatic event.
- Self-destructive behaviour.
- Avoidance of others due to shame.
- Experience of pleasure inhibited.

Impact of Torture and Trauma on the Family

The impact of torture and trauma can alter family functioning to compound the trauma experience for young people.

- Roles within the family and responsibilities are often dramatically altered.
- Traumatised parents often have reduced capacity for emotionally supporting and protecting children.
- Extreme disturbances in parents, such as violence, become new traumas for family members.
- Financial difficulties and generational conflict produce extra burdens on all family members.
- Traumatisation for the family continues if there is bad news from the country of origin.
- Dislocation from culture and tradition and the language barriers add enormous pressure.
- Children are often taught not to trust anyone.
- Guilt associated with leaving family behind disrupts emotional recovery for all family members.

7.6 Implications for Settlement

"Refugee young people cannot just be like most Australian young people, as they often do not have a life of their own. They must deal with housing issues, pressure and high expectations from the family at home."

(Farnan 1999)

The resettlement process means starting a new life, generally in a country that has a different culture. For refugees, departure from their home country is usually abrupt, and they may have few or no belongings with them, so they often lack any paperwork such as birth certificates. Usually, there is little possibility of going home again to visit or return permanently.

The resettlement process is likely to be associated with socioeconomic disadvantage and low social status. This can have an impact on health and well-being, and compounded by poor or no English skills, further reduces opportunities to access information and services.

Diversity of cultural groups means there are differing concepts about health and illness from the country of settlement. This can further exclude refugees from access to culturally sensitive interventions, or mean they receive no assistance at all.

In the country of settlement, many circumstances and encounters can maintain and exacerbate the trauma reaction. Life in the new country is different: the sights, the smells, the language and social practices are all unfamiliar. Many refugees must cope with other significant family members and friends being left behind. They often draw mutual support from other refugees from the same country. This can be a double-edged sword because they can remind the person of earlier trauma, or be associated with a faction linked to perpetrators and informers.

The resettlement process can be a cause of stress. Refugees are likely to be fearful of government institutions and suspicious of all services, including health facilities. Disrupted attachments continue after arrival and cultural differences create a sense of dislocation that seriously affects a person's sense of belonging. The language barrier, and even simple differences such as the use body language, can compound the social isolation.

Some resettlement factors can exacerbate the trauma reaction. These may coincide with the early stages of settlement; others can occur later as a person confronts each new stessor. Some key considerations of settlement include:

- Isolation. Language can become a barrier so it is important to be able to communicate in English. Language is a vehicle for identity; therefore, use of interpreting services and availability of information in a range of languages are essential to promote a sense of control and dignity.
- Adult Migrant English Services (AMES) classes restricts enrolment to within the first three months of a refugee's arrival in Australia. Consequently, many people miss these classes as they are often faced with more pressing settlement priorities. However, adults are entitled to 510 hours of instruction and there can be grounds to defer, but they must enrol within a three-month period. There are English language centres at primary and secondary school levels in some areas, and DEET can provide information about English language centres.
- Sengaaga Ssali (1998 p. 25) states that many young people [she was specifically speaking about Horn Of Africa young people] have disrupted schooling, cannot speak or write English well, and are facing difficulties with Australian education. Consequently, dropout rates are high. Schools are not effective in identifying refugee children and addressing their specific issues and concerns. To cope with school, many require additional tutoring support with homework and English.
- The simple tasks of everyday living can demand adjustment. These may include operating to a timetable, using money or shopping. For example, a Somali woman who bartered for onions in a marketplace in her country of origin now shops at an Australian supermarket where she has to use money and is faced with an enormous level of choice.
- Often young people become socialised into Australian society more rapidly than their parents and this can create a rift. Professionals need to develop skills to work with the youth culture and parents in a sensitive manner without alienating either.

Most refugees have concerns about:

- Finding accommodation.
- Losing their first language and needing to learn a new language.
- Finding employment.
- Experiencing social and racial discrimination.
- Having financial worries.
- Gaining an education or continuing their education.
- Developing an understanding of the dominant culture, social expectations and customs.

"Kids cannot or do not know how to communicate all the problems encountered at school. Young people are very unhappy at school and tend to leave early, then form groups in their local areas."

(Farnan 1999)

7 REFUGEE YOUNG PEOPLE

CASE EXAMPLE

When I was 15, I was forced to be part of the national army. This involved training for six months to fight for the Ethiopian Government and to then go on and kill your own people. Those who refused to comply were executed.

Luckily, I managed to escape and eventually I found my way to Egypt from Djibouti. All this time, I worried about the fate of my family. Were they being persecuted by the military police to pay for my escape? I soon learnt that my parents had been forced to sign my death certificate should I return to Ethiopia.

I arrived in Australia late 1992 to a migrant hostel. As a teenager and refugee, I found it difficult to adjust to a new and completely foreign environment. I felt homesick. I went to English language school and worked at a factory in the evening.

I eventually went to a technical school, but found that I was being picked on and drawn into fights too often. Flashbacks of the violence and terror I had known in Ethiopia kept coming back to me too regularly. I couldn't sleep at night.

I left school to go to secondary college and here I met many other African students. It was a very multicultural environment and, for the first time, I felt I was accepted by the teacher and the students.

All of us Africans struggled to do well with our studies, but this was difficult without extra help. In fact, some of my friends dropped out and drifted into drugs. The help, however, did come with the setting up of the African Youth Group and a homework support scheme.

The volunteer tutors became our friends and eventually our family. They were willing to come to our homes, even in the evenings and on weekends if required. Even if we just needed to speak to someone about our troubles they would answer our calls. Without their support, I don't know whether I would have survived mentally.

(Sengaaga Ssali 1998, p 26)

Education

Most newly arrived refugee young people want to gain an education or continue their schooling. Often, these young people have had little or no schooling in their country of origin and so they lack the relevant concepts, skills and knowledge for success in the Australian school system. They need to be taught basic skills that teachers take for granted in students who have attended school regularly.

The health promoting schools approach offers an excellent opportunity for teachers and school communities to create safe environments that promote connectedness and participation. Facilitating the genuine participation of young refugees within such a model would be an appropriate strategy for addressing recovery goals in a school context.

For personal and cultural development, the Ethnic Youth Issues Network (1998) has identified some considerations in relation to schooling:

- Give these students a great deal of reassurance.
- Provide them with opportunities to be successful.
- Realise they may not respond in class due to cultural considerations; for example, they may feel it is inappropriate to criticise or question the teacher.
- Be aware that they may have had educational experiences where they were not permitted to make judgements or give opinions.
- Understand that they may have few long-term aspirations.
- Realise they may be skilled at communicating orally in more than one language.
- Be aware that past experiences may make them reluctant to reveal information about themselves, their lifestyle and families.

Implications for Support/Service Access

All Humanitarian Program entrants are eligible for immediate access to income support through the Department of Social Security and to Medicare. They have access to torture and trauma counselling, English language tuition, an interpreting and translation service and Migrant Resource Centres which provide information and support to new arrivals.

A significant issue in recovery however, is the opportunity to access support as required beyond the immediate on arrival program. Recovery from torture and trauma is commonly a long process and life experiences at any stage can trigger an intensification of the trauma reaction. One of the gaps which has been identified through research (Farnan 1999; Luntz 1998) is the inaccessibility of support for young people through counselling services, or even through their day-to-day school environments. School language centres were noted as the exception, in that staff there were able to provide sensitive and relevant support and understanding.

Access difficulties do not necessarily relate to unwillingness or disinterest in providing support. These difficulties are predominantly due to the complexity of issues that confront refugees, such as negotiating language barriers and managing the perceived alien nature of Australian systems of providing help and support. People are required to present to a service where they are expected to ask for help for an identified problem. The trauma reaction is likely to generate an unwillingness to trust, an avoidance of exploring painful past experiences, and a profound mistrust of authority figures. Yet, in seeking help, they are expected to speak about family issues, and to place their trust in strangers who are in positions of authority and who may be perceived as imposing solutions on young people and their families. Furthermore, our models of service provision often pay little attention to dealing with language, cultural and gender barriers.

Part of the solution is to be more physically accessible, to be flexible in our response in terms of who we see and where we see them. However, real accessibility implies a much deeper rethinking of our service provision. We are challenged to redevelop our practice and service models if we are serious about ensuring access and equity for young refugees and their families.

7.7 Assessment

As a professional working with refugees in a clinical setting, it is important to gain an account of the history of the presenting problem and the experience of trauma. A refugee client is likely to need time to build a relationship and a sense of trust before they will feel comfortable talking about their traumatic past. The information gathered during an interview will direct appropriate interventions. In gathering this information, special consideration needs to be given to people who come from culturally diverse backgrounds where their understanding of illness, culture and service provision will differ from Western constructs.

In treating non-Western populations, Coffey and Dinh (1998, p. 34) have found that somatic and dissociative symptoms are more frequently prominent. They state:

> *"Our experience is that somatic complaints and chronic pain are often the presenting symptoms, and the causative effect of the original trauma is frequently not recognised."*

Therefore, to be culturally relevant or to gain the client's acceptance of your professional ability, it may be better to first provide practical advice and treatment of somatic complaints. Then it may be possible to address the traumatic experience.Coffey and Dinh (1998, p. 35) suggest that there are fundamentals common to all psychotherapy of trauma. In therapeutic treatment with refugees, it is worthwhile considering:

> *"The process of reconstructing meaning and purpose in life after trauma through bereavement is highly culturally determined, but the search for meaning itself and the struggle with grief (which includes the reconstitution of the self-concept and comfort in interpersonal relationships) are universal experiences for all groups of people who have experienced severe trauma."*

CASE EXAMPLE

Zenebe is a fifteen-year old student from Ethiopia who had two years of schooling in his country before coming to Australia to join his estranged father after the death of his mother. Since arriving in Australia, he has completed two semesters (one year) in an English language centre. Although a confident speaker, Zenebe has very low literacy. His current literacy skills are below a survival level and are inadequate for a mainstream educational environment.

Secondary school is therefore an inappropriate option, as is TAFE due to Zenebe's age and low language level. Zenebe was placed in a school-based literacy program in the northern region which catered for students under 18 with little or no schooling. However, the school had difficulty resourcing this course and the program did not go ahead. Zenebe's only option was to be placed in a community-based program.

Zenebe cannot get much support from his father, who has a low level of education, almost no English and poor employment and economic prospects. Zenebe's future is not looking much better.

(Ethnic Youth Issues Network 1998)

7 REFUGEE YOUNG PEOPLE

A helpful approach to gain an understanding of the presenting problem and the experience of trauma is to encourage the client to express their version of events according to their worldview. Personal narration and expression of experience can confer a sense of the person's depth of suffering beyond the limits of language. This may also allow you to gain insight into denial by the client. Recalling images can be so painful they may deny the experience ever happened. Retelling and reframing the trauma story is a central tenet of treatment so recovering memories is important, but it needs to occur in a supportive environment and the person needs to be ready.

A full account of the person's experiences and problems in the past and in their country of settlement are paramount for developing a holistic response. The client's social service needs are as critical as their physical and mental health needs. Many refugees struggle with housing, finance and employment needs, as well as having deep concerns about family and friends left behind. Meeting these needs is just as important to enable the healing process to begin. Working collaboratively across sectors is therefore fundamental.

Suffering may be so long standing that it has become incorporated into a person's sense of self; they will not recognise their poor mental and physical health as abnormal so they are less likely to seek help.

The extent to which the following areas are explored will depend on the role of the worker and the mandate of the agency. However, to make appropriate referrals and formulate a course of action, some knowledge of the following is needed where there are indicators of distress or behavioural disturbance.

The following information is derived from Kaplan and Strehlow (2000).

A Checklist of Assessment Issues for Professionals

Trauma History

- Country of origin.
- Refugee camp.
- Route to Australia.
- Is there a history of exposure to trauma and/or loss?

Developmental History

- School attendance history.
- Language in which previous schooling occurred?
- Age of likely trauma.
- Illnesses, milestones, accidents.
- Possible causes of learning disabilities—congenital, acquired or role of trauma.
- It is important to note that many of the assessment tools and tests have been developed for populations that have had continuous schooling relevant to their chronological age, labelling versus funding implications. This may cause a dilemma for the worker.

Cultural Barriers

- Issues of loyalty and appropriate confidante.
- Stigma and acceptability of interventions.

Access Issues

- Language.
- Familiarity with systems.
- Fears and inhibitions related to trauma and culture.

Settlement Issues: Demands and Resources

- Financial situation.
- Eligibility for benefits and pensions.
- Accommodation.

Psychological Impact: Use Framework

- Anxiety, post traumatic stress disorder (PTSD) symptoms, helplessness, grief, depression, suspiciousness, shame and guilt, anger.
- Quality of interpersonal behaviour.
- Patterns of distress including antecedents and consequences, duration and course.

Family Context

- Intactness of family.
- Obvious family strain.
- Absent family members.

Support Systems

- The client's current support system needs to be established, as does the intactness of family (actual and psychological) and their suitability for support
- Supports in the broader cultural community, other community supports.

Personality Strengths

- Self-esteem, coping strategies, sense of future.
- Belief systems, spirituality.

Physical Health

- Injuries, sensory and motor impairments.

Current Stressors

Such as settling in a new country and dealing with a very different way of life.

CASE EXAMPLE

A Hmong family was captured by Communist Lao soldiers as the family was preparing to cross the Mekong River. Soldiers began systematically beating the family with the butts of their rifles. The father and two children died at the site. Lao villagers brought the mother and one son to a local hospital. Both mother and son remained unconscious for several days but survived. The son, previously the brightest offspring, was notably duller after the injury. At the time of our evaluation, the 11-year-old son had been unable to learn English and had other learning disorder symptoms. A skull X-ray revealed an old skull fracture, and language-fair intelligence testing demonstrated an IQ consistent with that of a person with a chronological age of 6 years. This boy improved with academic tutoring and parental counselling, both directed at setting expectations consistent with his remaining intellectual capacity.

(Westermeyer and Williams 1998, pp. 66-89)

Westermeyer and Williams go on to report that the patient had previously been evaluated and treated by other service providers, but generally a trauma history had not been elicited and a complete bio-psychosocial assessment had not been conducted. The earlier clinical history was:

The 11-year-old boy, injured at age 8, had been evaluated by a school psychologist and by a paediatrician, both of whom had experience with Indochinese refugee children. They had assessed the child as having a family problem due to a mother who spoke only Hmong at home and who was unable to control her child. They had failed to obtain historical information regarding the head injury or to demonstrate the extent of the child's brain injury.

Involvement of Other Workers/Services

Ideally, an assessment needs to be conducted over time. However, even within a limited time frame, it is important to form a sense of what is happening in these areas. Collaborative partnerships with the range of services providing care for the young person are important, to ensure clarity about roles, reduce confusion and duplication of services.

7.8 Practice Issues

You can't generalise about each ethnic group. Workers should never assume that because they come from, for example, Somalia that all Somalians are the same. There is enormous diversity within residents from one country of origin. Workers need to ask clients their wishes/ beliefs.

(Farnan 1999)

As Luntz (2000) reports on the question of therapeutic interventions being sufficient to be applied cross-culturally:

> *"It is not so much the methodology used but the way the therapist engages with the client, and the extent to which the response is flexible and creative, that brings success and satisfaction."*

Working with cultural factors such as ethnicity or country of origin is complex. There will be a range of cultural variables shaping people's values, beliefs and needs *(see also section 3.2 and 3.3).* Even within one family, ethnicity issues may vary depending on the level of acculturation. It is common for young people to acculturate more rapidly than their parents and, consequently, to find themselves bridging or living between two worlds (Farnan 1999). Workers building relationships with clients and their family will need to take such differences into account.

We need to learn about different cultures as well as identifying our own culture and its influence in shaping our beliefs about what is 'normal' or 'proper' in our social constructions.

Treatment of young survivors of torture and trauma involves a multifaceted approach because the symptoms may include physical, psychological, cognitive and sociopolitical problems.

A major consideration in working with refugees is the timing of various interventions. Westermeyer and Williams (1998, p. 71) state for example that 'abreactive-interactive psychotherapy that focused on victimisation was not helpful for a suicidal, melancholic, or psychotic patient'.

However psychotherapy for a range of symptoms and problems usually has to be delayed until current stressors and barriers to forming a trusting relationship are addressed.

Westermeyer and Williams (1998) go on to report that some previous clinicians had overlooked history that was critical to understanding the case. The bereaved boy was placed in a milieu that hampered the grieving of his recent losses and his sociocultural adjustment, and resulted in a major depressive disorder.

CASE EXAMPLE

A 14-year-old Vietnamese boy was seen for an inability to learn English, apathy and social withdrawal. He was found also to have fatigue, hypersomnia, feelings of helplessness and worthlessness, headaches, loss of interest and enjoyment and suicidal ideas. No cognitive deficits were noted.

During his escape from Vietnam on a boat, both of his accompanying relatives (his father and uncle) died from starvation. Placed with an American family, the patient had no contacts with other Vietnamese in the United States. He had no contacts with his family remaining in Vietnam and no notion of how they might be contacted. Diagnosed as having a major depressive disorder and missed bereavement, he responded to antidepressant medication, bereavement counselling, being given information regarding methods to contact his family, and a milieu change that included placement with a Vietnamese family and attendance at a school with numerous Vietnamese adolescents.

(Westermeyer and Williams 1998, pp. 66-69)

Many cultures have different understandings of what is 'healing', and other avenues for seeking help with problems, and many have no concept of 'counselling'. They may be more likely to find their support within the family/extended family/community elders. Healing for them may occur through spiritual avenues, or through natural therapies such as the use of herbs. For many, the concept of working with an individual is quite alien and, in the case of collectivist cultures, without the community or its designated representatives.

The impact of trauma is so profound that families are unlikely to consider healing in a context where there is no space to acknowledge and explore a sense of life and its meaning. The worker needs to be open to this kind of exploration. The worker's capacity to provide this level of openness will depend on their ego strengths and the opportunities for debriefing and worker support.

