A Profile and Longitudinal Evaluation of Multiple Risk Factors, Protective Factors, and Outcomes for Suicidal and non-Suicidal out-of-home Adolescents who applied for the Independent Youth Benefit (IYB)

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ABSTRACT

This research contributes new knowledge to those working in the areas of welfare, child and adolescent safety, and suicide prevention. The aim of this thesis was to succinctly provide clinicians, government and community agencies, researchers and policy advisors, with a snapshot profile of 2029 welfare seeking young people who were homeless and frequently discouraged by negative life events. The research aim was to identify risk and protective factors that impact life outcomes for those seeking the Independent Youth Benefit (IYB), and particularly, to scrutinize salient factors that led a vulnerable group of IYB applicants to die by suicide. It was further aimed that by documenting comments from 200 young adults from this population across a span of seven years, both gaps within the IYB process, as well as useful resources, could be identified in order to improve life outcomes for other homeless youth. For those who attempted suicide and survived, file records and interviews have indicated the triggers and life histories that potentially impacted their decision to try to end their pain of life, and factors that influenced survival and recovery.

Four separate studies were included in this thesis. Study 1 profiled 2029 IYB applicants and determined the most potent risks that led to the granting of the IYB. Study 2 revealed the salient factors that related to the suicide of 6 IYB applicants. Study 3 investigated the outcomes for those who were granted or declined a benefit across the variables of education, employment, income, adverse life circumstances, wellbeing, and family relationships. Study 4 examined a psychological construct, termed cynical distrust, which appeared to be a characteristic trait in welfare seeking youth.

Conclusions from this research provided indicators of youth who will usually be granted an IYB, they are, those who report bullying, abuse, parent psychopathology, single parent homes, a parent on a benefit and foster placement. Applicants who reported suicidal thoughts and suicide attempts and had contact with Police and Child Youth and Family Services also were more likely to be granted an Independent Youth Benefit (IYB). If the applicants were Maori and had previously seen a counsellor for a mental health problem, they also were more likely to receive the IYB. However, when applicants were referred to Family Reconciliation Counselling (FRC), there was a statistically significant association between benefit application and benefit declined.

A unique finding from this population related to the association of 'unknown fathers' with suicide. Absent father literature is now extensive, however, little research has been conducted into the effects of 'unknown fathers', particularly for Maori youth who place much of their strength and wellbeing in their genealogy. Other salient factors leading to suicide for IYB applicants included, previous suicide attempt, co-morbid disorder, unresolved anger, no identified caring adult, foster placement and an impending legal or disciplinary event. Maori males with such factors posed the greatest risk for suicide. Counsellors, psychologists, families and policy analysts need to acknowledge that IYB applicants who attempted suicide, show cynical distrust, and were declined a benefit, had extremely poor life outcomes. The New Zealand youth welfare system could be functioning far more efficiently if documented recommendations become realities.

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Dedication

This thesis is dedicated to Cassie, whose file recorded the words, "I'm just a black bitch, I've become the monster he created, I'm directionless, Godless, and fatherless." Cassie died by hanging after she had been sexually abused for years by her step-father who was consumed by pornography, yet publicly admired for his sporting prowess. For all who support the pornography industry, and who keep secrets about abuse within families, you carry the guilt of her death on your shoulders.

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INTRODUCTION

Personal Prologue of Interest in This Topic

In 1993, the government introduced a new welfare benefit, the Independent Youth Benefit (IYB), to assist young people aged 16-18 years who left home due to family breakdown. At that time, New Zealand was experiencing a youth suicide problem where the rates of youth suicide led all OECD countries. Study 2 provides references and a conceptual framework for this phenomenon.

Although the government believed that this benefit would assist in helping youth who needed to leave abusive homes, the IYB was introduced with no protocols for a national assessment procedure to ensure that those who needed the benefit actually received it, and conversely, that those who did not need welfare did not abuse the system. It was evident in 1993 that any community or school counsellor, any therapist or psychologist, could conduct a "family breakdown" assessment based on extremely vague guidelines. No attention had been given to assessment protocols that addressed the additional psychological needs for many of these applicants, such as depression, anxiety or behavioural disorders. No attention had been given to developing a national database, and no procedures were set in place to research trajectories that led applicants to apply for the benefit. Of further concern was that no national or international research had been conducted on outcomes for applicants following either the granting, or the declining, of a youth benefit.

Simply, no one had developed an operational protocol that examined a research-based model that included an evidenced based design, an acceptable standard of assessment, a scientifically scrutinized measurement and monitoring protocol and a

robust guideline to evaluate measures of change following receipt of the benefit. Little attention had been given to the construction of an appropriate intervention protocol, assessment procedures had no guidelines that recognised familial, cultural, social or biological influences, there were no recommendations on how to measure the severity or symptoms that might be observed at the IYB assessment interview, no protocols existed to monitor outcomes, nor did the guidelines suggest that the assessor was required to establish the variables that might maintain either positive or negative outcomes for the applicant. Very little consideration had been given to identifying the individual needs for each applicant once the benefit had been either granted or declined. If the benefit was granted, no accountability structures were set in place, such as continued school engagement or, "work for welfare" contracts.

Consequently, the original operational protocols for the implementation of the IYB were limited. There were no psychologically-driven investigations into the effect of welfare on young recipients' self esteem or motivation to seek employment, there appeared to be huge gaps in assessment and follow-up protocols, and there were many questions left unanswered. For example:

- Considering New Zealand's high rate of youth suicide, how would the IYB assessment interview identify previous attempters, those at risk of attempting, and the profile of teens who might go on to suicide or attempt suicide, following placement on the IYB?
- What would happen to adolescents across a range of life events, after they were placed on the benefit?

- Once on the benefit, would violence, anger, pregnancies and substance abuse increase or decrease?
- Would lack of parental supervision promote a greater increase in youth breaking the law? Would these adolescents have less or greater contact with police and courts once they were on the benefit?
- What would be the short and long term consequences of granting or declining the benefit?
- What positive or negative impacts might be associated with granting or declining the benefit, e.g., would education and training increase during time on the benefit or would it be a time when youth simply wasted tax-payer money?
- Would the IYB widen family gaps or allow a breathing space for adolescents that, in the long run, would assist family reconciliation?
- Would withdrawing an adolescent from a home filled with conflict reduce the rate of suicide and/or depression?
- Would a suicide attempt precipitate the IYB assessment or would long term family problems?
- Would Maori be highly represented in this group, and what changes would granting or declining the IYB make to their lives?
- What weight would be placed on psychologists recommendations outlined in the IYB eligibility assessment report to Work and Income New Zealand (WINZ) case managers?

- Would young people, who were "safe" in their own homes but had conflict with their parents, be offered, or referred for Family Reconciliation Counselling (FRC)? What might be the barriers to FRC proceeding?
- How might bullying be implicated in IYB applications and what was the association with suicidal behaviours? Would bullying still exist to the same extent following removal from home and the granting of a benefit?
- What other variables might operate to maintain adolescents becoming targets to bullies? Would the propensity to be targeted by bullies generalise across time, settings and situations to reappear for ex-IYB applicants in the workplace setting?
- What might be the etiological implications for IYB clients who had attempted or completed suicide? We knew that when young people took drugs combined with depressed mood, that there would be a greater risk of self-harm. Were WINZ case managers trained to identify high risk applicants?
- Had WINZ research staff investigated the possibility of developing a measure that had the potential to predict whether or not clients would engage in dangerous, high-risk behaviours?

By 1994, when I posed these questions to the Chief Executive of the Department of Work and Income New Zealand, they could not be answered either nationally or internationally. Although by the mid 90's significant literature was developing on the impact of family structure and family change on child and adolescent wellbeing, (Chase-Lansdale, Lindsay, & Hetherington, 1995; Dawson, 1991; Fergusson, Lynskey, & Harwood, 1994; Mitchell, Wister, & Burch, 1989; Mortimer & Finch, 1996.), there

remained a dearth of research into the profile or longitudinal evaluation of multiple risk factors, protective factors, and outcomes for suicidal and non-suicidal out-of-home adolescents who applied for welfare benefits.

Canadian researchers Blackstock and Trocme (2005), report that until as recently as 2005, there remains little information regarding children and families receiving welfare services, and that it was not until 1998 that the first study to examine the profile of children and families coming into contact with the welfare system even began in their country. The scope of the 1998 Canadian study reported on maltreated children coming into welfare care, but did not include research on the provision of welfare assistance to youth or provide research that tracked their outcomes.

In Britain during the mid 1990's, there also existed negligible research into the outcomes for youth placed on government benefits. Williamson (1997), a leading youth researcher wrote that during the years 1975-1995 the government had failed to understand and had a duty to explain youth, youth policy and youth research. He wrote of the lack of research into 'welfare to work' initiatives, and into the reasons contributing to educational exclusion, drug misuse and criminality of homeless youth. He further suggested that the withdrawal of the income support entitlements for 16 and 18 year olds in 1988 required urgent investigation as it had seemed to provide a stumbling block for those transitioning from dysfunctional homes into work or further training.

American researchers Mortimer and Finch (1996), also reported that although employment was the key dimension of most adults' identity, that there were critical gaps in the literature regarding out-of-home youth who were not in 'work'. Australian research, (Hansson, 1996) in the mid 90's was beginning to review the literature on the

effects of unemployment on youth. Although no outcome research was conducted with welfare recipients, (of particular absence was research around suicide associations with welfare engagement), their investigations did highlight the emerging differences in wellbeing between youth who stayed at school or moved into employment, and those who became unemployed. Hansson, (1996), had noted that the primary predictors of out-of-home, out-of-work youth included, socioeconomic status, ethnic minority status, and having a benefit dependent person in the family of origin.

With such a paucity of research into trajectories leading to welfare, and no available literature that examined long term outcomes for youth who applied for welfare, and in the interests of contributing to new knowledge, I initiated a longitudinal research design that would examine over 2000 IYB applicant files. The intention was to profile this cohort and assess, through both quantitative and qualitative methodology, their outcomes over a 7 year period. Prior to beginning the study, I implemented an IYB assessment and intervention pilot programme in Hamilton that with resulting recognition and government endorsement became a national initiative.

A new national operational manual was written by the Operations Manager of WINZ and me. Recommendations were made that the eligibility interview assessing family breakdown and entitlement to the IYB, must be conducted by a registered psychologist so that psychological disorders, abuse, parental psychopathology, bullying or suicidal concerns could be identified and appropriate referral pathways established. As I observed that some IYB applicants should not be given a benefit, but that family therapy was required in order to solve current conflict, a specialized reconciliation programme was developed. The Chief Executive of WINZ accepted concerns from me

that a family reconciliation process needed to be made available to the applicant and the applicant's family, following the IYB assessment interview, contingent upon safety concerns being met. Although a family reconciliation counselling (FRC) protocol was established, (i.e. for suitable families, 6 free counselling sessions were made available, and a sum of $1,200-00 was paid to the psychologists from Special Education Services who conducted the assessment), WINZ demanded that there must be an 80% minimum success rate for FRC to continue. Success was defined by WINZ as no IYB benefit granted.

Late in 1994 I was appointed the National Professional Consultant for Specialist Education Services (SES) with responsibilities to train all psychologists employed by SES, in IYB assessment an FRC processes. A national database was established to collect and collate national IYB data. This position was held by me for 2 years until maternity leave intervened. The position was then filled by a SES national office manager who had no training in psychology. The new national manager of this contract, in a cost cutting exercise, stopped all national collection of IYB data and later allowed any SES employee with a minimum of 3 years work with children, to conduct IYB interviews. Data collection however was continued in the Waikato region by several psychologists and myself. This thesis contains the analyses of those data collected over a 7 year time frame from 1995 to 2001.

Thesis Overview

The thesis overview introduces the historical, political and social framework that encompasses welfare seeking adolescents in New Zealand, and presents a brief literature review and the rationale behind each of the four major studies contained within the thesis.

Study 1 provides a descriptive snapshot of an entire cohort of young New Zealanders between the ages of 16 and18 years who applied for the Independent Youth Benefit (IYB) in the Waikato region between 1995-2001. Personal, family, adverse life and social risk factors were identified across this cohort. An insight has been provided into who they are, why they want independence, freedom and emancipation. Some were viewed as expendable, deserving of abuse, too costly to keep at home or simply too difficult to control, particularly for single parents on benefits or for those parents with psychopathologies. For the first time, research data has been collated that shows what determined the decision to grant the IYB, what were the major risk factors across this cohort, and the particular difficulties for indigenous youth who report abuse less often than their European counterparts, yet die more frequently from its effects.

Study 2 examined a concerning issue for people of this age, i.e., suicide, and attempted to isolate the salient factors that led some young IYB applicants to take their own life. This second study provided through a retrospective file audit, a comparison and contrast of risk/asset or vulnerability/resiliency factors that contributed to adolescent suicide and suicide attempt. The file records of six deceased ex-IYB applicants were closely scrutinized against 36 matched controls. Results revealed 7 salient factors that discriminated those who died by suicide from those who survived suicide attempts.

Study 3 looked at the outcomes of four different groups of ex-IYB applicants to see how well they are doing now and to add new knowledge to the literature on factors that seem to relate to both poor and positive outcomes in relation to welfare application. The 200 subjects in Study 3, were divided into four groups:

Those granted the IYB who had attempted suicide (GAS) – 50 subjects

Those declined the IYB who had attempted suicide (DAS) – 50 subjects

Those granted the IYB who had made no attempt at suicide (GNoAS) – 50 subjects

Those declined the IYB who made no attempt at suicide (DNoAS) – 50 subjects

Through recent face-to-face interviews, and using a mixed methodological design, research examined educational, employment, income, adverse life, wellbeing and family relationship outcomes for this group who were originally assessed for benefit eligibility between 1995 and 2001. New information was obtained on factors aiding family reconciliation, suggestions to improve the current IYB assessment system, triggers that had led IYB youth to attempt suicide, and factors that had mitigated suicide. Over 50 recommendations for families, schools, suicide researchers, policy makers, and government and community agencies were documented, and appear in Appendix A.

An emerging factor in Study 3 that appeared to relate to outcome, was a general concept of cynicism and distrust that appeared to be excessively high within the IYB population. This characteristic seemed too important to ignore, so Study 4 investigated this psychological construct. Consequently, the final study in this thesis (Study 4) developed the unpublished work of Evans and Fitzgerald (2003), by assessing cynical distrust levels across a population of 200 ex-IYB applicants, who were either granted or declined a welfare benefit, and who were either suicidal or non-suicidal. It had been hypothesised that those who attempt suicide have elevated levels of depression and

hostility toward others. These emotions often lead to breakdown in relationships and a substrate of hostility and unresolved resentment. Such individuals often lack the ability to trust. The cynical distrust test, composed of nine items, compared the ex-IYB population of 200 adults, with a population of 324 New Plymouth mixed-gender high-school students. Cynicism was conceptualized in this study as a negative emotional state that may well be the psychological combination of both anger and depression. Although further research will be required for the development of assessment tools that can identify the emotional precursors to suicide, this study suggested that cynicism may be one of those precursors that could be identified through a measurement tool i.e., the Cynical Distrust Test. Study 4, provided promising data for the use of this test.

Finally, the thesis concludes with a summary that puts together the most salient implications for psychologists counselling youth from family breakdown backgrounds, and for those who manage and make decisions affecting this population of welfare seeking youth.

Historical Background to New Zealand's Welfare System

The foundation for New Zealand's social security rights are based on the Social Security Act 1938, introduced by Prime Minister Walter Nash who stated,

> "*There are five major threats to security – sickness, accident, unemployment, old age and death. Neither a man's prudence nor the beneficence of his neighbours can any longer assure social and economic security to him and his family.*" (McClure, 2004).

In the pre-World War II generation, social security was based on the assumption that dealing with private need was a public obligation. The manner in which private needs were transmuted into welfare rights, and the manner in which those rights were presented to the public, (i.e., in ways that promoted a strong sense of entitlement), were the most significant features of the Social Security Act 1938.

New Zealand's commitment to social solidarity was highlighted when universal family benefits were introduced at the end of World War II. In the Social Security Amendment Act 1945, the family benefit became available to every family in the nation regardless of wealth or perceived entitlement. Inevitably however, the universal allocation of benefits began to be questioned, as some recipients were seen as less needy, less worthy of help or lazy impostors.

In the early 20th century, welfare administrators made a clear distinction between deserving and undeserving, which often meant favouring the widowed and the old, yet showing bias toward unmarried and deserted mothers, as well as the unemployed. Maori poverty at this time was seen as a sign of lower expectation rather than greater need and, by the 1920's, living in a Pa (stockaded village) had become a reason to disbar Maori from full pension entitlement (McClure, 2004). Following World War II however, and the heroism displayed by Maori during the war, it then became impossible for government to continue the belittling of Maori benefit rights.

McClure (2004) also noted that during the 1960's, special assistance schemes were initiated that required an interview in which applicants had to expose exact details of their need. For example, the number of clothes they possessed (and underclothes), the nature of their illness and/or the absence of, or access to bedding. The conditions of

eligibility were defined by statute, and the outcome was predictable. The discretionary nature of special assistance, the lack of certainty over outcome of an interview, and the lack of professionalism in the assessment of these benefits, all denied beneficiaries the formality and dignity which the social security system had been set up to provide. The application process contributed as much hardship itself to making people feel poor, less confident of their rights, and less secure in their freedom from need. The one real benefit of these special assistance schemes was to highlight the need that fathers should support their families. The Department of Social Security was determined not to encourage men to desert their families to the care of the state, and was very reluctant to supplant an absent father.

In 1973, the Domestic Purposes Benefit (DPB) was introduced, which was the first real step that imbued a firm sense of children's rights into the social security system and welfare payments. Unfortunately, by the 1980's, problems for Maori entitlement to social security were resurfacing and the financial position of sole mothers with children was again causing concern. The 1990's brought in a new climate of thinking under the political influence of Ruth Richardson (Member of Parliament). Welfare became a term of abuse. The community was perceived as divided between givers and takers, and the concept of need became correlated with the concept of dependence. The government's goal was no longer to conform to peoples desires, but to meet 'real' need (Bolger, Richardson & Birch, 1990). The new ethos was captured in the following statement,

> *"The major shift in perspective of social welfare in New Zealand is simple. The state will continue to provide a safety net – a modest standard below which people will not be allowed to fall, provided they demonstrate they are prepared to*

help themselves. Most people would recognise the safety net as the basket of benefits now known collectively as social security. Assistance will be targeted on genuine need."

As history had shown, the more 'targeted' income support becomes the more intrusive and humiliating its method of ascertaining need (McClure, 2004). It has been suggested that targeting doesn't work because organisations get the money, not the communities that need it. (Jackson, 2005).

In 1991, the general manager of the Children and Young Person's Service told the Minister of Social Welfare that, "The state cannot be a family for a child," (Dalley, 1998). Ian Hassall (1997), a former Commissioner for Children, had stated clearly that the social reforms of the late 1980's and the 1990's were responsible for the poor outcomes for New Zealand children. In his opinion, this time period was seen as one in which the community, family and individual were considered responsible for their own wellbeing and there was castigation of welfare dependency. The key question that was posed to researchers of the time was, not whether the welfare state eroded the family, but in what form it reconstituted and preserved it. Moving people out of poverty, ensuring families had funding for health care, clothing and food, was seen as a basic right that would support the stability of the family unit.

A similar question remains today and forms the basis of this research. Does granting a benefit to youth who report abuse, family breakdown, or suicidal behaviour improve outcomes across education, employment, income, wellbeing and family relationships? Such a question can only be answered when research assesses outcomes for those who were both granted or declined a benefit. Given the range of strongly held

opinions regarding social welfare and its effects on individuals and families, there is clearly a dearth of significant research in New Zealand that addresses the measurable social and psychological consequences of receiving benefit entitlements. One of the goals of the research reported in this thesis was to provide some of the necessary data that would allow for more balanced and objective judgments of the social consequences of benefit programmes, specifically awarded to young people no longer able to live at home, but not yet old enough to be expected to earn their own way in life or receive the assistance available to adults.

Introduction to the Independent Youth Benefit (IYB)

The Independent Youth Benefit (IYB) was introduced in 1993 along with an outcry that it would destroy families, encourage teenagers to leave home, and, with no parental supervision available, lead to increases in crime, pregnancies, drug abuse, police involvement, school dropout rates, and suicide.

At the time that the IYB was introduced, the government had raised the entitlement of the Unemployment Benefit to 18 years of age. It was recognised then that some 16 and 17 year olds could/would not be supported by their parents, and that a 'safety net' provision was required. To qualify for the IYB, the young person had to be a New Zealand citizen or permanent resident, aged 16-17 years, with no dependents and either be unable to live with their parents for a serious reason, or not be supported financially by their parents. The individual had to be unemployed, seeking work or training, or be a full time student at secondary school. An eligibility interview followed where one specific criteria had to be met; that was, a decision needed to be made by the

interviewer as to whether family breakdown had occurred. If family breakdown had occurred (i.e. the applicant was not allowed to live at home or abuse was evident), the IYB was automatically granted. Usually a parent was contacted and invited to a separate interview. Parents frequently did not show for their interview.

Once granted income support, young people were often left to their own devices with few reciprocal obligations being imposed and very little follow up. The needs of this group also were very complex and they often seemed unable to 'connect' with the help required. This was compounded by the fact that a proportion of these adolescents were third generation beneficiaries. Anecdotal reports from WINZ case managers indicated that IYB recipients tended to live with relatives or friends in flatting situations, and problems often arose when several young people set themselves up together in accommodation. Police youth aid officers identified many examples of IYB flats acting as magnets and encouraging truancy.

As a consequence of these concerns, WINZ (as it was then called), in December 1994, set up six pilot sites with each site trialling different customized service approaches. The pilot programme was called BOOST. The aim of BOOST was to provide support, resources and information to IYB 'customers', so that they would become aware of, and participate in, life skill courses, education, training, employment or other activities. Following a 12 month trial the pilot scheme was evaluated by a research team from Waikato University (Evans, 1995).

The BOOST evaluation found that with a small sample of adolescents receiving the IYB (n=235) who reported via a postal questionnaire, young beneficiaries were often trapped in negative affect that limited their responsiveness to the development of

constructive activities which mediate favourable outcomes such as continuing in school, obtaining further training, or seeking and gaining employment (Evans, Wilson, Hansson & Hungerford 1997). Negative affect was not operationally defined in this study, but general non-clinical measures of anxiety, depression, self esteem, social support, positive activities, delinquent activities and risk activities were incorporated into the assessment. Results were as expected, in that the subjects' revealed social disadvantage with very high rates of sexual and physical abuse in their histories. Ethnic differences did not emerge as significant factors in the sample studied, and boys were found to be more depressed than girls. Unfortunately, the BOOST programme was terminated due to funding concerns and the scope of the Evans et al. (1997) evaluation was not designed nor funded to respond to critically emerging questions that remained unanswered.

Thesis Research Initiated

There was now good reason to obtain evidenced-based research on a much larger cohort of IYB youth than had previously been explored by the BOOST evaluators. There existed the foundation for a strong study i.e., there was a good sample of at-risk adolescents to be studied (2029), there had been no research on long term follow-up or outcome measures for adolescents who had applied for welfare assistance, and the escalating trend in completed suicides in New Zealand meant an urgent priority needed to be given to understanding what was going on in this IYB group of multiple problem youth. A new difficulty was presented to me. What theoretical model and research methodology could best be utilized to answer the question, does granting a welfare

benefit to a vulnerable group of out-of-home adolescents really work in promoting better life outcomes?

As no research had ever been conducted showing outcomes for IYB applicants who either received or did not receive an IYB, and no theoretical models had been tested with non-clinical heterogeneous groups of emancipated or independent youth, a compatible model from the literature was required to guide this research. Models outlined by Beautrais (2003a, 2003d), were personally discussed with her and appropriate methodological suggestions were raised. A useful guide in deciding what to measure (i.e., the hypothesised links between applicants predictor risk variables, decisions to grant or decline the benefit and consequential outcomes), was provided by Weiss (1998). As the IYB population had similar demographic, relational, social, educational, mental health problems and exposure to similar adverse life events as young people seen within the Justice system, models of prediction from that cohort were influential in the present research design (Borum, 1996; Meehl, 1954; Monahan, 2001; Quinsey, Harris, Rice, & Cormier, 1998; Rice & Harris, 1995).

In order to assess the 'usefulness' of the IYB system, the models from literature advised that a set of hypotheses be logically presented that would encourage assessment of the links between the applicants life history and the IYB outcome (i.e., IYB grant or decline). With such a theory in hand, I set up four major studies with the intention to provide an evaluation of the IYB process, and the ways in which such processes influenced either poor or positive outcomes for participants of that process. The research was designed to highlight the actual process to which IYB youth were exposed, and provide an insight into the profile of these young people. The thesis did not propose to

answer if the IYB process recruited youth with the most need, or if youth were recruited by word of mouth and peer influence. The scope of the research also did not propose to explore if all of the components of the IYB process actually occurred for each participant. For example, I did not plan to investigate if all WINZ case managers were trained and supervised in the same consistent manner, or if all IYB eligibility assessors conducted their interviews with applicants in the same manner and with similar skills.

Of particular importance in designing this research back in 1995, was the alarming numbers of IYB youth who seemed to become involved with suicidal behaviour. Kreitman (1990) had noted that action about suicide behaviour was more likely to succeed when it was informed by knowledge of causal factors. He emphasized the need for the development of appropriate research strategies that would enable researchers to examine the risks associated with suicidal behaviour and the need to test putative causal mechanisms. Research since 1990 had concentrated on developing two research approaches that were effective in studying suicidal behaviour, these being case control studies and longitudinal designs. The strengths of these approaches have been outlined by Beautrais (2003d). A mixed methodological research design based on evidence from the literature was consequently constructed for this thesis.

Relevance of This Research

The debate has intensified over the apparent culture of entitlement that has insidiously crept into New Zealand since the days when individuals were stalwart, stoic, resolute, resourceful and non-dependent survivors of the depression. There is nothing new in the recent criticisms levelled at beneficiaries, for, as Katz (2001) has reminded us,

ancient questions lie at the heart of modern debates about welfare dependency and intergenerational abuse of the social security system. Questions considered are: who should provide help in time of need, who should have a claim on the community's resources, who should interpret needs and give them political status, who should define welfare rights, or how can the needs of a single mum be balanced against the needs of the aged, the wage earners, the disabled and others?

Political leaders and national figures of all persuasions have commented on the problems associated with welfare policy. For example, Don Brash (2005), leader of the National party, has in recent weeks called for a work-for-dole approach in order to address the escalating numbers of New Zealanders seeking benefits. Dame Kiri Te Kanawa (2003) has condemned Maori for these rising figures, labeling them a 'lazy' group who rely on welfare for much of their lifetime. Meanwhile, John Tamihere MP (2003) blames dependency on welfare as destroying Maori communities.

Politicians in Denmark and the United Kingdom have been warned against appearing 'client-centred' with welfare applicants, while at the same time introducing large scale compulsory activation programmes. Such approaches risk lurching toward a 'workfacist approach', suggests Lindsay (2004), and are likely to prove politically fragile. Kieselbach (2003) however, argues that the European Union must fund further research into considering the psychological implications of youth unemployment and provide more social support for the rising levels of social exclusion within the welfare seeking population. Psychological stress appears to be predictable amongst this cohort (Bjarnason & Sigurdardottir, 2003), as are mental health problems (Dooley & Prause, 2002), dysphoria (Axelsson & Ejlertsson, 2002), self esteem (Goldsmith, Veum & Darity, 1997;

Harris, Lum, & Rose, 2002; Kunz & Kalil, 1999), poor attitudes toward further education (Bolam & Sixsmith, 2002; Edwards, Plotnick, & Klawitter, 2001), health and addictive behaviours (Hammarstrom & Janlert, 2002; Wadsworth, Montgomery, & Bartley, 1999), crime (Baron, 2001), and lack of motivation (Fryer, 1997; Rodriguez, 1997). Some researchers however, take the blame of needing welfare off the shoulders of the applicants by suggesting that out-of work youth are not 'problem young people', but young people who have problems inflicted on them, and suffer damaging consequences (Hannan, O'Riain, & Whelan, 1997).

So, does the international profile of welfare seekers match the New Zealand profile? Who are these IYB youth? Who are these individuals who are seen by some as bludgers, lazy, users and parasites hanging on like leeches and sucking the financial resources from the New Zealand taxpayer? There are many myths and ideas that surround these young people that have developed as a result of insufficient research. The following chapter (Study 1), looks at the real demographics of the youngsters, and takes a snapshot profile to see what we can learn from 2029 archival records.

STUDY 1 ABSTRACT

New Zealand Teens on the Independent Youth Benefit: Profile and Trends

Objective. This study provided a descriptive snapshot of 2029 16-18 year old IYB applicants who self-reported exposure to a number of risk predictor variables including suicidal behaviour, foster placement, sexual and physical abuse, involvement with drugs, contact with police, bullying, parental psychopathology, historical welfare dependency, and family breakdown. It was hypothesised that certain risk factors would be associated with granting a benefit, with suicide, with ethnicity and with negative life outcomes.

Method. At a semi-structured eligibility interview for the Independent Youth Benefit (IYB), adverse life risk factors, family risk factors, personal risk factors, and social risk factors were recorded. Data also were collected from family members, school staff and/or other related professionals. A SPSS Chi-Square analysis of data was conducted.

Results. Almost 80% of IYB applicants were granted the benefit, and 30% made a medically serious suicide attempt prior to the interview. Risks associated with granting the IYB were: bullying, physical, sexual and emotional abuse; parent psychopathology, single parent, parent on a benefit, foster placement, suicidal thoughts and suicide attempt, police and CYFS contact, and a self-reported need to be seen by a counsellor for a mental health concern (MHC). Attendance at family reconciliation counselling sessions meant that, on most occasions, the IYB was declined. More Maori applicants were granted the IYB than European applicants. Of the six who completed suicide in the 2029 cohort, all identified as Maori and five of the deceased had been granted the IYB.

Conclusion. Abused Maori young people who have reported abuse, familial and individual mental health and economic problems, foster placement, suicidal thoughts and attempts, and have had contact with Police and CYFS, are more likely to be granted the IYB than European applicants, but are at greater risk of suicide. Attendance at Family Reconciliation Counselling sessions (FRC) most often resulted in the decline of the IYB.

STUDY 1

Introduction

The welfare seekers for the 'Independent Youth Benefit' are a group of 16 to18 year old New Zealand adolescents who are un-researched, out-of-home, transient and reporters of family breakdown. Currently no one knows the profile or outcomes for this group. Their exposure to risk, the protective factors they engage, their reasons for shunning family, why some of them are granted benefits while others are declined, their cultural make-up and their school experiences, all remain hidden from investigative research.

To gain an insight into the typical profile of an IYB applicant, Tama, Kate and Allan's brief case histories are provided (names changed to protect anonymity).

Tama. At the time I first met Tama, a Maori male, he was 16 years of age. He was not attending school. He came to the welfare agency simply to support his mate, who was applying for a benefit. Only after his friend insisted that Tama too needed help, and I had

contacted the WINZ case manager for permission to proceed, did Tama agree to receive some assistance. In appearance he was a dirty, poorly dressed, small young man, with a sad demeanour. He reported that he had not been bullied at school as he always managed to hide or stay at home. He was slow to engage, made no eye contact but finally had the courage to tell his dysfunctional family story.

Tama's step-father was a sports hero who was powerful, well-known and in full time employment. His mother had been on a benefit prior to meeting this man. She was frequently beaten by him. Tama reported severe personal drug abuse and addiction problems. He had been placed in four foster homes. Casually he mentioned that there was frequent bleeding from 'his rear'. Tama's step-father had sodomised him since the age of 6 years. There were multiple hospital visits and three previous medically serious suicide attempts. Medically serious suicide attempts were defined as being admitted to a hospital ward following the suicide attempt. Doctors had feared that Tama would die at the last two attempts. Tama had never been to a counsellor and had never told doctors of his abuse. He had been threatened with death if he disclosed, including the death of his mother. Tama had tried to run away, but he had been picked up by police and placed by Child Youth and Family Services (CYFS) into foster care.

Tama was granted the IYB. Maori elders were called in with Tama's permission to be part of the counselling process. Respect for Maori tikanga (customs) was to be a crucial component of this intervention. The Department of Work and Income New Zealand (WINZ), would not pay for Family Reconciliation Counselling (FRC) that could have been useful in providing help for Tama and his mother, as it was part of their protocol only to provide FRC if the aim was to reconcile the IYB applicant back into the

family. This option was obviously unsafe for Tama. It was essential that Tama was removed from his home (although it would have been preferable to remove the stepfather), and to be involved in counselling that addressed both suicidality and abuse issues. The Accident Compensation Corporation (ACC) Sensitive Claims Department agreed to pay for the abuse counselling but refused to pay for counselling that directly related to the prevention of suicide. Whole-of-Government funding across agencies to address the issue of this one boy seemed surprisingly simple, yet unfortunately, with silo funding, it was intersectorally impossible.

Four weeks after the IYB was granted Tama stood at the edge of a nine story building, ready to jump. This was his fourth suicide attempt. Tama's fate will be described in the outcome chapter, i.e., Study 3, of this thesis.

Kate. Kate was 17 years old when she attended the IYB eligibility assessment interview. Her parents were devout European Christians. There were five younger children in the family. Kate attended a religious high-school. She had never taken drugs, alcohol or smoked. There was no history of family abuse, foster placement or any suicide ideation. However, in the three months preceding Kate's application for the IYB, her school grades had seriously deteriorated.

Both parents worked, the father full time, the mother part time. Two days before the assessment interview, Kate moved in with her boyfriend who was ten years her senior. Kate had met him on the internet and he had a police record for violence and sexual assault. Kate's parents were adamant that their daughter was not to receive the IYB and that she was to return home. New Zealand law allows for a young person to leave home after the age of 16 years. Kate's mother tried to forcibly remove her daughter

from the boyfriend's house, but the disturbance resulted in the neighbours calling the police to intervene.

Following the IYB interview with Kate, a family meeting was called, however, Kate refused to attend. Kate agreed to stay with her grandmother until the situation was resolved. The IYB application was declined and a decision made to proceed with Family Reconciliation Counselling (FRC). Despite weeks of extreme emotional disturbance within this family, FRC finally resulted in Kate returning home, and no benefit granted.

Kate resided at home for the following six months, her boyfriend moved out of the region and her school grades improved dramatically. At this same time, a political decision was made by the Ministry of Social Development (MSD), and the Ministry of Education (who monitored the national IYB contract), to allow IYB assessors to function with differential levels of professional competency. The psychologist who had originally declined Kate's IYB had moved away from this assessment work. Six months after returnin45g home, Kate re-applied for the IYB and was assessed by a new IYB assessor at Special Education Services. Her boyfriend had returned to her local area and Kate had resumed living with him. The new IYB assessor (a counsellor who usually worked for a child-care agency), did not contact Kate's parents, or the psychologist who had declined Kate's application. On Kate's second application the IYB was granted. Serious policy implications are raised by the examination of this case and Kate's outcome will be followed though in Study 3, of this thesis.

Allan. Allan arrived at the IYB assessment interview dressed in black leather bike pants, black leather jacket, and a bandana around his head and asked to smoke during the interview. He was 16, vibrant, and funny, with flowing shoulder length fair hair that

matched his pale European skin. Allan reported that he needed the IYB because his parents were abusing him. The 'abuse' turned out to be that he was not allowed to smoke dope late into the night with his friends while in his home environment. Allan portrayed his parents as 'unreasonable', the 'olds', 'out of touch farmers', and 'retarding his potential to be creative'.

There was no indication of abuse. Allan had left school without any qualifications. He admitted to smoking dope, he was educationally and economically inactive. Allan's parents wanted their son to stay living at home and for Family Reconciliation Counselling (FRC) to proceed. At the interview, Allan, was asked to list some 'positives', some happy family memories and experiences that he could recall. Allan began to talk of swimming and diving lessons with his father, of family picnics, and recounted a sensitive, moving experience of a special time spent with his dad during an illness. Allan was asked to consider the option of attending three family meetings with the aim to 'problem solve', and attempt to resolve the family breakdown issues. He was informed that at that point, a decision would be made as to whether or not he met the criteria in order for the IYB to be granted. It also was requested by the assessment interviewer, that considering Allan had not spoken to his father for over three months, that on his return home, he talk with both his parents about the positive stories he told during the interview.

It was recommended that Allan's IYB application be declined while the family proceeded with FRC. A few days later a call was received from Allan's mother. She expressed the happiness that she and her husband felt, when Allan recounted the stories that were told at the assessment interview. She informed me that Allan had hugged his

dad for the first time in several years. An appointment was set to begin FRC. The day before the appointment, Allan was killed in a car crash.

Tama, Kate, and Allan, are typical of the heterogeneous, non-clinical adolescents who present at welfare offices seeking financial support. Recently, when I asked a question to 25 ordinary citizens, ('how would you describe young people who apply for benefits?'), the following descriptors were stated. They are lazy, freeloaders! They have no motivation or self-respect! They should have worked harder at school! They are just modelling their parent (usually a solo mum who is also a bludger)! They'd all be Maori wouldn't they! I guess they need the money to buy their drugs somehow! Why shouldn't they get a benefit, aren't the taxpayers funding television advertisements telling people to apply for all the benefits they can get, like 'Family Assistance'! Only one person made an empathetic comment, that was, ' I would describe them as very sad , for if they came from a happy home that gave them love and support, they would never think of needing to leave home and go on welfare.

What is Homelessness. Literature reveals no agreement on a definition for homelessness. However, a definition involving relativism (Chamberlain & MacKenzie, 1998) was established stating that homelessness is the absence of a secure, adequate and satisfactory shelter which may involve: a) the threat of loss of that shelter, b) high mobility between places of abode, and c) lack of occupancy, security, or lack of emotional support and stability in the residence. Homelessness covered three specific areas, i.e., primary (living on the streets), secondary (moving around/temporary accommodation), or tertiary (living in shared facilities with no secure tenure). Many of the young people who presented for welfare assistance were classified as secondary level

homeless youth, who were often marginally housed, i.e., living in a caravan or doubling up in one room

Brief, historical context to the research. The Overview section of the thesis provided the framework for the government criteria required to receive the Independent Youth Benefit (IYB), and also noted that only one evaluation, or piece of research, had ever been conducted with the IYB population, i.e., the BOOST report outlined in the Overview. Consequently, there were no comparative studies available, no guidelines for researching this unique population, and no longitudinal measures that assess outcomes.

When the research commenced with this group in 1995, I was faced with a multitude of unanswered questions (some of those questions relating to government policy have already been outlined within the thesis Introduction). Other questions asked were; why were so many adolescents suddenly leaving home and declaring irreconcilable family breakdown? What dynamics were operating in families to cause this problem? Had a 'social policy' set up to do one thing i.e., support needy, abused young people who could not remain in an unsafe home, suddenly have an unintended consequence? For those who did have to leave home, what were the main factors that were placing them at risk? What did family conflict actually mean? Did it relate to boundary-setting, religious freedom, sexual orientation, finances, step-parenting, mental health problems or general poverty? Were all the problems actually related to family issues? What were the implications of drug abuse, disengagement from school, peer influence or simply; maybe these adolescents just wanted to be emancipated and free of permanent adult supervision?

It was not possible within the scope of this thesis to answer all proposed questions. What was possible was to offer an evidenced-based theoretical/ conceptual

model, (or models), that aided in understanding behavioural, attitudinal, and social controls that negatively impact young lives, resulting in family conflict, dysfunction, and the desire to leave home. However, unless we had a profile of what IYB adolescents had in common, it was difficult to construct primary prevention strategies or scientifically robust interventions that would help reduce engagement in dangerous behaviours, and poor life outcomes.

Early emerging pattern of youth applying for the IYB. With no scientifically based studies available that offered descriptors of the entry profiles of those youth who were seeking welfare, general patterns were observed across this population, prior to the construction of the research design. Those patterns included exposure to adverse life events i.e., young people who were both bullies and targets of bullies and victims of all forms of abuse (sexual, emotional and physical). This group had specific family problems i.e., parents with psychopathologies, many came from single parent homes with parents on benefits or they had been placed in foster care. Personal risk behaviours were clearly evident amongst this group including drug use, consumption of excess alcohol, cigarette use, suicidal thoughts and suicide attempts. Social risk factors also clearly identified this group in that many were not attending school, very few seemed to have school qualifications, police contact seemed quite common, and it appeared that a significant number of this group had been associated with Child Youth and Family Services.

The IYB Application Process. Any 16-18 year old adolescent in New Zealand who believed they were no longer able to live at home due to family breakdown, had the right to apply for the Independent Youth Benefit. Prior to the eligibility assessment,

individuals wishing to apply for the IYB made an appointment to see a local case manager from the Department of Work and Income New Zealand (WINZ) that in turn was part of the Ministry of Social Development (MSD). The case manager was responsible for interviewing the applicant and if family breakdown was mentioned, the case manager was obligated to refer the applicant to an IYB assessor. The assessors were paid by the Ministry of Education (the Special Education Services section), who were in charge of the national IYB contract. Some IYB counsellors were clinical psychologists, some were educational psychologists, some were family therapists, and some were psychotherapist, while others had some counselling experience of at least three years.

Following their meeting with the WINZ case manager, and receiving clearance to pursue an eligibility assessment with an IYB assessor, the IYB applicant was responsible for telephoning the assessor in order to make an appointment. In the Waikato region, a letter was then sent to each IYB applicant informing him or her of an appointment time, direction to the assessment venue, and encouragement was offered to bring support personnel to the interview if so desired. A letter of warm welcome to the assessment was sent to the applicant that was written both in Maori and English languages. The Maori welcome included respectful tikanga (customs), and an acknowledgement of the strengths that the Maori applicant would bring with them into the assessment environment.

The assessment interview was semi-structured. Both qualitative and quantitative data were collected. An evaluation sheet was completed for each client containing demographic information and numerous categorical variables. The categorical variables included gathering information on the following:

a) Adverse life risk factors, included: exposure to bullying, physical abuse, sexual abuse, emotional abuse.

b) Family risk factors, included: parent psychopathology, single parent home, parent on benefit, foster placement.

c) Personal risk factors, included: drug use, consumption of excess alcohol, cigarette use, perpetrator of bullying, suicidal thoughts, suicidal attempt, requiring counselling for a mental health disorder.

d) Social risk factors, included: not attending school, no school qualifications, police contact, CYFS contact.

Demographic data also were collected on age, ethnicity, gender, date and time of assessment, position in family and number of children in family.

During the interview, the usual approach was for the assessor to establish whether or not the IYB applicant met the prescribed IYB criteria for family breakdown. Following the interview parents/caregivers, and school counsellors if appropriate, were contacted and invited to attend a meeting with the IYB assessor. At the conclusion of this meeting a decision was made to recommend to the WINZ case manager either a 'decline decision' or 'grant decision' in relation to the IYB.

