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Evidence-based interventions for adolescent health and wellbeing: additions to the VCAMS catalogue (bullying, eating disorders, victims of crime, sexual initiation, family violence, family stress, and a person for advice)

Nick Marosszeky
Macquarie University, marossz@uow.edu.au

Pamela Grootemaat
University of Wollongong, pamg@uow.edu.au

David Fildes
University of Wollongong, dfildes@uow.edu.au

Darcy Morris
University of Wollongong, darcy@uow.edu.au

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CHSD

Centre for Health Service Development

Evidence-based interventions for adolescent health and wellbeing: additions to the VCAMS catalogue (bullying, eating disorders, victims of crime, sexual initiation, family violence, family stress, and a person for advice)

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UNIVERSITY OF WOLLONGONG

Centre for Health Service Development

August, 2010

Nick Marosszeky

Pam Grootemaat

Dave Fildes

Darcy Morris

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1   Introduction

This report by the Centre for Health Service Development (CHSD), University of Wollongong, to the Victorian Department of Education and Early Childhood Development (DEECD) adds to the existing *Catalogue of Evidence-Based Strategies for Adolescent's Health and Wellbeing*. It extends our previous work for the Victorian Government in the area of children's health and wellbeing.

In 2006, CHSD was originally commissioned by the Victorian Department of Human Services (DHS) to develop a catalogue of evidence-based strategies for the health and wellbeing of children aged 0-8 years. This in turn built on the work of the *Strategies for Gain* project commissioned by DHS in 2005 (Eagar, et al. 2005). The catalogue has now been published by the Victorian DEECD and is available online at:
http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/summary.htm

The catalogue complements the Victorian Child and Adolescent Monitoring System (VCAMS) which contains 150 indicators of importance to children and young people (0-18 yrs). The catalogue is promoted by the DEECD as a dynamic document which is regularly updated. As a result, we were commissioned to review the evidence and compile catalogue entries for the following seven indicators:

- Proportion of children and young people who are bullied

- Proportion of young people with an eating disorder

- Crimes (including assaults) where the victim was a child or young person

- Age of initiation of sexual intercourse in young people

- Proportion of family violence incidents where children and young people are involved as other parties

- Proportion of children living with high family stress

- The proportion of young people who have someone to turn to for advice when having problems

This is the first of two reports for 2010 for the Victorian Government updating and adding to the catalogue.

2   Background

2.1   Best Start

The original catalogue was created for the Best Start program, which has a particular focus on prevention and early intervention with vulnerable families, including socially disadvantaged families, Aboriginal and Torres Strait Islander (ATSI) families, people from culturally and linguistically diverse (CALD) backgrounds, and families living in rural areas.

Best Start projects involve collaborations between local government, community health, non-government organisations, social service agencies, education providers such as schools, child care and kindergartens (preschools), and other community organisations such as service clubs and churches. The goals of Best Start are to promote:

- Improvements in access to child and family support, health services and early education for families and children

- Improvements in parents' capacity, confidence and enjoyment of family life

- Communities that are more child- and family-friendly

The catalogue now has wider application beyond the Best Start program, and is a key element in the Victorian Child and Adolescent Monitoring System (VCAMS), providing practical guidance to policy makers and program developers. Nevertheless, the above goals, priorities and service delivery models remain relevant.

2.2   *Victorian Child and Adolescent Monitoring System (VCAMS)*

VCAMS is based on the Victorian Child Outcomes Framework which consists of 35 outcomes in four domains reflecting an ecological perspective: children and young people; families; community; society. A process of consultation and collection of evidence took place in order to identify suitable measures for these 35 outcomes, resulting in a set of 150 indicators, each of which is linked with an outcome.

Sources of data for the monitoring system include selective use of existing administrative data sets, other existing data collections (e.g. non-government organisations, universities), supplemented by new collections to address identified gaps.

Priority populations are Aboriginal and Torres Strait Islander (ATSI) families, people from culturally and linguistically diverse (CALD) backgrounds, especially newly arrived immigrants and refugees, disabled people and those who are socially and economically disadvantaged.

The VCAMS system is complemented by the:

- Evidence base for each indicator (compiled by DEECD)

- Profiles on the indicators where data are available – this began with Best Start sites and Indigenous Best Start projects and has now been made available to all local government areas in Victoria to help them identify priority areas for intervention

- Annual report on the indicators (e.g. Victorian Government, Department of Human Services - The state of Victoria's children report 2006)

- Catalogue of evidence-based strategies (previous work by CHSD – Williams, et al. 2006)

- Potential for feedback from the catalogue to VCAMS via new survey data being collected on the indicators currently covered by the catalogue

A supportive context for this work is provided by the Victorian Government's requirement for all Local Government Areas (LGAs) to have a Municipal Early Years Plan, and support for new infrastructure via grants to LGAs.

3   Methods

Our search and review strategies and the system we have developed for classifying the evidence are described in full in the catalogue's accompanying *Technical Report* (Williams, Fildes, Marosszeky and Eagar, 2006), which can be downloaded from http://www.education.vic.gov.au/ocecd/docs/soc_technical_report_catofevid_2007.pdf.

The following sections briefly summarise the methods and the specific search strategies employed in this project.

3.1   *General approach*

Given the wealth of evidence available on strategies for enhancing childhood and adolescent health and wellbeing, one of the major tasks of this review was deciding how to narrow down to the most relevant material in terms of target groups, settings and types of programs. Consultations with the client resulted in agreement on a set of principles to guide and focus the review process.

Interventions are likely to include a mixture of universal, indicated and selective strategies, depending on the indicator. A broad range of settings and intervention types are suitable for implementation in the Victorian context. These may include: family skills training, mentoring, educational support, brief counselling in a primary care setting, addiction treatment, and others.

3.2 Search strategy

A set of key words and search terms was developed for each indicator. Where necessary, this involved a term analysis using existing glossaries or MeSH headings.

3.2.1 Sources of evidence

We developed a checklist for the search process, which includes a set of bibliographic databases that cover the major national and international journals. These included:

- MEDLINE (international, medical and health)
- PsycINFO (international, psychological, social sciences)
- ERIC (international, education)
- AEI (Australian Education Index) (national, education)
- CINAHL (international, nursing and allied health)
- Cochrane Database of Systematic Reviews (reviews only, narrow focus on high quality medical and health trials)

In order to keep the number of references to a manageable level when searching the relevant bibliographic databases, it was necessary to introduce limiters to the searches, particularly in terms of the time period included (e.g. publication years: 2001 – 2010). Wherever possible we drew on recent systematic reviews and worked backwards from these to the most relevant original papers. The reference lists of useful articles and reviews were examined for relevant material, a technique known as 'snowballing'.

In addition to this high quality academic literature, we sought practice literature, such as reports published by governments, agencies, non-profit organisations, universities and research organisations. A focused internet search was conducted, encompassing the websites of Australian governments (state and commonwealth) and specific Australian and international sites known to be reliable sources of information on the health and wellbeing of children and adolescents. These included (where applicable):

- Department of Human Services, Victoria
- Department of Health, Victoria
- Department of Education and Early Childhood Development, Victoria
- Australian Government Department Families, Housing, Community Services and Indigenous Affairs, particularly pages dealing with the Communities for Children (previously the Stronger Families and Communities Strategy) and related publications
- Australian Government Department of Health and Ageing
- Australian Council for Educational Research
- Australian Institute for Health and Welfare
- Australian Institute for Family Studies
- Communities and Families Clearinghouse Australia (CAFCA)
- Australian Research Alliance for Children and Youth (ARACY)

- California Evidence-Based Clearinghouse for Child Welfare
- Promising Practices Network, Rand Corporation
- Blueprints for Violence Prevention, Center for the Study and Prevention of Violence
- The Campbell Collaboration Library
- EPPI-Centre (UK)
- What Works Clearinghouse (WWC) U.S. Department of Education's Institute of Education Sciences

3.2.2 Data management

An Endnote database was created for each indicator. After culling to a reasonable number of references, team members downloaded citations into Endnote. Abstracts were skimmed before downloading full text articles.

A Microsoft Excel spreadsheet was used in compiling a 'short list' of strategies which were submitted to DEECD for consultation.

3.3 Inclusion criteria

From the 'short list' of approximately six or seven strategies for each indicator, three or four were selected for inclusion in the catalogue. Selection was based on the quality of the evidence for each intervention and its relevance and feasibility in the Victorian context. This latter criterion was judged in consultation with DEECD officers who work in areas related to these indicators and have practical knowledge of what has been tried and what is likely to work on the ground in Victorian schools and communities.

3.3.1 Evaluation of the evidence

The quality of the evidence was judged against the evaluation framework used in the original catalogue (Appendix A). Development of the evaluation framework is described in detail in the *Technical Report* accompanying the catalogue (Williams, Fildes, Marosszeky and Eagar, 2006). A table summarising the supporting evidence, replication, documentation, theoretical basis and cultural reach of each of the recommended strategies is provided for each indicator.

3.3.2 References

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4 Proportion of children and young people who are bullied

4.1 *Narrative review*

4.1.1 Background

There is no standard or universally accepted definition of bullying (Rigby, 2002). However, it is useful to think of it as a 'systematic abuse of power' (Smith and Sharp, 1994).

Broadly speaking there are three types of bullying:

- Direct physical bullying – such as punching or hitting
- Direct verbal bullying – such as teasing, and
- Indirect bullying – such as social exclusion from a group (McElearney, et al. 2008).

In recent times; with the growth of technology, online social cruelty or cyber-bullying has also been included as an act of bullying (Lodge, 2008). Cyber bullying uses e-mail, text messages and the internet to intimidate and hurt (Grand, 2008).

Indirect bullying is more often practised by girls, while direct bullying is more often the domain of boys. In general, boys bully both boys and girls, but mainly other boys, while girls almost exclusively bully other girls (Grand, 2008). However, with regards to cyber-bullying, both boys and girls are equally likely to be involved (Lodge, 2008).

Common to the different types of bullying is a situation in which there is an imbalance of power favouring the perpetrator(s) and the bullying action is regarded as unjustified and typically repeated (Rigby, 2002). Victims of bullying are perceived by their peers as physically or psychologically weaker than the aggressor(s), and victims perceive themselves as unable to retaliate (Vreeman and Carroll, 2007).

Research indicates that the rates of school bullying appear to vary. The highest rates of bullying occur in primary school and peak when children are 10 to 12 years of age (McElearney, et al. 2008; Cross, et al. 2003). The rate of bullying then steadily declines as students move through high school. There are also gender differences along this continuum with boys being more likely to be both bullied and bully others (Parada, 2010).

Australian research from the late 1990s indicates that approximately one in six primary school children are bullied 'once a week or more often' and one in 10 are active bullies (Slee and Mohyla, 2007). A more recent survey of Victorian school students revealed that almost a quarter of students from years 6 and 8 had experienced bullying less than once a week (Williams, 2007).

Rates for witnessing bullying are much higher, with an American study revealing that almost 9 out of 10 high-school students witnessed someone being hit, slapped, or punched at school. The same study also highlighted that four percent of school students reported that they had missed school within the last 30 days because they feared being intimidated or bullied (Song and Stoiber, 2008).

With regards to cyber-bullying, a recent survey of Australian teenagers aged 12-17 years indicated that one in five had received hateful messages via their mobile phone or through an Internet-based medium during the current school year (Lodge, 2008). Another Australian study revealed that approximately 11% of Year 8 students had partaken in cyber bullying as a bully, and about 14% said that they had been victims (Grand, 2008).

Empirical studies in a number of countries have also demonstrated that bullying occurs in kindergarten. An Australian study conducted at four early childhood centres in Canberra provided

graphic evidence of both physical and verbal bullying, perpetrated mainly by boys and frequently ignored by kindergarten staff (Main, 1999).

From an institutional perspective bullying negatively affects the entire school, creating an environment of fear and intimidation (Whitted and Dupper, 2005). At an individual level both being bullied and being a bully are both linked to detrimental outcomes for young people (Parada, 2008).

Students who are victims of bullying tend to engage in school avoidance behaviours and at its most severe victims can end up dropping out of the school system entirely (Merrel, et al. 2008). Bullying also affects school adjustment and bonding affecting the victims' perception of their school, completion of homework, their concentration levels and desire to do well at school (Vreeman and Carroll, 2007).

Victims tend to have low self-esteem and low school attainment, and tend to be lonely, unpopular, rejected, and friendless (Farrington and Ttofi, 2009). This can have negative short-term effects on physical and psychological health. For example, victims of bullying more often report sleep disturbances, enuresis, abdominal pain, headaches, and feeling sad than children who are not bullied. It is also reported that students who are victimised are 3 to 4 times more likely to report anxiety symptoms than uninvolved children (Vreeman and Carroll, 2007).

Bully victims can also experience long-term effects on their psychosocial adjustment. One study highlighted that children who were bullied repeatedly through middle adolescence had lower self-esteem and more depressive symptoms as adults (Vreeman and Carroll, 2007).

Children who bully others are also at risk of social and emotional problems. In the shorter term bullying at primary school is a precursor to more violent behaviour in later grades and bullies are also more likely to drop out of school early (Whitted and Dupper, 2005; Lodge, 2008). In the longer term bullies are more likely to become involved in the criminal justice system (Whitted and Dupper, 2005). Studies conclude that aggressive and dominating behaviours displayed at age 8 are a powerful predictor of criminality and violence at the age of 30 (Lodge, 2008). In accordance with this, one study highlighted that 60 percent of boys identified as bullies between the sixth and ninth grades had at least one criminal conviction by age 24, and 40 percent of these individuals had more than three arrests (Olweus, 1991).

Even students who are not directly involved may be negatively affected by bullying. Bullying witnesses have reported that witnessing bullying was unpleasant, and many reported being severely distressed by bullying. There is also an effect on academic performance with witnesses performing poorly in the classroom because their attention is focused on how they can avoid becoming the targets of bullying rather than on academic tasks (Chandler, et al. 1995).

4.1.2   The evidence base

Initiatives to tackle school bullying have expanded world wide in the last couple of decades with a wide variety of intervention programs being implemented. The good news is that there is fairly consistent evidence to suggest that children's bullying behaviour can be significantly reduced by well-planned interventions (Vreeman and Carroll, 2007). Some examples of the positive effects of anti-bullying programs reported in the literature include substantial reductions in student reports of bullying, improved attitudes toward school and an increased willingness to seek help when bullied (Frey, et al. 2005).

A recent Cochrane review of 44 bullying prevention evaluations covering 26 years of intervention research revealed that, on average, bullying decreased by 20%-23% and victimisation decreased by 17%-20%. However, some caution must be taken with regards to these positive results as 17 of the 44 demonstrated ineffective results, and one was even associated with increased rates of bullying and victimization (Farrington and Ttofi, 2009).

The first published research on school bullying interventions stemmed from the pioneering work of Norwegian researcher Dan Olweus in the 1970s. This anti-bullying prevention/intervention program carried out nationally in Norway achieved a decrease in bullying of 50% (Olweus, 1991). This model served as the blueprint for most efforts that were developed during the 1980s and 1990s, and still exerts great influence on contemporary intervention models and programs (Merrell, et al. 2008). The Olweus approach is collectively referred to as the 'whole-school' approach to bullying.

Certainly the majority of research evidence suggests that the chance of success of an anti-bullying program is greater if the intervention incorporates a whole-school approach which involves multiple disciplines and the whole school community (Vreeman and Carroll, 2007). This approach moves beyond just reaching out to the individual child and seeks to change the culture and climate of the school (Whitted and Dupper, 2005). Successful interventions move towards this by educating bullies, victims, teachers, peers, parents and the community on all aspects of bullying (Finger, et al. 2006).

According to the literature, the most important program elements associated with a decrease in bullying are disciplinary methods, parent meetings, playground supervision, information for parents, school conferences, classroom rules, and classroom management (Lodge, 2008).

The evidence also suggests that the greatest reductions in bullying behaviour were made in interventions that targeted children of primary and pre-primary ages (Rigby, 2002). However, it must be recognised that successful interventions need to be tailored to the age of the child. For primary aged children interventions should include stronger parental involvement with more of a focus upon visual stimuli. Conversely, interventions that target older students should involve greater peer group activity with a focus on discussion type activities (Finger, et al. 2006).

Another important factor relating to the success of bullying intervention programs relates to the intensity and duration of the program. With regards to intensity, there appears to be a 'dose response' relationship between the number of components of a program and its effect on bullying (Farrington and Ttofi, 2009).

With regards to duration it must be recognised that "bullying is an ongoing problem" and therefore a 'one-off' effort over a term or a year without continuation will have little or no lasting impact" (Smith, 2004, p. 101).

4.1.3   Selection of recommended interventions

Based on the evidence outlined above the recommended interventions can all be described as whole-school programs. Perhaps the best known of these and the prototype of the whole-school approach is the Olweus Bullying Prevention Program (OBPP).

The OBPP is a multilevel, multi-component school-based program that attempts to restructure the existing school environment to reduce opportunities and rewards for bullying (Lodge, 2008). Efforts are directed toward improving peer relations and creating a safe environment. The anti-bullying measures mainly targeted three different levels of intervention: the school, the classroom and the individual (Song and Stoiber, 2008).

Strategies at the school level relate to better classroom and playground supervision, teacher training by researchers about bullying, and the establishment of an overall school climate which does not support bullying. Strategies at the class level concern formulating and displaying class rules against bullying and promoting regular class meetings with students. Strategies at the individual level are to do with providing help for bullies and their targets (Parada, 2010).

The OBPP has been extensively evaluated around the world and is an internationally recognised school based bullying prevention program. The program is designed to be used with primary and high school children.

Another strongly recommended intervention is the Friendly Schools and Families program developed in Western Australia for use in primary schools. This school and family based initiative features a 'Whole-school pack' which is divided into six handbooks. These school-based handbooks provide a systematic plan of 'small steps' for school teams to implement a successful social skill building and bullying reduction program based upon the National Safe Schools Framework.

The Friendly Schools and Families program also incorporates parent and community involvement. The intervention specifically engages families in the process. A parent booklet provides tips on how to help young people prevent or deal effectively with bullying. The focus is on improving parent-child communication, building social skills and strategies for managing bullying at school and in the family (http://www.friendlyschools.com.au/index.php).

There is a lot of evidence to support this program and it is based on six years of detailed scientific research involving over 6000 school students, and their parents and teachers. It is one of the few evidence-based programs that has been rigorously evaluated and found to improve young people's social skills and to reduce bullying behaviour. The research is recognised nationally and internationally as a successful and comprehensive evidenced-based bullying prevention program (Child Health Promotion Research Unit, 2006).

The third of four whole-school interventions is the Steps to Respect Program. This Program, targeting school grades 3-6, is a multilevel program that coordinates a school-wide environmental intervention, three sequential classroom curricula, and a selected intervention for students involved in bullying. The program includes manuals, written material, and audiovisual presentations for school administration, staff training, classroom curricula, and parent outreach (Frey, et al. 2009).

The program is designed to decrease school bullying problems by:

- increasing adult monitoring and intervention in bullying events,
- improving systemic supports for socially responsible behaviour,
- changing student normative beliefs that support bullying, and
- addressing student social– emotional skills that counter bullying and support social competence.

The most recent published evaluation of the Steps to Respect Program involving 624 students from six elementary schools demonstrated a 31% decrease in bullying rates, a 70 percent reduction of destructive bystander behaviour and a 36 percent decline in non-bullying aggressive behaviour (Frey, et al. 2009).

The final recommended intervention is The Peace Pack. The PEACE Pack is a program that provides a framework for schools to assess the status of their anti-bullying policy in relation to policy and grievance procedures, curriculum initiatives and student social support programmes. These components are organized and grouped under the acronym of PEACE (Preparation, Education, Action, Coping and Evaluation), which represents the orderly stages in the process for initiating, conducting and evaluating a programme for reducing school bullying. The actual pack provides practical resources, such as examples of policy, grievance procedures and lesson plans, as part of a comprehensive package for schools to develop their own intervention.

The Peace Pack has been evaluated in 4 primary schools in Adelaide revealing one-fifth of pupils reporting that they were being bullied 'less' as a result of year-long interventions. This effect was greatest in the primary schools, particularly for boys (Slee and Mohyla, 2007).

4.1.4 Discussion

Evidence suggests that whole-school interventions are, on the whole, effective in reducing the prevalence of bullying. However, there are grounds for some caution in supposing that anti-bullying initiatives will invariably produce the intended results and there is some risk of equivocal or even harmful results (Farrington and Ttofi, 2009). With this in mind it is important that close attention is paid to ensure that programs are carried out as they were designed. The temptation to 'cut corners' and deliver 'watered down' programs can result in incomplete, inadequate, and ineffective implementation (Whitted and Dupper, 2005).

The evaluation results have highlighted that the intensity and duration of a program are directly linked to its effectiveness, with a 'dose-response' relationship between the number of components of a program and its effect on bullying. Therefore programs need to be intensive and long-lasting in order to have an impact. In more difficult cases a considerable time period may be needed in order to create an appropriate school ethos to tackle bullying (Farrington and Ttofi, 2009).

Programs are also more likely to be successful if the entire school community is engaged, committed, and involved. Administrators must express their support for the program, financial resources must be made available, and the program should be integrated into the school curriculum (Whitted and Dupper, 2005).

