Mental Health & Wellbeing in Young People

Prevention of Anxiety, Depression & Substance Abuse

MonashLink Community Health Service
Mental Health & Wellbeing in Young People
Health Promotion Initiative

Mental Health & Wellbeing in Young People

Prevention of Anxiety, Depression & Substance Abuse

MonashLink Community Health Service
Mental Health & Wellbeing in Young People
Health Promotion Initiative

Foreword

It gives me great pleasure to present this report on the work of MonashLink Community Health Service's Mental Health and Wellbeing in Young People Working Party. MonashLink values its partnerships with key stakeholders and appreciates the work undertaken by both internal and external members of the Working Party. The past two years has seen the Working Party achieve many of their goals. This has culminated in the development and implementation of two pilot programmes designed to enhance the resilience of young people during key points of transition. I hope that the Working Party will continue to work towards promoting mental health and wellbeing among young people in the Monash community. On behalf of MonashLink Community Health Service, I would like to thank all past and present members of the Mental Health and Wellbeing Working Party:

Sophie Banfield	Primary Mental Health and Early Intervention Service
Kym Cockroft	MonashLink Community Health Service
Kristen Douglas	Department of Education and Training
Chris Edmonds	Greater South Eastern Division of General Practice
Sandra Erickson	Wellington Secondary College
Shlom Eshel	City of Monash Youth and Family Services
Carmel Fox	MonashLink Community Health Service
Lucas Gosling	City of Monash Youth and Family Services
Nicole Harris	Primary Mental Health and Early Intervention Service
Melanie Jones	MonashLink Community Health Service
Sankaran Kasynathan	Consumer representative
Jo Lajbcygier-Penella	MonashLink Community Health Service
Angela McEwen	City of Monash Youth and Family Services
Angela Peos	Eastern Drug and Alcohol Service - MonashLink Community Health Service
Helen Riddell	Ashburton, Ashwood, Chadstone Neighbourhood Renewal Project
Wendy Sutherland	MonashLink Community Health Service
Mandy Taylor	Primary Mental Health and Early Intervention Service
Nick Voulanas	MonashLink Community Health Service
Mandy Wallis	MonashLink Community Health Service

I would also like to thank the students and staff of the two secondary colleges that participated in the pilot programmes, particularly Tim Hall (Mount Waverley Secondary College) and Annette Ford (South Oakleigh Secondary College).

Regards,
Naomi Adams –
Chair, Mental Health & Wellbeing in Young People Initiative

Contents

Introduction	7
Literature summary: The Role of Risk, Protection and Resilience in the prevention of Anxiety, Depression and Substance Abuse in Adolescence	9
Service mapping: Resilience Programmes in Monash Schools	23
Needs assessment: Creative Resilience Programmes in Monash Secondary Colleges	37
Literature review: Creative Resilience Programmes - Dramatherapy and Animal-Assisted Therapy (AAT) Groups for Adolescents	41
Review of Creative Resilience Programmes	52

Introduction

MonashLink Vision

MonashLink Community Health Service will be a recognised innovative leader in the provision of local, accessible community health services and will promote community health and wellbeing.

A commitment to health promotion is an integral part of this vision.

The Role of Health Promotion

According to the World Health Organisation, health promotion is the process of enabling people to increase control over, and to improve, their health. The goal of health promotion is to help people stay healthy and to achieve a higher level of wellbeing. A key quality of health promotion is working with the well population, or those most at risk of poor health, to prevent them from becoming unwell (VicHealth, 2005).

Mental Health & Wellbeing in Young People

Mental health is a state of emotional and social wellbeing in which the individual can cope with the normal stresses of life and achieve his or her potential (Australian Health Ministers, 2003). Mental health is fundamental to physical health, quality of life and productivity, and is of particular importance for children and young people.

An area of significant concern in the City of Monash is the mental health and wellbeing of young people. Health promotion initiatives for young people can prevent mental health problems from becoming entrenched, thereby minimising the impact of these problems on young peoples' lives (Raphael, 2000). Mental health and wellbeing has also been identified as a health promotion priority area by the Inner East Primary Care Partnership and more broadly in the state of Victoria. It was also recognised that mental illness represents a significant proportion of the disease burden in Australia and is often intergenerational (Weissman, 2005).

Outline of the Project

In MonashLink's 2005-2006 Health Promotion planning, mental health and wellbeing in young people was identified as an 'emerging issue'. MonashLink recognised that there was an increasing focus in government and communities on mental health and wellbeing. It was hypothesised that prevention initiatives may help break the cycle, particularly if focused on youth, which is when many difficulties begin to emerge.

Goals:

1. To build the capacity of schools and youth service providers to increase the resilience of young people in the City of Monash, through the development of a working party and community information and education.
2. To explore the role of risk and resilience in the prevention of anxiety, depression and substance abuse in young people through the development of a risk, prevention and resilience research paper.

In 2006-2007, following research conducted in the area of risk and resilience, the Mental Health and Wellbeing in Young People Working Party explored the nature of services being delivered to young people in schools in the City of Monash and gaps in service delivery. Drawing from this knowledge, two creative resilience programmes were developed. The programmes were piloted in early 2008 and subsequently evaluated.

Goals:

1. To explore the types of resilience programmes already being run in City of Monash schools and determine where gaps exist, through the development of a service mapping document and a needs assessment document.
2. To increase the resilience of young people attending secondary colleges in the City of Monash by developing two creative prevention initiatives.
3. To pilot and evaluate Creative Resilience Programmes in Animal-Assisted Therapy and Dramatherapy.

Where to from here?

To have the maximum impact, resilience programmes and other preventative interventions should ideally be incorporated into 'whole of school' initiatives. The Mental Health and Wellbeing in Young People Working Party will work in consultation with schools and the Department of Education to establish the best pathways by which this may be achieved. This will include guidelines for the inclusion of external service providers in the delivery of such initiatives.

MonashLink, in collaboration with the Mental Health and Wellbeing Working Party, are committed to delivering a comprehensive range of health promotion initiatives. To date, work has focused on individual young people within their school communities. Looking forward into 2008 and beyond, the Project seeks to incorporate families and local communities, particularly those communities who are seen to be at risk due to their disproportionate level of socio-economic disadvantage. The Neighbourhood Renewal Area of Ashburton, Ashwood and Chadstone is an ideal area in which to provide preventative interventions that include families and communities. The Working Party will explore services and needs within this area in order to continue developing relevant and effective mental health promotion initiatives.

> *"Mental health is fundamental to physical health, quality of life and productivity…"*

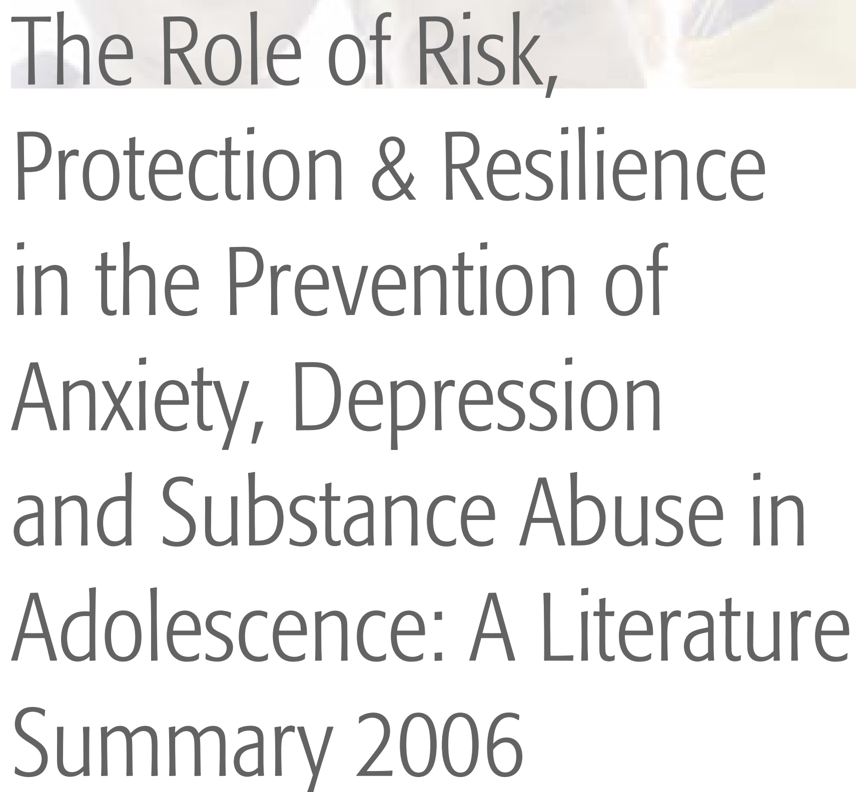
References

Australian Health Ministers (2003). National Mental Health Plan 2003–2008.

Raphael, B (2000). *Promoting the mental health and wellbeing of children and young people. Discussion paper: Key principles and directions.* Canberra, Australian Government Publishing Service.

Victorian Health Promotion Foundation (Vic Health) (2005). A Plan for Action 2005–2007: Promoting Mental Health and Wellbeing.

Weissman, M (2005). *Intergenerational derpession/interpersonal psychotherapy.* Retrieved July 30, 2006 from http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s1412304.htm



The Role of Risk, Protection & Resilience in the Prevention of Anxiety, Depression and Substance Abuse in Adolescence: A Literature Summary 2006

Melanie G. Jones, Psychologist/Youth Counsellor
Naomi J. Adams, Alcohol & Other Drugs Counsellor
MonashLink Community Health Service

The concept of Resilience

In the past few decades, much has been made of the notion of resilience. Significant amounts of research, time and effort have gone into the concept of developing resilient individuals, schools and communities. As a result, there are numerous models of risk factors and protective factors and how they may interact to create resilience.

Risk can be defined as being a set of circumstances, events or conditions which increase the likelihood of an adverse outcome for an individual. They may increase the incidence (onset), severity, or maintenance of a problem condition (Fraser, 2004). In contrast, protective factors are those internal or external factors which promote positive developmental outcomes, and guard against adversity (Fraser, 2004). Protective factors cannot simply be defined as positive events per se, but rather can be conceptualised as resources. Indeed their effects may only become apparent in times of stress or adversity (Rutter, 1985). What is particularly important to remember when examining the literature on risk and resilience, is the developmental level of an individual at the time they're exposed to risk. Rutter (1985) describes for

example how age can mediate the impact of separation from a parent. He points out that prior to six months of age a child has not developed selective attachment, and will not become distressed. By age four or five years, a child has developed the cognitive capacities to maintain an attachment to a primary figure despite periods of predictable separation. Hence, 'separation from parents' may be a 'risk factor' for emotional distress, but usually only between the ages of six months and four years. A person's perception is also crucial in determining whether a factor is risky or protective. Rutter (1985, p.606) writes that "a person's appraisal of a situation may define whether or not it is seen as positive or threatening" and can be affected by age, individual and a range of other factors.

Mechanisms of risk and protection:

Risk and protection are rarely defined in the literature as discreet incidents, although they may be (Fraser, 2004). For example a serious car accident, or major illness may be a risk factor for a young person, but it is likely that if the young person has appropriate support (protective) mechanisms around her, she will not experience long term harmful effects from the incident (Rutter, 1985). It is important then, to look at how risk factors and protective factors interact and the mechanisms by which they can influence outcomes.

There is a consensus that risk factors tend to cluster together, in that if you experience one type of risk, for example poverty, you are likely to experience other risks, such as unstable housing or poor neighbourhood conditions (Appleyard, Egeland, van Dulmen & Sroufe, 2005; Fraser, 2004; Marsh & Dale, 2005; Patton, Coffey, Posterino, Carlin, & Bowes, 2003; Rutter, 1985; Sanson & Smart, 2004; Wolff, 1995). However this is not to say that individual risk or protective factors do not have varying degrees of impact. Wolff (1995) points out that they can exert varying levels of influence depending on their proximity and intensity. That is they can be described as acute or chronic, and distal or proximal. A car accident may therefore be described as an acute factor, and a prolonged illness as a chronic factor. Likewise if the incident occurred to a distant acquaintance it could be described as distal and if to someone close to the individual, or the individual herself, proximal.

It is generally agreed that the more risk an individual is exposed to the more likely she is to experience an adverse outcome (Fraser, Kirby & Smokowski, 2004; Lopez, Turner & Lissette, 2005; Sanson & Smart, 2004; Wolff, 1995). Conversely, the more protective factors she has, including supportive interventions, the more likely she is to be able to overcome the adversity to which she is exposed (Andrews & Wilkinson, 2002; Edward, 2005; Fraser et al., 2004; Kirisci, Vanyukov & Tarter, 2005; Marsh & Dale, 2005; Wolff, 1995). Whilst there is some evidence to suggest that some adverse outcomes are directly attributable to 'causal factors', there are not many studies which talk about causal models. One exception is identified as bullying, which has a clear cumulative effect – the more bullying there is, the poorer the outcome (Fraser et al., 2004). Nevertheless, as Rutter (1985) points out, many of these 'causal' relationships may be cumulative but are not simple additive relationships - that is to say they may be statistically 'positive' but remain 'non-linear'. This view is in line with much research which indicates that identified risk factors are interactional in their influence (Edward, 2005; Fraser, 2004; Marsh & Dale, 2005; Rutter, 1985; Sanson & Smart, 2004; Wolff, 1995). For example "...early parental loss predisposes to depression only if it leads to inadequate care of the children and to lack of emotional stability in the family" (Rutter, 1985, p. 603). Hence 'parental loss' is an identified risk factor, but it is mediated by the protection afforded by an emotionally stable family.

In order to accurately describe how risk and protective factors interact, some researchers have explored the notion of pathways and trajectories (Compas, Hinden & Gerhardt, 1995; Fraser et al., 2004; Fuller, 2006; Marsh & Dale, 2005; Sanson & Smart, 2004). Sanson and Smart (2004) discuss 'trajectories' of emotional wellbeing and antisocial behaviours. The authors point out that one single event or factor is not sufficient on its own, but may lead to a chain of events and circumstances that

will accumulate to create a negative (or positive) outcome. They point out the multiplicity of influences on various trajectories and indicate that intervention can divert young people from negative trajectories. Likewise Compas et al. (1995) and Marsh and Dale (2005) identify a number of 'pathways' in the development of resilience. These papers examine the influence of individual traits and how they interact with environments and circumstances to produce outcomes. Fuller (2006) identifies a number of developmental risk points during these trajectories, at which time children and young people are especially vulnerable to both risk and intervention. These points will be explored more fully in subsequent sections. Fraser et al. (2004) discuss the interactive processes by which protective mechanisms impact on risk. With respect to the positive emotional development of children and young people, they refer to four discrete mechanisms:

1. *Reduction of risk impact.*
2. *Reduction of negative consequences.*
3. *Development of self perceptions, especially self-esteem and self-efficacy.*
4. *Opening of opportunities.*

Risk and protective factors, then, have complex and interactive influences on the development of 'resilience' and 'adversity'.

Resilience:

Resilience cannot be conceptualised merely as the absence of psychological distress, or the absence of risk - indeed some researchers argue that there cannot be resilience without first having adversity, as it is the successful resolution of a struggle that develops resilience (Edward, 2005). There is for example, some evidence to suggest that family adversity can lead to the development of personality strengths when young people are able to take on positive roles of responsibility (Rutter, 1985). Resilience then represents an adaptive outcome despite adversity. Resilience does not imply invulnerability nor can it be explained wholly by examining discrete areas of competence. Just as there are many mechanisms of risk and protection, there are many domains of competence such as academic, emotional, or social competencies. To be truly resilient an individual would display competency in a number of domains. As mentioned previously, different domains will be more influential depending on the developmental stage of the individual. For example it is more important for an infant to have strong family attachments and an adolescent to have social competence (Fraser et al., 2004).

Importantly, resilience can be both learned and enhanced (Fraser, 2004; Fraser et al., 2004; Sanson, 2002; Sanson & Smart, 2004; Sawyer, 2004; Toumbourou, Douglas & Short, 2004; Wolff, 1995). If it is true that resilience can divert young people from their risky pathways, then enhancing resilience should be able to prevent multiple adverse outcomes for many individuals. This would have resounding impacts across generations and communities. Indeed, if key elements of resilience could be identified as being influential in certain conditions and at certain developmental stages, then interventions could be tailored specifically to enhance those areas of resilience that may produce the most beneficial outcomes.

The goal of this Health Promotion Project is to look specifically at enhancing resilience in order to prevent anxiety, depression and substance abuse in young people. This is crucial to the development of healthy individuals and communities. Good mental health in childhood and adolescence often underpins mental health and wellbeing throughout later life. Interventions can prevent mental health problems from becoming entrenched, thereby minimising the impact of these problems on young peoples' lives (Raphael, 2000). Recent research being released in the United States shows clear pathways in the development of depression, anxiety and substance abuse. A longitudinal study shows that these disorders may be multi-generational. Children born to depressed parents have much higher rates of mental and physical illness than their peers and it appears that the grandchildren are following along a similar trajectory. The study indicates that the children of depressed parents often develop anxiety disorders, such as phobias and then go on to develop depression in adolescence (especially girls) and substance use disorders by late adolescence and early adulthood (especially boys) (Weissman, 2005).

Mental disorders account for 55% of the burden of disease in young people aged 15-24 years. Anxiety disorders are the most common mental health issue in adolescence and are most likely to be comorbid with depression and substance use disorders. The onset of even mild mental health problems at this time can have profound effects through crucial psychosocial developmental changes (Commonwealth Department of Health & Aged Care, 2000). The adolescent (aged 13-17) component of the Australian Bureau of Statistics National Survey of Mental Health and Wellbeing (based on parents' reports) revealed that 13.6% of males and 10.7% of females experience internalising problems which include depression and anxiety, with 4.8% of males and 4.9% of females actually diagnosed with a depressive disorder (Raphael, 2000).

Individuals with an alcohol use disorder are 10 times more likely to have a comorbid drug use disorder, four times more likely to have an affective disorder (such as depression) and three times more likely to have an anxiety disorder than those without an alcohol disorder (Burns & Teesson, 2002, cited in Turning Point, 2004). Cannabis use is also associated with a higher incidence of anxiety (14%) and mood disorders (17%), compared to rates of

6% and 5% in non users (Degenhardt, Hall & Lynskey, 2003, cited in Turning Point, 2004).

Within the City of Monash, 98% of secondary college students who participated in a forum in 2004 reported that they had come into contact with alcohol, while 78% had come in to contact with cannabis (City of Monash, 2004). A further 27% of young people in the City of Monash are impacted by nine or more risk factors for substance abuse including family breakdown, mental illness, homelessness, poverty and unemployment (Bond, Thomas, Toumbourou, Patton & Catalano, 2000, cited in City of Monash, 2004).