John Byrne (1992, p. 32) youth support worker at Maribyrnong Secondary School Melbourne provides some insight into how he interacts with refugee young people:

> *I start by explaining who I am and what my job is and I ask them if there is an equivalent job in their country. This gives me an indication of the young person's expectations of my position. It is completely foreign concept for a stranger to come in wanting to know personal details. The young person may think 'Why does he want to know this? What is he going to use it for?' So I talk about myself and my job and break down some of the barriers to establish a comfortable platform from which to work. I tell the young person some of the things I know about their country and about some experiences other young people I know have had. This usually turns on some lights for them. They might say, 'Yes, that's how it is for me'. By talking to them in this way, I am trying to show them that I have a certain amount of understanding, and that I'm sympathetic. I explain to them that it is my job to help young people and that maybe I can help them in some way.*

7 SUMMARY SHEET

Worker Strategies for Identifying Clients Who May Be Survivors of Torture or Trauma

When dealing with a possible refugee, the worker's objective should be reducing the intrusiveness of the consultation. The following list of questions (from an overhead produced by the Foundation for Survivors of Torture and Trauma) is intended to provide a worker with a means of determining if a client is a refugee and their history:

- When did you leave your country?
- Did you choose to leave or were you forced to?
- What was the journey to Australia like?
- Have you spent time in a refugee camp?
- Terrible things have happened to people who have been forced to leave their country. There is no need to tell me what happened, but have you had any terrible experiences?

Aristotle (1990, p. 14) has outlined the following principles of service delivery that apply across all levels of work—individual, family, community:

- Services must respect and reinforce the concept of human rights as expressed in various charters and international agreements.
- Services must strive to be culturally relevant, sensitive and understanding of the history and struggle of the service user in the international, national and local context.
- A service needs to address both the internal and external needs of the individuals and groups while promoting access, equity, and participation.
- In working with those who have lived through the experience of torture, the agency must give due respect to the fact that, as survivors, they have already displayed remarkable resourcefulness, resilience and strength.
- The agency should have an absolute commitment to informed consent, with the provision of services guided by needs as identified and expressed by the survivors themselves. A primary role of the service is to inform those seeking assistance of their rights and to reinforce those rights.
- The agency must be committed to increasing the level of power that survivors have over their lives in psychological, social, cultural and economic terms. They are socially and economically disadvantaged in their new society and, as such, the agency must understand the importance of the redistribution of income and resources as necessary for empowerment.
- Services should be provided in a context where the therapeutic benefits are derived from understanding the relationship between the social, physical and psychological worlds of the client.
- The provision of services must be guided by the expressed needs of clients, and the capacity to heal or to recover is recognised as being predominantly in their hands. The VFST provides practical assistance and support through crisis intervention, therapeutic assistance and the facilitation of access to services required to meet the total needs of clients.
- Forms of support/strategies are needed to promote the sustainability of the training. (Such as policies, paperwork, listing resources, processes to promote close linkage to specialist agencies).

Issues for Consideration in Service Development

- **Individual versus community approach to care (deconstructing the culture of the service provider).** For communities fragmented by torture and trauma (in particular, collectivist cultures), a goal is supporting community rebuilding. The community is a legitimate and vital unit of healing because, for refugees, destruction has actually occurred at the whole community level. If this is not addressed, individual/family healing in isolation may not make any sense.

CHALLENGES FOR OUR MODELS OF SERVICE DELIVERY

A well-functioning organisation is essential to ensuring quality service provision and optimising the achievement of recovery goals for clients ... An organisation's internal structure and the development of collaborative relationships with other services and government are as vitally important as working with people on the ground.

(VFST 1998)

- **Collaboration between specialist services (for example, mental health services or non-specialised services).** If agencies are to communicate effectively, common understandings about confidentiality, information sharing and duty of care need to be developed. While development of trust between workers is crucial in building and maintaining collaboration, it is also important to develop protocols so such understandings are broadly available. Collaboration is essential to provide an appropriate level of response to multiple needs. Collaborative activity can occur through training, forums for discussing service provision and discussions about barriers to access and opportunities.

Working with Interpreters

The idea of using someone as an interpreter, simply because they speak the language (such as a family member or friend) is not only inherently dangerous (particularly in the health field), it is entirely inappropriate and inadequate. Under stress, people who may be fluent in a language can become less articulate. A qualified interpreter should there be used whenever possible.

Delivering a service via an interpreter should involve more than transferring facts back and forth; there needs to a sense of the overall conversation, not just the words. This is likely to improve the outcome of service provision and client satisfaction. Interpreters should have a level of awareness of cultural difference and appreciation of the processes of cross-cultural communication.

It is easy to assume that all people from the same country of origin are members of one cultural group, and that they behave in exactly the same manner. Workers need to consider that an interpreter may belong to a group on one side of the conflict in their country of origin, and that the client may belong to a group on the opposite side. This situation can be avoided if adequate information is given when booking interpreter services.

Language/Interpreter Issues

It is not uncommon for parents to use their children as their interpreters. However, it is often inappropriate especially when specialist understanding is required (for example, when dealing with a medical condition). There are legal implications and the likelihood of inaccurate explanations due to language incompetence can be high. It is recommended that workers always seek to use a qualified interpreter. The following points are intended to assist the worker in this process.

Points for Consideration When Working with a Person from a Culturally and Linguistically Diverse Background (CALD)

- Cultural factors affect communication. As information is interpreted based on a particular society's point of view, there will generally be some level of cultural bias. It is important to appreciate the cultural bias during the interaction. A lack of understanding about other cultures will affect communication.
- Competency in English can become compromised when a person is under stress, such as during an interview with a service provider.

- Interviews can become tiring given the level of concentration needed.
- Using family or inappropriately qualified interpreters may lead to people settling for inaccurate explanations, given the higher level of language competence needed to correctly present the information.
- It is important to become extremely sensitive to unconscious, non-verbal signals (for example, body language, tone of voice, eye contact, gestures and so on).
- The interview process may make a client feel everybody is talking about them.
- The client may remain passive and silent rather than initiate a conversation just in case they get lost for words.
- It is important to learn interviewing techniques that are culturally acceptable to a community (for example, the acceptability or meaning of eye contact and body language varies between cultures).
- Three points should be kept in mind when asking questions: Is it simple? Is it culturally specific? Could it be offensive?
- It is important to consider interpreter issues such as client mistrust of the interpreter due to their ethnic group and potential shame.

Points to Remember When Booking an Interpreter

- Book the right interpreter for the right language and/dialect. For example, a person born in Bosnia may speak Albanian, Bulgarian, German, Hungarian, Romanian, Turkish and Croation, Macedonian, Serbian or Slovenian.
- When booking, explain the importance of maintaining the intimacy and trust built up during a session, and that it is useful to keep the same interpreter because there is a likelihood of a series of interviews/sessions.
- Consider that the genders of the client and interpreter may be significant, particularly where matters of sexual sensitivity may be discussed.
- Always use a professionally qualified interpreter who is accredited with National Accreditation Authority for Translators and Interpreters (NAATI). Try to avoid using BYO interpreters (family, spouse, children, and friends).
- Try to consider whether regional, religious or cultural factors are likely to affect the acceptability of an interpreter for a client.
- Plan the interview carefully and brief the interpreter.
- Remember that an interview with an interpreter is likely to take twice as long as one conducted without an interpreter.

7 REFUGEE YOUNG PEOPLE

NAATI suggest telephone interpretation is inappropriate when:

- A number of people will be involved.
- The interview will be lengthy (one to two hours).
- The client is unfamiliar with telephones or frightened of them.
- If the person is psychologically or emotionally disturbed.
- If the information is of a sensitive nature.

Working with Interpreters

- Remember that cultural differences occur within a country.
- Pre-brief the interpreter.
- Warn an interpreter if the interview is likely to be distressing.
- Explain interviewing techniques such as open-ended questions, paraphrasing, summarising, reflection of feelings and so on.
- Alert the interpreter to the significance of the interview's emotional content and the need to render it faithfully.
- Reassure the interpreter that you are capable of dealing with client reactions such as anger, grief or hostility.
- Alert the interpreter to any special requirements. For example, a client may show thought disorder. In this case, it is important that the interpreter interprets exactly and does not try to make sense of what is being said.
- Remember that interpreters have the right to refuse a briefing if they feel it might jeopardise their professional impartiality.

During the interview

- Do not have the client ushered into a room where the worker and interpreter are already seated. This may alienate the client or make them suspicious.
- Arrange seating to ensure all participants can see each other. Observing body language can be important.
- Speak directly to the client and always use the first person. Use 'How are you?' *not* 'Ask him how he is.'
- Use short sentences to ensure the interpreter can remember and interpret them accurately. One idea per sentence is ideal.
- Speak clearly, do not use slang or sayings, and give full explanations of technical terms.
- Conclude the interview in the usual way in the presence of the client. The client and interpreter should leave together.
- Conduct telephone interpreting in the same way as ordinary interpreting. Sit facing the client and watch their body language. Include a pause after each sentence so participants do not talk over each other or cut each other off.
- Ask the interpreter to be aware of the cultural meanings of particular expressions your client may use during the session as these may have significance.

Languages Spoken by People from Non-English Speaking Countries

Before booking the services of an interpreter, it is important to establish what language your client speaks. The following list is intended as a general guide only to help confirm what language the interpreter should speak. (This material is derived from Roberts-Smith et al. 1990).

Table 6: Languages spoken by people from Non-English speaking countries.

Country	Language/Dialects
Afghanistan	Afghani, Pushtu, Dari
Albania	Albanian
Argentina	Spanish, Italian, German
Australia	Aboriginal languages, English, Auslan
Austria	German
Belgium	Flemish, French, German
Brazil	Portuguese, Spanish, German
Bulgaria	Bulgarian, Macedonian, Russian, Turkish
Cambodia	Khmer, Chines languages/dialects, French
Chile	Spanish
China	Cantonese, Mandarin, Hakka, Hokkien, Teo-Chew and so on
Cyprus	Greek, Turkish
Czechoslovakia	Czech, Slovak, German
Denmark	Danish
East Timor	Tetum, Portuguese
Egypt	Arabic (Egyptian), Armenian
El Salvador	Spanish
Ethiopia	Amharic, Tigre, Eritrean
Fiji	Fijian, Hindi
Finland	Finnish
France	French
Germany	German
Greece	Greek
Guatemala	Spanish
Hong Kong	Cantonese, other Chinese languages/ dialect
Hungry	Hungarian, Slovak, German, Romanian
India	Bengali, Hindi, Punjabi, Tamil, Urdu, Rajuput, Gujerati, and so on
Indonesia	Indonesian, Malaysian, Chinese languages/ dialects, Dutch
Iran	Farsi (Persian), Arabic, Armenian, Assyrian, Kurdish, Pushtu
Iraq	Arabic, Armenian, Assyrian, Kurdish, Pushtu
Israel	Hebrew, Yiddish, Arabic
Italy	Italian
Japan	Japanese

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Country	Language/Dialects
Kenya	Swahili, English
Korea	Korean
Laos	Laotian, Miao/Meo, Hmong, Chinese languages/dialect
Lebanon	Arabic (Lebanese), Assyrian, Armenian
Malaysia	Malaysian, Chinese languages/dialect
Malta	Maltese, English
Mauritius	Mauritian, French, French-Creole, Hindi
Netherlands	Dutch
Nicaragua	Spanish
Norway	Norwegian
Pakistan	Urdu, Punjabi
Philippines	Tagolog (Filippino), Hokkien, English, Spanish, other languages/dialects
Poland	Polish, German, Yiddish
Romania	Romanian, Serbian, German, Hungarian
Samoa	Samoan
Singapore	Mandarin, Cantonese, Malaysian, English
South Africa	Xhosa, Zulu, Swahili, Afikaans, English
Spain	Spanish
Sri Lanka	Sinhalese, Tamil
Sweden	Swedish
Switzerland	German, French, Italian, Romansh
Syria	Arabic, Armenian, Assyrian
Taiwan	Chinese languages/ dialects
Thailand	Thai, Hokkien, other Chinese languages/dialects
Tonga	Tongan
Turkey	Turkish, Kurdish, Armenian
Uruguay	Spanish
USSR	Russian, Estonian, Lithuanian, Ukrainian, Latvian, Armenian, Yiddish and so on
Vietnam	Vietnamese, Chinese languages/dialects
Yugoslavia/ Bosnia	Croatian, Serbian, Macedonian, Slovene, Slovak, Albanian and so on
Zimbabwe	English, Shone, other languages/dialects

7.9 Worker Reactions

As a worker, it is a difficult to find a balance between compassionate engagement with a person and emotional detachment. Nevertheless, it is imperative to strive for such balance for your emotional well-being and the person's best interests. The following points are intended to assist workers to protect their well-being and provide proficient care:

- It can be distressing to witness a person's emotional turmoil and pain. It is important to remain cognisant of the value of such expression. Many people experience relief and feel understood as a result of having had an opportunity to express their emotions. Expression of feelings through storytelling, drama, art and other special activities can be encouraged where there are conditions of trust and safety.
- It is important to clarify limits. Clarify with the person their expectations and your own. Set limits of acceptable behaviour. If a person's expectations are different, look at ways they can get additional support.
- It is important to appreciate that the trauma reaction can affect relationships. It is not unusual for the worker to be perceived in extreme ways: as a saviour or inadequate. It is useful to examine your behaviour to see if it has contributed to these emotions. For example, saying to the person, 'It would seem that I can do little of any use to you, when you are facing so many problems that cannot be solved quickly enough' indicates to them that you are supportive but limited in how you can help.
- A source of frustration, if unrecognised, can be person unfamiliarity with customs and services in Australia. For example, many refugees may not understand the concept of appointments. Their past experience of health services may have been to arrive at a clinic and wait their turn.
- Workers typically experience anger and helplessness and this may be displaced onto other services. It is vital that services prioritise debriefing or regular supervision to address these issues. Uncontained reactions have the potential to interfere with interagency collaboration and to create emotional barriers in dealing with torture and trauma people that are disengaging, unsupportive and untherapeutic.
- Organisational responses need to recognise and promote the value of secondary consultation, and to encourage staff to be honest about their capacity to manage a situation. Staff are better able to offer support to people, and to engage with them in a genuine way, when their limits are acknowledged and allowed for. Additional or specialist resources may be accessed if required either directly or through secondary consultation.
- Given the many settlement challenges and potential concerns regarding family who are lost or still in danger, it is important to attend to immediate needs either directly or through ensuring effective case management is occurring.
- It is important for the worker that support/intervention occurs at the young person's pace and that of their family/network, and that the worker establish a role with cultural significance and meaning for them. It may initially revolve around quite practical assistance.

- Workers respecting personal boundaries may be reluctant to push people to explore painful issues. While sensitive practice is imperative, it is also important in the context of a working relationship to be mindful that avoidant responses may, at one level, be a defence. At another level, there can be therapeutic benefits in challenging the belief that such exploration is to be avoided at all costs.

Table 7: Emotional Response of Workers and Implications for Practice

Emotional response	Implications for practice
Helplessness	• Losing confidence in skills. • Underestimating person's resources by taking on more and more of an advocacy role, and so disempowering the person. • Taking on the role of rescuer and neglecting professional limits.
Guilt	• Experiencing 'bystander guilt' because you are exempt from the trauma and suffering and not taking enough action against the violation of others. • These are effects. Taking on excessive responsibility or too much. • Avoiding painful topics for fear of inducing more hurt.
Anger	• Being angry with perpetrators and bystanders can affect reactions to people and services who do not seem to do enough. • Being over-sensitive to injustice can produce a crusader approach.
Dread and horror	• Feeling overwhelmed by survivor's despair can lead to hopelessness and loss of belief in effort and strategies.
Idealisation	• Feeling inadequate compared to the survivor. • Neglecting and minimising your own pain and suffering as a result.
Personal sense of vulnerability and intolerance of violence	• Being hyper-aware of the dangers of hatred and brutality in society. • Being intolerant of violence.

Dealing with Emotional Reactions to Traumatic Events

The following material is derived from Danieli (1980) and Yassen (1995):

- Recognise your reactions by developing awareness of the signals of distress and by trying to find words to articulate your inner experiences and feelings.
- Contain your reactions by identifying a personal level of comfort, and remember the reactions are normal and unlikely to be overwhelming if their phasic nature is recognised.
- Come to accept that being affected is to be expected. Share the trauma-related work with others. Allow time for relaxing. Self-expression is important.
- Dealing with your reactions is an ongoing process of thoughtfulness and acknowledgment of conflict.

Most workers have different personal and professional ways of coping that include:

- Sharing emotions with someone close and ensuring you get enough humour, relaxation, exercise and good nutrition.
- Ensuring balance in the variety and nature of work, pacing work.
- Setting boundaries concerning overtime spent with people, taking work home, understanding, self-disclosure boundaries, realism about the effect you have.
- Developing trusting professional relationships: peer support, supervision, consultation with specialist agencies *(see resource list),* and role models.
- Planing for difficult times.
- Undertaking professional training and replenishment.

7.10 Resources

Department of Immigration and Multicultural Affairs
This department provides a 24-hour, seven days a week translating and interpreting service that is available to assist any applicants for a protection visa. The service can be contacted anywhere in Australia by a local telephone call.
Toll-free: 131 450.

General Interpreting Services
Telephone interpreter services (TIS) offers professional interpreters for help over the telephone or on-site 24 hours a day, 365 days a year.
Toll-free: 13 1450 (for cost local call)

State Government Services: Victorian Ethnic Affairs Commission
Tel: (03) 9419 0044

National Accreditation Authority for Translators and Interpreters (NAATI
A directory of NAATI-accredited interpreters and translators can be ordered through capital city offices.

Victorian Foundation for Survivors of Torture and Trauma
The Foundation provides psychological counselling and community support services to survivors of torture and trauma now residing in Victoria. The service focuses on the provision of assistance to people entering Australia via the refugee and humanitarian migration program.
House 23
35 Poplar Road
Parkville 3052
Tel: (03) 9388 0022
Fax: (03) 9387 0828
Email: administrator@survivorsvic.org.au

7 REFUGEE YOUNG PEOPLE

Useful Publications

Refugee and Humanitarian Issues: Australia's Response, October 1997.
Department of Immigration and Multicultural Affairs
Contact the Department for copies.
Tel: 13 18 81
Website: www.immi.gov.au

Rebuilding Shattered Lives
This was produced to provide professionals with a comprehensive training resource that will help them in responding to people who have survived torture and trauma. A training manual can be purchased with the guide. This training manual is suitable for use by trainers who have had extensive experience of working with survivors of torture and trauma, and who are involved in conducting training programs for practitioners who work with survivors in a number of settings such as mainstream schools, language centres, settlement services and primary health care.
Order from the Victorian Foundation for Survivors of Torture. Contact details as above.