Occasionally, recommendations would be made to proceed with Family Reconciliation Counselling (FRC), where WINZ would pay $1,200.00 for six counselling sessions to take place aimed at returning the applicant to their home, with no IYB granted. If a benefit was declined and FRC was recommended, it was thought by the assessor that if the young person went to FRC, then the family would continue to provide support and the IYB would therefore not be necessary. However, fear of therapists not

meeting WINZ's required success rate of 80%, meant that only cases guaranteed of success were referred on for FRC sessions.

The need for an ongoing referral also was documented on the report back to the case manager, especially where issues of self-harm and mental health were diagnosed. The assessment report sent back to the WINZ case manager who was responsible for the overall case management, did not specify all the details of family breakdown. The main function of the assessment report was to a) recommend a decline or grant of the IYB, b) advise whether or not the family breakdown was irreconcilable, c) state if FRC was a viable option, and d) to isolate psychosocial areas of immediate concern. The WINZ case manager maintained the authority to make the final decision on whether the benefit was granted or declined, despite recommendations made by the IYB assessor. Once the WINZ case manager had contacted the IYB assessor with the final decision to either grant or decline the IYB, the data containing the demographic and categorical variable information, was then entered onto the database for later analysis.

Theoretical models influence IYB reports. Contingent upon the theoretical orientation and training of the assessor, post assessment intervention recommendations or referrals to other service providers, were included as part of the IYB eligibility assessment report. Conceptual models provided in psychology literature, such as behaviourally-orientated CBT (Cognitive Behaviour Therapy) or CAT (Cognitive Analytic Therapy), the Family Therapy/System approach, the Scientist-Practitioner model and/or Social Learning Theory; combined with the expansive literature on resiliency and connectedness, to inform the orientation required to both provide a service for, and to conduct research on, the IYB population. In the Waikato region of New

Zealand, cultural responsiveness was an important component of the assessment report for indigenous youth. Work with this cohort required a commitment to the Treaty of Waitangi, (recognising the partnership, participation and protection between Maori and the Crown), and an understanding of Maori models of wellbeing, such as, the Te Whare Tapa Wha, Te Wheke, Te Roopu Awhina o Tokanui and Nga Pau Mana (Palmer, 2004).

Hegemonic conceptual models cause concern for Maori. Nairn (2004) suggests that the field of psychology has an obligation to make practices bicultural and to develop appropriate tools and methodologies for the measurement of psychological disorders and attributes (Palmer, 2004). When psychologists or counsellors enter into the sanctity of the family, a mandatory component when following IYB protocol, Palmer (2005), warns that the concept of "matauranga" must be recognised and valued. The main distinction between conventional science models and a matauranga Maori approach to scientific inquiry is, the European models are based on "know-how", whereas the Maori model is based on "know-why". Palmer (2005) explains that conventional science is seen to elevate the "know-how" approach to knowledge, and as long as there is "know-how", the knowledge will be pursued no matter what the consequences. In contrast, matauranga Maori science is driven by "know-why", where the reasons for seeking knowledge must be irrefutable. Palmer (2005) claims that some forms of knowledge are sacred, dangerous, and best protected until "know-why" is understood.

European science has its foundation in the principle of, "first do no harm", which seems analogous with the matauranga concept, but further exploration is required in order for investigators of child safety and familial abuse, to understand the child protection boundaries of the "know-why' scientific approach to knowledge. Research for this thesis

was based on both the "know-why" and the "know-how" models, and, according to Nairn (2004), when conducting practice and research, psychologists intentionally expose themselves and their profession to the informed and informative comments and critiques of Maori. When it comes to welfare however, he raises concerns that we may not be focusing on the understanding of "why" Maori are so highly represented in the welfare, poverty, and crime statistics. Nairn (2004) suggests that New Zealand has been colonized by welfare talk that originated in the English class system amid British notions of 'charity' and of the 'deserving poor'.

With Maori representing only 15% of the population, yet Maori IYB applications similar in number to European IYB applications, the over-representation of New Zealand's indigenous adolescents was cause for concern. Durie (2003) offered as explanation, the radical late '80's restructuring of the economy that had seen Maori unemployment skyrocket 20% for school leavers. He suggested that the level of participation that a group enjoys within society can be measured against their involvement in education, the economy, and their overall standard of living.

Unfortunately for Maori, negative indicators such as unemployment, homelessness, criminal conviction, poor health, educational failure, low incomes and a high index of deprivation score (MSD Wellbeing Report, 2004), revealed the truth of their level of participation in society. Durie (2003) further lamented that around 35% of Maori adolescents leave school with no qualifications and 20% of Maori families face serious material hardship. Te Puni Kokiri (a government department set up to address and monitor policies affecting Maori), published research into Maori family violence, and in 1997 stated that "delicate phrasing could no longer mask the fact that Maori children

were not being successfully taught, and that the Education system was in breach of the Treaty" (p17). Maori leaders continued to show concern as the deteriorating rates of Maori suicide paralleled youth unemployment and poor health statistics.

Almost ten years after the statement from Te Puni Kokiri, little has changed in outcomes for Maori. The Social Report (2005), recently released by the Ministry of Social Development revealed that the suicide rate for Maori youth in 2002 was 31.2 per 100,000, compared to the non-Maori rate of 13.7 per 100,000. Maori have the highest rates of smoking, obesity, and unemployment, particularly amongst the 15-24 age groups. The school leavers qualifications disparity between Maori and European had consistently from 1991-2003 shown that on average 40% of Maori, and 69% of European students gain sixth form certificate/ NCEA Level 2 or higher, and 4% Maori compared to 22% European obtain Bursary or higher qualifications. Maori youth also were more likely to be victims of crime compared European youth, with the greatest difference appearing for violent victimization. Interestingly, despite being harmed more viciously and more frequently than Europeans, Maori reported that they generally felt safer than any other ethnic group (this phenomenon will be explored further in Study 2, of this thesis). So, recent 2005 outcomes for Maori suggest that their perceptions of safety, do not match the reality of their experiences, as outlined in the following figure.

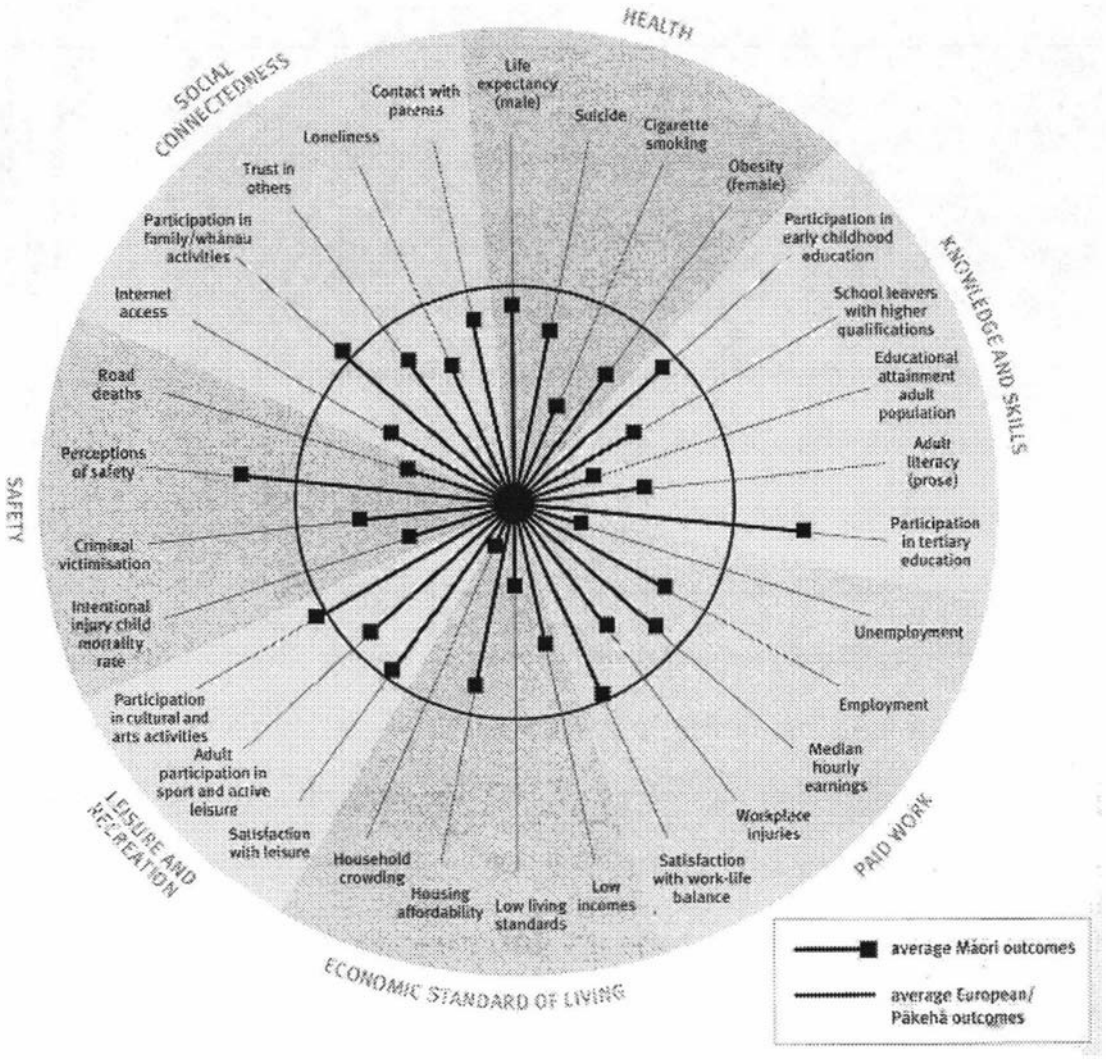

Figure 1.1. Social wellbeing for Maori, relative to Europeans/Pakeha.

This figure has been used with permission from the 2005 Social Report. The circle represents average outcomes for European/Pakeha against each indicator, and the spokes represent outcomes for Maori. Where a spoke falls outside of the circle, this means outcomes for Maori are better than for Europeans/Pakeha; the further the spoke is from the circle, the more pronounced the difference. Where a spoke falls within the

circle, outcomes for Maori are worse than for Europeans/Pakeha; the further the spoke is from the circle the more pronounced this effect. This style of presentation has a limitation however, in that is does not directly compare the size of changes for different indicators, nor does it offer an explanation for the misleading assumption that Maori are involved in more higher institutions of learning, compared to Europeans, (i.e., in New Zealand the government is now withdrawing funding from some Maori tertiary institutions that offered Maori students courses in areas such as hip-hop dancing, or courses irrelevant to developing skills for trades or professional employment).

At the design stage of this research back in 1995, similar trends were observed. Maori were certainly well represented in the population of those applying for welfare, but other factors were beginning to become common to this unique cohort for both Maori and European applicants. For example, suicidal behaviour, dysfunctional family relationships, sexual abuse, violence in the home, anti-social behaviour, lack of internal control and motivation, foster placements, and intergenerational patterns of poverty and welfare dependence were regularly reported by the IYB group.

Common presenting problems in the IYB cohort. (a) Youth suicide-a critical concern for New Zealand in the mid 1990's. Adolescent suicide in the mid 90's was escalating in New Zealand, placing rates at the top of OECD countries (MSD Wellbeing Report, 2004). A new phenomenon had struck our teenagers; a dangerous interest in group discussions about suicide, suicide attempts and completed suicide. Government allocated extra funding to encourage scientists and researchers to find answers. Was it the new liberalism that had pushed more adults back into the workforce and left children unattended, or was it a failure of the education system? Could the suicide trend be related

to the common assumption that teenagers were now raised in a country where they were taught the price of everything and the value of nothing? Had citizens become consumers and economic policy replaced social policy? Maybe exposure to television! Maybe general increased pressure on families! Maybe poverty! No one seemed to be able to find answers.

Study 2, of this thesis explores this phenomenon in greater depth, but at this point it is suffice to note that around 1995, there were growing concerns by WINZ staff at the number of IYB applicants talking about suicide ideation, and suicidal friends. A major goal of this research was to provide new knowledge to the existing conceptual framework of suicide and prevention science, by studying a group of young people who were previously un-researched. Suicide risk and protective factors, and their complex interactions with each other, form the empirical base for the formulation of suicide prevention strategies. The IYB group of young people, provided me with an opportunity (in Study 2), to develop the conceptual model showing that particular risk factors are associated with a greater likelihood for suicide and suicide attempts, while particular protective factors are associated with a reduced likelihood for suicide and suicide attempts.

Case managers in the mid 90s responsible for the delivery of welfare benefits and who worked for WINZ, struggled with the phenomenon of suicidal concerns with their clients, as well as the rise in numbers of adolescents seeking financial independence. Many were untrained in recognising genuine risk from fabricated stories. The demographics of this new population were unknown. The long-term outcomes of their homelessness and transient lifestyles had not been assessed. At this time, neither

government nor clinicians had any idea whether the population seeking the IYB would show improved life outcomes once the benefit was granted, or display negative attributions associated with leaving home without adult supervision.

(b) Common presenting profile of IYB youth- dysfunctional family relationships. Theorists of parent-adolescent conflict seem to agree that the stage of adolescence is one of storm and stress, but there is often disagreement about what causes the stress. Traditionally, parent-adolescent stress has been viewed as the result of biological changes in the level of aggression (Hall, 1904), the beginning of adult sexuality (Blos, 1962; Freud, 1905), the need for independence (Ausubel, Montemayor, & Svajian, 1977), and identity (Erikson, 1968). Parents have been blamed for causing conflict due to marriage and career disillusionment and mothers have been targeted for refusing to relinquish control (Turner, 1970). Popular treatment programmes to address family conflict across the 1970's and up till the late 1980's, were based on social learning theory (Gant, Barnard, Kuehn, Jones, & Christopherson, 1981), behavioural contracting (Stuart, 1971), systems theory (Alexander & Parsons, 1973), and communication skills training (Robin, 1981). More recently, theorists have moved away from focusing simply on individual characteristics in an attempt to explain parent-adolescent conflict, and are now focusing on family patterns of change and interaction, to explain this phenomenon (Mackay, 2003).

Much of the family conflict literature noted above, concentrated on "normal" adolescent developmental conflict, and accepted that much of the stress was simply "transitional" and "healthy". Stress in the homes of the IYB population however, appeared to be more sinister in nature. Before this research began, we had no idea of the

extent of stress or the patterns of conflict occurring in the homes of young people seeking independence through welfare.

Questions needed to be answered as to what problems were these IYB applicants escaping from, that allowed them to leave comfortably built homes to live in cramped and often squalid conditions? Was their home life dysfunctional, and if so, what was a dysfunctional family? A dysfunctional family has been described as a family unit in which parent/carer-child relationships may, or may not be, biologically based, and where the behaviour of one or more members of the family unit has a negative psychological, social, or health impact on others in the unit (McKellar & Coggans, 1997).

Negative childhoods experienced in dysfunctional families have consistently been associated with suicidality (Fergusson, Woodward & Horwood, 2000). A Cognitive Behavioural Therapy (CBT) model would suggest that what we think about, what we surround ourselves with, and what we are constantly told about ourselves, we become. In the next chapter, Study 2, we will read the story of Cassie, who was sexually abused by her step father for many years. He told her she was a "worthless black bitch" and that she really enjoyed being with him in the bath. Before Cassie hanged herself she had stated to her IYB assessor; "I am just a black bitch."

"He paid my school camp fees so I had sex with him."

"I really wanted to get away from home and go to school camp"

"I've become the monster he said I was"

"I'm worth nothing"

"Mum said I was a liar and if the marriage broke up it would be my fault"

"The porn stuff was so sick; I often held back my vomit"

Where there is a family history of dysfunction and suicide, there also is an associated risk for adolescents from these homes to view, (through social learning) suicide as an acceptable option (Brent et al., 2003; Brent, Perper, Moritz & Loitus, 1994; Gould et al., 1996; Roy et al., 1997). Again in Study 2, the case studies of Daniel, Taine and John all record familial breakdown and losing friends and family to suicide. Their words were recorded in their files;

"My brother got it right when he left this f------ planet the right way."

"I can't to stop thinking about suicide as a continual option."

Adolescents from these homes often use drugs and have seen drug use by parents (Dube, Anda, Felitti, Chapman, Williamson & Giles, 2001) and succumb in turn, to model similar behaviour thus supporting Bandura's (1977) social learning theory whereby adolescents model dysfunctional behaviour. Multiple problem adolescents are more likely to not live with both parents (Wichstrom, 2000). Parental psychopathology (Chan, Hung, & Yip, 2001), psychosocial stress (Gould, Fisher, Parides, Floy & Shaffer, 1996), legal, disciplinary and school problems (Brent, Perper, Moritz, Allan, Friend & Roth, 1993), and interpersonal loss (Rich, Fogarty & Young, 1988) are often implicated in dysfunctional family formation.

The critical criteria that had to be met in order to receive the IYB, was that an irreconcilable breakdown had occurred between the parent/carer and the adolescent.

However, in order to recognise the traits within dysfunctional families, it was first necessary to understand the dynamics that operate within functional families.

Functional families. According to Mackay (2003) a review of the international literature on family resilience shows that healthy families are those who can cope with adversities, have strong emotional bonds, effective communication and coping strategies, have a strong family belief system (especially those based on spiritual or religious values), and are still able to sustain positive parenting practices in times of financial hardship. Many of those applying for the IYB described their families in terms that a psychologist would describe as, "multiple problem environments", where various forms of deviance occurred.

(c) Common presenting profile of IYB youth- sexual abuse. With Maori youth so highly represented in the welfare application rates, psychological research focussing on sexual abuse issues that also is couched in cultural sensitivity, has often been lacking in the body of New Zealand research. However, Mortimer (2005), in recent months, has compiled an annotated bibliography of New Zealand literature on sexual abuse, highlighting extensive published and unpublished research from around the country. Findings from these studies add to our understanding of the consequences of sexual abuse on New Zealanders generally, but the local literature relating to Maori sexual abuse and assault remains scarce.

Familial and non-stranger sexual abuse of children in New Zealand accounts for 85% of reported sexual abuse cases (Anderson, Martin, Mullen, Romans & Herbison 1993), with an overall rate of 15% of the population experiencing sexual abuse with physical contact, and another 10% experiencing non-contact abuse (Clarkson & Kenny,

2001). It has been known for many years that there were associations between measures of family change, conflict, and the risk of child sexual abuse (CSA), but associations between CSA and parenting-child relationships, also has been established (Fergusson, Lynskey & Harwood, 1996). These researchers reported that the risk of CSA was elevated among young people raised in families where the parents had alcohol and substance abuse problems.

A sizeable number of IYB applicants that came to the attention of WINZ in the mid 90's, reported having contact with Child Youth and Family Services (CYFS), and told of their experiences while in foster care. Concerns emerged, not only around the reporting of sexual abuse in these settings, but also around the rates of suicidal behaviour for this 'foster care cohort'. A decade earlier Von Dadelszon (1987), had written a report for the CYFS department, (at that time called the Department of Social Welfare), noting that over two-thirds of the girls in their care (all under the age of 16), had been sexually abused. Familial and known perpetrators committed 90% of the offending, while strangers sexually abused 10% of the girls. This state department was housing a large population of hurting, mentally and physically injured children and adolescents, many of whom would later be diagnosed as exhibiting Post Traumatic Stress Disorder (PTSD), comorbid with other abuse related disorders.

Geddis, (1989) published the leading article in the New Zealand Medical Journal, raising concerns of the problems faced by those charged with diagnosing sexual abuse and offering guidelines for assessment. A further landmark article was published by Romans, Martin, Anderson, O'Shea and Mullen (1995), showing factors that mediate between child sexual abuse and adult psychological outcome. This research was essential

reading for those working with the IYB cohort, as it explored family relationships and their connection with the formation of later psychopathology in children, following conflictual relationships and childhood abuse. Romans, Martin and Mullen (1996) published further relevant research that would add knowledge to the IYB process, when they isolated 5 factors that were evidenced in low self esteem (i.e., pessimism, fatalism, lack of self confidence, likeability, and determination), and, outlined the predictors of low self esteem (i.e., childhood temperament, poor relationship with the mother, low qualification achievement, psychiatric morbidity, and genital contact childhood sexual abuse). As many of the IYB applicants were coming from fatherless homes, and many were sexually abused, these research findings influenced the foundation design of the thesis. Papers examining sexual abuse among Maori were scarce (Wright, 1998), and research recognising maternal collusion in allowing child sexual abuse to continue was rare. Fielding (1995) contributed to the "wellbeing" aspect of outcome research by highlighting the finding that, the level of support from the mother, following sexual abuse disclosure, was found to be a stronger predictor of the child's psychological functioning, than the type or length of abuse, or the perpetrator's relationship to the child. This information was critical in developing family reconciliation counselling sessions for IYB applicants.

There is little doubt that early intervention to protect children from abuse has a major impact on both individual mental health, and national expenditure. A Massey University study conducted by Julich (2002) found that by the time they reach 16, a quarter of girls and 9% of boys will have experienced sexual abuse. Carmichael (2002) has noted that there is a correlation between child abuse and mental health problems, and

has expressed concerns that health professionals often treat people without recognising family violence as an underlying cause of their health problems. She states, "Children who live in violent households are more likely to have diseases caused or exacerbated by neglect and have stunted cognitive, emotional, behavioural and social development" (p.8)

(d) Common presenting profile of IYB youth- violence in the home. New Zealand's role of shame in relation to family violence is unacceptable. One child dies by intended injury every five weeks in our country as well as unknown numbers who die through neglect and unrecognised and unreported abusive treatment. The Ministry of Health (2001) recorded the following figures:

- 400 women are hospitalised each year after being beaten by a partner.
- 11 women are killed each year by their partner at home.
- $2.74 billion is estimated to be spent each year on police callouts to family violence.
- $141 million estimated cost to the health sector associated with family violence.
- Up to 35% of women are hit or forced to have sex by their partners at least once in their lifetime.
- 21% of women report having experienced physical or sexual abuse in the previous 12 months.
- 53% of women report psychological abuse at home in the previous 12 months.
- Up to 5% of older people (over 65) are abused each year.

Although New Zealand has ratified their agreement to commit to the United Nations Convention on the Rights of the Child, our government still refuses to repeal Section 59 of the Crimes Act (1961) which allows reasonable physical force to be used on our children. With 'reasonable force' lacking definition, children in New Zealand are placed at serious risk of harm without legal redress.

Psychologists need to promote psychological theories about family discipline across the community in a manner that can be understood by all families. There are a range of psychological and sociological theories which lie behind why particular methods of family discipline are effective and others are not. Behavioural theory, for example, emphasises that there are consequences for behaviour and that parents who display aggressive models toward their children only encourage their children to use aggressive behaviour to control others. Socio-cultural theory purports that children will internalise and control their behaviour and cognitions according to the interactions they have experienced at home. Consequently, it seems that when children experience fear, negativity and pain from their caregivers, they internalise these modes of interaction, and use them to guide their own actions. Attachment theory (Karen, 1998), describes the relationships that children develop towards their caregivers. Inappropriate use of discipline threatens secure attachment, and sets a child up to feel unloved, inept with relationships, and to have negative feelings and anger toward authority figures throughout their life. Attachment theory suggests that children who have secure attachments with their parents are more likely to develop a conscience and control their own behaviour.

Ritchie (2004) noted that children who are physically punished may become aggressive, their academic potential, their mental health, and the quality of the

parent/child relationship may be affected, and they are likely to have a less well developed conscience. Ecological theory suggests that the wider environment affects the way children are treated within a family, and that when parents live in poverty and stress, and do not receive social support, they are more likely to use violence toward their children, thus promoting poor life outcomes. The sociology of childhood considers that children are thought of as social actors, who can understand and contribute meaningfully to their family and community, thus according to this model, their views should be listened to and respected.

Violence within the home produces negative developmental outcomes in the area of social behaviour, intellectual development, relationships, mental health problems, moral internalisation and the risk of lowered resiliency and connectedness (Smith, Gollop, Taylor & Marshall, 2004). There is little doubt, based on the meta-analysis of 92 studies on violence toward children (Gershoff, 2002), that IYB applicants, who have been exposed to violence at home, will show signs of dysfunction and antisocial behaviour, to varying degrees.

(e) Common presenting profile of IYB youth- antisocial behaviour. A large body of evidence exists suggesting childhood aggression as a pathway antecedent to both drug use and delinquency (Brook, Whiteman & Finch, 1992). Angry adolescents are often produced by aversive or punitive environments that predictably promote antisocial behaviours (Azrin, Hale, Holz & Hutcheson, 1965; Mayer, 1995; Ritchie & Ritchie, 1984). Hostile parenting significantly elevates the risk of later aggression and misconduct in children. (Brannigan, Gemmell, Pevalin & Wade, 2002). Such research is theoretically

crucial to this thesis, in offering theoretical insight into the subject that attends the IYB assessment interview.

Adolescent mental health is influenced not only by individual strengths and vulnerabilities but also by the character of the settings in which young people lead their lives. Schools, homes, neighbourhoods, whanau (family), social groups, churches, all play important roles in shaping children's perceptions of themselves. A large number of researchers have acknowledged the importance of developing a sense of belonging, a sense of connectedness in shaping positive life outcomes (Resnick et al, 1997) that will act as barriers to the development of antisocial behaviour. Maori have traditionally placed enormous importance on family history and connectedness (whakapapa), so the implications for Maori youth who disengage from their ancestral heritage and from their biological ties, are serious. Calvert and Lightfoot (2001) have recognised that just as multiple pathways lead to normal development, so there are multiple pathways leading to pathology. Study 2, of this thesis examines the concerns for Maori youth who are deprived of the knowledge of their biological fathers, and the resulting consequences that led to pathology, then death.

Many of the adolescents applying for an IYB, reported problems with police, and many seemed to joke about 'petty' crime. There seemed amongst the youth in the mid '90's, a culture that thought it was acceptable to steal as long as you had no money to pay for the items, and as long as you were sensible enough not to get caught. There also appeared to be a high proportion of applicants who had dropped out of school with no qualifications.

(f) Common presenting profile of IYB youth - limited self-efficacy, motivation, and internal locus of control. The concept of self-efficacy refers to a person's belief in his or her ability to succeed with a specific task or that he or she can succeed in making changes to a problem area in their life. Millar and Rollnick (1991) continue by suggesting that self-efficacy is just one element in a series of eight elements that influence a young person's motivation that will lead to self change. Adolescent motivation is depleted when there is a cognitive blueprint, that you are beaten by forces over which you have no control (Kienhorst, 1992), or the belief that events happen 'to' you due to forces outside of your control. Within this context, lack of control may include areas such as cultural alienation and prejudice, abuse, rejection, neglect, loss, lack of safety, poor caregiver arrangements, transient accommodation, limited access to health resources, and maintenance within violent environments (Durie, 1994; Durie, 2003; Chamberlain & MacKenzie, 1998; Miles, 2000; Spirito & Overholser, 2003).

Perceived controllability can be two-edged for at risk adolescents, due to the nature of the concept of 'control'. Wilson (1995) suggests that perceived controllability can be helpful in situations where the adolescent has the power to change the problem in order to stop it recurring. Unfortunately, perceived controllability can be detrimental if the adolescent feels guilty, or deserving of blame for the negative event that could have been avoided. This theoretical concept was evidenced in reality when we examined the case of Cassie, previously mentioned in this chapter, and to be explored further in Study 2 of this thesis.

Locus of control, defined more completely by Kelley and Stack (2000) is a well-known psychological construct that is inextricably linked to either well-being or degrees

of distress, depending upon a person's characteristic way of seeing the world. When an individual's locus of control is external, he or she will see life events as being the result of other people, luck or circumstances beyond their control. That person has limited agency to influence how life turns out. However, when the locus of control is internal, an individual feels more in control of outcomes and life circumstances. Either way, Millar and Rollnick (1991) suggest, that locus of control, self-efficacy and motivation, emanate from cognitive processes, so, in its simplest form, individuals have the ability to change the way they think and in turn, change the way they feel, especially once they are living in safe environments. When adolescents who are frightened at home, receive help to exit that environment, no longer do life events need to control and cause continued anxiety, depression, and anger. Individuals can choose, according to simplified CBT theory, that by changing the way they think about past problems, they can change their level of distress. Adolescents can learn that it is not always the events in their lives that cause them to fail and fear, but the way in which they think about those events (Bernard & Joyce, 1984; Geldard, 1998; Kidman, 1988; Millar & Rollnick, 1991; Smith, 1996). The CBT conceptual framework formed the theoretical foundation of both the assessment and intervention strategies employed with IYB applicants.

(g) Common profile of IYB youth-foster placement. An additional concern with this unique population was that a small group of applicants had been placed in foster care for long periods of time, i.e., ranging from several weeks to several years. There is considerable agreement in the literature that foster care constitutes a common beneficial option for children in need of out-of-home care (McDonald, 1996; Minty, 1999). However, Beautrais, Ellis and Smith (2001) presented evidence of concern indicating that

those who were in Child Youth and Family Services (CYFS) care, were at greater risk of suicidal behaviour, and that if you were a female in CYFS care, there was 23 times the likelihood that you would engage in suicidal behaviour compared to females who were not involved with CYFS.

The best predictors of unsuccessful transition to foster care are adolescents with mental health or behavioural problems (Barber, Delfabbro & Cooper, 2001), so with IYB applicants who appeared to have relational, behavioural and psychological disorders, foster care seems to be an inappropriate placement according to the literature. Further issues involving foster placement and issues of rejection are discussed in Study 2 of this thesis and recommendations for change are outlined in Appendix A.

(h) Common profile of IYB youth- poverty and intergenerational welfare dependency. Many of the presenting IYB applicants reported financial difficulties within their families. Poverty has been linked to a range of adverse outcomes for young people including reduced cognitive ability, poor academic achievement, and poor mental health and conduct disorders. Many of the presenting applicants appeared malnourished so their readiness for learning would be impaired. Mackay (2003) noted that children from such families are 'predestined' to do less well, and parents from these families often have reduced ability to nurture, monitor, and discipline their children effectively. Parents from these families also may have reduced expectations about their children's life chances.

These young people also lacked what has been called social capital i.e., lacking access to developing relationships with those who are able to help improve positive life outcomes. For example, financially secure parents are more likely to have networks of

relationships with people and institutions of influence than poor parents, which in turn has consequences for the children's chances of success.

Mayer (2002) suggests that poor families are not able to purchase 'human capital' by investing in their children's education, health, good neighbours and other 'inputs' that will improve children's future wellbeing. She proposes theories as to why there is a correlation between parental income and children's outcomes. Educational attainment is clearly affected by poverty as parental income affects parents expectation and ability to enrol children at high decile rated schools (research regarding adolescent outcome and attendance at low decile rated schools is expanded in Study 2 of this thesis).

It was observed with these IYB applicants, that it was not income per se that was affecting the outcomes for these youth, but people with lower incomes often have lower skill level, lower educational attainment and poorer access to health, education and general resources. It had been hypothesised that family income during adolescents was more important than family income during earlier childhood. Alienation and exclusion was more likely to result from low income during adolescence than low income during earlier years (Duncan & Brooks-Gunn, 1997).

The poorest group in New Zealand come from single, benefit dependent parents who have children (MSD, 2005). There was a pattern emerging that indicated many of these youth came from a single parent home where the parent also was on welfare. The MSD Social Report (2005), has noted that the most significant change in families in the past two decades has been the shift from two parent, to one parent families (from 14%-29%). This trend is expected to increase with analysts suggesting that by 2021, one parents families are projected to make up 35% of all families with dependent children.

New Zealand has a high proportion of sole-parent families, second only to the USA with 31% of their families fitting this category. These projections, in turn have serious implications for the related predicted rise in welfare applications.

Understanding risk and protection predictor variables with the IYB cohort. Tama, Kate and Allan's very brief vignettes provide enough information to identify immediate indicators of risk and also indicators of protection. A risk is defined as an early predictor of later unfavourable outcomes and something that renders a person vulnerable to unfavourable outcomes (Kaplan, 1999). A risk also has been viewed as a variable that may lead directly to psychopathology and problematic outcomes (Rutter, 1985). Alternatively, protective factors are 'buffering' variables that interact with risk to change or moderate the predictive relationship between risk factors and outcomes (Kalil, 2003).

It is this interactional effect that Jessor (1998) attempted to encapsulate in the risk/protection model he constructed. In his model he captured a new way of thinking about adolescent risk behaviour and the multiple linkages between risk, protection and outcomes. For years researchers had known that risk behaviours can directly or indirectly compromise the educational, employment, income, wellbeing and/or relationship life outcomes for individuals, and in some cases impact suicide or survival outcomes. Traditionally risk factors had been viewed as separate legal or normative 'transgressions' such as, drug use, alcohol abuse and 'immoral' behaviour. The model provided by Jessor (1998) opened new trajectories for researchers to begin to examine the functional commonality of 'traditional' risk behaviours with other domains of adolescent activity or risk environments that may impede healthy life outcomes. Parent psychopathology, parents on a benefit, not attending school, being bullied, foster placement, absent fathers,

also were now linked into the web of poor outcome causation. Jessor's (1998) risk factor, risk behaviour, risk outcome model, clearly outlined the linkage of risk behaviours, and risky lifestyles to life compromising outcomes.

There seems little doubt that early behaviour choices and early life environments put young people at risk of poor or positive outcomes in later life. Two substantial bodies of literature offer insight into processes that may effect a young person's involvement with risk behaviours. One body of research focuses on risk factors or deficit models, and the second body of research focuses on the concept of resiliency and the development of cognitive emotional behavioural assets. Both approaches have been expanded and explored in Study 2, where retrospective file audits indicate the risk /vulnerability factors that led 6 of the subjects to suicide, as well as examining the asset/resiliency factors that led 36 control subjects to survive, despite having previously attempted suicide.

A Risk Predictor Model that may generalise to the IYB population. As no research had been conducted with the IYB population regarding the association between risk and the granting or declining of the benefit, it was necessary that other predictor models be searched within the literature that may be generalised to welfare seeking adolescents. As many of these young people were involved in crime, the risk predictor model that seemed most appropriate to use with the IYB cohort was a model that proposed to predict dangerousness and violence from a population with mental health disorders.

Models that have been developed for predicting behaviour are generally based on either actuarial or clinical strategies, or a combination of the two. Clinical prediction tends to be based on professional training, experience and observation of the client. Actuarial strategies on the other hand, predict an individual's behaviour on the basis of

how others have acted in similar situations and based exclusively on empirically established relationships between the variables and the criterion (Borom, 1996). The general consensus is that actuarial methods are the more accurate of the two (Borom, 1996; Meehl, 1954; Rice & Harris, 1995), however, the combination of actuarial and clinical strategies is also effective.

Currently, there is no universal, professional standard existing in the mental health profession for assessing risk of dangerous behaviour such as suicide completion. Consequently, the ability to predict which IYB applicants will require welfare assistance in order for them to escape the risk of engaging in dangerous behaviour is fraught with difficulties. Those involved in assessment of this unique group of young people need to establish predictor variables that may be useful in assessing the risk level to these young people if they are maintained within their home setting, and the risk level that is anticipated should they be removed from their home.

Risk predictor variables include thorough assessments into childhood history, adolescent criminal and dysfunctional behaviour, demographic variables, and psychiatric diagnoses (Quinsey, Harris, Rice & Cormier, 1998). Monahan (2001), in his research that focuses on predicting dangerousness in people with mental health disorders, emphasised that risk predictor variables need to distinguish between high and low risk cases. IYB assessors attempted to do this by granting the IYB to those of high need and declining the IYB to those with low need, but unfortunately, no evidence was available that might justify their decisions.

Are multiple risk factors predictive of deviance? Longitudinal research indicates that a young person can usually cope with two risk factors simultaneously, but when

three or more are present, the outcome almost always results in some emotional or behavioural problems (Stevens & Griffin, 2001). The combination of familial and individual risk factors significantly increases the likelihood that a young person will engage in some risk behaviour. The absence of a 'buffer' between the individual and any number of the stresses weakens a young person's ability to tolerate the pressure and stress of life (Benson, Galbraith & Espeland, 1995; Masten & Coatsworth, 1998). Simply put, a buffer can be described as a positive barrier that separates or shields a vulnerable young person from negative experiences, situations or circumstances.

Benson (1993) developed a list of 30 assets, 10 deficits and 20 indicators of at-risk behaviour. These measures were constructed from a 152-item questionnaire that was administered to 46,799 13-18 year old students. This study illustrated the link between deficits and the increase in risky behaviours, and showed that the fewer number of developmental assets held by a young person and the greater number of deficits, the greater the at risk behaviour. Unfortunately, studying assets and deficits and applying the model that the greater the number of risks the greater the number of deviant outcomes will ultimately follow, is too simplistic. Dukes and Stein (2001) took the basic asset/deficit model, and from the perspective of social control theory (Glasser, 1990), confirmed by means of structural equations modelling the hypothesis that risk factors were predictive of deviance. They suggested that social controls are connections, or bonds to family, school or churches, and those personal controls are individual characteristics such as self-concept or personality traits. Control theory suggests that deviant adolescents are deficient in personal and/or social controls and further that these

deficits represent risk factors for deviant behaviour. Conversely, assets (protective factors) are positive controls that mitigate poor life outcome

Applying theory to practice. This terminology is really just a mass of psychological jargon unless the principles can be 'simply' applied and be understood by parents, school counsellors, social workers and youth workers, who operate on the coal face with youth from multiple problem families. For this to happen scientist-practitioners must bring together evidence 'users' with evidence 'providers', in a manner that promotes practical, easily implemented interventions that are grounded in empirical research. Those working in the Departments of Corrections and Justice, and academics commenting on Departmental programmes, have published some useful articles addressing the scientist- practitioner model in action (Andrews & Bonta, 1994; Evans et al., 1995, 1997; & Howard, 1993).

It was a goal of this research to apply a scientist-practitioner model in order to study a previously un-researched group of youth, to utilise measures of inquiry to establish factors that led this group to have positive life outcomes, and factors that led them to poor life outcomes, and further, to examine the roles of both government and practitioners in influencing those outcomes.

To illustrate the scientist-practitioner model, we could use an example from the "science of suicide prevention". As a conceptual framework for suicide prevention, recommendations from evidenced based findings suggest an important approach to preventing suicide is recognition that mental and substance abuse disorders are the most potent risk for suicidal behaviour. Such a recommendation suggests an important approach to preventing suicide would be to address the problems of undetected and

untreated mental and substance abuse disorders in conjunction with community and other public health and education approaches. Applying the scientist-practitioner model would then include the development of a constructive public health policy, measurable overall objectives, providing ways to manage, monitor and evaluate progress toward these objectives, and resource provision for agencies and groups targeted to implement the recommendations

Using the scientist-practitioner model, it is my intention to highlight the acronym "AIM" in using the research findings from this thesis to raise "Awareness" of the risks and protective factors faced by out-of-home, welfare seeking youth, to recommend "Intervention" services that are universal, selected and indicated (see Study 2), and to continue to use appropriate "Methodology" to advance the science of family breakdown prevention and child safety. The recommendations in Appendix A of this thesis mark the beginning of this process. The following 3 paragraphs show how, using a scientist-practitioner model approach and the AIM acronym, the IYB population could benefit from the new knowledge contained in this thesis. (The acronym was originally used in a report for the U.S. Public Health Service in1999, but was not related to welfare research).

Awareness: Appropriately broaden the public's awareness of family breakdown and the risk factors leading to homelessness, welfare dependency and suicidal behaviour. Enhance resources to community groups for assessment, counselling and treatment.

Intervention: Extend collaboration and networks among public and private sectors to complete a national strategy to reintegrate homeless, welfare dependent youth back into education, employment, and healthy relationships. Improve detection of early signs

of youth stress by training school staff, youth workers, and primary care providers. Provide easily accessible, funded family training programmes.

Methodology: Advance the science of family breakdown prevention and child safety, by developing culture-specific interventions and develop strategies to evaluate intervention.

In order to improve outcomes for IYB applicants, and to provide evidenced-based findings outlining their unique needs, firstly it was important to examine the profile of this group accurately describing who they were, where they came from, and what were their self reported experiences across adversity, family, personal and social interactions. To do this, I retrieved and analysed archived data, which resulted in a snapshot profile of 2029 IYB applicants who were interviewed between 1995-2001 within the Waikato region of New Zealand.

Method

Ethical Approval. Approval for the research was gained from the Special Education Service Chief Executive, and from the Ministry of Social Development's Legal and Ethics Committee (Appendix D). The Massey University Ethics Committee also was available throughout the study for advice on any ethical concern that might have arisen.

Participants. During the years 1995-2001, each IYB applicant that presented for an eligibility assessment was given the choice to become involved in 'outcome research' that would be conducted in later years. Participants, who agreed, signed a consent form that allowed the release of their information according to the Privacy Act 1993

regulations that ensured anonymity. A total of 2029 gave their consent and were included in this research.

Retrieving archived data. The database encompassed data from 2029 young people, aged 16-18 years, who had applied for the Independent Youth Benefit. Following entry of demographic data, the following variables were recorded. Date of assessment, age, gender, ethnicity, number of children in the family, position within the family, name of parents, employment status of parents, bullied, physical abuse, sexual abuse, emotional abuse, parent psychopathology, single parent home, parent on benefit, foster placement, drug use, excess alcohol consumption, cigarette use, perpetrator of bullying, suicidal thoughts, suicide attempt, school attendance, school qualification, police contact, CYFS contact, counselling required for mental health disorder previously diagnosed, and recommendation and/or attendance at Family Reconciliation Counselling (FRC).

Analysis of archived data. All records were checked for discrepancies and to ensure the categories for data analysis were robust. As the data were categorical, analyses were performed using the SPSS-13 programme. A Chi-Square analysis was used to investigate if factors reported by IYB applicants at an eligibility assessment interview were associated with the granting of the IYB.