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Table 1   *Proportion of children and young people who are bullied*

	Supporting evidence	Replication	Documentation	Theoretical basis	Cultural reach
(41.1) The Olweus Bullying Prevention Program	1	Yes	Yes	Yes	LOW SES CALD
(41.2) Friendly Schools and Families	1	Yes	Yes	Yes	
(41.3) The Steps to Respect Program	2	Yes	Yes	Yes	
(41.4) The Peace Pack	2	Yes	Yes	Yes	

Key

Supporting evidence:
1. Well supported practice – evaluated with a prospective randomised controlled trial.
2. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication.
3. Promising practice – evaluated with a comparison group.
4. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data).
5. Emerging practice – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation).

Replication:
Has the intervention been implemented and independently evaluated at more than one site? (yes or no)

Documentation:
Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:
Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field? (yes or no)

Cultural reach:
Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD)

Recommended Strategy 41.1: Proportion of children and young people who are bullied	
Name of intervention	The Olweus Bullying Prevention Program
Organisation	Clemson University
Brief literature review	The Olweus Program is a comprehensive, school-wide program designed and evaluated for use in elementary, middle, or junior high schools. The program's goals are to reduce and prevent bullying problems among school children and to improve peer relations at school. The program has been found to reduce bullying among children, improve the social climate of classrooms, and reduce related antisocial behaviours, such as vandalism and truancy.
How and why does this intervention work?	The initial prevention program was carefully evaluated in a large-scale project involving 2,500 students from forty-two schools followed over a period of two and a half years. Statistics showed: ▪ Reductions of 50% or more in student reports of being bullied and bullying others. Peer and teacher ratings of bullying problems have yielded roughly similar results. ▪ Marked reductions in student reports of general antisocial behaviour, such as vandalism, fighting, theft, and truancy. ▪ Clear improvements in the classroom social climate, as reflected in students' reports of improved order and discipline, more positive social relationships, and more positive attitudes toward schoolwork and school
On what population does this intervention work best?	This program has been extensively evaluated around the world and is an internationally recognised school based bullying prevention program. The program is designed to be used with primary and high school children.
Where will this intervention work best?	This program has been extensively evaluated around the world and is used nationwide in Ireland and in Norway.
What is required to implement this intervention?	An extensive range of materials supporting the implementation of the Olweus Bullying Prevention Program are available via the websites listed below.
Resources and contact information	Email: olweuswebmaster@hazelden.org For information about training or ongoing research to support the Olweus Bullying Prevention Program, please visit the Clemson University website. Website: http://www.clemson.edu/olweus/
References	http://www.clemson.edu/olweus/ http://www.olweus.org/public/index.page

Recommended Strategy 41.2: Proportion of children and young people who are bullied	
Name of intervention	Friendly Schools and Families
Organisation	Child Health Promotion Research Unit, Edith Cowan University.
Brief literature review	This intervention is a 'Friendly Schools and Families Whole-School Pack' which is a resource that aims to help school communities enhance their skills, knowledge and capacity to implement an evidence-based whole-school approach to the prevention and reduction of bullying. It also helps schools to engage families in this process. The Whole-School Pack is divided into six handbooks to provide a systematic plan of 'small steps' for school teams to implement a successful social skill building and bullying reduction program that also addresses the National Safe Schools Framework. The Whole-School Pack consists of this School Team Handbook and CD-ROM, a parent's guide and six component handbooks that are full of resources and school case studies outlining how real schools have successfully reduced bullying and created a Friendly School community environment.
How and why does this intervention work?	The Friendly Schools and Families Program is based on six years of detailed research involving over 6000 school students, and their parents and teachers. It is one of the few evidence-based programs that has been rigorously evaluated and found to improve young people's social skills and to reduce bullying behaviour. The research has been recognised nationally and internationally as a successful and comprehensive evidenced-based bullying prevention program. It is frequently reported in the literature that school bullying can have an adverse effect on student attendance and therefore any mechanism that successfully addresses bullying can also favourably influence school attendance.
On what population does this intervention work best?	Although this model has been developed in Western Australia its research is based upon an evidence-based program that incorporates shared practice and learning from over two hundred schools from Australia. The program reach is therefore very inclusive.
Where will this intervention work best?	The program guidelines and activities are designed to build on and support strategies to reduce bullying as advocated by the Australian National Safe Schools Framework for both Primary and Secondary Schools.
What is required to implement this intervention?	The program is based upon the 'Whole-School Pack' which is divided into six handbooks to provide a systematic plan of 'small steps' for school teams to implement a successful social skill building and bullying reduction program that also addresses the National Safe Schools Framework.
Resources and contact information	Contact: Shelley Brown (Administration Officer and Survey Service Coordinator) Phone: (08) 9273 8140.
References	http://www.friendlyschools.com.au/index.php

Recommended Strategy 41.3: Proportion of children and young people who are bullied	
Name of intervention	The Steps to Respect Program
Organisation	Committee for Children
Brief literature review	Steps to Respect is a multilevel program designed to reduce bullying problems by coordinating a school-wide environmental intervention, a classroom-based cognitive-behavioural curriculum, and a selective intervention for students involved in bullying events. The universal environmental intervention aims to provide adults and children with systemic support and specific procedures that counter bullying and motivate socially responsible behaviour. Classroom lessons and instructional practices starting in grade 3 or 4 target children's normative beliefs related to bullying as well as social-emotional skills for responding to bullying and increasing peer acceptance.
How and why does this intervention work?	A rigorous evaluation study in 2005 determined that an initial implementation of the Steps to Respect program resulted in approximately 25 percent fewer bullying events. This evaluation included six elementary schools that were randomly assigned to either the intervention or control group. A more recent evaluation involving 624 students from six elementary schools demonstrated a 31% decrease in bullying rates, a 70 percent reduction of destructive bystander behaviour and a 36 percent decline in non-bullying aggressive behaviour.
On what population does this intervention work best?	The interventions are targeted specifically towards primary school children (Grades 3 – 6).
Where will this intervention work best?	This intervention has been implemented widely in the United States.
What is required to implement this intervention?	The program includes manuals, written material, and audiovisual presentations for school administration, staff training, classroom curricula, and parent outreach. Professional staff training and implementation consultation are available.
Resources and contact information	http://www.cfchildren.org/programs/str/overview/
References	Frey KS, et al. (2009) Frey KS, et al. (2005)

Recommended Strategy 41.4: Proportion of children and young people who are bullied	
Name of intervention	The Peace Pack
Organisation	School of Education, Flinders University
Brief literature review	The programme provides a framework for schools to assess the status of their anti-bullying policy in relation to policy and grievance procedures, curriculum initiatives and student social support programmes. These components are organised and grouped under the acronym of PEACE (Preparation, Education, Action, Coping and Evaluation), which represents the orderly stages in the process for initiating, conducting and evaluating a programme for reducing school bullying.
How and why does this intervention work?	A recent evaluation of the PEACE Pack in four primary schools (954 pupils) in Adelaide resulted in approximately one-fifth of pupils reporting that they were being bullied 'less' as a result of year-long interventions. This effect was greatest in the primary schools, particularly for boys.
On what population does this intervention work best?	The resource is intended for use by schools from reception (prep) to year 12 and has a focus on children with special needs. It is particularly directed at teachers, school counsellors and school administrators interested in implementing or reviewing anti-bullying programs in their classroom or school. It could also be used in conjunction with associated resources by social welfare workers who are delivering programs in schools and communities.
Where will this intervention work best?	The program has been evaluated in Australia and has been translated into Japanese.
What is required to implement this intervention?	The P.E.A.C.E. Pack comprises a 24-page booklet and 14 worksheets. The booklet contains: ▪ Information about the nature and effects of bullying in Australian and overseas schools ▪ Details of the outcomes of intervention programs implemented in schools ▪ A resource list and resources that can be copied for use in seminars, school meetings and conferences The worksheets provide: ▪ Ideas for policy and grievance procedures ▪ Examples of lesson plans addressing the issues of bullying ▪ Details of interventions with bullies and victims ▪ Ideas for involving parents in anti-bullying programs
Resources and contact information	Phillip T. Slee School of Education, Flinders University GPO Box 2100 Adelaide, SA. 5001 Phone: (08) 8201 3243 Fax: (08) 8201 3184 Email: phillip.slee@flinders.edu.au Website: www.caper.com.au
References	http://www.caper.com.au/ http://www.kidsmatter.edu.au/programs-guide/peace-pack/ Slee, et al. (2007)

5   Proportion of young people with an eating disorder

5.1   Narrative review

5.1.1   Background

Information in this review relates primarily to anorexia nervosa and bulimia nervosa. These are the two most common eating disorders in young people. Information and interventions relating to overweight and obesity can be found elsewhere in the Catalogue of Evidence.

As mentioned above the two major diagnostic categories for eating disorders are anorexia nervosa (AN) and bulimia nervosa (BN). AN is characterised by a refusal to maintain a minimally normal body weight through restrictive eating patterns and binge-eating and purging. People with restricting-type anorexia limit their food intake so severely that their bodies experience starvation. People with binge-eating and purging type anorexia use inappropriate compensatory measures, such as self- induced vomiting after eating (Keca and Cook-Cottone, 2005).

BN is characterised by reoccurring episodes of binge eating followed by inappropriate compensatory behaviour such as self-induced vomiting, misuse of laxatives, diuretics or other medications, fasting or excessive exercising (Keca and Cook-Cottone, 2005).

The international prevalence of AN among females in late adolescence and early adulthood is 0.5% to 1% (Pratt, 2009). Data from a recent Australian study suggest that AN is the third most common chronic illness for adolescent girls after obesity and asthma (Beumont, 2000). The international prevalence rate for (BN) is slightly higher with estimates believed to involve approximately 1% to 3% of adolescents and young adult females (Pratt and Woolfenden, 2009). The incidence of BN in the Australian population is higher at approximately 5% (Sullivan, 1995). However, these rates could be conservative as at least two studies have indicated that about one tenth of the cases of bulimia in the community go undetected (The Victorian Centre of Excellence in Eating Disorders and the Eating Disorders Foundation of Victoria, 2004).

The major risk factors for both AN and BN are body dissatisfaction, dieting behaviour and being female with the average age of onset occurring in early to mid adolescence, ranging from 14 years to 20 years of age (Pratt and Woolfenden, 2009). For this age group research has indicated that between 20% and 40% of adolescents try to lose weight by dieting (Raich, et al. 2008). Girls of this age group who engage in unhealthy behaviours to control their weight have twice the risk of later engaging in more extreme weight control behaviour, and six times greater risk of binge eating during a 5 year follow-up compared to girls who were not trying to control their weight (Raich, et al. 2010).

An Australian study of 1947 girls aged 14 to 15 years indicated that girls who dieted at a severe level were found to be 18 times more likely to develop a new eating disorder (ED) within six months than those who did not diet, and those who dieted at a moderate level were five times more likely to develop an eating disorder (Pratt and Woolfenden, 2009).

Other risk factors for eating disorders reported in the literature are highlighted in Table 2:

Table 2   ED risk factors

Family factors:	Individual factors:
Critical comments by family about shape, weight or eating,	Childhood obesity
Low perceived social support from family,	Early puberty
Parental obesity,	Perfectionism and negative self-evaluation
Parental psychiatric disorder,	Low self esteem
Genetic predisposition,	High levels of body concern and escape avoidance coping.
Physical and sexual abuse	Emotional sensitivity
Low levels of parental connection and poor communication	

(Adapted from Cook-Cottone, 2009)

These factors can be exacerbated by mass media messages and other social influences that promote thinness which may influence women to feel dissatisfied about their body (McVey, et al. 2007; Cook-Cottone, 2009). The current cultural focus on dieting has also created increased exposure to diet commercials, diet talk, and dieting behaviour. The media's influence on this is considered by some to be a particularly important and, some suggest, a causal factor leading to ED (Haines, 2007).

Both AN and BN have the potential to impact upon the sufferer's long-term physical health and social and emotional well-being (Hellings and Bowles, 2007; Perkins, et al. 2009). In fact, clinically significant eating disorders are characterised by high mortality rates, destructive physical and psychological consequences, comparatively poor treatment outcomes and an estimated lifetime prevalence of 6% to 12% (Wilksch, et al. 2009). From a mental health perspective, eating disorders represent the seventh major cause of mental disorders for women in Australia (Pratt and Woolfenden, 2009).

For many adolescents, ED sufferers are also forced to defer their education whilst they seek treatment, thus furthering the potential negative impact of their condition on their social and cognitive development (Hellings and Bowles, 2007).

5.1.2   The evidence base

Clearly, body image concerns, weight loss behaviours and eating disorders such as AN and BN pose a serious and increasing threat to the short and long term physical, psychological and social health of children and adolescents. This factor is complicated by the fact that less than one third of those with eating disorders finally receive treatment and of those who do receive such treatment, fewer than half attain remission of symptoms (Wilksch, et al. 2009; Raich, et al. 2008). Given the destructive course and poor treatment outcomes for some eating disorders prevention programs have become an important international endeavour.

There have been a multitude of approaches to the prevention of eating disorders, yet successful prevention has proven largely ineffective. It is reported that only 5% of the programs that have been evaluated in controlled trials have produced lasting reductions in current or future ED symptoms (Stice, et al. 2008). Some programs have demonstrated an increase in awareness of eating disorders, but few report actual shifts in prospectively identified risk factors (Wilksch, et al. 2008).

Where evaluations do exist, the methods employed have frequently suffered from insufficient sample sizes, absence of control groups, inappropriate statistical analyses, use of non-validated outcome measures, and inadequate follow-up assessments. Prevention programs themselves have also often been of insufficient intensity to produce significant post-intervention effects (Wilksch, et al. 2009).

There is also a concern about the potential to cause harm via eating disorder prevention programs as they may inadvertently serve to heighten awareness of body weight and increase weight concerns and weight loss attempts among children and adolescents (Pratt and Woolfenden, 2009).

The types of programs and their methods of delivery have evolved over the past decade. With regards to school-based programs, the first generation of prevention interventions were didactically delivered and universally focused. They were developed under the premise that providing education related to eating disorders (e.g. physical and emotional consequences) would deter individuals from future engagement in eating disordered attitudes and behaviours (Newton, et al. 2006).

These universal prevention efforts focus on healthy development and the prevention of eating disordered attitudes and behaviours. The four core areas of prevention practices are: encouraging body acceptance, decreasing appearance-related teasing, addressing nutrition and physical activity, and increasing coping skills (Cook-Cottone, 2009).

According to the evidence these school-based programs are largely ineffective in reducing prospectively identified risk factors, leading to the conclusion that research should look beyond a public health approach to eating disorders (Wilksch, et al. 2009).

As a result, research turned to selected prevention programs where only those at high-risk for developing an eating disorder (e.g. adolescent females), or in some cases, already expressing features of disordered eating, were included (Stice, et al. 2008). This more targeted approach features the provision of focused supplemental interventions involving frequent, small-group sessions relating to the identification and correction of eating disordered attitudes and behaviours in the very early stages (Mintz, et al. 2008).

This approach also features a more interactive, experiential approach that embraces wellness and increasing coping skills. This is a move away from the more didactic approach of previous universal programs. Typical curriculum features of a more targeted approach include such topics as: self-care (e.g. instruction in relaxation techniques), self-concept work, life skills (e.g. assertiveness training), coping skills (e.g. instruction in emotional regulation), and media literacy (Cook-Cottone, 2009).

Research suggests that these targeted interventions, when carried out with adolescents as early as 15 years of age and aimed at specific risk groups can produce significantly more pronounced and lasting effects than those of universal interventions (Stice, et al. 2004). However, it is suggested that whilst these programs are generally effective in increasing participants' knowledge, they have mixed results in their ability to produce attitudinal and behavioural change in participants (Hellings and Bowles, 2007).

Targeted interventions can also have limitations with regards to stigmatising their participants (Hellings and Bowles, 2007). It is also difficult to accurately identify adolescents at high risk in the first place given the high prevalence of abnormal eating attitudes and behaviours in this population (Wilksch, et al. 2006).

Recent evidence suggests that school-based interventions are more likely to be effective if the entire school community is involved. Parents and teachers can be important role models and it is important to involve them both in a more universal and ecological approach to ED prevention programs. In this whole-school approach, the target of the intervention is the school environment not just the individual student (Russell-Mayhew, et al. 2007).

Whether the method of intervention is universal or targeted, involves the individual student or the whole school community, the consensus view among professionals is that the key to prevent EDs from becoming chronic is early intervention. Given that 15 to 16 years is the age when disordered

eating behaviours are most likely to emerge it is important that prevention programs be administered before this age (Perkins, et al. 2009; Cook-Cottone, 2009).

Moving away from the school, the focus on programs that increase participant interactivity has been consistently linked over the past decade to the utilisation of computers and the development of internet-based ED interventions. However, results pertaining to the impact of Internet prevention programs are also disappointing. A recent meta-analysis of internet-based intervention strategies was carried out in Canada and published in 2006. Of the five published studies reviewed no robust evidence was found on the impact of Internet-based prevention strategies on eating disorders and on the acknowledged factors that contribute to eating disorder development (Newton, et al. 2006).

5.1.3   Selection of recommended interventions

A recent Cochrane review into interventions for preventing eating disorders in children and adolescents was carried out by Pratt and Woolfenden (2009). The review identified several eating disorder prevention programs that had been developed and trialled with children and adolescents. However, the review only found limited evidence to suggest that any particular type of program is effective in preventing eating disorders. The review also highlighted concern that some interventions even have the potential to cause harm.

Due to the lack of evidence relating to the outcomes of ED programs together with the concerns relating to their possible deleterious effects this section does not recommend particular interventions as in the normal style of the catalogue.

For more information about eating disorders the following Australian websites provide excellent information:

- http://www.rch.org.au/ceed/index.cfm?doc_id=2783
  The Victorian Centre of Excellence in Eating Disorders (CEED) is a key program within the Victorian government's response to the provision of quality services for those with eating disorders. CEED aims to undertake strategies to build quality, sustainable eating disorder treatment responses delivered by public specialist mental health services.

- http://www.eatingdisorders.org.au/
  The Eating Disorders Foundation of Victoria is the primary source of support, information, community education and advocacy for people with eating disorders and their families in Victoria.

- http://www.thebutterflyfoundation.org.au/
  The Butterfly Foundation is a community based charitable organisation that supports eating disorder sufferers and their carers through direct financial relief, advocacy, awareness campaigns, health promotion and early intervention work, professional training in primary and secondary schools and supporting eating disorder and body image research.

- http://www.healthinsite.gov.au/topics/Eating_Disorders
  A healthdirect Australia health information service relating to information about eating disorders such as bulimia and anorexia nervosa.

5.1.4   Discussion

There is still much to be learned about the most effective form and target for eating disorder prevention. However, there appears to be general agreement on a few issues:

Firstly, the risk of inadvertently harming ED program participants or creating unintentional adverse effects is something that health educators and others involved in preventive activities must take very seriously. This is particularly the case with prevention programs that purely focus on the didactic teaching of ED signs and symptoms. Interventions that do this run the risk of glamorising dieting, reinforcing the thin-ideal, or perpetuating fat-prejudice (Russel-Mayhew, et al. 2007).

Secondly, the literature indicates that the most favourable outcomes are achieved through programs that rely on participatory, interactive approaches. This includes developing strategies to enhance self-esteem and building social and relational practices that include family and teachers. This participatory approach allows all parents, teachers, and students to work together toward a school environment that allows students to feel good about their bodies (Russel-Mayhew, et al. 2007).

Thirdly, there is agreement that prevention programs should start early. Restrictive dieting has been found in children as young as 8 years old and accordingly, prevention programs are considered most effective in the lower elementary years, before crystallization of the preoccupation with body shape and weight (Cook-Cottone, 2009).

Further research into the incidence and prevalence of eating disorders (and associated risk factors) via high quality epidemiological studies as well as further randomised controlled trials of prevention programs is necessary. In particular, further research aimed at identifying both risk factors and protective factors for eating disorders will be an important precursor to the refinement of the content of prevention programs (Pratt and Woolfenden, 2009).

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6 Crimes (including assaults) where the victim was a child or young person

6.1 Narrative review

6.1.1 Background

Young people aged between 10 and 24 years of age make up 34% of all reported assaults in Victoria (DEECD and DPCD, 2007). While young people are more likely to become victims of certain types of violent crimes (rape, other sexual offences and assault) they are less likely to report a violent crime (AIC: Johnson, 2005). A Canadian study found that the most common violence experienced in childhood is psychological violence, followed by physical violence and then sexual violence (Tourigny, et al. 2008).

In 2005 the victimisation prevalence rate for assault among young people aged 15-24 years was 8.9% (AIHW, 2007). Data from the 2004 National Drug Strategy Household Survey showed that in the 12 months prior to the survey, 31% of young people aged 14–24 years were the victim of drug-related violence (including alcohol-related violence). In addition, in 2004–05, there were 7,359 hospital separations among young people aged 12–24 years for an injury caused by assault, a rate of 203 per 100,000 young people (AIHW, 2007). The rate for Aboriginal and Torres Strait Islander young people aged 12-24 years was significantly higher at 1,248 per 100,000 males and 1,502 per 100,000 females (AIHW, 2007).

Nofziger (2009) reported on a study of victimisation and self-control among high school students. Among the sample the most common form of victimisation was having something stolen (84%) but 57% reported this happening only once and 7.4% reported it happening many times. Assault with a weapon was the most serious and least common type of victimisation with 17% reporting this happening to them.

