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1 Introduction

This is the second of two reports by the Centre for Health Service Development (CHSD), University of Wollongong to the Victorian Department of Education and Early Childhood Development (DEECD) presenting the evidence on effective strategies for improving outcomes for adolescents. Our review has focused on a number of indicators selected by DEECD for their relevance as predictors of adolescent disengagement from school and society. This extends our previous work for the Victorian Government in the area of children's health and wellbeing.

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

The catalogue complements the Victorian Child and Adolescent Monitoring System (VCAMS) which contains 150 indicators of importance to children and young people (0-18 yrs).

Currently, the Statewide Outcomes for Children Branch has a specific interest in identifying strategies to prevent disengagement from school and promote success for adolescents who are at risk of leaving school early. Therefore we have been asked to review the evidence on effective strategies for eight adolescent indicators, namely:

- Proportion of young people who use/age of initiating use of: alcohol
- Proportion of young people who use/age of initiating use of: tobacco
- Proportion of young people who use/age of initiating use of: illicit drugs
- Year 10-12 apparent retention rate
- Teen pregnancy rates
- Number of young people convicted and placed on a community order
- Proportion of young people who have a trusted adult in their life
- Proportion of early school leavers who are unemployed six months after leaving school

In August 2008, we completed a report on the first four indicators listed above. In this report we present narrative reviews and catalogue entries for the second four of these indicators.

2 Background

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

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

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

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

The VCAMS system is complemented by

- Evidence base for each indicator (compiled by DEECD)
- Profiles on the indicators where data are available – this began with Best Start sites and Indigenous Best Start projects and has now been made available to all local government areas in Victoria to help them identify priority areas for intervention
- Annual report on the indicators (e.g., Victorian Government, Department of Human Services - The state of Victoria's children report 2006)
- Catalogue of evidence-based strategies (previous work by CHSD - Williams et al., 2006)
- Potential for feedback from catalogue to VCAMS via new survey data being collected on the indicators currently covered by the catalogue

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

2.2 The adolescent disengagement project

Prevention of youth disengagement has been identified as a strategic priority by the Victorian Government Department of Education and Early Childhood Development. This report (and the subsequent report) extending the VCAMS catalogue is one component of a larger project, which also includes a review of processes, effects and possible predictors of disengagement among young people (due for completion end June 2008) and a policy development workshop involving expert advisors (planned for September 2008).

The core audiences for the VCAMS catalogue adolescent entries will be

- Schools
- Local networks

The local networks incorporate activities of local government (e.g., youth planning and services) plus two existing programs: 'School-focused youth services' which link schools with health services and target at-risk young people aged 10-14; and 'LENSES' which is a transition-to-work/study program linking schools with TAFE and employment services.

3 Methods

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

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

3.1 General approach

Given the wealth of evidence available on strategies for enhancing childhood and adolescent health and wellbeing, one of the major tasks of this review was deciding how to narrow down to the most relevant material in terms of target groups, settings and types of programs.

Consultations with the client resulted in agreement on the following principles to guide and focus the review.

It was agreed that early intervention strategies (i.e., pre-school and early primary) could be recommended if they were supported by strong evidence; however, such studies should incorporate long-term follow-up to ensure early gains were maintained. Many of the interventions likely to be recommended for inclusion in the catalogue will be designed for children at the transition to secondary and in early high school.

Interventions are likely to include a mixture of universal, indicated and selective strategies, depending on the indicator. Treatment (tertiary prevention or selective) services are of interest for VCAMS, so should not be excluded.

A broad range of settings and intervention types are suitable for implementation in the Victorian context. These may include: family skills training, mentoring, educational support, brief counselling in a primary care setting, addiction treatment, and others.

3.2 Search strategy

Starting with the background information (evidence base) provided by DEECD, a set of key words and search terms was developed for each indicator. For the school retention indicator, the *Thesaurus of Psychological Index Terms* (Gallagher Tuleya, 2007) was used to define suitable search terms. In addition, consultation with staff in the University of Wollongong's Education faculty helped identify the types of interventions that may be used in Australian schools and communities to assist youth at risk of disengagement.

Team members worked in pairs: one pair focused on the three substance use indicators, and the other on the school retention indicator and the related issue of preventing youth unemployment after early school leaving (to be included in the next report).

3.2.1 Sources of evidence

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

- Medline (international, medical and health)
- Psycinfo (international, social sciences)
- ERIC (international, education)
- CINAHL (international, nursing and allied health)
- Cochrane Database of Systematic Reviews (reviews only, narrow focus on high quality medical and health trials)

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

In addition to this high quality academic literature, we sought grey literature, such as reports published by governments, agencies, non-profit organisations, universities and research organisations. A focused internet search was conducted, encompassing the websites of Australian governments (state and commonwealth) and specific Australian and international sites known to be reliable sources of information on the health and wellbeing of children and adolescents. These included (but were not limited to):

- Department of Human Services, Victoria, particularly Statewide Outcomes for Children Branch and its links
- Australian Government Department of Family and Community Services, particularly pages dealing with the Stronger Families and Communities Strategy and publications
- Australian Government Department of Health and Ageing
- Australian Council for Educational Research
- Australian Institute for Health and Welfare
- Australian Institute for Family Studies
- Centre for Adolescent Health
- Communities and Families Clearinghouse Australia (CAFCA)
- Australian Research Alliance for Children and Youth (ARACY)
- National Drug and Alcohol Research Centre, UNSW
- National Drug Research Institute, Curtin University
- National Registry of Evidence-Based Programs and Practices, Substance Abuse and Mental Health Services Administration (United States)
- California Evidence-Based Clearinghouse for Child Welfare
- Promising Practices Network, Rand Corporation

3.2.2 Data management

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

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

3.3 Inclusion criteria

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

3.3.1 Evaluation of the evidence

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

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4 Teen pregnancy rate

4.1 Teen pregnancy rate narrative review

4.1.1 Background

Nationally, teenage mothers account for 4.8% of all births (Jordan, Bayly and Sawyer, undated). Victoria has the lowest proportion of teenage births of all Australian states, at 3.1%, although this varies across the state and is as high as 6% in some rural areas and up to 22% among Indigenous women (Jordan et al., undated).

The fertility rate of Australian teenagers is relatively high: this country ranked 11th among 28 OECD countries on Unicef's teenage birth 'league table' in 2001. With a birth rate of 18.1 per 1000 women aged 15 to 19, Australia was similar to Ireland, Poland and Canada, but considerably lower than the United States (which has the highest teen birth rate in the developed world, at 52.1/1000), the United Kingdom and New Zealand (Unicef, 2001).

It is difficult to estimate teenage pregnancy rates in Australia as there is no requirement for mandatory reporting of abortion nationally or in any state, with the exception of South Australia. In 2006, 892 South Australian teenagers gave birth, and a further 998 had abortions (Chan, Scott, Nguyen and Sage, 2007). These data indicate that teen pregnancy rates could be at least twice birth rates. This is supported by estimates derived from Australian Bureau of Statistics and Australian Institute of Health and Welfare data, which suggest that Australia's rate of teenage pregnancy is around 38.9/1000 women aged 15-19 years (Shine SA, 2008).

A series of national surveys of secondary students in Australia show that adolescents are becoming sexually active earlier, and there are high rates of risky behaviour (Smith, Agius, Dyson, Mitchell and Pitts, 2003; Agius, Dyson, Pitts, Mitchell and Smith, 2006). In 2002, a quarter of Year 10 students and more than half of the Year 12 students surveyed had had sex. Of these sexually active adolescents, only 65.8% of Year 10s reported that they always used a condom, and this fell to 51.8% in Year 12, although the older group may be using the contraceptive pill at higher rates. Six percent of the sample reported having been pregnant (Smith et al., 2003).

Early motherhood is associated with considerable disadvantage, both for the young woman and her child, increasing her risk of poverty, poor physical and mental health, exposure to domestic violence, crime and substance abuse, low educational attainment and social exclusion (Jordan et al., undated). Children of teenage mothers are more likely to grow up without fathers, to be the victims of abuse or neglect, and eventually to become teenage parents themselves (Unicef, 2001).

Reducing teenage births offers an opportunity to reduce the likelihood of poverty, and of its perpetuation from one generation to the next (Unicef, 2001, p. 2).

4.1.2 The evidence base

Policy approaches to reducing teenage pregnancy vary widely, depending on the prevailing value system (Unicef, 2001). Much prevention and evaluation research in this area has been conducted in the United States, where policy is dominated by a religious viewpoint that sex and childbearing before marriage are primarily moral issues. This means that many of the school-based programs developed in that country emphasise abstinence from premarital sex rather than providing comprehensive information about sexuality and sexual health. Recent reviews have concluded that 'abstinence-only' interventions are, on the whole, ineffective (Santelli et al., 2006; Trenholm et al., 2008; US Government Accountability Office, 2008; but see also Manlove, Franzetta, McKinney, Romano Papillo and Terry-Humen, 2004). In any case, such interventions are inconsistent with Australian social policy which approaches the problem from the perspective of

improving health and reducing disadvantage. In Victoria, the purpose of universal school-based sexuality education is to:

build on knowledge, skills, and behaviours, thus enabling young people to make responsible and safe choices (DEECD, 2007).

In one large national study in the US, adolescents who received comprehensive sex education in school were significantly less likely to report teen pregnancy and marginally less likely to have had sex than those who had received no formal sex education, while abstinence-only education had no effect on either measure (Kohler, Manhart and Lafferty, 2008). Overall, however, the evidence for sex education in schools is mixed: some reviewers have concluded it has no effect on age of initiating sexual intercourse, teen pregnancy or use of birth control (DiCenso, Guyatt and Griffith, 2002; Sabia, 2006). Other reviewers (McKay, Fisher, Maticka-Tyndale and Barrett, 2001; Kirby, 2002a, 2002b; Manlove et al., 2004; Bennett and Assefi, 2005) have identified effective programs, some of which are described below.

School-based programs that provide knowledge and seek to change attitudes and behaviour are, however, only part of the solution (Jordan et al., undated). Teen pregnancy rates are strongly linked to inequality in society and those most at risk are adolescents who dislike school, underachieve and have low life expectations (Fergusson and Woodward, 2000; Bonnell et al., 2003; Harden et al., 2006; Fletcher, Harden, Brunton, Oakley and Bonnell, 2008). Broad-based, multi-component youth development programs are designed to address these social determinants of teenage pregnancy along with a host of common risk and protective factors for other problem behaviours and outcomes among young people. Such programs are well supported by evidence (Kirby, 2002b; Harden et al., 2006) but can be expensive and difficult to replicate (e.g., Wiggins et al., 2008).

The influence of parents on adolescents' behaviour has been acknowledged in the design of another group of interventions (Meschke, Bartholomae and Zentall, 2002). These approaches focus on improving communication and strengthening family relationships. Some promising strategies are emerging, but many of these studies do not include measures of safe sex behaviour, contraceptive use or pregnancy outcomes.

Another approach that would appear to be relevant and potentially cost-effective is individual counselling in a primary health care setting (e.g., see Danielson DATE, below). There is, however, a lack of studies providing high-quality evidence in this area (Moos, Bartholomew and Lohr, 2003).

4.1.3 Selection of interventions

There is an abundance of school-based sex education programs that aim to prevent teenage pregnancy. An expert review panel for the Program Archive on Sexuality, Health and Adolescence identified 56 programs they classified as 'effective' (Card, Lessard and Benner, 2007). Our review narrowed the field by focusing on studies with strong research designs and reported, longer-term outcomes for teenage pregnancy or contraceptive use.

Safer Choices is a well-documented school-based sex education program that incorporates information on AIDS/STD prevention information, parent involvement and links with community health services. Although it is an American program, it takes a harm minimisation approach. The program is taught in 20, 45-minute lessons delivered in two blocks or levels: 10 in the first year, and 10 in the following year, starting in 9th grade (US). Staff training events are held in preparation. A randomised, controlled trial demonstrated that the program had statistically and clinically significant effects on students' contraceptive use and safe sex practices 31 months after baseline (Basen-Engquist et al 2001; Coyle et al 2001, 2006).

