

# Risk and resiliency factors amongst young people attending a youth health centre

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## Introduction

Young people between 10 and 25 years are going through many changes as they develop from children to adults. One of the most obvious is the physiological change around puberty and sexual maturity. However, hard to see but just as life influencing, are the changes in the way the brain functions. The ability to have abstract ideas, communicate those ideas, make complex decisions and think about the future all develop in this time period. Around the world much research has been undertaken in the last 30–40 years to investigate what contributes to healthy development. Researchers have looked at factors that make

young people more vulnerable to harm and those that protect from harm as they develop.<sup>1,2,3,4,5</sup> The contexts for development include family, school and community. Some of the factors that have been described include connection to school and family, spiritual belief, cultural identity and poverty.

In 2001 the Auckland Youth Research Group undertook a national survey of NZ high school students looking at many of these factors.<sup>6</sup> This was dubbed the Youth 2000 study and used laptop computers to record answers from over 9000 students.

The study reported here was undertaken at the 198 Youth Health Centre (198) in order to investigate similar factors amongst young people who attended the centre. 198 has been open since 1995 and provides free primary health care for 10–25-year-olds. It runs on a drop-in basis, with young people on reception, a GP, practice nurse, counsellors and a social worker, and is open for 30 hours a week. When 198 first opened, the initial statistics for first time attenders showed that most clients were self-referred, lived in the central city of Christchurch and fell

into three main age groups: 14–18, 19–22, 23–25. It has always been felt that the clients of 198 are at high risk of poor health outcomes and hence the need to provide free care to attempt to overcome some of the barriers and to enhance any protective or resiliency factors that might be present. This research was designed to help further define the risk and resiliency factors present in these clients.

## Method

A decision was made to carry out a paper and pencil questionnaire based on the questions used in the Youth 2000 study. This meant that the number of questions able to be used was less than in the original survey. In order to help decide which questions to include, a focus group session was held with a Maori researcher and some young people from Youthline. During a brainstorming session by the group, all the risk and resilience factors that

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were thought to be the most important were noted, and this helped to guide the final choice from the many questions on the original questionnaire. Some questions were truncated from the originals, as it was not as

easy to use 'branching tree' questions on paper. Ethics Committee approval was obtained from the Canterbury Ethics Committee.

The sampling procedure involved using the young people who work at the centre as receptionists and peer supporters to randomly recruit attendees. An information sheet and consent form were given to young people as they attended 198 during July and August 2003. If they agreed to take part in the survey they were given the form to complete. The peer supporters were available if the young people needed any assistance. If they had any problems with the questions they had an opportunity to raise these with the health professional they were going to see. Under 16-year-olds who were attending on their own were deemed capable of giving their consent by virtue of the fact that they were capable of attending on their own for health advice. If they were attending with their guardian then the guardian was asked to also give consent.

Completed questionnaires were placed in a box that was separate from the consent forms so that anonymity was ensured. Care was taken to reassure young people about the confidentiality of the research.

## Results

Approximately 140 people were asked to complete the questionnaire. Of the 135 questionnaires that were handed in, five were only partially completed. This was because clients were called to their appointment before they had finished and didn't get time to complete the questionnaire afterwards. During July and August there were 1149 visits to the Centre. Some clients may have visited more than once.

The age of those completing questionnaires was recorded in seven groups ranging from 12 and under to 26 and over. Twenty-three per cent were aged between 16 and 18, 33% between 19 and 21 and 25% between 22 and 23 years. Only 3% were un-

Table 1. Age, gender and ethnicity (n=135)

Age	
13-15	3.7%
16-18	23%
19-21	33%
22-23	25%
24-25	14%
26 and >	0.7%
Gender	
Male	25%
Female	74%
Ethnicity	
NZ Maori	18.4%
NZ European	72.1%
Other European	2.9%
Samoan/Pacific	0.7%
Cook Island M	1.5%
Indian	0.7%
Other	2.9%

der 16. Three-quarters of the respondents were female. Ethnicity included 72% European, 18 % Maori and 10% other (Table 1).

