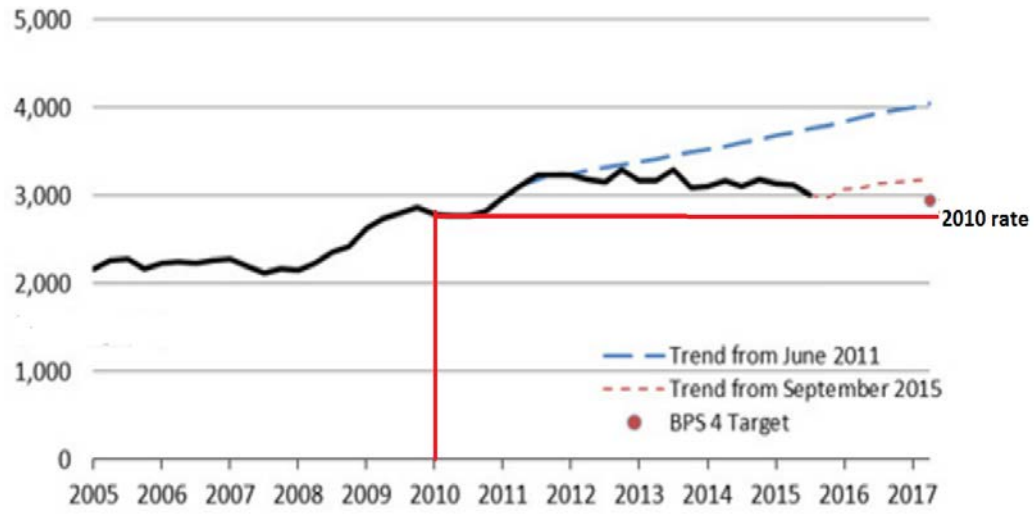
Outline of the evaluation of Jade Speaks Up pilot project Violence Free Communities and ACC 2016

Contents

Introduction

Violence towards children in New Zealand is major problem (OECD, 2009; Clark et al, 2013). Its reduction is one of the five Better Public Service target areas for New Zealand, one of which is *Supporting vulnerable children* (State Services Commission, 2016a). The measure for this target is that between 2010 and 2017, the number of children suffering substantiated *physical* abuse will rise (our emphasis) by 5% (Ministry of Social Development, 2015). MSD's projection in 2015 suggests they will not achieve the target by 2017 (see figure 1).

Figure 1: Children experiencing substantiated [physical] child abuse (12 months to September 2015). Figure from Ministry of Social Development (2015).



As noted by Bridgman & Dyer (2015) "Figure 1 shows that across New Zealand, the number of children experiencing substantiated physical abuse has risen from about 2750 in 2010 to 3000 in 2015. This is an 8.5% increase in substantiated child *physical* abuse prevalence" (p16). We have already noted in the proposal the enormous financial costs of family violence in New Zealand.[1]

The *Jade Speaks Up* (Dyer, 2014) programme is one of several programmes designed by Violence Free Communities to reduce violence towards children (Bridgman & Dyer, 2015) and is based on the experience gained from the earlier *Violence Free Begins with Me (VFBWM)* (Woodley, 2009) run in several West Auckland Schools from 2004 to 2012. In 2011-2012 evaluation was conducted in programmes run in four schools (Violence Free Waitakere, 2011, 2012). Table 1 (Bridgman, 2011) shows the outcome with 142 students who completed the programme and did the pre- and post-questionnaires. Overall only 5% were definitely not going to recommend the programme to a friend and 61% definitely were. The overall "usefulness" of the programme was judged as being "quite useful" or better by almost all of the sub-groups. One clear difference stood out: girls were more supportive than boys. Age and cultural groups who were lower on the measure of usefulness were higher on their preparedness to recommend the programme, and generally all sub-groups seemed to benefit from it.

Here are two comments from enthusiastic student promoters:

[1] See appendix 1 for more details on the *Assumptions behind Violence Free Begins with Me / Jade Speaks Up schools programme.*

'I looooooooooooooooovvvvvvvveeeeeeeee school Survey cause its really good for my anger'

and

'I would like to say thank you for doing this because when I go home after school I see people on the road doing violence and get mad at their kids and hit them and its sad so thank you very much. AT SCHOOL I DONT LIKE WHEN PEOPLE FIGHT AND UPSET OTHER PEOPLE AT ALL BUT I WANT EVERYONE TO BE HAPPY THANK YOU'

Table 1: post-test measures of satisfaction	N	Overall, how useful did you find Violence Free Begins With Me? Average rating	Would you recommend that other students do the programme?			% responding
		1= Not at all useful,2=Not particularly useful, 3=quite useful. 4=very useful	Yes	Maybe	No	
Female	59	3.31	68%	31%	2%	100%
Male	83	3.01	55%	35%	6%	96%
Year 8	72	3.06	68%	26%	4%	99%
Year 7	70	3.22	53%	40%	4%	97%
School A	55	3.16	60%	35%	4%	98%
School B	87	3.12	61%	32%	5%	98%
Multi-ethnic	12	3.27	83%	17%	0%	100%
Other	14	3.38	76%	24%	0%	100%
Maori	14	2.91	73%	27%	0%	100%
Pākehā/Euro	20	3.29	68%	29%	4%	100%
Pacific Island	62	3.14	57%	32%	6%	96%
Asian	20	3.05	48%	48%	5%	100%
Culture not clearly stated	27	2.67	7%	11%	4%	22%
Total	142	3.13	61%	33%	5%	98%

We have already discussed in the project proposal the problem with finding resources and maintaining focus for the 14 weeks of VFBWM and the need to reduce the keeping ourselves and others safe project to its essential messages of "communication skills, understanding of feelings, safety planning, self-esteem, healthy relationships, making positive choices and conflict resolution". Our evaluation is deigned to explore whether or not these skills and behaviours have been learned and whether children's feeling of well-being has improved as a result.

The project would contain the following.

Participants

We will involve intermediate level children (aged 10-12) from at least 4 schools, with one being rural and with a mix of deciles and cultural composition of schools. Some potential schools considered: Whakatane, Huntly, Mt Roskill (Council project or Logos), Newton Primary, Kelston and Bruce McLaren Intermediates, Ranui and Lincoln Heights. The gender, age, culture and decile mix will be compared with the New Zealand population of 10-12 year olds using chi-square. There should be no difference between the sample and New Zealand for gender and age. Culture and decile

equivalence may require a larger sample. We will use 2015 Education Counts data to guide us on sample selection to match the New Zealand population, where choices are possible.

A minimum of 800 students will be involved (40 classes and 20 teachers), with roughly equal numbers in each of the three age groups. Educations Counts has 173,765 10-12-year-olds in schools in New Zealand 2015 and a sample of 400 is statistically representative of that population with a 4% margin of error (Survey Monkey, 2015), given a matching of demographic features between the sample and the school population. To get 800 completions after the consent process, student non-completion of the pre-and post-assessments, and loss from dropouts, we will have to expect a 25% loss from the beginning sample which would mean selecting 1066 students to begin with (Bridgman, 2011; Esbensen, Osgood, et al, 2013).

We are approaching schools who have already been involved in the MOE's PB4L (Positive Behaviour for Learning) course, on the assumption that they will already have policies and practices in place which will deal with issues such as disclosures (though of course will check this) and also who have a staff group that is proactive around supporting their students to deal with issues affecting their behaviour.

Pre- post- and follow-up programme student questionnaire

The full project uses pre- and post- programme and follow-up (6-months later) student and teacher questionnaires and qualitative data drawn from training and support conversations with teachers. The questionnaires (tick box and open ended questions) are designed to assess the change in students exposed to the Jade Speaks Up programme. The student questionnaires (pre-, post- and follow-up) will be conducted as an online questionnaire, and have the components shown in table 1.