Results

The results of the analysis are summarized and recorded as percentages in Figure 1.2. Risk factors have been grouped into four categories; adverse life risk factors, family, personal and social risk factors. From a total sample of 2029 IYB applicants, 51% had contact with police, and combined scores show that half of all cases reported abuse, 60% came from homes that were struggling financially, 40% reported mental health concerns,

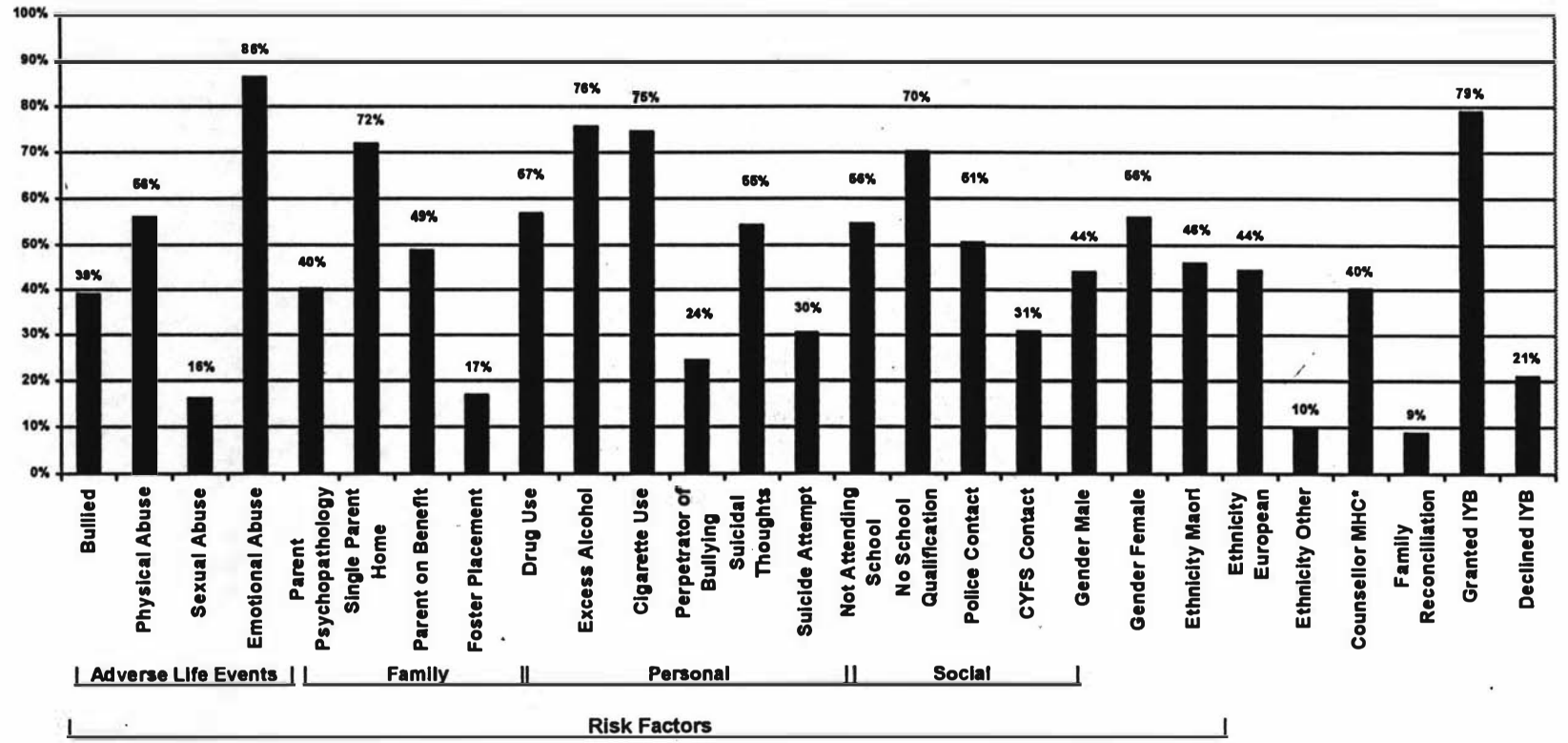

Figure 1.2. Snapshot profiles of 2029 youth who applied for the IYB between 1995-2001 showing common risk factors and demographics. (MHC* = Mental Health Concern).

62% indicated educational problems, and 69% reported substance abuse issues. Over half of the youth thought about suicide, and 30% made a medically serious suicide attempt (defined and examined in Study 2). Child Youth and Family Services had been involved with 31% of this group. More females than males applied for the IYB, more Maori applied than Europeans, and only a very small number were recommended for Family Reconciliation Counselling (9%). Almost 80% of those who applied for the IYB received it.

Interesting trends emerged across the seven year time period where data was collected. Table 1.1 shows that until 2001 there were increasing numbers of youth applying for the IYB. The year 2001 saw an overall decrease in applications and consequently, a resulting decrease in risk variables. Family reconciliation counselling referrals provided an exception to the lowered rates by showing a marked increase in families agreeing to be involved with counselling. Maori, over the seven year time frame, applied for the benefit more than European applicants, but more Europeans were declined the IYB. Suicide attempts were beginning to decrease by 2000 which matched community trends (MSD Social Report, 2005).

Table 1.1 indicates that fewer Maori young people reported being bullied than Europeans, but more Maori reported that they were the perpetrators of bullying. The number of Maori who had experienced physical abuse was also higher than those young people of European descent. European IYB applicants had greater parental mental health concerns than Maori applicants, but more Maori parents were reported as being in receipt of welfare benefits. Both groups of young people indicated that many of them had grown up in single parent homes and had engaged in excessive alcohol consumption, cigarette

smoking and drug use, as well as being disconnected from school and achieving only poor educational outcomes. Suicidal ideation was reported frequently by individuals in both ethnic groups, but proportionately fewer Maori applicants had attempted suicide than European applicants, but die more frequently from their attempt. More Maori young people had contact with the police and with CYFS, but fewer of them were referred as suitable candidates for family reconciliation counselling. As differences between Maori and European young people was not a central question for this research project, and would be confounded with other factors, I report these differences for interest only, with no further analysis of their statistical or social significance.

Table 1.1

Numerical Trends Showing Demographic and Risk Variables for both European and Maori IYB Applicants from 1995-2001 (other ethnicities excluded).

	1995		1996		1997		1998		1999		2000		2001		Grand Total
	Euro	Maori	Euro	Maori	Euro	Maori	Euro	Maori	Euro	Maori	Euro	Maori	Euro	Maori	
Bullied	19	17	39	34	46	51	63	38	80	52	81	93	57	44	714
Physical Abuse	29	31	53	59	43	69	83	72	93	100	90	143	71	102	1038
Sexual Abuse	12	11	18	11	13	15	31	21	41	24	29	40	10	30	306
Emotional Abuse	51	42	79	76	80	99	120	98	139	153	144	192	143	161	1577
Parent Psychopathology	20	11	29	32	57	56	41	33	24	18	112	108	114	94	749
Single Parent Home	40	35	64	56	71	90	87	89	123	136	133	161	108	138	1331
Parent on Benefit	30	38	44	60	40	73	49	66	63	99	57	128	45	93	885
Foster Placement	8	9	6	17	5	14	19	23	44	48	38	40	23	21	315
Drug Use	34	35	45	47	48	59	66	49	115	134	117	146	77	86	1058
Excess Alcohol	54	43	78	67	72	84	98	77	142	147	141	171	108	124	1406
Cigarette Use	46	40	69	60	72	86	106	90	136	141	142	161	103	134	1386
Perpetrator of Bullying	11	13	14	25	18	35	30	37	26	55	43	80	31	44	462
Suicidal Thoughts	35	25	47	39	53	57	95	66	113	102	105	120	77	70	1004
Suicide Attempt	24	15	27	19	36	33	68	45	65	50	50	56	32	41	561
Not Attending School	35	25	43	39	65	69	90	76	90	106	105	151	45	81	1020
No School Qualification	41	37	49	62	56	72	93	90	120	148	116	156	105	132	1277
Police Contact	27	33	42	46	49	73	59	54	80	106	86	130	74	90	949
CYFS Contact	17	14	26	35	21	31	42	45	58	65	58	78	32	52	574
Gender Male	24	23	37	37	37	47	52	47	65	93	70	105	73	81	791
Gender Female	40	26	54	46	59	64	81	65	108	82	106	107	93	108	1039
Ethnicity Maori	0	49	0	83	0	111	0	112	0	175	0	212	0	189	931
Ethnicity European	64	0	91	0	96	0	133	0	173	0	176	0	166	0	899
Ethnicity Other	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Counsellor MHC*	20	11	29	32	57	56	41	33	24	18	112	108	114	94	749
Family Reconciliation	15	4	17	9	29	17	8	4	8	3	6	7	20	12	159
Granted IYB	48	39	72	73	72	98	103	91	118	115	136	184	140	165	1454
Declined IYB	16	10	19	10	24	13	30	21	55	60	40	28	26	24	376
Total Youths Seen	64	49	91	83	96	111	133	112	173	175	176	212	166	189	1830

*MHC = Mental Health Concern

New questions needed to be answered regarding benefit accountability i.e., were the benefits going to applicants with the greatest need? One way of answering this question was to examine exposure to risk for those who were granted benefits, and for those who were declined benefits. For both groups, results indicated applicants who were granted the IYB had on average, two more risk factors in their life compared to the

average number of risks for applicants who were declined the IYB, and that overall, Maori and European risk factors were similar. So, results revealed that those with more risk factors were being granted the IYB. When I examined the exposure to risk of Maori, European and other ethnicities shown in Figure 1.5. results suggested that the difference was not statistically significant.

Figure 1.5. data relates to the number of applicants (within each ethnic group), reporting 1, 2, 3,... 18 risk factors. Data show that Maori are exposed to a greater number of risk factors compared to European and other ethnicities. The average number of risks for Maori was 9, and although the results were similar for the European applicants, overall, more Maori were exposed to a greater number of risks compared to other groups. For example, Maori who reported thirteen to eighteen risk factors in their life were more frequent than Europeans who reported exposure to thirteen to eighteen risk factors.

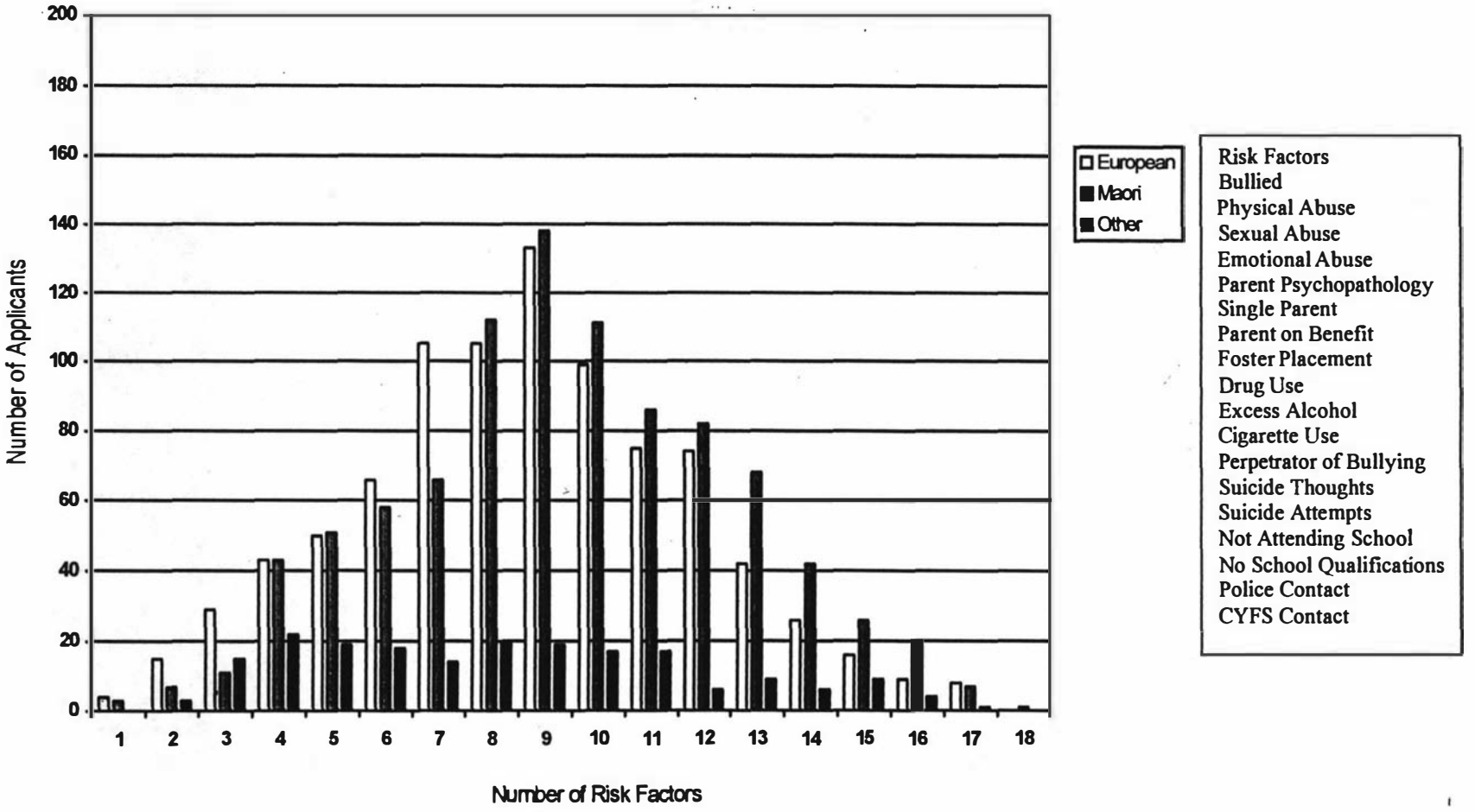

Figure 1.3. Frequency distribution of risk factors based on ethnicity for 2029 youth who applied for the IYB between 1995-2001.

During their eligibility assessment for the IYB applicants had reported yes or no to a range of questions regarding their exposure to risk factors across various life domains (adverse life events, family, personal and social). In order to establish which of these risk factors indicated a statistically significantly relationship to the granting of the IYB, a Chi-Square analysis was conducted. Table 1.2. outlines the findings of that analysis.

Table 1.2

Chi-Square Analysis Investigating Association of Factors Reported by IYB Applicants at an Assessment Interview with the Granting of the IYB

Factor	Chi-Square	df	Sig
Bullied	17.3196	1	.000
Physical Abuse	112.818	1	.000
Sexual Abuse	24.902	1	.000
Emotional Abuse	152.449	1	.000
Parent Psychopathology	11.131	1	.000
Single Parent Home	30.707	1	.000
Parent on Benefit	20.251	1	.000
Foster Placement	25.367	1	.000
Drug Use	.264	1	.607
Excess Alcohol	.162	1	.688
Cigarette Use	.031	1	.860
Perpetrator of Bullying	7.017	1	.008
Suicide Thoughts	30.474	1	.000
Suicide Attempt	51.786	1	.000
Not Attending School	.480	1	.488
No School Qualifications	7.451	1	.489
Police Contact	20.771	1	.000
CYFS Contact	63.928	1	.000
Combined Ethnicities	11.890	8	.156
Maori/European	10.421	2	.005
Required Counselling for MHC (Mental Health Concern)	11.131	1	.000
Family Reconciliation	172.658	1	.000

Maori Ethnicity was shown to be a statistically significant factor associated with the granting or declining of the IYB with Table 1.3. highlighting an issue that is to receive further examination in Study 2 of this thesis. Although exposures to risk factors were similar for all IYB applicants, it was of concern that the only applicants that went on to die by suicide were Maori.

Table 1.3.

Ethnicity Comparisons of Maori / European IYB Applicants' Suicide Attempts, and Resulting Death Rates.

	Total seen	Total suicide attempt	Total death by suicide
Maori	931	259 (27.82%)	6
European	899	302 (33.59%)	0

Results outlined in this table indicate that in the IYB cohort studied, although Maori IYB applicants attempted suicide less than European IYB applicants, they die more frequently from those attempts.

Discussion

When examining the data in the various tables, it is important to remember that each variable was measured at one point in time, and is influenced by all of the issues related to self-reported perceptions. It cannot be said that any one variable is a cause of suicide attempt, or a 'cause' in obtaining an Independent Youth Benefit. Rather, the data

indicate the association that each variable has to the outcome of being granted or declined the IYB.

A profile of 2029 IYB applicants was provided in Figure 1.2., revealing concerning patterns in adverse life events, family, personal and social areas of functioning. Rates of bullying (39%), perpetration of bullying (24%), and rates of sexual abuse (16%), are similar to those reported in the general population (Mortimer, 2005; Nairn & Smith, 2002), but the emotional (86%), and physical abuse (56%) rates reported by IYB applicants, and the poor educational attainment rates (70%), and suicide attempt rates (30%), seem higher than would be expected in the general community (Beautrais, 2003b; Durie, 2003; McDowell, 1995; Smith, Gallop, Taylor & Marshall, 2004; Watson, 2001). The high percentage of IYB applicants from single parent homes (72%), and the rates of alcohol (76%), cigarette (75%) and drug abuse (57%), combined with 40% of applicants reporting mental health problems, raises serious concerns for those providing intervention and follow up services. With almost half of the applicants reporting that they were raised by a parent on a benefit, and 40% of parents allegedly having a mental health diagnosis, implications for more effective collaboration between adult mental health services and welfare providers appears evident. This data has highlighted the evidenced-based suicidogenic truth (Gould & Kramer, 2001) that there is an association with parental psychopathology and mental health disorders in the offspring (40% of IYB applicants reported having seen a counsellor for a mental health disorder).

Watson (2001) and Fleming (2003), have recently conducted a secondary data analysis on their Youth 2000 data set. In personal correspondence with these researchers they stated that they have begun to look deeper into the dimension of violence amongst

New Zealand youth, particularly within the area of bullying by ethnicity. Their preliminary, unpublished latest analysis supports my findings that European/Pakeha report bullying at school less than Maori students, but when Maori report incidents of bullying they are more likely to report acts that are bad or terrible. This could mean that Maori children/youth set their tolerance level for bullying at a higher or more violent level than Europeans. Although the Youth 2000 researchers also found that European reported bullying more than Maori they also revealed that Maori are less likely to report bullying if it is really bad or terrible. The findings from my research with 2029 youth, show that Maori report bullying and attempt suicide less than Europeans, but die more frequently from the effects of violence, abuse and bullying. Study 2, will expand further on this finding.

The multiple problem family profiles reported by IYB applicants, confirm the literature that the probability of negative adolescent outcomes are amplified, or increase, by the presence of stress within the family (Kalil, 2003). Risk factors (a variable that increases the likelihood of an adverse outcome, which is measurable and precedes the outcome), are influenced by distal risk factors (e.g. parent on a benefit), proximal risk factors (e.g. sexual abuse), static predictors (e.g. being Maori), as well as dynamic predictors (e.g. attending counselling), and/or the applicants attitude to change.

Trends across this unique population from 1995-2001 are displayed in Table 1.1. European and Maori differences highlight that Maori applicants report physical abuse, parents on a benefit, excess alcohol consumption, not attending school, no school qualifications, police and CYFS contact, more regularly than do European applicants. More Maori applied for the IYB compared to Europeans, but more Europeans were

declined the IYB, and suicide attempts peaked in 1999.Other results show that up till 2001 there was a rapid increase in applications for a benefit, with 79% of benefit applications granted (21% declined), and only 9% of applicants and their families referred for family reconciliation counselling. More females applied than males.

Interestingly, recent data provided by the Ministry of Social Development (Honeybone, 2004), indicate that the trends in granting the IYB are currently changing. Data from the MSD Swift Main Benefit Time Series computer programme indicate that nationally in 2004, 56% of IYB's were granted and 44% declined, that more females were declined than males, and that more European applicants were declined the IYB than Maori applicants. These figures may be pleasing to MSD financial advisors, however it may well be that young people who really need the IYB, and who should be helped by this benefit, are not in fact receiving it.

A most notable change in the 2001 figures compared to figures across1995-2000, was the increase in numbers of families involved in Family Reconciliation Counselling (FRC). Attending FRC produced a significant association with benefit decline (p=.000). In other word, if an applicant attended FRC the chances of them being granted a benefit are almost zero. The reasons for this change are not surprising. Prior to 2001, WINZ national policy had informed IYB assessors that owing to the fact that WINZ paid $1,200.00 to Special Education Services (i.e., employers of those who assessed applicants), for each family that agreed to FRC, it was expected that there must be an 80% success rate if the FRC system was to continue. A success rate was defined as the applicant returned home and WINZ did not provide a benefit. This instruction worried many IYB assessors, as many felt that IYB assessments were not part of the core work

for those employed in educational settings, and many felt they lacked the 'scope of practice' to work in the field of therapeutic family counselling. In late 2000 WINZ lifted the 80% success criteria, and with the 'penalty' for failure exited from the contract, more IYB assessors entered into the field of family therapy.

The relationship between risk variables and the granting of the IYB is an important issue for those who, in the future, might be charged with predicting which cases might be most deserving of a full psycho-social eligibility interview, and which applicants might not be provided with this service. An analysis of the data from 2029 applicants seen between 1995-2001, indicate that the variables that were significantly associated with the granting of the IYB were; being bullied, physical and emotional abuse, parental psychopathology, placement in foster care, emanating from a single parent home and where a parent is on a benefit, suicidal thoughts and attempting suicide, contact with Police and CYFS as well as requiring counselling for a mental health concern, being Maori and attending family reconciliation counselling.

Table 1.3. revealed the numbers of Maori youth completing suicide. The 6 suicide deaths from the 2029 cohort, match suicide death rates seen in cohorts who have had contact with CYFS, i.e. 150 per 100.000 (Beautrais, Ellis & Smith, 2001). Suicide rates in the general population averaged around 24 per 100,000 between 1995-2001.This phenomenon is investigated in depth in Study 2 of this thesis. A further complicating issue for clinicians and policy analysts is that five out of the six of those who completed suicide were granted the IYB. When 83% of those who died were granted an IYB, serious concerns must be raised as to factors operating that lead to such a disastrous outcome. Questions must be asked about what referral pathways were set in place once

the IYB had been granted. The following chapter (Study 2) examines variables implicated in this outcome, and Appendix A, lists over fifty recommendations directed at multiple agencies that may address such concerns.

Family breakdown was the criteria that allowed a young person to apply for a benefit. Sabbath (1996) examined the role of family in the emergence of adolescent suicidal behaviour, suggesting that it was the lack of conflict resolution, or the inability to solve problems, that was implicated in poor outcomes for youth. This study has provided a descriptive snapshot of a cohort of 2029 IYB applicants, profiling their self reported exposure to family problems and to risk factors outside the family setting.

As previously noted, Beautrais (1998) published a case control study in which 129 young people who made medically serious suicide attempts were compared with 153 control subjects of similar age (15-24) who were randomly selected from the community. The aim was to provide an overview of the extent to which different domains of risk factors contribute to risk of serious suicide attempt among young people. Her research indicated that those young people who lacked formal educational qualifications and those in the lowest socio-economic groups were at risk of serious suicide attempt. The principle family factors associated with risk of serious suicide attempt included: exposure to childhood sexual abuse, poor parental maternal relationship and parental problems with alcohol. Two personality traits were associated with serious suicide attempt risk: hopelessness and neuroticism. The principle mental disorders associated with suicide attempt risk were affective disorders and substance use disorders. The life events found to be seriously related to suicide attempt risk were: exposure to interpersonal losses and conflicts and problems with the law and/or police.

Beautrais (1998) suggests that these risk factors may act cumulatively to determine the extent of individual risk to serious suicide attempt. In my research, it was clear that young people are reporting exposure to multiple risk factors, with Maori youth reporting the highest levels of risk exposure. Indeed, six young Maori youth died by suicide, and their exposure to cumulative risk is examined in the following study. However, there are limitations to merely counting the numerical risks to which an individual has been exposed. Maybe it is not so much the number of risks that is important, rather it is the individual perception and reaction to each of those risk events.

Psychological theory has offered some explanation as to why certain families were maintained in the cycle of poverty, why abuse occurred in some families, why particular clusters of individuals become dysfunctional, why suicidal rates peak and wane, why particular antecedents and influences in early childhood produce antisocial behaviour in adolescent phases of life, why some individuals turn to crime, why addictive behaviours develop, why some parents developed psychopathologies, why bullies were often reinforced, and why some young people seek nurturing and attachments outside of their home environments. Through the development of robust psychological models, we now know how the seeds of suicide grow, how negative family factors influence children to develop poor life outcomes, and how living in a home where there is no physical or psychological safety develops distrust, cynicism and unhealthy cognitive distortions. We now know how children needed to be treated at particular stages of development in order for them to develop healthy attitudes and social relationships. We know how families have the power to provide the happiest environment for a child, or alternatively, provide environments filled with despair, hopelessness, fear, abuse and neglect. Understanding

the theoretical models of human behaviour seems to be a pre-requisite for those involved in the assessment and intervention work with the high-risk youth who apply for welfare.

Conclusions

Study 1 provided new learning to the literature by identifying the first profile of the cohort of youth who leave home to seek independence through welfare assistance. Adverse life events, family, personal and social risk factors were identified, with findings revealing that those who were most likely to be granted a benefit were those who reported that they had been bullied, abused, and had a parent with a psychopathology, who was single and on a welfare benefit. Those from foster care, those who thought about suicide and those who reported a previous suicide attempt, as well as those who reported police and CYFS contact, also were more likely to be granted the IYB. If the applicant was Maori or had seen a counsellor for a mental health concern, again the chances of receiving the IYB were higher than those who did not report these factors. An interesting finding was that when an applicant was referred for FRC, there was a significant association with the welfare benefit being declined.

The risk of suicide attempts for this group of IYB seeking youth, greatly exceeded rates in the general community. The risk for Māori suicide was highlighted; a phenomenon expanded upon in the following study. Through case studies presented in this chapter, administrative flaws were identified, it was acknowledged that that there were inherent problems in the IYB assessors' ability to predict which applicants were at greatest risk if a benefit was not granted, and which applicants were at greater risk if a benefit was granted. It was further emphasised that both clinical and actuarial strategies

were not free of methodological and conceptual errors. If these difficulties were posed to clinical psychologists who traditionally conducted the IYB assessments, and who have extensive training in the scientist practitioner model, then there are concerning implications when non-psychologists are employed to conduct these assessments. IYB assessors, who have no training in detecting and/or diagnosing mental health disorders, and lack abilities in predicting dangerousness, suicidality, or other indicators of dysfunction, may place this cohort of high-risk individuals at even greater risk of harm. With 30% of this cohort making medically serious suicide attempts, it seems appropriate that IYB assessors have the skills and scope of practice required to identify psychological disorders, and to recommend appropriate referral pathways.

In order to avoid negative and fatal outcomes, future research needs to focus more on appropriate risk and need assessments, conducted by professionals who understand that many of the IYB applicants exist within families that are highly loaded with suicidogenic risks such as abuse, family violence, mental health disorders, substance abuse, crime, as well as educational and financial pressures. Future research also needs to focus on establishing 'individual assets' (Gilgun, 2000), and on developing interventions that assist the movement from adverse life conditions to finding pathways to resiliency (Gilligan, 2005).

All adolescents are exposed to some risk at some point in time. Risk is unavoidable. Many youth are exposed to a range of risk factors yet appear to have positive life outcomes. Research suggests that protective factors, buffers, or development of personal assets, are crucial in producing well adjusted adolescents. The following study explores the risk, protection and resiliency research in relation to welfare seeking

youth. Protection for youth is powerfully impacted not by running from risk, but in successful engagement with it. Individual, community, and whole-of-government education and awareness rising of practical strategies required to foster functional families, is required.

Findings from the present study indicated a need to explore the association between IYB applicants who had attempted suicide and compare risk factors for this group with IYB applicants who went on to die by suicide. Rather than comparing and contrasting suicide risk factors between a group of suicide attempters and young people of similar age from the community as Beautrais (1998) has done, the second study of this thesis took a matched sample group (i.e., all were IYB applicants, all had made a medically serious suicide attempt), and compared and contrasted over 22 variables, a series of childhood/adolescent experiences that led some IYB applicants to survive, and some IYB applicants to suicide.

The aim of the second study of this thesis was to construct a profile of the range of characteristics which may contribute to completed suicide among a group of young people who are considered highly at risk by engaging in previous suicide attempts and demonstrating exposure to the additional stress of seeking welfare assistance following a breakdown in family relationships. I believe that it would be of interest to examine retrospectively the files of IYB youth who went on to die by suicide following a previous suicide attempt, with files of IYB youth who went on to survive following a previous suicide attempt, and try to predict such an outcome prospectively through identification of risk and protective factors. Study 2 conducted such a comparative analysis and findings highlighted a significant risk factor that has received little attention in the

literature, as well as confirming previously recognised risk factors that may lead to suicide.

STUDY 2 ABSTRACT

Suicide and Serious Suicide Attempts: A Retrospective Matched-Group Comparison Study.

Objective. This study, through a retrospective file audit, reviewed and compared factors that influence risk/assets or vulnerability/resiliency of homeless adolescents to suicide attempt and suicide. The hypothesis predicted that there would be identifiable factors that existed within the files of the deceased group of 6 IYB applicants that were not present, or were less evident when contrasted to the files of the 36 controls.

Method. Data were gathered during a seven year (1995-2001) longitudinal study from a large cohort of New Zealand young people who applied for government financial assistance, the Independent Youth Benefit (IYB), due to family breakdown. Within this group of 16-18year old applicants, 6 died by suicide between 1996-1998. All had self identified as Maori with one identifying as part Maori, part European; four were males and two were females. The files of these 6 deceased youth were compared with the file records of 36 non-deceased youth. They were matched for IYB status (granted/declined) age, gender, time of assessment and ethnicity, prior involvement in counselling, family breakdown, lower SES status, exposure to loss through suicide and police contact. All 42 applicants had made at least one medically serious suicide attempt. Applicants' file notes were compared across a range of individual and parental mental health disorders, childhood and family adversity, socio-demographic and psychosocial factors. File data included information provided by IYB applicants, parent and family members, school teachers or guidance counsellors, work and income staff, and/or significant others (e.g., general practitioners, police, hospital staff, extended family/whanau, private counsellors).

The majority of the original IYB assessments were conducted by Clinical Psychologists; however 20% were assessed by an educational psychologist or counsellor.

Results. The hypothesis was supported. Differences were seen between the deceased and living contrast group in several areas, indicating that the seven salient factors to suicide in this cohort were: 1) previous suicide attempt, 2) co-morbid disorder, 3) unresolved anger, 4) no identified caring adult, 5) unknown father, 6) foster placement, and 7) impending legal/disciplinary event. Suicides also were characterized by male gender and Maori ethnicity. Five of the six deceased had been granted the IYB.

Conclusions. Numerous risk factors were shared by both the deceased and living contrast subjects in this group of young people where all 42 engaged in suicide attempts (six resulting in death by suicide). However, after controlling for shared risk factors, there appears to be some evidence that critical protective factors or assets may lead to greater resiliency and wellbeing in a population highly at risk. Protective factors include, specifically addressing co-morbid diagnoses in youth who have previously attempted suicide, and addressing unresolved anger and issues of isolation with youth who feel no connection to even one caring adult. This research indicated a need to examine not just the effects of absent fathers but particularly to address the issue of 'unknown' fathers. Of particular importance to statutory agencies are the concerns around foster placement, and threats of an impending legal/disciplinary event as a possible antecedent trigger to suicide.

STUDY 2

Introduction

Study 1, provided a profile of a group of welfare applicants who had an elevated risk of suicide. Between 1996-1998 the national New Zealand figures for suicide across the youth population (aged 15-24), were 26.2 per 100,000 (MSD Wellbeing report, 2004). Between 1996-1998 the suicide figures for the sample studied in this research indicate that within the IYB population, the extrapolated suicide rate is similar to the rate of suicide for young people who are placed in foster homes under the care of Child Youth and Family Services (CYFS) i.e., 150 per 100,000 (Beautrais et al., 2001).

The aim of Study 2 was to attempt, with a very small cohort, to retrospectively compare and contrast risk factors for suicide and for medically serious non-fatal suicide attempts, among six deceased Independent Youth Benefit (IYB) applicants and 36 living contrast applicants. Through the auditing of all 42 files of adolescents who had applied for the IYB this investigation offered some conclusions about factors that were associated with suicide, and factors that were associated with survival.

What trajectories lead to suicide? Through staunch allegiance to the empirical sciences, psychologists and psychiatrists have traditionally tried to answer the question, what makes one person more vulnerable to suicide than another? Several researchers (e.g. Rowling, 2003; Silburn, 2003) however, have suggested that multidisciplinary researchers in mental health promotion need to push the boundaries of research paradigms and extend their often contrary ontological and epistemological positions. As the causes of suicide are multifaceted (and prevention programmes need to be multimodal

and multi-strategic), research designs they suggest, need to include more action research and participatory research. Mind Matters, a national mental health promotion programme for secondary schools in Australia was successful in attaining such a balance (Rowling, 2003).

Research has isolated a range of risk factors that lead to suicide (Beautrais, 2003). Goodwin, Beautrais and Fergusson (2005) recently provided research showing an association between parental and offspring suicidal ideation and attempt. Another New Zealand researcher (Fortune, 2003), after studying one hundred clinical files of adolescents with significant suicidal behaviours, revealed that there were universally high loadings of biopsychsocial risk factors (sexual abuse, previous self harm, maternal substance abuse and family offending) for suicide among adolescents presenting for clinical intervention at the outpatient Child and Adolescent Mental health Service (CAMHS) Auckland. Although Fortune (2003) in a prospective study with 66 similar adolescents attempted to explore successful treatment outcomes for suicidal youth, the lack of randomised control trials (RCT) made it difficult to indicate robust treatment pathways for suicidal youth in clinical or non-clinical populations.

Gould and Kramer (2001) have provided a comprehensive analysis for completed and attempted suicide, implicating: familial and subject psychopathology (substance abuse and comorbidity); cognitive factors (hopelessness and poor problem solving ability); stressful life events (legal/disciplinary crisis); family factors (familial history, divorce and exposure to abusive relationships); contagion, socio-environmental factors (SES status, attendance at school and work problems); sexual orientation and biological risk factors (i.e., abnormalities in the serotonergic symptoms or association of suicide to

anger). Researchers have agreed that combinations of certain risk factors promote pathways to suicide.

Do 'normal' kids think about killing themselves? Fergusson et al. (2003), pose the question, "if a depressive disorder is the strongest risk for suicidal behaviour, why is it that evidence indicates that the majority of those with depressive disorders do not develop suicidal tendencies?" (p. 62). O'Connor et al. (1999) similarly concur that a large proportion of those who kill themselves are not diagnosed as suffering from a psychiatric illness and not conspicuously 'abnormal'. Smith and Crawford (1986) in earlier years had tackled this same conundrum by asking, 'do normal kids kill themselves'? These researchers back in 1986 discovered a disconcerting fact that also has recently been reported by Watson et al. (2001), that suicide concern is an issue faced by a large percentage of adolescents, but fortunately, most do not act on these concerns.

Estimates of suicidal thinking range from 15-65%, although the average prevalence of suicide ideation is 20-25% (Allison, Roeger, Martin & Keeves, 2001; Brener, Krug & Simon, 2000; Fergusson & Lynskey, 1995; Krug et al., 2002; Lessard & Moretti, 1998; and Martin et al., 1995). The World Health Organisation SUPRE MISS study indicates that suicide ideation in adolescents over the age of 14 years ranges from 2.6% in India to 25% in South Africa (Bertolote, 2003). My personal communications with Indian and Fijian parliamentary Ministers from the Fijian government, would lead me to question such low figures from the Indian population. As lead researcher into the current suicide situation in Fiji, Ministers from the Fijian Government have provided me with information that suicide rates amongst young Indian women living in Fiji are the highest rates currently collected amongst indigenous peoples.

Do New Zealand kids think about killing themselves? A national study of New Zealand young people indicated 29% of young females and 17% of young males had thought about killing themselves in the previous 12 months (Watson et al., 2001). Official statistics usually underestimate both suicide ideation and completed suicide, as police and coroners hesitate in bringing shame and added grief to already grieving families. In New Zealand, we still maintain a very high rate of suicide, particularly with those in the 25-40 age brackets, and with those who are male and Maori.

The Youth 2000 study provided to the New Zealand population our own home-grown picture of the state of our young people's mental health. It was the first confidential national computer survey to access information from young New Zealanders on a range of protective and resiliency factors, as well as risk factors and problems faced by youth across all regions of the country (Watson et al., 2001). Many 'Kiwis' were shocked to learn that on average 20% of their youth had thought about ending their life by suicide despite the fact that for several years New Zealand has been ranked among the highest OECD countries for suicide deaths (Beautrais, 2003e). Although these international ranking must be analysed with caution, the fact remains that neither New Zealand or any other country has yet found the 'smoking gun' that causes suicide. So far no devised programme or intervention is able to accurately predict which individual will follow the suicide trajectory.

Why would non-clinical groups of kids think about suicide? Smith and Crawford (1986) in discussing whether normal kids kill themselves highlighted the issue that most suicide attempters report chaotic home environments as well as conflict problems with both parents. Anger, abuse, and violence were predominant factors in their lives and

many perceived their parents as very unhappy, arguing individuals, who could hardly be models of loving, hopeful, coping adults. The rate of sexual abuse and unpleasant changes in lives of youth, and the need for many to be involved in counseling, indicates a pessimistic picture of 'normal' adolescents who not only think about suicide, but often personally know someone who has chosen suicide as an alternative to life's frustrations. Researchers have raised the concern that among teenagers who attempt suicide, 90% do not request medical assistance prior to the attempt. Many of the attempters seem to be reacting to frustrations with controlling or threatening actions that model a way of coping or communicating that is consistent with ways attempters describe interactions within their families. The conclusion from Smith and Crawford's (1986) research was that 'yes', normal kids do think about and attempt suicide, but those who think about suicide are often similar to those who have never thought about it, and those who have made plans about how they might kill themselves and those who have attempted are similar in profile, and those who have planned but never attempt suicide are similar to high risk adults. It is clear from the evidence that if we wish to help troubled adolescents, we need not target our efforts solely at the seriously suicidal young person (indicated interventions), but rather at whole populations (universal interventions) and high risk groups not yet exhibiting symptoms of suicidality (selective interventions).

Suicide trends. Within the New Zealand setting, Beautrais (2003b) has outlined time trends and epidemiology across the span of 50 years (1950-1999), indicating a steady increase in both male and females fatalities. A rapid increase in rates of male youth (15-24 years) suicide occurred after 1970, peaking to internationally high levels from the mid 1980's to the mid 1990's. From 1996-1998 there was a dramatic increase in

suicide by hanging for both males and females accounting for 65% of male and 75% of female youth suicides. Similar trends had occurred in Europe with Rutter and Smith (1995) concluding that the rapid increase in youth suicide might be related to: increased rates of depression; the increase in the use of alcohol and psychoactive drugs; the possible role of anti-social behaviour; the influence of suicidal models, either within the family and intimate circle, or in the mass media; the possible increase in family conflict and decline in parental support associated with changes in family structures; the possible effect of an extended period of social dependency during adolescents; and the likely role of changing circumstances in society as a whole.

As mentioned in the previous chapter, social changes that extend adolescent dependency on home or state (Schneider, 2000), and changing familial beliefs regarding adolescent 'independence', 'emancipation' and 'expendability', take some responsibility in the confusion, disengagement, and directionless image frequently portrayed by 'homeless', 'benefit dependent' young people. New Zealand's first Commissioner for Children, Ian Hassall, has publicly condemned New Zealand's 1985-1988 social reforms stating that, *"many of the young people that kill themselves are casualties of the market reforms"* (1997, p157). The New Zealand government also has received criticism, not just of their economic policies, but also of their educational facilities in contributing to youth suicide.

Low decile schools raises suicidal risk in youth. The New Zealand Government has been advised to carefully consider Watson (2001) and Fleming's (2003) findings that data from 9699 secondary school students from 114 randomly selected schools, suggested that

there were 3 powerful risk factors that must be acknowledged when formulating suicide prevention interventions:

a) Depressive symptoms in youth

b) Attendance at a low decile rated school

c) Awareness of a friend or family member attempting to kill themselves.

Fleming (2003) documented that lower decile rating of school was significantly associated with higher rates of suicide attempts. She noted that students at these schools have 3 to 4.5 times the suicide risk of students at the highest decile (least deprived schools) even when other risk and protective factors were taken into account. In New Zealand, schools are rated between one and ten based on the socioeconomic status (SES) of the local area and the parents' general income status. Although educationalists were concerned with Fleming's (2003) finding, there is evidence that the decile rating of a school seems to be a predictor of suicide risk and has implications for suicide prevention efforts within these schools.

In South Australia, schools are not discriminated in terms of 'decile ratings', rather , schools are distinguished by the number of students holding 'school cards' i.e., the students family has been assessed as being in need of financial support, and the school students are considered 'at-risk' due to poverty and disadvantage. Howard and Johnson (2003) document an account of how two of these severely disadvantaged schools, through a process they have termed 'mesosystem links' were successful in changing the culture of these schools. Expansion of these initiatives is not within the scope of this study; however generalisations of their success could certainly be applied across the Tasman.

In order to address the problem of economically deprived schools and related mental health needs of students, Murphy (1983) argued that until policy makers and clinicians are able to work together to design programmes and policies that actually relieve the substrate of despair that is the proximate base for most suicides, governments will continue to be ineffective in addressing suicidality. Murphy's insightful recommendations suggest that by promoting help seeking and problem solving skills, ensuring that children are kept safe at home and at school, addressing family violence and providing early intervention services for mental health disorders, we begin to recognise the need to work more at the micro and individual level of prevention.

A model that encapsulates evidence-based factors leading to suicide and suicide attempts. Evidence based literature targeted at youth who deliberately self harm, provides extensive data on theories that postulate scientifically scrutinized factors that appear to be associated at highly significant probabilities with fatal and non-fatal behaviours (Brent et al., 2003; de Wilde, 2000). Beautrais (2003e) provides an orderly conceptual framework to graphically present a life course model of a multiplicity of factors that link, hibernate, and accumulate on their culminating pathway to suicidal intentions and behaviours. This model provides at an immediate glance, an organised picture of the huge body of literature on the domains of factors for suicidal behaviour.

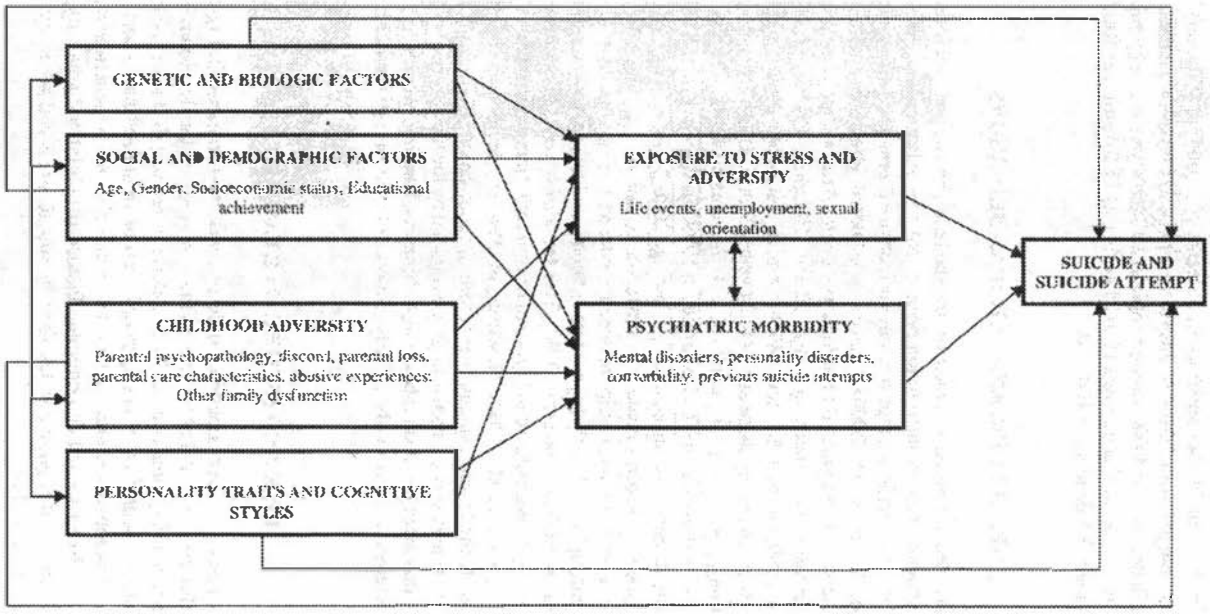

Figure 2. 1. Conceptual model of domains of factors for suicidal behaviours among young people.