Given the impact of mental health and wellbeing on individuals and communities, it is prudent to identify the risk and protective factors that relate to these disorders. There are a number of key areas or domains of risk and protective factors explored in the resilience literature. Key areas identified most commonly include:

- *Family context*
- *Social and peer relationships, including school*
- *Individual and biological factors, and*
- *Environmental and systemic influences.*

These areas will be explored with respect to their influences specifically on the development of anxiety, depression and substance abuse.

Risk & Protection from Depression & Anxiety

Family Factors

The family environment plays a crucial role in the development of resilience and vulnerability. Research indicates that for young people, parental disharmony or parent-child conflict is a risk factor for mood disorders (Wolff, 1995). Single parent and step-parent families are also considered risk factors for mental disorders (Sawyer, 2004). Some research talks specifically about the quality of the emotional relationships in families as being influential. For example relationships that are hostile, rejecting, critical and disorganised are more likely to lead to depression (Gilbert, 2004). Low levels of attachment to and connection with family is also considered a risk for emotional distress (Sanson, 2002). Parenting specifically is also mentioned – significantly overprotective, non-protective or abusive parenting is considered a risk for depression (Gilbert, 2004). Similarly child abuse and neglect are mentioned (Gilbert, 2004; Goodwin, Fergusson & Horwood, 2004a). Other research refers simply to 'family dysfunction' and poor family relationships as being key contributors to depression (Compas et al., 1995).

Parental depression and/or anxiety can also be considered a risk, (Compas et al, 1995; Gilbert, 2004; Goodwin et al, 2004a; Ono et al., 2002). Whilst this may be considered an environmental issue, there may also be a biological or genetic component (Ono et al., 2002).

While harsh and inconsistent parenting is considered a risk, good parent boundaries and relationships are considered protective (Compas et al., 1995; Marsh & Dale, 2005; Wolff, 1995). A positive family climate is also considered protective (Edward, 2005; Fraser, 2004) or more specifically, feeling close to one's family, having opportunities and rewards for pro-social behaviour within the family (Toumbourou et al., 2004) and feeling secure emotionally within the family (Sanson, 2002). Parental competence and resources are also considered protective for depression (Gilbert, 2004). In addition, it may be important to have a strong and positive relationship with a significant adult who is not a family member (Fuller, 2006; Wolff, 1995).

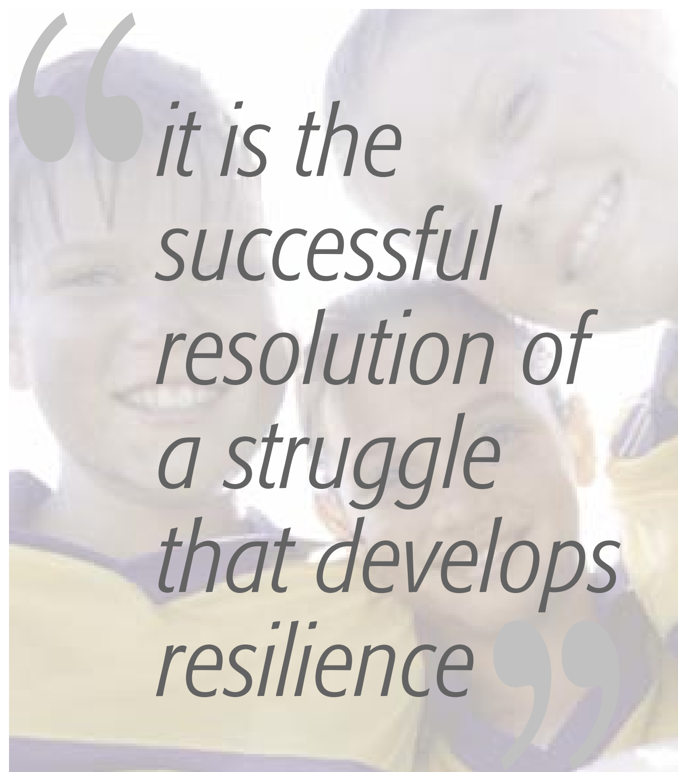
Social, Peer & School Factors

Positive social relationships appear to be crucial across the life-span. Rutter (1985) writes that in adults, social support is the main variable of influence in the development of depression after a stressor (Rutter, 1985, p. 602). Positive peer relationships are also considered crucial in adolescent and childhood resilience, as are social skills and school competencies. Indeed Rutter (1985, p.604) states that "the most influential prior protective factor [to the development of depression] proved to be some form of good experiences at school – in terms of social relationships, athletic prowess, musical success or (less often) scholastic achievement". Positive school experiences are in fact, said to be influential in the development of emotional wellbeing in general and these are thought to be cumulative and long-term (Wolff, 1995). Connectedness to and enjoyment of school, and opportunities and rewards for pro-social behaviours are also considered central to healthy youth development (Toumbourou et al., 2004). Risk factors associated with school are often inter-related with social problems. For example Gilbert (2004) writes that school related problems such as interpersonal problems with teachers or peers can be a risk factor for depression.

Although it is difficult to separate many school factors from social and peer influences, school may also exert some protective influence by impacting upon general educational levels and abilities. These abilities may in turn influence adaptive coping styles (Edward, 2005). Schooling is also likely to effect the development of vocational skills and ability to secure employment; both being important in the prevention of mental disorders and other negative outcomes (Edward, 2005; Wolff, 1995).

There are however, many social, peer or life skills that have been examined independently of the school context. Social

opportunities are crucial in the development of wellbeing (Wolff, 1995). Specifically, having strong support networks, peer involvement, being able to elicit social support and being involved in a wide range of extracurricular activities (Edward, 2005; Gilbert, 2004). Conversely, having low peer attachment (Sanson & Smart, 2004), social dysfunction, psychosocial stress and poor peer relationships (Compas et al., 1995) may be risk factors for emotional wellbeing and depression. It has also been shown that having good social and interpersonal skills (e.g. good communication) are important in protecting against emotional distress (Sanson, 2002). In addition, having social-psychological strategies can protect against depression (Edward, 2005; Gilbert, 2004). Social victimisation has been associated directly with depression, but only in females (Patton et al., 2003). Compas et al. (1995) also identify a number of interactional processes between social factors and temperament or gender. These will be explored more fully in the following section.



Individual and Biological Factors

Individual factors which contribute to wellbeing and resilience largely centre on temperament, cognitive abilities, cognitive style and intrinsic factors/elements of emotional intelligence such as empathy and self-efficacy (Edward, 2005; Sanson & Smart, 2004; Wolff, 1995). With respect to anxiety and depression, there is also discussion about how these individual factors interact with heredity and genetics to create resilience or adversity (Compas et al., 1995; Gilbert, 2004; Goodwin et al., 2004a; Ono et al., 2002; Weissman, 2005). For example Compas et al. (1995) discuss the interactional impact of hormones in adolescence. The authors state that hormones interact with mood and behaviour, parent-child relationships, sexual and social development, depression and aggression. These diverse interactions then impact on social and interpersonal factors to produce positive or negative outcomes.

In addition to the notion of inheritance, predisposition may be expressed as early signs of depression, or early anxious/withdrawn behaviours which have been shown to predict later internalising or mood disorders (Compas et al., 1995; Goodwin et al., 2004a; Wolff, 1995) and possibly result in a longer duration or severity of illness (Gilbert, 2004).

A ‘difficult’ temperament and/or an ‘emotional’ or ‘reactive’ temperament may be risk factors for emotional distress, whilst having a high IQ plus a sensitive temperament can be a risk for depression. However a high IQ plus a positive cycle of interests or achievements, or a generally positive, sociable or adaptive temperament can promote emotional wellbeing (Wolff, 1995). Hence it is not simply one’s IQ which may be a mediating factor in resilience - a person’s cognitive style is also influential. The ability to stay optimistic, reframe obstacles and have an active or adaptable coping style is important, as is the ability to set goals and articulate them (Edward, 2005). Rutter (1985) points out that having a problem solving strategy, any strategy, ameliorates helplessness and assists individuals to feel more competent. This highlights the importance of developing a “repertoire of social problem-solving approaches” which may be called upon in times of need (Rutter, 1985 p. 607). In addition to genetic predisposition or a difficult temperament, Compas et al., (1995) point out that depression and emotional distress may result from mismatches between adolescents’ expectations and their circumstances. The authors highlight that these risks can be mediated by good adaptive capacities – the ability to be flexible, solve problems and foster positive growth. The authors go further, listing a number of key cognitive styles which are risk factors for depression. These include having a negative self concept, hopelessness, negative attributional style or maladaptive coping styles. Again the authors identify some complex interactional processes such as early puberty (for girls) and low impulse control/ aggression or anti-social/ hostile style (for boys).

Many of the elements considered important in emotional intelligence are also crucial in the development of resilience. Self-efficacy, perceived success and competence, an internal locus of control, empathy and the ability to ‘help seek’, are all described as protective factors in the development of emotional wellbeing (Sanson, 2002; Sawyer, 2004; Wolff, 1995). Self-efficacy and self-esteem are also described as protective against depression (Edward, 2005; Fraser et al., 2004). This can be contrasted against such intrinsic factors as low task persistence, high activity levels and low emotional control which contribute to the risk of depression (Sanson & Smart, 2004).

Environmental and Systemic Factors

An adolescent's environment or context can play a crucial role in the development of depression and anxiety. Low socio-economic status (S.E.S.) or 'poverty', poor family assets and low income families are considered risks for emotional wellbeing and depression (Compas et al., 1995; Fraser, 2004; Gilbert, 2004; Sawyer, 2004; Wolff, 1995). These factors often interact with those mentioned earlier such as parenting capacity, marital conflict and educational attainment. Systemic issues have also been examined in some depth with regard to the development of antisocial behaviours and substance abuse. These will be considered more fully in subsequent sections.

In addition to environmental circumstances, life events may have a major impact on the trajectory an adolescent's life takes (Sanson & Smart, 2004). As discussed, risks can exert varying influence depending upon proximity and intensity (Wolff, 1995). A person's perception will also play a crucial role in the impact of an event (Fraser et al., 2004; Patton et al., 2003). Nevertheless traumatic events or chronic life stress and adversity are considered risks for the development of depression (Compas et al., 1995; Edward, 2005; Patton et al., 2003; Wolff, 1995). It is difficult to define what may constitute an adverse or traumatic event for any given individual. Examples cited are often general, as impact relies heavily on an individual's perception (Compas et al., 1995; Patton et al., 2003; Rutter, 1985). For example some authors refer to negative political or economic climates (Wolff, 1995) and neighbourhood disadvantage or violence (Gilbert, 2004; Sanson & Smart, 2004; Toumbourou et al., 2004). Life events which impact directly on an individual's family may include death, physical or mental illness of a parent (or caregiver) (Edward, 2005; Rutter, 1985).

Summary Table 1: Risk and Protective Factors for Depression & Anxiety

Domain	Risk Factors	Protective Factors
Family	• Poor quality family relationships or attachment • Family, parent-parent or parent-child conflict • Single-parent or step-parent families, or loss of a parent • Abuse or neglect • Parental depression or anxiety	• Clear, consistent & appropriate parent boundaries • Positive family climate • Close & supportive parent-child relationships • Parental competence & resources • Connection to significant adult outside of the family
Social, Peer, School	• School-related problems e.g. interpersonal problems with teachers or peers • Peer victimisation (for females) • Poor peer attachment • Poor quality peer relationships • Psycho-social stress	• School success e.g. social, athletic, musical or academic • Educational or vocational skill • School connectedness • Strong support networks • Social opportunities & engagement • Effective social & interpersonal skills • Reward & recognition
Individual, Biological	• "Difficult", "emotional" or "reactive" temperament • Negative self concept & attributional style • High IQ + sensitive or stressed • Genetic predisposition • Maladaptive coping style • Female • Previous depression • Early anxious or withdrawn behaviour • Mis-match between expectations & circumstances	• Adaptive coping skills e.g. flexibility & problem solving • High IQ + positive coping/ lifestyle • Self-efficacy • Self-esteem • Empathy • Internal locus of control • Help seeking • Perceived success & competence • Goal setting
Environmental, Systemic	• Low socio-economic status • Traumatic life events • Chronic stress or adversity	• Opportunities for support & engagement

Risk & Protection from Substance Abuse (Alcohol and other Drugs)

Many of the factors identified above are also influential in the development of substance abuse and other problems such as antisocial behaviour (Fraser, 2004; Sanson, 2002; Sanson & Smart, 2004). Indeed, there has been a focus in the literature on the links between alcohol and other drug (AoD) abuse and mental illness, particularly anxiety and depression (see for example Marsh & Dale, 2005). Although many factors overlap, this section will examine those factors identified as having an impact on AoD abuse.

Family Factors

Poor family relationships are considered influential in the development of drug and/or alcohol abuse (Goodwin, Fergusson & Horwood, 2004b; State Government of Victoria, 1998). Specifically, low levels of attachment or connection to family, negative consequences to drug experimentation including a negative response by the family (Compas et al., 1995), parental depression - especially for boys (Weissman, 2005), parental substance abuse (Jenson, 2004; Kirisci et al., 2005) and childhood physical or sexual abuse (Marsh & Dale, 2005; State Government of Victoria, 1998). In their comprehensive review of the literature, Marsh and Dale (2005) discuss a number of specific family factors which are risks for the development of AoD abuse; insecure attachment (characterised by a lack of self-confidence and difficulties maintaining relationships), severe family disturbance and dysfunction, high levels of family conflict and 'disturbed' or drug abusing parents. With respect to parenting directly, the authors point out that the use of authoritarian and coercive discipline and the absence of parental love and acceptance are risks. In working families that experience a lack of leisure time, this may lead to poor child supervision and boredom, both of which constitute risks for substance abuse (Spooner et al., 2001). Marsh and Dale (2005) report that poor parent-child relationships and a negative or rejecting reaction to drug use are likely to escalate a negative situation. Developmental stage is also important in substance abuse risk, for example the earlier in life a child is exposed to risk, the more likely it is he will develop a chronic pathway of substance abuse (Compas et al., 1995).

Positive family relationships including parent-child relationships are considered protective (Compas et al., 1995; Marsh & Dale, 2005; Windle & Wiesner, 2004). In his review of the literature, Jenson (2004) identifies a number of specific family factors as being protective against substance abuse; positive family relationships including low parent conflict, attachment to parents and caring relationships with siblings and extended family, being in a small family and being a first-born child.

Social, Peer & School Factors

Development of AoD abuse appears to be closely linked to the types and quality of peer and social relationships. There is a consensus in the literature that associating with pro-social or anti-social peer groups can be quite influential. Broadly speaking, certain peer relationships, lack of social bonding, poor school performance, antisocial behaviour, a lack of coping and support mechanisms and adolescence itself, can all represent risks for the development of substance abuse (State Government of Victoria, 1998). More specifically, it seems to be the 'norms' expressed by one's social and peer groups that exert the most influence. An attitude of acceptance and a prevalence of substance use or abuse amongst the people a young person associates with is considered a risk (Andrews & Wilkinson, 2002; Goodwin et al, 2004b; Jenson, 2004; Marsh & Dale, 2005; Sanson & Smart, 2004; Windle & Wiesner, 2004). Research indicates that when a young person is rejected by his socially conforming peers and subsequently associates with drug-using or non-conforming peers, he is at a much higher risk of developing an AoD disorder (Jenson, 2004; Marsh & Dale, 2005; Sanson & Smart, 2004). As with other risk factors, the earlier a person starts using alcohol or drugs the more likely he is to develop an AoD disorder (Andrews & Wilkinson, 2002; Compas et al., 1995; Kirisci et al., 2005).

Alcohol and other drug abuse is also strongly linked with psychosocial problems (Kirisci et al., 2005; Marsh & Dale, 2005; Sawyer, 2004). However positive social adjustment has been found to reduce the risk of developing a substance abuse disorder by over 50% (Kirisci et al., 2005). If a young person has positive connections to non AoD using peers and peers who are pro-social (Kirisci et al., 2005; Windle & Wiesner, 2004), has skills to actively resist drug offers (Andrews & Wilkinson, 2002), has involvement in conventional activities and believes in pro-social norms and values (Jenson, 2004), these will act as protective factors.

Just as school success is important in protecting against mood disorders, it is also protective against substance abuse. Jenson (2004) refers to school failure and a low commitment to school as being risk factors in the development of AoD abuse and a commitment to school as being protective. Similarly, educational disadvantage is thought to be a risk (Marsh & Dale, 2005) whilst school achievement has been found to be protective (Windle & Wiesner, 2004).

Individual and Biological Factors

There are a number of researchers who have examined the link between substance abuse and mental illness. It appears that mental health problems and mental disorders are a risk for developing substance abuse (Sawyer, 2004). Although, there is some debate about exactly how mental illness interacts

with circumstance to create risk (Marsh & Dale, 2005). Lopez and colleagues (2005) examined the link between anxiety and substance abuse, and stated that while this link is very clear in adults, it is less clear in adolescents. Their study concluded that psychiatric disorders generally precede the onset of substance dependence, particularly Post-Traumatic Stress Disorder (PTSD). This is supported by Marsh and Dale (2005) who report strong links between AoD use and PTSD. Zimmerman et al. (2003) examined the link between anxiety and alcohol use in adolescents and found that panic and social phobia were predictive of subsequent alcohol problems. Goodwin et al. (2004b) report that causal links between anxiety and substance abuse are non-linear. They report that anxiety only predicts substance abuse in the presence of a confounding factor such as depression, prior substance dependence, peer affiliations and family or childhood factors. Marsh and Dale (2005) point to possible mediating factors such as childhood abuse and personality disorders (i.e. Borderline or Antisocial Personality Disorder).

There also appears to be a strong link between impulsivity and AoD use. Marsh and Dale (2005) discuss 'behavioural disinhibition' and 'reward sensitivity' pathways as being influential. A behavioural disinhibition pathway is identified by high scores on impulsivity and antisociality, and low scores on harm avoidance and constraint. The reward sensitivity pathway is identified by novelty and reward seeking, extraversion and gregariousness. The authors also point to links with childhood Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder as well as personality traits that lead to poor self regulation, impulsivity and attention seeking. Kirisci et al. (2005) also identify an impulse related pathway – neurobehavioural disinhibition disorder. This is thought to be characterised by deficient inhibitory regulation, leading to conduct problems and antisociality and then to a substance abuse disorder. It is also suggested that delinquent activity may be, in itself a risk for AoD disorders (Windle et al., 2004). Many of these factors are also discussed by Jenson (2004) who identifies sensation seeking, poor impulse control, attention deficits and hyperactivity as risks for AoD abuse.

Cognitive style, problem solving abilities and coping skills may also be influential in the development of AoD abuse. Marsh and Dale (2005) point to negative emotionality and emotion focused coping styles as being risk factors. Kirisci et al. (2005) suggest that it may be a 'difficult temperament' that leads to psychiatric disorder and subsequently to substance abuse.