TABLE 1: Questionnaire components	JSU programme			Class as usual	
	pre-test	post-test	follow-up	pre-test	post-test
Demographic questions: school, decile, class, age, gender, culture.	✓	✓	✓	✓	✓
Emotional literacy questions: two picture based and a four short answer questions.	✓	✓		✓	✓
Protection resources: five short answer questions.	✓	✓	✓	✓	✓
Safety skills questions: five tick box questions	✓	✓		✓	✓
Measures of global distress: the 20-item Center for Epidemiologic Studies' Depression Scale for Children (CES-DC; Weissman, Orvaschel, & Padian, 1980) and the Child Outcomes Rating Scale (Duncan, Sparks et al, 2006).	✓	✓	✓	✓	✓
Outcome scenario		✓	✓		✓
Rating and comment questions on the overall value of JSU		✓			

All of the questions are able to scored (see the attached print out for details) and it is possible to see over the time period of the research improvements in emotional literacy, knowledge of protection resources and knowledge of safety skills and reductions in global distress, all of which are objectives of the Jade Speaks Up project. The images used in the first of the emotional literacy questions are from the *Body Language Quiz / Test Your Emotional Intelligence* produced by the Greater Good Science Centre (2016) of the University of California Berkley. All other questions apart from the tests of global distress have been created by the study authors

The emotional literacy, protection resources and safety skills questions align with the core learning goals of the course - e.g. understanding feelings, the concept of trust and evidence of thinking about

ways to create a safety plan, some self-care strategies and understanding different forms of violence. For emotional literacy, we are using photographs of adults displaying different emotions, to show how accurately children aged between 10-12 can read/recognise adult emotions.

Center for Epidemiologic Studies' Depression Scale for Children

One of the expectations from a successful programme is that children will feel safer at home and school and that in turn will mean less anxiety, less depression, more positivity and better relationships. Both the standardized scales in this evaluation are capable of measuring reliable small changes in these areas.

Table 2: The four subscales of the CES-DC. (The numbers are the order of the questions)	
1. I was bothered by things that usually don't bother me	Somatic symptoms and retarded activity
2. I did not feel like eating, I wasn't very hungry	Somatic symptoms and retarded activity
5. I felt like I couldn't pay attention to what I was doing	Somatic symptoms and retarded activity
7. I felt like I was too tired to do things.	Somatic symptoms and retarded activity
11. I didn't sleep as well as I usually sleep.	Somatic symptoms and retarded activity
13. I was more quiet than usual.	Somatic symptoms and retarded activity
20. It was hard to get started doing things	Somatic symptoms and retarded activity
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	Depressive affect
6. I felt down and unhappy	Depressive affect
9. I felt like things I did before didn't work out right.	Depressive affect
10. I felt scared.	Depressive affect
14. I felt lonely, like I didn't have any friends.	Depressive affect
17. I felt like crying.	Depressive affect
18. I felt sad.	Depressive affect
4. I felt like I was just as good as other kids	Positive affect
8. I felt like something good was going to happen	Positive affect
12. I was happy	Positive affect
16. I had a good time	Positive affect
15. I felt like kids I know were not friendly or that they didn't want to be with me.	Interpersonal problem
19. I felt people didn't like me.	Interpersonal problem

CES-DC is a 20-item scale with a good record of internal consistency (a= 0.88, Brage, Merdith, & Woodward, 1993; 0.87–0.92, Hudson, Elek & Campbell-Grossman, 2000; 0.84-0.89; Froh, Fan et al, 2011; 0.91, Brown, Harris, Woods & Cox, 2012); and convergent validity - correlated with the Childrens's Depression inventory, r=-0.61 (Kovacs, 1992; Faulstich, Carey et al, 1986); the Social Adjustment Scale Self-Report, r=-0.75 (Weissman & Bothwell, 1976; Weissman, Orvaschel & Padian, 1980); and with self-report of loneliness via the Revised UCLA Loneliness Scale (Roberts, Andrews, Lewinsohn & Hops, 1990). More recently, the German translation of CES-DC (Barkmann, Erhart & Schulte-Markwort, 2008) has been shown to have convergent validity for self-report with a number

of protective factors for children such as family cohesion, parental support, social support, peer competence, self-efficacy, self-esteem and optimism (r=0.23 to 0.43) and for a range of quality of life measures (r=-0.26 to -0.51) Bettge, Wille et al, 2008).

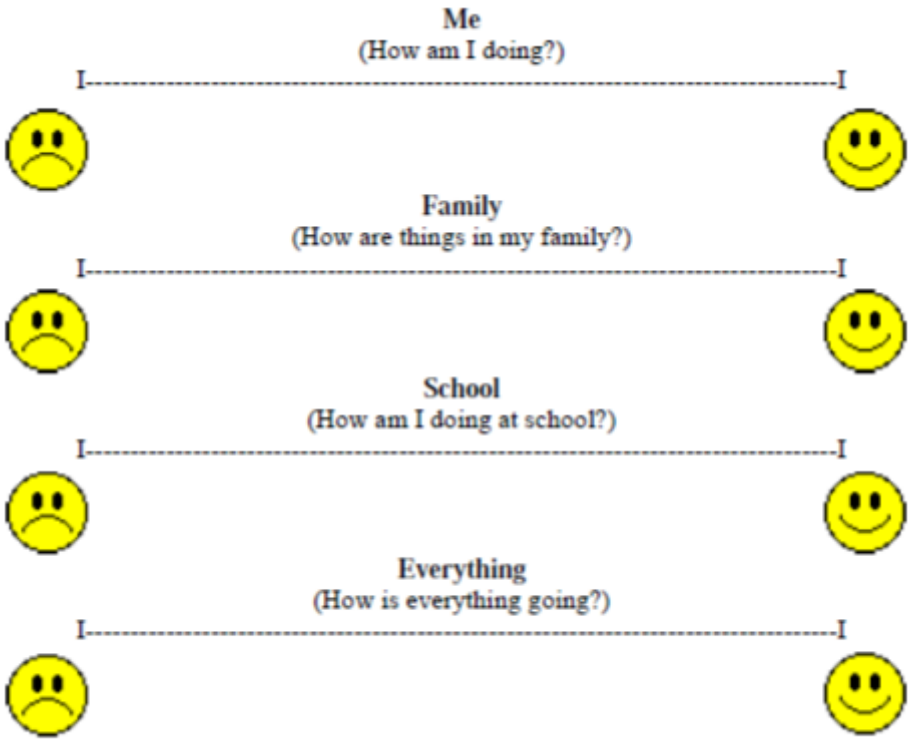
The CES-DC has been used in topics ranging from the connection between internet use and depression (Banjanina, Banjaninb, Dimitrijevicc, & Pantic, 2015); validation of an instrument for OCD assessment (Jones, De Nadai et al, 2012); the relationship between gratitude, materialism and well-being (Froh, Emmons et al, 2010); and the effectiveness of therapeutic play for children with cancer (Li, Chung & Ho, 2011).

The German translation of the CES-DC has also been factor analysed into four distinct subscales - somatic symptoms and retarded activity, depressive affect, positive affect, interpersonal problem (Barkman et al, 2008) – see table 2). This factor analysis was confirmed in the development of a Chinese version of CES-DC (Li, Chung & Ho, 2010) who also reported strong convergent validity with standardised tests of anxiety and self-esteem. Other translations have been into Swedish (Olsson & von Knorring , 1997), Farsi in Iran (Essau, Olaya et al (2013) and Kinyarwanda in Rwanda (Betancourt, Scorza et al, 2012) again showing good internal consistency and convergent validity.

CES-DC has been designed as a screening test for childhood depression and has a scoring range of 0 - 60, and 15 has been set the cut-off indicating risk of depression (Wiessman et al, 1980), at which point it has a sensitivity of 71% and a specificity of 57% (Fendrich et al, 1990).

