Preventing Violence in Schools:
An international perspective and the role of Health and Family Life Education (HFLE) in the Caribbean

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LLOYD ERSKINE SANDIFORD

I. Introduction

Distinguished Ladies and Gentlemen,

I am very happy to be here with you today in Barbados – a culture, land and people I truly love. My talk today addresses four key issues:

1. The importance that we as educators address violence in our own lives first, enabling us to deal with violence in our schools, with our students and families.
2. Internationally, regionally: what does the research say about trends?
3. What does research say about effective strategies for schools?
4. What is the role of Health and Family Life Education (HFLE) in violence prevention? What can we learn from the recent Caribbean study?

The perspectives I share today come from my early years as a teacher in Montreal and my many years now at Education Development Center, Inc. EDC is an international non-profit organization that conducts research and develops innovative programs to address issues in health, education and economic development worldwide. We have 1,300 staff in over 30 countries. It makes me very happy to say that Arlene Husbands from Barbados leads our office here for the Caribbean.

I direct the division of EDC dedicated to healthy human development. Since 1985, violence prevention has been one of the major public health issues we have tackled—especially violence prevention in and through schools with the World Health Organization (WHO) and other partners. Our work began with Dr. Deborah Prothrow-Stith, a physician. When doing her medical residency at Harvard, she stitched up a young man in the emergency room one night. He warned her not to go to bed because he was going to go back out on the street to 'get the guy who did it.' She would then have to tend to him. Dr. Prothrow-Stith marveled that had she treated a suicidal patient, protocol would have been to admit him to the hospital, but not so for a person committing violence. With homicide rates in the US seven times higher among young Black men than among young Caucasian men, she worked with us for over a decade to create and evaluate innovative violence prevention programs for schools. Today, EDC is involved with many different violence prevention efforts and has many resources to share with educators (see Resources at the end). For example, in the US we provide training and technical assistance to hundreds of schools that have received funding, after the Columbine incident, to address issues of mental health, violence and substance abuse. We work with Education International designing and delivering worldwide a curriculum on gender-based violence prevention.

To begin, what is our personal experience with violence (for it inevitably affects what we will do with students)? Through EDC projects, I have seen firsthand how educators and health care providers first need an opportunity to address what has happened in their own lives and to process any remaining trauma. If they do not have that opportunity, is often difficult for them to take it on with their students or patients. I would estimate that at least one third of you or more in this audience has had some personal experience with one or another form of violence: physical, sexual, verbal or emotional. The United Nations (UN) World Report on Violence Against Children adopted the definition of violence introduced in Article 19 of the Convention of the Rights of the Child:"all forms of physical or mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse" (quoted in Pinheiro, 2006).

Personally speaking, I have been very lucky. Yes, I have experienced discrimination as a girl and adult woman and occasionally been sexually harassed. Yet, my mother would tell me stories of how my alcoholic grandfather was abusive to her and to my grandmother. She explained and somewhat forgave his behavior, attributing it to his experiences in the British army on the battlefield in Germany during World War I. We know now the effects of post-traumatic stress, but few people understood it and its longer-term effects at that time.

Fortunately, for my brothers and me, my mother did not repeat the cycle that so many women do. Instead, she sought refuge with my father, a gentle and caring person. However, the effects of the domestic violence she experienced in her early years plagued her with depression as an adult woman. In the mental health field, we know so much more about the follow on to these events than we ever did before. Early violence can lead to mental health and substance abuse; bullying can lead to suicide; sexual abuse can lead to depression, substance abuse and continued victimization by pursuing prostitution or other abusive partners.

All these lifelong consequences are ***why it is so important*** that we stop the cycle in the early years. Stopping violence for its own sake is necessary. In addition, violence and unsafe learning environments have a negative effect on academic achievement. We also know the opposite is true. When schools provide curricula and opportunities for young people to engage in gaining social and emotional skills, there are benefits to academic performance. A Meta analysis of social-emotional learning programs has shown that such programs contribute to as much as a 10% increase in student academic achievement (Durlak & Weissberg, 2007).

I would like to ask *you* some questions about violence. Given all the attention today to corporal punishment, I would really love to see a show of hands of how many of you still support it, but publicly that might be unfair. Let us concentrate on the behaviors of violence you see in your schools. Is there…

- Corporal or physical punishment of students for misbehavior?
- Teacher verbal abuse, humiliation or ridicule of students?
- Physical fights among students?
- Verbal bullying, teasing of any kind student to student?
- Sexual abuse of any kind?

