Communities That Care®

Guide to Australian Prevention Strategies

Communities That Care® Ltd. Australia

A Guide to Australian Prevention Strategies

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About this Guidebook

In every country where *Communities That Care (CTC)* operates, one of the tasks is to develop a guidebook of evidence-based strategies. The present guidebook has been updated by *Communities That Care Ltd*. (Australia) to support the dissemination of community-level prevention strategies. Community-level prevention strategies are programs and actions that can be managed or influenced by local communities to improve the social environments for children and young people, with the aim of reducing future health and social problems.

This guidebook aims to assist *CTC* management Boards to select evidence-based prevention strategies for their local prevention plan. *CTC* Board members, community members and key leaders should use this guide after they have:

- completed a risk audit for their community;
- identified between two and five priority risks that they intend to target; and
- completed a resources audit to identify services already working in the community that are relevant to reducing those priority risks.

Together with the *CTC* training program, this guidebook is designed to help make local prevention plans as effective as possible by providing a menu of prevention strategies with a track record of success. The prevention strategies included in this guidebook have been selected based on:

- the potential for the strategy to be initiated by local communities and to be implemented with monitoring by local *CTC* Boards;
- high quality evaluation evidence showing the potential to reduce risk factors and enhance protective factors reported by children and young people; and
- high quality evaluation evidence showing that the strategy can reduce three major health and social problems that threaten the future for the current generation of children and young people. These problems include alcohol abuse, school disengagement and depressive symptoms.

The prevention strategies have also been selected to address the main environments in which *CTC* seeks to reduce risks and enhance protection. These are described under three main headings:

- Family focus
- School focus
- Community focus

Additionally, this guidebook provides information and advice for *CTC* Boards on the detailed processes of:

- action planning; and
- implementation, monitoring and evaluation.

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Preface

Originating in the United States, the *CTC* process has been adapted for use in Australia by *Communities That Care Ltd*. (*CTC Ltd.*). *CTC Ltd*. is the licensed provider of the *CTC* process in Australia. It is a non-profit company set up under a joint initiative of The Royal Children's Hospital and the Rotary Club of Melbourne. Since 2000 the work of *CTC Ltd.* in Australia has been supported by the Rotary Club of Melbourne and a range of financial supporters including the State governments of Victoria and Western Australia, the Victorian Health Promotion Foundation (VicHealth), the Baker Trust, the Myer Foundation, Perpetual Trustees, the Jack Brockhoff Foundation and the Financial Markets Foundation for Children.

In its first decade *CTC Ltd.* (Australia) and partners facilitated the work of three 'pioneer' communities that successfully used the *CTC* process to implement, disseminate and evaluate strategies for building community-based prevention capacity. Pre-post student surveys demonstrated that in the majority of the communities where action plans were developed, risk factors were reduced, protective factors enhanced and health and social problems reduced. The work of the pioneer communities has yielded valuable lessons for improving the future implementation of the *CTC* process in Australia.

A key goal of *CTC Ltd.* is to remain current with prevention science in order to keep communities at the cutting edge. This guidebook has been revised based on new research findings, particularly in areas such as the evaluation of prevention strategies. Included is a selection of evidence-based programs and strategies, drawn from across the developmental spectrum from before birth through adolescence, and categorised into the following focus areas:

Family focussed programs

Prenatal/infancy and early childhood support

Parent training

Family therapy

School focussed programs

Encouraging school success

Social and emotional competence education

School organisational improvement

Drug and health education curricula

Community focussed programs

Regenerating communities

Reducing access to alcohol and tobacco

Social marketing and community mobilisation

Mentoring

Prevention Planning with Communities That Care

Section 1.1

Communities That Care: The story so far

Communities That Care (CTC) is aimed at promoting the healthy development of children and young people through the prevention of health and social problems. *CTC* offers an evidence-based way of understanding local needs and deciding how support for local children and young people can be made more effective.

***Communities That Care*:**

- has operated in Australia since 2000.
- is a long-term program strengthening community capacity to create social environments where children and young people are valued, respected and encouraged to achieve their potential.
- establishes a working partnership between local people, agencies and organisations to promote healthy personal and social development among young people, while reducing the risks of health and social problems.
- applies up-to-date knowledge about the factors most likely to encourage healthy behaviour, achievement and social commitment among young people.
- leads to local action plans whose principal goals are to:
  - support and strengthen families;
  - promote school commitment and success;
  - encourage healthy and responsible behaviour; and
  - achieve a safer, more cohesive community.

By mobilising whole communities behind a holistic, multi-agency approach, *CTC* ensures that prevention ceases to be the responsibility of a few, specialist organisations. The process leads to a community-wide strategy where community agencies and community members can better coordinate their activities. By increasing community capacity and understanding, the process seeks to place communities in a stronger position to apply for, and responsibly manage, prevention funding.

Communities That Care has been adapted from a program devised in the United States that has been successfully implemented in more than 500 communities with US Government support. The program has also been implemented in the UK, Canada, the Netherlands and Germany.

1.2.1 Understanding local needs: Community profiling

Using a step-by-step approach, including the administration of a local youth survey, *CTC* makes it possible to map factors in the lives of local children and young people that are influencing the likelihood that they will experience:

- school failure
- mental health problems
- sexually transmitted diseases and school-age pregnancies

or become involved in:

- alcohol and drug abuse
- violence and crime.

The resulting profile of risk and protective factors in the community equips local coalitions with a powerful tool for planning prevention strategies where genuine priorities are targeted for action. Informed decisions can be made about ways to improve existing prevention-focussed services that benefit children and young people. Gaps in service provision can also be identified and filled by introducing new interventions as necessary.

1.2.2 Risk and protective factors

CTC aims to create awareness of the risk and protective factors of healthy development, and to reduce risk and strengthen positive influences in the four domains of family, school, community and individuals/peers. The major risk factors that it targets include:

Family risk factors:

- Poor family management and discipline
- Family conflict
- A family history of antisocial behaviour
- Favourable parental attitudes to the problem behaviour

School risk factors:

- Academic failure (low academic achievement)
- Low commitment to school

Community risk factors:

- Low neighbourhood attachment
- Community disorganisation
- Community transitions and mobility
- Personal transitions and mobility
- Laws and norms favourable to drug use
- Perceived availability of drugs

Risk factors relating to individuals/friends/peers:

- Rebelliousness
- Early initiation of problem behaviour
- Impulsiveness
- Antisocial behaviour
- Favourable attitudes toward problem behaviour
- Interaction with friends involved in problem behaviour
- Sensation seeking
- Rewards for antisocial involvement

An important way that *CTC* supports children and young people is by enhancing protective factors shown by research to act as a buffer against risk in otherwise adverse circumstances. The Social Development Strategy (refer to 'Introducing Communities That Care', Cahir et al., 2003) is the framework that explains how protective factors and processes can be drawn together to help children and young people avoid being exposed to high levels of risk, and enable them to grow into healthy adults. The SDS framework identifies:

- **Healthy beliefs and clear standards for behaviour:** Young people are more likely to engage in healthy, socially responsible behaviour when parents, teachers and the community around them communicate healthy beliefs and clear standards.
- **Social bonding:** Strong, attached relationships with those who hold healthy beliefs and clear standards are an important protective influence. To create these bonds, young people need:
  - **Opportunities** for meaningful involvement with their families, schools and communities.
  - **Skills** - social, reasoning and practical skills to take full advantage of the opportunities on offer.
  - **Recognition and praise** for their efforts and accomplishments.
- **Individual characteristics and personality traits** are significant in the way that they affect children's ability to take advantage of other protective processes. Thus:
  - Families raising children in disadvantaged communities may need more intensive support.
  - Children who are outgoing and have a positive social outlook will generally find it easier to make friends and receive recognition from adults than those who are anxious and socially awkward.
  - Children who have a resilient temperament will be better able to make the best of any setbacks or disruptions in their lives.
  - Children who are highly intelligent will find it easier to acquire the skills to become successful in school.

It is especially important that children who lack these protective characteristics are given appropriate opportunities, skills and recognition, at each stage of their development, to encourage social bonding.

The *CTC* youth survey specifically measures the following protective factors:

Family protective factors:

- Attachment/bonding
- Opportunities for prosocial involvement
- Rewards for prosocial involvement [i.e. recognition/praise]

School protective factors:

- Opportunities for prosocial involvement
- Rewards for prosocial involvement [i.e. recognition/praise]

Community protective factors:

- Opportunities for prosocial involvement
- Rewards for prosocial involvement [i.e. recognition/praise]

Peer/individual protective factors:

- Social skills
- Belief in the moral order
- Emotional control

1.2.3 Community engagement and readiness for action

Communities ready for action will have:

- **Built a working partnership** between residents, organisations and agencies in their neighbourhood. They will also have secured the commitment of key leaders. These include the elected representatives in local government and chief officers in agencies such as education, social services, health and policing as well as prominent figures in the community, such as school principals.
- **Established a community-wide management board** responsible for planning and implementing the program. A diverse membership is critical to the Board's success. That means recruiting members who are parents, teachers, local government officials, health service professionals, business people, voluntary workers, religious and community representatives - not forgetting young people themselves.
- **Employed a coordinator accountable for day to day implementation and administration.** In addition to assisting the Board in preparing its action plan, the coordinator has an important part to play in liaising with the community and securing funding for implementation.
- **Taken part in an audit of the main risk and protective factors influencing the lives of children and young people in the community.** *CTC* provides specialist technical support and training in compiling a risk profile for the neighbourhood. The unique *CTC* auditing tool includes survey information from school students, yielding important information on attitudes to family, school and the wider community. Official archival data is also used.
- **Used the risk profile to select between two to five priority risk factors for action.** This is followed by an audit of existing preventive services in the neighbourhood that are relevant to reducing those risks. The resources audit serves to pinpoint gaps in services and to identify opportunities where existing work can be made more effective.

1.2.4 Community action planning using the Prevention Strategies Guide

The evidence gathered during community risk and resource audits is used by *CTC* Boards when developing a community action plan. The overall aim of the plan is to reduce the influence of the target risk factors in children and young people's lives, whilst also taking steps to increase the level of protective factors. Plans will normally combine two different components:

1. A re-direction of existing services to tackle the priority risks identified.
2. The introduction of new, focused interventions.

This guidebook is an aid for community Boards that have reached the action planning stage of the *CTC* process. It provides suggestions for re-organising existing services and for introducing new interventions, and includes examples of specific strategies whose effectiveness in reducing risk factors and enhancing protective factors has been established through convincing evaluative research. Importantly, for each of the included strategies there are practitioners who can advise Australian communities on implementation, and *CTC* have included the relevant contact details.

There are some areas of prevention practice where few, if any strategies have been convincingly evaluated. As a general rule, the 2012 guidebook excludes strategies that lack evaluation evidence. However, where such strategies are listed it is because they are based on strong theoretical foundations, or have shown evidence as being valuable in previous Australian *Communities That Care* action plans.

A key learning from *CTC* internationally in the past decade has been that local Boards need to be more involved in **monitoring** the implementation of prevention strategies. For this reason, the 2012 guidebook provides a new emphasis on monitoring measures that local Boards can include in their action plans.

Taken as whole, the guidebook can be used in three different ways:

1. As a benchmark to assess the likely effectiveness of existing service provision in the community that is directed at reducing risk and increasing protection.
2. As a guide to ways in which existing strategies and actions could be better monitored or evaluated to assess whether they are contributing to the improvements for children and young people that community members are seeking.
3. As a guide for introducing and monitoring new prevention strategies.

1.2.5 How do we judge strategies to be effective?

The most basic question to be asked about any existing program or strategy for reducing risks and enhancing protection in the lives of children and young people is 'does it work?'. We would also like to know 'who?' it works for, 'where?', 'for how long?' and - no less important – 'why?' it works. Evaluation research helps us to answer these questions, however:

- Many strategies have never been evaluated. No matter how promising they appear, we have no evidence on which to assess their effectiveness.
- Other strategies have had their progress monitored, and have carried out pre- and post-tests. The results may be encouraging, but it is still difficult to be confident about their effectiveness.
- Many popular strategies that are currently delivered to children and young people have been carefully evaluated and shown to be ineffective, or worse still, potentially harmful.

Prevention strategies are being rapidly developed and increasingly evaluated using experimental designs. *CTC Ltd.* encourages local communities and Boards to take a responsible approach to seeking out and encouraging the dissemination of evaluated prevention strategies. Where previously unevaluated strategies are implemented, Boards can request good quality evaluations.

Evaluating strategies for children, young people, families and the wider community is rarely as straightforward as testing a new drug or health treatment. Even those that have been

evaluated in experimental trials (randomised controlled trials) may not have been replicated in enough settings to be sure they will 'work' with every child, family, school or community. The strategies selected for inclusion in the 2012 guidebook include information on whether they have been subjected to randomised controlled trial evaluations. The guidebook also provides information to assist local community Boards to monitor the implementation of prevention strategies.

Prevention strategies in the Guidebook have been selected based on the following three criteria:

1. Evidence from good quality evaluation studies that they have been effective in preventing adolescent and/or youth health and social problems by reducing developmental risk factors, while also enhancing protective factors;
2. Feasibility for implementation and monitoring by Communities That Care coalitions in Australia; and
3. Availability of support and advice to assist Australian implementations.

1.2.6 Monitoring and evaluating your community action plan

The history of prevention science has shown that there have been many well-intended strategies that failed to make any difference, or worse, contributed to increasing problems. The reality is that prevention strategies need to be carefully conceived and implemented. This need underpins the insistence that the prevention strategies used in the *CTC* approach should have evidence for their effectiveness. In cases where a community decides to innovate and do something new it is particularly important to ensure an appropriate investment in evaluation.

Evaluation of the first decade of *CTC* activity in Australia revealed that the intention to increase evidence-based prevention was achieved, but with considerable opportunity for improvement. In particular:

- Although pre-post survey evaluations were conducted in all three pioneer communities, only one of the three communities completed a formal evaluation of program delivery.
- Most community Boards reported that they had limited ability to know whether the strategies included in their action plans were delivered as specified.