Risks associated to suicide. A plethora of research has contributed to our understanding of risks that may be implicated in fatal and non-fatal behaviours and the protective factors that seem to mitigate the desire to die (Cantor & Neulinger, 2000; Catalano & Hawkins, 1996; Gould et al., 2003). Researchers (e.g. Fergusson & Woodward et al., 2000) have suggested that there is a linear relationship between the number of risk factors, e.g. poverty, family breakdown, bullying, abuse, parental divorce, in a child's early development, and the number of psychosocial problems during later adolescence. It is suggested that increasing opportunity for interaction among risk factors increases as a function of increasing numbers of risk factors. Consequently, the effect of multiple risk factors may be exponential.

For example, when subjects present with multiple suicide attempts and have used alcohol in their attempt (Bennett et. al., 2002), are diagnosed with co-morbid disorders (Shaffer, Gould & Fisher, 1996), have a sense of hopelessness combined with no spiritual connection (Durie, 2001, 2003), are filled with unresolved anger (Robinson, 1999), have absent or unknown fathers with no caring adult connection in their lives (Resnick, 2000), and are involved in an impending legal or disciplinary process (Brent et. al., 1993), there are incremental effects on suicide risk. When such subjects have been abused (Kienhorst et al., 1990), culturally dislocated and disconnected (Norris & Platz, 2003; Walker, 2001), seen as failures within the school system (McLaren, 2003), have experienced years of poverty (Krishnan et al., 2002), have been raised in sole parent families (Jensen, et al., 2003), have had a friend or family member die by suicide (Stroebe et al., 1993; Van Dongen, 1991) and have a family history of mental health disorders (Gould et al., 1996) the risk of impending suicide is extremely high.

Literature indicates that fatal and no-fatal behaviours are influenced by biological, psychological, intrapsychic, interpersonal, sociological, cultural and philosophical agents. Neither suicide nor suicide attempt can be explained by single factors. There will never be one global solution just as there will never be one global protective factor that will mitigate against any single risk factor. Suicide it seems, is the result of a complex interplay between multiple influences.

Protective factors are buffers against risk factors. Protective factors are buffering variables that interact with risk to change or moderate the predictive relationship between risk factors and outcomes (Kalil, 2003). Protective factors have been described as assets (Dukes & Stein, 2001), as strengths (Gilgun, 2000), and as resilient to suicidal behaviour

(Masten, Hubbard et al., 1999). Conversely, risk factors have been described by Kaplan (1999) as an early predictor of later unfavourable outcomes and something that renders a person vulnerable to unfavourable outcomes. Rutter (1985) viewed risk as a variable that leads directly to psychopathology and problematic outcomes. Recently, researchers have begun to examine alternative richer approaches to designing research that critically questions the interplay between resiliency and risk.

Analysis of individual suicide cases necessary for overall understanding of suicide. Zilboorg (1996) states, "there is a trend to disindividualise suicide as researchers have turned an empirical direction emphasizing statistical, economic, biological and sociological investigation. But today, as in the past, suicide cannot be clinically understood, estimated, or even prevented without careful study of the individual patient" (p. 63). O'Connor et al. (1999) agree with Zilboorg's (1996) suggestion, adding that if researchers are to design sensitive assessment tools of suicide risk, more needs to be done through integrating studies of attempted suicide with retrospective analysis of completed suicide.

IYB applicants: a non-clinical cohort. Non-clinical groups of 'normal' kids who attempt or complete suicide may simply lack a formal DSM-IV diagnosis of a mental disorder. Cavanagh, Carson, Sharpe and Lawrie (2003) identified from 76 psychological autopsy studies that the median proportion of cases with mental disorder was 91%. Beautrais (2000) also has suggested that within the New Zealand cohort of suicide attempt and suicide, that 70-90% of subjects had a mental disorder. Fergusson (2003) suggests that a depressed subject also may have been exposed to other childhood personal, family, social and life adversities, which may increase later vulnerability to

suicide. Alternatively, researchers may consider that the depressed subject did not become suicidal because of strong social support and family connectedness, which in turn decreases the risk of suicide. Within this model vulnerability/risk and resiliency/assets are interchangeable. So, according to Fergusson (2003), if sexual abuse increases vulnerability to suicidal behaviour, adding a risk to the subject's life, then the absence of such abuse contributes to resiliency, adding an asset to the subject's life.

Unfortunately, few researchers have concentrated on examining the strengths, competencies and assets of adolescents that in turn provide pathways to survival and the promotion of resiliency. It is from this perspective that research was initiated for this retrospective audit of the files of Dave, Daniel, Cassie, Mischa, Taine and John, who were four young males and two young females who lived in the north island of New Zealand. They are now dead. Brief scenarios of these youths will help contribute to our understanding of the multi-complex pathways that lead IYB youth to suicide.

Brief introduction to 6 deceased welfare seeking adolescent: Dave. Dave's mother had several placements in a psychiatric institution. Dave described himself as the main caregiver. He reported incidents where she would stand at the gate of their home and scream obscenities at him as he walked to school. He described the humiliation and isolation he felt, as his peers observed this behaviour. Dave did not know his fathers name, only that he had spent most of his life in jail. Dave angrily criticized hospital counsellors. He said that they never followed up on his mother and they expected him to give all the support to her. He stated that he would never choose to see a counsellor and the only place he could find help was in a joint.

At various intervals Dave had been placed in foster homes. He had been sodomised while in CYFS care. While attending school Dave was seriously bullied. He frequently had his glasses knocked off, and his head pushed into the workbench. His clothes were taken after psychical education classes while he was still in the shower. He was left naked only to be taunted and jeered at by the other boys. Just prior to his death, Dave was discovered smoking a joint. He was told by police to go home and tell his mother before they arrived. By the time the police car drove to the front gate, Dave had died by hanging himself in the garage. Dave had been granted the IYB.

Daniel. Daniel had been jailed for assault and obstruction. He had a trespass order against him so that he could not go near his family home. He stated that he had lost count of the number of foster homes he had lived in. Daniel never knew his father, his older brother had completed suicide, and the only friends he ever had at high school also died by suicide. Daniel was hospitalised for two suicide attempts prior to being granted the IYB.

At high school Daniel was frequently bullied and beaten by other boys. His file contains several sad accounts of issues related to bullying. Daniel stated that he was unable to control his anger. He had been suspended from school. A trespass order from Daniel's family increased his anger, pushing him into uncontrollable rage. File notes indicate that Daniel was extremely cynical. A further suicide attempt followed. Daniel reported that prior to leaving hospital a doctor asked him, "Do you think you will be okay?" Apparently when Daniel left hospital he received no follow-up treatment.

At the time of the IYB assessment, Daniel stated that his mother was dying. He informed the psychologist that his mother had said he was a real bad boy and did not

want him near her. Daniel was referred to an anger management programme and a recommendation was made for the case manager from WINZ to arrange paid individual counselling for Daniel. He never kept his appointment. Daniel hanged himself in his backyard.

Cassie. Cassie was extremely popular at school. Although she gained no academic qualifications, she was well liked by teachers and peers. She was always first to school and last to leave. Cassie never knew her real dad. She was sexually abused by her stepfather from the age of 6 to 16. Three times she was hospitalised after trying to kill herself. She received no follow-up counselling after each release. After her last suicide attempt, her stepfather stated that she was an attention seeker and he would not pay for her funeral if she died. He stated that she was a loser and didn't belong in his family. Although Cassie tried to be happy, she believed him.

Cassie felt culpable for the abuse as she had agreed to have oral sex with her stepfather, in order to have her school camp fees paid. Her disclosure of years of sexual abuse to her mother was met with disbelief and anger. Cassie's mum told her daughter that she would take her own life if Cassie informed the police. Cassie kept quiet. At the time of the IYB assessment Cassie had left home and had moved into a lesbian relationship with an older woman. Cassie reported at the assessment that she had become the person her stepfather said she'd become. She stated, "I've become the monster he formed, just like modelling clay. I truly am a loser. Just a black bitch." Seven days after receiving a beating from her lesbian lover, Cassie hanged herself. Cassie had been granted the IYB.

Mischa. This young woman's parents separated when she was three. A vicious custody battle raged for many years. During this time Mischa had her own lawyer and was placed in several foster homes. Her mother is a nurse and her father, a highly qualified barrister. Animosity between relatives on either side exacerbated the already volatile situation. Mischa's mother was hospitalised with a mental health disorder.

At the age of 13, Mischa was finally placed with her father. He chose her clothes, went to movies with her, slept in the same room in another single bed, refused to allow friends to visit the house, and walked her to and from school insuring her isolation and total dependency on him. This obsession to 'protect' and control his daughter existed up until the time of Mischa's death.

A school guidance counsellor referred her for sexual abuse counseling. Mischa told the counsellor that a male neighbour had abused her. The counsellor believed the abuse was perpetrated my Mischa's father, but noted in the file that fear of his power prevented accurate disclosure. At 16, Mischa ran away to live at a friends home. She applied for the IYB and sexual abuse counselling continued. Mischa's father initiated legal proceedings to force his daughter to return home. He made a 2 hour telephone call to his daughter late one night. She was found dead from an overdose the next morning. Mischa had been granted the IYB.

Taine. Taine's file records had very few notes. They were made by a European male psychologist. Taine appeared to be the scapegoat in the family. He had three friends die by suicide. His father was unknown, and his mother, despite being a beneficiary, adamantly opposed the welfare benefit system that supported young people leaving home.

Taine had been bullied at school yet he was the one to be suspended. He revealed that he had been sexually abused while in foster care. He wanted no contact with his Maori culture. The psychologist recommended that Taine's application for the benefit be declined, and that the family proceed with family reconciliation counselling. The file did not record if counselling eventuated. Taine died by hanging.

John. John was the eldest of four children. After two suicide attempts the school counsellor referred John for an IYB assessment suggesting that he needed to live away from home. At the IYB assessment interview John stated that he had lied about his selection into the top rugby team as he desperately wanted his mother and step father to like him and be proud of him. He also stated that he lied to his mother and step-father about passing his school exams. When John was suspended from school, he never told his parents. John stated that he was too ashamed to tell his mother and step-father or his girlfriend how useless he was.

John reported to the IYB interviewer that his home life and school life were 'shit'. He was bullied at school, and felt that no matter what he did, nothing in his life would ever change. Notes record that at the interview he appeared incredibly cynical, sad and depressed. There were some concerns noted that John had been sexually abused by his mother's partner when he was a young boy. Notes also record possible homosexual preference.

John refused to acknowledge his Maori culture and expressed anger at the lack of protection for children on the Marae. A recommendation was made to John's case manager that she arrange free counselling for this young man. The recommendation was

not followed through. John killed himself by inhaling Carbon monoxide in his mother's car. John had been granted the IYB.

The following statements were directly recorded from the files of these six deceased youth.

"Foster parents just want free sex"

"I don't go to foster homes anymore, I go to cells"

"I'll get back at all those F***** B******* for what they did to me at school"

"My older brother got it right when he left this F***** planet the right way"

Mum said, "If we split up it's your fault"

Mum said, "If you don't take him to court you're a liar"

Mum said, "He'll kill you one day"

He said if I wanted my school camp fees paid, I better earn it ... "Come and bath with me"

"Just listen to your father and be a good girl"

"Mum's crazy, she screams at the gate while I'm walking to school... the kids all think I'm weird"

"Dad walked out on us, he's in jail now... no one cares"

"When mum was dying she told my brother she didn't want me near her"

"I want to stop thinking about suicide as a continual option"

"I had my own lawyer at 3... my parents weren't prepared to just destroy themselves, they had to destroy me to"

"If I was nice to one parent, the other one hated me"

"When I made the second 15 I told them I made the first 15... Nothing I ever did made my parents proud of me"

"I thought I'd be loved in a lesbian relationship, but she beat me up as much as he did"

These statements came from six New Zealand youth lost to suicide. Yet similar statements are made in other audited files, and those young people lived. Why? What are the factors associated with adolescent pathways to death, and what are the factors associated with adolescent pathways to survival. Literature indicates that for young people, the following factors are associated with suicidal behaviour.

Anger. The psychological construct of anger is frequently a precursor to suicide or suicide attempt. Rohde, Mace and Seely (1997) report that conduct and oppositional defiant disorders were associated with higher rates of suicide attempts in males, but lower rates of attempts in females. Although depression is often associated with adult suicidality, not all adolescent suicide attempters are depressed. Feldman and Wilson (1997) report that less than half of the suicidal adolescents in their study were depressed. The relationship between anger and adolescent suicide is well documented (Boergers, Spirito & Donaldson, 1998; Brown, Overholser, Spirito & Fritz, 1991; Goldston, Daniel, Reboussin, Keely & Brunstetter, 1996; Negron, Piacentini, Graae, Davies & Shaffer, 1997; Pinto & Whisman, 1996; Rotheram-Borus, Piacentini, Millar, Graae & Gastro-Blanco, 1994; Stein, Ratzoni, Har-Even & Avidan, 1998).

Spirito (2003) has suggested that the investigation of anger may be more relevant for understanding motivation for a suicide attempt than looking at differentiating types of suicide attempts such as impulsive or premeditated. Future research needs to concentrate

on the importance of anger as an emotional correlate of adolescent suicide. There is a need to closely dissect the psychological constructs that are integral, yet separate components of the overall emotions of anger. Such constructs might be irritability, cynicism or hostility.

Stein et al. (1998) made an interesting observation when he concluded that repeat or previous attempters reported more anger than non-suicidal subjects. Data collected by Meyers, McCauley, Calderon and Treddor (1991) indicate that a previous suicide attempt combined with the construct of anger, best predicted later suicidality. Rotheram-Borus et al. (1994) found that more attempters reported feeling frequently angry (50%) than their non-attempting counterparts (27%).

Assessment of the construct of anger consequently becomes a crucial task for those involved in working with youth at risk. External anger is easily identified; however, internal components of anger (i.e., irritability or cynicism), bear a close resemblance to depression and hopelessness (Lehnert, 1994), and thus may be more difficult to diagnose.

Hostility has been identified as one of the constructs that may make up the emotional state of anger (Buss & Durkee, 1957; Buss & Perry, 1992) as are the constructs of dislike, resentment, and contempt for others. The negative emotion of cynicism also has been seen as a component of negative interaction (Drury & Dennison, 1999). The advantage of examining these constructs is that researchers may be able to isolate the discreet emotions that cause distress to different suicidal populations. For example, within adult populations, depression is highly associated with suicidality. However, in adolescent populations, anger or cynicism may be more closely associated to suicidal behaviour than the psychological construct of depression. This area requires further

research across diverse populations, including those with suicidal behaviour and those who show no suicidal behaviours.

Gender and culture. Langford, Ritchie & Ritchie (1998) provide a comprehensive document reviewing gender and cultural differences in relation to suicidal behaviour for New Zealand adolescents. They raise an interesting traditional Maori view of 'suicide' that relates this type of death (whakamomori) to a 'loss of alternatives'. Exposure to interpersonal loss has been found to be gender specific, i.e., a significant risk factor for male youth but not female youth (Chan et al., 2001). The most recent government report on the wellbeing of the nation (MSD Social Report, 2005), clearly establishes that there is a much higher rate of suicide for males than females, particularly Maori males.

Many adolescents, who have engaged in suicide attempts or completed suicide, have engaged in the behaviour of deliberate self-harm, particularly self-mutilation caused through 'cutting'. Ritchie and Ashcroft (2004) suggest that this is an outward expression of inner pain that in Maori young people is symbolic of cultural oppression. Curtis (2003), after providing a detailed examination of self mutilation concludes however that self mutilation should be seen as distinct from suicidal behaviour.

Comorbidity and multiple attempts. Psychological autopsy studies of youth who complete suicide show that the majority of youth had psychiatric problems, including previous suicide behaviour, depressive disorders and substance abuse. The highest rate of suicide attempts was seen in adolescents with comorbid diagnosis of substance abuse and depressive disorder (Cavanagh et al., 2003; Kovacs et al., 1993). Around 25% of youth suicide victims have made a prior attempt (Brent et al., 1993a). Previous suicide attempt is a powerful predictor for suicide especially for males as it increases the risk thirty fold

(Brent, 1995). More recently Hawton et al. (1999), compared first time attempters with multiple attempters concluding that those who made more than one suicide attempt had higher scores on measures of anger, and lower scores on problem solving.

An Auckland study conducted by Bennett et al. (2002) highlighted two groups of particular concern who presented to the emergency department following a suicide attempt. They were those who involved alcohol in the attempt, and those who showed again at the Emergency Department for multiple attempts. Many of these young people were living out-of-home preferring to flat rather than continue with the stress and conflict experienced at home with their family.

Foster placement and suicide risk for children and young people under the care of CYFS. Research indicates that females aged 13-16 years who have contact with Child Youth and Family Services (CYFS) are 23 times more likely to die by suicide than females with no contact with the department (Beautrais, Ellis & Smith, 2001). Table 2.1 presents supporting data documented by these researchers. The suicide rate for Maori males in 1998 was 30.5 deaths per 100,000, almost 50% higher than the non-Maori male rate (20.4 per 100,000). Evidence suggests that Maori are over represented amongst those with social and health problems and it is likely that the suicide rates reflect these disadvantages (Ministry of Health Strategy, 2001).

Table 2.1

Rates of Suicides per 100,000 for Youth 13-16 Years of Age in Contact with Child, Youth and Family (Average for 1994 to 1998), Compared with General Population not in Contact with the Department taken from Beautrais, Ellis & Smith (2001)

Ethnicity	Gender	Rate per 100,000 13 – 16 years in contact with CYF	Rate per 100,000 13 – 16 years not in contact with CYF	Relative Risk
Maori	Female	156.4	9.1	12.2
	Male	69.9	25.6	2.7
	Total	102.3	17.4	5.9
Pacific	Female	76.1	0	
	Male	87.2	0	
	Total	82.3	0	
Other	Female	97.4	2.9	24.9
	Male	59.3	11.6	5.1
	Total	72.5	7.9	9.2
Total	Female	119.4	5.1	23.4
	Male	66.1	12.3	5.4
	Total	85.4	8.7	9.8

The most notable differences between the two populations (those in contact with CYFS and those not in contact with CYFS), are that females aged 13 to 16 years in contact with Child, Youth and Family Service, are 23 times more likely to die by suicide than females with no contact with the Department. Among youth who do not have contact with CYFS, males have higher rates of suicide than females; however, in Beautrais et al. (2001) research of CYFS adolescents, females have higher suicide rates than males, especially Maori females. The rate of suicide for youth taken into care, is 1 suicide for every 370 CYFS clients. In my IYB cohort, there was I suicide for every 338 WINZ clients.

When comparing the rates of suicide of IYB youth and CYFS youth with the general community, it is important to note that these very elevated levels of suicide do not imply that contact with CYFS or WINZ is in itself the cause of suicide, or even a major contributor to suicide. Literature confirms that youth who come into contact with

statutory agencies tend to have lived lives that include many of the risk factors shown to be associated with suicide. The suicidal risk for those in foster care was highlighted by Lawlor and Kosky (1992), when they studied suicide attempters ranging in age from 11-17 years who were placed in out-of-home residential care. They reported that 1 in every 100 residents remaining longer than seven days at the centre, seriously attempted suicide. The methods were lethal and would have resulted in death if staff had not intervened immediately. Suicide attempters were more likely to be males over 16, to have a history of foster or institutional care, to have been angry and violent, to have previously attempted suicide, and to have been involved previously with a psychiatrist or counsellor.

Family Conflict, Parental Rejection, Abuse, and Absent or Unknown Fathers. While family cohesiveness has been shown to be a protective factor against suicidal behaviour (Rubenstein, Halton, Kasten, Rubin & Stechler, 1998; Svetaz, Ireland & Blum, 2000), numerous studies support the hypothesis that suicide attempters have more conflicted family relationships compared to community samples (Swedo, Rettew, Kuppenheimer, Lum, Dolan & Goldberger, 1991), and turned less to a parent when they had trouble with police, were feeling low and/or experienced problems at school (Berit et al., 2000).

Parental rejection can play a major role in adolescent suicide. This phenomenon remained poorly researched until Sabbath (1996) illustrated in rich clinical detail how adolescents who suicided had often succumb to the feeling that they were 'expendable' as they moved down a path of destruction from anger, to cynicism, to indifference, then to death. The expendable adolescent refers to one who no longer can be tolerated or needed by the family. The adolescent comes to believe that they are not useful either as an object

of affection, or as the vicarious fulfiller of the needs of parents (Sabbath, 1996). Clinical experience has shown that these young people often move through the grief cycle of loss, the loss of being needed, the loss of being treasured, the loss of succeeding in the eyes of adults, and the loss of a connection to the very basic need of surviving in life, the loss of ones family. Teicher and Jacobs (1966) stated that 88% of adolescents who suicided at that time, did so in their own homes, often with a parent in an adjoining room. It has been believed by many clinicians that adolescents frequently experience extreme alienation and cynicism (examined in Study 4) prior to completing suicide, especially when exposed to familial abuse.

Lost fathers, and /or separation from parents have been associated with a variety of psychological disorders within adolescents. Glaser (1965) admonished parents with a reality check suggesting that many were "emotionally detached' from their children and that 'absent fathers' in particular, were not available to their children either psychologically or physically during times of adolescent stress. Marttunen et al. (1994) reported that violent male suicide completers had been separated from their parents and 88% had lost their father before the age of 12.

Adoption research with adolescents provides findings that show similar life trajectories with IYB youth. Both groups might be living with one biological parent, but are refused information on the identity of the other biological parent. Slap, Goodman and Huang (2001) reported that attempted suicide is more common among adolescents who live with adoptive parents than among adolescents who live with biological parents. It was confirmed in their study that anger and suicidal behaviour were associated with adoption. Issues involving distrust of others (i.e., cynicism), and holding beliefs that

adults abandon and cannot be relied upon (i.e., lack of connection to a caring adult), also produce negative emotional states within this cohort (Verrier, 1993).

Maori youth who have no knowledge of their biological father, are of particular concern as their individual identity is often inextricably interwoven into their ancestral heritage and intergenerational stories. In not knowing the identity of a biological parent there may be a lost spiritual connection (Hutcheson, 2004). Absent fathers have been linked to economic hardship and pressure that is placed on sole mothers and her children, and it has been documented that half of all solo mothers living in Australia, Canada and the USA, live in poverty (UNICEF, 2004). In New Zealand, sole-parent families living with dependent children had the lowest standard of living of any family type (Jenson et al., 2003). Dharmalingam, Pool, Sceats and Mackay (2004) further report that life-table estimates indicate that close to one in two mothers (46%), had been a sole parent by the time they reached 50 years of age. Study 1 of this thesis reported that from a sample of adolescents seeking welfare support, 30% attempted suicide and 72% came from sole-parent homes. From the sample of 2029, six completed suicide, all of whom had absent and unknown fathers.

From Anna Freud's (1958) paper describing the difficulties around attachment between parents and their adolescent offspring, to Ritchies' (1970, 1981, 1984) and Ritchie's (2004) continued evidenced-based pleas for parents to resolve family conflict without physical violence, researchers continue to provide strategies to parents that will promote resilient, safe and happy homes. Duncan and Bowden, 2004; Durrant, 2004; and Smith, Gallop, Taylor and Marshall, 2004, support the family-based truth that physically punished children are more prone to become angry, drop out of school earlier, exhibit

mental health problems, have impaired relationships, and are more likely to have a less well developed conscience.

Impact of impending legal or disciplinary event on vulnerable youth. Psychological autopsy data supports the association of legal or disciplinary problems with suicide (Brent et al., 1993a, 1993b; Gould et al., 1996; Marttunen et al., 1994; Rich et al., 1988). Even after adjusting for psychopathology, an impending legal or disciplinary problem, especially in youth with anger and/or substance abuse issues, are still associated with an increased risk of suicide (Lewinsohn et al., 1996).

Issues for out-of-home adolescents. Spirito (2003) provides evidence that approximately 30% of youth who are out-of-home have reported a history of attempted suicide. When young people are homeless and on substance abuse programmes the situation for attempted suicide is even worse, i.e., 53% compared to 30% for housed youth in the same programme. For out-of-home indigenous adolescents poor outcomes escalate. Rotheram-Borus (1993), in working with a group of African-Americans reported that 54% had depressive symptoms, 37% had conduct problems, 44% had dropped out of school, 22% had been expelled, 14% had been arrested and 8% belonged to gangs.

Causes of the suicide phenomenon often associated with 'out-of-home' youth are complex. Exposure to potent risks by one individual will produce no negative outcomes, while similar exposure to risk for a different person may produce an entirely devastating outcome. Variations across individual characteristics, perceptions of events, culture, personal and social contacts, and the related interactions between them, continue to complicate research designs aimed at establishing solutions to suicide prevention. Cairns

et al. (1998) and Mackay (2003) report that causal processes for suicide or negative life outcomes are direct, indirect, proximal, and distal processes that continue to present methodological challenges to researchers in the area of suicidality.

Researchers however, continue to question; how do such processes combine to make one 'homeless' person more vulnerable to suicide than another? The sociologists Drury and Dennison (1999) implicate unpredictable transitions from education to employment, job losses or broken relationships. Many researchers view family as the predominant source of influence on suicidal behaviour. Lewinsohn and colleagues (1994) followed 1,500 high school students for one year and established that those who reported attempted suicide had significant lower level of family support and disturbed relationships with parents, even after statistically controlling for depression. Lack of parental care and lack of family care resulting in 'homeless youth' led researchers Chamberlain and MacKenzie (1998) to study 11,000 homeless students in Australian schools. They have issued a strong warning to the Australian government that suicide in 'out-of-home' populations, and problems with early school leaving need to be urgently prioritized.

Assessment and Intervention for Young People at Risk of Suicide. The process of identifying assets, deficits, strengths, weaknesses, risks, resources or protective factors in young people who are at risk of suicide, requires assessment of their personal protective capacities. For example, a resilience-based approach to such an assessment would include accessing information on their networks of support (with both the family and the community), their coping and problem solving abilities, locus of control, and a thorough

exploration and inquiry into their social, emotional, physical, economic, cultural and spiritual health.

Just as there is a spectrum of assessment strategies for this population, so too is there is a spectrum of interventions for the mental health promotion of social and emotional well-being for those who may be at risk of suicide. Mrazek and Haggerty (1994) constructed a population based approach targeting all members of the community in the prevention, treatment and continuing care across the lifespan for those in need of mental health support. In line with expert opinion and international trends (Jen and Si, 2000), this model moves away from a singular focus on young people, and towards a whole-of community, whole-of-government, whole-of life approach, with priority focus directed to high-risk cohorts. Vulnerability to suicide has often been shaped within community settings, so it is therefore accepted that suicide prevention is the responsibility of familial, local and national communities.

Hawgood and De Leo (2002), in their suicide prevention skills training sessions, support a national suicide prevention strategy that identifies response levels as universal, selected and indicated. Universal suicide prevention focuses on whole populations, selected targets individuals and groups at risk ,and indicated targets prevention strategies that assists individuals or groups where suicidal behaviour is present.

Methodological concerns for generalisation capability from small "n". The question is often asked, can generalisations be made from small 'n' cohorts i.e., from small targeted groups to selected or even universal groups? Due to the low base rate of suicide, it is obvious that attempts to predict fatal behaviour in those individuals who have already attempted suicide, will be extremely difficult. If the cohort studied by

researchers also is extremely small, neither parametric nor non-parametric tests will be optional. To seek statistical significance when testing data from 6 deceased and 36 living controls, it is clear that the terms would not be orthogonal if there are unequal cell sizes (Tabachnick & Fidell, 1996), and that any attempt to analyse two-way variance or multiple regression would be impossible (Pett, 1997). However, research designs constructed for much larger matched sample cohorts (e.g. Sakinofsky, 2000) certainly can be utilised as providing guiding principles for small numbered research cohorts.

Is Prediction of Suicide Possible? Prediction of those who will go on to suicide following a suicide attempt has puzzled and motivated researchers for years, for it seems to most researchers that the psychiatric profiles and gender-specific diagnostic profiles of both attempters and victims of suicide, are almost identical (Beautrais, Joyce & Mulder, 1996; Gould et al., 1998). As risk fluctuates and is not a static state, assessment and prediction is more accurate in the short-term rather than making huge generalisation across time, settings, situations and populations.

Hawton and van Heeringen (2000) argue that the literature has failed to focus on interviewing survivors of suicide attempts in order to address this question. Goldstein et al. (1991) stated that it is not possible to predict who will suicide, even among extremely hi-risk subjects. Maybe researchers need to be focusing on examining how hurting young people can have their opinions heard, and more importantly, how adults working with vulnerable adolescents can learn more effective 'active listening' skills.

Do suicidal adolescents seek help? It is a well known fact that many suicidal youth visit a doctor within one month of attempting suicide (Royal New Zealand College of General Practitioners, 1999), and that around 80% of adolescent attempters and

completers communicate their intention prior to the attempt (Brent et al., 1996). Unfortunately, the research indicates that completers communicate less about their plans to die, compared to attempters who prepare for suicide more openly (Handwerk, 1998). Such knowledge raises the questions, 'who do youth go to in order to seek help; what affects their choice; is there a relationship between suicide ideation and communication patterns of both the listener and the attempter; and for suicidal youth who say little but have well developed plans for death, what clinical learnings are available to aid in identifying the antecedents to suicide (e.g. cynicism, unresolved anger, distrust, comorbidity, lack of connection to home or school or fear around impending legal or disciplinary events)?

Can tests, scales or scientists accurately forecast impending suicide? Screening scales, such as the 'Life Attitude Schedule' (Lewinsohn et al., 1995) or scales that assess one of the concerning psychological constructs (e.g. Cynical Distrust Test described in Study 4 of this thesis), become important instruments in eliciting life-saving information from at-risk youth who have difficulty communicating negative emotional states. However, literature regarding an inability to predict suicidal behaviour has been extended to those considered experts in the field of suicidology. Furst and Huffine (1991) provided histories and demographic clinical data to 300 members of the American Association of Suicidality. Two of the four subjects had committed suicide and members were asked to delineate on a five point scale, the risk of suicide for those subjects. The degree of accuracy was lower than expected by chance. In future research on predictability, multiple disciplines might combine their specialties in order to examine risk factors from a more holistic perspective.

If accurate prediction is impossible are there some strongly associated risk variables for parents, teachers and youth workers to be aware? Although Beautrais (1996; 2000; 2003e; 2004b) has noted that previous suicide attempts, psychological disorders, foster placement, adverse life events, and impending legal or disciplinary events have been strongly associated with suicide attempts, she is cautious of the ability of health professionals to predict further fatal or non-fatal attempts for individuals previously involved in suicide attempts. Her work in New Zealand has highlighted methodological issues pertinent to suicide research and the need to apply both case control and longitudinal designs when investigating risk and putative causal mechanisms of suicide (Beautrais, 2003d).

Description of current thesis research (i.e., Study 2), based on insights from literature. With a similarly matched case controlled cohort of homeless, vulnerable, welfare seeking adolescents, a retrospective analysis of file data sought to establish salient 'life- saving' or 'life- destroying' factors that may in turn, provide sufficient generalised exemplars to other at-risk groups of young people.

This study investigated a small group of vulnerable 16-18 year old adolescents from the Waikato community in Hamilton, New Zealand, who had left home due to family breakdown, had applied for a government welfare benefit and had all engaged in a medically serious suicide attempt .Retrospectively audited clinical files investigated factors that may characterise vulnerability/risk or resiliency/asset type behaviours or conditions, to suicidal behaviour across a cohort of 42 previous IYB applicants. Six of this group died by suicide, and 36 other files provide contrasting controls. The aim was to

examine which risk factors were shared by both groups and which risk factors were different.

Method

This retrospective study examined the files of 6 deceased IYB applicants, all self identifying as Maori, (Callister, 2004; Kukutai, 2004), and contrasted the 6 files with an examination of files from 36 controls. For the scope of this research, 36 controls were considered a manageable and appropriate number. This discreet study involved no interviews with participants. From the original cohort of 2029 IYB applicants (described in the previous chapter), 30% made medically serious suicide attempts prior to the initial IYB interview. Medically serious suicide attempts were defined as requiring an admission to a hospital ward. At the initial IYB interview, all applicants who reported suicidal behaviour were asked if they had been admitted to a hospital ward following their suicidal attempt. They were not asked to detail their treatment following hospital admission as outlined by Beautrais' (2003a) definition of a medically serious suicide attempt. From the original 30% of the 2029 applicants who attempted suicide, this current study retrospectively identified through file audits, those who went on to die by suicide (six IYB clients), and to examine their personal, family, adverse life and social risk factors. The same process was applied to thirty-six files of living controls (i.e., applicants who had previously tried to attempt suicide), in order to assess associations between risk and protective factors, and their interplay leading to either suicide or survival.

Terminology regarding the use of the term 'control' or 'contrast group' was addressed based on research recommending tighter commitment to random and non-

random assignment (Wilkinson, 1999). As the 36 files from the 'control' group were matched for comparison to the files of the suicide group, the term 'control group' is used cautiously in this study and there is a recognition that the function of the control group is certainly that of a 'contrast group'. With knowledge of this distinction both terms are used interchangeably in this study.

Mortality Measure. In order to determine which IYB applicants had died by suicide, the New Zealand Health Information Service (NZHIS) was contacted. After seeking ethical approval for this to occur, the NZHIS provided me with names and methods of suicides for all suicidal deaths occurring between 1995-2001 (Appendix F). Names of the deceased were checked against the names of the research participants in the overall study. The names of 6 IYB youth matched the NZHIS list. Other IYB applicant names did appear as deceased through car accidents, which may or may not have been suicidal intent. A comparison of mortality for welfare dependent adolescents with the general population of adolescents, in a matched time-frame, was established.

Selection of files. Files of subjects for the contrast group (n=36) were selected from the 30% who had attempted suicide within the original 2029 cohort. For each deceased IYB applicant file, 6 other matched 'control' files were located. Control files were matched for age, time of assessment, gender, ethnicity, IYB status (i.e., granted or declined), prior involvement in counselling, family breakdown, and socio-economic status, exposure to loss through suicide of a friend or family member and police contact. Data were entered onto a SPSS-13 spreadsheet.

Measures. Inter-rater reliability checks occurred with all 6 files of deceased IYB applicants and with 6 of the contrast group files. A psychology graduate conducted the

blind reliability ratings. The task was to isolate risk factors that could influence suicidal behaviour. Concordance agreement was calculated using the Cohen's Kappa on individual item agreement. Robson (2002) provided a formula and matrix concept to assess inter-observer concordance overall, and Fleiss (1981) provided a formula for the individual items if further confirmation was required.

A psychology graduate, blind to previous coding, undertook a 100% re-code of all 6 files from deceased IYB applicants, and 6 of the 36 files. Using Robson's (2002) formula for calculating proportion of agreement (Po), a good inter-observer agreement was achieved with 91.3% concordance overall. Resolution of a small number of discrepancies was reached following discussion between myself and the psychology graduate. These few discrepancies related to the definitional issues of the behaviour or emotion being measured against records on the case file. Definitions were kept simple as to reflect the idiosyncratic nature of adolescent language. Definitions, where necessary, appear in column 1 of Table 2.2.

Results

The hypothesis was confirmed in that there were identifiable factors that existed in the files of the 6 deceased that were not present, or less evident, when contrasted to the files of the 36 controls. Findings from 42 files are graphed in Figure 2.2., comparing risk percentages for both groups. Findings are summarised in Table 2.2., where the risks/vulnerabilities of the suicide group, and the asset/resiliency factors from the files of those who survived a suicide attempt are recorded. Conclusions were reached after comparing and contrasting the 6 suicide victims and the 36 living controls across a range

of personal, family, adverse life and social risk factors. Column 3 of Table 2.2. shows that both groups were matched for ethnicity, gender, age, and were interviewed at the eligibility assessment during a similar period of time.

Both the deceased and living controls had all engaged in at least one medically serious suicide attempt, and they had all been involved with a counsellor to address at least one mental health disorder. The disorders with this cohort included, substance use disorder, mood disorder, anti-social behaviours or anxiety disorders. All applicants had experienced family adversity and had left home due to family conflict. The socio-economic status of these applicants were closely matched in that all 42 had a parent on a government welfare benefit or reported low income levels in their home of origin. All six deceased subjects had a parent on a welfare benefit and 28 of the 36 controls came from homes where one parent was supported by the government. Each of the six deceased subjects came from single parent homes and 29 of the 39 control subjects also came from sole parent situations. All 42 applicants were exposed to the loss of a friend, family member or student acquaintance to suicide, and each had witnessed violence and family conflict. Police involvement was high with this cohort where 34 of the 42 applicants had been involved with police. Within the deceased group, four of the six subjects had prior contact with police and 30 of the 36 controls had prior contact with police. From the overall group of 42, only seven of the applicants were attending school at the time of the original IYB assessment.

Personal Risk Factors. Personal risk factors within this study included multiple prior suicide attempts, co-morbid disorders, unresolved anger, external locus of control, hopelessness, lack of spiritual beliefs and same sex orientation. Three personal risk

factors were indicated as providing the largest difference between those who died by suicide and the living controls. Difference was defined by the discrepancy between both group scores. A decision was made that any difference greater than 75% would be documented as a salient factor. As seen in *Figure 2.2.*, seven variables were categorised as salient factors. 'Previous suicide attempt', 'co-morbid disorders' and 'unresolved anger' were personal characteristics of suicide within the group who died. However, these three risk factors featured at minimal levels amongst the living controls. Only 5% of living controls engaged in more than one suicide attempt (deceased =100% multiple attempts); only 19% of controls were diagnosed with co-morbid disorder (deceased = 100% comorbid diagnosis); and only 19% of controls reported unresolved anger (deceased =100% unresolved anger).

Family Risk Factors. Family risk factors within this study included a parent with psychopathology, subject unable to identify one caring adult in their life, unknown father, and absent father. Two family risk factors were indicated as providing the largest difference between those who died by suicide and the living controls. 'No caring adult' and 'unknown father' were characteristics of suicide within the group who died. However, these two risk factors featured at minimal levels among controls. Only 17% of the controls were unable to identify a caring adult (deceased = 100%); and only 5% of the controls were unable to identify their biological fathers (deceased = 83%).

Adverse Life Risk Factors. Adverse life risk factors within this study included sexual abuse, physical abuse and being bullied. There were no adverse life risk factors that indicated any major differences between the two groups.

Social Risk Factors. Social risk factors within this study included CYFS involvement, foster care placement, attendance at a low decile school, negative school perception, drug affiliation, cultural disconnection, no sport/hobby, and subject's involvement with an impending legal or disciplinary event. Two social risk factors were indicated as providing the largest difference between those who died by suicide and the living controls. 'Foster care placement' and an 'impending legal/disciplinary event' were associated with suicide within the group who died. Only 19% of the living controls had foster care placements (deceased = 100%); and only 14% of the living controls had an impending legal/disciplinary event (deceased = 100%).

Overall, the risk factors that indicated the greatest difference were; (a) multiple suicide attempts, (b) co-morbid disorders, (c) unresolved anger, (d) no caring adult available to the subject, (e) biological father unknown to the subject, (f) foster care placement, and (g) subject's involvement with impending legal or disciplinary event as shown in Figure 2.2. and Table 2.2

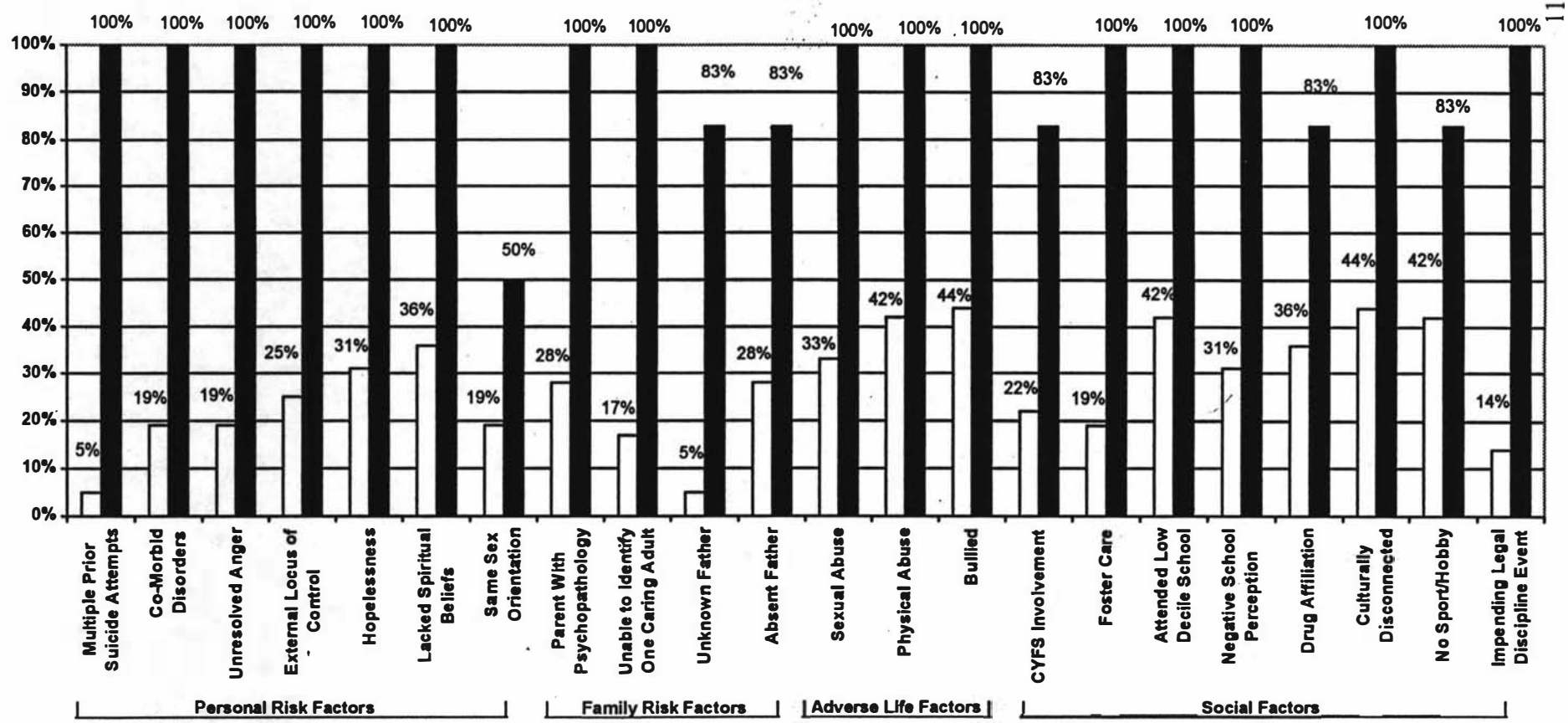

Figure 2.2. Percentage comparisons between risk factors for six deceased youth and thirty-six surviving IYB controls.

