TEACHING RESILIENCE TO CHILDREN IN AUSTRALIA

A Thesis submitted by

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Abstract

Resilience interventions are recommended to address the psychological distress experienced by children in Australia. However, it is still unclear how best to teach resilience. This research contained a systematic literature review analysing 9 quantitative studies since 2017 that explored Australian resilience interventions for children aged 8-14. Intervention designs were explored by comparing program elements to key areas that contribute to building resilience in children and considering ecological reach. Outcomes were also recorded. Additionally, this research evaluated the Bouncing Back Resiliency Workshop, a locally designed resilience intervention for children. The workshop was delivered to a grade 5 class in a Queensland Primary School. Participants included students (n = 11), their parents, and teacher. The mixed methods study design included exploring the workshop contents, recommending improvements, and measuring changes pre- to post-program. Overall, Australian resilience interventions are addressing individual resilience factors but neglecting family and community factors. Positive outcomes include increased resilience, reduced symptoms of psychopathology, and increased factors contributing to resilience. It is strongly recommended that resilience programs continue to be designed from an ecological perspective and delivered to children in Australia. The Bouncing Back Resiliency Workshop demonstrated increased resilience and reduced emotional and behavioural problems in children. These findings are most notable because the participating children were experiencing high levels of adversity. These findings indicate that the Bouncing Back Resiliency Workshop is an effective intervention for increasing resilience and reducing emotional and behavioural problems. It is recommended that further exploration of the workshop includes a larger, more varied sample and a control group.

Certification of Thesis

I Jessica Swann declare that the Thesis entitled *Teaching Resilience to Children in Australia* is not more than 40,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references, and footnotes. The thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Date: 29 June 2023

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Student and supervisors' signatures of endorsement are held at the University.

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Abbreviations

ASEBA:	Achenbach System of Empirically Based Assessment
BBRW:	Bouncing Back Resiliency Workshop
CBCL:	Child Behaviour Checklist
CBT:	Cognitive Behaviour Therapy
COVID-19:	The Coronavirus Disease pandemic
RCI:	Reliable change index
RSCA:	Resiliency Scales for Children and Adolescents
SLR:	Systematic literature review
TRF:	Teacher's Report Form
UniSQ:	University of Southern Queensland

Chapter 1: Introduction

The importance of resilience in overcoming adversity has been well documented. However, it is not entirely understood how resilience is best taught. The key aim of this research is to investigate the areas believed to contribute to building resilience in Australia's children. While much work has been done to produce and evaluate locally designed resilience interventions, more research needs to be done to understand the outcomes of these evaluations. Future programs can then be designed with a deeper understanding of what works to build resilience in Australian children.

This research used a mixed methods design, incorporating a systematic literature review (SLR) and a quasi-experimental program evaluation to explore interventions for children aged 8-14. The SLR aimed to explore the research done on resilience interventions in Australia in the previous 5 years. The program evaluation aimed to measure the efficacy of a children's resilience workshop being delivered in a metropolitan Queensland primary school. This design was chosen so that recent findings on Australian resilience interventions could give context to the outcomes of the program evaluation (Creswell & Creswell, 2018).

The research design and findings were influenced by the ecological theory of resilience (Beyond Blue, 2017a) and considered through a postpositivist lens (Creswell & Creswell, 2018). The researcher aimed to remain conscious of the theory limitations, research limitations, and personal biases (Creswell & Creswell, 2018). Consequently, the research findings were integrated with existing knowledge and the experience of undertaking the research to form a deeper understanding of children's resilience (Creswell & Creswell, 2018). Clinical psychology focuses on the application of psychological principals, making it the discipline most suited to investigate, design, and deliver preventative mental health solutions (Australian Psychological Society, 2023). The findings of both studies will contribute to existing knowledge in this field.

This chapter will discuss the state of mental health for children and youth in Australia, define resilience, and introduce the Ecological Resilience Theory (Beyond Blue, 2017b). Following, the necessity for resilience interventions for children in Australia will be discussed. It will then be argued that there is a need for psychological research to investigate the progress on the development of resilience programs for children and in Australia since 2017 and that a program evaluation on the Bouncing Back Resiliency Workshop (BBRW; McCausland-Green, 2015) for Primary School children adds to existing knowledge. The chapter will conclude by presenting the aims, objectives, and research questions.

1.1 Burden of Mental Health for Young People in Australia

In 2020, 59% of 15-19 year old young Australian's "reported feeling happy or very happy with their life as a whole" (Australian Institute of Health and Welfare, 2021b, Key Findings section). In contrast, some young people in Australia are struggling. In 2013-2014, 20% of 11-17 year old's reported "either high or very high levels of psychological distress" (Australian Institute of Health and Welfare, 2021a, Key Findings section). Four years on, it was estimated that 15% of 18-24 year old's "experienced high or very high levels of psychological distress" (Australian Institute of Health and Welfare, 2021a, Key Findings section). This snapshot is devastating when considering the possible outcomes of psychological distress.

In 2019, 461 young people between the ages of 15 and 24 died by suicide (Australian Institute of Health and Welfare, 2021a, Key Findings section). Within the same age group in 2015, "suicide and self-inflicted injury was the leading cause of the total burden of disease, followed by anxiety disorders and depressive disorders" (Australian Institute of Health and Welfare, 2021c). With the health and lives of young people being such a pressing matter, the Australian Government has made mental health for young people a priority. In 2020, the National Action Plan for the Health of Children and Young People: 2020-2030 (National

Action Plan) outlined two priority areas; one of which is to "tackle mental health and risky behaviours" (Australian Government Department of Health, 2020). One of the actions under this priority area includes a focus on children and youth aged 8-14 and building their resilience (Australian Government Department of Health, 2020).

1.2 What is Resilience?

Beyond Blue (2017a) defined resilience as "doing well during or after an adverse event, or a period of adversity" (p. 7). In order to become resilient adults, all children need to overcome failure and disappointment, manage conflict and fractured relationships, and deal with the multiple pressures of growing up. Though resilience was first considered an innate trait, more recent research has highlighted that resilience is a fluid state; changing in accordance with many factors that contribute to resilience (Beyond Blue, 2017b; Masten, 2014; Morgan et al., 2021; Ungar & Hadfield, 2019). Those factors are outlined in the Ecological Resilience theory (Beyond Blue, 2017a).

1.3 Ecological Resilience Theory

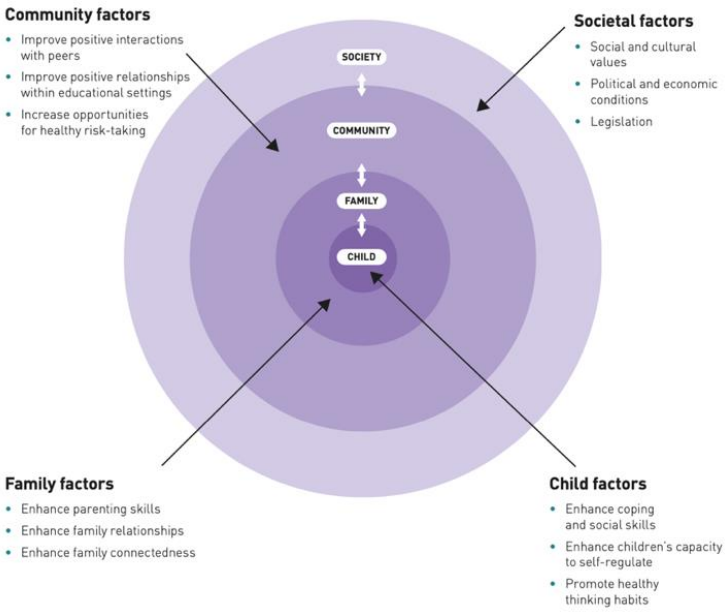
Resilience results from a child's interaction with their environment (Beyond Blue, 2017b; Morgan et al., 2021; Ungar & Hadfield, 2019). Figure 1 depicts an ecological model of resilience comprising four areas that contribute to resilience in children. Individual or child factors are central to resilience, while environmental factors come from family, community, and society (Beyond Blue, 2017a).

Societal factors include social and cultural values, public policies, and legislation (Beyond Blue, 2017a). Founder of resilience research, Garmezy (1987), posits that, though individual differences may affect how individuals avail themselves of it, governments could provide resources that increase protective factors and, in turn, resilience. Australian social and cultural values towards children are complex but are largely in favour of adults making decisions that consider children and their interests (Whelan, 2016). The National Action Plan

states that, “the health of children and young people in Australia is fundamental to us all, to the individuals themselves, to their families and communities and to our nation” (Australian Government Department of Health, 2020; foreword). The recommendations presented in the National Action Plan provide the opportunity for policies, legislation, and investment in Australia’s children (Australian Government Department of Health, 2020). This creates a national atmosphere conducive to producing resilience building communities.

Figure 1

Ecological Factors that Build Resilience in Children



Note. From "Building Resilience in Children Aged 0-12: A Practice Guide," by Beyond Blue, 2017, p. 19. Copyright 2017 by Beyond Blue Limited. Reprinted with permission.

Community factors can be addressed through positive relationships in educational settings, positive interactions with peers, and healthy risk taking (Beyond Blue, 2017a). Many Australian schools are addressing these factors through the Australian Student Wellbeing Framework, focusing on positive learning in inclusive, safe, and supportive school environments (Australian Government Department of Education, 2020). By their nature, school-based interventions reach into the community and encourage educators to consider

how they might be building resilience in children (Werner, 2012). In a 2017 review, Beyond Blue (2017b) found that 45% of Australian resilience interventions included social skills and relationship building in their content and 37.5% of evaluations measured social outcomes. Resultingly, community factors appear to be widely addressed in Australia. This social skills training is enhanced when taught concurrently across community and family factors, with social skills first developing in the home (Borowski et al., 2021).

Protective family factors comprise parenting skills, family relationships, and connectedness (Beyond Blue, 2017a). Parents or carers can add to generationally learned parenting skills through parenting programs. Their parenting can also be enhanced through school-based resilience interventions that reach out to parents or carers, teaching them how to build resilience in their children (Beyond Blue, 2017a). This is demonstrated in a meta-analysis of Cognitive Behaviour Therapy (CBT) based resilience interventions, where follow-up effects were greater in interventions that included homework (Ma et al., 2020). Kern et al. (2017) reports that parental support is essential in school-based interventions and researchers suggest that parental engagement is underutilised (Halliday et al., 2020; Oud et al., 2019; Singh et al., 2019; Spence et al., 2019). Some resilience interventions will offer concurrent parent workshops (Beaumont et al., 2019; Fisak et al., 2018; Singh et al., 2019) but the majority of programs will focus solely on child factors (Beyond Blue, 2017b).

Child factors comprise individual skills and traits like social skills, self-regulation, self-confidence, and coping skills (Beyond Blue, 2017a). These are all skills and traits that can be fostered in children through psychoeducation and skills training (Ang et al., 2022; Yohannan & Carlson, 2019). Beyond Blue (2017a) suggests that child factors can be fostered through a sense of autonomy and responsibility. A sense of autonomy and responsibility gives children the opportunity to make decisions and practice skills that foster resilience (Beyond Blue, 2017b; Vella-Brodrick et al., 2020).

Most existing resiliency programs target teachable child factors (Ang et al., 2022; Beyond Blue, 2017b; Gartland et al., 2019). This could be because accessing children through schools or clinics is convenient. Furthermore, changing individuals could appear simpler than accessing busy parents or carers, effecting community factors, or changing policy. However, Ungar (2011) warned that focusing solely on individual factors disregards environmental factors, which are largely outside of the child's influence. This places a disproportionate amount of responsibility for resilience on the child (Ungar, 2011). Thus, building resilience is best achieved through interventions that affect the child's life in all four areas (Beyond Blue, 2017b; Ungar, 2013).

1.4 Resilience Interventions

Resilience can be increased by interventions that teach resilience skills and strengthen environmental resilience factors (Garmezy, 1987; Masten, 2013). However, each community, demographic and culture have different considerations, making it impossible to create one intervention to suit all situations (Miljević-Riđički et al., 2020; Ungar, 2011). For example, healthy risk-taking looks different within communities based on cultural norms, perceived safety, and availability of green-space (Beyond Blue, 2017b; Brussoni et al., 2021; Niehues et al., 2016; Oliver et al., 2022). Healthy risk-taking will also vary by age, as children are allowed to lose, travel alone or make mistakes in developmentally appropriate ways (Beyond Blue, 2017a). To meet local needs, an existing resilience intervention may need to be adapted or a new intervention designed (Beyond Blue, 2017b).

Some practical considerations when designing resilience interventions include the setting, training and background of the designers, and capacity of facilitators (Beyond Blue, 2017b). Intervention designers will also consider a theoretical basis, method of delivery, frequency, length, and cost of delivery (Beyond Blue, 2017b; Yates, 2020). A resilience intervention delivered by social workers for parents or carers at risk of child safety

intervention might focus on healthy attachment (Maxwell et al., 2021), whereas an intervention delivered by teachers for children might focus on positive peer interactions and problem solving (Pinto et al., 2021; Rodgers & Dunsmuir, 2015). The mode of delivery may include emotional regulation, behavioural activation, mindfulness, or CBT (Gibbs et al., 2021; Pinto et al., 2021). The frequency and length of the program will differ depending on intervention aims, setting, and resources (Fenwick-Smith et al., 2018; Pinto et al., 2021; Yates, 2020).

To meet local needs, many resilience interventions have been designed and evaluated. When designing children's resilience interventions, the developmental needs of the target age range are considered. This will often include developing skills around making social connections, problem solving, and seeking resources (Hartup, 1996). Skill development can be taught consistently and repeatedly by the adults in a child's life, where interventions directed to the child alone may be limited to time and location. Children spend most of their early years in the home, so engaging parents in interventions can increase a child's resilience (Shaykhi, 2018; Singh, 2019). Additionally, adults in the children's community that can be an additional resource include sports coaches, therapists, and staff at local shops. These adults can influence small teachable moments for children if they understand the ecological resilience theory (Beyond Blue, 2017a; Brussoni et al., 2021; Oliver et al., 2022). However, practitioners have found that schools are a convenient setting to teach children who may have less access to their wider communities.

In exploring Australian resilience interventions for children, Beyond Blue (2017b) found that 83% of interventions were school-based. Several meta-analyses explored school-based resilience interventions and found outcomes including increased resilience, increased wellbeing, and decreased symptoms of mental health problems like depression and anxiety (Ang et al., 2022; Fenwick-Smith et al., 2018; Gibbs et al., 2021; Ma et al., 2020; Pinto et al.,

2021; Yohannan & Carlson, 2019). This demonstrates that designing, implementing, and evaluating resilience interventions is an investment worth making. Australians have a strong history of contributing to this field. Geelong Grammar School's Timbertop campus (Timbertop; Geelong Grammar School, 2023; Vella-Brodrick et al., 2020) for grade 9 students is arguably one of Australia's oldest and most intensive resilience programs.

Throughout the year, Timbertop builds resilience by infusing a range of outdoor activities, hobbies, and traditional learning with positive psychology strategies (Geelong Grammar School, 2023; Vella-Brodrick et al., 2020). Using a positive education framework, they address individual resilience factors including social skills, self-regulation, self-confidence, and coping skills. Community and family factors are also addressed by providing positive education training to staff and parents or carers (Institute of Positive Education: Geelong Grammar School, 2023). Vella-Brodrick et al. (2020) found that Timbertop increased student's competence, autonomy, and relatedness. However, applications to Timbertop are accepted according to merit and the fee-based boarding school is not widely accessible.

Accessibility to resilience training can be increased by delivering elements of Timbertop's program on a smaller scale (Vella-Brodrick et al., 2020). Pinto et al. (2021) looked at resilience interventions for children globally and found that most were delivered in schools for 10 to 120 minutes over 6 to 23 sessions. Fenwick-Smith et al. (2018) found no dose effects for interventions, with programs running for 6 weeks and 12 months both revealing positive results. In 2017, one of the major resiliency programs delivered to children in Australia was the American designed Penn Resiliency program, which is delivered in 90 – 120 minute sessions over 12 sessions (Bastounis et al., 2016). Results for the Penn Resiliency program are mixed, with a meta-analysis by Bastounis et al. (2016) finding that it did not

reduce anxiety or depression and a meta-analysis by Ma et al. (2020) finding that programs based on the Penn Resiliency program reduced symptoms of depression.

The other major resilience program delivered in Australia in 2017 was the Australian designed FRIENDS programs, which are endorsed by the World Health Organisation (Friends Resilience, 2019). The Fun Friends and Friends for Life programs can be delivered via different modes, from 90-minute weekly sessions over a term, to intensive day long sessions over 2 – 3 days. Both programs have been found to reduce symptoms of anxiety and depression (Fisak et al., 2018; Wright et al., 2019). The FRIENDS programs also address family factors by offering a companion program for adults (Fisak et al., 2018). When the adult program was completed alongside the pre-school aged program, the children benefited and the parents or carers experienced decreased parental stress, symptoms of anxiety, and symptoms of depression as well as increased resilience for parents or carers (Fisak et al., 2018).

Other Australian resilience interventions designed to meet local needs have demonstrated changes that would reflect increased resilience. Outcomes have included increased coping strategies (McAllister et al., 2018), self-compassion (Chillemi et al., 2020), challenging unhelpful thinking (Chillemi et al., 2020), social skills (Beaumont et al., 2019), self-efficacy (McAllister et al., 2018), help-seeking (Chillemi et al., 2020), quality of life (Wright et al., 2019), well-being and resilience associated with the acculturation process (Khawaja & Ramirez, 2019). These programs engage the community and family to varying degrees. They reveal the positive change that Australian children can experience through locally designed resilience interventions. It is important to understand what has already been discovered around resilience and resilience interventions to avoid replication of existing work (Yates, 2020). Part of this exploration has been done through the Children's Resilience Research Project (Beyond Blue, 2017b).

1.5 Why Research Children's Resilience Interventions?

1.5.1 The Children's Resilience Research Project

To gain a greater consensus of resilience among Australian experts and the community, Beyond Blue (2017b) funded the Children's Resilience Research Project. During the project, a literature review was done to build upon existing literature reviews around interventions, theories, and epidemiological evidence. Consensus-building surveys using the Delphi method focused on expert definitions, measures, and interventions. Parent or carer surveys were undertaken as well as professional, parent or carer and child consultations. The result of the project was Building Resilience in Children Aged 0-12: A Practice Guide (Practice Guide; Beyond Blue, 2017a), which defines resilience as Australians see it, outlines the ecological model of resilience and makes recommendations for designing and evaluating resilience programs. There had been no synthesis of information around the elements and outcomes of resilience programs in Australia since the Children's Resilience Research Project (Beyond Blue, 2017b).

The SLR in this thesis will aim to fill this gap in knowledge by illuminating whether recently evaluated Australian resilience interventions addressed individual, family, and society factors. Additionally, it will assess whether the interventions were teaching in the five key areas that determine the building of resilience (Beyond Blue, 2017a). Disseminating and implementing research findings can take 17 years (Morris et al., 2011) so it was unlikely that the Practice Guide (Beyond Blue, 2017a) had been widely adopted. However, this literature review will illuminate whether researchers reference the Practice Guide (Beyond Blue, 2017a) in their designs. It will also clarify which areas of resilience building are lacking in current resilience interventions. Additionally, this literature review will give context to the findings of the evaluation of the BBRW (McCausland-Green, 2015) and inform revisions of its design.

1.5.2 The Bouncing Back Resiliency Workshop

The BBRW (McCausland-Green, 2015) in primary schools is a universal intervention aimed at increasing resilience. It was developed by University of Southern Queensland (UniSQ) staff member and Clinical Psychologist Mrs Jean McCausland-Green at the request of a former vice-principal who was concerned that children were struggling with disappointment and adversity (McCausland-Green, 2021). Mrs McCausland-Green designed the workshop based on CBT. The Workshop utilises a combination of discussion and play to develop individual factors in children. It has been delivered by UniSQ Psychology Masters students in a Queensland State School for 7 years. In 2022, a 1-hour optional workshop for parents or carers was added to the program to include a focus on family factors and enhance resilience training in the home.

Following from the SLR of resilience interventions for children in Australia, a program evaluation will investigate whether the BBRW (McCausland-Green, 2015) is having the intended effect on its participants. The intent of the BBRW (McCausland-Green, 2015) is to increase participant's ability to overcome difficult circumstances. In this case, the ability to overcome difficult circumstances is measured under the constructs of resilience as well as emotional and behavioural problems. If the BBRW (McCausland-Green, 2015) is working as intended, it is expected that investigations will uncover an increase in resilience and a decrease in emotional and behavioural problems over the course of the intervention. Feedback from children, parents or carers and teachers will give context to findings by indicating how participants are experiencing the intervention (Creswell & Creswell, 2018). This research provides the first formal program evaluation on the BBRW (McCausland-Green, 2015).

1.5.3 The Origins of this Research

With each personal achievement, I have been aware that community connections and a sense of belonging contributed to my development and resilience. Having volunteered in my community for most of my adult life, I understand that adults who care can contribute in lasting ways to the development of children who are not their own. Furthermore, early intervention with allied health professionals has been incredibly valuable to my nuclear family, extended family, and our community. As well as having a depth of lived experience in disability and mental health, my studies further shaped me and inspired me adopt the theories I work under today, including the ecological resilience theory.

Furthermore, studying nursing for the electives of my science (psychology) degree ignited my keen interest in primary health care. It was inspiring to learn that early intervention and the right resources could increase health outcomes and a person's quality of life. While working for a psychiatrist and delivering crisis support in suicide prevention, I faced the enormity of the ongoing mental health care crisis and the repercussions of long waitlists and too few providers. I theorised that group therapy could be a solution to delivering primary care in mental health. These interests in mental health prevention, early intervention, and group work contributed to my decision to do research around children's resilience, including this SLR of resilience interventions for children and the evaluation of the BBRW (McCausland-Green, 2015).

1.6 Aims, Objectives and Research Questions

Two studies were proposed to explore the teaching of resilience to children in Australia. Both studies will be presented in this thesis.

1.6.1 Study 1: Systematic Literature Review

Study one aimed to produce a literature review on Australian resilience interventions for children within Australia since the Children's Resilience Research Project in 2017. Following the PRISMA (Page et al., 2021) systematic literature review checklist and search

protocol, the review outlines key concepts in resilience and answers the following research questions:

1. Have resilience interventions for children within Australia since 2017 met the guidelines in the Building Resilience in Children Aged 0-12: A Practice Guide (Practice Guide; Beyond Blue, 2017a)?
2. What outcomes have been demonstrated from resilience interventions for children within Australia since 2017?
3. What are the gaps in the research around resilience interventions for children within Australia since 2017?

1.6.2 Study 2: Program Evaluation

Study two aimed to evaluate the Bouncing Back Resiliency Workshop. More specifically, it aimed to answer the following research questions:

1. Does the Bouncing Back Resiliency Workshop teach resilience within the key areas that determine the building of resilience as outlined in the Building Resilience in Children Aged 0-12: A Practice Guide?
2. Does the Bouncing Back Resiliency Workshop improve children's resilience in the context of school settings as measured by the Resiliency Scales for Children and Adolescents from pre- to post-workshop?
3. Does the Bouncing Back Resiliency Workshop decrease behavioural and emotional problems in children as reported by parents or carers and measured by the Child Behaviour Checklist, and reported by teachers and measured by the Teacher's Report Form from pre- to post-workshop?
4. Do changes in resilience correlate with levels of parental engagement with a 1-hour workshop and weekly handouts?

5. How do children, parents or carers and teachers perceive the Bouncing Back Resiliency Workshop as reported on the feedback form?

Chapter 2: Literature Review

This research specifically focuses on resilience interventions for Australian children. Understanding the elements that contribute to resilience and the difficulties in measuring resilience will be imperative in usefully applying the findings of this research. Therefore, this chapter will present some of the known risk and protective factors contributing to resilience. It will also give an overview of the five key areas that contribute to the building of resilience in children (Beyond Blue, 2017a). Following, the barriers to measuring resilience outcomes will be discussed and CBT will be explored.

2.1 Resilience Risk and Protection Factors

Resilience research emerged from a curiosity around children who were found to have positive outcomes despite experiencing adversity in early childhood (Rutter et al., 1975). Risk factors were those factors assumed to increase a child's risk of poor educational, health, and psychological outcomes; where protective factors were thought to increase a child's likelihood of overcoming risk factors (Luthar et al., 2000). Major resilience researchers all consider resilience from some form of ecological perspective, including individual, family, and community factors (Garmezy et al., 1984; Luthar et al., 2000; Rutter, 2013; Werner, 1996). Common themes include levels of resilience fluctuating over the lifespan in response to complex interactions between individuals, environment, and exposure to risk and protective factors.

Michael Rutter explained resilience as an interaction between the child and environment that results in positive outcomes for a child, despite experiencing risk factors (Rutter, 2012). He posits that some stress can help children develop skills that build resilience and emphasised that individual children respond to particular risk and protective factors differently depending on their genetics, personality and temperament (Rutter, 2013). This means that rather than some individuals being inherently resilient and others not, they are all

more likely to respond to different risk and protective factors in different ways, appearing more resilient at different times of their lives, including adulthood (Rutter, 2007). For Rutter, positive outcomes were influenced by individual skills and traits, like self-efficacy, confidence, planning, and determination (Rutter, 2013). However, environmental factors were always central, including the role of family relationships (Rutter, 2007).

Garmezy (1991) posits that children display resilience by demonstrating the capacity to function competently following a stressful event despite experiencing emotional reactivity. He posited three models of resilience: compensatory, protective vs. vulnerability, and challenge (Garmezy et al., 1984). The compensatory model suggested that one protective factor could meet needs that compensate for a coinciding risk factor (Garmezy et al., 1984). For example, the negative effects of instability in the home can be reduced by a warm relationship with an adult outside of the home (Garmezy et al., 1984). The protective vs. vulnerability model posited that children could be resilient in one area and not another, depending on their personal strengths and protective factors (Garmezy et al., 1984). Much like Rutter's work, the challenge model suggested that, though high levels of stress lower functioning, some stress can be beneficial by presenting children with the opportunity to learn coping skills and support seeking behaviours (Garmezy et al., 1984). Finally, Garmezy (1991) demonstrated the fluidity of resilience over time.

Emmy Werner (2012) summarised resilience as coping with internal stressors like emotional sensitivity and psychopathology and external stressors like poverty, illness, loss, and family breakdown. Werner (1996) posited that stress caused by risk factors could be balanced with protective factors; specifically, autonomy self-efficacy, and the ability to access resources through a caring relationship with at least one adult (Werner, 1996). Werner (1996) explored how the temperament of children can increase their ability to make relationships. Protective factors could also be direct or indirect, acknowledging the influence

that parental support can have on the child. She suggests that when individuals are adequately resourced, they will "self-right" (p.105) and that each developmental stage is a chance to provide resources and protective factors or reduce risk factors and increase resilience (Werner, 1996).

Suniya Luthar et al. (2000) posits that resilient individuals "display positive adaptation despite experiences of significant adversity or trauma". Children display positive adaptation through secure attachment with parents or carers, and later through academic performance and positive relationships with peers and other adults (Luthar et al., 2000). Luthar et al. (2000) challenged ideas around what constitutes risk or protective factors and proposed a model to differentiate protective factors into three categories. Protective-stabilising effects are attributes that at buffer risk, protective-enhancing effects are factors that support a child through risk factors, and "protective but reactive" (p. 6) effects are positive attributes that are helpful in low stress situations but are not sufficient for high stress situations (Luthar et al., 2000). Like Rutter and Werner, Luthar (1991) posited that individuals have different levels of resilience in different areas, like behavioural, emotional, and educational. She also addressed indirect protective factors like support for parents or carers, teachers, and other adults in children's lives (Luthar, 2021). Luthar has suggested that genetic and biological influences in resilience be explored further (2006).

Ann Masten (2009) defines the "ordinary magic" (p. 1) of resilience as successfully adapting and recovering after experiencing adversity that threatens their "system function, viability, or development" (Masten, 2014). Masten (2021) studied resilience using two models: the Variable Focused and Person Focused models. The Variable Focused model looked at how a child's individual factors, environment, and experiences contributed to levels of resilience (Masten, 2014). The Person Focused Model explored individual experiences and resilience across the life span (Masten, 2021). She posits that individuals are more likely to

be resilient if they have access to resources and opportunities to adapt and recover successfully (Masten, 2021). She also highlighted the dose effect of risk factors (Masten, 2014); that is, the more risk an individual is exposed to the, the greater number and severity of symptoms they will experience. Like Luthar et al. (2000), Masten (2021) questioned definitions around risk and protective factors, as the perception of risk, rather than the risk itself appeared to predict resilience. She discussed the role of culture in influencing these perceptions (Masten, 2021). Masten (2021) suggests that there are optimal times during development to deliver interventions. These interventions should target individual and environmental factors, provide resources, and support parents or carers and teachers (Masten, 2021).

Michael Ungar posited that individual factors interact with structures, services, and health knowledge to build resilience (Ungar, 2008). Resilience was demonstrated by the ability to access resources and find opportunities to "experience feelings of wellbeing" (Ungar, 2008, p. 225). Ungar (2011) focused on four principals: decentrality, complexity, atypicality, and cultural relativity. Decentrality emphasises environmental factors, reducing the responsibility for resilience from the individual (Ungar, 2011). Complexity asks researchers to avoid the simplification of factors that lead to resilience, remembering that resilience is affected by a complex combination of individual experience, agency, interactions with the environment, and physical and social change (Ungar, 2011). Atypicality warns against determinism and requests researchers focus on function of behaviour (Ungar, 2011). Ungar and Hadfield (2019) also explored Differential Impact Theory, finding that resilience interventions were more beneficial for children who experience more risk and had less psychological problems. Like Masten, Ungar (2008) focused on the cultural significance of what might typically be considered a risk factor, with cultural relativity exploring how culture shapes individual understanding of resilience.

Researchers appear to agree that risk and protective factors influence development and resilience. However, the following section 2.1.1 and section 2.1.2 must be read with the understanding that what constitutes a risk or protective factor can differ within situations, cultures, and individuals (Masten, 2021; Ungar, 2011). An individual's perception of events, including how they perceive their ability to access resources can change the outcome for an individual (Masten, 2021; Ungar, 2011). Nevertheless, risk and protective factors appear to influence levels of resilience and are important to note when looking at population trends.