In recent years this problem has been addressed in the US by *CTC* Boards including **monitoring** as part of their local action plans. In this new approach local action plans now include details of how the Board can receive monitoring information on the local delivery and impact of prevention strategies in changing targeted risk and protective factors. Examples of monitoring include reports of attendance or participation rates, client satisfaction with services, progress reports, and direct observation of program delivery.

Prevention strategies assessment criteria — Section 1.3

The prevention strategies in the 2012 guidebook have been chosen because they fulfil the requirements for including a strategy in an action plan as detailed below. To assess the suitability of a particular strategy for inclusion in their action plans, communities should ask themselves the following questions:

Will it reduce known risk factors?

CTC works by reducing the major risks associated with child and adolescent health and behaviour problems. The key leaders and community Boards who implement each strategy need a clear understanding of the risk factors they have targeted and how the chosen interventions will reduce those risks. To be credible, a local community action plan should have a logical connection between the planned activities and the risk factors targeted for reduction.

Will it strengthen protective factors?

Reducing risk factors and increasing protective factors should be two sides of the same coin. Prevention strategies buffer children and young people against risk when they:

- Promote social bonding
- Set clear standards for social behaviour
- Give children the opportunities and skills to participate and feel they belong
- Show children that their contribution is valued.

Will it tackle risk factors at the right stage in children and young people's development?

Different risk factors are significant during different developmental stages in children's lives. For example, as children grow older they are influenced less by their families and more by their peers. Thus, efforts to reduce negative peer pressure become more relevant for children in late primary school and beyond.

Will it intervene early enough?

The point of risk and protection-focused prevention is to take action before children are drawn into problem behaviours. In some communities children show a high level of problems at the start of secondary school. In such communities it may be necessary to intervene in primary school or pre-school. In other communities problems emerge while children are in secondary school, suggesting intervention during adolescence.

Will it reach those at greatest risk?

Research shows that children who are exposed to multiple risk factors, or risk factors at extreme levels, for longer periods of time, have a greater overall likelihood of growing up to experience severe health and social problems. The *CTC* process takes the view that targeting high-risk neighbourhoods or schools is preferable to targeting high-risk individuals. *CTC Ltd*. recognises that Australian society is changing such that social disadvantage is increasingly "geographically clustered".

The aim of the *CTC* process is to get everyone in the community working together in a common cause to reduce the isolation of neighbourhoods and schools that experience disadvantage. The *CTC* process helps communities to develop action plans that can be effective in disadvantaged communities through:

- Risk auditing that makes it possible to identify and target the priority risk factors experienced by children and young people in a defined, geographical area.
- Highlighting prevention strategies that can assist children from very early in their development.

Will it recognise the needs of different racial, cultural and economic groups in the community?

Prevention strategies must be appropriate for use in the communities where they are applied. The interventions must be accessible, and potential obstacles such as language, transport and childcare must be taken into account. Participants must feel comfortable with the locations chosen for particular strategies and staffing should, so far as possible, reflect ethnic diversity. Cultural differences regarding family life, education and communities must be respected.

Will it make a significant contribution to the overall strategy for reducing priority risks?

Interventions will not be appropriate unless they reach enough local children, young people and adults to make a difference. Nor will they succeed if they assume too dominant a role and are implemented in ways that make it difficult for the plan as a whole to succeed.

Whether Boards are proposing to re-direct existing services or to fill gaps in existing provision by introducing new interventions, they *must* be able to justify action plans by providing positive answers to the above assessment questions.

Prevention strategies that may be harmful and should be avoided

Section 1.4

As prevention strategies become popular they are often enthusiastically supported by various members of the community. A number of agencies have taken action to develop prevention strategies such that a range now operate in each community. Unfortunately, the history of prevention evaluations reveals that some of the currently operating prevention strategies are ineffective or, worse still, harmful. That is to say that some strategies actually have a counter-productive effect of making child and youth problems worse.

CTC is distinctive in making efforts to implement programs that are safe and beneficial based on evidence from good quality evaluations. The present guidebook lists a range of strategies that have evidence for effectiveness. However, it is important to also be aware of the types of strategies that are not effective and are, hence, not supported. The following provides a list of some strategies that have evidence that they are ineffective.

- **Drug or health education funded by vested interests** such as the tobacco, alcohol or fast-food industries. Vested interests have a history of funding programs that look good but are often ineffective in reducing use of the products that they profit from.
- **Strategies that group children that have problems.** For example these may include peer-education programs that group children experiencing problems at school, or programs that take young offenders for "group training" exercises. These commonly used strategies have been shown to make things worse by failing to recognise that relationships between children experiencing problems typically increase their risk of subsequent health and social problems.
- **Drug or health education delivered at the wrong stage of a child's life.** Although children and parents tend to enjoy the entertaining presentations provided by visiting drug or health education presenters or from a visiting health education bus, evaluations show such interventions are often ineffective and can increase interest in drugs when childhood attitudes and commitments are revised in adolescence. Ineffective drug and health education wastes valuable resources that can be more productively used through careful selection and monitoring of prevention strategies.
- **Risky driving or elite road skill programs** are often championed by professional racing car drivers or by community members after there has been a car accident involving youth in the local community. Although these programs make intuitive sense, evaluations show them to lead young people to become over-confident, resulting in increased accidents and injuries.
- **One-off talks or "war stories"** where young people receive presentations from ex-addicts or people reformed after a life of crime. These strategies can encourage adventure seeking youth to experiment with the risky behaviours described in the presentations.

Family focussed programs

Families have the first, critical opportunity to weave a protective web around children that will reduce the risks of later health and behaviour problems. Programs that reduce foetal exposure to poor nutrition, alcohol and tobacco smoke, and encourage healthy parenting practices in infancy can make an important contribution to early development in families where mothers are experiencing difficulties. A child's attachment to its parents, and the positive standards of behaviour set by its family, exert a powerful influence in support of healthy development throughout childhood and adolescence.

The information in Section 2 presents an initial overview of what *CTC* Boards can do to encourage more effective local services in the early years (i.e. pre-natal and early childhood), as well as for parent education and support in general. **Specific prevention strategies** are also presented relevant to different settings and approaches. The presented strategies have been selected based on evaluation evidence that they reduce child and adolescent health and social problems by reducing risk factors and enhancing protective factors.

Section 2.1 Encouraging effective pre-natal and early childhood services

Pre-natal and infant care services offer support and guidance to parents and their babies at a critical time. Research shows that new parents will be more effective if they are prepared for pregnancy and childbirth, and receive adequate information about their baby's care and development.

Good pre-natal care can reduce the chances of premature births and low birth weight, as well as the baby's exposure to alcohol, tobacco and drugs, which can contribute to individual risk factors. It also supports protective factors in the baby's life by helping new parents to bond with their babies. The most effective support programs during pregnancy and in the months following a birth are those that aim to be comprehensive in their scope, embracing parent social support, physical and mental health care, parent education and children's development.

The uptake of pre-natal care is lower where prospective parents have their own history of problem behaviours (such as educational failure and drug abuse), and live on low incomes in disadvantaged neighbourhoods. Services such as home visits (see p.12) that reach out to socially excluded and isolated parents who are least likely to make use of mainstream services – whether before or after a birth – are essential. Action to improve uptake of the available care is, in itself, likely to reduce risk among babies and infants, and increase protective factors such as bonding.

Pre-natal programs should be seen as the first piece of a developmentally comprehensive support strategy for children and young people. Research suggests that the best long-term outcomes relate to interventions around the time of birth that are sustained by continuity of care.

What can *Communities That Care* Boards do?

When local data suggests problems are evident at an early age (see Box A), Boards need to specifically focus on early childhood. By monitoring trends in local data, and by taking action where trends show problems are not improving, Boards can advocate for healthy pre-natal and infant development in their community.

For more information:

The Australian Government, through the Family and Children's Services Branch of the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), is encouraging and facilitating a national approach to parenting and early childhood intervention, and promoting best practice in the area of child abuse prevention.

Some funding opportunities are publicised here: www.fahcsia.gov.au/grantsfunding/currentfunding

BOX A

Focus on pre-natal and early childhood services

Risk factors

Community and personal transitions & mobility

Community disorganisation

Poor family management

Family history of problem behaviour

Favourable parental attitudes to the problem behaviour

Low achievement beginning in primary school

High aggregation of risk factors from primary school

Protective factors

Social bonding/Family attachment

Family opportunities for prosocial involvement

Family rewards for prosocial involvement

Social/learning skills

Community Indicators

High child abuse and neglect rates

High rates of early child development problems

Low income and poor housing

Unemployment

Teenage mothers

Specific pre-natal and early childhood strategies

Strategy: Family Support using Home Visitors

Description

Family Support using Home Visitors is a key strategy for assisting highly disadvantaged communities to break the cycle of inter-generational risk. Home visitors are trained to build a trusted relationship with referred families based on shared respect, and in this way put themselves in a strong position to support parents with information and advice on child care, development and parenting. The strategy is intensive as each home visitor may hold a case load of around twenty to forty families per year. The home visitors encourage use of health and social services and ensure that problems can be dealt with before crises place children at risk of harm or abuse.

Evaluation Evidence

Randomised trials in Australia and the US consistently support the benefits of home visiting programs. Trials completed with disadvantaged mothers showed positive outcomes such as improvements in the early family environment and increased length of breastfeeding (Kemp et al., 2011), and lower levels of child abuse (Olds et al., 1997). A 15-year follow-up of the US Pre-natal/Early Infancy Project found 46% fewer verified reports of child abuse, 44% fewer behavioural problems from alcohol and drug abuse among the mothers, and 69% fewer maternal arrests compared with a control group (Olds, et al., 1997).

Monitoring Recommendations

- Advice on developing service contracts is available – see contact details below.
- Boards should negotiate agreements to receive a series of service delivery reports, including information on:
  - number and characteristics of families that receive services;
  - number of visits and services delivered;
  - client satisfaction with services; and
  - mother's mental and physical health.
- A check that child physical and behaviour development is proceeding normally is an important process indicator of a successfully implemented strategy.

Implementation Tip

This program is unlikely to provide benefits if delivered to low-risk families.

Program details

Target Audience

Pre-natal to 2 years

Target Risk Factors

- ✓ Community disorganisation
- ✓ Community transitions & mobility
- ✓ Personal transitions & mobility
- ✓ Poor family management & discipline
- ✓ Family conflict
- ✓ Family history of antisocial behaviour
- ✓ Favourable parental attitudes to the problem behaviour

Target Protective Factors

- ✓ Community attachment
- ✓ Community and family opportunities for prosocial involvement
- ✓ Community and family rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ Local area shows problems on AEDI
- ✓ High rates child abuse & neglect
- ✓ High rates of early developmental problems
- ✓ Low income and poor housing
- ✓ High rates of teenage mothers
- ✓ High aggregation of risk factors from primary school

Contact

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Improving community access to parenting information and support

Parenting is crucial to the way that children are socialised. Helping parents to learn family management skills, including non-violent discipline, can result in long-term benefits for their children. Fewer behaviour problems, improved parental confidence, better family relationships, and a more positive attitude to learning and school, are among the positive outcomes that have been reported by research. Parenting programs should help parents to form stronger, more protective bonds with their children, encouraging them to make healthy choices and holding clearly stated expectations for their behaviour. As such, they can play a vital part in any prevention strategy to reduce children's exposure to the risks associated with problems during adolescence.

Skills that are especially relevant to reducing the risks of problem behaviours include:

- understanding different stages in children's development and avoiding expectations that are inappropriate to a child's age
- supervising children and monitoring their behaviour
- setting clear expectations, boundaries and ground rules for behaviour
- providing praise and recognition for appropriate behaviour
- setting clear consequences for unacceptable behaviour
- enforcing the consequences consistently, while avoiding extreme punishments
- encouraging good relations and bonding within the family
- effective listening, communication and problem-solving

What can *Communities That Care* Boards do?

Integrated services: Boards should actively encourage activities and forums that support local professionals and organisations to work together to provide integrated parenting information and support to the community. By encouraging local agencies to redeploy staff and resources to organise and host local professional development forums, Boards can assist family and parent education services to build capacity in effective prevention models.

Appropriate interventions: Boards should ensure that any parenting interventions selected for implementation are developmentally appropriate, as well as addressing the particular risk factors that have been identified as priorities.

Specific parent education and support strategies

Program: Triple P – Positive Parenting Program

Description

The Triple P Positive Parenting Program is the most commonly implemented parenting program in Australia. Triple P is a parenting and family support strategy that targets the developmental periods of infancy, toddlerhood, pre-school, primary school and adolescence. The program aims to prevent behavioural, emotional and developmental problems in children by improving the skills and confidence of parents.

There are five levels of the program, provided at increasing intensity and narrowing population reach, to accommodate the differing severity in disrupted family functioning or child behaviour problems.

Evaluation Evidence

Based on cognitive behavioural and social learning theories, Triple P has been developed through more than 30 years of clinical research, and has been implemented and researched with a variety of different family populations.

Evaluations consistently find the program to be beneficial. Positive outcomes include significant improvements in parenting behaviours, improvements in parenting self-esteem and stressors relating to parenting (Bodenmann, Cina, Ledermann, & Sanders, 2008), and lower rates of child misbehaviour (Bodenmann, et al., 2008; Sanders, 2000; Sanders, Bor, & Morawska, 2007).

Monitoring Recommendations

- The Triple P program provides a recommended monitoring system.
- Boards should negotiate agreements to receive a series of service delivery reports from service provider.
- Monitoring information should include: number and characteristics of families receiving program at various service levels, parent and staff reports of improvements in child behaviour problems.