Thank you for sharing. Judging from your show of hands, there is some fighting, but I certainly do not see all hands in the air, not even half. There are many more for verbal abuse by teachers, which is not uncommon. A few of you acknowledge that you see sexual abuse in your schools.

It may or may not comfort you to know that these situations are typical worldwide. The international and regional data confirm such patterns and set the stage for why it is so important to deepen the teaching of HFLE in the Caribbean.

II. International Data on Trends

Over the past decade, there have been several important studies on violence prevention. Three most valuable sources are: the WHO World Report on Violence and Health, the UN World Report on Violence Against Children, with a companion study on schools, and the Global School Health Survey (GSHS).

The WHOs World Report on Violence and Health, published in 2002, set the stage for children's rights (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). This report put the UN Convention on the Rights of the Child at the forefront, charging that every country must protect its children from "all forms of physical or mental violence." Specifically, the UN Committee on the Rights of the Child has emphasized that "corporal punishment of children is incompatible with the convention" (quoted in Krug, et al., 2002). Though Barbados has signed on to that Convention, still very high rates of corporal punishment have been documented in its schools. Moreover, as we have heard from Mr. Peter Wickham, many people in Barbados still condone and support it. Eliminating corporal punishment in schools is a critical first step in changing social norms, providing positive adult role models that respect and nurture children and that make schools physically and emotionally safe for children.

Following on the WHO report, the UN World Report on Violence Against Children was prepared between 2003 and 2006. This report noted that 106 of the 223 nations and dependent territories – only half— have laws banning corporal punishment in all schools. Yet, even those countries that have such policies report that the policy is very difficult to enforce (Pinheiro, 2006).

A companion document to the full study is Violence Against Children in Schools and Educational Settings (Pinheiro, 2006, 108-169). In creating these reports, UNICEF held nine regional consultations, including the Caribbean. Youth were involved extensively. CARICOM was involved actively. These reports elaborate worldwide patterns and effective prevention strategies. Some statements in the report about schools, for example, say that:

- In Barbados, 95% of interviewed boys and 92% of interviewed girls said they had experienced corporal punishment by caning or flogging in school (p. 118).
- Worldwide, sexual harassment of school girls is so common that teachers see it as a normal and so typically ignore it (p. 119). (For additional resources on gender-based violence and sexual harassment see Resources at the end)
- Worldwide, one third of students experience bullying. In more than half the cases, bullying stopped when a bystander intervened. This data underscores the critical and positive role that bystanders can play (pp. 122-123). (For additional resources on bullying see Resources at the end)

The third source is both international and regional for the Caribbean: the Global School-based Student Health Survey or GSHS. The GSHS was created by the WHO and the US Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health (CDC & WHO, 2008). Countries in the Caribbean are now implementing the survey extensively across the Caribbean. The GSHS survey is administered in schools to students of ages 9-14. GSHS provides important information on student risk behaviors, which can be most useful to inform the design and selection of school-based programs.

Looking at the survey results across just four of the many other Caribbean countries involved (Grenada, St. Lucia, Trinidad and Tobago, and St. Vincent and the Grenadines; for complete results see http://www.cdc.gov/gshs/results/index.htm) we see the prevalence of reported violence. For example:

- More than half the boys and close to a third of the girls report that they were in a physical fight one or more times during the past 12 months
- One quarter of both boys and girls, report that they were bullied on one or more days during the past 30 days. (CDC & WHO, 2008)