There is surprisingly little written about the individual and biological factors that protect against the development of AoD abuse. In his review of the literature, Jenson (2004) reports that a positive attitude, temperament and high intelligence may be influential. Given the apparent links between AoD abuse and mental illness, it would seem logical that enhancing those coping skills relevant to preventing anxiety and depression will also have flow-on effects in preventing AoD abuse. It also seems apparent that teaching impulse control and problem solving skills would reduce the risks attributed to poor impulse control pathways. In addition it would seem prudent to increase self awareness and empathy in an attempt to ameliorate the impact of antisocial and delinquent pathways.

Environmental and Systemic Factors

Neighbourhood, community and societal factors have a well recognised impact upon substance use. The most obvious and logical factor being availability, however availability is not a simple and straightforward issue. Jenson (2004) discusses the impact of taxation, regulation and criminal laws on availability and on cultural 'norms' of acceptability. Most of the literature on environmental and systemic influences focuses on the impact of neighbourhood and community factors. Young people who live in environments with high levels of crime, violence, a lack of resources and support, high population density, high levels of poverty and unemployment, are at increased risk of moving into pathways that may lead to AoD abuse (Jensen, 2004; Marsh & Dale, 2005; Sanson & Smart, 2004; Spooner et al., 2001; State Government of Victoria, 1998). Feeling alienated or excluded from meaningful participation in society is also thought to

Summary Table 2: Risk and Protective Factors for Substance Abuse

Domain	Risk Factors	Protective Factors
Family	• Poor attachment & connection to family • Parent/family substance abuse • Parental depression (for boys) • Childhood physical or sexual abuse • Family dysfunction or conflict • Negative consequences to drug use • Authoritarian, coercive or rejecting parenting style • Poor supervision & boredom	• Positive family relationships including; attachment to parents, close to siblings, close to extended family • Low levels of family conflict & parent conflict • Small families • Being a first-born child
Social, Peer, School	• Early drug or alcohol use • Rejection by socially conforming or non drug-using peers • Association with antisocial or drug-using peers • Psychosocial problems • Poor commitment to school or educational disadvantage • School failure	• Positive social adjustment • Commitment to school • School success • Skills to actively resist drug offers
Individual, Biological	• Mental illness or personality disorder • Anxiety disorder, especially panic, social phobia or PTSD • Prior substance dependence • Impulse related disorders including ADHD, Conduct Disorder & antisociality • Emotion focused coping style • Poor problem solving skills	• Effective problem solving skills • Positive attitude • Temperament • High I.Q.
Environmental, Systemic	• Social, economic or educational disadvantage • High levels of community crime or violence • Participation in anti-social sub culture • Chronic stress or traumatic life events	• Opportunities for meaningful participation

exacerbate a young person's tendency to seek out delinquent or anti-social sub-cultures (Marsh & Dale, 2005).

Widening socio-economic gaps are also thought to increase feelings of relative deprivation, further worsening feelings of social rejection and exclusion. There is some debate about the impact of cultural influences, as it has been found to be both a risk and a protective factor in different circumstances. It is clear that social disadvantage may cluster in certain cultural communities such as Aboriginal and Torres Straight Islander communities, however such clustering is not confined to cultural groups (Spooner et al., 2001).

Meaningful participation in communities and a sense of belonging is thought to be protective (Marsh & Dale, 2005; Spooner et al., 2001; Toumbourou et al., 2004). Given the impact of chronic stress (Marsh & Dale, 2005; State Government of Victoria, 1998) and post-traumatic stress (Lopez, et al., 2005; Marsh & Dale, 2005), it would seem important to protect young people from serious environmental adversity, increase their sense of meaningful inclusion and provide adequate supports where traumatic incidents have occurred.

The Role of Resilience in Prevention – Developing Preventative Interventions

It is often very difficult and perhaps simplistic to divide risk and protective factors into discrete domains. As discussed, risk and protective factors have complex mechanisms of interaction in order to influence outcomes. How then, do we take all of this knowledge and research and use it to create effective prevention programmes? Many of the researchers who have tackled the issue of resilience have also considered the notion of intervention and prevention (Andrews & Wilkinson, 2002; McLennan, MacMillan & Jamieson, 2004; Sanson & Smart, 2004; Sawyer, 2004; Toumbourou, et al., 2004; Wolff, 1995). Specifically where, when and how should we intervene? There are a few key recommendations from the literature which will be explored below.

Where - areas and contexts to intervene

A number of different areas and contexts in which to intervene have been discussed in the literature. It is clear that some communities suffer disproportionate levels of social and economic disadvantage (Compas et al., 1995; Marsh & Dale, 2005; Spooner et al., 2001). This has been identified previously as a risk in the development of anxiety, depression and substance abuse. It has been suggested that preventative interventions are

best targeted at those populations that experience disadvantage, for example single parent families, Aboriginal and Torres Straight Islander communities (Spooner et al., 2001).

Whilst is seems logical to target disadvantaged populations, where and how do we access young people within these populations in order to maximise impact on outcomes. A number of researchers support the efficacy of using schools as a location to access large numbers of children and young people (Sanson, 2002; Sanson & Smart, 2004; Toumbourou et al., 2004). Indeed Sawyer (2004) states that school is the ideal place to intervene as this is where most young people seek help. Whilst many interventions for younger children are ideally placed within the family (Rutter, 1985), adolescence is a time of individuation and separation from family. It is a time when the peer group becomes a central part of the adolescent's world and as discussed previously, exerts significant influence. Therefore schools may provide the infrastructure and context which most appropriately targets adolescents.

As young people reach an age when they may be moving out of the school system or into alternative education settings, it may be appropriate to consider interventions which are located within community or other 'social' settings. The key point is to locate interventions in areas which young people will readily access and where the social group can be engaged within the intervention.

When - ages and stages to intervene

Pathways or trajectories for risk and resilience start early and remain open to change (Sanson & Smart, 2004), however there are a number of ages or stages at which intervention, or risk, is likely to have a more significant impact (Compas, et al., 1995; Fuller, 2006; Sanson & Smart, 2004). Fuller (2006) identifies three Developmental Risk Points; entry into (primary) school, at grade three to four ('critical period') and in the transition to puberty and secondary school ('transitional time'). A number of other authors also point out that this time of transition is important in the development of resilience (Sanson, 2002; Sanson & Smart, 2004; Wolff, 1995). It appears that preventative interventions aimed at adolescents may best be timed during the onset of puberty and the transition to secondary school, or at least prior to mid-adolescence. This is consistent with data that shows many first episodes of mental disorder occur in mid to late adolescence and young adulthood. Depression, anxiety and substance use disorders also have their peak period of incidence at this stage of the lifespan (Weissman, 2005).

Research exploring drug use would also indicate that experimentation begins as early as 12 years of age. The State Government of Victoria (1998) defined the key stages in drug use as:

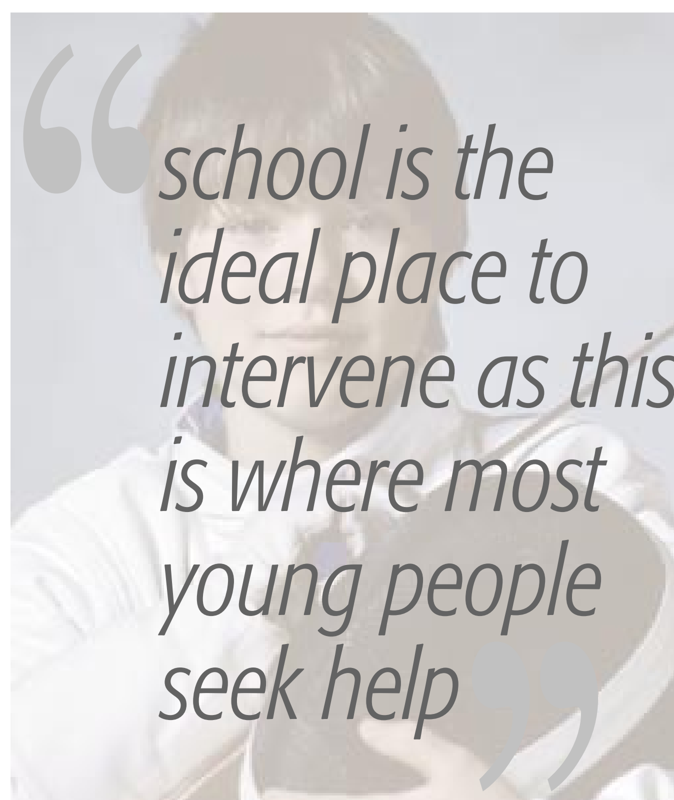
Age 12-14: Experimentation commences

Age 15-17: Experimentation continues, but may also involve 'binge' use

Age 18-20: Use becomes more regular and dependency becomes an issue, and

Age 21-24: Problematic use becomes an intrinsic part of the young person's life.

It is important to remember that 'turning points' or 'significant events' can dramatically alter trajectories, positively or negatively irrespective of age/stage. For example life events such as marriage, army service or spiritual conversion may have a positive impact, whereas a car accident or arrest is likely to have a negative impact (Fraser et al., 2004) at any time. It is important to develop protective interventions which help individuals or populations overcome specific adversities or traumas in addition to key support during vulnerable ages/stages. Being able to respond to significant events within communities, such as a school that offers support after the death of a student or teacher, may be a hallmark of a resilient community (or indeed family).



How - effective ways to intervene

Once target populations have been identified, the "how to?" of the intervention becomes important. For example there are varying ideas about the efficacy of intervening with whole populations (universal) or key individuals (targeted) when attempting to enhance resilience (Andrews & Wilkinson, 2002;

McLennan et al., 2004; Sanson, 2002; Spooner et al., 2001; Toumbourou et al., 2004). With regard to AoD use, universal prevention programmes are more effective among non-users and experimenters than those who misuse (Andrews & Wilkinson, 2002). However, the "Lifeskills Training Programme" (a targeted intervention) has been found to be the most effective school-based substance abuse prevention programme (McLennan et al., 2004). It is apparent that there is no clear cut consensus about the efficacy of one intervention over another (Sanson, 2002). It seems that a mix of clinical, targeted and universal preventative interventions would ideally be delivered by organisations, communities and governments. It may be important here to consider the objectives of interveners and the political, economic or resource constraints that may impact.

Community Health is ideally placed to have a wide and varied impact across a number of levels of intervention. The principals of access and equity state that community health should provide interventions for those most at risk within our communities, those who would not otherwise be able to afford or access service. This is in line with Spooner and colleagues' (2001) call for interventions that target those experiencing the highest levels of disadvantage. Community Health may also be in an ideal position to use its unique knowledge and skill base in community education, awareness and capacity building, particularly within its health promotion portfolio. *The role of this health promotion project is to offer targeted interventions to those young people most at risk, whilst offering capacity to schools, families and communities to enhance their own wellbeing and participation.*

As stated above many factors can enhance 'at-risk' young people's resilience. It is important to engage and work with them to achieve goals that enhance self esteem and self efficacy and provide them with productive strategies that can be used in their daily lives. Interventions must be relevant and interesting to young people – achieving success in an area that does not interest a young person is unlikely to increase feelings of self efficacy, nor provide a trajectory of improved outcomes. As Rutter (2004, p. 607) points out "...it is probably crucial that the individual defines the areas of success as central to his interests and involvement". Perception is really the key here. Just as a person's perception of a traumatic event can impact on how he copes, a person's perception of a positive factor – and by extension an intervention – will determine how well he responds to it (Patton et al., 2003; Rutter, 1985). Perception is also key when exploring social connection and support. It is not necessarily the availability of support that is important, rather it is the individual's perception of the quality and adequacy of those relationships (Rutter, 1985) and their ability to seek out support (Sawyer, 2004; Wolff, 1995). It is also likely that long term positive effects are only sustained if a young person attaches meaning to an event (such as a personal success or an intervention) and incorporates it into his daily life, beliefs and sense of self (Rutter, 1985). Effective problem solving skills are also a key factor in resilience. If one has an effective method of coping with daily conflicts and difficulties, he is unlikely to experience helplessness (Rutter, 1985). Hence, one's cognitive and attributional styles are very important factors to address in effective preventative interventions (Andrews & Wilkinson, 2002; Rutter, 1985).

Interventions that facilitate personal success, a sense of social connectedness and the ability to problem-solve, in a format that is interesting and relevant to the young person, are therefore key elements in prevention and resilience. Interest and relevance alone are not sufficient to create change. A young person may find a brief conversation very interesting, however he may not integrate it into his life and benefit from it. In order to achieve sustained change, interventions must not only be interesting, but must be delivered in a way that allows the young person to take his success home and live it. Therefore many researchers argue that one-off and short-term interventions are insufficient (see for example Sawyer, 2004). A recent review of the prevention literature showed that most interventions for adolescents were eight to 12 weeks in duration, with shorter programmes often requiring booster sessions (Fuller, 2006; Kulic, Horne & Dagley, 2004; McLennan et al., 2004). Interventions should also be delivered by trained staff (Andrews & Wilkinson, 2002) and be evidence based (Spooner et al., 2001; Weissman, 2005) in order to ensure efficacy, as some interventions may actually do harm – for example the "Scared Straight" programme (McLennan et al., 2004).

Although the peer group of an adolescent is paramount in delivering resilience based prevention initiatives, it is important to consider how a young person may take his resilience home to his family and community. One method is to follow the above recommendations in order to ensure that the young person has fully integrated the change within his own self concept and has had sufficient time and practice within his peer group to master his new skills. In this way, he may be able to have an individual impact on his own immediate environment. The alternative is to open lines of communication between young people, families and communities in order to assist the flow-on effects of interventions. Communication may be as simple as sending a diary home with a young person, having open-days at a school, or encouraging young people to engage in neighbourhood projects or volunteering (Richman, Bowen & Woolley, 2004). Social connections are also likely to assist in generalising impacts of interventions. For example parenting education offered to parents of year seven students was found to generalise to associated parents via peer affiliations (Toumbourou et al., 2004).

In summary, resilience based preventative interventions should;

- *Be engaging, interesting and relevant to the young person*
- *Incorporate peer group*
- *Focus on achieving success, ameliorating helplessness and facilitating connectedness*
- *Be at least 8-12 weeks/ sessions' duration, with booster sessions as required*
- *Be evidence based and delivered by trained facilitators*
- *Cover a diversity of issues and areas in order to affect a multitude of outcomes*
- *Target ages or stages that are most likely to see benefit – for example transition points or after traumatic events*
- *Target populations or individuals who experience a disproportionate level of risk*
- *Communicate with families and communities (such as schools and neighbourhoods), and*
- *Use readily accessible locations.*

Conclusion

Resilience is a complex interaction of processes combining to produce pathways or trajectories to wellbeing. It is almost impossible to define clear main effects as influences are interactive (Compas et al., 1995). It is important to identify the types of factors which have been shown to be influential in preventing anxiety, depression and substance use. The literature explored in this summary document suggests that it is wise to intervene in multiple areas and across multiple levels in order to have the broadest impact. For example working on multiple protective factors is likely to produce positive or upward trajectories which are likely to have multiple positive influences (Sanson & Smart, 2004). Similarly, intervening in a wide array of risk factors is likely to have a broader impact, for example working with both internalising and externalising tendencies will positively impact both boys and girls (Compas et al., 1995). It has also been shown that interventions that target multiple levels of influence – such as individuals, families, local and macro environments - will have the most sustained and generalised impacts (Spooner et al., 2001). It is important to remember that, just as risk factors are cumulative, so too are protective factors (Rutter et al., 2004). Every risk factor that can be reduced matters (Appleyard et al., 2005). The ideal is that an intervention will itself act as a 'turning point' in order to significantly alter a young person's developmental trajectory.

It is relevant here to refer back to Rutter et al's (2004) key points about the four main ways in which protective mechanisms operate and ensure that preventative interventions measure up. For example increasing supervision and engagement in prosocial activities may reduce risk impact. Support following a stressful event is likely to reduce the negative consequences or risk. Interventions which are timed during crucial periods, of sufficient length etc, are likely to enhance the development of self perceptions, especially self-esteem and self-efficacy. Encouraging the generalisability of interventions, capacity building and lobbying for social and policy change can enhance the opening of opportunities for young people.

It is important to keep in mind that most young people do adapt well (Fraser, 2004; Fuller, 2006; Patton et al., 2003). Rutter (1985) comments, that even with severe stress it is rare for more than 50% of children to have adverse outcomes. Resilience can be learnt, enhanced and generalised. Even those young people who do experience adverse outcomes can, through 'turning points', be diverted into upward positive trajectories.

References

Andrews, G., & Wilkinson, D. (2002). The prevention of mental disorders in young people. *The Medical Journal of Australia, 177*, 97-100.

Appleyard
outcomes. *Journal of Child Psychology and psychiatry, 46*, 235-245.

City of Monash (2004). Have Your Say Youth Consultation Forum – Evaluation Report. Internal document – City of Monash Youth & Family Services.

Commonwealth Department of Health and Aged Care (2000). *National Action Plan for Promotion, Prevention, & Early Intervention for Mental Health 2000*. Canberra, ACT: Australian Government Publishing Service.

Compas, B., Hinden, B., & Gerhardt, C. (1995). Adolescent development: pathways and processes of risk and resilience. *Annual Review of Psychology, 46*, 265-293.

Edward, K. (2005). Resilience: A protector from depression. *Journal of the American Psychiatric Nurses Association, 11*, 241-243.

Fraser, M. (2004). The ecology of childhood: A multisystems perspective. In M. Fraser (Ed.). *Risk and resilience in childhood: An ecological perspective*, pp.1-12. Washington: National Association of Social Workers Press.

Fraser, M., Kirby, L., & Smokowski, P. (2004) Risk and resilience in childhood. In M. Fraser (Ed.). *Risk and resilience in childhood: An ecological perspective*, pp.13-66. Washington: National Association of Social Workers Press.

Fuller, A. (2006). Resilience; what do animals have to do with it? Paper presented at 'Psychologists for the Promotion of Animal Welfare' Conference on "Animal Cruelty and Bullying", Australian Psychological Society, Melbourne, Victoria, 3 August.

Gilbert, M. (2004) Childhood depression: A risk factor perspective. In M. Fraser (Ed.). *Risk and resilience in childhood: An ecological perspective*, pp. 315-346. Washington: National Association of Social Workers Press.

Goodwin, R. D., Fergusson, D. M., & Horwood, L. J. (2004a). Association between anxiety disorders and substance use disorders among young persons: Results of a 21 year longitudinal study. *Journal of Psychiatric Research, 38*, 295–304.

Goodwin, R.D., Fergusson, D. M., & Horwood, L. J. (2004b). Early anxious/withdrawn behaviours predict later internalizing disorders. *Journal of Child Psychology and Psychiatry, 45*, 874-883.

Jenson, J. (2004). Risk and protective factors for alcohol and other drug use in childhood and adolescence. In M. Fraser (Ed.). *Risk and resilience in childhood: An ecological perspective*, pp.183-208. Washington: National Association of Social Workers Press.