A Guide to Working with Young People Who Are Refugees: Strategies for Providing Counselling and Group Work
This manual is designed to assist those working with young people who are refugees and have experienced trauma and torture. Some sections comment specifically on working within schools, and the material is relevant to a range of settings. The material can be used, for example, in supported accommodation, community centres and recreational programs.
Order from the Victorian Foundation for Survivors of Torture. Contact details as above.

Resource Guide for Professionals
A resource guide is included in the "Cultural Competence in CAMHS Stage 2 Project Report". The resource is available on the Victorian Transcultural Psychiatry Unit (VTPU) website. The internet address is: http://www.atmhn.unimelb.au/library/services/specialist_reports/camhs_stage2.html

SBS World Guide
This is available from Dymocks bookstores. It retails for $43.90 and provides an outline of all the countries of the world. The reporting covers such topics as population, geographical, economic and political information. It would provide workers with good background knowledge of a person's country of origin.

Amnesty International Report
This is available directly from Amnesty International. It retails for $33.00 and provides an annual outline of all the countries of the world. The reporting concentrates on significant human rights issues that take place in the country over the year. It would provide workers with good background knowledge of a person's possible experiences in their country of origin.

Intercultural Dialogue: Supporting and Resourcing Refugee Parents and Their Families
The Torture and Trauma Service of the Northern Territory produced this guide for practitioners in June 2000 with funding from Commonwealth Department of Family and Community Services and Northern Territory Office of Ethnic Affairs. It summarises the experiences of developing a model to support parents from a refugee background who settle in the Northern Territory. It could be used by childcare services, teachers, family counsellors, welfare agencies and social workers. There are some useful suggestions for those who have not previously worked in a cross-cultural context.
Order from the Torture and Trauma Survivors Service of the Northern Territory.
Tel: (08) 8985 3311
Email: ttssnt@topend.com.au

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CHAPTER 8

Same Sex Attracted Young People

8.1 Introduction

8.2 Same Sex Attracted Defined

8.3 Understanding the Specific Needs of Same Sex Attracted Young People

8.4 Same Sex Attracted Young People and Suicide Rates

8.5 Sexual Identity Formation

8.6 Adolescent Development

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8.10 Good Practice Strategies for Workers

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8 SAME SEX ATTRACTED YOUNG PEOPLE

8.1 Introduction

Same sex attracted (SSA) youth are part of a high-risk population for suicide, self-harm and risk-taking behaviour not because of their sexuality, but because society's heterosexual norms serve to isolate and silence them. Cohler and Galatzer-Levy (1996) state that there is little evidence to support the view that sexual orientation is related in any way to poor psychological adjustment, except as a consequence of stigma. To understand and respond effectively to SSA young people's needs, we first need to have some knowledge of these needs.

This chapter has been divided into three sections. The first section attempts to provide an understanding of the needs and experiences of SSA young people. This section needs to be understood as a developmental framework. Adolescence is a time of significant physical and psychological change and a major task is the formation of sexual identity. The development of a homosexual identity can result in isolation from the usual influential supports such as family, religious organisations, schools and peer groups.

The second section discusses practice strategies that promote an inclusive and supportive response to meeting SSA young people's needs. The most important factors in reducing the risk for suicide are access to a supportive person or having a sense of connectedness and meaning in life. In working with SSA young people, the ability to respond in a non-judgemental and caring way to their needs will increase their sense of safety.

The final section outlines ideas for responding locally to SSA young people's needs. It is important to acknowledge that the work of individuals can have a direct impact on how SSA young people experience their sexuality. There is a need to make changes at a broader level in the community to respond to service gaps, and to promote community awareness of the needs of young people who are marginalised.

8.2 Same Sex Attracted Defined

Many terms or 'names' have been coined to describe a person who is attracted to someone of the same sex. Phases relating to sexuality can have different meanings and understandings. It is important to clarify the intended meaning when these phrases are used within the context of the STEP manual. Throughout this manual, same sex attracted (SSA) has been used when referring to young people who may be attracted to a person of the same sex. The term SSA was first used by Hillier et al. (1998) in a research project. It is regarded as a broad term that refers to attraction, not identity. This means the term is fluid, which is particularly important with respect to adolescence or those people still grappling with their sexuality. Though for the young people themselves, it is not a term they would use. They are more likely to use terms such as gay, queer and leso.

8.3 Understanding the Specific Needs of Same Sex Attracted Young People

Knowledge of some of the needs and experiences of young people in general is important for responding effectively to SSA young people. Australian research has identified a number of key elements that contribute to the *resilience* and *emotional* well-being of young people. In summary, these comprise:

- The need to feel safe and secure in their home, school and overall environment.
- The ability to communicate openly and honestly with at least some people in their lives.
- A sense of positive regard from others: a person/s who expresses a level of care and respect toward them.
- The opportunity to develop new skills and abilities, and to make some mistakes as they learn.

When we consider these needs and how they relate to SSA young people, we begin to see why as a group they are at significantly higher risk for suicide. Many SSA young people report victimisation, harassment, and intimidation in describing their experience of school. Generally, they do not feel comfortable or safe in disclosing their sexuality in such an environment, and are often required to grow up in a social context that denies them the support they need in a culture that frequently fails to recognise that not all young people are heterosexual.

The vital point to grasp in reviewing the incidence of youth suicide amongst SSA young people is that being SSA does not put a person at risk of suicide; it is the *stressors* associated with being SSA that increase the risk for suicidal behaviour.

Ryan and Futterman (1998) suggest that in the absence of hard facts and figures, all service providers should follow accepted guidelines used for adolescent suicide risk assessment *(refer suicide intervention chapter and resource list).* In the case of adolescents who are SSA, there should be careful assessment of the:

- Level of support available to them.
- Young person's readiness for, and awareness of, the risks associated with coming out.
- Level of psychological adjustment *(see also to figure 12 Adolescent Assessment Interview).*

There is very little Australian forensic information about the number of completed suicides among SSA youth. However, statistics have consistently shown that a significant number have attempted suicide (Ryan and Futterman 1998; Hillier et al. 1998; Nicholas & Howard 1999; Victorian Task Force Report 1997).

An Australian study (Nicholas and Howard 1999) compared gay young people's risk of suicidal behaviour with that of straight young people. The study, which was conducted with a small population of young men in

During a focus group held by members of the STEP project, a young girl who had attended a country school commented:

> During sex education, homosexuality was talked about as being abnormal, that there was a need to help homosexual people to get back on track, to become straight.

As a result, she stated that she could not come out, was depressed and wanted to kill herself.

CASE EXAMPLE

The following case example concerns a young man coming to terms with his sexual identity. It is intended to provide a chance to explore his risk for suicide using the guidelines set out in the section **Understanding the link between sexuality and suicide.**

A 16-year-old male comes to visit a community health service on the pretext of wanting some information about accommodation. The atmosphere in the worker's office is relaxed. The worker finds that, after spending a little time just chatting and getting to know each other, the young man divulges he is worried about being rejected by his family and asked to leave home, as he feels sure that he is gay. He does not have a good emotional relationship with his family. He is feeling stressed about the fact that he is constantly lying about his sexuality. He finds it very isolating not being able to talk to anybody about his questions in relation to homosexuality.

As a worker:

- How will you assist this young man?
- What strategies will you devise to support him?
- Do you have information you can provide to better inform him about sexual diversity?
- Are you legally permitted to assist this young man without informing his parents?
- Are you legally permitted to supply information?
- Can you put him in touch with a peer support group?
- Do you feel confident that he is not at risk for suicide?

a metropolitan area, found that gay youth reported significantly higher levels of suicidal ideation and more frequent depressive thoughts, thoughts of suicide, intrusive thoughts of suicide, and frequent thoughts of how they would kill themselves *(table 8).* The table identifies that gay men are four times more likely attempt suicide than their heterosexual counterparts.

Table 8: Comparison of Gay and Straight Participants: Current Depression, Lifetime Suicidal Ideation and Suicide Attempt

Variable	Gay Mean (s.d)/%	Straight Mean (s.d)/% n=54	t/x2 df=109	p
Current depression	1.40(0.53)	1.41(0.67)	-0.11	0.92
No point to living	2.58(0.95)	2.06(0.80)	3.15	0.00
Suicidal thoughts	2.42(0.99)	1.74(0.76)	3.96	0.00
Intrusiveness of thoughts	2.50(1.21)	1.70(1.14)	3.46	0.00
Thought of method	2.45(1.07)	1.70(0.82)	4.04	0.00
Had access to means	38.6%	14.8%	7.95	0.00
Lifetime suicidal ideation	2.49(0.96)	1.80(0.76)	4.10	0.00
Suicide attempt	28.1%	7.4%	8.10	0.00

Source: Nicholas & Howard (1999)

Two extensive research projects (Hillier et al. 1998; Trenchard, and Warren 1987)) revealed that between 8 and 11 per cent of young people indicated that their sexuality was other than heterosexual. It was found that many of these young people regularly experienced verbal or physical abuse because they were lesbian or gay. As a consequence of social responses to their sexuality, some were sent to see a doctor/psychiatrist or were thrown out of home. Perhaps the most frightening figure was that one in five of these young people had attempted suicide as a consequence of their SSA.

Sears (1998) found that nearly two-thirds of a sample of 142 guidance officers expressed negative attitudes and feelings about homosexuality. Personal prejudice, lack of knowledge and fear can prevent workers with such attitudes from being effective resources for the students.

SUMMARY SHEET

Link between Sexuality and Suicide

Being SSA does not increase a young person's risk for suicide, but the broader social context, and the factors associated with being SSA (such as rejection, isolation and victimisation) do. These negative consequences result in stressors that contribute to the risk for suicide. They include:

- Harassment and victimisation, which can undermine a SSA young person's sense of safety and security. Some young people live a life of secrecy and are fearful of people discovering their homosexuality.
- An inability to fully and freely develop all aspects of identity, which is a major task of adolescence. Unlike their heterosexual counterparts, many SSA young people lack information, role models and opportunities to adequately develop and openly explore their sexual identity.
- A social context that fails to acknowledge diverse sexualities. This creates a pervading sense of isolation and rejection for SSA young people.

If there is a concern about suicide risk, it is recommended that professionals should provide careful assessment using their service's accepted risk assessment guidelines or by seeking the assistance of an appropriate agency (such as CAMHS).

For SSA young people, the following key assessments should occur with the general risk assessment. A worker should:

- Carefully assess the level of support available to them.
- Discuss the young person's thoughts about coming out.
- Check their readiness for, and awareness of, the risks associated with coming out to family and friends.
- Never encourage a young person to come out. It is their decision and they need to have a strategy in place if the response is unfavourable.
- Consider the level of psychological adjustment to their sexuality.

8.4 Same Sex Attracted Young People and Suicide Rates

Much has been written about youth suicide and its prevention, but little attention has been given to the relationship between sexuality and suicide. It is important to note that there are difficulties in obtaining accurate information about suicide in SSA young people. This is due to the way coronial data is gathered and the tendency for homosexuality to be concealed. In addition, it is necessary to know whether sexuality was the core reason for the suicide and, in most circumstances, only the victim knows this.

As a significant minority group, it is essential that the level of suicide risk of people who are SSA be identified, especially in view of the body of research that supports the contention they are at greater risk of suicide. Much of this research is from the USA. The studies vary in their estimation of the level of risk associated with SSA young people, but all agree that they are at least two to three times more likely to attempt suicide than their heterosexual counterparts, and that many attempt more than once (Bell & Weinberg 1978; Gibson 1989; Hillier et al. 1998; Jay and Young 1977; Refamedi et al. 1991). SSA young people may also comprise 30 per cent of all completed youth suicides in the USA (Refamedi et al. 1991).

The 1997 Victorian Task Force Report on Suicide Prevention in Australia quotes the US research and calls for further study to clarify, 'the epidemiology of suicide and attempted suicide among gay men and lesbians' (p. 40). The Task Force acknowledged that written and oral evidence presented indicates that SSA people, especially in rural areas, are a high-risk group.

Risk Factors

If we consider that health is created by factors such as individual behaviour and the social, political and environmental context, then a negative experience of these factors (such as in the case of many SSA young people) will have a detrimental the impact on the individual.

It is important to understand that suicide is a complex phenomenon. Suicide occurs as a response to an accumulation of circumstances that are referred to as *risk factors*. These include depression resulting from the ongoing pressure of dealing with sexual diversity. Events known as *precipitating factors* (such as harassment, loss of family support and substance abuse) when occurring in conjunction with risk factors may tip the balance and lead to suicide.

Social Factors

Many factors in the social environment can affect a person's mental health and well-being. Stress and alienation often feature in the SSA young person's life. They can be the target of a range of abusive behaviours and often make the person feel unsafe (Hillier et al. 1998). Society generally discriminates against homosexuality and portrays SSA in a negative way. Cultural and religious factors may be incompatible with a homosexual orientation. The denial of homosexuality prevents access to posi-

tive role models that, for the heterosexual majority, are a significant ingredient of identity development. These external pressures may compound the internal pressures. Consequently, the young person may experience emotional distress such as depression, hopelessness, self-blame and internalised homophobia. The young person rejected by family, friends and peers loses significant sources of support.

Hartstein (1996) found many studies that looked at the prevalence of suicide attempts amongst SSA youth identified that a proportion of the attempts followed the young person self-identifying as a homosexual.

Baume & Clinton (1997) argue that the personal vulnerabilities of rural youth are made worse by their isolation and decreased access to resources. In other instances, the characteristic familiarity of rural communities forces them to flee because they feared detection, or to enable them to live a more free and open lifestyle. This can mean some SSA young people are mourning the loss of intimacy and sense of belonging that can exist in a small town.

SSA young people may feel compelled to leave school early because of harassment and conflict. They may face total rejection from families and thus leave home. US and Australian (Hillier et al. 1998) studies have demonstrated a link between homelessness and homosexuality, and Gibson (1994, p. 22) further posits that this, 'leads to fulfilment of a suicidal script which sees them engaging in increasingly self destructive behaviours'. Closer to home, the Victorian Task Force Report (1997) clearly identifies the homeless as a population of special concern.

Mental Health and Illness Issues

As with depression, it is useful to view behaviour such as self-harm or internalised homophobia as a direct emotional response to stigma rather than as a clinical disorder. However, the young person still requires appropriate support and intervention whatever name is attached to their emotional state. It is important to be aware that there are increased suicide rates for SSA youth with a psychiatric diagnosis relating to conduct disorders and drug or alcohol problems.

Many gay and lesbian young people cope with the difficulties they encounter because of attitudes toward their sexuality, but some do not cope. They may internalise their negative treatment by others and feel overwhelmingly isolated. The psychological symptoms that may occur as a result can lead to a depressive illness. Young people may try to alleviate the pain they are feeling through using drugs and alcohol, and this further increase their risk for suicide.

Self-Harm

Self-harm is a symptom within a broader context that the person uses to express their feelings. It occurs as a result of precipitating factors. Basic differences can exist between genders in the way self-harm is expressed, so it is important to examine what the behaviour is saying: is the behaviour conveying that the young person is expressing internalised homophobia or is related to another issue?

The function and meaning of self-harm will vary for individuals. It may be:

- A physical way to express and relieve emotional pain.
- Self-stimulation. Feelings may be so deadened that physical pain provides a feeling of 'aliveness'.
- Self-punishment. The desire to inflict pain to punish the self may derive from internalised beliefs about being bad or shameful. These beliefs may be related to:
  - Sexual abuse.
  - Internalised homophobia.
  - Internalisation of cultural expectations of a perfect body.
- A mixture of the above.

When young people self-harm as a way of expressing and relieving emotional pain, they may be experiencing great difficulty managing or regulating intense emotions, especially anger. These people may have a cluster of difficulties that also include:

- Suicidal threats or gestures.
- Fear of abandonment or fear of being alone.
- Unstable and intense personal relationships that fluctuate between extreme love to extreme hate.
- Impulsive 'risky' behaviour such as substance abuse, unsafe sex, reckless driving and binge eating.
- Identity disturbance.

When present in adulthood, this cluster of difficulties may be understood as borderline personality disorder. When these difficulties present in adolescence, may be understood as borderline personality traits.

Young people who self harm are also at risk of homelessness and poor social support. They require intensive case management to help *contain* their behaviour to reduce the risk of it escalating and resulting in further psychosocial problems.

To develop consistent, clear plans, goals and strategies to help these young people, crisis plans and regular case conferencing are needed with all people involved in the young person's care.

The follow-up into adulthood of these adolescents indicates that two out of three do not meet the criteria for borderline personality disorder, especially when they have received appropriate treatment.

How Do Workers Respond to Self-Harm?

- Complete a suicide risk assessment. If you are satisfied the suicide risk is *low* and hence not a main focus of intervention.

Then

- Try to assess whether the young person has a cluster of difficulties that fits a picture of borderline personality traits. If this seems to be the case, consult with your local Child and Adolescent Mental Health Service (CAMHS).

- Even though the suicide risk is low, it may still be helpful to consult with CAMHS in order to develop a support/ management plan.

In terms of self-harm, it may be useful to:

- Make a clear statement that self-harm is breaking the boundary of keeping yourself safe and that, as their worker, it is not something you are comfortable with or you think is okay.
- Invite them to explore *why* they self-harm so they have more control or more options about how to reduce or stop it. This could include:
  - Encouraging them to monitor the urges to self-harm on a scale from 1 to 5 and actual self-harm for one or two weeks. Ask them to include the strategies they used to stop urges becoming action.
  - Asking them to note the thoughts, situations and feelings that trigger self-harm urges and actions.