The Child Outcome Rating Scale

The Child Outcome Rating Scale (CORS) is an adaptation of the Outcome Rating Scale (ORS) developed by Miller and Duncan (2000) as part of a project to get therapists (counsellors, psychotherapists, psychologists) to pay greater attention to the outcome of each therapeutic session in an attempt to improve treatment outcome. CORS is four-item measures recorded as marks on 10cm lines anchored at each end by the positive and negative limits of each item. It takes less than 5

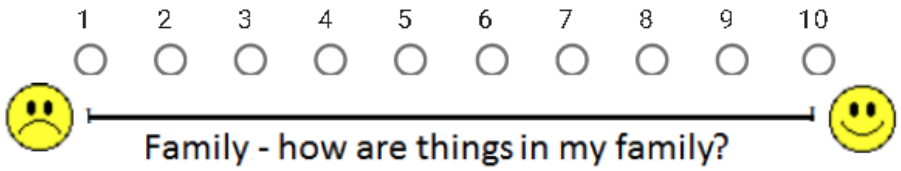


minutes to complete. In 2003 (Duncan, Miller & Sparks) produced the CORS (see below) and in 2006 Duncan, Sparks et al demonstrated CORS test-retest reliability (r=0.60) across clinical and non-clinical self-report populations; internal consistency (a=0.84) and between caregiver and self-report administrations (r=0.63) and convergent validity between caregiver administrations of CORS and the 64-item Youth Outcome Scale (r=--0.43, Lambert & Burlingame, 1996). Cooper, Stewart, Sparks & Bunting (2013) found that CORS caregiver and teacher administrations correlate with the Strengths and Difficulties Questionnaire (Goodman, 1999), r=0.49 for caregivers at baseline and r=0.60 at endpoint, and r=0.58 and r=0.69 for teachers respectively.

The scoring for each scale is from 0 to 10 (measuring the distance of the mark from the left hand anchor point) and the maximum total score is 40. Based on the difference between the clinical and non-clinical samples a cut-off point of 32 was suggested for an indication of "global distress" for children aged between 7 and 12 (Duncan, Sparks et al. 2006). In later British clinical school-based samples 73% were below 32 on first assessment and 9% at completion of the counselling in one study (Cooper, Stewart et al, 2013); and 53% and 15% respectively in a second study (Fernandes, 2015). Generally, there is a recent strong uptake of the use of CORS in counselling services in British schools and generally in child mental health services (Timimi, Tetley, Burgoine & Walker, 2012; Barth, Lee, Lindsey, Collins et al 2012; Law & Wolpert, 2014).

CORS use as a feedback system for focussing teacher attention

In the pre- and post-test children will mark their CORS wellbeing by digitally ticking a circle on a 10-circle continuum (see below) rather than making a mark on a line, which may affect the scoring.



However, CORS will also be used in pencil and paper form as part of a feedback process of teaching children how to manage frightening and potentially violent situations. In counselling situations the use of CORS has been shown to improve counselling outcomes because of the session by session feedback it provides to the therapist (Cooper, Stewart et al, 2013; Fernandes, 2015), so getting the children to do the pencil and paper version on weeks 1,3, and 5 of the project and feeding those results back to the teacher will not only confirm or otherwise the reliability of our digital version of CORS, but give the teacher information about where she might best focus her attention.

In contrast to the more detailed pre- /post-questionnaire, we see value in the CORS being done by pencil and paper, as it will be easier for all of a classroom to do this at the same time, early in the day near the beginning of the week while the course is being conducted. This would take no more than 5 minutes. Children whose scores are below the cut-off point for risk of distress will be brought to the attention of the teacher so that they can pursue their own inquiries with and support of such children, where needed. The disadvantage with this process is that the data has to be collected and entered into a Google form by a research assistant. The results would then be available to the research team and through them to the teacher.

Focus on specific children

On the basis of the pre-test 40 children will be chosen (2 children per class) from the JSU programme group for closer attention from the teacher:

- 20 “vulnerable” children scoring 4-points below the cut-off points for the CORS (28 and below) and 10 points above the cut-off point for CES-DC (25 and above) and a lower score on the safety skills knowledge questions 16, 23 and 24; and
- 20“safe” children scoring above the CORS cut-off point (33 and above), below the CES-DC cut-off point (15 and below) and a higher score on questions 16, 23 and 24.

We seek, through a questionnaire, a teacher’s view of the progress these two children have made. The teacher will not be told about pre-test scores or labels, only that the children have been randomly selected.

Pre- and post-programme teacher questionnaires[2]

Approximately 20 teachers will be involved with the JSU programme group. The pre-programme teacher questionnaire assesses the following using a mix of tick box and comment questions:

- Pre-existing conditions that might affect the value and uptake of the programme such as previous keeping ourselves safe programmes and the atmosphere of the class.
- Perceived value of the training
- Knowledge of protective resources and teacher CORS wellbeing assessment for two selected students, one “vulnerable” and one “safe”.

The post-programme teacher questionnaire assesses the following using a mix of tick box and comment questions:

- Classroom conditions (repeat of the pre-test) that may have changed as a function of Jade Speaks Up
- Perceived value of the training and implementation of the programme
- Knowledge of protective resources and teacher CORS wellbeing assessment for two selected students, one “vulnerable” and one “safe” – repeat of pre-test, plus descriptions of change that may have occurred.
- Global assessment of programme effectiveness.

The follow-up questionnaire to teachers will be a reduced form of the post-test covering

- Classroom conditions (repeat of the pre-test) that may have changed as a function of Jade Speaks Up
- Global assessment of programme effectiveness.

In addition, the programme leaders will have conversations with teachers (email, skype, face-to-face) at the training, two and four weeks into the programme and at the end of the programme. These conversations are aimed at answering the “how’s it going” question, as well as identifying any issues of concern for children. However, this contact won’t be structured as a narrative interview as the aim is to give advice and support as well as answering the above question. The development of an online webinar process to allow several teachers who are participating in the programme to share notes and review progress is part of our planning.

Analysis

The sample size will be generalizable to the New Zealand school cohort of 10-12 year olds with a margin of error of 4% at 95% confidence level. Data from Education Counts (2016) permits an a-priori analysis of the degree to which the population of 10-12 year olds in a sample of schools are a

[2] JSU Teacher pre-programme questionnaire is available at https://goo.gl/forms/gbQUkJmMEHljEUCv1; the post-programme questionnaire at https://goo.gl/forms/QlfsGVF5rgTwYUV73

statistical match for the New Zealand cohort, and this will have some influence on the schools we select. This means that all the pre-test measures could give a general indication of where New Zealand schools are functioning in terms of vulnerability and preparedness around the issue of addressing violence prevention in the lives of 10-12-year-old children.

We will use multiple regression analysis to explore the inter-related effect of the key demographic variables (age, gender, culture, decile, school) of the measures of change in project. Using Soper's (2016a) A-priori Sample Size Calculator for Multiple Regression, a sample of 400 with five predictor variables and a statistical power level of 0.8 will be able to detect small differences (Cohen's f2= 0.0324) at $p<0.05$. Medium sized differences (Cohen's f2= 0.015) could be detected be detected with a sample/sub-sample sizes of 91 and for medium to small differences (Cohen's f2= 0.085) as many as 50 predictor variables could be addressed with a sample size of 400.

Again using Sopers' (2016b) calculators, looking at the statistical power for pre and post comparisons on the individual and consolidated measures used in the project, using Cohen's d=0.8 (strong effect size), statistical power level of 0.8 and a two-tailed hypothesis, 53 is the minimum sized group to enable the detection of significant small differences ($p<0.05$). This means that we should be able to detect significant changes in relatively small sub-samples (e.g. specific cultural groups) of the sample.