Program Details

Target Audience

0 – 10 years

Target Risk Factors

- ✓ Poor family management and discipline
- ✓ Family conflict
- ✓ Antisocial behaviour
- ✓ Early initiation of problem behaviour
- ✓ Interaction with antisocial peers

Target Protective Factors

- ✓ Family attachment
- ✓ Family opportunities for prosocial involvement
- ✓ Family rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ Current and projected proportion of households with dependent children

Contact

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Program: Families and Schools Together (FAST)

Description

The Families and Schools Together (FAST) programs are designed to strengthen families, enhance parenting skills, and connect families to their schools, with a view to helping children succeed academically and socially. The major intervention elements aim to build social support (social capital) for families within the school context, improve parent confidence and empower parents, improve family relationships, and increase child competence. Primary School (Kids) FAST requires considerable coordination and volunteer support as it invites all families within the targeted primary school to participate in the program.

Evaluation Evidence

Evidence from overseas randomised trials supports the benefits of the program. Positive outcomes include significant reductions in behavioural problems (Fisher, 2003), improved academic competence and improvements in parent ratings of anxiety (Kratochwill, McDonald, Levin, Young Bear-Tibbetts, & Demaray, 2004), and improved family adaptability and cohesion (Fischer, 2003). The program has been successfully trialled in Victoria, beginning in 1997, and demonstrated positive changes from pre- to post- program (Coote, 2000). *Communities That Care* Mornington Peninsula have included delivery of the FAST program in many of their local action plans.

Monitoring Recommendations

- Advice on program monitoring requirements is available – see contact details below.
- Boards should negotiate agreements to receive regular progress reports and request to monitor examples of session delivery.
- Monitoring information should include: number and characteristics of participating families; parent and professionals reports on changes in child behaviour problems.
- Where feasible, evaluate pre-post changes in parent confidence, child behaviour, and targeted risk and protective factors against control schools.

Implementation Tip

CTC Ltd. may be able to assist with evaluation designs and academic partnerships

Program details

Target Audience

6 – 14 years

Target Risk Factors

- ✓ Low neighbourhood attachment
- ✓ Community transitions & mobility
- ✓ Personal transitions & mobility
- ✓ Community disorganisation
- ✓ Poor family management and discipline
- ✓ Family history of antisocial behaviour
- ✓ Favourable parental attitudes to antisocial behaviour
- ✓ Family conflict
- ✓ Low commitment to school
- ✓ Low social skills
- ✓ Early initiation of problem behaviour
- ✓ Interaction with antisocial peers
- ✓ Friends' use of drugs

Target Protective Factors

- ✓ School, family and community opportunities for prosocial involvement
- ✓ School, family and community rewards for prosocial behaviour
- ✓ Social skills
- ✓ Belief in moral order

Community Indicators

- ✓ Low parental education
- ✓ Sole parents
- ✓ Low income and poor housing
- ✓ Unemployment
- ✓ High aggregation of risk factors from primary school

Contact

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W: www.familiesandschools.com.au

Program: The Strengthening Families Program 10 – 14

Description

The Strengthening Families Program for 10 – 14 year olds (SFP 10-14) is a universal prevention program that aims to assist families within late primary school/early high school. The program is designed to increase resilience, and reduce risk factors for substance abuse, depression, violence and aggression, delinquency, and school failure.

SFP 10 – 14 involves seven, 2 hour sessions. Parents and adolescents are in separate groups for the first hour, and combine to one group to practice skills for the second hour. Young people's sessions focus on strengthening positive goals, dealing with stress, and building social skills. Parent sessions focus on communication, monitoring and conflict resolution.

Evaluation Evidence

Randomised trial evaluations in the US support the benefits of this program for young people and their parents. Outcomes for young people include reductions in substance use, reductions in hostile and aggressive behaviour, and fewer problems in school (Spoth & Redmond, 2000). Outcomes for parents include gains in specific parenting skills such as setting appropriate limits and building a positive relationship with their youth, gains on general child management such as setting rules and following through with consequences, and an increase in positive feelings towards their child (Foxcroft, Ireland, Lowe, & Breen, 2002 ; Spoth & Redmond, 2000). The program is currently being implemented and evaluated in the UK and in New Zealand.

Monitoring Recommendations

- Boards should negotiate agreements to receive regular progress reports and request to monitor examples of session delivery.
- Monitoring information should include: information on training quality; number and characteristics of participating families; parent and professionals reports of changes in child behaviour problems.
- Given no prior Australian implementation, it is recommended to evaluate pre- post changes in targeted risk and protective factors and compare to a control group.

Implementation Tip

To adapt this program for implementation in Australia, a minimum of two facilitators would need to complete the Train the Trainer accreditation steps, and then evaluate its implementation in an Australian trial. For more information on associated costs, visit the website link. *CTC Ltd.* would be interested in supporting costs if there was interest in running an Australian training.

Program details

Target Audience

Ages 10 – 14 years

Target Risk Factors

- ✓ Low neighbourhood attachment
- ✓ Community transitions & mobility
- ✓ Personal transitions & mobility
- ✓ Community disorganisation
- ✓ Poor family management and discipline
- ✓ Family conflict
- ✓ Favourable attitudes to problem behaviour
- ✓ Low social skills
- ✓ Antisocial behaviour

Target Protective Factors

- ✓ Family attachment
- ✓ Family opportunities for prosocial involvement
- ✓ Family rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ Low parental education
- ✓ Sole parents
- ✓ Low income and poor housing
- ✓ Unemployment
- ✓ High aggregation of risk factors from primary school

Contacts

Karol Kumpfer, PhD
University of Utah

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W: www.
strengtheningfamiliesprogram.org

Program: Resilient Families – Early Secondary School Parenting Project/Parenting Adolescents: a Creative Experience

Description

The school-based Resilient Families prevention program is designed to develop the knowledge, skills and support networks of students and their parents in order to promote adolescent health and wellbeing.

The program consists of the following five intervention components: 1) a 10-session curriculum for students; 2) the Parenting Adolescents Quiz (PAQ) evening; 3) Parenting Adolescents: a Creative Experience (PACE); 4) policies and processes implemented by the school to build a community of parents to enhance support for, and communication with, parents during the early secondary school years; and 5) parent education handbooks.

The PACE program is an 8-week sequential parenting program that comprises one of the five components of the Resilient Families program. This program is based on an adult learning model, and follows a curriculum that covers adolescent communication, conflict resolution and adolescent development (Jenkin & Bretherton, 1994).

Evaluation Evidence

A Victorian evaluation of the program found that students in the intervention schools reported increases in family attachment and high school rewards compared to control schools (Shortt, Hutchinson, Chapman, & Toumbourou, 2007). Students whose parents attended the extended parent education group (8 week PACE group) were more than twice as likely as their peers to report positive problem solving at follow-up.

The PACE program demonstrated positive outcomes in a large quasi-experimental study in Australia. At the twelve-week follow-up parents and adolescents reported a reduction in family conflict, and adolescents reported increased maternal care, less delinquency, and less substance use (Toumbourou & Gregg, 2002).

Monitoring Recommendations

- At the planning stage Boards can obtain information on monitoring processes, and expected participation rates and participant changes.
- Boards should negotiate agreements to receive regular progress reports and request to monitor examples of session delivery.
- Monitoring information should include: attendance and satisfaction with training; services delivered and number of participants; participant ratings of service quality; and parent and youth reports of changes in risk and protective factors.
- Where feasible, evaluate pre-post changes in parent confidence, child behaviour, and targeted risk and protective factors and compare to control schools.

Conflict of Interest Note

John Toumbourou wrote this report and led the program development.

Program details

Target Audience

11 – 14 years

Target Risk Factors

- ✓ Poor family management
- ✓ Poor discipline
- ✓ Family conflict
- ✓ Parental attitudes favourable to problem behaviour
- ✓ Low commitment to school
- ✓ Low family attachment

Target Protective Factors

- ✓ Family attachment
- ✓ Family opportunities for prosocial involvement
- ✓ Family rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ Sole parents
- ✓ Parental social isolation
- ✓ Poor links between schools, families and family services

Contact

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Section 2.3 Family therapy

Family therapy is an approach targeted at high-risk youth that aims to prevent or reduce behaviour problems in adolescence by strengthening family cohesion. Maladaptive systems of interaction and communication between family members are addressed over the course of the program.

Family therapy programs have been extensively implemented in the US. The Functional Family Therapy (FFT) program has been developed as a brief program aiming to improve communication and behaviour management skills, with an emphasis on reinforcing and rewarding positive behaviour. FFT for young people sent to court for minor offences achieved significant improvements in family communication and fewer court appearances up to 18 months later, compared with the other treatment and control groups. The proportion of younger brothers and sisters from FFT families who had been referred to the courts two and a half years later was less than half the proportion in other groups (Alexander & Parsons, 2002).

A recent development based on FFT has been the Parenting Wisely program which uses an interactive CD-Rom to teach parenting skills., and controlled studies have found significant improvements in applied parenting skills, and in children and young people's behaviour being maintained six months after using the program (Gordon and Kacir, 1997).

Program: Behaviour Exchange Systems Training PLUS (BEST PLUS)

Description

BEST PLUS is a brief family therapy program designed to help families cope with adolescent substance abuse and other high-risk and disruptive behaviours. Parents often experience considerable distress when they recognise adolescent substance abuse and mental health problems, which can undermine effective responding. The BEST PLUS program aims to reduce parental stress and depression, increase communication and encourage assertive parenting, including the use of appropriate consequences for adolescent misbehaviour.

The core program is an eight-week, professionally led, group intervention. Parents-only attend sessions from weeks one to four, with siblings and the young people experiencing problems invited to attend from the fifth week. The program uses a brief and structured family therapy program to assist families where parents initially recognise adolescent substance abuse or mental health problems

Evaluation Evidence

Evidence supporting this program is limited to a waiting-list controlled trial and findings from pre-post evaluation studies. Positive outcomes included improvements in mental health, parental satisfaction and assertive parenting behaviours for those involved in the intervention (Toumbourou, Blyth, Bamberg, & Forer, 2001). A consortium of agencies are now working together in the Deakin Family Options project, to complete a randomised trial of the BEST Plus program.

Monitoring Recommendations

- At the planning stage Boards can request advice on monitoring processes, and expected participation rates and participant changes.
- Boards should negotiate to receive regular progress reports and request to monitor examples of session delivery.
- Monitoring information should include: attendance and satisfaction with training; services delivered and the number of participants; participant ratings of service quality; and parent and youth reports of changes in risk and protective factors.
- Where feasible, evaluate pre-post changes in parent perspectives, child behaviour and targeted risk and protective factors.

Conflict of Interest Note

John Toumbourou wrote this report and led the program development.

Program details

Target Audience

Ages 11 – 18

Target Risk Factors

- ✓ Low neighbourhood attachment
- ✓ Poor family management
- ✓ Poor family discipline
- ✓ Parental attitudes favourable to problem behaviour
- ✓ Family conflict
- ✓ Rebelliousness

Target Protective Factors

- ✓ Family attachment
- ✓ Family opportunities for prosocial involvement
- ✓ Family rewards for prosocial involvement

Community Indicators

- ✓ High number of parents seeking help to cope with their adolescent's alcohol or drug abuse or mental health problems
- ✓ Problems elevating in the high school years

Contact

For more options or to arrange an interview contact:

Deakin Family Options

E: familyoptions@deakin.edu.au
P: 03 9663 6733 (Melbourne) or 03 5227 8415 (Geelong)
W: www.deakin.edu.au/health/psychology/research/dfo

School focussed programs

Schools have a crucial part to play in reducing risk and enhancing levels of protection among their pupils. Unfortunately, children exposed to the greatest number of risk factors in their early years are those that most often underachieve upon reaching primary school. Falling behind in school with reading, writing and arithmetic is, in itself, an important risk factor for later problems. Thinking and other social competence skills may also be poorly developed. Children who develop a sense of failure at this stage are more likely to become alienated from school and exhibit behaviour problems, including disruption in the classroom and bullying of fellow pupils. Aggressive, disruptive pupils tend to be unpopular with classmates, making it more likely they will spend time with disaffected peers, thereby reinforcing anti-social behaviour. Schools that are disorganised - through difficulties ranging from lack of community support, resource constraints, leadership disruptions, teaching gaps and ineffective, inconsistent discipline - are in danger of compounding these problems.

Prevention holds the key for breaking through this downward spiral, and includes:

- High quality pre-school education, which ensures that children are ready to learn when they reach school and also exerts a long-term influence on their achievement and behaviour.
- School-based interventions such as tutoring, classroom and curriculum approaches that show a track record of success in providing timely support for individual children who are falling behind with basic skills. Other effective school-based programs are designed to develop students' social and reasoning skills, making it less likely they will engage in problem behaviour.
- Promising approaches to changing the way in which schools as a whole are organised and seek to motivate as well as educate their pupils. These 'whole school' approaches have proved a valuable means of tackling such issues as bullying, truancy and exclusion that are directly linked to low achievement, aggressive behaviour and lack of commitment to school. In addition, they also lead staff and pupils to assess and remedy factors contributing to school disorganisation.

What can *Communities That Care* Boards do?

Boards should seek to develop positive relationships with school staff, and play a role in supporting activities that enable local professionals and organisations to work together to provide integrated support for effective school-based prevention programs. In order to build community links, Boards should encourage the involvement of a range of schools in training events.

Encouraging school success for more children in your community

Apart from the family, experiences through pre-school and at school have the most important influence on children's development. The strategies that are listed in this guidebook can assist school education in a range of areas including: reading, tutoring and discipline; social and emotional competence; school organisation and; alcohol and drug education.

Pre-school

Children's readiness for school tends to be highly influenced by pre-school experiences such as playgroups and kindergartens. Pre-school experiences give children the opportunity to learn through play, mix with other children, and master a range of basic skills. Research shows that these experiences assist children's educational and social development and stand them in good stead for the years of compulsory education. The strategies offered in this guidebook that can improve pre-school development include: pre-natal and early childhood services (Family Support using Home Visitors, p. 12), parenting programs (Triple-P, p. 14); pre-school programs (PATHS, p. 29) and community programs (Communities for Children, p. 35).