2.1.1 Risk Factors

Michael Rutter (2015) theorised that experiences of successfully overcoming brief, controlled exposure to stress can strengthen a child's resilience. However, prolonged adversity or acute adversity that leads to physical deprivation or psychological distress, can increase the risk of mental-health problems (Rutter, 2015) and decrease resilience (Morgan et al., 2021). For example, experiencing violence towards self or others, loss of family, and displacement are adversities associated with war that are risk factors for decreased mental health in children (Werner, 2012). A literature review by Werner (2012) reported that war increases children's symptoms of depression, anxiety disorders, and posttraumatic stress disorder. These outcomes are exacerbated by a dose effect, meaning the more risk a child experiences, the more likely they are to experience poor outcomes (Heard-Garris et al., 2018; Masten, 2013; Werner, 2012).

Though Australian children are not currently impacted by war on Australia's shores, they are likely to experience similar dose effects from multiple exposure to natural disasters, like flood, drought, and fire(Commonwealth of Australia, 2020; Gibbs et al., 2021). These extreme weather events effect families through disruptions to employment, transport, food, health, and education (Commonwealth of Australia, 2020). In turn, children experience increased mental health problems and decreased resilience post-disaster (Cadamuro et al.,

2021). A more recent risk factor for Australian children is the Coronavirus Disease pandemic (COVID-19), which has increased parent burnout (Wiemer & Clarkson, 2023) and presentations for child mental health support (Tedja et al., 2023). Other risk factors directly related to community and social environment include identifying as part of the Lesbian, Gay, Bisexual, Transgender, Queer community (Campbell et al., 2022); witnessing and being a victim of community violence (Miliauskas et al., 2022); low socio-economic status (Gartland et al., 2019); and emotional abuse by teachers (Nearchou, 2018).

Childhood trauma including neglect and abuse is also a risk factor for decreased resilience with dose effects (Campbell et al., 2022; Heard-Garris et al., 2018; Shields et al., 1994). Maternal acculturative stress is a risk factor that can negatively affect mental health from preconception (Liu et al., 2023). Other risk factors related to family include exposure to domestic violence (Alaggia & Donohue, 2017), experiencing the death of a parent (Gartland et al., 2019), placement in foster care (Dubois-Comtois et al., 2021), and family discord (Auersperg et al., 2019), which all reduce resilience. However, some children will have better outcomes than their peers after experiencing similar risk factors (Rutter, 2015; Werner, 2012). Werner (2012) posits that this could be due to the presence of protective factors.

2.1.2 Protective Factors

Determinism would indicate that children experiencing one or more risk factors would have poor outcomes. However, Emmy Werner (2012) posits that a child's level of resilience is instead determined by a balance of risk and protective factors. The ecological resilience factors most commonly studied are individual factors (Gartland et al., 2019). Resultingly, there is strong evidence for individual protective factors that build resilience, like social skills (Haddow et al., 2021), self-regulation (Gartland et al., 2019; Noroña-Zhou & Tung, 2021; Yule et al., 2019), self-confidence (Nearchou, 2018), and coping skills (Liu et al., 2020; Masten, 2013). Teachable individual factors are arguably the most convenient

factors to target for intervention as they only require access to the child. However, there is danger in focusing on these to the exclusion of environmental factors, which are just as important to building resilience but are largely outside of a child's control (Keelan & Browne, 2018; Ungar, 2011).

Family factors can also balance out risk factors and be protective. For example, early neglect and abuse (Campbell et al., 2022) and placement in foster care (Dubois-Comtois et al., 2021) are risk factors whose affects can be reduced by post-adoption family conditions including family cohesion and open communication (Duncan et al., 2021). Meta-analyses have found positive relationships with caregivers is protective for children who had experienced adversity including poverty and community violence (Gartland et al., 2019; Miliauskas et al., 2022). These positive relationships are essential to positive parenting, which is also protective and a predictor for resilience (Noroña-Zhou & Tung, 2021). Family support is protective for children facing a range of adversity (Gartland et al., 2019; Yule et al., 2019). However, children who do not have access to support within their family can find protective factors outside of the home (Haddow et al., 2021; Heard-Garris et al., 2018; Werner & Johnson, 2004).

Outside of the home, community connection including school support is protective for children, with academic engagement increasing resilience (Gartland et al., 2019; Yule et al., 2019). Strong social support, including positive peer relationships is also protective and has been found to reduce the effects of emotional abuse experienced by children in schools and out-of-home care (Haddow et al., 2021; Nearchou, 2018; Yule et al., 2019). Other community protective factors that increase resilience include religious practices, beliefs and involvement in a religious institution (Heard-Garris et al., 2018; Yule et al., 2019) and, to a lesser extent, extra-curricular activities (Yule et al., 2019). In Australia, this can be delivered through school, sports, other extra-curricular activities, religious institutions, and social groups.

Just as experiencing consecutive or concurrent risk factors increases the likelihood of negative outcomes, compounding protective factors increases the likelihood of positive outcomes (Beyond Blue, 2017b; Masten, 2014). It follows that resilience can be strengthened through interventions that increase a range of individual, family, and community factors (Masten, 2014). The Beyond Blue (2017a) Practice Guide encourages stakeholders to design resilience interventions that decrease risk factors and increase protective factors. To do this, it suggests five key areas that determine the building of resilience in children (Beyond Blue, 2017a).

2.3 The Five Key Areas That Determine the Building of Resilience

The Practice Guide (Beyond Blue, 2017a) suggests that resilience interventions should be designed around clear goals based on local need. The broad goals suggested in the guide include introducing or enhancing protective factors, reducing risk factors, providing resilience building resources and experiences, and building resilience attributes. To meet these goals, Beyond Blue (2017a) outlined five key areas that determine the building of resilience in children. These include building, strengthening and promoting supportive relationships; focusing on autonomy and responsibility; focusing on managing emotions; creating opportunities for personal challenge; and educating people about resilience.

Increasing resilience through building, strengthening and promoting supportive relationships can be done by increasing family communication (Acuña & Kataoka, 2017; Boumis et al., 2023), encouraging families to increase their social and community networks (Heard-Garris et al., 2018), and increasing a child's sense of belonging and cultural connectedness (Planert et al., 2023). Individual social skills are also important here so children gain the ability to make and keep relationships within their families and in their community (Haddow et al., 2021). An intervention can focus on autonomy and responsibility by increasing parents or carers' knowledge about autonomy and responsibility (Dettweiler et

al., 2023; Niehues et al., 2016; Vella-Brodrick et al., 2020). This includes encouraging parents or carers to give children choices and provide opportunities for making decisions (Dettweiler et al., 2023).

Resilience interventions can focus on managing emotions by teaching individual skills like positive self-talk, self-awareness, coping skills and choosing a positive attitude (Ma et al., 2020; Oud et al., 2019; Planert et al., 2023). Opportunities for personal challenge have been found to increase resilience and can be created through activities that encourage problem solving using creative and critical thinking (Ellis et al., 2022; McAllister et al., 2018; Vella-Brodrick et al., 2020). Lastly, educating people about resilience allows resilience building messages to be consistent across environments and situations (Khawaja & Ramirez, 2019; Shaykhi et al., 2018; Singh et al., 2019). This might include teaching coaches and other care givers about resilience and how they can support resilience and build it in their context (McDonald-Harker et al., 2021). Structured resilience interventions that are designed with these five key areas in mind will be more likely to produce measured increases in resilience for Australian children during program evaluations (Beyond Blue, 2017a).

2.4 Barriers to Measuring Resilience

The many ecological factors that influence resilience make resilience difficult to measure (Cosco et al., 2017; Ungar & Hadfield, 2019). Environmental factors are in a constant state of change, increasing or decreasing any number of risk or protective factors at any one time (Ungar, 2011; Werner, 2012). Children will respond to these environmental changes in diverse ways, depending on individual factors like their coping skills (Liu et al., 2020; Ungar, 2011). In response, individual resilience levels fluctuate, making it difficult to predict how children will overcome adversity over time (Ungar & Hadfield, 2019).

For these reasons, researchers have largely avoided measuring resilience using resilience measures alone (Gartland et al., 2019). Instead, researchers have been more likely

to explore factors related to resilience (Gartland et al., 2019). For example, if children are experiencing increased mental health problems and decreased resilience post-disaster (Cadamuro et al., 2021; Gartland et al., 2019), it follows that measures of psychopathology can be used in accordance with or as a substitute for resilience measures (Dray et al., 2017b). Outcomes from resilience interventions that are indicative of increased resilience include increased wellbeing, emotional regulation, and relationships with caregivers (Gartland et al., 2019; Yule et al., 2019). Additionally, researchers have been exploring whether resilience interventions have decreased symptoms of depression, anxiety, and stress (Ang et al., 2022; Dray et al., 2017b; Gartland et al., 2019; Ma et al., 2020).

Other problems with measuring resilience include the primary use of Likert-type self-report measures, which are recommended to be used in children with caution (Mellor & Moore, 2014; Pinto et al., 2021). This can be addressed using cross-informant reporting; gathering evidence from the child, parent, and teacher (Mellor & Moore, 2014). Additionally, the diversity of psychometric measures used across Australian program evaluations make it difficult to undertake a meta-analysis (Pinto et al., 2021). In the Children's Resilience Research Project, for example, only 15% of 32 studies used the same measurements (Beyond Blue, 2017b). Nevertheless, researchers continue to consider the complex factors that contribute to resilience and choose measures that are applicable to their aims of their specific resilience intervention and their research design (Ang et al., 2022; Ma et al., 2020).

2.5 Cognitive Behaviour Therapy

The BBRW (McCausland-Green, 2015) was designed based on CBT. CBT comes from a cognitive model founded on the premise that all psychological disturbances originate from dysfunctional thinking (Beck & Beck, 2020). Treatment is based on examining maladaptive beliefs, implementing behavioural strategies, and eliminating maintaining factors

(Beck & Beck, 2020). After 44 years of demonstrated positive outcomes, there is strong evidence for CBT in treating a range of psychological disturbances (Beck & Beck, 2020).

The Australian Psychological Society (2018) ranks evidence for treatment of specific disorders from level 1 to level 5, with level 1 evidence being the most robust. For children, The Australian Psychological Society (2018) classified CBT as a level 1 or 2 evidence-based intervention for 15 different disorders. This includes all anxiety disorders, conduct disorder, binge eating disorder, and bulimia nervosa. It also includes bipolar disorder, depression, sleep disorder, body dysmorphic disorder, pain disorder, and substance use disorder.

Meta-analyses found that children receiving CBT have reduced symptoms of internalising disorders (Wergeland et al., 2021) externalising disorders (Riise et al., 2021), and subclinical depression (Ma et al., 2020; Oud et al., 2019) among others. Additionally, meta-analysis by Sigurvinsdottir et al. (2020) found CBT to be as effective as selective serotonin reuptake inhibitors for children and youth with anxiety disorders. These effects remain over time. von Brachel et al. (2019) found that improvements in outpatients with varied psychological disorders continued for 5 to 20 years after receiving CBT in routine care.

It is no surprise then, that CBT is the modality used most often in resilience programs for children (Pinto et al., 2021). A scoping review by Gibbs et al. (2021) discovered that psychosocial resilience training for children was most effective when delivered by CBT. A meta-analysis by Yohannan and Carlson (2019) found that school-based CBT interventions were a fitting modality to improve resilience in trauma-affected children. Additionally, a meta-analysis by Ma et al. (2020) found that resilience focused CBT including cognitive training, problem-solving, and social skills training decreased symptoms of depression in a population that includes non-clinical participants. This demonstrates that CBT is an appropriate basis upon which to design school-based resilience interventions.

Chapter 3: Elements and Outcomes of School Based Resilience Programs for Children Within Australia: A Systematic Literature Review of Quantitative Studies

3.1 Abstract

Background: In 2017, Beyond Blue published Building Resilience in Children Aged 0-12: A Practice Guide (Practice Guide; Beyond Blue, 2017a). The Practice Guide (Beyond Blue, 2017a) provided guidelines for designing resilience interventions for children in Australia. The aim of this SLR was to assess whether Australian resilience interventions were adhering to the Practice Guide (Beyond Blue, 2017a). Additionally, it aimed to report outcomes of Australian program evaluations, and present any gaps in the research.

Methods: All included studies used psychometric measures to test pre-to-post intervention changes in samples that included children aged 8-14. All reports were published in English between 2017 and 2022. SCOPUS and Ebscohost Megafile Ultimate was searched for studies. Risk of bias was assessed using JBI Sumari Checklist for Quasi-Experimental Studies (Non-Randomized Experimental Studies) (Joanna Briggs Institute, 2017). Evidence was synthesised regarding compliance with the Practice Guide (Beyond Blue, 2017a) and outcomes of the interventions.

Results: The search identified 21 records and 9 eligible reports that included a combined 7681 participants. Data was extracted for 7 prescribed resilience interventions. The interventions mainly focused on individual factors. They were less likely to address family and community factors. Overall, vote counting demonstrated studies reporting positive effects in at least one domain. Domains included increased resilience and wellbeing and decreased symptoms of depression and anxiety. Future studies should focus on resilience training that engages parents or carers to increase children's responsibility and autonomy and encourages the growth of community networks (Dettweiler et al., 2023).

Discussion: Effects indicate that resilience interventions are contributing to the mental health of Australian children. However, the wide range of measurements and test statistics used to evaluate interventions make results inconsistent and meta-analysis impractical. Limitations include the small number of trials analysed, missing data around intervention contents, and difficulty with measuring the resilience domain. Overall, resilience interventions are meeting some of the guidelines from the Practice Guide (Beyond Blue, 2017a) and contributing to positive mental health outcomes.
Other: Funding was provided by the University of Southern Queensland. This study is registered with PROSPERO, number CRD42022318372.

3.2 Introduction

Most Australian children and youth report feeling happy and satisfied in their lives (Australian Institute of Health and Welfare, 2021a, Key Findings section). However, 20% of 11-17 year old's report experiencing psychological distress (Australian Institute of Health and Welfare, 2021a, Key Findings section). In response, the Australian Government is encouraging stakeholders to focus on building resilience in children aged 8-14 (Australian Government Department of Health, 2020).

Resilience is fluid, fluctuating in response to an individual's interaction with their environment (Beyond Blue, 2017b). There are many risk factors, like adverse childhood experiences, that decrease resilience (see 2.1.1). However, the effect of these risk factors is buffered by protective factors, like positive relationships with peers, parents or carers, and other adults (see 2.1.2). This is conceptualised in the ecological resilience theory, which categorises the influences that build resilience into individual, family, community, and societal factors (see 1.3; Beyond Blue, 2017a).

Though the ecological factors that contribute to resilience are well understood, it would not be possible for one intervention to meet the needs of all communities (Beyond

Blue, 2017b; Miljević-Riđički et al., 2020). For example, one community's tolerance for child autonomy could encourage children to play at the park or travel to school independently, while another community's tolerance for child autonomy may be more restrictive (Brussoni et al., 2021; Niehues et al., 2016; Oliver et al., 2022). In these situations, autonomy may need to be encouraged in different ways. Therefore, there will always be a requirement for resilience interventions that consider local needs (Beyond Blue, 2017b; Miljević-Riđički et al., 2020). The Children's Resilience Research Project (Beyond Blue, 2017b) explored resilience in the Australian context and resulted in a Practice Guide (Beyond Blue, 2017a) for designing resilience interventions.

Resilience interventions have been found to increase wellness and decrease symptoms of psychopathology worldwide (Ang et al., 2022; Cadamuro et al., 2021; Ma et al., 2020; Pinto et al., 2021). Though these results are promising, it has been more difficult to demonstrate changes in the resilience domain (see 2.4; McAllister et al., 2018; Moore et al., 2021). This is unsurprising considering the complexity in measuring a domain that fluctuates in response to risk and protective factors both within and outside of the participant's control (Masten, 2013; Werner, 2012). Further challenges in measuring resilience come from the lasting effects of psychological training which become more effective when practiced, as results are more likely to manifest over time (Pinto et al., 2021; von Brachel et al., 2019). Despite these difficulties, any intervention that demonstrates positive mental health or wellbeing outcomes for children is valuable.

This SLR followed from the systematic review done for the Children's Resilience Research Project (see 1.5.1; Beyond Blue, 2017b) and explored the uptake of the Beyond Blue (2017a) Practice Guide in the design of Australian resilience interventions. Interventions that were designed from an ecological standpoint and met more of the guidelines were expected to have better outcomes. If any interventions demonstrate a change in the resilience

domain, understanding what elements of the Practice Guide (Beyond Blue, 2017a) may have contributed to that change will contribute to a deeper understanding of how to teach resilience. Finally, areas highlighted by the Practice Guide (Beyond Blue, 2017a) that were not being addressed by Australian resilience interventions need to be identified for future research. The objectives of this SLR were to investigate these concepts by comparing each intervention to the elements in the Practice Guide (Beyond Blue, 2017a), report on the outcomes of each intervention, and highlight areas for further research.

3.3 Methods

3.3.1 Registration and Inclusion Criteria

This literature review was registered with Prospero (CRD42022318372; National Institute for Health Research, 2022), who automatically published the registration due to higher than usual registrations regarding COVID-19. Following the PRISMA systematic literature review checklist and search protocol (Page et al., 2021), an SLR was undertaken to examine quantitative studies about Australian resilience interventions for children since the Children's Resilience Research Project (Beyond Blue, 2017b). Reports were included if resilience interventions were delivered to a sample that included children aged 8-14. All quantitative studies assessing the outcomes of resilience interventions using psychometric measures were included. Peer reviewed journals published in English between 2017 and 2022 were chosen. Exclusion criteria were studies containing adults, non-original research, and unavailable full texts. Outcome domains included mental health problems, wellness, and resilience.

3.3.2 Search Strategy

On April 7, 2022, searches were conducted using SCOPUS and Ebscohost Megafile Ultimate. Databases in the Ebscohost Megafile Ultimate search included Academic Search Ultimate, APA PsycArticles, APA PsycInfo, CINAHL with Full Text, Education Research

Complete, E-Journals, Psychology and Behavioral Sciences Collection, and Sociology Source Ultimate. The principal investigator designed a search strategy, which was peer reviewed and refined through consultation before the search for this literature review began. As presented in tables 1 and 2, Scopus and Ebscohost were searched using a combination of words and words similar to resilience, workshop, child, and Australia. It was also planned that a manual search would be conducted by searching the reference lists of the finally included articles.

3.3.3 Report Selection

Each record was independently screened by two reviewers (JS, GB), with a third reviewer (JM) available when a report inclusion was disputed. Reviewers used JBI Sumari (Joanna Briggs Institute, 2017) to select reports that met the inclusion criteria. Initially, records were excluded if it was clear from their title and abstract that they did not contain a program evaluation with quantitative, psychometric measures or if the sample did not include Australian children aged 8-14. Subsequently, reports were excluded under the same criteria based on their full text.

3.3.4 Data Extraction and Coding

The principal investigator independently extracted data from each study, which a second member of the research team reviewed. Extraction was completed manually, with no automation tools used. Only data reported was used. No additional information was sought from reporters. The reports were from seven different studies. Data was entered into an excel spreadsheet, organised by research question and colour coded for ease of analysis.

The outcomes sought were elements of the resilience intervention found in the Practice Guide (Beyond Blue, 2017a), changes in outcome domains from pre-to-post intervention testing including follow-up over any time period, and gaps in the research. All variables for which data are sought are outlined in the tables described below. Outcomes of quantitative results included overall test scores and sub-domains of test scores from validated

psychometric measures. They were also reported using bespoke measures including selected items from validated measures and new measures created by the study's authors. Changes on resilience measures were considered a particularly important outcome as changes in the resilience domain are the primary objective of a resilience intervention. All significant and non-significant results in any outcome domain over any time point were recorded to avoid bias.

3.3.5 Risk of Bias

The JBI Sumari Checklist for Quasi-Experimental Studies (Non-Randomized Experimental Studies) (Joanna Briggs Institute, 2017) was used to assess risk of bias in the included studies. The checklist addressed clarity of cause and effect, confounding variables, control groups, pre-to-post testing, follow-ups, measurements including reliability and validity, and appropriateness of statistical analysis. Additionally, funding sources and conflicts of interest were also recorded and appraised. The principal investigator independently assessed each report against these criteria and recorded them in the excel spreadsheet as yes, no, unclear or not applicable. A second investigator reviewed level of bias with the primary investigator. Strengths and limitations of each report were included in the results.

3.3.6 Data Synthesis

To explore what outcomes have been demonstrated from resilience interventions for children within Australia since 2017, it was planned that the mean difference would be extracted for qualitative outcomes of each domain in each study. It was anticipated that there would be limited studies and that, as per previous reviews, outcome domains and measures of effect would vary (Fenwick-Smith et al., 2018; Ma et al., 2020; Pinto et al., 2021). For this purpose, the synthesis of study outcomes would be presented as vote counting based on the direction of the effect (Cochrane Training, 2023; Crowther et al., 2011). Where information

Table 1

Searches on Ebscohost Megafile Ultimate

Line	Search strategy	Results	Field search	Limits	Notes
1	(resilien* N5 (workshop? OR program* OR intervention? OR teaching OR education)) AND (child* OR adolescen* OR youth?) AND (Australia* OR Queensland* OR "New South Wales" OR Victoria* OR "Northern Territory" OR Tasmania*)	257	All fields	2017 onwards; English language	
2	(resilien* N5 (workshop? OR program* OR intervention? OR teaching OR education)) AND (child* OR adolescen* OR youth?) AND (Australia* OR Queensland* OR "New South Wales" OR Victoria* OR "Northern Territory" OR Tasmania*)	25	Title-Abstract-Keyword	2017 onwards; English language	
3	(resilien* N5 (workshop? OR program* OR intervention? OR teaching OR education))	5599	Title or Abstract or Keyword	2017 onwards; English language	Test search of just concepts 1 and 2
4	(child* OR adolescen* OR youth?)	1,042,685	Title or Abstract or Keyword	2017 onwards; English language	Test search of just concept 3
5	(Australia* OR Queensland* OR "New South Wales" OR Victoria* OR "Northern Territory" OR Tasmania*)	143,203	Title or Abstract or Keyword	2017 onwards; English language	Test search of just concept 4
6	Lines 3-5	90	Title or Abstract or Keyword	2017 onwards; English language	Combined searches with "Search with AND"
7	(resilien* N5 (workshop? OR program* OR intervention? OR teaching OR taught OR education OR educating OR educated))	11441	Title or Abstract or Keyword	2017 onwards; English language	Test search of just concepts 1 and 2
8	Lines 4, 5 and 7	93	Title or Abstract or Keyword	2017 onwards; English language	Combined searches with "Search with AND"
9	(resilien* N5 (workshop? OR program* OR intervention? OR teaching OR taught OR education OR educating OR educated))	5636	Title or Abstract or Keyword	2017 onwards, peer reviewed	Test search of just concepts 1 and 2

Line	Search strategy	Results	Field search	Limits	Notes
10	(child* OR adolescen* OR youth?)	1,044,129	Title or Abstract or Keyword	2017 onwards, peer reviewed	Test search of just concept 3
11	(Australia* OR Queensland* OR "New South Wales" OR Victoria* OR "Northern Territory" OR Tasmania*)	143,394	Title or Abstract or Keyword	2017 onwards, peer reviewed	Test search of just concept 4
12	Lines 9-11	92	Title or Abstract or Keyword	2017 onwards, peer reviewed	Combined searches with "Search with AND", all results were in English

Note. Databases included: Academic Search Ultimate, APA PsycArticles, APA PsycInfo, CINAHL with Full Text, Education Research Complete, E-Journals, Psychology and Behavioral Sciences Collection, Sociology Source Ultimate.

Table 2

Search on Scopus

Line	Search strategy	Results	Field search	Limits	Notes
1	(resilien* W/5 (workshop? OR program* OR intervention? OR teaching OR taught OR education OR educating OR educated)) AND (child* OR adolescen* OR youth?) AND (Australia* OR Queensland* OR "New South Wales" OR Victoria* OR "Northern Territory" OR Tasmania*)	29	Title-Abstract-Keyword	2017 onwards, articles and reviews, English	

was available, the results would be reported for each study for each domain. In the instance of missed information, that would be reported.

3.3.7 Data Categorisation and Presentation

The potential benefit or potential harm of each intervention was displayed using a harvest plot (Cochrane Training, 2023; Crowther et al., 2011). Outcome domains were categorised into 1 of 2 categories: decreasing psychopathology, building resilience, and building resilience factors. Where the Cohen's *d* effect size was above 0.2 (at least small), an effect was recorded. Where the effect size was below 0.2 (very small), no change was recorded. However, the potential benefit of these studies would be reported narratively.

While the categories simplified the synthesis, a limitation of including several measures in one category is that the nuance of the measure is lost. For example, resilience in the context of acculturation and a child's resilience resources are technically different domains but will both be categorised as building resilience. Some limitations of vote counting are that it excludes information about the size of effect and the differences in power between studies (Cochrane Training, 2023). For this reason, accompanying information about the study designs was given.

To align the analysis with the research questions, the data was grouped into six tables. Table 3 comprised information about the studies like that of the Children's Resilience Research Project. This included the first author, year, sample size, demographics, randomisation, timing of testing including follow-up, and information about conditions including control groups. Table 4 comprised information about each intervention including the setting (e.g., school, home, clinic), type (e.g., universal, targeted), community participation, family participation, length of intervention, dose of intervention, mode of delivery, and type of therapy informing the design (e.g., CBT, martial arts). This gave an overall picture of intervention design and delivery.

Table 5 was data drawn from Tables 3 and 4 with additional information about statistical analysis, conflicts of interest, funding, strengths, and limitations, assisting in assessing risk of bias. To compare each intervention to the elements of the Practice Guide (Beyond Blue, 2017a), Table 6 included data as outlined in the Practice Guide (Beyond Blue, 2017a), including the five key areas that contribute to the building of resilience, goals for resilience interventions, and each intervention's ecological reach. This demonstrated how resilience interventions were adhering to the Practice Guide (Beyond Blue, 2017a). For this reason, accompanying information about the study designs was given. Tables 7 and 8 included results over time and results comparing the intervention to a control, respectively. This included information about the first author, intervention, domains tested, measures used, and effect sizes. This was to assist in interpreting the synthesis (Cochrane Training, 2023).

3.3.8 Heterogeneity

Heterogeneity of the synthesis findings was expected due to clinical, methodological, statistical and sample variability amongst the studies. Sample populations were diverse in terms of their geography, socio-economic circumstances, and age. For example, geographic classifications including metro, regional, and rural and an age range between 8-14 presenting a large developmental range. The final investigation of heterogeneity was reported in the results.

3.3.9 Missing Data

Missed data was indicated in the tables. If the same category of data was missing in four different studies, a consultation with a second member of the research team would be undertaken. Where it was agreed that the missed data was systematic, causing bias, this was referred to in the results section.

3.3.10 Certainty of Evidence

The reported results were assessed for certainty by two members of the research team using Grading of Recommendations Assessment, Development and Evaluation (GRADE; Schünemann et al., 2013). The rating of the certainty of evidence started low as the review included quazi-experimental designs, some with no control groups. The small number of program evaluations reduced confidence. However, effect sizes were small to medium, which is worth noting in program evaluations (Ahlen et al., 2015), especially when considering the balance of potential benefit to potential harm. For this reason, the rating of the certainty of evidence increased to moderate. Resultingly, a strong recommendation is warranted.

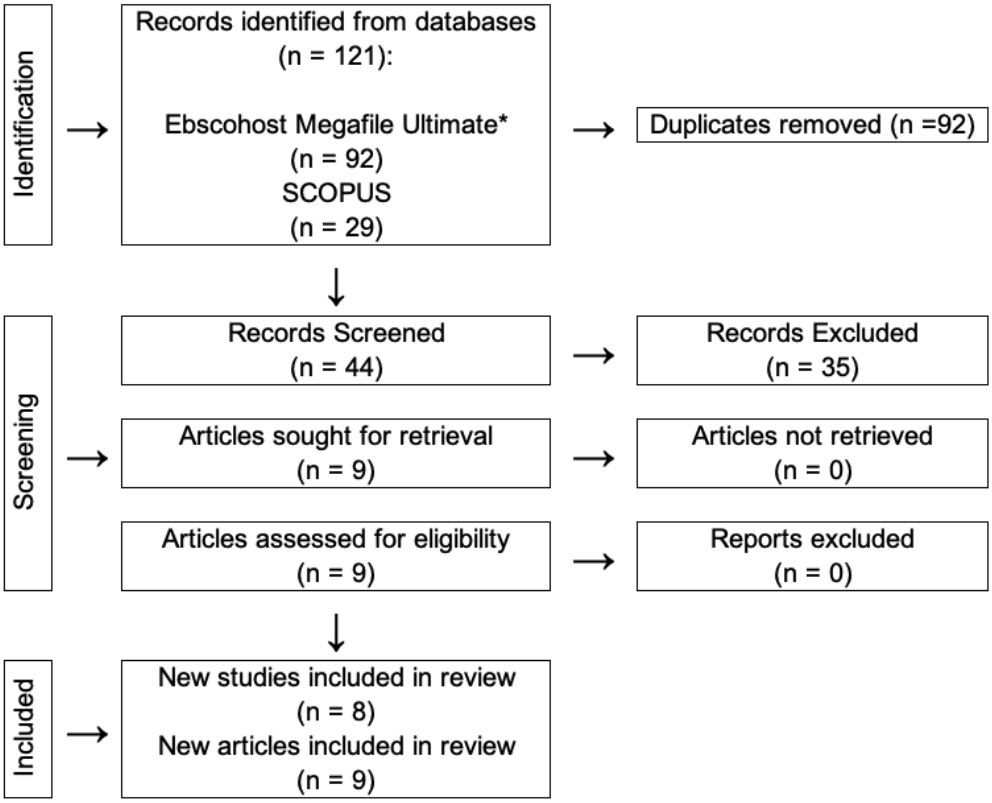
3.4 Results

The search of nine databases resulted in 121 records (See Figure 2). Duplicates were removed, leaving 44 articles to screen at the title and abstract level. The initial 2 reviewers had a substantial level of agreement (k = 0.84), with 7 of 44 records disputed and resolved by the third reviewer. This screening resulted in the exclusion of 35 articles because they did not include a program evaluation, the samples did not include children aged 8-14, or there were no quantitative results reported. Of the nine remaining articles, all were reviewed in full text and were found to meet the inclusion criteria.

Table 3 presents each article identified for review with its study design details. The nine articles reported findings from eight studies that evaluated seven resilience interventions. The studies included 7411 participants. Control groups were assigned using clustering in six of the studies (Chen, 2022; Dray, 2017a; Johnstone, 2020; Moore, 2021; Shaykhi, 2018; Singh, 2019). Follow-up was completed for seven of the studies (Chen, 2022; Dray, 2017a; Johnstone, 2020; McAllister, 2018; Moore, 2021; Shaykhi, 2018; Singh, 2019). All studies used psychometric measures, including total scores and subdomains. Bespoke measures partly or fully derived from a psychometric measure were used by two studies (Chillemi, 2020; Shaykhi, 2018).