The risk and resiliency factors that were asked included questions around culture, family, school, work, spiritual beliefs, group activities and driving behaviour. Outcome behaviours included: belief in the future, suicide and depression, alcohol and other drug use, and sexual behaviour including pregnancy. Participants were also asked if they enjoyed taking part and if they had any comments.

## Resiliency (Table 2)

Many non-Maori participants did not complete the section on education about culture or knowledge of iwi, but more indicated the importance to them of their family's culture and their satisfaction with that knowledge. Questions to gauge some perception

Table 2. Prevalence of 'protective' factors amongst participants

Culture	
Education about culture	68% Maori
	88% knew iwi
Missing	70%
Satisfied with knowledge of culture	52% Maori
	58% non-Maori
Unsatisfied	48% Maori
	18% non-Maori
Missing	23% of non-Maori
Family	
Can talk to someone in family	57%
Mum warm	64%
Dad warm	37%
Enough time with Mum	47.4%
Enough time with Dad	32%
Community	
Adult outside family can talk to	59.3%
Belong to a group	26.7%
Have a faith/belief	45.1%
Importance of belief	63%
School	
Median age left school	17 sd 25.4
% left school at 16	42%
Like school	34%
Feel cared about	12.7%
Felt safe	67.4%
Never suspended	57%

of connection to family included the ability to talk to a member of the family, the degree of warmth experienced and the amount of time spent together. For the warmth question 8% and 21.5% didn't feel it applied to them for their mother or father respectively, and many said that spending time with their mother (18%) or father (32%) was also not applicable to them. Religion has also been found to be a protective factor.<sup>7</sup> Of the 45% who said they had a faith or religion, 24% were Christian or one of the mainstream churches and 20.7% held their own personal beliefs. It is considered protective to stay on at school as long as possible,<sup>8</sup> but 42% had left school by age 16, 67% by age 17. Twelve per cent were still at school at the time of the study.

## Risk factors (Table 3)

Risk factors, or those things that cause young people to be more vulnerable to harm, have been established for longer than resiliency factors, and many could have been used. Parenting style and parental health, personality factors, learning ability and poverty are all factors that have been found to play a part.<sup>9,10,11,12</sup> These were difficult to gauge in a questionnaire of this sort, but the proxy measures are shown in Table 3. Approximately 14% of the participants rated the questions about adult behaviour as not relevant for them. Twenty-nine per cent lived with flatmates and 29% with Mum either on their own or with others. Only 12% lived with both parents. Approximately one third of the participants lived with or experienced some violence of a physical nature. The question about part-time jobs was not answered by 7.4% and this may have been because they were working full-time. One participant wrote a comment to this effect. The question about the Community Services Card applied either to them or a member of their family, so this does give a guide to the level of income in the family as well as personally.

Table 3. Factors that put young people at risk of harm

Violence	
Hit in last year	32%
Adults in environment	
Yelling and swearing	34.5%
Hitting each other	11%
Level income*	
Regular work	53%
Income <\$100/week	22%
Work <20hours/week	35.8%
No benefit	46.7%
Sickness Benefit	20.7%
Student loan/allowance	12%
Community Services Card	71%
Activity if left school*	
Attend course	19%
University	8%
Polytech	5%
Work part-time	12%
Work full-time	31%
Involved in arts	4%
Other	14%
Missing	12.5%

\* Adds up to more than 100% as some people ticked more than one option

## Outcome behaviours (Table 4)

The outcome behaviours fell under driving, mood, sexual behaviour and alcohol and drug use. As an overall indicator of hope, the question was asked 'If you run into tough times do you believe you could make it through?' – 57.8% said yes, 33% maybe and five people (3.7%) said no. The question of sexual abuse was not asked explicitly in this questionnaire, but participants were asked whether first intercourse was wanted or not; 15 (11%) said that it was not wanted and 30% said they didn't mind. The median number of part-