Primary school

The entry to primary school is an important transition that can influence the development of school attachment and antisocial behaviour. Evidence shows that school performance tends to improve when there is support from families and communities. Strategies in this guidebook that can support primary schools include: Reading Recovery (p. 22), Classwide Peer Tutoring (p. 23), The Good Behaviour Game (p. 24), social and emotional competence education (You Can Do It!, p. 26; Friends for Life, p. 27; PATHS, p. 28), and bullying prevention programs (Friendly Schools and Families p. 30).

Secondary school

Secondary school has also been shown to have a lasting impact on adolescent development, affecting rates of school completion, antisocial behaviour, substance abuse and sexual risk taking. Secondary school strategies presented in this guidebook have shown that they can encourage healthy adolescent development by enhancing parent education in the early secondary school years (Resilient Families, p. 17), by enhancing school organisation (The Gatehouse Project, p. 31), and by encouraging effective alcohol and drug education (SHAHRP, p. 33).

Specific strategies: Reading, Tutoring, Discipline

Program: Reading Recovery

Description

Reading Recovery is a program for children who have been in formal schooling for a year and are in the bottom 20% of their class in reading skills. Children take part daily in 30 minute individual tuition sessions lasting over a period of 12 to 20 weeks. The specially-trained staff work to raise children's reading skills until they have reached the average level for their class - at which point a new pupil is recruited to take part.

Implementation Tip

Reading Recovery is a difficult package to implement unless adopted by the School and Education Department. A Reading Recovery Tutor is required and this position is responsible for training teachers, monitoring pupils' progress and providing staff with continuing support. Tutors are required to complete a two-year course, including a one-year academic qualification and a year's practical work within the local educational sector.

Evaluation Evidence

The Reading Recovery program is one of the most thoroughly evaluated programs for children with reading difficulties in the world (Hurry, 1996; Pinnell, Lyons, DeFord, Bryk, & Seltzer, 1994; Shanahan & Barr, 1995). Findings from randomised evaluation trials that include long-term follow-up support the benefits of this strategy. A UK evaluation found that children doubled their reading progress during the course of the program compared with a control group of similar children (Sylva & Hurry, 1996). A long-term follow-up, when children were aged 10, found that children whose reading skills were in the lowest 10% when they took part in Reading Recovery were reading better than their peers in the control group. But this was not the case with children whose skills had not been so poor.

Monitoring Recommendations

- At the planning stage Boards can request advice on monitoring processes, andexpected participation rates and participant changes.
- Boards should negotiate agreements to receive regular progress reports.
- Monitoring should include information on teacher training (i.e. attendance, satisfaction with the training delivered by the Reading Recovery Tutor; the number of local people undertaking training), and program delivery (i.e. number of students assisted; number of tutor sessions delivered; and student progress in reading levels).

Program details

Target Audience

5 – 7 years

Target Risk Factors

- ✓ Academic failure (low academic achievement)
- ✓ Low commitment to school

Target Protective Factors

- ✓ School opportunities for prosocial involvement
- ✓ School rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ Poor reading progress in the first year of primary school
- ✓ Low parental education
- ✓ School truancy

Contacts

Reading Recovery

W: www.readingrecovery.org

State Education Departments

W: www.deewr.gov.au

Program: Classwide Peer Tutoring

Description

The Classwide Peer Tutoring Program (CWPT) was developed to improve early academic competence for children living in low-income areas. It is an instructional model based on reciprocal peer tutoring that can be used at any grade.

The program has been designed to be flexibly incorporated into school curriculum. Students are pre-assessed on Fridays on their next week's work. From Monday to Thursday, they work with an assigned partner, taking turns tutoring each other on their spelling, maths, and reading, and reading comprehension. Points are awarded for both tutor and tutee. At the end of each week, students are individually tested on the week's work and pre-tested on the next week's work.

Evaluation Evidence

The program has been found to have lasting outcome benefits on academic competence at least three years later. Evaluation has shown that students who participate in CWPT in Grade 1 have better comprehension in that grade than students in Grade 2 who have not participated in the program. Students who participate in CWPT are also 20 – 70% more likely to stay on task, remain engaged with all lessons and respond to the teacher. The program has been used successfully with many population groups including schools with many low-income children (e.g. Greenwood, Delquadri, & Hall, 1989; Kohler & Greenwood, 1990).

Monitoring Recommendations

- At the planning stage Boards can request advice on how tutoring will be managed and monitored, as well as expected student participation rates and academic improvements.
- Boards should negotiate agreements to receive regular progress reports.
- Monitoring information should include: tutoring coordination; progress with class and student recruitment; number and length of tuition sessions; and academic progress for tutors and tutees.

Implementation Tip

CTC. Ltd. is interested in supporting Boards to innovate with trialling Classwide Peer Tutoring programs as a strategy for building relationships across different school populations that may vary in socioeconomic disadvantage. Assistance may be available with program design and evaluation tasks.

Program details

Target Audience

5 – 11 years

Target Risk Factors

- ✓ Academic failure (low academic achievement)
- ✓ Low commitment to school

Target Protective Factors

- ✓ School opportunities for prosocial involvement
- ✓ School rewards for prosocial involvement Social skills
- ✓ Social skills

Community Indicators

- ✓ Low parental education.
- ✓ School truancy
- ✓ Low income, poor housing, unemployment

Contacts

State Education Departments

W: www.deewr.gov.au

For further information on delivery strategies go to:

Reading Rockets

W: www.readingrockets.org/article/22029/

Program: The Good Behaviour Game

Description

The Good Behaviour Game (GBG) has been carefully designed to provide a feasible method for introducing a positive classroom discipline system, and is typically delivered across the first three years of primary school. Classroom disruptions in early primary school can increase aggressive peer behaviour and trigger early pathways to behaviour problems such as violence, aggression, and attention and impulsivity problems. Positive discipline practices are well known to assist in reducing behaviour problems and are more effective where they can be reinforced with positive peer support.

Evaluation Evidence

A number of randomised trials support the effectiveness of the GBG as a strategy for improving classroom management and reducing student behaviour problems. Outcomes for GBG students include reductions in rates of attention-deficit/ hyperactivity problems, oppositional defiant problems, and conduct problems relative to control classrooms (van Lier, Muthén, van der Sar, & Crijnen, 2004).

Monitoring Recommendations

- At the planning stage Boards can request advice on how the program will be managed and monitored.
- Boards should negotiate agreements to receive regular progress reports and request to observe some sessions.
- Monitoring information should include: program coordination; progress with implementing key intervention strategies; and staff and professional ratings of change in student behaviour problems.
- Where feasible, pre-post changes should be monitored against non-participating control schools.

Program details

Target Audience

Primary School: Grades 1 – 3

Target Risk Factors

- ✓ Low commitment to school
- ✓ Antisocial behaviour
- ✓ Peer rewards for antisocial involvement

Target Protective Factors

- ✓ School opportunities for prosocial involvement
- ✓ School rewards for prosocial involvement
- ✓ Social skills
- ✓ Belief in the moral order

Community Indicators

- ✓ Low parental education
- ✓ School suspension
- ✓ School truancy
- ✓ Low income, poor housing, unemployment
- ✓ Bullying

Contacts

State Education Departments

W: www.deewr.gov.au

For further information on delivery strategies go to:

W: www.interventioncentral.org

Site search: Good Behaviour Game

School social and emotional competence education

There is increasing recognition of the part that schools can play in helping children to improve their social and emotional competence, including their basic reasoning ('cognitive') skills, and their ability to share, listen to others and work co-operatively in a group. A checklist of skills derived from research studies can be found in Box B, below. As children grow older the curriculum can be broadened to include a wider range of skills, such as stress management, problem solving, setting goals, community service and citizenship, as well as strategies for resisting peer pressure to take part in under-age smoking and drinking, inappropriate and unprotected sex, drug misuse and crime.

Curricula concerned with social competence teaches specific skills that help children and young people to behave in responsible and healthy ways, and equips them with a sense of self-efficacy (the confidence that they can set themselves realistic goals and then reach them). Programs and curricula vary widely in their content and structure according to the ages of those taking part. However, there are a number of key principles that should govern the choice of suitable programs:

- **Focus on developing skills:** programs should include strategies that ensure active learning and use of the skills being taught.
- **Use effective teaching methods:** interactive teaching approaches where new skills are taught, modelled by others, practiced and where feedback and encouragement is provided.
- **Classroom tolerance:** openness and acceptance are important to encourage students to try out new skills that may seem unfamiliar, for example working co-operatively in groups or listening carefully to others. The teacher should model appropriate attitudes and ways of interacting.
- **Parent involvement:** parents should be consulted and involved before a particular curriculum is adopted, and they should be encouraged to help their children through discussion of issues raised in the classroom and to practise new skills at home.

BOX B

Social and emotional competence skills

Social competence requires an ability to adapt and integrate feelings (emotions), reasoning (cognition) and actions (behaviour) to achieve specific goals. Skills that can help children take advantage of opportunities for involvement in their families, schools and communities include:

Emotional skills

- Identifying and labelling feelings
- Managing anger and other strong feelings
- Expressing feelings
- Delaying gratification
- Controlling impulses
- Reducing stress

Cognitive skills

- Step-by-step problem solving and decision making
- Anticipating and evaluating consequences
- Coping with challenges through 'inner dialogue' and self-encouragement
- Noticing and interpreting social 'cues' (e.g. understanding the most appropriate time and approach to request help)
- Understanding other people's feelings and perspectives
- Self awareness and self-esteem (e.g. having positive but realistic expectations)

Behavioural skills

- Non-verbal communication (e.g. eye contact, voice tone etc)
- Verbal (e.g. making clear requests, resisting negative influences, responding to criticism etc.)
- Taking action (e.g. walking away from confrontation and negative influences, helping others, teamwork etc.)

Specific strategies: Reading, Tutoring, Discipline

Program: You Can Do It!

Description

You Can Do It! is designed to improve academic outcomes for late primary students by encouraging social-emotional and problem solving skills. The program aims to:

- Build the social, emotional, and motivational capacity of young people rather than focus on their problems and deficits.
- Encourage the social and emotional competence of young people by working with the strengths in their school, home and community.

You Can Do It! is included in this guidebook following recommendations from *Communities That Care* Mornington Peninsula.

Evaluation Evidence

Evidence from a number of small randomised trials shows support for this program. Studies have shown improvements in academic achievement, homework performance and academic engagement (Pina, 1996 as cited in Bernard, 2006), including specific improvements in reading and mathematics (Hudson, 1993 as cited in Bernard, 2006).

Monitoring Recommendations

- At the planning stage Boards can request advice from the developer on how the program can be managed and monitored.
- Boards should negotiate agreements to receive regular progress reports and request to observe some sessions.
- Monitoring information should include: program coordination; satisfaction with training; and progress with implementing key components.
- Where feasible, evaluate pre-post changes in student risk and protective factors and compare against randomly assigned non-participating control schools.

Implementation Tip

CTC Ltd. will be available to assist with the design and fundraising for a controlled evaluation.

Program details

Target Audience

10 – 14 years

Target Risk Factors:

- ✓ Academic failure (low academic achievement)
- ✓ Low commitment to school
- ✓ Low social skills
- ✓ Low emotional control

Target Protective Factors

- ✓ School opportunities for prosocial involvement
- ✓ School rewards for prosocial involvement
- ✓ Social skills
- ✓ Belief in the moral order

Community Indicators

- ✓ Low parental education
- ✓ Poor academic achievement in late primary school

Contact

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You Can Do It!

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W: www.youcandoit.com.au

Program: FRIENDS for Life

Description

FRIENDS for Life (FRIENDS) is a 10-session cognitive behaviour therapy program designed to prevent anxiety and depression in children and young people. The program teaches practical behavioural, physiological and cognitive strategies to identify and deal with anxiety that children and young people experience. The program also builds emotional resilience and promotes self-development. FRIENDS is effective as a treatment or as a school-based prevention course, and can be delivered by teachers in a school system.

Implementation Tip

Based on current evaluation evidence, *CTC* recommends that FRIENDS for Children be considered for implementation with Grade 6 students.

Evaluation Evidence

Evaluation evidence supports the benefits of the FRIENDS program in preventing and treating anxiety. An evaluation of the effectiveness of the program with Grade 6 students found reduced symptoms of anxiety, and increased coping skills, relative to control students (Lock & Barrett, 2003). A follow up study showed beneficial effects were maintained at 12 months, 24 months and 36 months. A Grade 9 implementation was less effective. The FRIENDS intervention is being implemented internationally and the website reports a number of favourable evaluations.

Monitoring Recommendations

- At the planning stage Boards can request advice on monitoring systems from the developer.
- Boards should negotiate agreements to receive regular progress reports and request to observe some sessions.
- Monitoring information should include: program coordination; satisfaction with the 1-day training; progress disseminating the books; components delivered in the 10 sessions; and number of parents participating.
- Require monitoring of pre-post changes on standardised measures of student anxiety and depressive symptoms, and emotional health.

Program details

Target Audience:

10 – 14 years

Target Risk Factors:

- ✓ Poor coping skills
- ✓ Antisocial behaviour
- ✓ Favourable attitudes to problem behaviour
- ✓ Interaction with antisocial peers

Target Protective Factors

- ✓ Social skills
- ✓ Emotional control

Community Indicators

- ✓ Mental health problems in children and adolescents
- ✓ Depressive symptoms in late primary school

Contact

For curriculum purchases:
Australian Academic Press

E: info@australianacademicpress.com.au
P: (07) 3257 1176
W: www.friendsinfo.net

Program: Promoting Alternate Thinking Strategies (PATHS)

Description

The PATHS curriculum provides teachers with systematic, developmentally-based lessons for teaching their students emotional literacy, self-control, social competence, positive peer relations, and interpersonal problem-solving skills. A key objective of promoting these developmental skills is to prevent or reduce behavioural and emotional problems.