Figure 2

PRISMA (Page et al., 2021) Flow Diagram



Note. * Databases searched within the Ebscohost Megafile Ultimate platform = Academic Search Ultimate, APA PsycArticles, APA PsycInfo, CINAHL with Full Text, Education Research Complete, E-Journals, Psychology and Behavioral Sciences Collection, Sociology Source Ultimate

Table 3

Studies Extracted for Review

Author	Year	*n*	Age range (M)	F (%)	Setting	Geographic Category	Randomised	Timing of Testing	Follow-up	Control	Conditions
Chen	2022	316	8-12 (10.1)	52.2	6 Primary schools	Metro	Yes (cluster)	Pre Post	6 months 12 months	Yes	Emotion Regulation Behavioural Activation
Chillemi	2020	54	14-16 (14.7)	11.0	2 High schools	-	No	Pre Post	-	No	iRCB[a]
Dray	2017	3115	11-16	50.0	37 High schools	Metro Regional Remote	Yes (cluster)	Pre	3 years	Yes	Various
Johnstone	2020	295	8-13 (11.04)	52.5	5 Schools	Metro Rural	Yes (cluster)	Pre Post	6 months	Yes	Emotion Regulation Behavioural Activation
Khawaja	2019	229	12-20 (14.0)	47.0	70% High schools 30% Community organisations	-	No	Pre Post	-	No	BRiTA Futures[b]
McAllister	2018	850	11-14 (13.0)	48.9	23 High schools	Rural Regional	No	Pre Post	8 weeks	No	iCARE-R
Moore	2021	283	12-14 (12.9)	50.5	35 High Schools	Urban	Yes (cluster)	Pre Post	12 weeks	Yes	WW[c]
Shaykhi	2018	2539	(12.3)	57.0	24 High schools	Metro	Yes (cluster)	Pre	14 months	Yes	ResFam[d] ResFam with PA[e]
Singh	2019	2539	(12.3)	57.0	24 High schools	Metro	Yes (cluster)	Pre	14 months 3 years	Yes	ResFam[d] ResFam with PA[e]

Note. [a]iRCB = Increasing Resilience to Cyberbullying program, [b]BRiTA Futures = Building Resilience in Transcultural Australians, [c]WW = Wellbeing Warriors, [d]ResFam = Resilient Families, [e]ResFam with PA = Resilient Families with Parent Attendance.

Table 4

Elements of Interventions in Reviewed Articles

Intervention	Setting	Type	Community participation	Family participation	Length	Dose	Mode of delivery	Therapy
ER[a] BA[b]	School	Universal	Including schools and staff	None	50 minutes	8 sessions	Face-to-face	ER[a] BA[b]
iRCB[c]	School	Universal	Including schools and staff	None	60 minutes	1 session	Online	CBT[d]
Various	School	Universal	School setting Encourage community connection	Varied	Various	>9 hours	Face-to-face	Various
BRiTA Futures[e]	School Community	Targeted: CALD[f]	Including schools and staff Run in community setting Encourage community connection	Handouts	Various	20 hours total	Face-to-face	Strengths Based CBT[d]
iCARE-R	School	Universal	Including schools and staff	None	1 module	6 modules	Face-to-face	Strengths Based CBT[d]
WW[g]	School	Universal	Including schools and staff	None	60 minutes	10 sessions	Face-to-face	Psychoeducation Martial Arts Meditation
ResFam[h]	School	Universal	Including schools and staff Encourage community connection	9 workshops Handbook	50 minutes	10 sessions	Face-to-face	Psychoeducation Mindfulness

Note. [a]ER = Emotion Regulation, [b]BA = Behavioural Activation, [c]iRCB = Increasing Resilience to Cyberbullying program, [d]CBT = Cognitive Bahviour Therapy, [e]BRiTA Futures = Building Resilience in Transcultural Australians, [f]CALD = Culturally and linguistically Diverse, [g]WW = Wellbeing Wariors, [h]ResFam = Resilient Families

Table 4 outlines the interventions evaluated in the studies. One of the studies looked at a pragmatic implementation based off varied recommendations (Dray et al., 2017a). All other studies gave an overview about the implementation and contents of one or two specific programs. All the programs were designed to include the targeted age group. Six of the 7 programs were universal, with 1 targeted to culturally and linguistically diverse participants (Khawaja & Ramirez, 2019). The ecological reach was varied. Some programs were wide-ranging in the structure of delivery timing (Dray, 2017a; Khawaja & Ramirez, 2019), while others were more prescriptive. More will be explored about the programs in 3.4.1.

The JBI Sumari Checklist for Quasi-Experimental Studies (Non-Randomized Experimental Studies) (Joanna Briggs Institute, 2017) was used to assess risk of bias in the included studies (see Table 4). The risk of bias evaluation revealed that five studies had a low risk (Chen, 2022; Dray, 2017a; Johnstone, 2020; Shaykhi, 2018; Singh, 2019), 4 studies had a medium risk (Chillemi, 2020; Khawaja & Ramirez, 2019; McAllister, 2018; Moore, 2021), and no studies had a high risk. Lack of controls and possible confounding factors were the main contributors to risk of bias.

	Cause and Effect	Similarity of Participants	Similar treatment	Control	Measures	Follow-up Complete	Measures the same	Measures Reliable	Statistical analysis	Overall risk
Chen	Y	Y	Unclear	Y	Y	Y	Y	N/A	Y	Low
Chillemi	Y	N/A	N/A	N	Y	Y	N/A	N/A	Y	Med
Dray	Y	Y	Y	Y	Y	Y	Y	N/A	Y	Low
Johnstone	Y	Y	Unclear	Y	Y	Y	Y	N/A	Y	Low
Kahwaja	Y	N/A	N/A	N	Y	Y	N/A	N/A	Y	Med
McAlister	Y	N/A	N/A	N	Y	Y	N/A	N/A	Y	Med
Moore	Y	Y	N	Y	N	Y	Y	N/A	Y	Med
Shakhi	Y	Y	Unclear	Y	Y	Y	Y	N/A	Y	Low
Singh	Y	Y	Unclear	Y	Y	Y	Y	N/A	Y	Low

Table 5

Risk of Bias for Each Study

Note. Y = yes, N = no, N/A = not applicable

3.4.1 Meeting the Guidelines in the Beyond Blue Practice Guide

The resilience interventions evaluated included Emotion Regulation (Chen, 2022; Johnstone, 2020); Behavioural Activation (Chen, 2022); Increasing Resilience to Cyberbullying program (Chillemi, 2020; Johnstone, 2020); Building Resilience in Transcultural Australians (Khawaja & Ramirez, 2019); iCARE-R (McAllister, 2018); Wellbeing Warriors (Moore, 2021); and the Resilient Families Program (See Table 6; Shaykhi, 2018; Singh, 2019). One study took a pragmatic approach, preferring to give guidelines and leave specifics up to the individual school (Dray, 2017a). This synthesis of findings focuses on whether resilience interventions for children within Australia since 2017 meet the guidelines in the Building Resilience in Children Aged 0-12: A Practice Guide (Practice Guide; Beyond Blue, 2017a).

Beyond Blue (2017a) outlined five areas that determine the building of resilience. Overall, all interventions focused on building, strengthening and promoting supportive relationships; and 8 out of 9 interventions focused on managing emotions and creating opportunities for personal challenge (Chen, 2022; Chillemi, 2020; Johnstone, 2020; Khawaja & Ramirez, 2019; McAllister, 2018; Moore, 2021; Shaykhi, 2018; Singh, 2019). None of the programs focused on autonomy and responsibility. Outside of teachers, only the pragmatic program encouraged educating people about resilience (Dray, 2017a).

In terms of the Beyond Blue (2017a) goals for resilience interventions, all of the interventions focused on reducing risk factors among children. This was done particularly well through teaching children individual skills like strategies for emotional regulation. Seven out of 8 interventions did well at introducing protective factors for child and building attributes in children (Chen, 2022; Chillemi, 2020; Johnstone, 2020; Khawaja & Ramirez, 2019; McAllister, 2018; Moore, 2021; Shaykhi, 2018; Singh, 2019). Again, this was done well by including opportunities to build individual skills like problem-solving, social skills,

and communication skills (Chen, 2022; Chillemi, 2020; Johnstone, 2020; Khawaja & Ramirez, 2019; McAllister, 2018; Moore, 2021; Shaykhi, 2018; Singh, 2019). Only two interventions focused on enhancing existing protective factors for children (Dray 2017a; Shaykhi, 2018; Singh, 2019), and only one intervention provided resources and experiences that build children's resilience (Dray 2017a).

Table 6

Elements of Interventions Compared to the Practice Guide

	5 areas[a]				Goals for resilience interventions[b]						Ecological reach[c]		
Program	1	2	3	4	5	6	7	8	9	10	Individual	Family	Community
ER[d]	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	N
BA[e]	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	N
iRCB[f]	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	Y
Various	Y	N	N	N	Y	N	Y	Y	Y	N	Y	Y	Y
BRiTA Futures[g]	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	Y
iCARE-R	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	Y
WW[h]	Y	N	Y	Y	N	Y	N	N	Y	Y	Y	N	N
ResFam[i]	Y	N	Y	Y	N	Y	Y	N	Y	Y	Y	Y	Y

Note. Comparisons are made to criteria from Building Resilience in Children Aged 0-12: A Practice Guide (Beyond Blue, 2017). [a]5 areas = five areas that determine the building of resilience in children: 1 = building, strengthening and promoting supportive relationships, 2 = focusing on autonomy and responsibility, 3 = focusing on managing emotions, 4 = creating opportunities for personal challenge, 5 = educating people about resilience. [b]Goals for resilience interventions: 6 = Introducing protective factors for children, 7 = Enhancing existing protective factors for children, 8 = Providing resources and experiences that build children's resilience, 9 = Reducing risk factors among children, 10 = Building attributes in the child. [c]Ecological reach: individual factors, family factors, community factors.
[d]ER = Emotion Regulation, [e]BA = Behavioural Activation, [f]iRCB = Increasing Resilience to Cyberbullying program, [g]BRiTA Futures = Building Resilience in Transcultural Australians, [h]WW = Wellbeing Warriors, [i]ResFam = Resilient Families

The ecological reach of the resilience interventions varied. All the interventions focused on individual factors. Increased community connection outside of the school was encouraged in 5 out of 8 interventions (Dray, 2017a; Johnstone, 2020; Khawaja & Ramirez, 2019; McAllister, 2018; Shaykhi, 2018; Singh, 2019). However, only two interventions focused on parental parenting skills, family relationships and connectedness (Dray, 2017a; Shaykhi, 2018; Singh, 2019).

3.4.2 Program Evaluation Outcomes

The synthesis of outcomes demonstrated from resilience interventions for children within Australia since 2017 are presented in the harvest plot in Figure 3. This plot classifies outcomes into one of three categories and reports each outcome as a potential benefit, no change, or potential harm. This plot gives the additional information of how many measures were used in that category by stacking each outcome to make a bar for each study. The black cubes indicate changes in comparison to a control group and that white cubes indicate changes over time.

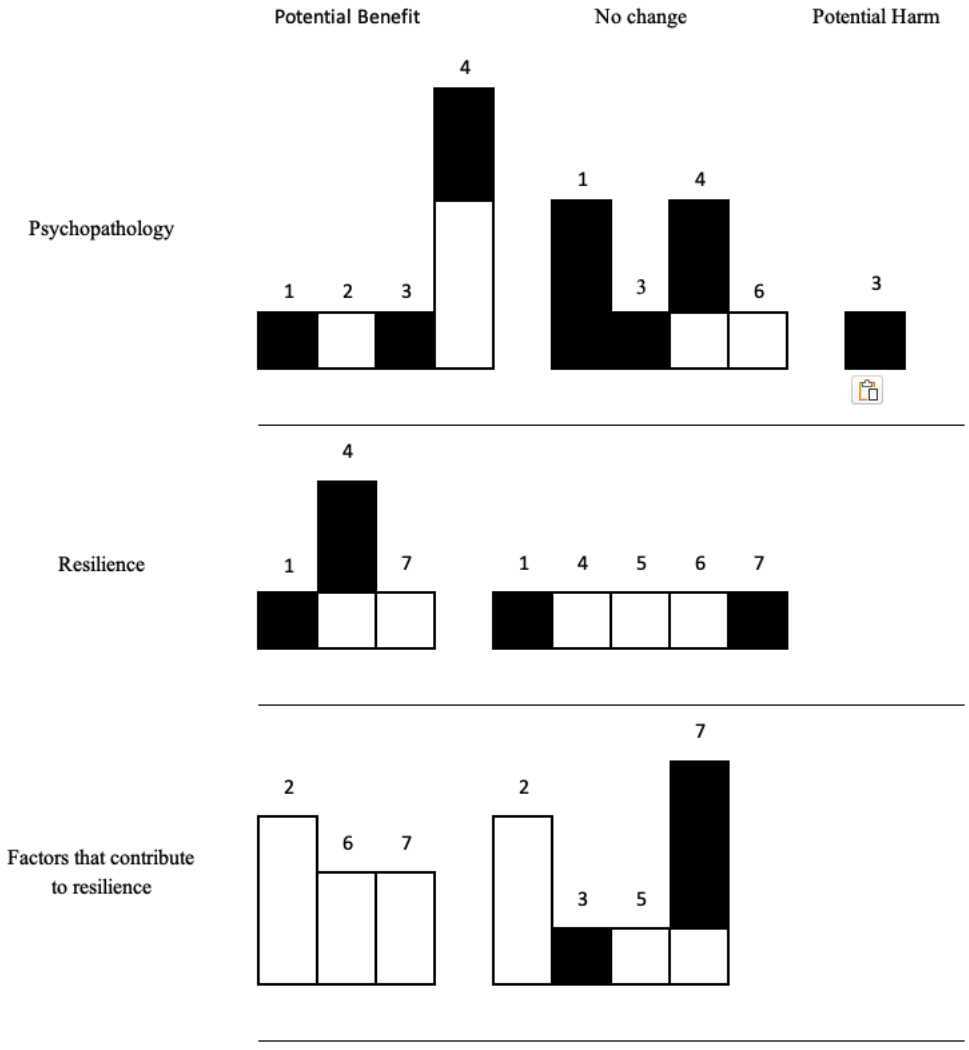
To give greater understanding of individual studies, Tables 7 and 8 present the effect estimates over time and compared to a control group, respectively. Where significant p-values were reported, they are noted with an asterisk. Some studies reported no effect estimates, reducing their comparability and excluding them from the figure and tables (Chen et al., 2022; Shaykhi et al., 2018; Singh et al., 2019). Chen et al. (2022) explored changes in worry, anxiety and depression, and resilience from Emotional Regulation and Behavioural Activation interventions. Changes in both groups over time were non-significant. They did not report the respective effect estimates.

Shaykhi et al. (2018) and Singh et al. (2019) evaluated data from a study on the Resilient Families Program, with and without parent or carer engagement in optional parent or carer workshops. Their results were reported as unstandardised regression coefficients.

Shaykhi et al. (2018) explored antisocial behaviour and found that changes were non-significant without parent or carer engagement, but significant with parent or carer engagement. Singh et al. (2019) explored depression and social emotional skills and found that changes in depression without parent or carer engagement and social emotional skills in both groups were non-significant. However, they reported a significant decrease in depression in the group with parent or carer engagement.

Figure 3

Reported Changes from Resilience Interventions



Note. Black cubes represent changes compared to a control group, white cubes represent changes over time. The numbers represent the study: 1 = Chen, 2 = Chillemi, 3 = Dray, 4 = Johnstone, 5 = Khawaja, 6 = McAlister, 7 = Moore. E.g. Johnstone et al. (2020) reported five

potential benefits to psychopathology (3 over time and 2 compared to a control), 3 no change to psychopathology (1 over time and 2 compared to a control), 3 potential benefits to resilience (1 over time and 2 compared to a control), and 1 no change to resilience over time.

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Table 7

Reported Changes from Resilience Interventions Over Time

Author	Intervention	Measure	Domain	Post	Follow-up
Chillemi	iRCB	Bespoke	likelihood of using the coping skill of self-compassion in the event of cyberbullying	small*	-
		Bespoke	likelihood of using the coping skill of challenging unhelpful thinking in the event of cyberbullying	small*	-
		Bespoke	likelihood of seeking support in the event of cyberbullying	small	-
		Bespoke	confidence in their ability to cope with an experience of cyberbullying	medium	-
		Bespoke	confidence in their ability to help a friend cope with an experience of cyberbullying	no change	-
		GHSQ	general help-seeking behavioural intentions	no change *	-
		ATSPPH-S	attitudes toward seeking professional psychological help	no change *	-
Johnstone	Emotion Regulation	PSWQ-C	Worry	small	medium
		CYRM-12	Resilience	no change	no change
		RCDAS	Anxiety and Depression	medium	medium*
		ERQ-CA	Emotional regulation (cognitive reappraisal)	no change *	no change
		ERQ-CA	Emotional regulation (expressive suppression)	no change	small
Johnstone	Behavioural Activation	PSWQ-C	Worry	no change	no change
		CYRM-12	Resilience	small	large*
		RCDAS	Anxiety and Depression	no change	small
		BADS-SF	Behavioural Activation	no change	large*
Khawaja	BRiTA Futures	MRYQ	Resilience	no change *	-
		GHQ	Wellness	no change *	-
McAlister	iCARE-R	SEARS-A	Resilience	no change	-
		Kidcope	Mean number of positive coping strategies	small *	?*
		Kidcope	Mean number of negative coping strategies	no change	no change
		GSE	Self-efficacy	small*	small*
Moore	PMM	CYRM	Individual capacities	no change*	small*
		CRYM	Relationships with primary caregivers	no change	no change
		CRYM	Contextual factors	no change	small*
		CRYM	Total Resilience	no change *	small*

Note. GHSQ = The General Help Seeking Questionnaire, ATSPPH-S = Attitudes Toward Seeking Professional Psychological Help Scale short form, PSWQ-C = Penn State Worry Questionnaire - Child Version, CYRM-12 = Child and Youth Resilience Measure- Short Version, RCDAS = Revised Child Anxiety and Depression Scales, ERQ-CA = Emotion Regulation Questionnaire for Children and Adolescents, BADS-SF =

Behavioural Activation for Depression Scale—Short Form MRYQ = Multicultural Youth Resilience Questionnaire-Adapted, GHQ = General Health Questionnaire, SEARS-A = The Social Emotional Assets and Resilience Scale –Short Form – Adolescent, GSE = The General Self-Efficacy scale, CYRM = Child and Youth Resilience Measure.

Small effect size = 0.2 – 0.5, medium effect size = 0.51 – 0.8, large effect size = 0.81 – 1.0, *p = <.05.

Table 8

Reported Changes from Resilience Interventions Compared to a Control Group

Author	Intervention	Measure	Domain	Post	1st follow-up	2nd follow-up
Chen	Emotion Regulation	PSWQ-C	Worry	no change	no change	no change
		CYRM-12	Resilience	small	small	no change
		RCDAS	Anxiety and Depression	no change	no change	no change
		ERQ-CA	Emotional regulation (cognitive reappraisal)	small	small	small
		ERQ-CA	Emotional regulation (expressive suppression)	small	no change	no change
		BADS-SF	Behavioural Activation	no change	small*	small
Chen	Behavioural Activation	PSWQ-C	Worry	small	small	small
		CYRM-12	Resilience	small*	no change	small
		RCDAS	Anxiety and Depression	no change	small	no change
		ERQ-CA	Emotional regulation (cognitive reappraisal)	no change	no change	no change
		ERQ-CA	Emotional regulation (expressive suppression)	no change	no change	no change
		BADS-SF	Behavioural Activation	no change	small	small
Dray	Various	SDQ	Total	-	small	-
		SDQ	Internalising	-	no change	-
		SDQ	Externalising	-	small*	-
		SDQ	Prosocial Behaviour	-	no change	-
		SDQ	Protective Factor (Internal)	-	no change	-
		SDQ	Protective Factor (External)	-	no change	-
Johnstone	Emotion Regulation	PSWQ-C	Worry	small	medium	-
		CYRM-12	Resilience	no change	medium	-
		RCDAS	Anxiety and Depression	medium	small	-
		ERQ-CA	Emotional regulation (cognitive reappraisal)	small	no change	-
		ERQ-CA	Emotional regulation (expressive suppression)	medium	small	-
		BADS-SF	Behavioural Activation	small	small	-
Johnstone	Behavioural Activation	PSWQ-C	Worry	no change	no change	-
		CYRM-12	Resilience	medium	large	-
		RCDAS	Anxiety and Depression	no change	no change	-
		ERQ-CA	Emotional regulation (cognitive reappraisal)	small	no change	-
		ERQ-CA	Emotional regulation (expressive suppression)	medium	small	-
		BADS-SF	Behavioural Activation	small	medium	-

Author	Intervention	Measure	Domain	Post	1st follow-up	2nd follow-up
Moore	PMM	CRYM	Individual capacities	no change*	-	-
		CRYM	Relationships with primary caregivers	no change*	-	-
		CRYM	Contextual factors	no change*	-	-
		CRYM	Total Resilience	no change*	-	-

Note. PSWQ-C = Penn State Worry Questionnaire - Child Version, CYRM-12 = Child and Youth Resilience Measure- Short Version, RCDAS = Revised Child Anxiety and Depression Scales, ERQ-CA = Emotion Regulation Questionnaire for Children and Adolescents, BADS-SF = Behavioural Activation for Depression Scale—Short Form, SDQ = Strengths and Difficulties Questionnaire, CYRM = Child and Youth Resilience Measure. Small effect size = 0.2 – 0.5, medium effect size = 0.51 – 0.8, large effect size = 0.81 – 1.0, *p = <.05.

3.5 Discussion

3.5.1 Meeting the Guidelines in the Beyond Blue Practice Guide

The Practice Guide (Beyond Blue, 2017a) outlined five areas that determine the building of resilience in children. Resilience interventions have many elements and their design and implementation will differ depending on the catalyst for program design, the background and knowledge of the designer, and the target audience. This review found that most resilience interventions for children in Australia were designed to be delivered within the school system. The elements found within those interventions reflected this.

All eight structured interventions focused on individual elements including building, strengthening and promoting supportive relationships; managing emotions; and creating opportunities for personal challenge. This reflects the needs of children who are developing the skills to solve problems, make friends, and maintain relationships (Hartup, 1996). The focus on individual factors also reflects the school's limited influence over the home and other environments. While building individual factors can help children focus on the things they have the most control over, children are more likely to build resilience if care givers understand resilience theory and how to apply it in their settings to create opportunities for resilience building (Beyond Blue, 2017b; Brussoni et al., 2021; McDonald-Harker et al., 2021).

Facilitators of the interventions included teachers, researchers, students, or health practitioners. While it can be assumed that some school staff would obtain knowledge about resilience by having a resilience intervention delivered in their school, none of the interventions reported teaching people other than children about resilience. The pragmatic program (Dray et al., 2017a) suggested teaching coaches about building resilience during sport, however, this was not a requirement of the program. Where possible, children will benefit from adults in their communities who understand about the ecological resilience

theory, building resilience, and applying resilience building skills in varied contexts. By repeating themes of resilience across different settings and situations, adults within the community can increase the likelihood that children will learn and practice resilience building skills (Beyond Blue, 2017a).

Another of the five areas that determine the building of resilience that was sparse in Australian resilience interventions for children was a focus on autonomy and responsibility. Responsibility may be a low priority for school-based resilience interventions because responsibility for one's behaviour and belongings are already taught within school environments (Nye & Williams, 2022). Additionally, autonomy could be a lower priority in schools due to the pressure to reduce risk (Jerebine et al., 2022). A focus on children's autonomy would be better addressed in the home environment, where parents or carers can more easily encourage decision-making and healthy risk-taking (Brussoni et al., 2021; Niehues et al., 2016; Oliver et al., 2022). However, Australian parents or carers are resistant to encourage decision-making and healthy risk-taking due to perceptions of safety and how their choices may be perceived by others (Niehues et al., 2016; Niehues et al., 2013). As community culture is contributing to the deficit in responsibility and autonomy, encouragement from an intervention aligned with the child's school could give parents or carers the courage to allow their children to climb trees or make mistakes.

The Beyond Blue (2017a) goals for resilience that interventions most focused on were introducing protective factors, reducing risk factors, and building attributes in the child. The interventions introduced protective factors for children by focusing on healthy mind habits and communication skills. Resilient Families was the only intervention that aimed to improve family communication skills (Shaykhi et al., 2018; Singh et al., 2019). Risk factors among children were reduced by increasing a child's sense of belonging as well as teaching coping and strategies to manage stress. Attributes were built in the child through problem solving

and teaching social skills. It is of note that the goals most frequently met were focused on individual factors.

Those goals that focused on community factors were not met except one goal in one intervention (Shaykhi et al., 2018; Singh et al., 2019). The Practice Guide (Beyond Blue, 2017a) recommended providing resources and experiences that build children's resilience by educating people about resilience and promoting responsibility and autonomy for children. As already discussed, no study specified that an intervention focused on this. Resilient Families (Shaykhi et al., 2018; Singh et al., 2019) was the only intervention that enhanced existing protective factors. They did this by encouraging families to increase their social networks.

Those elements of the Practice Guide (Beyond Blue, 2017a) that can be addressed through individual factors were addressed by all interventions analysed. Elements that could be better addressed through community and family factors were less likely to be addressed. These elements included increasing social or community networks; teaching other carers, like coaches, how to contribute to building resilience; and teaching parents or carers about the importance of responsibility and autonomy.

Schools are part of the community, making school-based interventions a natural setting for community connection. However, this synthesis of intervention elements concentrated on purposely increasing community connection outside of the school. Seeking community engagement, increasing social networks, and contributing to acts of service were encouraged in 4 out of 7 interventions (Chillemi et al., 2020; Khawaja & Ramirez, 2019; McAllister et al., 2018; Shaykhi et al., 2018; Singh et al., 2019). BRiTA Futures (Khawaja & Ramirez, 2019) was unique as it encouraged building support networks as well as delivering the intervention to 30% of the participants in a community setting.

Family factors were addressed by engaging with parents or carers at varying levels. This ranged from sending home handouts, to offering separate workshops for the parents or carers. Most notably, Shaykhi et al. (2018) and Singh et al. (2019) discovered that the Resilient Families Program had increased efficacy when coupled with parental or carer engagement. It may be that families who prioritised engaging in a resilience intervention in their community were already making more choices that build resilience in children. Even so, parental engagement is an opportunity to focus on the elements less likely to be included in resilience interventions for children in Australia. For example, handouts or workshops for parents or carers that deliver psychoeducation and encouragement about how to build resilience, the benefit of increasing social or community networks, and the importance of responsibility and autonomy could fill this gap.

A limitation of this synthesis and analysis was that information about intervention elements was drawn from the articles alone. It is possible that some of the interventions included elements that were not specifically reported. Additionally, there may be a presence of overlap in some elements, making an intervention appear to be achieving more than it is. For example, by teaching a child to solve problems, a program could be building, strengthening, and promoting supportive relationships; creating opportunities for personal challenge; introducing protective factors; and building attributes in the child. This could be used to advantage in intervention design but serves as a caution about the value of looking at these synthesis results without the context of the individual interventions. None of the studies mentioned the Children's Resilience Research Project (Beyond Blue, 2017b) or the Beyond Blue (2017a) Practice Guide, however, it would not be reasonable to expect a publication be applied to research and published within five years (Morris et al., 2011).

3.5.2 Program Evaluation Outcomes

As in the Children's Resilience Research Project (Beyond Blue, 2017b), the outcomes of the resilience interventions analysed for this SLR demonstrate that resilience interventions can positively impact the lives of Australian children. These interventions demonstrated beneficial changes on 20 tests (Chen, 2022; Chillemi, 2020; Dray, 2017a; Johnstone, 2020; McAlister, 2018; Moore, 2021). This included increased resilience (Chen, 2022; Johnstone, 2020; Moore, 2021), self-compassion, challenging unhelpful thinking, support-seeking, confidence in coping (Chillemi, 2020), positive coping strategies, self-efficacy (McAlister, 2018), individual capacities, and contextual factors (Moore, 2021). It also included reduced emotional and behavioural problems (Dray, 2017a;), worry (Chen, 2022; Johnstone, 2020) and symptoms of anxiety and depression (Johnstone, 2020).

There were eight outcomes demonstrating reduced psychopathology in four studies (Chen, 2022; Chillemi, 2020; Dray, 2017a; Johnstone, 2020). There were five outcomes demonstrating increased resilience, with improvements in child's resilience building resources reported in three studies (Chen, 2022; Johnstone, 2020; Moore, 2021). Changes in factors that contribute to resilience were reported for seven outcomes in three studies (Chillemi, 2020; McAlister, 2018; Moore, 2021). In 23 outcomes, participants experienced no change. In one outcome, externalising behaviours increased. Participants whose parents or carers engaged with the Resilient Families intervention experienced significant decreases in antisocial behaviour (Shaykhi et al., 2018) and symptoms of depression (Singh et al., 2019).

Caution must be employed when considering aggregated results as limitations of this synthesis include a small number of reports as well as considerable variance in measurement, analysis and reporting within the studies. In nine studies, seven test statistics were used to report the effects of seven resilience interventions on 27 domains. Of 98 outcomes reported, effect sizes were reported for 43 outcomes; these were included in the harvest plot. P-values were reported for 31 of those outcomes. The variation of outcome domains used to measure

changes prevented the employment of meta-analysis, meaning results could only be synthesised by vote counting based on direction of effect. Though this demonstrates that an effect has been measured, the average effect of the interventions is not clear.

It must also be noted that evaluating universal interventions using measures designed to detect symptoms of psychopathology can cause ceiling effects in samples that include non-clinical participants. For example, it is estimated that 6.2% of Australian children aged 4-11 will suffer from an anxiety disorder (Australian Institute of Health and Welfare, 2022). With this percentage reflected in a sample, an evaluation tool that screens for anxiety disorders (with higher scores indicating an anxiety disorder) would likely result in 93.8% of the sample having a low baseline. From a low baseline, a decrease in score is likely to be small.