This information can provide a basis for understanding the pattern of self-harm, and for building up new coping strategies such as ways to better manage feelings and high-risk situations. Finally, a crisis plan to manage self-harm should be written up.

If these strategies are not helpful in reducing self-harm, or the person cannot be engaged in working on these strategies, a secondary consultation with a CAMHS is recommended.

If suicide risk increases during the work on self-harm, referral to a CAMHS for a crisis assessment would be appropriate.

Drug and Alcohol Abuse

> *Higher rates of suicidal ideation and behaviours have been shown among people who are substance abusers across populations and over time.*
>
> *(Victorian Task Force Report 1997)*

Studies show that SSA young people are more likely to abuse drugs and alcohol (Gibson 1989). The recent study *Writing Themselves In* clearly demonstrates this increased likelihood (Hillier et al. 1998). The increased rates of drug abuse in young women and in rural areas are particularly disturbing (Hillier et al. 1998).

Grief

For SSA young people, the issue of grief is relevant particularly when the pathway of adolescent development is considered *(refer also to section covering grief in chapter 5).* These young people experience grief as a consequence of their sexuality. It is important to note that not all young people are equally affected, or are affected to a similar level. The issues of grief that arise for these young people might include:

- Loss of significant relationships, such as rejection by family or school friends when homosexuality is disclosed.
- Associated consequences that arise whenever a SSA young person makes a decision to disclose their homosexuality. As this is an extremely vulnerable time for a SSA young person, their risk for suicide is increased.

8 SAME SEX ATTRACTED YOUNG PEOPLE

- The development of one's sexual identity as a key task of adolescence. It is a time that is fraught with internal conflict and turmoil. The process is more complex for SSA young people because the sense of unrequited love is strong and, unlike their heterosexual peers, they are often unable to disclose their sexuality.
- Situations that enable a young person to cope with their diverse sexuality. These include leaving school early due to ongoing harassment and intimidation, or moving to the city and thus losing the intimacy, security and sense of belonging that comes with living in a small country town. These situations can create a sense of mourning about forced change or a lost sense of security.

SUMMARY SHEET

Same Sex Attracted Young People and Suicide Rates

It is important to keep in mind that many young people feel good about their sexuality. This is enhanced by their experience of coming to terms with their SSA in a supportive environment. Regrettably, for other SSA young people, coming to terms with their sexuality can often involve a great sense of isolation, and high levels of fear and anxiety in relation to how others may respond if they express their gay or lesbian feelings. These factors can contribute to an overall sense of isolation and may lead to a SSA young person feeling they do not belong or fit anywhere, either at home, school or in their local community. This gives us some insight into why SSA young people are at greater risk of suicide than heterosexual young people.

The factors listed below are implicated in increased rates of self-harming behaviour and suicide among SSA young people. These have been set out as external and internal pressures.

External Pressures

- Loss of family support.
- Harassment.
- Alienation.
- Religion.
- Homelessness.
- Discrimination.
- Substance abuse.
- HIV risk.

Internal Pressures

- Hopelessness.
- Ambivalence about sexual identity.
- Self-blame.
- Internalised homophobia.
- Early awareness that homosexual orientation is perceived the higher the risk.
- Grief.

Associated Risk Factors

Studies indicate for SSA young people there is an increased likelihood of:

- Substance abuse.
- Dropping out of school.
- Conflict with the law.
- Homelessness.

8.5 Sexual Identity Formation

Human Sexuality

In society, sexuality is generally presented in exclusively heterosexual terms, yet it is estimated that one in 10 people identify as being SSA (Liggins et al.1994; Ryan and Futterman 1998; Hillier et al. 1998).

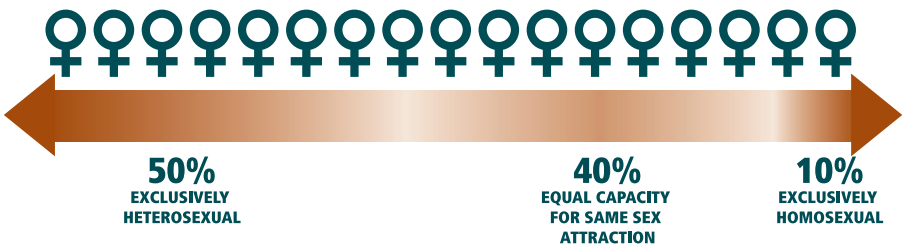
The term 'human sexuality' is better understood when considered on a continuum that includes sexual orientation, behaviour and identity. Slee (1993, p. 415) suggests:

> *"Neither gender identity nor sex role necessarily determine sexual preference, such that males and females can be heterosexual or homosexual with little apparent detriment to their psychological functioning."*

Ryan and Futterman (1998, p. 7) in discussing homosexuality and sexual orientation, also support the idea that sexuality takes place along a continuum. They refer to the definition used by the American Academy of Paediatrics that suggests that homosexuality should be regarded as a variation in sexual orientation: 'Homosexuality is the persistent and emotional attraction to members of one's own gender and is part of the continuum of sexual expression'.

Kinsey et al. (1948, 1953) devised a spectrum that suggests human sexuality should be thought of as being fluid and complex *(see figure 4).* The spectrum or continuum presents sexuality as a scale. Kinsey's model is based on the assumption that people are attracted to individuals, rather than gender or sexuality. The model was regarded as useful tool for using when working with SSA young people. The continuum is fluid and allows for everyone to fit themselves along it. While permitting people to define themselves in terms of sexual orientation, behaviour and/ or identity. For example a young person is more likely to regard themselves in terms of their current sexual behaviour, rather than their attraction or how they see themselves. The Kinsey model suggests that if sexuality was set out along a scale then approximately 50% of the population would be exclusively attracted to people of the opposite sex and approximately 40% of the population would identify as bisexual or having an equal capacity for attraction to both sexes. While remaining approximate 10% would be exclusively attracted to the same sex. The model distinguishes a percentage of the population who fluctuates in their sexual attraction.

Figure 4: Kinsey's Continuum of Sexuality



It is important to clarify two myths concerning sexuality:

- Sexual orientation is not influenced by negative experiences such as sexual abuse.
- Research is yet to establish whether sexual orientation is or is not a conscious choice.

Sexual Orientation

This refers to a person's basic sexual attraction or physical behaviour. The attraction may be to people of the same sex (homosexual), of the other sex (heterosexual), and of both sexes (bisexual). Expert opinion identifies that sexual orientation is likely to be determined in early childhood (Ryan and Futterman 1998). Sexual orientation encompasses fantasy, conscious attraction and emotional and romantic feelings.

Sexual Behaviour

This refers to a person's sexual activity: what we do sexually and with whom. It is important to note that behaviour does not always match sexual orientation and identity.

Sexual Identity

This refers to how people see themselves and present themselves to others. Identity development begins during adolescence, it can be influenced by a range of factors. Consolidation of sexual identity can be influenced by access to accurate information; supportive services, and the availability of role models.

Summary

- Human sexuality should be thought of as fluid and diverse.
- It is believed that sexual orientation is not a conscious choice. It is generally established during early childhood, usually before five years of age.
- People vary considerably, not only in the proportion of homosexual to heterosexual behaviour they practice, but also in the way their behaviour varies over time.
- The development of positive sexual identity is crucial to self-esteem and mental well-being.
- Fear of repercussions in disclosing sexual identity can influence consolidation of sexual identity.
- The effect of disclosing one's different sexual orientation, behaviour or identity from the accepted 'norm of heterosexism' can have negative consequences such as:
  - Psychological conflict.
  - Risk taking behaviour.
  - Social isolation and rejection.
  - Victimisation and violence.
- To avoid isolation, non-judgemental and informed support from service providers is critical when a young person is beginning to establish their sexual identity.

8.6 Adolescent Development

Adolescence is a time when identity, self-knowledge, social skills and independence are being developed and so it can potentially be an extremely vulnerable time for SSA young people. Society does not acknowledge SSA young people. Popular culture caters for heterosexual young people who are also free to discuss issues of sexuality among themselves. Conversely, SSA young people usually hear about themselves in negative terms with put-downs from their peers, from people in authority, or from within their families and communities. SSA young people may be vulnerable through:

- Discrimination.
- Isolation.
- Lack of role models.
- Lack of information, resources and support.

Table 9: The Eight Ages of Development and the SSA Perspective

Stages	Developmental Process	Identity
Basic Trust vs Mistrust (Birth to 1 year)	An infant is developing a sense of trust.	
Autonomy vs Shame and Doubt (18 months to 3.5 years)	The toddler is developing a sense of physical independence and free choice or thinking skills.	By three years of age, the child has a personal sense of being male or female and thus has established a gender identity.
Initiative vs Guilt (3.5 to 5.5 years)	The child is discovering behavioural limits and continuing to become more assertive and take initiative.	Between ages 3 to 7, the child is developing sex (gender) roles. Social and cultural expectations, attitudes (that is, stereotypes) and beliefs of male and female behaviour are established.
Industry vs Inferiority (5.5 to 12 years)	The child deals with productivity and mastery whether school, in this case, is field, jungle or classroom.	SSA young people often identify an awareness of difference from an early age, yet have no reference points. By early childhood, the pattern of physical and emotional behaviour, and sexual attraction to others is believed to be established.
Identity vs Role Confusion (Adolescence 12 to 18 years)	The adolescent is developing a sense of identity in terms of they are good at, sexual identity and peers, what they believe to be important and their values. This involves an intense exploration of personal values, beliefs and goals	If a young person socially deals with negative experiences or a lack of role models, or is seen as different, there will be implications for their identity and sense of self-esteem.

Source: Erikson (1963). The above table incorporates theories of gender identity, sex (or gender) roles, sexual orientation and personality outlined by Slee (1993) and Ryan and Futterman (1998, p. 9).

I would not come out at school. You would walk around your local area and the looks you would get. The school is focused around sporting achievements. I would feel really threatened if I came out.

(Farnan 1999)

8.7 Homophobia

Penley Miller and Mahamati (1994) have defined homophobia as:

> *"The fear and hatred of those who love and sexually desire those of the same sex. Homophobia, which has some of its roots in sexism, includes prejudice, discrimination, harassment, and acts of violence brought on by fear and hatred."*

Homophobia compromises human integrity by promoting a learned hatred and sanctioning of the use of violence and discrimination against homosexuals. Individuals who are SSA have experienced violence as a result of their sexual orientation. Most have experienced verbal assault; large numbers have been threatened with violence, or been chased or followed.

Homophobia inhibits young people's opportunity to learn about human diversity. In Australia's multicultural society, it is important to learn to accept and tolerate difference. Affirmation of sexual diversity can only occur by challenging and dismantling assumptions about homosexuals' lifestyle as immoral, inferior or deviant from that of heterosexuals.

Stages of Homophobia

Penley Miller and Mahamati (1994) have set out four homophobic stages that are expressed on a continuum of attitudes *(Table 9).* The attitudes are better understood as being fluid, as opposed to occurring in neat stages that a person moves through. The attitudes can be relevant to the individual coming to terms with their own sexual orientation, or apply to the broader community response to homosexuality. The responses will be tempered by interactions between a person and their surrounding environment.

Figure 5: Continuum of the stages of homophobia.

Table 10: Eight Stages of Homophobia

Attitude	Stages of Homophobic Attitude
Rejection	Sees being gay, lesbian or bisexual as a 'crime against nature'; any treatment or punishment can be justified.
Pity	Pities homosexuals and believes they should be encouraged to be straight.
Tolerance	Puts up with homosexuality rather than accepting it.
Acceptance	Implies there is something to accept, and that there is still something inherently not right about homosexuality.
Support	Safeguarding the rights of gay and lesbian people regardless of feelings of discomfort. These people are aware the discrimination and inherent unfairness of homophobia.
Admiration	Recognises the difficulties, courage and strength it takes to be homosexual.
Appreciation	Values the diversity of humanity and appreciates same sex attracted people as part of that diversity.
Nurturance	Gays and lesbians are viewed as an indispensable component of society.

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CASE EXAMPLE

A chilling example of the pressure to conform to the accepted dominant group norm occurred in Sydney in 1990. Richard Johnson, a homosexual, was lured by four schoolboys to a Sydney park and violently and repeatedly bashed. One of the offenders admitted during the trial that he had been repeatedly teased at school and called a poofter because of his quiet and gentle behaviour. The boy's desire to be accepted and to shake off his image as a sissy had played a significant role in his behaviour.

(The Age Newspaper)

Reflect on your personal attitudes by considering:

- Are the boys perpetrating the violence also victims?
- Has failure by the boys' families, school, educators and the broader community to adequately explain human diversity, allowed hatred, fear and ignorance to grow?

Levels of Homophobia

Personal or Internalised Homophobia

Internalised homophobia is self-hatred for a homosexual person because of their sexuality. The person believes feelings of attraction to the same sex are bad, sinful, immoral or repugnant. For the heterosexual person, this may manifest as the fear of being perceived by others as homosexual and results in them trying to 'prove' their heterosexuality.

Rogers (1998) suggests that some SSA youth may express their internalised homophobia by attempting suicide. Those who maintain self-loathing about their sexuality are at high-risk for suicide. It is recommended that they undergo suicide risk assessment in addition to receiving assistance to deal with the psychological challenges that result from social hostility toward homosexuals. Signs of internalised homophobia may be present as:

- Having poor self-esteem.
- Having poor body image and language, or feeling dirty or unclean.
- Feeling unworthy.
- Feeling defeated.
- Feeling isolated.
- Blaming themselves.
- Being intensely closeted or rampantly anti-gay.
- Actively seeking assistance to change their sexual inclination.

(Refer also to section on self-harm section in this chapter)

Interpersonal Homophobia

This usually results in expressing hatred or dislike of others who are thought to be gay, lesbian, bisexual or transgender. This may be shown through behaviours ranging from name calling to violence.

Institutional Homophobia

Fear of homosexuality in our society is evident as discrimination. Governments, corporate structures, churches and other institutions and organisations discriminate against SSA people in a variety of ways. Examples of this discrimination include policies and legislation that prevent homosexuals from marrying, not being regarded as the next of kin for a dying partner, or superannuation not going to the surviving same sex partner.

Cultural Homophobia

This is shown through societal norms that imply heterosexuality is 'better', and that everyone is or should be heterosexual. The media perpetuates heterosexuality as the norm by not reporting or representing the homosexual view. Where SSA people are depicted in the media, it is usually in stereotypical form.

8.8 Coming Out

Adolescence is a time of enormous turmoil and coming out is just one of many struggles occurring during development of an identity. Broadly speaking, coming out entails a person coming to terms with their homosexuality then moving on to public acknowledgment. This is only necessary because of the dominance of heterosexuality in our society. For some people, realisation about their diverse sexuality comes early in life, for others later, and some people decide not to come out at all.

A person can have a range of responses in coming to terms with their sexual identity, and external forces will influence the coming out process. Recently, many young people have used the Internet to 'out themselves' anonymously and safely.

Several models have been developed that outline the coming out process *(see Coming Out model below).* A young person can be most vulnerable at this time. An understanding of this process helps workers to provide appropriate support for SSA young people. Ryan and Futterman (1998) state that there are several models that have been proposed to describe the coming out process. They suggest that nearly all models recognise the following key aspects:

- The impact of stigma affects the formation and expression of SSA identity.
- The process unfolds over a period of time.
- It involves increasing acceptance of a SSA identity.
- It includes disclosure to non-SSA people.

Coming Out Model

The following is derived from Cass (1995, pp. 188–91):

- **Stage 1: Identity Confusion.** Recognition by a person that their behaviour may be 'homosexual'. Some will come to realise they may be SSA; others may deny or ignore the situation. Subsequently, there will be a range of emotional responses from positive to negative that result in feelings of anxiety, stress or fear.
- **Stage 2: Identity Comparison.** The personal sense of being SSA leads to a consideration of the likely consequences of their sexual identity. The most obvious is a recognition of difference from family, friends and others. Consequently, some feel wonderful because they understand themselves. For others, the notion can create fear of rejection, violence, isolation and alienation. The endpoint of this stage comes with the recognition by a person that they may be lesbian or gay.
- **Stage 3: Identity Tolerance.** The sense of identity tolerance is affected by social contacts with SSA groups. Positive social contacts can help overcome the damaging feelings that can arise from being part of a minority group. If the social experiences are negative, they can lead to self-hatred.
- **Stage 4: Identity Acceptance.** A person is feeling comfortable and accepting of their sexual identity. They may wish to tell family and friends about their homosexuality.

- **Stage 5: Identity Pride.** A sense of pride about their identity may involve wanting to support activities to help strengthen homosexual rights. There can be a sense of confrontation with, and criticism of, heterosexuals about the ideal sexual orientation.
- **Stage 6: Identity Synthesis.** Individuals are completely proud and open about their homosexual identity. They will still confront homosexual oppression, yet they recognise their identity is simply one of being a person.

The stages a SSA individual generally moves through *(as set out above)* are often represented as a continuum. It should not be assumed that a person moves neatly from one stage to the next. The experiences may occur at different times for individuals. Educators should be aware that it is more likely that they will encounter adolescents moving through the first three stages:

- Initially, a person is likely to be aware of feelings of being different. This can occur from early childhood to adulthood.
- There is awareness of being attracted to people of the same sex and there can be a sense of confusion about sexual difference. In an effort to make sense of this, there may be homosexual and heterosexual experiences.
- Family and friends will be told about their sexuality.

The experience of disclosure to family and friends can be easy for some and difficult for others. Depending on the circumstances in which the young person finds themselves, the most appropriate decision may be to not come out at all, even though this may not be the best decision for the young person. The impact of self-disclosure on the young person will be affected by the response of the immediate support network of family and friends, and their tolerance of the disclosure.

While we know the experiences of SSA young people are not universally negative, table 10 below provides some understanding of these negative experiences.

Table 11: Negative Experiences for SSA Young People

Social	Feeling alone in every social situation (with family, peers, school and so on).
	Feeling they have no one to talk to.
	Fearing discovery, they continue to hide.
Emotional	Feeling they must be vigilant at all times, and thus increasing their emotional distance.
	Feeling emotionally separate from others, especially family.
	Fearing SSA friends will misunderstand friendships, or give away their secret.
Cognitive	Lacking accurate information about homosexuality, including appropriate role models.
	Basing their information on other lesbians and gay males (including future life options) or crude stereotypes.