With respect to changes in the CES-DC and CORS. The large CES-CD Swedish sample (2270) had a SD=10.80 (Olsson & von Knorring, 1997), which means for a sample of 400, a pre-/post- or an experimental/control difference of ±1.4 will be significant at $p<0.01$, and ±1.05 at $p<0.05$, and for sub-sample of 50 the difference would have to be ±4.1, and ±3.1 respectively (Soper 2016c). With CORS the non-clinical group (n=119) SD in Duncan, Sparks et al 2006 validation study was 7.8, which means for a sample of 400, a pre-/post- or an experimental/control difference of ±1.4 will be significant at $p<0.01$, and ±1.00 at $p<0.05$, and for sub-sample of 50 the difference would have to be ±3.0, and ±2.2 respectively. In summary small, significant changes with large effect sizes will be able to be detected even, in most cases, at sub-sample level.

With 80 possible comparisons between student pre- and post-test CORS and student pencil and paper CORS 1 and 3 and between student pre- and post-test CORS and teacher pre- and post-test CORS, correlations of r=0.19 will be significant.

Thematic analysis will be used with the comment data from questionnaires and teacher observations of the children selected as case studies to add depth to the statistical analysis, as will narratives from conversations with teachers.

Ethical issues

There are five key ethical issues apart from the standard one of preserving the anonymity of the students, teachers and the schools involved (Loveridge, 2010).

- *Perceived risk to vulnerable children* if their issues are exposed and not properly addressed. Schools are required under the Education Act to properly address issues of violence that are outside the school as well as inside. In using JSU, schools are trying to improve their capacity to respond. This project is born out of many years' experience of both the principal researcher and the project leader working in violence prevention in schools and in the community.
- *Disclosure of sensitive information* about children's negative experience/vulnerability gained in the research thus breaking rules of confidentiality. The project would follow procedures under the Vulnerable Children's Act on reporting of acts and threats of violence towards

children. The process of responding to student disclosures is a key part of the training for teachers. We believe the chances of acts of concern being disclosed in the assessments we are using to be very low. We would, of course, check out whether action had been taken where issues of concern were reported.

Otherwise, we will not pass on the individual results from CES-DC or CORS gained (which can identify unspecified but significant distress) in the child pre-/post-tests or the CORS from the teacher pre-/post-programme as the teachers will already be privy to the results from three CORS assessments done in class to help them identify and support vulnerable children. CES-DC and CORS both have cut-off points for risk of distress which although reasonably sensitive in clinical populations have high false alarm rates with non-clinical groups. Some care has to be taken with their interpretation with individual students, and the approach we are taking is practical – is there an issue that needs to be addressed, if so what can be done? If not, it's a false alarm and ignore it. All of data from these pre/post assessments will be presented in aggregate form so as to preserve the anonymity of the participants.

- *Consent.* We will need to get school board consent, parental consent, student and teacher consent for the research project. We can expect that about 20% of parents will either refuse consent or not respond to requests for consent and that a small percent of students may not complete the assessments (Esbensen, Osgood et al. 2013). To minimise loss of participants through the failure of parents to respond to consent requests, we will state on the consent form that non-return of the form will be taken as an indication of consent. Teachers will be informed that their check-up conversations are being recorded (notes or audio), and will be asked for permission to do this each time. Refusal would not mean that advice and support would be withdrawn. Students for whom consent to engage with the research has not been given, will still be full participants in the programme, but no data will be collected from them that will go back to the researchers.

- A research approach that is *sensitive to the needs of Māori and Pacific Island students* and those of other non-European/Pākehā cultural background. As can be seen from table 1 all of our preliminary work involved has involved a wide range of cultural groups and Pākehā/European origin have been only around 20% of our cohort. The Jade Speaks Up film addresses the multi-ethnic character of New Zealand and is designed so that a wide variety of children could recognise aspects of themselves in the characters, many of whom are voiced by Māori and Pacific Island actors. Similarly, the content of the modules is drawn and reflects our multi-ethnic background. In the Auckland region Social Workers in Schools working for the Catholic and state schools with a high non-Pākehā/European roll have purchased more than 60 copies of the JSU programme.

  As a researcher and a supervisor of graduate and under-graduate research, Geoff Bridgman, has 30 plus years of extensive engagement with research projects involving Māori and Pacific Island participants and researchers. Elaine Dyer trained as teacher, but has worked in prisons and in her 15 years as CEO of Violence Free Waitakere designed and ran projects, some involving more than 10.000 people, all of which engaged with and promoted the wellbeing of Maori, Pacific Island and the wide range of smaller cultural groups in West Auckland. One of the trainers in our project is Carol Smith (Te Rarawa), also a teacher, who has worked in Vanuatu and now lectures in the Bachelor of Education at Unitec. Andrea O'Hagan, programme co-developer/ trainer is currently active in Whakatane where a large proportion of her interaction in schools and community is bi-cultural by nature. Andrea is

also a teaching fellow at University of Waikato where Maori values are a guiding principle. (see original Business plan for more details of the team)

- *Teacher deception*. Telling the teacher that their two case study students have been randomly selected rather than selected as representatives of "vulnerable" or "safe" students is to prevent our perceptions of the students influencing how the teacher responds to them. Test results can have a strong effect on teacher behaviour and thus deception is small, but necessary.

Project delivery timeline

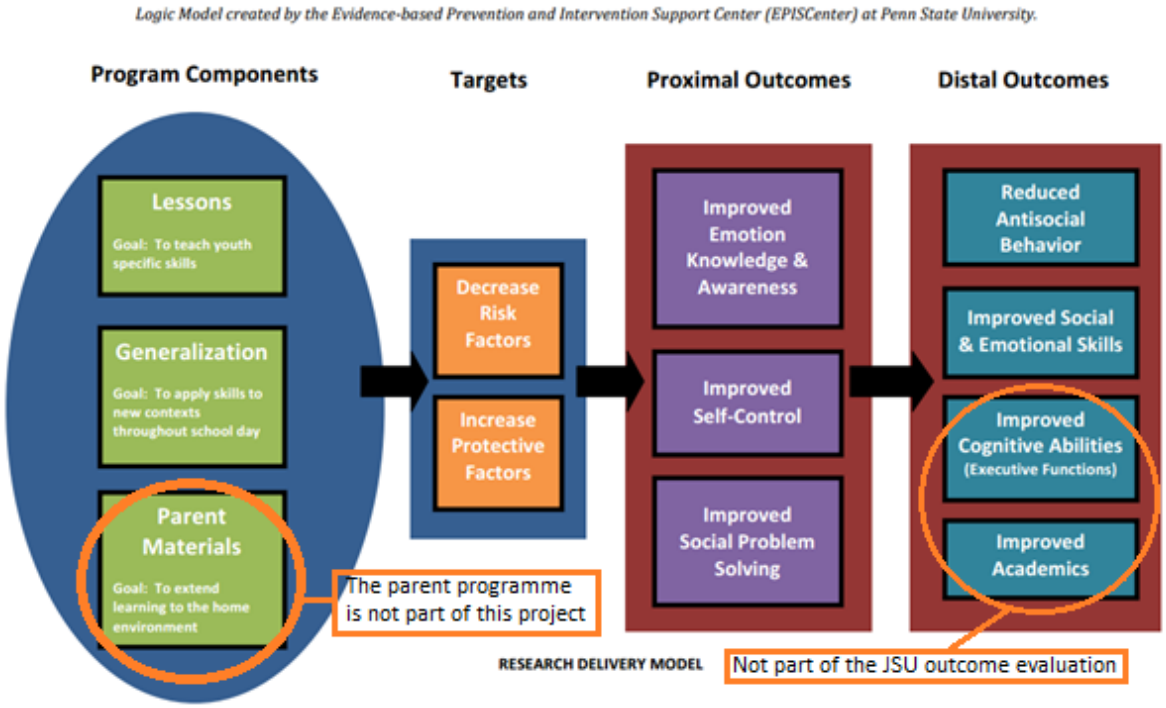
Table 2: Stages of the project delivery to schools.	
Ethics approval by end September 2016	The delivery and the tools of the project will have ethics approval, before recruitment can be finalised.
Recruitment October / November 2016	Anything that hopes to engage schools for 2017 needs to be available to be considered by October when schools are planning their budgets and timing for the following year. In September a flier about the pilot will be sent to principals in schools which might be interested. Presentations will be made to each school, maybe to a collection of several schools in the area, by showing the JSU DVD to representatives from these potential schools, explaining the programme logic and the research/ evaluation process. Each school then will have a week to decide if it wishes to commit to the pilot and that they can assure us of a minimum of 80% buy-in from staff before we enter into a signed agreement between the school and VFC. No more than eight classrooms would be needed from each school. The process of obtaining parental consent would begin in November and the selection of the JSU programme and class at usual groups.
Training (as negotiated with schools - February/ March 2017	Training will involve the teachers of the classes selected in year 6, 7 & 8 cohort, and be made available to other professionals such as SWIS workers, guidance counsellors, health nurses and deans. Ideally a community network representative is also available, and suggest that a good person to have included could be the local police youth education person. The delivery to participating schools will be staggered across February and March, with provision made for Easter and other school holiday breaks.
Programme begins Week 2	Student pre-questionnaires delivered and completed online, and two case-study students (one "vulnerable" and one "safe") identified for each JSU programme class teacher prior to their completion of the teacher pre-questionnaire. Teacher delivers first teaching session for JSU in which paper version of CORS is done by all students in the selected classrooms. Teacher keeps notes and follows closely how the two selected students are responding to the programme. CORS data entered into Google forms and fed back to the teacher noting children of possible concern. Teacher checks with these students and addresses issues that need to be addressed
Week 3	Second teaching session. Again teacher keeps notes and follows closely how the two case-study students are responding to the programme. Teacher keeps a watching brief on children identified previously by CORS as children of concern