Physical and sexual assault has short and long-term effects on development (Paolucci, et al. 2001) and a history of abuse has been associated with depression, anxiety and substance abuse (Molnar, et al. 2001; Vuijk, et al. 2007). In a study of adults about violence experienced in childhood, men were more likely to report physical violence while women were more likely to report sexual violence (Tourigny, et al. 2008). Boys are more likely to experience physical victimisation and suffer depression and anxiety as a result whereas girls are more likely to develop these disorders as a result of relational victimisation (Vuijk, et al. 2007).

Victimisation as a child also increases the risk of a person being victimised as an adult (AIC: Johnson, 2005). Elliott, et al. (2009) suggested that children who have experienced one type of victimisation (e.g. sexual) have also experienced other types of victimisation (e.g. physical or peer abuse) and found that those who had experienced multiple types of victimisation in childhood were more likely to suffer adjustment problems in adulthood than those who have experienced only one type of victimisation.

Lataster, et al. (2006) reported a strong association between victimisation as a child, including unwanted sexual experiences and bullying, and the emergence of non-clinical psychotic experiences as an adult. Violent children and adolescents show an enhanced likelihood for later underachieving, dropping out of school, below-potential career performance, and committing physical and sexual abuse (Beland, 1996).

New and Berliner (2000) found that the two most common variables for seeking mental health service support among victims of crime were sexual assault and the diagnosis of Post Traumatic Stress Disorder. Longer period of sexual abuse or chronic physical abuse were also associated with mental health service use (New and Berliner, 2000).

There are a number of risk factors related to children and adolescents becoming victims of crime. Juveniles living in intact families with greater economic resources are less likely to be victimised (Nofziger, 2009). Children of single father homes, where there is no joint custody by the mother, may be at higher risk of victimisation such as physical violence (Jablonska and Lindberg, 2007). Higher rates of admission to hospital for assault are associated with deprivation across all age groups, including those less than 15 years old, with evidence showing a sixfold increase in admission rates between the wealthiest and poorest quintiles of residence (Bellis, et al. 2008).

In an Australian sample of children, aggression at age 5 was the strongest predictor of delinquency in adolescence (Bor, et al. 2001). In addition, individuals with greater self-control are less prone to victimisation however; opportunity for crime increased the rate of both victimisation and perpetration (Nofziger, 2009).

In a study of young adults (median age 20) Martin, et al. (2009) found that alcohol use was significantly associated with being a victim and with perpetrating violent crime while methamphetamine use wasn't associated with either outcome.

Evidence suggests that there are a proportion of young people in Victoria suffering as a result of being a victim of crime, in particular, as victims of assault. Programs aimed at reducing the number of assaults and the perpetration of violent crime are highlighted in the following sections.

6.1.2 The evidence base

The search for interventions for this indicator focused on interventions aimed at reducing the likelihood of young people becoming a victim of crime, in particular, becoming a victim of assault. Terms used in the search for interventions included assault, victimisation, 'victims of crime' and 'victims of violence' along with the terms evaluation, intervention and program. This indicator applied to all age groups up to the age of 18. Databases including the Cochrane Library, MEDLINE, PsychINFO, CINAHL, ERIC and CINCH-health were searched. A Google search was also performed using the terms and limits given above, as well as a search of appropriate government and non-government websites.

Evidence suggests that programs implemented with children before they reach adolescence, that address more than one risk factor (for example, a child's disruptive behaviour and parenting), and that last for an extended period (at least one year) have the greatest likelihood of showing positive results (Tremblay and Craig, 1995, p. 219). Further, programs should target multiple risk factors including the community, school, family and individuals (Wasserman and Miller, 1998, p. 244). Early life interventions can prevent violence against and between children and reduce development of violent tendencies in youths and adults (Bellis, et al. 2008).

Early intervention programs with young, single mothers have consistently reduced the injury suffered by children in the first two years of their life as well as ongoing positive effects into adolescence, including fewer arrests, convictions and violations of probation (Olds, et al. 2004; Olds, et al. 1998). Preschool programs that reduce aggression are also indicated (Cameron, 2000). In spite of the attention given to juvenile behaviour, early intervention is the most cost effective due to the cumulative benefits felt later in life (Tremblay and Craig, 1995, p. 224).

An early review of school-based violence prevention interventions by Howard, et al. (1999) suggested that for effectiveness, school-based interventions should be combined with home and community-based efforts to reduce violence. The authors argued that interventions need to be integrated across these settings and include greater collaboration between those working in these areas (Howard, et al. 1999).

While a well designed curriculum component for a school-based intervention is important it is not sufficient for effectively preventing violence among young children (Clayton, et al. 2001). More

effective programs are those aimed at both the individual and the environment, in particular programs that take into account that violence has multiple causes and requires multi-component interventions (Clayton, et al. 2001).

On the contrary, a meta-analysis of school-based violence prevention programs (Park-Higgerson, et al. 2008) found some surprising results indicating that there was little evidence for multiple approach programs involving family peers and community. Instead the authors found that there was some evidence for a focussed single component approach to reducing school-based violence. The authors also pointed out in developing a multi-component approach, consideration must be given to how the components are combined to maintain program fidelity and integrity (Park-Higgerson, et al. 2008).

Park-Higgerson, et al. (2008) also did not find evidence for a theory-based approach or for starting the program at an early age. The authors pointed to small effect sizes, missing pre-tests, differences in outcome focus, small sample sizes and heterogeneity among studies as having contributed to a lack findings (Park-Higgerson, et al. 2008).

A review of school-based violence prevention programs by Mytton, et al. (2002) found that interventions may produce reductions in violence and aggressive behaviour in students who already display such behaviour. The authors also found that there was a greater effect among older students and for mixed sex groups rather than boys alone (Mytton, et al. 2002).

Another review of school based programs argued that the most effective programs for reducing violence in young people were those programs aimed at teaching peace (Clayton, et al. 2001). In particular they take a proactive approach to teaching children to value themselves and others, to relate to all people in peaceful ways and to respond to conflict creatively (Clayton, et al. 2001).

While early intervention programs have shown to be most effective in reducing violence among young people there is still a growing problem of violence among older youth. Some researchers have looked at the problem of alcohol related violence in older youth.

A study by Shepherd and colleagues (2006) found an association between alcohol consumption and being a victim of assault. They argued that reducing alcohol consumption may reduce victimisation without actually reducing violent behaviour and that violence reduction should focus on victims or potential victims as much as offenders (Shepherd, et al. 2006).

A community-based approach to reducing alcohol related violence in young adults aged 15-29, including community mobilisation, community awareness and responsible beverage service (Treno, et al. 2007) showed a reduction in assaults and motor vehicle crashes.

Emergency department-based violence prevention interventions have also emerged in recent years. These secondary prevention programs are designed for those who have already been affected by violence such as violent assault.

An ED-based violence prevention program in Chicago showed a reduction in self-reported re-injury rates but there was no change in the arrest rate or re-injury rates from ED and police data sources (Zun, et al. 2006). The program also showed a lack of change in attitudes and a decrease in parental support over the term of the study (Zun, et al. 2004).

Another study of a violence intervention program targeting assault injured youth (Cheng, et al. 2008) found that while the program was accepted by patients and their families the study was unable to show a significant improvement in risk factors for injury, re-injury rates or service use. Loss to follow up was a major limitation of this study.

In a systematic review by Snider and colleagues (2009) they found that case management based programs can reduce future involvement in criminal activity, however, the US-based programs

studied had small numbers and limited follow up, decreasing their ability to show significant decreases in re-injury.

Cameron (2000) reviewed programs for young men and argued that while programs that showed promise with this group included new approaches to policing, anger management and provision of recreational facilities, early intervention programs were the most effective.

6.1.3 Selection of recommended interventions

The focus of this review aims to identify programs that help to reduce the number of young people who are victims of crime, in particular, victims of assault. Evidence suggests that early intervention programs are the most effective in reducing both the victimisation of young people through violence as well as the perpetration of violence by young people. Clayton, et al. (2001) identified five points for choosing or developing violence prevention programs:

Violence prevention programs:

- should be founded on sound psychological, sociological, and / or educational theory
- should be comprehensive
- should be appropriate for all children and take into consideration unique populations
- must include adequate teacher training
- should strengthen children's sense of self-worth

Programs chosen to support the prevention of violence, and in particular assault, include the following:

- Social Decision Making / Problem Solving Program (SDM/PS)
- PeaceBuilders
- Multisite Violence Prevention Project (MVPP)
- Nurse-Family Partnership

The Social Decision Making / Problem Solving (SDM/PS) program is a school-based program designed to help young people from grades K through to 8 learn social and decision making skills that will help them make healthy life choices and avoid social problems such as substance abuse, violence and academic failure. The program can be used with both regular and special education students.

The SDM/PS approach is primarily curriculum-based with lessons in three main areas:

- Self-control and social awareness
- Social decision making and problem solving
- Applications to academics and 'real life' problems.

The first evaluation of SDM/PS included 109 boys in special education classes at a residential treatment facility for emotionally and educationally handicapped children (Elias, et al. 1983). The 109 participants ranged from 7 to 15 years of age and the sample was 50% African American, 30% Caucasian and 20% Hispanic.

A second study (Elias, et al. 1986) included 158 fifth-grade students from a mainly white community of 15,000 residents in New Jersey. This group was followed up six years after the study in high school with a low rate of attrition (Elias, et al. 1991).

The overall pattern of findings suggests that those students who had received a two-year social decision-making and problem-solving program in elementary school showed higher levels of positive pro-social behaviour and lower levels of antisocial, self-destructive, and socially disordered behaviour when followed up in high school four to six years later than did the control students who had not received this program (Elias, et al. 1991).

PeaceBuilders is a universal, school-based violence prevention program aimed at altering the school climate through teaching students and staff ways to improve child social competence and reduce aggressive behaviour (Flannery, et al. 2003). The program focuses on changing circumstances that lead to aggressive behaviour, reward pro-social behaviour and provide strategies to avoid reinforcing negative behaviour (Vazsonyi, et al. 2004).

The original study of PeaceBuilders (Embry, et al. 1996) included eight schools with high rates of juvenile arrests and histories of suspensions and expulsions, grouped into four matched pairs and then randomly assigned to either the intervention or a waitlist control. Schools composed of students in grades K-5 who were surveyed twice a year over two years, beginning with a baseline survey in Autumn 1994.

After one year there was a decrease in nurse visits in intervention schools and a slight increase in visits in control schools (Krug, et al. 1997). In addition, visits to the school nurse for fighting related injuries remained stable in intervention schools but rose 56% in control schools (Krug, et al. 1997).

Flannery, et al. (2003) reported on the two year follow-up of the study. Participation rate varied between schools. A total of 4,679 (n = 2,268 control; n = 2,411 intervention) students participated in the study, a participation rate from 86% to 93%. There were equal numbers of boys and girls in the sample as well as a high proportion of Hispanic children.

Flannery and colleagues (2003) found that schools where the program was implemented had significant gains in student social competence, self reported peace-building behaviour and reductions in aggressive behaviour compared to wait list schools after one year. Effects on aggression and pro-social behaviour were also maintained after two years (Flannery, et al. 2003).

Another study by Vazsonyi and colleagues (2004) found that, for schools participating in a PeaceBuilders intervention, children who were at high-risk for future violence reported more decreases in aggression and more increases in social competence compared to medium and low risk children.

Peacebuilders was implemented in a pilot school in Australia in 1997 (Christie, et al. 1999). Preliminary results indicated a number of positive changes in the school context, in particular there were reductions in police call-outs to the school, parents being called to the school, increased positive contacts between police and the school and increased voluntary parent visits to the school.

The Multisite Violence Prevention Project (MVPP) was trialled to reduce violence among middle school adolescents. The school-based trial compared the effects of a universal intervention involving the implementation of a violence prevention curriculum and teacher training, a selective intervention that included a parent component with a subset of high risk students and the combination of the universal and selected interventions.

As part of the project the GREAT (Guiding Responsibility and Expectations for Adolescents for Today and Tomorrow) student curriculum is currently being developed. This includes a universal program involving a social-cognitive framework approach to problem-solving skills, self-efficacy for

nonviolence, goals and strategies supporting nonviolence, and individual and school norms against the use of violence (Meyer, et al. 2004). Further work is still being done to refine the curriculum, however, this resource is based on the RIPP (Responding in Peaceful and Positive Ways) program (Meyer, et al. 2000).

The researchers are also currently developing a GREAT Families Program (Smith, et al. 2004). This 15 week intervention was targeted at a sample of sixth graders whom teachers considered both aggressive and influential among their peers (Smith, et al. 2004). The GREAT curriculum, teacher and family program resources are still under development; however, the MVPP is a well designed project that has shown promise in reducing violence among young people

The MVPP involved 37 schools in four locations in the USA, randomised to either the universal program, the selected program, a combined program or a control group. There was little difference between the four groups of schools apart from some ethnicity differences between schools assigned to the universal intervention and other school groups (fewer Hispanic and more African American students) (MVPP, 2008).

At the end of the first year the project showed that students exposed to the universal intervention expressed higher individual norms supporting non-violent behaviour than students at comparison schools, however they also reported higher levels of goals and strategies that supported the use of aggression (MVPP, 2008). Further analysis also showed that pre-intervention risk levels moderated effects, with those at highest risk tending to benefit from the program whereas low-risk students showed results in the opposite direction (MVPP, 2008). Analysis of data collected in the subsequent two years found that there was some evidence that the universal intervention was associated with increases in aggression and reductions in victimization; however, these effects were moderated by pre-intervention risk (MVPP, 2009). In contrast, the selective intervention was associated with decreases in aggression but no changes in victimization (MVPP, 2009).

Nurse-Family Partnership® is an evidence-based, nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. Mothers who are at risk are first enrolled at 20 to 28 weeks into their first pregnancy. Nurse home visits are aimed at improving prenatal, maternal, and early childhood health and well-being. Nurses focus on therapeutic relationships with the family and improving family functioning in areas of health, home and neighbourhood environment, family and friend support, parental roles, and major life events. The program is provided for up to three years after the birth of the child according to need.

The NFP program is based on the work done by Professor David Olds and his colleagues over a thirty year period. The findings of the original trial of the project conducted in Elmira, New York in 1977 (Olds, et al. 1994) were very encouraging and so further large trials of the program were conducted in Memphis, Tennessee in 1987 (Kitzman, et al. 1997) and in Denver, Colorado in 1994 (Olds, et al. 2004).

Olds, et al. (1998) reported that participants from the original trial of the program in 1977, who were followed up over 15 years had fewer subsequent pregnancies, use of welfare, child abuse and neglect, and criminal behaviour on the part of low-income, unmarried mothers. Investment in the program was estimated to be recovered before the child turned 4 years old, however, benefits only exceed costs where the mother was low income and unmarried (Olds, et al. 1997). A 19-year follow-up of this cohort found that nurse home visiting reduced the number of girls with arrests and convictions (Eckenrode, et al. 2010).

Results from these trials are most effective when the program is delivered exactly as designed. Washington State Institute for Public Policy conducted a cost effectiveness study in which they reported that there was a US$2.88 return for every dollar spent with a net benefit of US$17,180 per family served (Aos, et al. 2004). RAND Corporation also conducted a cost effectiveness study of the program and estimated that there was a US$5.70 return for every dollar spent or a US$34,148 net benefit for every family served (Karoly, et al. 2005).

The Australian Nurse-Family Partnership Program has now also been implemented and funded by the Australian Government Department of Health and Ageing to assist Aboriginal and Torres Strait Islander young first time mothers. The program has now commenced in four locations across Australia, including Melbourne, Cairns, Alice Springs and Wellington.

6.1.4 Discussion

Young people who are victims of crime, particularly violent crime, form a small but significant group within our community. There are a number of social consequences of victimisation as young people grow up, including poor lifetime outcomes, increased service usage due to ongoing social and emotional outcomes and the possibility of victims becoming perpetrators. In addition, specific groups, such as Aboriginal and Torres Strait Islander young people may be affected by violence at higher rates than the general population.

The best evidence indicates that early intervention programs, such as the programs described above, are the most effective in reducing both the victimisation of young people through crimes such as assault and perpetration of crime.

The Nurse Family Partnership is a proven program that begins with children at the earliest ages and has been shown to have long term positive effects for young people. In particular this program has been shown to reduce the number of infants and young children suffering injuries related to abuse and neglect. The use of this program in Australia to support Aboriginal and Torres Strait Islander people is also an exciting development.

The three remaining programs are school-based programs, however they each contain family and community components to support the curriculum component of the program. The PeaceBuilders and Social Decision Making / Problem Solving programs have been shown to be effective in reducing violence among young people. These programs have easily accessible program resources ready for use by schools.

The Multisite Violence Prevention Project has shown promising results in reducing aggression among high risk students. Program resources are still under development, however, the project represents best practice in school-based violence prevention programs.

Evaluations of school-based programs have shown mixed results and many have not been able to provide conclusive evidence of a reduction in violence and crime. However, there is good evidence that they reduce aggression and victimisation, promote a positive school environment as well as improving student outcomes, increase pro-social behaviour, and capacity to respond peacefully to conflict.

Each of the programs recommended in this review have been trialled using either a controlled or randomised controlled trial design to evaluate their effectiveness and some with long term follow-up over many years. They each satisfy Clayton's list of points for violence prevention programs in that they are theoretically based, comprehensive programs that have been trialled with diverse populations and are adaptable for unique populations. They also include teacher / health worker training and aim to improve participant's self worth.

Victimisation of young people within our community through criminal activity, particularly in relation to assault must be addressed in ways that are productive and proven to work. We encourage the implementation of interventions included in this review.

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Table 3   *Crimes (including assault) where the victim was a child or young person*

	Supporting evidence	Replication	Documentation	Theoretical basis	Cultural reach
(43.1) Social Decision Making / Problem Solving Program (SDM/PS)	2	Yes	Yes	Yes	LOW SES CALD
(43.2) PeaceBuilders	2	Yes	Yes	Yes	LOW SES INDIGENOUS CALD
(43.3) Multisite Violence Prevention Project	2	No	No	Yes	LOW SES CALD
(43.4) Nurse-Family Partnership	1	Yes	Yes	Yes	LOW SES INDIGENOUS CALD

Key

Supporting evidence:
1. Well supported practice – evaluated with a prospective randomised controlled trial.
2. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication.
3. Promising practice – evaluated with a comparison group.
4. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data).
5. Emerging practice – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation).

Replication:
Has the intervention been implemented and independently evaluated at more than one site? (yes or no)

Documentation:
Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:
Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field? (yes or no)

Cultural reach:
Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD)

Recommended Strategy 43.1: Crimes (including assault) where the victim was a child or young person	
Name of intervention	Social Decision Making / Problem Solving Program (SDM/PS)
Organisation	University of Medicine and Dentistry of New Jersey
Brief literature review	The Social Decision Making/Problem Solving (SDM/PS) program was originally developed in 1979 as the Improving Social Awareness—Social Problem Solving Program. The program provides teachers with training and curricula for grades K through 8, to assist students in the acquisition of social and decision-making skills to enable them to make sound decisions, pursue healthy life choices, and avoid serious social problems such as substance abuse, violence, and academic failure. The SDM/PS Program is run by the University of Medicine and Dentistry of New Jersey.
How and why does this intervention work?	The SDMP program has been trialled in the USA with special needs children (Elias, et al. 1983). In 1986, results showed that students participating were better at coping with stressors and adjusting to middle school than those who didn't participate (Elias, et al. 1986).
	In 1991, a longitudinal study in elementary and middle school showed that participants had higher levels of positive pro-social behaviour and decreased anti-social, self destructive and socially disordered behaviour (Elias, et al. 1991). The SDM/PS website also reports that in 2007, in an urban school district, schools implementing SDM/PS obtained significant results as compared with control schools. Results included:
	▪ An increase in student engagement and effort in school.
	▪ Significant decrease in aggressive and delinquent behaviours, as compared with an increase in control schools.
	▪ Increased connectedness and more positive school relationships.
	▪ Results from a suburban school also highlighted a decrease in the frequency and acceptance of verbal and physical aggression together with an increase in school engagement and effort.
On what population does this intervention work best?	Trials of this program have been conducted with boys from different racial backgrounds aged 7 to 15 years with special education need (Elias, et al. 1983) as well as a broader 5th grade population from a mostly white, working class neighbourhood from New Jersey (Elias, et al. 1986). Since then the program has been implemented successfully in a range of urban and rural communities in the USA.
	The programme was developed for middle school students in the USA. Similar populations in Australia are late primary school and early high school students.
	It is expected that this program would work well in a range of Australian communities with populations from culturally in linguistically diverse and low socioeconomic backgrounds. Adaptation for Aboriginal and Torres Strait Islander communities may be required.
Where will this intervention work best?	This intervention is a school-based intervention that has been trialled in urban, suburban and rural areas of the USA.
What is required to implement this intervention?	This is a curriculum-based program that includes teacher training for program implementation, training for leadership and management of the program, parent information, curriculum materials and a consultation service.
Resources and contact information	http://www.ubhcisweb.org/sdm/index.htm
	Prices for training, materials, and consultation are available by contacting program staff at (732)-235-9280.
	http://education.qld.gov.au/studentservices/protection/sel/social-decision-making.html
References	Elias, et al. (1986) Elias, et al. (1991) Bruene-Butler, et al. (1997)

Recommended Strategy 43.2: Crimes (including assault) where the victim was a child or young person	
Name of intervention	PeaceBuilders
Organisation	PeacePartners Inc.
Brief literature review	PeaceBuilders is a school-based, universal program aimed at reducing levels of violence and antisocial behaviour. Created for young people from childhood through to teens, PeaceBuilders addresses risk factors, which predict violence, bullying, poor academic achievement and drug use. The program was first implemented in Tucson, Arizona in 1993-1995. The program initially looked at changes in academic outcomes but was later expanded to observe outcomes in social competence and aggressive behaviour, delinquency, exposure to violence, victimization from violence, parental monitoring and weapon carrying. Since then the program has been studied in other areas in Arizona (Flannery and Vazsonyi, 2001) and the Bronx (Vosskuhler and Issman, 2003). The program has now been implemented in many schools in the USA. PeaceBuilders has also been trialled in Australia (Christie, et al. 1999).
How and why does this intervention work?	Participation in PeaceBuilders reduces aggression, promotes language development, teaches pro-social skills, increases parenting skills, creates inclusion for special needs children and fosters safer communities. The program attempts to change the culture of the whole school (Flannery, et al. 2003) including antecedents that trigger aggressive behaviour, reward pro-social behaviour, and provide strategies to avoid reinforcing negative behaviour (Vasonyi, et al. 2004).