Source: Ryan and Futterman (1998, p. 11)

Acceptance occurs, as homosexuality becomes a way of life. This generally takes place from the end of adolescence through to adulthood. It involves fusing sexual and emotional feelings, and believing homosexuality is valid. Increased happiness comes with the self-identification process. It may also be marked by external transitions such as the first SSA love relationship, disclosure to parents, co-workers and other heterosexual people.

Coming Out: Some Guidelines for Professionals

Coming out can be a time of positive and negative experiences. Many young people, struggling with sexual identity in a predominantly heterosexual environment, can experience a range of feelings and psychological effects.

When a young person comes out, they can be extremely vulnerable. This is the time when SSA young people are at greatest risk for suicide. When a young person is coming to terms with their sexuality, professionals should realise that *a young person should not be encouraged to come out until they are ready.*

The following questions are intended to provide professionals with some guidelines to ensure a young person has considered all the issues before deciding to come out.

SSA young people need to think through the issues and the potential impact of disclosing their sexuality. It is important to use the material in a sensitive manner. *It is recommended that only professionals who are competent in assessing an adolescent's emotional state* (such as counsellors, school welfare staff and youth workers) *use the questions.* In some situations, even though coming out is a normal stage of SSA identity development, ongoing emotional distress about sexuality may occur such as depression, anxiety or anger. Therefore, a worker needs to have the assessment skills to detect emotional distress.

The guidelines outlined below are derived from Penley Miller and Mahamati (1993) to assess the safety and readiness of a SSA young person in coming out. They suggest that the young person should be asked if they have considered the following issues:

- Can you sit down with your parents and talk openly about your sexuality?
- Should you tell them in a letter?
- Should you ask one of your siblings or a close friend to break the news?
- Should you tell just one parent and not the other?
- Should you let your parents know about your sexuality by dropping hints, or simply by introducing your partner and letting them draw their own conclusions?
- Do you think your friends would accept your sexuality?
- Would it be safer not to reveal your homosexuality, lesbianism or bisexuality (and possibly your relationship)?

Further issues that the worker needs to discuss and consider with the young person are:

- What alternative financial resources are available to you if your family asks you to leave home?
- What is happening at home at present? Are there other issues of concern that your parents are dealing with?
- Have you considered your motives before telling your parents?
- In case there is a negative response from your parents, are you sure there are supportive friends/people for you to depend on?
- Australian role models of SSA people who are living happy and productive lives can help promote self-esteem. Do you know other Australians who are SSA: pop stars, sportspeople, politicians and TV personalities?

8.9 Referral and Advocacy

When referring a young person, the worker should be sure that the service will support them appropriately and not focus on the issue of their sexuality.

Family support is generally seen as important. Where disclosure results in family support being removed when it was freely offered in the past, the experience can be extremely distressing and is often a real issue for SSA youth. Many of the young people interviewed in the focus groups indicated that their families demonstrated rejection on many levels.

If the young person appears to be very distressed or indicates that they are suicidal it is appropriate to refer them to a CAMHS. Otherwise referral to a local community health centre or support group is suitable. The service would need to have empathic practitioners with gay friendly/sensitive practice.

SUMMARY SHEET

Coming Out

- Coming out is necessary for SSA young people due to acceptance of heterosexuality as the norm.
- Self-disclosure can be a vulnerable time.
- Confusion about sexual identity is part of adolescent development and is not likely to contribute to a young person's vulnerability (except for internalised homophobia).
- Societal attitudes affect a person's sense of a positive or negative identity. The stigma and rejection that can be associated with disclosure can lead to a high risk for depression, substance abuse and suicide among SSA young people.
- The impact of coming out is influenced by a range of environmental factors and may vary for each SSA young person.
- Role models and peer groups are an important influence in personality development. Promoting awareness of, and contact with, other SSA people can assist to develop a sense of belonging and understanding of similarities.
- When school personnel or professionals encounter SSA young people, it is important that they aware that the young people are likely to be moving through the first three stages of coming out. Treating the issue sensitively is vital in promoting the young person's positive homosexuality identity.
- Young people should not be encouraged or allowed to come out too early. Rather they should be encouraged to wait until they are ready *(see Workers Strategies section on coming out).*

CASE EXAMPLE

Shaun, a 15-year-old secondary school student, told a few of his close friends at school that he was gay. He told them in confidence and asked them not to tell anyone else in the school. The so-called friends betrayed him by telling other classmates. By the next day, the reaction by many fellow students toward Shaun included verbal abuse and social isolation. In the change rooms, the reaction was horrifying for Shaun. He was afraid that he might be beaten up. The sports teacher condoned the behaviour by conveniently ignoring the torment and bullying. The verbal abuse and harassment continued unchecked. Shaun was so emotionally distressed by the experience that he dropped out of school and started using drugs as a way of easing his distress.

CASE EXAMPLE

Conversely Michael's experience below outlines a positive outcome for a young person disclosing his homosexuality:

Michael, who is 15 years of age, told a few school friends he was gay. He said, 'their reaction was so terrible that I regretted telling them. Now people are leaving me alone and it is okay'. Over time, he felt there was a real shift in people's feelings. He explained this shift as being a result of sexuality being taught as a curriculum subject and homosexuality was explored as part of this. He also felt comfortable enough to be able to share his experiences of being gay with the class when the teacher was talking in a positive and open manner about homosexuality. Since discussing his sexuality with fellow students in class, he feels that life at school has improved for him.

(Case Examples reworded from STEP focus groups)

8.10 Good Practice Strategies for Workers

Best practice can be modelled through:

- Case examples and discussion.
- Information provision and discussion.
- Provision of resources.
- The development of specific materials, such as poster or brochures.

This section is intended to outline ideas, activities and practice strategies to create a supportive environment and more sensitive service provision. In the case of clients from diverse backgrounds, we need to be mindful of:

- Automatic responses that are based on narrow assumptions.
- 'Difference' or diversity.
- What we are saying.
- Our responses and how these impact on the client.

When interacting with a client, professional skills are used to build a therapeutic relationship to enable the person to obtain assistance. This is often considered tacit knowledge. This knowledge consists of four key skills that professionals use during interaction with a client:

- Listening, hearing and understanding the specific needs of the client.
- Engaging and connecting with the client.
- Intervening and knowing how to assist the client.
- Reviewing and evaluating the interaction and its effect.

Listening, Hearing and Understanding the Specific Needs of an SSA Young Person

Hillier et al. (1998) found that SSA young people rarely spontaneously spoke to professionals about their sexuality. Workers need to be proactive and demonstrate that they and their service are sensitive to SSA young people's needs.

Professionals need to consider their values and attitudes and understand that their point of view can impact on an interaction with a young person. There is an onus on professionals to create a safe and supportive environment that encourages young people to feel comfortable enough to discuss and explore their needs and interests. It is important to validate young people's sexual feelings, identity, interests and behaviours. Harrison et al. (1996, p. 69) suggest that a value-neutral stance in relation to teachers is unfeasible because:

> *"Teacher values are imparted to students not only through the spoken language but also through silences, body language, role modelling and the way we choose to live our lives."*

This statement is relevant for all professionals working with young people. If professionals are cognisant that their viewpoint will be conveyed during an interaction with a young person, it is important to adopt a value-neutral stance.

Strategies and Guidelines for Being More Proactive and Inclusive

- Use a non-judgemental and supportive approach such as, 'Do you think you might be SSA?' instead of 'Are you SSA?'
- Use inclusive language that is gender neutral (for example, using terms like partner).
- Ensure client confidentiality.
- Examine your own values and attitudes.
- Develop an understanding of sexual identity.
- Be acquainted with legal and institutional restrictions.
- Positively affirm the young person's identity.
- Display a rainbow sticker on the front door of your organisation's building to indicate that the service is SSA supportive. Alternatively, display the sticker on your office door. *(For availability, refer to Hares and Hyenas Bookshop in Resource section 8.11).*
- Affirm organisational acceptance by displaying such things as posters and flyers in prominent places such as waiting areas and offices.
- Provide SSA young people with access to resources and information.
- Use role models to promote positive self-esteem such as supporting colleagues who are SSA.
- Ensure service forms and documents account for diversity of clients *(see chapter 3).*
- Take available opportunities to become better informed. Read, discuss and observe.
- Look for opportunities to participate in activities that allow you to experience being different.
- Assume that approximately 10 per cent of people are SSA (this includes clients and colleagues).
- Be aware of relevant references and general reading material that covers sexuality issues: relationships, orientation, behaviour and identity.
- Do not assume you know the sexual identity or orientation of your person when interacting with them.
- Include different family structures in any discussions on family and community.
- Use language that signals to a young person that they are safe to share their situation with you.
- Encourage tolerance and discourage harassment as a group norm in your work and social circles.
- Be prepared to respond to anti-same sex attracted slurs, just as you would to racist or sexist slurs.
- Respond to homophobic slurs in a well-informed manner. Respect the person challenging you. Focus on challenging the negative opinions rather than the person.
- Discuss sexuality issues in terms of how the person is feeling rather than debating ideas when a person has strongly held views.
- Be aware of the issues and risk factors associated with SSA young people.
- Be aware of local organisations and resources for making appropriate referrals.

(Some of these suggestions were recommended by Liggins et al. 1994, Selkrig et al. 1998.)

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CASE EXAMPLE

A 14-year-old girl lives in a small rural town with a population of around 7000. There is a major regional centre 45 km away. There is no public transport system between to the two centres. The young girl (pseudonym Sally) has for some time felt different from her friends and sisters. Sally is unclear about how or why she feels different, but it seems to be about relationships and how she feels about some people is different from how others feel.

The sense of being different is starting to bother Sally. She knows she cannot talk to her family. They would not understand, may be very angry and may even throw her out of home. Sally attempts to find some books at the school library. There are lots of books about male and female relationships. The books do not mention the variety of relationships that do exist. She creates an opportunity to visit the welfare guidance counsellor at school, on a benign pretext, hoping for a chance to discover some information that the counsellor may have displayed in the office. The counsellor knows her parents. Sally is concerned about confidentiality so she does not feel it is safe to talk frankly with the counsellor.

Sally feels confused and isolated about her identity. Most of her friends talk about their boyfriends and tease her because she still has not been out with a boy. She is afraid that her family or friends may discover her feelings, so she retreats to her room with the excuse that she has lots of study and becomes increasingly withdrawn.

- As a worker, how do you help someone like Sally?
- More often than not, workers need to develop proactive approaches to increase the likelihood of making contact with SSA young people. How might this be achieved?
- Consider Sally's experience. What strategies can professionals initiate in their local region to assist and be more inclusive of the needs of SSA young people?

You can still support a SSA young people even if you feel uncomfortable discussing issues about sexuality. Be prepared for such circumstances and have a few reference books and pamphlets available. Refer the young person to colleagues/counsellors who have and do feel comfortable discussing sexuality.

Engaging and Connecting

The challenge of engaging effectively in a working relationship with a young person is something we all face in our work. Young people are often inexperienced in seeking help and can be self-conscious, shy, and easily embarrassed. Frequently, they are impatient with delays and expect immediate results, yet are reluctant to disclose much about themselves. Some elements that have been identified as important in engaging with young people are:

- Adolescent-friendly and age-appropriate communication. Understand their language and be able to show a generally tolerant and non-judgemental attitude toward their values and beliefs *(see Adolescent Profile Interview below).*
- Ensure confidentiality while remaining aware of the medico-legal issues related to minors and consent *(refer Suicide Intervention chapter 5).*
- Be aware of developmental stages and understand that young people are vulnerable to the physical, emotional, and psychological changes going on for them.
- Always use the basic counselling skills.
- Assess any risk for suicide *(refer suicide intervention guiding principles chapter 5).*
- Be aware of specific risk factors for SSA young people.
- Try to respond as quickly as possible to any young person seeking support or assistance. Often they may have spent a lot of time working up the courage to talk to someone.

Working with adolescents can be challenging. The Adolescent Profile Interview can be a used as a guideline for navigating your way through the session in a sensitive and supportive manner.

The Adolescent Profile Interview

Table 12: The Adolescent Profile Interview

Home	Where do you live? Who do you live with? How much time do you spend at home? What do you and your family argue about? Can you go to your parents with problems? Have you ever run away from home?
Education	What year are you in? What are your marks like? Have they changed? Have you ever failed any classes or been kept back a grade? Do you ever cut classes? Have you ever been teased or attacked at school? Do you work after school or on weekends? What are your career/vocational goals?

Activities	What do you do for fun? What activities do you do during and after school? Are you active in sports? Do you exercise? Who do you do fun things with? Who are your friends? Who do you go to with problems? What do you do on weekends? Evenings?
(If appropriate)	Does anyone in your home/family know you are lesbian/gay? Why/why not? Do any of your friends know you're SSA? Do you have any SSA friends? Are they your age, older? Do you go anywhere to meet other gay people? Do you go to gay bars or clubs? What do you know about local social and recreational organisations for SSA?
Drugs	Do you drink tea or coffee? Do you smoke cigarettes? Have you ever smoked one? Have you ever tried alcohol? When? What kind and how often? Do any of your friend's drink or use drugs? What drugs have you tried? Have you ever injected steroids or drugs? When? How often do you use them? How do you get money to pay for drugs? Are drugs used or available in places where you hang out?
Sexual activity/ identity	Have you ever had sex unwillingly? How many sexual partners have you had? How old were you when you first had sex? How old was your partner? Have you ever had sex with men? Women? Both? Do you think you might be SSA? Do you think you need to have sex to find out if you're SSA? Have you ever had an infection as a result of having sex? Do you use condoms and/or another form of contraception for STD and HIV prevention?
Depression	How do you feel today, on a scale of 0-10? (0 = very sad 10 = very happy) Have you ever felt less than a 5? How long did that feeling last? What made you feel that way? Does thinking you may be SSA make you feel that way? Did you ever think about hurting yourself, that life wasn't worth living, or hope that when you went to sleep you would not wake up?

Author's note: It is extremely important that professionals ask the specific questions, 'Are you thinking about suicide? Have you thought about this in the past? Refer to the Suicide Intervention chapter for greater detail.

Source: Material in Ryan & Futterman (1998) was adapted for use with adolescents who may be SSA or questioning their sexuality.

Intervention/How To Help the SSA Young Person

Listed below is a range of ideas and strategies that are intended for professionals to assist in better meeting SSA young people's needs. They include:

- Provision of information booklets or resources for the young person. Many service providers, such as the ALSO Foundation, cater specifically for SSA people and can provide you with such materials. Other organisations with such resources include Family Planning/Action Centre and Victorian AIDS Council *(see 8.8 for a resource list and contact details).*
- Peer support. It can provide SSA young people with social and emotional support. A SSA peer support group can create a chance to socialise and mix with young people of their own age. Access to such groups assists in identity development and establishment. Adolescents who have positive identities and connection to support are more able to counter the effects of victimisation and harassment. A useful document for this purpose is *Protocol Document 2000 page 152*, a protocols document for establishing a peer social support group for young SSA people. It was written by the Boroondara Council together with regional School Focused Youth Service (SFYS) and is included below.
- Minus 18. It is a supervised, no drugs or alcohol social evening for SSA young people *(see 8.11, page 152)*.
- Support for parents. Some parents will need support to openly discussion their feelings and thoughts without fear of rejection. P-FLAG is an informal support group for parents and families of someone lesbian, gay or bisexual *(see 8.11, page 152)*.

Schools

Young people are more likely to feel safe to disclose problems or concerns in a non-judgemental and supportive environment. For SSA young people, school has been identified as a major site where victimisation and harassment occur. Many young people experience some level of harassment when they have openly identified as SSA, are suspected of being SSA, or when their appearance and behaviour may be regarded as a stereotype of a SSA person. Research by Hillier et al. (1998, p. 33) found that for SSA young people, 'school is a more violent place than the general community'.

Young people are obliged to attend school; however, schools are failing in their duty of care if they don't provide a safe environment for *all* students regardless of their sexual orientation. Actions can influence behaviour, and if the school is open and clear about its stance on sexuality, students are likely to feel at liberty to seek guidance.

There are many ways in which the school could support or recognise homosexuality. Whether teachers openly support the concept or idea of SSA issues is not important; what is important is that they demonstrate concern for the well-being of individual students. To be effective in tackling discrimination and harassment, a school needs to engage in a range of strategies on a number of levels.

Policy

- There needs to be a commitment to action. Schools should have procedures and policies that ensure justice and prevent harassment recurring (such as the school support service framework).
- The staff should address negative school-based incidents on the spot (such as targeting harassment and put-downs).
- School staff should be encouraged to attend training that promotes an understanding of the impact of being SSA, as well as ensuring they have (and can) provide students with balanced views and information about homosexuality.
- All school professionals have a basic responsibility to maintain confidentiality. Student concern about a lack of confidentiality has been shown to cause young people to avoid or delay seeking help or support. A school is responsible for dealing with any lack of confidentiality by staff, and for providing clarity about a teacher's obligation in regard to state laws and informing parents.
- The school, especially the welfare coordinator, should have an awareness of gay, lesbian and bisexual community activities and support services.
- Equal opportunity legislation protects people from being discriminated against for being 'different'.

Curriculum

A school's curriculum should:

- Incorporate SSA issues, not just in the health education subjects but also in subjects such as English and History. Various education departments have created useful resources. Queensland Family Planning's *Safe Schools Pack* explores issues of sexuality including homophobia, gender, discrimination, families and support (phone (07) 3252 7922). The NSW Department of Education has a kit dealing with homophobia and a video *Mates* that is suitable for secondary school students.
- The STEP project has produced a video for professionals that would be suitable for education and welfare staff, as well as, parents. The video is called *"STEP ON IT Encountering Diversity—Questioning Ourselves" (to order see section 8.11)*.
- Lay the ground rules. For example, as a teacher, suggest that your classroom environment is *free* from sexism, racism, put-downs of any kind and homophobia. This can create an environment where the students can feel safe to be open. If these subjects remain unspoken, this is likely to increase the sense of rejection and isolation and ostracism for SSA students.
- Identify gay/lesbian contributions throughout the curriculum (that is, famous gays, bisexuals and lesbians in history, literature, art, cinema, science and religion).
- Include resources in learning areas and libraries (fiction and non-fiction) that are inclusive of sexual diversity.