Kirisci, L., Vanyukov, M., & Tarter, R. (2005). Detection of youth at high risk for substance use disorders: a longitudinal study. *Psychology of addictive behaviours, 19*, 243-252.

Kulic, K., Horne, A., & Dagley, J. (2004). A comprehensive review of prevention groups for children and adolescents. *Group Dynamics: Theory, Research and Practice, 8*, 139-151.

Lopez, B., Turner, R., & Lissette, M. (2005). Anxiety and risk for substance dependence among late adolescents/young adults. *Journal of Anxiety Disorders, 19*, 275-294.

Macgowan, M. (2004) Suicidality among youths In M. Fraser (Ed.). *Risk and resilience in childhood: An ecological perspective*, pp.347-384. Washington: National Association of Social Workers Press.

Marsh, A., & Dale, A. (2005). Risk factors for alcohol and other drug disorders: A review. *Australian Psychologist, 40*, 73-80.

McLennan, J., MacMillan, H., & Jamieson, E. (2004). Canada's programmes to prevent mental health problems in children: the research-practice gap. *Canadian Medical Association Journal, 171*, 1069-1071.

Ono, Y., Ando, J., Onoda, N., Yoshimura, K., Momose, T., Hirano, M., & Kanba, S. (2002). Dimensions of temperament as vulnerability factors in depression. *Molecular Psychiatry, 7*, 948-953.

Patton, G.C., Coffey, C., Posterino, M., Carlin, J.B., Bowes, G. (2003). Life events and early onset depression: Cause or consequence? *Psychological Medicine, 33*, 1203-1210.

Raphael, B. (2000). *Promoting the mental health and wellbeing of children and young people. Discussion paper: key principles and directions*. Canberra, Australian Government Publishing Service.

Richman, J., Bowen, G., Woolley, M. (2004). School failure: An eco-interactional developmental perspective, In M. Fraser (Ed.). *Risk and resilience in childhood: An ecological perspective*, pp.133-160. Washington: National Association of Social Workers Press.

Rutter, M. (1985). Resilience in the face of adversity. *British Journal of Psychiatry, 147*, 598-611.

Sanson, A. (2002). *Children's health and development: new research directions for Australia*. Retrieved March 20, 2006 from http://www.aifs.gov.au/institute/pubs/resreport8/main.html

Sanson, A., & Smart, D. (2004). *Pathways to social and emotional wellbeing: lessons from a 20 year longitudinal study*. Proceedings from Australian Council for Educational Research (ACER) Conference: Supporting Student Wellbeing: what does the research tell us about social and emotional development of young people? Adelaide, South Australia, 24-26 October.

Sawyer, M. (2004). *The mental health and wellbeing of young people in Australia*. Proceedings from Australian Council for Educational Research (ACER) Conference: Supporting Student Wellbeing: what does the research tell us about social and emotional development of young people? Adelaide, South Australia, 24-26 October.

Spooner, C., Hall, W., & Lynskey, M (2001). *Structural determinants of youth drug use: ANCD research paper*. Woden, ACT: Australian National Council on Drugs.

State Government of Victoria - Department of Human Services (1998). *Young People and drugs: Needs analysis*. Victoria: State Government of Victoria

Toumbourou, J., Douglas, M.E., & Short, A. (2004). *Family and school influences on healthy youth development; an examination of social interaction between parents within the early high school context*. Proceedings from Australian Council for Educational Research (ACER) Conference: Supporting Student Wellbeing: what does the research tell us about social and emotional development of young people? Adelaide, South Australia, 24-26 October.

Turning Point (2004). PsyCheck II Study (internal document).

Windle, M., & Wiesner, M. (2004). Trajectories of marijuana use from adolescence to young adulthood: predictors and outcomes. *Development and psychopathology, 16*, 1007-1027.

Weissman, M. (2005). *Intergenerational depression/ interpersonal psychotherapy*. Retrieved July 30, 2006 from http://www.abc.net.au/rn/talks/8.30/helthrpt/ stories/s1412304.htm

Wolff, S. (1995). The concept of resilience. *Australian & New Zealand Journal of Psychiatry, 29*, 565-574.

Zimmerman, P., Wittchen, H. U., Hogler, M., Pfister, H., Kessler, R. C., & Lieb, R. (2003). Primary Anxiety Disorders and the development of alcohol use disorders: a four year community study of adolescents and young adults. *Psychological Medicine, 33*, 1211-1222.

Appendix One

COMMUNITY HEALTH PRINCIPLES

Access: Services will be accessible to individuals, families and the community, at a level affordable to them and the health system. To ensure accessibility, services will reach out, using engagement strategies when required. Services will be physically accessible and culturally and linguistically appropriate.

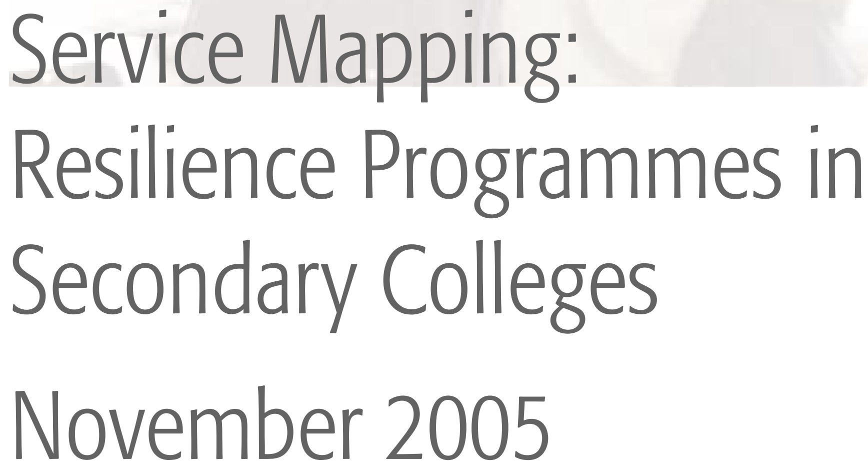
Equity & targeted services: Services will be targeted to respond to greatest existing or potential health risks within a population health and wellbeing model

Health & wellbeing: The focus will be on improving and maintaining the health and wellbeing of individuals, families and communities and addressing the social determinants of health.

Capacity building: Services will work to enhance the power of individuals, families and communities to be self-reliant in managing, maintaining and enhancing their health and wellbeing.

Population-based services and planning: Services will be delivered to an identified geographic area requiring population orientated planning.

Partnerships: A range of factors determines the health of individuals and communities and services will work in partnership with other organisations both within and outside the formal health system.



Service Mapping: Resilience Programmes in Secondary Colleges

November 2005

In July 2005, MonashLink Community Health Service commenced a Health Promotion initiative which aimed to promote mental health and wellbeing in young people. Three sets of objectives were set and implemented in conjunction with a working party comprised of both MonashLink and external agency staff. The Mental Health & Wellbeing in Young People (MHWB in YP) objectives aim to enhance the mental health and well being of young people aged 12-18, attending secondary school in the city of Monash by:

1. Establishing and developing partnerships with networks providing services to young people aged 12-18 attending secondary colleges in the City of Monash, and enhancing services' capacity to promote mental health and wellbeing.
2. Conducting a literature review, service mapping and needs assessment of prevention and early intervention programmes to develop resilience and capacity with a view to preventing anxiety, depression and substance use issues in young people in the City of Monash.
3. Developing two prevention and early intervention initiatives (as identified by needs assessment) to develop resilience and capacity to prevent anxiety, depression and substance use issues in young people in the City of Monash.

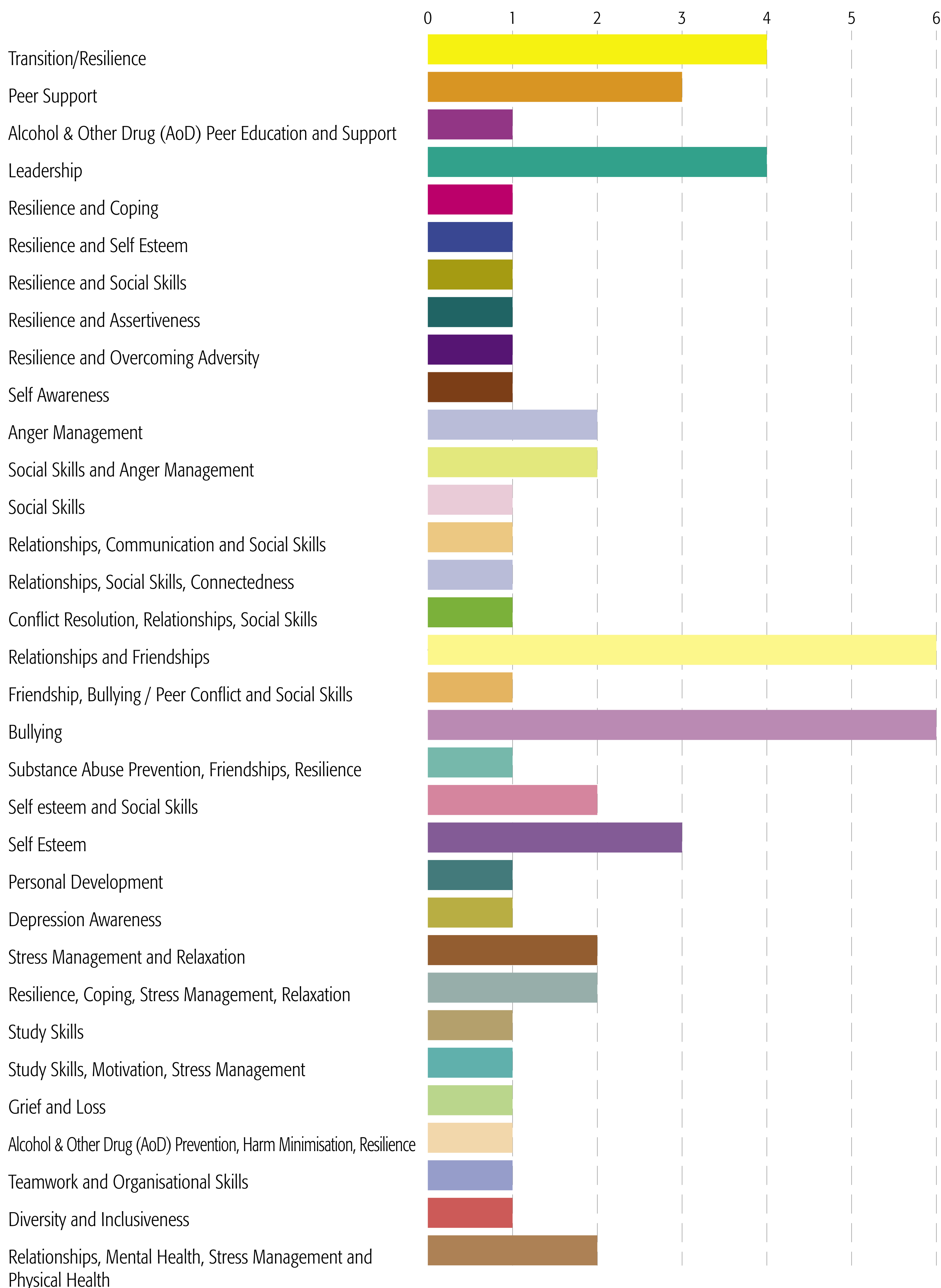
In order to research existing resilience programmes, the MHWB in YP Working Party approached secondary colleges and agencies providing services to young people in Monash, to provide information on programmes that have been delivered in / offered to secondary colleges. Many schools and agencies responded to this request, and the information provided is summarised overleaf.

Programmes by Resilience Area

Resilience Area	Programme Name	Facilitator/s	Schools	Timeline	Target Group
Transition, resilience	Making the Difference Transition Programme Resilience Programme	 MYFS, Monashlink, SEAAC, EDAS	Highvale SC Wellington SC Syndal South PS	 2 sessions	Year 6 (pre Year 7) Year 7 Year 6
Transition, resilience, leadership	Peer Support		South Oakleigh SC Wellington SC Ashwood College	Full year 1 term 2 terms	Year 7 & 10 Year 7,10 & 11 Year 7 & 10
Peer support	Supportive Friends Peer Support VCE Support Friends		Wesley College Brentwood SC Brentwood SC	Ongoing Ongoing	Years 10, 11, 12 Years 7, 8, 10, 11 Years 11 & 12
AoD Peer education & support	PEP	EDAS	Wellington SC	10 sessions	Year 9
Leadership	Connect Programme Leadership Development Leadership Training Leadership Programme	MIC	Ashwood College Mount Waverley SC Brentwood SC Brentwood SC Brentwood SC		ESL students (CALD & newly arrived) Years 10, 11, 12 Years 10, 11, 12 Years 8, 9, 10
Resilience, coping	Coping strategies		Highvale SC		Year 7
Resilience, self esteem	Resiliency Programme	School staff	Wesley College		Year 7
Resilience & social skills	Personal Development	MYFS	Mazenod College South Oakleigh SC		Years 9 & 10
Resilience, assertiveness	Peer Workshop Programme (drama programme)	School staff	Wesley College	Workshops 2-3 x per yr	Year 5 & 9
Resilience, overcoming adversity	Pathways	TAFE, Army Reserve	Wheelers Hill SC	½ day	Year 10
Self awareness	Puberty Programme		Wellington SC	2 sessions	Year 7
Anger management	Going Off Tap Anger Management		Mount Waverley SC Highvale SC Ashwood Special School	6 weeks	Year 8 & 9 Males Year 7 Males Years 9 – 12
Social skills, anger management	Social Skills How Rude	MYFS	Ashwood College Brentwood SC	4 weeks	Year 7 & 8 Males Year 9 Males
Social skills	Social Skills		Highvale SC Wellington SC		Year 7 Year 8
Relationships, communication skills, social skills	Personal & Social Ed	School staff	Wesley College	1 term	Year 5 & 6
Relationships, social skills, connectedness	Community Building	MYFS	Wheelers Hill SC		Year 10
Conflict resolution, relationships, social skills	Peer Mediation	MYFS	Avila College Wheelers Hill SC Glen Waverley SC		Years 10 – 12
Relationships/friendship	MPOWER Connect/Reflect/Respect Healthy Relationships Friendship Group Friendship Girls Friendship Group	 CSAPP School staff School staff MonashLink	Mount Waverley SC Ashwood College Wheelers Hill SC Wellington SC Ashwood College Mount Waverley SC	8 weeks 1 day 1 day 4 weeks	Year 7 & 8 Females Year 9 & 10 Year 7 Year 7 Year 7 Year 7 Females

Resilience Area	Programme Name	Facilitator/s	Schools	Timeline	Target Group
Friendship, bullying/peer conflict, social skills	Sisterhood (Girls Drama Group	Monashlink	Highvale SC		Year 9 & 10 Females
Bullying	Anti-bullying Programme Anti-bullying Programme Bullying Awareness Bullying workshops No bully (on line) Having Your Say (creative art & conversation)	MYFS WEAC School staff	Wellington SC Monash SC Ashwood SC Glen Waverley SC Ashwood College Ashwood College Brentwood SC Brentwood SC Brentwood SC	1 term 1 day ½ day	Years 7 - 10 Year 7 Females Year 7 Year 7 Years 7 – 12 Years 7 – 10
Substance abuse prevention, friendships, resilience	Snap Happy (Phototherapy)	EDAS	South Oakleigh SC	6 weeks	Targeted year 9 -11 Females
Self esteem, social skills	Shake Up, Make Up Pre-VCAL	WEAC MYFS	South Oakleigh SC South Oakleigh SC	6 weeks	Year 7 Females Year 10
Self esteem	Standing Tall Shine Essence	MYFS	Greek Orthodox College Brentwood SC Brentwood SC	 1 term 1 term	Year 7 Year 8 Females Year 9 Females
Personal development	Personal Enrichment Day		Brentwood SC	1 day	Year 10
Depression awareness	Knowing the Blues		Mount Waverley SC Highvale SC Wellington SC	1 day	Year 8
Stress management / relaxation	 CHILL Chill Skills	 EDAS ADAVIC	Mount Waverley SC Monash SC Wheelers Hill SC	1 – 2 days 8 sessions 1 day	Year 12 Targeted students Year 10
Resilience, coping, stress management, relaxation	Year 12 Orientation Year 11 Wellbeing		Wellington SC	1 day 1 day	Year 12 Year 11
Study skills programme (inc stress management, goal setting, motivation)			Mount Waverley SC	3 sessions	Year 11
Study skills, motivation, stress management	Study Skills Camp	Range of facilitators	Wheelers Hill SC	3 days	Year 12
Grief & loss	Seasons		Brentwood SC	1 term	Years 7-10
AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	South Oakleigh Wellington SC Ashwood College Monash SC Brentwood SC	1 day	Year 10 Year 9 Year 9 Year 11 & 12 Year 9, 10, 11
Teamwork, organisation skills	Soccer Club	MYFS	South Oakleigh	1 term	Male students
Diversity, inclusiveness	Sexuality	MYFS	Glen Waverley SC		Year 9
Relationships, mental health, stress, physical health	Youth Health Access Workshop (YHAW)	GSEDGP	Berengarra School Monash SC	2 days	Years 9 & 10

Programmes by Resilience Area



Creative programmes:

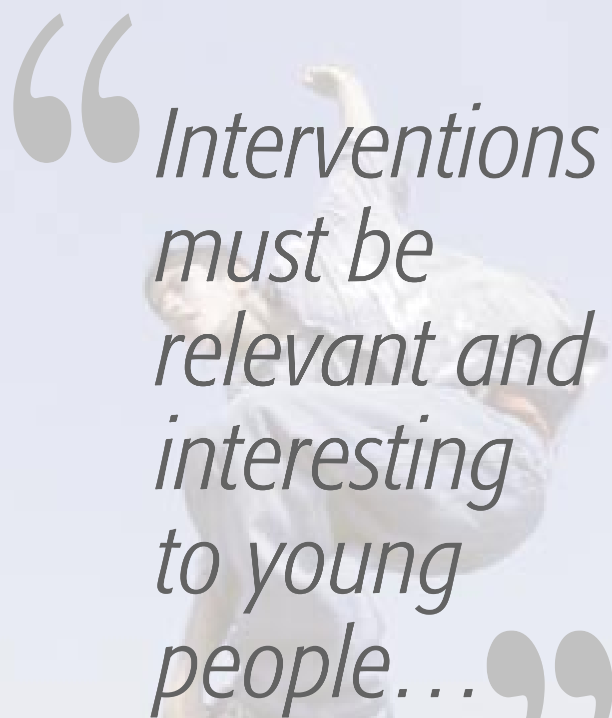
- 'Peer Workshop Programme'
  Drama workshops focusing on resilience & assertiveness, in a peer support context
  Years 5 & 9
  Wesley College
- 'Sisterhood' – Girls Drama Group
  Friendship, bullying/peer conflict, social skills
  Year 9 & 10 (females)
  Monashlink Community Health Service
  Facilitated at Highvale Secondary College
- 'Snap Happy' – Phototherapy
  Substance abuse prevention/harm minimisation, resilience, friendships
  Year 9 – 11 (females)
  Eastern Drug & Alcohol Service (EDAS)
  Facilitated at South Oakleigh Secondary College
- 'CHILL' - includes drumming, yoga, art therapy
  emotional awareness & stress management
  Targeted students
  Eastern Drug & Alcohol Service (EDAS)
  Facilitated at Monash Secondary College
- 'Having Your Say' – Creative Art & Conversation
  Bullying
  Years 7 – 10
  Brentwood Secondary College