The SHARE program was piloted with more than 14,000 adolescents aged 11-15 years in 15 secondary schools in South Australia over three years from 2003. Like Safer Choices, SHARE has broader aims beyond teenage pregnancy prevention, namely promoting the sexual health,

safety and wellbeing of young people. This 'whole-school' program supports positive changes to the school ethos and involves parents and the community. The curriculum involves 15 one-hour lessons delivered to students in years 8, 9 and 10 (ages 11-15) by teachers who receive specific training (Shine SA, circa 2006). It was developed by Shine SA, based on extensive consultation, research and a review of the literature on effective comprehensive sex education in schools (Dyson et al., 2003).

The pilot program was independently evaluated (Dyson and Fox, 2006), although this did not include behavioural outcome measures. A qualitative evaluation examined course content and implementation and concluded that the SHARE program was

an exemplary model of a comprehensive sexual health and relationships program. It is a thoroughly researched, theoretically rigorous, comprehensive and 'usable' set of materials and guides (Johnson, 2006, p. 33).

This program has been included in the catalogue as a promising strategy that is particularly relevant to the Australian context. In order for it to be disseminated and used more widely, further evaluation (preferably measuring outcomes such as contraceptive use) is strongly recommended.

The Teen Outreach Program uses a 'service learning' approach to enhance teenagers' social development and connections with school and the community. This school-based program incorporates a minimum of 20 hours' community service activities annually, supervised by trained staff. Weekly classroom discussions are wide-ranging, and sexuality education forms only a small part of the curriculum. Instead, classroom sessions are designed to maximise the learning opportunities from the volunteer experiences and address participants' social and personal development needs. This intervention significantly reduced pregnancy rates among participants (4.2%) compared with a control group (9.8%), after controlling for demographic factors and other existing differences between the groups. The program also had large positive impacts on school failure and suspension (Allen, Philliber, Herrling and Kuperminc, 1997).

Another 'service learning' program that has also been well evaluated is Reach For Health (O'Donnell et al., 2002). Two years after the program, participants were less likely than controls to report sexual initiation and recent sex. Contraceptive use and pregnancy outcomes were not reported. Other service learning and youth development programs recommended by reviewers include the Seattle Social Development Project and Quantum Opportunities Program (see Harden et al., 2006, for a summary).

The strategy with the strongest evidence in terms of demonstrated reductions in teen pregnancy rates is the Children's Aid Society (CAS) Carrera Program (Philliber, Kaye and Herrling, 2001; Philliber, Williams-Kaye, Herrling and West, 2002). CAS-Carrera is an intensive and sustained intervention for at-risk youth aged 13-15 years. It runs 5-6 times per week over three years as an after-school program and incorporates seven activities, one of which is family life and sex education. The goal is to develop genuine, long-term relationships with program staff, treat participants as if they have potential and provide tailored, integrated health, educational and social services to them and their families. A randomised, controlled trial at 12 sites in seven American cities found that after three years in the program, female participants had less than half the risk of teenage pregnancy than girls in the control group (Philliber et al., 2001). They were more than twice as likely as controls to have used a condom and a hormonal contraceptive method at last intercourse (Philliber et al., 2002).

A recent replication of this model in the United Kingdom did not achieve positive results, however. The Young People's Development Programme was holistic and intensive, and included education (literacy, numeracy, IT and vocational skills), training and employment opportunities, life skills, mentoring, volunteering, health education, arts, sports and advice on access to services. Young women who took part had poorer outcomes than controls relating to teen pregnancy, truancy and school exclusion, expectation of teen parenthood and sexual activity (Wiggins et al., 2008). The

evaluators recommended that youth development programs may be better offered separately to females and males. Also, it is important to ensure that the program does not bring participants into contact with 'a more risky group of friends' (Wiggins et al., 2008, p. vi). They offered suggestions on how this could be avoided: work with different age groups, or with broad groups defined by general social disadvantage (as CAS-Carrera does) rather than defined by specific risks, or work with pre-existing friendship groups.

A very different, yet effective, approach was taken in an innovative study of reproductive health counselling for young men (Danielson, Marcy, Plunkett, Wiest and Greenlick, 1990). This strategy was designed to increase knowledge, provide personalised, directive advice, reduce coercive behaviours (which have been shown to influence early initiation of intercourse and unprotected sex) and make participants more comfortable in discussing sexual and contraceptive topics with their partners.

The counselling intervention was provided individually to almost 1200 adolescent males aged 15-18 years, during a one-hour medical appointment at the participant's usual medical clinic. Each participant sat alone in a private room to view a half-hour audiovisual presentation, which included explicit photographs and information on reproductive anatomy, fertility, hernia, testicular self-examination, STDs, contraception, couple communication and access to health services. This was followed by a consultation focusing on contraception and guided by the participant's own interests and questions. Those who received the consultation were more likely than controls to report that their last sexual intercourse was protected by the pill and that their main method of contraception in the previous year was the pill. Effects were strongest among those not sexually active at the time of the baseline survey (Danielson et al., 1990). A similarly personalised, primary care-based approach for teenage girls at 'high risk' of pregnancy succeeded in persuading many participants to use contraception and postpone motherhood for six months or more (Cowley, Farley and Beamis, 2002).

4.1.4 Discussion

A 'whole-school approach' to sexuality education has been advocated by recent Australian reviewers (Dyson, Mitchell, Dalton and Hillier, 2003; Jordan et al., undated; Dyson et al., 2008). This is defined (Mitchell et al., 2000, cited in Dyson et al., 2008) as going beyond a formal curriculum to include consultation and interaction with parents and the school community, access to community resources, student involvement and changes to school policy and guidelines. There is evidence that this approach has been implemented internationally, although there appear to be no formal evaluations (Dyson et al., 2008).

Nevertheless, a whole-school approach harmonises with recommendations by reviewers who have identified elements of successful prevention programs (e.g., Goulay, 1996 and Ollis, 1996, both cited in Dyson et al., 2003; Kirby, 2001, cited in Manlove et al., 2004). Below is a summary of the key factors (for a full list, see Dyson et al., 2003):

- Acknowledging young people as sexual beings
- Addressing and catering for diversity
- Using developmentally based curricula that are appropriate and inclusive
- Identifying and addressing educators' training needs
- Involving parents and communities

In their review of sexual risk-reduction interventions for adolescents, Robin and colleagues (2004) noted that successful programs focused on building specific skills that reduced particular risk behaviours. Broad, multi-component youth development strategies also have much to offer, however. In particular, programs that build life expectations and connection with school have the potential to reach those most at risk of teenage parenthood (Fletcher et al., 2008).

Many studies have demonstrated that sex education in schools does not, as feared by some conservative elements in society, lead to increased sexual behaviour among high school students (Kirby, 2002b). However, these attitudes represent a potential barrier to successful implementation of evidence-based programs (see Johnson, 2006, for an Australian example).

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Table 1 Teenage pregnancy rates – recommended strategies

| | Supporting evidence | Replication | Documentation | Theoretical basis | Cost effectiveness | Cultural reach |
|---|---------------------|-------------|---------------|-------------------|--------------------|-----------------|
| (20.1) Reproductive health counselling for young men | 1 | N | N | Y | N | Universal |
| (20.2) Teen Outreach Program (TOP) | 1 | Y | Y | Y | Y | Universal |
| (20.3) Children's Aid Society Carrera Program (CAS-Carrera) | 1 | Y | Y | Y | Y | Low SES CALD |
| (20.4) Sexual Health and Relationships Education (SHARE) | 4 | N | Y | Y | N | Universal |
| (20.5) Safer Choices | 1 | Y | Y | Y | Y | Universal |

Key

Supporting evidence:

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

Replication:

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

Documentation:

Are the content and methods of the intervention well documented (such as provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:

Is the intervention based on a well-accepted theory or developed from a continuing body of work in its field? (yes or no)

Cost Effectiveness:

Are cost-effectiveness studies available? (yes or no)

Cultural reach:

Has the program been trialed with people in disadvantaged communities, Indigenous people or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD). Universal if no specific target group identified.

Recommended strategy 20.1: Teenage pregnancy rate

| | |
|---|---|
| Name of intervention | Reproductive health counselling for young men |
| Organisation | Kaiser Permanente Center for Health Research, Oregon |
| Brief literature review | Interviewing/counselling was delivered individually in a health setting, combining a personal health consultation with a half-hour audiovisual presentation. Adolescent males aged 15-18 years were recruited through a Health Maintenance Organisation, with parental permission. The intervention took place during a one-hour medical appointment at the participant's usual medical clinic. The practitioner provided a brief introduction, then left the participant alone in a private room to view the half-hour audiovisual presentation, which included explicit photographs and information on reproductive anatomy, fertility, hernia, testicular self-examination, STDs, contraception, couple communication and access to health services. This was followed by a consultation focusing on contraception and guided by the participant's own interests and questions, with the goal of increasing the participant's comfort level regarding discussion of sexual and contraceptive topics. |
| How and why does this intervention work? | The evaluation used a randomised, controlled design with 12-month follow-up. The intervention reduced 'sexual impatience' among participants (this was a composite measure of dissatisfaction with being a virgin, which was found to be strongly related to intentions to have unprotected sex). Those who received the consultation were more likely than controls to report that their last sexual intercourse was protected by the pill and that their main method of contraception in the previous year was the pill. Participants also had better knowledge of fertility and prevention of STDs and were more likely to practise testicular self-examination. |
| On what population does this intervention work best? | This was a universal intervention targeting male adolescents aged 15-18 years. The trial population consisted of 1195 young men in three US states. The intervention worked best with those who were not sexually active at the time of the baseline survey. |
| Where will this intervention work best? | Primary health care setting such as a community health centre. |
| What is required to implement this intervention? | The intervention was delivered by nurse practitioners, nurses or physicians' assistants who had received specific training. It requires a culturally appropriate audiovisual presentation (this intervention adapted materials from two programs made by the University of Minnesota, "Young Men's Reproductive Health" and "Young Men's Sexual Responsibility") and computer or DVD on which to play it in a private setting. |
| Resources and contact information | Contact details provided in the journal article are no longer current (see http://www.kpchr.org/public/default.aspx). However, the methods are described in full in the article referenced below. |
| References | Danielson et al., 1990 |

Recommended strategy 20.2: Teenage pregnancy rate

| | |
|---|---|
| Name of intervention | Teen Outreach Program (TOP) |
| Organisation | The Wyman Center, Missouri |
| Brief literature review | TOP is a school-based service learning program incorporating community service and classroom instruction, which does not focus specifically on sexuality education but addresses more general developmental needs of participants. The program is designed to involve adolescents in volunteer activities supervised by trained staff and often working with staff and volunteers of local community organisations such as hospitals or nursing homes. Activities may include working as a nursing aide or peer tutoring. A minimum of 20 hours' volunteer experience is provided over a year, although participants in the trial actually received 45 hours on average. Weekly classroom discussions also take place, with the aim of maximising the learning opportunities from the volunteer experiences. Material specifically about sexuality forms only a small part of the curriculum. Instead, the program aims to give adolescents a forum in which thoughts and feelings can be safely discussed and they can understand and evaluate their future life options. The structured community service provides an opportunity to establish skills and autonomy and to be viewed in a positive role. |
| How and why does this intervention work? | Evaluation design was a randomised controlled trial with outcomes measured after 12 months. Rates of pregnancy were significantly lower in the intervention group (4.2%) than the control group (9.8%) at follow-up, after controlling for demographic factors and other existing differences between the groups. The program also had large positive impacts on school failure and suspension. Costs of the program were estimated (in 1997) at US\$500-US\$700 per student when delivered to classes of 18-25 students, including costs for a facilitator and site co-ordinator. |
| On what population does this intervention work best? | TOP can be run as a universal youth development strategy or as a more targeted intervention (see below). It is designed for young people aged 12-17 years. The trial population consisted of 695 high school students (342 intervention and 353 control group) at 25 randomly chosen sites in the US. |
| Where will this intervention work best? | The program is designed for high schools and can be implemented in various ways: during class time, either as an elective or integrated with core subjects; as an after-school voluntary program; or as a component of enrichment programs such as social clubs, recreation, mentoring and tutoring initiatives, or other after-school activities. |
| What is required to implement this intervention? | In the US, facilitators attend a 2 ½ day training course before delivering TOP. Curriculum materials are available commercially and include a guide to evaluating TOP. The program's publisher offers technical support in setting up and running the program. |
| Resources and contact information | Claire Wyneken, The Wyman Center, 600 Kiwanis Drive, Eureka, Missouri 63025, USA. clairew@wymancenter.org http://www.wymancenter.org/teenoutreach.htm |
| References | Allen et al., 1997 |