The Preschool PATHS program is based on the PATHS program, and can be adapted to suit individual classroom needs. Preschool PATHS teaches children skills such as self-control, positive self-esteem, emotional awareness, social skills, basic problem-solving skills and friendships to help reduce classroom disruptions caused by bullying and other hostile behaviour.

Implementation Tip

Ideally, the PATHS Program should be initiated at the entrance to schooling, and continue through Grade 5.

Evaluation Evidence

The PATHS program has good evidence from randomised trials that it can prevent violence, aggression and other behavioural and mental health problems by promoting primary school children's social and emotional competence. The results of a randomised clinical trial of the PATHS preschool program suggested that children exposed to the intervention had higher emotional knowledge skills and were more socially competent (as rated by teachers and parents) than their peers (Domitrovich, Cortes, & Greenberg, 2007). PATHS has been field-tested and researched with children in regular education classroom settings, as well as with a variety of special needs students (deaf, hearing-impaired, learning disabled, emotionally disturbed, mildly mentally delayed, and gifted).

Monitoring Recommendations

- A standard monitoring system is available from the program developer.
- Boards should negotiate agreements to receive regular progress reports and request to observe some sessions.
- Monitoring information should include: program coordination; satisfaction with training; and components delivered.
- Request monitoring of pre-post changes on standardised child adjustment measures.

Program details

Target Audience

5 – 7 years

Target Risk Factors

- ✓ Academic failure (low academic achievement)
- ✓ Low commitment to school
- ✓ Rebelliousness
- ✓ Early initiation of problem behaviour
- ✓ Antisocial behaviour
- ✓ Favourable attitudes to problem behaviour
- ✓ Sensation seeking
- ✓ Low social skills
- ✓ Interaction with antisocial peers

Target Protective Factors

- ✓ School opportunities for prosocial involvement
- ✓ School rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ High proportion of special needs primary school students (sensory disability, emotional problems)
- ✓ School bullying
- ✓ Depressive symptoms in primary school

Contact

Mark T. Greenberg, PhD
Prevention Research Center
Pennsylvania State University

E: prevention@psu.edu
W: www.prevention.psu.edu/projects/PATHS.html

Professor Mark Greenberg has supported the development of the PATHS program in Western Australia. *CTC Ltd.* can support further Australian dissemination.

Organisational change in schools: community partnerships

Section 3.3

What can *Communities That Care* Boards do?

A number of recent commentators have noted an increase in the gap in economic and health outcomes for children and young people growing up in disadvantaged neighbourhoods and schools. Boards are in a unique position to encourage schools to develop community partnerships to reduce inequalities in education opportunities. Although students in disadvantaged schools and neighbourhoods are known to have worse health and social outcomes, there are often fewer resources in these schools to enable effective prevention responses to be implemented.

By encouraging school partnerships, Boards can encourage training and prevention service delivery opportunities to be shared across all schools to benefit more students within the local community. *CTC Ltd.* is available to support the evaluation of innovative local partnerships.

Schools serving disadvantaged and socially disorganised communities face a far harder task than those in middle-class neighbourhoods where parents and community members are committed to their children's education. Research studies of schools that work effectively with students from high-risk backgrounds suggest that the achievements of these schools is built on more than offering remedial help to individual students. The school organisation and ethos, and their links with the community, are critical to success in addressing problems such as bullying and aggressive behaviour and low school commitment, including truancy.

The benefits of adopting a 'whole school' and 'community integrated' approach to tackle school disadvantage have been increasingly recognised by education policy makers and by school leaders. The ingredients of a 'whole school' approach can be varied according, but the following areas of school life and management will need to be reviewed (Mortimer, Sammons, Stoll, Lewis, & Ecob, 1988):

- Parent and community involvement and consultation with pupils to raise standards of achievement, tackle risks and problem behaviours and increase pupil attachment to school;
- The quality of leadership provided by the head and deputy head;
- The level of involvement and commitment of teaching and non-teaching staff;
- Teaching methods, including lesson structure and ways of maintaining order in an environment that encourages learning;
- Curriculum content, including the availability of social skills training and other material relevant to reducing risks and increasing protection;
- Discipline policy to ensure that rules are fair and supported by appropriate sanctions that are consistently applied;
- The school environment, including the design of playgrounds, and other facilities that may contribute to anti-social behaviour; and
- Administration, including adequate record keeping to ensure that risk factors like low achievement or unauthorised absence are tackled as early as possible.

Efforts to enhance school-parent and teacher-student relationships and reduce negative school peer interactions appear to be important in reducing the translation of early developmental risk into pathways of social marginalisation through early primary school.

Specific strategies: Organisational change in schools

Program: Friendly Schools and Families/Friendly Schools Plus

Description

Friendly School and Families is a whole-school bullying prevention program that incorporates evidence-based strategies to manage and prevent bullying in schools. The program provides resources to build school capacity to systematically respond to bullying, and provides strategies to parents, teachers, and students to effectively prevent and manage bullying.

Friendly Schools Plus extends and updates the Friendly Schools and Families program, incorporating an additional 6 years of research into best-practice bullying prevention processes. Friendly Schools Plus incorporates evidence-based strategies to deal with cyber-bullying in schools.

Evaluation Evidence

A three year effectiveness trial called Friendly Schools Friendly Families demonstrated positive outcomes for students exposed to the intervention. These students experienced a significant reduction in bullying behaviour, greater feelings of safety and happiness at school and an increase in social skills relative to the students in schools that did not receive the program (Cross et al., 2010).

Monitoring Recommendations

- An outline of a monitoring system is available from the program developer (details of monitoring will differ between schools).
- Boards should negotiate agreements to receive regular progress reports and request to observe some activities.
- Monitoring information should include: program coordination; satisfaction with training; list of components selected for delivery; trends in bullying; and relevant standardised child behaviour and adjustment measures.

Program details

Target Audience

6 – 14 years

Target Risk Factors

- ✓ Low commitment to school
- ✓ Antisocial behaviour
- ✓ Favourable attitudes to problem behaviour
- ✓ Low social skills
- ✓ Interaction with antisocial peers

Target Protective Factors

- ✓ School and family attachment
- ✓ School and family opportunities for prosocial involvement
- ✓ School and family rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ School bullying

Contact

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Program: The Gatehouse Project

Description

The Gatehouse Project is a school-based intervention designed to build the capacity of school communities to address the emotional and mental health needs of young people. The program includes classroom and whole-school components, providing strategies to increase students' connectedness with the school, and increase students' skills and knowledge for dealing with the challenges of daily life.

Evaluation Evidence

A rigorous evaluation of the Gatehouse strategy utilising random assignment of schools has been completed. Random assignment of schools to the program was associated with reductions in adolescent drug use (Bond et al., 2004), antisocial behaviour and risky sexual behaviour (Patton et al., 2006). The intervention is currently being disseminated and evaluated in Canada.

Monitoring Recommendations

- Boards may need to employ a consultant to assist with developing monitoring and implementation plans.
- Boards should negotiate agreements to receive regular progress reports and request to observe some activities.
- Monitoring information should include: program coordination; training plans and delivery; and implementation of selected components.
- Request pre-post monitoring of trends in risk and protective factors, and compare to control schools where feasible.

Implementation Tip

CTC Ltd. is interested in supporting Australian training events.

Program details

Target Audience

11 – 14 years

Target Risk Factors

- ✓ Low commitment to school
- ✓ Favourable attitudes to problem behaviour
- ✓ Poor emotional control
- ✓ Low social skills
- ✓ Interaction with antisocial peers
- ✓ Friends' use of drugs

Target Protective Factors

- ✓ School opportunities for prosocial involvement
- ✓ School rewards for prosocial involvement
- ✓ Social skills
- ✓ Emotional control

Community Indicators

- ✓ School disorganisation
- ✓ Antisocial behaviour
- ✓ Indicators of sexual risk taking behaviour
- ✓ School bullying
- ✓ Problems elevating in the high school years

Contact

For information on currently available Australian expertise, contact:

Andrea Krelle
Centre for Adolescent Health

E: andrea.krelle@unimelb.edu.au
W: www.rch.org.au/gatehouseproject

Section 3.4 School drug and health education curricula

Literature reviews on drug education in schools have reported similar findings on the factors that maximise the effectiveness of programs in preventing or delaying the onset of drug use, and reducing drug use (Lloyd, Joyce, Hurry, & Ashton, 2000; Loxley et al., 2004; Midford, Lenton, & Hancock, 2000; Midford, Snow, & Lenton, 2001; White & Pitts, 1998).

The more successful approaches to drug education are grounded in the theory of what is known about the causes of adolescent drug use, as well as their developmental pathways in relation to drug abuse and in the psychological theoretical frameworks of social learning and problem behaviour. Those considering developing drug education programs should be careful to base them on what is known rather than what seems intuitive or ideologically sound. Poorly conceptualised programs have historically been ineffective or, worse still, harmful.

To be effective drug education programs in schools should:

- Be research-based/theory-driven
- Be part of an integrated health and socioemotional education curriculum
- Incorporate broader social and emotional skills training from primary school
- Deliver coherent and consistent messages and relevant skills
- Present balanced information that fits children's developmental stage
- Provide resistance skills training from late primary school
- Incorporate normative education in secondary school
- Educate before behavioural patterns are established
- Address values, attitudes and behaviours of the individual and community
- Address the interrelationship between individuals, social context and drug use
- Focus on prevalent and harmful drug use (e.g., alcohol rather than a low prevalence illicit drug)
- Be cautious when using peer leadership
- Be delivered within an overall framework of harm minimisation
- Employ interactive teaching approaches
- Ensure optimal training and support for teachers
- Provide adequate initial coverage and continued follow up in booster sessions
- Be sensitive to cultural characteristics of the target audience
- Incorporate additional family, community, media and special population components
- Ensure fidelity of implementation and evaluation

The explanation of these factors and the papers from which they derive are presented in the review by Midford, Snow and Lenton (2001).

What can *Communities That Care* Boards do?

Boards can coordinate fundraising and local training events in order to support school staff to develop relevant resources and expertise. For advice and assistance with evidence-based school alcohol and drug education go to www.adf.org.au.

Specific strategies: School alcohol education

Program: The School Health and Alcohol Harm Reduction Project (SHAHRP)

Description

The School Health and Alcohol Harm Reduction Project (SHAHRP) is an evidence based classroom curriculum designed to reduce alcohol related harm among secondary school students. The key focus of the program is on the development of utility knowledge and harm reduction skills and strategies.

The SHAHRP lessons are conducted in three phases with eight lessons in the first year of the program, five booster lessons in the following year during phase two and four additional booster lessons in phase three, two years later. Student workbooks, a teacher manual and teacher training support the delivery of the SHAHRP lessons.

Evaluation Evidence

The SHAHRP study evaluated the program in a true experimental design with schools randomly assigned to intervention or control conditions. Over the period of the study (from baseline to final follow-up 32 months later), students who participated in SHAHRP had greater alcohol related knowledge, consumed less alcohol and were less likely to drink to harmful or hazardous levels, and experienced less harm associated with their own use of alcohol and less harm associated with other peoples use of alcohol, than students who participated in other alcohol education programs. These behavioural effects were maintained and/or increased up to one year after the final phase of the program.

Monitoring Recommendations

- Monitoring and implementation advice is available from the program developers.
- Boards should negotiate agreements to receive regular progress reports and request to observe some activities.
- Monitoring information should include: program coordination; training delivery; and implementation of curricula.
- Request pre-post monitoring of trends in student risk and protective factors, and compare to control schools where feasible.

Program details

Target Audience:

11 – 14 years

Target Risk Factors:

- ✓ Favourable parent attitudes to problem behaviour
- ✓ Favourable attitudes to problem behaviour
- ✓ Low social skills
- ✓ Friends' use of drugs

Target Protective Factors

- ✓ Social skills

Community Indicators

- ✓ Low utilisation of alcohol harm minimisation strategies and skills
- ✓ High rates of youth alcohol misuse
- ✓ Problems elevating in the high school years

Contact

For information on program training, or to order SHAHRP materials, contact the National Drug and Research Institute (NDRI) Secretary

E: ndri@curtin.edu.au

W: http://ndri.curtin.edu.au/research/shahrp/ordering.cfm

Community focussed programs

The community is the context in which families raise their children, and in which young people grow up. Aspects of the community (e.g. adults in the community; sport, recreation and community service organisations; recreation and entertainment opportunities) can increase the risks in children and young people's lives, or can work hand-in-hand with families, schools and youth work organisations to help create a web of protection.

As young people move into late childhood and adolescence, their world expands beyond the family and school, and the wider community becomes a potentially powerful source of support for them. Successful community-based programs increase the level of protection for young people and encourage pro-social behaviour by:

- Providing them with opportunities for pro-social involvement;
- Equipping them with the skills they need to participate successfully; and
- Offering recognition and due praise for their efforts, progress and success.

Community-based activities can complement the work of schools in helping young people to understand the 'rights and responsibilities' of citizenship. Specialist programs can also offer support to young people whose early involvement in crime and drugs places them at risk of chronic difficulties by the time they reach young adulthood. Young people who leave school with few or no qualifications will be at heightened risk of unemployment and social exclusion without further education, training and work experience provided in the community.

Section 4.1

4.1 Regenerating communities

Children and young people are more likely to be affected by the neighbourhood in which they live than other age groups because they spend more time close to home. They are disproportionately victims of crime and antisocial behaviour, as well as perpetrators. Yet attempts to regenerate the most disadvantaged communities in the past 20 years have tended to focus on physical conditions, with few resources devoted to young people. In many cases, the only direct benefit to children has been through play areas and other environmental improvements. The concentrations of children living in socially disadvantaged communities have, meanwhile, increased (Mitchell et al., 2001). This makes it more important than ever that local people and agencies should be willing and able to mobilise, and work together, to raise the quality of children and young people's lives.