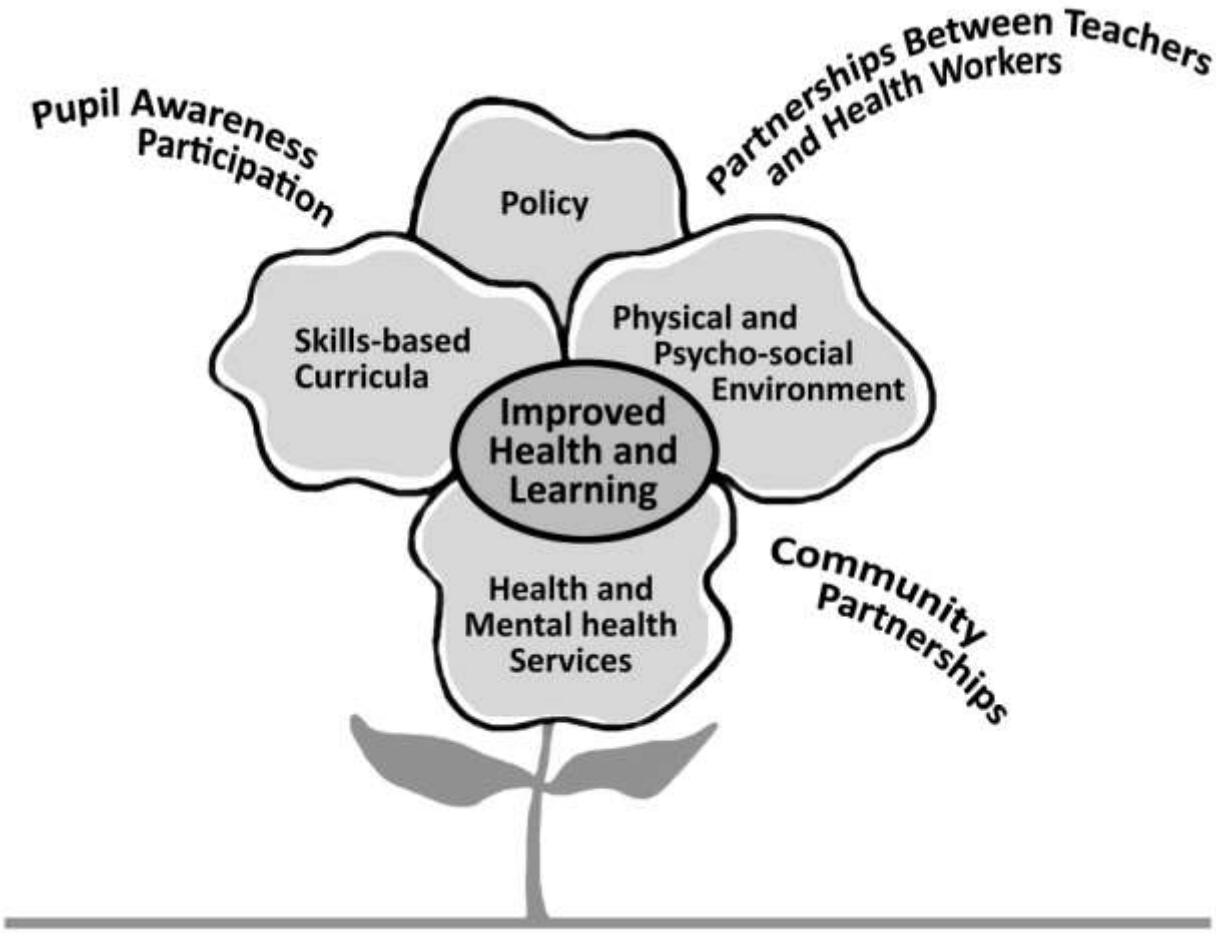
Clearly, physical fights and bullying affect a large number of Caribbean students –both boys and girls. What strategies, then, are effective to address violence in schools and what role is **HFLE** playing in the Caribbean?

III. Effective Strategies for Schools

The research evidence points to the benefits of a whole school approach for violence prevention (Cowie & Jennifer, 2007). What is a whole school approach? It is one that draws on every facet of school life and uses multiple strategies in a coordinated way to address health issues with a public health approach (WHO, 1998). Curriculum is important, but insufficient alone. The coordination of multiple strategies is much more likely to bring about positive change (Stewart-Brown, 2006).

This whole school approach to any health or human development challenge is represented in the petals of the flower or the concept of the Health Promoting School in Figure I below. I know many of you in the Caribbean are familiar with this model and are using it. This approach combines policies with curricula and instruction such as HFLE, and addresses the psycho-social and physical environment and safety of the school. A whole school approach has systems to detect and screen for mental health and potential violence problems early on and refers students, families and staff to services. This approach must be carried out with the full participation of teachers, students, parents and the community. Having agency and the opportunity to affect one's circumstances are very important factors and have mental health and other benefits for all (Sen, 1999).