Recommended strategy 20.3: Teenage pregnancy rate

| | |
|---|--|
| Name of intervention | Children's Aid Society Carrera Program (CAS-Carrera) |
| Organisation | Children's Aid Society, United States |
| Brief literature review | This is a long-term intensive holistic program incorporating: family life and sex education; individual academic assessment and tutoring; a work-related intervention; artistic and sporting activities; mental health care; comprehensive health care. Young people join the program in early teens (13-15 years). CAS-Carrera is run as an after-school program five days a week during the school year and there are occasional meetings, trips and help with employment during holidays. Services are tailored and integrated. Program staff build relationships with the participating youth and their families. |
| How and why does this intervention work? | A randomised, controlled trial at 12 sites in seven American cities found that after three years in the program, female participants had less than half the risk of teenage pregnancy than girls in the control group (Philliber et al., 2001). They were more than twice as likely as controls to have used a condom and a hormonal contraceptive method at last intercourse (Philliber et al., 2002). In addition, young people in the program were more likely to have work experience and to receive medical care. There were no significant program impacts on males' sexual behaviour outcomes and young men most at risk – those who had initiated sexual intercourse before enrolment – were least likely to attend regularly. |
| On what population does this intervention work best? | CAS-Carrera targets adolescents at risk of teenage pregnancy and other poor health and social outcomes (although organisers refer to them as 'at promise'). The trial population was about 600 adolescents attending six agencies in New York City, plus 100 young people at each of six other sites in different US cities. Most were from minority ethnic groups and all were socially disadvantaged, with about half from single-parent homes and high rates of substance use, illness, parental incarceration and domestic violence in their families. About half lived in families with no working adult and/or reliant on public assistance. |
| Where will this intervention work best? | The original program was run through youth agencies, boys and girls clubs and multi-service agencies. Participants were recruited through schools, letterbox fliers, contacting families already on agency lists and recruiting teens involved in youth activities at the participating agencies. |
| What is required to implement this intervention? | Part-time staff are required to run the program activities, with a full-time coordinator and a full-time community organiser who handles logistics and maintains continuous contact with participants and their families. This person needs to have good rapport with community members. The program requires coordination with health and mental health services. |
| Resources and contact information | Children's Aid Society http://www.childrensaidsociety.org |
| References | Philliber et al., 2001, 2002 |

Recommended strategy 20.4: Teenage pregnancy rate

| | |
|---|---|
| Name of intervention | Sexual Health and Relationships Education (SHARE) |
| Organisation | SHine SA |
| Brief literature review | SHARE is not specifically a teen pregnancy prevention program but has broader aims for high school students, their parents and families, teachers and the school environment or ethos. Its goal was to improve the sexual health, safety and wellbeing of young people. The curriculum involved 15 one-hour lessons delivered to students in years 8, 9 and 10 (ages 11-15). Parent information evenings were held in schools, and student health and wellbeing teams set up including representatives from parents, teachers, students and local community agencies. |
| How and why does this intervention work? | The SHARE model was based on extensive consultation, research and review of the literature on effective comprehensive sex education in schools. Two independent evaluations were conducted of the pilot program (2003-2005). Dyson and Fox (2006) surveyed students in three SHARE and three control schools in 2003 and 2005. Due to very small numbers of completed surveys from control schools, these data were not used. Instead the evaluators compared student responses in 2003, before the SHARE program, to responses from a (different) group of students who had received two or three years' SHARE training. After the program, students had improved understanding of safe sex behaviours but there was no change in their confidence about talking to prospective partners about using condoms or obtaining condoms (these were at high levels before and after). Impacts on safe-sex behaviours were not measured. A qualitative evaluation by Johnson (2006) examined course content and implementation but not behavioural outcomes for young people. This study concluded that the SHARE program was "an exemplary model of a comprehensive sexual health and relationships program. It is a thoroughly researched, theoretically rigorous, comprehensive and 'usable' set of materials and guides ..." (p. 33). |
| On what population does this intervention work best? | This is a universal program for high school students. It is particularly relevant to the Australian context. The trial population consisted of more than 14,000 adolescents aged 11-15 years in 15 metropolitan and regional secondary schools in South Australia. |
| Where will this intervention work best? | High schools. |
| What is required to implement this intervention? | Teachers who delivered the SHARE curriculum received 15 hours of training. Program coordinators from SHine SA provided support to participating schools. Materials include a teacher activity manual, and parent and student booklets. |
| Resources and contact information | Mel Cameron, SHine SA, (08) 8300 5300. http://www.shinesa.org.au |
| References | Dyson and Fox 2006; Johnson 2006; Shine SA circa 2006 |

Recommended strategy 20.5: Teenage pregnancy rate

| | |
|---|---|
| Name of intervention | Safer Choices |
| Organisation | ETR Associates, California. |
| Brief literature review | Safer Choices consists of school-based sex education with AIDS/STD prevention information plus parent involvement and community health links. Although American in origin, this is not an abstinence-only program. It is taught in 20, 45-minute lessons delivered in two blocks or levels: 10 in the first year, and 10 in the following year, starting in 9th grade (US). Other components of the program are a School Health Promotion Council involving teachers, parents, students, administrators and community representatives; a peer team that hosts school-wide activities; parent education via newsletters, homework and parent events; and links between schools and community services. |
| How and why does this intervention work? | A randomised controlled trial was conducted with 31-month follow-up (79% retention rate). Sexually experienced students in intervention schools reported less intercourse without condoms in the past three months than those in control schools (ratio of 0.63) and fewer partners with whom they had unprotected sex (ratio 0.73). Intervention group students were 1.68 times more likely than comparison students to use condoms, and 1.76 times more likely to use an effective pregnancy prevention method such as the pill, pill plus condoms, or condoms alone. An economic evaluation found a return of US\$2.65 in medical and social cost savings for every dollar spent on the program (Wang et al., 2000). |
| On what population does this intervention work best? | This is a universal program for younger adolescents. The trial population was 3869 students attending 20 high schools in California and Texas. |
| Where will this intervention work best? | High schools |
| What is required to implement this intervention? | In the US, training events are held for teachers who will deliver Safer Choices. Program materials include curricula, workbooks, Peer Leader Training Guide, implementation manual and activity kit. They are available commercially (2008 cost is US\$179 for the whole program). |
| Resources and contact information | http://www.etr.org/recapp/programs/saferchoices.htm Dr Karin Coyle, ETR Associates, PO Box 1830, Santa Cruz CA 95061-1830, karinc@etr.org |
| References | Wang et al 2000; Basen-Engquist et al 2001; Coyle et al 2001, 2006 |

5 Proportion of young people who have a trusted adult in their life

5.1 *Proportion of young people who have a trusted adult in their life narrative review*

5.1.1 Background

A supportive relationship with a trusted adult is important for ensuring healthy adolescent development. A trusted adult can include biological parents, foster carers, older siblings, mentors and any other adult who provides the young person with support and encourages healthy and pro-social behaviour.

This concept is increasingly recognised as important given that young people who lack supportive relationships with a trusted adult are at an increased risk of delinquency, substance use, conduct problems, poor academic performance, emotional problems and suicide (Carbone, Sawyer, Searle, and Robinson, 2007; Griffin, Botvin, Scheier, Diaz, and Miller, 2000; Mak, 1994; Stewart-Brown, 2008).

There are several factors that reduce the likelihood that a young person will have a supportive relationship with a trusted adult. These include a family background with a low socio-economic status, single-parent families and poor parenting skills (e.g. parental neglect, overprotection, poor communication) (Beyers, Toumbourou, Catalano, Arthur, and Hawkins, 2004; Fergusson, Woodward, and Horwood, 2000; Gorman-Smith, Tolan, Zelli, and Huesmann, 1996; Griffin, Botvin, Scheier, Diaz, and Miller, 2000; Mak, 1994; Stewart-Brown, 2008).

Adolescents in foster care settings also lack supportive relationships with trusted adults given that they have backgrounds characterised by familial dysfunction and social problems (Carbone, Sawyer, Searle, and Robinson, 2007; Miller, Fan, Christensen, Grotevant, and van Dulmen, 2000).

Young people with Indigenous or culturally and linguistically diverse (CALD) backgrounds are also less like to have a supportive relationship with a trusted adult (Astone and McLanahan, 1991).

5.1.2 The evidence base

A number of strategies have been developed to promote supportive relationships between trusted adults and at-risk youth. These strategies generally aim to achieve this by improving the skills of parents or foster carers, or by providing suitable adult mentoring for at risk youth. Strategies involving intensive therapy-based interventions (e.g. cognitive-behavioural therapy) were not considered for this indicator, as these are expensive and time consuming and are therefore not accessible for at-risk adolescents and their parents or foster carers.

The quality of the evidence base for these strategies is mixed. Some strategies have been evaluated in a range of different settings and populations using randomised controlled trials (RCTs) or prospective studies with appropriate control groups. In contrast, other programs have only been evaluated in a limited number of settings and populations using less robust research designs.

Nevertheless, the evidence base is of sufficient quality to conclude that parent skills training, foster care training and adult mentoring programs are effective in promoting adult-adolescent relationships, and improving adolescent outcomes. The programs that are most effective are those that are easily accessible, where the aim is to build positive social networks of support for both the adolescent and adult. However, with the exception of Big Brothers Big Sisters, these strategies have rarely been evaluated in CALD or indigenous populations.

5.1.3 Selection of interventions

A total of seven major strategies/interventions that aim to enhance adult-adolescent relationships were identified through the literature review; four of these are included in the final catalogue. The evidence regarding the efficacy of each intervention is discussed below.

Families and Schools Together (FAST), Strengthening Families Program, Teen Triple P, Parenting Adolescents Wisely (PAW) and Systematic Training for Effective Parenting (STEP) are skills-based training programs for parents. FAST is an early intervention school based program that enhances support networks for families and children, increases parental involvement and prevents at-risk behaviours in children aged 6 to 12 years (Family Service Canada, 2005; Layzer, Goodson, Creps, Werner, and Bernstein, 2001; McDonald, Billingham, Conrad, and Morgan, 1997). The program involves groups of 5 to 15 families meeting on a weekly basis over a period of 8 weeks. The meetings are structured and involve activities such as family communication games, role playing and group feedback, play therapy and shared meals. After completing the program, families attend a graduation ceremony and maintain support networks through informal monthly meetings for up to two years (McDonald, Billingham, Conrad, and Morgan, 1997).

RCTs, pre/post-test studies and case reports indicate that FAST leads to improved behavioural outcomes in children aged 6 to 12 years (Layzer, Goodson, Creps, Werner, and Bernstein, 2001; McDonald, Billingham, Conrad, and Morgan, 1997; Terrion, 2006). For example, a nationwide evaluation of FAST in approximately 1500 Canadian children indicated that the program led to a 25% decrease in ratings of problem behaviours (Family Service Canada, 2005). These results indicate that the FAST program is effective in improving the long term behaviour of children and adolescents at risk of academic failure, delinquency and psycho-social problems. As a consequence, this program is included in the catalogue.

Triple P is a parent training program that incorporates media and information based strategies, brief consultation primary care interventions, intensive parent training, and enhanced behavioural family interventions (Ralph and Sanders, 2004; Sanders, Markie-Dadds, and Turner, 2003). It was initially developed for parents of children aged 0 to 12 years, and several RCTs demonstrate that it is effective in improving child outcomes (Bor, Sanders, and Markie-Dadds, 2002; Markie-Dadds and Sanders, 2006; Sanders, Markie-Dadds, Tully, and Bor, 2000; Thomas and Zimmer-Gembeck, 2007).