It is for this reason that some of the included studies explored the notion that even small changes are worth noting, regardless of significance (Ahlen et al., 2015; Chen et al., 2022; Johnstone et al., 2020; Moore et al., 2021). This review reported outcomes based on direction and magnitude of effect size, with effect sizes as low as 0.20. However, researchers from some of the included studies reported changes smaller than 0.20, citing the practical significance of any change (Ahlen et al., 2015). For example, Khawaja and Ramirez (2019) rightly reported increases in resilience associated with the acculturation process, though the effect size of .18 did not meet the 0.20 cut off to be classified as a small effect size in this synthesis. From this perspective, all the included studies demonstrated potential benefits from resilience training. Of note, is the study of a pragmatic intervention by Dray et al. (2017a) which found no potential benefits for children in comparison to a control group. Though resilience interventions are more likely to be effective when designed around local needs (Miljević-Riđički et al., 2020), these findings highlight the importance of balancing flexibility around local needs with structure in a program.

Australian children aged 11-17 are grappling with psychological distress at greater rates than previously recorded (Australian Institute of Health and Welfare, 2021a, Key Findings section). If left unaddressed, this can lead to further distress throughout the teen years and into early adulthood (Australian Institute of Health and Welfare, 2021c). It is for this reason that grade 6 children can benefit from preventative mental health programs as they face the transition from primary school to high school (Masten, 2014). By building resilience through well designed interventions, stakeholders "tackle mental health and risky behaviours" (Australian Government Department of Health, 2020) and decrease psychological distress for Australian children.

3.5.3 Suggestions for Further Research

Family and community factors are least likely to be addressed in school-based interventions, leaving a gap in interventions around increasing social or community networks; teaching people about resilience; and teaching parents or carers about the importance of a child's opportunity to exercise responsibility and autonomy. Though delivering resilience interventions in schools is convenient, and teaching individual factors simplifies a program by narrowing its scope, it is recommended that further research be done around resilience training that engages parents or carers to encourage the growth of community networks and increase children's opportunity to exercise responsibility and autonomy.

3.6 Conclusion

The Australian Government Department of Health (2020) aims to encourage the creation of resilience interventions for children in Australia aged 8-14 years. Additionally, Beyond Blue (2017b) has synthesised a cultural view of resilience in Australia and laid the framework for designing effective resilience interventions. This SLR explored articles reporting the quantitative outcomes of resilience interventions for children in Australia since the Children's Resilience Research Project in 2017 (Beyond Blue, 2017b). This study

demonstrated that overall, Australian resilience interventions are doing well at addressing those elements from the Practice Guide (Beyond Blue, 2017b) that are central to individual resilience factors. However, family and community factors are less likely to be addressed. The resilience interventions for children in Australia that were included in this SLR are largely beneficial. Positive outcomes of nine program evaluations include increased resilience, reduced symptoms of psychopathology, and an increase in factors that contribute to resilience. It is strongly recommended that resilience programs continue to be designed and delivered to children in Australia. Further, it is recommended that more work be undertaken to design resilience interventions that reach into the home and community, teach people other than children about resilience, and encourage parents or carers to provide opportunities for children to exercise responsibility and autonomy.

Chapter 4: **Evaluation of the Bouncing Back Resiliency Workshop**

4.1 Introduction

Improving the mental health of Australia's children are a priority for the Australian Government (see 1.1; Australian Government Department of Health, 2020). One of 2 priority areas identified to contribute to that is building the resilience of children aged 8-14 (Australian Government Department of Health, 2020). Resilience has been defined as "doing well during or after an adverse event, or a period of adversity" (p.7; Beyond Blue, 2017a). This ability to bounce back fluctuates within the individual as they interact with their environment (see 1.2; Beyond Blue, 2017b; Masten, 2014; Ungar & Hadfield, 2019). Risk factors like loss or violence decrease resilience (see 2.1.1; Alaggia & Donohue, 2017; Werner, 2012). Protective factors increase resilience and can reduce the impact of risk factors (see 2.1.2; Werner, 2012). Protective factors include family and peer relationships and access to resources (Masten, 2014; Nearchou, 2018).

4.1.1 The Ecological Resilience Model and Local Needs

The ecological resilience model posits that protective factors can be found within four areas: individual, family, community, and society (see 1.3; Beyond Blue, 2017a). Individual factors include social skills, self-regulation, self-confidence, and coping skills (Beyond Blue, 2017a). Family factors include parenting skills, family relationships and connectedness (Beyond Blue, 2017a). Community factors include positive relationships in educational settings, positive interactions with peers, and healthy risk taking (Beyond Blue, 2017a). Resilience training increases knowledge about resilience and teaches skills, like coping and relationship skills, that feed into protective factors (see 1.4; Garmezy, 1987; Masten, 2013). With environment being fundamental to resilience, resilience training is more effective when designed around local needs and circumstances (Miljević-Riđički et al., 2020; Ungar, 2011).

The BBRW (McCausland-Green, 2015) was designed specifically for a local primary school around local needs (see 1.5.2).

4.1.2 The Bouncing Back Resiliency Workshop

The BBRW (McCausland-Green, 2015) was designed by Clinical Psychologist Mrs. Jean McCausland-Green based on CBT principles like examining beliefs and implementing behavioural strategies (Beck & Beck, 2020). The manual provides outlines of weekly lessons and activities plus handouts for parents or carers and teachers. During the workshop children are taught resilience skills using discussion, play, and problem solving. Content includes psychoeducation about resilience, relationship skills, increasing autonomy and responsibility, emotional regulation, and encouraging personal challenge. The program is designed to be universal, however, it has also been delivered to groups of children identified to need additional support.

The BBRW (McCausland-Green, 2015) is delivered by UniSQ 5th year Psychology Masters students within schools. It is delivered in 60-minute sessions, weekly, for 6 weeks. Each week, handouts are made available for parents or carers and teachers. The handouts included information on what was presented during that week's session, what the students were taking home from the session, what would be covered in next week's session, and ideas for home or classroom practice. Before week one of the workshop, parents or carers received an invitation to participate in a 1-hour information session delivered by Mrs McCausland-Green where parents or carers could learn about the BBRW (McCausland-Green, 2015), ask questions, learn about resilience, and learn how to teach resilience to their children.

4.2 Methods

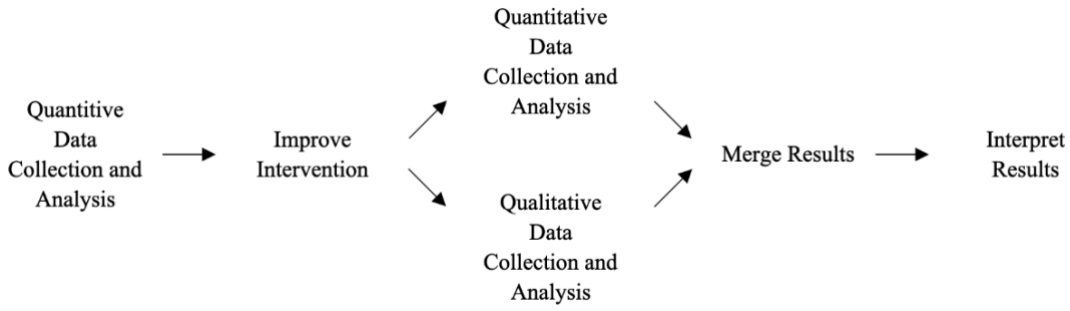
4.2.1 Study Design

Figure 4 outlines the modified exploratory sequential design used in this study (Creswell & Creswell, 2018). The mixed methods study design includes a qualitative

assessment of the BBRW (McCausland-Green, 2015) contents (see Appendix A), followed by improvements to the workshop, then a simultaneous quantitative program evaluation and qualitative collection of feedback data. This design was chosen to ensure that the BBRW (McCausland-Green, 2015) was informed by Australian best practice for resilience programs before testing its effectiveness (Beyond Blue, 2017a; Creswell & Creswell, 2018). Additionally, the collection of qualitative feedback on the workshop would provide a deeper understanding of the quantitative pre- and post-workshop testing (Creswell & Creswell, 2018).

Figure 4

Modified Exploratory Sequential Design



Note. A convergent design nests inside the exploratory sequential design. Modified from "Research Design: Qualitative, Quantitative, and Mixed Methods Approaches" by Creswell and Creswell, 2018, p. 218.

The first aim was to explore whether the BBRW (McCausland-Green, 2015) was teaching resilience within the key areas that determine the building of resilience as outlined in the Building Resilience in Children Aged 0-12: A Practice Guide (Practice Guide; Beyond Blue, 2017a). A qualitative analysis would be used to compare the contents of the workshop manual to information about the key areas in the Practice Guide (Beyond Blue, 2017a). Any key areas that were missing from the workshop content would be reported to Mrs McCausland-Green, who would make the necessary changes to the program based on that

feedback. It was concluded that the workshop would be considered ready for a program evaluation when the content covered all five key areas.

With the first aim complete, the second aim was to explore whether there would be a change in children's resilience in the context of school settings pre- to post-workshop. This qualitative analysis would be measured using the Resiliency Scales for Children and Adolescents (RSCA; Prince-Embury, 2007). It was hypothesised that children's resilience in the context of school settings would increase and vulnerability would decrease pre- to post-workshop. The third aim was to further explore whether there would be a change in children's behavioural and emotional problems pre- to post-workshop. This qualitative analysis would be measured using the Child Behaviour Checklist (CBCL) and Teacher's Report Form (TRF; Achenbach & Rescorla, 2001). It was hypothesised that behavioural and emotional problems in children would decrease pre- to post-workshop.

The fourth aim was to explore whether changes in resilience pre- to post-workshop correlated with levels of parental engagement with the BBRW (McCausland-Green, 2015) 1-hour workshop and weekly handouts. It was hypothesised that the results of this quantitative analysis would demonstrate a positive correlation between parental engagement and changes in children's resilience in the context of school settings as measured by the RSCA. The fifth aim of the study was to explore how children, parents or carers and teachers perceived the BBRW (McCausland-Green, 2015). This qualitative analysis would be completed using ratings and text from the feedback forms. Merging quantitative and qualitative findings from the second, third and fifth aims would lead to a greater understanding of how the participants experienced the workshop. The unique perspective of the participants could contribute to recommendations around how the workshop could be improved.

4.2.2 Sample

Research participants were grade 5 students aged 10 (n = 11; 4 female), their parents or carers, and teacher. The participants were recruited from a state primary school in Brisbane. The sample was chosen in collaboration with the school principal. During this process, many factors were considered including time impost, disruption to classroom routines, supervision and environment. Disruption to classroom routines could be minimised by nature of delivering a universal program to one class, meaning the class and teacher could stay together. With UniSQ Master of Psychology students working under the supervision of the class teacher, the school hall was chosen so the teacher could supervise both groups simultaneously.

24 students participated in the workshop and were invited to participate in the research. There were more males than females. There were no exclusion criteria. The teacher reported that one child had a mental health condition (Attention Deficit Hyperactivity Disorder, dyspraxia) and one parent reported that a separate child had a mental health condition (anxiety). The sample was unique because of the adversity that the child's community experienced in the year preceding and during the workshop. While specific information cannot be shared to protect the identity of the school, the effects of COVID-19 were exacerbated by local health concerns and more than one natural disaster. One of the natural disasters occurred immediately preceding the study.

The RSCA was completed by nine students (four females). The CBCL was completed by parents or carers for seven students (two females). The TRF was completed by the teacher for 10 students (three females). The student feedback forms were completed by 11 students. The parent information session was attended by one parent. No parent feedback forms were received. The teacher feedback form was partially completed.

4.2.3 Measures

Changes were measured using the RSCA (Prince-Embury, 2007) as well as the CBCL and TRF from the Achenbach System of Empirically Based Assessment (ASEBA; Achenbach & Rescorla, 2001). The RSCA was completed by the children, the CBCL was completed by the parents or carers, and the TRF was completed by the teacher. All measurements were taken pre- and post-program. Additionally, children, their parents or carers, and teacher were given feedback forms post-program. By collecting information from two sources, a greater understanding of individual's behaviour and was gained. This also highlighted the difference in how children, parents or carers and teachers perceived the child's behaviour. Demographic information collected included school, age, and sex.

4.2.3.1 Resiliency Scales for Children and Adolescents.

A benefit of the RSCA (Prince-Embury, 2007) is that the children directly report their own experiences. All validation and reliability information reported here will be from Resiliency Scales for Children and Adolescents: A Profile of Personal Strengths (Prince-Embury, 2007) unless stated otherwise. The RSCA is a 64-item Likert-type measure used to assess resiliency in the context of school settings. Items on the rating scale refer to factors contributing to resilience, including, "If I have a problem, I can solve it". Items are written at a Canadian third grade reading level. The items are rated on a 5-point rating scale ranging from 0 to 4 and indicate: never, rarely, sometimes, often, and almost always.

The items form 10 subscales that contribute to two global scales and two index scores. The global scales include Sense of Mastery, Sense of Relatedness, and Emotional Reactivity. Scores of the global scales are summed to give a total raw score with a range from 0-80, 0-96, and 0-80 respectively. For Sense of Mastery and Sense of Relatedness, higher scores indicate resilience and lower scores indicate vulnerability; whereas, for Emotional Reactivity, lower scores indicate resilience and higher scores indicate vulnerability. Internal consistency of the

global scales for children aged 9-11 was good to excellent with alphas of .85, .89, and .90 respectively. Test-retest reliability for nonclinical children aged 9-14 was good to excellent with coefficients of .87, .90, and .91 respectively (Prince-Embury, 2010). Prince-Embury (2010) suggests that only the Sense of Relatedness and Emotional Reactivity global scores are appropriate to identify change in individuals, with Sense of Mastery only being appropriate to identify change in groups. They suggest this may be due to instability in a child's sense of optimism and adaptability (Prince-Embury, 2010).

The Resource Index is the average of the Sense of Mastery and Sense of Relatedness scores with a range from 0-88. The Vulnerability Index is calculated by subtracting the Resource Index score from the Emotional Reactivity score with a range from 0-80. For the Resilience Index higher scores indicate resilience and lower scores indicate vulnerability; whereas, for the Vulnerability Index, lower scores indicate resilience and higher scores indicate vulnerability. Internal consistency of the index scores for children aged 9-11 was excellent with alphas of .93. Test-retest reliability for non-clinical children aged 9-14 was excellent with coefficients of .94 (Prince-Embury, 2010). Prince-Embury (2010) indicates that both Index scores are appropriate to identify change in individuals.

Concurrent validity of the RSCA is strong, with the Beck Youth Inventory Second Edition, having positive correlations with Emotional Reactivity and negative correlations with Sense of Mastery and Sense of Relatedness (Prince-Embury, 2008). Conduct problems on the Conners Adolescent Symptom Scale: Short Form also positively correlated with Emotional Reactivity and negatively correlated with Sense of Mastery and Sense of Relatedness. Also, the Reynolds Bully Victimization Scales were positively correlated with Emotional Reactivity in males. The RSCA was adequately able to predict members of clinical and non-clinical groups, with large effect sizes for differences (Prince-Embury, 2008). The non-clinical group scored higher on Sense of Mastery and Sense of Relatedness, and the

clinical group scored higher on Emotional Reactivity (Prince-Embury, 2008). Classification sensitivity was 73% and specificity was 81% (Prince-Embury, 2008).

While the RSCA has demonstrated reliability and validity in global scores, subscales and indexes, scores must be interpreted with some caution. Though no normative information is available for Australian children, Prince-Embury (2009) found no change due to race among an American sample after controlling for parent education level. Additionally, resilience factors like environmental and relational factors would cause some variance in resilience over 12 weeks. However, high test-retest reliability reduces the chance that any change would be due to error variance or chance. Nevertheless, this measure was chosen because it comfortably captures resiliency competence within individual, family and community factors as outlined in the ecological model of the Beyond Blue (2017a) Practice Guide.

4.2.3.2 The Child Behaviour Checklist and Teacher's Report Form.

The CBCL and TRF are from the ASEBA suite of assessments (Achenbach & Rescorla, 2001). All validation and reliability information reported here will be from the Manual for the ASEBA School-Age Forms & Profiles (Achenbach & Rescorla, 2001). There are 118 items on the rating scale which refer to factors contributing to problems, including, "acts too young for his or her age". The items are rated on a 3-point rating scale ranging from 0 to 2 and indicate: not true (as far as you know), somewhat or sometimes true, and very true or often true. The CBCL and TRF have been validated for use with children aged 6-18 with evidence gathered over 40 years in many different languages and samples.

The CBCL is made up of three summary scales: Total Problems, Internalising Problems and Externalising Problems. These are each derived from a unique combination of syndrome scales: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behaviour, and Aggressive

Behaviour. The internal consistency of the summary scales and syndrome scales was acceptable to excellent, with alphas between .78 to .97. Test-retest reliability of Total Problems was excellent, with a Pearson's correlation of .94. Test-retest reliability of all 118 problem items was also excellent, with an intraclass correlation of .95. Some CBCL problem scales have been found to have small practice effects, though this should not affect this study as re-test will happen after more than 1-month. When comparing CBCL scores between 3 interviewers in 723 matched children, all 118 problem items had excellent inter-interviewer reliability, with an intraclass correlation of .96 (Achenbach & Edelbrock, 1981). Scale scores remained stable for the CBCL over 12- and 24-months. The test-retest scores signify that all two scales are appropriate for calculating individual change (Cicchetti & Tucker, 1994).

The clinical scales on the TRF are identical to the CBCL. Internal consistency of the summary and syndrome problem scales on the TRF was acceptable to excellent, with alphas between .72 to .95. Test-retest reliability of Total Problems on the TRF was also excellent, with a Pearson's correlation of .95. Using the standard set by Cicchetti and Tucker (1994), only the test-retest coefficients for Total Problems would be suitable for identifying change in individuals on the TRF.

Content validity for the CBCL and TRF has also been collected over 40 years through literature searches, consultation with appropriate professionals, and pilot testing. They have consistently demonstrated criterion validity, discriminating between referred and non-referred children, with the summary and syndrome problem scales more closed related to children's referral status than their demographic information. The CBCL and TRF have been validated for use in Australian populations (Ivanova et al., 2007). However, some small effect sizes were detected between children from lower socio-economic backgrounds and higher problem scores on five CBCL scales and 15 TRF scales. Construct validity for the CBCL and TRF has been established when comparing scale scores against DSM-5 diagnoses (American

Psychiatric Association, 2022), and scores on the DSM-5 checklist (Hudziak et al., 2004), parent (Conners, 1997a) and teacher (Conners, 1997b) ratings on the Conners Scales, and parent and teacher ratings on the Behavior Assessment System for Children Scales (Reynolds & Kamphaus, 1992). With many studies on resilience programs failing to demonstrate changes on resilience measures, the use of the CBCL and TRF would be useful as additional measures to assess whether reductions in behavioural and emotional problems are apparent after learning resilience skills.

4.2.3.3 Feedback Forms.

The feedback form for the children included a 20cm visual analogue scale ranging from 'not at all' to 'lots'. Smiley and frowny faces were used to assist children in understanding which direction the scale was going. Children were asked to rate the warmup games, activities, enjoyment, and how much they learned. Parent and teacher feedback forms were on a 7-point scale, indicating excellent, good, fair and poor, with one rating between each indicator. Parents or carers and teachers were asked six questions, including 'How would you rate the quality of the service your child or student received?'

4.3 Procedure

4.3.1 Ethics and Consent

Ethical clearance was granted by UniSQ's Human Research Ethics Committee (Approval number H21REA306; see Appendix B). The Queensland Department of Education granted permission to approach the school (Reference 550/27/2555; see Appendix C). Information sheet and consent forms were given to children, parents or carers and teachers. Additionally, children were given assent forms and parents or carers were given permission forms. The incentive for participation was the opportunity for children to participate in the program with no out of pocket expenses for the school or the parents or carers. It was anticipated that participation in the BBRW (McCausland-Green, 2015) would benefit

students and their immediate community through gained knowledge and skill, improved social welfare and individual wellbeing. It was also anticipated that participants could experience inconvenience in giving up their time to participate in the information session or workshop, and spending time filling out forms and tests. These risks were minimised by advising participants of the risks during the consent process.

4.3.2 Workshop Implementation

All workshop facilitators were required to have a Blue Card. They also underwent induction training including a review of the relevant sections of the Australian Psychological Society code of ethics, Ethical Research Involving Children, and the Department of Education's Student Protection Guidelines. Sessions were conducted in the school hall, with one class (n = 24) of students split into two groups. Each group had two facilitators, with an additional facilitator floating between groups to assist with resources. The class teacher was also present to supervise the workshop. The primary researcher was present at random intervals to ensure ethical compliance and that the BBRW (McCausland-Green, 2015) was being delivered in accordance with the workshop manual.

4.3.3 Data and Risk Management

Qualitative data was considered sensitive and confidential, with all tests and forms accompanied with a return addressed envelope marked 'private and confidential'. Paper tests were administered to the teacher, parents or carers, and students. Tests were sent home to parents or carers and collected by the teacher, who kept them locked in a file at the school until collection. Tests for students were administered by the facilitators at the conclusion of the first and final workshops. The sealed envelopes were collected by the primary researcher as soon as possible after collection and immediately delivered to UniSQ Ipswich campus. Once the tests and forms were on campus, data was entered electronically in a non-

identifiable manner. Hardcopies of data were kept in a locked cabinet in accordance with UniSQ's data management procedures.

4.4 Data Analysis

4.4.1 Qualitative Data Analysis

The first and fifth aims of the study required qualitative data extraction. As a modest amount of information needed to be recorded and the sample was small, it was decided that Excel would suffice for software. To explore whether the BBRW (McCausland-Green, 2015) was teaching resilience within the key areas that determine the building of resilience, data was extracted from the Practice Guide (Beyond Blue, 2017a) and the workshop manual (McCausland-Green, 2015) and entered into Excel for comparison. A manual analysis was made about what areas weren't being covered by the workshop. To explore how children, parents or carers and teachers perceived the BBRW (McCausland-Green, 2015), text from the feedback forms was also entered into Excel and manually analysed.

4.4.2 Quantitative Data Analysis

The second and third aims of this study were to determine whether children experienced changes in resilience in the context of school settings as well as behavioural and emotional problems from pre-workshop to post-workshop. Though originally intended as a within group design, the small sample size lent itself to an idiographic approach, considering changes within each participant (Jacobson & Truax, 1991). In contrast to losing the nuance of individual experience when averaging group data, this was viewed as an opportunity to gain insight regarding individual experience within a profession that aims to support individuals (Blampied, 2022). As this study pertains to the discipline of clinical psychology, it follows that the method of evaluation would have origins in clinical practice. Accordingly, pre- and post- workshop scores over a 6-week interval on the RSCA, CBCL and TRF were compared using two indicators: scores within clinical range and the Reliable Change Index (RCI;

Blampied, 2022; Jacobson & Truax, 1991). By identifying scores within clinical range and calculating the RCI, a greater understanding of individual and group results was gained. A recently published study by Shochet et al. (2022) was used as an example of how to report the findings of the RCI in the context of psychological program evaluation.

4.4.2.1 Scores Within Clinical Range.

When scores on a test fall within clinical range, they indicate that an individual may need further support or be part of a clinical group (Achenbach & Rescorla, 2001; Prince-Embury, 2007). Scores fell within clinical range on the RSCA where standardised results appeared in low or high categories depending on the desired direction for that domain, as per the test manual (Prince-Embury, 2007). Scores fell within clinical range on the CBCL and TRF where standardised results were 64 or above, as per the scoring sheet (Achenbach & Rescorla, 2001). It was anticipated that the number of scores falling within clinical range within the group and within individuals would decrease from pre- to post-workshop. Though it is promising to see participants move outside of the clinical range, considering this alongside the statistical size of that change gives greater depth to what that means for the individual.

4.4.2.2 Reliable Change Index.

The reliable change index converts the change in an individual's test scores from pre- to post-workshop to a standardised score (Jacobson & Truax, 1991). Scores above a predetermined cut-off indicate whether the change was statistically significant (Jacobson & Truax, 1991). It was anticipated that children's resilience in the context of school settings would see a reliable change increase, and their behavioural and emotional problems would see a reliable change decrease pre- to post-workshop.

The RCI was calculated by subtracting the pre-workshop score from the post-workshop score and dividing it by the standard error of difference (S_{diff}). The S_{diff} was

calculated using the standard error of measurement (S_E). The S_E was calculated using the test-retest reliability from the RSCA or ASEBA handbooks (r_{xx}) and the SD of the normative scores (s_1). A calculated score of 1.96 or above would indicate that the individual's change was within a 95% confidence interval (Jacobson & Truax, 1991). That is, the likelihood that the change was due to chance or measurement error would be less than 5% (Jacobson & Truax, 1991).

$$RC = \frac{x_2 - x_1}{S_{diff}} \qquad S_{diff} = \sqrt{2\,(S_E)^2} \qquad S_E = s_1\sqrt{1 - r_{xx}}$$

4.4.2.3 Missing Data.

When item level data was missing from tests, it was assumed that the corresponding behaviour had not been flagged in the individual. As individual change pre- to post-workshop was being considered, an individual with a missing test had insufficient information to see whether the participant had moved in or out of clinical range, or to calculate the RCI.

4.4.3 Parental Engagement and Changes in Resilience

The fourth aim was to explore whether changes in resilience pre- to post-workshop correlated with levels of parental engagement with a 1-hour workshop and weekly handouts. It was not possible to explore this aim as only 1 parent attended the parent information night and no parent feedback forms were returned. Hence, there was an insufficient number of participants.

4.5 Results

4.5.1 Teaching in Key Areas that Contribute to Resilience

The key areas that determine the building of resilience in children, with examples, were extracted from the Practice Guide (Beyond Blue, 2017a) and entered into an Excel spread sheet. As the contents of the BBRW (McCausland-Green, 2015) were examined, the elements that fit those key areas were recorded. It was determined that the BBRW

(McCausland-Green, 2015) was teaching resilience within the key areas if the contents of the workshop covered all key areas.

Table 9 outlines the key areas that determine the building of resilience in children (Beyond Blue, 2017a), the content that was already within the BBRW (McCausland-Green, 2015), and the changes made to the BBRW (McCausland-Green, 2015) to strengthen its theoretical evidence base. The pre-workshop evaluation established that the BBRW (McCausland-Green, 2015) had content that covered 4 out of the five key areas. The only area not covered was a focus on autonomy and responsibility. This was rectified by adding suggestions for home and classroom practice that encouraged parents or carers to provide their child with opportunities to make their own decisions, try new things, and make mistakes. By addressing all five key areas, the theoretical evidence-base for the BBRW (McCausland-Green, 2015) was strengthened, increasing its likelihood of efficacy (Beyond Blue, 2017a).

Table 9

Pre-workshop Evaluation of Key Areas that Determine the Building of Resilience in Children

Key areas that build resilience	Contained in the BBRW	Added to the BBRW
Building, strengthening and promoting supportive relationships	Helping hand- identifying adults to talk to if they are having a problem Sharing helping hand with parents or carers Identifying what is a friend Identifying how to make a friend Role playing friendly behaviour Problem solving around problems in friendships Encourage parents or carers and teachers to have conversations around feelings Encourage parents or carers and teachers to have conversations around good friendships	-
Focusing on autonomy and responsibility	-	Encourage parents or carers and teachers to provide children with opportunities to make meaningful decisions about their environment Encourage parent and teachers to provide their child opportunities to try new things and make mistakes

Key areas that build resilience	Contained in the BBRW	Added to the BBRW
Focusing on managing emotions	Identifying and naming emotions Recognising physical signs of emotions Progressive muscle relaxation Diaphragmatic breathing Identifying unhelpful thoughts Cognitive restructuring around helpful thoughts Discussing friendly and unfriendly behaviour Encourage parents or carers and teachers to model coping behaviour	-
Creating opportunities for personal challenge	Problem solving around ways to calm down Problem solving around helpful and unhelpful thoughts Creating coping statements Role playing using new cognitions Journaling Problem solving around problems in friendships Encourage parents or carers and teachers to assist with critical thinking skills and problem solving in the home and classroom	-
Educating people about resilience	Psychoeducation including: Reading books about emotions Case studies on helpful or unhelpful thoughts Discussion about friendly and unfriendly behaviour 1-hour parent workshop about resilience and how to foster resilience in their children covering all other areas Handouts for parents or carers and teachers about workshop contents and suggestions for home practice	-

4.5.2 Quantitative Analysis of Program Evaluation

4.5.2.1 Descriptive Statistics.

Table 10 presents the descriptive statistics for the RSCA, CBCL, and TRF at time 1 and time 2. However, the small and non-normally distributed sample reduces the reliability of mean and standard deviations as measures. Students were considered within clinical range according to the RSCA if their scores were within the low category (t-score of 40 or less) for Total Sense of Mastery, Total Sense of Relatedness, or Total Resource Index. They were also considered within clinical range according to the RSCA if their scores were within the high category (t-score of 64 or more) for Total Emotional Reactivity, or Total Vulnerability. Students were considered within clinical range according to the CBCL and TRF if their standardised scores were 64 or above for Internalising Problems, Externalising Problems, or Total Problems.

Students were considered in a subclinical range according to the RSCA if their scores were within the below average category (t-score of 41-44) for Total Sense of Mastery, Total Sense of Relatedness, or Total Resource Index. They were also considered in a subclinical range according to the RSCA if their scores were within the above average category (t-score of 55-59 or more) for Total Emotional Reactivity, or Total Vulnerability. Students were considered in a subclinical range according to the CBCL and TRF if their standardised scores were 60 - 63 for Internalising Problems, Externalising Problems, or Total Problems.

Table 11 presents the distribution of students categorised with average, subclinical, or clinical scores in each domain at pre- and post-workshop. Half of the children scored within clinical range on at least one domain of the RSCA at time 1. More than half of parents or carers scored their children within clinical range for at least one domain on the CBCL at time 1. More than half of the children scored within clinical range on the internalising domain on

the CBCL at time 1. The teacher reported that none of the children were within clinical range on the TRF.

Table 10

Descriptive Statistics for Child, Parent, and Teacher Measures Pre- and Post-Workshop

Measure	Time 1 *M (SD)*	Time 2 *M (SD)*
RSCA (*n* = 9)		
Total Sense of Mastery	42.78 (13.95)	37.89 (13.46)
Total Sense of Relatedness	40.89 (11.02)	44.44 (9.89)
Total Emotional Reactivity	53.67 (11.29)	48.78 (10.95)
Resource Index	40.33 (12.69)	40.00 (11.06)
Vulnerability Index	58.56 (13.48)	55.78 (12.16)
CBCL (*n* = 7)		
Internalising Problems	64.29 (6.97)	60.29 (9.48)
Externalising Problems	51.57 (10.20)	48.43 (11.07)
Total Problems	57.43 (7.83)	54.57 (7.09)
TRF (*n* = 10)		
Internalising Problems	51.30 (7.03)	54.00 (5.23)
Externalising Problems	46.30 (6.41)	48.90 (6.82)
Total Problems	48.10 (7.74)	52.30 (3.34)

Note. Resiliency Scales for Children and Adolescents (RSCA), Child Behaviour Checklist (CBCL), Teacher's Report Form (TRF).