Figure I. Components of a Whole School Approach in a Health Promoting School (Vince Whitman, 2005)



The research points to the success of:

Policy: Schools must have policies that do not use corporal punishment. However, policies must go beyond banning corporal punishment to foster positive and respectful norms of the way all treat each other. School policies that state clearly that no form of violence will be tolerated can drive and support behavior toward that norm. Such policies must also ban any weapons in school. Sanctions must be clear, but not further isolate and reject students at high risk (National Center, 2004). For effective learning and social development, learning environments must be safe and free from violence. Policies create norms for all to know what is acceptable behavior. These norms must be promulgated, discussed and come alive in every day school life.

Most often bans on weapons or fighting and other school violence prevention policies entail punitive responses when students do not adhere to them. Results from the CDC's School Health Policies and Programs Study strongly suggest that bans and other efforts to reduce school violence should help to promote a positive school climate that gives priority to offering services to students or others who break the rules (Jones, Fisher, Greene, Hertz, & Pritzl, 2008).

Psycho-Social and Physical Environment: Along with policy, I would argue that school ethos is probably the most important and effective component in violence prevention. Extensive research has shown how important it is for students to feel connected to caring adults at school. The study by Blum, et al., of thousands of students in the United States found that when they feel attached to their school and to caring teachers, coaches, or counselors, they engage in fewer risk behaviors (Blum, McNeeley, & Rinehart, 2002). One simple strategy invented by teachers with whom we have worked was to identify those students whose names no one knew. As teachers became aware of these 'lost students', they made extra efforts to connect with them and their families (Education Development Center (EDC), 2002).

Preventing violence also requires attention to the physical environment. Practical strategies to make schools safer include identifying and improving areas that are difficult to monitor by school staff, such as courtyards or hallways not centrally located. Research also supports the importance of ensuring sufficient lighting (CDC, 2001). A recent study of schools in Kentucky concluded that a school's immediate context, such as reduced congestion in bus-loading areas and improved surveillance, were more important for addressing violence among students than broader community-level factors, such as nearby vacant lots, etc (Wilcox, Augustine, & Clayton, 2006).

Curricula: Skills-based health curricula that provide students with many opportunities and hours to practice skills before they encounter risks can change behavior (WHO, 2003). Skills in conflict resolution, anger management, and ways for girls and boys to overcome entrenched role differences are essential. Enabling students to understand the roles of aggressors, witnesses and bystanders and to enhance the role of bystander in de-escalating bullying and fighting can make a difference (Stueve, et al., 2006). Teaching media literacy skills to young people, beyond simply attempting to censor or reduce their exposure to negative messaging, can enable young people to be able to critically assess media information and make more responsible decisions about appropriate behavior. Such skills can help to counter violence in the media and reduce levels of violence among children (Bergsma & Carney, 2008) All these life skills in social and emotional learning have benefits not only for preventing violence but also for academic performance.

Services: Early intervention is critical. Most adults with mental health disorders were ignored or did not receive diagnosis and treatment in childhood or adolescence when their disorder first presented. Research has shown that early intervention can save years of later suffering and harm (WHO, 2004). Often, by the time that these individuals make contact with a mental health professional, they present with co-morbid conditions and other complications that would have been much easier to treat earlier on in their childhood or adolescence (Kessler, et al., 2007).

This whole school approach is essential for change. Combining policy that does not tolerate *any form* of violence or weapons in school is the cornerstone of change. Such policy can also go further to foster positive social norms in a caring school community, one where the staff truly connect with students. For some students, such caring does not exist in any other sphere of their lives. In this context, curricula that equip students with a range of skills and services that identify and refer students and families who need support early on can prevent all forms of violence and serious mental health problems later in life. What then is the experience of HFLE in the Caribbean and what can we learn from a recent four-country study?

IV. Important Role of Health and Family Life Education

HFLE has a twenty-year tradition in the Caribbean. Originally, most of the attention was on teacher training colleges. In the last five years, with the vision, leadership and financial support of UNICEF and CARICOM, there has been a giant leap forward to experiment with and evaluate the implementation of HFLE among 9-14 year-olds. Barbados has been a leader in its HFLE activities and I am sure many of you here today have been involved in different ways.