Teen Triple P is based on the Triple P, and was recently developed for parents of adolescents to promote healthy adolescent development and prevent delinquency and behavioural problems (Sanders, Markie-Dadds, Tully, and Bor, 2000; Sanders, Markie-Dadds, and Turner, 2003). Teen Triple P consists of an eight week group-based family intervention program aimed at enhancing parenting skills through observation, discussion, practice and feedback. Ralph and Sanders (2003, 2004) evaluated the effectiveness of the Group Teen Triple P using a pre-post test design with no control group. They found that the Group Teen Triple P led to significant improvements in parenting styles, improved parental self-efficacy, self-sufficiently and self management, and reduced parent-adolescent conflict (Ralph and Sanders, 2003; Ralph and Sanders, 2004). The effect sizes were moderate (d 's = 0.26 – 0.39) and were maintained at 6 months follow-up. These results suggest that the Teen Triple P could be effective in improving parental skills and ultimately adolescent outcomes; therefore, it is included in the catalogue.

PAW is a brief (3 hours) interactive CD program developed to improve parenting skills such as active listening and problem solving (Gordon, 2000). The program is comprised of interactive scenarios depicting common family problems; appropriate behaviours are modelled and are accompanied by quizzes to reinforce the content. PAW has been shown to lead to significant improvements in ratings of adolescent behaviour and parent knowledge over a period of four months, with moderate effect sizes (i.e. d 's = 0.35 – 0.36) (Kacir and Gordon, 1997). Two pre-test/post-test studies have also indicated that PAW is associated with significant improvements in parent behaviours (O'Neill and Woodward, 2002; Segal, Chen, Gordon, Kacir, and Gylys, 2003); the effect sizes observed in these studies are moderate (d 's = 0.41 - 0.61). However, this program

is not included in the catalogue given that evidence of its effectiveness in at-risk youth (e.g. CALD, low income families) has not been determined.

The Strengthening Families Program is a 14 session, skills training program specifically designed for high-risk families. It is typically held at schools where parents and children meet each week for a period of seven weeks. It is comprised of separate child and parent training sessions which are followed by combined sessions where the skills are practiced and reinforced (Molgaard, Kumpfer, and Fleming, 1997). A longer and more intensive version is also available for high-risk teenagers.

The efficacy of the teenage version of the Strengthening Families Program on US families with children aged 11 to 14 years has been evaluated through three RCTs. These studies indicated that the Strengthening Families Program led to improvements in parenting behaviours, which were associated with improvements in adolescent outcomes (e.g., substance use, conduct problems, school-related problem behaviours, peer resistance) (Molgaard, Kumpfer, and Fleming, 1997). Spoth et al. (2001, 2005) also found that the program led to a reduction in alcohol use, with small to moderate effect sizes (d 's = 0.16 - 0.38). The available evaluation data indicate positive benefits but are limited in scope. As a consequence this strategy is not included in the final catalogue.

Systematic Training for Effective Parenting (STEP/Teen) is a training package targeted towards parents of teenagers (Step Publishers, 2008). The package involves seven sessions that the parent can complete at home that addresses a range of parenting issues (Step Publishers, 2008). Although it is claimed that the STEP package is one of the most commonly used parent training programs worldwide, empirical data do not support the effectiveness of STEP. For example, most studies indicate that STEP has no effect on adolescent behaviour (Jackson and Brown, 1986; Robinson, Robinson, and Dunn, 2003). As a consequence, this intervention is not included in the catalogue.

Multidimensional Treatment Foster Care is a foster-family community based intervention that targets children and adolescents at risk of multiple foster-care placements or restrictive placements (e.g. youth justice, hospitals) (Chamberlain, 2003; Macdonald and Turner, 2008). The program is managed by a program supervisor who identifies at risk adolescents (e.g. incarcerated juvenile offenders) and matches them to a foster carer, who has received additional training (McGuinness and Dyer, 2007). Together with the foster carer, the supervisor develops a behavioural management program tailored specifically for the adolescent (Chamberlain, 2003). This program aims to improve behavioural outcomes by rewarding positive behaviour, providing the adolescent with a supportive adult relationship and limiting exposure to deviant peers (Chamberlain, 2003). The foster carer maintains regular contact with the program supervisor and receives additional support and advice as required. The program can also incorporate additional individual therapy for the adolescent (Chamberlain, 2003).

A systematic review of 40 evaluation studies conducted between 1976 and 1997 indicated that this program led to improvements in social skills and reductions in problem behaviours with moderate-to-strong effect sizes (Reddy and Pfeiffer, 1997). Recent RCTs have demonstrated that Multidimensional Treatment Foster Care leads to significant reductions in delinquent behaviours in adolescent males and females released from juvenile detention (Chamberlain and Reid, 1998; Leve, Chamberlain and Reid, 2005). A recent case study has also indicated that Multidimensional Treatment Foster Care leads to improved outcomes for at-risk adolescents (Chamberlain, 2003). As a consequence, this strategy is included in the final catalogue.

Big Brothers Big Sisters is an international planned mentoring program targeted towards young people aged 7 to 17 years who are at risk of academic, psychosocial and/or behavioural problems. It is typically community or school based and involves trained staff screening adult volunteers and matching them to a young person. The Big Brother or Big Sister then meets regularly with the adolescent and provides mentoring, friendship and general concern for their well-being for a

minimum of 12 months. Big Brothers Big Sisters is already established in Australia and operates in most states (Big Brothers Big Sisters Australia, 2008).

RCTs demonstrate that Big Brothers Big Sisters leads to improvements in academic, psychosocial and behavioural outcomes (Grossman and Rhodes, 2002; Herrera et al., 2007), reductions in substance abuse (Rhodes, Reddy, and Grossman, 2005) and improved self esteem (Turner and Scherman, 1996) in at risk youth. Other non-randomised studies indicate that Big Brothers Big Sisters programs lead to improvements in academic performance relative to control groups (Thompson and Kelly-Vance, 2001). The effect sizes observed in these studies are small (d 's = 0.05 to 0.20), but are clinically significant (Du Bois, Holloway, Valentine, and Cooper, 2002; Grossman and Rhodes, 2002; Thompson and Kelly-Vance, 2001). Studies also indicate that Big Brothers Big Sisters is cost effective, with the benefits of the programs largely outweighing the costs (Aos, Lieb, Mayfield, Miller, and Pennucci, 2004).

5.1.4 Discussion

Four strategies are included in the final catalogue for this indicator. These include the FAST and Teen Triple P programs, which are group-based family training programs. These two programs have been shown to be effective in improving behaviour and psychosocial outcomes in at risk youth, and are suitable for implementation in Australia.

As noted above, adolescents in foster care settings are at an increased risk of a range of psychosocial problems and delinquency. Evaluation studies indicate that the Multidimensional Treatment Foster Care is effective in improving outcomes for adolescents in foster care settings. As a consequence, Multidimensional Treatment Foster Care is also included in the final catalogue.

Finally, Big Brothers Big Sisters is included in the catalogue as a universal intervention to provide adult support to adolescents through mentoring. Numerous evaluation studies demonstrate that this strategy improves outcomes for at risk youth from diverse backgrounds. Furthermore, it is already established in most Australian states including Victoria and is therefore a convenient and effective program to target at-risk youth.

Three strategies were also identified during the literature search but these were not included in the final catalogue. The decision to omit PAW and the Strengthening Families Program is based on insufficient evidence for their effectiveness in at-risk youth, particularly CALD, indigenous populations and adolescents from low-income families. STEP has been widely implemented and evaluated, particularly in the US. However, the data indicate that this program has little or no positive impact on adolescent behaviour or outcomes. As a consequence, STEP was not included in the final catalogue.

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Table 2 *Proportion of young people who have a trusted adult in their life – recommended strategies*

| | Supporting evidence | Replication | Documentation | Theoretical basis | Cost effectiveness | Cultural reach |
|--|---------------------|-------------|---------------|-------------------|--------------------|-------------------------------|
| (21.1) Teen Triple P Positive Parenting Program | 3 | N | Y | Y | N | Low SES |
| (21.2) Families and Schools Together (Teen FAST) | 2 | Y | Y | Y | N | Low SES CALD |
| (21.3) Multidimensional Treatment Foster Care | 1 | Y | Y | Y | Y | Low SES |
| (21.4) Big Brothers Big Sisters | 1 | Y | Y | Y | Y | Low SES Indigenous CALD |

Key

Supporting evidence:

6. Well-supported practice – evaluated with a prospective randomised controlled trial
7. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication
8. Promising practice – evaluated with a comparison group
9. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (such as pre- and post-testing, post-testing only or qualitative methods) or historical comparison group (such as normative data)
10. Emerging practice – evaluated without an independent assessment of outcomes (such as formative evaluation, service evaluation conducted by host organisation)

Replication:

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

Documentation:

Are the content and methods of the intervention well documented (such as provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:

Is the intervention based on a well-accepted theory or developed from a continuing body of work in its field? (yes or no)

Cost Effectiveness:

Are cost-effectiveness studies available? (yes or no)

Cultural reach:

Has the program been trialed with people in disadvantaged communities, Indigenous people or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD). Universal if no specific target group identified.

Recommended strategy 21.1: Proportion of young people who have a trusted adult in their life

| | |
|---|---|
| Name of intervention | Teen Triple P Positive Parenting Program |
| Organisation | Triple P International |
| Brief literature review | <p>The Triple-P program is a comprehensive, multilevel system of parenting and family intervention. It consists of an eight week group-based family intervention program that aims to enhance parenting skills through observation, discussion, practice and feedback. Available data from several trials indicate that it has positive benefits on adolescent outcomes.</p> <p>The adolescent version of Group Triple P is currently being trialled in four Queensland state high schools.</p> |
| How and why does this intervention work? | <p>This program works by improving parenting skills (e.g. communication) and facilitating the development of positive relationships between parents and their teenage children.</p> <p>Teen Triple P has been evaluated via a randomised controlled trial of 771 adolescents from four Queensland schools (Ralph et al., 2004). Adolescents were randomly allocated to the Triple P intervention or placed on a waiting list. The results demonstrate that over a period of six months there were significant improvements in parent and adolescent outcomes compared to the control group.</p> |
| On what population does this intervention work best? | This program is most effective in families where parental skills and knowledge are poor. This includes targeting high risk parenting factors such as overly harsh parenting, communication difficulties, parental monitoring of adolescents' activities and marital conflict |
| Where will this intervention work best? | School and Community settings |
| What is required to implement this intervention? | <p>Accredited training materials (e.g. manuals)</p> <p>Provider training courses</p> |
| Resources and contact information | <p>Triple P International</p> <p>PO Box: 1300 Milton, Qld, 4064, Australia</p> <p>Email contact@triplep.net</p> <p>Ph: 61 7 3236 1212</p> <p>Fax: 61 7 3236 1211</p> |
| References | <p>Sanders et al. (2000, 2003)</p> <p>Ralph et al. (2003)</p> |

Recommended strategy 21.2: Proportion of young people who have a trusted adult in their life

| | |
|---|---|
| Name of intervention | Families and Schools Together (Teen FAST) |
| Organisation | FAST National Training and Evaluation Center |
| Brief literature review | FAST is an early intervention/prevention school and community based program. It aims to provide support networks for families and children, increase parental involvement and prevent at-risk behaviours in young people aged 11 to 14 years. The program consists of eight weekly meetings attended by groups of families who engage in a range of activities such as family communication games, role playing and group feedback, play therapy and shared meals. |
| How and why does this intervention work? | <p>FAST works by building trust and support networks for families and children, increasing parent involvement with children both at school and at home, and enhancing social support networks.</p> <p>Layzer et al. (2000) examined the impact of FAST on 407 adolescents in Canada through a randomised controlled trial. These adolescents were randomised into the FAST program or a control group. The results demonstrated that over a 12 month period, adolescents in the FAST program had improved behavioural outcomes relative to the control group.</p> |
| On what population does this intervention work best? | Adolescents who are at an increased risk of substance abuse, violence, delinquency and school failure. |
| Where will this intervention work best? | School based setting |
| What is required to implement this intervention? | Certified trained staff and school support. |
| Resources and contact information | <p>FAST National Training and Evaluation Center</p> <p>2801 International Lane, Suite 105 Madison, WI 53704 Phone: (608) 663-2382 Fax: (608) 663-2336</p> <p>E-mail: fast@fastnational.org</p> <p>Web site: http://www.fastnational.org</p> |
| References | <p>Family Service Canada (2005)</p> <p>Layzer et al. (2000)</p> <p>Macdonald et al. (1997)</p> |