Summary of programme themes identified:

- Transition programmes, encompassing resilience, peer support & leadership
- Peer support programmes
- Leadership programmes
- Resilience programmes, some encompassing coping, social skills, self esteem & substance prevention
- Self-awareness & personal development programmes
- Anger management programmes
- Social skills programmes
- Relationship & friendship programmes, some encompassing bullying and peer conflict/mediation
- Bullying programmes
- Self esteem programmes, some encompassing social skills & team building
- Mental health awareness programmes (including depression, anxiety, stress management & relaxation)
- Grief & loss programmes

Gaps/issues identified by student welfare staff:

- School refusal
- Self harming
- Empathy training
- Racism/Diversity/Tolerance
- Grief & loss within friendships
- Dealing with subtle & insidious bullying
- Sexual health
- Mental health
- Space and timetabling constraints
- Male mentors
- External facilitators – issues with longer notice required to book programmes
- Data base (internet) of local services, speakers, upcoming events



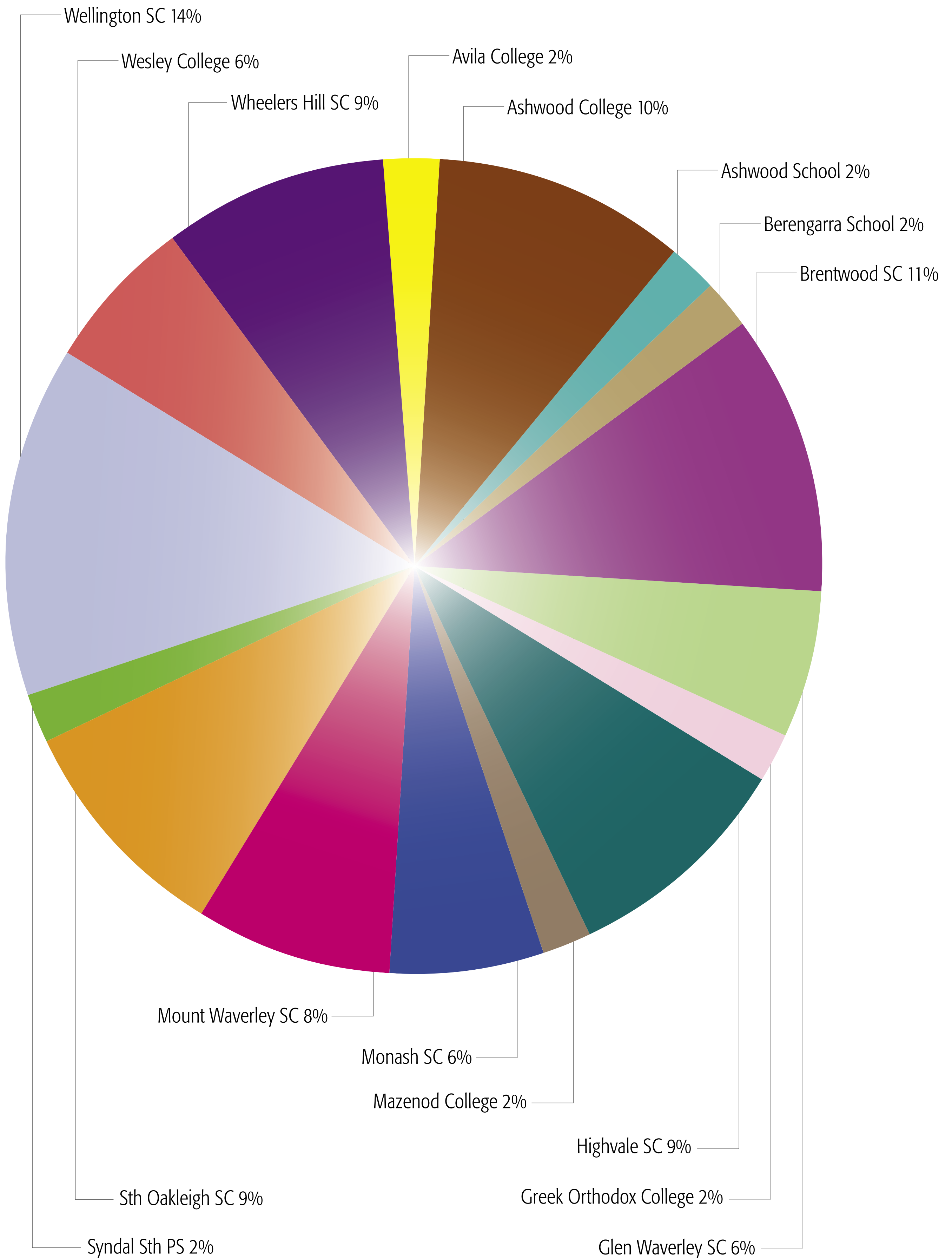
Resilience Programmes by School

School	Resilience Area	Programme Name	Facilitator/s	Timeline	Target Group
Avila College	Conflict resolution, relationships, social skills	Peer Mediation	MYFS		Years 10 - 12
Ashwood College	Transition, resilience, leadership	Peer Support		2 terms	Years 7 & 10
	Leadership	Connect Programme	MIC		ESL students (CALD & newly arrived)
	Relationships	Connect/Reflect/Respect		1 day	Years 9 & 10
	Social skills, anger management	Social Skills	MYFS	4 weeks	Year 7 & 8 Males
	Friendship	Friendship	School staff	4 weeks	Year 7
	Bullying	Anti-bullying Programme Bullying Awareness Anti-bullying Programme	MYFS School staff WEAC	1 term ½ day 1 day	Years 7 - 10 Year 7 Year 7 Females
	AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	1 day	Year 9
Ashwood Special School	Anger management	Anger management			Years 9 - 12
Berengarra School	Relationships, mental health awareness, physical health	Youth Health Access Workshops	GSEDGP	2 days	Years 9 & 10
Brentwood SC	Peer support	Peer Support VCE Support Friends		Ongoing	Years 7, 8, 10, 11 Years 11 & 12
	Leadership	Leadership Development Leadership Training Leadership Programme			Years 10, 11, 12 Years 10, 11, 12 Years 8, 9, 10
	Social skills, anger management	How Rude			Year 9 Males
	Bullying	Bullying workshops No Bully (on line) Having Your Say (Creative Art & Conversation)			Year 7 Years 7 – 12 Years 7 - 10
	Self esteem	Shine Essence		1 term 1 term	Year 8 Females Year 9 Females
	Personal development	Personal Enrichment Day		1 day	Year 10
	Grief & loss	Seasons		1 term	Years 7 - 10
	AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	1 day	Year 9, 10, 11
Glen Waverley SC	Conflict resolution, relationships, social skills	Peer Mediation	MYFS		Years 10 - 12
	Bullying	Anti-bullying Programme	MYFS	1 term	Years 7 - 10
	Diversity, inclusiveness	Sexuality	MYFS		Year 9

School	Resilience Area	Programme Name	Facilitator/s	Timeline	Target Group
Glen Waverley SC	AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	1 day	Year 9
Greek Orthodox College	Self esteem	Standing Tall	MYFS		Year 7
Highvale SC	Transition, resilience	Making the Difference			Year 6 (pre Year 7)
	Resilience, coping	Coping Strategies			Year 7
	Anger management	Going Off Tap			Year 7 Males
	Social skills	Social Skills			Year 7
	Friendship, bullying/peer conflict, social skills	Sisterhood (Drama Group)	Monashlink		Year 9 & 10 Females
	Depression awareness	Knowing the Blues		1 day	Year 8
Mazenod College	Resilience & social skills	Personal Development	MYFS		Years 9 & 10
Monash SC	Relationships, mental health awareness, physical health	Youth Health Access Workshops	GSEDGP	2 days	Years 9 & 10
	Bullying	Anti-bullying Programme	MYFS	1 term	Years 7 -10
	Stress management/ relaxation	CHILL	EDAS	8 sessions	Targeted students
	AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	1 day	Years 11 & 12
Mount Waverley SC	Anger management	Going Off Tap		6 weeks	Year 8 & 9 Males
	Relationships/friendship	MPOWER Girls Friendship Group	 Monashlink	8 weeks	Year 7 & 8 Females Year 7 Females
	Leadership	Connect Programme	MIC		ESL students (CALD & newly arrived)
	Stress management/ relaxation	Stress Management		1-2 days	Year 12
	Study skills (inc stress management, goal setting, motivation)	Study Skills		3 sessions	Year 11
South Oakleigh SC	Transition, resilience, leadership	Peer Support		Full Year	Year 7 & 10
	Resilience & social skills	Personal Development	MYFS		Years 9 & 10
	Teamwork, organisation skills	Soccer Club	MYFS	1 term	Male students
	Substance abuse prevention, friendships, resilience	Snap Happy (Phototherapy)	EDAS	6 weeks	Year 9 – 11 Females

School	Resilience Area	Programme Name	Facilitator/s	Timeline	Target Group
South Oakleigh SC	Self esteem, social skills	Shake Up, Make Up Pre VCAL	WEAC MYFS	6 weeks	Year 7 Females Year 10
	AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	1 day	Year 10
Syndal South PS	Transition, resilience	Resilience Programme	MYFS, Monashlink, SEAAC, EDAS		Year 6
Wellington SC	Transition, resilience	Transition Programme		2 sessions	Year 7
	Transition, resilience, leadership	Peer Support		1 term	Year 7 & 10, 11
	AoD peer education & support	PEP	EDAS	10 sessions	Year 9
	Self awareness	Puberty Programme		2 sessions	Year 7
	Social skills	Social Skills			Year 8
	Relationships/Friendship	Friendship Group	School staff		Year 7
	Bullying	Anti-bullying Programme	MYFS	1 term	Years 7 - 10
	Depression awareness	Knowing the Blues		1 day	Year 8
	Resilience, coping, stress management, relaxation	Year 12 Orientation Year 11 Wellbeing		1 day 1 day	Year 12 Year 11
	AoD prevention/harm minimisation, resilience	Party Safe	EDAS, MYFS, school staff, Police, Ambulance	1 day	Year 9
Wesley College	Peer support	Supportive Friends	School staff	Ongoing	Years 10, 11, 12
	Resilience, self esteem	Resiliency Programme	School staff		Year 7
	Resilience, assertiveness	Peer Workshops (drama programme)	School staff	W' shops 2-3 x per year	Year 5 & 9
	Relationships, communications skills, social skills	Personal & Social Ed.	School staff	1 term	Years 5 & 6
Wheelers Hill SC	Resilience, overcoming adversity	Pathways	TAFE, Army Reserve	½ day	Year 10
	Relationships, social skills, connectedness	Community Building	MYFS		Year 10
	Conflict resolution, relationships, social skills	Peer Mediation	MYFS		Years 10 - 12
	Relationships, bullying	Healthy Relationships	CSAPP	1 day	Year 7
	Stress management, relaxation	Chill Skills	ADAVIC	1 day	Year 10
	Study skills, stress management, motivation	Study Skills Camp	Range of facilitators	3 days	Year 12

Number of Resilience Programmes Per School



Resilience Programmes by Year Level

Year Level	Resilience Area	Programme Name	Schools	Timeline	Facilitator/s
Year 5	Resilience, assertiveness	Peer Workshop Programme (Drama)	Wesley College	workshops 2-3 x per year	School staff
	Relationships, communication skills, social skills	Personal & Social Ed.	Wesley College	1 term	School staff
Year 6	Relationships, communication skills, social skills	Personal & Social Ed.	Wesley College	1 term	School staff
	Transition, resilience	Making the Difference Resilience Programme	Highvale SC South Syndal PS		MYFS, Monashlink, SEAAC, EDAS
Year 7	Transition, resilience	Transition Programme	Wellington SC	2 sessions	
	Transition, resilience, leadership	Peer Support Peer Support Peer Support	South Oakleigh SC Wellington SC Ashwood College	Full Year 1 term 2 terms	
	Resilience, coping	Coping Strategies	Highvale SC		
	Peer support	Peer Support	Brentwood SC	Ongoing	
	Self esteem	Standing Tall	Greek Orthodox College		MYFS
	Resilience, self esteem	Resiliency Programme	Wesley College		School staff
	Self esteem, social skills	Shake Up, Make Up	South Oakleigh SC	6 weeks	WEAC
	Self awareness	Puberty Programme	Wellington SC	2 sessions	
	Anger management	Going Off Tap	Highvale SC	6 weeks	
	Social skills, anger management	Social Skills	Ashwood College	4 weeks	MYFS
	Relationships/Friendship	MPOWER Friendship Group Friendship Girls Friendship Group	Mount Waverley SC Wellington SC Ashwood College Mount Waverley SC	8 weeks 4 weeks	 School staff School staff Monashlink
	Bullying	Anti-bullying Programme Anti-bullying Programme Bullying Awareness Bullying Workshops No Bully (on line) Having Your Say (Creative Art & Conversation)	Wellington SC Monash SC Ashwood SC Glen Waverley SC Ashwood College Ashwood College Brentwood SC Brentwood SC Brentwood SC	1 term 1 day ½ day	MYFS WEAC School staff
	Grief & loss	Seasons	Brentwood SC	1 term	School staff
Year 8	Peer support	Peer Support	Brentwood SC	Ongoing	
	Leadership	Leadership Programme	Brentwood SC		

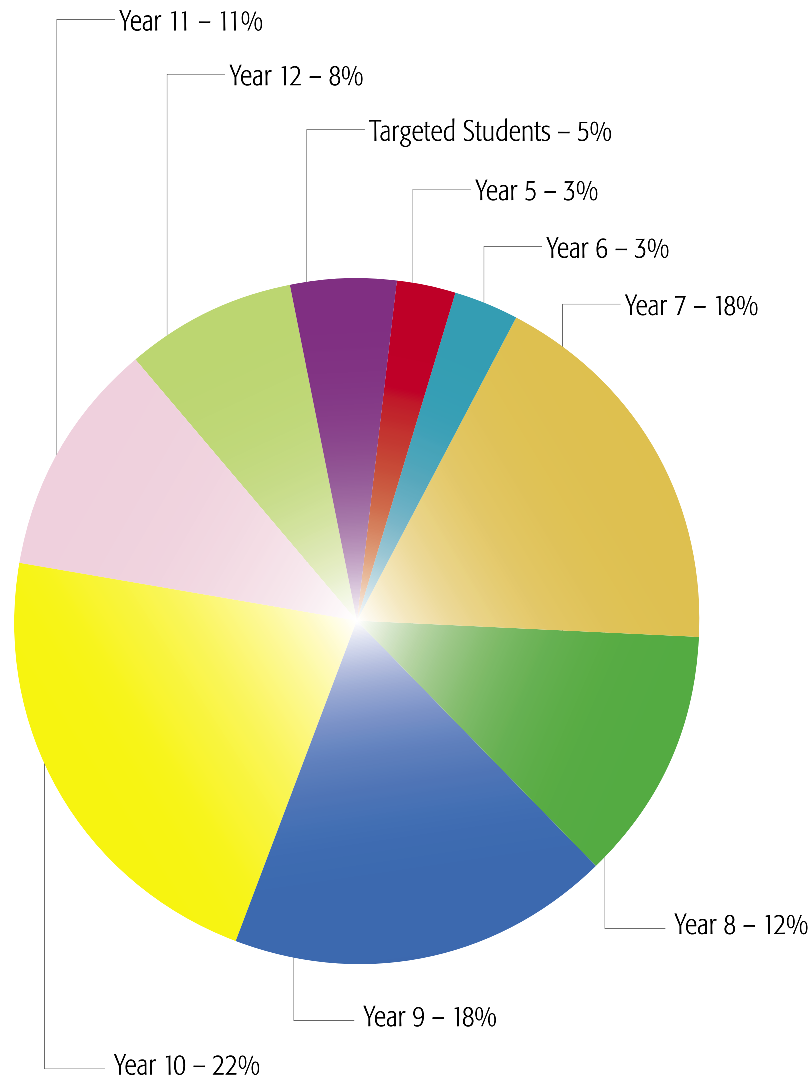
Year Level	Resilience Area	Programme Name	Schools	Timeline	Facilitator/s
Year 8	Anger management	Going Off Tap	Mount Waverley SC	6 weeks	
	Social skills, anger management	Social Skills	Ashwood College	4 weeks	MYFS
	Relationships/friendship	MPOWER	Mount Waverley SC	8 weeks	
	Self esteem	Shine	Brentwood SC	1 term	
	Bullying	Anti-bullying Programme Having Your Say (Creative Art & Conversation) No Bully (on line)	Wellington SC Monash SC Ashwood SC Glen Waverley SC Brentwood SC Brentwood SC	1 term	MYFS
	Grief & loss	Seasons	Brentwood SC	1 term	School staff
	Depression awareness	Knowing the Blues	Mount Waverley SC Highvale SC Wellington SC	1 day	
Year 9	AoD Peer education & support	PEP	Wellington SC	10 sessions	EDAS
	Leadership	Leadership Programme	Brentwood SC		
	Resilience & social skills	Personal Development	Mazenod College South Oakleigh SC		MYFS
	Resilience, assertiveness	Peer Workshop Programme (Drama)	Wesley College	workshops 2-3 x per year	School staff
	Anger management	Going Off Tap Anger Management	Mount Waverley SC Ashwood Special School	6 weeks	
	Social skills, anger management	How Rude	Brentwood SC		
	Relationships/friendship	Sisterhood (Drama Group)	Highvale SC		Monashlink
	Self esteem	Essence	Brentwood SC		
	Bullying	Anti-bullying Programme Having Your Say (Creative Art & Conversation) No Bully (on line)	Wellington SC Monash SC Ashwood SC Glen Waverley SC Brentwood SC Brentwood SC	1 term	MYFS
	Grief & loss	Seasons	Brentwood SC	1 term	School staff
	Diversity, inclusiveness	Sexuality	Glen Waverley SC		MYFS

Resilience Programmes by Year Level (cont)