Preliminary evaluation results for the program indicated an increase in students' pro-social behaviour as well as reductions in aggressive behaviour (Flannery, et al. 2003). Further analysis also showed that students at the highest risk of aggression and antisocial behaviour were those who benefited most from the program (Vasonyi, et al. 2004).

The Australian trial of PeaceBuilders (Christie, et al. 1999) showed a fall in detentions and suspensions, improvements in academic achievements and other positive changes in school culture. |
On what population does this intervention work best?	The PeaceBuilders program has been trialled with students in the USA as well as other countries, including Australia. As an early intervention program it was designed for children in elementary schools, similar to primary schools in Australia. Trials have been conducted with students from schools and school districts with high rates of juvenile arrests and histories of suspensions and expulsions (Flannery, et al. 2003). Other trials have included ethnically diverse populations from disadvantaged communities in the Bronx (Vosskuhler and Issman, 2003). In Australia, the program has been trialled in a low-socioeconomic community with high incidence of crime and drug use and a high population of young people from an ethnically diverse background (Christie, et al. 1999).
Where will this intervention work best?	This intervention will work in most school settings. Although the program was developed in the US it has been successfully trialled in Australia. PeaceBuilders can be implemented in rural and urban school settings and may also be suitable for schools with an Aboriginal and Torres Strait Islander population as well as schools with a culturally and linguistically diverse population.
What is required to implement this intervention?	A teacher's kit, staff guide, leadership guide, research and evaluation tools and materials for specific issues and initiatives are available. Materials are supplied on a CD-ROM. Pricing is negotiated depending on entity and license provided.
Resources and contact information	Website: http://www.peacebuilders.com/ PeacePartners Inc. 741 Atlantic Avenue Long Beach, CA 90813 Toll-free: 1-877-4peacenow (1-877-473-2236) Phone: (562) 590-3600 Fax: (562) 590-3902 E-mail: info@peacebuilders.com
References	Vasonyi, et al. (2004); Flannery, et al. (2003); Flannery and Vazsonyi (2001); Vosskuhler and Issman (2003); Christie, et al. (1999); Embry, et al. (1996)

Recommended Strategy 43.3: Crimes (including assault) where the victim was a child or young person	
Name of intervention	Multisite Violence Prevention Project
Organisation	The National Centre for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention (CDC), Duke University, The University of Georgia, University of Illinois at Chicago, and Virginia Commonwealth University.
Brief literature review	The Multisite Violence Prevention Project was a 5-year collaborative project to compare the effects of a universal intervention (all students and teachers) and a targeted intervention (family program for high-risk children) on reducing aggression and violence among sixth graders (MVPP, 2004). The program was implemented and evaluated over four sites in the USA and included a total of 37 schools.
How and why does this intervention work?	The intervention aimed to reduce aggression and victimisation through the combination of a universal student curriculum and teacher training intervention and a selected family based intervention. The 20-session student curriculum (Meyer, et al. 2004) and teacher program (Orpinas, et al. 2004), which included a two day workshop and 10 consultation/support group meetings, formed the basis of the universal intervention. The programs were based on the RIPP program (Meyer, et al. 2000) and the Bully Busters teacher training program (Horne, et al. 2003; Newman, et al. 2000). A 15-week intervention conducted in groups of 4–8 high-risk students and their parents or guardians (Smith, et al. 2004), was used for the selected intervention. The evaluation of the programs found mixed results in which students at high risk for aggression tended to benefit from the intervention whereas results for low risk students tended to move in the opposite direction (MVPP, 2009). Overall the program showed moderate effects, however, this may be related to the differential effects of the program depending on student aggression risk levels.
On what population does this intervention work best?	The program was implemented for students in grades 6 to 8 for most school but schools in one community (n = 12) included students from grades K-8. Evaluation of the program was conducted with sixth graders only. School populations were diverse in ethnic background with 48% African American, 18% Caucasian, 23% Hispanic and 8% multiracial. Of the four school communities, two communities were of low socioeconomic status (MVPP, 2009).
Where will this intervention work best?	This program included both a universal school-based intervention as well a targeted intervention involving families of high risk students. Participants were students at 37 schools from four communities: Chicago; Durham, North Carolina; North Eastern Georgia; and Richmond, Virginia. This intervention would be expected to work best in mostly urban or regional schools and communities with some ethnic diversity and low socioeconomic status.
What is required to implement this intervention?	This intervention was trialled in three different modes: a universal school-based intervention that included a school-based curriculum and a teacher training component. The student component consists of twenty 40-minute lessons taught by a trained facilitator on a weekly basis during the school day. The teacher component includes training, manuals and supervision. The family component is composed of 15 weekly multiple family group meetings (e.g. 4–6 families per group).
Resources and contact information	The RIPP student program is available from Prevention Opportunities, LLC. Contact: Wendy Bauers Northup 12458 Ashland Vineyard Lane Ashland, Virginia 23005 Phone: +1 804 301 4904 Email: contact@preventionopportunities.com Website: http://www.preventionopportunities.com/ Bully Busters Teacher Manuals are available from Research Press http://www.researchpress.com/product/item/5192/
References	MVPP (2009); Meyer, et al. (2004); Orpinas, et al. (2004); Smith, et al. (2004); MVPP (2004); Meyer, et al. (2000); Horne, et al. (2003); Newman, et al. (2000)

Recommended Strategy 43.4: Crimes (including assaults) where the victim was a child or young person	
Name of intervention	Nurse-Family Partnership
Organisation	Nurse-Family Partnership
Brief literature review	This project was first run in Elmira, New York, USA between 1978 and 1982. The program was aimed at low income, first time mothers and their children from the prenatal period (prior to 25 weeks gestation) to 2 years. Home visits by nurses focused on providing parent education, enhancing social support from family and friends and linking the family with outside support services. This program has been proven to reduce injuries sustained by young children due to child abuse as well as reducing violent and aggressive behaviour and other behaviours associated with violence, including alcohol consumption, in adolescents (Olds, et al. 2004).
How and why does this intervention work?	In the Elmira study the program evaluation followed the group until the children were 15 years of age. Children in the intervention group had significantly fewer arrests, convictions and violations of probation compared to controls (Olds, et al. 1998). In addition, adolescents born to unmarried women of low socioeconomic status had fewer instances of running away, fewer sexual partners and fewer days in which alcohol was consumed.

In the Memphis trial (Kitzman, et al. 1997) at 24 months, nurse visited women had fewer injuries and accidental ingestions, their children were hospitalised for fewer days and they had fewer beliefs about childrearing that were associated with child abuse and neglect.

The Australian Nurse Family Partnership Program has now also been implemented in Australia to assist young Aboriginal and Torres Strait Islander mothers. |
On what population does this intervention work best?	This program has been tested in three randomised controlled trials with different study populations. A study of four hundred first time mothers in Elmira, New York (Olds, et al. 1998) was primarily composed of white women. Another study involving 1,139 women in Memphis, Tennessee, was mostly composed of African-American women (Kitzman, et al. 1997). A third study in Denver, Colorado (Olds, et al. 2004), involved 734 women from a range of backgrounds who had no health insurance and were eligible for Medicaid.
Where will this intervention work best?	This is a community-based intervention that is effective in both rural and urban settings.
What is required to implement this intervention?	The main requirement is for registered nurses and a nurse supervisor. Nurses must be trained in the delivery of the program. Costs are involved with training however the main costs are in employing nurses. The program stipulates there should be one nurse per 25 families and one nurse supervisor per four nurses.
Resources and contact information	Nurse-Family Partnership National Service Office
1900 Grant Street, Suite 400
Denver, CO 80203
Phone: +1 303 327 4240
Toll-free: +1 866 864 5226
Fax: +1 303 327 4260
info@nursefamilypartnership.org
Website: http://www.nursefamilypartnership.org/

Australian Nurse Family Partnership Program
Contact Claire Runciman (Program Manager)
Phone: (07) 3114 4630
Email: claire.runciman@anfpss.com.au
Website: http://www.anfpp.com.au/ |
| **References** | Olds, et al. (1998)
Olds, et al. (2004)
Kitzman, et al. (1997) |

7 Age of initiation of sexual intercourse in young people

7.1 Narrative review

7.1.1 Background

First sexual intercourse, described here as sexual initiation, is a normal element of human development. Sexual initiation at an early age however, is associated with a range of negative health and life outcomes.

Early initiation of sexual intercourse increases the risk of unintended pregnancy and sexually transmitted infection (STIs), including HIV. The consequences of both unintended pregnancy and STIs can seriously affect adolescents' health and wellbeing. These two topic areas are examined in their respective entries in the Victorian Child and Adolescent Monitoring System (VCAMS) Catalogue of Evidence (http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/).

Early sexual initiation is associated with increased sexual risk behaviours, such as larger lifetime numbers of sexual partners (Sandfort, et al. 2008); and an increased chance of non-consensual sex (Wellings, et al. 2006).

In Australia, a survey of young people relating to sexual health conducted in 2002 (the 3rd National Survey of Secondary Students and Sexual Health) found that 26% of Year 10 students and 47% of Year 12 students had had sexual intercourse. Slightly more males than females reported having had sex in both Years 10 and 12 (AIHW, 2007). The Australian Institute of Health and Welfare (AIHW) make a distinction between sexual intercourse and sexual activity, listing forms of sexual activity as deep kissing, genital touching / being touched, and giving / receiving oral sex (AIHW, 2007, p. 87).

The median age of initiation of sexual intercourse taken from two representative samples of young people aged 16–25 was 17 years of age. Data from same-sex-attracted young people aged 14–21 found that 11% first had sex at 15, 13% at 16, 12% at 17 and 18% were aged 18 and over (DEECD, 2009, p. 54).

In the Victorian Healthy Neighbourhoods School Survey (HNSS), 4.1% of 12 year olds and 5.4% of 13 year olds reported they had had sex (DEECD, 2008, p. 49).

A number of factors influence young people's choice to delay first sexual intercourse. For instance, young people in families with higher education and income levels are more likely to delay sexual initiation, as are those with high quality relationships with their parents, and those that perform well at school. Timing of first sex is also affected by individual attitudes about sex and peer norms (Family Planning Victoria, et al. 2005).

Considering the potential adverse impacts of early sexual initiation on young people's lives, the benefit of delaying sexual initiation is clear. This review will examine a number of interventions designed to postpone first sexual intercourse among young people. School-based sexuality education programs will be the focus, with a number of other types of interventions also examined.

7.1.2 The evidence base

The appropriate search term was identified as 'coitus' on the MeSH Browser (which has the associated entry term 'first intercourse'). The literature review was then conducted around this term (along with the terms 'sexual initiation' and 'sexual debut'), using the PsycINFO and

MEDLINE databases. Relevant websites from the professional practice literature were also searched to find appropriate interventions for delaying sexual initiation.

Although no reviews specifically addressing the topic of sexual initiation were located, reviews addressing other aspects of adolescent sexual health were identified which had relevance to the topic. In particular, reviews of interventions relating to the prevention of STIs (including HIV) and unintended pregnancy were most valuable, as the topics are closely interrelated.

Initiation of sexual intercourse among young people is a topic area closely related to several other indicators in the VCAMS catalogue. The indicators for 'Outcome 14 – Health teenage lifestyle' are of relevance, especially 'Sexually transmitted infections in young people' and 'Teenage pregnancy'.

These reviews identified a relatively large number of interventions which aimed to delay sexual initiation, either as a primary focus or within a context of promoting healthy sexual behaviour and reducing risk behaviour among young people more generally. The studies included delay of sexual initiation as an outcome measure, among a number of other commonly used measures (such as condom use, contraceptive use, frequency of sexual intercourse, number of sexual partners, sexual knowledge and attitudes, and STI rate).

Although a large number of interventions were identified in the literature, the evidence for the effectiveness of interventions in delaying the onset of sexual intercourse appears somewhat contentious, with mixed findings reported in a number of reviews. A recent Cochrane review assessing the effectiveness of pregnancy prevention interventions has questioned whether these interventions positively affect several secondary outcomes (including initiation of sexual intercourse, use of birth control methods, abortion, STI, knowledge and attitudes about the risks of unintended pregnancy). While the review found a number of interventions lowered the rate of unintended pregnancy among adolescents, the evidence of effectiveness on these secondary outcomes was inconclusive (Oringanje, et al. 2009). This finding lends support to those of previous reviews, which found interventions to be ineffective in delaying the initiation of sexual intercourse, and also found negative effects (DiCenso, et al. 2002; Robin, et al. 2004).

However, there are other reviews that have provided a more positive assessment of the overall evidence of effective interventions. This is especially the case for school-based interventions. For example, one review found that 41% of curriculum-based sex and STI education programs were effective in delaying sexual initiation. This same review revealed no negative effects, and in particular none hastened sexual initiation (Kirby and Laris, 2009).

A variety of individual interventions have been shown to be effective in delaying sexual initiation. These include sexuality education programs, family-based interventions with parental involvement, service learning programs, health education curriculum combined with service learning, and STI, HIV and / or pregnancy prevention interventions (Kirby, 2002; Sales, et al. 2006; DiClemente, et al. 2004 and 2008).

Programs that have a primary objective other than delaying sexual initiation, such as reducing STI or pregnancy, may still have a positive effect on this outcome. Even some interventions which have no content covering sexuality issues may have positive effects. For instance, it has been found that some programs which effectively reduce adolescent alcohol and drug use have the additional benefit of delaying the initiation of sexual intercourse (Caminis, et al. 2007).

Additionally, a number of books which review a range of evidence-based sexual health programs for young people give further support to the effectiveness of some interventions in promoting better sexual health and reducing negative health outcomes (including delaying sexual initiation). For example, a directory of effective STI, HIV and pregnancy prevention interventions from the United States has been published, and includes one of the recommended interventions from this review (namely the Draw the Line / Respect the Line program) (Card and Benner, 2008)

While some evidence exists for effectiveness of individual interventions, further research strengthening the evidence base is clearly warranted. With respect to the issue of evidence, it should be noted that a recent Cochrane Collaboration protocol (Mukoma, et al. 2009) was identified which proposes a review of the evidence for effectiveness of school-based interventions aimed at delaying sexual initiation (as well as postponing future sexual intercourse and increasing condom use among sexually active young people). This is an encouraging indicator that further research is being conducted in this area.

7.1.3   Selection of recommended interventions

Based on a search of the scientific literature the following two interventions were recommended:

- Draw the Line / Respect the Line (Coyle et al. 2004)
- Pupil-led sex education (RIPPLE) (Stephenson et al. 2004)

The two selected interventions have been recommended as they have both demonstrated positive effects and were evaluated using randomised controlled trial designs. Both are school-based interventions with a focus on sexuality education, although the approaches of each are different. One intervention was delivered by professional health educators (Coyle, et al. 2004), whereas the other utilised students in its peer-led sex education (Stephenson, et al. 2004).

The first intervention selected is the Draw the Line / Respect the Line program. It was a three-year middle school-based STD/HIV and pregnancy prevention program aimed at reducing the number of students initiating or having sexual intercourse, and increasing the use of condoms among those already sexually active. The intervention was based around a 20-session curriculum which involved interactive lessons taught by experienced health educators. Topics covered included limit setting and refusal skills in non-sexual situations, and consequences of unplanned intercourse (including pregnancy, STIs and HIV). The lessons were designed to have a cumulative effect (from grade 6 to 8). The study included a high proportion of Latino students (30% or more of the students in the schools within the three selected school districts were Hispanic), and although aspects of the program were tailored to suit this, the curriculum was designed to be appropriate across racial / ethnic groups.

Findings indicated that the intervention successfully delayed sexual initiation among boys over a 36-month period. Additionally, boys in the intervention group had "greater [HIV and condom-related] knowledge, perceived fewer peer norms supporting sexual intercourse, had more positive attitudes toward not having sex, had stronger sexual limits, and were less likely to be in situations that could lead to sexual behaviours" (Coyle, et al. 2004, p. 843). Despite the positive impact for male participants, no significant effects were found for females.

Draw the Line curriculum was used by the 19 schools in the study as their main source of HIV, other STD, and pregnancy prevention education. However, it seems to complement the approach of current sexuality education in Australia, and incorporating it into a schools' ongoing sexuality education program may be of benefit. There is also potential for this intervention to be effective in community-based settings that provide programs for boys.

The second intervention selected, known as RIPPLE, is based on student-led sexuality education. In this intervention, peer educators (aged 16 – 17 years old) delivered three sessions of sex education to 13 – 14 year old students from the same schools. The sessions focused on issues such as relationships, STIs, and the use of condoms and contraception.

Although not a specific aim of the brief intervention, it was found that sexual initiation was delayed for girls, with fewer girls in the peer-led arm reporting having had initiated sexual intercourse. At follow-up, girls also reported fewer unintended pregnancies. Students also reported greater satisfaction with peer-led sex education rather than teacher-led sex education. Despite these

positive findings, the proportion of participants reporting unprotected first sex did not differ (Stephenson, et al. 2004).

Although they were not selected for recommendation in this review, many other individual interventions aimed at delaying sexual initiation in young people were identified in the literature, with varying degrees of evidence of effectiveness. Some of these interventions will now be discussed.

Another example of a school-based HIV, STI, and pregnancy prevention program that has been shown to be effective in delaying sexual initiation is It's Your Game… Keep it Real. The intervention is a curriculum delivered in seventh and eighth-grade (12 lessons in each grade), integrating group-based classroom activities with individualised computer-based sessions and personal journaling. Parent – child homework activities were also incorporated into the program. The target population was English-speaking students from low-income, urban schools in a predominantly African-American and Hispanic school district in the United States. At ninth-grade follow-up (after adjusting for covariates) results found that students in the comparison group were 1.29 times more likely to have initiated sex than those in the intervention group (Tortolero, et al. 2010).

Non school based interventions may also help delay initiation of sexual intercourse among young people. For instance, a number of interventions that address adolescent sexual activity (including delaying sexual initiation) involve the family. These types of interventions recognise the significant role and influence parents have in improving health outcomes of their adolescent children, including the prevention of risky sexual behaviours. Specifically, the importance of parent – adolescent communication has been identified in the literature, as has parental monitoring (DiClemente, et al. 2004; Sieverding, et al. 2005; Aspy, et al. 2007; Blake, et al. 2001).

Saving Sex for Later is an example of an intervention involving parents. Education was provided to parents (with predominantly Latino and African-American backgrounds) in an attempt to improve effective communication with their children about issues involved in adolescent development, such as sexuality, and sexual risk behaviours (including the importance of delaying sexual initiation). An evaluation of the education program found that it was "a promising intervention for promoting youths' sexual abstinence", which also had the potential to promote positive parenting practices more generally (O'Donnell, et al. 2005). However, further evaluation has been recommended (O'Donnell, et al. 2007).

Another parent – adolescent intervention designed to increase communication about sexual risks between parents and their children and reduce sexual risk behaviours among adolescents is ¡Cuidate! (Take Care of Yourself): The Latino Youth Health Promotion Program. Although a strong focus was on HIV risk reduction and prevention, results indicated that the intervention increased both the quality and quantity of parent – adolescent communication related to both sex-specific issues and general issues (Villarruel, et al. 2008). Furthermore, results found decreased rates of sexual activity and increased rates of condom use among the adolescent participants (Villarruel, et al. 2006).

As mentioned earlier, some interventions that utilise a 'service learning' approach (usually combined with health education curriculum) have evidence of effectiveness. An example of such a program that has been shown to be effective for delaying sexual initiation is the Reach for Health Community Youth Service (RFH CYS) intervention. The program combined classroom health lessons with participation in community youth service (i.e. placement in a community health agency). Results showed long-term benefits, with service learning participants being less likely to have initiated sex or report recent sex compared to those assigned to the curriculum-only condition (O'Donnell, et al. 1999; O'Donnell, et al. 2002). RFH CYS was included in the selection of recommended interventions for the indicator 'Rate of sexually transmitted infections in young people', the review of which provides more detailed information on the program.

Another intervention already selected as a recommended intervention for a separate indicator in this catalogue (Teen pregnancy rate) but which also has relevance to this indicator is the Children's Aid Society (CAS) Carrera Program. Evaluation of this long-term intensive, multi-component program found a number of positive outcomes. Pregnancy and birth rates were reduced, and female participants were significantly less likely to have initiated sex (although this was not the case for male participants) (Philliber, et al. 2001; Philliber, et al. 2002; Kirby, 2002).