	and addresses issues that need to be addressed. Teacher is contacted by researchers/trainers to check how things are going and provide help and advice where possible.
Weeks 4	Third teaching session. The teacher keeps notes and follows closely how the two case-study students are responding to the programme. The paper version of CORS is done again by all students in the selected classrooms. CORS data entered into Google forms and fed back to the teacher noting children of possible concern. Teacher checks with these students and addresses issues that need to be addressed
Week 5	Fourth teaching session. Again teacher keeps notes and follows closely how the two case-study students are responding to the programme. Teacher keeps a watching brief on children identified previously by CORS as children of concern and addresses issues that need to be addressed. Teacher is contacted by researchers/trainers to check how things are going and provide help and advice where possible.
Week 6	Fifth teaching session. The teacher keeps notes and follows closely how the two case-study students are responding to the programme. The paper version of CORS is done again by all students in the selected classrooms. CORS data entered into Google forms and fed back to the teacher noting children of possible concern. Teacher checks with these students and addresses issues that need to be addressed
Week 7	Student and teacher post-questionnaires delivered online.
Week 10	Preliminary aggregated (by school) data on key pre / post numeric measures of change fed back to schools, with some narratives. Short presentation to and feedback from schools.
Week 22	Draft report available for peer review and feedback from schools. This would be 22 weeks after the first school to begin the project and could be as much 8 weeks after the last school. From the start to this point could be 7 months – end of August 2017. Decision made whether the results justify delivering the JSU programme to the class as usual group.
Weeks 23-27	Class as usual group begin JSU programme.
Weeks 31-35	Follow-up questionnaire for JSU programme group if post-test results are positive.
Weeks 33-37	Class as usual JSU data preliminary aggregated (by school) data on key pre / post numeric measures of change fed back to schools, with some narratives. Short presentation to and feedback from schools. Recruitment for roll out of programme to other schools for 2018 funding dependent.
Week 45	Final report available to schools. Presentations to schools including parents and children where possible. Beginning of December

Intervention logic for the Jade Speaks Up programme

The Jade Speaks Up is an example of what the US Centre for Disease Control's 2014 (David-Ferdon & Simon, 2014) review of best practice fits into the category of *Universal School-based Youth Violence Prevention* (p22). Such programmes "provide students and school staff with information about violence, change how youth think and feel about violence, and teach nonviolent skills to resolve disputes." (p22). Within this category the model that JSU follows is the one of *Promoting*

Alternative Thinking Strategies (PATH - Kam, Greenberg & Walls, 2003). This, in turn, is based on social and emotional learning in the affective, behavioural and cognitive domains covering "self-awareness, regulation of emotions, social awareness, good relationship skills, and responsible decision-making" (EPIScenter, 2012, p4). In addition to the Centre for Disease control several other major agencies have named PATH as a model violence prevention programme (SAMHSA, 2007, CASEL, 2013, Blueprint, 2016). The intervention logic behind PATH and JSU is shown below (EPIScenter, 2012. p4), with the parts circled in orange identifying the areas in which our programme differs from PATH.



JSU is a fraction of the size (typically a 2-year programme) and cost (around US$400/child) of the PATH programme (Blueprint, 2016).

The logic behind the Jade Speaks Up /Violence Free Begins with Me project was partly informed by Hassall and Hanna's review done for ACC in 2007. Hassall and Hanna use Webster-Stratton & Taylor's (2001) guidelines as the core criteria for effective school-based interventions. We believe that JSU meets most of those criteria, with the understanding that JSU is a programme delivered to all children to help create an environment where all children feel safer from potential acts of violence. This particular iteration of JSU is not directed at parents (although JSU has a parent programme which includes facilitator's guides in the DVD package) and does not attempt to directly address the recovery of children traumatised by violence or the rehabilitation of children who are, themselves, unacceptably violent (though the package includes a third manual for therapists for use in such situations) We are also mindful of the new child protection policies required by the *Vulnerable Children Act 2014* and will show how JSU is congruent with these policies.

Firstly, then, following Webster-Stratton & Taylor's (2001) guidelines:

1. **Programmes take a skills enhancing perspective**: JSU focuses on developing skills for emotional intelligence by expanding the feeling vocabulary of children, unpacks the concept of trust, assists children in developing a safety plan of safe and accessible places, people and messages, increases awareness of other people's responses and choices, practises making non-violent choices and exploring qualities of resilience and adaptability.

2. **Programme content is broad-based. Programme content includes cognitive, behavioural, and affective components:** *Cognitive* – we provide book marks and a Helping Hands pamphlet/plan which help children do the thinking, research and recognition of the ways that they can keep themselves safe. *Behavioural* - the learning of the *Breathe, Think and Do* behavioural sequence as well as action strategies such as find somewhere safe and ask for help are all clear instructions on actions that can be taken. *Affective* - the focus on emotional literacy, expanding the feelings language as well as empathy for the characters in the story are all parts of this element. This component is addressed in a way that makes the messages accessible, relatable and memorable. We have been careful with language, cultural inclusion, and holding any potential 'shock effect' at productive levels rather than traumatizing children.

3. **Programme length is typically greater than 20 hours for children and families at elevated risk of developing problems.** JSU is designed to lower risk of violence and trauma and children identified with elevated risk would need further support. Our trials of the longer 14-week VFBWM programme, showed that it was too long and resulted in teachers dropping out of the programme. This also has been a major problem with the PATH programme (Blueprint, 2016). Schools seem to be open to the JSU format which takes about teacher 12 delivery hours plus training and support/supervision time over six weeks. The JSU animated DVD has, from teacher feedback, the ability to encapsulate and embed key messages that otherwise had taken much more time to cover in the VFBWM programme.

4. **Programmes intervene as early as the risk factors can be clearly identified**. Because we are working with all children (not just the clearly at risk children) and are using CORS as an early detection system, we have the capacity to detect at risk children very early in the process and to monitor progress. Feedback from RTLBs and other professionals already using JSU affirmed the value of the programme in assisting early identification of children who were vulnerable.

5. **Programmes are developmentally focused. (i.e., targeted at specific ages).** JSU is focused on 8-12 year-olds. Developmentally the focus is on being competent within the moral frameworks of home and school. JSU presents a consistent moral and practical framework for keeping ourselves and others safe that all children in this pre-adolescent period can follow. This framework builds basic skills around trust, communication, respect, choices and rights and is the bedrock of relationship as children come into adolescence and struggle with finding an individual identity.