In 2005, working with a team of Caribbean educators, EDC facilitated the process to create the first Caribbean Regional Curriculum Framework for HFLE (UNICEF, EDC, & CARICOM, 2008 Draft). The Framework sets forth standards, learning objectives and outcomes for four themes: 'Sexuality and Sexual Health', 'Self and Interpersonal Relationships' (which addresses violence), 'Eating and Fitness', and the 'Environment'. To accompany the Framework, educators created lessons to be part of a core curriculum for Forms I, II, and III.

In the last three years, CARICOM and UNICEF have supported and guided a four-country study of the core curriculum for the first two modules ('Sexuality and Sexual Health' and 'Self and Interpersonal Relationships'). The study took place in four countries: Barbados, St. Lucia, Grenada, and Antigua and Barbuda.

Approximately 2,000 students were involved from Forms I-III. Three matched pairs of schools for each country participated. Students in Form I at the beginning of the study were on average 12 years old. By the end of the study in Form III, students were on average 14.7 years old. Surveys captured students' knowledge, attitudes and reported behaviours at the beginning and end of the study in both the intervention and comparison sites. Many other forms of data were also collected from classroom teachers and students throughout

the study to understand their experiences with the implementation process and their reactions to and use of the core lessons.

A weeklong training for country coordinators took place in the first year. Coordinators then trained teachers in their countries.

The study aimed to answer:

- To what degree did teachers use the ten lessons of each module? How comfortable were they? What activities and methods did they use?
- Did the knowledge, attitudes and behaviors of students who participated in this core curriculum (or what I will call the intervention schools) differ significantly from the students of the same age in matched schools? These were not schools that had no health education. Instead, teachers taught traditional health education lessons.

It is important to emphasize that the intervention site was using the core curriculum lessons, aligned with the Framework. Comparison countries used traditional HFLE activities and lessons that had been in place.

From the full HFLE study, highlighted here are results that examine the above answers specifically related to the module on 'Self and Interpersonal Relationships', including lessons on violence prevention. The ten lessons for each Form examine such issues as self-concept, pressures on youth, domestic violence, substance use, refusal skills, and anger management.

The following results come from the upcoming four-country evaluation of HFLE (EDC, 2008)

What did teachers teach? Of the ten lessons in a module, about half of the teachers report they were able to complete 7-9 lessons averaging forty-five minutes. Only a third of teachers said they did all ten. Research tells us that it takes approximately 30 hours of instruction to reach a point of behavior change ---so students have not had anywhere near the depth of exposure that is possibly needed to create change (National Professional School Health Education Organization, 1984).

Teachers reported that it was always a challenge to have enough time to implement the lessons. Only 20-35% of teachers said the lessons fit the teaching time allocated to HFLE throughout the study. It often took teachers longer to teach an individual lesson than was estimated. Knowing what and how much was taught clearly sets the stage for understanding the student outcome results.

How did teachers react to the core curriculum lessons? Overall, teachers were very enthusiastic about the core curriculum. Most were comfortable with lesson content. Teachers reported students were engaged in activities and learned new things. They felt lessons were developmentally and culturally appropriate and covered important topics.

The majority of teachers said they would be "very likely" to recommend lessons to their peers. Over half of students reported that they used the skills outside the classroom.

Other findings were that teachers in the intervention site using the core curriculum reported:

- receiving more HFLE training than comparison school teachers;
- higher levels of preparedness to teach HFLE and greater comfort teaching HFLE topics than the comparison teachers. Comparison teachers began in the study with many more years of HFLE teaching experience.

By follow up time, three years after the study began, nearly 60% of teachers in the intervention site using the common core curriculum, but less than 20% of comparison site teachers, said HFLE is more important than other subjects. Fewer of the intervention teachers also reported administrative barriers to teaching HFLE.

It is interesting to compare how teachers in the intervention site, using the common core curriculum, perceived barriers to implementation in contrast to the comparison site. Over the three years, as shown in Table I below, intervention teachers experienced increasing administrative support – the lack of administrative support as a barrier dropped from 23 to 8 percent. In comparison sites, teachers reporting lack of administrative support as a barrier increased from 15-25 percent.

Table I. Percentages of Teachers Reporting Barrier "Moderate" or "Large"

	Baseline		Follow up	
	Comparison	Intervention	Comparison	Intervention
Lack of administrative support/encouragement	15%	23%	25%	8%

At the end of the study, it is very encouraging to note that teachers in the intervention site, using the common core curriculum (67%), were more likely than comparison school teachers (20%) to report their level of preparation as "very good" "or excellent".