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Positive Imagery

Visual cues are a good way of giving young people a message that it is safe to explore topics such as sexual diversity. The welfare guidance officer, teachers and principals can use resources such as posters, flyers, brochures and books to give encouraging messages.

When displaying resources, it is important to remember that young people will want to collect information while remaining unidentified. Therefore, a small card that someone can quickly grab and slip into their pocket is more likely to be used. A poster will need to be large enough so it can be read from a distance.

Parents

It is important to gain the cooperation of parents. Some possible ways of accomplishing this include:

- Inviting parent support groups like P-flag to conduct an information session for parents *(see 8.8 for contact details).*
- Frame discussions about homosexuality in terms of discrimination. It is morally unacceptable to incite hatred and discrimination based on a person's sexuality.

The Federation of State Schools Parents Club Inc. Curriculum Policy provides clear support for the right of all students to a safe and supportive school environment.

The Victorian Federation of State School Parents' Club Inc.'s curriculum policy section 1.8 Handling Individual Differences states:

> *The Federation supports Ministerial Paper Number 6 which states that all students should have access to educational experiences that are challenging, purposeful and comprehensive, and that result in all students experiencing success. If the goal of access and success is to be achieved then acknowledgment of, and provision for, individual differences is essential.*

In writing school policies and planning programs, schools need to take into account the major individual differences that affect a student's learning. These occur in:

- Abilities.
- Motivation and self-concept.
- Pace and style of learning.
- Gender.
- Social and cultural backgrounds.
- Sexual orientation.

Policy Document

The following document is a policy document that sets out the policies for setting up a SSA peer support group. This document has been created by a working party of local Boroondara youth workers, teachers, social workers, health workers and other community members. We would like to thank Boroondara Local Council and Youth Services for providing the document.

Aim of the Document

The document aims to outline guidelines to ensure quality and standards of service in the development and implementation of a peer/social support group in Boroondara for young people who are questioning sexuality.

What Is SAQS?

Supporting Adolescents Questioning Sexuality (SAQS) is:

- A peer social support group for young people questioning their sexuality.
- Open to people aged 14-18 years.

It conducts weekly meeting facilitated by two youth workers. Meetings take place in a safe, supportive and confidential environment where people are able to share stories and experiences with each other and with trusting and non-judgemental adults.

SAQS affirmation of diversity is pertinent to the project.

From time to time, group facilitators will conduct special workshops relating to the group's development and issues raised.

Proposed SAQS Model—Pilot Program

- Six-month semi-closed format with provision of five-week intake cycles over two school terms.
- Term 1: referrals open and interviews occur.
- Twelve participants selected and invited to attend.
- Participants attend with the expectation that they will remain for at least five weeks.
- At five weeks, waiting list referrals are invited to attend. Group numbers not to exceed 12.
- At six months, the peer support group is closed. This will include some sort of closure activity.
- Upon completion, it will be the role of the facilitators and Boroondara Youth Services to resource the participants with information about services available to them.
- If the peer group chooses to continue independently, it will not be the responsibility of Boroondara Youth Services. Possible further support could be in the form of telephone support, information and advice for individuals.
- Individuals identified by facilitators as requiring further peer support group work will be invited to attend the next six-month program when appropriate.

The Facilitators

The peer support group will be facilitated by:

- Boroondara Youth Services Youth Worker.
- Another key agency worker.

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Requirements

- One facilitator is to be gay, lesbian, bisexual or transgendered
- Preference is for a gender-balanced team.

Facilitators should:

- Have experience in working with same-sex attracted young people.
- Understand and have knowledge of group processes and demonstrated ability in fostering good group culture.
- Have knowledge of the lesbian and gay community.
- Be willing and open to participate when appropriate.
- Recognise suicide/self-harm risk and make referrals.

Intake and Referrals

Referrals into the SAQS program will be coordinated by Boroondara Youth Services. Referrals will be taken by phone from 8.30 p.m. to 5.15 p.m. Monday to Friday, or in person from 1.00 to 5.00 p.m. Monday to Friday.

At this initial access point, the young person, worker or family member will be informed of the program model and intake procedures. An interview time will be arranged between the young person and one of the facilitators.

Intake Interview

The intake interview (a one-to-one meeting between the young person and facilitator) will take place at the Boroondara Young People's Resource Centre. It will be informal and informative: a 'let's have a chat session'. Information about the group operations will be discussed.

The worker will assess the participant according to age and presenting issues, and ask why they have come and what they hope to get out of the program.

The worker will seek to assess young person's family situation, accommodation stability, friendships, sense of connectedness, level of risk and to the level of disclosure.

Confidentiality will be discussed.

File Notes and Storage

File notes are to be taken and stored in the locked filing cabinet at the Boroondara Young People's Resource Centre.

Rights of the Client

Welcome to the Boroondara Young People's Resource Centre. Our mission is to assist young people aged 12–25 years who live, work or study in the city to maximise their potential as community members.

As a visitor here, it's your right to:

- Feel welcome during opening hours.
- Use your resource centre regardless of gender, race, sexuality, religion or personal beliefs.

- Make complaints if there is something you are not happy with.
- See a youth worker if you need someone to talk with.
- Have information kept confidential (a youth worker needs to explain this in detail).

We request is that, while here, you are free from the effects of drugs and alcohol, look after the building, and help us make the centre a safe and a non-threatening place.

The workers will facilitate a group rules and expectations workshop upon commencement of each five-week cycle. The workshop will address rights of the client, confidentiality and expectations raised by participants.

Selection Criteria

- Age and capacity to benefit and participate in a group demonstrated.
- Preparedness to make a commitment for at least five weeks.

Exclusion Criteria

- Over the age of 18.
- Suicidal ideation, self-harming, violent behaviours.
- Presenting under the influence of drugs or alcohol on the day of the support group. Workers will ensure they follow up with the individual.

Confidentiality

- The facilitators and services will be mindful of confidentiality issues related to running a group.
- The intake interview will outline confidentiality issues relating to the group.
- Confidentiality issues will be discussed with the group in the development of group rules and expectations.

Confidentiality has been defined as:

> *In order to create an environment of trust, what is discussed in the group remains private and is not discussed by anyone, including the workers, outside the group. There is an exception if anyone within the group is at risk of being harmed in some way or there is a risk of someone else being harmed or harming someone else. Then the situation will be raised with appropriate family members, professional workers and agencies. Confidentiality is about respecting everyone within the group and protecting the safety and well-being of all group members.*

Parental Consent (for those Aged 14–18 Years)

Parental consent will not be required for young people attending the support group. According to legal advice from the Youth Advocacy and Legal Service, parental permission is not necessary. However, workers will need to evaluate and be satisfied that each young person has the ability to understand the consequences of their decision, and has a level of maturity to be able to understand their participation within the program.

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Child Protection Protocols

Boroondara Youth Services has a notification agreement with Department Human Services:

> *Applies to people 16 years and under who are at risk of harm including circumstances of child abuse and/or neglect.*

Individual Support

Participants may request individual support, or facilitators may identify such needs. In this case, referrals will be made to appropriate services made.

Supporting Young People Outside the Target Group

Under 14—With parental consent and with consideration of their level of maturity, a person under 14 years of age could be considered for the group.

Referrals to support services would be necessary for individuals under 14 years, without parental consent.

Over 18—Not eligible. Referrals to support services and links should be a responsibility of Boroondara Youth Services.

Promotions and Publicity

A schools kit consisting of a letter, posters and handbills will be developed. Two kits will be sent out to each school in Boroondara: one to the principal and one to the student welfare coordinator.

A flyer and poster will be designed and distributed to:

- Local youth providers via the Boroondara Youth Providers Network.
- Local libraries.
- GPs and health centres.
- Local press *(Progress Press, Boroondara Bulletin).*
- Street press—community Groups (Brother Sister).
- *Did You Know?* (Youth directory).
- Gay & Lesbian Switchboard.
- Cafes and other hot spots
- Kmart, Coles, MacDonald's, Safeway.

Promotions of any type will not include any information in relation to the location, time or day of meetings.

Secondary Consultation

Secondary consultations with Austin CAMHS are available over the telephone. Contact (03) 9496 3620.

Supervision

Supervision is available through the COBAHLT Project. Supervision sessions occur fortnightly at the Boroondara Young People's Resource Centre. Facilitators will need to contact Boroondara Youth Services to book in a place. Tel: (03) 9882 2621

Debriefing

When necessary, the facilitators will be able to call nominated people for debriefing. These calls can be made during business hours and up to 7.00 p.m. on the night of the group session.

Evaluating the Service

Evaluation of the service will be formative:

- Participant feedback forms will be handed out at the end of each session.
- The working party will meet monthly and review forms and consider recommendations.
- Recommendations of the working party and participants are be implemented by the facilitators.
- Two evaluation reports are to be written by Boroondara Youth Services in April and June 2000.

8.11 Resources

This extensive resource list is provided to give professionals access to a range of materials beyond the mainstream. It is relevant to note that virtually all the resources are located in the metropolitan area. This has occurred, due to a lack of resource in the rural regions. However, some of the services are set up to be available to young people statewide.

Australian Research Centre in Sex, Health and Society: Latrobe University Victoria

For a copy of the research report *Writing Themselves In: A National Report on the Sexuality, Health and Well-being of Same Sex Attracted Young People.* A poster is also available.
Tel: (03) 9285 5382
Website: www.latrobe.edu.au/survey/ssay.html

Context

A discussion/working group for teachers and youth workers interested in GLBT/queer issues. The group hosts events, write submissions and so on, and meets every third Wednesday of the month (February to November).
Tel: (03) 9386 0397

The Action Centre

A support/information group for young queer people. The group offers an easy going, non-judgmental safe place, and welcomes all GLBT for discussion with like-minded people. It also provides individual support as well as opening projects, programs and workshops.
Tel: (03) 9654 4766

ALSO Foundation

For 20 years, ALSO Foundation has been developing our community by providing funding options to community groups. Assistance extends to a resource centre where office equipment and services are available.
35 Cato Street
Prahran 3181
Tel: (03) 9510 5569

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Y-GLAM
Y-GLAM is for 14 to 25 year olds who identify as gay, lesbian, bisexual, transgendered or queer and who want to make theatre or video. No skills are necessary, just dedication and enthusiasm Rehearsals take place every Monday from 4.00 p.m. to 6.00 p.m.
Tel: (03) 9350 4000

Generation Q
For young people under 18 years.
Good Shepherd Youth and Family Services
Tel: (03) 9364 3200

Young and Proud
Frankston Youth Resource Centre
Tel: (03) 9784 1868

Access Information Centre at the Alfred
Victorian community resource centre on HIV, hepatitis and STDs. A body/mind spirit approach is adopted. There is a drop-in resource centre, lending library and web page, Information is sent out on request. PCs are available for Internet use.
Tel: (03) 9276 6993

Gay and Lesbian Switchboard
Switchboard is a free and confidential telephone counselling, referral and information service provided by trained gay and lesbian volunteers between 6.00 p.m. and 10.00 p.m. six days, and 2.00 p.m. and 10.00 p.m. Wednesdays.
Tel: (03) 9510 5488
Toll-free: 1800 631 493
For information on volunteering or membership, call the office:
Tel: (03) 9510 1846.

The Victorian AIDS Council/Gay Men's Health Service
The VAC/Gay Men's Health Service provides a broad and diverse range of services that address different individual and community needs. These include community projects, support and discussion groups, services for lesbian and gay men, and for people living with HIV/AIDS. It is staffed by professionals and volunteers.
6 Claremont Street
South Yarra
Tel: (03) 9865 6700
Toll-free: 1800 134 840

Melbourne Sexual Health Centre
The centre's specialist doctors and nurses provide services for people concerned about sexual health, sexually transmitted infections and HIV/AIDS. All services are free and absolutely confidential. A medical card is not required. Phone for appointment.
580 Swanston Street
Carlton 3053
Tel: (03) 93470244
(03) 9347 8619
Fax: (03) 9347 2230

Melbourne University Queer Department

MUSU's Queer Department provides support, information, activities and political activism. It is a resource for coming out, meeting with other queer students, and making sure people know that queer youth care about more than fashion!
Tel: (03) 9344 8159

Melbourne Youth Support Service

This service is an information and referral service for young people. It is mainly for 16to 21 year olds. It is open seven days a week for lesbian and gay HIV+. It is friendly provides a referral for emergency housing, food, advocacy, ongoing counselling, income support issues, youth allowance, employment, primary health care and so on.
Tel: (03) 9624 3688

Knox SSA Support Group

A support group for young GLBT people under 20 years of age, it meets every first and third Thursday. Call the general office for referral to the youth worker.
Tel: (03) 9298 8308.

P-FLAG (Parents and Friends of Lesbian and Gays)

An informal support group for parents and families of someone lesbian, gay or bisexual. It exists to support and inform, and meets every fourth Tuesday in the month at ALSO, 35 Cato Street Prahran.
Helpline (03) 95114083
(03) 97522081
P-FLAG:
PO Box 741
Glen Waverley 3150

Minus 18

A PFLAG fundraiser. It is a no alcohol or drugs, and is a fully supervised party for gay, lesbian, bisexual and transgender youth. It is a strictly under-18 only event (14-17).
PFLAG: (03) 9511 4083
ALSO: (03) 9510 5569

Young and Gay

Young and Gay is a free and confidential six-week discussion group for men under 27 years. Young men can make friends, talk about coming out, relationships and self-esteem, and get information on safe sex and HIV/AIDS.
Tel: (03) 9865 6700
Toll-free: 1800 143 840

Joy Melbourne

Radio station 90.7FM JOY Melbourne is a gay and lesbian volunteer-based community radio station committed to providing a voice for the diverse lesbian communities. It enables freedom of expression, breaking down of isolation and celebration of lesbian culture, achievements and pride.
Tel: (03) 9690 0907

Police—Lesbian & Gay Liaison Committee

Assistance is offered on police matters and referrals are made to police. The committee is sensitive to gay and lesbian issues, and provides legal and other services. The committee would like to hear from witnesses or victims of violence, crime and inappropriate police behaviour.
Tel: (03) 9521 1021
Mobile: 0411 225 933

Hares & Hyenas Bookshop
Melbourne's queer bookshop.
135 Commercial Road
South Yarra 3141
Tel: (03) 9824 0110
Fax: (03) 9824 2839

Gay Lesbian Bisexual Transgender Network
The network is focused on defending the human rights of gay, lesbian, bisexual and transgendered people.
Tel: (03) 9427 7055

Victorian Gay & Lesbian Rights Lobby Inc
A lobby group that aims to achieve equality and social justice for gay men and lesbians. Areas of work include research and education, monitoring and responding to media, working with government and policy makers, and working with other community organisations.
Mobile: 0417 484 438

Victorian Federation of State School Parents' Clubs Inc.
112 Trenerry Crescent
Abbotsford
Tel: (03) 9417 4140
Fax: (03) 9417 4108
Email: vfsspc@c031.aone.net.au

Videos/Films

STEP ON IT Encountering Diversity—Questioning Ourselves
Department of Human Services—Mental Health Branch
The video has been funded by the Department of Human Services. The purpose of the video is to raise awareness about potential consequences for SSS young people who are subjected to discrimination, harassment and abuse due to others attitudes towards their sexuality. The video's target audience is professionals working with young people. It would be also suitable for parents. To obtain a copy contact the Mental Health Promotion Officer at your regional CAMHS.
Length: 12 minutes and it is accompanied by comprehensive booklet.

It's Elementary Talking About Gay Issues in School
Debra Chasnoff and Helen Cohen
A film about addressing homophobia and heterosexism in primary schools. This video shows how it can be done and is a resource for teachers and educators. It examines early development of values and attitudes and addresses homophobia. Treating everyone with respect to prevent prejudice and violence needs to start in primary school.
Length: 72 minutes and accompanied by comprehensive written teacher support material.
For further information or ordering, contact:
Healthcliff Distribution
Fax: (07) 55759488
Email: Hcliff@ozemail.com.au/~hcliff/

Internet Links

Internet Sites	Website Address
Australian Queer Resources Directory	http://ausqrd.queer.org.au/qrd/
Rainbow Community Centre	http://gloa.queer.org.au/html/rainbow_entre.htm
Queer Perth	http//www.iinet.net.au
Cyberqueer Australia	http://cyberqueer.rainbow.net.au
Geekgirl E-zine	http://206.251.6.116/greekgirl/
Lemonzine	http://lemon.rainbow.net.au
ANU Sexuality page	http:/student.anu.edu.au/sexuality
Rainbow net	http://http://home.rainbow.net.au
ALSO Foundation	http://www.also.org.au
Yahoo search engine	http://www.yahoo.com.au
Rural lesbian, gay and bisexual youth	http://outlook.trump.net.au
Healthcliff Distribution	http://www.ozemail.com.au/~hcliff/H
SSA	http://www.gettingreal.com.au
Reachout	http://www.reachout.asn.au
Hares & Hyenas	http://www.hares-hyenas.com.au
Victorian Gay and Lesbian Youth Resource Directory	www.geocities.com/ssay_vic
Enough is Enough, report by Victorian Gay & Lesbian Rights Lobby	www.vicnet.net.au/~vglrl
OutProud	www.outproud.org
STEP Focus Group results of SSA young people	www.youthmentalhealth.org

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APPENDIX 1

Focus Group Results and Methodology

1A: Focus Group Report—Indigenous Young People

1B: Focus Group Report—Refugee Young People

1C: Focus Group Report—Same Sex Attracted Young People

Appendix 1: Focus Group Results And Methodology

Methodology

Assessing the needs of young people who are representative of the target group was achieved by conducting semi-structured discussions. The STEP Project Coordinator facilitated the sessions and asked questions in a relaxed atmosphere. The MHPOs scribed responses. All sessions were only tape recorded for transcription purposes. The format was fluid to ensure participants felt comfortable and free to express their views and opinions.