Program: Communities for Children

Description

Communities for Children (CfC) is a strategy that encourages healthy community environments for disadvantaged children. It is an initiative of the Federal Government Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and is part of the Family Support Program.

A key local non-government organisation (Facilitating Partner) in each site acts as broker in engaging smaller local organisations to deliver a range of activities in their communities. The Facilitating Partner oversees the development, implementation and funding allocations for activities and strategies in the community. Funding is mostly allocated to local service providers who deliver the activities.

Examples of activities being implemented under CfC are:

- home visiting
- early learning and literacy programs
- early development of social and communication skills
- parenting and family support programs
- child nutrition
- community events to celebrate the importance of children, families and the early years

Evaluation Evidence

An evaluation of the early impacts of the CfC program on child, family and community outcomes (Edwards et al., 2011) found evidence that CfC had positive preliminary impacts including:

- fewer children were living in a jobless household
- parents reported less hostile or harsh parenting practices
- parents considered themselves to be more effective in their roles as parents

Monitoring Recommendations

- Boards can monitor change over time by examining trends in publically available data such as the Australian Early Development Index.

Implementation Tip

Access to the Communities for Children intervention is at the discretion of FaHCSIA. Boards can propose, and advocate for, disadvantaged neighbourhoods that may benefit by being included in the initiative.

Program details

Target Audience

Pre-natal – 2 years

Target Risk Factors

- ✓ Low neighbourhood attachment
- ✓ Community disorganisation
- ✓ Community transitions & mobility
- ✓ Personal transitions & mobility
- ✓ Laws and norms favourable to drug use
- ✓ Family conflict
- ✓ Family history of antisocial behaviour
- ✓ Favourable parental attitudes to the problem behaviour

Target Protective Factors

- ✓ Community opportunities for prosocial involvement
- ✓ Community rewards for prosocial involvement
- ✓ Social skills

Community Indicators

- ✓ Low income, poor housing, unemployment
- ✓ Teenage mothers, sole parents
- ✓ Lack of successful community coalitions
- ✓ High rates of early developmental risk factors

Contact

Federal Department of Families, Housing, Community Services and Indigenous Affairs

E: fahcsiafeedback@fahcsia.gov.au
P: 1300 653 227

Communities for Children

W: www.communitiesforchildren.com.au

Section 4.2 Reducing access to alcohol and tobacco

Access to tobacco

Legislation restricting tobacco sales to adolescents has been in place since the early part of this century. There is considerable evidence that such legislation has not had high adherence in Australia, however growing evidence suggests that it is possible to influence individual retailers around sales of cigarettes to young people.

Interventions that may be used to ensure enforcement of legislation include media campaigns to inform shopkeepers and their communities of the law, mobilising community support, introducing rewards for compliance, penalties for non-compliance, and compliance checks with feedback to store proprietors about sales to young people. A strategy to improve retailer compliance around tobacco sales legislation is included in this guidebook.

Access to alcohol

Despite legal age restrictions on alcohol sales, young people often have little difficulty purchasing alcohol. Evidence shows that it is possible to reduce alcohol sales to underage youth using interventions that ensure enforcement of legislation. Such interventions include media campaigns to inform alcohol retailers and communities of the law, mobilising community support, introducing rewards for compliance, penalties for non-compliance and compliance checks with feedback to alcohol retailers about sales to young people. This guidebook includes a compliance strategy to reduce alcohol sales to minors.

Program: Reducing access to tobacco for young people under age 18

Description

Compliance checks and enforcement of legislation banning sales to young people under age 18 can reduce smoking prevalence in this group. Compliance checks involve a young person that appears to be under the legal age seeking to purchase tobacco products from a retailer. Retailers that comply with current legislation by refusing to sell tobacco receive a letter advising of the monitoring program and its outcome. Retailers that fail to comply can receive a warning letter or penalty. In general, penalties are increased for second and subsequent offences.

Evaluation Evidence

Evidence suggests that it is possible to reduce tobacco use in young people through the application of a combination of regulatory, early-intervention and harm-reduction approaches. A Cochrane Review of interventions to reduce tobacco sales to minors found evidence to support compliance checks and enforcement of legislation as effective strategies for restricting tobacco access for minors (Stead & Lancaster, 2005). A Sydney study which sent retailers a warning letter threatening prosecution if they failed to comply with legislation resulted in a second offence rate of 31% compared to 60% amongst retailers who had not been warned.

Monitoring Recommendations

Variations of this strategy currently operate in each state, coordinated through the state health departments. Boards that have evidence that tobacco is being sold to minors can apply to work with their relevant state authorities to implement increase tobacco sales monitoring.

Program details

Target Audience:

11 – 17 years

Target Risk Factors:

- ✓ Community disorganisation
- ✓ Perceived availability of drugs (tobacco)
- ✓ Laws and norms favourable to drug use

Community Indicators

- ✓ Tobacco sales to young people under age 18
- ✓ High rates of youth tobacco use

Contact

VIC: QUIT Victoria
P: (03) 9663 7777

QLD: Queensland Health Call Centre
P: 13 74 68

WA: Tobacco Control Branch, DoH
P: 1300 784 892

NSW: Tobacco Information Line
P: 1800 357 412

TAS: QUIT Tasmania
P: (03) 6228 2921

ACT: Cancer Council ACT
P: (02) 6257 9999

SA: Tobacco Surveillance, DoH
P: 1300 363 703

NT: SmokeFreeNT, DoH
P: 1800 888 564

Program: Reducing access to alcohol for young people under age 18

Description

A research partnership between Deakin University and *CTC Ltd.* is developing and testing an intervention to check retailer compliance with minimum age laws for alcohol sales. Purchase attempts are monitored for a young person who looks to be under the legal age for alcohol purchase. Retailers receive information about the purchase attempt and the law.

This strategy is supported through media stories and public information. In subsequent years the strategy may be expanded to discourage other community practices that increase the availability to minors including secondary supply (adults buying and providing alcohol to minors), and the promotion of child-friendly alcohol products such as the discounting of alcopops (premixed sweetened alcohol products).

Evaluation Evidence

Evidence shows that enforcement of liquor laws can increase compliance with minimum age laws. A US intervention to increase retailer compliance with underage sales laws used a strategy of compliance checks coupled with media advocacy to deter retailers from selling alcohol to minors (Scribner & Cohen, 2001). The evaluation found substantial gains in compliance (51%) among retailers who were issued with citations for failing compliance checks, as well as gains in compliance for those who had not been cited (35%).

Monitoring Recommendations

- *CTC Ltd.* is currently introducing a monitoring program.
- Boards can apply to participate in the monitoring program to receive information on the number of test purchase visits conducted in their locality and the outcomes.
- The effectiveness of the strategy can be evaluated by monitoring youth reports of supply sources for underage alcohol use.

Program details

Target Age

11 – 17 years

Target Risk Factors

- ✓ Community disorganisation
- ✓ Perceived availability of drugs (alcohol)
- ✓ Laws and norms favourable to drug use

Community Indicators

- ✓ Alcohol sales to young people under age 18
- ✓ High rates of youth alcohol use

Contact

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Social marketing and community mobilisation

In the US, efforts have been made to reduce rates of youth alcohol use and alcohol-related harm using a range of community mobilisation strategies that typically include social marketing as a central component. In some cases programs have attempted to prevent children starting to use alcohol by exposing them to school-based drug education, while also attempting to encourage less favourable community attitudes to youth alcohol use, and make it more difficult for young people to obtain alcohol.

Currently in Australia, children have high rates of alcohol use, and community attitudes tend to be tolerant toward youth using alcohol prior to age 18 (Beyers, Toumbourou, Catalano, Arthur, & Hawkins, 2004). Parental supply of alcohol to children is a prevalent risk factor for increased levels of adolescent binge drinking (McMorris, Catalano, Kim, Toumbourou, & Hemphill, 2011). A considerable amount of work is required in Australian communities to change these tolerant family and community attitudes.

Program: Social marketing and community mobilisation to reduce alcohol-related harms

Description

A new social marketing intervention is being developed and trialled in a partnership between Deakin University and *CTC Ltd.* The intervention has been designed using an evidence-based behaviour change approach called the Theory of Planned Behaviour. The social marketing intervention focuses on alerting parents and adolescents to the NHMRC (2009) guidelines for safe alcohol use, and seeks to convince parents and adolescents to set agreements that adults will not supply alcohol to underage youth.

Evaluation Evidence

Evidence from community mobilisation interventions suggest that multi-level, targeted prevention programs are effective at reducing adolescent alcohol use. In the US, Project Northland combined community-wide taskforce education with peer leadership and parental involvement/education to achieve a small but significant reduction in weekly adolescent alcohol use in those exposed to the intervention, compared to the control group. Australian programs have also achieved success in reducing alcohol-related harm through a combination of community mobilisation (evident through increased media activity, the formation of coalitions and groups, and increased community awareness and concern for alcohol-related harm) and social marketing strategies (Cooper, Midford, Jaeger, & Hall, 2001; Midford & Boots, 1999).

Monitoring Recommendations

- Monitoring information should include: the local dissemination of social marketing materials; consumer recognition and reactions; improvements over time compared to controls communities in targeted risk and protective factors and alcohol behaviours.

Conflict of Interest Note

John Toumbourou wrote this review and led the Deakin program development.

Program details

Target Audience:

11 – 17 years

Target Risk Factors:

- ✓ Community disorganisation
- ✓ Perceived availability of drugs (alcohol)
- ✓ Laws and norms favourable to drug use
- ✓ Parental attitudes favourable to problem behaviour
- ✓ Favourable attitudes to alcohol use

Target Protective Factors

- ✓ Community attachment
- ✓ Community opportunities for prosocial involvement
- ✓ Community rewards for prosocial involvement

Community Indicators

- ✓ High rates on indicators of youth alcohol-related harm
- ✓ High rates of alcohol misuse

Contact

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Mentoring programs

Mentoring programs are a way of providing young people in difficulties with adult role models who offer friendship, support and reinforcement as they seek to make positive changes in their lives; for example, by attending school regularly, taking part in further education or training and avoiding criminal activity.

Mentoring programs can involve trained volunteers from the community, or paid professionals. They may be adults or (slightly older) peers. Usually mentors meet regularly with the young person they are mentoring and help them to develop social skills and positive attitudes. However, research suggests that mentoring programs are unlikely to be effective in promoting change if they only rely on building a supportive relationship. In particular, there need to be clear and specific targets for behaviour (including attendance at meetings) and a system of rewards and sanctions (contingencies) for meeting them.

Program: Big Brothers/Big Sisters

Description

Big Brothers/Big Sisters (BBBS) is an established organisation, in Australia, Canada and the United States, that provides mentoring support to vulnerable young people.

The community-based BBBS program matches a young person (Little) with an older volunteer (Big) who provides guidance and friendship with the aim of becoming a long-term positive role model. Bigs and Littles take part in shared-interest activities, however the emphasis is on the development of a friendship rather than on the activity. The program is flexible to meet the needs and availability of the young people and their mentors.

Evaluation Evidence

A 2009 Australian study (Moodie & Fisher) Australian study found that BBBS represents 'excellent value for money', as the program has the potential to provide long term savings related to modest reductions in the prevalence rates of high risk behaviours. Other studies have also reported positive outcomes for participants of the program. Tierney et al. (1995) found young people involved in the program were less likely to skip school or begin using illegal drugs and alcohol, and were more confident in their school work, and reported better relationships with their families.

Monitoring Recommendations

- Boards should negotiate agreements to receive regular progress reports.
- Monitoring information should include: training activity; the number of mentor - mentee relationships; and the amount of mentor - mentee activity.
- Boards should request information on improvements to targeted risk and protective factors, and target behaviours over time compared to control communities.

Program details

Target Age

7 – 17 years

Target Risk Factors:

- ✓ Low neighbourhood attachment
- ✓ Community disorganisation
- ✓ Person transitions and mobility
- ✓ Community transitions and mobility
- ✓ Poor family management and discipline
- ✓ Family history of antisocial behaviour
- ✓ Parental attitudes favourable to the problem behaviour
- ✓ Family conflict
- ✓ Rebelliousness
- ✓ Antisocial behaviour
- ✓ Favourable attitudes to the problem behaviour
- ✓ Sensation seeking
- ✓ Interaction with antisocial peers
- ✓ Friends' drug use

Target Protective Factors

- ✓ Community opportunities for prosocial involvement
- ✓ Community rewards for prosocial involvement
- ✓ Social skills
- ✓ Belief in the moral order

Community Indicators

- ✓ Low income, unemployment
- ✓ Sole parent, family breakdown

Contact

Big Brothers Big Sisters of Australia Ltd.