7.1.4 Discussion

Several issues relevant to the topic of age of initiation of sexual intercourse will now be discussed.

A group of programs relevant to sexual initiation, but beyond the scope of this review, are abstinence-based programs. The evidence for the effectiveness of such programs is mixed. Several reviews have found abstinence programs (especially abstinence-only) lack evidence of effectively delaying the initiation of sex (for example see Kirby and Laris, 2009; Underhill, et al. 2009a; Silva, 2002; DiCenso, et al. 2002). However, some abstinence programs demonstrating positive effects were also identified in the literature. For instance, a recent review of abstinence-plus programs (although primarily designed to reduce HIV risk in high income countries) assessed interventions that included incidence of sexual initiation as a behavioural (secondary) outcome measure. Four of the 19 indentified interventions found significant program effects for this measure (Underhill, et al. 2009b; see also Jemmott III, et al. 2010).

While these results suggest that sexual initiation may be delayed by some abstinence programs more research is required in this area. Such abstinence-based approaches are also inconsistent with Australian social policy, which promotes more comprehensive sexuality and sexual health education to improve health.

Interventions looking at the issue of the age of initiation of sexual intercourse in the context of adolescents' substance use are also beyond the scope of this review, although associations have been identified in the literature (Guo, et al. 2005; Caminis, et al. 2007). Matters concerning non-consensual sexual initiation have been deemed outside the scope of the review.

This review did not identify intervention trials and reviews specifically relating to sexual initiation for Aboriginal and Torres Strait Islander people. However, relatively high rates of early sexual initiation have been reported in the literature, indicating that the issue is pertinent for this population (Blair, et al. 2005; Larkins, et al. 2007).

CALD and low SES populations were targeted in a number of studies, primarily those conducted in the Unites States. Further research is needed however, to determine implications in the Australian context, and to inform development of better interventions for these populations.

A number of initiatives exist throughout Australia to address a variety of issues concerning adolescent sexual health, including delaying the initiation of sexual intercourse. The importance of inclusion of sexuality education programs in primary, secondary and special schools is well-recognised in Australia. A National Framework, 'Talking Sexual Health', has been developed to support schools to implement effective and appropriate comprehensive sexuality education programs (Department of Health Ageing, 1999).

In Victoria, a particularly significant initiative of the DEECD and DHS has been the Whole-school Sexuality Education Project (2006 – 2008). The project led to the development of the Department's 'Catching On' sexuality education program, which promotes delivery of sexuality education across curriculum and with a whole-school learning approach, which "aims for maximum student learning in the classroom, in the school environment and in the school's community partnerships" (Dyson, et al. 2008, p. vii). A number of valuable resources have been produced, namely the program development training and support resource 'Catching On *Everywhere*', and the comprehensive sexuality education website 'Catching On-*line*' which provides a range of

relevant resources and information (see Dyson, et al. 2008 and
www.education.vic.gov.au/studentlearning/teachingresources/health/sexuality). Resources for this
program continue to be developed, including curriculum materials and student assessment
materials.

The Victorian Adolescent Health and Wellbeing Survey, while not available at the time of
publication will be a valuable future source of data, and will help support the development and
implementation of effective adolescent sexual health interventions (as well as services and
programs aimed at improving adolescent health and wellbeing more generally).

It is evident that further research into effective interventions for delaying sexual initiation is
warranted. However, a number of research challenges are apparent.

Of the two interventions selected in this review, one was more effective for females and the other
was more effective for males. Differences in sexual debut across gender and racial / ethnic
groups have also identified in the literature (Cavazos-Rehg, et al. 2009) and require further
exploration in the Australian context.

A significant limitation of the research is associated with measurement validity. Studies revealed
heavy reliance on adolescents' self reported data, the accuracy of which may be questioned.
Inconsistencies specific to adolescents' reporting of occurrence and timing of first intercourse have
also been identified in the literature (DiClemente, et al. 2008; Upchurch, et al. 2002).

Additionally, studies are rarely evaluated in a rigorous and systematic way. Improving the
methodological approaches employed and outcome data generated in future research is
necessary to provide conclusive evidence for the effectiveness of interventions (Mukoma, et al.
2009).

In summary, although this review found some contention in the literature regarding the strength
and level of evidence around effective interventions designed to delay sexual initiation among
young people, the effectiveness of a number of individual interventions was apparent.

Two interventions were recommended each with the support of a single RCT, representing two
differing approaches to delaying sexual initiation among young people in a school based setting
(one delivered by professionals, the other by peers). Although individual school based
interventions appeared to have the strongest evidence, other interventions were also shown to be
effective, and a number of examples were discussed. Several other issues relevant to the topic
were also addressed.

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Table 4 Age of initiation of sexual intercourse in young people

	Supporting evidence	Replication	Documentation	Theoretical basis	Cultural reach
(44.1) Draw the Line / Respect the Line	1	No	Yes	Yes	CALD LOW SES
(44.2) Pupil-led sex education (RIPPLE)	1	No	No	Yes	CALD

Key

Supporting evidence:
1. Well supported practice – evaluated with a prospective randomised controlled trial.
2. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication.
3. Promising practice – evaluated with a comparison group.
4. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data).
5. Emerging practice – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation).

Replication:
Has the intervention been implemented and independently evaluated at more than one site? (yes or no)

Documentation:
Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:
Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field? (yes or no)

Cultural reach:
Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD)

Recommended Strategy 44.1: Age of initiation of sexual intercourse in young people	
Name of intervention	Draw the Line / Respect the Line
Organisation	ETR Associates and the Center for AIDS Prevention Studies, University of California, San Francisco
Brief literature review	This STD/HIV and pregnancy prevention program was conducted in middle school (grades 6 – 8). The curriculum consists of 20 interactive lessons, the objectives of which emphasise the importance of setting and maintaining personal sexual limits, with the aim of reducing sexual risk behaviours. Skills involved in postponing sexual initiation are taught (e.g. limit setting and refusal skills). Characteristics of the curriculum are shared by many other successful HIV prevention and sex education curricula. Experienced health educators were trained by project staff. These educators than delivered the lessons (which were designed to have a cumulative effect from grade 6 to 8), as well as providing time outside the classroom to meet with individual students or small groups of students.
How and why does this intervention work?	Results of a large-scale randomised controlled trial involving 2829 students from 19 schools in northern California found that the intervention was successful in delaying sexual initiation among boys over a 36-month period. In comparison to the control group, boys in the intervention group also "exhibited significantly greater knowledge […], perceived fewer peer norms supporting sexual intercourse, had more positive attitudes towards *not* having sex, had stronger sexual limits, and were less likely to be in situations that could lead to sexual behaviors" (Coyle, et al. 2004, p. 843). Despite the positive results (for males), it should be noted that no evidence of effectiveness of the intervention for girls was found.
On what population does this intervention work best?	Intervention was conducted with middle school students (grades 6 – 8) aged 11 – 14 years old.
Where will this intervention work best?	High schools. Although Draw the Line curriculum was used by schools in the study as their main source of HIV, other STD, and pregnancy prevention education, it may be suitably incorporated or linked into a schools' ongoing sexuality education.
What is required to implement this intervention?	In the study experienced health educators were trained by project staff to deliver the curriculum and teach the lessons. It is possible that adequate training to dedicated members of school staff may achieve comparable results, although this has not been demonstrated by the study. The support of principals, teachers and other school staff is also critical to the success of the program.
Resources and contact information	Dr. Karin Coyle http://programservices.etr.org/index.cfm?fuseaction=About.StaffSummary&StaffID=1 Program manual available for purchase at: http://pub.etr.org/Default.aspx Program package available for purchase at: http://www.socio.com/srch/summary/pasha/full/passt20.htm
References	Coyle, et al. (2004)

Recommended Strategy 44.2: Age of initiation of sexual intercourse in young people	
Name of intervention	Pupil-led sex education (RIPPLE study)
Organisation	The RIPPLE Study Team
Brief literature review	In this intervention, peer educators aged 16 – 17 years delivered three sessions of sexuality education to students from the same school, aged 13 – 14 years. The duration of each session was approximately one hour. Classroom sessions were designed to improve the younger students' skills in sexual communication and condom use, and increase their knowledge about pregnancy, STIs, contraception and local sexual health services. Although teachers were not present during sessions, they did provide ongoing support for peer educators. The control group schools received their usual teacher-led sexuality education.
How and why does this intervention work?	Results of the randomised controlled trial found that sexual initiation was delayed for female participants. Girls in the peer-led arm of the study were significantly less likely to have reported having had sex by age 16 years than were those in the control group. Girls from the intervention group also reported fewer unintended pregnancies at follow-up. Additionally, students reported greater satisfaction with peer-led sex education than teacher-led sex education. However, the proportion of students reporting unprotected first sex (the primary outcome of the study) was not affected by the intervention.
On what population does this intervention work best?	The intervention was conducted with high school students (aged 13 – 14).
Where will this intervention work best?	High schools.
What is required to implement this intervention?	Peer educators require training to become proficient in delivering sexuality education, including support in preparing lesson plans and identifying suitable resources. A motivated teacher in a coordination and support role is also necessary. NB: In this intervention, peer educators were trained by the external team of health promotion practitioners which designed the program.
Resources and contact information	Professor Judith Stephenson Centre for Sexual Health and HIV Research UCL Research Department of Infection and Population Health Profile: http://www.ucl.ac.uk/sexual-health/staff-members/stephenson.htm
References	Stephenson, et al. (2004)

8 Proportion of family violence incidents where children and young people are involved as other parties

8.1 Narrative review

8.1.1 Background

This review will examine community-based and selective prevention interventions and early interventions for children and adolescents exposed to violence, but not necessarily demonstrating conduct or behavioural problems.

"Research studies have shown that individual children respond differently to witnessing interpersonal violence, from those who develop major psychological disorders and post traumatic stress symptoms, to those who appear resilient and unaffected immediately after exposure to violence. Generally, it is believed that most children who witness violence, including the battering of their mothers, are at-risk for developing emotional and social problems as they grow older. For example, children who observe interpersonal violence are considered to be at-risk for learning that violence is an acceptable way to solve problems and that power determines behavior in relationships, including dating relationships. Further, many children tend to blame themselves for violence in the family, which is clearly out of their control. Others may put themselves at-risk for harm during the violent episodes by trying to intervene, while others develop fears and worries about the behavior of important people in the family. Yet there is often little opportunity to discuss their perceptions, worries, and fears, or to get new information about how to think about and to cope with violence in their lives" (The Kids* Club webpage: http://www.sandragb.com/intervention.htm).

The terms family violence / domestic violence / intimate partner violence are used interchangeably. The behaviours range from physical abuse, sexual abuse, threats, and emotional abuse and intimidation (Centers for Disease Control and Prevention, 2009) and "exposure may be associated with an increased display of aggressive behaviour, increased emotional problems, and lower levels of academic functioning and social competence. School-aged children show a greater frequency of withdrawal and anxiety, aggressiveness, and delinquency" (Cooper, et al. 2004, p. 9).

Signs / symptoms of distress in young children in relation to domestic violence exposure include: "Sleep difficulties, nightmares, fear of falling asleep; separation anxiety, persistent worries about a parent; vague or diffuse somatic complaints; increased aggressive behaviour or angry feelings; loss of previously acquired developmental skills; distractibility, difficulties with concentration; repetitive play or talk of upsetting events" (McAlister Groves and Fox, 2004, p. 14).

There is no data on witnessing family violence in the latest AIHW report on Young Australians (AIHW, 2007) and Gelles (2006) reports that there is scant data in this area. Based on survey data he estimates the overall rate of exposure to minor forms of violence (e.g. pushing, shoving and slapping) to be 91 children per 1000 children and more severe violence is 62 children per 1000 children. Gelles (2006) then breaks down his figures further:

- Husband to wife minor violence = 27 / 1000
- Wife to husband minor violence = 25 / 1000
- Bidirectional minor violence = 39 / 1000

- Husband to wife severe violence = 16 / 1000
- Wife to husband severe violence = 27 / 1000
- Bidirectional severe violence = 19 /1000

However, it should be noted that this data is based on the US population and is taken from a 1985 survey.

Gewirtz and Edleson (2004) review the literature on the impact of domestic violence exposure. They highlight:

- Associations between violence exposure and child behaviour and emotional problems

- Children exposed to violence on average, exhibit more aggressive and antisocial behaviors (externalising) as well as fearful and inhibited behaviours (internalising behaviours) when compared to non-exposed children

- Children exposed to violence show higher anxiety, trauma, depression and temperament problems than children not exposed to violence at home

- Witnessing domestic violence in the preschool years leads to behaviour problems at age 16 for both sexes, for boys middle childhood exposure was related to contemporaneous behaviour problems

- There is a differential impact at different ages.

However, they point out that there is a clear need to examine the impact of violence exposure in a developmental context using longitudinal studies.

On the other hand, Gelles (2006) argues that the behavioural consequences of children's exposure to intimate or domestic violence have been 'over-determined' in the literature, leading to simplistic causal models and poor examination of the research evidence.

The main programs in this area have been selective and indicated interventions - as Stover, Meadows and Kaufman (2009) said the focus is on symptom reduction in children exposed to intimate partner violence (see Stover, Meadows and Kaufman, 2009, p. 228). Selective interventions are for those children exposed to violence but not necessarily demonstrating problems, while indicated interventions are for those children exposed to violence and manifesting difficulties, such as child behaviour problems (from Becker, et al. 2008). "Most clinic-based programs fall into the "selective" category (citing Graham-Bermann, 2000). These programs encounter a challenge in that some children exposed to family violence manifest behavioural emotional problems while others do not. Although selective intervention programs appropriately focus on domestic violence safety or attitudinal issues, it remains unclear how many children who are at risk for long-term behavioural or emotional difficulties benefit from these sorts of programs" (Becker, et al. 2008, p. 189).

School based interventions for children exposed to violence are often low dose (one or two sessions), mainly focus on teens with an emphasis on preventing dating violence, and have a paucity of research evidence (Gelles, 2006). It is also not ethical or appropriate to screen and identify problem families in a school environment without adequate treatment and support being provided. Clinical supports in terms of professional therapists and social workers would need to be in place and strict confidentiality procedures would have to be maintained.

In terms of scope, this review will not include issues related to PTSD symptoms, exposure to community violence, problems with foster care, or justice system / policing approaches.

8.1.2 The evidence base

Due to the clinical nature of this indicator, the medical and psychological literature (MEDLINE and PsycINFO databases) were utilised for this review. Search headings were: Domestic Violence and Family Violence, as well as the key word "exposure". The standard limiters were applied (abstracts, humans, English language, publication years 2001- current), as well as using age

limiters targeting children and adolescents. A+ Education was also scanned for references on this issue. The standard practice literature websites were also consulted.

Additional searching for review papers and high quality treatment interventions for intimate partner violence exposure for children and adolescents were conducted.

Upon reviewing the literature, only a few interventions were identified and no systematic review on the topic area was found. The interventions that were identified were at the level of promising practices. This reflects a research evidence base that is small and developing. In this context it is interesting to note that much of the research literature is in the form of published books or texts rather than journal articles (see McAlister Groves, 2002, Geffner, et al. 2009, Jaffe, et al. 2004).

As Cooper, et al. (2004) states "There are very few published or unpublished rigorous studies demonstrating the effectiveness of group or individual approaches to treatment for children who have witnessed domestic violence" (Cooper, et al. 2004, p. 9). This view is also supported by Crusto, et al. (2008). Becker, et al. (2008) states "The literature on treatment outcomes for children who witness family violence, while promising, remains small and incomplete" (p. 190). Gelles (2006) and Gewirtz and Edleson (2004) also comment that this is a new area of research.

Rossman, et al. (2004) goes on to say that "… further rigorous research is also needed to evaluate program outcomes and which children are best treated by which types of programs. Program fidelity, lack of a comparison group, small samples, what outcomes to measure when, and how to deal with the lack of a pre-exposure baseline for child functioning are all problems that need to be addressed" (Rossman, et al. 2004, p. 43). "A key challenge for the field is to gather information on event parameters, children's experiences, and reactions during and immediately after a traumatic event. Such information is more readily accessible for events occurring in the community than for violence occurring within homes, which is often underreported" (Gewirtz and Medhanie, 2009, p. 65)

In a recent and innovative piece of research Gerwitz and Medhanie (2009) analysed 911 calls and police reports for family violence in Minneapolis. They rated the reports and coded the children as either: not in home; present in home (but asleep or not in same room) - indirect witnessing; direct witnessing (in the same room); and direct involvement in violence (e.g. physically hurt, intervened in the violence, or made the 911 call). They found that most children in the call incidents where direct witnesses to the incident (direct witness or direct involvement), and that older children were more likely to be directly involved.

Cooper, et al. (2004) also comment about the evidence base "there is little helpful information available on approaches to treatment for children with disabilities, immigrant children, ethnically diverse children, and Aboriginal children. Caution should be exercised in the design and delivery of such programs to ensure that they respect and reflect culturally diversity" (Cooper, et al. 2004, p. 9).

Finally, in terms of straightforward violence prevention, a recent review by MacMillan, et al. (2009) found "No evidence of any existing interventions that prevent intimate-partner violence against women, and by extension, children" (MacMillan, et al. 2009, p. 252). Stover, Meadows and Kaufman (2009) also report that "Studies that measured recidivism as an outcome for child-witness-to-IPV were not found" (Stover, Meadows and Kaufman, 2009, p. 228). At the other end of the spectrum, where children are experiencing clinical levels of conduct problems Jouriles, et al. (2009) reports on a recent RCT into Project Support for children between 4 and 9 years old. This intervention teaches mother's child management skills, and provides instrumental and emotional support for women leaving shelters. In relation to the comparison group of people attending existing services, Jouriles, et al. (2009) found that the intervention group had improvements in child conduct problems and parenting behaviour, as well as maternal psychiatric symptoms.

8.1.3 Selection of recommended interventions

The recommended four interventions for this indicator are:

- The Kids* Club (Graham-Bermann prevention intervention) (Graham-Bermann, et al. 2007)
- Haupoa Family Component (part of Parents and Children Together - PACT) (Becker, et al. 2008)
- Parents Accepting Responsibility Kids Are Safe (PARKAS) (Bunston, 2008a)
- 'Peek a Boo' Club / BuBs on Board (Bunston, 2008a)

These interventions represent promising practices in the indicated / early intervention area. They are community based and professional group therapy based interventions for children and their parents. They are designed for children and mothers who are identified as being exposed to intimate partner violence.

The Kids* Club (Graham-Bermann, et al. 2007) is a small group based treatment program (10 weeks) which has a child and a parent component. It creates a supportive environment for the children, and provides lessons looking at the child's sense of safety, making sense of the violent experiences, managing emotions and conflict resolution / self-control skills. The parenting program involves education, building parenting competency and group support. "Most activities address family violence through displacement - that is by using stories, films, drawings, puppet plays, etc. This method is comfortable for most children because it allows them to react openly to the issues without the pressure to discuss their own particular family" (from http://www.sandragb.com/intervention.htm). The parents group discusses "the impact of violence on their child's development" and provides "a safe place to discuss parenting fears and worries" (Graham-Bermann, et al. 2007, p. 200). A Preschool Kids* Club has also been developed for children aged 3 to 6. The programs are run by trained therapists and 600 families have completed the program (from website).

Haupoa Family Component (HFC) is a program of the Parents And Children Together (PACT) family service organisation in Hawaii (see http://www.pacthawaii.org/oahu_peace_center.html). It is a community based group therapy intervention (Becker, et al. 2008). HFC is a 12 week (90 minutes per week) course of support and therapy for children exposed to domestic violence which is culturally appropriate. Topics include: safety skills, trust, building, self-awareness, communication, self-blame, nonviolent conflict resolution. The program is age appropriate and involves games, role-plays and stories. The aim of the groups are "to provide a safe setting in which children could learn more about family violence, explore their beliefs and attitudes regarding violence, and develop or enhance healthy coping skills" (Becker, et al. 2008, p. 192). A simultaneous parenting group is run to assist the parents with helping their children cope with domestic violence exposure and improve their own parenting skills and self-esteem. Other services provide by HFC include: violence intervention groups for children who act or are at risk of acting violently, support for teen girls who experience dating violence, school based counselling and positive parenting classes.

Parents Accepting Responsibility Kids Are Safe (PARKAS) and 'Peek a Boo' Club / BuBs on Board are innovative interventions from The Royal Children's Hospital Integrated Mental Health Program (http://www.rch.org.au/mhs/services/index.cfm?doc_id=9924).

PARKAS is a mental health / counselling group intervention (8-10 weeks) for women and children who have experienced family violence (Bunston, 2008a). Both the parent, child and joint sessions are run by the same facilitators. The program works on healing and improving parent child attachment styles. The program starts with detailed assessment and the shared history about the traumatic events. Children are also involved in listening and discussing these events - body language, pictures, and play are used if required. In the group sessions, the counsellors provide a place for 'safe healing and safe play'. Themes include: What I have in common with others, What are my strengths, How is anger passed onto others, How do I keep safe, What different feelings are. Play therapy is used and drawings are also used to get 'in the mind of the child'.