Recommended strategy 21.3: Proportion of young people who have a trusted adult in their life

| | |
|---|--|
| Name of intervention | Multidimensional Treatment Foster Care |
| Organisation | TFC Consultants, Inc. |
| Brief literature review | This program targets adolescents placed in foster care homes who are at an increased risk of multiple foster-care placements or restrictive placements (e.g. youth justice, hospitals). |
| How and why does this intervention work? | <p>This program involves the identification of at risk adolescents and matching them to a foster carer, who has received additional training. A program supervisor develops a management program for the adolescent along with the carer.</p> <p>The program aims to improve behavioural outcomes by rewarding positive behaviour, providing the adolescent with a supportive adult relationship and limiting exposure to deviant peers.</p> <p>Two randomised controlled trials have examined the effect of this program in 79 adolescent male and 81 adolescent female juvenile offenders over a 12 month period (Chamberlain et al., 1998; Leve et al., 2005). The control group consisted of adolescent offenders receiving routine care. The results indicate that this program led to a reduction in delinquent behaviours and improved outcomes relative to the control groups.</p> |
| On what population does this intervention work best? | Young people in foster care settings who have experienced trauma, neglect, abandonment and have mental health problems, exhibit anti-social behaviours and/or have serious medical conditions. |
| Where will this intervention work best? | Foster care settings |
| What is required to implement this intervention? | Certified trained staff (program supervisors) and trained foster carers |
| Resources and contact information | <p>TFC Consultants, Inc. Gerard Bouwman, President 1163 Olive St. Eugene, Oregon 97401 Telephone: 541-343-2388 ext. 204 Email gerardb@mtfc.com</p> |
| References | Macdonald and Turner (2008) |

Recommended strategy 21.4: Proportion of young people who have a trusted adult in their life

| | |
|---|--|
| Name of intervention | Big Brothers Big Sisters |
| Organisation | Big Brothers Big Sisters of Australia |
| Brief literature review | <p>Community based preventive program involving planned adult mentoring for young people aged 7 to 17 years at risk of academic, psychosocial and/or behavioural problem. It is widely used in a number of countries including Australia.</p> <p>Trained staff screen adult volunteers and then match them a young person of the same sex. The Big Brother or Big Sister then meets regularly with the young person for a minimum of 12 months and provides mentoring, friendship and general concern for the well-being.</p> |
| How and why does this intervention work? | <p>Big Brothers Big Sisters works by providing mentorship and adult support to youth who are at risk of psychosocial, behavioural and/or academic problems.</p> <p>This intervention has been evaluated through a number of randomised controlled trials and longitudinal studies. For example, Rhodes et al. (2005) recently conducted a randomised controlled trial examining this intervention in 928 adolescents over a period of 18 months. The control group was comprised of adolescents placed on a waiting list for this program. The results demonstrated that adolescents in the Big Brothers Big Sisters program had improved behavioural outcomes compared to the control group. This effect was most pronounced in those who had been in the program for at least 12 months.</p> |
| On what population does this intervention work best? | Most effective in young people from low income, single-parent families, and also where psychosocial, behavioural or academic problems are emerging. |
| Where will this intervention work best? | In community and school settings. |
| What is required to implement this intervention? | Adult volunteers and trained staff to screen and match potential mentors to young people. |
| Resources and contact information | <p>Big Brothers Big Sisters of Australia Ltd</p> <p>National Office</p> <p>87 Queens Parade</p> <p>CLIFTON HILL VIC 3068</p> <p>AUSTRALIA</p> <p>Ph: +61 3 9489 4511</p> <p>Email: enquiries@bbbs.org.au</p> |
| References | <p>Rhodes et al. (2005)</p> <p>Royce (1998)</p> |

6 Number of young people convicted and placed on a community order

6.1 *Number of young people convicted and placed on a community order narrative review*

6.1.1 Background

In Australia, responsibility for juvenile justice lies with the states and territories and involves both juvenile justice agencies and other justice agencies such as the police and the courts (AIHW, 2008). The Juvenile Justice System deals with juvenile offenders aged 10-17 years. Children younger than that cannot be convicted of an offence and once a person reaches 18 they enter the adult justice system.

When a young person is convicted of a crime a magistrate has a choice from a range of penalties depending on the severity of the offence. Custodial sentences involve detention or imprisonment. Adult community based order may be set for a young person aged 17. For less serious offences a young person may be placed under a Youth Intensive Supervision Order, which may or may not include detention, or a Youth Community-Based Order, often involving community-based work or course based work or some form of rehabilitation. For minor offences no punishment may be imposed but conditions set, such as a good behaviour bond or fines and restitution.

The number of persons aged 10 to 17 years in Australia in detention has generally declined since the early 1980's, however, in 2006 there were 601 juvenile males and 50 juvenile females held in detention (Taylor, 2007). On an average day in 2006–07, there were around 6,000 young people under supervision—around 5,000 in community-based supervision and nearly 1,000 in detention (AIHW, 2008).

There are, however, some trends in the data that are of concern. The younger people are when they first enter juvenile justice supervision, the more supervision periods they are likely to complete compared with those who are older and those who were younger at their first supervision were also more likely to spend time in sentenced detention rather than sentenced community-based supervision (AIHW, 2008).

There has been an increase in juvenile offenders involved in the assault of another person and an increase in the involvement of girls in such crimes as assault (National Crime Prevention, 1999). The ratio of adult to juvenile assault cases dropped from 2.1:1 to 1.2:1 for males and from 3.4:1 to 1.9:1 for females between the periods 1973-74 and 1993-94 and the ratio of boys arrested for assault to girls arrested for assault dropped in the same period from 23.5:1 to 4.4:1 (National Crime Prevention, 1999).

Only 5% of Australians aged 10–17 years are Indigenous, but Indigenous young people were 14 times more likely to be under supervision than non-Indigenous young people in 2006–07 (AIHW, 2008). In New South Wales, Queensland and Western Australia Indigenous persons aged 10-14 years made up the majority of juveniles in detention in that age group while in the 15-17 years age group Indigenous persons comprised the majority of juveniles in detention in Queensland Western Australia and the Northern Territory (Taylor, 2007).

Early aggressive behaviour is a risk factor for later violence and criminal behaviour (Mytton et al, 2006). There is also a link between child maltreatment, particularly repeated maltreatment and later juvenile offending (Stewart, Dennison & Hurren, 2005).

The prevention of and early intervention in behavioural problems and criminal activity among young people has the potential to provide significant gains for communities, families and young people, including young offenders. A broad range of prevention and early intervention programs have been developed that follow the child's development from infancy and early childhood,

through the school years and into adolescence where serious problems may begin to emerge. Custody diversion, such as cautions or family conferencing, can also help in reducing the number of young people entering the criminal justice system.

6.1.2 The evidence base

Interventions that best help young people are those based upon principles of participation and social inclusion, including young people themselves (White, 2007). A recent review of effective interventions (AIC, 2003) found that those programs that are targeted at the individuals needs are likely to be most effective.

In particular social competence training, family conferencing, education style programs, comprehensive programs and programs targeting specific groups were found to be most effective (AIC 2003).

Interventions that use a developmental approach are often targeted at young and school aged children with a focus on reducing aggression and increasing social competence. A meta-analysis of school-based interventions for aggressive and disruptive behaviour found that the most effective programs were universal programs delivered in schools and targeted programs for selected/indicated children who participated in the programs outside their regular classes (Wilson & Lipsey, 2007). A review of school-based prevention programs for children identified as aggressive or at risk of being aggressive found that they do improve behaviour for primary and secondary students in groups consisting of boys and girls or boys only (Mytton et al, 2006).

In Australia mentoring has been used effectively as part of programs for programs for Indigenous youth (Hartley 2004). Youth from environmental risk and disadvantaged backgrounds are most likely to benefit from mentoring programs (DuBois et al, 2002). Mentoring for young indigenous offenders is most effective when there are strong links with Aboriginal communities and services, and when historical, cultural and social background influences are taken into account (ARTD Management and Research Consultants 2001). Importantly though, research has found that benefits of mentoring programs are often modest and may disappear over time unless they are based on theoretical and empirical 'best practice' and strong relationships are emphasised (DuBois et al, 2002; AIC, 2003). Evaluation of an Australian pilot mentoring program found that while mentoring could be effective suitable young offenders, its scope is limited and should be considered only one element of a larger strategy for young offenders (Delaney & Milne 2002).

Mediation in the form of family conferencing is an option increasingly used as a custody diversion option for young offenders and appears to be effective in reducing the likelihood of a young person continuing to offend (AIC, 2003). A review by Polk (2003) found that Indigenous offenders were underrepresented in family conferencing and that there were differential effects for girls compared to boys. Maxwell and Kingi (2001) found that girls were less responsive to family group conferencing, possibly because girls were less likely to reach agreement and felt less included in the process, more intimidated and unable to contribute. Polk (2003) also argued that as conferencing requires more resources than other options it should be kept for more serious cases.

Multisystemic therapy (MST) has emerged as a comprehensive program for youth with aggressive behaviour and at risk of or having already offended. MST is family-based therapeutic approach that has demonstrated long term reductions in criminal activity, violent offences, drug-related arrests and incarceration (Bourduin, 1999). Swenson and colleagues (2005) described the implementation of MST at community level and argue that programs that work to reduce criminal behaviour in adolescence are family-based behavioural interventions and structured pro-social neighbourhood projects. In contrast though, a systematic review of MST by Littell, Poppa and Forsythe (2005), using a rigorous intent-to-treat approach, did not find any substantive benefit in relation to restrictive out-of-home placements and arrests or convictions compared to usual services.

TFC is a foster family-based intervention tailored for at-risk young people and (if appropriate) their biological/adoptive families. A review conducted by Macdonald and Turner (2008) found that there was some decrease in antisocial behaviour, days spent running from placements, the number of criminal referrals and time spent in locked settings and improvements in school attendance, homework completion and finding work associated with treatment foster care.

Armeliuss and Andreassen (2007) reviewed cognitive behavioural therapy (CBT) for treating antisocial behaviour in youth in residential treatment and found that while it was more effective than standard treatment there was no evidence that CBT was any more effective than alternative treatments. Fisher, Montgomery and Gardner (2008) reviewed CBT interventions in relation to gang membership were only able to find marginal positive effects, mainly due to flawed study design.

Fisher, Gardner and Montgomery (2008) reviewed education and employment interventions aimed at reducing gang involvement but did not find any evidence that these strategies were effective. This may be because such programs are often run in isolation from other interventions and may not actually provide long term employment (AIC, 2003).

Interpersonal skills training as an isolated intervention has limited effectiveness unless it is part of an overall strategy or system of care (Taylor Eddy & Biglan, 1999).

Intensive regimes such as boot camps are unlikely to be effective in reducing recidivism unless they also contain a therapeutic component and taught skills that the young person could generalise to their regular social environment (AIC 2003). The literature indicates that when a young person returns to their normal social environment and there is no provision of aftercare, short-term positive gains made during a programme may be rendered ineffective (AIC 2003; Singh & White 2000).

Programs aimed at scaring young people into not offending have had some popularity but have not held up under research. Petrosino and colleagues (2002) conducted a review of programs that involve organised visits to prison by juvenile delinquents or children at risk for criminal behaviour and found that such programs are more harmful than doing nothing. Results indicated that these programs not only fail to deter crime but actually lead to more offending behaviour (Petrosino et al, 2002).

Other programs found to be ineffective include intensive supervision probation and peer mediation (AIC, 2003).

6.1.3 Selection of interventions

Communities That Care is a comprehensive community-wide program that focuses on modifying risk and protective factors by providing a framework for community prevention efforts. Communities That Care was originally developed in the United States where it was implemented in 500 communities with federal government support (Utting, 1999). Pilot programs have also been implemented in the UK (Crow et al, 2006) and the Netherlands (Jonkman et al, 2005) and the program is currently being trialled in a number of communities in Australia (Toumbourou, 1999).

Communities That Care (CTC) aims to promote the healthy development of children and young people through long term community planning to prevent health and social problems. CTC is theoretically based on the social development model as described by Catalano and Hawkins (1996). A number of steps are included in the CTC approach:

- Community leaders with financial and organisational influence are identified and invited to participate in training in the CTC approach.
- A Community Prevention Board is then established and training provided for members.