Table 11

Distribution of Students According to Clinical Cut-Offs from Child, Parent, and Teacher Measures Pre- and Post-Workshop

Measure	Average	Subclinical	Clinical	Total
RSCA (n = 9)				
Total Sense of Mastery				
Time 1	4	2	3	9
Time 2	3	0	6	9
Total Sense of Relatedness				
Time 1	4	1	4	9
Time 2	4	3	2	9
Total Emotional Reactivity				
Time 1	5	1	3	9
Time 2	7	0	2	9
Resource Index				
Time 1	3	2	4	9
Time 2	3	0	6	9
Vulnerability Index				
Time 1	4	1	4	9
Time 2	5	1	3	9
CBCL (n = 7)				
Internalising Problems				
Time 1	2	1	4	7
Time 2	2	0	5	7
Externalising Problems				
Time 1	5	1	1	7
Time 2	6	0	1	7
Total Problems				
Time 1	5	0	2	7
Time 2	6	0	1	7
TRF (n = 10)				
Internalising Problems				
Time 1	9	1	0	10
Time 2	8	2	0	10
Externalising Problems				
Time 1	10	0	0	10
Time 2	10	0	0	10
Total Problems				
Time 1	10	0	0	10
Time 2	10	0	0	10

Note. Resiliency Scales for Children and Adolescents (RSCA), Child Behaviour Checklist (CBCL), Teacher's Report Form (TRF).

4.5.2.2 Reliable Change Index.

Table 12 displays results from the RCI for each participant in each domain. As some scores showed improvement by increasing and others by decreasing, the table simplifies findings by demonstrating improvement or deterioration. Arrows pointing up denote reliable change improvement, arrows pointing down denote reliable change decline, and x's denote no reliable change. Dashes indicate that there was incomplete data collected for the individual on that measure. The Total Sense of Mastery Scale on the RSCA and the Internalising and Externalising Problems domains on the TRF are not suitable for identifying change in individuals so, while those results are included in the table, they have been excluded from reporting (Achenbach & Rescorla, 2001; Cicchetti & Tucker, 1994; Prince-Embury, 2010). Additionally, caution must be used when considering these findings as test-retest scores used to calculate the RCI were from a non-clinical population and this sample had a high number of participants within clinical range.

Overall, there were 22 instances of reliable change improvement and 11 instances of reliable change deterioration. Six participants demonstrated more reliable change improvements overall. Four participants demonstrated more reliable change deterioration overall, although one of those participants was only tested on the TRF, which uniquely trended toward reliable change deterioration.

On the RSCA, there were 16 instances of reliable change improvement and 7 instances of reliable change deterioration. The highest number of reliable change improvement was seen in the domain of Total Sense of Relatedness, impacting 5 out of 9 participants. Additionally, the Resource Index and Vulnerability Index saw reliable change improvement in 4 out of 9 participants. Participant 10 exhibited reliable change improvement in all four domains and participants 1, 3, and 7 demonstrated reliable change improvement in

3 out of 4 domains. Conversely, participants 2 and 11 demonstrated reliable change deterioration in 3 out of 4 domains.

Table 12

Reliable Change for Each Participant According to Domains Within Each Measure

ID	1	2	3	4	5	6	7	8	9	10	11
RSCA (n = 9)											
Total Sense of Mastery*	▼	▼	x	-	-	x	x	x	x	▲	▼
Total Sense of Relatedness	▲	x	▲	-	-	x	▲	x	▲	▲	▼
Total Emotional Reactivity	▲	▼	x	-	-	x	x	x	x	▲	▲
Resource Index	x	▼	▲	-	-	▼	▲	x	▲	▲	▼
Vulnerability Index	▲	▼	▲	-	-	x	▲	x	x	▲	▼
CBCL (*n* = 7)											
Internalising Problems	-	-	▲	x	-	x	-	▼	x	x	▲
Externalising Problems	-	-	x	▲	-	x	-	▲	x	x	x
Total Problems	-	-	▲	▲	-	x	-	x	x	x	x
TRF (*n* = 10)											
Internalising Problems*	x	x	-	x	x	x	x	x	x	x	x
Externalising Problems*	x	x	-	x	▼	x	x	x	x	▼	x
Total Problems	x	x	-	▼	▼	x	▼	x	x	x	x

Note. Resiliency Scales for Children and Adolescents (RSCA), Child Behaviour Checklist (CBCL), Teacher's Report Form (TRF). ▲ statistically significant improvement, ▼ statistically significant deterioration, × no change, – no data available, *domains not suitable for individual results

On the CBCL, there were six instances of reliable change improvement and one instance of reliable change deterioration. Participants 3 and 4 demonstrated reliable change improvement in 2 out of 3 domains. The TRF indicated no reliable change improvement and three instances of reliable change deterioration.

4.5.2.3 Moving In or Out of Clinical Range.

Another positive indicator of intervention success would be seeing students move from within clinical range pre-workshop to outside of clinical range post-workshop. Table 13 summarises participants moving in or out of clinical range pre- to post-workshop in each domain. An up arrow denotes improvement or moving from within clinical range to outside

of clinical range. The inverse is true for the down arrows. The RSCA indicated that six participants moved out of clinical range on 10 instances and three participants moved into clinical range in 10 instances. The highest number of participants moving out of clinical range was seen in the domains of Total Sense of Relatedness and the Vulnerability Index, impacting 3 out of 9 participants. Participant 10 moved out of clinical range in 3 out of 5 domains. Participants 2 and 11 moved into clinical range in 4 out of 5 domains.

The CBCL indicated one instance of a participant moving out of clinical range and one instance of a participant moving into clinical range. The TRF indicated no movement in or out of clinical range.

Table 13

Moving Into or Out of Clinical Range

ID	1	2	3	4	5	6	7	8	9	10	11
RSCA (*n* = 9)											
Total Sense of Mastery	x	▼	x	-	-	▼	x	x	x	x	▼
Total Sense of Relatedness	x	x	▲	-	-	x	▲	x	▲	x	▼
Total Emotional Reactivity	x	▼	x	-	-	x	x	x	x	▲	▲
Resource Index	x	▼	x	-	-	▼	x	x	x	▲	▼
Vulnerability Index	▲	▼	x	-	-	x	▲	x	x	▲	▼
CBCL (*n* = 7)											
Internalising Problems	-	-	x	x	-	x	-	▼	x	x	x
Externalising Problems	-	-	x	x	-	x	-	x	x	x	x
Total Problems	-	-	x	▲	-	x	-	x	x	x	x
TRF (*n* = 10)											
Internalising Problems	x	x	-	x	x	x	x	x	x	x	x
Externalising Problems	x	x	-	x	x	x	x	x	x	x	x
Total Problems	x	x	-	x	x	x	x	x	x	x	x

Note. ▲ moved from within clinical range to outside clinical range, ▼ moved from outside clinical range to within clinical range, × no change, – no data available

4.5.2.4 Reliable Change and Moving In or Out of Clinical Range.

Of the 23 instances of reliable change improvement, there were 10 instances of clients moving out of clinical range. Of the 16 instances of reliable change deterioration, there were 10 instances of clients moving into clinical range. Of the instances where there was reliable

change, six participants mostly moved out of clinical range and four participants mostly moved into clinical range.

4.5.3 Participant Feedback

The child feedback form had seven items that asked questions like “How much did you learn about things at our group?”. The first four questions had intended to be measured on a 20cm analogue scale that could be measured for a score from 1-20. However, children instead circled the frowny face, neutral face, and smiley face that were there as a guide to assist them to know which direction the scale was going. Resultingly, item scores for the first four questions had a range from 1 to 3. The last two items were yes/no questions with a range from 1 to 2. Total scores ranged from 6 to 16. The average total score across the group was 14.

Overall, the item asking, “did you enjoy coming to our group?” received an average score of 1.88 out of 3. All the children indicated that it was “okay coming to our group”. The item asking, “how much did you learn about things at our group?” received an average score of 1.63 out of 3. When asked if the students had “any ideas about how we could make our group better”, 5 out of 11 students indicated that they wouldn’t change anything about the BBRW (McCausland-Green, 2015) and 2 out of 11 children indicated that the workshop could be improved with more games.

The teacher answered half of the items on the feedback form. Those six items asked questions like, “Has the program helped you to learn skills that can be applied to other children?”. These questions were answered on a Likert-type scale that ranged from 1 to 6. The average score on the teacher feedback form was 5.1, indicating that the teacher felt that the BBRW (McCausland-Green, 2015) helped them learn skills that they could apply to other students and that the workshop helped students deal more effectively with their problems. No parent feedback forms were returned.

4.6 Discussion

The BBRW (McCausland-Green, 2015) is a universal resiliency workshop aimed at increasing resilience in children. It was evaluated using a mixed methods design to explore its theoretical foundation, evaluate its outcomes and get feedback form participants. By working directly with children, holding a 1-hr parent workshop, delivering the workshop within the school environment, and including handouts for the home and classroom, the BBRW (McCausland-Green, 2015) aimed to affect individual, family, and community factors that build resilience. Pre-workshop comparison of the BBRW (McCausland-Green, 2015) contents and information in the Beyond Blue (2017a) Practice Guide found that the original workshop had an excellent theoretical foundation, with extra content only needed to be added in the area of autonomy and responsibility. With those changes made, a quantitative program evaluation using pre- and post-workshop measures indicated that the BBRW (McCausland-Green, 2015) was beneficial for participants, demonstrating an overall increase in resilience on the child measure and an overall decrease in emotional and behavioural problems on the parent measure. The teacher measure indicated an increase in emotional and behavioural problems; however, unanticipated confounding factors may have contributed to those results. Qualitative feedback demonstrated that the children enjoyed the program and that they and their teacher perceived the program as being helpful. Altogether, the evaluation of the BBRW (McCausland-Green, 2015) revealed an engaging and effective program to increase resilience in children.

4.6.1 Local Considerations

While this program evaluation was undertaken in the same school where the BBRW (McCausland-Green, 2015) had been delivered over 7 years, the year of this program evaluation presented unique adversity for the local community. This adversity included COVID-19 with its accompanying disruption and restrictions, two natural disasters, and other local health concerns. In 2022, Australian teachers reported declining wellbeing, increased workloads, and a lack of perceived support as effects of the pandemic (Billett et al., 2022; Carroll et al., 2022). Declining wellbeing, with missed school cited as a contributor, was also reported by 41% of Australia's 9 to 17 year old students (Australian Human Rights Commission, 2022). With parental stress being linked to children's emotional and behavioural problems, parental stress may have exacerbated child distress (Fields et al., 2021). Additionally, 1 of 2 natural disasters faced by this community during 2022 happened immediately preceding the Workshop, with effects continuing through the weeks that students were engaging in the BBRW (McCausland-Green, 2015). Overall, the pandemic and natural disasters functioned as risk factors for low resilience, with dose effects compounding this influence (Masten, 2013; Werner, 2012).

With resilience fluctuating in response to the individual's interaction with the environment, it was anticipated that these risk factors would affect baseline measurements. As expected, students demonstrated lower than average resilience and higher than average emotional and behavioural problems pre-workshop, with 10 out of 11 participants within the clinical range on at least one domain on the RSCA or CBCL. It was also expected that these confounding factors would reduce the likelihood of improving resilience or emotional and behavioural problems post-workshop. However, 8 out of 11 students demonstrated reliable change improvement in at least one domain on the RSCA or CBCL. However, without a

control group, it is difficult to know how much the program alone contributed to the improvements.

4.6.2 Parental Engagement

As discovered during the literature review, parental engagement could increase the outcome of resilience interventions but it is often underutilised (Halliday et al., 2020; Singh et al., 2019). The BBRW (McCausland-Green, 2015) attempted to explore the effect of parental engagement on changes in resilience by offering a 1-hr parent workshop and gauging parental engagement with weekly handouts through a feedback form. However, 11 out of 24 parents or carers gave permission for their child to participate in this research and returned the initial CBCL. Furthermore, parental engagement in the 1-hr workshop was poor, with one participant attending. No parents or carers returned feedback forms. Poor parental engagement in this study meant this aim could not be explored.

Other Australian interventions have had varied success engaging parents or carers. Fisak et al. (2018) had an attrition rate of 62% in a sample of 178 children in a targeted intervention delivered in an outpatient clinic. Alternatively, one school in remote Northern Australia had so little parent engagement, they relied on an opt-out consent strategy in their research (Robinson et al., 2020). Building home-school partnerships can be difficult at any time (Graham et al., 2021). In this instance, many factors could have contributed to low parental engagement, including increased parental stress from COVID-19 (Hiraoka & Tomoda, 2020; Wiemer & Clarkson, 2023) and local natural disasters (Caruana, 2010; Johar et al., 2022).

4.6.3 Teacher Engagement

As stated previously, Australian teachers are reporting reduced wellness and perceived increased workloads resulting from COVID-19 (see 4.6.1; Billett et al., 2022; Carroll et al., 2022). With perceived increased workloads, teachers could be less likely to

participate in a program that does not contribute to the national curriculum (Carroll et al., 2022). For this research, the participating teacher was aware of the BBRW (McCausland-Green, 2015) being delivered in previous years and expressed a desire to continue what they perceived as a valuable program. It is unclear how many of the handouts the teacher engaged with, as that question was not answered on the feedback form. However, the teacher supervised the delivery of the BBRW (McCausland-Green, 2015) and reported they felt it was helpful in learning resilience skills that could be used to increase resilience in other children.

4.6.4 Reporting Discrepancy

Moderate cross-informant discrepancy is normal. For example, parent and teacher reports in the ASEBA suite demonstrated an average correlation of .23 in samples from 21 countries (Rescorla et al., 2014). A cursory glance at outcomes of this research reveals a higher parent-teacher discrepancy. For example, the CBCL demonstrated reliable change in seven instances, with six of those being improvement. Conversely, the TRF demonstrated reliable change in five instances, with all of those being deterioration. Out of 11 participants, six parents or carers reported that their children were within the clinical range for at least one domain at time 1. However, the teacher reported that none of the 11 participants were in the clinical range at time 1.

This research uncovered greater similarity between parent and child reports than parent and teacher reports. This is normal, with parent and youth reports in the ASEBA suite demonstrating a correlation of .34 in an Australian sample (Rescorla et al., 2013; Sawyer et al., 2001). In this research, 9 out of 11 children reported being within the clinical range for at least one domain of the RSCA at time 1 or time 2. Correspondingly, parents or carers reported that 7 out of 11 children were within the clinical range on the CBCL at time 1 or time 2. By considering the child's voice, researchers and practitioners gain a greater

understanding of what might be happening for the children, which can help shape theories and strengthen the outcomes of resilience programs (Beyond Blue, 2017b).

De Los Reyes (2011) suggest that the discrepancies between parent and teacher reports could indicate measurement error. It could also indicate a legitimate change in child behaviour in response to a different environment (De Los Reyes, 2011). It's difficult to know what would lead to such a large discrepancy at baseline testing. However, the direction of the time 2 changes on the reliable change index indicate that the discrepancy could be attributed to the teacher's close supervision of the BBRW (McCausland-Green, 2015). It was not originally intended for the teacher to supervise the delivery of the BBRW (McCausland-Green, 2015), as it could be seen as a confounding factor. This exposure to the BBRW (McCausland-Green, 2015) may have sensitised the teacher to the high levels of distress being experienced by their students, causing the TRF to reflect the child's experience more accurately at time 2.

4.6.5 Positive Feedback

Children learn better when engaged in ways that induce interest and increase their sense of belonging (Kahu & Nelson, 2018). It is important, therefore, to seek the feedback of participants and assess how they perceive the usefulness and enjoyment of the program. The student feedback was overwhelmingly positive, indicating that the workshop was enjoyable and helpful from their perspective. However, the absence of parent feedback made it impossible to know how parents or carers perceived the workshop's utility. The teacher reported being happy with program, learned from the program and felt they could generalise the teaching to other children. However, as previously reported, the teacher engaged more in this workshop than would be expected in future workshops (see 4.6.3). Overall, feedback for the BBRW (McCausland-Green, 2015) has been positive, indicating the delivery of the resilience training was engaging and useful.

4.6.6 Strengths

The strengths of this quasi-experimental research include the initial evaluation to ensure that the workshop was meeting best practice and addressing the five key areas that contribute to the building of resilience in children (Beyond Blue, 2017a). The measures were psychometrically sound and related to the factors contributing to resilience. Cross-informant reports afforded the ability to gain a deeper understanding of what was happening for the children by considering child, parent, and teacher perspectives. The mixed-methods research design allowing for the simultaneous collection of psychometric quantitative data and qualitative data in the form of feedback was helpful in assessing that overall, the workshop was increasing resilience, decreasing emotional and behavioural problems, and was enjoyable for children who, along with their teacher, perceived the intervention as helpful. The successful delivery of this workshop in a school environment demonstrated that this universal intervention aimed at increasing resilience in children should continue to be implemented, evaluated, and refined.

4.6.7 Limitations

Limitations in this study included a lack of control group, difficulty in generalising findings, lack of follow-up measures, and use of the RCI. The lack of a control group in this study limited the ability to assess how much change could be attributed to the workshop or chance. With only one class and one teacher participating, it is difficult to know how much their specific circumstances affected results. This was especially pertinent amid such extreme local conditions including COVID-19 and natural disasters. This sample, with its local considerations, may be difficult to generalise to other populations.

In school-based interventions, it is difficult to know how the child, parent and teacher's results are influenced by the timing of the intervention. For example, the teacher in this research described a natural phenomenon of students' tiring over the course of the term,

resulting in declines in behaviour. Additionally, the use of the RCI was inappropriate with some domains on the measures, reducing the ability to gauge individual change. Finally, time restraints prevented post-workshop follow-up. There is strong evidence for CBT interventions decreasing symptoms of psychopathology long after CBT training has ceased (Ma et al., 2020; von Brachel et al., 2019). This phenomenon may be attributed to participants becoming more effective at practicing CBT strategies over time and in different situations (Beck & Beck, 2020; Brunwasser et al., 2009; von Brachel et al., 2019).

4.6.8 Recommendations for Future Research

The positive reception of the workshop and findings of this study indicate that the BBRW (McCausland-Green, 2015) is worth further exploration. It is recommended that future research into the BBRW (McCausland-Green, 2015) use a control group to reduce the impact of confounding factors. For the same purpose, it is also recommended that, where possible, groups across classrooms or schools are used. A redesign to fit the workshop into the national curriculum could be considered to support schools to deliver the content without adding to busy classroom schedules. A program evaluation at a time when a community is not facing so much adversity may increase the likelihood that parents or carers will participate in the 1-hr workshop. Finally, delivery of the 1-hr workshop by Zoom or a pre-recorded video could also increase parent participation, with busy parents or carers able to engage in a time and manner that suits their schedules.

4.7 Conclusion

As mental health struggles continue to be a concern for children in Australia, the Australian Government aims to build the resilience of children aged 8-14 (Australian Government Department of Health, 2020). Guidance has been given about how best to do that through the Beyond Blue (2017a) Practice Guide. The BBRW (McCausland-Green, 2015) is a school-based, universal resilience intervention that addresses the Beyond Blue

(2017a) five key areas that determine the building of resilience in children. This study demonstrated that, overall, primary school aged children who attended the BBRW (McCausland-Green, 2015) increased resilience and reduced emotional and behavioural problems. The BBRW (McCausland-Green, 2015) was also found to be enjoyable and perceived by the students and their teacher as useful. These findings are most notable considering the high levels of adversity being experienced by this specific sample. These promising findings indicate that it would be worth continuing to deliver the BBRW (McCausland-Green, 2015), with further exploration including a larger, more varied sample and a control group.

Chapter 5: General Discussion

This research used a mixed methods design, with an SLR and a quasi-experimental program evaluation to explore resilience interventions for Australian children aged 8-14. The SLR followed from the Children's Resilience Research Project (Beyond Blue, 2017b), exploring quantitative program evaluations of resilience interventions in Australia from the previous five years. This was followed by a program evaluation of the BBRW (McCausland-Green, 2015) in a Queensland primary school. The findings of the SLR helped contextualise the outcomes of the program evaluation. This chapter will present a summary of both studies with this context added.

5.1 Background Leading to this Research

To reduce child psychological distress, self-harm, and deaths by suicide (Australian Institute of Health and Welfare, 2021), the National Action Plan (Australian Government Department of Health, 2020) recommends building resilience in children aged 8-14 years through resilience interventions. The Children's Resilience Research Project (Beyond Blue, 2017b) resulted in a Practice Guide (Beyond Blue, 2017a) that presents a consensus about what resilience means in Australia and gives guidelines on how to design a resilience intervention and build resilience in children. The Practice Guide (Beyond Blue, 2017a) was published in 2017, so it was not expected that there would be widespread uptake in five years (Morris et al., 2011). However, this research aimed to explore the ecological reach of the BBRW (McCausland-Green, 2015) and other Australian resilience interventions and to investigate how they were adhering to the guidelines. This was done by comparing the interventions to the ecological resilience theory and the five key areas that determine the building of resilience in children.

5.2 Meeting the Guidelines in the Practice Guide

Overall, the BBRW (McCausland-Green, 2015) and other Australian resilience interventions did well at addressing most of the key areas prescribed, especially around individual resilience factors, like building resilience attributes in the child. However, the BBRW (McCausland-Green, 2015) and other resilience interventions did not provide resources and experiences that build children's resilience. These resources and experiences can be provided by teaching parents or carers or other care givers about resilience, autonomy, and responsibility. However, accessing parents or carers and other caregivers in various locations is more difficult than accessing children, who are conveniently available in their classrooms. To rectify this deficit, the interventions would have to increase their ecological reach.

Before its program evaluation, the BBRW (McCausland-Green, 2015) was altered to encourage parents or carers to provide their children with opportunities to make decisions and mistakes. This was added to a 1-hour parent workshop and handouts. However, parental stress from COVID-19 (Hiraoka & Tomoda, 2020; Wiemer & Clarkson, 2023) and multiple local natural disasters (Caruana, 2010; Johar et al., 2022) contributed to a parental engagement sample of one. The practical difficulties in engaging stakeholders to participate in a program, especially in the context of COVID-19 pandemic induced teacher burnout (Billett et al., 2022; Carroll et al., 2022), could make reaching into homes and communities difficult. Though, it is worthwhile making the effort to overcome this when considering the contribution that resilience interventions are making to the mental health of children.

5.3 Outcomes of Program Evaluations

Overall, the BBRW (McCausland-Green, 2015) and other resilience interventions had beneficial effects on the mental health of Australian children. Participation in resilience interventions increased resilience in the context of school-settings, child’s perception of

resilience resources, wellness, self-compassion, support-seeking, confidence in coping, individual capacities, and contextual factors. It also reduced emotional and behavioural problems, worry, and symptoms of anxiety and depression. Most notable were the BBRW (McCausland-Green, 2015) outcomes, which demonstrated increased resilience in the context of school-settings and decreased emotional and behavioural problems in a program evaluation completed shortly after multiple local natural disasters. Additionally, students who participated in the BBRW (McCausland-Green, 2015) had fun, perceiving it as useful. Their teacher also felt it was useful.

5.4 Recommendations for Further Research

It is recommended that further research be done to continue exploring resilience interventions, their ecological reach, and their outcomes. Specifically, more research is recommended to expand upon the work of Shaykhi et al. (2018) and Singh et al. (2019) and explore the effect of parental or carer engagement in resilience interventions. Teaching parents or carers and other caregivers about resilience, child responsibility, and child autonomy is essential to building resilience. This is especially pertinent with most Australian resilience interventions being school-based (Beyond Blue, 2017b) and Australian parents or carers' lacking confidence to allow their children autonomy (Niehues et al., 2016; Niehues et al., 2013). It is recommended that more research is done around how to engage parents or carers and other caregivers in resilience interventions. Finally, the findings of the BBRW (McCausland-Green, 2015) program evaluation and child feedback indicate that the BBRW (McCausland-Green, 2015) is an effective intervention to increase resilience and decrease emotional and behavioural problems. It is recommended that the BBRW (McCausland-Green, 2015) is explored further using a larger, more varied sample and a control group.

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Appendix A

The Bouncing Back Resiliency Workshop contents

"Bouncing Back" Resiliency Workshop

Program previous groups

Term 3, 2015 – Grade 2
Term 4, 2015 – Prep/Grade 1
Term 1, 2016 –Grade 4
Term 2, 2017 - Prep/Grade 1
Term 3, 2018 – Grade 1
Term 2, 2019 – Grade 3
Term 2. 2021 – Grade 4 x 2 groups

Program

1 Hour x 6 weeks
Facilitators: Two to three provisional psychologists – student needs to show proof of a Blue Card
Maximum of 10 students

Resources required

Resource:	Who to provide:	When:
Attendance sheet	USQ	Every week
Name labels	USQ	Every week
Whiteboard markers	School	Every week
Blu Tack	USQ	Every week
Textas	School	Every week
2 balls	USQ	Week 1,3
Social and emotional learning HO x2	USQ	Week 1
Home 4 figurines	USQ	Week 1, 2
Butchers paper	School	Week 1,2,6
Feelings books (happy, sad, scared)	USQ	Week 1
Dr Seuss feelings book	USQ	Week 1, 2
Feelings cards	USQ	Week 1, 2
Sheet of blank body for feelings x4	USQ	Week 1, 2
Feelings book (angry)	USQ	Week 2
Sad, happy, scared, angry word cards	USQ	Week 2
Scenarios for feelings	USQ	Week 2
PMR script x 2	USQ	Week 3
Paper towel	USQ	Week 3
Pinwheels (many)	USQ	Week 3
Bean bag	USQ	Week 3
13 Bubbles	School	Week 3
Rag doll (for PMR younger 3-8)	USQ	Week 3
Soft toy elephant x2 (for PMR older 8+)	USQ	Week 3
Feather	USQ	Week 3
Supporting Children's Confidence HO	USQ	Week 4
Traffic light picture	USQ	Week 4
Red thought sign	USQ	Week 4
Green thought sign	USQ	Week 4
Coping statements sheet x10	USQ	Week 4
Stickers for boys and girls	School	Week 4
A4 paper x10 sheets	USQ	Week 5
Resource:	Who to provide:	When:
Problem solving HO x 20	USQ	Week 5
Role play challenging scenarios	USQ	Week 5
Friendly things to do etc cards	USQ	Week 6
Being a good friend handout x 20	USQ	Week 6
"Yes" and "No" cards	USQ	Week 6
Role play friendship scenario cards	USQ	Week 6
Friendship skills: Suggestions for Families HO	USQ	Week 6
Certificates	USQ	Week 6
Feedback forms x 10	USQ	Week 6

Structure of Program

Week 1:

TOPIC: Identifying and Naming Emotions

Resource:	**Who to provide:**
Attendance sheet	USQ
Name labels	USQ
Whiteboard markers	School
Blu Tack	USQ
Textas	School
2 balls	USQ
Social and emotional learning HO x2	USQ
Home 4 figurines	USQ
Butchers paper	School
Feelings books (happy, sad, scared)	USQ
Dr Seuss feelings book	USQ
Feelings cards	USQ
Sheet of blank body for feelings x4	USQ

Warm up exercise – Throw ball and say name

Make group rules

Identifying Sadness
Read feelings book on sad or Dr Seuss' book (for younger children)
Pick out Home "sad" figurine
All children to pick feelings cards to show sad
Draw around a child's body on butchers paper and identify sad signs and names for sad – therapist to also replicate this on an A4 piece of paper to give to parents – signs, words for feelings, what can do if have the emotion, causes

Identifying Scared
Read feelings book on scared or Dr Seuss' book (for younger children)
Pick out Home "scared" figurine
All children to pick feelings cards to show scared
Draw around a child's body on butchers paper and identify scared signs and names for scared – therapist to also replicate this on an A4 piece of paper to give to parents

Identifying Happy
Read feelings book on happy or Dr Seuss' book (for younger children)
Pick out Home "happy" figurine
All children to pick feelings cards to show happy
Draw around a child's body on butchers paper and identify happy signs and names for happy – therapist to also replicate this on an A4 piece of paper to give to parents

Week 2:

TOPIC: Identifying and Naming Emotions

Resource:	**Who to provide:**
Attendance sheet	USQ
Name labels	USQ
Whiteboard markers	School
Blu Tack	USQ
Textas	School
Home 4 figurines	USQ
Butchers paper	School
Dr Seuss feelings book	USQ
Feelings cards	USQ
Sheet of blank body for feelings x4	USQ
Feelings book (angry)	USQ
Sad, happy, scared, angry word cards	USQ
Scenarios for feelings	USQ

Warm up exercise - Stand up if you…

Review group rules

Identifying Anger
Read feelings book on angry or Dr Seuss' book (for younger children)
Pick out Home "Angry" figurine
All children to pick feelings cards to show angry
Draw around a child's body on butchers paper and identify angry signs and names for angry – therapist to also replicate this on an A4 piece of paper to give to parents

Walk around the room acting out emotions
Walk around the room acting sad, happy, scared, angry

Emotional charades
Emotional charades using sad, happy, scared, angry cards or Home figurines – act these out and children have to guess the feeling
Do emotional charades using feelings scenarios cards – children have to guess the feeling they would have for different scenarios

Week 3:

TOPIC: Managing Emotions

Resource:	**Who to provide:**
Attendance sheet	USQ
Name labels	USQ
Whiteboard markers	School
Blu Tack	USQ
Textas	School
PMR script x 2	USQ
Bean bag	USQ
Feather	USQ
13 Bubbles	School
Rag doll (for PMR younger 3-8)	USQ
Soft toy elephant x2 (for PMR older 8+)	USQ
Pinwheels	USQ
Balls	USQ
Papertowel	USQ

Warm up exercise – toss ball and say favourite food

Review group rules

Progressive Muscle Relaxation
Use Progressive Muscle Relaxation (e.g. robots/jellyfish/towers or older children's script)
If using robots/jellyfish/towers then write these on the board and get children to take turns in throwing a beanbag at which one we will practice – use rag doll to show how floppy they can be
If using older children's script use soft toy to "walk" on their tummy
Handout PMR script to students

Diaphragmatic breathing
Use bubbles to get children to make the biggest bubble they can – have a competition in 3 smaller groups
Use feathers to do feather breathing – breathe in and then release the breath as the feather is released from up high onto the ground
Soup breathing – everyone to cup their hands together to make a "bowl", ask what flavour soup everyone has in their "bowl". Then breathe through nose to "smell" the soup and breath out through mouth slowly to "cool" the soup
Pin wheels – use pinwheels to show diaphragmatic breathing – try to keep the wheel spinning as long as possible
Handout "Relaxation for Children" to students

Activities

Brainstorm on board different activities that calm them down and make them feel happier
Handout "Anxiety Management" script to students

Meditation
Smiling mind – bubble journey (7 minutes)

Homework
Practice diaphragmatic breathing

Week 4

TOPIC: Coping Skills for Disappointments or Challenging Situations

Resource:	**Who to provide:**
Attendance sheet	USQ
Name labels	USQ
Whiteboard markers	School
Blu Tack	USQ
Textas	School
Supporting Children's Confidence HO	USQ
Traffic light picture	USQ
Red thought sign	USQ
Green thought sign	USQ
Coping statements sheet x10	USQ
Stickers for boys and girls	School

Warm up exercise – Jelly fish and robots and tall tower or feather breathing

Review group rules

Review homework

Red thoughts and green thoughts

Introduction
Show them a traffic light and ask them what the colors mean
Show the children the red and green thought signs and explain that green thoughts are helpful ways of thinking – we call it "green thinking" and it tells us to GO! – just like a green traffic light. This way of thinking makes us feel brave, happy and we try our best to have this way of thinking.
Then explain that red thoughts are unhelpful ways of thinking and make us feel sad, scared or angry – they tell us to STOP!
Explain a scenario of Sarah who is starting a new school tomorrow – she could have green thoughts like "I will learn so many new things at school", "I will make new friends", "My new school has so many nice playgrounds", "I can tell my mum and dad all about my new school", "My teacher will help me to learn so much" – Ask the children how they might feel if they have these green thoughts
Ask what would happen if Sarah has red thoughts like "I don't like my new school uniform", "I will not like school", "I will miss my mum", "School is boring" and "I don't want to go to school" – how will Sarah be thinking.