The focus groups were run in association with a person who was familiar to the young people. A session was conducted over one to two hours, and the young people who participated were provided with refreshments. They were provided with a movie voucher as a means of thanking them for their time.

The session commenced with introduction of staff, purpose of focus group, reason for taping the session, importance of open, honest feedback, and an assurance about confidentiality.

Target Group

The young people were representative of one of the project's identified groups: refugee, Indigenous, or same sex attracted young people. In general, the focus groups were conducted with young people between the ages of 12 and 18 years to correspond with the STEP Project's target age group.

During consultations with key stakeholders, it was suggested that the identified young people were not likely to be engaged with services as yet, or might still be too distressed by their experience to discuss their views openly. In some cases, this meant it was necessary to consult older participants. This provided the added benefit of having their wisdom of hindsight.

General Parameters

- Number of sessions: one rural, one metropolitan.
- Duration of each session: about two hours.
- Number of participants: five to 10 young people.
- Staff requirements: facilitator/scribe/person associated with young people.

1A: Focus Group Report—Indigenous Young People

Preface

The purpose of this report is to outline the indigenous young people's views during focus groups. There were common issues raised by both groups of indigenous young people, as well as individual concerns.

Both groups were conducted in the presence of adult members of the indigenous community. This had positive and negative consequences. The Aboriginal Mental Health Liaison Officer was present during the Shepparton focus group. He left the group at one stage, and the young men appeared a little more open to discussing the issues.

The Healesville focus group was, in effect, a consultation with an adolescent indigenous schoolgirl who was brave enough to be articulate and frank despite the presence of 17 adults. This young woman's candid responses raised the issue of broken promises about intended action for the indigenous community's young people. This meant the adults of the Healesville Indigenous community had to reflect on their level of support for their young people.

The issues identified by the participants are summarised in key findings, then the detailed discussions are set out under broad topic headings.

The term 'Koori' refers to indigenous people from South Eastern Australia (Victorian region).

I would like to thank the young people who participated for giving honest and open answers.

Focus Group Discussions with Indigenous Young People

The purpose of this report is to outline the indigenous young people's views during a focus group.

Both groups were conducted in the presence of adult members of the indigenous community.

Key Findings

- The breakdown of family was suggested as being a main cause of distress for indigenous young people.
- When indigenous young people have a problem, they tend to keep it to themselves.
- The young men indicated that they do not talk to their friends about problems, they only discuss more superficial issues.
- Indigenous young people draw strength and support from their relationships and connection to the older community members. The connections with older community members were highly esteemed.
- Participants indicated that connections with the elders gave their lives a sense of purpose and control.
- Participants stated that they would like to develop stronger connections with community elders.

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- Recreation was important to all participants, as it is a means of productively occupying leisure time. For the young men, membership of the local indigenous football team was significant. It was considered 'a good way to use your time' and provided them with a sense of connection to community elders.
- Indigenous young people wanted more opportunities to take part in recreation activities that would give them a chance to learn more about their origins and indigenous culture.
- All the participants indicated that they were looking for an opportunity to learn from the elders and to understand more about their culture.

Detailed Discussion of Focus Group

Participants

Two focus groups were conducted: one in outer metropolitan Melbourne and the other in a large rural city. The rural group consisted of four young men: three were 16 years old and still at school, the other was 18 years old. He said he was unemployed and had been looking for work for a couple of years. He later stated that he has been working with a cultural centre and learning about and making indigenous art and culture. He is also part of a dance group that performed in district schools. Interestingly, he did not identify these activities as "work".

In Healesville, the focus group was really a consultation with an adolescent indigenous schoolgirl.

Family Discord

The young participants in the rural focus group identified the biggest issue for indigenous young people as being the breakdown of parental relationships. Parental discord caused their children to feel powerless. There was no opportunity for the children to talk about their problems. The sense of security and connection was lost, the young person felt isolated and powerless.

It was suggested that family discord is often associated with parental drug and alcohol abuse problems. This led to the young person being subjected to abuse and living in a violent atmosphere where parents may be drunk and abusive.

The Healesville participant did not identify family discord as being of any significance during her overall discussion. Her discussion was more a personal rather than an overall view about her peers.

Support/Service Usage

When asked the question, 'What do you or your friends do when you have a problem?' All the young people stated that they kept it to themselves. Their reasons are outlined below.

The rural participants stated that, 'you do not talk about problems with your friends, you only talk about everyday issues such as football. If you have a concern you do not tell, you keep it to yourself'.

The young metropolitan participant stated that young people, 'keep things to themselves'. She did not know of any services in Healesville where young people could get help when they had a problem. She suggested, 'you would need to go to Melbourne to get help. I don't know anything locally.'

Recreation

All the participants spoke of a need to provide the indigenous community's young people with productive activities to keep them occupied in their leisure time. The young people saw the recreation activities as providing a two-fold purpose: to keep them occupied in their spare time, and to provide an opportunity to learn more about their culture and develop connections with community elders.

The rural participants suggested a drop-in centre or an indigenous youth centre would give young people something to do. The country town was seen as, 'too boring with not enough choice'. These young men suggested that they would like to be taken on bush trips with their elders. 'A bus full of young men spending time in the bush learning from the elders would be good'. It was suggested that this would help them have more connection with their elders and the bush. It would be part of learning about their culture.

All of the rural participants played football for a team formed by the regional Aboriginal Co-op. These young men regarded football as providing them with a worthwhile activity. 'Being part of the team means you have to look after yourself and be at training twice a week. It is a good team in the league. We are on top of the ladder.'

For these young men, playing football meant they were mixing with older community members. The young men regarded this as providing a sense of connection. 'It was a good thing to be around the elders. They are older and wiser.'

There was a further issue associated with the football team. The young men also felt that because they played in the junior section of the club, they felt invisible. Beyond training and the match, most activities catered for the adults rather than the younger players. The young men wanted an opportunity to be more visible or more included in associated club events. Overall, they wanted more interaction with adults, as they considered this contact allowed them to receive positive encouragement and support.

The metropolitan participant said that she wanted more activities, 'to keep kids out of mischief'. She stated that 'Koori young people have nothing to do. They want an opportunity to actively involve themselves in something that is interesting and fun'.

Again, recreation was not only about occupying time. This young woman saw it as an opportunity to learn more about her origins and the indigenous culture. 'I would like some of the recreational activities to have more involvement with cultural groups. This would provide a chance to learn about Koori culture.'

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History

When asked if the previous generation's experiences were a concern to them, the rural participants indicated that it was not an issue for them but was important for the community elders.

All participants expressed a desire to learn about indigenous history and increase their understanding of the culture. 'Knowing your tribal connections is important for Koori people.'

School

The young men felt school seemed irrelevant to their future needs. 'There is too much theory and not enough practice with the hands on.' This statement was made with particular reference to the future when they would be looking for work. They generally felt more apprenticeship or work-based training would be good.

The metropolitan participant suggested that students do not talk to the school welfare coordinator (SWC). 'If you have a problem, nobody talks to them [the SWC] as there is no confidentiality. If you go and speak with them, everyone in the school knows that you have gone to them. The welfare coordinator will discuss your problem with other teachers, then they know all about your problem.

This young woman was also concerned about broken promises that concerned having an opportunity to include indigenous history as part of external school curriculum. She stated, 'It is not only Koori kids that wanted to participate, non-Koori kids had shown an interest too. The idea of running external studies about indigenous history and culture had been planned some time ago by local Koori community members, yet this had not gone ahead. Young people are being promised things that are never delivered.'

1B: Focus Group Report—Refugee Young People

The purpose of this report is to outline the refugee young people's views during a focus group.

Participants

There were five participants: two young men and a young woman from the Horn of Africa, one young man from Chile and another from East Timor who identified as an asylum seeker. The participants were in their late teens or early twenties. All participants had been in Australia for more than a year.

Key Findings

- Overall, the participants felt were many issues that set them apart from their Australian-born counterparts.
- The past experiences of refugee young people carried through to their present circumstances with differing consequences.
- The English Language Centre was regarded as a positive schooling experience where the teachers understood their needs and responded appropriately in a supportive environment.

- The mainstream education system was considered to be insensitive to refugee students' needs. These students experienced a range of difficulties such as isolation, communication problems, post-traumatic stress disorder (PTSD) or other mental health problems, but felt unassisted and misunderstood.
- Young refugee people often leave school early. This may be a direct result of their unhappiness at school, or because they had to help their family financially.
- There was a general sense that mental health services need to be more culturally sensitive and ethnospecific to reduce the barriers against service usage.
- The Australian way of life was so culturally different for these young people that it was alienating. These young people's lack of understanding of the new culture compounded the seemingly endless difficulties they contended with.
- Settlement in Australia led to changes in family dynamics, or created extenuating pressures for the young people who arrived without their families.
- There was no direct mention of suicidal ideation or behaviour, but there was an overwhelming sense of the ceaseless difficulties of what these young people face.

Detailed Discussion of Focus Group

Family Discord

- 'For young people who come to Australia without their family, their migration problems increased 10-fold. As well, there are pressures from home to send money.'
- 'Refugee young people cannot just be like most Australian young people, as they often do not have a life of their own. They must deal with housing issues, pressure and high expectations from the family at home.'
- 'The cultural divide between old country and new creates fiction between parents and children.'
- 'My parents suffered a lot of torture in their own country. They have left family and friends dead back in Chile. My father went through rage, depression, crazy outbursts and guilt because he was not killed.'
- A young man spoke about the fact that his whole family was here in Australia after fleeing Timor. It was suggested he was lucky. He replied, 'Very lucky, but very sad. If there is no peace, we can never go back'.
- Young people often have to act on behalf of their parents who are often unable to speak or read English. This means they lose their youth much earlier than most, and will often be further disadvantaged by missing school days to help their parents.

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School

Often refugee young people are put into classes in Australia according to age, not ability. Refugee young people may be at differing levels of educational ability than would be expected for their age group. This difference may be due to a lack of education in their country of origin or while in refugee camps or while fleeing.

Mainstream schools are a source of many problems, as is clearly evident in the statements made by these young people:

- 'Kids cannot or do not know how to communicate all the problems encountered at school. Young people are very unhappy at school and tend to leave early, then form groups in their local areas.'
- 'Young people may be suffering from post-traumatic stress disorder. There is no counselling or support at school. They need procedures to deal with health and mental health problems.'
- 'I had difficulties making friends at school. I came to Australia with high expectations, often under pressure to succeed.'
- 'The nuances in difference between cultures can create problems between teacher and student; for example, people from Horn of Africa do not make eye contact with teachers and elders as this is considered a sign of disrespect.'
- 'There is a lack of information about schooling and the courses, especially year 11 and 12.'

The English Language Centre is the first school experience for these young people when they arrive in Australia. They spoke positively of their experiences and felt it specifically adapted to their needs:

- 'The English Language School was really good. The teachers are trained to help. I stayed at school till year 10, and then stopped because financially my family needed money. I am always quitting jobs, I do not like the work.'
- 'I'm still friends with teachers from the Language Centre. They give encouragement.'

Mental Health

Refugee young people raised the issue of mental health to make suggestions about how service providers could improve relationships with clients and be more appropriate to their needs. There was a general concern that services needed to adopt more culturally sensitive approaches:

- 'Workers need to develop a good relationship with clients before any counselling can occur.'
- 'You can't generalise about each ethnic group. Workers should never assume that because they come from, for example, Somalia, that all Somalians are the same. There is enormous diversity within residents from one country of origin. Workers need to ask clients their wishes/beliefs.'
- 'There is a cultural lack of understanding about "mental illness". Health professionals need to use simple and appropriate wording to

ensure a person and their family understands the illness. Family orientated and culturally sensitive service is important.'

- 'In Australia, there is a diagnosis of trauma and torture for refugees, but in the Horn of Africa there is no such thing. It is described as "still memorising what happens in war".'
- 'The requirement of mental health services to have people declare their need, or to have a need, can result in putting off or discouraging Horn of Africa people in using mental health services.'
- 'Traditionally, elders solve disputes. This is an effective strategy for dealing with young people.'
- 'There is a lack of information for parents, especially about services.'
- 'Counsellors in Australia are not relevant to meeting the needs of the Horn of Africa clients.'
- 'Confidentiality is an issue, as generally a person from the Horn of Africa does not want to talk about an issue outside their family. This cultural barrier needs to be dealt with in a way that encourages people from the Horn of Africa to feel comfortable and compelled to speak.'
- 'Young people do not actively seek help from health services for problems, they generally seek help through a religious leader, friend or older person.'
- 'Sometimes I have to take them [parents] to the doctor, do everything. Lots of days off school.' When asked about the use of interpreters, one young person replied, 'Earlier they did, but some not. The family doctor not so much. Some can't get interpreters'.

General Issues

These young people raised a broad range of issues concerning the problem of settlement in a new country. The settlement process further alienated them, and compounded their distress:

- 'There is a need for an orientation program to Australia to advise refugees in how to use and access services to enable them to reach their potential.'
- 'Young people are not used to speaking out, they tend to keep an issue to themselves.'
- One young man stated that when he came to Australia from the Horn of Africa, he spoke no English. What helped him the most was, 'being involved with a youth worker who helped my understanding of Australia'.
- 'Fear of forgetting your identity: two faces, one for home and one for outside. You lead a double life speaking native language and behaving in a certain way at home, then speaking English at school and work.'

Some of the young men felt a real concern was knowing their rights as they are often spoken to by the police:

- 'Need to understand rights and Australian culture to survive.'
- 'Young refugee people do not know their rights. We need strategies to deal with police abuse. We're used to police being top dog in our country of origin.'

Other comments included:

- 'There is a lack of understanding by Australians of Horn of Africa culture.'
- 'Being an asylum seeker causes many problems. I can't study. No human rights. You do not have permanent status so cannot get a job, and this causes financial worries. You are not eligible for Medicare so it's difficult to get medical treatment. I need to go to Red Cross every two weeks or I will lose my money,'
- 'Lack of paperwork [that is, birth certificate, passport]. When I left my home, there was no time to get such necessary items. In Australia, a lack of appropriate paperwork causes all sorts of difficulties. If you do not have the appropriate paperwork, then every time a refugee must tell their story.'
- 'When I arrived here, I found out through workers coming to the flats about youth support service which was helpful.'
- 'I am still predominantly seen as a refugee. It is like a label, a stigma. For example, we accept you because you were desperate.'

Some of the young men talked about a lack of support for sports from their own community or the general community.

Employment

- One young girl, who observes Muslim religious clothing requirements for women, felt she has experienced discrimination from potential employers as a result of her difference.
- A young man who is an asylum seeker spoke about leaving school early to help his family financially. He had tried many different jobs and then quit because he did not like them. He would like to try other challenging jobs but those jobs needed a permanent residency visa.

History

- A young man whose family was forced to flee Chile in the mid-1970s spoke about the range of emotions and guilt that his parents, especially his father, went through when they first arrived. They are trying to 'bury the ghosts and now see themselves as Australians, and don't want to go back'. Even though this young man has Australian citizenship, he stated that he would be expected to sign up for conscription if he ever went back to live in Chile. On a recent visit to Chile, he was detained for a short while due to this eligibility for conscription and this had a big impact on his father.
- A young man from Timor spoke about the government corruption and the torture and killings that occurred.

1C: Focus Group Report—Same Sex Attracted Young People

The purpose of this report is to outline same sex attracted young people's views during focus groups.

Participants

There were seven participants at the metropolitan focus group: four young women and three young men. Some of the female participants had moved from the country to the city, and so they could reflect on their school experiences in a rural and metropolitan setting. The participants' average age was around 15 years. One young woman was 13 years old and another was 19 years old. Most participants were still at school and therefore their responses largely centred on their experiences at school.

The Mildura focus group comprised 10 participants: four women and six men. Participants were mainly aged over 25 years so they reflected on their past experiences. The older participants have started a local support group for young same sex attracted people. They provided some insight about the current experiences of these young people.

Key Findings

- All the participants experienced mostly verbal harassment that commonly occurred at school. The taunts were based on issues of sexual activity. This demonstrates that other young people regard SSA young people only in the light of the sexual act. There is no understanding of their needs and issues.
- The young people draw strength and support from a range of sources. They stated that teachers who have 'come out' are positive role models. It encourages them to be seen in a positive light when 'coming out'.
- School has a pivotal role when a young person is dealing with their sexual identity. Participants had a range of experiences at school. Around half had been supported by teachers and welfare coordinators. The other participants talked about the damaging effects caused by the disapproving views and reactions of teachers and welfare coordinators, and the school's failure to respond when fellow students were harassing them.
- The participants did not experience outright rejection by their parents when they disclosed their sexuality. There was a prevailing sense of disapproval that included ignoring the issue, assuming their child would become heterosexual again, or treating their child as substandard.
- Most participants stated that they had come out to friends at school. The responses they received ranged from support to outright rejection. When there was a negative reaction, it was extremely damaging for the young people.
- Some of the young people feared the reaction from fellow school students and kept their sexual identity to themselves.

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- Most participants indicated an awareness of their homosexuality from an early age. Only over time did they come to understand their differences. All participants were still trying to understand their homosexuality.
- Participants stated that in the country, homophobia is more pronounced and information is difficult to obtain. One young woman said, 'the strain of living in the country and dealing with my sexuality had caused me to become suicidal'.
- Young people who came from marginalised backgrounds accepted same sex attracted young people more readily.

Detailed Discussion of Focus Group

Family Discord

One young woman talked about the fact that she had not come out to her family as they were overtly heterosexual and she was not sure how they would respond, especially as she had a low status in the family. She was worried that they would reject her and ask her to leave. She did not have a good emotional relationship with the family. She said, 'They may know and pretend to be naive and ignore the fact I am gay. If they accept that I am gay, then my family have to react or deal with this so they do not make any response'.

One young woman mentioned that when she was younger, she was homophobic along with her heterosexual family.

Another young woman said, 'Even though my family are heterosexual, I know that they feel it was okay for others to be homosexual and they know some homosexuals'.

One of the young men told his mother about his sexuality and she was supportive. He could not tell his father but his mother did. Since then, his father has not made any comment to him about his sexual attraction, but the young man was worried his father would react badly. He thought he might be thrown out, even though his father had not reacted in any way. This young man's mother drove him to the support group.