Table 4. Behavioural outcomes

Driving	
Wear a seatbelt always/mostly	83.7%
Drive with someone drunk	42%
Drive drunk	22.8%
Don't drive	9.6%
Mood	
Sad >2 weeks	72%
Thoughts killing self	40%
Plan	25%
Attempt	31%
Sex	
Age first SI median	15
First SI wanted	44.8%
Missing	12.5%
No condom with 1st sex	40%
>5 partners	57.4%
No pregnant	35%
Most of time condom use	46%
A & D	
Nicotine	
Ever use	75%
Most days	46.3%
>10/day	21%
Age first start 15 or under	41.5%
Alcohol	
Ever use	95%
Age first started	13–15
Median	18
15 or under	80%
No problems	22%
Cannabis	
Ever use	92%
Age first use 15 or under	57%
No problems	29.4%
Tried other drugs	
Used needles	11%

ners was 10–14 and the mode was over 20. Seventy-five (55%) of the 134 people responding to the question on pregnancy had never been pregnant. Eight per cent felt the question on condom use did not apply to them. Nicotine use was common and the mode for the age of first starting smoking was 13–15, the same as alcohol and cannabis. Although 30 participants stated that they had no problems with alcohol, 10 of them then marked problems such as not remembering or getting into trouble or breaking up a relationship as a result of alcohol use. The most common consequences of alcohol use were: forgot what you did, 63% (sex which was later regretted, 37%) and arguments with the family, 37%. More than 40% said their friends had told them to cut down and 32.5% had been told that they had a problem by a teacher or parent. Twenty-five participants checked more than six consequences. With regard to cannabis use, four participants who had ticked no problems subsequently said they did have. The most common problem was difficulty in remembering things (53%) and 36% said that they had done something they wouldn't normally do. Twenty-three per cent indicated that they had got into trouble, with a further 23% indicating that they had been in trouble with the police. Twenty-four people (21.5%)

had been told by friends to cut down and 20 (15.5%) by parents or teachers. Twelve participants indicated more than six consequences.

Approximately 59% of participants said that they had tried other drugs, the most common of which was hallucinogens (63%) and several participants indicated that mushrooms and acid were the most common substances within that group. Fifty-one (41.5%) participants marked stimulant use, 22% had used tranquilisers, 18%

of participants that had tried cocaine and also narcotics and 17.7% had used inhalants. Thirty-two (24%) of those who had used other drugs said that they used them weekly or more often, and 10 (7.4%) said that they had only used them once.

Finally, 83% of participants thought that completing the questionnaire was OK or enjoyed it, and 20% of people wrote comments which were mostly supportive or suggesting that 198 should be providing services for more people.

### Discussion

The purpose of this study was to describe some risk and resiliency factors present amongst users of 198. It was hoped to be able to compare these with the population sample in Christchurch carried out by the Youth 2000 study of high school students.<sup>6</sup> Unfortunately, 198 has not taken on new clients since May 2003 due to funding shortages and hence the average age has risen. Specifically, only 27% of this sample were under 18, making it difficult to compare any statistics with the 2000 study.

In this study the proportion of those who identified as Maori was 18% and this compares with the Christchurch results of the school study in which 16.8% identified as Maori, and in which there was a much higher proportion of Asian students (8.8%).

In comparison with other national statistics this sample seems to be a high risk group in terms of poor behaviour outcomes. The young people attending 198 seem to have a relatively violent environment, with 32% reporting having been hit in the last year, and high levels of thoughts of, and attempts at, self-harm. Only about half of the participants showed much connection to family or satisfaction with knowledge of their culture, whether from Maori or non-Maori

culture. Blum and Resnick show that family and cultural connections are very important to resilience.<sup>4,5</sup> Nearly 60% could, however, talk to another adult outside the family and this is similar to the proportion of students in the national 2000 study. There is a high proportion of alcohol and drug use, with over 75% using nicotine, alcohol and cannabis and 58% having tried other drugs in addition to these. Nationally, one in three women aged 20 to 24 years is a regular cigarette smoker, making this youth age group the most likely to smoke one cigarette or more a day. Almost half (47.1%) of Maori women aged 15 to 24 years are regular cigarette smokers.<sup>13</sup> In our sample 62% smoked more than one cigarette a day.