E: admin@bbbs.org.au
P: (03) 9526 8409
W: www.bigbrothersbigsisters.com.au

Programs-at-a-glance

Program	Risk Factors Addressed	Protective Factors Addressed	Age Range	Page
Family Focus				
Family Support Using Home Visitors	• Community disorganisation • Community transitions and mobility • Personal transitions and mobility • Poor family management • Poor family discipline • Family conflict • Family history of antisocial behaviour • Favourable parental attitudes to problem behaviour	• Community attachment • Community and family opportunities for prosocial involvement • Community and family rewards for prosocial involvement • Social skills	Pre-natal to 2 years	p. 12
Triple P – Positive Parenting Program	• Poor family management • Poor family discipline • Family conflict • Antisocial behaviour • Early initiation of problem behaviour • Interaction with antisocial peers	• Family attachment • Family opportunities for prosocial involvement • Family rewards for prosocial involvement • Social skills	0 – 10 years	p. 14
Families and Schools Together	• Low neighbourhood attachment • Community transitions and mobility • Personal transitions and mobility • Community disorganisation • Poor family management and discipline • Family history of antisocial behaviour • Parental attitudes favourable to problem behaviour • Family conflict • Low commitment to school • Low social skills • Early initiation of problem behaviour • Interaction with antisocial peers • Friends' use of drugs	• School, family and community opportunities for prosocial involvement • School, family and community rewards for prosocial behaviour • Social skills • Belief in moral order	6 – 14 Years	p. 15
The Strengthening Families Program 10 – 14	• Low neighbourhood attachment • Community transitions and mobility • Personal transitions and mobility • Community disorganisation • Poor family management • Poor family discipline • Family conflict • Low social skills	• Family attachment • Family opportunities for prosocial involvement • Family rewards for prosocial involvement • Social skills	10 – 14 years	p. 16

Program	Risk Factors Addressed	Protective Factors Addressed	Age Range	Page
Resilient Families / Parenting Adolescents: A Creative Experience (PACE)	• Poor family management • Poor family discipline • Family conflict • Parental attitudes favourable to problem behaviour • Low commitment to school • Low family attachment	• Family attachment • Family opportunities for prosocial involvement • Family rewards for prosocial involvement • Social skills	11 – 14 years	p. 17
Behaviour Exchange Systems Training PLUS (BEST PLUS)	• Low neighbourhood attachment • Poor family management • Poor family discipline • Parental attitudes favourable to problem behaviour • Family conflict • Rebelliousness	• Family attachment • Family opportunities for prosocial involvement • Family rewards for prosocial involvement	11 – 18 years	p. 19
School Focus				
Reading Recovery	• Academic failure (low academic achievement) • Low commitment to school	• School opportunities and rewards for prosocial involvement • Social skills	5 – 7 years	p. 22
Classwide Peer Tutoring	• Academic failure (low academic achievement) • Low commitment to school	• School opportunities and rewards for prosocial involvement • Social skills	5 – 11 years	p. 23
The Good Behaviour Game	• Antisocial behaviour • Low commitment to school • Peer rewards for antisocial involvement • Bullying	• School opportunities and rewards for prosocial involvement • Social skills • Belief in the moral order	5 – 7 years	p. 24
You Can Do It!	• Academic failure (low academic achievement) • Low commitment to school • Low social skills • Low emotional competence	• School opportunities and rewards for prosocial involvement • Social skills • Belief in the moral order	10 – 14 years	p. 26
FRIENDS for Life	• Poor coping skills • Antisocial behaviour • Favourable attitudes to problem behaviour • Interaction with antisocial peers	• Social skills • Emotional control	10 – 14 years	p. 27
Promoting Alternate Thinking Strategies (PATHS)	• Academic failure (low academic achievement) • Low commitment to school • Rebelliousness • Early initiation of problem behaviour • Antisocial behaviour • Favourable attitudes to problem behaviour • Sensation seeking • Low social skills • Interaction with antisocial peers	• School opportunities and rewards for prosocial involvement • Social skills	5 – 7 years	p. 28

Program	Risk Factors Addressed	Protective Factors Addressed	Age Range	Page
Friendly Schools and Families / Friendly Schools Plus	• Low commitment to school • Antisocial behaviour • Favourable attitudes to problem behaviour • Low social skills • Interaction with antisocial peers	• Family attachment • School and family opportunities for prosocial involvement • School and family rewards for prosocial involvement • Social skills	6 – 14 years	p. 30
The Gatehouse Project	• Low commitment to school • Favourable attitudes to problem behaviour • Poor emotional control • Low social skills • Interaction with antisocial peers • Friends' use of drugs	• School opportunities for prosocial involvement • School rewards for prosocial involvement • Social skills • Emotional control	11 – 14 years	p. 31
The School Health and Alcohol Harm Reduction Project (SHAHRP)	• Favourable parent attitudes to problem behaviour • Favourable attitudes to problem behaviour • Low social skills • Friends' use of drugs	• Social skills	11 – 14 years	p. 33
Community Focus				
Communities for Children	• Low neighbourhood attachment • Community disorganisation • Community transitions and mobility • Personal transitions and mobility • Laws and norms favourable to drug use • Family conflict • Family history of antisocial behaviour • Parental attitudes favourable to problem behaviour	• Community opportunities for prosocial involvement • Community rewards for prosocial involvement • Social skills	Prenatal to 2 years	p. 35
Reducing access to tobacco for young people under age 18	• Community disorganisation • Perceived availability of drugs (tobacco) • Laws and norms favourable to drug use		11 – 17 years	p. 37
Reducing access to alcohol for young people under age 18	• Community disorganisation • Perceived availability of drugs (alcohol) • Laws and norms favourable to drug use		11 – 17 years	p. 38
Social marketing and community mobilisation to reduce alcohol-related harms	• Community disorganisation • Perceived availability of drugs (alcohol) • Laws and norms favourable to drug use • Parental attitudes favourable to problem behaviour • Favourable attitudes to alcohol use • Interaction with antisocial peers	• Community opportunities for prosocial involvement • Community rewards for prosocial involvement • Community attachment	11 – 17 years	p. 40
Big Brothers/Big Sisters	• Low neighbourhood attachment • Community disorganisation • Community transitions and mobility • Personal transitions and mobility • Poor family management & discipline • Family history of antisocial behaviour • Family conflict • Antisocial behaviour • Favourable attitudes to problem behaviour • Sensation seeking • Interaction with antisocial peers • Friends' drug use	• Community opportunities for prosocial involvement • Community rewards for prosocial involvement • Social skills • Belief in the moral order	7 – 17 years	p. 42

5.1 Index of programs by risk & protective factors

Risk and Protective Factors	Family Support using Home Visitors	Communities for Children	Triple P - Positive Parenting Program	Reading Recovery	Promoting Alternate Thinking Strategies (PATHS)	The Good Behaviour Game	Classwide Peer Tutoring	Families and Schools Together (FAST)
	Developmental Stage							
	Pre-natal - 2 years	Pre-natal - 2 years	0 - 10 years	5 - 7 years	5 - 7 years	5 - 7 years	5 - 11 years	6 - 14 years
Community								
Low neighbourhood attachment	✔	✔						✔
Community disorganisation	✔	✔						✔
Personal transitions & mobility	✔	✔						✔
Community transitions & mobility	✔	✔						✔
Laws & norms favourable to drug use		✔						
Perceived availability of drugs								
*Opportunities for prosocial involvement	✔	✔						✔
*Rewards for prosocial involvement	✔	✔						✔
Family								
Poor family management	✔		✔					✔
Poor family discipline	✔		✔					✔
Family conflict	✔	✔	✔					✔
Family history of antisocial behaviour	✔	✔						✔
Parental attitudes favourable to drug use	✔	✔						✔
Parental attitudes favourable to antisocial behaviour	✔	✔						✔
*Attachment			✔					
*Opportunities for prosocial involvement	✔		✔					✔
*Rewards for prosocial involvement	✔		✔					✔
School								
School failure (low academic achievement)				✔	✔		✔	
Low commitment to school				✔	✔	✔	✔	✔
*Opportunities for prosocial involvement				✔	✔	✔	✔	✔
*Rewards for prosocial involvement				✔	✔	✔	✔	✔
Peer/Individual								
Rebelliousness					✔			
Early initiation of problem behaviour			✔		✔			✔
Impulsiveness								
Antisocial behaviour			✔		✔	✔		
Favourable attitudes toward antisocial behaviour					✔			
Favourable attitudes toward drug use					✔			
Perceived risks of drug use								
Interaction with antisocial peers			✔		✔			✔
Friends' use of drugs								✔
Sensation seeking					✔			
Rewards for antisocial involvement						✔		
*Social skills	✔	✔	✔	✔	✔	✔	✔	✔
*Belief in moral order						✔		✔
*Emotional control								

Friendly Schools and Families	Big Brothers/ Big Sisters	FRIENDS for Life	The Strength-ening Families Program	You Can Do It!	Resilient Families/ PACE	The School Health and Alcohol Harm Reduction Project	The Gatehouse Project	Behaviour Exchange Systems Training (BEST PLUS)	Reducing Access to Tobacco for Young People Under 18	Reducing Access to Alcohol for Young People Under 18	Social Marketing and Community Mobilisation to Reduce Alcohol-Related Harms
Developmental Stage											
6 - 14 years	7 - 17 years	10 - 14 years	10 - 14 years	10 - 14 years	11 - 14 years	11 - 14 years	11 - 14 years	11 - 17 years	11 - 17 years	11 - 17 years	11 - 17 years
	✔		✔					✔			
	✔		✔						✔	✔	✔
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Additional Resources

Australian resources

Mental Health and Wellbeing Resources Programs and Research (MindMatters Plus)

This website provides an index of programs, resources, research and case studies that support the mental health and wellbeing of young people. The index was created by the Australian research and development project known as MindMatters Plus, funded by the Commonwealth Department of Health and Ageing.

Weblink: www.mhws.agca.com.au/mmppi_search.php

Department of Education and Early Childhood Development (Vic) – Catalogue of Evidence

The catalogue of evidence is organised around key sections that contain indicators of improvement in outcomes for children and adolescents, including behavioural difficulties, substance use and underage convictions. Each indicator has up to four recommended strategies (including evidence for each) that can be implemented and adapted to local needs.

Weblink (early childhood): www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/sections/default.htm

Weblink (adolescents): http://www.education.vic.gov.au/healthwellbeing/childyouth/catalogue/adolescent/default.htm

International resources

OJJDP Model Programs Guide

The Office of Juvenile Justice and Delinquency Prevention (OJJDP), Office of Justice Programs, US Department of Justice has a focus on assisting communities with evidence-based prevention and intervention programs. The OJJDP website offers a searchable database of evidence-based programs rated according to four summary dimensions of program effectiveness:

- conceptual framework of the program
- program fidelity
- evaluation design
- empirical evidence demonstrating the prevention or reduction of problem behaviour, the reduction of risk factors or the enhancement of protective factors.

Weblink: www.ojjdp.gov/mpg

SAMHSA National Registry of Evidence-based Programs and Practices (NREPP)

The Substance Abuse and Mental Health Services Administration (US Department of Health and Human Services) NREPP is a searchable database of interventions for the prevention and treatment of mental and substance use disorders, including youth violence and antisocial behaviour.

Weblink: http://nrepp.samhsa.gov

References

Bernard, M. E. (2006). It's time we teach social-emotional competence as well as we teach academic competence. *Reading & Writing Quarterly, 22*, 103-119.

Beyers, J. M., Toumbourou, J. W., Catalano, R. F., Arthur, M., & Hawkins, J. D. (2004). A cross-national comparison of risk and protective factors for adolescent substance use: The United States and Australia. *Journal of Adolescent Health, 35* (1), 3-16.

Bodenmann, G., Cina, A., Ledermann, T., & Sanders, M. R. (2008). The efficacy of the Triple P-Positive Parenting Program in improving parenting and child behavior: a comparison with two other treatment conditions. *Behaviour Research And Therapy, 46*(4), 411-427.

Bond, L., Patton, G., Glover, S., Carlin, J. B., Butler, H., Thomas, L., et al. (2004). The Gatehouse Project: can a multi-level school intervention affect emotional wellbeing and health risk behaviours? . *Journal Epidemiology and Community Health, 58*, 997-1000.

Botvin, G. J., Baker, E., Filazzola, A. D., & Botvin, E. M. (1990). A cognitive-behavioural approach to substance Abuse prevention: One year follow-up. *Addictive Behaviours, 15*, 47-63.

Cahir, S., Davies, L., Deany, P., Tange, C., Toumbourou, J., Williams, J., et al. (2003). *Introducing Communities That Care*. Melbourne: Communities That Care Ltd.

Cooper, M., Midford, R., Jaeger, J., & Hall, C. (2001). *Partysafe Evaluation Report*. Perth: National Drug Research Institute, Curtin University of Technology.

Coote, S. (2000). *Families and Schools Together (FAST)*. Paper presented at the Australian Institute of Criminology Conference - Reducing Criminality: Partnership and Best Practice. Retrieved from http://www.aic.gov.au/conferences/criminality/coote.pdf

Cross, D., Monks, H., Hall, M., Shaw, T., Pintabona, Y., Erceg, E., et al. (2010). Three year results of the Friendly Schools whole-of-school intervention on children's bullying behaviour. *British Educational Research Journal. 24 February 2010 (iFirst). 37*(1), 105-129.

Domitrovich, C. E., Cortes, R. C., & Greenberg, M. T. (2007). Improving young children's social and emotional competence: A randomized trial of the preschool "PATHS" curriculum. *The Journal of Primary Prevention, 28*(2), 67-90.

Edwards, B., Gray, M., Wise, S., Hayes, A., Katz, I., Muir, K., et al. (2011). Early impacts of Communities for Children on children and families: findings from a quasi-experimental cohort study. *Journal of Epidemiology and Community Health, 65*(10), 909-914.

Fischer, R. L. (2003). School-based family support: evidence from an exploratory field study. *Families in Society, 84*(3), 339-347.

Foxcroft, D., Ireland, D., Lowe, G., & Breen, R. (2002). Primary prevention for alcohol misuse in young people. *Cochrane Database of Systematic Reviews, 2002*(3), Article CD003024.

Greenwood, C., Delquadri, J., & Hall, R. (1989). Longitudinal effects of Classwide Peer Tutoring. *Journal of Educational Psychology, 81*, 371-384.

Hurry, J. (1996). What is so special about Reading Recovery? *Curriculum Journal, 7*(1), 93-108.

Jenkin, C., & Bretherton, D. (1994). *PACE Parenting Adolescents: A Creative Experience.* Camberwell, Australia: The Australian Council for Educational Research.

Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., et al. (2011). Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Archives of Disease in Childhood, 96*(6), 533-540.

Kohler, F., & Greenwood, C. (1990). Effects of collateral peer supportive behaviours within the Classwide Peer Tutoring Program. *Journal of Applied Behavior Analysis, 23*(3), 307-322.