Same event, different thoughts exercise
Use cards to show different thoughts for the same scenario – get different children to hold the red thought and green thought and act out how they would feel if they had these thoughts. Talk about what they would do if they had these thoughts i.e. what actions they would take. Place the cards at two

ends of the room and get the children to pick which thought they would have normally

Walking exercise
Get the children to walk around the room and therapist will read out a "thought" (I can't do it, It's okay to make a mistake, People will laugh at me, I don't want to try it, My friend likes me, I can run really fast, I give up, Mummy will forget to pick me up, I can do my best, I feel really silly, I've done this before and I can do it again, I'm no good at running, I will find someone to play with, I will try this) - the children should call out if it is a red thought or green thought and stop if it is a red thought and keep walking if it is a green thought – "GO on the green thoughts and STOP on the red thoughts". Get them to come up with their own green and red thoughts.

OR for older children – get them to complete the sheet on hot and cold thoughts in "Thought challenging journal", challengers to hot thoughts and "The way I think and feel" sheet for cog restructuring
Turn red thoughts into green thoughts on the board

Coping statements development
Ask the children what situations they find challenging and write these on the board e.g. standing up in front of the class, tests, running races,
Help the children to develop their own "green" thoughts (coping statements) to help them during difficult times using coping statements sheet e.g. "It's okay to make a mistake", "I can just try my best", "I've done this before and I can do it again", "Nothing is going to happen", "I will be fine". "It will be over soon", "I've seen other people do it and I can do it to", "Come on you can do it", "Let's do it and see what happens" "You will feel so happy that you tried it" – then give to parents

Homework
Catch people and yourself having red thoughts!

Week 5:

TOPIC: Coping Skills for Disappointments or Challenging Situations

Resource:	**Who to provide:**
Attendance sheet	USQ
Name labels	USQ
Whiteboard markers	School
Blu Tack	USQ
Textas	School
A4 paper x10 sheets	USQ
Problem solving HO x 20	USQ
Role play challenging scenarios	USQ

Warm up exercise – Freeze game using green and red thoughts

Review group rules

Review homework

Cognitive work –Scientific explanation (only for older children 8years+)
See Facing your fears workbook on "a Scientific Approach" and use challengers to hot thoughts in "Thought challenging journal", and "The way I think and feel" sheet for cog restructuring

Problem Solving
Show children solving problems sheet and go through examples on the board or in small groups: when I try something and make a mistake, when someone annoys me, when I lose a game, when I am not first in line, and when Mum says I can't play on the computer.

Helping hand
Draw around their hands and identify people they can talk to if they are having problems – give these to parents

Facing Challenging Situations
Role play facing challenging situations in small groups and what they can do and say to themselves "green thoughts" using scenarios

Week 6:

TOPIC: Friendship Issues

Resource:	**Who to provide:**
Attendance sheet	USQ
Name labels	USQ
Whiteboard markers	School
Blu Tack	USQ
Textas	School
Butchers paper	School
Friendly things to do etc cards	USQ
Being a good friend handout x 20	USQ
"Yes" and "No" cards	USQ
Role play friendship scenario cards	USQ
Friendship skills: Suggestions for Families HO	USQ
Certificates	USQ
Feedback forms x 10	USQ

Warm up exercise – feather breathing

Review group rules

What are Friends & How to Make a Friend –
On butchers paper brainstorm what makes a friend and how to make a friend (e.g. like to play together, share, let other people be first sometimes, take turns, listen to other people's ideas, let other people to choose what to play sometimes, like the same things, have the same sense of humour, like to talk together)

How to Keep a Friend-
Get into small groups and sort out cards into "friendly things to do" and "unfriendly things to do"
Read the "Being a good friend" handout (P56 Developing social skills) and give to students

How to Ask to Play-
Role play how to ask to play with someone – use "yes" and "no" cards (and how to say yes or no nicely and how to respond if they say yes or no). Write down their responses on the board/

Problems in Friendships-
Role play (using scenario cards) problems in friendships and what to do (e.g. want to play something you don't, not sharing, not taking turns, can't find them, saying mean things, pushed you)

Give out Certificates of Attendance – ask Principal or Vice Principal to hand these out

Give out Feedback Form and Questionnaires to Children

Post Week 6:

School to distribute post- questionnaires to parents and teachers

Clinic director to provide report to parents/teachers

Report for Parents and Teachers

When sessions completed send parents and Teachers a report on their child's progress and attendance in the sessions. Also provide recommendations for parents/teachers if needed.

Handouts for Parents and Teachers (weekly)

Bouncing Back Resiliency Group
Week 1: TOPIC: Identifying and Naming Emotions

Building resilience comes through the development of social and emotional skills, which include coping skills. These are the same skills that will help children deal with stress, so it follows that building resilience will really help kids deal with stress. A resilient child has social and emotional skills for their age that help them to name their feelings, manage their emotions, be aware of other people, solve problems and make good decisions.

Content Presented Today:
Today in session we did a number of things to get to know each other and make our group safe to talk openly:
We did a warm up exercise to learn each others' names
We made a set of group rules which we will use each week

We also started to identify and name the emotions of sadness, anxiety (scared) and happiness by:
Picking out drawings of bears (feelings cards) showing these feelings
Talking about how we know we are feeling sad, scared and happy – that is, what we look like (e.g. smiles, tears) and how our bodies feel (e.g. heavy, trembling)
Identifying other names for "sad", "scared" and "happy"

Handouts:
Completed body sheets for each feeling done in session (happy, sad, scared)
Social and emotional learning: suggestions for families (Kids Matter)
Social and emotional learning: suggestions for school staff (Kids Matter)

Next Week:
Next week we plan to identify and name the feeling of anger. We will also talk about the feelings of happy, sad and scared again and act out all four feelings (in a safe way)!

Home Practice:
Ask your child to talk to you about the feelings sheets that we completed in session and what they learnt about sad, scared etc. Ask them what situations make them feel sad, scared and happy.
Try to find examples on TV, in movies or in books when someone is feeling happy, sad or scared and highlight this to your child e.g. "look at the Minion shaking his body and running away – he is really scared"

Bouncing Back Resiliency Group
Week 2: TOPIC: Identifying and Naming Emotions

Building resilience comes through the development of social and emotional skills, which include coping skills. These are the same skills that will help children deal with stress, so it follows that building resilience will really help kids deal with stress. A resilient child has social and emotional skills for their age that help them to name their feelings, manage their emotions, be aware of other people, solve problems and make good decisions.

Content Presented Today:
Today in session we did a number of things to get to know each other some more and to make our group safe to talk openly:
We did a warm up exercise to learn more about each other
We reminded everyone of our group rules

We also identified and named the emotion of anger:
Picking out drawings of bears (feelings cards) showing anger
Talking about how we know we are feeling angry – that is, what we look like (e.g. gritting teeth) and how our bodies feel (e.g. tight and tense)
Identifying other names for "angry"

We then reinforced the work we had done on "happy, sad, scared and angry" by:
Walking around the room acting these feelings out (in a safe way)!
Acting out these emotions in a game of emotional charades (we all had to guess the emotion someone was acting)

Handouts:
Completed body sheet for the feeling of anger done in session

Next Week:
Next week we plan to talk about how we can manage our emotions by teaching relaxation skills and using other activities.

Home Practice:
Ask your child to talk to you about the feelings sheet done in session and what they learnt about anger etc. Ask them what situations make them feel angry.
Act out feelings (sad, anger, scared, happy) and see if the other person can guess what you are acting. When you guess your child's acting make sure that you verbalise what signs you can see e.g. "you have a droopy mouth, are looking down, look really heavy so I think that you are being sad"
Day-to-day when you feel an emotion (that's appropriate to share with your child) make sure that you verbalise this to your child and also what you are going to do to make yourself feel better e.g. "there are no more tickets to the concert I wanted to go to – I am feeling very disappointed and sad but I will see if there is another concert around"

Bouncing Back Resiliency Group
Week 3: TOPIC: Managing Emotions

Building resilience comes through the development of social and emotional skills, which include coping skills. These are the same skills that will help children deal with stress, so it follows that building resilience will really help kids deal with stress. A resilient child has social and emotional skills for their age that help them to name their feelings, manage their emotions, be aware of other people, solve problems and make good decisions.

Content Presented Today:
Today in session we did a number of things to get to know each other some more and to make our group safe to talk openly:
We did a warm up exercise to learn more about each other
We reminded everyone of our group rules
Today we talked about how we can manage our emotions by:
Using Progressive Muscle Relaxation (PMR) - we practiced this together
Using bubble (diaphragmatic) breathing (we practiced this together and had a competition to see who could blow the biggest bubble).
Using feather breathing (taking in a deep breath and then releasing a feather from high in the air and breathing out until the feather hits the ground)
Using pinwheel breathing (taking a deep breath and making the pinwheel spin as long as possible) and soup breathing (cup your hands and smell the "soup" in your hands then blow the soup gently
The aim of bubble, pinwheel, soup and feather breathing is to get children to take a deep breath and release the air in a slow and controlled way (similar to the action needed to blow big bubbles)
Doing other activities that make us feel relaxed and happy

Handouts:
Progressive Muscle Relaxation (3-8yo)
Progressive Muscle Relaxation (older children script)
Anxiety management
Relaxation for children

Next Week:
Next week we plan to talk about one coping skill for managing disappointments and challenging situations – identifying red "unhelpful" thoughts and green "helpful" thoughts and using coping statements in challenging situations.

Home Practice:
Help your child to practice PMR once per day (maybe before bed) by reading out the PMR script to them whilst they do the actions or for younger children asking them to pretend to be a jellyfish/rag doll or a robot and walk around acting these out.

Help your child to practice bubble breathing at least once per day (they have to try and blow the biggest bubble they can) – maybe they could have a competition against you.
When they can do bubble breathing well then get them to try it without the bubbles being actually present!
Your children can also practice soup, feather or pinwheel breathing.

Bouncing Back Resiliency Group

Week 4: TOPIC: Coping Skills for Disappointments or Challenging Situations

Building resilience comes through the development of social and emotional skills, which include coping skills. These are the same skills that will help children deal with stress, so it follows that building resilience will really help kids deal with stress. A resilient child has social and emotional skills for their age that help them to name their feelings, manage their emotions, be aware of other people, solve problems and make good decisions.

Content Presented Today:

Today in session we did a number of things to get to know each other some more and to make our group safe to talk openly:
We did a warm up exercise to learn more about each other
We reminded everyone of our group rules

Today we talked about one coping skill for managing disappointments and challenging situations:
By identifying red "unhelpful" thoughts and green "helpful" thoughts
We learnt that we GO on the green thoughts (e.g. "I will try this") and STOP on the red thoughts (e.g. "I give up")
We also developed individualised coping statements that children could use in challenging situations

Handouts:
Supporting Children's Confidence (Kids Matter)
Coping Statements sheet completed in session by your child

Next Week:
Next week we plan to talk about some more strategies for coping with disappointments or challenging situations – problem solving skills and asking for help from others. We will also continue to talk about using green "helpful" thoughts to cope with challenging situations.

Home Practice:
Practice identifying "red" and "green" thoughts as they come up – practice as much as possible
Model turning "red" thoughts into "green" ones and assist your child in doing the same with their own "red" thoughts
Put your child's coping statements sheet somewhere they can easily see it (e.g. on the fridge) and encourage your child to use these when they face challenging situations
Model to your child using coping statements to get through your own challenging situations

Bouncing Back Resiliency Group

Week 5: TOPIC: Coping Skills for Disappointments or Challenging Situations

Building resilience comes through the development of social and emotional skills, which include coping skills. These are the same skills that will help children deal with stress, so it follows that building resilience will really help kids deal with stress. A resilient child has social and emotional skills for their age that help them to name their feelings, manage their emotions, be aware of other people, solve problems and make good decisions.

Content Presented Today:
Today in session we did a number of things to get to know each other some more and to make our group safe to talk openly:
We did a warm up exercise to learn more about each other
We reminded everyone of our group rules

We talked today about some strategies for coping with disappointments or challenging situations:
Problem solving skills
Asking for help from others (we made a helping hand of all the people we can talk to when we are having problems)
Using green "helpful" thoughts to cope with challenging situations

Handouts:
Helping hand handout (completed by your child in session)
Problem solving handout

Next Week:
Next week is our final session together. We will talk about friendship issues including what is a friend, how to make a friend, how to keep a friend and how to deal with problems in friendships.
We will also give out a certificate to your child for attending the group. We will ask your child for feedback on the group.
We will give the school some questionnaires for you and your child to complete to compare if your child has made any changes since starting the group six weeks ago.

Home Practice:
Look at your child's "Helping Hand"
Encourage your child to talk to others when they are having a difficult time
Provide your child with opportunities to make their own decisions e.g. if they should take a toy to school.
Provide your child with opportunities to try new things and make mistakes e.g. take money to school for tuckshop, pay for something at the shops, order a takeaway meal.

Use the Problem Solving handout to assist your child to sort out a difficult situation or verbally use these prompts e.g. “What are your choices?” “What is your best choice?” and “Now try it”!

Bouncing Back Resiliency Group
Week 6: TOPIC: Friendship Issues

Building resilience comes through the development of social and emotional skills, which include coping skills. These are the same skills that will help children deal with stress, so it follows that building resilience will really help kids deal with stress. A resilient child has social and emotional skills for their age that help them to name their feelings, manage their emotions, be aware of other people, solve problems and make good decisions.

Content Presented Today:
Today in session we did a number of things to get to know each other some more and to make our group safe to talk openly:
We did a warm up exercise to learn more about each other
We reminded everyone of our group rules

Today was our last session and we talked about friendship issues:
What is a friend
How to make a friend
How to keep a friend
How to ask to play with someone (using role plays)
How to deal with problems in friendships (using role plays)

To celebrate the hard work done by the children over the past 6 sessions each child was given a certificate of attendance.

Your child also completed a feedback form to tell us what they thought of the group.

Handouts:
Friendship skills: Suggestions for Families (Kids Matter)
Being a good friend social script (P56 Developing social skills)

Home Practice:
Review the "being a good friend" social script with your child and discuss the friendships they have and if they and others are "being a good friend"

Completion of the Group:
We have given the school some questionnaires for you and your child to complete to compare if your child has made any changes since starting the group six weeks ago. We would really appreciate you completing these forms for us in order to evaluate our program.

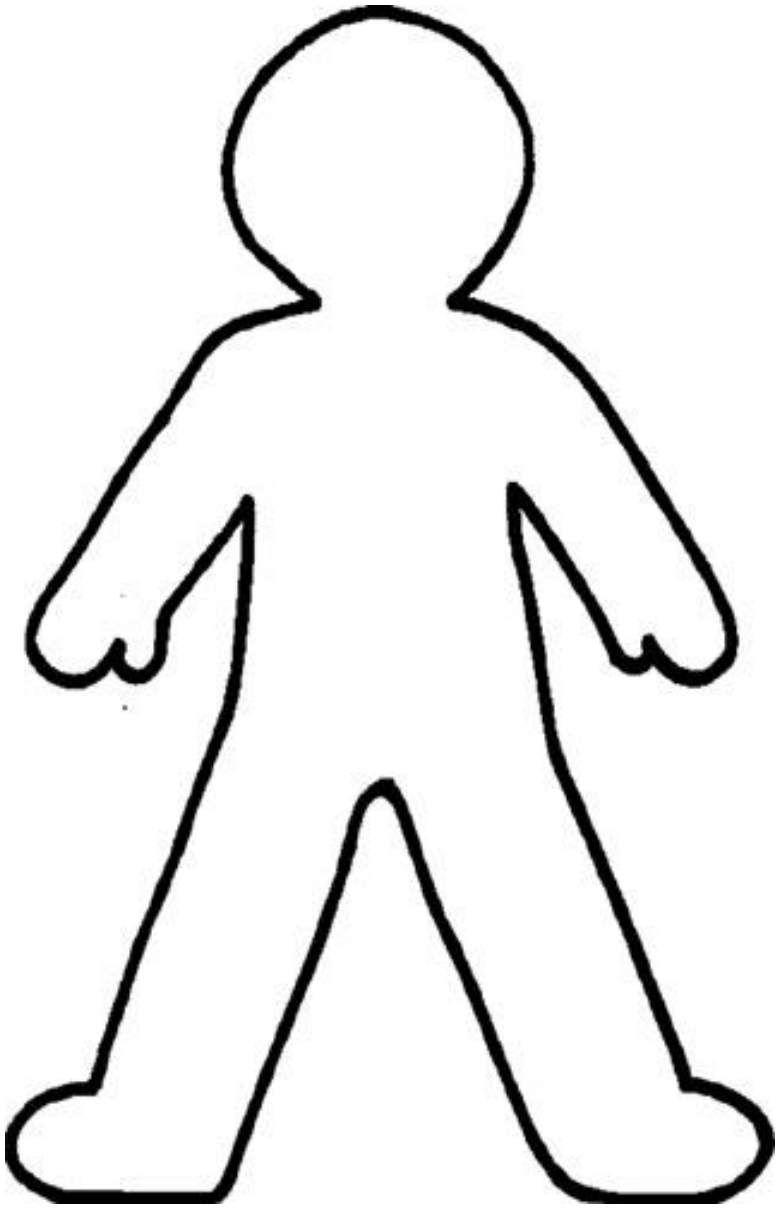
It was a pleasure to run this group with your child and we will provide feedback on your child's progress in this group within the next few weeks.

HANDOUTS

Week 1 Name: _____

When I'm feeling _____

I look like:



Other names for _____ are _____

_____

Week 2
Emotional Charades cards (Print out and cut out and laminate)

Angry
Sad
Scared
Happy

Angry
Sad
Scared
Happy

Week 2

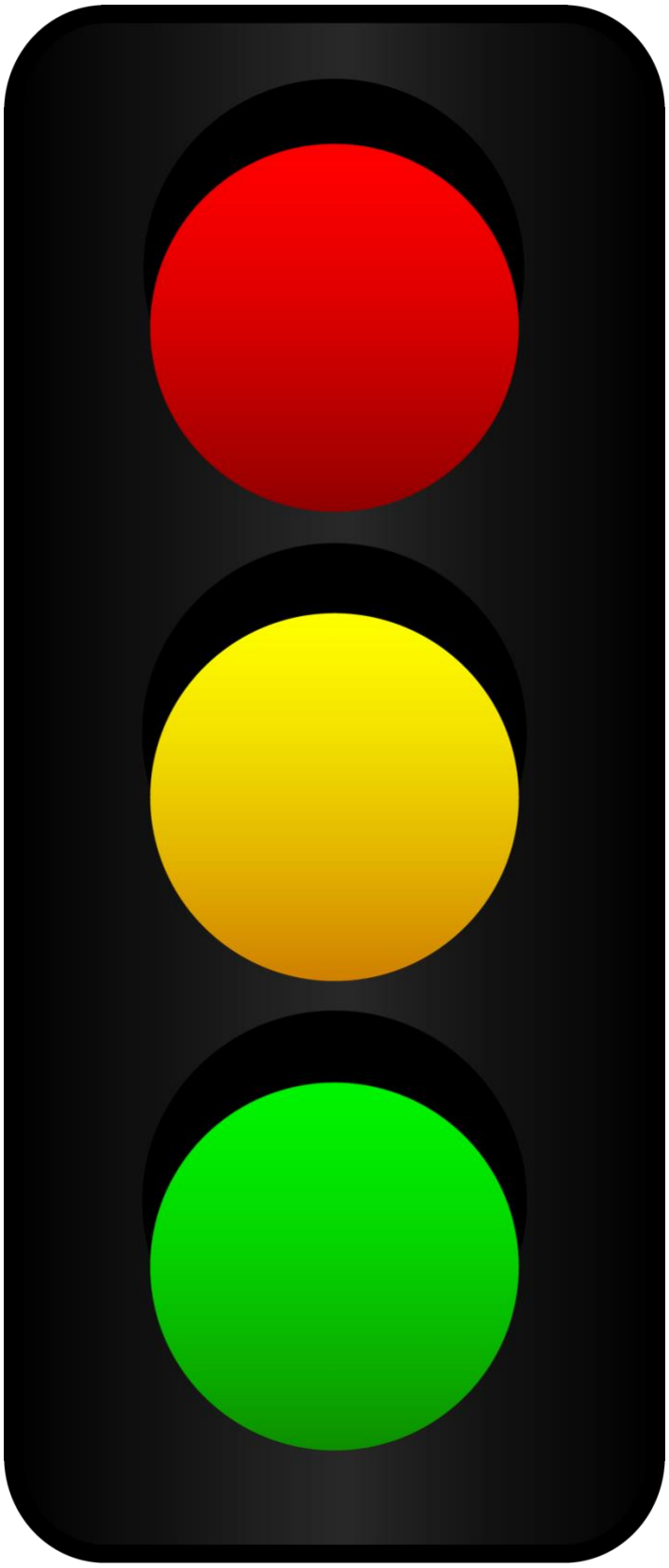
Scenarios for emotional charades

You have been invited to a birthday party for your best friend
Your favourite video game has been broken by your brother
Your pet goldfish dies
You are the only person in your class not invited to a party
You come first in a running race
Your mum gives you a hug
Someone gives you a present
You're watching your favourite movie
You have to dive off a very high diving board
You break your mum's favourite vase accidentally
You have to speak in front of the whole school at parade
You lose your tuckshop money
Your teacher tells you that you are doing a great job

Red Unhelpful Thought

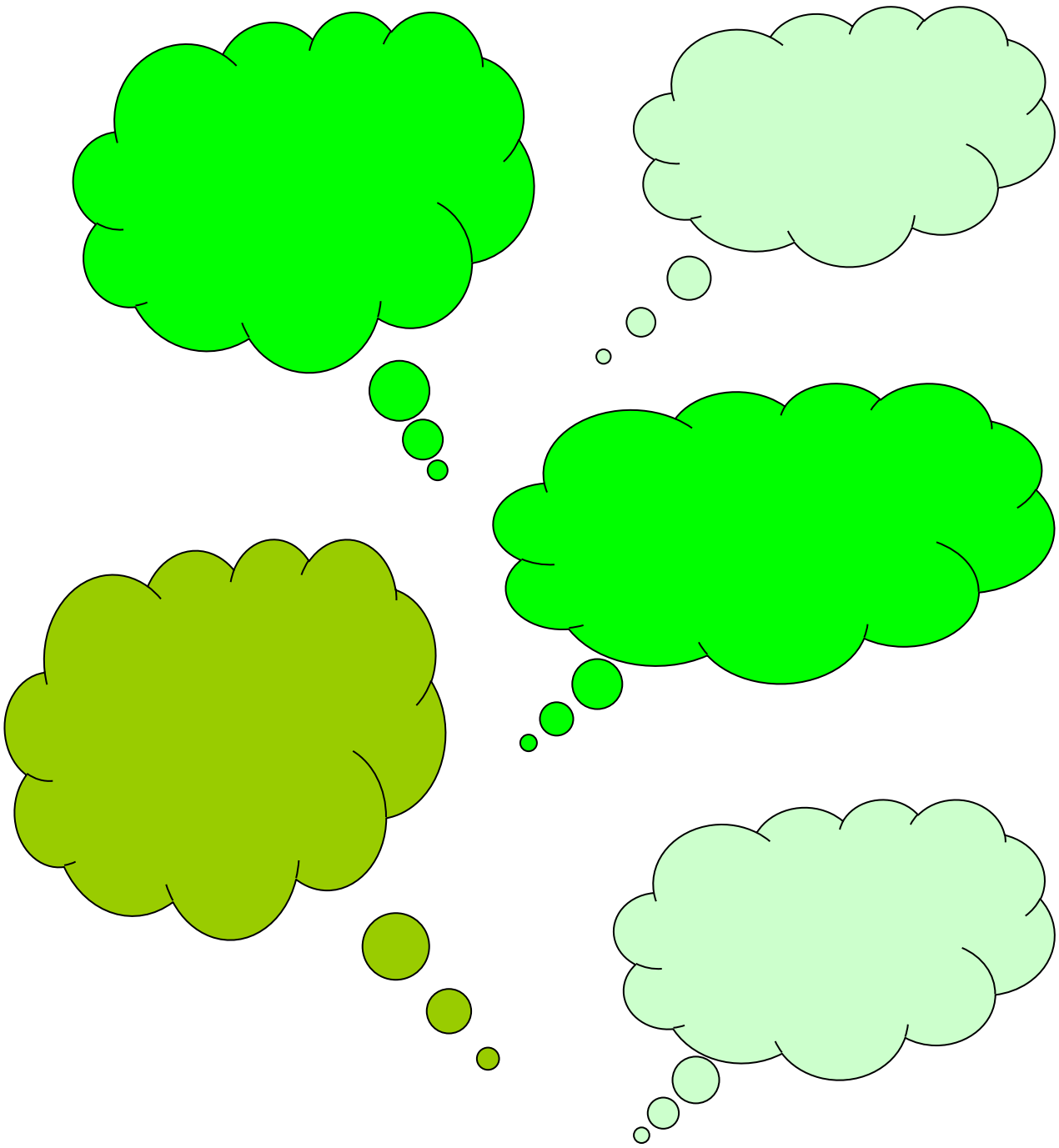

Green
Helpful
Thought

WEEK 4:



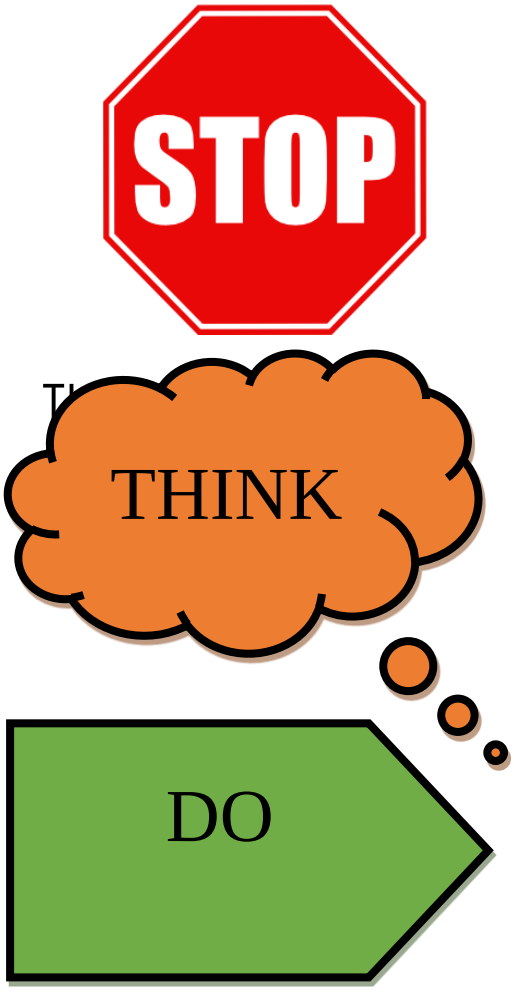
Week 4:
COPING STATEMENTS

_____'S "green" thoughts to help me



Week 5:

Solving Problems



STOP

Think about what the problem is

What are the choices?

Choose the best one

DO IT

Try it!

Week 5

Scenarios for challenging situations

Mum is running late
Can't see parents when out shopping
You make a mistake in front of everyone
Starting a new football team
Come last in a race
Mum says that can't go on the computer
Kids at school aren't following the teacher
Friends are playing a game that you don't like

Week 6

YES	NO
YES	NO
YES	NO

Week 6

Scenarios for role plays re: problems with friendships (cut out strips)

Your friend wants to play a game that you don't

Your friend won't share his ball with you

Your friend does not give you a turn

Your friend keeps running off and leaving you

Your friend is saying mean things about you

Your friend pushes you.

Your friend takes your food without asking

Appendix B

Human Research Ethics Application and Approval

ResearchMaster

Human Ethics Application

Application ID :	21008710
Application Title :	Evaluation of the Bouncing Back Resiliency Workshop
Date of Submission :	N/A
Primary Investigator :	Mrs Jessica Beth Swann; Principal Investigator
Other Personnel :	A/Pr Gavin Beccaria; Co-Investigator Mrs Jean McCausland-Green; Co-Investigator

Instructions

Instructions

Click the green arrow to go to the next page.