The Social Policy Interagency Network (SPIN) has recently produced a collaborative plan for Christchurch Youth<sup>14</sup> and in this they have included some statistical appendices. A directly comparable statistic with this study is found in the number of suspensions in Christchurch schools. Their statistic, derived from the Ministry of Education figures for 2002, showed that 226 students had been suspended out of a total of 31 500 13–19-year-olds in Christchurch. Of course not all of this number will be at school, but this gives a minimum rate of 0.7%. Our proportion of 43% seems very high. According to MOYA<sup>13</sup> the proportion of students in New Zealand staying at secondary school beyond the compulsory age has increased over the last 10 years. In 1996, 83.7% of students stayed at school until the age of 16 and 14.9% until the age of 18. In this study 42% had left school by 16. In addition, the Add-Health study in the USA<sup>5</sup> demonstrated that connection to school was also important. In this study 55% of the young people felt that people at school cared about them a bit and 17% not at all. The high suspension rate amongst our sample and the fact that only 34% liked school, with 66% saying it was OK or they disliked it and 29% saying that they only felt safe some of the time or not at all, would indicate that school connection

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was also not high amongst our sample. Eighty-four per cent were working full or part-time, often in association with study. The Mayoral taskforce in New Zealand aims to make this figure 100%. The quarterly unemployment rate for March 1999 for 15–24-year-olds was approximately 18% (statistics Department of Labour). In 1993 it was 26%. Our sample is thus around the national average.

The main limitation of this study was the number recruited. The decision was made to use peers to recruit participants, which worked well, in that nearly 100% of those asked took part. However the peers have many other duties and they were not good at remembering to ask every person who came in. Larger notices could have been put up around the waiting room to encourage young people to ask if they had not been approached, but this may not have worked either. The small number means that generalisability of these results to the whole population of 198 clients is limited and is invalid for any population of young people outside 198. The small number also means that the answers to the questions could be biased in that the people who were given a questionnaire may have been the more outgoing sociable people who could not be 'forgotten' by the peers, so that they were more likely to recruit them. The tool used for this study (paper and pencil questionnaire) is limited in its usefulness

as it is not able to gather large quantities of data and the questions have to be fairly simple and are mostly closed in nature. In addition it is much easier to misinterpret questions or misread them. An example in this study was where the participants were asked to state the number of people living in their house and often checked less than the number they had indicated when listing the individuals they were living with. Advantages include its simplicity to administer, ease of analysis and the fact that it is non-threatening in nature.

The construction of the questions did not need to be pre-tested as most of these questions had been in the NZ 2000 study. However, the fact that this was to be used in a different context in a slightly older age group should have been taken into account and the questions re-worded appropriately.

The small number compromised statistical analysis. Other studies have tried to amalgamate the overall affects of a 'summative score' for risk and resiliency<sup>9</sup> (Watson personal communication), but this has been limited by the multiplicity of factors that are involved including personality type and parenting style, all of which are hard to estimate using a survey tool. To be

done with more accuracy, precise measurements of such factors, using well-established tools, would need to be carried out. With further research it may be possible to develop a tool to predict behavioural health outcomes

such as alcohol and drug use, mood disturbance and self-harm and sexual behaviour, by estimating the balance of predisposing risk and resiliency factors in the life of a young person. However, there needs to be further work done on the correlation between risk, and resiliency factors.<sup>15</sup>

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## Conclusion

In conclusion, it is not possible to say from this study whether or not the clients of 198 are more or less at risk of poor health outcomes than any other population of young people in Christchurch or New Zealand. However, this sample has a high prevalence of low mood, self-harm and alcohol and drug use and appears to not have had good connections to family or school. In spite of this, a relatively high number found spiritual beliefs important and are in either full-time or part-time work.

## Competing interests

None declared.

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