   JSU is largely concrete operational in its approach. Violence is not abstract and children are presented with a wide range of frightening situations that affect children, so that the key messages are transferrable to a daily life which may include bullying, natural disasters, crime, scary movies, and violence from older siblings and adults. Most children find something that is applicable to them. We have been careful to make the violence involved in the programme real enough (from a range of cultural perspectives) for children who have been exposed to violence to recognise something of their situation, yet not traumatizing for these children or those who have not been thus exposed. This makes it suitable for children across the spectrum of cultural and socio-economic settings.

6. **Programmes use a collaborative process with parents, teachers, and children.** We invite participation and feedback from parents with the programme, and inform parents about JSU as part of negotiating with the school. The programme is also effective at engaging with parents in awakening them to the impact of their behaviours on children's lives, as seen through the eyes of a child. We have developed a parent's programme which can be run in tandem with the children's programme, and could be picked up by a community agency. The parent programme is not part of this application, however, we would expect parents to be involved where clearly at

risk children are identified, although there is evidence that single approach programmes work better than multi-approach ones (Park-Higgerson, Perumean-Chaney, Bartolucci, Grimley & Singh, 2008).

JSU is highly collaborative with children in that while it is a whole of class activity that fosters positive group identity and morality, each child will have their own unique story and will have to create their own unique safety plan. Peer support and peer-to-peer learning is very important here. Teacher collaboration is encouraged in the training and supervision components of the programme (see 7 below) and our goal is to see JSU as a basis for a whole of school programme.

7. **The teachers are supported through a professional development programme pre-programme delivery**. Teachers and support staff (RTLBs, social workers in schools, etc.) are all part of the pre training where they explore and unpack the different forms of violence that can manifest in families. We have found that teachers find this either personally transformative or challenging as it intersects with their own experience of violence. For this and general reasons we support the teachers as they deliver the programme and are accessible to be consulted should teachers feel the need. Some supervision is done in groups to encourage peer support.

8. **Programmes focus on parents' and teachers' strengths (not deficits).** Through the training offered to the teachers, we are building upon their skills, strengths and relationships with their students. We are particularly interested in working in schools where the staff have undergone the PB4L training and development as we are confident that this indicates a proactive orientation of the school towards tackling the problems which are part of their student's lives. It is also likely that they will have already developed the policies and procedures for example responding to disclosures of sensitive material from the students. While asking teachers to follow the manual, we also encourage their innovation in extending the lessons, and offer several examples of effective extensions for the motivated teachers and students. As noted in 6 above we are not delivering the parent programme.

9. **Programmes utilize performance training methods. For example, programmes that utilize videotape methods, live modelling, role-play or practice exercises, and weekly home practice activities are more effective than programs relying on didactic presentations**. The learning in JSU/VFBWM is largely interactive, but with some aspects that require reflection or research. It encourages children to share in small groups, play 'team sports' as they learn the names of emotions, to analyse responses of characters in the DVD with a small group, to listen to stories read to the group and decide when different decisions could have been made, to work with creating posters or other technical materials, to use role plays to investigate and try out possible choice strategies. The programme does not take a didactic approach, instead JSU relies considerably on experience based learning.

10. **Programmes educate participants not only in strategies, but also in the developmental and behavioural principles behind them**. There is a limit to the extent this can be done with 8-12 year olds. However, key messages of the programme are unpacked so that, for example, 'trust' is explored through a variety of modalities and shared among the students. The concepts of helping hands assists the children not only to make conscious the adults that they can trust, but to do the research to gather their phone numbers and make a plan should they need to ask for help. Similarly, the "I have a right to be safe" is explored so that children understand the baseline to recognise times when they are in danger. Too often these situations are 'normalised' into invisibility by regular exposure to times of tension and violence.

11. **Programmes promote partnerships between parents and teachers**. See section 6 above. We hope that the parent programme may be a later development in schools using JSU as a consistent component of their yearly health curriculum. Our parent programme is ready to roll, but it important to see how far we can get without it. Our experience with VFBWM was that parents were reluctant to come to meetings to learn about the programme and collaborate with teachers and children. Should there be obvious signs of distress in a child, we would address this through the school's process and policy of informing and working with parents. We will check that these are in place and appropriate when negotiating programme implementation with the school.

12. **Programmes emphasize the clinical skills of the intervention staff.** When training the 'expert' staff e.g. Social Workers in Schools or the Youth workers in the schools, we build upon their existing expertise to affirm their prior knowledge and skills. Similarly, with teachers who have completed the PB4L courses or coped with working in diverse and often vulnerable student communities. Our training approach is consultative facilitation and we are aware that it is often not our expertise that needs to be highlighted in a given teaching moment, but the opportunity to affirm the skills of the people we are training. We encourage this same attitude of respect for the students as they go through the course.

13. **Programmes are sensitive to barriers for low socioeconomic families and are culturally sensitive.** In developing our material, we deliberately worked with choosing culturally diverse characters for the film, and focusing especially on the needs of Māori, Pacific Island and Asian populations in our examples. So, particularly in the DVD, the troubled family is Pākehā, and middle class, the nurturing teacher is male, and Māori/ Pacific Island, the voices we used for the characters are similarly diverse. We have created a bi-lingual feelings chart to expand Te Reo naming of emotions. We have been careful not to typify gender assumptions, though the primary aggressor is the father, reflecting the higher statistical probability of male initiated violence in families. We have had guidance the whole way through, from design to development from experts in the field from a wide range of cultures. There are no additional costs to families of children for participating in the course. All the programme work is done within the setting of school classrooms and the students involved will have all necessary resources provided free of charge.

14. **Programmes have been empirically validated in control and comparison group studies using multiple methods and provide follow-up data**. As described in the introduction to the section the social and emotional learning model that underpins JSU has been extensively tested in the US. In the work done with JSU/VFBWM we have relied on assessments of concepts learned and teacher and student assessments of programme value (Woodley, 2009; Bridgman, 2011), but not changes in attitudes, behaviours, skills and wellness as we are attempting to do in this research. The most powerful effect (using Cohen's d) from all of the PATH evaluations was the change in the children's depression scores (SAMHSA, 2007) – an area that we have well covered in our research design.

In creating a safer environment for children JSU is also aligned with child protection policies required by the *Vulnerable Children Act 2014* (Children's Action Plan, 2015). While child protection is the responsibility of the school, and JSU would not operate in a school that did not have "clear policies and procedures" (p3) around child protection, the JSU programme supports schools in implementing those policies and procedures. It provides part of the staff training needed for safe and child-centred practice where teachers are encouraged to collaborate with other professionals and where the processes for preventing violence, identifying issues of concern and responding to them early and with a minimum of fuss are learned. Because it is a whole class, whole school project it helps create

a culture of “continuous improvement [where] staff [are] constructively challenging poor practice” (p3).