Pre Application

1 Application Type

Ethics category*
Human Research Ethics Application

1.1 Has this application been reviewed and approved by another Human Research Ethics Committee (HREC)?

○ ◉

Select "Yes" if your project has already been approved by a human research ethics committee (HREC) that is not operated by the University of Southern Queensland, (i.e. you wish to register your ethics approval with USQ).
Select "No" if the University of Southern Queensland Human Research Ethics Committee will review and approve your proposed research.
*

Yes No

1.2 Does this research project involve?
Tick all that apply.
*

- ☑ Direct recruitment and/or observation of human participants
- ☐ Use and/or disclosure of existing data sets and/or archival data
- ☐ Use and/or disclosure of existing biospecimen collections
- ☐ Any form of genetic testing or analysis of genetic material
- ☐ Clinical trial

Review outcome comments for **1 Application Type**

This question is not answered.

Click the green arrow to go to the next page.

2 Potential Participant Group

Does this project involve (a) the direct recruitment of participants that specifically targets, and/or (b) the use of existing data and/or tissue of participants from a project that specifically targeted...

2.1 Women who are pregnant, the human foetus, or human foetal tissue?*
○ Yes ◉ No

2.2 Children or young people under the age of 18 years?*
◉ Yes ○ No

Check that you have assessed and confirmed all investigators on this project comply with relevant working with children requirements prior to contact with children and/or young people taking place.
If you are conducting research that involves a state education site/data, you may also be required to apply for permission from the relevant Department of Education. For research involving department sites and/or data in Queensland refer to Queensland Education Research Inventory (QERI)

2.2.1 Children who are the subject of a child protection order?*
○ Yes ◉ No

2.3 People with a cognitive impairment, an intellectual disability, or a mental illness?*
○ Yes ◉ No

2.4 People considered to be a forensic or involuntary patient?*
○ Yes ◉ No

2.5 People with impaired capacity for communication?* ○ Yes ◉ No

2.6 Prisoners or people on parole? *

○ Yes ◉ No

2.7 People highly dependent on medical care, including a person who is unconscious? *

○ Yes ◉ No

2.8 Military personnel? *

○ Yes ◉ No

2.9 Military veterans? *

○ Yes ◉ No

2.10 People who would not usually be considered vulnerable but would be considered vulnerable in the context of this project? *

○ Yes ◉ No

2.11 Aboriginal and/or Torres Strait Islander peoples? *

○ Yes ◉ No

2.12 Hospital patients? *

○ Yes ◉ No

2.13 People in other countries? *

○ Yes ◉ No

2.14 People who would consider English to be their second language? *

○ Yes ◉ No

Review outcome comments for **2 Potential Participant Group**

This question is not answered.

Click the green arrow to go to the next page.

3 Proposed Procedures

Does this project include...

3.1 Any physical, psychological, social, economic, and/or legal risks greater than inconvenience or discomfort, in either the short or long term, resulting from participation in, or use of data in this project? *

◉ Yes ○ No

3.2 The collection and/or analysis of any biological material obtained from a person (e.g. tissue, blood, urine, sputum, or any derivate of these such as cell lines) in laboratory based research? *

○ Yes ◉ No

3.3 Generating, gathering, collecting, conveying or using genomic data, information, or biological materials (such as germline/germ cells or somatic cells) that has **hereditary implications** and/or **is predictive of future health** in research involving participants, relatives and other family members? *

○ Yes ◉ No

3.4 Research intended to study and/or expose illegal activity? *

○ Yes ◉ No

3.5 Radioactive substances and/or ionising radiation? (e.g. DXA, X-ray) *

○ Yes ◉ No

3.6 Sensitive and/or contentious issues? (e.g. suicide, eating disorders, body image, trauma, violence, abortion, etc.) *

◉ Yes ○ No

3.7 Toxins, mutagens, teratogens or carcinogens? *

○ Yes ◉ No

3.8 Deception of participants, concealment or covert observation? *

○ Yes ◉ No

3.9 Seeking disclosure of information which may be prejudicial to participants? *

○ Yes ◉ No

Review outcome comments for **3 Proposed Procedures**

This question is not answered.

Click the green arrow to go to the next page.

4 Operational Requirements

Does this project involve...

4.1 collection or use of information or data from or about **USQ Students** ?*
○ Yes ◉ No

4.2 collection or use of information or data from or about **USQ Staff** ?*
○ Yes ◉ No

4.3 International travel for data collection purposes? *
○ Yes ◉ No

4.4 Collecting data in a rural and remote setting? *
○ Yes ◉ No

4.5 The collection, use or disclosure of IDENTIFIABLE personal information (eg, names and contact details on consent forms) *
◉ Yes ○ No

4.5.1 Will this IDENTIFIABLE information be collected or used **WITHOUT** the consent or knowledge of the individual whose information is being used? *
○ Yes ◉ No

4.6 The collection, use or disclosure of RE-IDENTIFIABLE personal information (eg, when identifying details are replaced by codes, pseudonyms, etc) *
◉ Yes ○ No

4.6.1 Will this RE-IDENTIFIABLE information be collected or used **WITHOUT** the consent or knowledge of the individual whose information is being used? *
○ Yes ◉ No

4.7 The collection of information by observing participants **WITHOUT** their knowledge? *
○ Yes ◉ No

Review outcome comments for **4 Operational Requirements**

This question is not answered.

Click the green arrow to go to the next page.

Application Detail

5 Project Title and Summary

Researchers are encouraged to read Chapter 3.1 of the National Statement of Ethical Conduct in Human Research, 2007 (updated 2018). A critical feature of good research is clarity regarding how the research project will meet the ethical requirement that research has merit, as described in paragraph 1.1 of the National Statement. **The Elements of Research**, outlined in this chapter, offer advice and guidance about meeting this obligation and will assist you in completing this application across the following sections:
Element 1: Research scope, aims, themes, questions and methods
Element 2: Recruitment
Element 3: Consent
Element 4: Collection, use and management of data and information
Element 5: Communication of research findings or results to participants
Element 6: Dissemination of research outputs and outcomes
Element 7: After the project.

5.1 Project Title*

Evaluation of the Bouncing Back Resiliency Workshop

5.2 Using plain language, provide a succinct description of the background and the potential significance of the research project.*

Beyond Blue defined resilience as "doing well during or after an adverse event, or a period of adversity". In order to become resilient adults, all children need to overcome failure and disappointment, manage conflict and fractured relationships, and deal with the multiple pressures of growing up. The knowledge and skills that lead to resilience create a firm foundation upon which to build solid mental health strategies as children mature. It is fair to surmise that the ability to overcome adversity in the early years will affect academic, social and employment outcomes. In 2020, the Australian Government Department of Health outlined five priority areas in the National Action Plan for the Health of Children and Young People; one of which is to "tackle mental health and risky behaviours". One of the actions under this priority area includes building resilience in children aged 8-14.
While changes in some elements of resilience are resulting from some existing resilience programs, The Bouncing Back Resiliency Workshop could be the first evidence based resiliency program to date that is informed by the Beyond Blue Building Resilience in Children Aged 0-12: A Practice Guide. It will uniquely incorporate a focus on autonomy, responsibility and risk-taking. Additionally, using a psychometric measure developed specifically for resiliency and exploring the relationship between parental engagement and changes in resilience will add important information to an existing pool of knowledge, allowing others to build upon the work. In understanding more about the factors that affect resilience and resilience programs, the Australian community moves closer to teaching our children skills and attributes that will be protective against adversity.

5.3 Clearly state (a) the project aims; and (b) the research questions and/or hypotheses.*

While the importance of resilience in overcoming adversity has been well documented, it is not yet understood how resilience is best taught. The Bouncing Back Resiliency Workshop in primary schools is an evidence based, universal intervention aimed at increasing resilience. The Bouncing Back Resiliency Workshop was developed by University of Southern Queensland (USQ) staff member and Clinical Psychologist Ms. Jean McCausland-Green and is informed by the Children's Resilience Research Project. It has been delivered by USQ Psychology Masters students in Mount Crosby State School in Karana Downs, Brisbane for 7 years.
The proposed research project aims to answer the following research questions:
Does the Bouncing Back Workshop engage children in the key areas that determine the building of resilience as outlined in the Children's Resilience Research Project?
Does the Bouncing Back Project improve children's resilience in the context of school settings as measured by the Resiliency Scales for Childrenand Adolescents from pre- to post-program and at 6 week follow-up*?
Does the Bouncing Back Project decrease behavioural and emotional problems in children as reported by parents and teachers and measured by the Child Behaviour Checklist from pre- to post-program and at 6 week follow-up*?
Does parent engagement with a 1 hour workshop and weekly information improve changes in child resilience?
How do children, parents and teachers perceive the validity of the workshop as reported on the feedback form? *Follow-up data collected only if time permits

Review outcome comments for **5 Project Title and Summary**.

This question is not answered.

Click the green arrow to go to the next page.

6 Investigators

6.1 Enter the Academic Organisation Unit (AOU) (six-digit project code) that will be aligned to this project.

Search for the AOU by entering a portion of your school or centre (e.g. eng, health, psy, edu, sci) in the text box, then clicking on the magnifying glass. Choose the appropriate AOU code from the list returned and tab out of the text box. Attempt to select AOU that reflect school-level units rather than broader faculty-level units.

If the Principal Investigator for this project is NOT affiliated with the University of Southern Queensland, enter "EXTERNAL".*

Psychology & Counselling

6.2 Principal Investigator

The Principal Investigator (PI) of this project will hold ultimate responsibility for the ethical conduct of the research project in accordance with the University's Research Code of Conduct Policy, The Australian Code for the Responsible Conduct of Research, 2018,and the National Statement on Ethical Conduct in Human Research, 2007 (updated 2018).

The PI must ensure that all investigators involved in the conduct of this research project understand and accept their roles and responsibilities.

To complete this section...

Click on the hyperlinked investigator's name and complete all required fields (indicated with *). Ensure the "Primary Contact" is checked to "Yes". Click on "OK".

1	Order	1
	RIMS Code	0000189444
	Position	Principal Investigator
	Title	Mrs
	First Name	Jessica
	Last Name	Swann

	Full Name	Mrs Jessica Beth Swann
	Student Researcher?	Yes
	Primary Investigator?	Yes
	Primary Contact?	Yes
	ORCID ID (if known)	
	Email Address	W0107739@umail.usq.edu.au
	Secondary Email	
	Mailing Address Address Line 1	
	Address Line 2	
	Address Line 3	
	Address Line 4	
	Suburb/City	
	State	
	Postal Code	
	Country	Australia
	Contact Phone	
	Mobile Phone	

6.3 Other Investigators
List all investigators associated with this project and their role (including supervisors of student research projects).

To complete this section...
Enter the investigator's first name in the text box and click on the magnifying glass. Choose the correct investigator from the list returned. Repeat this step to add all investigators.
For each investigator listed, click on the hyperlinked investigator's name and complete all required fields (indicated with *). Ensure the "Student Researcher" question has been answered and that the Primary Contact is checked to "No".
Click on OK.
To add an External Collaborator, click on the "Add External Person" button and complete all required fields (indicated with *) and OK.

1	Order	1
	RIMS Code	0000163923
	Position	Co-Investigator
	Title	Associate Professor
	First Name	Gavin
	Last Name	Beccaria
	Full Name	A/Pr Gavin Beccaria
	Student Researcher?	No
	Primary Contact?	No
	Person Type	Internal
	ORCID ID (if known)	https://orcid.org/0000-0002-4341-804X
	Email Address	Gavin.Beccaria@usq.edu.au
	Secondary Email	

	Mailing Address Address Line 1	School of Psychology & Counselling
	Address Line 2	University of Southern Queensland
	Address Line 3	
	Address Line 4	
	Suburb/City	Toowoomba
	State	QLD
	Postal Code	4350
	Country	Afghanistan
	Contact Phone	+61 7 4631 2382
	Mobile Phone	+61 414 580 531
2	Order	2
	RIMS Code	0000169762
	Position	Co-Investigator
	Title	Mrs
	First Name	Jean
	Last Name	McCausland-Green
	Full Name	Mrs Jean McCausland-Green
	Student Researcher?	No
	Primary Contact?	No
	Person Type	Internal
	ORCID ID (if known)	
	Email Address	Jean.McCausland-Green@usq.edu.au
	Secondary Email	
	Mailing Address Address Line 1	Faculty of Health, Engineering and Sciences
	Address Line 2	University of Southern Queensland
	Address Line 3	11 Salisbury Road
	Address Line 4	
	Suburb/City	Ipswich
	State	QLD
	Postal Code	4305
	Country	Australia
	Contact Phone	+61 7 3812 6183
	Mobile Phone	

Review outcome comments for **6 Investigators**.

This question is not answered.

Click the green arrow to go to the next page.

7 Benefit and Risk

7.1 Outline the benefits to participants and/or to the community as a result of this research being conducted. *

Teaching resilience universally (and not just to clinical populations) is a preventative strategy to build skills that will help children combat every day adversity as well as complex personal and family issues. Though changes on resilience scales have been scarce in recent research, positive effects have been seen in factors that would indicate that children are doing well. Positive increases have been reported in coping strategies, selfcompassion, challenging unhelpful thinking, social skills, self-efficacy, help-seeking, quality of life, well-being and resilience associated with the acculturation process. Additionally, some studies reported decreasing symptoms of anxiety and depression.
The aim of the Bouncing Back Resiliency Workshop is that children build and strengthen supportive relationships, build autonomy and responsibility, and learn to manage emotions. Parents are invited to participate in a 1 hour workshop to inform them about the program and how to support resilience building at home. Parents and teachers also receive weekly information about what was covered in the workshop that week and how they can reinforce that learning at home and in the classroom. Parents and teachers could also benefit from practicing some of the strategies taught to the children. The Workshop has been delivered by provisional psychologists (USQ Psychology Masters students) at Mount
Crosby State School for 7 years, with staff and parents reporting benefits for the children that have participated.
As we continue to build upon our understanding of how resilience is taught, the wider public will benefit from a generation of students that learned evidence-based strategies of psychological well-being that will translate into any environment and circumstance. This psychological wellbeing will impact all areas of life including relationships, education, and the way that individuals engage with their communities.

7.2 Define the risks, in either the short and/or long term, of participation in this project
(e.g. physical, psychological, social, economic or legal risks greater than inconvenience or discomfort)*

There is a psychological risk that participants may become distressed during data collection. There is also a psychological risk that participants may be distressed if, in accordance with Queensland Government Guidelines for Conducting Research, researchers report to the school principal that a student participant would benefit from follow-up support, or that there are concerns regarding the mental health or safety of a child.

7.3 Are all of these risks outlined in the Participant Information Sheet or within the explanatory statement at the beginning of a data collection instrument, and (where relevant) on the consent form?*

◉ Yes ○ No

7.4 Outline the arrangements planned to minimise the risks involved in this project.*

These risks will be minimised by advising participants of the risks on the information/consent forms and by providing information for crisis counselling with Lifeline or Kids Helpline. Contact information for the research team is also provided on the information/consent forms.
Two members of the research team are Clinical Psychologists. The workshop will be delivered within the school and the students will remain the primary responsibility of the school. The workshop will be delivered by USQ psychology Masters students (Provisional Psychologists). All workshop facilitators will be required to have a BlueCard. They will also undergo induction training including a review of the relevant sections of the APS code of ethics, Ethical Research Involving Children, and the Department of Education's Student Protection Guidelines. They will undergo a 'what if' scenario to increase their confidence in reporting any child safety concerns to the school principal. An application for Permission to Approach has been made to QLD Education.

7.5 What will you do in cases where unexpected events or emergencies occur as a result of participation in this project?
For example, what facilities or services are available to deal with events such as adverse drug reaction, revelation of child abuse, illegal activities, participant becomes distressed during or after data collection.*

Risks will be minimised by advising participants of the risks and providing contact information for Lifeline, Kids Help Line, and the research team on the information/consent form. If a participant becomes distressed during or after data collection, they can contact those crisis lines, a member of the research team, and/or the school. In accordance with Queensland Government Guidelines for Conducting Research, researchers will report to the school principal if any student participant would benefit from follow-up support, if there are any concerns regarding the mental health or safety of a child, or if a participant is engaging in or intending to engage in criminal activity. In this instance, support will be provided by the school and/or by a member of the research team with suitable qualifications.

7.6 Is an appropriate list of referral services available within the Participant Information Sheet or explanatory statement?*

◉ Yes ○ No ○ Not applicable

7.6.1 Outline the referral services that you will include in the Participant Information Sheet or explanatory statement.*

Adult information/consent forms will have contact information for Lifeline and child information/consent forms will have contact information for Kids Help Line.

7.7 Outline the strategies that you have in place to reduce any risks to the researchers.*

Workshop facilitators will undergo induction training including a review of the relevant sections of the APS code of ethics, Ethical Research Involving Children, and the Department of Education's Student Protection Guidelines. They will undergo a 'what if' scenario to increase their confidence in reporting any child safety concerns to the school principal. In the case that facilitators or the student researcher uncovers information of a distressing nature, they will have access to support from a suitably qualified member of the supervisory team.

Review outcome comments for **7 Benefit and Risk**.

This question is not answered.

Click the green arrow to go to the next page.

8 Type of Research

Type of research - 1

8.1 Are you, as the Principal Investigator, a current USQ employee or student?*

◉ Yes ○ No

8.1.1 Will this project be undertaken **predominately** in a student capacity?*

◉ Yes ○ No

8.1.1.1 Program level:*

- ○ Honours
- ◉ Masters
- ○ Doctoral
- ○ Other

8.1.1.2 Program name:*

Master of Science Research (Psychology)

8.1.2 Will this project be undertaken as a **USQ Course project**?*

○ Yes ◉ No

8.2

Type of research - 2
Tick all that apply. *

- ☐ Action research
- ☑ Clinical research
- ☐ Qualitative
- ☐ Social science
- ☐ Other
- ☐ Epidemiological
- ☑ Mental health
- ☐ Public health and safety
- ☑ Quantitative
- ☐ Case study
- ☐ Clinical trial / use of drug or therapeutic device
- ☐ Medical research
- ☐ Oral history / biographical

Review outcome comments for **8 *Type of Research***

This question is not answered.

Click the green arrow to go to the next page.

9 Conflict of Interest

9.1 Do any of the investigators on this project have an actual, perceived, or potential personal or financial conflict of interest in the outcomes of this research, or in any of the organisations involved with, or funding this project?*

◉ Yes ○ No

9.1.1 Identify the investigator/s and the actual, perceived, or potential conflict of interest. Outline what measures have been implemented to reduce the possibility of coercion for participation in this research.*

Ms Jean McCausland-Green designed the workshop, so may have a conflict of interest in the outcomes of this research. However, in discussions with the team, Ms McCausland-Green has expressed her desire to see genuine outcomes in this research, has been open to suggestions for improving the workshop, and has not expressed inappropriate personal ambition around expanding the program.

Review outcome comments for **9 Conflict of Interest**.

This question is not answered.

Click the green arrow to go to the next page.

10 Funding

10.1 Has funding been obtained for this project? *

○ Yes ◉ No

10.1.1 Are you applying for funding for this project? *

○ Yes ◉ No

Review outcome comments for **10 Funding**.

This question is not answered.

Click the green arrow to go to the next page.

11 Data Access and Security

11.1 Outline the minimum recommended Research Data storage options (i.e. 1 x primary and 2 x back-up) that you will utilise for the duration of your research project and beyond. Refer to the University's Research Data Management Policy and Research Data Management Procedure to ensure your proposed practice is suitable.*

1 x primary and 2 x back-up
OneDrive
CloudStor
SharePoint

11.2 Will any individual or organisation external to the University of Southern Queensland (i.e. a third party) have access to the Research Data during the conduct of this research?*

○ Yes ◉ No

11.3 Do you plan to make available (or share) all, or part, of the Research Data via open access, restricted access, mediated access or as metadata only?
Note: It is recommended that unless your data can not be shared for ethical, privacy or confidentiality matters, that you incorporate the future use of data in your research design and include a statement within the participant information sheet/explanatory statement to this effect.*

○ Yes ◉ No

11.3.2 Outline the ethical reason/s for why the research data will not be shared or made openly or publicly available. **
As hardcopy data is identifiable and relating to a vulnerable population, data will not be shared or made openly or publicly avaiable.
This work will not be publicly disseminated as it is preparatory for future research around the workshop. Ms Jean McCausland-Green will have access to the findings, which will indicate whether further study of the workshop should be undertaken.

11.4 Are the data access and security arrangements detailed in the Participant Information Sheet or explanatory statement?*

◉ Yes ○ No

11.5 Will the Research Data be securely retained indefinitely for future use?*

○ Yes ◉ No

11.5.2 Outline the process of how the research data will be confidentially disposed a fter the minimum retention period has elapsed.
Note: Different Research Data items may be required to be retained for different retention periods, e.g. general research data versus signed informed consent documentation. Refer to the Queensland Government General Retention and Disposal Schedule (GRDS) for further information.*
Hardcopy and electronic records will be stored for at least 15 years after the last child has turned 18. At all times, records will be securely disposed of at the advice of USQ's ICT team and in accordance with the relevant USQ record management policy.

Review outcome comments for **11 Data Access and Security**.

This question is not answered.

Click the green arrow to go to the next page.

12 Communication of Research Findings to Participants and Dissemination of Project Outputs

12.1 Indicate in which format/s the research findings will be communicated to participants and research outputs disseminated
Tick all that apply.*

- ☑ Thesis
- ☐ Journal article
- ☐ Book / book chapter
- ☐ Conference
- ☐ Dataset
- ☑ Reports to participants
- ☑ Report to organisation
- ☐ Report to community or group
- ☐ Other

12.2 How will the identity of participants be disclosed in the dissemination of research outputs?*

- ☐ non-identifiable data
- ☑ re-identifiable data
- ☐ individually identifiable data
- ☐ other

12.3 Describe how participants and/or other interested stakeholders will be able to access the research findings and/or request a copy of a summary of the results **Note:** Provision of a theses/dissertation/exegesis to a participant is not considered to be timely and appropriate summary of the research findings or results. *

In accordance with the Queensland Government Terms and Conditions for Conducting Research, the Department of Education will be given a summary of the research findings at the conclusion of the research. Additionally, participants and departmental heads will be informed on the information/consent forms that they may request an email summarising the findings of the research upon its completion.

12.4 Will participants be subjected to any physiological or psychological testing during this project? *

◉ Yes ○ No

12.4.1 How will information about the results be communicated to participants and/or their parents or guardians?*

- ☐ non-identifiable data
- ☐ re-identifiable data
- ☑ individually identifiable data
- ☐ other

12.4.2 What arrangements will be in place to deal with participant's distress in the case of adverse test result?*

In accordance with Queensland Government Guidelines for Conducting Research, researchers will report to the school principal if any student participant would benefit from follow-up support, if there are any concerns regarding the mental health or safety of a child, or if a participant is engaging in or intending to engage in criminal activity. The participant will receive support from the school in collaboration with a suitably qualified member of the research team. Additionally, contact information for a suitably qualified member of the research team will be made available in the information/consent form.

Review outcome comments for **12 Communication of Research Outcomes**.

This question is not answered.

Click the green arrow to go to the next page.

No. of Human Participant Groups

Participant Group Recruitment

PG - How many groups of participants will you be recruiting and/or observing for this research project?*

3.00

This question is asking you to think about how many groups of participants you are likely to recruit as part of this project. The method of participant recruitment and how they will provide consent may change depending on the participant's age and how you propose to conduct that part of the project. For example:

- If you are conducting an online survey, followed by interviews with some of the survey participants, it is likely that you will recruit "2" groups. This will be the "survey group" and the "interview group".
- If you are conducting multiple focus groups with the same focus group questions, it is likely that you will recruit "1" group, but offer the same content multiple times. This can be conveyed in the next section.
- If you are conducting interviews with different groups, for example, students, teachers and school principals, then it is likely that you will recruit "3" groups.

The number of groups of participants you enter here will provide specific questions in the next section relevant to that group. That is, Group 1 = G1, Group 2 = G2, Group 3 = G3, and so on.
Sufficient space has been provided for up to **five** participant groups. If you propose to use more than five participant groups in your research, contact the Ethics Officer for further advice.

Review outcome comments for **Participant Group Recruitment**.

This question is not answered.

Click the green arrow to go to the next page.

Group 1 - Participant Recruitment and/or Observation

G1 - Participant Overview

PG1.1 Participant group 1 working title. (e.g. student focus group; teacher survey)*

Student workshop participants

PG1.2 How many participants are expected to be recruited in this group?*

34.00

PG1.3 Describe who the participants in this group are.*

Primary school aged students between 9 to 12 years of age.

PG1.4 Where will this group of participants be recruited from?*

One state primary school within Queensland.

PG1.5 Are the participants in this group likely to be under 18 years of age?*

◉ Yes ○ No

You may need to obtain a Working with Children Check (Blue Card).

PG1.5.1 Will you seek consent from a parent or legal guardian for the research team to approach their child and ascertain if he/she wishes to participate in the project?*

◉ Yes ○ No

PG1.5.1.1 Outline how you will obtain parental consent.*

Through a permission form.

PG1.5.2 Will you seek assent from a child and/or young person to ask if he/she wishes to participate in the project?*

◉ Yes ○ No

PG1.5.2.1 Outline how you will obtain assent from the child and/or young person to participate in this research.*

Through a child assent form.

PG1.6 Is there a pre-existing (unequal) relationship between the participants and anyone involved in recruiting and/or collecting data from this group of participants? (e.g. teachers and/or lecturers/students, doctors/patients, employers/employees, etc.) *

◉ Yes ○ No

PG1.6.1 Describe the nature of the pre-existing relationship and whom this involves.*

Teachers will be collecting data from the students.

PG1.6.2 Outline what special precautions have been implemented to preserve the rights of those participants who decline to take part or withdraw from the research once the project has begun.*

The child information/consent form says, "Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. If you do not wish to take part, you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected about you be withdrawn and confidentially destroyed before the data has been analysed. You will be unable to withdraw data collected about yourself after the data has been analysed. If you do wish to withdraw from this project or withdraw data collected about yourself, please contact the Research Team (contact details at the top of this form).
Your decision whether you take part, do not take part, or take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland or Mount Crosby State School or affect your grades."
The parental information sheet says, "Your childż participation in this project is entirely voluntary. If you do not wish for the research team to talk to your child, you are not obliged to grant permission. Your child is not obliged to take part if they do not wish to. If your child decides to take part and later changes their mind, they are free to withdraw from the project at any stage. Your child may also request that any data collected about them be withdrawn and confidentially destroyed before the data has been analysed. Your child will be unable to withdraw data collected about themselves after the data has been analysed. If your child does wish to withdraw from this project or withdraw data collected about themselves, please contact the Research Team (contact details at the top of this form). Your child's decision whether they take part, do not take part, or take part and then withdraw, will in no way impact their current or future relationship with the University of Southern Queensland or Mount Crosby State School."

PG1.7 Do these participants have any cultural needs? (e.g., specific consent arrangements or sensitivites, etc.)*

○ Yes ◉ No

Review outcome comments for **G1 - Participant Overview**

This question is not answered.

Click the green arrow to go to the next page.

G1 - Recruitment Method

PG1.8 Do you have any criteria for the selection, inclusion or exclusion of participants for this group to take part in the research? (e.g. minimum age requirements)*

◉ Yes ○ No

PG1.8.1 Describe the criteria for selection, inclusion or exclusion and outline why you require this for your research design.*

Participants will be 9 to 12 years of age. The lower range of age was chosen to fit the validity of the resilience measure chosen. The upper range of age was chosen to fit with primary school years. Parents and teachers will be the parents and teachers of the students.

PG1.9 Indicate which method/s you will use to recruit these participants:*

- [ ] Email
- [x] Personal contacts
- [ ] Telephone
- [ ] Advertisement
- [ ] Mail out
- [ ] Snowballing
- [ ] Participants from another study
- [ ] Participants approached in person by research team
- [ ] Participants will NOT be actively recruited - they will be observed without their knowledge
- [ ] Other

PG1.10 Indicate how you will obtain the contact details of these participants.*

- [x] From the participants themselves
- [ ] From a public domain source
- [ ] From a private or third party source
- [ ] Other

PG1.11 Explain who will invite these participants to be involved in this project.*

The principal of the school will select the class/es that will be invited to participate. The teachers of those class/es will send information/consent and permission forms home to parents with the children.

PG1.12 Will you be offering payment or any other incentives to this group of participants?*

○ Yes ◉ No

Review outcome comments for **G1 - Recruitment Method**

This question is not answered.

Click the green arrow to go to the next page.

G1 - Data Collection Methods

PG1.13 Will you collect data via questionnaires / surveys?*

◉ Yes ○ No

PG1.13.1 For each **questionnaire / survey** that will be administered to this group of participants, provide details about the name and purpose of the instrument, how the instrument will be administered (e.g., paper based, online), and how it will be returned.
Attach a copy of your survey instrument in the document upload section.*

The Resiliency Scales for Children and Adolescents measures children's resilience in the context of school settings. It will be administered to children on paper and returned directly to the research team by the teacher/s.
Feedback forms will be administered to children on paper and returned directly to the research team by the teacher/s.

PG1.14 Will you collect data via interviews or focus groups?*

○ Yes ◉ No

PG1.15 Will you collect data via observation?*

○ Yes ◉ No

PG1.16 Will you collect data via photography / videography?* ○ Yes ◉ No

PG1.17 Will you collect data via psychological inventories or any other published, standardised test?*

◉ Yes ○ No

PG1.17.1 Outline who will be involved in the administration of the psychological inventory, published, or standardised test and their qualifications to undertake this work.*

The standardised tests used for this research are all self-administered. Contact details for qualified members (Clinical Psychologists) of the research team will be provided on the information/consent forms if participants have any questions.

PG1.17.2 For each **psychological inventory, published or standardised test** that will be administered to this group of participants, provide details about the name and purpose of the instrument, how the instrument will be administered (e.g., paper based, online), and how it will be returned.
Confirm that you have (or will) meet copyright requirements for the use of the inventory and/or test prior to use.
Attach a copy of the psychological inventories, published, or standardised test in the document upload section if copyright permits OR include a sample of selected items to inform the USQ HREC of the nature of the questions and/or tasks that a participant will be expected to respond to.*

The Resiliency Scales for Children and Adolescents measures children's resilience in the context of school settings. It will be administered to children on paper and returned directly to the research team by the teacher/s. All copyright requirements for the use of the tests will be met.

PG1.18 Will you collect data via collection of human biospecimens? *

○ Yes ◉ No

PG1.19 Will you collect data via responses to tasks, stimuli or simulations? *

○ Yes ◉ No

PG1.20 Will you collect data via administration of a substance? *

○ Yes ◉ No

PG1.21 Will you collect data via any other procedure not outlined above? *

○ Yes ◉ No

Review outcome comments for **G1 - Data Collection Methods**.

This question is not answered.

Click the green arrow to go to the next page.