- Information is then gathered about community needs through school surveys, accessing local knowledge, demographic data and service analysis.
- A list of appropriate interventions is then developed to form the basis for local community strategies. (Toumbourou, 1999)

Preliminary results from the US and the UK have shown that effective implementation of the CTC approach is both sustainable (Harachi et al, 1996) and can produce impacts on problem behaviour among youth in participating communities (Crowe, 2006; Jonkman et al, 2005).

Multisystemic Therapy (MST) is an intensive family-based approach for youth with social, emotional and behavioural problems aimed at improving antisocial behaviour and reducing youth criminal activity and other negative behaviour. The aim of MST is to empower parents with the skills and resources needed to address difficulties in raising adolescents and to empower adolescents to deal with family and other problems (Borduin, 1999).

MST treatment is conducted in the youth's natural setting to allow the individual young person and their family to learn to function normally in their home, school and community. MST is tailored to the young person's individual circumstances, drawing on validated treatment strategies, including strategic family therapy, behavioural parent training, structural family therapy and cognitive behavioural therapy (Borduin, 1999).

A review by Littell and colleagues (2005) found that MST was effective as a comprehensive intervention, based on current knowledge and theory about the problems and prospects of youth and families. Earlier research found that MST was more effective than individual therapy in improving anti-social behaviour and family problems and that it was also more effective in reducing re-arrests over a 4-year period (Borduin et al, 1995).

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

- PeaceBuilders praise people
- PeaceBuilders avoid put-downs
- PeaceBuilders seek wise people
- PeaceBuilders notice hurts they have caused
- Peacebuilders right wrongs

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

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

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

6.1.4 Discussion

The development and implementation of effective programs that reduce juvenile involvement in criminal activity and alternatives to juvenile detention are likely to reduce the impact of crime and violence on both the community and young people themselves. While the number of young people in detention has declined in recent years there are still worrying trends in the rising involvement of young people in assault, particularly girls. The over representation of Indigenous young people in the juvenile justice system is also an issue that needs to be addressed.

Programs that are based on participation, social inclusion and targeted at young peoples needs are most effective. Comprehensive programs based in either school or community settings and address a range of developmental stages and levels of involvement aggressive, violent or criminal behaviour have been developed through a large body of research. The programs chosen for this catalogue of interventions are considered to have good evidence of effectiveness as well as relevancy in the Australian context.

Communities that Care recognises that there are often larger issues that need to be addressed outside the individual for individual changes to occur and be sustained. Multisystemic therapy on the other hand aims to address the needs of the individual to create lasting change. PeaceBuilders takes a development approach aimed at improving relationships between young people as well as their relationships between adults and the general community. Both Multisystemic Therapy and PeaceBuilders have good evidence for effectiveness and Communities that Care is a promising program. The continued implementation and evaluation of these programs in the Australian context is encouraged.

6.1.5 References

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Table 3 *Number of young people convicted and placed on a community order – recommended strategies*

| | Supporting evidence | Replication | Documentation | Theoretical basis | Cost effectiveness | Cultural reach |
|---------------------------------------|---------------------|-------------|---------------|-------------------|--------------------|-------------------------------|
| (22.1) Communities that Care | 4 | Y | Y | Y | N | Universal |
| (22.2) Peacebuilders | 2 | Y | Y | Y | N | Low SES Indigenous CALD |
| (22.3) Multisystemic Therapy (MST) | 2 | Y | Y | Y | N | Low SES CALD |

Key

Supporting evidence:

11. Well-supported practice – evaluated with a prospective randomised controlled trial
12. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication
13. Promising practice – evaluated with a comparison group
14. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (such as pre- and post-testing, post-testing only or qualitative methods) or historical comparison group (such as normative data)
15. Emerging practice – evaluated without an independent assessment of outcomes (such as formative evaluation, service evaluation conducted by host organisation)

Replication:

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

Documentation:

Are the content and methods of the intervention well documented (such as provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:

Is the intervention based on a well-accepted theory or developed from a continuing body of work in its field? (yes or no)

Cost Effectiveness:

Are cost-effectiveness studies available? (yes or no)

Cultural reach:

Has the program been trialed with people in disadvantaged communities, Indigenous people or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD). Universal if no specific target group identified.

Recommended strategy 22.1: Number of young people convicted and placed on a community order.

| | |
|---|---|
| Name of intervention | Communities that Care |
| Organisation | Substance Abuse and Mental Health Services Administration (SAMHSA) US Department of Health and Human Services. |
| Brief literature review | Communities That Care (CTC) is a community-based approach to crime prevention that aims to promote the healthy development of children and young people through long term community planning to prevent health and social problems. In the US evaluations have found that the CTC model was effective in mobilising community prevention boards to obtain training, conduct assessment processes and implement promising risk-reduction strategies (Harachi et al, 1996). A pilot program In the UK (Crowe et al, 2006) showed that, where the program was implemented as planned, there were positive impacts on problem behaviour (RR 4.5) when compared to students of the school who lived outside the implementation area (RR 12.0). CTC is currently being trialled through several pilot projects in Victoria. Results are yet to be fully reported, however, it appears that the CTC planning process has been successful in at least some areas in all three sites (Centre for Adolescent Health, 2005). |
| How and why does this intervention work? | CTC is a program for coordinating local prevention efforts that is theoretically based on the social development model as described by Catalano and Hawkins (1996). CTC initially identifies community leaders with financial and organisational influence. Training in the CTC approach is provided to these individuals. A Community Prevention Board is then established and training provided for members. The process then shifts to information gathering about community needs through school surveys, accessing local knowledge, demographic data and service analysis. A list of appropriate interventions is then developed to form the basis for local community strategies (Toumbourou, 1999). |
| On what population does this intervention work best? | This program has been implemented at a community level and no specific populations have been reported. CTC was originally implemented in more than 500 communities in the US with federal government support (Utting, 1999). This program has also been implemented in the UK (Crow, et al, 2006) and the Netherlands (Jonkman et al, 2005). Three pilot programs have been implemented in Australia through the Centre for Adolescent Health trial. These include Greater Bunbury in Western Australia, Mornington Peninsula and Ballarat. |
| Where will this intervention work best? | Communities That Care is a community based process that may include interventions that based around families, schools, community based youth and the overall community. |
| What is required to implement this intervention? | This program involves training for project leaders and stakeholders. A survey is also conducted to determine community needs. |
| Resources and contact information | A number of downloadable resources, including introductory material, a Getting Started guidebook, prevention strategies guide, Youth Survey and training materials are available from the Substance Abuse and Mental Health Services Administration (SAMHSA) website: http://preventionplatform.samhsa.gov Additional contact: Centre for Adolescent Health John Toumbourou, Ph: 0419 582 889. http://www.rch.org.au/cah/research.cfm?doc_id=10596 |
| References | Catalano R & Hawkins JD, 1996; Centre for Adolescent Health, 2008; Crow I, et al, 2006; Harachi TW, et al, 1996; Jonkman et al, 2005; Toumbourou JW, 1999; Utting D, 1999. |

Recommended strategy 22.2: Number of young people convicted and placed on a community order.

| | |
|--|--|
| Name of intervention | Peacebuilders |
| Organisation | Peacebuilders International |
| Brief literature review | <p>PeaceBuilders is a school-based, universal program aimed at reducing levels of violence and antisocial behaviour. PeaceBuilders has been extensively evaluated in the schools in the USA (Flannery et al, 2003; Flannery & Vazsonyi, 2001; Vosskuhler & Issman 2003; Vazsonyi et al, 2004) where findings have shown effects in both the school and the community that include decreases in aggression, increases in social competence and prosocial behaviour and improved relationships with authorities such as the police.</p> <p>Peacebuilders was also implemented and evaluated in an Australian school in South East Qld (Christie, 1999). The school was located in a community that was characterised generally as low-socioeconomic, in a high crime and drug use area, with a high population of young people and ethnically diverse. Within the first eighteen months of implementation there was a fall in detentions and suspensions, a positive increase in school satisfaction markers, a positive increase in reading markers, an increase in parent school involvement, reduced staff turnover and fewer police call-outs.</p> |
| How and why does this intervention work? | <p>PeaceBuilders addresses risk factors, which predict violence, bullying and drug and tobacco use. Participation in PeaceBuilders reduces aggression, promotes language development, teaches pro-social skills, increases parenting skills, creates inclusion for special needs children and fosters safer communities.</p> <p>The program focuses on changing circumstances that lead to aggressive behaviour, reward pro-social behaviour and provide strategies to avoid reinforcing negative behaviour (Vazsonyi et al, 2004). PeaceBuilders five main strategies include:</p> <ul style="list-style-type: none"> PeaceBuilders praise people PeaceBuilders avoid put-downs PeaceBuilders seek wise people PeaceBuilders notice hurts they have caused Peacebuilders right wrongs |
| On what population does this intervention work best? | PeaceBuilders was created for the young child, child, pre-teen and teenage children. The program is effective in both low socioeconomic/high crime communities and schools as well as culturally and linguistically diverse populations. |
| Where will this intervention work best? | This intervention works best when initiated in a school setting. |
| What is required to implement this intervention? | A teacher's kit, staff guide, leadership guide, research and evaluation tools and materials for specific issues and initiatives are available. Materials are supplied on a CD to education, government and community development organisations. Pricing is negotiated depending on entity and license provided. |
| Resources and contact information | PeaceBuilders International PO BOX 12158 Tucson, AZ 85732 USA Tel +1-520-298-7670 Fax: +1-520-844-8222 Email: mik@heartsprings.org website: http://www.peacebuildersintl.com/ |
| References | Flannery & Vazsonyi, 2001; Flannery et al, 2003; Christie et al, 1999; Vosskuhler & Issman 2003. |

Recommended strategy 22.3: Number of young people convicted and placed on a community order.

| | |
|---|---|
| Name of intervention | Multisystemic Therapy (MST) |
| Organisation | MST Services |
| Brief literature review | MST is an intervention program for youth already displaying severe multidimensional problems such as antisocial behaviour and juvenile offending. This program has been extensively evaluated in the USA where was shown to reduce aggression, levels of alcohol and drug use, re-arrest rates and increase family cohesion (Henggeler, 1992, 1993; Borduin 1995). |
| How and why does this intervention work? | MST is based on a model originally developed in mental health and provides a case management approach to dealing with at-risk young people (AIC, 2002). A number of factors affect youth behaviour (youth characteristics, family relations, peer influences, community influences) and, depending on individual circumstances, each of these factors can be changed to promote positive change. The program is conducted in the youth's natural setting rather than an external location so that the youth and their family can learn to function in their natural environment once the treatment is over. |
| On what population does this intervention work best? | MST is aimed at youth who are chronic, violent or substance abusing juvenile offenders at high risk of out-of-home placement or incarceration. Evaluation showed that MST was effective for youths of different ethnic backgrounds, ages, genders, prior arrest and incarceration records and different family, peer and behavioural problem profiles (Henggeler et al, 1991, 1992, 1993). Evaluation has shown mixed results for drug abusing young offenders and young people in psychiatric crisis (Henggeler et al, 1999a, 1999b). MST may need to be adapted to serve population group outside the 'typical' juvenile offender. |
| Where will this intervention work best? | For MST to be effective it must be delivered under regular, expert supervision and adhering to strict MST protocols. |
| What is required to implement this intervention? | There is no set curriculum for this program. MST treatment is provided by Masters-level therapists who work as employees of the MST program. Staff training and program development is provided by MST services and includes the following: Organisational assessment and assistance An initial five-day training session Weekly MST clinical consultations Quarterly booster training sessions and Ongoing monitoring for treatment fidelity and adherence. |
| Resources and contact information | Marshall E Swenson, Vice President, New Program Development, MST Services, 701 Johnnie Dodds Blvd., Suite 200, Mt Pleasant, SC 29464 Tel: 843 856 8226 ext 215 Direct: 843 284 2215 Fax: 843 856 8227 Email: marshall.swenson@mstservices.com Website: http://www.mstservices.com |
| References | Henggeler, et al, 1991, 1992, 1993; Bourduin, et al, 1995; Henggeller 1999a, 1999b. |

7 Proportion of early school leavers who are unemployed six months after leaving school

7.1 *Proportion of early school leavers who are unemployed six months after leaving school narrative review*

7.1.1 Background

This section is divided into four parts: description of the current situation; key data driving policy; current policy prescriptions; and recent government programs.