References

1. Banjanina, N. Banjaninb, N., Dimitrijevicc, I. & Pantic, I. (2015). Relationship between internet use and depression: Focus on physiological mood oscillations, social networking and online addictive behaviour. Computers in Human Behavior Volume 43, February 2015, Pages 308–312
2. Barkmann C., Erhart M. & Schulte-Markwort M. (2008) The German version of the Centre for Epidemiological Studies Depression Scale for Children: psychometric evaluation in a population-based survey of 7 to 17 years old children and adolescents – results of the BELLA study. European Child & Adolescent Psychiatry 17, 116–124.
3. Barth, R.P. Lee, B.R., Lindsey, M.A., Collins, K.S., Strieder, F. Chorpita, B.F., Becker, K.D. & Sparks, J.A. (2012). Evidence-Based Practice at a Crossroads: The Timely Emergence of Common Elements and Common Factors. Research on Social Work Practice 22(1) 108-119, DOI: 10.1177/1049731511408440
4. Betancourt T1, Scorza P, Meyers-Ohki S, Mushashi C, Kayiteshonga Y, Binagwaho A, Stulac S, Beardslee WR. (2012). Validating the Center for Epidemiological Studies Depression Scale for Children in Rwanda. J Am Acad Child Adolesc Psychiatry. 2012 Dec;51(12):1284-92. doi: 10.1016/j.jaac.2012.09.003. Epub 2012 Nov 8.
5. Bettge S, Wille N, Barkmann C, Schulte-Markwort M & Ravens-Sieberer, U. (2008). Depressive symptoms of children and adolescents in a German representative sample: results of the BELLA study. Eur Child Adolesc Psychiatry. 2008 Dec;17 Suppl 1:71-81. doi: 10.1007/s00787-008-1008-x.
6. Blueprint (2016) Promoting Alternative Thinking Strategies (PATHS) - Blueprints Program Rating: Model. Center for the Study and Prevention of Violence, University of Colorado, Boulder. Retrieved from http://www.blueprintsprograms.com/evaluation-abstract/promoting-alternative-thinking-strategies-paths
7. Brage, D., Meredith, W., & Woodward, J. (1993). Correlates of loneliness among Midwestern adolescents. Adolescence, 28, 685–693.
8. Bridgman, G. (2012). Summary of the internet surveys for the Violence Free Begins With Me programme, Violence Free Waitakere, Unpublished paper.
9. Bridgman, G. & Dyer, E. (2016). Using Results Based Accounability to Show Progress in a Long-Term Community Project. Whanake: The Pacific Journal of Community Development, 2(1), 19-38
10. Brown, J.D., Harris, S.K., Woods, E.R. , M.P. & Cox, J.E. (2012). Longitudinal Study of Depressive Symptoms and Social Support in Adolescent Mothers. Matern Child Health J (2012) 16: 894. doi:10.1007/s10995-011-0814-9
11. CASEL (2013). SEL Programs for Elementary School (K-5): Rating Tables - Program Design and Implementation Support. Collaborative for Academic, Social, and Emotional Learning. Chicago. Retrieved from http://www.casel.org/home.php
12. Children’s Action Plan (2015). Safer organisations Safer children - Guidelines for child protection policies to build safer organisations. Ministry of Social Development, Wellington.
13. Clark, T. C., Fleming, T., Bullen, P., Denny, S., Crengle, S., Dyson, B., Fortune, S., Lucassen, M., Peiris-John, R., Robinson, E., Rossen, F., Sheridan, J., Teevale, T., Utter, J. (2013). Youth’12 Overview: The health and wellbeing of New Zealand secondary school students in 2012. Auckland, New Zealand: The University of Auckland https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/2012prevalence-tables-report.pdf

14. Cooper, M; Stewart, D; Sparks J; Bunting, L (2013) School-based counselling using systematic feedback: A cohort study evaluating outcomes and predictors of change. Psychotherapy Research, 23(4), 474–488.
15. David-Ferdon C, & Simon TR. (2014). Preventing Youth Violence: Opportunities for Action. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, GA
16. Duncan, B. L., Miller, S.D., Sparks, J. A. (2003). The Child Outcome Rating Scale. Ft. Lauderdale, FL
17. Duncan, B.L., Sparks, J.A., Miller, S.D., Bohanske, R.T. & Claud, R.C. (2006) Giving Youth a Voice: A Preliminary Study of the Reliability and Validity of a Brief Outcome Measure for Children, Adolescents, and Caretakers. Journal of Brief Therapy 5:2, 71-87
18. Dyer, E. (2014). Jade Speaks Up. Children Making Choices to Keep Themselves and Other Safe. Violence Free Waitakere, Auckland.
19. Education Counts (2016). Time Series Data for Student Numbers, School Rolls by School 2010-2015, Indicators & Reporting Team, Ministry of Education. Retrieved from https://www.educationcounts.govt.nz/statistics/schooling/student-numbers/6028
20. EPISCenter (2012). Promoting Alternative Thinking Strategies. Penn State University, PA. Retrieved from http://www.episcenter.psu.edu/sites/default/files/ebp/PATHS-Section-Seven%202.2014.pdf
21. Esbensen, F., Osgood, W., Peterson, D., Taylor, T.J., Carson, D., Freng, A. & Matsuda. K. (2013). Process and Outcome Evaluation of the G.R.E.A.T. Program. Document No.: 244346, University of Missouri-St. Louis, MO.
22. Essau C.A., Olaya B, Pasha G, Gilvarry C, Bray D. (2013) Depressive symptoms among children and adolescents in Iran: a confirmatory factor analytic study of the centre for epidemiological studies depression scale for children. Child Psychiatry Hum Dev. 2013 Feb;44(1):123-36. doi: 10.1007/s10578-012-0314-1.
23. Faulstich ME, Carey MP, Ruggiero L, Enyart P, Gresham F (1986) Assessment of depression in childhood and adolescence: an evaluation of the center for epidemiological studies depression scale for children (ces-dc). Am J Psychiatr 143:1024–1027
24. Fendrich, M., Weissman, M. M., & Warner, V. (1990). Screening for depressive disorder in children and adolescents: validating the center for epidemiologic studies depression scale for children. American Journal of Epidemiology, 131, 538–551.
25. Fernandes, P. (2015). Evaluation of the Face to Face service using a solution-focused approach with children and young people in care or on the edge of care. Evaluation Department, National Society for the Prevention of Cruelty to Children, London, Retrieved from https://www.nspcc.org.uk/globalassets/documents/evaluation-of-services/face-to-face-final-evaluation-report.pdf
26. Froh, J.F., Emmons, R.A., Card, N.A., Bono, G. & Wilson, J.A. (2010). Gratitude and the Reduced Costs of Materialism in Adolescents. J Happiness Stud DOI 10.1007/s10902-010-9195-9
27. Froh, J.FJ., Fan, J., Emmons, R. A., Bono, G., Huebner, E. S., & Watkins, P. (2011, March 28). Measuring Gratitude in Youth: Assessing the Psychometric Properties of Adult Gratitude Scales in Children and Adolescents. Psychological Assessment. Advance online publication. doi: 10.1037/a0021590Miller, S. D., & Duncan, B. L. (2000, 2004). The Outcome and Session Rating Scales: Administration and Scoring Manual. Chicago, IL: ISTC.
28. Goodman, R., The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. J Child Psychol Psychiatry, 1999. 40(5): p. 791-9.
29. Greater Good Science Centre (2016). Body Language Quiz / Test Your Emotional Intelligence University of California Berkley. Retrieved from http://greatergood.berkeley.edu/ei_quiz/.