Black = Deceased White = Living

Table 2.2

Retrospective File Audits Identifying Risks Leading to Suicide and Assets Leading to Survival Following a Suicide Attempt

Column 1 (6 Deceased Subjects) **Risk factors** promoting pathways to suicide.	**Column 2 (36 Living Controls)** **Assets** providing pathways to promotion of resiliency.	**Column 3** **Shared risk factors** for both deceased and living controls.
Personal Risk Factors:	**Personal Protective Factors:**	
All 6 deceased subjects made more than 1 suicide attempt before completing suicide. *	Low lethality/rescuer available. 34 of 36 control subjects did not engage in more than one medically serious suicide attempt.	Both groups were matched for ethnicity, gender, age and time of assessment. All 42 subjects engaged in at least 1 medically serious suicide attempt.
All 6 deceased had co-morbid disorders *	Higher single psychiatric diagnosis. 29 of 36 control subjects presented with no co-morbid disorders.	All had seen a counsellor for at least one mental health concern or disorder including unresolved anger, feelings of hopelessness, substance use disorder, mood disorder, antisocial behaviours or anxiety disorders.
All 6 deceased held unresolved anger, i.e., their file recorded that they were currently angry at interview and had not resolved feelings resentment, cynicism, dislike, contempt and irritability. *	Higher rates of conflict resolution. 29 of 36 control subjects reported resolved anger.	
All 6 deceased indicated external locus of control (LOC), i.e., that they were controlled by events, people, circumstances outside of their own control.	Higher levels of internal LOC. 27 of 36 control subjects self-reported internal LOC i.e., they had some ability to control their own outcomes, decisions or emotions.	
All 6 deceased expressed hopelessness, i.e., unable to see a hopeful future, reporting pessimism, no likelihood of change.	Higher levels of hopefulness. 25 of 36 control subjects expressed future hopefulness.	
All 6 deceased lacked spiritual beliefs.	Higher rates of spirituality. 23 of 36 control subjects acknowledged spiritual beliefs.	
3 of 6 deceased subjects reported same sex orientation	Higher heterosexual rates. 29 of 36 control subjects identified as heterosexual.	
Family Risk Factors:	**Family Protective Factors:**	
All 6 deceased had parents with psychopathology.	Lower rates of parental psychopathology. 26 of 36 control subjects had no parent with psychopathology.	All experienced family adversity and had left home due to family conflict.
All 6 deceased unable to identify one caring adult. *	Higher rates of connection to caring adult. 30 of 36 control subjects identified at least one caring adult in their life.	All 42 subjects had a parent on a benefit and/or reported low SES status. All 6 deceased subjects had a parent on a benefit and 28 of 36 controls had a parent on a benefit.

5 of 6 deceased reported absent fathers. (Absent = three consecutive years with no form of contact.)	Higher rates of connection to biological father. 26 of 36 control subjects had some contact with fathers.	All deceased subjects came from single parent homes and 29 of 36 control subjects came from single parent homes.
5 of 6 deceased had unknown fathers. (Unknown = unable to identify name of biological father.) *	Higher rates of knowing at least the name/identity of the biological father. 34 of 36 control subjects knew the identity of their father.	
Adverse Life Risk Factors:	**Protective Life Factors:**	
All 6 deceased sexually abused.	Lower rates of sexual abuse. 24 of 36 control subjects reported no sexual abuse.	All 42 subjects were exposed to loss of friend, family member or student acquaintance to suicide. All 42 subjects witnessed violence and family conflict.
All 6 deceased physically abused.	Lower rates of physical abuse. 21 of 36 control subjects reported no physical abuse.	
All 6 deceased seriously bullied.	Lower rates of bullying. 20 of 36 control subjects reported no bullying.	
Social Risk Factors:	**Social Protective Factors:**	
5 of 6 deceased involved with CYFS.	Lower rates of contact with CYFS. 28 of 36 control subjects had no CYFS contact.	34 of 42 total cohort had some prior contact with police. i.e. 4 of 6 deceased subjects had prior police contact, 30 of the 36 living controls had prior police contact.
All 6 deceased placed in foster care. *	Lower rates of foster placement. 29 of 36 control subjects had no foster placement.	
All 6 deceased had attended low decile school, i.e. 1-5 decile rating. (Average 2.4 rating).	Higher numbers attending higher decile rated schools (5-10 rating). 21 of 36 control subjects attended high decile rated schools.	
All 6 deceased reported a negative school perception; 3 had been suspended.	Higher reports of positive school perception. 25 of 36 control subjects reported positive school perception.	Only 7 of the 42 applicants were attending school at the time of the original IYB assessment.
5 of the 6 deceased engaged in peer culture of drug taking.	Higher rates of avoiding engagement with peer culture of drug taking. 23 of 36 control subjects avoided engagement with peer culture of drug taking.	
All 6 deceased culturally disconnected	Greater sense of connection/belonging to culture. 20 of 36 control subjects reported affiliation to Marae and language.	
5 of the 6 no sport/hobby	Higher levels of sport/hobby participation. 21 of 36 control subjects participated.	
All 6 deceased experienced impending legal/disciplinary event. *	Lower rates of impending legal/disciplinary events. 31 of 36 control subjects reported no impending legal/disciplinary events.	

*Seven salient risk factors characterised suicide. Where the discrepancy between the two groups was greater than 75% (as seen in *Figure 2.2.)*, that particular variable was

then categorised as salient. All of the seven salient factors had a discrepancy of 78% or higher.

Table 2.3

Seven Salient Risk Factors Retrospectively Associated With Six IYB Suicides

1	Previously attempted suicide – 95% discrepancy
2	Co-morbid disorder – 81% discrepancy
3	Unresolved anger – 81% discrepancy
4	Cannot identify a caring adult in their life – 83% discrepancy
5	Unknown fathers – 78% discrepancy
6	Foster care placement – 81% discrepancy
7	Impending legal/disciplinary events – 86% discrepancy

Discussion

An obvious limitation to Study 2 is that although the hypothesis was supported, logistic regression analyses to statistically validate salient factors related to suicide were inappropriate for this study, due to small sample size and multiple risk variables. With twenty-two possible risk variables, a minimum of two hundred and seventy subjects would have been required to achieve a power level of .8 (Cohen, 1988; Howell, 2002). Consequently the data are reported in terms of frequencies. Considering this limitation, differences were seen between the deceased and living contrast group in several areas, indicating that there were seven salient factors to suicide in this cohort.
Suicides also were characterized by male gender and Maori ethnicity. A finding that will have implications for policy advisors and future IYB assessors is that five of the six deceased had been granted the IYB.

One of the main concerns in suicide research is the low base rate (relative rarity) of suicide, yielding large numbers of false positives and poor predictive power overall.

An area that seems to have received insignificant investigation is that deliberate self-harm in individuals is often not durable over time, and this temporary effect has implications for altered protective factors. The degree of vulnerability to suicide at one stage of life may not be relative at an alternative life phase, so rather than researchers focusing on general risk and protective factors, suicide prevention may be more relevant by treating those who belong to high risk groups, such as those who have made current, medically serious suicide attempts. Temporal protective factors such as having an adult to talk with, feeling connected to the school or belonging to a sports team, may reduce suicide risk at a specific time within the life span. These protective factors are certainly important for those moving through temporary suicide risks. However, small differences of this sort would be unlikely to be demonstrated as significant in case control or psychological autopsy studies, unless they were very large (Wichstrom, 2000).

Beautrais (2004a) agrees with targeting high risk individuals or groups such as those who have made multiple suicide attempts, or those who are comorbid, but she cautions that findings from suicide confirm that even amongst high risk samples, the occurrence of suicide is too low to predict those individuals who are likely to die by suicide and those who are not. This conclusion has important clinical implications since it suggests the need for high quality follow-up treatment and surveillance of all individuals making serious suicide attempts, rather than approaches that focus on providing care to those clinically deemed to be at risk of further suicide behaviour. These considerations may suggest a need to shift the emphasis in the care of suicidal youth away from short term crisis intervention to longer term management.

Leading international suicide prevention researchers Hawgood and De Leo (2000) have proposed that if suicide rates are to decrease, prevention strategies should be targeted across whole-of-government, whole-of-community, and whole-of-life and integrated with a multi-sectoral focus. This means that community involvement includes partnership with non-government organisations, church groups, voluntary agencies, parent groups, schools, tertiary institutions, city councils, gay and lesbian networks, men's groups, fathers supporting fathers groups, women's refuge centres, as well as government agencies. When researchers elevate protective factors instead of risk factors, Luther, Cicchetti and Becker (2000) suggest that communities will gain greater benefit from user-friendly research that is disseminated.

Findings from the present study indicate that there are seven salient protective factors found in the retrospective audit of files of IYB applicants who attempted suicide, but survived. The living controls had reported the following resilient behaviours and connections. They had (a) extremely low return to suicide attempt, (b) lower levels of co-morbid conditions, (c) higher rates of conflict resolution, (d) higher rates of connection to a caring adult, (e) higher rates of knowing the identity of the biological father, (f) lower rates of foster placement, and (g) lower rates of impending legal/disciplinary events, compared to the deceased group.

The case scenarios and file statements of six deceased IYB youth were documented earlier in this study. In examining protective factors the following file statements were extracted from the records of the thirty six contrasting files of living adolescents. These documented statements link into expressions relating to the seven salient protective factors:

"I know I often think about hurting myself again but it would kill my mum if I topped myself. She's always been there for me – stuck up for me, especially when I got bullied."

(Protection capacity = attachment, sense of responsibility to others and one caring adult.)

"My footy coach is great when I need some help."

(Protection capacity = engaged in help seeking behaviour and sporting activities.)

"It's not my fault I got in trouble with the cops. I had nothing to eat – sometimes you've just gotta steal."

(Protective capacity = ability to blame another person for their problems as supported by Seligman (1995)).

"When he wasn't at home beating us up, mum and we kids had a good laugh. That got us through and our belief in God."

(Protective capacity = humor and spiritual faith (Resnick, 1997; 2000))

"Life used to be real bad. Heaps of shit... but I got it sorted now... If I keep taking my medication... I'm sweet. I go to see the doctor every so often – she's cool."

(Protection capacity = mental health disorder diagnosed and treated and provision of resources to assist.)

"I used to think I was so stupid and the dumbest in the class but my teacher this year helped me heaps. I'm going to stay at school now. The bullying has finally stopped too. Our class talked about it openly."

(Protection capacity = positive teacher influence, success at school, zero tolerance for violence and problem solving strategies.)

"I thought his violence would never stop, so I did something stupid and tried to top myself... but not again. Mum and I got out. She got a protection order... that took guts."

(Protection capacity = hopefulness, fortitude and conviction. Tenacity in problem solving and resolution. Skill strategy to deal with violence and stress.)

"My kapa haka group gave me my strength to beat the drugs and the abuse. My wairua kept me alive."

(Protection capacity = cultural connectedness, recognition of the Te Whare Tapu Wha model.)

Risk/vulnerability or asset/ resiliency models. Some researchers have paid particular attention to whether or not community awareness should be raised through education around vulnerability and risk. Some have suggested awareness should be raised through a concentrated effort in providing community members with skills in promoting resiliency, strengths, and assets across the populations of their young. Evidence, however, indicates that regardless of which approach is taken, both are equally valid strategies of describing specific implications of the same problem. Vulnerability and resiliency are merely different ways of describing the same set of results with resiliency describing positive configurations of the various factors to decrease risk, and vulnerability describing how negative configurations increase risk. Fergusson et al. (2003) suggest that the debate over this issue is akin to suggesting that a business should pay attention to profit and disregard loss. Future research will need to provide a more balanced perspective for the social science researcher that is able to focus on both the strengths and assets that each individual can utilise in the protection against negative outcomes.

Comorbid disorders and multiple suicide attempts. Literature has been divided over the roll that depression plays in the trajectory toward suicide. The Youth 2000 Study (Watson et al., 2001), Beautrais'(2003e) paper on life course factors associated with suicidal behaviour, and results from this present study, have all indicated that depression is frequently a participant in the profile of those who complete and attempt suicide. Fergusson et al. (2003) report however, that when depression combines with high vulnerability, almost two thirds of depressed young people will develop suicidal ideation, and one third will make suicide attempts. Conversely, among depressed young people with high resiliency, less than one quarter develops suicide ideation and less than five percent make suicide attempts. These findings have important implications for assessment procedures for IYB youth, and for assessors being able to isolate (when assessing young people), which applicants have high resiliency/assets, and which subjects have high vulnerabilities/risks. However, for those who have made previous suicide attempts Owens et al. (2002), cautions that risk is maintained over time, (i.e., 2% risk of suicide within one year of attempt, and 5% risk after nine years). Ostamo and Lonnqvist (2001) further caution that mortality from multiple causes (e.g. accidents, disease and homicides) was greatly elevated for those who had engaged in previous suicide attempts.

Unresolved anger. The role played by the psychological construct 'anger' in the study of suicidality has recently received growing interest from researchers. Stein's (1998) findings indicate that those young people who made previous suicide attempts, reported greater levels of anger than non-attempters. This outcome has important implications for WINZ case managers and IYB assessors. All 6 IYB applicants who died by suicide had made previous suicide attempts and the presence of unresolved anger was

one of the salient factors associated with completed suicide. Within this study 'unresolved anger' became defined as, documented file reports that indicated expressions of persistent irritability, resentment, cynicism, dislike and/or contempt for others that was current and unresolved at the time of the IYB eligibility assessment. Future researchers may need to develop measures that discriminate between the different types of anger (e.g. unresolved anger or cynical anger).

Many 'kiwi kids' who are forced to become welfare dependent due to family breakdown, have succumb to a fatal disease influenced by entrenched cynicism and ruminating anger that at worst will end in suicide, and at best life threatening attempts at suicide. It is a disease through which thousands of New Zealand children and young people are being consigned to a world of horror and abuse. Many in the sample of IYB adolescents studied, have been undervalued, ignored, bullied, beaten and mentally stigmatised. More welfare money, more benefits without accountability criteria such as ongoing training or returning to work and education, will only translate into further isolation, agony and intergenerational welfare dependency. What seems to be required in order to address anger and entrenched cynicism is to provide 'parent care', 'family care', 'fair and safe schools', and opportunities to learn problem and conflict resolution skills.

Clinical psychologists have in recent years developed excellent programmes that are able to isolate the factors involved in the escalation of anger and now have a deeper understanding of strategies required to mitigate this powerful psychological construct. Looking at assessing anger now days, can be likened to assessing a cough. For example, in recent years, science has taught that coughs may be caused by pneumonia, cancer and asthma, but years ago the etiology of the cough was unknown. It was simply a cough.

The same analogy applies to the study of anger. Psychologists and psychiatrists are now able to examine the etiology of anger (psychological, social or biological), and isolate the components that work together to form the psychological construct of anger (e.g. which may be cynicism, hostility, irritability or ruminating rejection). The scientist- practitioner who works with youth at risk is now able to identify, measure, and evaluate triggers that spark anger, identify strategies used to maintain anger, measure successful interventions required to mediate anger, and evaluate procedures that measure reduction in anger. The youth 2000 study (Watson et al., 2001) showed that New Zealand adolescents want more time with their parents. Maybe there would fewer angry adolescents if more parents actively listened to the message behind that research.

Relationship with a caring adult. No caring adult available to a vulnerable adolescent was a risk factor that differentiated those who died from suicide and those who lived following a suicide attempt. As a clinician with 25 years experience working in suicide prevention, my priority wish list would be headed with a desire that all parents be required to attend 'parent skills training' and 'keeping children safe programs'. Such training must become a public priority in a similar manner to previous national priorities such as community vaccination programmes or safe driving campaigns. Drivers cannot be expected to know the road codes or master defensive driving techniques without specific skill training. Parents also require similar education in order to guide their offspring through the obstacles and joys along the road of life. When parents are unavailable to their children, mentors and mentoring programmes either at school or within the community provide a useful protective, capacity building alternative (Evans, Jory & Dawson, 2004; Osterman, 2000).

Unknown fathers. All but one of the deceased group were unaware of the identity of their biological father. A 'primal wound' were the words used by one deceased subject to describe the feeling of not knowing the identity of her biological father, thus her ancestral heritage remained unknown. Her file had documented her passionate words; "I'm fatherless, godless, and directionless". Implications of this risk factor for indigenous youth requires urgent research, as the area of 'unknown fathers' becomes an emerging centre of interest. Maori youth who are dislocated, disowned and disconnected from their whanau (family), stand on a plateau of suicidal dangerousness, for on one side of the plateau alienation from ancestors deprives them of spiritual safety, and on the other side of the plateau, alienation from biological parents deprives them from physical and psychological safety. There exists upon this plateau the potential for the development of depression, cynicism, anxiety, unresolved anger, and conduct and substance disorders.

Judge Summerville, in presenting her views on this Maori dimension, stated "*The basis of Maori identity comes purely from ancestral ties... These ties tell Maori where they belong as it is Whakapapa (genealogy) that ensures the interconnectedness of all living things, creating the imperative to maintain balance at all times. Without the ability to trace their ties in this way, individual Maori arguably experience a loss of identity*" (Summerville, 2003, p9).

Not knowing the identity of parents or indeed one parent, has been shown to have a greater effect on suicidal thoughts, school truancy and risk-taking behaviour (with sex, cars and drugs) than family lifestyles. Berg and Eriksson (1997) reported these findings after studying mental health, risk-taking and problem behaviours across a cohort of 125 adopted subjects who were compared with 9,329 controls. Although extensive research

has been conducted into 'absent fathers' there is a gap in the literature around the impact of 'unknown fathers' on the psychological wellbeing of their offspring. There also is a gap in the research regarding the short and long term effects of absent fathers to both individuals, and government agencies, seeking to identify unknown fathers for financial settlement of child support (Rich , 2003).

Foster care concerns. Foster care placement and the association with abuse of children have been well documented (Ward, 2000; Yates, 2000). Beautrais et al. (2001), have recorded that females aged 13-16 years in contact with Child, Youth and Family Services (CYFS), are 23 times more likely to die by suicide than females with no contact with the department. Of the 2029 IYB applicants who were the overall cohort studied in this present study, 31% were involved with CYFS. Within the present study 5 out of 6 deceased youth were involved with CYFS through foster placement and one was placed in foster care without CYFS involvement. Early in 2004 various New Zealand newspapers reported that there were more than 5000 child abuse cases waiting allocation: 15 critical cases were waiting, 24 extremely urgent cases were waiting, 3421 urgent cases and 1871 cases of low urgency were still waiting to be allocated. One immediate question that arises is, how will these future parents and workers of this country develop and raise their own offspring? With such high numbers of children and adolescents not allocated for assistance by CYFS, it leaves little doubt that those who have been placed into care are certainly considered the most at risk and the most vulnerable. Placing groups of these children and adolescents into residential homes or with individual families who frequently lack specific training in meeting the various psychological, behavioural, and

emotional needs of their foster child, adds further evidence as to why this group is so highly represented in New Zealand suicide statistics.

The unheard voices of children begging to be rescued from unsafe homes of violence and abuse, needs to be measured against the documented voices of those who were 'up-lifted' by CYFS, and who articulate their own stories of damage, despair and institutional agency abuse during a process of so-called 'rescue'. Strategies to genuinely hear and document the voice of 'service users' must be a commitment of 'service providers' if we are to reduce foster placements, and in turn welfare applications. Successful policy development will be committed to engaging unbiased, independent and skilled researchers who are able to become evidence providers to the evidence users (policy advisors). If positive outcomes are to be achieved for IYB applicants, there is a need to work in sustained partnership in delivering relevant assessments and interventions.

IYB applicants' relationship with police and those with statutory power. This study introduced Dave, a young male who was terrified that the police were coming to see his mother about his crime (i.e., smoking a joint), and in despair hanged himself in the garage before the police arrived. The literature has exhorted government officials (Gould & Kramer, 2001), to take heed of their recommendations to proceed carefully when dealing with young people who are currently involved with some impending legal or disciplinary event. Future research needs to clearly identify steps that can be taken by 'officials' when working with depressed, co-morbid youth, who are frequently angry, unsupported, disconnected, dislocated, and living in out-of-home environments.

Thorough evidenced-based assessment for IYB applicants is critical. Assessment is a crucial component for this population of young people. The Ministry of Social Development needs to fund the development of a 'suicide risk package' that covers the scope of practice from an IYB applicant walking through the door for an initial meeting with a WINZ case manager, right through to the monitoring and outcome evaluation processes. The 'formulation of suicide risk' packages, would offer youth workers, case managers, and clinicians, a disciplined method for assessing danger, and also affords a method for weighing up vulnerabilities as well as assets, strengths, and traits of resilience. Case managers from WINZ need to be provided with evidence based interview tools, and for those who are contracted to asses the eligibility criteria and decide whether the IYB should be granted or declined, a package of evidence-based protocols and tools should also be provided. Such packages and protocols need to be introduced, monitored and evaluated at a national level to ensure consistency and standards of best professional practice for the country's cohort of IYB applicants. A warning or ALERT system must be developed by WINZ case managers when granting or declining benefits to youth who have made previous suicide attempts, who have co-morbid conditions, who display unresolved anger, who are unable to identify one caring adult in their life, who have no knowledge of their biological father, who have a history of foster care placement, and who are currently moving through a legal or disciplinary pending event

Limitations of this study. Two immediate limitations of this study are the small numbers involved and the traditional issues that are involved in any retrospective research i.e., that there is a tendency for hindsight bias in assigning risk because it is known that a suicide occurred (Fawcett, Shefher, Fogg, Clark, Young & Hedeker et al.,

1990). This study may lack generalisation to other populations due to small sample size. Limitations existed in this study that also exist in psychological autopsy studies, in that retrospective audits of case files, and the more investigative tasks involved in psychological autopsies, provide little information about biological and physiological mechanisms that are crucial in understanding the suicidal process. Hawton and van Heeringen (2000) suggest that in future, more emphasis on investigation with survivors of serious suicide attempts would greatly increase our knowledge of this complex area and in the following study I have followed their suggestion.

Strengths of this study. In understanding vulnerability to suicide this study showed that some specific risks seemed more related to suicide than other risks, and conversely, that some particular protective factors seemed more related to survival. The risk and protective factor model was a useful model for the small numbers involved in this study. A further strength of this study was that file data were not simply self-reported information from the adolescent but records included multidisciplinary data provided by family members, school staff and significant others.

Future research. The concerning feature of this study was that from on original cohort of 2029 subjects, with 46% identifying as Maori, and 44% identifying as European, that 100% of those who died by suicide self-selected their ethnicity as Maori. From an original cohort of 2029 where Maori report bullying (16%) less frequently than Europeans (20%), it is concerning that while Maori report and talk less about trauma, they die more frequently from its impact.

The suicide rate for Maori youth in 2000 was 25.7 per 100,000 compared with a non Maori rate of 16.2 per 100,000 (MSD Social Report, 2003). Future research needs to focus on several critical areas

1. Culturally competent follow-up interventions for youth who have made a suicide attempt.
2. Evaluation of the efficaciousness of models of treatment for comorbid disorders that are based on the Te Whare Tapu Wha model and the Homai te Waiora ki Ahau model proposed by Palmer (2004).
3. Early recognition and active treatment of anti-social behaviour in pre-school children (Evans, Cicchelli, Cohen & Shapiro, 1995) should be examined with the added focus of keeping Maori children engaged within school settings.
4. Examination of the antecedents that trigger unresolved anger and exploration into the psychological constructs that make up the emotion of anger e.g. cynicism.
5. Evaluation of problem solving skills training that is relevant and culturally responsive to indigenous people e.g., the STAXI anger assessment inventory designed by Spielberger (1999), and the SOLVE cognitive therapy system designed by Spirito (2003) that provides a step-by-step method for solving problems.
6. Future research needs to investigate the familial transmission of suicidal ideation and suicide attempts. Further research is required into the impact of parental psychopathology on the mental health of their offspring. Since New Zealand's social reforms have encouraged community placement for individuals who several years ago would have been assigned to residential hospitals and in-house

treatment programmes, research has not yet established the impact on children who live with psychopathic parents.

7. Further research in required into the population of young people who have spent a major part of their lives in foster care with multiple caregivers. Bonding and attachment issues are frequently impaired, only to be exacerbated at the age of 17 when CYFS generally says, "Happy Birthday, Good-Bye" (Ward, 2000; Yates, 2000). The implications of mandatory discharge and the lack of preparation for independent living are poorly researched in New Zealand. Many of these young people become IYB applicants.

So far, the literature is inconclusive as to providing one proven intervention that will prevent suicide or suicide attempts. Similarly, researchers are unable to conclude that a combination of certain risk factors will result in suicide or suicide attempts. The same is true in the area of protective capacity. The literature is unable to state with accuracy which set of protective factors, when combined through the life span, will prevent suicide or suicide attempts. It would be interesting to investigate if the 'predictive' items of risk identified retrospectively in this study, would be useful prospectively across future research initiatives.

Conclusion

This chapter, through clinical insight and comparative retrospective study of deceased and non-deceased matched files, examined two small populations. One defined by the presence of death, and one defined by survival. The comparative group of survivors reported less of the risk factors that were reported by those that died. This research provides no evidence that there is one single factor that is protective against

suicide, and no single resilient factor that will stand alone to prevent suicide or suicide attempts. Protection lies in a constellation of factors that cluster around an individual and cumulatively come together in order to mitigate life course exposure to risk factors. With the acknowledged limitations of a small sample, this research highlighted seven warning signs for parents and professionals who liaise or live with vulnerable youth.

All of the young people in this study were exposed to risk. Some died, some lived. From the findings of this study, it seems that protection for suicidal welfare seekers lies in designing strategies to prevent a second suicide attempt (Beautrais, 2004b), early detection of mental health disorders, and implementing early interventions that address anger and isolation from caring adults. The findings have highlighted the importance of knowing the identity of biological fathers and also have further heightened awareness around the risks faced by children placed in foster care. Attention has been drawn to the need for those in power to take care with youth facing legal or disciplinary events.

The following study investigates the outcomes for 200 ex-IYB applicants, half of whom were suicide attempters, and half of whom received welfare assistance. Four groups were studied in order to assess outcomes. These groups were (a) former IYB applicants who were granted the benefit and had attempted suicide, (b) former IYB applicants who had been declined the benefit and had attempted suicide, (c) former IYB applicants who had been granted the benefit but had no suicidal concerns, and (d) former IYB applicants who had been declined the benefit and had no suicidal concerns.

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STUDY 3 ABSTRACT

A Prospective Study: Outcomes For Youth Who Applied for Welfare: Who Really Benefited?

Objective. This prospective study aimed to examine the outcomes across education, employment, income, adverse life circumstances, wellbeing and family relationships for 200 young adults who were either granted or declined a benefit, and who were previous participants in the original 2029 cohort of welfare applicants. The following questions were addressed in this study. Did the IYB system work? Did those who were granted the IYB have better life outcomes? Were family reconciliation rates higher when benefits were declined? Did those who attempted suicide and were granted the IYB have better outcomes than those who attempted suicide and were declined the IYB? What changes are now needed to improve outcomes? Does the competency and skill level of the IYB assessor impact on the applicants' outcomes? Does parental involvement in this process really matter? What factors turned pathways of risk into pathways of opportunity? Are specific personality traits more prone to negative life outcomes and in what ways does the IYB administrative process impact on applicant outcomes? The hypothesis predicted that outcomes for those who were granted the IYB would be more positive than for those declined the IYB, particularly in the groups where attempted suicide had occurred.

Method. Due to the large number of applicants who could be participants in the groups (a) the granted attempted suicide group-GAS; (b) the granted no attempted suicide group-GnoAS; (c) and the declined no attempted suicide group-DnoAS, random files

were selected for the participants of these 3 groups. However, due to the small number of applicants who were declined the benefit yet had attempted suicide (DAS), participants for this forth group were not randomly selected. I searched both Australia and New Zealand in order to find 50 DAS former IYB applicants, as from the entire 2029 original cohort, there were only 68 applicants who had been declined an IYB following an attempted suicide. Participants across the four groups however, were matched for equal representation of gender, ethnicity and age within each of the 4 sub-groups. As equal cell size had important implications for SPSS analysis, 50 participants for each sub-group were selected for this study. All 200 participants were interviewed to collect current outcome data. Comparisons were made across all four sub-groups. The questionnaires were scored and quantitative data were entered into the SPSS-13 programme for statistical analysis. Descriptive data, independent-samples t-tests, and one-way ANOVA were conducted. Quantitative data also were collected on factors that aid and hinder family reconciliation, suggestions for improving the IYB process, and factors that both facilitated and mitigated suicide attempts. Participants' suggestions were sought on gaps in the overall IYB system. That qualitative data were summarized into 5 major themes incorporating over 50 recommendations to policy advisors, school personnel and parents. Inter-rater reliability checks were conducted by a psychology graduate on 5% of cases to assess agreement in assignment to catagories Respondent validation also occurred with 5% of cases.

Results. Mean scores from the four subgroups showed that on average those who were granted the IYB and had no suicidal behaviour had better life outcomes than the

other 3 groups. Those who were declined the IYB and had attempted suicide had the worst life outcomes. Inter-rater reliability and respondent validity rates were high.

Conclusions. New knowledge has been added to the literature that gives hope for at-risk youth who will be granted a benefit; however, assessment, administration, and policy changes are needed to address the unresolved, untreated issues of those who will be declined benefits. Cautions were raised for a small group of those who were granted an IYB, as Study 2 of this thesis revealed that 5 out of 6 youth who died by suicide in the 2029 original cohort, were 'granted' the IYB. That meant that 83% of all suicides in this study were granted a benefit. Gaps in the IYB process and useful resources were identified by research participants (Appendix A), as well as triggers to suicide and factors that mitigate suicide. Of the 200 participants 89% believed that the IYB process had influenced their life outcomes.

Appendix A consists of 43 pages that provide useful information for families, schools, policy advisors, joined-up youth service providers and suicide prevention personnel who are willing to hear the voices of 200 young people on resources that they found helpful, and gaps across community and government interventions that they identified as requiring attention.

STUDY 3

Introduction

Historically outcomes research has been used to investigate, (a) the efficacy of an intervention, (b) to identify groups for which certain interventions are most effective, (c) to describe service provider and consumer characteristics related to different outcomes, and (d) to identify processes for favourable outcomes (Eisen & Dickey, 1996). In more recent times outcomes research has played two important roles; firstly relating to efficacy and economic analysis of the intervention, and secondly the area of quality improvement.

My search of the literature found no outcomes research, either nationally or internationally, that investigated the efficacy of the processes utilized to discriminate between youth who genuinely required welfare and those who did not. There was no evidence that compared outcomes for similarly matched cohorts, where one group was granted a benefit and the other group was declined the benefit. No longitudinal studies were isolated that identified outcomes for youth who were both declined and granted welfare, and no attempt had been made to bring together welfare service-users with welfare service providers, nor welfare evidence-users (policy makers), with welfare evidence-providers (researchers). Youth participation had not been sought in identifying processes that over several years had influenced either favourable or non-favourable outcomes.

In order to examine outcomes for a particular group, an assessment of change is required, and most importantly, this change must be attributed to the effects of the intervention. Consequently, the aim for the present study was to fill a hole in the

literature around youth who apply for welfare, and through the collection of outcomes evidence, facilitate decision making processes that will ultimately contribute to best practice in welfare settings.

Economic analysts of service interventions, recognise that the experiences in children's early years appear to predestine their future, thus predictive inferences can be made on what they will cost the country as adults (Irazuzta, McJunkin & Danadian, 1997; Karply, Greenwood & Everingham, 1998; Keating & Hertzman, 1999; Shonkoff & Phillips, 2000).Earlier papers in this research examined both the allocation and non allocation of government resources i.e., the Independent Youth Benefit (IYB) to a group of 2029 'homeless' young people. This present prospective study aims to examine the outcomes across education, employment, income, adverse life circumstances, wellbeing, and family relationships for 200 young adults who were previous participants in the original 2029 cohort.

Tama, Kate and Allan, were introduced at the beginning of the thesis as typical of the young people who presented as applicants for welfare assistance. Several years following their eligibility assessment for the IYB, the outcomes for these three individuals range from applauding delight, to unacceptable abuse of the welfare system, to incomprehensible sadness.

Tama's outcomes. To briefly recap, Tama had arrived at the IYB assessment merely to support his mate. He had no intention of applying for a benefit or talking to a European 'shrink'. As his mate told of his own abuse and family breakdown, Tama kept his eyes to the floor. He was tiny, showed signs of traumatised watchfulness and only smiled when his mate described him as a 'bloody useless Maori'. Near the end of the

interview Tama's friend turned to him and said, "Go on bro; show the shrink your chest". Cigarette burns and knife wounds patterned into his flesh, graphically displayed an historical text of torturous abuse. He had been sodomised by his sports hero step-father since the age of 6 years. When attempting to escape or to say no to the abuse, a knife was utilized in the attack. Beatings often led to a state of unconsciousness and Tama had been hospitalised with three medically serious suicide attempts before coming in to the IYB interview. Four schools had expelled him, he had lived on the streets, eaten out of McDonald's bins, and he had tried most of the drugs on the market.

Tama received the IYB that very day. He was placed into a safe house and over the following weeks was assisted back into education through the correspondence school. He was mentored, connected back to his marae and whakapapa, received drug and ACC sexual abuse counselling, he was provided with every resource possible through his WINZ case manager, and for the first time in his life, he lived in safety. However, four weeks into his apparent life of safety, Tama's new home was located by his step father, and Tama was again beaten and sodomised. Tama was found by a friend and admitted to hospital. When Tama regained consciousness he proceeded to the ninth floor roof where he stood contemplating suicide. Fortunately the help-seeking training, the problem-based counselling became a reality. Tama walked back from the rooftop ledge. That was 9 years ago. In September, 2004 the following outcomes for Tama were entered into the SPSS analysis programme along with 199 other ex IYB applicants.

- Education Outcome. Completed university degree.
- Employment Outcome. Full time employment.
- Income Outcome. Above $50,000.
- Adverse Life Outcomes. No involvement with police, CYFS, and no impending legal/disciplinary event. No sexual or physical abuse and no current bullying concerns.
- Wellbeing Outcomes. High outcome scores for taha tinana (physical health), taha hinengaro (mental/emotional health), taha wairua (spiritual health), and taha whanau (family health). Tama reported that counselling, marrying, and having a baby had influenced his high scores in resolving anger and gaining an ability to trust. He scored high on life satisfaction, he was not lonely, and he had good positive self-perception, good internal locus of control, good future hopefulness, and good comparison to others. High outcome scores were recorded for no recreational drugs, no consumption of excess alcohol, non smoker, no suicidal thoughts, no suicide attempts, at least one caring adult in his life, no need for counselling, no comorbid disorder, no sexual identity issues, and biological father known.
- Family Relationship Outcomes. Good relationship with mother but no contact with abusive step father.

Kate's outcomes. To briefly recap, Kate at 17 years left a supportive, safe home to live with an older man who had previous convictions for violence and sexual assault. Her application for the IYB was declined by an experienced clinical psychologist.

Without welfare money the boyfriend left town and Kate returned home. Kate returned to school for a further 6 months showed real improvement in her grades. With the return of the boyfriend to the city, Kate left home, moved in with her boyfriend, left school and again applied for the IYB. This time the eligibility assessment was conducted by a counsellor with no psychology training and who usually worked in a centre specializing with babies and toddlers. Kate's parents were not contacted. The IYB was granted. Kate continued to live with her boyfriend and she never returned to school.

That was 4 years ago. In September 2004 the following outcomes were entered into the SPSS analysis programme along with 199 others.

- Education outcome: Poor outcome, left school, no qualifications.
- Employment outcome: Poor outcome, unemployed.
- Income outcome: Poor outcome, currently on a welfare benefit and earning less than $9.55 per hour.
- Adverse life outcomes: Poor outcomes, multiple adverse life events.
- Wellbeing outcome: Poor outcome across most factors.
- Family relationship outcome: Poor outcome.

What shapes good or bad outcomes? Finding causal explanations for outcomes is a complex field of study as individual, familial, community and government factors all contribute to either negative or positive life outcomes. Beautrais (2000) and Cantor and Neulinger (2000) regard social disadvantage, unemployment and inequality as major influences in deciding outcomes. Mayer (2002) and Mackay (2003) focus on family level

factors, the economic circumstances of the family, the parenting practices and the family income level. Mackay (2003) provided an informative critique of the concept of family resilience suggesting that much of the criticism of literature focuses around definitional confusion. He makes a very clear distinction between risk factors and vulnerability factors concluding that the concept of risk refers to environmental circumstances whereas vulnerability refers to individual (and by extension, family) disposition. Both of these factors however focus on examining variables that elevate the risk of poor outcomes.

Why is it important to understand risk factors when dealing with adolescents and later outcomes? Whether an IYB applicant presents with more risk factors or more vulnerability factors, the most important consideration is, how can we reduce the risk encountered in these youths, for by decreasing risk, the chances of preventing problems associated with these risks is increased. Given that many problem behaviours exhibited by IYB youth share common risk factors, it is reasonable to expect that focusing on reduction of these risk factors should reduce many problem behaviours including suicide attempts, crime, drug use, and school drop out rates. The important question then becomes, does granting a benefit reduce or increase risk behaviours, and does it impact positive outcomes?

Through the study of risk, researchers are encouraged to ask important questions such as; are risk factors consistent across ethnicities, cultures and classes; do multiple risk factors mean greater risk; and how important are the inter-relatedness of protective factors and risk factors in suicidal behaviour. Catalano & Hawkins (1996) provide a thorough coverage of these issues advising that, interactive processes of risk factors do not vary across cultures; that a young person's risk of suicide is increased exponentially

by exposure to a greater number of risk factors and that protective factors do act as buffers in adverse life circumstances.

How do we evaluate outcomes? According to Rossi et al. (1999), there are two criteria for a good outcome measure. First, the outcome can be expected to change during the period of study. Second, the outcome is measurable and the chosen measure sensitive enough to detect the change. Weiss (1998) suggests that a good technique for selecting variables is to choose a range of proximal to more distal expected impacts. Proximal risk variables (e.g. sexual abuse or attitudes such as cynicism) are those that are directly experienced by the individual whereas distal risk variables (e.g. the family's socioeconomic status or being declined the IYB), are those that do not directly impinge on the individual but act through mediators (Baldwin, Baldwin & Cole, 1990).

Kalil (2003) suggests that macro-level distal factors, such as social policy that mandates receipt of the IYB, might also affect individual or family outcomes. For example, an abused adolescent who is declined the IYB might then be forced to return to an abusive environment due to lack of financial support, where outcomes may then move from familial abuse to suicide attempt. Other distal environmental forces such as access to health care or access to funding for education ultimately impact on the proximal outcomes of daily life for welfare seekers (Jessor, 1993).

When evaluating outcomes for ex- IYB applicants, the understanding of the influences of both distal and proximal risk is critically important. For example, when a child grows up in a 'stress-resistant' family and is shielded from many environmental risks by a protective family/parent, they can then live in a 'low-risk' proximal environment despite living in poverty i.e., a 'high-risk' distal environment (Baldwin et

al.,1990). The implication for benefit seekers, IYB assessors, and researchers, clearly is that merely counting the number of risk factors in order to decide eligibility for a benefit, or in order to assess change in outcomes, is fraught with difficulty unless the interaction between distal and proximal is variables is considered.

Why evaluate outcomes? Currently no one knows if granting the IYB provided benefits or protection during the intervening years since the initial assessment. No one knows that if by declining a benefit education, employment, income, wellbeing, and family relationships were permanently damaged. Without these questions being answered, governments are vulnerable to being criticized for allowing expenditure on schemes that have not been constructed on evidence from the literature, assessed according to robust scientific models, or evaluated to strict outcome designs.

Three New Zealand studies, although not directly involved in assessing outcome measures for IYB applicants who were either granted or declined the IYB, provide interesting outcome data on three different welfare populations. Barrett, Krsinich and Wilson (2002) estimated independent associations between observed family characteristics and benefit duration, while Ball and Wilson (2002) examined the number of children who had had contact with the benefit system since 1993. Evans et al. (1997) assessed the 'Boost' programme for a small proportion of young people on the IYB that was previously discussed in Study 1.

The Ball and Wilson (2002) study is of major concern to the New Zealand economy and to individual wellbeing. The figures documented, report that by the time children born in 1993 turned seven, half had been supported by one of New Zealand's main social assistance benefits at least once. Further, one in five children in the 1993

birth cohort spent at least five of their first seven years of life supported by a main benefit and, by implication on modest incomes. Bi-variate analysis of factors associated with long benefit durations were; having first contact with the benefit system at birth; living with a sole parent who was female, Maori or aged under 20 (Ball & Wilson, 2002). However, these factors are interrelated and this research has failed to recognise the influence of some very important factors that have not been captured in the analysis, i.e., educational attainment and employment history of the parent.

Barrett et al.'s (2002) contribution to this topic of investigation is that within his paper is provided New Zealand's first attempt to longitudinally assess why a group of young children, who had contact with the benefit system before age three, remained in, or exited from the welfare system across a span of four to eight years. He also addressed the variables that Ball and Wilson (2002) had omitted from their research. By analyzing administrative data for 28,600 children born in 1994, proportional hazard models were estimated to gauge the independent association between a range of observed characteristics and the probability of the child leaving benefit. Educational attainment, the amount of time the parent spent on a benefit before the child was born, part-time earnings, being a very young parent and residing in an economically deprived area, all were associated with lower exit rates from the benefit.