7.1.1.1 Description of the current situation

The current situation in Australia is best described by three papers: The Dusseldorp Skill Forum (2007); McMillan and Curtis (2008); and Sweet (2006).

The Dusseldorp Skills Forum (2007) states, 86% of teenagers (15-19 year olds) are either studying or working full-time. At 6 months, 9% of school leavers are unemployed. Teenage unemployment has fallen and part-time work has increased in past twenty years. The percentage of teenagers not in full-time study or work has fallen. The number of full-time jobs created for young people has remained static since 1995. Those completing year 12 are less likely not to be working or studying full-time (Year 12 – 20%, Year 11 – 45%, Year 10 – 50%). Using OECD data, 24 year olds who have not completed school are twice as likely to be unemployed as those who have completed year 12.

McMillan and Curtis (2008) show that school completion rates grew to the early 1990s, from 30% to 75%. They use questionnaire data to report that 19% of males and 13% of females do not complete Year 12, and that two thirds of early school leavers enter vocational education.

Sweet (2006) comments that school completion rates are not high by international standards and not much has changed in last decade. Teenage unemployment is high compared to OECD and higher than it should be in a healthy labour market. In response, the Australian government followed OECD advice by building better institutions and links between study and work to cater for the needs of these young people. Further work is needed in the area of separating compulsory and non-compulsory education – this creates more choice, larger student groups, more adult types of learning and adult disciplinary policies. This approach is more attractive to students and they are likely to learn more and therefore complete year 12.

7.1.1.2 Key data driving policy

Key pieces of data driving policy in Australia include:

- The rise of part time work - young people under 25 now account for 28% of all part time workers in Australia (Abhayaratna, et al. 2008).
- Low academic achievement (Pienaar, 2006; Marks, 2007) and overall motivation for schooling / education (Dowson, et al. (2005) are major drivers for students leaving school early.
- Curtis (2007) reports using LSAY data that apprenticeships programs contain more non school completers than do non apprenticeship courses and traineeships (50% vs 70-80%).

- With the recent focus on trade apprenticeships, a gender gap may be emerging, with women who leave school early obtaining casual, part-time and often low-skilled jobs, experiencing a highly competitive job market, with precarious and / or under-employment (Spierings, 2005; McMillan and Curtis, 2008).
- Using HILDA data, the Dusseldorp Skills Forum (2002) cites evidences that suggests that early school leavers are three times more likely to be unemployed than year 12 completers. Also young women who did not complete Year 12 are three times more likely to be unemployed than males who did not complete Year 12.
- McMillan and Marks (2003) in their analysis of LSAY data from the Year 9 cohort from 1995 until 2001 find that on the surface non-completion of school was associated with higher unemployment. However this association was blurred when other factors like social background and educational performance were taken into account. In terms of unemployment of recent school leavers, students from low socioeconomic status families, non-english speaking families and poor levels of literacy and numeracy were more likely to be unemployed.
- Gorgens and Ryan (2006) show data which suggests that those early school leavers with VET qualifications have the same full-time employment rates as those who do complete Year 12. They also show that early school leavers who have a period of unemployment for six months or more but then completed a VET course have improvement full-time employment rates than those who do not. The improvement is in terms of 10 to 13 percentage points (8 years post Year 9).
- Generally part time work and study in limited amounts does improve employment outcomes. However the research is unclear, in terms of whether part-time impacts on education performance, or does poor educational performance impact on the decision to work (Abhayaratna, 2008). This is a classic example of the chicken or the egg problem. For example, Vickers, et al. (2003) using Longitudinal Surveys of Australian Youth (LSAY) data found students who had a part-time job in school were more likely to be employed in full-time employment or have an apprenticeship or traineeship once they leave school. Early school leavers without any experience of part-time work are at more risk of being unemployed. However, in terms of the findings in relation to schooling, those male students working 5 to 15 hours per week in Year 9 were 40% less likely to complete Year 12 (NB: the poor completion rate was not significant for the sample of females).

7.1.1.3 Policy Prescriptions

Pienaar (2006) describes policy work in Australia, with better education pathways and flexible courses, improved funding and greater community employer partnerships and inter sectoral working a priority, but suggests more work is need in helping students who leave school early with no future plans and the need to develop employability skills in schools. Curtis (2007) in his study of LSAY data points out that those post-school who do not do any study have a greater risk of unemployment.

One alternative education pathway / flexible courses approach is the “VET in schools” program, for those students who find the academic curriculum a challenge, those in a “VET in schools” program in Australia, are likely to progress to further study, compared to those not in the program. As a group they are also more likely to be employed and interestingly they are more likely to go to university (Polesel, et al., 2007). Institutional and administrative inflexibilities between the school and TAFE sectors and the financial demands of VET make “productive and efficient cooperation so difficult”. These are “often most prevalent in those schools with the least capacity to address them” (pages 8-9, Polesel, et al., 2007). “There is also a need to move beyond institutional considerations and acknowledge that ultimately, it is the student, whether located in a school or in

TAFE, who must be the focus of policy. It is the student as a client whose best interests must be determined in the provision of accessible and suitable options.” (page 9, Polese, et al., 2007)

According to Karmel and Woods (2008), the VET sector is functioning well as a second chance for early school leavers aged 24 years and under. This group of students represented 41% of the student body in 2004. Some concerns were raised, however, with regard to completion rates for Certificate III or higher courses though more follow-up data is required.

The counter policy argument of extended schooling and government training programs is provided by the Centre for Independent Studies (Saunders, 2008) and it is to reduce the minimum wage (compensated by a change in the tax system) to allow more unskilled workers into the labour market, especially in the area of personal or home care services. This approach also recommends ending the unemployment benefit for early school leavers and the need for schools to better address social skills training. This view makes the case for the argument - why force students who are struggling to remain in school for another two years. If students are struggling at school, because of their academic ability it is unlikely that they will then go on and get higher qualifications and higher skilled jobs; as the report says “not everyone is capable of becoming a nurse, web designer or a mining engineer” (page 3). In this context, learning or the developing employability skills is important see the DEEWR web-site (http://www.dest.gov.au/sectors/career_development/programmes_funding/programme_categories/key_career_priorities/transition/#Employability_Skills_Framework) for further work in this area.

Internationally, the OECD recently reported on policy reforms for the youth labour market in the Netherlands, these were in line with its own policy recommendations (OECD, 2008). It further recommended, increased early childhood education, more effective pathways between school and the tertiary sector, and shorter courses (two years long). Some additional reforms to counter barriers to the labour market include: the need to introduce a sub-minimum wage, the need for more short term / entry level contracts for young people using wage subsidies, and the evaluation of the high level of absenteeism in supported work programs for young people. Additional measures in the Netherlands system which have application to all systems, including better evaluation, a mutual obligation approach for any second chance programs, more locally based implementation, developing programs for more disadvantaged groups, and ensuring that there is no displacement effect with mutual obligation causing disadvantaged young people to move to disability schemes.

7.1.1.4 Recent government programs

The following list highlights the work of recent government programs in Australia. It includes:

- Re-engaging early school leavers with learning in South Australia with a focus on non mainstream environments – using flexible learning environments; community input - volunteers and partnerships in education programs; and alternative pathways (TAFE/VET), negotiated learning plans and intensive support (Stehlik, 2006).
- An alternative second chance education pathway within the South Australian Educational system is described by Cook and Bills, 2005. It includes elements of adult learning, inter-agency collaboration, community leadership, advocacy and mental health support.
- Kellock 2002 examined the outcomes of transition workers in schools in Melbourne finding that the longer a transition worker operates in a school the fewer the percentage of students going to unknown destination and the higher percentage in training and full-time employment. This is further improved if the worker’s agency also provides employment service, providing greater number of early school leavers in full-time employment. Transition workers are not career guidance counsellors - they are formed as a partnership between a community based agency and schools, transition workers operate within schools providing assistance to potential early school leavers with employment and further

training. While encouraging students to complete their schooling if this appropriate, a one to one relationship is made with the student and contact is maintained after the student has left school.

Other noted Australian programs are Victorian Local Learning and Employment Networks (LLENs) and ICANs in SA. They bring together organisations and individuals to help students with transition to work and further education (Pienaar, 2006). The Innovative Community Action Network (ICAN) which brings together young people, their families, as well as community, business and government stakeholders to find local solutions to school retention issues (Social Inclusion Board, 2007). The Victorian LLENs program (<http://www.llen.vic.gov.au/about/default.asp>) brings together schools, TAFEs, employers and community organizations to work together in developing alternate education and training pathways (e.g. media production, retail) for young people in their area. Some programs include a mentorship component and are tailored to student needs. Another useful development is the OnTrack research project which follows up and examining student destinations post Year 12 completion is another useful step in this area.

7.1.2 The Evidence Base

A literature search was conducted into relevant programs or interventions designed to promote employment for early school leavers (thereby reducing the proportion who are unemployment at 6 months). The literature search included a number of components:

- Building upon the work from the Strategies for Gain report (Eagar et al., 2005) and the Best Start Catalogue of Early Intervention Strategies for Children's Health and Wellbeing report (Williams et al., 2006a, Williams et al., 2006b) looking for reviews of the evidence base
- Review of Best Start publications
- Building on the work of Lamb and Rice (2008)
- PsycINFO, MEDLINE and CINAHL (Term Analysis = MeSH and Thesaurus of Psychological Index Terms)
- Additional databases searched included: Sociological Abstracts and Education Resources Information Center (ERIC) data
- Plus feedback on search progress from the VIC Department of Education and Early Childhood Development (DEECD) - 24 July 2008
- Use of the COSI model (Bidwell & Jensen, 2003) to explore the Cochrane and Campbell Collaboration Libraries to move out into the web to search for specific programs.

This search found limited academic coverage in this area, finding no reviews comparing various educational and community interventions, and this led to a reliance on the practice literature to identify reports which compared interventions. An important source of information about interventions was the Dusseldorp Skills Forum (DSF) in Australia (web-site: <http://www.dsf.org.au/index.php>). This led to finding a two practice reviews by Gauntlett, et al. (2001) and Pienaar (2006). Gauntlett, et al. (2001) provided a useful meta-analysis of literature for community based programs for early intervention and prevention in the area of youth unemployment, while Pienaar (2006) highlighted innovative education programs.

In the absence of comparative evidence, an examination of single or individual studies into programs or interventions designed to improve early school leaver employment was conducted (see below for the list of recommended strategies for this indicator).

7.1.3 Selection of recommended strategies

Based on this search of the evidence the following strategies were recommended:

- Career Academies are drop-out prevention programs which create a school within a high school, providing alternative technical education curricula, career counselling, academic coursework and work experience with local businesses. The focus is on post-secondary education. Career themes covered in these mini-schools or learning communities include health care, finance, technology, communications and government. Career Academies have been in operation for more than 30 years and have been applied, to varying degrees, in over 2500 schools in the United States (What Works Clearinghouse, 2006).
- Work Force Youth Unemployment Prevention program in Massachusetts is a multi-partner community program includes: classes; homework; field trips; try-out employment; counselling and home visits. Parents play a key role and the program serves 100–125 young people per year (Gauntlett, et al., 2001).

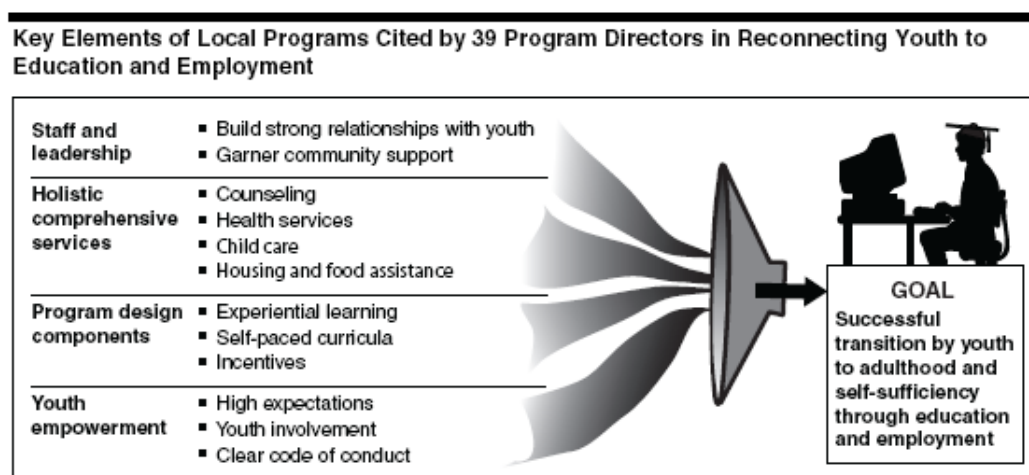
They represent two promising practices. Further details about these individual studies can be found in the catalogue.