Kratochwill, T. R., McDonald, L., Levin, J. R., Young Bear-Tibbetts, H., & Demaray, M. K. (2004). Families and Schools Together: an experimental analysis of a parent-mediated multi-family group program for American Indian children. *Journal of School Psychology, 42*(5), 359-383.

Lloyd, C., Joyce, R., Hurry, J., & Ashton, M. (2000). The effectiveness of primary school drug education. *Drugs: Education, Prevention and Policy, 7*(2,), 109-126.

Bernard, M. E. (2006). It's time we teach social-emotional competence as well as we teach academic competence. *Reading & Writing Quarterly, 22*, 103-119.

Beyers, J. M., Toumbourou, J. W., Catalano, R. F., Arthur, M., & Hawkins, J. D. (2004). A cross-national comparison of risk and protective factors for adolescent substance use: The United States and Australia. *Journal of Adolescent Health, 35* (1), 3-16.

Bodenmann, G., Cina, A., Ledermann, T., & Sanders, M. R. (2008). The efficacy of the Triple P-Positive Parenting Program in improving parenting and child behavior: a comparison with two other treatment conditions. *Behaviour Research And Therapy, 46*(4), 411-427.

Bond, L., Patton, G., Glover, S., Carlin, J. B., Butler, H., Thomas, L., et al. (2004). The Gatehouse Project: can a multi-level school intervention affect emotional wellbeing and health risk behaviours? . *Journal Epidemiology and Community Health, 58*, 997-1000.

Botvin, G. J., Baker, E., Filazzola, A. D., & Botvin, E. M. (1990). A cognitive-behavioural approach to substance Abuse prevention: One year follow-up. *Addictive Behaviours, 15*, 47-63.

Cahir, S., Davies, L., Deany, P., Tange, C., Toumbourou, J., Williams, J., et al. (2003). *Introducing Communities That Care*. Melbourne: Communities That Care Ltd.

Cooper, M., Midford, R., Jaeger, J., & Hall, C. (2001). *Partysafe Evaluation Report*. Perth: National Drug Research Institute, Curtin University of Technology.

Coote, S. (2000). *Families and Schools Together (FAST)*. Paper presented at the Australian Institute of Criminology Conference - Reducing Criminality: Partnership and Best Practice. Retrieved from http://www.aic.gov.au/conferences/criminality/coote.pdf

Cross, D., Monks, H., Hall, M., Shaw, T., Pintabona, Y., Erceg, E., et al. (2010). Three year results of the Friendly Schools whole-of-school intervention on children's bullying behaviour. *British Educational Research Journal. 24 February 2010 (iFirst). 37*(1), 105-129.

Domitrovich, C. E., Cortes, R. C., & Greenberg, M. T. (2007). Improving young children's social and emotional competence: A randomized trial of the preschool "PATHS" curriculum. *The Journal of Primary Prevention, 28*(2), 67-90.

Edwards, B., Gray, M., Wise, S., Hayes, A., Katz, I., Muir, K., et al. (2011). Early impacts of Communities for Children on children and families: findings from a quasi-experimental cohort study. *Journal of Epidemiology and Community Health, 65*(10), 909-914.

Fischer, R. L. (2003). School-based family support: evidence from an exploratory field study. *Families in Society, 84*(3), 339-347.

Foxcroft, D., Ireland, D., Lowe, G., & Breen, R. (2002). Primary prevention for alcohol misuse in young people. *Cochrane Database of Systematic Reviews, 2002*(3), Article CD003024.

Greenwood, C., Delquadri, J., & Hall, R. (1989). Longitudinal effects of Classwide Peer Tutoring. *Journal of Educational Psychology, 81*, 371-384.

Hurry, J. (1996). What is so special about Reading Recovery? *Curriculum Journal, 7*(1), 93-108.

Jenkin, C., & Bretherton, D. (1994). *PACE Parenting Adolescents: A Creative Experience.* Camberwell, Australia: The Australian Council for Educational Research.

Kemp, L., Harris, E., McMahon, C., Matthey, S., Vimpani, G., Anderson, T., et al. (2011). Child and family outcomes of a long-term nurse home visitation programme: a randomised controlled trial. *Archives of Disease in Childhood, 96*(6), 533-540.

Kohler, F., & Greenwood, C. (1990). Effects of collateral peer supportive behaviours within the Classwide Peer Tutoring Program. *Journal of Applied Behavior Analysis, 23*(3), 307-322.

Kratochwill, T. R., McDonald, L., Levin, J. R., Young Bear-Tibbetts, H., & Demaray, M. K. (2004). Families and Schools Together: an experimental analysis of a parent-mediated multi-family group program for American Indian children. *Journal of School Psychology, 42*(5), 359-383.

Lloyd, C., Joyce, R., Hurry, J., & Ashton, M. (2000). The effectiveness of primary school drug education. *Drugs: Education, Prevention and Policy, 7*(2,), 109-126.

Lock, S., & Barrett, P. M. (2003). A longitudinal study of developmental differences in universal preventive intervention for child anxiety. *Behaviour Change, 20*, 183–199.

Loxley, W., Toumbourou, J., Stockwell, T., Haines, B., Scott, K., Godfrey, C., et al. (2004). *The prevention of substance use, risk and harm in Australia: A review of the evidence*. Canberra: Australian Department of Health and Aging.

McMorris, B. J., Catalano, R. F., Kim, M. J., Toumbourou, J. W., & Hemphill, S. A. (2011). The influence of family factors and supervised alcohol use on adolescent alcohol use and harms: Similarities between youth in different alcohol policy contexts. *Journal of Studies on Alcohol and Drugs, 72*(3), 418-428.

Midford, R., & Boots, K. (1999). COMPARI: insights from a three year community based alcohol harm reduction project. *Australian Journal of Primary Health – Interchange, 5*, 46-58.

Midford, R., Lenton, S., & Hancock, L. (2000). *A critical review and analysis: cannabis education in schools*. Sydney: New South Wales Department of Education and Training.

Midford, R., Snow, P., & Lenton, S. (2001). *School-based illicit drug education programs: a critical review and analysis*. Melbourne: Department of Employment, Education, Training and Youth Affairs.

Mitchell, P., Spooner, C., Copeland, J., Vimpany, G., Toumbourou, J.W., Howard, J., et al. (2001). *A Literature review fo the role of families in the development, identification, prevention and treatment of illicit drug problems*. Canberra

Moodie, M., & Fisher, J. (2009). Are youth mentoring programs good value-for-money? An evaluation of the Big Brothers Big Sisters Melbourne Program. *BMC Public Health, 9*(1), 41-49.

Mortimer, P., Sammons, P., Stoll, L., Lewis, D., & Ecob, Rc (1998). *School matters: the junior years*. Somerset, England: Open Books

Olds, D. L., Eckenrode, J., Henderson Jr., C. R., Kitzman, H., Powers, J., Cole, R., et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect: 15-year follow-up of a randomised trial. *Journal of the American Medical Association, 278*, 637-643.

Patton, G. C., Bond, L., Carlin, J. B., Thomas, L., Butler, H., Glover, S., et al. (2006). Promoting social inclusion in schools: A group-randomized trial of effects on student health risk behaviour and well-being. *American Journal of Public Health, 96*, 1582-1587.

Pinnell, G. S., Lyons, C. A., DeFord, D. E., Bryk, A. S., & Seltzer, M. (1994). Comparing instructional models for literacy education of high-risk first graders. *Reading Research Quarterly, 29*(1), 9-32.

Sanders, M. R. (2000). Community-based parenting and family support interventions and the prevention of drug abuse. *Addictive Behaviours, 25*, 929-942.

Sanders, M. R., Bor, W., & Morawska, A. (2007). Maintenance of treatment gains: A comparison of enhanced, standard, and self-directed Triple P-Positive Parenting Program. *Journal of Abnormal Child Psychology, 35*(6), 983-998.

Scribner, R. A., & Cohen, D. A. (2001). The effect of enforcement on merchant compliance with the minimum legal drinking age law. *Journal of Drug Issues, 31*, 857-866.

Shanahan, T., & Barr, R. (1995). Reading Recovery: An independent evaluation of the effects of an early instructional intervention for at-risk learners. *Reading Research Quarterly, 30*(1), 968-995.

Shortt, A. L., Hutchinson, D. M., Chapman, R., & Toumbourou, J. W. (2007). Family, school, peer and individual influences on early adolescent alcohol use: First year impact of the Resilient Families program. *Drug and Alcohol Review, 26*(5), 625-634.

Spoth, R. L., & Redmond, C. S., C. (2000). Reducing adolescents' aggressive and hostile behaviors: Randomized trial effects of a brief family intervention 4 years past baseline. *Archives of Pediatrics and Adolescent Medicine, 154*, 1248-1257.

Stead, L. F., & Lancaster, T. (2005). Interventions for preventing tobacco sales to minors. *Cochrane Database of Systematic Reviews, 2005*(1), Article: CD001497.

Sylva, K., & Hurry, J. (1996). Early intervention in children with reading difficulties: An evaluation of Reading Recovery and a phonological training. *Literacy, Teaching and Learning, 2*(2), 49-68.

Tierney, J. P., Grossman, J. B., & Resch, N. L. (1995). *Making a difference: An impact study of Big Brothers/Big Sisters*. Philadelphia, PA: Public/Private Ventures.

Toumbourou, J. W., Blyth, A., Bamberg, J., & Forer, D. (2001). Early impact of the BEST intervention for parents stressed by adolescent substance abuse. *Journal of Community & Applied Social Psychology, 11*, 291- 304.

Toumbourou, J. W., & Gregg, M. E. (2002). Impact of an empowerment-based parent education program on the reduction of youth suicide risk factors. *Journal of Adolescent Health, 31*(3), 279-287.

van Lier, P. A., Muthén, B. O., van der Sar, R. M., & Crijnen, A. A. (2004). Preventing disruptive behavior in elementary school children: impact of a universal classroom-based intervention. *Journal of Consulting and Clinical Psychology, 72*(3), 467-478.

White, D., & Pitts, M. (1998). Educating young people about drugs: a systematic review. *Addiction 93*(10), 1475-1487.

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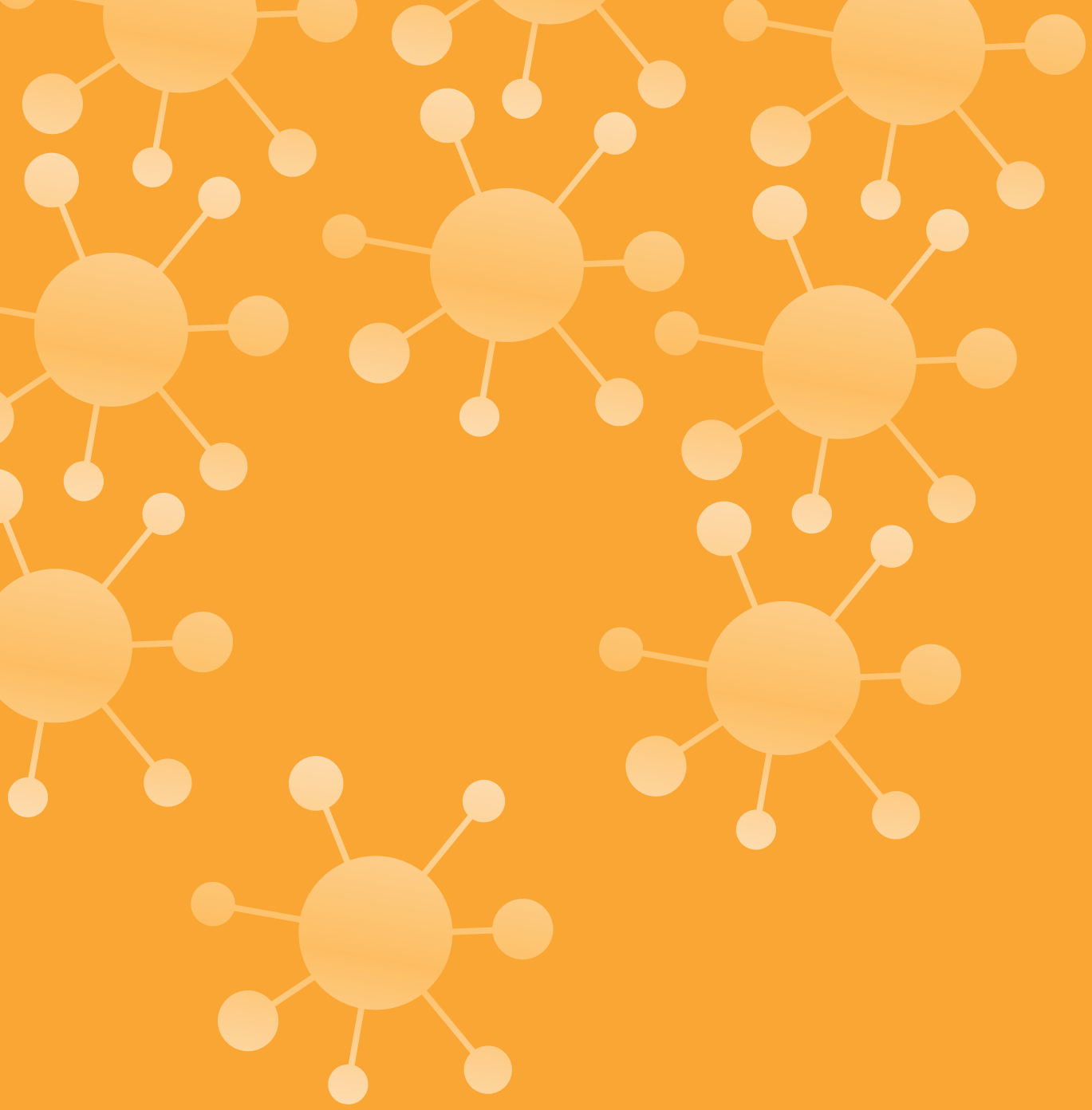

ROTARY INTERNATIONAL

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