Problems in conducting outcomes research when suicidal behaviour is a variable. The causal debate around pathways leading to suicide and assessment of outcomes for those who previously attempted suicide, have led researchers (Gilbody & Whitty, 2002) to conclude that the gold standard in attempting to resolve such debate lies in the implementation of randomised control trials (RCT). Such methodology is useful

and robust in establishing outcomes, however Robson (2002) suggests that this approach does little to provide meaning of 'why' interventions fail or succeed. A further limitation of this approach is that in studying a population of IYB applicants who were suicidal, it would not be ethical or practical to randomize 'treatment' applicants by withholding clinical care from one sub-set of the group (Pearson et al., 2001). At the XXII World Congress of the International Association for Suicide Prevention, Leenaars (2003) argued that aspiring to meet RCT standards often acted as a barrier to conducting much needed research into suicidality issues. He recommend a better alternative was what he termed the 'platinum standard', where rigorous mixed methodologies were able to address the 'realities' of research. Thus, the present study of assessing outcomes for 200 subjects who previously applied for an IYB between 1995-2001, applies the platinum model whereby mixed methodologies allowed triangulation of data, the inclusion of researcher and participant perspectives, and the opportunity to integrate both content and process observations (Robson, 2002).

Method

Ethical approval. Ethical and legal approval to conduct this research was obtained from the Ministry of Social Development after permission to proceed with the research was obtained from the Chief Executive of the Specialist Education Services (Appendix D).

Selection of participants. Random files were selected from the original 2029 cohort for 3 of the 4 groups, i.e., (1) the granted attempted suicide group-GAS; (2) the granted no attempted suicide group-GnoAS; (3) and the declined no attempted suicide

group-DnoAS. Participants however were matched for equal representation of gender, ethnicity and age within each of the 4 sub-groups. The 4th sub-group to be studied, the declined attempted suicide group-DAS was not randomly selected. As there were only a very small number of DAS subjects in the original 2029 cohort (n=68), the researcher searched both Australia and New Zealand in order to find 50 DAS ex-IYB applicants. As equal cell size has important implications for SPSS analysis (Tabachnick & Fidell, 1996), 50 participants for each sub-group were selected for this study.

Contacting participants. Each participant had previously at their eligibility assessment, signed a consent form giving permission for them to be re-contacted for research purposes. A telephone call was made to each participant regarding this current research, where they were offered a choice to be involved. Only four individuals declined. All consenting ex-IYB applicants were then posted information on the research outlining the processes for complaints, terminating engagement in the research, and follow up options for referral pathways or access to research results (Appendix E). It was suggested to each participant that they take time to read about the research and to re-consider their involvement. I then called the participant, and for those willing to proceed, an appointment time for the outcome interview was scheduled. All participants were informed that they could bring to the interview any support people with whom they felt comfortable.

Interview process. For safety reasons the interviews were held in various professional offices around Australia and New Zealand. Following a welcome (mihi greeting for Maori participants), and refreshments, each participant was assured of confidentiality through the reading of the statement appearing at the top of the semi-

structured interview questionnaire. The semi-structured interview took place working through the questions outlined in the 'Outcome Questionnaire' (Appendix B). I interviewed each participant and completed all questions on the Outcome Questionnaire. Near the close of the interview, confidentiality was again reassured, and particular attention was paid to offering support or referral pathways to the participant if during the interview issues of concern had been raised. Participants were thanked and informed that they may be contacted for respondent validation purposes, and that they could request research outcome information.

Measures.

The Outcome Questionnaire. The Outcome Questionnaire was designed (in consultation with a Maori cultural advisor), to measure a range of quantitative and qualitative outcomes, and to seek suggestions from participants that would assist best practice, and inform those responsible for making decisions, and quality improvement, in the area of welfare. The Outcome Questionnaire was constructed according to evidenced-based studies and theoretical frameworks that indicated education, employment, income, adverse life outcomes, wellbeing, and family relationship outcomes, were influenced by childhood experiences and family interaction patterns. Accordingly, questions (requiring yes/no, ranked, and narrative responses), were designed to examine these variables pre and post the IYB eligibility assessment, in order to establish an outcome measure that was both sensitive to change and could show that the IYB application could be linked to such change.

Inter-rater reliability. Inter-rater reliability checks using Cohen's kappa formula (Bryman, 2004), occurred on 5% of the questionnaires. A psychology

graduate scored the quantitative outcomes for the four groups across education, employment, income, adverse life, wellbeing, and family. An additional task was to count and provide a percentage showing which three factors were ranked most important in the following areas. (a) family reconciliation, (b) barriers to reconciliation, (c) improving the IYB application, (d) assessment and (e) follow up process, (f) identifying unhelpful gaps in the system, (g) isolating useful resources, (h) identifying the three main triggers to suicide and (i) identifying the three main mitigating factors of suicide. The final task for the inter-rater reliability individual was to place participants' responses relating to gaps and required resources (i.e., qualitative data appearing in Appendix A), into 'themes' or 'categories' that I had previously established.

Respondent validation. Following the 200 interviews assessing outcomes, I contacted a randomly selected group who had given permission for further contact. Ten young adults (5% of the cohort), were involved in respondent validation activities. Their task was to either corroborate or dispel my documented accounts of qualitative data they had supplied, and to offer agreement or otherwise, on whether their data fitted into the themes that had been devised.

Analysis. The Outcome Questionnaires were scored manually (Appendix C), and quantitative data were entered into the SPSS-13 programme for statistical analysis. Descriptive data, independent-samples t-tests, and one-way ANOVA were conducted to assess significance between the four groups studied. Outcomes were assessed across six domains (education, employment, income, adverse life events, wellbeing, and family relationships). Within each domain participants scored points

for worthwhile attributes, so the higher the score, the better the outcome. Each participant was allocated a total score for each of the six domains.

Results

Outcome measures. Mean scores obtained on the Outcome Questionnaire are presented for the four groups studied. To have the best outcome, a total score of 42 was possible. Both groups where suicide was not an issue (GNoAS and DNoAS), reported better life outcomes than the two groups where suicide attempts had been made (GAS and DAS). When suicide was not of concern, those that were granted the IYB scored better outcomes than those that were declined the IYB. When suicidal behaviour was a contributing factor, again, those that were granted the IYB scored better outcomes than those who were declined the benefit.

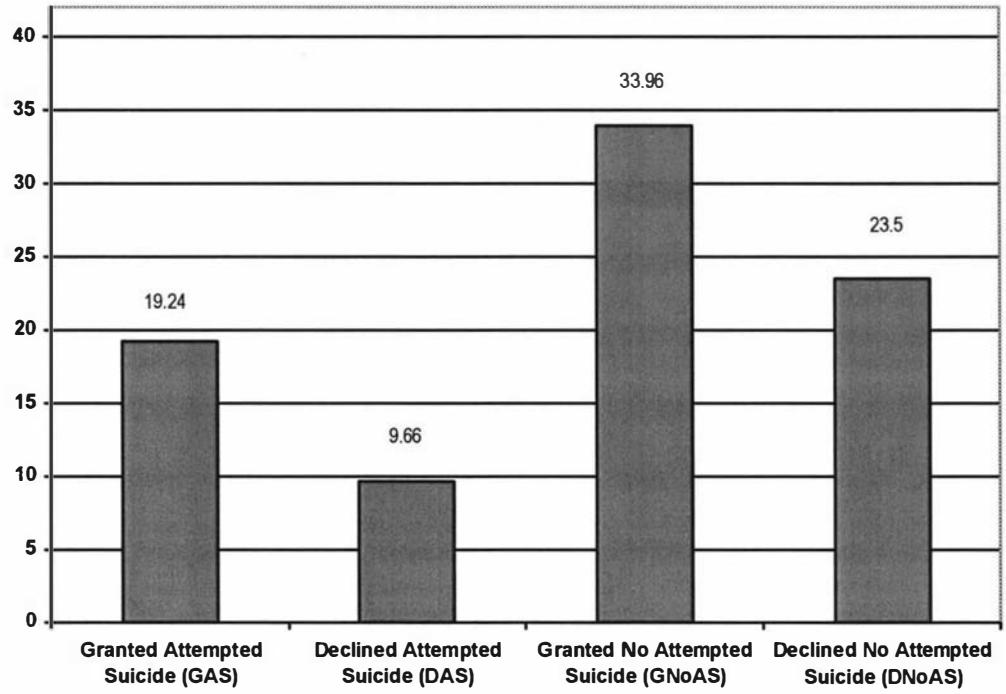

Figure 3.1 Mean outcome scores for the four subgroups across the combined variables of education, employment, income, adverse life events, wellbeing, and family relationships.

Interestingly, although the GNoAS group showed the best total outcomes, followed by the DNoAS group, this pattern did not remain stable when data was examined on each of the six independent variables. For education, employment, income and adverse life outcomes, those who had been granted the IYB and had no suicidal concerns (GNoAS), consistently scored the best outcomes, but the second highest outcomes across these variables, were scored by the GAS group, and not the DNoAS group that had rated second place in the total outcome placement. So both groups that had been "granted" the IYB, irrespective of suicidal behaviour, scored better outcomes in education, employment, income, and adverse life events. However, when the wellbeing and family relationship outcomes were examined, the GNoAS group and the DNoAS

groups took first and second place respectively, for best life outcomes. Across all variables the declined attempted suicide (DAS) group had the poorest outcomes.

Table 3.1

Outcomes for 200 ex-IYB Applicants (one-way ANOVA)

		N	Mean	Std. Deviation	Std. Error	df	F	*p*
Education outcomes	GAS	50	2.3800	.85452	.12085			
	DAS	50	1.1600	.46773	.06615			
	GNoAS	50	3.6600	1.00224	.14174			
	DNoAS	50	1.9400	.54995	.07778			
	Total	200	2.2850	1.187502	.08309	3	97.057	.000
Employment outcomes	GAS	50	1.8200	.59556	.08423			
	DAS	50	.7200	.49652	.07022			
	GNoAS	50	1.9600	.28284	.04000			
	DNoAS	50	1.6600	.55281	.08384			
	Total	200	1.5400	.70061	.04954	3	60.788	.000
Income outcomes	GAS	50	2.8000	.78246	.11066			
	DAS	50	1.0800	.34047	.04715			
	GNoAS	50	3.7200	.49652	.07022			
	DNoAS	50	2.1000	.30305	.04286			
	Total	200	2.4250	1.09562	.07747	3	233.299	.000
Adverse life outcomes	GAS	50	3.6000	.75593	.10690			
	DAS	50	2.5200	.67733	.09579			
	GNoAS	50	5.0200	.62237	.08802			
	DNoAS	50	2.4200	.49857	.07051			
	Total	200	3.3900	1.23105	.08705	3	176.009	.000
Wellbeing outcomes	GAS	50	7.2600	.80331	.11361			
	DAS	50	3.5600	.64397	.09107			
	GNoAS	50	17.7200	1.24605	.17622			
	DNoAS	50	13.6800	1.01900	.14411			
	Total	200	10.5550	5.59226	.39543	3	2207.41	.000
Family relationship outcomes	GAS	50	1.3800	.56749	.08025			
	DAS	50	.6200	.56749	.08025			
	GNoAS	50	1.8800	.38535	.5451			
	DNoAS	50	1.7000	.46291	.06547			
	Total	200	1.3950	.69382	.04906	3	61.531	.000
Total	GAS	50	19.2400	2.90362	.41063			
	DAS	50	9.6600	2.29115	.32402			
	GNoAS	50	33.9600	2.53916	.35909			
	DNoAS	50	23.5000	2.15946	.30539			
	Total	200	21.5900	9.08928	.64271	3	818.878	.000

One-way ANOVA indicated a significant difference in outcome scores between the four groups studied across the variables of education, employment, income, adverse life events, wellbeing, and family relationships. It is interesting, considering theoretical models outlined in this thesis, that when examining wellbeing and family relationship outcomes, both the groups that had no experience with suicidal behaviour, (GNoAS and DNoAS), scored better mean outcomes (irrespective of whether the IYB was granted or not), than the two groups who had attempted suicide (GAS and DAS).

Differences in outcomes between the four groups were explored statistically using a series of one-way ANOVAs, as although the different outcomes might be related, I had no way of determining in advance that these variables might be correlated. As seven comparisons were conducted, I used a Bonferrioni correction and set the alpha level at .05/7. All comparisons were significant at $p < .001$. Consequently, a follow-up comparison of each pair of means was undertaken, using a planned comparison *t*-test for equality of means. The groups that had been granted the benefit had the better outcomes for education, income and adverse life events; however the difference in employment outcomes was not significant.

Table 3.2

Outcomes for all Subgroups Ranging from Best to Poorest Outcomes Across Education, Employment, Income, Adverse Life, Wellbeing, and Family Relationships

	Best outcome ⟷ Poor outcome			
Education outcomes	GNoAS	GAS	DNoAS	DAS
Employment outcomes	GNoAS	GAS	DNoAS	DAS
Income outcomes	GNoAS	GAS	DNoAS	DAS
Adverse life outcomes	GNoAS	GAS	DAS	DNoAS
Wellbeing outcomes	GNoAS	DNoAS	GAS	DAS
Family relationship outcomes	GNoAS	DNoAS	GAS	DAS

GAS = Granted Attempted Suicide

DAS = Declined Attempted Suicide

GNoAS = Granted No Attempted Suicide

DNoAS = Declined No Attempted Suicide

Participant's percentage results attributing outcomes to the influences of familial, personal and IYB intervention processes. All research participants identified three factors aiding family reconciliation.

a. The violent parent has left the home of origin -67%.
b. Getting a job so no longer financially dependent on parents -65%.
c. Parents taking some time out to spend with their kids and learning to listen.-65%.

All research participants identified three barriers to family reconciliation.

a. Not safe at home - 70%.
b. Money problems, parents didn't want them back - 69%.
c. Kids refusing to conform to parents rules - 59%.

All research participants identified three improvements for IYB application process.

a. Process was humiliating – 60%
b. Concern over breach of privacy being interviewed in public area – 58%
c. Judgmental attitude of case managers – 58%

All research participants identified three improvements for IYB assessment process.

a. Travel problems. Moving the assessment site to where the case managers are based, seemed more sensible to ex IYB applicants – 70%
b. Concern expressed over WINZ case managers wanting too much information from their assessment interview -59%
c. Females found talking to a male IYB assessor about personal abuse issues difficult – 56%

'Granted' research participants identified three areas for improvement in IYB follow-up process.

a. Failure to follow through on assessment report recommendations – 69%

b. Payments suddenly stopped without notice – 65%

c. When WINZ case managers changed, lack of communication between them regarding the needs of the applicant caused problems – 65%

'Granted' research participants identified three helpful resources throughout the duration of the IYB process

a. Provided safety, away from home – 69%

b. Provided money to achieve goals – 69%

c. Able to talk to a psychologist, felt better about myself – 68%

'Granted' research participants identified three unhelpful events occurring in the IYB process.

a. Judgmental case managers and stigmatisation – 64%

b. Payments suddenly stopped without warning -59%

c. No privacy with case managers -58%

Granted and declined research participants attribute life outcomes to the effect of the IYB application process.

a. Current life outcomes significantly influenced by IYB – 88%

b. Positive life influences because of IYB granted – 89%

c. Negative life influences because of IYB declined – 86%

Suicidal research participants identified three triggers to suicide attempt.

a. Domestic violence at home and bullying at school – 72%

b. Not able to control anger due to cynical attitude of distrust i.e., that nothing would ever really change in this life-69%.

c. Having no-one who really cares or has the ability to help solve problems -68%.

Suicidal research participants identified three factors that mitigate suicide.

a. Leaving home and finding goals and a career path -78%.

b. Finding someone who believed in them and cared- 64%.

c. Believing in God -60%.

Inter-rater reliability and respondent validation. A psychology graduate compared her scores with my ratings, achieving a very good coefficient of 0.89 Additional participants' responses to questions included in the Outcome Questionnaire, contribute to the recommendations included in Appendix A. For the conclusions and recommendations included in Appendix A, respondent validation reached full agreement. From the ten participants who took part in the respondent validation process, there was good correspondence between my findings and the perspectives and experiences of the research participants.

Discussion

When interviewing these 200 young adults, I obtained a high level of cooperation as ex-IYB applicants were eager to tell their story. There were big variations in outcomes. After coding and categorising quantitative measures using descriptive statistics, ANOVA and t-tests from the SPSS package, the measures of success for four subgroups were revealed. It was crucial for new anecdotal knowledge from this population to be scrutinized scientifically, in order to empirically answer the question, does granting a benefit show a statistically significant difference in impacting successful life outcomes,

and does declining a benefit show a statistically significant difference in impacting poor outcomes?

By using an open-ended questionnaire, I was able to quantify the information in a way that showed which groups of young people had done well, and which groups had done poorly. By using reliability and validity measures (inter-related reliability using Cohen's kappa, and respondent validation), I also was able to show that qualitative data obtained from the participants was recorded accurately, and that five percent of respondents agreed that what they "meant" in the Outcome Questionnaire, was indeed recorded in the results. Despite recognising the limitations of respondent validation exercises (possible defensive reactions, reluctance to be critical, and respondents lacking understanding of social science analysis), the outcome results clearly are encouraging for youth who have been granted a benefit, and very concerning for youth who had attempted suicide yet were declined the IYB.

Each of the outcome variables measured across education, employment, income, adverse life, wellbeing, and family relationships reflected something worthwhile. Each participant was given an individual score for each of these variables, which translated into successful life outcomes, through to poor life outcomes. Consistently across all variables, those who had been granted the IYB and had made no attempt at suicide (GNoAS) did statistically significantly better in life outcomes than all other groups. Consistently across all variables, those who were declined the IYB and had made an attempt at suicide (DAS) reported poor life outcomes.

For participants who were either granted the benefit and had made an attempt at suicide (GAS), and for participants who had been declined the IYB and had made no

attempt at suicide (DNoAS), their outcomes consistently were mixed and sat between the highly successful outcomes of the GNoAS group, and the poor outcomes of the DAS group. This new knowledge to the literature will have important implications for government, policy advisors, psychologists, counsellors, WINZ case managers, and particularly for those working in the suicide prevention and youth safety arena.

In Study 1, of this thesis it was noted that on average those applicants who were granted the IYB had only two more risk factors in their life than the average number of risk factors for those who were declined an IYB. The issue then is not how many risk factors these youth are exposed to; rather it seems that it is the potency and individual perceptions toward particular risk factors that can determine negative outcomes. From this current research, it is clear that making a suicide attempt will impact on poor outcomes in the areas of wellbeing and family relationships, irrespective of whether a benefit is granted. Further, if a young person who has attempted suicide is declined a benefit, poor outcomes possibly will also extend to education, employment, income and continuance of adverse life events.

Although it appears from this outcome research that those receiving the benefit overall did better than those declined the benefit, it is important to examine on an individual basis why some who were granted the IYB did extremely well (e.g., Tama), and why some who were granted the IYB had poor outcomes (e.g., Kate). It is also worth remembering that from Study 2, of this thesis, five of the six IYB applicants who died by suicide had been "granted" the IYB. There needs to be caution when interpreting overall outcomes, and applying general principles to specific cases. When I compare two young

people who were both granted the IYB, yet reported wide variability in outcome scores, it becomes important to examine individual differences.

Tama's outcomes indicated that the IYB system was effective in offering temporary financial support during a difficult transition, and that this government sponsored 'hand-up' mechanism, met the goal of helping to move a beneficiary from dependency to independence. Kate however, worked hard, not at seeking employment, but seeking to abuse a system, so that she was able to live with her drug trafficking boyfriend. Tama's successful outcomes appeared to be influenced by obtaining a good education, marrying, and having a child. He was connected back to his ethnic origins and increased his skill level across education and communication. Tama had given up drugs, he had a highly successful job with a good salary, and he had kept out of legal trouble. Tama had also kept away from the step-father who had abused him. Although Kate was also granted the IYB, I believe her second assessment interview had not been thoroughly and professionally conducted, her parents had not been involved in the process, and I could find no evidence why this young woman was granted the benefit. Kate left school without any qualifications, she had not been employed in a full time job, she was currently receiving a benefit, she had been involved with the police, and she had been sexually abused in her relationship with her boyfriend, and had an impending legal event that was causing her distress. At the outcome interview, Kate revealed that there were mental and physical health problems, that she was currently taking drugs, and also was in counselling. Kate had rarely seen her family since being granted the IYB. The recommendations in appendix A will address these concerns and provide suggestions that hopefully will prevent this situation from recurring.

Tama's case however, seems exceptional, for in Study 2, it was revealed that Maori males, who are suicidal, are at risk of poor life outcomes. Flett, Kazantzis, Long, MacDonald and Millar (2004), assessed the ethnic differences in the prevalence of traumatic events from a New Zealand community sample, and concluded that Maori experience more child sexual assault, physical and domestic assault, motor vehicle accidents, and tragic death during the course of their lifetimes than European. Maori also experienced more exposure to adult sex assault. Flett et al. (2004) continued that Maori are often associated with poverty, higher levels of social stress, poorer health outcomes and frequent reliance on welfare benefits. These descriptors have been endorsed by Lloyd and Turner (2003), Williams, Spencer and Jackson (1999), and Hirini, Flett, Kazantzis, Long, MacDonald and Millar (1999). It is also possible that the Maori participants in our sample simply underreport the bad, and accentuate the good. In Study 1 it was noted that Maori rates for bullying are higher and abuse rates less than their European peers, yet Maori IYB applicants died more frequently by suicide.

Future research into outcomes for indigenous peoples may well incorporate analysis of information from both Maori IYB recipients, and service providers that are designed to assist policy makers develop care related and culturally competent interventions for welfare applicants. The Tidal Model (Barker, 2002) was developed in England between 1995-1998 initially as a 'care continuum' that recognised different 'critical', 'transitional' and 'developmental' stages of the care process. In more recent times it provides a model where no assumptions are made about the 'proper' course of a person's life, but rather the suggestions from health and welfare recipients are sought regarding 'their' perceptions of what they need 'now' for help. Already in New Zealand

the Homai te Waiora ki Ahau model (Palmer, 2004) is being promoted as a similar model that addresses wellbeing through decolonization of traditional assessment and intervention models. With the exploration of these new approaches, we may well see in future years a real change in the life outcomes for Maori.

How did ex-applicants rate their service? Of the 200 ex-IYB applicants interviewed, it appears that most of those who were granted the IYB reported positive influences (89%), while most of those who were declined the IYB reported that the decision to decline the benefit had resulted in the development of negative life outcomes (86%). In relation to whether the IYB intervention process affected outcomes, participants were very clear, in that 88% of them stated that the IYB process had influenced their life outcomes.

Aids and barriers to family reconciliation. Research participants provided useful commentary on factors aiding family reconciliation, and barriers that prevented reconciliation. Ensuring that homes are safe and free from domestic violence, addressing family poverty and financial hardship, and encouraging parents to spend more time with, and listening to their children, are critical factors in developing and strengthening healthy family outcomes. These suggestions support the findings of the Youth 2000 study conducted by Watson (2001). Barriers to family reconciliation included unsafe home environments, family financial problems and IYB applicants refusing to comply with parents' rules.

Identified triggers to suicide. If we are to truly advocate for youth and to actualise their suggestions, then their identified triggers toward suicidal trajectories must be heard by government. The New Zealand Prime Minister has already placed priority on

attending to one of the identified triggers to suicide by making 'domestic violence reduction' a key inter-agency priority target for 2005. The Opportunity for All New Zealanders 2005 report published by the Ministry of Social Development, outlines this commitment This report confirms that during the 2002/2003 year, police attended 49,682 incidents of family violence and that 45% of the violence in this country occurs within the home. Research participants who provided information for this thesis identified that their modeling of violent behaviour also led to a second trigger on the pathway to suicide, which was an inability to control their anger and a cynical distrust that nothing would ever change in their lives. The third trigger that they identified was that there was no one caring adult in their life to help them solve individual problems.

The theoretical framework on which this thesis is built, adopts the evidence-based tenet that adolescents who have a caring parent, or care from an extended family, are less likely to attempt suicide. Fleming's (2003) summary of the literature reports that the strongest evidence in the operation of protective factors is for family factors, and that these factors are significantly associated with reduced rates of suicide attempts. She continues that the strongest relationship is for "parent cares" and those adolescents who are without caring parents are five times more likely to attempt suicide than those who have a caring parent. Further, adolescents without extended family care are approximately 1.5 times as likely to have attempted suicide as those with extended family. When the extended family is as important as the immediate family of origin, as it is in Maori culture, then loss of this support structure for Maori youth will presumably have higher negative consequences.

Mitigating suicide. Ex-IYB applicants identified three factors that mitigated against suicide. They were, leaving home, connecting to someone who cared and a belief in God. The need to feel safe at home and the basic need to feel connected, or to belong (Osterman, 2000), is a basic human requirement that has been extensively researched by Resnick et al. (1997). However the third protective factor that mitigated suicide involved the concept of religiosity. This protective factor will need further research as participants did not identify an operational definition of what they meant by, 'believing in God'. Was it belief in some spiritual dimension that is tied in with gaining strength from ancestors and various gods as is evident throughout many indigenous cultures, was it regular attendance at church or varied places of worship, was it a belief in the traditional story of Christ, or some other spiritual realm that ex-IYB applicants failed to identify?

Religiosity and a belief in accessing the strength of a higher power have been identified as contributing to resiliency and positive life outcomes (Greening & Stoppelbein, 2002; Neelem, Halpern, Leon & Lewis, 1997; Stack, 2000). Ellison et al. (1999) showed that regular church attendance was negatively associated with spousal domestic violence while Mahoney et al.'s (2001) meta-analysis suggested that religion lowered the risk of child maladjustment, and the risk of adolescent drug and alcohol use. O'Connor, Cobb and O'Connor (2003) have suggested that indicators of religiosity are inversely associated with aspects of psychological distress. In other words, those that hold religious beliefs are less distressed than those who don't.

Some studies however, associating religiosity with improved outcomes are open to methodological criticism. A meta-analysis conducted by McCullough et al. (2000), found religious involvement to be associated with mortality in that, their data

indicated that individuals low in religious involvement were more likely to be dead at follow up than individuals high in religious involvement. It is this type of research that does not stand robust scrutiny, for these researcher have failed to account for other mechanisms that may be simultaneously operating e.g. religion may simply play the role of a 'buffer' where such beliefs buffer the impact of stress on general well-being. Religiosity may be viewed as a coping model where religion can have a problem solving focus. This could mean that IYB individuals who have a belief in God may also have higher levels of problem solving and coping strategies that therefore lower levels of psychological distress. There is also the possibility that religiosity often means associating with like-minded people, therefore the sense of belonging, connection, and social support in turn decrease suicidal thoughts.

Thoresen (1999) has suggested there was a dearth of research in this area, so Johnson, Jang, Larson and Spencer (2001) attempted to control for criticisms that have been documented in the literature, and tested whether the effects of religiosity on delinquent behaviour are spurious or completely indirect via social bonding, social learning, and socio-demographic variables. They found that the effects of religiosity on delinquency were independent of theoretical and statistical controls, and were only partly mediated by non-religious variables such as social control or socialization. A replication of the Johnson et al. (2001) study would be useful for a much larger prospective sample of the IYB population in order to establish the power of religiosity in protecting against suicidality.

Suggestions to improve the service. Information obtained using the Outcome Questionnaire with 200 ex-IYB applicants raises implications for training, supervision,

and monitoring of WINZ case managers. Ex-IYB applicants identified unhelpful processes to which they had been exposed while applying for the IYB. These problems included hostility, judgementalism and humiliating breach of privacy when applicants were interviewed by WINZ case managers in open-plan areas. Many had problems with statutory individuals seeking too much personal information and IYB females raised concerns about talking to male case managers and counsellors regarding family abuse. Research participants also identified failure of case managers to sometimes follow through on the psychologist's recommendations contained in the eligibility assessment. Clearly remembered by research participants as unhelpful process events, were examples of lack of communication between case managers when there were staff changes. They further disclosed that sudden cessation of welfare payments without warning had increased stress and turmoil in their lives, as was finding enough money to travel between appointment sites to attend meetings with case managers, then also with assessors from Group Special Education who conducted further interviews.

Kate's outcomes indicated a need to ensure that those who are responsible for assessing family breakdown, not only follow procedural guidelines such as consultation with the applicant's parents, but are qualified in the scope of practice required to assess and intervene with such a high risk population. Currently, the Accident Compensation Commission (ACC) has requested that clinical psychologists conduct assessments of persons who have cited stress or mental illness as a reason for being on a sickness benefit or invalids benefit. Chisholm (2005) reports that the Ministry of Social Development has been increasingly concerned at the rising rate of stress and mental disorder being cited as the reason why an individual cannot work, and the increasing costs of numerous benefits

to the taxpayer. When Study 1 of this thesis reported that 30% of IYB applicants have reported medically serious suicide attempts prior to applying for a benefit, when 40% reported a parent with a mental health disorder, when 76% reported substance abuse problems, when 86% reported varying forms of abuse, when 55% reported disengagement from school, and 31% had been involved with CYFS, it then seems crucial that only assessors qualified to conduct appropriate assessments with this multiple-problem group, are contracted to provide the service. Only by understanding risk and protective factors in a theoretical context, can a thorough assessment occur that is evidenced-based, develops an intervention plan that is commensurate with the estimated risk, and from a detailed analysis of need can then recommend appropriate referral pathways. Questions must be asked as to whether non psychologists working in an education setting such as Group Special Education can provide the scope of practice that enables them to work with IYB applicants who arrive at the interview with such complex psychological need.

Where are the gaps in New Zealand research regarding outcomes for those placed on youth benefits? Presently no data is available on the profile, risk, trends or significant indicators that lead to the granting or decline of a benefit, and no data is available on life outcomes for those applicants. No data is available that can evaluate the validity of decisions made by IYB assessors. No data base is kept by those administering the IYB contract (Ministry of Education), on highly vulnerable youth who may have attempted suicide, thus no follow up monitoring or inter-agency checks are established to facilitate safe and healthy outcomes for IYB youth. IYB assessors have no national training, they follow no nationally consistent evidenced-based model of intervention, and

their professional backgrounds are as varied as their skill level. These problems all combine to raise serious questions regarding outcomes for the population of IYB youth, especially when so many have serious mental health concerns, yet are assessed by some assessors with no mental health training and who work in an educational, not a mental health setting.

Strengths of the IYB system. In balancing the previously mentioned unhelpful process events, research participants were extremely grateful that the IYB system had offered them physical and psychological safety, financial security, and had introduced them to a psychologist who helped them to feel less stigmatized and more normal.

Conclusion

Our introductory paragraph for this study, presented defining features of outcomes research. The outcomes research included in this current study, has indeed identified the intervention to be examined, (i.e., the IYB), the groups in which the effects of either the decline of the IYB or the granting of the IYB would be tested, the theoretical characteristics of the consumers (i.e., IYB applicants) have been described, and the processes leading to favourable outcomes have been documented. Participants were able to identify gaps in the system and offer recommendations for change (Appendix A), and most importantly, they were able to quantitatively rate their attributional life outcomes to the effect the IYB application process had on their lives.

Did the IYB system work? Within the Waikato cohort of applicants the system provided more favourably for those who were granted the IYB than those who were declined the IYB. Did the IYB system work for those who had attempted suicide and

were granted the benefit (GAS group), compared to those who attempted suicide and were declined (DAS group)? Outcomes for the GAS group certainly were more favourable than outcomes for the DAS group. However, we do not know what might have been the outcomes for the DAS group, if they had been granted the IYB and in turn been given the opportunity to leave their home. It cannot be said that in all cases of those granted a benefit, there were better life outcomes, for in Study 2 of this thesis, six youth died by suicide that had been granted the benefit. The answer may be that it is not so much the IYB system that did not work, rather it might have been the complementary services that should have paralleled the granting of the IYB for previous suicide attempters, which was at fault. Services such as well monitored, free, culturally competent, mental health counselling for both the applicants as well as their families, might well have prevented such sad outcomes.

Did the IYB system work for those who attempted suicide and were declined the benefit? Clearly not! Their outcomes across the entire spectrum of variables studied were poor. Their cynical distrust levels (as we will see in Study 4), and adverse life outcome scores were worse than any of the other three groups. They had the poorest outcomes across education, employment, income, adverse life events, wellbeing, and family relationships. Should this group have been granted the benefit? Maybe not! Should they have been supported by some of the recommendations they, and the other 150 participants made. Most certainly!

From the structured interview conducted with these young people, over 50 recommendations emerged (appendix A). This data was not scientifically scrutinized; it was simply documenting participants' ideas on gaps and useful resources within the IYB

process, and also contains clinical recommendations that endorsed the participants' suggestions. The data obtained in Appendix A is supplied specifically to inform policy but it is not asserting scientific principles that have not been proved. I am simply providing fascinating data collected from those who have used the system and have summarized their suggestions.

The outcomes for those granted the benefit appear to support the basic tenet that when young people with broken families and varying levels of adverse life events are placed into new environments where their stories have been heard, where they have gone through an assessment process that has identified their genuine need, when they have a belief that they are able to change life events, when they are given a sense of power that enables them to move into a safe environment, then we see that young people are able to achieve better life outcomes. When youth are supported in moving away from family breakdown environments, they are also then able to change their beliefs about what constitutes safety, about their own self image, and about their own ability to improve life outcomes. Albert Ellis (1974) stated that it is not the events in our life that distress us; rather it is the perception of those events and the way we deal with those events that shapes life outcomes. It seems then from my research, that when unsafe (physically or psychologically) youth are made safe (i.e., given financial means to leave broken homes), their perceptions and behaviours change so that their outcomes become more positive than youth who are left unsupported in broken homes. To date there has been no research or funding made available allowing government research contractors to assess whether providing hundreds of millions of taxpayers dollars to welfare seeking youth, has done

any good whatsoever. My research has now begun the process of addressing such a deficit.

The results of this outcome study contribute to our understanding of the nature of a theoretical framework by which beliefs about oneself as an independent agent, influence social behaviour. Simply put, when young people believe they can change the bad things happening in their lives, i.e., to move away from family breakdown and abuse, they are more likely to develop new beliefs and behaviours that lead to good things happening in their lives. The key, according to cognitive theory, lies in the 'beliefs'.

Unfortunately, it seemed that many of the IYB applicants experienced difficulty with their beliefs around trust, and when I engaged with these youth, cynicism appeared to be a frequent psychological construct that wove itself through their conversations and behaviours. Consequently, the variable of cynical distrust was examined as part of the Outcome Questionnaire (Appendix B), and results of this investigation appear in Study 4.

STUDY 4 ABSTRACT

The Cynical Distrust Test: Measuring a Psychological Construct Associated with Anger, Depression and Suicide.

Objective. The aim of this study was to expand the development of a quick, user-friendly screening tool that could be used by Work and Income case managers, school counsellors and youth workers, to measure the psychological construct 'cynical distrust'. This negative emotional state has been linked to both anger and depression disorders that in turn may influence suicidal behaviour. The hypothesis predicted that the cynical distrust level of IYB applicants, who had reported suicide attempts, would show elevated levels of cynical distrust compared to IYB applicants who had not reported attempting suicide. Comparative analysis with a high school cohort would indicate similarities or differences in levels of cynical distrust between two data sets.

Method. Two hundred ex IYB applicants were re-interviewed several years after their original eligibility assessment interview (between 1995-2001) for welfare assistance. As part of an 'outcomes' study conducted in 2004, data from four groups of young adult, former IYB applicants , were compared using the 9 item 'Clinical Distrust Test'. These groups were, (1) those that attempted suicide and were granted the IYB abbreviated to GAS, (2) those that were declined the IYB and attempted suicide, DAS, (3) those that were granted the IYB but had no attempted suicide, GNoAS, and (4) those that were declined the IYB with no attempted suicide, DNoAS.

The Cynical Distrust Test also had been previously administered to 324 high school students in the general community from a different geographical region. The SPSS programme was utilized to assess statistical differences within the welfare seeking cohort, and also to assess differences between former IYB applicants and the school community comparison group.

Results. The predicted hypothesis was supported in that cynical distrust scores for 200 former IYB applicants across four sub-groups indicated that those who had made medically serious suicide attempts had elevated levels of cynical distrust compared to former IYB applicants who had made no attempt to suicide.

Conclusion. Future research is required to assess whether extremely elevated levels of cynical distrust contribute to a diagnosis of mental illness, whether this psychological construct is a predictor of suicide risk, and whether the construct is indeed definable and measurable. Contingent upon further research aimed at developing the 'Cynical Distrust Test', there is a strong possibility that this instrument may provide a useful screening tool for counsellors, case managers, teachers and youth workers who interface with those at risk of suicide.

Further research is required for the development of assessment tools that can identify the emotional precursors to suicide. Cynical distrust may be one of those precursors that are identifiable through a new measurement tool, i.e. The Cynical Distrust Test.

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STUDY 4

Introduction

The past President of the World Health Organisation Committee on suicide prevention, Diego De Leo (2004), has made it abundantly clear that no one strategy or predictive measurement tool is capable of, or accurate in, predicting either a suicide attempt or completed suicide. Agerbo, Nordentoft and Mortensen (2002), support this view after conducting one of the largest population based nested case- control studies in Europe. Taking data from longitudinal Danish registers they compared data from 496 young people aged 10-21 years who had committed suicide between 1982-97 with 24,800 controls matched for sex, age and time. Although these researchers concurred with Van der Sande, Buskins, Allart, Van der Graaf and Van Engeland (1997), who stated that "preventive strategies cannot be based on empirical evidence as this does not exist". Agerbo et al. (2002) still concluded that suicide is more likely among young people if a parent commits suicide or there is a history of mental illness in the individual or their siblings.

O'Conner (1999) argued that one of the most obvious measures for suicide prevention is for mental health professionals to better integrate studies of attempted suicide with the retrospective analysis of completed suicides. He also expands on the theory postulated by Maris (1981), that suicides can be divided into 4 sub-types one of which relates to the psychological construct of 'aggression'

Unresolved anger was identified as a salient factor for death by suicide in the retrospective study of this thesis (Study 2), where completed suicides were compared

with attempted suicides. It was concluded that there were 7 salient factors that were associated with suicide when compared with those who did not die by suicide. Three of those factors related to: (a) previous suicide attempt, (b) comorbid disorders, and (c) unresolved anger.

Hostility has received renewed interest as one of the possible constructs of anger and aggression (Evans, Heriot & Friedman, 2002). According to Buss and Durkee (1957), and Buss and Perry (1992), hostility represents the emotional and cognitive substrate of dislike, resentment, and contempt for others. These emotions may act as barriers to accessing help from adults when vulnerable adolescents are confronted with thoughts of suicide.

Research participants in the previous prospective study where 200 ex IYB applicants were interviewed, indicated that being able to trust at least one adult or having one adult in your life that cared about you, were key factors in allowing them to be able to seek help at crucial points in their lives. Many identified however, that anger and distrust of adults, an emotion and behaviour developed in childhood, frequently generalized across time, settings and situations to impact negatively on relationships with individuals who were actually attempting to help them. Ciarrochi, Deane, Wilson and Rickwood (2002), Deane and Todd (1996), and Wilson and Deane's (2001) research, support the concept of 'help negation' in non clinical youth populations, suggesting that a problem has been identified in this cohort whereby as suicidal ideation increases, willingness to seek help from adults decreases.

Drury and Dennison (1999) in reporting on welfare case managers' perceptions of communications with teenage benefit applicants documented that young people were

particularly negatively affected by the welfare seeking process and often exhibited 'cynicism'. The psychological impacts of needing to be "benefit dependent" include other psychological constructs such as apathy, fatalism and low self esteem (Winefield, Tiggemann, Winefield & Goldney, 1993).

Cynicism has been associated with suicidal ideation in young adults. Miros and Hofstra (2000) examined the manner in which anger-proneness, cynicism and anger rumination interacted as predictors of suicide risk. Cynicism is built on the foundation of distrust which research suggests comes from unmet dependency needs (Knittle, 1980). An adolescent dealing with the consequences of unmet childhood needs is typical of the sad picture often presented to IYB assessors and WINZ case managers. Cynicism and distrust seem to grow from exposure to many of the risk factors noted in previous studies in this thesis i.e., lack of access to a caring adult, unknown fathers, placement in foster homes, sexual, physical and psychological abuse. Personality traits associated with an increased risk of suicide include dichotomous (all or nothing) type thinking (Asarnow & Guthrie, 1989; Rotheram-Borus, Piacentini, Miller, Graae & Castro-Blanco, 1994) and negative biases in future judgments (Pfeffer, 2000b; Williams & Pollock, 2000).

Unfortunately, the psychological construct of cynical distrust, although exhibited frequently by suicidal adolescents and often confused with depression, has not been well served by researchers. There is a paucity of investigation into this isolated small construct that in every day life has the ability to impact whole-of-family, and whole-of-life outcomes. Interestingly, the construct of trust, has recently become a whole-of government interest, whereby government bodies are requesting that creative methodologies be designed in order to ascertain how much confidence the population has

in them. A factor analysis method, similar to factor analysis methods used in psychology to measure intelligence quotient (IQ), has been designed to quantify trust (Killerby, 2005). This interest has developed from a belief that trust in others is an important indicator of community wellbeing. The Ministry of Social Development Social Report (2005), suggests that this psychological construct facilitates co-operative behaviour, and contributes to people's ability to develop positive relationships with others. Of particular interest in this report is that Maori are considered to have the lowest scores for feeling that people could be trusted, yet earlier in the same publication (and in Figure 1.1. of this thesis), Maori are reported as having the highest levels of perceptions of safety.

Trust however, is an abstract concept that seems to provide a foundation for an array of attitudes, feelings, behaviours and relationships. Cynical distrust may indeed be partly responsible for the reported negative interactions that frequently occur between welfare benefit case managers and their young clients. Often gatekeepers, who are key individuals in assisting adolescents obtain better life outcomes, become the targets of youth directed distrust and hostility. Gatekeepers include WINZ case managers and school teachers. As distrust and cynicism toward adults is seen in the literature as a barrier to accessing appropriate help when an adolescent may be suicidal, there appears to be a need for a screening tool that is able to measure an IYB client's level of cynical distrust. Gould, Greenberg, Velting and Shaffer (2003), suggest that screening for at-risk youths has provided promising suicide prevention strategies.

Screening tools and measurements to assess help-seeking barriers or suicide proneness have increased throughout the last 15 years (Lewinsohn, Garrison, Langhinrichsen & Marsteller, 1989; Reynolds, 1990; Reynolds, 1991; Scott & Cabral,

1998; Smith & Crawford, 1986.) More recently, Kuhl, Jarkon-Horlick and Morrissey (1997) constructed an instrument that would measure barriers to help-seeking behaviour in adolescents, and Lewinsohn, Langhinrichsen-Rohling, Langford, Rhode, Seeley and Chapman (1995) developed a scale to assess adolescent life-enhancing and life-threatening behaviours (Suicide Proneness Questionnaire/ Life Attitudes Schedule). The Child-Adolescent Suicidal Potential Index (CASPI) developed by Pfeffer, Jiang and Kakuma (2000a), has a reported 70% sensitivity level in distinguishing between suicidal and non-suicidal behaviour, focusing particularly on measurement of depression, anxiety and hopelessness.