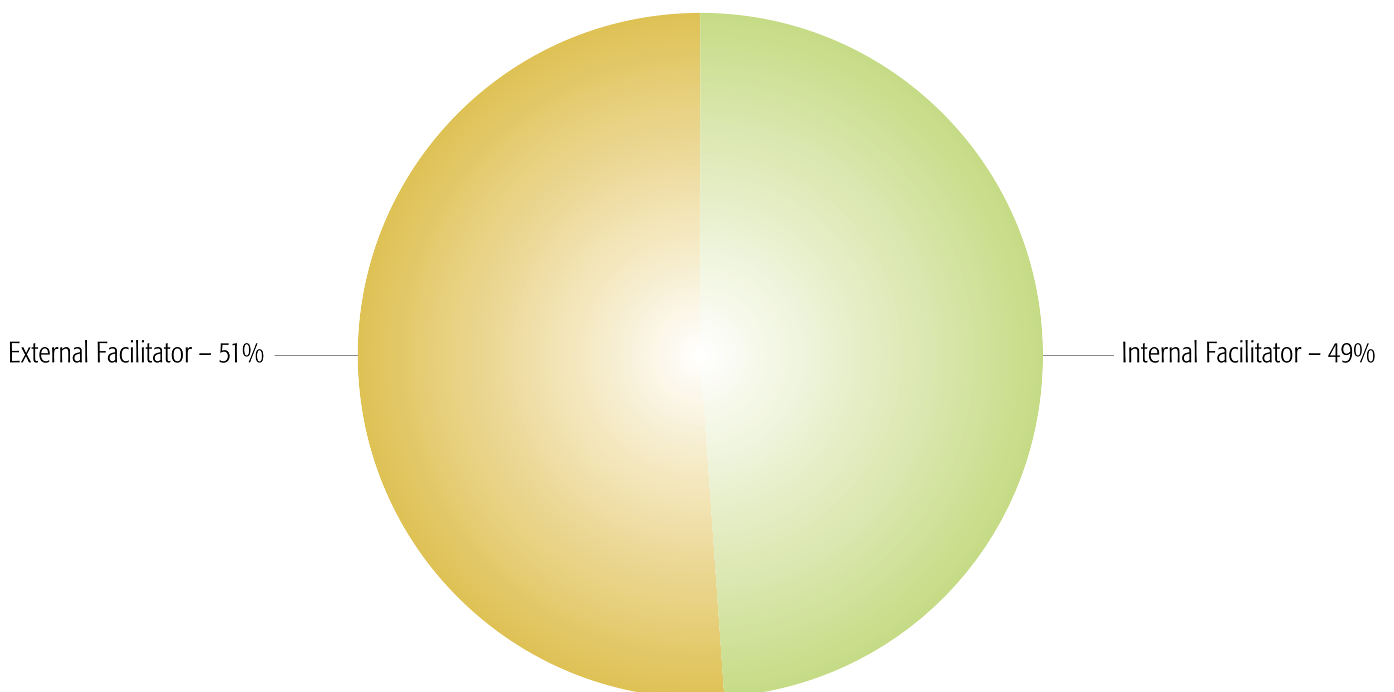
Year Level	Resilience Area	Programme Name	Schools	Timeline	Facilitator/s
	Relationships, mental health, stress, physical health	Youth Health Access Workshop (YHAW)	Berengarra School Monash SC	2 days	GSEDGP
	AoD prevention/harm minimisation, resilience	Party Safe	South Oakleigh SC Wellington SC Ashwood College Monash SC Brentwood SC	1 day	EDAS, MYFS, School staff, Police, Ambulance
Year 10	Transition, resilience, leadership	Peer Support Peer Support Peer Support	South Oakleigh SC Wellington SC Ashwood College	Full Year 1 term 2 terms	
	Peer support	Supportive Friends Peer Support	Wesley College Brentwood SC	Ongoing Ongoing	
	Leadership	Development & Training Leadership Programme	Brentwood SC Brentwood SC		
	Resilience & social skills	Personal Development	Mazenod College South Oakleigh SC		MYFS
	Resilience, overcoming adversity	Pathways	Wheelers Hill SC	½ day	TAFE, Army Reserve
	Anger management	Anger Management	Ashwood Special School		
	Relationships/friendship	Connect/Reflect/Respect Sisterhood (Drama Group)	Ashwood College Highvale SC	1 day	Monashlink
	Relationships, social skills, connectedness	Community Building	Wheelers Hill SC		
	Conflict resolution, relationships, social skills	Peer Mediation	Avila College Wheelers Hill SC Glen Waverley SC		MYFS
	Self esteem, social skills, team building	Pre-VCAL	South Oakleigh SC		MYFS
	Bullying	Anti-bullying Programme Having Your Say (Creative Art & Conversation) No Bully (on line)	Wellington SC Monash SC Ashwood SC Glen Waverley SC Brentwood SC Brentwood SC	1 term	MYFS
	Grief & loss	Seasons	Brentwood SC	1 term	School staff
	Relationships, mental health, stress, physical health	Youth Health Access Workshop (YHAW)	Berengarra School Monash SC	2 days	GSEDGP
	AoD prevention/harm minimisation, resilience	Party Safe	South Oakleigh SC Wellington SC Ashwood College Monash SC Brentwood SC	1 day	EDAS, MYFS, School staff, Police, Ambulance
	Stress management/ relaxation	Chill Skills	Wheelers Hill SC	1 day	ADAVIC
	Personal development	Personal Enrichment Day	Brentwood SC	1 day	

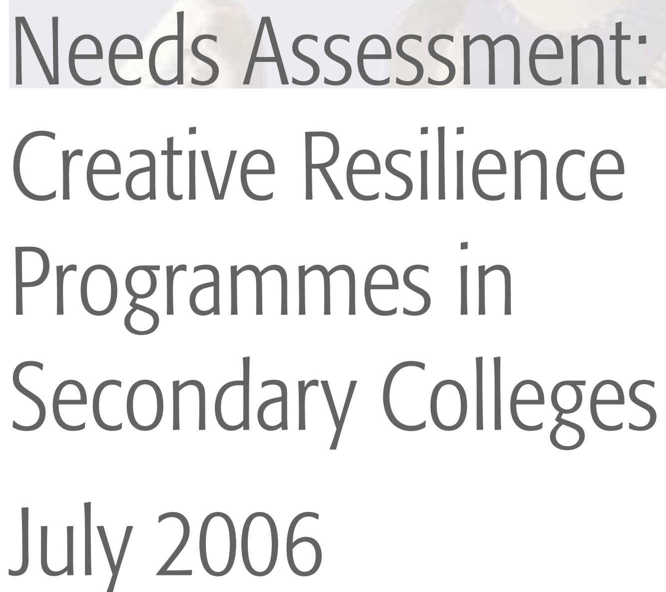
Year Level	Resilience Area	Programme Name	Schools	Timeline	Facilitator/s
Year 11	Transition, resilience, leadership	Peer Support	Wellington SC	1 term	
	Peer support	Supportive Friends VCE Support Friends	Wesley College Brentwood SC	Ongoing	
	Leadership	Development & Training	Brentwood SC		
	Anger management	Anger Management	Ashwood Special School		
	Bullying	No Bully (on line)	Brentwood SC		
	Conflict resolution, relationships, social skills	Peer Mediation	Avila College Wheelers Hill SC Glen Waverley SC		MYFS
	AoD prevention/harm minimisation, resilience	Party Safe	South Oakleigh SC Wellington SC Ashwood College Monash SC Brentwood SC	1 day	EDAS, MYFS, School staff, Police, Ambulance
	Resilience, coping, stress management, relaxation, motivation	Year 11 Wellbeing Study Skills Programme	Wellington SC Mount Waverley SC	1 day 3 sessions	range of facilitators
Year 12	Peer support Leadership	Supportive Friends Peer Support VCE Support Friends Development & Training	Wesley College Brentwood SC Brentwood SC Brentwood SC	Ongoing Ongoing	
	Anger management	Anger Management	Ashwood Special School		
	Bullying	No Bully (on line)	Brentwood SC		
	Conflict resolution, relationships, social skills	Peer Mediation	Avila College Wheelers Hill SC Glen Waverley SC		MYFS
	AoD prevention/harm minimisation, resilience	Party Safe	South Oakleigh SC Wellington SC Ashwood College Monash SC Brentwood SC	1 day	EDAS, MYFS, School staff, Police, Ambulance
	Resilience, coping, stress management, relaxation, motivation	Year 12 Orientation Study Skills Camp Stress Management	Wellington SC Wheelers Hill SC Mount Waverley SC	1 day 3 days 1-2 days	range of facilitators
Targeted students	Leadership	Connect Programme	Ashwood College Mount Waverley SC		MIC
	Substance abuse prevention, resilience, friendships	Snap Happy (Phototherapy)	South Oakleigh SC	6 weeks	EDAS
	Teamwork, organisation skills	Soccer Club (males)	South Oakleigh SC	I term	MYFS
	Stress management, relaxation, emotional awareness	CHILL	Monash SC	8 sessions	EDAS

Number of Programmes Per Year Level



Type of Programme Facilitator





Needs Assessment: Creative Resilience Programmes in Secondary Colleges

July 2006

The needs assessment survey asked student welfare staff to respond to questions that, when combined with the outcomes of the literature review and the service mapping exercise, would assist the Mental Health & Wellbeing in Young People Working Party to develop two creative resilience programmes, to be piloted at two secondary colleges in the City of Monash.

The Working Party received responses from six secondary colleges (Ashwood College, Brentwood Secondary College, Mount Waverley Secondary College, South Oakleigh Secondary College, Wellington Secondary College, and Wesley College). The information provided is summarised overleaf.

1. Would your school be interested in running 2 creative resilience programmes?

All schools surveyed stated they would be interested in running two creative resilience programmes.

2. The overarching focus of this health promotion project is to build resilience, with a view to prevent anxiety, depression and substance abuse in young people. What do you perceive to be triggers or precursors of anxiety, depression and substance use in young people?

Table 1 shows what schools perceive are triggers or precursors of anxiety, depression and substance use in young people.

Table 1: Triggers of anxiety, depression and substance use in young people

Issue	Responses
Family Dysfunction	6
Poor Peer Relations	3
Poor School Connectedness	3
Low Self Esteem	3
Peer Pressure	2
Poor Academic Progress	2
Unrealistic Expectations	2
Hopeless Feelings	2
Stress	1
Experimentation	1
Poor Problem Solving Abilities	1
Poor Coping Mechanisms	1
Bullying	1
Grief	1
Disconnectedness with Community	1
School demands	1
Relationships with teachers	1
Lack of Social Responsibility	1
Fast Paced Society	1
Current World Climate	1

3. Do you think that there are any gaps in delivery of resilience programmes? If so, in which area/s?

All schools surveyed believed there were gaps in delivery of resilience programmes. The key areas identified are displayed in Table 2.

Table 2: Schools perceived gaps in the delivery of resilience programmes

Gap/Issue	Responses
Relationship Building vs Curriculum	1
Developing Confidence	1
Parentified Teenagers	1
Living with Mentally Challenged Parent/s	1
Seeking an Identity	1
No Resilience Policy Across Schools	1
Cost of Programmes	1
The Number, Choice, Frequency and Type of Programme	1
Access to programme	1
Time	1
Expertise of Programme Facilitators	1
Family vs School	1

4. Research indicates that young people respond well to more creative programmes. What programmes do you think that your students would like to participate in?

Schools believed that students would respond well to the creative programmes identified in Table 3.

Table 3: Programmes schools believe students would participate in

Programme type	Responses
Martial Arts	2
Drama	1
Activity Based Role Play	1
Discussion	1
Audio Visual Sessions	1
Self -Esteem	1
Adventure Activities	1
Learning New Skills e.g. Building	1
Learning a Musical Instrument	1
Caring for Others	1

5. Please rank your preferences for the following creative programmes, by numbering each option from 1 to 4 (1 for your first preference, 2 for your second preference, and so on).

Schools ranked their preferences for creative programmes showing most support for the animal-assisted therapy, followed by drama, music then art therapy, as seen in Table 4. Lower numbers indicate a higher preference.

Table 4: Ranked Preferences for Creative Programmes

Programme type	Preference
Dog Programme (animal-assisted therapy)	9
Drama Programme	12
Music Programme	14
Art Therapy Programme	15

6. Are there any other creative programmes that you would like to see delivered?

Schools identified other creative programmes they would like to see within the school. Table 5 indicates additional ideas not listed in Table 3.

Table 5: Additional creative programmes schools would like to see delivered

Programme	Responses
Programmes for Teachers and Parents	1
Rock and Water	1
Peer Support	1
Refer to Table 3	1

7. These creative programmes will be designed to build resilience, with the view to preventing anxiety, depression and substance abuse. What year level do you think would be most appropriate to target these resilience programmes?

Schools surveyed indicated that resilience programmes that are designed to prevent anxiety, depression and substance abuse would be most appropriate for Years 7, 8, and 10. Table 6 indicates that most schools believe Year 9 would be the most appropriate year level for resilience programmes.

Table 6: Year level schools believe are the most appropriate for resilience programmes

Year level	Responses
Year 7	2
Year 8	3
Year 9	4
Year 10	1

8. Which do you think would be more beneficial – a small group targeting specific students, or a universal programme?

All schools except one believed that both small groups targeting specific students and universal programmes had advantages. One school stated that a universal programme was more beneficial to promote well-being for all students, not just 'at risk' students.

9. How would you select students for a resilience programme?

Surveyed schools believed that it would be best for students to self select for the resilience programmes. Table 7 shows the schools responses on how students should be selected for resilience programmes.

Table 7: Selecting students for resilience programmes

Student selection preference	Responses
Year Level Co-ordinators	1
Staff	3
Parents	3
Students	5
Student Services	1
Primary School Information	1
Application for Leadership	1

10. How many students would make an optimal group number for such a programme?

Optimal group numbers as perceived by the school are shown in Table 8.

Table 8: Optimal Group Numbers

Group number	Responses
10	3
12	1
15	1
8	2
16 if 2 staff	1
25 if 4 staff	1
up to 30	1

11. Programme duration and length: How many sessions would you recommend? Should each session be held in a single or double period?

All surveyed schools preferred groups to run over a double period, ranging from 4 – 8 weeks, 6 being the average.

12. What opportunities exist for creative resilience programs to be further supported in the wider school curriculum?

Surveyed schools believed they were flexible enough to include novel extra curricular programs for a limited time. It appears that there would be a strong potential for success, given factors like the schools' commitment to welfare and willingness of the staff.

13. Would your school approve the creative resilience programs to be independently evaluated by Monash University Psychology staff/student?

Surveyed schools agreed that the programmes could be independently evaluated by Monash University Psychology Department.

Creative Resilience Programmes: Dramatherapy and Animal-Assisted Therapy Groups for Adolescents 2007

Melanie G. Jones, Psychologist/Youth Counsellor
Naomi J. Adams, Alcohol & Other Drugs Counsellor
MonashLink Community Health Service

Enhancing mental health and wellbeing is likely to create positive developmental pathways for young people and subsequently adults and communities. Further, reducing the disease burden associated with mental illness and substance abuse is significant and can have profound social, emotional and economic benefits. Developing initiatives which enhance mental health and wellbeing are therefore an important area for research and development within Health Promotion portfolios.

Developing Prevention Groups

An exploration of the risk and resilience literature indicates that enhancing resilience in young people is likely to enhance mental health and wellbeing (Jones & Adams, 2006). This exploration highlighted a number of recommendations, including guidelines for programme development and key areas of resilience that have been shown to be effective in the prevention of anxiety, depression and substance abuse. In summary interventions need to:

- Be engaging, interesting and relevant to young people
- Incorporate the peer group
- Target those most at risk
- Intervene at points of transition, and
- Have a focus on achieving success, ameliorating hopelessness and facilitating connectedness.

Key areas of resilience identified in the literature include:

- Positive peer relationships
- Self esteem and self efficacy
- Problem solving skills, and
- Opportunities for reward and recognition.

Based on these recommendations from the literature, MonashLink Community Health Service has sought to pilot creative interventions that enhance those areas of resilience shown to be effective in the prevention of anxiety, depression and substance abuse. In their comprehensive review of primary prevention and mental-health promotion programmes, Weisz, Sandler, Durlack and Anton (2005) note the importance of facilitating positive youth development in order to prevent mental disorders. More specifically, they cite interpersonal skills, self efficacy, quality adult and peer relationships, positive academic performance and commitment to school. In general, social and peer adaptation is considered crucial and predictive of positive outcomes for adolescents (Lomonaco, Scheidlinger & Aronson, 2000).

Given the importance of peers and peer relationships to young people, the efficacy of the group modality was explored. Kulic, Horne and Dagley (2004) assert that groups are the best modality to use with children and adolescents given the amount of time spent with peers and their primary socialising influence, the ability for 'real life' applications of strategies within the group modality and their high levels of research based efficacy. Groups may also help young people work through difficult family and peer dynamics. This is due to their ability to provide universality, interpersonal feedback, normative peer support, reduced isolation and enhanced self esteem (Lomonaco, et. al., 2000).

Ideally, interventions should be targeted at times when they are likely to affect the greatest positive impact. Times of transition (such as the transition to puberty or secondary school), or following traumatic events are such times. Studies exploring the transition to secondary school show that this is a time of great change and possible stress (Jones & Adams, 2006). This is also a time when young people may be starting to experiment with alternative and perhaps unhelpful behaviours, such as peer or drug experimentation. Transition is therefore an ideal time to enhance resilience and target preventative initiatives (Jones & Adams, 2006).

Schools have been identified as an ideal location for preventative interventions to occur, as they have an ability to reach the widest audience (Kulic et. al., 2004; Weisz, et. al., 2005). This assertion is supported by studies indicating that schools are ideally placed to deliver resilience based interventions (Jones & Adams, 2006).

Consultation was hence undertaken with secondary schools and local services in order to determine what types of creative and resilience based programmes were already being offered within the City of Monash and where gaps existed. School welfare teams were asked to nominate their preferred creative modalities based on a list of options available. These options represented the range of skills and abilities available via MonashLink staff, for example art, drama, music and animal-assisted therapy (AAT). *Following this consultation, two preferred creative group modalities were identified for the 2007 pilot, dramatherapy and animal-assisted therapy.*

Dramatherapy

Dramatherapy can be defined as the intentional, goal directed use of drama and theatre as a therapeutic process. Dramatherapy is an action-based method of increasing insight and self awareness by using group process and group dynamics. It provides opportunities to practice alternative ways of thinking, behaving and hence feeling (Kyriacou, 2006). By using the innate ability of individuals to play, dramatherapy acknowledges the fundamental importance of play in development (Kyriacou, 2006; Landy, 2005).

Dramatherapy uses the creation of metaphorical or fictional roles to explore issues. It is recognised as a tool for enhancing relationships, self esteem and self awareness. Through the use of role play, observation and experimentation with alternative behaviours and strategies, dramatherapy provides an avenue for the exploration of issues or problems (Kyriacou, 2006; Landy,

2005). Individuals and groups develop skits, routines or entire plays, allowing participants to focus on issues of relevance to them. Groups will often conduct a performance at the culmination of therapy. In summary, dramatherapy allows one to explore what *is* and practice what *could be*.