Extending the work of PARKAS, the Peek a Boo Club / BUBs on Board aims to strengthen the relationship between mothers and their babies / toddlers. It is a group based mental health intervention for mothers and infants who have been exposed to family violence (eight sessions) (Bunston, 2008a). Groups are broken into developmental stages and they provide "a therapeutic space within which the infants and mothers can safely play with alternative ways of experiencing and communicating with one another" (p. 338). Play, mother-child observation of attachment and group facilitator modelling of interactions are used. Session topics included: how do we manage our stress, how do babies know when we are stressed, our wishes for us and our babies, what are the messages our parents have given us about ourselves, and what are the messages we want our children to have about themselves. Activities were designed to get mother and child to play together, and for the mothers to be mindful of the child and their experiences. The activities for toddlers included "singing, play dough, musical instruments, story books, building blocks and balls" (Bunston, 2008b, p. 6). Audette and Henry in Bunston and Heynatz (2006) outline the goals for mother and baby relationships. These include: fostering enjoyment with the mother / baby relationship, enhancing the mother's capacity to respond to the baby's communication signals, facilitating eye contact and prolonging affectionate gaze between mother and baby, facilitating shared rhythms, facilitating a sense of containment and being held. Activities can include: bubbles, baby massage, singing, dancing, playing 'peek a boo', follow the leader, singing songs, clapping hands, and giving voice to baby's communications.

Other promising practices that were identified but did not make the list include:

- Collaborative Child and Family Violence Prevention and Intervention Program (McWhirter, 2008)

- Violence Intervention Program for Children and Families - VIP program (Osofsky, 2004)

- Safe Start demonstration project of the Office of Juvenile Justice and Delinquency Prevention (Safe Start Center, 2008)

- The Child and Family Interagency Resource Support and Training Program (Child FIRST) (Crusto, et al. 2008)

- Child-Parent Psychotherapy (MacMillan, et al. 2009)

The Collaborative Child and Family Violence Prevention and Intervention Program (McWhirter, 2008) is another community based, group based program which involves five weeks of group therapy for mothers and children (aged between 6 and 12 years). These sessions use play and therapeutic activities. Individual sessions looked at feelings, expression of feelings and keeping safe. It aims to reduce family conflict and improve family cohesion and management. Results indicate a positive group effect on well-being (pre-post treatment design) (McWhirter, 2008).

The VIP program is a community program for the police, social workers, psychologists, parents, teachers and children. It is a community based policing initiative aimed at children exposed to domestic violence. The program targets infants and school aged children, and involves police education sessions, a 24-hour hot-line using VIP cards for families and police officers. A police education manual, resource directory and parent and children booklets have been produced. It is designed to raise awareness and improve collaboration between services. In an analysis of the hot-line calls for police and families, they found improved awareness and sensitivity of police, as well as earlier referrals for intervention and treatment (Osofsky, 2004; Osofsky, et al. 2004).

In terms of government led community based interventions the Safe Start demonstration project of the Office of Juvenile Justice and Delinquency Prevention (US Department of Justice) (http://www.safestartcenter.org/) is the most developed. "The initiative seeks to prevent and reduce the negative consequences of children's exposure to violence, as well as to create conditions that enhance the well-being of all children and adolescents through preventive interventions" (Safe Start Center, 2008, p. 1). A number of demonstration sites (Phase 1 and Phase 2) have been developed with federal, state and local communities working together. Phase

1 focused on system change in 11 sites across America and improvements in identification, screening and referral strategies (e.g. a 911 protocol was developed), plus improvements in service integration, engagement with families and cultural competence, as well as raising community awareness were achieved. Case study and descriptive methodology was used to evaluate the sites (see Kracke and Cohen, 2008; Hyde, Lamb and Chavis, 2008; Hyde, Lamb, Arteaga and Chavis, 2008). Phase 2 is focusing on the implementation of evidenced based practice across 15 sites. These are described in detail in the Safe Start Center (2008) report. Chamberlain (2009) reports on the adaptation of a home visiting program to help parents and children exposed to family violence with the Safe Start initiative.

The Child and Family Interagency Resource Support and Training Program (Child FIRST) (Crusto, et al. 2008) is a home based or community based case management (wrap around) for children younger than five years old exposed to domestic violence. It includes a parent-child intervention and mental health assessment and treatment. Pre and post treatment results suggest decreases in the number of potentially traumatic / violent events in families, and a reduction in PTSD-like symptoms and caregiver stress.

In response to witnessing intimate partner violence, MacMillan, et al. (2009) in their review, highlight positive outcomes for child-parent psychotherapy for mothers and preschoolers citing the work of AF Lieberman and colleagues. They also describe a post-shelter counselling intervention for violence reduction against women. Stover, Meadows and Kaufman (2009) also reviewed the research literature on interventions for child witnesses for intimate partner violence. Like MacMillan, et al. (2009) they cited the studies of Lieberman (child-parent psychotherapy) and Graham-Berman (The Kids* Club). They also identified a trauma focused CBT intervention by JA Cohen and colleagues, but the children in this study were sexually abused and experiencing PTSD. Stover, Meadows and Kaufman (2009) also questioned the generalisability of many RCTs in this area as maternal substance abuse is an exclusion criteria.

For indigenous family violence programs, key learnings are incorporated in a formal program evaluation, the Department of Family and Community Services (2005). These include: a focus on prevention and early intervention, better partnerships and co-ordination, improved data collection, local plans, community needs identification, knowledge sharing, and staff training. A program logic framework, and good and bad practice in indigenous family violence programs are described.

Chauvin, Sullivan and Woolcock (2003) provide a detailed community development and action framework around the issue of domestic violence in a Queensland community. It includes service provider and community member views. The project recommended improved co-ordination and prevention / early intervention efforts, with a focus on strengths and resilience, better data collection, and programs for children and the elderly.

Other identified programs and recognised centres include (see McAlister Groves and Fox, 2004; Buchanan, 2008):

- Mothers In Mind from the Child Development Institute in Canada which provides group therapy and counselling for mothers of children 0 – 3 years, with a focus on parent training and parent child relationships (http://www.childdevelop.ca/thirdpagefile/family_violence/mothers_in_mind/index.html).

- The Advocacy for Women and Kids in Emergencies (AWAKE) project at the Children's Hospital Boston providing counselling, advocacy and referrals to welfare services (http://www.childrenshospital.org/clinicalservices/Site1856/mainpageS1856P4sublevel5.html).

- The Child Witness to Violence Project (CWVP) provides counselling and family therapy to children exposed to family violence, as well as broader training and advocacy. The project is located at the Department of Developmental and Behavioral Pediatrics at Boston Medical Center (http://childwitnesstoviolence.org/pmwiki.php?n=Main.HomePage).

A number of useful resources for clinicians have been found. These include:

- McAlister Groves and Fox (2004) who provide recommendations for paediatric healthcare practices in dealing with children affected by domestic violence

- Buchanan (2008) on the application of attachment theory to domestic violence exposure

- Boyes (2007) outlines the research on the potential effects on children's learning ability and education as a result of family violence and family violence exposure

- Humphreys et al. (2006) are developing age appropriate activity packs (including play figures, reading stories and photos) to help with mother-child communication in discussing the emotional effects of domestic violence exposure.

- Brendler (2006) provides a useful clinical description for therapeutic individualised family counselling intervention for disrupting cycles of violence in families

- Rossman et al. (2004) outlines the history and developmental influences on intervention programs used today (e.g. the Kids* Club) in the 1980s and 1990s

- McAlister Groves (2002) provides powerful arguments and clinical examples for the general reader. For example:

"The take home message for all parents from this series of studies is that marital conflict is not inherently bad for children. Children may even learn positive and prosocial lessons from seeing their parents argue and then resolve the conflict. If the argument is resolved, children can cope. If the arguments are chronic and unresolved, however children react negatively. In Cummings's research, fighting that included physical aggression was much more psychologically harmful for children than verbal arguing. This is not surprising, but the consistency of their findings builds a powerful case for the ways in which physical fights or even threats of personal injury overwhelm children's abilities to cope. Children who lived with physical aggression were more likely to blame themselves and to see themselves negatively. This distorted self-appraisal affected children in all areas of social functioning" (McAlister Groves, 2002, p. 57).

8.1.4 Discussion

Summarising the research, Baker, et al. (2004) reports that some children exposed to domestic violence may demonstrate more emotional, social, behavioural and cognitive problems when compared to other children. However some children show "no elevated rate of problems, or rates consistent with other factors in their lives (e.g. maltreatment, poverty, parental substance abuse)" (Baker, et al. 2004, p. 223). A number of factors may interact with violence exposure (like age, sex and intelligence) to either create problems or foster resiliency. Also the effects of violence exposure vary according to "duration, severity, frequency, recency and age of onset" (Baker, et al. 2004, p. 223). They make the point that violence in the home is usually associated with other risk factors.

In this review four interventions were recommended (The Kids* Club; Haupoa Family Component; Parents Accepting Responsibility Kids Are Safe; 'Peek a Boo' Club / BuBs on Board). The remainder of this review discusses: service development issues; other related VCAMS indicators; sources of evidence for violence prevention and problem behaviour programs for children and adolescents; and program developments in Victoria.

In terms of service development, Cooper, et al. (2004) citing the Guidelines for Domestic Violence Treatment for Children, highlight the best approaches in this area. These are summarised below:

- Treatment should be part of a co-orientated effort

- Safety issues need to be addressed

- Domestic violence must be the primary focus

- "Treatment programs should provide opportunities for children to share their stories, express their feelings, identify and have there feelings validated, learn safety skills, practice problem solving and social skills, experience violence-free relationships, understand that violence is the responsibility of the person who chooses the abusive behaviour, and improve their emotional health and self-esteem" (Cooper, et al. 2004, p. 10)

- Treatment providers must be aware of: developmental stages; the impact of trauma on development and attachment; cross cultural issues; and community resources

- Confidentiality protocols that allow for information sharing, and child abuse reporting to welfare agencies need to be in place

Another useful work for service developers is provided by Sessions and Fanolis (2006). They describe a social worker led school-based mental health program for children and families (Partners for Success). This program has developed and evolved "Systems of Care" principles. They include: "(1) an emphasis on community-based programs that are (2) culturally responsive that (3) engage families as partners in all aspects of planning and delivery, that are (4) based on assessment of strengths more than deficits, that are (5) holistic in understanding the ecological context of families and children and multi-systematic in intervening at different levels in that ecology, that deliver (6) individualised services around the needs of particular families, that are (7) meaningfully integrated across service systems and professional disciplines, and that (8) incorporate and renew program priorities based on evaluative studies and partnership goals" (Sessions and Fanolis, 2006, pp. 357-358).

Related indicators discussing some of these issues and identifying preventative interventions can be found by looking at the following indicators in the VCAMS catalogue:

- the proportion of children whose parents report high levels of social support

- the decreased rate of re-notifications to child protection

- the decreased rate of unintentional injury

- the proportion of children and young people living in families with healthy family functioning

- and the percentage of parents and young people who believe their community is an accepting place for people from diverse cultures and backgrounds.

By focusing on children and young people with violence exposure, this review did not look at violence prevention and problem behaviour programs for young people in schools and adults in the community. However, promising practices that are supported with evidence can be found at the Campbell Collaboration (http://www.campbellcollaboration.org/) (for example, Smedslund, et al. 2007 and Davis, et al. 2008) and the Blueprints for Violence Prevention, a project of the Center for the Study and Prevention of Violence at the University of Colorado, (http://www.colorado.edu/cspv/blueprints/). Also the DART (Development and Risk Together) model (Williams, et al. 1999) is another important source of knowledge.

Key program developments in this area have occurred in Victoria recently. These include: the launch of the "Enough" campaign regarding family violence and the introduction of new laws and policies in this area (http://www.familyviolence.vic.gov.au/Home). (A list of contact numbers for help is provided at http://www.familyviolence.vic.gov.au/WhereToGoForHelp) Victoria Police have a family violence unit (see http://www.police.vic.gov.au/content.asp?Document_ID=10441 for details on police information resources and policing strategy) and 10 full-time family violence advisors across the five police regions (https://www.police.vic.gov.au/content.asp?Document_ID=288). The Maternal and Child Health Service (http://www.education.vic.gov.au/earlychildhood/mch/visits.htm) has incorporated a family violence screening and response program into there training sessions (see http://www.education.vic.gov.au/ecsmanagement/matchildhealth/learndevelop/kastraining.htm). This Common Risk Assessment Framework (CARF) is developed by the Domestic Violence

Resource Centre and run from Swinburne TAFE (for details see
http://www.tafe.swinburne.edu.au/CRAF/identifying.htm). The Domestic Violence Resource
Centre Victoria also runs an active website (http://www.dvirc.org.au/) with information on domestic
violence for adolescents (http://www.burstingthebubble.com/ and local violence prevention projects
(http://www.dvirc.org.au/PublicationsHub/101WaysPrevent.htm).

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Table 5   Proportion of family violence incidents where children and young people are involved as other parties

	Supporting evidence	Replication	Documentation	Theoretical basis	Cultural reach
(45.1) The Kids* Club	1	No	Yes	Yes	
(45.2) Haupoa Family Component	4	No	Yes	Yes	CALD
(45.3) Parents Accepting Responsibility Kids Are Safe (PARKAS)	5	No	Yes	Yes	
(45.4) 'Peek a Boo' Club / BuBs on Board	5	No	Yes	Yes	

Key

Supporting evidence:
1.   Well supported practice – evaluated with a prospective randomised controlled trial.
2.   Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication.
3.   Promising practice – evaluated with a comparison group.
4.   Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data).
5.   Emerging practice – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation).

Replication:
Has the intervention been implemented and independently evaluated at more than one site? (yes or no)

Documentation:
Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:
Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field? (yes or no)

Cultural reach:
Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD)

Recommended Strategy 45.1: Proportion of family violence incidents where children and young people are involved as other parties	
Name of intervention	The Kids* Club
Organisation	Sandra A. Graham-Bermann, Ph.D Department of Psychology, University of Michigan
Brief literature review	This small group based treatment program involves a child and a parent component. The child program involves a 10 week manualised program which creates a supportive environment, and provides lessons looking at the child's sense of safety, making sense of the violence experiences, managing emotions and conflict resolution / self-control skills. The parenting program involves education, building parenting competency and group support. Including discussion about "the impact of violence on their child's development" and providing "a safe place to discuss parenting fears and worries" (page 200). A Preschool Kids* Club has also been developed for children aged 3 to 6. The program is run by trained therapists.
How and why does this intervention work?	Using a wait list control group design (n = 181 children) Graham-Bermann, et al. (2007) found that those in the combined parent and child therapy group had significant improvements (i.e. a small to moderate effect) in externalising behaviour (as measured by CBCL ratings from mothers) and attitudes about violence (on a short children's survey) at post treatment and at 8 month follow-up. Taking baseline factors into account improvements in internalising and externalising behaviour were also found for the combined group at follow-up. NB: The groups contained children with no or low diagnosable symptoms, so study mixed prevention and intervention issues.
On what population does this intervention work best?	Target group: children aged 6 - 12 years.
Where will this intervention work best?	Children and mothers who are identified as being exposed to intimate partner violence.
What is required to implement this intervention?	Trained group therapists and counsellors working closely with community facilities (e.g. community mental health and shelters for women).
Resources and contact information	Professor Sandra A. Graham-Bermann http://www.lsa.umich.edu/psych/people/directory/profiles/faculty/?uniquename=sandragb http://www.sandragb.com/
References	Graham-Bermann, et al. (2007)

Recommended Strategy 45.2: Proportion of family violence incidents where children and young people are involved as other parties	
Name of intervention	Haupoa Family Component
Organisation	Parents And Children Together (PACT), Hawaii
Brief literature review	Haupoa Family Component is a community based group therapy intervention (Becker, et al. 2008). It is a 12 week (90 minutes per week) course of support and therapy for children exposed to domestic violence which is culturally appropriate. Topics include: safety skills, trust building, self-awareness, communication, self-blame, nonviolent conflict resolution. The program is age appropriate and based on the framework of Peled and Edleson (1992) (cited by authors) and involves games, role-plays and stories. It also involves culturally relevant symbols, like using an erupting volcano to symbolise anger. The aim of the groups are "to provide a safe setting in which children could learn more about family violence, explore their beliefs and attitudes regarding violence, and develop or enhance healthy coping skills" (p. 192). A simultaneous parenting group is run to assist the parents with helping their children cope with domestic violence exposure and improve their own parenting skills and self-esteem. (Most parents have attended a survivors of domestic violence course.) ** "Haupoa" is Hawaiian for "make the ground soft for planting". **
How and why does this intervention work?	The study used a pre-post treatment design involving 106 families (one child selected per family) enrolled in the program between 2001 and 2003. The families experienced severe and frequent levels of violence. Also 53% of families reported multi-ethnic backgrounds - "blends of Caucasian, Chinese, Hawaiian, Japanese, and Filipino backgrounds" (p. 191). For the 83 families completing the intervention, improvements in internalising and externalising behaviours (parenting rating on the CBCL) and improvements in parent and child skills in dealing with violence exposure (on counsellor rated instruments) were found.
On what population does this intervention work best?	Target group: children aged 3 – 17 years (CALD background).
Where will this intervention work best?	Children and mothers who are identified as being exposed to intimate partner violence.
What is required to implement this intervention?	Trained group therapists and counsellors working closely with community facilities (e.g. community mental health and shelters for women).
Resources and contact information	The program is run from the Family Peace Center-Oahu in Hawaii (and is a program of PACT). http://www.pacthawaii.org/oahu_peace_center.html
References	Becker, et al. (2008)

Recommended Strategy 45.3: Proportion of family violence incidents where children and young people are involved as other parties	
Name of intervention	Parents Accepting Responsibility Kids Are Safe (PARKAS)
Organisation	Wendy Bunston, Manager, Addressing Family Violence Programs, The Royal Children's Hospital Integrated Mental Health Program
Brief literature review	PARKAS is a mental health / counselling group intervention (8-10 weeks) for women and children who have experienced family violence (Bunston, 2008a). Both the parent, child and joint sessions are run by the same facilitators. The program works on healing and improving parent child attachment styles. "The toll from years of living with violence is considerable, even when the perpetrator has gone (e.g. the distress, and disruption around access visits, the fear of being found / re-assaulted by the perpetrator or the re-enactment of traumatic and abusive relational styles). The attachment styles of these child / parent dyads are often deeply anxious, fragile and chaotic and move between highly ambivalent, avoidant or disorganised" (p. 336). The program starts with detailed assessment and the shared history about the traumatic events. Children are also involved listening and discussing these events - body language, pictures, and play are used if required. In the group sessions, the counsellors provide a place for 'safe healing and safe play'. Themes include: What I have in common with others, What are my strengths, How is anger passed onto others, How do I keep safe, What different feelings are. The program encourages in parent - child relationships "reciprocity, healthy relational parenting and affect regulation" (p. 340). Drawings are also used to get 'in the mind of the child'. A follow-up session two months after the intervention is also conducted. Detailed information about the counselling frame work and process is provided by Bunston (Chapter 2) in Bunston and Heynatz (2006).
How and why does this intervention work?	The PARKAS program has been evaluated by the authors (Bunston, 2008a; Bunston and Dileo - Chapter 15 in Bunston and Heynatz, 2006) using a pre and post treatment design utilising questionnaires like the Strengths and Difficulties Questionnaire (SDQ). Some evidence of improvement was found in changes to SDQ scores for the small evaluation sample (parents = 18, teachers = 12) in terms of total difficulties and emotional problems, as reported by teachers and parents. Teachers also reported a reduction in hyperactivity. However a increase in conduct problems was noted by parents and teachers, but this may be due to the effects of therapy where children are not internalising as much but expressing there emotions - "moving away from avoidance and a 'coming to life'" (p. 158). Improvements in peer relationships were also reported by parents, which may also be an indicator of the success of the group work. Finally, a 15% drop-rate was reported and most parents (85%) reported that they found the group useful.
On what population does this intervention work best?	Target group: children aged 8 -12 years.
Where will this intervention work best?	Children and mothers who are identified as being exposed to intimate partner violence.
What is required to implement this intervention?	Trained group therapists and counsellors working closely with community facilities (e.g. community mental health and shelters for women).
Resources and contact information	The Royal Children's Hospital Integrated Mental Health Program (RCH IMHP) http://www.rch.org.au/mhs/services/index.cfm?doc_id=9924 Experiential training in PARKAS is offered by the organisation.
References	Bunston (2008a) Bunston and Heynatz (2006)

Recommended Strategy 45.4: Proportion of family violence incidents where children and young people are involved as other parties	
Name of intervention	'Peek a Boo' Club / BuBs on Board
Organisation	Wendy Bunston, Manager, Addressing Family Violence Programs, The Royal Children's Hospital Integrated Mental Health Program
Brief literature review	Extending the work of PARKAS, the Peek a Boo Club / BUBs on Board program aims to strengthen the relationship between mothers and their babies / toddlers. It is a group based mental health intervention for mothers and infants who have been exposed to family violence (8 sessions) (Bunston, 2008a). Groups are broken into developmental stages and they provide "a therapeutic space within which the infants and mothers can safely play with alternative ways of experiencing and communicating with one another" (p. 338). Play, mother-child observation of attachment and group facilitator modelling of interactions are used. "Within the group itself we use playful activities, observations and discussions as a means through which to invite reflection from individual mothers and the group as a whole about what their infants might be communicating about their internal world" (p. 339). A major focus of the groups is the child: "Observing and noting the infant's responses during the group is extremely powerful … Through their non-verbal communication, proximity seeking/distancing behaviours, gaze, affect and verbal utterances the babies show us how violence has impacted on themselves and their relationships (p. 339). Session topics included: how do we manage our stress, how do babies know when we are stressed, our wishes for us and our babies, what are the messages our parents have given us about ourselves, and what are the messages we want our children to have about themselves. Activities were designed to get mother and child to play together, and for the mothers to be mindful of the child and their experiences. The activities included "singing, play dough, musical instruments, story books, building blocks and balls" (Bunston, 2008b, p. 6).