One young man's family knows about him being gay. 'My family talk about it [my homosexuality] using analogies in terms of highways and changing lanes. They are quite stressed about it. There seems to be an underlying hope I will become straight one day.'

One young girl said that her family knew, but her mother is sick and she has left school to do her mother's job. She said her father had threatened to throw her out of home, but her mother's illness means she will be staying because she is needed to do all the housework and cooking.

School

Teachers and welfare coordinators could be positive or negative. Some teachers who were open about their homosexuality became positive role models for the young people.

One young man said that when stressed about being homosexual, he talked at school to friends who he had told about his homosexuality, as

well as the student welfare coordinator. He also found it helpful to have the support from staff from the Action Centre at Family Planning Victoria. He wanted the welfare coordinator to organise a support group at the school, but this has not happened and seems unlikely.

One of the participants said, 'A school teacher disapproved of "lesbian girlfriends" hugging in class implying that for other girls who are not homosexual, hugging each other is okay because they are not lesbians. However, it was not appropriate for the two students who are lesbians to behave this way'.

When some of the young people had approached welfare staff for help, they were met with the response, 'You should just be straight, then you would not have a problem'.

One young woman talked about being attracted to her teacher; other students were verbally abusive toward her about it.

One of the young men talked about having teachers who were positive role models. He recalled, 'One of my teachers had come out recently. There were other teachers in school who were same sex attracted and openly demonstrative toward each other at school. I found this to be helpful because it gave permission to other young homosexual people to come out and be seen in a positive light'.

Country Schools

One young woman, who had attended school in a country town, said, 'During sex education, homosexuality was talked about as being abnormal; that there was a need to help homosexual people to get back on track, to become straight'. She said that, as a result, she could not come out, was depressed and wanted to kill herself.

When one of the young women at a country school went to the welfare coordinator but not to discuss her sexuality. She wanted to create an opportunity to search for information about homosexuality. She looked for information about services for gays and lesbians but could only find Melbourne-based services. She was too scared to contact a service because she felt her parents might trace the number.

One young woman said, 'In a country town, some young people felt being gay was not normal. You are supposed to reproduce. The teacher also made statements that supported this view.'

Harassment

Some of the young women indicated that they were constantly harassed verbally by other students and that these taunts were generally of a sexual nature.

One woman, who has now left school, reflected on the fact that she found friends were not supportive. They challenged her sexuality and were verbally abusive and negative about sexual acts with women. 'They would put pictures of models in magazines in my face, then ask me did she turn me on?' She made a complaint to a teacher. Being fearful of the teacher's reaction, she did not want to disclose that she was a lesbian, only that she was being taunted. She went on to say that if confronted about it now, she would explode.

One of the young women said, 'At my school, there are a number of other peers who are homosexual. Other students felt fearful that the homosexual students might proposition them'.

When other young people responded to these young gay and lesbian people, they associated homosexuality with the sexual act in negative context. The sexual implications were constantly being used in an abusive manner. One young man said, 'When gay men come out people automatically think of the act of sodomy'.

One young woman felt people treated her sexuality as a joke. When she was more assertive about being a lesbian, people isolated her.

Coming Out

When one young man first came out at school and talked about his sexuality, his peers were not supportive. Other participants in the focus group suggested, 'It is how it is put, you have to be blunt about it'. One young man said, 'I gained a lot of support from a teacher who was lesbian, at a time when I felt rejected by my peers'.

One young man said he came out to his family but could not come out at school because he did not think he could talk about the experience. 'You would walk around your local areas and the looks that you would get'. He went on to say, 'I am not that popular at school. The school is focused around sporting achievements. I would feel really threatened if I came out'.

One young man told a few school friends he was gay. He said, 'Their reaction was so terrible that I regretted telling them. Now people are leaving me alone and it is okay'. He feels there was a real shift in people's feelings because sexuality was taught as a curriculum subject and homosexuality was explored. He felt comfortable enough to be able to share his experiences of being gay with the class when the teacher was talking in a positive and open sense about homosexuality. Since discussing his sexuality with fellow students in class, it is better for him at school. There is acceptance and understanding about homosexuality because he was able to break down the myths and stereotypes by providing his personal experience and this made it much more of a reality for other young people.

Another young man said, 'If you do come out you are isolated'.

Most participants indicated an awareness of their homosexuality from an early age, but only came to understand their difference over time. All participants were still trying to understand their homosexuality.

One participant indicated that even when he was young, he felt he was different. Other children made comments about him being effeminate.

Diversity

A number of young people stated that if you're different or belong to a minority group, you're rejected. Same sex attracted people are more accepted by others who are 'different'. These groups have a broader acceptance of difference.

APPENDIX 2

Some Guidelines for Training

2A: Refugee Training Session Agenda and Flyer

2B: Same Sex Attracted Training Session Agenda and Flyer

2C: Standard Evaluation Form

APPENDIX 2

Some Guidelines for Training

Information for the Facilitator

1. Length of Training

The training can occur over 1 or 2 days. Suggested times are 9.30 am till 4.30 pm each day. It is recommended that if there are to be two-day workshops that the training is separated out by a week to allow participants to reflect upon and review the first day training.

2. Preparation of Participants

The invitation of participants requires careful consideration and active involvement by the mental health promotion officers (MHPOs). Participants need to be aware of nature and aims of the training. The training will be promoted as not being highly specialised but providing an important opportunity of bringing relevant service providers together. The training is an opportunity to acknowledge and demonstrate each person's role and responsibility, and promote understanding of the importance of each service's role.

3. Strategies for Managing Participant Distress

- It is recommended that there be provisional warning at commencement of training about the potential impact of the material.
- Discussion about avenues for workers to debrief.
- Care exercised in the selection of case examples.
- Allow time to elicit people's reactions about the issues/material following particular sessions.
- The size of the group is important (18-25 maximum participants). It is essential to read participants reactions and feelings and have time to discuss responses.
- Talk about organisational response and the importance of debriefing and recognising the value of secondary consultation and being honest about your capacity to manage the situation. Referral is not about just hand balling on but working *collaboratively.*
- A screening process to determine participants level of involvement with the target group.
- A training group that comprises of professionals whose work brings them into contact with the young people. It can include professionals working in a clinical capacity, such as general practitioners, nurses, psychologists, psychiatrists, and accident and emergency staff. It can also include, but is not limited to professionals such as teachers, student welfare coordinators police, juvenile justice workers, social service workers, youth and community workers, social workers, institutional staff, legal and drug/ alcohol workers.

- The training should also be regarded as an opportunity to consult with local groups and services providers to develop local health promotion activities and strategies, as a means of supporting continuance of the impact of the training. It is recommended that the training finish with discussion about the level of local service provider interest in developing regional initiatives.
- Key stakeholders who work with the young people from one of Project's three target groups to facilitate the training in conjunction with the regional MHPO. Approach regional key stakeholders where appropriate to promote expert knowledge that is available at a regional level, and promote partnerships between key agencies and local service providers.
- An MHPO or appropriate CAMHS worker hosting the training will assist in the facilitation of the training session. They will take the lead in presenting the segment about the link between suicide and the young people from the target group.
- STEP program proviso for suitability of a facilitator:
  - Previous training experience.
  - Potential to be available as a local/ regional resource/referral point.
  - Expertise or extensive experience in working with the young people from the target group.
  - Preparedness to utilise STEP manual to conduct the training.

The Mental Heath Promotion Officers are available for consultation to assist in organising regional workshops. Their contact details are available at their website www.youthmentalhealth.org

APPENDIX 2

2A: Refugee Training Session Agenda and Flyer

Standard Agenda for Training Session

Agenda

Facilitator's Name

Organisation details

MHPO details

Venue

Dates

Day one

9.30–9.45	Welcome and introduction
9.45–10.15	Suicide Prevention to Mental Health Promotion—STEP Model
10.15–10.45	Australia's Humanitarian Program
10.45–11.00	Morning tea
11.00–11.15	Asylum seekers
11.15–12.30	The impact of trauma on young people's mental health
12.30–1.15	Lunch
1.15–2.15	Video and discussion
2.15–2.45	Settlement issues for families, children and adolescents (including cultural issues)
2.45–3.00	Afternoon tea
3.00–3.30	Settlement issues (continued-include resources)
3.30–4.30	Case study presentation

Day Two

9.30–10.00	Review of response to previous session
10.00–11.00	Clinical and psychosocial assessment
11.00–11.15	Morning tea
11.15–12.15	Recovery strategies
12.15–1.00	Lunch
1.00–2.30	Working with young refugees in practice (case scenario)
2.30–3.15	Emotional impact on workers
3.15–3.30	Afternoon tea
3.30–4.30	Workplace practice implications and where to from here

Standard Flyer for Advertising Workshop

Who should attend?
Professionals whose work brings them into contact with young people. It includes, but is not limited to teachers, student welfare co-ordinators, general practitioners, nurses, psychologists, psychiatrists, police, juvenile justice workers, social service workers, youth and community sector workers, institutional staff, legal and drug/alcohol workers, accommodation and support service workers

REGISTRATION

Name (for name tag) _____

Occupation _____

Organisation _____

Address _____

Telephone (BH) _____

Facsimile _____

Email _____

Special Dietary/Access Requirements _____

Cost: $10.00 to book your place
Please make cheques payable to SERVICE NAME

GET YOUR REGISTRATION IN EARLY - PLACES ARE LIMITED

Return registrations to:

Address

Phone Fax

Email

REFUGEE YOUNG PEOPLE

A TWO DAY WORKSHOP FOR PROFESSIONALS WHO WORK WITH YOUNG PEOPLE

DAY

DATE

TIME

VENUE

A Statewide Project of Mental Health Promotion Officers

DO YOU WORK WITH YOUNG PEOPLE?

IF SO, YOU MAY WORK WITH SOME YOUNG REFUGEES. RESEARCH SHOWS THAT YOUNG REFUGEES ARE AT GREATER RISK FOR MENTAL HEALTH PROBLEMS

YOU ARE INVITED TO ATTEND TRAINING AIMED AT ASSISTING WORKERS TO PROMOTE THE MENTAL HEALTH OF YOUNG REFUGEES

Day and Date
AT Time

FEATURING: FACILITATORS NAME

INSERT DETAILS ABOUT FACILITATORS WERE WORK

AIMS OF THE TRAINING
Professionals whose work brings them into contact with young refugees will gain a better understanding of:

- the higher incidence of depression and other mental health problems amongst young refugees.
- the associated risk factors for young refugees.
- the impact on young refugees of the experience of trauma and torture and the compounding challenges arising through the experiences of flight and resettlement within an alien culture.
- strategies, resources and skills for working effectively and inclusively with young refugees.
- strategies that prevent the escalation of depression and other mental health problems including the benefits of using a mental health promotion framework as an appropriate means of preventing suicide and depression.
- discuss opportunities for developing local responses and support for young refugees.

PROGRAM

The program includes activities, discussion, and information sessions. You will learn about:

- the refugee experience of young people
- the risk factors for depression and suicide
- a framework for understanding torture and trauma
- Australia's Humanitarian Program
- challenging myths and stereotypes.
- cultural issues
- implications for service organisation and practice
- skills to enable you to deal with your own and others' reactions and attitudes in a positive way
- strategies, skills and resources that lead to effective and inclusive involvement with young refugees
- appropriate referral strategies and agencies.

This training is part of the STEP Project funded by Commonwealth Department of Health & Aged Care as part of the National Youth Suicide Prevention Strategy (N.Y.S.P.S.).

The purpose of STEP is to develop and deliver training activities in youth suicide prevention to workers with three high risk groups:

- Aboriginal young people
- Same Sex Attracted (SSA) young people
- Refugee young people.

The training is intended to meet the needs of professionals whose work brings them into contact with young people from the Project's target groups.

APPENDIX 2

2B: Same Sex Attracted Training Session Agenda and Flyer

Standard agenda for training session

Agenda

Facilitator's name

Organisation details

Venue

Date

9.30–9.40	Registration/introduction & aim of training (MHPO)
9.40–10.00	What increases the risk of suicide for same sex attracted (MHPO)
10.00–11.00	Understanding sexuality-models of sexuality
9. 11.00–11.20	Morning tea
11.20–12.00	Challenging the myths and stereotypes
12.00–12.30	Coming out
12.30–1.00	Reviewing levels of understanding
1.00–1.45	Lunch
1.45–3.15	Strategies for working with SSA young people Case scenario and discussion Referrals
3.15–3.30	Afternoon tea
3.30–4.15	Where to from here? Planning a local response
4.15–4.30	Close

Standard Flyer for Advertising Workshop

Who should attend?
Professionals whose work brings them into contact with young people. It includes, but is not limited to teachers, student welfare co-ordinators, general practitioners, nurses, psychologists, psychiatrists, police, juvenile justice workers, social service workers, youth and community sector workers, institutional staff, legal and drug/alcohol workers, accommodation and support service workers

REGISTRATION

Name (for name tag) _____

Occupation _____

Organisation _____

Address _____

Telephone (BH) _____

Facsimile _____

Email _____

Special Dietary/Access Requirements _____

Cost: $10.00 to book your place

Please make cheques payable to ?????? Mental Health Service

GET YOUR REGISTRATION IN EARLY - PLACES ARE LIMITED

Return registrations to: Name
Mental Health Promotions Officer
Service
Address
Ph: Fax:
Email:

SAME SEX ATTRACTED YOUNG PEOPLE

A WORKSHOP FOR PROFESSIONALS WHO WORK WITH YOUNG PEOPLE

DAY

DATE

TIME

AT

VENUE

A Statewide Project of Mental Health Promotion Officers

DO YOU WORK WITH YOUNG PEOPLE?

IF SO, YOU ARE BOUND TO WORK WITH SOME SAME SEX ATTRACTED (SSA) YOUNG PEOPLE. RESEARCH SHOWS THAT SSA YOUNG PEOPLE ARE AT GREATER RISK FOR SUICIDE

YOU ARE INVITED TO ATTEND TRAINING AIMED AT ASSISTING WORKERS TO PROMOTE THE MENTAL HEALTH OF (SSA) YOUNG PEOPLE.

DAY DATE
TIME

FEATURING: ie IAN SEAL
Ian has worked with gay and lesbian young people for over 8 years. He currently works as a project worker with Family Planning

AIMS OF THE TRAINING

Professionals whose work brings them into contact with SSA young people will gain a better understanding of:

- **the higher incidence of suicide** amongst same sex attracted (SSA) young people.
- the **associated risk factors** for SSA young people.
- the **impact** for SSA young people of a **lack of social support, contacts, information and role models.**
- **strategies, resources and skills** for working effectively and inclusively with SSA young people.
- strategies that prevent the escalation of risk of suicide including the benefits of using a **mental health promotion framework** as an appropriate means of preventing suicide.
- discuss opportunities for developing **local responses and support** for SSA young people.

PROGRAM

The program includes activities, discussion, and information sessions. You will learn about:

- the terminology used in relation to SSA young people.
- the latest research about SSA young people, including suicide rates.
- models of sexuality - orientation, behaviour and identity.
- challenging myths and stereotypes.
- inclusive language and behaviour
- supporting a young person 'Coming Out'.
- skills to enable you to deal with your own and others' reactions and attitudes in a positive way
- strategies, skills and resources that lead to effective and inclusive involvement with SSA young people
- appropriate referral strategies and agencies.

This training is part of the STEP Project funded by Commonwealth Department of Health & Aged Care as part of the National Youth Suicide Prevention Strategy (N.Y.S.P.S.).

The purpose of STEP is to develop and deliver training activities in youth suicide prevention to workers with three high risk groups:

- **Aboriginal young people**
- **Same Sex Attracted (SSA) young people**
- **Refugee young people.**

The training is intended to meet the needs of professionals whose work brings them into contact with young people from the Project's target groups.

APPENDIX 2

2C: Standard Evaluation Form

STEP Program Evaluation

Survey of Training Participants

Filling out name and contact details below is optional.

Name: _____

Organisation: _____

Position: _____

Workshop (tick): ❑ Same sex attracted ❑ Refugee ❑ Indigenous

Please circle the number that measures the level of importance you give to each question

1. How often do you work with young people from the target group for whom the training is being conducted?

   All of the time

   Most of the time

   Some of the time

   Infrequently

   Never

   Do not know

2. In your current work, how important is the issue of youth suicide?

   Extremely important 1 2 3 4 5 6 7 8 9 10 Not at all important

3. Do you feel confident about tackling a young person's needs to promote their mental health and well-being?

   Extremely confident 1 2 3 4 5 6 7 8 9 10 Not at all confident

4. Would you like to receive suicide intervention training? (If yes, you will need to include your contact details so we can follow this up.)

   Yes No

5. After today's training, how confident do you now feel about promoting the mental health and well-being needs of a young person from the target group?

   Extremely confident 1 2 3 4 5 6 7 8 9 10 Not at all confident

6. After today's training, how would you now rate your understanding of the factors causing young people from the target group to be a risk?

   Very clear 1 2 3 4 5 6 7 8 9 10 Not at all clear

7. Before the training, how confident did you feel about addressing the risk factors of a young person from the target group?

   Extremely confident 1 2 3 4 5 6 7 8 9 10 Not at all confident

8. After today's training, how confident do you feel about addressing the risk factors of a young person from the target group?

   Extremely confident 1 2 3 4 5 6 7 8 9 10 Not at all confident

9. How clear was the training program in terms of how you might implement the ideas and strategies in your work?

   Very clear 1 2 3 4 5 6 7 8 9 10 Not at all clear

10. How practical did you find the training?

    Very practical 1 2 3 4 5 6 7 8 9 10 Not at all practical

11. How would you rate the presentation of the content?

    Very clear 1 2 3 4 5 6 7 8 9 10 Not at all clear

12. As a whole, did the training course fulfil your expectations?

    Fulfilled expectations 1 2 3 4 5 6 7 8 9 10 Did not fulfil expectations

13. Please make any comments or suggestions about the training, or how you think it could be improved in the future:

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

    _____

Thank you for taking the time to complete the evaluation form.