Perhaps this level of confidence in preparation may be one reason for the many different teaching methods that core curriculum teachers used. Since research has also reported that participatory engagement of students in learning is much more likely than lecture to lead to skill development and behavior change (Mangrulkar, Vince Whitman, & Posner, 2001), we can see that teachers trained in the core curriculum were much more likely to use these participatory methods. As Table II reports, none of the comparison teachers used role-play while 54% of the intervention site teachers did. Similarly, a much higher percentage of

intervention site teachers used brainstorming (62 to 38%) and case studies (54 to 38%). There are several additional examples in the full report.

Table II. Participatory Teaching Methods Percentages of Teachers Reporting Using Technique "Very Often" or Always"		
	Follow up	
	Comparison	Intervention
Role plays	0%	54%
Brainstorming	38%	62%
Case studies/real life scenarios	38%	54%

Most importantly, training was an important factor in implementation. No matter which condition, intervention or comparison, at follow up, over 90% of teachers wanted additional training on HFLE.

Let us now turn to the second major question of the 4-country study: what was the effect on students' knowledge, attitudes and behaviors of the core curriculum lessons for 'Self and Interpersonal Relationships' compared to traditional ways that teachers had of teaching HFLE. Overall, across all questions, findings show no major statistically significant patterns in either positive effects between students exposed to the common core curriculum and those in the comparison site exposed to more traditional HFLE lessons. Importantly, the data also do not show many statistically significant negative effects, which one would expect as young people grow from 12 to 15 years of age.

There is a statistical difference in the fighting behaviors that girls report seeing among peers at their school. See Table III below. The percentage of girls who report that all or most girls 'fight weekly' was 22% in the intervention site and 28% in the comparison site. There is no statistically significant difference in the fighting that boys report. On average, 55% of males in both conditions reported that all or most males at their school fight weekly. This high number is consistent with worldwide patterns in the global reports cited earlier.

Table III. Reported Fighting Behavior in HFLE Study				
Item	Total	Comparison	Intervention	P value
Most/all males the same age: In physical fight	56%	55%	56%	ns
Most/all females the same age: In physical fight	25%	28%	22%	<.01

Table IV illustrates students' answers to questions about acquiring skills to refuse fighting. When students were asked about how much they agree (1=strongly disagree; four=strongly agree) with statements regarding their refusal skills, boys in the intervention group agreed more strongly with the statement "I can say no to fight if someone pushes me around" than the comparison group (3.25 versus 2.29). Girls in the intervention group reported only slightly higher average scores (2.60) versus the comparison group (2.48). However, these differences were not statistically significant.

Table IV. Refusal Skills for Fighting				
	Males		Female	
	Comparison	Intervention	Comparison	Intervention
I can say no to fight if someone pushes me around	2.29	3.25	2.48	2.60

In terms of students' feelings about their school environment and school attachment:

- At Form I, almost all boys and girls (90%) reported liking school and being happy there. By Form III, students continued to report positive school experiences, with 80-85% of youth reporting they feel like they are a part of their school and happy there. There was no significant change.
- At Form I, the majority of students felt there was an adult at school they could go to if they needed help with a problem (79%). By Form III, a smaller proportion of students (59%) report there is a teacher they could go to for help with a personal problem.

In summary, the study in itself has pushed forward the boundaries of implementation of HFLE in schools and our learning's about what is required. Clearly, there is the value and importance of:

- providing extensive training;
- dedicating adequate teaching time to HFLE –at least 10 periods for each module across Forms and ensuring teachers can cover the material in each lesson in the allocated time;
- offering steady and consistent administrator support; and
- providing curricular and training materials.

Teachers in the intervention site reported that they are growing in their confidence and skill to teach the subject, see its value and importance and they are using a variety of participatory methods. Students say they are using the skills outside the classroom. In addition, while the student findings do not scream with statistical significance, they are showing some positive direction and the interventions are perhaps retarding escalation of behaviours as youngsters enter years of greater experimentation and risk behaviour.