Audette and Henry in Bunston and Heynatz (2006) outline the goals for mother and baby relationships. These include: fostering enjoyment with the mother / baby relationship, enhancing the mother's capacity to respond to the baby's communication signals, facilitating eye contact and prolonged affectionate gaze between mother and baby, facilitating shared rhythms, facilitating a sense of containment and being held. Activities can include: bubbles, baby massage, singing, dancing, playing 'peek a boo', follow the leader, singing songs, clapping hands, and giving voice to baby's communications.

Further insights into the counselling sessions and the dynamics of the group are provided by chapters in Bunston and Heynatz (2006) and Bunston (2008b). |
| **How and why does this intervention work?** | In a small sample (seven mothers), using a parent infant attachment scale, positive shifts into the normal range were found between pre and post group scores. Mothers also reported high satisfaction with the relationship forming and bonding aspects of the groups, as well as the environment.

This approach has been applied in five women's shelters in Tasmania (Bunston, 2008b). Qualitative feedback from shelter staff, in this trial was provided. They reported that they were very positive and supportive of the program.

Some quantitative information describing the problems of the group (20 mothers) in relation to attachment, relationship difficulties and developmental delay was provided at one time point while the group was running. |
On what population does this intervention work best?	Target group: Infants (birth to 36 months)
Where will this intervention work best?	Children and mothers who are identified as being exposed to intimate partner violence.
What is required to implement this intervention?	Trained group therapists and counsellors working closely with community facilities (e.g. community mental health and shelters for women).

University of Wollongong

Resources and contact information	The Royal Children's Hospital Integrated Mental Health Program (RCH IMHP) http://www.rch.org.au/mhs/services/index.cfm?doc_id=9924
References	Bunston (2008a) Bunston (2008b) Bunston and Heynatz (2006)

9 Proportion of children living with high family stress

9.1 Narrative review

9.1.1 Background

It is a truism that families play an important part in children's lives and development. Just living together with parents and other family members in close proximity may directly or indirectly influence a child's health, development and well-being (Australian Institute of Health and Welfare, 2007).

This review attempts to identify and examine interventions designed to assist children and families in dealing with high stress. It looks at stress and stressors in general - whether they are caused by internal and external factors. In doing so this review emphasises the importance of family functioning and family cohesion on child development, especially in response to individual circumstances and life events. "Research suggests that being part of a cohesive family unit is a protective factor for children and young people, helping them to better cope with any stressors or adversity they may encounter" (Australian Institute of Health and Welfare, 2007, p. 94). "In families where cohesion is high there are benefits for the child, including having positive role models for building relationships, the ability to cope with stressful events in life and the development of high self-esteem. In contrast, in families where there is discord and high levels of conflict there can be adverse effects on the well-being of children and young people" (VCAMS website http://www.education.vic.gov.au/researchinnovation/vcams/parents/24-2familystress.htm).

These stressors on families take place in a background of a changing and mobile society where traditional family support structures may not exist. Also "the traditional nuclear family is now one of many forms of family in Australian society. There are now nuclear families based on an egalitarian partnership relationship, sole parents, blended and stepfamilies, and same-sex families" (Silberberg, 2001, p. 57).

By looking at family stress in general, this review does not examine specific or individual topics or causes of stress in families. Such issues could include: death of a father or mother or grand-parent, a major car accident, house fire, catastrophic events (like earth-quakes, floods), sudden life changing medical illnesses (like HIV, traumatic brain injury, or the birth of a disabled sibling), moving house, unemployment, financial or mortgage stress, a poor community environment, problems with the criminal justice system, problems with learning and education, mental health problems (e.g. psychological distress, anxiety, depression, post-traumatic stress), drug and alcohol problems, and parental disability and caring.

Other indicators which are related to this topic area and include interventions and approaches in the area of improving family support and family functioning are on: the proportion of children whose parents report high levels of social support; the decreased rate of re-notifications to child protection; and the proportion of children and young people living in families with healthy family functioning. These indicators cite significant and well-established interventions for families, like the Triple P Positive Parenting Program, Early Head Start, and The Incredible Years programs. Other interventions related to this topic area can be found in the area of adolescent substance abuse prevention, these include the Strengthening Families Program and the Resilient Families Program.

A number of useful individual interventions or programs related to this topic area have also been reviewed in the catalogue, they include the Nurse Home Visiting program and the Penn Resiliency Program (information on these interventions can be found in the indictors for decreased rate of unintentional injury or low birth weight and proportion of children with emotional of behavioural difficulties indicators respectively).

9.1.2   The evidence base

The key databases (PsycINFO, MEDLINE, ERIC and A+ Education) were searched for the terms families, family, stress, stress$ and whether there were any interventions or programs associated with these terms. As discussed above, the focus of the search was stress in general or family responses to major life events / experiences. The results of the searches found no reviews or prevention interventions. Additional searching then looked at interventions for families around coping behaviour, protective factors, family crises, life experiences and events (experiences-events), and life events. Again no associated review papers or interventions on these topics were found. It may be that interventions for family stress are tailored around specific experiences and events, for example dealing with a chronic illness, death in the family, moving to a new school, divorce or separation of parents, remarriage, a new baby in the house, problem gambling in the family, and a parent's loss of a job. It was felt that these specific issues are best dealt with in individual reviews.

In response to this lack of evidence on identified interventions for families living with high stress, it was decided that the best way to deal with this indicator was to look at prevention interventions and approaches looking at family strengthening and family resilience in general. In other words, this means that this review is not looking at specific instances of family strengthening in response to child abuse, family violence or parental drug addiction. The key search terms were family, and resilienc$ or strength$.

In this area, the key prevention challenge is the wide range of potential stressors, as Kumpfer and Alvarado (2003) comment:

> "The challenge is to implement interventions that effectively address such a broad range of family factors to prevent interrelated youth behaviour problems (Jessor, 1993, cited by Kumpfer and Alvarado, 2003)."

9.1.3   Selection of recommended interventions

No review papers or prevention interventions were identified in the area of high family stress in general, so a summary of prevention interventions and approaches looking at family strengthening and family resilience follows.

A number of useful review articles (both practice and academic) were found in the area of family strengthening and family resilience in general. Four key papers were identified. These were the National Network for Family Resiliency (1995); Robinson and Parker (2008); Silberberg (2001); and Kumpfer and Alvarado (2003). These are briefly described below. However, it must be noted that the research evidence base in terms of prevention in this new area of family strengthening and family resilience is small. This view is supported by Robinson and Parker (2008); Simon, Murphy and Smith (2005); and Benzies and Mychasiuk (2009).

The National Network for Family Resiliency (1995) provides a useful definition –

> "Resiliency is the family's ability to cultivate strengths to positively meet the challenges of life" (National Network for Family Resiliency, 1995, p. 3).

This paper looks at individual, family and community resiliency and provides a neat summary of the existing research literature. Some authors show how strong families help children learn resilient behaviour by teaching problem solving skills and by providing "positive, non-critical support and a sense of togetherness." Others stress the importance of cooperation, problem solving and openness, while others emphasise the role of social support and social connectedness (for further details, see National Network for Family Resiliency, 1995, p. 5).

Robinson and Parker (2008) in their research review on strengthening families and relationships mainly looked at couple and interpersonal relationships, and the need to develop a family well-being framework.

Robinson and Parker (2008) emphasise the importance of positive relationships in promoting resilience.

> "From a resilience perspective, the literature clearly indicates that attachment to at least one parent figure and supportive/responsive parenting are among critical factors in resilience (Luthar, 2006). This would indicate a need to encourage families to celebrate strong connections and actively engage in accessing information about parenting throughout their children's lives. Warm and supportive relationships, combined with appropriate discipline, are key to positive socialisation in childhood, with strong intimate relationships such as marriage providing the strength to meet challenges in adulthood (Luthar, 2006). As such, resilience feeds into positive relationships, just as positive relationships are a factor in resilience" (Robinson and Parker, 2008, p. 5).

Silberberg (2001) outlines the development of a strengths based approach to family policy, practice and research. Some of these ideas have made there way into the Commonwealth's Stronger Families and Communities Strategy (2000-2004). It follows the traditional line that "that strong and healthy families form the best social welfare system there is, and that strengthening families represents a very sound investment in Australia's future" (Ministerial statement, Senator Jocelyn Newman, cited in Silberberg, 2001, p. 57).

Specifically, Silberberg (2001) reports on qualitative and quantitative research which has developed the Australian Family Strengths Template. The template is based on eight qualities: communication, togetherness, sharing activities, affection, support, acceptance, commitment, and resilience. This template was developed by the Family Action Centre at the University of Newcastle (http://www.newcastle.edu.au/research-centre/fac/) and is a teaching tool and guide for those working with families.

Kumpfer and Alvarado (2003) have written a review on effective parenting and family programs in relation to the prevention of behaviour problems in young people. They focus on effective parenting and report that there is evidence of the effectiveness of behavioural parent training, family skills training and brief family therapy for high risk youth. This review mainly looks at problem behaviours (e.g. conduct disorder) and substance abuse. But it does outline 13 principles for effective family focused programs and interventions. These are summarised here:

- Comprehensive multi-component interventions
- Focus on family strengths, resilience and protective factors
- Addressing strategies for improving family relations, communication and parental monitoring
- Produce changes in the family dynamic and environment
- Increased dosage is in needed for high risk families
- Age and developmentally appropriate
- Good timing is required when families are in need and receptive to change
- Begin early in childhood
- Need to be tailored to cultural traditions
- Use of incentives; food, child care, transportation, rewards for completing homework / attendance
- Importance of the trainer's personal efficacy and style
- Using interactive training methods (role plays, modelling, homework, videos)

- Developing a collaborative approach

The National Network for Family Resiliency (1995) also comments on the common elements of effective programs. They are: community based, comprehensive, empowering, complex, culturally relevant, collaborative, respectful, intergenerational and accountable.

The remainder of this narrative review briefly highlights: promising community practices and interventions, therapeutic approaches, models of family strengths, and useful resources for parents and teachers.

A number of promising community practices were identified in this review. They were Raviv and Wadsworth (2010), Olson (2007), and Roach, et al. (2009). Raviv and Wadsworth (2010) have developed the Families Coping with Economic Strain (FaCES) program to help parents and children increase the use of adaptive coping skills and techniques in response to financial stress. Olson (2007) reports on community initiatives designed to strengthen families across the USA. They include programs: Helping parents of fussy babies; Early childhood centres hosting Dinner Chats and Stay and Play afternoons; establishing a crisis relief nursery for parents experiencing multiple stressors (http://www.familynurturingcenter.org/index.asp); supporting collaboration between organisations and bringing parents and early childhood teachers together for parent training and support groups. Roach, et al. (2009) describe partnership activities between early childhood and family service providers, training on building family protective factors (http://www.supportingfamiliestogether.org/families/) in Wisconsin and developing a curriculum for professionals and families (http://www.uwex.edu/ces/flp/impact/ece.pdf), and parental resources (http://www.uwex.edu/ces/flp/families/FamilyResiliency.cfm).

In terms of therapy and counselling approaches, Froma Walsh has outlined a research based family resilience framework (Walsh, 2003). It highlights the key processes in family resilience – belief systems, organisation patterns and communication, and problem-solving. Simon, et al. (2005) also outline the application of the concept of family resilience to clinical practice, highlighting the contribution of the solution-focused therapy approach to this area. Becvar (2007) provides detailed therapeutic approaches and clinical case examples for family therapy counsellors and practitioners. These approaches are designed to facilitate family resilience by supporting a positive self-concept, encouraging effective parenting and creating supportive contexts. Benzies and Mychasiuk (2009) in their review outline the key protective factors for resilience at an individual, family and community level. They described the following family factors: family structure, intimate partner relationship stability, family cohesion, supportive parent-child interaction, stimulating environment, social support, family of origin influences, stable and adequate income, and adequate housing. Benzies and Mychasiuk (2009) argued that each of the individual, community and family protective factors are "an excellent starting point for the development of clinical interventions to support family resiliency" (Benzies and Mychasiuk, 2009, p. 109). Thomlison (2008) also outlines the theoretical basis, the principles for effective practice, and the research evidence, for family centred practice in social work and welfare. She recommends many family interventions reviewed in the VCAMS catalogue (e.g. Incredible Years, Nurse-Family partnership, Fast (Families and Schools Together] Track).

This search also identified a number of models of family strengths. The National Network for Family Resiliency (1995) outlined the Double ABCX Model of Family stress by McCubbin. This is briefly described in the following quote:

> "A family's ability to recover from stress is influenced by additional life stressors and by family perceptions. A family's goals, values, problem-solving skills, and support networks impact its adaption to long term stress and crisis" (National Network for Family Resiliency, 1995, p. 5).

Silberberg (2001) also emphasises the importance of shared values as underpinning family strengthening.

"Sharing similar values makes the process of developing family strengthening practices a lot smoother, and induces a sense of belonging. In turn, these practices increase the family's resilience" (Silberg, 2001, p. 57).

Another key model of family strengths is Olson's Family Circumplex Model which has three main dimensions: cohesion, flexibility and communication (cited in Silberg, 2001).

Kumpfer and Alvarado (2003) also cite three protective factors: positive parent-child relationships, positive discipline methods, and the communication of "prosocial and healthy family values and expectations" (Kumpfer and Alvarado, 2003, p. 458). They go on to say that:

"Resiliency research suggests that parental support in helping children develop dreams, goals, and purpose in life is a major protective factor" (Kumpfer and Alvarado, 2003, p. 458).

Reviewing the practice literature a few useful resources were found. These included: The Community Guide website (http://www.thecommunityguide.org/index.html) (from the Centers for Disease Control and Prevention, CDC), the National Registry of Evidence-based Programs and Practices (NREPP) of the Substance Abuse and Mental Health Services Administration (SAMHSA) (http://www.nrepp.samhsa.gov/), and the Center for the Application of Substance Abuse Technologies (CASAT) (http://casat.unr.edu/). This work identified another family strengthening program for adolescents in the context of substance abuse and violence prevention. It is called "Creating Lasting Connections" and detailed information about it can be found on the following websites: (https://casat.unr.edu/bestpractices/view.php?program=26 and http://www.nrepp.samhsa.gov/programfulldetails.asp?PROGRAM_ID=126).

Materials on stress for students and teachers can be found on the CDC's innovative Body and Mind (BAM) website (for students - http://www.bam.gov/sub_yourlife/yourlife_stressometer.html; for teachers - http://www.bam.gov/teachers/stress.html). Another lesson plan "From Family Stress to Family Strengths" is provided by Clemson University (http://www.clemson.edu/psapublishing/PAGES/FYD/HEL70.pdf).

The American Psychological Association also has produced the "Road to Resilience" guide (http://www.apa.org/helpcenter/road-resilience.aspx) and the Resilience Guideline for parents and teachers (http://www.apa.org/helpcenter/resilience.aspx). This guideline includes 10 tips for building resilience in children and teens.

Information and experiences of teachers dealing with these issues can be found by Dellar (2008) and Tilling (2008). Tilling (2008) also makes the important point that resilience programs need to do two things, namely reduce risk factors and build protective factors. Patterson and Kirkland (2007) also provide guidelines for teachers and parents for creating resilient families. They highlight the importance of communication and family traditions and routines. A list of good books to promote resilience in primary grade children is also provided. In this context, Halgunseth, Peterson, Stark and Moodie (2009) provide guidelines to early childhood educators for practices that promote strong family engagement. These include: integrate culture and community, provide a welcoming environment, strive for program-family partnerships, make a commitment to outreach, provide family resources and referrals, and set and reinforce program / professional standards.

9.1.4 Discussion

From a policy and practice perspective, extending a family strengths model into service delivery has important implications. As Silberg (2001) states:

"A family that is classified as troubled and needy is more likely to find itself on the receiving end of all sorts of services and programs designed and delivered by outside experts. This model of service delivery positions families as passive recipients. On the other hand, a family that is depicted as resourceful and skilled is more likely to become actively engaged in the

process of addressing their issues and solving their problems. In the strengths-based model of service delivery, it is the family who sets the agenda for their path of recovery rather than the outside expert" (Silberberg, 2001, p. 57).

However, Robinson and Parker (2008) outline the difficulties in getting people to undertake preventative family strengthening programs.

"The strengths-based approach, however, mainly operates in a service environment where people are accessing help for difficulties they are already experiencing. While this approach has obvious merit, the "missing link" is encouraging people to access support and help prior to problems occurring, in a preventative effort to increase strengths and offset future difficulties" (Robinson and Parker, 2008, p. 1).

They then discuss other related initiatives in mental health that encourage help-seeking behaviour and reducing stigmatisation. These include online programs and universal school based programs (like Mindmatters).

Finally, interested readers are advised to look at the related VCAMS indicators in this area that address parental training, social support, family functioning, family violence and child protection.

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10 The proportion of young people who have someone to turn to for advice when having problems

10.1 Narrative review

10.1.1 Background

Young people may be faced with a large variety of problems and challenges during their transition into adulthood. When experiencing difficulties, having someone to turn to for advice can be of great benefit for young people, assisting them to better overcome their problems.

The notion of having someone to turn to for advice may be understood from the perspective of having social support or social cohesion. Having high levels of social cohesion / support and close personal networks and community networks is seen to positively affect young people's health, development and wellbeing in a number of ways (AIHW, 2007; DEECD, 2008). Thus, having a relationship with someone that can provide sensible and appropriate guidance may lead to improved outcomes for young people.

Commonly, when young people have problems they will turn to their parents, relatives or other trusted adults in their life when seeking advice and support. Within the VCAMS Catalogue of Evidence, another indicator has examined this topic in detail (Proportion of young people who have a trusted adult in their life), with a focus on the role of parents. Considering the close similarity between the two topic areas, the focus of this review will be on people that may provide advice and guidance to young people experiencing problems who are non-parent adults. In particular, this review will examine mentorship programs. Although seemingly at the periphery of the topic area, mentoring interventions have certain potential to promote positive youth development, and involve the fostering of a relationship which can be seen to provide young people with someone to turn to for advice when having problems.

Data on social support is available from a number of sources, which gives some indication of the proportion of young people who have someone to turn to when having problems. For instance, the 2004 HILDA Survey and 2007 CIV Survey report on social support and personal relationships in relation to youth (see AIHW, 2007 and DEECD, 2008). Additionally, a valuable future data source for this indicator will be the Victorian Adolescent Health and Wellbeing Survey.

10.1.2 The evidence base

The term 'advice' was not located on the MeSH Browser, nor was it useful when conducting searches in the PsycINFO and MEDLINE databases. Instead, the MeSH headings 'child guidance' and 'mentors' were identified, and were used to conduct the literature review in the aforementioned databases.

Upon reviewing the found literature, an apparent lack of information specifically addressing the issue of advice for young people and child guidance was identified. Thus, the focus was turned to the concept of mentorship. In particular, formal mentor relationships promoted by an intervention were examined.

Variation in how mentoring is defined is evident in the literature. Tolan, et al. (2008), however, provide a definition applicable to the context of juvenile delinquency, but which is also of use for this review:

> "Mentoring usually involves older, usually adult, persons in the community who provide
> opportunities for imitation, gaining advice, pleasurable recreational activities that show care

and interest in the mentee, and emotional support, information, and advocacy through a one-to-one relationship" (Tolan, et al. 2008, p. 6).

Three particularly valuable reviews were located however on mentoring programs and youth development: a synthesis of the literature (Jekielek, et al. 2002); a meta-analysis (DuBois, et al. 2002); and a systematic review on mentoring interventions in relation youth at risk of delinquency and associated problems (Tolan, et al. 2008).

These reviews identified numerous individual interventions based on mentorship. The approach has been used to address a variety of program goals relating to promotion of youth development. These include: improving parent–child relationships, improving self esteem, reducing antisocial behaviours such as substance use, promoting academic achievement, improving school attendance, and preparing for future employment and education (Jekielek, et al. 2002).

Many of the interventions identified were targeted to at risk youth. At risk youth targeted by mentoring interventions include not only juvenile offenders as mentioned, but other populations such as academically at risk students, pregnant and parenting adolescents, abused and neglected youth, and youth with disabilities (DuBois and Karcher, 2005). Mentoring interventions are commonly multifaceted, with mentoring as the key component combined with other components (such as life skills training or community service activities).

A number of reviews identify the potential for effective mentoring programs to produce positive outcomes for youth, and it is indicated that they offer the greatest potential benefits to youth who can be considered to be at risk (DuBois, et al. 2002; Jekeilek, et al. 2002; Tolan, et al. 2008). The strength of the evidence is questioned in these reviews, however. For example, one review providing support for the effectiveness of youth mentoring programs quantifies this appraisal in the statement: "it may be most appropriate to expect the typical youth participating in a mentoring program to receive benefits that are quite modest in terms of absolute magnitude" (DuBois, et al. 2002, p. 187). Another review supporting mentoring programs as a useful approach for lessening delinquency risk or involvement also notes that a lack of detail in the literature about specific theoretical and practical components of effective mentoring programs means that "the valuable features and most promising practices can not be stated with any certainty" (Tolan, et al. 2008, p. 5).