For clinical samples of suicide attempters, numerous scales have been developed that aim to predict which patients may engage in a fatal attempt (Bagley & Greer, 1971; Beck & Steer, 1989; Buglass & Horton, 1974; Motto, Heilbron & Juster, 1985; Myers, 1991; Pallis, Gibbons & Pierce, 1984). These scales focused on general predictors such as living alone, gender, alcoholism, reasons for living and commitment to non-rescue during an attempt. Beautrais (2004) examined data drawn from a five year study of 302 individuals making further medically serious suicide attempts, noting that none of the features that were targeted in the previously mentioned 'predictive' scales, were found in her study to be associated with either suicide or suicide attempts. An explanation may be, she suggests, is that the 302 sample involved high-risk individuals, and the factors that predict suicide repetition in lower-risk samples, might lack predictive ability in high-risk samples. For researchers constructing a new psychological scale or test, Beautrais (2004) emphasizes a pertinent issue that there is a need for scales that are assessing suicide

potential to be tested using criteria derived from the population to which these scales will be applied.

Data obtained from the original 2029 IYB applicants from this study, plus data analysed from the retrospective file audits of 6 deceased and 36 living controls, plus interviews with 200 young adults who were part of the prospective study, indicated that it would be useful to develop a screening tool that measured the negative affect that sometimes appears in youth as hostility, sometimes as anger, sometimes as overt beliefs regarding the untrustworthiness of others. The psychological construct of "cynical distrust" seemed to encapsulate such negativity.

In 1989, Greenglass and Julkunen published the results of a factor analysis of the Cook-Medley Hostility Scale, and argued that nine of the items could be conceptualized as a dimension of the more global construct of hostility, which they labelled as Cynical Distrust. The particular reason that they were interested in this scale was because they argued that it was this type of dimension that was critical in Type A behaviour, and the link between Type A behaviour and heart disease. The scale, however, seemed to tap a dimension that may be relevant to disaffected young people and the accounts of their world views that they sometimes provided in clinical contexts. Similarly, in popular reports of the characteristics of such young people as Harris and Klebold, responsible for the Columbine High School shootings in Colorado, USA, it is this sort of negativity and general distrust of others that seem to be a prominent feature.

It also is apparent that for many young people, good social supports are an important factor in coping with stress and maintaining positive adjustment and mental health. Study 2, of this thesis has already mentioned that the importance of the

availability of at least one trusted adult person in their environment, is highly significant in reducing the at risk status of young people who are experiencing difficulties. Thus, one could imagine that a set of affectively-laden beliefs regarding the untrustworthiness of others would be especially counter- productive for young people.

In order to explore the cynical distrust construct with a population of young people in New Zealand, Evans and Fitzgerald (2003) made minor modifications in the language of the Cynical Distrust scale. The construction of the scale was of Pakeha (European) orientation, it was not bi-lingual, nor had there been an opportunity to work in partnership with Maori consultants, to ensure cultural sensitivity to either the wording or conceptual framework of the scale. Evans and Fitzgerald (2003) did establish that items 1, 2, and 7 represented distrust of others, and the remaining items represented a cynical view of human nature and individuals' motives. They also reported the correlations between the total scores on the Cynical Distrust Scale and the adolescents' scores on the Beck Depression Inventory-11 (Pearson $r = .56$, $p < .01$, two tailed), and the Tennessee Self Concept Scale (Pearson $r = -.44$, $p < .01$, two tailed). Consequently, they reported that the higher the cynical distrust score, the lower was the young person's overall self concept and the higher their BDI score.

The school cohort from New Plymouth consisted of 324 students. The participants were male and female high school students selected from a number of different high schools in the Taranaki region of New Zealand. Although this area may not have been totally representative of the New Zealand youth population, it seemed to researchers (Evans and Fitzgerald, 2003) to be a reasonable sample of young people in this country. New Plymouth is a small city with a mix of urban, suburban and rural dwellers; the

ethnic distribution of the population is similar to the country as a whole, and the mix of private (church) and public schools allowed for some variety in family background and demographics. Students were rewarded for participation in the overall study with small vouchers that they were able to exchange for items from the school tuck shops. Consent to carry out the survey was first obtained from the school boards and principals, then from parents, and finally the young people themselves were told that their participation was voluntary. The New Plymouth project was approved by the Human Research Ethical Review Committee of the University of Waikato. The Cynical Distrust scale and other scales assessing depression were administered to the school cohort.

I now report on the findings from two data sets, i.e., the school population studied by Evans and Fitzgerald (2003), and the 200 ex-IYB cohort previously described in Study 3, of this thesis. It was hypothesised that IYB applicants who had attempted suicide would score highly on the cynical distrust scale compared to those who had not attempted suicide.

Method

Measurement. The cynical distrust test containing nine questions that were rated on a five point Likert scale had a possible cynical distrust total score of 45. The higher the score, the higher the level of cynicism. This test appears on the final page of the outcome questionnaire in Appendix B of this thesis.

IYB participants. Following the previously described structured outcomes interview, 200 ex IYB young adults were asked to rate 9 items on a Likert scale ranging between 1-5. Each participant recorded their gender, ethnicity and age. The researcher

read aloud each item while simultaneously allowing the participant also to view the recording sheet. The subjects' responses were documented by the researcher. No explanation was given to the subjects regarding cynical distrust, nor did the test sheet indicate the name of the test. Previous to both the structured interview and the administration of the 'Cynical Distrust Test', subjects had been advised of the confidentiality clause, permission to exit clause, the complaints procedure, and optional support referral pathways if required.

Analysis. All questionnaires from both the school population and the IYB population were hand scored and entered onto a spreadsheet for subsequent analysis by means of SPSS-13 programme. Descriptive data and independent-samples t-tests were conducted. Data were checked for accuracy and were verified.

Results

Results from the IYB population. Data from former IYB applicants who constituted the prospective research cohort indicate that those applicants who had attempted suicide had higher cynical distrust scores than those who had not, see Table 4.1, $t(19.759) =$, $p<.001$. Table 4.1, shows that there was a large difference between cynical distrust mean scores when suicidal behaviour was involved.

Table 4.1

Cynical Distrust Scores for IYB Participants Who Attempt Suicide and Who Did Not Attempt Suicide

	N	Mean	Std. Deviation	Std. Error Mean
Total score for those who attempted suicide (DAS/GAS)	100	38.81	4.865	.487
Total score for those who did not attempt suicide (DNoAS/GNoAS)	100	23.97	5.722	.572

A pattern emerged from these results, suggesting that irrespective of whether a benefit was granted or not, IYB applicants who had engaged in suicidal behaviour, reported significantly higher levels of cynical distrust. The IYB cohort was not expected to provide data that fitted neatly in to a normal distribution, so when cynical distrust score distributions were presented, and compared with the high school cohort, two very distinct profiles were observed as shown in Figure 4.1. and Figure 4.2.

The cynical distrust scores for all four of the IYB groups could be compared to the normative data obtained from the typical high school student sample. In each case, the mean score for the IYB groups was higher than for the school sample. However, Levene's test for equality of variance indicated that the distributions for the two cohorts were not equal. Thus no further statistical comparisons were made. The large absolute difference in scores raises intriguing possibilities for future research, however, the

present data will need more careful and thorough analysis before firm conclusions can be drawn.

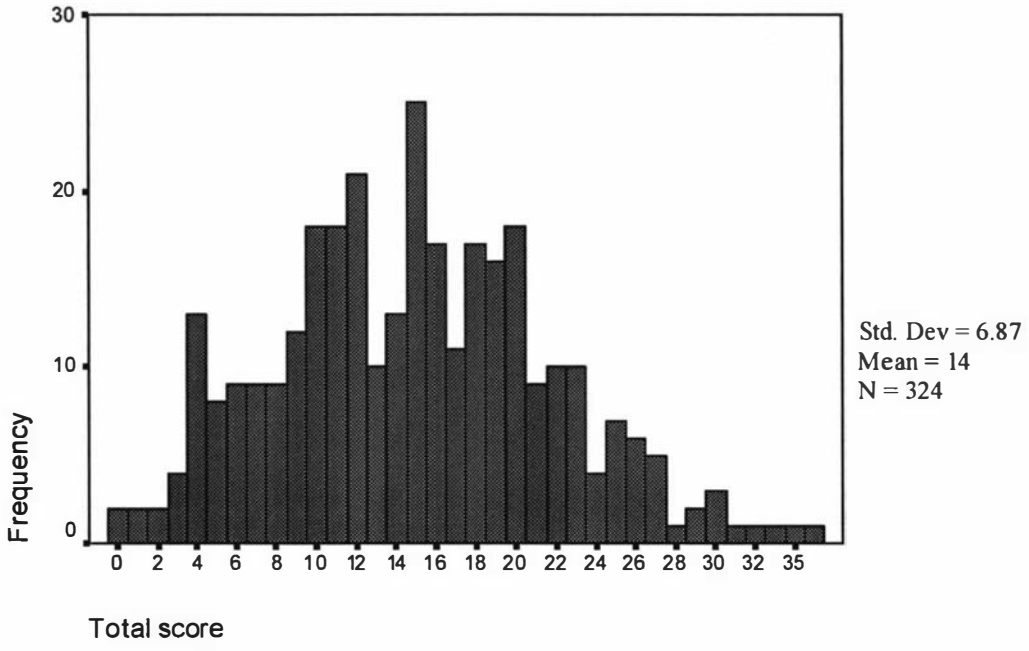

Figure 4.1. Total Cynical Distrust score distribution for 324 high school student.

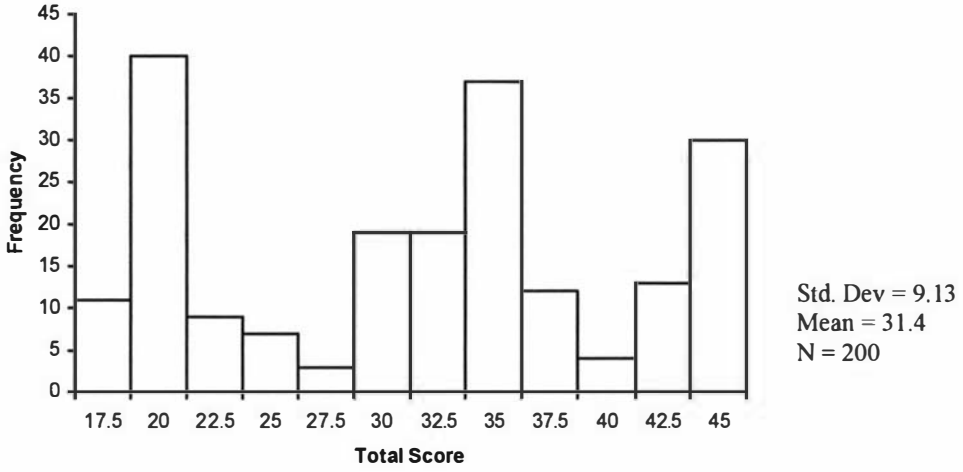

Figure 4.2. Total Cynical Distrust score distribution (Tri-modal) for IYB cohort.

Figures 4.1. and 4.2., represent the variations across two separate cohorts, one displaying a normal distribution from school students, the other showing an unusual, three peaked, or tri-modal combination. Although literature has suggested that there can be potential problems with skewed, non-normal distributions (Pett, 1997), given recent research with non-normal data (Pallant, 2001), it will be important for future research to consider the theoretical framework behind these results, and match to the understanding of the uniqueness of the IYB population. Many scales used in psychological studies have scores that are skewed, which simply reflects the nature of the construct being measured. Some authors (e.g. Tabachnick & Fidell, 1996) have suggested that when studying skewed data, (often appearing in studies of depression or anxiety), the scores be "transformed" statistically. This mathematically modified formula was not attempted in this study

Discussion

It was not within the scope of this thesis to conduct more than a preliminary investigation into the use of the Cynical Distrust Test. This tool is user-friendly, short, and appears to have the potential (with further psychometric exploration), to assess cynicism. Results indicated that the IYB applicants who engaged in suicidal behaviour scored extremely high on this test measuring cynical distrust. This scale looks promising and it will be interesting to conduct future research that examines further psychometric properties of the scale.

According to Evans and Fitzgerald (2003), the Cynical Distrust Scale, modified for use with New Zealand adolescents, seems to represent a useful measure of young

people's hostility. The population of school students that they studied showed a good distribution of item scores and overall scores that provided an adequate representation of the overall construct. These authors suggest that the construct represents distrust of other people's motives and the overall cynical distrust score correlated quite highly with Beck Depression Inventory (BDI) scores. It appears that with this initial research that when young people have a cynical view of others; they are not likely to rely on outside help for social or emotional support. It has been suggested by Evans and Fitzgerald (2003), that in the absence of such support, it would be expected that young people who experience depression for other reasons, are less likely to be able to rely on others for the sorts of corrective feedback that might mitigate a depressed mood.

From both data sets (the school and IYB cohorts) it appears that this scale has utility in identifying young people that have a pessimistic view of human nature and are distrustful of people's motives. A limitation is that this tool was not designed to integrate the specific language or spiritual considerations of a bi-cultural country such as New Zealand. It was constructed as a simple generic tool that could quickly supply information to a youth worker, case manager or school counsellor as to the level of cynical distrust held by the interviewee.

What new knowledge has this study added to the literature? Firstly, there is a clear understanding that when youth have family connections damaged, when they self report unresolved anger, hostility or symptoms of depression, and they have engaged in suicidal behaviour, they may show high levels of cynical distrust. This study showed that those who attempted suicide had higher cynical distrust, but the association between these variables needs further testing.

This study expanded the development of a modified diagnostic tool that can be built on by those working with suicidal and at-risk youth from multiple problem backgrounds. The Cynical Distrust Test, considering its infancy in psychometric validation, seems to measure a psychological construct that appears less with non-suicidal youth, and more with suicidal youth who are disconnected from their families.

Data provided from the structured interviews held with 200 prospective research participants prior to the 'Cynical Distrust Test' being administered, indicate that unresolved anger is frequently described as including the psychological constructs of aggression, cynicism, distrust of adults, hostile feelings over parental rejection, and irritability regarding continued exposure to familial domestic violence and conflict. A literature search found that there is extremely limited research that examines the influence of cynicism or distrust on suicidal behaviour.

The scope of this paper cannot reach the robust enquiry of population based studies; neither can the scope include investigation of all the risk factors associated with suicide, or provide evidenced-based comment on the debate over cultural relevancy or validated authenticity of western mental health diagnoses for indigenous people. However, it is possible that from our small sample of 6 deceased and 36 living controls as outlined in chapter 2, one mental health concern can be targeted, i.e., unresolved anger, and a possible component of that construct termed, 'cynical distrust'. By defining this emotion as a 'psychological construct,' cynical distrust can be identified and may be measured in young people at risk of self harm, by those working with the IYB population.

Suicide ideation is a barrier to seeking help (Saunders, 1994). As research indicates that suicidal issues reduce adolescent ability to seek help, the cynical distrust screening tool may be a useful measure for school counsellors, youth workers or WINZ case managers to use in identifying clients who may need additional support in seeking appropriate referral trajectories. As females seek help more than males (Kuhl et al., 1997), it would be wise for male clients to be actively monitored to ensure referral options were explored and activated. It also appears that the concept of help-seeking is a culturally determined behaviour. This opinion has implications for Maori males in particular. The cynical distrust tool does little to indicate if problem responding predicts actual help-seeking behaviour or whether adolescents with distressing problems simply seek help less.

The findings of this study support the evidenced-based literature that suicide prevention strategies should be aimed at the early recognition and treatment of mental illness, irrespective of the etiology or the multiple adverse life circumstances that may have led to such a diagnosis. Future research is required to assess whether extremely elevated levels of cynical distrust contribute to a diagnosis of mental illness, whether this psychological construct is a predictor of suicide risk and whether the construct is indeed definable and measurable.

Currently, the scale requires further validity testing (face, content, criterion and construct), in order to ensure that the scale measures what it is supposed to measure. Convergent and divergent validity tests also will be necessary to ensure that if the scale is used with IYB applicants, the data from it provides information that will facilitate meaningful judgments about ensuing interventions. Reliability tests will need to address

the issue that the scale is free from errors of measurement, and that there is internal consistency, test-retest reliability, and inter-rater reliability. If the scale is to be used as an outcome measure it must be sensitive enough to detect change in the IYB applicant post intervention. Contingent upon further research aimed at developing the 'Cynical Distrust Test', there is a strong possibility that this instrument may provide a useful indicated and/or selected screening tool for counsellors, case managers, teachers and youth workers who interface with those at risk of suicide.

Conclusion

Based on the archival data retrieved from the files of 2029 IYB applicants and described in detail in Study 1, it is known that for this cohort of welfare seekers, 55% often thought about ending their life and 30% of them actually made a medically serious attempt prior to coming to Work and Income. They are a population of hurting adolescents who present with varying negative emotional states. No wonder, when 39% have been bullied, 56% beaten, 16%sexually abused, 86% emotionally abused, 17% put into foster homes, 72% raised in a single parent home, 70% had no school qualifications and 49% lived in benefit dependent homes.

These young people belong to a cohort where negative emotional states are frequently maintained over time. The outcome study (Study 3), showed that youth who had attempted suicide and were declined welfare assistance had very poor life outcomes compared to those who had attempted suicide and were granted the IYB. The

implications of this finding are important to WINZ case managers who are assigned the responsibility of assessing whether the applicant should proceed through the system.

Findings support the notion that suicide risk is increased by a combination of negative emotional states, especially when these emotions have existed over an extended period of time (Kovacs et al., 1993). Cynicism is a negative emotional state that may well be the combination of both anger and depression. Further research is required for the development of assessment tools that can identify the emotional precursors to suicide. Cynicism may be one of those precursors that are identifiable through this measurement tool. Two data sets have provided an interesting validation of this scale. It appears to have good criterion related validity, and could be a quick, user-friendly screening tool for cynical distrust, that has promising potential.

SUMMARY OF EMPIRICAL FINDINGS FROM OVERALL THESIS

This research has provided new evidence to the existing knowledge platform around New Zealand youth who apply for welfare assistance. I have approached the research from the perspective of the scientist-practitioner model with the appreciation that practicing or teaching psychology is not necessarily the same as applying research skills, with real people, and producing robust results. Consequently, I have attempted to bring together the academic, culturally responsive skills of the practitioner, combined with well grounded theoretical paradigms, in order to communicate clear learnings for utilisation with youth who are homeless, and at risk of suicidal behaviour.

My purpose in conducting this research was to raise evidenced-based awareness around a population of welfare seeking young people, to offer suggestions for best practice in working with this group, and explore a series of myths that had clustered around those who apply for benefits. What I found was that the literature focusing on this population, both nationally and internationally, was scarce. From the 2029 young people studied in my research, new knowledge has been added to the literature that (a) showed the profile of youth applying for benefits (b) identified factors that were related to benefits being granted (c) provided risk variables for welfare seeking youth who may go on to suicide (d) offered previously un-researched information on the outcomes for those who were both granted and declined a youth benefit, (e) explored a personality trait often observed and reported in youth that may have implications for suicide prevention, and (f) added to the development of an assessment tool that may identify an emotional precursor to suicide.

The transition between school and work is often difficult for groups of adolescents who have grown up in multiple problem families. There will always be a small percentage of young people who require welfare assistance as they move through this transition. However, the simple fact remains, 'life rewards action', and unless there is sickness or severe psychological barriers, most individuals will attain more positive life outcomes if they have connections within the work force. To find a connection with family or other caring adults, to appropriately attend to mental and physical wellbeing, and to hold a valued, safe place in the community, is a goal that assists individuals to move from dysfunctional backgrounds to positive life outcomes.

A crucial goal for parents, teachers, communities and government is to enable young people to find their vision. Visions are actualized through activity. Employment needs to be viewed by youth as a positive life activity.

'A vision without a task is a dream,
And a task without a vision, is drudgery
- but a vision with a task can change the world'

Black Elk, Indigenous American novelist.

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APPENDIX A: CONCLUSIONS AND RECOMMENDATIONS TARGETING FAMILIES, SCHOOLS, POLICY ADVISORS, AND SUICIDE PREVENTION PERSONNEL

Social policy affecting the young has generally been driven forward without hearing from the young. The following conclusions and recommendations emerged from the qualitative research conducted with 200 ex-IYB applicants. Clinical observations and comments from participants addressed "gaps" and required "resources" across suicide prevention, welfare reform, and advocacy across whole-of life, whole-of-community, and whole-of-government.

Wolf (2004), recently published a comprehensive and timely paper advising researchers that they can fail to be 'policy relevant' when their research pays too little attention to the 'why' and 'how' of policy change in the real world. The following series of recommendations were developed out of extensive data collected from 200 young adults who, in previous years, had applied for welfare assistance. The 'whys' for policy change were established in the empirical-based body of this thesis, and the 'hows' are written into these recommendations.

For coding and collating of this qualitative data I used a psychologist, a psychology graduate and a senior policy advisor, to conduct inter-rater reliability checks on 5% of responses Five themes or 'target areas' emerged from a series of questions that had been asked of the research participants during the outcome questionnaire. These questions were;

What factors aided family reconciliation?

What were the barriers to family reconciliation?

What areas for improvement did you see in the welfare application, assessment and/or follow-up process?

What resources did you find useful during the welfare application, assessment and/or follow-up process?

What gaps did you see in the welfare application, assessment and/or follow-up process?

What positive influences from government, family and personal perspectives had an impact on best outcomes in your life?

What negative influences from government, family and personal perspectives had an impact on outcomes in your life?

Remembering your suicide attempt, what were three things that led you to take such drastic action?

Remembering your suicide attempt, what three factors stopped you completing suicide?

How can government policy advisors, communities, professionals and families help to reduce suicide attempts in young people who need to apply for welfare benefits?

All of the participants' suggestions and recommendations were categorised into 5 themes or target areas. The final 5 target areas were;

A. Targeting families, including sole parents and children of prison inmates.
B. Targeting schools and their impact on suicidality and advocacy.
C. Targeting suicide prevention and bereavement.
D. Targeting child and family advocacy through both public policy and building community capacity, i.e., the 'Institutionalisation of Advocacy'.

E. Targeting the current Independent Youth Benefit (IYB) national criteria for evidence-based best practice standards, eligibility, assessment procedures, intervention protocols, monitoring, management and evaluation systems.

A. Targeting Families and Sole Parents on Benefits

Mandatory attendance for ALL parents (including those on benefits), at NZQA accredited parenting courses where financial and qualification incentives are offered.

The majority of the research participants in this prospective study with 200 subjects were extremely vocal on 'issues of parenting' and the need for schools, community organisations and government to work together to give 'pre-parent' courses on how to raise kids without violence and double standards, and to offer courses on how to parent effectively for adults who already have children. Their opinion is backed up by evidence provided in the literature.

What we are as adults is determined by what we experienced as children. Our society reflects our child rearing practices. Simply, we sow what we reap and our national indicators of wellbeing, connectedness, safety or violence, represent the thoughts and priorities of the elected government. In Britain, parents can be held legally responsible for their children's illegal behaviour. Fines and attendance at specified parenting programmes have become mandatory. Coleman and Roker (2001) present sound argument that parents of multiple problem teenagers require different types of parental support due to the volatile nature of challenging teen behaviour and parents isolation from other parents of matched-aged offspring.

New Zealand has witnessed increasing media and political attention to family functioning with the Care of Children Bill, the Civil Union Bill, the Agenda for Children Initiative, the New Zealand Bill of Rights Act, the Strengthening Families Policy, the Children Young Persons and their Families Act 1989, the United Nations Convention on the Rights of the Child (UNCROC) principles, and the recent attention to repealing the Crimes Act 1961 that allows parents to hit their children. It seems a sensible step for the New Zealand Government to provide legislation promoting mandatory attendance at parenting courses in order to provide parents with skills at various developmental stages.

Currently in New Zealand, we put more value on training to drive a car, than training to raise a child. Longitudinal New Zealand studies have found that sole parenthood is the strongest predictor at birth for a range of problems exhibited by teenagers. (Mayer, 2002; Rich, 2003). Multiple problem families however, are woven throughout the social, cultural, educational and financial tapestry of our population

Adverse family life is implicated in poor outcomes for children involved within these families. Most parents want to provide the best environment for their children, but unfortunately, lack the education and skills to provide environments that will encourage and facilitate positive life outcomes. The New Zealand Government has an opportunity with parents on benefits in particular, to ensure that those in receipt of government benefits are accountable for their funding by attending a series of training programmes that concentrate on parenting skills, management of child behaviour and training (Dawson, 2000; 2002; 2003).

All parents/caregivers of children under the age of 16 will benefit from such training. The government has an opportunity to introduce new legislation requiring that a

parent/caregiver license be compulsory for those about to give birth, contemplating establishing a family and for those who already have children under the age of 16. This legislation would be similar to legislation already existing for drivers' license application. Professor Alex Mabe has produced a package that develops the existing strengths and skills of parents. This video package is available through the Werry Centre (Auckland University) and is able to be used by both non-government organisations and government agencies to enhance existing parenting skills. The content of this programme is evidenced-based and developed to improve outcomes for children and their parents.

Research offers a caution .Legal changes alone have minimal affect on parenting behaviour, especially when the law does not reflect the social and economic reality of how families live (Atkin & Black, 1999; Barlow & Duncan, 2000). Financial and qualification incentives are imperative motivators required to trigger change. Government coffers would ultimately benefit by decreases in child abuse, domestic violence, criminal and drug activity.

New Zealand is one of the most violent countries within the OECD countries. In Sweden, where violence towards children was outlawed 25 years ago, their death rate of children dying through violence was reduced to 15 deaths across the last 25 years. However, in New Zealand, where we allow our children to be beaten, we have watched as 235 children have been violently beaten to death in the last 25 years. Homicide is the third leading cause of death for those aged 0-14 years in New Zealand, coming closely behind drowning and motor-vehicle accidents.

Recommendations from research participants regarding 'adult' behaviours that aid family reconciliation.

The parent needs to provide a safe environment, free from domestic violence and abuse.

The parent has a sense of humour and can initiate family 'fun' times together without drugs and alcohol.

The parent provides unconditional aroha (love) with NO broken promises.

The parent is available both physically and psychologically.

The parent has the ability to listen before judging.

The parent has unconditional acceptance but has clearly outlined boundaries.

The parent is able to model honesty.

The parent is able to say that they too make mistakes and can apologise.

The parent can move past the mistakes of their children, refusing to regurgitate the 'incident of conflict', at each ideal opportunity.

The parent to introduce 'new partners' into the family home gradually and only when the children feel safe in the company of the new partner.

The parent not to be continually stressed by poverty.

The parent to provide a crime free environment.

Recommendations from research participants on accredited training courses for 'parents of adolescents'. Subjects indicated that there seemed a plethora of parenting courses to teach parents skills in interacting with young children and babies, but a paucity of endorsed, practical and community credible parenting skills programmes that address specific teen and young adult issues. Coleman & Roker (2001) have addressed this

criticism by providing a useful resource for professionals working with parents of youth who are similar in profile to youth who often exit home at an early age i.e., the IYB population. Attention has been paid in their handbook to two crucially important issues that are often neglected in community training programmes, those issues relate to privacy and stigma.

Names of biological fathers need to be recorded on birth certificates and made available to young people unless exceptional circumstances apply. All of the young people in this research cohort who died by suicide did **not** know the identity of their biological father. This has serious implications for rangatahi (Maori youth) in particular.

Children of criminals to be "targeted" for "early" additional educational and psychological assistance and 'tracked' to provide trajectories to successful life outcomes.

Tracking and targeting can prevent children from becoming criminals like their parents or following a pathway of intergenerational welfare dependency. Literature provides evidence that relatively accurate predictions can be made identifying risk factors that may lead a child into offending behaviour. Care must be taken not to stigmatise these children, however, if special services are provided from nappy to teenage years, where parents become an integral part of the programme, (e.g., sports, drama, art), successful outcomes are achievable.

Provide greater funding for restorative justice initiatives set within a culturally competent framework. A small number of the 200 ex-IYB cohort interviewed (7 individuals, all from the declined IYB/attempted suicide sub-group), had spent time in detention. All knew off the restorative justice process and they believed it to be more useful than prison placement in influencing positive life outcomes. Prison placement is

known at times, to be conducive to teaching young offenders skills in becoming better educated in criminal activity. Restorative justice strategies have been shown to be effective in shifting young people from lives of criminal behaviour to lives where they have mentored other young people who are beginning a life of crime. Bruce Parr's restorative justice practices in Wanganui have provided alternatives to conventional sentencing without standing results. He reports that between 90-92% of clients who work through their restorative justice system are non-reoffenders. (Hewitt, 2004).

Caution recommended from research participants with regard to fast or drastic changes to the current benefit system. Many research subjects shared a similar concern that no parent or caring adult was available to them when they needed adult contact the most. Many reported that the hours from 3.00pm to 6.00pm was the time where they engaged in high risk behaviours as no caregivers were around. Interestingly, almost all of the suicides retrospectively studied, occurred during these hours. It seems sensible that in changing the eligibility criteria for benefits for sole parents or for IYB applicants, graduated schemes might be examined combined with robust research facilities being made available in order to assess the outcomes of such change. It may well be that in an effort to get more parents into the workforce, thus pushing more children, and younger children into childcare, in time the government may be creating a new problem for itself. Longitudinal outcome research studies are an essential investment for government, as are skilled scientific-practitioner researchers who are able to advise and work in evidenced-based decision partnership with the crown.

Targeting alcohol abuse and family violence. A common factor in family violence, both exposure to and witnessing of violence, often involves large consumption

of alcohol. Ex-IYB applicants emphasised the need to examine ways in which alcohol abuse can be addressed by government in a similar legislative manner as has occurred in the anti-smoking campaigns. Research participants were not able to offer suggestions of how this could be done, but a common theme was expressed by this group that alcohol and domestic violence had been the most powerful triggers that induced family breakdown, abuse and poor life outcomes.

B. Targeting Schools

Develop the 'No Hits' (Non-Offending Healthy Interactions Training: (Dawson, 2001) programme nationally throughout New Zealand schools. No research participant reported that being hit was a useful strategy in developing good relationships at home. Literature supports that the acceptance of violence and abuse as an option to control the behaviour of others, develops in young children within the home setting. It is imperative that if we are to stop the growth of domestic violence offending and abuse throughout this country we must introduce programmes into both primary and secondary schools that give children specific tools so they can choose non-violent healthy interactions, which will lead to greater positive life outcomes for both themselves and their children. In supporting this initiative schools need to be out spoken and leaders in repealing Section 59 of the Crimes Act 1961 whereby parents are afforded legal license to use violence toward their children but would breach the law if those same actions were used against adults. The children and young people of New Zealand must not only be taught the 'No Hits' tools, but they also must be trained in appropriate help-seeking behaviour so they

are able to access adult support in keeping safe, both at home and at school, from both school bullies and home bullies.

Young adults surveyed in the prospective research study as well as evidence based literature, constantly report that family conflict is the most powerful precursor to suicide attempts (Spirito & Overholser, 2003), and a common trigger that forces young people to leave home and seek welfare assistance.

Review Anti-bullying programmes in schools for teacher and peer bullies. Data from this study and a review of the literature indicates that negative life outcomes have been impacted by bullying both from peers and teachers within the school setting. It is imperative that before any anti-bullying programme is introduced into the school curriculum that all school staff have been trained in zero tolerance of bullying and are prepared to model the tenets of the programme. There is a strong association with bullying and suicide. Also, there needs to be an acknowledgement that students often promoted by teachers as paragons of exemplary behaviour (i.e., prefects, sports captains), may indeed be the most powerful of the school bullies (Hewitt, 2004).

The Anti-Bullying Handbook authored by Keith Sullivan (2000) and the School Anti-Violence Toolkit written by the Post Primary Teachers' Association (2004) provide excellent resource material for primary and secondary schools. Recent attention has been directed at female to female bullying (Simmons, 2003), that tend to include different bullying behaviours than exhibited by males.

A recent Australian initiative (i.e., reflective suspension), has noted successful outcomes for both bullies and their targets, when 'internal suspensions' rather than 'external suspensions' have been implemented within school settings. External

suspensions tend to 'reward' bullies by giving them time off school whereas internal suspensions encourage bullies to stay at school, spend time in reflective counselling while concurrently being refused contact with other students. A further very recent anti-bullying initiative occurring in March 2005 in Australia incorporates the use of school computers where any target of bullying is able to email for staff assistance and be provided with immediate 'confidential' help. With 1:6 students targeted by bullies and 56% of 12-13 year old students feeling unsafe at school (Carr-Gregg, 2005) the Australian National Coalition against Bullying believes that more students will report bullying if anonymity is assured. The unspoken rule for being 'accepted' at school is, 'thou shalt not dob', but for personal wellbeing the rule must be, 'tell, tell, and tell'. Emailing complaints facilitates confidentiality and addresses the 'dobbing' issue. The website (date 14.03.05), ninemsn.com.au/today for bullying, also records data indicating that bullying behaviour is learned at home. As empathy is learned in childhood and in the home, Mary Gordon's 'Roots of Empathy' programme is a useful resource in reducing pro-active aggression. Her research has shown the inverse relationship between empathy and aggression and there is emphasis on the monitoring of peaceful interactions and developing co-operative behaviours.

Establish national mentoring programmes. Of the 2029 individuals who applied for the IYB between 1995-2001, those who had the most positive outcomes following placement on a benefit, were those who were encouraged by a mentor or caring adult to go back into school, training or work placement. This group of welfare recipients spent a shorter time span on a welfare benefit. These successful individuals reported that access to a mentor or caring adult who supported their transition from home had significant

positive impacts on their trajectory to success. National mentoring programmes are seen as a useful service provision that will enhance wellbeing, and reduce long duration welfare dependency for New Zealand youth (see paper by Evans, Dury and Dawson, (2005) in 'Handbook on Youth Mentoring').

Child Safety Officer appointed for each educational region. With escalating suspension and stand-down trends (Collin, 2001), as well as increases in serious bullying behaviour (Nairn & Smith, 2002), it is recommended that each education region within the Ministry of Education appoint a Child Safety Officer who has responsibility to assess individual school commitment to zero tolerance of bullying, to advise on appropriate practical intervention and to monitor the safety of children. The Child Safety Officer would also be a registered child advocate and be available to represent students and parents involved in suspensions. This position must have the same authority to implement change in a similar manner to the powers held by those in the Education Review Office (ERO) and staff members from Child Youth and Family Services (CYFS). Children's voices must be heard within school settings and under UNCROC principles, must be involved in decision making and evaluation processes within school settings .Currently, there is an ad hoc commitment to anti-bullying programmes in schools and little recognition given to the culture of teacher bullying and discrepancies between schools over suspension rates.

- In 1998, 19.94% of students in New Zealand were Maori, yet 43.8% of suspensions were Maori students (Ministry of Education, 1999).

- Of the 2029 IYB applicants in this study, 70% had no school qualifications and 39% reported serious bullying while at school, (24% of the 2029 cohort were the perpetrators of serious bullying).

- 63% of suspended students report family conflict at home and 44% reported that their families had financial/unemployment issues (Overton, 1995).

- 80% of suspended students disclosed criminal prosecutions within their families. The most common reasons for suspensions are, physical assault, unresolved or uncontrolled anger, substance abuse or sexual misconduct.

- There is a strong association with suspension and welfare dependency (Hayden, 1997). Alternatives to suspensions need to be developed that have been designed by those who hold an evidenced based knowledge of interventions required for youth who have been marginalized, stigmatized, and/or have emanated from adverse life backgrounds and/or multiple problem families.

- Positive approaches to these problems have been observed at several New Zealand schools, Aranui and Papanui High Schools, Waimea College in Nelson and the Karori Unit in Wellington.

Gatekeeper training in suicide prevention for all school staff. Strong opinions were expressed by research subjects regarding teachers' ability to help vulnerable, depressed,

stressed, anxious or suicidal young people. Concern was also expressed over the lack of teacher knowledge around referral pathways when students had indicated to teachers that they needed help. Crawford, Geraghty, Street and Simpnoff (2003) outline major concerns over the lack of staff knowledge for professionals working with suicidal youth and Smith and Scoullar (2001) also document concerns regarding the lack of information that General Practitioners have about adolescent suicide and implications for primary prevention.

Other researchers (e.g. Wilson & Deane, 2001) have documented adolescent opinions about reducing help-seeking barriers and increasing appropriate help engagement. Their recommendations are:

- Teacher knowledge and attitude is crucial in reducing help-seeking barriers and increasing help engagement.
- Social problem-solving programmes need to be initiated through peer networks.
- Processes for engagement must be directed from the student's perspective.
- Cognitive student distortions (rumination, over-generalisations) are barriers to help-seeking and basic cognitive behavioural therapy (CBT) courses need to be part of the school curriculum so that problem-solving skills are as readily available to young people as reading or sports skills. Connelly (2001) provides step-by step strategies for dealing with cognitive distortions and conflict between parents and adolescents. Such evidenced-based suggestions are generalisable to school settings.

- Secondary students frequently have difficulty in building 'trustful' relationships in schools. Future research needs to examine how problems with trust can be identified and ameliorated within school settings.

The Ministry of Education (MOE) to provide evidence through independent researchers, of the beneficial or detrimental outcomes of MOE traumatic incident teams visiting schools following a critical event. Stewart (2004) suggests that when responding to a critical incident in schools, the first concern must be to do no harm (Primum non nocere). Some participants from Study 3 reported that the MOE teams coming into their schools were unhelpful and did not aid in the process of grief. Stewart (2004) provides an extensive literature review on the debate around this issue and questions why government has spent money contracting this work to Group Special Education (GSE) when there has been no robust evaluation of this service, when GSE staff have an educational focus and lack training in understanding the clinical nature of suicide, and users of this service have not been consulted as to its effectiveness.

Address research concerns on low decile rated schools and their association with increased student suicide risk. All of the deceased IYB applicants attended low decile rated schools and all had reported a negative perception of school. Research subjects from the 200 ex-IYB prospective study group who attended low decile schools reported that in these settings, there was a culture of bullying and drugs that school staff was unable to control. Fleming (2003) stated that lower decile of school was significantly associated with higher rates of suicide attempts with students at these schools having 3-4.5 times the suicide risk of students at the highest decile (least deprived) schools, even

when other risk and protective factors were taken into account. Fleming's research indicated that the three most powerful risk factors for suicide were;

1. Depressive symptoms
2. Attendance at a low decile school
3. Having a family member or friend attempt suicide.

Very little research has been done in New Zealand to explore the interaction between suicide attempts and low decile school attendance. Further research funding needs to be allocated to this area.

Training teachers in 'successful pedagogies' designed to reach needs of diverse learners. Seventy five percent of IYB applicants in the cohort of 2029 left secondary school without any formal qualification. The Queensland Government has introduced one of the most innovative strategies that enables teachers to reach students who have previously left school feeling failures. The NCEA standard units system goes some way to reducing the failure rate of student in New Zealand schools, however, the Queensland programme specifically examines the strategies teachers use to improve assimilation of learning. Detailed training is offered to both primary and secondary school teachers in successful pedagogies that are evidenced-based in meeting the need of diverse learners.

Child Protection Studies (CPS) training for "all" teachers. Sixteen percent of the 2029 IYB applicants involved in this research reported that they had been sexually abused. Many of those interviewed for the 200 subject prospective study, suggested that not enough was done by teachers at both primary and secondary schools to make students

feel safe enough to disclose their sexual and physical abuse. John Bailey from the Hamilton Ministry of Education is currently piloting a unique programme whereby all Hamilton school teachers are to be trained by CPS. This training equips graduates from the 6 week, part-time course with knowledge and skills that will enable greater protection for school children across the ages.

Support the 'Keeping Kids in School, Education and off the Dole' programme.

Over 80 Australian high schools have introduced a new plan to encourage students to sign a charter agreeing to stay at school or in education rather than going on the dole. For many, receiving the dole has been a tempting option, but follow up research of high schools implementing this programme has revealed incredible success. Graduates from all 80 high school were surveyed one year after leaving school, and all ex-students had kept their pledge to be in full time study or employment. Going on the dole was not an option for them. Students interviewed reported that when they signed the charter while attending school, they were then forced to think about what they would do if they were unable to achieve their first tertiary or employment option. Students had developed a plan B, which proved to be an effective strategy in reducing benefit dependency. When asked why signing a charter made such a difference, many of the students stated that they made a personal commitment and they had learnt the importance of 'cognitive rehearsals' of options. Students believed they had time to process options, form back-up plans and were saturated with vocational assistance and guidance while still in the safety of the secondary school setting. Napean High School in Sydney is an example of the success of this programme. Within that school there was close cooperation between industry and the

school environment with 'choices workshops' being offered regularly at school so students were exposed to a vast range of work experience offers. This no-dole project also offered personal individual counselling for students, lots of exposure to different work activities throughout the year, and lots of guest speakers coming into the school that enabled the students to widen their work choice and work options. This project seemed to have a powerful psychological effect in signing a charter and making a commitment to a planned life pathway. Napean High School in Sydney can be contacted for further details.

Schools to actively define their commitment to students' need for belonging in the school community. Many research participants maintained a sense of regret and failure that not only did they not do well academically at school, but also they never felt that they 'belonged'. Schools need to address three questions according to Osterman (2000). Is the experience of 'belongingness' important in an educational setting? Do students currently experience school as a community? How do schools influence students' sense of community? He suggests that students' experience of acceptance influences multiple dimensions of their behaviour but although recognition is often given to this fact in principle, unfortunately in concrete, operational and actualisational terms, the opposite applies.

C. Targeting Suicidality

Research participants recommend more doctors need better training in identifying immanent suicide risk. Several accounts were recalled where GP's offered little help to suicidal IYB youth and no referral pathways were suggested. Smith and Scoullar (2001)

provide a study on this crucial area where they assessed Australian GP knowledge about adolescent suicide. This research may be generalisable to the New Zealand setting

National Bereavement Centres recommended by participants. New Zealand needs to set up a national bereavement centre that offers support services throughout the country for two cohorts of the suicidal population. Firstly, for those who have made a previous suicide attempt, best practice guidelines must be developed to target both the attempter, and their significant others. Secondly, these support centres need to develop evidenced based strategies to work with survivors of suicide, i.e. the parents and friends of the suicide victim. Carlton and Deane (2000) have documented both barriers and trajectories toward seeking professional help within the suicidal population.

Research participants suggest the development of Police Protocols in dealing with youth facing impending legal/disciplinary crisis. Evidence from literature and documented IYB cases have revealed that threats made to vulnerable youth by Police (e.g. "you have half an hour to get home and tell your parents about the drugs found in your school bag"), can be the trigger that pushes an already frightened young person over the edge into then becoming a suicide statistic. Protocols of informing family or schools of a young person's misdemeanour must be re-drafted based on robust psychological evidence.