As I end this presentation, I ask myself what difference it will make in your work. What new actions, if any, will you take when you return to schools next week? I suggest a few. I sincerely hope you will select even one or two. There are also many resources at the end of this paper to assist you.

1. Talk to a trusted colleague or form a discussion group about violence in your own lives. Support one another. To help your students, you must help yourself and each other too.
2. Talk with your administrator if your school does not have a policy to ban corporal punishment. Ban it. If you cannot have a policy, stop using it yourself. Move beyond policy on corporal punishment to one that encourages all in the school not to tolerate any form of physical, verbal, emotional or sexual abuse. Make it explicit, talk about it. Create positive norms of a caring, safe, respectful community.
3. Consider your own teaching practices. Are they authoritarian and didactic or democratic, respectful and participatory? Connect to your students. Know them as people. Know and use their names. Have them know they can come to you.
4. Consider if there are any physical spaces that are particularly unsafe. At times, there are places that girls must frequent that are isolated and risky. Bathrooms can be

particularly unsafe. How can you identify physically unsafe places for students in your school and do something about them?

5. Take the pulse of the psychosocial environment of your school. There are many tools for staff and students to do this.

6. Deepen your implementation of HFLE. Get the richest materials you can. Spend time using skills dedicated to violence prevention and related behaviours. Train, train, and train your teachers. They will grow in their confidence with the content and methods. Assure them they can take time in the week to teach the lessons. It will make a difference and academic performance should improve.

7. Last, consider creating coalitions that connect the school with the health and mental health services in your community and with the police. Together, perhaps, you will be able to identify those young people and families at most risk. Instead of punitive actions, perhaps you can direct them to much needed services, and engage then in prevention and intervention activities that might save delinquency, gang involvement and school dropout.

You can make a difference in one life, in ten lives or in hundreds of lives. You must. If, in your role of educators, you do not act, who will? You will find great rewards in doing so.

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Resources

Classroom Curricula and Evidence-Base

- Slaby, R., Wilson-Brewer, R., Dash, K. (1994). Aggressors, Victims, and Bystanders: Thinking and Acting to Prevent Violence (a unit of Teenage Health Teaching Modules). Newton, MA: EDC. Available from: http://www.thtm.org/special

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- The Psychosocial Environmental (PSE) Profile:
  WHO and EDC (2003). *Creating an Environment for Emotional and Social Well-Being: An important responsibility of a Health-Promoting and Child Friendly School*. Geneva: WHO. This assessment tool enables school staff to assess school ethos and plan actions. It is available from
  http://www.who.int/school_youth_health/media/en/sch_childfriendly_03.pdf

- Management Systems International (2008). *Are schools safe havens for children? Examining school-related gender-based violence*. Washington, D.C.: United States Agency for International Development (USAID). Available from http://www.usaid.gov/our_work/cross-cutting_programs/wid/pubs/Safe_Havens_Corrected_10-14-08.pdf

- Development & Training Services (2003). *Unsafe Schools: A Literature Review of School-Related Gender-Based Violence in Developing Countries* Washington, D.C.: USAID. Available from http://pdf.usaid.gov/pdf_docs/PNACU253.pdf

Some evidence-based programs

- Olweus Bullying Prevention Program
  www.clemson.edu/olweus

- The Child Development Project
  www.devstu.org/cdp

- Steps to Respect
  www.cfchildren.org

- Don't Laugh at Me
  www.operationrespect.org

- The High/Scope Perry Preschool Project
  www.highscope.org

- The Incredible Years
  www.incredibleyears.com

- Linking the Interests of Families & Teachers (LIFT)
  www.oslc.org

- Eyes on Bullying
  www.eyesonbullying.org

- Stop Bullying Now!
  www.stopbullyingnow.org

- Online course: Bullying Prevention
  http://www.ed.gov/admins/lead/safety/training/bullying/bullying.html

Other online resources

- Harvard University's Center on Media and Child Health:
  Database on Research
  www.cmch.tv/research/searchCitations.asp

- International Alliance for Child and Adolescent Mental Health and Schools (INTERCAMHS)
  www.intercamhs.org

- Center for Effective Collaboration and Practice:
  School Safety and Violence Prevention Links
  cecp.air.org/guide/websites.asp

- Search Institute
  www.search-institute.org

- Resourceful Adolescent Manual: a program for teachers to promote school connectedness
  www.rap.qut.edu.au