G1 - Data Collection Procedure and Competence

PG1.23 Provide details about what you are asking participants in this group to do or what is to be done to them. Include a step-by-step description of what participants will experience if they choose to take part in this project.*

Information/consent and permission forms given to teachers and sent home to parents and students.
The Bouncing Back Resiliency Workshop will be delivered by USQ Psychology Masters students at Mount Crosby State School in Karana Downs. This will be delivered in 60-minute sessions, within the school, once per week, for 6 weeks. Each week, handouts will be made available for parents and teachers including information on what was presented during that week's session, what the students were taking home from the session, what would be covered in next week's session and ideas for home/classroom practice.
The Resiliency Scales for Children and Adolescents will be completed by the children pre- and post-program and at 6 week follow up (if time permits). A feedback form will be completed by children post-program.

PG1.24 How much time are you asking of participants in this group and when will this time be required? (e.g. 30 minutes after class).*

6hrs 45 min during school time

PG1.25 Where will the data be collected (venue and geographical location)? (e.g. front of 'venue')*

The classrooms of the participants.

PG1.26 Does the research involve the administration of any tests or procedures that require particular qualifications?*

◉ Yes ○ No

PG1.26.1 Provide details of the tests or procedures, the qualifications required, the proposed administrator and their qualifications and experience with this technique.*

The Resiliency Scales for Children and Adolescents (RSCA) is a valid and reliable psychometric measure which assesses resiliency and vulnerability. The RSCA is a 64-item Likert-type measure used to assess resiliency in the context of school settings. Items on the rating scale refer to factors contributing to resilience, including, "If I have a problem, I can solve it". Items are written at a Canadian third-grade reading level. The items are rated on a 5-point rating scale ranging from 0 to 4 and indicate: never, rarely, sometimes, often, and almost always.
The items form 10 subscales that contribute to three global scales: Sense of Mastery, Sense of Relatedness, and Emotional Reactivity. Scores are summed to give a total raw score with a range from 0-80, 0-96, and 0-80 respectively. In Sense of Mastery and Sense of Relatedness, higher scores indicate resilience and lower scores indicate vulnerability; whereas, in Emotional Reactivity, lower scores indicate resilience and higher scores indicate vulnerability.
The RSCA is self-administered with the support of a psychologist if required. Contact details for the research team are provided on the information/consent forms.
The research team: Gavin Beccaria is an experienced Clinical Psychologist and Associate Professor at the School of Counselling and Psychology at USQ, Toowoomba. Jean McCausland-Green is an experienced Clinical Psychologist and the Clinic Director at the School of Counselling and Psychology at USQ, Ipswich. Jessica Swann is a USQ graduate of Bachelor of Science (Psychology) and current USQ student of Master of Science Research (Psychology).

PG1.27 Does the research involve measures or procedures that are **diagnostic** or **indicative** of any **medical** or **clinical** condition, or any other situation of concern? (e.g. anaemia, bulimia, anorexia, anxiety, suicidal tendencies, aggressive behaviours, etc.)*

◉ Yes ○ No

PG1.27.1 Describe the criteria you will use to assess when participants in your research have results indicating that they or others are 'at risk'.*

The Resiliency Scales for Children and Adolescents is a valid and reliable psychometric measure which assesses resiliency and vulnerability. Cut off scores indicate whether a child would benefit from further intervention to build resiliency.
The Child Behavior Checklist and Teacher's Report Form (see groups 2 and 3) are also valid and reliable psychometric measures assessing total, internalising, and externalising problems. Cut off scores indicate if a child is at risk of an externalising or internalising disorder.

PG1.27.2 Outline how you will deal with your duty of care to participants in your research identified as 'at risk'.*

If a participant is identified as 'at risk', it will be reported to the school principal, who will follow the Queensland Department of Education procedures, including informing parents and providing support. Qualified members of the research team will work with the principal and participants to ensure the welfare of participants.

PG1.27.3 Have you acquired the necessary competence to administer, score and interpret the proposed measures and procedures, with the type of participants that will be involved in this research?*

◉ Yes ○ No

PG1.27.4 Will you indicate the procedure proposed above to potential participants in your Participant Information Sheet? *

◉ Yes ○ No

Review outcome comments for **G1 - Data Collection Procedure and Competence**

This question is not answered.

Click the green arrow to go to the next page.

G1 - Consent Method

PG1.28 Are these participants able to consent for themselves?*

○ Yes ◉ No

PG1.28.1 Outline how you intend to obtain informed consent and from whom.*

Informed consent from child participants will be obtained from their parents/caregivers.

PG1.29 Will you use a written Participant Information Sheet or Explanatory Statement to inform participants about this project?*

◉ Yes ○ No

PG1.30 Will these participants be fully informed about the true nature of the research?*

◉ Yes ○ No

PG1.31 Indicate how you will obtain consent from this group of participants.*

- ○ Implied consent
- ◉ Consent form (must be attached with this application)
- ○ Opt-out consent
- ○ Other

Consent may be expressed in a number of ways. **A signed consent form** has traditionally been the accepted method of documenting a participant's consent to participate in a research project. Where used, information about the research project is generally presented in a participant information sheet, explanatory statement, or similar document that a participant retains. The process of communicating information to participants and seeking their consent should not be merely a matter of satisfying a formal requirement. The aim is mutual understanding between researchers and participants. This aim requires an opportunity for participants to ask questions and to discuss the information and their decisions with others if they wish.

PG1.31.2 Outline the process by which the participants will give consent and how they return the consent form to the researchers.*

Participants will be given an information/consent form and permission forms, which will be returned directly to the research team by the teacher/s. Children will have the opportunity to ask questions throughout the workshop. Contact information for the research team will be supplied on the information/consent form if the participants have any further questions.

Review outcome comments for **G1 - Consent Method**.

This question is not answered.

Click the green arrow to go to the next page.

Group 2 - Participant Recruitment and/or Observation

G2 - Participant Overview

PG2.1 Participant group 2 working title. (e.g. student focus group; teacher survey)*

Parents of children

PG2.2 How many participants are expected to be recruited in this group?*

34.00

PG2.3 Describe who the participants in this group are.*

Parents of the children participating in the Bouncing Back Resiliency Workshop

PG2.4 Where will this group of participants be recruited from?*

Through the student participants from a state school in Queensland

PG2.5 Are the participants in this group likely to be under 18 years of age?*

○ Yes ◉ No

PG2.6 Is there a pre-existing (unequal) relationship between the participants and anyone involved in recruiting and/or collecting data from this group of participants? (e.g. teachers and/or lecturers/students, doctors/patients, employers/employees, etc.) *

◉ Yes ○ No

PG2.6.1 Describe the nature of the pre-existing relationship and whom this involves.*

Parents will have existing relationships with their child's teachers.

PG2.6.2 Outline what special precautions have been implemented to preserve the rights of those participants who decline to take part or withdraw from the research once the project has begun.*

The parent consent form says, "Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. If you do not wish to take part, you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected about you be withdrawn and confidentially destroyed before the data has been analysed. You will be unable to withdraw data collected about yourself after the data has been analysed. If you do wish to withdraw from this project or withdraw data collected about yourself, please contact the Research Team (contact details at the top of this form). Your decision whether you take part, do not take part, or take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland or Mount Crosby State School. "

PG2.7 Do these participants have any cultural needs? (e.g., specific consent arrangements or sensitivites, etc.)*

○ Yes ◉ No

Review outcome comments for **G2 - Participant Overview**

This question is not answered.

Click the green arrow to go to the next page.

G2 - Recruitment Method

PG2.8 Do you have any criteria for the selection, inclusion or exclusion of participants for this group to take part in the research? (e.g. minimum age requirements)*

◉ Yes ○ No

PG2.8.1 Describe the criteria for selection, inclusion or exclusion and outline why you require this for your research design.*

Participants will be 9 to 12 years of age. The lower range of age was chosen to fit the validity of the resilience measure chosen. The upper range of age was chosen to fit with primary school years. Parents will be the parents of the students.

PG2.9 Indicate which method/s you will use to recruit these participants:*

- ☐ Email
- ☑ Personal contacts
- ☐ Telephone
- ☐ Advertisement
- ☐ Mail out
- ☐ Snowballing
- ☐ Participants from another study
- ☐ Participants approached in person by research team
- ☐ Participants will NOT be actively recruited - they will be observed without their knowledge
- ☐ Other

PG2.10 Indicate how you will obtain the contact details of these participants.*

- ☑ From the participants themselves
- ☐ From a public domain source
- ☐ From a private or third party source
- ☐ Other

PG2.11 Explain who will invite these participants to be involved in this project.*

The principal of the school will select the class/es that will be invited to participate. The teachers of those class/es will send information/consent and permission forms home to parents with the children.

PG2.12 Will you be offering payment or any other incentives to this group of participants?*

○ Yes ◉ No

Review outcome comments for **G2 - Recruitment Method**

This question is not answered.

Click the green arrow to go to the next page.

G2 - Data Collection Methods

PG2.13 Will you collect data via questionnaires / surveys?*

(●) Yes ( ) No

PG2.13.1 For each **questionnaire / survey** that will be administered to this group of participants, provide details about the name and purpose of the instrument, how the instrument will be administered (e.g., paper based, online), and how it will be returned.
Attach a copy of your survey instrument in the document upload section.*

The Child Behavior Checklist measures behavioural and emotional problems in children and the feedback form will indicate parental engagement. They will be administered to parents on paper and returned to teachers in a sealed envelope marked 'private and confidential' and with the contact details for the research team on it. They will be then be returned directly to the research team by the teacher/s.

PG2.14 Will you collect data via interviews or focus groups?*

( ) Yes (●) No

PG2.15 Will you collect data via observation?*

( ) Yes (●) No

PG2.16 Will you collect data via photography / videography?* ( ) Yes (●) No

PG2.17 Will you collect data via psychological inventories or any other published, standardised test?*

(●) Yes ( ) No

PG2.17.1 Outline who will be involved in the administration of the psychological inventory, published, or standardised test and their qualifications to undertake this work.*

The standardised tests used for this research are all self-administered. Contact details for qualified members (Clinical Psychologists) of the research team will be provided on the information/consent forms if participants have any questions.

PG2.17.2 For each **psychological inventory, published or standardised test** that will be administered to this group of participants, provide details about the name and purpose of the instrument, how the instrument will be administered (e.g., paper based, online), and how it will be returned.
Confirm that you have (or will) meet copyright requirements for the use of the inventory and/or test prior to use.
Attach a copy of the psychological inventories, published, or standardised test in the document upload section if copyright permits OR include a sample of selected items to inform the USQ HREC of the nature of the questions and/or tasks that a participant will be expected to respond to.*

The Child Behavior Checklist measures behavioural and emotional problems in children. It will be administered to parents on paper and returned to teachers in a sealed envelope marked 'private and confidential' and with the contact details for the research team on it. They will be then be returned directly to the research team by the teacher/s.

PG2.18 Will you collect data via collection of human biospecimens? *

( ) Yes (●) No

PG2.19 Will you collect data via responses to tasks, stimuli or simulations? *

( ) Yes (●) No

PG2.20 Will you collect data via administration of a substance? *

( ) Yes (●) No

PG2.21 Will you collect data via any other procedure not outlined above? *

( ) Yes (●) No

Review outcome comments for **G2 - Data Collection Methods**.

This question is not answered.

Click the green arrow to go to the next page.

G2 - Data Collection Procedure and Competence

PG2.23 Provide details about what you are asking participants in this group to do or what is to be done to them. Include a step-by-step description of what participants will experience if they choose to take part in this project.*

Information/consent and permission forms for parents.
With the consent forms, parents will receive an invite to participate in a 1-hour information session delivered by Ms McCausland-Green where parents will learn about the program and be given the opportunity to ask questions. They will also learn about resilience and how to teach resilience to their children. The Child Behavior Checklist will be completed by the parents pre-and post-program and at 6 week follow up (if time permits). A feedback form will be completed by parents post-program.

PG2.24 How much time are you asking of participants in this group and when will this time be required? (e.g. 30 minutes after class).*

1hr 45min during personal time

PG2.25 Where will the data be collected (venue and geographical location)? (e.g. front of 'venue')*

The classrooms of the child participants.

PG2.26 Does the research involve the administration of any tests or procedures that require particular qualifications?*

◉ Yes ○ No

PG2.26.1 Provide details of the tests or procedures, the qualifications required, the proposed administrator and their qualifications and experience with this technique.*

The Child Behavior Checklist (CBCL) is from the Achenback System of Empirically Based Assessment and is a valid and reliable psychometric measure assessing total, internalising, and externalising problems. There are 118 items on the rating scale which refer to factors contributing to problems, including, "acts too young for his/her age". The items are rated on a 3-point rating scale ranging from 0 to 2 and indicate: not true (as far as you know), somewhat or sometimes true, and very true or often true. The CBCL is scored using a specialised computer program. The CBCL is self-administered with the support of a psychologist if required. Contact details for the research team are provided on the information/consent forms. The research team: Gavin Beccaria is an experienced Clinical Psychologist and Associate Professor at the School of Counselling and Psychology at USQ, Toowoomba. Jean McCausland-Green is an experienced Clinical Psychologist and the Clinic Director at the School of Counselling and Psychology at USQ, Ipswich. Jessica Swann is a USQ graduate of Bachelor of Science (Psychology) and current USQ student of Master of Science Research (Psychology).

PG2.27 Does the research involve measures or procedures that are **diagnostic** or **indicative** of any **medical** or **clinical** condition, or any other situation of concern? (e.g. anaemia, bulimia, anorexia, anxiety, suicidal tendencies, aggressive behaviours, etc.)*

◉ Yes ○ No

PG2.27.1 Describe the criteria you will use to assess when participants in your research have results indicating that they or others are 'at risk'.*

The Child Behavior Checklist is a valid and reliable psychometric measure assessing total, internalising, and externalising problems. Cut off scores indicate if a child is at risk of an externalising or internalising disorder.

PG2.27.2 Outline how you will deal with your duty of care to participants in your research identified as 'at risk'.*

If a participant is identified as 'at risk', it will be reported to the school principal, who will follow the Queensland Department of Education procedures, including informing parents and providing support. Qualified members of the research team will work with the principal and participants to ensure the welfare of participants.

27.3 Have you acquired the necessary competence to administer, score and interpret the proposed measures and procedures, with the type of participants that will be involved in this research?*

◉ Yes ○ No

PG2.27.4 Will you indicate the procedure proposed above to potential participants in your Participant Information Sheet? *

◉ Yes ○ No

Review outcome comments for **G2 - Data Collection Procedure and Competence**

This question is not answered.

Click the green arrow to go to the next page.

G2 - Consent Method

PG2.28 Are these participants able to consent for themselves?* ◉ Yes ○ No

PG2.29 Will you use a written Participant Information Sheet or Explanatory Statement to inform participants about this project?*

◉ Yes ○ No

PG2.30 Will these participants be fully informed about the true nature of the research?*

◉ Yes ○ No

PG2.31 Indicate how you will obtain consent from this group of participants.*

- ○ Implied consent
- ◉ Consent form (must be attached with this application)
- ○ Opt-out consent
- ○ Other

Consent may be expressed in a number of ways. **A signed consent form** has traditionally been the accepted method of documenting a participant's consent to participate in a research project. Where used, information about the research project is generally presented in a participant information sheet, explanatory statement, or similar document that a participant retains.
The process of communicating information to participants and seeking their consent should not be merely a matter of satisfying a formal requirement. The aim is mutual understanding between researchers and participants. This aim requires an opportunity for participants to ask questions and to discuss the information and their decisions with others if they wish.

PG2.31.2 Outline the process by which the participants will give consent and how they return the consent form to the researchers.*

Participants will be given an information/consent form and permission forms, which will be returned directly to the research team by the teacher/s. Additionally, participants will be invited to a 1 hour information session, where time will be allocated to answering questions. Contact information for the research team will be supplied on the information/consent form if the participants have any further questions.

Review outcome comments for **G2 - Consent Method**.

This question is not answered.

Click the green arrow to go to the next page.

Group 3 - Participant Recruitment and/or Observation

G3 - Participant Overview

PG3.1 Participant group 3 working title. (e.g. student focus group; teacher survey)*

Teacher/s

PG3.2 How many participants are expected to be recruited in this group?*

2.00

PG3.3 Describe who the participants in this group are.*

Teachers of the student participants

PG3.4 Where will this group of participants be recruited from?*

A state primary school in Queensland

PG3.5 Are the participants in this group likely to be under 18 years of age?*

○ Yes ◉ No

PG3.6 Is there a pre-existing (unequal) relationship between the participants and anyone involved in recruiting and/or collecting data from this group of participants? (e.g. teachers and/or lecturers/students, doctors/patients, employers/employees, etc.)*

◉ Yes ○ No

PG3.6.1 Describe the nature of the pre-existing relationship and whom this involves.*

Ms Jean McCausland-Green has been delivering the workshop within the school for 7 years.

PG3.6.2 Outline what special precautions have been implemented to preserve the rights of those participants who decline to take part or withdraw from the research once the project has begun.*

The teacher information/consent form says, "Your participation in this project is entirely voluntary. If you do not wish to take part, you are not obliged to. If you do not wish to take part, you are not obliged to. If you decide to take part and later change your mind, you are free to withdraw from the project at any stage. You may also request that any data collected about you be withdrawn and confidentially destroyed before the data has been analysed. You will be unable to withdraw data collected about yourself after the data has been analysed. If you do wish to withdraw from this project or withdraw data collected about yourself, please contact the Research Team (contact details at the top of this form).
Your decision whether you take part, do not take part, or take part and then withdraw, will in no way impact your current or future relationship with the University of Southern Queensland or Mount Crosby State School."

PG3.7 Do these participants have any cultural needs? (e.g. specific consent arrangements or sensitivities, etc.)*

○ Yes ◉ No

Review outcome comments for **G3 - Participant Overview**

This question is not answered.

Click the green arrow to go to the next page.

G3 - Recruitment Method

PG3.8 Do you have any criteria for the selection, inclusion or exclusion of participants for this group to take part in the research? (e.g. minimum age requirements)*

◉ Yes ○ No

PG3.8.1 Describe the criteria for selection, inclusion or exclusion and outline why you require this for your research design.*

Participants will be 9 to 12 years of age. The lower range of age was chosen to fit the validity of the resilience measure chosen. The upper range of age was chosen to fit with primary school years. Teachers will be the teachers of the students.

PG3.9 Indicate which method/s you will use to recruit these participants:*

- [ ] Email
- [x] Personal contacts
- [ ] Telephone
- [ ] Advertisement
- [ ] Mail out
- [ ] Snowballing
- [ ] Participants from another study
- [ ] Participants approached in person by research team
- [ ] Participants will NOT be actively recruited - they will be observed without their knowledge
- [ ] Other

PG3.10 Indicate how you will obtain the contact details of these participants.
*

- [x] From the participants themselves
- [ ] From a public domain source
- [ ] From a private or third party source
- [ ] Other

PG3.11 Explain who will invite these participants to be involved in this project. *
The principal at the school where they work.

PG3.12 Will you be offering payment or any other incentives to this group of participants?*
○ Yes ◉ No

Review outcome comments for **G3 - Recruitment Method**

This question is not answered.

Click the green arrow to go to the next page.

G3 - Data Collection Methods

PG3.13 Will you collect data via questionnaires / surveys? *
◉ Yes ○ No

PG3.13.1 For each **questionnaire / survey** that will be administered to this group of participants, provide details about the name and purpose of the instrument, how the instrument will be administered (e.g., paper based, online), and how it will be returned.
Attach a copy of your survey instrument in the document upload section.*

The Teacher's Report Form measures behavioural and emotional problems in children. It will be administered to teachers on paper and returned directly to the research team by the teacher/s.
Feedback forms will be administered to teachers on paper and returned directly to the research team by the teacher/s.

PG3.14 Will you collect data via interviews or focus groups?*
○ Yes ◉ No

PG3.15 Will you collect data via observation? *
○ Yes ◉ No

PG3.16 Will you collect data via photography / videography? *
○ Yes ◉ No

PG3.17 Will you collect data via psychological inventories or any other published, standardised test? *
◉ Yes ○ No

PG3.17.1 Outline who will be involved in the administration of the psychological inventory, published, or standardised test and their qualifications to undertake this work.*

The standardised tests used for this research are all self-administered. Contact details for qualified members (Clinical Psychologists) of the research team will be provided on the information/consent forms if participants have any questions.

PG3.17.2 For each **psychological inventory, published or standardised test** that will be administered to this group of participants, provide details about the name and purpose of the instrument, how the instrument will be administered (e.g., paper based, online), and how it will be returned.
Confirm that you have (or will) meet copyright requirements for the use of the inventory and/or test prior to use.
he psychological inventories, published, or standardised test in the document upload section if copyright permits OR include a sample of selected items to inform the USQ HREC of the nature of the questions and/or tasks that a participant will be expected to respond to.*

The Teacher's Report Form measures behavioural and emotional problems in children. It will be administered to teachers on paper and returned directly to the research team by the teacher/s.
All copyright requirements for the use of the tests will be met.

PG3.18 Will you collect data via collection of human biospecimens? *

○ Yes ◉ No

PG3.19 Will you collect data via responses to tasks, stimuli or simulations?*

○ Yes ◉ No

PG3.20 Will you collect data via administration of a substance?*

○ Yes ◉ No

PG3.21 Will you collect data via any other procedure not outlined above? *

○ Yes ◉ No

Review outcome comments for **G3 - Data Collection Methods**.

This question is not answered.

Click the green arrow to go to the next page.

G3 - Data Collection Procedure and Competence

PG3.23 Provide details about what you are asking participants in this group to do or what is to be done to them. Include a step-by-step description of what participants will experience if they choose to take part in this project. *

Information/consent and permission forms for teachers.

PG3.24 How much time are you asking of participants in this group and when will this time be required? (e.g. 30 minutes after class). *

2hrs 10min during work time

PG3.25 Where will the data be collected (venue and geographical location)? (e.g. front of 'venue') *

Their classrooms.

PG3.26 Does the research involve the administration of any tests or procedures that require particular qualifications? *

◉ Yes ○ No

PG3.26.1 Provide details of the tests or procedures, the qualifications required, the proposed administrator and their qualifications and experience with this technique. *

The Teacher's Report Form (TRF) is from the Achenback System of Empirically Based Assessment and is a valid and reliable psychometric measure assessing total, internalising, and externalising problems. There are 118 items on the rating scale which refer to factors contributing to problems, including, ¿acts too young for his/her age¿. The items are rated on a 3-point rating scale ranging from 0 to 2 and indicate: not true (as far as you know), somewhat or sometimes true, and very true or often true. The TRF is scored using a specialised computer program.
The TRF is self-administered with the support of a psychologist if required. Contact details for the research team are provided on the information/consent forms.
The research team: Gavin Beccaria is an experienced Clinical Psychologist and Associate Professor at the School of Counselling and Psychology at USQ, Toowoomba. Jean McCausland-Green is an experienced Clinical Psychologist and the Clinic Director at the School of Counselling and Psychology at USQ, Ipswich. Jessica Swann is a USQ graduate of Bachelor of Science (Psychology) and current USQ student of Master of Science Research (Psychology).

PG3.27 Does the research involve measures or procedures that are **diagnostic** or **indicative** of any **medical** or **clinical condition**, or any other situation of concern? (e.g. anaemia, bulimia, anorexia, anxiety, suicidal tendencies, aggressive behaviours, etc.) *

◉ Yes ○ No

PG3.27.1 Describe the criteria you will use to assess when participants in your research have results indicating that they or others are 'at risk'.*

The Teacher's Report Form is a valid and reliable psychometric measure assessing total, internalising, and externalising problems. Cut off scores indicate if a child is at risk of an externalising or internalising disorder.

PG3.27.2 Outline how you will deal with your duty of care to participants in your research identified as 'at risk'. *

If a participant is identified as 'at risk', it will be reported to the school principal, who will follow the Queensland Department of Education procedures, including informing parents and providing support. Qualified members of the research team will work with the principal and participants to ensure the welfare of participants.

PG3.27.3 Have you acquired the necessary competence to administer, score and interpret the proposed measures and procedures, with the type of participants that will be involved in this research? *

◉ Yes ○ No

PG3.27.4 Will you indicate the procedure proposed above to potential participants in your Participant Information Sheet? *

◉ Yes ○ No

Review outcome comments for **G3 - Data Collection Procedure and Competence**

This question is not answered.

Click the green arrow to go to the next page.

G3 - Consent Method

PG3.28 Are these participants able to consent for themselves? * ◉ Yes ○ No

PG3.29 Will you use a written Participant Information Sheet or Explanatory Statement to inform participants about this project? *
◉ Yes ○ No

PG3.30 Will these participants be fully informed about the true nature of the research? *
◉ Yes ○ No

PG3.31 Indicate how you will obtain consent from this group of participants. *

- ○ Implied consent
- ◉ Consent form (must be attached with this application)
- ○ Opt-out consent
- ○ Other

Consent may be expressed in a number of ways. A signed consent form has traditionally been the accepted method of documenting a participant's consent to participate in a research project. Where used, information about the research project is generally presented in a participant information sheet, explanatory statement, or similar document that a participant retains. The process of communicating information to participants and seeking their consent should not be merely a matter of satisfying a formal requirement. The aim is mutual understanding between researchers and participants. This aim requires an opportunity for participants to ask questions and to discuss the information and their decisions with others if they wish.

PG3.31.2 Outline the process by which the participants will give consent and how they return the consent form to the researchers. *

Participants will be given an information/consent form and permission forms, which will be returned directly to the research team by the teacher/s. Additionally, contact information for the research team will be supplied on the information/consent form if the participants have any further questions.

Review outcome comments for **G3 - Consent Method**.

This question is not answered.

Click the green arrow to go to the next page.

Supporting Documentation

Supporting Documents

17 Below is a list of documents that may be required with this application. Upload each applicable item against the matching document name. If you require more than one document to be uploaded per item please use the 'Add New Document' button .
****Note**** there are multiple pages in the grid below, use the change page buttons at the bottom of the grid to browse each page.

Allowable file extensions are pdf, doc, docx, xls, xlsx, msg, jpg, ppt, pptx.

Description	Reference	Soft copy	Hard copy
Evidence of permission to recruit participants - External organisation(s)	Bouncing Back Resiliency Workshops Letter of Support.pdf		
Invitation letters and/or emails	Letter to Gatekeeper.pdf		
Participant Information Sheet and/or Explanatory Statement (as required, for each participant group)	InformationConsentAssentFormsQuestionnaires.pdf		
Copy of instrument(s) - for collecting data via surveys/questionnaires	MeasurementInstruments.pdf		
USQ Data Management Plan	Data Management Plan.pdf		
Risk Management Plan	RiskManagementPlans - RMP_2021_6230.pdf		

Review outcome comments for **Documents (1)**.

This question is not answered.

Review outcome comments for **Documents (2)**.

This question is not answered.

Review outcome comments for **Documents (3)**.

This question is not answered.

Review outcome comments for **Documents (4)**.

This question is not answered.

Review outcome comments for **Documents (5)**.

This question is not answered.

Click the green arrow to go to the next page.

Declaration

USQ Principal Investigator Declaration I the undersigned declare that I:

- have considered engaging with the peer review of this ethics application, in accordance with the USQ Statement on Peer Review;
- accept ultimate responsibility for the ethical conduct of this research project in accordance with the principles outlined in USQ's Research Code of Conduct Policy, the Australian Code for the Responsible Conduct of Research (2018), and the National Statement on Ethical Conduct in Human Research, 2007 (updated 2018); have ensured that all people involved in this research project understand and accept their roles and responsibilities;
- undertake to conduct this research project in accordance with the protocols and procedures outlined in the proposal as approved by USQ's Human Research Ethics Committee (USQ HREC);
- inform the USQ HREC of any changes to the protocol after the approval of the Committee has been obtained using the USQ HREC Amendment Application procedure AND inform all people involved in this research project of the amended protocol;
- have read and agree to comply with USQ's Research Data Management Policy and pursuant policies and procedures and have a plan for managing and/or sharing Research Data securely; and
- understand and agree that project files, documents, research records, and data may be subject to inspection by USQ HREC, a research integrity officer, the sponsor or an independent body for audit

18 USQ Principal Investigator Declaration

1	Full Name	Mrs Jessica Beth Swann
	Position	Principal Investigator
	Declaration signed?	Yes
	Signoff Date	03/12/2021

From: human.ethics@usq.edu.au
Subject: [RIMS] USQ HRE Amendment - H21REA306 (v1) - Expedited review outcome - Approved
Date: 11 April 2022 at 3:23 pm
To: W0107739@umail.usq.edu.au
Cc: Gavin.Beccaria@usq.edu.au

Dear Jessica

The revisions outlined in your HRE Amendment have been deemed by the USQ Human Research Ethics Expedited Review process to meet the requirements of the National Statement on Ethical Conduct in Human Research (2007). Your project is now granted full ethical approval as follows.

USQ HREC ID: H21REA306 (v1)
Project title: Evaluation of the Bouncing Back Resiliency Workshop
Approval date: 11/04/2022
Expiry date: 21/03/2025
Project status: Approved with conditions.

The standard conditions of this approval are:

(a) conduct the project strictly in accordance with the proposal submitted and ethics approval, including any amendments made to the proposal required by the USQ HREC, or affiliated University ethical review processes;

(b) advise the USQ HREC (via human.ethics@usq.edu.au) immediately of any complaint or other issue in relation to the conduct of this project which may warrant review of the ethical approval of the project;

(c) make submission for ethical review and approval of any amendments or revision to the approved project prior to implementing any changes;

(d) complete and submit a milestone (progress) report as requested, and at least for every year of approval; and

(e) complete and submit a milestone (final) report when the project does not commence within the first 12 months of approval, is abandoned at any stage, or is completed (whichever is sooner).

Additional conditions of this approval are:

(a) Ensure appropriate permission is obtained from the relevant Department prior to commencing the project.

Failure to comply with the conditions of approval or the requirements of the National Statement on Ethical Conduct in Human Research (2007) may result in withdrawal of ethical approval for this project.

If you have any questions or concerns, please contact an Ethics Officer.

Kind regards

Human Research Ethics

University of Southern Queensland
Toowoomba – Queensland – 4350 – Australia
Email: human.ethics@usq.edu.au

Appendix C

Queensland Department of Education Permission to Approach Approval

From: human.ethics@usq.edu.au
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If you have any questions or concerns, please contact an Ethics Officer.

Kind regards

Human Research Ethics

University of Southern Queensland
Toowoomba – Queensland – 4350 – Australia
Email: human.ethics@usq.edu.au