7.1.4 Discussion

In terms of providing an overview of the area of improving employment for early school leavers only a few papers were found. This is not surprising as most of the interventions in this area are not distinct programs but require systemic or structural changes (e.g. alternative pathways in post secondary education, more funding for apprenticeships).

In the absence of academic evidence, a useful diagram comes from a survey of programs in the United States designed to reconnect youth to education and employment (Government Accountability Office, 2008). It outlines a number of key elements or success factors. These include: staff and leadership, holistic comprehensive services, program design components, and youth empowerment.

Figure 1 Key elements in reconnecting youth to education and employment – Government Accountability Office, United States



Source: GAO analysis of information provided by 39 local program directors; Images (Art Explosion).

Additional interventions worth highlighting include:

- Durham North Carolina (NC) - is a community-based prevention program, combining mentoring, employment and entrepreneurial training (Gauntlett, et al., 2001). Included

conflict resolution and anger management training. Also known as SAGE - Supporting Adolescents with Guidance and Employment.

- Adelaide Hills Vocational College (AHVC) is an alternative school / second chance program for 16 year olds and over. Provides an adult learning environment links students to TAFE, work placement and includes mental health support if required. Individualised learning with an emphasis on literacy and numeracy (Cook and Bills, 2005).

Other noteworthy papers or reports were also found. These include

- The NSW YWCA runs a community building program “Y It Takes A Village” in three disadvantaged areas (Osbourne, 2005). The program includes projects for early school leavers - enterprise projects, alternative learning & vocational pathways and Outward Bound.
- The PACTS (Parents As Career Transition Supports) program is a series of interactive and small group workshops for parents. They address issues regarding current career information and transitional resources in the community, as well as effective communication and support skills for helping young people with their decision making. This program was a pilot run by the Brotherhood of St Laurence on the Mornington Peninsula. It has reported positive outcomes in terms of meeting parental information needs and communication (Bedson & Perkins, 2006).
- The Early School Leaver program in Victoria reconnects young people in the juvenile justice system and schooling (Clifford, 2002). Run by the Salvation Army, it uses a program worker for 3- 6 months, who provides help with school / education re-entry advocacy, life skills training, as well as classroom support and family support and aid.
- Roy-Stevens (2004) outlines three programs for young people leaving custody and re-entering school. Smedslund, et al. (2006) have undertaken a systematic review of welfare to work programs for the Campbell Collaboration.
- A useful typology of for early school leavers has been used by the Youth Engagement Team, Department of Education and Children’s Services, Government of South Australia (Web-site: <http://www.youthengagement.sa.edu.au/pages/default/ThinkingRetention/?reFlag=1>). This classification system groups students according to their risk of not completing school. From lowest risk to highest risk of poor schooling outcomes, the groups are: positive leavers, opportune leavers, would-be-leavers / reluctant stayers, circumstantial leavers, discouraged leavers and alienated leavers.

Additional references on interventions for youth transitioning to adulthood can be found at the California Evidence-Based Clearinghouse for Child Welfare (web-site: <http://www.cachildwelfareclearinghouse.org/search/topical-area/10>).

Finally, a few caveats about this review should be noted.

Firstly, this review included interventions for all groups (i.e. universal) or selected groups (i.e. population defined). It did not include interventions for high risk young people with demonstrated conditions (i.e. indicated groups) like young people with parents with mental health problems, young people with physical disabilities, school refusers, homeless youth, young people with conduct disorders, young people with mental health problems, young people with substance abuse and young people in foster care.

Secondly, the focus of this review was on interventions for adolescents or young people, for example interventions for the early childhood years like the Perry Preschool Project were not included.

Finally, in examining unemployment rates and local program interventions, a multiple measures framework (Bernhardt, 2002) which examines school processes, student learning, demographic statistics (like retention rate) and school community perceptions is recommended as a valid evaluation approach to examine the context of schooling and the impact of any changes brought about by an intervention.

7.1.5 References

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Table 4 *Proportion of early school leavers who are unemployed six months after leaving school – recommended strategies*

| | Supporting evidence | Replication | Documentation | Theoretical basis | Cost effectiveness | Cultural reach |
|--|---------------------|-------------|---------------|-------------------|--------------------|-----------------|
| (23.1) Career Academies | 1 | N | Y | Y | Y | Low SES CALD |
| (23.2) Work Force Youth Unemployment Prevention program in Massachusetts | 4 | N | Y | Y | N | Low SES CALD |

Key

Supporting evidence:

16. Well-supported practice – evaluated with a prospective randomised controlled trial
17. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication
18. Promising practice – evaluated with a comparison group
19. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (such as pre- and post-testing, post-testing only or qualitative methods) or historical comparison group (such as normative data)
20. Emerging practice – evaluated without an independent assessment of outcomes (such as formative evaluation, service evaluation conducted by host organisation)

Replication:

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

Documentation:

Are the content and methods of the intervention well documented (such as provider training courses and user manuals) and standardised to control quality of service delivery? (yes or no)

Theoretical basis:

Is the intervention based on a well-accepted theory or developed from a continuing body of work in its field? (yes or no)

Cost Effectiveness:

Are cost-effectiveness studies available? (yes or no)

Cultural reach:

Has the program been trialed with people in disadvantaged communities, Indigenous people or people from culturally and linguistically diverse backgrounds? (LOW SES/INDIGENOUS/CALD). Universal if no specific target group identified.

Recommended strategy 23.1: Proportion of early school leavers who are unemployed six months after leaving school

| | |
|--|--|
| Name of intervention | Career Academies |
| Organisation | Career Academy Support Network, Graduate School of Education, University of California at Berkeley, Berkeley, CA. |
| Brief literature review | <p>Career Academies have been implemented in approximately 2500 high schools in the United States and they have been evaluated by the MDRC group since 1993 - producing 8 major reports using a random assignment research design (Kemple, 2008).</p> <p>The most recent report by Kemple (2008) highlights previous research which suggests that those student's who have a high risk of dropping out and who enter Career Academies increased school attendance, improved school progression to Year 12 and obtained more credit points toward graduation. In the present study, 1428 students (41% were males, 50% Hispanic background, 30% African American background), across 9 high schools were followed up 8 years post Years 11 and 12. Those who were assigned to Career Academies, and those who wanted to attend but where not accepted by a lottery system (i.e. random selection) had no major differences in school completion and post secondary education or school attainment - though both groups were higher than the national average. These non significant findings also applied when students at high risk of drop-out (approximately 25% of the total sample) were examined. The major finding of this study was improved employment outcomes (including earnings and time in employment) for Career Academy members, especially for young men. This significant finding also applied to students who were at high risk of drop-out.</p> |
| How and why does this intervention work? | <p>Career Academies have three core elements: small learning communities within schools to create a supportive learning environment; combining academic and technical courses around a career theme (e.g. health care, finance, technology, communications and government) to enrich learning; and establishing partnerships with local employers to provide work based learning and awareness (Kemple, 2008). Career Academies come from a range of educational backgrounds. For those students at risk of dropping out, Career Academies seek to re-engage them by providing more applied learning experiences and promoting higher goals for further education and employment (Kemple, 2008).</p> |
| On what population does this intervention work best? | <p>The intervention works for schools catering for a diverse population and with students at risk of dropping out (Kemple, 2008).</p> |
| Where will this intervention work best? | <p>Career Academies have been evaluated in low income urban communities in the United States, containing large proportions of students from African-American and Hispanic backgrounds. Most of the research for this intervention has been conducted in the United States.</p> |
| What is required to implement this intervention? | <p>Supportive school and education systems in partnership, with local employers.</p> |
| Resources and contact information | <p>http://casn.berkeley.edu/</p> |
| References | <p>Kemple & Snipes (2000) Career Academies: Impacts on students' engagement and performance in high school. New York: MDRC (Manpower Demonstration Research Corp.)</p> <p>Kemple (2008) Career Academies: Long-term impacts on labor market outcomes, educational attainment, and transitions to adulthood. New York: MDRC (Manpower Demonstration Research Corp.)</p> <p>What Works Clearinghouse (2006)</p> |

Recommended strategy 23.2: Proportion of early school leavers who are unemployed six months after leaving school

| | |
|---|--|
| Name of intervention | Work Force Youth Unemployment Prevention program in Massachusetts / The Work Force Youth Program |
| Organisation | Cambridge Housing Authority http://www.cambridgema.gov/jobs2.cfm?message_id=8 |
| Brief literature review | <p>The Work Force Youth program is a multi-partner community program including: educational classes; homework; field trips; work experience; counselling and home visits. Parents play a key role and the program serves 100–125 young people per year (Gauntlett, et al., 2001).</p> <p>The original study was published in 1988 with young people (13 to 16 years of age) from mainly African American or Hispanic backgrounds. Gauntlett, et al., 2001 in their review report a reduction in unemployment and stronger community links.</p> <p>The project's website reports very high graduation (100%) and retention rates (80%), with good job placement outcomes (completion and skills = 95%) and high levels of post-secondary course enrolment (95%). However there was no comparative or control group evidence.</p> |
| How and why does this intervention work? | <p>Started in 1984, the Work Force Youth Program offers “a structured series of work and community-based learning experiences for youth in CHA housing” (from Program Description). This 5-year program supports Year 8 / Year 9 and Year 12 / Post secondary or employment transitions; helping students develop “social, educational and vocational competencies”.</p> <p>The program includes the following experiences /activities to develop the three competences:</p> <p>Social - Teaching about personal values and choices, including critical thinking and effective decision making; workshops on financial literacy and financial measurement;</p> <p>Educational - Homework centres, computer labs, one to one tutoring, exam preparation classes, literacy camps;</p> <p>Vocational - Paid work experiences with local employers, workshops on job readiness and career options, guidance counseling, college visits and a post-secondary scholarship program.</p> <p>These experiences / activities are undertaken within a framework which involves parents, as well as utilises mentorship, case management and individual development plans.</p> |
| On what population does this intervention work best? | The intervention is designed for disadvantaged youth (13 – 19 years of age) living in public housing and currently enrolled in school. |
| Where will this intervention work best? | The Work Force Youth Program is currently being run in a number of public housing estates in Cambridge, Massachusetts. |
| What is required to implement this intervention? | Supportive school and education systems in partnership, with local employers. College students are also required to act as tutors and mentors. |
| Resources and contact information | http://www.bc.edu/schools/cas/pulse/placements/Workforce.html |
| References | Gauntlett, et al., 2001 (Review) Lassen 1995 (Original paper) |

Appendix A Evaluation framework

| | | |
|----------------------------|--|--|
| Supporting evidence | <ol style="list-style-type: none"> 1. Well supported practice – evaluated with a prospective randomised controlled trial. 2. Supported practice – evaluated with a comparison group and reported in a peer-reviewed publication. 3. Promising practice – evaluated with a comparison group. 4. Acceptable practice – evaluated with an independent assessment of outcomes, but no comparison group (e.g., pre- and post-testing, post-testing only, or qualitative methods) or historical comparison group (e.g., normative data). 5. Emerging practice – evaluated without an independent assessment of outcomes (e.g., formative evaluation, service evaluation conducted by host organisation). | Code: 1, 2, 3, 4 or 5. <input type="checkbox"/> |
| Replication | Has the intervention been implemented and independently evaluated at more than one site? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Documentation | Are the content and methods of the intervention well documented (e.g. provider training courses and user manuals) and standardised to control quality of service delivery? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Theoretical basis | Is the intervention based upon a well accepted theory or developed from a continuing body of work in its field? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cost-effectiveness | Are cost-effectiveness studies available? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Cultural reach | Has the program been trialled with people in disadvantaged communities, Indigenous people and/or people from culturally and linguistically diverse backgrounds? | Low SES <input type="checkbox"/> Indigenous <input type="checkbox"/> CALD <input type="checkbox"/> |