Although not included in the selection of recommended interventions, other examples of effective and relevant individual interventions identified in the literature will be discussed.

10.1.3 Selection of recommended interventions

Three interventions are recommended, based on the literature search on mentorship programs:

- Across Ages (LoSciuto, et al. 1996; Taylor, et al. 1999; Aseltine, et al. 2000; Jekeilek, et al. 2002)
- Project BELONG (Jekeilek, et al. 2002)
- Mentoring Program for At-Risk Youth (Keating, et al. 2002; Tolan, et al. 2008)

The three interventions have some evidence of effectiveness, and each of the three combine an emphasis on mentoring with other program components. Across Ages was selected as example of an intergenerational mentoring intervention aimed at drug prevention; Project BELONG was an example of a program designed to reduce substance use and improve school functioning, and used younger people in the mentoring role; and the Mentoring Program for At-Risk Youth represents another example of an intervention aimed at at-risk youth, which addressed the specific issue of delinquency.

The first selected intervention is Across Ages, a comprehensive intergenerational mentoring approach to drug prevention for at risk youth. The main component of the intervention is the involvement of older adult volunteers as mentors to the students (grade 6). In addition, the

intervention engages students in community service activities involving visits to nursing homes, and also includes classroom-based life skills curriculum, and activities and support for parents and families.

One study evaluating the effectiveness of Across Ages on drug prevention found that participants who received all components of the intervention (mentoring, curriculum, community service, and family workshops) had increased positive attitudes to school, the future, and older people. Findings also showed improved reactions to situations involving drug use, increased knowledge about older people, higher levels of community service, and improved school attendance. Participants who did not receive the mentoring component of the intervention did not achieve the same positive outcomes (LoSciuto, et al. 1996; Taylor, et al. 1999; Jekeilek, et al. 2002).

Another evaluation of Across Ages, conducted by Aseltine, et al. (2000), aimed to assess the effectiveness of the elements of the intervention (excluding the parent / family component) in improving student outcomes in four areas: personal and social resources, school performance, problem behaviour (including substance use), and attitudes toward the elderly. Compared to the control group, a range of positive outcomes were found for students that were subject to mentoring, curriculum, and community service: "significantly lower levels of problem behaviour and alcohol use and significantly higher levels of self-control, cooperation, attachment to school and family, school attendance, and attitudes towards the elderly and helping" (Jekeilek, et al. 2002, p. 38). Program effects were not maintained at six-month follow-up, however, except for cooperation. Future initiation of marijuana use was also found to be reduced at follow-up (Jekeilek, et al. 2002; Aseltine, et al. 2000). The cost effectiveness and feasibility of the program has also been reported in the literature (Taylor and Bressler, 2000).

Building Essential Life Options Through New Goals (known as Project BELONG) is the second intervention selected for recommendation. This mentoring / tutoring program aimed to improve school functioning and discourage substance use in at risk middle school students. Over one school-year, students (grades 5 – 8) were taught various technical, academic, and life skills by undergraduate (university) students. Mentoring activities were undertaken for 10-12 hours each week. In addition, tutoring (including assistance with homework) and instruction in life skills (including discussion of behaviour skills, critical thinking skills, and drug / alcohol use) were provided by the undergraduates.

In comparison to the control group, experimental evaluations of Project BELONG found mentored youth were more engaged in the classroom, placed greater value on school, and exhibited fewer behavioural problems at school (as rated by their teachers). Participants were also less likely to fail mathematics (although this positive outcome was not found for English, reading, or social studies). Furthermore, participants committed fewer criminal offences, and the seriousness of these offences was less than the control group (Jekeilek, et al. 2002). Project BELONG is included as an example of a mentoring program that uses young people as mentors, whereas typically programs utilise older adults in the mentoring role.

The third recommended intervention is an intensive mentoring program for at risk youth, with a specific focus on youth at risk for juvenile delinquency or mental illness. Participants were children and adolescents (aged 10-17) who were deemed at risk and referred to the program by a professional (i.e. school counsellor or principal, or another agency). Youth were matched with volunteer adult mentors (over 18 years old) living in surrounding communities, who were screened for commitment to the program and appropriateness for involvement with at risk youth, and subsequently received training. Training sessions included: education about child development, warning signs of child abuse, common problems experienced by youth, and information on effective interaction. Supervision and support was also provided to mentors. Mentors interacted with their mentee for one year (university students were also used in the mentoring role, representing older young people, and were required to commit for six months). During the 6 to 12 months of intervention, youths and their mentor spent at least three hours together each week (which commonly involved activities such as going to the movies, a park, or a sporting event). They also participated in program-sponsored group activities, such as community service projects,

cultural events, and educational experiences. In addition to the mentoring component of the intervention, life skills training was also provided in the form of monthly seminars conducted by local professionals, on topics such as child abuse prevention, drug and alcohol abuse, cross-cultural awareness, health, nutrition, and school problems (Keating, et al. 2002; Tolan, et al. 2008).

Findings from the study showed that following six months in a mentoring relationship, both internalising and externalising behaviours at school and at home significantly decreased (as reported by teachers and mothers respectively), from a clinical range to a level nearer to a nonclinical range. These results suggest that "exposure to caring adults helped youth to feel better about themselves and to engage in less destructive behaviors toward themselves and others" (Keating et al. 2002, p. 731). No significant effect was found, however, on self-reported measures. Although results showed that mentoring during a six-month period can be effective in promoting positive outcomes for youth, it is unclear which component was most effective. Interpretation of results is also made more difficult by the fact that a large percentage of youth in the study were receiving other assistance, including school or family counselling, had a parent in therapy, or were also participating in another program. It should be noted that the intervention seemed to affect African-American youth differently than Caucasian and Latino youth, although program affects were not found to be different for gender (Keating et al. 2002).

As previously mentioned, interventions included for other indicators that are relevant to this indicator will be discussed.

Big Brothers Big Sisters (BB/BS) (included in the indicator: Proportion of young people who have a trusted adult in their life) is a program with particular relevance to this indicator. The organisation operates in many countries across the world, including Australia. Unlike other interventions described in this review, Big Brothers Big Sisters does not involve any components other than mentoring.

The BB/BS mentoring program is targeted toward youth at risk of academic, psychosocial and / or behavioural problems. Typically community or school based, it involves trained staff screening adult volunteers and matching them to a young person. Big Brothers or Big Sisters meet regularly with their 'Little' (the young person being mentored) for a minimum of 12 months, providing mentoring, friendship, and general concern for their well being. Various randomised controlled trials have demonstrated that the program leads to a range of positive outcomes for at risk youth, including improvement in academic, psychosocial, and behavioural outcomes, reductions in substance abuse, and increased self-esteem (Grossman, et al. 2002; Herrera, et al. 2007; Rhodes, et al. 2005; Turner, et al. 1996). A recent survey of adults who had been mentored as youth in the BB/BS United States program found that participation in the program had been very important in their lives, and had had a positive influence in their lives, in areas such as self confidence, stability, goal setting, decision making, and success in terms of education and employment. It was also found that longer matches (more than three years) were associated with more positive outcomes (Harris Interactive, circa 2009). Additionally, a number of studies have indicated that the program is cost effective, including a recent study by Moodie and Fisher (2009) of BB/BS in Melbourne, which concluded the mentoring program represents excellent value for money (see also Aos, et al. 2004). Further information about the organisation in Australia is available on their website (http://www.bigbrothersbigsisters.org.au/).

Another indicator that has relevance to this indicator is 'Proportion of children with emotional or behavioural difficulties'. Recommended interventions from this indicator included FRIENDS and the Penn Resiliency Program, both of which will briefly be discussed. Both are cognitive-behavioural school based interventions. Although neither utilise mentoring, they have been shown to have positive outcomes for young people, including the development of positive relationships, which is particularly pertinent to this indicator.

The FRIENDS program aims to teach young people strategies to deal with anxiety and challenging situations. One-hour group sessions are run over 10 weeks, with booster sessions and parent sessions also provided. The program, conducted by trained school teachers, promotes self

development, problem-solving, resilience, self-esteem, self-expression, and the development of positive relationships. A number of evaluations of the program, in Australia and abroad, have found a range of long-term positive effects for youth (for example see Barrett, et al. 2006; Neil and Christensen, 2007). Positive effects have also been found for culturally and linguistically diverse populations (Barrett, et al. 2001).

The Penn Resiliency Program teaches young people techniques for assertiveness, negotiation, decision-making, social problem-solving, and relaxation. Trained teachers use role plays, short stories, or cartoons to teach students these skills, with group discussions and homework assignments reinforcing the lessons taught in class. Evaluations have indicated the program is effective in preventing symptoms of depression and anxiety, and benefits have been found for some CALD and low income groups (for example see Cardemil, et al. 2007; Cutuli, et al. 2006). The skills taught in the program can be applied to many aspects of young people's lives, including relationships with peers and family.

Indigenous mentoring programs that acknowledge and respect cultural values and beliefs were searched for in the literature. The Panyappi project was identified as an example of a mentoring program specifically for Indigenous young people aged 10-18 living in the Adelaide area. The program's primary aim is to reduce the incidence of high risk behaviours and criminal acts. Evaluation of the program found positive outcomes for youth, including the strengthening of relationships and the majority of participants having decreased rates of offending (Stacey, et al. 2004; http://www.healthinfonet.ecu.edu.au/health-resources/programs-projects?pid=164).

Many books provide further comprehensive discussion and analysis of issues relating to youth mentoring, giving useful insights into the benefits of mentoring, critical elements of programs, additional examples of effective programs, and other aspects of youth – adult relationships (for example see Rhodes, 2002; DuBois and Karcher, 2005; Allen and Eby, 2010).

10.1.4 Discussion

A number of reviews have identified factors that strengthen mentoring programs and increase intervention effectiveness. Factors identified by Jekeilek, et al. (2002) include:

- significant positive impacts increase the longer a mentoring relationship lasts (with short-lived relationships potentially harming children
- youth benefit from mentors who know, and maintain frequent contact with, the mentee's family
- high levels of contact between mentor and mentee are associated with better outcomes
- youth-centred mentoring relationships are associated with better academic outcomes
- mentees who are most disadvantaged or at risk are especially likely to benefit
- cross-racial mentoring matches are just as successful as same-race matches
- long-lasting interventions may be needed to create life-changing impacts for at risk students.

Program characteristics that support high quality mentor-mentee relationships were also identified:

- structure and planning
- pre-match training
- post-match training and support
- supervision of the match
- consideration of the mentor / mentee interests in the matching process
- social and academic activities (especially social, as such activities apparently help build trust)
- a youth-driven or 'developmental' approach to the relationship
- cross-race matching, which appears to produce quality relationships as effectively as same-race matching (Jekeilek, et al. 2002, p. 31-32).

Another review found programs to have stronger positive effects when a key process involved in

the mentoring was emotional support, and when a motivation for mentors was professional development (Tolan, et al. 2008).

Although mentoring programs are primarily designed to benefit the mentee, benefits for mentors have also been reported in the literature. Although effective mentoring makes great demands on mentors (such as long-term commitment to mentoring relationships, frequent and regular contact with mentees, and participation in ongoing training and communication with program directors), perceived benefits for mentors are worth noting. For some older adults who volunteer as a mentor, a need to be appreciated and productive can be met by participating in mentoring programs. The activity may give them a greater sense of purpose, and they may become more connected in the community. For instance, in the Across Ages intergenerational mentoring program, mentors reported that they valued the opportunity to share with a young person the knowledge, skills, and wisdom learned over a lifetime. Many reported that mentees valued or appreciated their life experiences more than their own children or grandchildren (Taylor, et al. 1999; Jekeilek, et al. 2002).

A variety of other sources can potentially provide young people with someone to turn to for advice when having problems. A national survey found friends and parents to be the tops two sources of advice and support for people aged 11-19 years. Other sources listed included relative / family friend, internet, magazines, community agencies, school counsellor, teacher, someone else in the community (e.g. doctor, church minister), and telephone helpline (DEECD, 2009, p. 101).

Other established initiatives and organisations exist that are of potential value for this topic area. In Victoria, the Mentoring and Capacity Building Initiative (MCBI) for Young Victorians has been funded by the Victorian Government. This has established a shared strategic approach to mentoring between all Victorian Government Departments, and led to a coordinated, evidence-based framework for mentoring young people (Victorian Government, 2005; DEECD, 2007).

Another example of a national organisation is Peer Support Australia, which provides "dynamic peer led programs which foster the mental, social and physical wellbeing of young people and their community. The Peer Support Program is integrated into curricula and sustained through all year groups. It supports positive cultural change within schools by incorporating a range of strategies developed through collaboration with members of the whole school community for the specific needs of the school". For further information see the Peer Support Australia website: www.peersupport.edu.au/.

Finally, some methodological limitations were identified in the literature. Many studies gave limited details about what comprised mentoring activity and key implementation characteristics (such as intervention organisation, components, implementation and delivery). This limitation encourages caution in interpretation of effects, and reveals a need for more careful design of evaluations to direct effective practice of mentoring programs (Tolan, et al. 2008). The current review on mentoring and prevention of drug and alcohol use, which is being undertaken by the Cochrane Collaboration (see protocol by Thomas, et al. 2008) will provide useful information on best practice in this area as well as improved research designs.

10.1.5 References

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Table 6 ***The proportion of young people who have someone to turn to for advice when having problems***

	Supporting evidence	Replication	Documentation	Theoretical basis	Cultural reach
(47.1) Across Ages	1	Yes	Yes	Yes	CALD / LOW SES
(47.2) Project BELONG	1	No	No	Yes	
(47.3) Mentoring Program for At-Risk Youth	2	No	No	Yes	CALD

Key

Supporting evidence:
1. Well supported practice – evaluated with a prospective randomised controlled trial.
2. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication.
3. Promising practice – evaluated with a comparison group.
4. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data).
5. Emerging practice – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation).

Replication:
Has the intervention been implemented and independently evaluated at more than one site? (yes or no)

Documentation:
Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:
Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field? (yes or no)

Cultural reach:
Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD)

Recommended Strategy 47.1: The proportion of young people who have someone to turn to for advice when having problems	
Name of intervention	Across Ages
Organisation	Temple University Center for Intergenerational Learning
Brief literature review	Across Ages is a comprehensive intergenerational mentoring approach to drug prevention for at risk youth. The main component of the intervention is the involvement of older adult volunteers as mentors to the students (grade 6). In addition, the intervention engages students in community service activities (visits to nursing homes), and also includes classroom-based life skills curriculum, and activities and support for parents and families.
How and why does this intervention work?	Evaluations of Across Ages have reported a range of positive outcomes for youth. One study found the intervention (when comprising all components i.e. mentoring, curriculum, community service, and family workshops) increased positive attitudes to school, the future, elders, and older people among participants. Improved reactions to situations involving drug use, increased knowledge about older people, higher levels of community service, and improved school attendance were also reported (LoSciuto, et al. 1996; Taylor, et al. 1999; Jekeilek, et al. 2002). Another evaluation of Across Ages (which excluded the parent / family component) found that students that were subject to mentoring, curriculum, and community service intervention exhibited "significantly lower levels of problem behaviour and alcohol use and significantly higher levels of self-control, cooperation, attachment to school and family, school attendance, and attitudes towards the elderly and helping" (Jekeilek, et al. 2002, p. 38). Levels of self-control, school bonding and problem behaviour were also improved for this group. Improved levels of cooperation were found to persist, and future initiation of marijuana use was reduced, at six-month follow-up (Jekeilek, et al. 2002; Aseltine, et al. 2000). The cost effectiveness and feasibility of the program was also reported (Taylor and Bressler, 2000).
On what population does this intervention work best?	The intervention was conducted with grade 6 students (and may be particularly effective for at risk youth).
Where will this intervention work best?	The main mentoring component can be conducted in school based settings, and other components are appropriate to be conducted in various community settings (e.g. community service in residential aged care facilities, and recreational mentoring activities).
What is required to implement this intervention?	Older adult volunteers from the local community are needed as mentors, and require appropriate training.
Resources and contact information	Andrea S. Taylor, Ph.D. Temple University Center for Intergenerational Learning Contact details available at: http://acrossages.org/contact A range of program materials are available (see http://acrossages.org/)
References	Aseltine, et al. (2000) Jekeilek, et al. (2002) LoSciuto, et al. (1996) Taylor, et al. (1999) Taylor and Bressler (2000)

Recommended Strategy 47.2: The proportion of young people who have someone to turn to for advice when having problems	
Name of intervention	Building Essential Life Options Through New Goals (Project BELONG)
Organisation	Public Policy Research Institute, Texas A&M University
Brief literature review	Project BELONG is a mentoring / tutoring program which aims to improve school functioning and discourage substance use in at risk middle school students. Over one school-year, students (grades 5 – 8) are taught various technical, academic, and life skills by undergraduate (university) students. Mentoring activities were undertaken for 10-12 hours each week. In addition to the mentoring component, tutoring (including assistance with homework and time management) and instruction in life skills (including discussion of behaviour skills, critical thinking skills, and drug / alcohol use) were provided by the undergraduates.
How and why does this intervention work?	Experimental evaluations of Project BELONG found mentored youth (n = 206) were more engaged in the classroom, placed greater value on school, and exhibited fewer behavioural problems at school (as rated by their teachers) compared to the control group (n = 179). It was also found that mentored youth were less likely to be referred to school administrators for a sever discipline problem, and were less likely to fail mathematics (although this positive outcome was not found for English, reading, or social studies). Additionally, it was found that participants committed fewer criminal offences, and the seriousness of these offences was less than the control group (Jekeilek, et al. 2002).
On what population does this intervention work best?	The intervention was conducted with students in grades 5 – 8 (and may be particularly effective for at risk youth).
Where will this intervention work best?	Mentoring can be delivered in schools (i.e. during the school day or after school) or possibly in community settings.
What is required to implement this intervention?	Undergraduate university students are needed as mentors, and require appropriate training.
Resources and contact information	No resources or contact information was located for this intervention.
References	Jekeilek, et al. (2002)

Recommended Strategy 47.3: The proportion of young people who have someone to turn to for advice when having problems	
Name of intervention	Mentoring Program for At-Risk Youth
Organisation	Department of Psychology, University of Miami
Brief literature review	This intensive youth mentoring program had a specific focus on youth at risk for juvenile delinquency or mental illness. Participants were youth who were deemed at risk and referred to the program by a professional (such as a school counsellor or principal, or a professional from another agency) for reasons such as behavioural or emotional problems, poor school performance or attendance, or minor crimes. Youth were matched with volunteer adult mentors (over 18 years old) from the community or university, who had first been screened and provided with training. Ongoing supervision and support was also provided to mentors during the program. Mentors interacted with their mentee for 6 to 12 months. During the intervention, youths and their mentor spent at least three hours together each week (which commonly involved activities such as going to the movies, a park, or a sporting event). They also participated in group activities (e.g. community service projects, cultural events, educational experiences). Another component of the intervention, life skills training, was also provided in the form of monthly seminars conducted by local professionals on a variety of topics (e.g. child abuse prevention, drug and alcohol abuse, cross-cultural awareness, health, nutrition, and school problems) (Keating, et al. 2002; Tolan, et al. 2008).
How and why does this intervention work?	Following six months in the program, both internalising and externalising behaviours at school and at home were significantly decreased (as reported by teachers and mothers respectively), from a clinical range to a level nearer to a nonclinical range. These results suggest that contact with caring adults through the mentoring relationship "helped youth to feel better about themselves and to engage in less destructive behaviors toward themselves and others" (Keating, et al. 2002, p. 731). However, no significant affect was found for youth on self-reported measures (delinquent acts, self-concept, social support, and hopelessness). Although results showed that mentoring during a 6 – 12 month period can promote positive outcomes for youth, it was unclear which component was most effective. It should be noted program effects were found to be different between African-American youth compared to Caucasian and Latino youth, but no difference was found for gender (Keating et al. 2002).
On what population does this intervention work best?	At risk youth aged 10 – 17 years old
Where will this intervention work best?	Mentoring can be conducted in school or community based settings, although some mentoring activities (e.g. going to the movies, a park, or a sporting event) are undertaken outside school. Life skills training seminars could be conducted in either school or community settings.
What is required to implement this intervention?	Volunteer adult mentors from the community are needed. Program coordinator(s) are also needed, particularly for screening, training and support of mentors. Participation from local professionals to deliver education / life skills training seminars is also needed.
Resources and contact information	Dr. Michael Alessandri Department of Psychology, University of Miami http://www.psy.miami.edu/faculty/malessandri/
References	Keating, et al. (2002) Tolan, et al. (2008)

Appendix A   Evaluation framework

Supporting evidence	1. ***Well supported practice*** – evaluated with a prospective randomised controlled trial. 2. ***Supported practice*** – evaluated with a comparison group and reported in a peer-reviewed publication. 3. ***Promising practice*** – evaluated with a comparison group. 4. ***Acceptable practice*** – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre- and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data). 5. ***Emerging practice*** – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation).	Code: 1, 2, 3, 4 or 5. ☐
Replication	Has the intervention been implemented and independently evaluated at more than one site?	Yes ☐ No ☐
Documentation	Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery?	Yes ☐ No ☐
Theoretical basis	Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field?	Yes ☐ No ☐
Cultural reach	Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds?	Low SES ☐ Indigenous ☐ CALD ☐