30. Hassall, I. & Hanna, K. (2007). Violence Prevention Programmes: A Literature Review. Prepared for the Accident Compensation Corporation. Institute of Public Policy, Auckland University of Technology, Auckland. Retrieved from http://www.aut.ac.nz/__data/assets/pdf_file/0016/110473/violence-prevention-programmes.pdf
31. Hudson DB, Elek SM, Campbell-Grossman C (2000) Depression, self-esteem, loneliness, and social support among adolescent mothers participating in the new parents project. Adolescence 35:445–453
32. Jones, A.M., De Nadai, A.S.. Arnold, E.B., McGuire, J.F., Lewin, A.B., Murphy, T.K. & Storch, E.A. (2012). Psychometric Properties of the Obsessive Compulsive Inventory: Child Version in Children and Adolescents with Obsessive–Compulsive Disorder. Child Psychiatry Hum Dev. DOI 10.1007/s10578-012-0315-0
33. Kam, C. M., Greenberg, M. T., & Walls, C. T. "Examining the role of implementation quality in school-based prevention using the **PATHS** curriculum." *Prevention Science* 4 (2003): 55-63.
34. Kovacs M. The Children's Depression Inventory (CDI). Psychopharmacology Bulletin. 1985; 21:995– 998. [PubMed: 4089116]
35. Lambert, M. & Burlingame, G. (1996). Youth Outcome Scales. American Professional Credentialing Services, Stevenson, MD.
36. Law D. & Wolpert, D. (2014) Guide to Using Outcomes and Feedback Tools with Children, Young People and Families, Child Outcomes Research Unit and the Evidence Based Practice Unit of the National Health Service. Retrieved https://www.ucl.ac.uk/ebpu/docs/publication_files/Guide_COOP_Book010414.pdf
37. Li H.C.W., Chung O.K.J. & Ho K.Y. (2011). The effectiveness of therapeutic play, using virtual reality computer games, in promoting the psychological well-being of children hospitalised with cancer. Ltd, Journal of Clinical Nursing, 20, 2135–2143 doi: 10.1111/j.1365-2702.2011.03733.x
38. Loveridge, J. Ed (2010). Involving Children and Young People in Research in Educational Settings, Jessie Hetherington Centre for Educational Research, Victoria University, Wellington
39. Ministry of Social Development. (2015). Snapshot: September 2015. Wellington, New Zealand: Author. Retrieved from http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/better-public-services/supporting-vulnerable-children/snapshot.html
40. OECD (2009). Comparative Child Well-Being Across the OECD, Chapter 2 of *Doing Better for Children*, Organisation for Economic Co-operation and Development, Paris. Retrieved from https://www.oecd.org/els/family/43570328.pdf
41. Olsson, G., von Knorring A. L. (1997). Depression among Swedish adolescents measured by the self-rating scale Center for Epidemiology Studies-Depression Child (CES-DC). European Child & Adolescent Psychiatry 6:81-87 (1997)
42. Park-Higgerson, H. K., Perumean-Chaney, S. E., Bartolucci, A. A., Grimley, D. M., & Singh, K. P. (2008). The evaluation of school-based violence prevention programs: A meta-analysis. Journal of School Health, 78, 465–479. http://dx.doi.org/10.1111/
43. SAMHSA (2007). National Registry of Evidence-Based Programmes and Practices - Promoting Alternative THinking Strategies (PATHS), PATHS Preschool. U.S. Department Of Health And Human Services, Retrieved from http://legacy.nreppadmin.net/ViewIntervention.aspx?id=20
44. State Services Commission. (2016a). Better Public Services: Reducing crime. Wellington, New Zealand: New Zealand Government. Retrieved from http://www.ssc.govt.nz/bps-reducing-crime
45. Soper, D.S. (2016a). A-priori Sample Size Calculator for Multiple Regression [Software]. Available from http://www.danielsoper.com/statcalc
46. Soper, D.S. (2016b). A-priori Sample Size Calculator for Student t-Tests [Software]. Available from http://www.danielsoper.com/statcalc

47. Soper, D.S. (2016c). Post-hoc Statistical Power Calculator for a Student t-Test [Software]. Available from http://www.danielsoper.com/statcalc
48. SurveyMonkey (2015). Margin of Error calculator. Retrieved from https://www.surveymonkey.com/mp/margin-of-error-calculator/
49. Timimi, S., Tetley, D., Burgoine, W & Walker, G. (2012). Outcome Orientated Child and Adolescent Mental Health Services (OO-CAMHS): A whole service model. Clin Child Psychol Psychiatry published online 1 May 2012, DOI: 10.1177/1359104512444118. Retrieved from http://79.170.40.177/criticalpsychiatry.net/wp-content/uploads/2009/12/oocamhsccppfull1.pdf
50. Violence Free Waitakere (2011). Annual Report, Violence Free Waitakere, Auckland
51. Violence Free Waitakere (2012). Annual Report, Violence Free Waitakere, Auckland
52. Webster-Stratton, C., & Taylor, T. (2001). Nipping Early Risk Factors in the Bud: Preventing Substance Abuse, Delinquency, and Violence in Adolescence Through Interventions Targeted at Young Children (0-8 Years). Prevention Science, 2(3), 165-192.
53. Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. Archives of General Psychiatry, 33, 1111-1115.
54. Weissman, M. M., Orvaschel, H., & Padian, N. (1980). Children's symptoms and social functioning self report scales: Comparison of mothers' and children's reports. Journal of Nervous and Mental Disease, 168, 736–740.
55. Woodley, A. (2009). Violence Free Begins with Me Full Evaluation, Point Research, Auckland

Appendix A: Assumptions behind Violence Free Begins with Me / Jade Speaks Up schools programme.

Child abuse and neglect is an issue impacting on an unacceptably large number of New Zealand children… in 2015, there were 38 substantiated cases of child abuse each day! Child abuse costs the country $2 billion per year! A police call out to family violence incidents occurs every 5 minutes' day and night (2015) and in the majority of these cases, children are witnessing the violence.

Families affected by family violence range across the socio-economic and cultural spectrum of our country.

Change needs to happen on many levels and while there is legislation (Vulnerable Children Act 2014 and others such as the Crimes Amendment Act 2011) there is no one approach that will solve this problem.

Many of the resources that exist look at it through the eyes of the adults involved. *Jade Speaks Up* is a unique New Zealand production of a resource that explores the issue through the eyes of a child and is proving popular with both children and the adults who work with them. The resource is also applicable therapeutically with adults and children impacted by family violence.

For a resource to be effectively used within schools and agencies dealing with young people, the topic of family violence needs to be handled sensitively. The material needs to be facilitated by teachers and adults well trained in ways that are both real enough yet not traumatising for children.

The target group of this material is children aged between 8-12 years of age. It is easily adapted for older students and has been usefully applied to adults and parent educators also. For the ACC pilot the cohort is 10-12 years of age.

The focus of Jade Speaks Up is on preventative approaches, with strategies supporting children to develop transferrable skills to apply to a variety of situations as well as family violence.

Many adults involved with children such as teachers/ neighbours or relatives are often reluctant to report abuse if they suspect it is happening. This area represents a significant need for training and awareness raising. As a society we are fast becoming more aware of the obligation of adults in our to be proactive in the protection of our children. Schools and agencies are recognising it is fast becoming mandatory to address the needs to train their staff in dealing with disclosures.

In evaluating the effectiveness of the material, **some of the key assumptions** are isolated here. This is not an exhaustive list.

- Children thrive by developing emotional literacy to assist them in identifying their feelings and being able to communicate about feelings when they recognise the need to ask for help
- Identifying and articulating our own feelings makes it easier to read other people's emotional states, thus leading to greater safety
- Children need coaching to identify criteria for trust. Who / when / how / what / why
- Identifying safe (trustworthy people) and making a personal safety plan is a reassuring and supportive thing for children to do ahead of when such a plan may be needed.
- Trusting and respectful relationships between students and teachers are important templates/ role modelling for future social interactions as children move into adolescence and beyond.
- Breathe, Think & Do is a strategy for finding a calm place within, considering options and taking appropriate action. Children living in a toxic stressed environment have their capacity to find a calm inner space severely compromised. Living in a state of heightened stress also compromises their ability to think, learn and behave sensitively towards others.
- Understanding "I have a right to be safe" creates a benchmark to encourage children to seek help.
- Seeking help by letting an adult they trust know what is going on when it is needed is the safest and most appropriate way that children could get involved in any violence happening in their homes, it is not their 'job' to step into any other intervention.
- In any situation children can make non-violent choices to keep themselves and others safe
- Children will understand qualities of resilience that support them in adapting to change… and that strategies such as positive self-talk, stress reducing visualisations and being aware of options combine to make them safer. These aspects and qualities are most negatively impacted by growing up in an abusive or neglectful environment.
- Children under the age of 12 are particularly influenced in their expectations of what adult / family relationships look like by the model of relationship they are exposed to in their own families.
- When a family has problems and high risk factors such as history of abuse, drugs and alcohol, relationship problems, poverty, isolated parents or issues with mental health or depression, children are particularly vulnerable to abuse and mental health issues.

Children are most at risk in their first three years. Sometimes older children are in the position of becoming aware that they could help their younger siblings by seeking other adult support.