Dramatherapy is well established in both theory and practice. The use of drama as a therapeutic application emerged in Europe in the 19th Century and inspired many theoretical branches throughout the early 20th Century. One notable branch, often confused with dramatherapy is Psychodrama, developed by Jacob Moreno in Vienna in the 1920's. Psychodrama differs from dramatherapy in that it assigns roles to participants so that they can act out a patient's "real-life" personal and emotional problems. These are then immediately discussed at length with other group members and/or the therapist (Landy, 2005).

By the 1950's dramatherapy was recognised as a specific theoretical orientation and by the 1960's training programmes and clinical applications were widespread across Europe, the UK and the USA. As early as the 1980's dramatherapy was largely professionalised and regulated, for example the registration of clinicians in the UK (Kyriacou, 2006).

Given the long standing history of dramatherapy and its sound theoretical underpinnings, it is not surprising that drama is an accepted intervention modality in use by many agencies, schools and individual clinicians. At the time of service mapping in 2005, two of the 15 secondary schools in the City of Monash identified that they had run drama groups at their school.

The dramatherapy programme developed by MonashLink for the current pilot draws heavily on the models developed by Walsh-Bowers (1992) and Johnson, Healey and Tracey-Magid (1985). Johnson et. al. (1985) incorporated a specific problem solving technique based on the principals of Cognitive Behavioural Therapy (CBT) into a creative and interesting medium, namely drama. The problem solving technique, called Interpersonal Cognitive Problem Solving (ICPS) is managed as an informal component of the group process rather than being explicitly taught to participants. Facilitators encourage a stepwise approach to problem solving as follows:

- Define the problem
- Examine feelings of self and others
- Consider antecedents to the conflict
- Generate a variety of alternative solutions
- Identify the sequential steps to goal achievement, and
- Reflect on potential consequences of proposed action.

This model serves to provide a formalised structure to assist facilitators in managing issues of group process and conflict. Participants were hence encouraged by facilitators to explore and manage conflict in their groups and successfully develop skits, role-plays and dramas that were of relevance.

The work conducted by Walsh-Bowers (1992) explores the use of drama in assisting the transition from primary to secondary school. Walsh-Bowers (1992) strongly advocates the need to attend to issues of group process, claiming that group responsibility, teamwork and interpersonal problem solving all assist with social skill development. Although the author does not define a specific problem solving model, he states that facilitators can promote positive peer relations by modeling active listening, giving supportive feedback and facilitating peer communication. He states that encouraging group centered problem solving and decision making can build a sense of cohesiveness from co-operative action.

Walsh-Bowers (1992) investigated the efficacy of drama to assist the social and emotional development of young people during the transition to secondary school. He states that developing and performing plays or dramas requires cognitive functioning, imagination, impulse control and social perspective taking. He advocates drama as an ideal modality to use with this age group due to its inherent appeal and the fact that play acting allows participants to practice new skills. As drama requires controlled expression of emotion, plus attention, it helps develop emotional mastery.

The results of Walsh-Bowers (1992) research showed an increase in self efficacy and improved skills at follow-up, for example learning to confront others appropriately (conflict management) and preventing students from regressing post-transition (protective to coping and well-being). The research indicates that the group environment is conducive to understanding others' feelings, managing disappointments and highlights the importance of group generated rules. Walsh-Bowers (1992, p.144) concludes that "...any type of group centered activity in which members have to confront their group process directly might lead to behaviour change".

Therefore dramatherapy demonstrates evidence as a resilience building modality and as a preventative intervention shown to enhance the mental health and wellbeing of young people experiencing the transition to secondary school.

Animal-Assisted Therapy (AAT)

Whilst dramatherapy has been well established as an evidence based intervention, animal-assisted therapy or AAT is less well established as a preventative intervention or resilience building modality. Both drama and AAT are reflective however, of a trend towards creative activity based interventions, especially for young people. There is increasing acceptance of the use of nature, for example wilderness and adventure based programmes. Neill and Dias (2001, p.6) assert that "experiencing challenges [of Adventure Education] with social support offers an effective mechanism for building psychological

resilience". Interaction with the natural world (including plants and animals) has also been shown to promote health in a number of domains, such as physical, emotional and social health (Prior, Townsend, Maller & Field, 2006).

The investigation of AAT programmes has drawn upon a perception that interacting with nature is therapeutic. There is also a well established body of evidence indicating the positive social, emotional and physical health benefits of animal companionship (Friedman, 2000; Hart, 2000; Mallon, 1992; Menzies, 2003). Research throughout the 1990's began to confirm earlier perceptions that even visiting pets could produce positive outcomes. There is a sound body of literature which supports the use of AAT to facilitate engagement and rapport between client(s) and therapist(s) (Fine, 2000; Chandler, 2005), for example increasing attention and focus (Mallon, 1992), easing the stress of therapy and helping the environment to appear less threatening and more friendly (Friedman, 2000; Menzies, 2003), encouraging voluntary participation and retention in therapy (Barker & Dawson, 1998; Kruger, Trachtenberg & Serpell, 2004) and conversation starting (Fine, 2000).

Using visiting pets and farm animals in AAT programmes can also facilitate therapeutic process. Consider for example the role of an animal in a counselling situation – be it individual or group. Animals can provide a sense of comfort (Menzies, 2003), offer affection, touch, contact and non-judgmental acceptance (Chandler, 2005; Kruger et. al., 2004; Mallon, 1994). Whilst animals are well renowned for their ability to provide unconditional positive regard, animals will also provide immediate feedback for inappropriate (e.g. violent or frightening) behaviour, offering opportunities for the clinician to reflect and direct group dynamics (Chandler, 2005; Fine, 2000). Animals can act as emotional catalysts for clients, for example via story telling (Menzies, 2003), as an adjunct to the clinician (Fine, 2000), or by acting as a 'confidant' (Mallon, 1994). Clinicians may take advantage of this process, such as using a dog to access feelings via metaphor, symbolism, storytelling, puppetry, asking 'dog-perspective' questions or extending traditional therapy into walks, visiting or training (Chandler, 2005; Fine, 2000).

Experimental studies on the use of AAT have shown numerous psychosocial benefits across a wide range of ages and clinical diagnoses. There is a general consensus in the literature that AAT works well for those individuals experiencing internalising disorders (e.g. anxiety, depression, social withdrawal or shyness) and also for those experiencing externalising disorders (e.g. conduct disorders, ADHD, or other behaviour problems) (see for example Menzies, 2003). Increasingly, the teaching of dog-training is considered effective in skill development and self esteem (Kogan, Granger, Fitchett, Helmer & Young, 1999). The presence of an animal in a workplace may even be perceived to positively affect employee health and organisational issues (Wells & Perrine, 2001).

Results indicate that AAT can reduce depression and anxiety (Barker & Dawson, 1998; Kruger et. al., 2004; Folse, Minder, Aycock & Santana, 1994; Hart, 2000; Parshall, 2003; Menzies, 2003) and may be more effective than psychotherapy alone for adolescents with anxiety and depression (Urichuk & Anderson, 2003). Animal-assisted therapy is considered highly effective at increasing positive relationships with others (Menzies, 2003) and increasing socialisation in general (Barker & Dawson, 1998; Hart, 2000; Jalongo, Astorino, Bomboy, 2004; Menzies, 2003; Nathan-Barel, Feldman, Berger, Modai & Silver, 2005; Parshall, 2003). It is effective in decreasing state and trait anger (Hanselman, 2001), can improve antisocial behaviour (CIAS, 2004; Menzies, 2003) and assist in managing conduct disorder (Fawcett & Gullone, 2001) as well as increasing empathy (Ascione, 2004; Menzies, 2003). In a comprehensive review of AAT programmes in mental health, Kruger et al. (2004, p.19) concluded that "statistically significant positive results were demonstrated related to behaviour and affect, social skills, self esteem and locus of control and decreases in aggression and hostility" across a broad range of adolescent diagnostic populations.

A number of mechanisms have been proposed to explain why interacting with an animal is so effective. In the mid 1980's the notion of Biophillia was proposed by Wilson (1984, cited in Menzies, 2003). He contended that humans historically relied on animals and so we remain intrinsically drawn to and in tune with them. Indeed it has been said that "animals predominate in the dreams, wishes, fantasies, drawings and writings of children" (Jalongo, 2004, cited in Jalongo et. al., 2004, p.16). Other researchers have since proposed that animals meet a natural and perhaps biological need for companionship, affiliation and affection (Mallon, 1992; Odendaal, 2000). This may be particularly true for children and adolescents. Reports indicate that young people aged 10 to 13 years may find a pet more supportive than humans and young people aged seven to 15 years have been found to readily attach to an unfamiliar (visiting) dog (Kruger et. al., 2004).

Extending from this work and from previous studies examining health benefits associated with companion animals, considerable research indicates immediate physiological benefits from interacting with animals. Studies have shown clear reductions in stress related physiology, such as reductions in blood pressure and heart rate, stress chemicals (e.g. cortisol), stress reactions (e.g. coping with a 'stressful' activity) (Friedmann, 2000; Odendaal, 2000) and reductions in fear and anxiety responses (Barker & Dawson, 1998; Barker, Pandurangi & Best, 2003; Friedmann, 2000). Some authors state that working with animals may actually facilitate human development, for example by

providing attachment and love (Mallon, 1992; Nathans-Barel et. al., 2005), working with life-cycle issues such as grief and loss (Mallon 1992; Menzies, 2003) and by providing non-gendered opportunities for care-giving (Kruger et. al., 2004; Hart, 2000; Menzies, 2003).

The current pilot project seeks to draw on these intrinsic benefits of human-animal interaction. By incorporating the use of dog training, it is hoped that participants will develop additional useful skills. A number of programmes have explored the efficacy of using dog training (Kruger et. al., 2004), primarily with 'delinquent' or prison populations who have retrained shelter dogs for adoption. These programmes have consistently found improvements in self esteem, mood, self control and behavior (Walsh & Mertin, 1994; Seigel, Murdock & Colley 1997).

The Toronto Young Offender Program, known as YAPP (Youth & Animal Pilot Project) found that young people improved after participating in programmes to retrain shelter dogs for adoption by disabled individuals. The authors noted positive effects on behaviour, affect, interpersonal skills, self esteem, self efficacy and empathy. In addition, they noted a reduction in offending behaviour (Menzies, 2003). Walsh and Mertin (1994) also found that retraining shelter dogs was beneficial for adult prison inmates. They noted reductions in depression for the women involved in the project and increases in self esteem. Chandler (2005) has worked for a number of years with young offenders and consistently reports that AAT is useful with this population. She states that by teaching dog training techniques these young people show improvements in their communication, frustration tolerance, self efficacy and peer leadership skills.

Dog training may also be useful for young people who have behaviour problems but are not involved with the prison system. Kogan et. al., (1999) worked with two boys (aged 11 and 12) in primary school, who had social and learning problems. Results indicated that the boys achieved key skills which seemed to generalise from the AAT situation into their wider school experience. Specifically they noted improvements in social skills, including tone of voice and verbalisations, eye contact and concentration. Regarding behavior they noticed a reduction in aggressive behaviours and vocalisations, improved sharing and an increase in personal sense of power and control (i.e. internal locus of control). Their format consisted of 10 to 20 minutes of rapport building followed by positive dog training and culminating in a class presentation. Siegel et. al. (1997) also worked with two students in a school setting (a male and female both aged 13) who had significant behavior problems. The students retrained a

shelter dog, so that it could be adopted by a disabled individual. They worked one-on-one with a dog trainer for 45 minutes daily. One student worked for 18 days, the other for only six days due to time constraints. The students showed a reduction by an average of 53% and 67% respectively in aggressive (verbal and physical) and non-compliant behaviours. These changes were measured outside of the dog training sessions, in regular classes, indicating that the changes were able to generalise.

MonashLink Community Health Service's Creative Resilience Programmes

MonashLink has sought to pilot a dramatherapy programme and an animal-assisted therapy (AAT) programme. In accordance with the prevention literature, the programmes will be small-groups, designed to enhance social and problem solving skills and foster connectedness. The groups will aim to enhance resilience by adhering to the following principles;

Accessibility & incorporation of peers

As discussed previously, it is important that interventions are based in highly accessible locations for young people. It is equally important that interventions incorporate the peer group (Jones & Adams, 2006). For these reasons the interventions will take the form of small group programmes run in schools.

Duration

An exploration of the literature indicates that effective resilience programmes ideally last between 8 and 12 weeks, in order to create long-term change (Jones & Adams, 2006). Lomonaco et al., (2000) state in their review of children's groups, that the facilitation of 12 sessions has a clearly demonstrable effect. This assertion is in line with research conducted on both AAT and dramatherapy programmes. Hanselman (2001) developed an anger management programme incorporating a dog and recommends that 12 two-hour sessions are required for sustained behaviour change. Whilst a five week AAT intervention created some change, a 10 week intervention was required in order to significantly reduce anhedonia in patients with schizophrenia (Nathans-Barel et al., 2005). Whilst some change has been shown in as few as six sessions, these were intensive programmes with sessions occurring on consecutive days. The pilots will therefore last one entire school term, i.e. nine weeks (nine sessions).

Walsh-Bowers (1992) found that a brief 40 minute session (one school period) inhibited team building and recommended that future drama programmes attempt to provide longer session times. There is some indication that the physiological and psychological benefits of AAT may take up to 30 minutes to show significant effects (Barker, et. al., 2003; Barker & Dawson, 1998; Hanselman, 2001; Odendaal, 2000) and that incorporating approximately 20 minutes of animal contact time into sessions may be beneficial (Kogan et. al., 1999). In order to take full advantage of group process and to allow time for students to interact with the dog, the current programme will run for two class periods (one and a half hours), followed by a recess or lunch break.

"The Dramatherapy Pilot-Programme has been specifically developed by MonashLink staff in response to the current research"

Use of group process

The literature reviewed in this paper clearly advocates the importance of using group process to establish change for young people. It is important that facilitators have experience and skill in utilising the elements of group problem solving, group communication and group rules to fully take advantage of this modality. Facilitators who are well trained in group process, in addition to having strong clinical skills, are best able to manage group dynamics and adapt them to any creative modality (Jones & Adams, 2006). It is also well recognised that non-participant observers may alter the dynamics of a group (see for example Siegel et. al., 1997). The current group programme will therefore be co-facilitated by experienced counsellors who have training in animal handling for AAT or full professional dog training qualifications. Both facilitators will therefore be well equipped to manage group dynamics, process and – for the AAT group – dog training and animal handling. There will be no volunteer dog handlers or school staff present in the room during group sessions.

Targeted small groups

Resilience and prevention programmes are ideally suited to those individuals who are experiencing some form of risk, but are not suffering clinical disorder. Risk factors for the development of depression, anxiety or substance abuse include feeling disconnected from school or peers, having delinquent peers, having unstable or dysfunctional family life, having poor social skills or behaviour problems, lack of resources and low socio-economic status (Jones & Adams, 2006). Small group interventions must therefore be accessible to those who experience some form of risk, but who are functioning well enough that they will be able to benefit from a social group intervention. Participants wishing to be involved in the groups will therefore be pre-screened for current levels of anxiety, depression or substance abuse. Those individuals found to be at risk will be offered referrals to assessment and/or treatment services.

Given resource and time constraints, all schools expressing interest in the pilot may not be able to participate. Schools experiencing the most disadvantage and/or those able to provide administrative support to the pilot (including ethics approval for research) will be selected in phase one. Voluntary participants will then be sought from all students in year seven. Should interest exceed capacity, those students thought to be experiencing some risk (according to school staff) and those most likely to benefit from group process will be selected to participate in the groups.

Creative and evidence based modalities

To be successful, interventions should be engaging, interesting and relevant to participants (Jones & Adams, 2006). For this reason, students will self-select for participation in the groups and will be asked to nominate their preference for creative modality, i.e. drama or AAT. The groups will be action based and goal focused to maintain the interest and motivation of the participants. Whilst there will be ample opportunities for group discussions and problem solving, these issues will be facilitated and drawn from the creative modality itself. For example students may have to negotiate and problem-solve allocation of roles for the play or selection of obedience exercises for the demonstration. Whilst participants are actively learning problem solving skills, they are not exploring problem solving as an abstract concept without a concrete outcome. There is also an inherent motivation for participants to solve their problems, for the success of the performance.

Being creative, engaging and interesting is necessary, but does not ensure efficacy. Evaluation remains an important component of good practice. Interventions should be developed around sound theoretical concepts and subsequently measured to ensure that they deliver what is expected of them. Good intentions or theories alone are insufficient. Evaluation should seek to measure those areas thought to be impacted by the intervention. These should directly reflect the programme goals. The current pilot aims to enhance self-efficacy, empathy, general resilience, peer/relationships/problem solving and self-esteem. These will be assessed before and after the group (pre- & post-testing) using the following self-report questionnaires: General Self-Efficacy Scale (GSE), Index of Empathy for Children & Adolescents, Resilience Scale (RS15), Strengths & Difficulties Questionnaire and the Rosenberg Self-Esteem Scale. It is believed that the self-report format will be an accurate representation of the participants' perceptions of the group's success and their own personal achievement. Self perception has been shown to be an important factor when measuring resilience (Jones & Adams, 2006). The participants will also complete general Feedback Questionnaires, developed by the facilitators, which will gather qualitative information about the groups. The Feedback Questionnaires will be collected at group completion (post-test). All of the questionnaires will be collated by an independent university researcher to ensure impartiality and data accuracy, whilst qualitative analysis will be completed by the facilitators in order to capture important case-study and general information.

Skill building

As mentioned above, having creative and action based groups allows for key skill development, such as problem solving. Facilitators are able to take advantage of the everyday skills participants will develop during the course of the activity. Drama and dog training both require the development of confidence, tone of voice, memory and concentration, awareness of body-language and the ability to plan and collaborate with others. In addition, both groups will conduct a performance, providing participants with the motivation to achieve their set

goals. By incorporating these modalities into a group format, they can be enhanced via the use of group process. Groups must make decisions together, understand how they impact on other participants, ensure all group members feel heard and understood, manage difficult personalities, behaviours or differences of opinion. The group process may also be drawn out when considering task allocation, for example finding one task more interesting or boring than another, and exploring what participants should do if they feel bored or frustrated. In addition to these skills, each group modality will offer different challenges and advantages. For example the AAT group members must share one dog, however this affords them the ability to use peer learning/teaching and increase human directed and animal directed empathy. For the drama group, participants will be provided with the opportunity to explore roles, however they wil also need to manage the potential difficulties of script writing.