Ensure single and previous suicide attempters do not leave medical centres or are discharged from hospital wards alone or without a psychological assessment and/or a monitored safety plan. Anecdotal evidence obtained from the suicide attempters who were part of the 2029 IYB population studied, and reports from the 200 prospective research group indicate that the majority of IYB applicants who made a medically serious

suicide attempt, did not have a follow up treatment or safety plan available when they left the hospital ward. One girl reported, "I sat in the waiting area for five hours. I had no family to pick me up. The lady at the desk told me to just move on and go and find the friend that had brought me in. That had not been a friend, it was just someone from the party where I cut my wrists and took a heap of pills. I don't have proper friends."

Another girl reported; "I was sitting on the hospital bed. A doctor came and had a quick talk. He asked if I thought I'd be ok. I told him I'd be fine. I had no assessment, no one contacted my parents. I was told not to do such a stupid thing again as it was a waste of doctor time. When I was hospitalized the next time they told me I nearly didn't live. I saw a shrink that time."

Develop closer inter-agency, inter-disciplinary and inter-cultural ties, in order to address comorbid or dual diagnosis, and suicide risk. In New Zealand there has been no national commitment to the development of an inter-agency collection and publication data base for child and adolescent abuse, names of domestic violent offenders /recipients, or dangerous mental health cases. There appears to be limited research capability within Child Youth and Family Services, with Davies et al. (2003) suggesting that there is a serious lack of information to inform government policy and planning in this area.

Unite 'evidence-providers' and 'evidence-users' in actualizing a culturally competent mental health assessment and conselling service within the national IYB contract. For several years there has been a token acceptance of the Te Whare Tapa Wha model of assessing and treating mental health issues with Maori. Recently, a tool for the measurement of wellbeing among Maori has been developed. Homai te Waiora ki Ahau weaves together the constructs from Whare Tapa Wha, Te wheke, Nga Pou Mana and the

model provided by Te Roopu Awhina o Tokanui. The Treaty of Waitangi establishes that Maori are entitled to protection, participation and partnership. In terms of psychology, the treaty obligates mental health professionals to develop culturally appropriate tools and methodologies that are suitable measures of Maori psychological constructs.

Dr Stephanie Palmer (2004) describes wellbeing among Europeans (i.e., non-Maori) as involving a quality of life, a state of contentment or happiness, a sense of dignity and choice, genuine opportunity for personal control and self-determination, freedom from oppression and the right to participate in a safe, positive and functional society. Among Maori however, she notes that the concept of wellbeing was irrevocably tied to the resolution of land and sovereignty issues, balanced between the physical and spiritual realms and protection of Maori identity. In providing assessment protocols when working with young Maori youth and offering family reconciliation counselling which has been attached to the national IYB contract, it is imperative that assessors and counsellors employed to fulfil this contract, are trained in understanding the constructs of wellbeing and their relationship to assessment and counselling, for both European and Maori clients.

Provide funding to divert violence in young Maori males. Most cultures have domestic violence; however the media, prison reports and New Zealand's school expulsion rates indicate that young indigenous males are overrepresented in statistics on violent offending. Mita Mohi (Hewitt, 2004) reports success in redirecting anger in Maori males through his programme conducted at Mokoia Island, where he teaches the ancient skills of Maori warfare, but in a context of pride, spirituality, respect for life and peace. Ex IYB males who attended this training reported that the outcomes were extremely

positive and that attitudes and skills learnt within this setting redirected their life trajectory.

Improve standards of care in foster placements. Beautrais et al. (2001) offered a timely reminder of the elevated levels of suicide for people previously involved in foster care under the Child Youth and Family Services. The levels of reported abuse and suicidality in these settings are unacceptably high. If child and youth advocacy becomes institutionalised as recommended in this research and every town and city in New Zealand has a registered child advocate, then targeting foster care residence will be a critical component of the registered advocates work. Given the predictability of adolescents with mental health or behavioural problems not doing well in foster settings, we urgently need wider option placements for troubled adolescents. Barber et al. (2001) suggests those options need to include the residential facilities that most Western countries have been relentlessly closing down, as well as more family-based treatment options.

Develop a national multi-agency network data base naming attempted suicides. Making a previous suicide attempt is a predictive indicator of future suicide. No interagency database currently exists that is able to alert organisations such as the Ministry of Social Development or Group Special Education or Emergency Wards or Police to those who are at risk of suicide due to previous suicide attempts. There is also no present protocol available so that MSD clients who have completed suicide can be checked against the New Zealand Health Information Statistics database. Although it is important that privacy, confidentiality, and ethics are crucial considerations, an alert system must be devised so that when MSD case managers interview a highly vulnerable

young person, they will be alerted to provide an interview protocol that has previously been established advising on strategies to utilise when interviewing a highly vulnerable, sensitive and possibly suicidal youth.

It is encouraging to see that legal authorities are now beginning to recognise the need to apply differentiating codes of practice in disclosing private information on threats of suicide between school, family, and health professionals (Stewart, 2001). However, Stewart (2001) suggests that while we have made great advances in understanding risk factors (Hyde, Kirkland, Bimler & Pechtel, 2005), warning signs and symptomology associated with suicide, the application in preventing the cycles of violence that precipitate and perpetuate suicidality, remain inchoate.

Ensure suicide prevention strategies are indicated, selective and universal encompassing whole-of-government, whole-of community and whole-of-life. The 6 deceased IYB applicants were not protected by their families, their schools, their communities or their government. For them the Youth Suicide Prevention Strategy failed! It is important that research and prevention strategies are not just targeted to those who appear (due to risk factors) high-risk, but also adopt broad universal measures of prevention. Targeting only high-risk cohorts (such as IYBs who have previously attempted suicide, i.e., the 'ice-berg' phenomenon of treating the high-risk populations), is like sending wars ships to control ice-bergs by shooting off their visible portions, and nothing is done to address the other diverse risk factors. There is no doubt that the IYB population could be considered high-risk along with youth who have had contact with CYFS. They are a small cohort of New Zealand youth, who are considered high-risk. However, if government policies address the diverse range of those at risk, their needs to

be early intervention strategies across universal, selected, and indicated prevention initiatives. Government needs to fund researchers so that more valid screening measurements can be utilized with this high-risk population, particularly those IYB cases who are exhibiting a combination of the 7 salient risk factors described in chapter two.

D. Institutionalising Child Advocacy

Registered child and family advocates in each community, and city throughout New Zealand. Research subjects' and evidenced based literature indicates that abuse, suicidality, bullying, long duration domestic violence and child murder could have been prevented in many cases if an advocate had been available to an at-risk child or family. Access and connection to those who have the knowledge and power to change cycles of abuse has been a real problem in the New Zealand setting. Fear of statutory agencies or lack of knowledge on human rights, often has prevented help seeking behaviour within abused families. This recommendation to register child advocates and have at least one advocate available in each city and community throughout New Zealand, is achievable through Government legislation and is urgently required. Youth Advocates are presently available to represent young people charged with offending (Morris, Maxwell & Shepherd, 1998), however advocacy for children and families remains less certain and frequently, less accessible.

Rethinking children's rights to protection from violence. There was overwhelming agreement among research participants who had attempted suicide, that the key trigger to their attempt was exposure to violence either within their home environment or within the school environment. It has been estimated that it costs taxpayers $2.74 billion for Police

callouts to family violence and $141 million in health related costs associated with family violence (Dawson, 2003). It is recommended that where ever Police are called to a domestic violence incident, that children from that home are offered free counselling and are enrolled into 'Healing from Domestic Violence' programmes. Davies, Wood, and Wilson (2003), offer a comprehensive comment on New Zealand's performance in protecting its children from violence. These researchers also suggest that reduction in violence toward children requires changes in macro-level policies, as well as a combination of universal and targeted community-based prevention programmes. They further report that support, protection and rehabilitation rights of children caught up in domestic violence are not adequately recognised or responded to.

Extend sex offender treatment programmes currently aimed at adults and adolescents, to include young sexually reactive boys aged 6-12 years. Research subjects supplied anecdotal accounts of being sexually abused not just by adults, but also by siblings or older children. Of the 2029 cohort of IYB applicants studied, 16% reported sexual abuse. Although there are several treatment programmes for adolescent and adult sex offenders in New Zealand, there is currently only one treatment programme for 'children who sexually abuse other children'. A programme called 'Problem Wrestlers' is run by Parentline Advocacy Service in Hamilton and is offered to sexually reactive children aged 7-12 years (Flanagan & Dawson, 2004; Flanagan & Lamusse, 2000). It seems incongruent that when government spends millions of dollars on locating adult sex offenders, putting them through court and detaining them in prison, programmes such as 'Problem Wrestlers' is funded mainly through community donations. Early intervention in dealing with young sex offenders is a proactive measure in combating escalating rates

of rape, sexual assault and violence. CYFS recently published a small free publication, *Ending Offending Together*, noting that ¾ of sexual abusers start abusing before the age of 14 years. The Problem Wrestlers programme must become a national initiative with full government funding.

Agencies to share data on abuse and violence. Children may become the victims of institutional abuse because agencies lack the resources, the intent or the permission to share relevant information and network together. Silo funding mentality and protected patch syndrome has done little to help children exposed to domestic violence, sexual, physical, emotional or psychological abuse

Re-evaluate the advantage to NZ children of passing the currently morgued 'Review Child Mortality Bill'. A small number of research subjects mentioned incidents where either a baby/toddler had died due to what they believed as neglect (i.e. drowning), or incidents where they thought that a family car accident should have been classified as manslaughter, not as accidental death. Previous MP Bob Simcock had tried to introduce the 'Review of Child Mortality Bill' however this recommendation to government has not proceeded. In order to abide by UNCORC principles and to honour New Zealand's Agenda for Children it is recommended that this Bill be revisited in parliament.

Government responsibility in protecting children in foster care by listening to their opinions and involving them in decision making. Ex IYB applicants who had been placed in foster care all told similar stories of having no say in the decision making process that took them from their homes and placed them with strangers. They talked of multiple uncaring social workers, lack of counselling and poor access to the family

origin. Many of the research participants noted their sense of powerlessness in preventing the further abuse that occurred within the foster placement and many resented the lack of consultation regarding their removal from home. Several recommended that consultations with children should be documented and their signatures obtained showing that their voice was heard within decisions regarding their life outcomes.

Research indicates that children are likely to be more resilient to adversity if they are part of the decision making process. Children are disempowered when they do not understand why they are in care, who the professionals are in their lives and on what basis they were removed from their home. Smith (2001) states "Children are not just victims, who passively experience misfortune, their views are worth listening to and they are not simply passive recipients of welfare or adults actions and decisions" (page 3).

Ward (2000) confronts an issue that has been raised by numerous IYB applicants, i.e. why can't CYFS ex-foster home young people be better prepared for independent living? If fewer ex foster care youth are to by-pass the welfare system, it appears that 3 robust research investigations must be initiated to establish:

a. The extent to which foster adolescents are prepared and ready for life after care.

b. Evaluation of policies and programmes in place to support foster adolescents at mandatory discharge.

c. An examination of the extent to which the State as 'parent', compared with other countries, meets its obligations to prepare its young people for adult, independent life.

I am currently lobbying government to work with non-government organizations (NGO) in order to provide the 'SAFECATS' and 'COFFI Advocates' programmes to children and young people in government care. The acronym

SAFECATS stands for, Safe Advocates for Foster-kids in Every Court Appointed Situation, and COFFI Advocates are responsible for the Care Of Foster Families through Independent Advocates. It is imperative that the caregivers of foster children be trained and supported in order for them to effectively manage and promote healthy life outcomes for these frequently damaged children and young people.

E. Targeting the National IYB Contract

Recognise the gaps in the system during transition from one benefit to another benefit. Many of the subjects, who were involved in the prospective study, raised concern for IYB applicants when changing from one benefit to another, such as moving off the IYB and on to the Independent Circumstances Allowance. Stand down times, then further delays while applicants arranged for another 'eligibility assessment' were remembered as the most difficult period of stress by many research participants.

Make the IYB accountable. In retrospect, many ex-IYB applicants wished that they had received more pressure from adults to stay at school or training. Consequently, IYB Benefits need to be tagged with accountability actions such as return to school, enrolment into a tertiary service provider, drug counseling, anger management, problem solving strategy training or other areas of need that have been identified during a full psycho-social assessment.

Family Reconciliation Counseling (FRC) seriously underutilized. Some IYB benefits are granted without a parent or significant other being contacted. FRC must be the first intervention option considered, contingent upon client safety within the home

setting. Many subjects reported that FRC should have been more actively encouraged by case managers and IYB assessors. It was reported by research participants that lack of training among many IYB assessors, and parental refusal to engage in counseling with their adolescent, resulted in many IYB benefits being granted unnecessarily. Sometimes parents had not been invited by the IYB assessor to participate in FRC. Some parents had not been told that the option of FRC even existed! Of those who applied for the IYB only 5-9% were referred for FRC and around 80% of parents did not show for a face to face interview with the IYB assessor. Most parents were contacted by telephone.

Multisystemic treatment (MST) has been empirically validated as an intervention model that emphasises recognised risk factors associated with antisocial behaviour. This treatment modality targets the individual, family, peer, school and community factors that contribute to, and maintain problematic behaviour (Curtis, Ronan & Borduin, 2004). MST has been successful in comorbid populations (i.e., delinquency comorbid with substance abuse and/or emotional disturbance), and focuses on empowering parents to facilitate change in their adolescent and the family. A recommendation for national training in MST for IYB assessors and FRC therapists would be an appropriate initiative for this population. Such an initiative should also result in a decrease in the allocation of the IYB. With the majority of IYB applicants, MST might be considered as a pre-requisite to receiving the IYB or worked concurrently with IYB allocation through a transition time of, 'out-of- home' placement.

Registered clinical psychologists required to conduct IYB assessments. IYB assessments for benefit eligibility should be conducted by registered psychologists whose

scope of practice is centred on youth assessment and is in line with The Health Practitioners Competency Assurance Bill recommendations. Assessors need to be skilled in diagnosing DSM-IV disorders. Studies have found that previous specialist training was the best predictor of case identification and initiation of appropriate care (Currier, Barthauer, Begier & Bruce, 1996). With such elevated levels of suicidality within this population, assessors must be skilled in identifying evidence-based indicators of depression, familial psychiatric patterns, and adverse life events, and be competent in working within a multisectoral framework. Assessors require a comprehensive knowledge of referral pathways, both locally and nationally.

The current ad hoc system of employing a range of individuals and organisations to conduct these assessments is, in my opinion, inappropriate. Untrained, IYB assessors may have aided in the escalation of youth entering into welfare dependency. There is no national training or regular contact between assessors, and the research on outcomes for this population is, until now, non existent. There is evidence that trained clinicians often miss accessing critical knowledge, so concerns must be raised for those with no mental health training conducting IYB assessments.

> "New Zealand studies have found that the response of clinicians following disclosures of abuse leaves much to be desired. Policies about routine inquiry may not be affective unless accompanied by staff training ... in how and when to ask about, and how to respond to abuse histories" (Lothian & Read, 2002, p102).

If this is the case for trained clinicians, the concerns over 'non-clinically trained' interviewers assessing high risk adolescents become even more acute. The current IYB operational processes require close scrutiny. Evidence-based best practice standards need

to be examined, and guidelines on welfare eligibility, assessment procedures, intervention protocols, and monitoring, maintenance, management and evaluation systems require urgent attention.

Training for Work and Income IYB case managers. Although many stories were reported of caring and compassionate case managers, unfortunately numerous incidents of rudeness, breach of privacy and blatant humiliation of IYB applicants were emotionally recalled by research subjects. For many welfare seeking adolescents, communication with case managers became a crucially important aspect in their life. How case managers perceive their communication with welfare seeking youth is an area neglected by research. Drury and Dennison's (1999) unique research with benefit staff indicated that they generally believed that there were no differences between adult and adolescent clients, and they made generalisations about adolescent applicants such as lacking motivation, attitude problems, and lack of understanding.

Considering the New Zealand government's commitment to 'welfare-to-work' programmes, IYB applicants will be involved in increased interview sessions with their case managers. As this cohort of young people do require a different interview approach than do adult applicants for welfare, and as they represent a group with diverse need, it is recommended that Work and Income staff responsible for this sector, attend youth orientated communication and assessment training programmes developed by suicide prevention specialists. Similar training also should be offered to other staff as research now indicates that those applicants that present for a benefit who are in the 20-45 age brackets may be at greater risk of suicide than younger applicants. Beautrais (2003b) suggests that the needs of this older group have not been well served by current policies.

Case managers also need to develop alert protocols for IYB clients reporting this cluster of risks:

- Previous suicide attempt
- Co-morbid disorder
- Unable to identify one caring adult in their life
- Unresolved anger
- Unknown father
- Impending legal/disciplinary event
- Previous foster care placement

As 30% of this population made a medically serious suicide attempt before applying for the IYB, best practice guidelines urgently need to be designed for this significant proportion of IYB applicants.

Benefit reform. Data from research participants have indicated that with vulnerable, suicidal young people, the IYB has been a life-saving initiative offered by Government. However, there also are numerous cases whereby the IYB has been abused by adolescents and their families. The question should not be whether to stop this benefit, but rather, how to improve assessment of need so that only those genuinely requiring this benefit receive it. The critical issue for government is how to provide a full range of services (including benefits) so that a quarter-million children living in families where no one earns a living through work, do not repeat the intergenerational cycle of benefit dependency. Defining the term 'benefit dependent' requires clarification that is beyond the scope of this thesis. Cheyne, O'Brien and Belgrave (2005) document a critical examination of these issues.

There certainly are advantages for a 'single benefit' system to be adopted as long as the certain conditions apply such as:

- Time limits on benefits.
- Beneficiaries to reapply annually in order to reduce fraud.
- Better evidence-based training offered for case managers to increase their knowledge and skills in working with beneficiaries. Case managers need to be proactive and are crucial in the process of achieving successful outcomes in any benefit reform.
- Engaging those on a benefit who are able to work in a 40 hour, work for benefit programme. 'Work for benefit' approach would also include time allocated for education and skill development. There needs to be a greater emphasis on shifting income support to work accountability if New Zealand is to decrease the dependency and entitlement culture that currently exists within specific subgroups of the population. Within such changes, it is imperative that people are not lost in the politics of benefit change or reform, and that the new initiatives can indeed deliver sustainable employment. However, strategies aimed at reducing stigmatization for those who cannot take up employment are worthy of development.

Public Goods and Private Wants: a psychological approach to government spending. Kemp (2002) has raised some innovative suggestions regarding the targeting of government spending. He makes a strong case that psychologists need to be involved in this area for all too often government spending has not reflected the individual choice of

the people. He suggests that psychologists are well placed to identify the heuristics that individuals use to decide whether government spending should be increased or decreased. Many of the goods provided by governments such as welfare spending have complex dimensions, and clinical psychologists are ideally trained to develop a behavioral model of individual preferences for a variety of government services. This work raises some interesting concepts for decision research across government spending and has implications for a new direction in examining welfare reform.

Evidence 'providers' to inform evidence 'users' on interagency collection and publication of data relating to children and young people at risk. Policy advisors need to develop practical systems whereby research evidence informs the development of joined-up policy and practice to protect children and young people from violence and abuse. Lack of shared information between organisations, both government and non-government, has led to the continued abuse and violence toward young people. Information sharing impediments reduce cooperation between agencies, which has led to a fragmented approach to the care and protection of young New Zealanders.

Policy advisors to design family packages that recognise barriers to adolescent learning and wellbeing. Policy advisors need to be informed by longitudinal studies and neurobiological studies indicating that childhood neglect, stress, and trauma emanating from within the immediate care giving environment, are likely to be a source of compromised brain development. Recognition must be made that children raised in multiple problem families may manifest learning problems, depression, suicide and substance abuse behaviours during adolescents. When 75% of the 2029 IYB participants

left school with no school qualifications, public policy must do more to implement practical strategies to protect our young from violence and neglect, and develop strategies to improve learning outcomes for such children.

New Zealand policy advisors are recommended to support the 'No Dole project' contingent upon adolescent safety. The majority of subjects stated that they never wanted a benefit to be any more than a temporary measure that met a temporary need. Not one subject ever mentioned that going on a benefit brought 'mana' or respect. Many however commented on the stigma associated with benefit dependence. The "No Dole" programme has been highly successful in secondary schools in Australia and has been detailed in section B – Targeting Schools. Such an approach appears valuable for those who have the psychological and physical resources to transition safely from the school to the work setting. For adolescents more vulnerable in the psychological and physical realms, student allowances or 'transition scholarships' seem a sensible, less stigmatizing support structure that will aid the attainment of individual goals in an environment of safety.

IYB contract work should include early intervention work with younger siblings of IYB applicants. Subjects reported that they wished that they had done more to prevent their siblings from following a similar trajectory to themselves. Intergenerational benefit dependency will only be decreased when proactive family skills training is implemented at an 'early' stage and parents are given both financial and educational incentives to do so.

Further questions that need to be asked by policy advisors regarding the IYB contract and assessment model presently used:

- How can WINZ further enhance the total care, wrap around protection and education packages?
- What are the main strategies used by MSD case managers for effectively working with such a large cohort of youth in transition who have mental health issues?
- What are the main measurements used in assessment of youth in transition? What methodologies are involved, how does assessment data relate to intervention, how are interventions monitored across times, settings and situations, are they durable, and what are there outcomes?
- What steps have been taken to change the focus of assessment and intervention to 'risk opportunities' and prodigal analysis when working with a large cohort of youth in transition as outlined by Jessor (1993)?
- Who trains those in MSD who work with youth in transition, what philosophy is endorsed by such training and how are these trainers and WINZ staff supervised in order to promote better life outcomes for their clients?
- How is interagency collaboration managed within WINZ to holistically meet the needs of the client?
- What percent of funding is allocated to researchers who specialize in analysis of youth issues and formulating evidence-based, protective and successful outcomes?
- In what ways does research impact on the day to day work with youth in transition?

- Is WINZ involved in prospective research and analysis in order to promote positive outcomes for those just beginning transition?
- By what measure does WINZ examine treatment integrity and efficacy?
- How does WINZ address complex issues of inter-agency collaboration and 'whole of government' funding philosophy in order that 'silo-funding mentality' does not negatively impact on youth at risk?
- What does the organisation do to keep kids feeling valued and connected?
- What sort of questions and interactions establish good communication, mutual respect and truth between young adolescent clients and case managers.
- How does WINZ effectively establish whether the applicants can be managed within the WINZ framework or need to be referred to another agency?
- How do WINZ case managers recognise the risk factors, assess imminent danger and manage risk?
- How does WINZ ensure that when key workers are absent, case work is still covered at a high standard of care and protection?
- How does WINZ assess the consequences of abuse and work with clients to provide necessary interventions?
- Are interventions designed, constructed, assessed, monitored and evaluated according to robust, scientific standards?
- In what way does WINZ address the UNCROC standards?
- How does supervision impact on client well-being?
- What networks of support does WINZ have for a multi-ethnic population?

- What are the most effective strategies to engage families and whanau within the assessment / intervention follow up processes?
- What information has been useful to WINZ clients and how does WINZ obtain such information?
- What information regarding clients, should WINZ case managers pass on to other service providers?
- How does MSD hear the voice of needy families and hurting children?
- In what ways can WINZ case managers monitor, or even predict, the ever changing face of danger of harm to IYB applicants?
- Does intervention work align with national and international research and government strategic plans?
- In what ways can WINZ ensure that the voices of adolescents are heard at a political level?
- Does WINZ have a 'model of advocacy' and interventions that promote mental health and resiliency that can be substantiated and sustained?
- Are the evaluation procedures ongoing in assessing all interventions regarding the IYB process?
- Do MSD case managers regularly visit the ethical and Privacy Act (1993) guidelines regarding the collection of private information in a public, open space, as well as inter-agency access to client data?
- In what ways has the Treaty become a living, daily document with the assessment, intervention and evaluation protocols for youth?

- Is the content of interventions appropriate for age, gender and cultural background?
- In what ways does WINZ encourage self empowerment for welfare applicants?
- What are the major safety considerations for clients and staff?
- What are the most effective strategies in preventing a re-occurrence of family breakdown?
- How better can WINZ elevate the platform of Advocacy in Partnership with Maori?
- How can WINZ work more effectively with community agencies and stakeholders in order to make a successful IYB model transportable?
- Are evaluation surveys sent to ex-applicants? Are they being actioned?
- What other qualifications, skills and experience do we need to bring into WINZ protocols in order to continue to improve services to applicants and their families?

Qualitative data sourced from my research group established a rich insight into the needs, requirements and recommendations from ex-IYB applicants who were either declined or granted the IYB. Their documented suggestions, (accurately interpreted by 100% agreement with respondent validation), provides for policy advisors, educationalists, parents and counsellors a varied array of beliefs and perceptions that were collated into 'themes 'for future family, community and government focus.

However, there is an urgent need for policy makers to foster prevention research that is scientific and valid within our community based cultural context.

A problem yet to be targeted. A problem of research generally is that, for the most part, it is not determined by the consumers themselves. Champ (2000) provides an example from research with schizophrenia, highlighting the fact that when consumers are asked what aids recovery, high on their list is the need for hope. Although this is seen as a key to recovery by consumers, it rarely rates in research agendas. A reason may be that researchers have found it difficult to actually operationally define and measure the psychological construct of hope. The same argument might well apply to the concept of cynicism that is noted as a frequent emotional construct across the adolescent suicide population. The exclusion of research participants from decision making within research teams is a problem that requires attention.

Meager (2002) has suggested that despite the rhetoric of social inclusion and partnerships, many consumers of research are maintained in dependent positions within the psychiatric system and its social service allies. Rogers' (1995) research supports this view believing that psychology and psychiatric medicine continue to dominate systems for encoding and treating human beings. However, within this current thesis I have addressed these issues by hearing and documenting the comments of research participants.

A longer term perspective to prevention however must be adopted with research initiatives that track children into adulthood and evaluate the long term impact of interventions. Only with research 'providers' interacting closely with research 'users' can

critical evaluations and true prevention of multiple risks to New Zealand children be met. Prevention research will only be effectively developed in the long term if researchers collaborate with communities of interest, share information and power and foster community building and sustainability. Researchers need to become more skilled at the identification of risk and protective factors that make sense to communities within their differing cultural contexts and at working with them to reduce risks and promote protective factors. Without such collaboration, prevention initiatives will remain irrelevant to most people. We must find effective ways to translate research findings into mainstream educative, screening and support programmes.

Community-based research will need to influence policy development and practices. The linking of research outcomes to more effective policies and practices at community level (Bartar, 2001) will come to be the true test of whether prevention research has developed to the point of being an effective true science. The IYB contract needs more effective evidence-based models to ensure that services reach families early, "before" they have problems. Currently, there is a paucity of evidence on the effects of interventions targeting IYB youth who are depressed, vulnerable, often homeless and suicidal. Burns and Patton (2000) suggest that it will only be through effective interventions, i.e. indicated (interventions designed for young people already exhibiting symptoms of a disorder), selected (interventions for groups at high risk who are not currently manifesting disorders) and universal (interventions that are designed to favorably shift risk and/or protective factors across a whole population), that better life outcomes will be promoted across this population of benefit-seeking adolescents.

Indicated, selected, and universal interventions can be developed that in time could lower benefit rates, improve family relationships, retain youth in school, and encourage behaviour that will lead to better life outcomes. However, until that occurs, it seems to me, after listening to over 3,700 IYB applicants, that when young people are transitioning from home, to work, or welfare, their self expressed needs configurate into four inter-related areas; the need for association (somewhere to go), the need for activities (something to do), the need for autonomy (some space of their own), and the need for advice (someone to talk to).

APPENDIX B

Outcome Questionnaire: For ex-Independent Youth Benefit (IYB) Applicants (Plus Cynical Distrust Test)

Prior to interview, telephone consent has been gained for ex-IYB applicant to be involved in this research . Written consent also has been obtained for research involvement .

At the face-to face interview, the following statement is read to each ex-IYB applicant: 'This research is to help New Zealand young people and policy makers. You will never be identified in the research or your comments traced back to you. I am the only researcher who has access to this completed questionnaire. This document will be destroyed once the information has been recorded on the computer. Your name will not be recorded on the computer. Your confidentiality is guaranteed. You can decide at any time not to complete this interview and the information you have already provided will be destroyed. If any question raises issues for you, please let me know and we can discuss support options for you. If you have any complaints or concerns regarding this research, please know that you can contact my supervisor, Professor Ian Evans, at Massey University in Palmerston North. Thank-you so much for your help.' Narelle Dawson, Clinical Psychologist/Ph.D. researcher.

Code:

1. Granted – Attempted suicide (GAS)
2. Declined – Attempted suicide (DAS)
3. Granted – No attempted suicide (GNoAS)
4. Declined – No attempted suicide (DNoAS)

General:

1. Your name/number/code is _____
2. Your date of birth is: ____/____/____
3. Are you male female
4. Are you 19-21 22-25
5. Are you European/Pakeha Maori Pacific Asian Other
6. Were you granted the IYB when you applied? Yes No
7. Had you attempted suicide prior to applying to the IYB? Yes No

Outcomes in Education:

8. Did you attend school after applying for the IYB? Yes No
9. Did you complete 7th form? Yes No
10. Did you complete certification/apprenticeship in a trade or career interest, e.g. hairdressing/plumbing? Yes No
11. Did you complete a tertiary diploma? Yes No
12. Did you complete a tertiary degree? Yes No

13. Are you currently in education or work related training? Yes No

Employment/Income Outcomes: (Including Benefit Status)

14. Have you been employed since applying for the IYB? Yes No

15. Are you currently employed? Yes No

16. Are you on a welfare benefit? Yes No

17. Which standard of living category best describes your situation? Choose one of the following four options.

    A. On the poverty line: less than $9.55 per hour
    B. Scrapping by, but okay: $9.55 - $13.85 per hour
    C. Average standard of living: $15.44 - $18.44 per hour
    D. Above average standard of living: above $18.44 per hour

Social Outcomes:

18. Did you have involvement with police prior to applying for the IYB (Apart from speeding tickets)? Yes No

19. Have you had any involvement with police since applying for the IYB (Apart from speeding tickets)? Yes No

20. Did you have contact with Child Youth and Family Services prior to applying for the IYB? Yes No

21. Have you had contact with Child Youth and Family Services since applying for the IYB e.g. to make notification of a child at risk or for problems with your own child or to offer your services as a caregiver? Yes No

22. Do you have a current Work and Income case manager? Yes No

23. Do you currently have an impending legal/disciplinary event in your life? Yes No

24. Do you currently have children who have been placed in the care of Child Youth and Family? Yes No

Adverse Life Outcomes:

25. Were you bullied prior to the IYB application? Yes No
26. Are you currently being bullied? Yes No

27. Were you physically abused prior to the IYB application? Yes No

28. Are you currently being physically abused? Yes No

29. Were you sexually abused prior to the IYB application? Yes No

30. Are you currently being sexually abused? Yes No

31. Were you emotionally abused prior to the IYB application? Yes No

32. Are you currently being emotionally abused? Yes No

33. Prior to applying for the IYB, did you lose friends or family members to suicide? Yes No

34. Following your application for the IYB, have you had friends or family members die by suicide? Yes No

35. Do you have children who have been bullied? Yes No

36. Do you have children who have been physically abused? Yes No

37. Do you have children who have been sexually abused? Yes No

38. Do you have children who have been emotionally abused? Yes No

39. Do you currently have a successful and safe relationship within your workplace environment? Yes No

Personal Well Being Outcomes:

40. Do you currently take drugs for recreational use? Yes No

41. Do you currently consume excess alcohol? Yes No

42. Do you currently smoke? Yes No

43. Do you currently have suicidal thoughts? Yes No

44. Have you attempted suicide since applying for the IYB? Yes No

45. Do you rate your physical health (taha tinana) as good? Yes No

46. Do you rate your mental and emotional health (taha hinengaro) as good? Yes No

47. Do you rate your spiritual health (taha wairua) as good? Yes No

48. Do you rate your family health (taha whanau) as good? Yes No

49. Do you have at least one caring adult in your life? Yes No
50. Are you currently in counselling? Yes No

51. Have you been diagnosed with a co-morbid disorder? Yes No

52. Is there unresolved anger in your life? Yes No

53. Do you think that people can usually be trusted? Yes No

54. Are you satisfied with your current life outcomes? Yes No

55. Do you feel lonely most of the time? Yes No

56. Do you have friends over to your house at least once every month? Yes No

57. Do you have a positive perception of yourself? Yes No

58. Does your sexual identity cause any negative consequences in your life? Yes No

59. Do you feel you have a degree of control over what happens in your life? Yes No

60. Do you believe you will be successful in ten years time? Yes No

61. Do you believe you are worse off than most of those around you? Yes No

Family Relationship Outcomes:

62. Have you reconciled with your parents/caregivers? Yes No

63. Do you currently have a parent with a mental health disorder? Yes No

64. If your parent has a mental health disorder, has this had a negative impact on your life? Yes No N/A

65. Do you spend some time with at least one parent most weeks? Yes No

66. Do you regularly participate in family/whanau activities?(cultural connectedness) Yes No

67. Do you know your biological father? Yes No

68. Do you know your biological mother? Yes No

69. Do you have telephone/internet access in your home? Yes No

70. Do you have a partner? Yes No

71. Do you have children? Yes No

72. If you have children, is the father actively engaged in their upbringing? Yes No N/A
73. Were you raised in a single parent home? Yes No

Policy Implications: Gaps and Useful Resources:

74. What factors contributed to changing your family relationships from one of breakdown to one of connectedness or, what factors maintained the family breakdown?

Factors aiding reconciliation:

_____

_____

_____

Barriers to reconciliation:

_____

_____

_____

75. In what ways could the IYB process be improved over the following three areas?

The application process:

_____

_____

_____

The assessment process:

_____

_____

_____

The follow-up process:

_____

_____

76. What resources did you find helpful throughout the IYB process?

77. What do you see as the gaps or unhelpful events that occurred during the IYB process?

78. Do you think your current life outcomes were significantly influenced by this IYB process? Yes No

79. Do you think you have more positive life outcomes because of the IYB process? Yes No

80. Do you think any of your negative life outcomes were influenced by the IYB process? Yes No

81. List three influences or resources of government, family and your own personal choice that resulted in positive outcomes in your life:

Government: _____

Family: _____

Personal Choice: _____

82. List three influences of government, family and your own personal choice that resulted in negative outcomes in your life:

Government: _____

Family: _____

Personal Choice: _____

Outcomes for those who Attempted Suicide Only:

Interviewer reads to interviewee:
Please close your eyes and think about the time when you wanted to suicide. What were the things that were bothering you the most? Go back to the week before you attempted suicide. What can you remember? Think about life at home, kids in your class or maybe a special song. Now please think carefully about the next three questions. You can keep your eyes closed if you wish or you may open them.

83. If you could change three things in your life that led to your suicide attempt, what would they be?

_____

_____

_____

84. What were the main factors that stopped you completing suicide?

_____

_____

_____

85. How can government policy advisors and professionals help to reduce suicide attempts?

_____

_____

_____

NB: At the end of this interview, reinforce again to the interviewee that confidentiality and strict adherence to the Privacy Act 1993 will be honoured as was discussed prior to this interview being initiated. The interviewer will pay particular attention to offering support or referral pathways to the interviewee if this interview process has raised issues of concern.

Name/Number: _____ Gender: ____ Ethnicity: _____ Age: 19-21 22-25

Codes: 1. GAS 2. DAS 3. GNoAS 4.DNoAS

1. No one cares much about what happens to you.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

2. It is safer to trust nobody.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

3. I think most people would lie to get ahead.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

4. Most people inwardly dislike putting themselves out to help other people.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

5. Most people will use somewhat unfair means to gain profit or an advantage rather than lose it.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

6. Most people are honest mainly because of their fear of being caught.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

7. I usually wonder what hidden reason another person may have for doing something nice to me.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

8. Most people make friends because friends are likely to be useful to them.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

9. When a guy is with a girl, he is usually thinking about things related to sex.

1	2	3	4	5
Strongly disagree	Disagree	Not sure	Agree	Strongly agree

APPENDIX C

SCORING MEASURE FOR OUTCOME QUESTIONNAIRE

Code

1. Granted – Attempted suicide (GAS)
2. Declined – Attempted suicide (DAS)
3. Granted – No attempted suicide (GNoAS)
4. Declined – No attempted suicide (DNoAS)

Case number _____

Gender

1. Male
2. Female

Ethnicity

1. Maori
2. European

Age

1. 19-21 years
2. 22-25 years

Education Outcomes (possible six points for best outcome)

0. Left school with no qualification
1. Attended school after applying for IYB
2. Completed 7th form
3. Completed certification or apprenticeship training
4. Completed a diploma
5. Completed or completing a degree
6. Currently in further education or training

Employment Outcomes (possible two points for best outcome)

0. No employment since IYB application
1. 50-75% employment since IYB application
2. 76-100% employment since IYB application

Income Outcomes (possible four points for best outcome)

0. No income or benefit
1. Currently on a benefit i.e. less that $9.55 per hour
2. Low income: $9.55-$13.84 per hour
3. Medium income: $13.85-$18.44 per hour
4. Above average income: $18.45 per hour +

Adverse Life Outcomes (possible six points for best outcome)

Adverse life outcomes are scored as one point for each of the following; involvement with police (excluding traffic infringements), involvement with Child Youth and Family Services, impending legal/disciplinary event, currently being bullied, currently being physically abused, currently being sexually abused.

0. All six adverse life problems currently occurring
1. Five adverse life problems currently occurring
2. Four adverse life problems currently occurring
3. Three adverse life problems currently occurring
4. Two adverse life problems currently occurring
5. One adverse life problem currently occurring
6. No adverse life problems currently occurring

Wellbeing Outcomes (possible 22 points for best outcome)

Wellbeing (personal) outcomes are scored as one point for each of the following; good physical health (taha tinana), good mental/emotional health (taha hinengaro), good spiritual health (taha wairua), good family health (taha whanau), no unresolved anger, good ability to trust, good life satisfaction, not lonely, good positive self-perception, good internal locus of control, good future hopefulness, good comparison to others.

Social objective wellbeing outcomes are scored as one point for each of the following; no recreational drugs, no consumption of excess alcohol, non-smoker, no suicidal thoughts, no suicidal attempts, at least one caring adult in subject's life, no need for counseling, no co-morbid disorder, no sexual identity issues, and client knows biological father.

One wellbeing point is allocated for each of the following:

- Good physical health
- Good mental health
- Good spiritual health
- Good family health
- No unresolved anger
- Good ability to trust
- Good life satisfaction
- Not lonely
- Good positive self-perception
- Good internal locus of control
- Good future hopefulness
- Good comparison to others
- No recreational drugs
- No consumption of excess alcohol
- No smoking
- No suicidal thoughts
- No suicide attempts
- Having one caring adult in participant's life
- No need for counselling

- No co-morbid disorder
- No sexual identity issues
- Participant knows identity of biological father

Family Relationship Outcomes (Possible two points for best outcome)

0. No family contact
1. Some time with family
2. Regular participation with family

Cynical Distrust Outcomes:

Nine items were scored on this test with each item ranging between 0-5. A total score of 45 was possible.

APPENDIX D

Work and Income NZ
Te Hiranga Tangata

Work & Income NZ
PO Box 12 136
WELLINGTON

3 November 2000

Narelle Dawson
C/- SES Waikato
PO Box 774
HAMILTON

Dear Narelle

Thank you for returning the signed Confidentiality statement to me. The Department is happy for your research to proceed now.

I wish you well with this.

Yours faithfully

Pat Brocklebank
National Contracts Advisor

Cc Peter Cowley
CE Specialist Education Services

APPENDIX E

PO Box 11077
Hamilton
E-mail: narelle.dawson@xtra.co.nz

Dear _____,

Information on Narelle Dawson's prospective research with ex-IYB clients:

Thank-you for agreeing during our recent telephone call to participate in this research. As you know, I will be calling you back within the next month to arrange an appointment time with you and any support people you may wish to bring to the interview. Directions to the interview will be given at my next phone call. In the meantime, have a read of what the research is about, its purpose and what will happen to the information you provide. Remember, at any time you can withdraw from participating in this research and at any time, if you have a question, problem or complaint, you can contact me, or my supervisor Ian Evans at 0508 554331.

The Upcoming Interview:

When we meet at the interview you will be asked a series of questions about what has happened to you since you applied for the IYB in the areas of education, employment, income and problems you might have experienced. You will not be asked to talk about the reasons why you initially wanted to leave home, but if the interview raises issues for you, I can arrange for you to receive counselling if you wish.

You will also be asked about the gaps you saw in the system when you applied for the IYB, and the resources you found helpful. I will be interested to hear what you think can now make life easier for other young people who have to leave home due to family breakdown. For example, you might think about what families, schools, communities or the Government can do to better help kids who are now going through what you went through several years ago. That's the whole purpose of this research – to make life better for kids who have problems at home and need to apply for a benefit. That's why the information you provide is going to be so useful.

Consent for Involvement in Research and Confidentiality:

At your first interview where you applied for the IYB, you might remember signing a consent form where you agreed that information you provided could be used in research as long as you would not be identified from any published material. You also agreed to be contacted for further research, but had the right to say yes or no. From our telephone call, you have now agreed to be involved in further research and you can be assured that I am the only person who will know your identity. No one else can identify you with any of the information you have, or will, provided. Following the interview, I will transfer your information to my private computer (without your name) and once the information

has been double-checked, the questionnaire from the interview with your name and written material will be destroyed.

Confidentiality Limitation:

There is one circumstance in which confidentiality cannot be assured. If information is disclosed that indicates either you or another person may be harmed or is not safe, and permission to disclose this information is denied, I will consult with my supervisor and use my professional judgment in deciding whether to breach confidentiality.

Please Bring to the Interview:

Please bring this letter back to the interview with the boxes underneath completed.
Thank-you,
Narelle Dawson.

If you still wish to be interviewed, please sign on the line giving your written consent to be interviewed:

_____

Do you wish to help me validate my research? That means to meet with me following our interview to ensure that I have recorded your information in the way that you said and meant. This process is called respondent validation. If you would like to help me with this process, please tick the box.
Yes No

Do you wish to be contacted with the research results?
Yes No

APPENDIX F

Narelle Dawson

From: Jim_Fraser@nzhis.govt.nz
Sent: Monday, 24 December 2001 10:56
To: Narelle@tpc.org.nz
Subject: Data Request

Dear Narelle

Thanks for your letter, which I received on 20 December.

I have discussed your request with colleagues. Health information about identifiable persons, including deceased persons, is protected by the Health Information Privacy Code. Before we can provide the information
requested we will require:

- a copy of your study proposal
- a copy of any any ethics committee approval
- copies of memoranda from SES and WINZ supporting the research
- written assurance that the information provided will be stored securely
- written assurance that information from the study will not be published in a form that enables identification of individuals
- written assurance that the information provided will be used only for the purpose for which it is provided and returned or destroyed when the project is completed.

Yours sincerely

Jim Fraser
Chief Analyst
New Zealand Health Information Service\Information Delivery
Ministry of Health
DDI: 04 922-1862

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