Conducting a performance

Many skill based group interventions for young people culminate in giving a performance (Johnson et. al., 1985; Kogan, et. al., 1999; Walsh-Bowers, 1992) or a formal recognition/feedback session (Neill & Dias, 2001). Indeed giving a performance is a fundamental theoretical component of dramatherapy (Landy, 2005). Conducting a performance may be of benefit to participants, as it provides opportunities for reward and recognition and is a forum to include parents, families, significant others or even neighbourhoods. Acknowledging change in a public way may increase the sense of achievement of the participants and may also provide opportunities for participants to be viewed by others in a new, and hopefully more positive, light. It is thought that this may lead to a positive feedback cycle that will further enhance the self esteem, coping and social skills of participants. This further supports the contention that interventions maintain a focus on achieving success, alongside their goal to ameliorate hopelessness and facilitate connectedness (Jones & Adams, 2006). Giving a performance may also assist the participants to remain goal focused throughout sessions. This will present challenges such as conflict and time management, which may be managed through group process. There is also a certain amount of performance anxiety to be expected. Again, this will present more of a challenge for some participants than others and an ideal opportunity for group process work to occur.

MonashLink Community Health Service Dramatherapy Pilot-Programme

The Dramatherapy Pilot-Programme has been specifically developed by MonashLink staff in response to the current research. It will run over a whole school-term, consisting of eight double-period sessions (one and a half hours), followed in week nine by a performance to which young people may invite a number of peers and significant adults. The group will consist of eight to ten self-selected participants from year seven who do not currently suffer clinical disorder, but who may be experiencing some risk. There are two volunteer schools within the City of Monash who will offer the programme.

The participants will be expected to generate group rules, develop some basic drama skills and write a play that reflects current concerns for year seven students in 2007. The play will provide an opportunity for participants to role-play some of their fears or concerns and provide opportunities for practicing alternative ways of managing these fears and concerns. Participants will develop a learning plan as part of the group that will form the outline of their goals and timelines.

Facilitators will encourage group based problem solving and skill development and will aim to encourage the participants to work towards the successful completion of their goals. The group will encourage specific skill development according to the needs of participants, for example tone of voice, eye contact, problem solving, communication skills, performance anxiety, creativity, frustration tolerance, writing and speaking skills, goal setting and time management.

"Lead The Way Animal-Assisted Therapy Programme"

Lead The Way (LTW) Animal-Assisted Therapy Programme developed by Jones (2005) has been chosen for the AAT component of the current pilot study. LTW incorporates a specific dog training method known as the Lifestyle Canine Communication System (LCCS) (Fontana, 2004) into the therapeutic group process. This method is a reward based system of training that effectively teaches pattern learning, the use of positive reinforcement such as praise and encouragement, and the use of rewards. It encourages appropriate use of tone, timing and limit setting. These specific skills are in addition to the generally accepted benefits of human-animal interactions, such as reduced physiological stress (e.g. blood pressure), a sense of comfort, increased rapport building, appropriate use of touch and other 'feel-good' benefits. Jones (2007) outlines the benefits of the programme as follows:

> " The Lead The Way Programme aims to take advantage of the benefits listed above [i.e. of human-animal interactions], in addition to teaching specific skills via dog training. By teaching individuals to work with a therapy dog, they will learn key skills including;
>
> - The use of tone of voice, praise and encouragement
> - Understanding rewards, consequences and non-violent limit setting
> - Developing clear communication, consistency and persistence

- Managing frustration and focusing attention
- Managing performance anxiety (giving an obedience demonstration)
- Developing empathy and leadership, by helping the dog and fellow group members through new and difficult tasks
- Developing good interpersonal skills (developing group rules, goals, sharing, problem solving, giving and receiving direction & feedback)"

The LTW programme is flexible, in that it can grow or extend in accordance with the skill levels of the participants and time available. For example, time and skill level permitting, young people will be provided with opportunities to teach the dog new and unknown commands such as tunnel or jump work, or playful tricks such as shake or roll-over. The minimum time frame recommended for an LTW programme is eight weeks (Jones 2005). Facilitators begin teaching the young people to work the dog in simple commands such as 'sit' and 'step away' (stay) and extend the programme as needed. The LTW Programme culminates in a performance of the skills learned in the form of an obedience demonstration (Jones 2005; Jones 2007).

Of the dog training programmes reviewed, LTW is most like Kogan et. al. (1999) in that the participants will work with a registered therapy dog on commands already known to the dog and sequences of commands or tricks. The group will meet weekly for nine weeks, culminating in a performance. LTW differs from other programmes however, in that a group of participants must 'share' one therapy dog. This provides opportunities to process issues of competition, boredom and even lack of practice. For many young people this provides opportunities not only to teach the dog, but to assist their fellow participants in a group learning format, led by the facilitators.

The LTW Programme is very closely matched to the dramatherapy programme, in that it relies heavily on group process, works with small groups to develop skills (dog training) and culminates in a performance developed by the participants (an obedience demonstration). The group will be run by the same two facilitators in the same two schools as the dramatherapy group. As with the dramatherapy group, the LTW participants will need to develop a learning plan to ensure they successfully achieve their goals. The LTW Programme will run on the same day as the dramatherapy programme, in the same location, for the same duration and with similar participants. By reducing as many variables as possible, it is hoped that comparative evaluation will be more reliable.

Conclusion

It is anticipated that the current pilot study will enhance resilience in young people, with the view to contributing to the prevention of anxiety, depression and substance abuse. The programmes have been chosen or developed according to their format, i.e. whether or not they adhere to the research principles for developing effective resilience groups. Specifically, recommendations from research state that interventions should:

- be engaging, interesting and relevant to young people
- incorporate the peer group
- target those most at risk; intervene at points of transition
- focus on achieving success, ameliorating hopelessness and facilitating connectedness.

Interventions also need to build resilience in the areas of:

- positive peer relationships, self esteem and self efficacy, problem solving skills, and opportunities for reward and recognition.

On a broader level, the two modalities (AAT and dramatherapy) reflect a change in focus by services and schools to delivering creative and activity based interventions that are of interest to young people.

> *"statistically significant positive results were demonstrated related to behaviour and affect, social skills, self esteem and locus of control and decreases in aggression and hostility"*

References

Ascione, F. (2004, July). The psychology of human-nonhuman interactions and relations: basic, applied and methodological issues. Paper presented at the 2004 Psychologists for Animal Welfare (PAW) Conference, Melbourne, Australia.

Barker, S., & Dawson, K. (1998). The effects of animal-assisted therapy on anxiety ratings of hospitalized psychiatric patients. *Psychiatric Services, 49*, 797-801.

Barker . *Journal of ECT, 19*, 38-44.

Chandler, C. (2005). Animal assisted counseling techniques. In Chandler, C Ed.), *Animal Assisted Therapy in Counseling* (pp. 73-126). New York: Routledge.

Fawcett, N., & Gullone, E. (2001). Cute and cuddly and a whole lot more? A call for empirical investigation into the therapeutic benefits of human-animal interaction for children. *Behaviour Change, 18*, 124-133.

Fine, A. (2000). Animals and therapists: Incorporating animals in outpatient psychotherapy. In Fine, A. (Ed). *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (179-211). California: Academic Press.

Folse, E., Minder, C., Aycock, M., & Santana, R. (1994). Animal-assisted therapy and depression in adult college students. *Anthrozoos, 8*, 188-194.

Fontana, G. (2004). Alpha Professional Dog Trainers Course Manual (5th ed.).

Friedmann, E. (2000). The animal-human bond: health and wellness. In Fine, A. (Ed). *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp.41-58). California: Academic Press.

Hanselman, J. (2001). Coping skills interventions with adolescents in anger management using animals in therapy. *Journal of Child and Adolescent Group Therapy, 11*, 159-195.

Hart, L. (2000). Psychosocial benefits of animal companionship. in Fine, A. (Ed). *Handbook on Animal-Assisted Therapy: Theoretical Foundations and Guidelines for Practice* (pp 59-78). California: Academic Press.

Jalongo, M., Astorino, T., & Bomboy, N. (2004). Canine visitors:The influence of therapy dogs on young children's learning and well-being in classrooms and hospitals. *Early Childhood Education Journal, 32*, 9-16.

Johnston, J., Healey, K., Tracey-Magid, D. (1985). Drama and interpersonal problem solving: A dynamic interplay for adolescent groups. *Child Care Quarterly, 14*, 238-247.

Jones, M. G. (2005). Lead the Way Animal-Assisted Therapy Programme Manual. Unpublished manuscript.

Jones, M. G. (2007, April). Lead The Way Animal-Assisted Therapy Programme. Paper presented at the 2007 "What Works" Family Services Expo, Melbourne, Australia.

Jones, M.G., & Adams, N.J. (2006). The Role of Risk, Protection & Resilience in the Prevention of Anxiety, Depression and Substance Abuse in Adolescence: A Literature Summary. Unpublished manuscript, MonashLink Community Health Service.

Kogan, L., Granger, B., Fitchett, J., Helmer, K., & Young, K. (1999). The human-animal team approach for children with emotional disorders: Two case studies. *Child and Youth Care Forum, 28*, 105-121.

Kulic, K., Horne, A., & Dagley, J. (2004). A comprehensive review of prevention groups for children & adolescents. *Group Dynamics: Theory Research and Practice, 8*, 139-151.

Kruger, K. A., Trachtenberg, S. W., & Serpell, J. A. (2004, March). *Can animals help humans heal?* Proceedings of the Animal-assisted interventions in adolescent mental health conference. Retrieved January 18, 2007 from www2.vet.upenn.edu/research/centers/cias/pastconferences.html

Kyriacou, D. (2006). *What is Dramatherapy?* Retrieved December 19, 2006 from http://www.badth.org.uk/Dth/therapy.htm

Landy, R. (2005). Drama therapy and psychodrama. In Malchiodi, C. (Ed), *Expressive Therapies* (pp 91-116). New York: The Guilford Press.

Lomonaco, S., Scheidlinger, S., & Aronson, S. (2000). Five decades of children's group treatment. *Journal of Child & Adolescent Group Therapy, 10*, 77-96.

Mallon, G. (1992). Utilization of animals as therapeutic adjuncts with children and youth: A review of the literature. *Child and Youth Care Forum, 21*, 53-67.

Mallon, G. (1994). Some of our Best Therapists are Dogs. *Child and Youth Care Forum, 23*, 89-101.

Menzies Inc. (2003). Animal assisted therapy and young people – A review of selected literature. Retrieved April 1, 2006 from www.menzies.org.au/_publications/Animal-Assisted-Therapy-Report.pdf

Nathans-Barel, I; Feldman, P; Berger, B; Modai, I; Silver, H. (2005). Animal –assisted therapy ameliorates anhedonia in schizophrenia patients. *Psychotherapy and Psychosomatics, 74*, 31-35.

Neill, J., Dias, K. (2001) Adventure Education and resilience. The double-edged sword. *Journal of Adventure Education and Outdoor Learning, 1*, 35-42.

Odenadall, J. (2000). Animal-assisted therapy: Magic or medicine. *Journal of Psychosomatic Research, 49*, 275-280.

Parshall, D. (2003). Research and reflection: Animal-assisted therapy in mental health settings. *Counselling & Values, 48*, 47-56.

Prior, A., Townsend, M., Maller, C., & Field, K. (2006). Health and well-being naturally: Contact with nature in health promotion for targeted individuals, communities and populations. *Health Promotion Journal of Australia, 17*, 114-123.

Siegel, W., Murdock, J., Colley, A. (1997, March).S.T.A.R.T.1 Students Training Animals: Role therapy. Paper presented at the 17th annual Super Conference, Baton Rouge, LA (USA). Retrieved March 15, 2004, from http://ed.uno.edu/sites/wsiegel/manusc.html

Walsh-Bowers, R. (1992). A creative drama prevention programme for easing early adolescents' adjustment to school transitions. *The Journal of Primary Prevention, 13*, 131-147.

Walsh, P., & Mertin, P. (1994). The training of pets as therapy-dogs in a women's prison: A pilot study. *Anthrozoos, 7*, 124-128.

Weisz, J., Sandler, I., Durlak, J., & Anton, B. (2005). Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist, 60*, 628-648.

Wells, M., & Perrine, R. (2001). Critters in the cube farm: Perceived psychological and organizational effects of pets in the workplace. *Journal of Occupational Health Psychology, 6*, 81-87.

Review of Creative Resilience Programmes

About the programmes:

The Creative Resilience Programmes were developed in a way that would make them engaging and interesting for young people, by using the creative modalities of animal-assisted therapy (AAT) and dramatherapy. Young people were offered the opportunity to express an interest in participating in the 'dog training' group or the 'drama' group, although first preferences were not always able to be met. Both groups were offered opportunities to practice problem solving, social skills and friendship enhancement, building self esteem and self efficacy and practicing communication skills and empathy. The groups ran throughout term two, 2008 for a double period once a week. Each group participated in approximately eight rehearsals, followed by a performance. The groups ranged in size from seven to 11 participants.

Animal-Assisted Therapy (AAT): An exsisting programme, called Lead The Way, was chosen for the AAT pilot. This group worked with a trained and registered "Therapy Dog". Participants were given the opportunity to learn some of the dog's existing commands, teach him a new command (to run through an agility tunnel) and to develop a performance routine to present to invited guests upon completion of the group.

Dramatherapy: The dramatherapy programme was developed specifically for this pilot by Monashlink staff. This group involved the participants developing a play based on a theme that was relevant to themselves and other year seven students. It involved the development of a script, stage directions, music and costumes culminating in a performance presented to invited guests upon completion of the group.

About the facilitators:

The groups were facilitated by Melanie G. Jones and Naomi J. Adams, both highly skilled and experienced facilitators from the General Counselling and EDAS (Eastern Drug and Alcohol Service) teams at MonashLink Community Health Service. Naomi, the Team Leader for the EDAS team, has extensive experience in counselling, group programmes and has training in social work and psychology. Melanie, the Youth Counsellor, is a registered psychologist with experience in counselling and group programmes and has a special interest in the areas of transition and creative therapies including AAT.

Melanie, also a professional dog trainer, provided her Therapy Dog "Tarlach", a black Labrador Retriever. Tarlach and Melanie are registered with the Victorian Canine Association (VCA) as a working team. Naomi has also received specialised training in animal handling and dog training specifically for use in AAT.

About the participants:

The groups were open to all students currently in year seven at the two participating pilot schools – Mount Waverley Secondary College and South Oakleigh Secondary College. Students were voluntary, nominating which group they would prefer to participate in. The AAT group filled early, hence some students volunteered to attend the drama group instead.

Participants were pre-screened to determine if they were at risk of having an anxiety, depressive or substance use disorder. Participants considered to be 'at risk' were encouraged to seek independent support and assessment.

Assessment and Evaluation:

Participants completed a number of self report questionnaires both at the beginning of the group and upon completion of the performance. These results will be independently evaluated by Monash University Psychology Department research staff. Results will be made available in a comprehensive report.

Qualitative feedback included teacher and student reports and observational data from the facilitators. In summary, it was found that many participants felt that the group programmes were too brief, hence increasing performance anxiety. Engagement and participation were excellent and above expectation, particularly for the AAT group.

Teachers identified improvements in participation, mood, confidence and social skills in participants of both the AAT and dramatherapy programmes. Facilitators observed significant changes to insight and awareness of social and group processes, an increase in empathy and some improvement of negotiation and conflict management skills. Some participants approached the facilitators for additional support with issues external to the programme.

Participants results are summarised in the table overleaf, by school and by programme type (AAT or drama).

Feedback Summary – Mean scores out of five (Animal-Assisted Therapy Group/ Dramatherapy Group).

Question	SO Animal	MW Animal	Average Animal	SO Drama	MW Drama	Average Drama	Average SO	Average MW	Average overall
Did you enjoy coming to the group	4.7	5	4.85	4.8	4.7	4.75	4.75	4.85	4.8
Would you recommend the group to others	3.9	4.9	4.4	5	4.8	4.9	4.45	4.85	4.65
Did you learn anything new by coming to the group	4	4.9	4.45	4	4.3	4.15	4	4.6	4.3
Do you understand yourself better since coming to the group	3.3	4.2	3.75	4.6	3.6	4.1	3.95	3.9	3.92
Do you understand other people better since coming to the group	3.2	4.4	3.8	4.7	3.9	4.3	3.95	4.15	4.05
Did the workers care about you and listen to you	4.1	4.3	4.2	4.2	4.8	4.5	4.15	4.55	4.35
Thinking about the other young people in your group... How supportive/helpful was the LEAST supportive group member	3.2	3.8	3.5	4.2	3.1	3.65	3.7	3.45	3.57
How supportive/helpful was the MOST supportive group member	4.2	4.4	4.3	4.8	4.3	4.55	4.5	4.35	4.42
Overall, how well did the group co-operate and support each other	4.2	4.1	4.15	4.8	4.2	4.5	4.5	4.15	4.32
Did having DRAMA/DOG as an activity make you more likely to want to come to group	4.4	4.9	4.65	5	4.6	4.8	4.7	4.75	4.72
Did having a PERFORMANCE make you more likely to want to come to group	3.4	4.5	3.95	4.8	3.8	4.3	4.1	4.15	4.12

MW = Mount Waverley Secondary College

SO = South Oakleigh Secondary College

What did you LIKE or DISLIKE about the group (how can we make it better for the future?)

South Oakleigh DRAMA (Dramatherapy)

"I actually loved everything"

"Nothing much it was really good. 10/10"

"They did very they don't need to improve"

"I loved everything. It was the best. Thank you"

"I think everything is the same and that I'm the same"

"Nothing it was great!"

"I liked that we all got along. No."

Mount Waverley DRAMA (Dramatherapy)

"Everything was fine I loved it!"

"I liked every thing about the group and don't know how it could be better"

"More rehearsals"

"I loved everything about it. I was a bit scared but its all-good. Improvement be more organised and party food for vegetarians. Love you x"

"I liked everything, Disliked the prodeeding."

"I liked how we got together & did heaps of cool things I think that Mel & Noames are AWESOME."

"Nothing"

"People were nice to me"

"I didn't dislike anything in the group except next time we should practice more before the performance"

"I thought it was good, however it could have used more practice sessions."

South Oakleight ANIMAL (AAT)

"I did not dislike anything"

"I liked everything about the groop & you don't need to change anything"

"No"

"Make it longer"

"I liked getting out of class to see a gorgeous dog and my friends"

"I like playing with the dog"

Mount Waverley ANIMAL (AAT)

"I LOVED Tarly. It was a pleasure having me in the group. I loved working and playing with Tarly. He was an absolute wonder! I'm going to miss Tarly, Nomes & Mel. I don't think you should make anything better because you're perfect!!!!!!"

"I like having to train the dog and I think that they should use music next time which would make it better"

"I liked it because it was fun"

"I liked putting on the performance. I disliked when the drama group came an joined us for lunch. [I disliked] The final session because I can't do it anymore. It was too late."

"I loved Tarly, I liked the performance & the lollies. I disliked the end when we had to say by to Tarly. I think you could make it better by nothing, because it was perfect."

"I liked the dog being there but it would be better next time if we get a puppie and Tarly and start from scratch with the puppie."

"I liked the way everyone worked together, and I like the way everything ran smoothly!"

Designed by Kreate Graphics. Phone (03) 9416 3577