

Healthy Youth Development  
A Review of Effective Programs and  
Approaches

By Simon Denny

August 2004

The Centre for Youth Health

## **TABLE OF CONTENTS**

---

<b>EXECUTIVE SUMMARY</b>	<b>3</b>
<b>INTRODUCTION</b>	<b>4</b>
<b>DESCRIPTION OF EFFECTIVE PROGRAMS</b>	<b>6</b>
<b>SUMMARY OF EFFECTIVE YOUTH DEVELOPMENT INTERVENTIONS</b>	<b>13</b>
<b>WAYS FORWARD</b>	<b>19</b>

## **Executive Summary**

---

This report examines the evidence around ‘what works’ to improve the health and well-being of young people in New Zealand. Based upon a systematic review of literature reviews, this report examines the components of effective interventions that address common youth health concerns.

The recommendations from this report are:

### **Close and caring relationships between parents and youth should be promoted and strengthened.**

A strong relationship with parents is fundamental requirement for healthy youth development. When relationships with parents cannot be strengthened, connections with supportive adults elsewhere within the family or community should be encouraged.

### **Youth need support from and opportunities at school.**

Schools remain vital for the health and well-being of young people. While the most successful schools already support healthy youth development through academic and extracurricular activities, schools can do more to promote healthy youth development. More supportive school environments and recognition of the impact that teachers have on the health and well-being of students are areas that can be strengthened in schools. Schools can also be settings for interventions that enhance the healthy youth development for students at risk of poor outcomes.

### **Youth need opportunities to contribute and participate.**

Young people are too often seen as problems, rather than part of the solution. A shift in perspective that allows for meaningful contributions and participation by young people in their communities is required.

### **Interventions need to be intensive and sustained.**

To foster the growth of healthy and vibrant young people takes time. Interventions and programs that hope to improve the health and well-being of young people need to be intensive and be of sufficient duration to make a significant impact on the lives of young people. Investment in young people is a long term investment in the health and well-being of society.

## **Introduction**

---

Most young people in New Zealand are mentally, physically and socially healthy. The majority of young people are thriving in their home, school and community lives and are free from serious mental, behavioural and addictive disorders. However, adolescence is a time of transition and risk and a small but significant number of young people do face serious emotional, physical and behavioural problems. These young people are on a trajectory of poor outcomes and face a lifetime of disadvantage. Young people are often the last to receive the health services, social supports and resources that enable them to become adults who are fully prepared and free from harm. This is despite the fact that the majority of problems faced by young are preventable.

This report documents 'what works' to help young people make the transition to adulthood and prevent the poor outcomes associated with emotional, behavioural and other health concerns. Based on a systematic review of evidence-based literature reviews, this report identifies effective programs to improve the health and well-being of young people. This report is divided into two sections: evaluations of interventions to prevent youth health problems and synthesis of the critical elements of successful interventions. Case studies are provided throughout to highlight examples of effective programs.

---

## Methodology

This report summarises the findings of evidence-based reviews that evaluate the effectiveness of programs aiming to improve the health and well-being of young people. A systematic search of the literature for published reviews and reports incorporating an evidence-based approach was used to determine the components of effective programs. Only reviews and reports that used randomised controlled trials as the ‘gold standard’ were included in this report. The main advantage of using randomised controlled trials as the ‘gold standard’ is its rigour and accuracy in determining ‘what works.’ The main disadvantage of this approach is that the number of programs

eligible for inclusion is limited. Other factors considered in assessing the quality of program evaluations included: random sampling for participation to allow for generalisation to other young people; long term follow-up to ensure the results are long lasting; and large sample size to allow for accurate estimation of program effects.

The evidence considered in this report is taken from reviews of evidence-based literature and meta-analyses published in the last 10 years. This report has also been the subject of peer review and discussion with clinicians and researchers from the Centre for Youth Health.

---

## Considerations when Reading this Report

This report should be interpreted with few considerations. First, while there is often scant evidence for ‘what works’, this should not be interpreted in meaning that nothing works. Few rigorous evaluations have been conducted on most of the programs targeting improvements in young people’s health and well-being. Many programs may in fact be beneficial to their participants, but have not been evaluated by robust, rigorous studies. This lack of data should not be taken to mean that current programs and services are ineffective. It is clear that further research to evaluate existing programs needs to implement more rigorous study designs.

Second, this report includes intervention programs only; it does not address what parents can do or examine community-wide responses to youth health concerns. Likewise, this report does not attempt to summarise treatment programs or protocols in tertiary health settings.

Last, although many things can be done to improve the health and well-being of teenagers, no one program can completely foster the healthy development of a teenager in today’s world. No one program can be a 100% solution to the challenges and risks young people face in today’s society

## **Description of effective programs**

---

### **Programs for Educationally Disadvantaged Youth**

Educational failure among young people remains a major concern for educators, parents and communities. In New Zealand, nearly 20% of young people leave high school with no formal qualifications (MOH 2002) and substantial numbers do not go on to receive any further tertiary education. Students who are not successful at high school often come from backgrounds of low socio-economic status, low levels of parental education and other disadvantaged environments. They are also likely to be vulnerable to behaviours that endanger their health, such as drug and alcohol use, risky sexual behaviours and risky motor vehicle use than students who have success in their schooling (Denny, Clark et al. 2003). The outcomes for students who fail at school are poor and they are more likely to end up imprisoned or on Welfare (Coley, 1995). In the US it is estimated that for every student who fails to complete high school, the cost to society is over half a million dollars (Cohen 1998). Therefore it is important to look at programs that can improve outcomes for youth who are not succeeding at school.

A review of programs for educationally disadvantaged youth by Redd, et al. highlights that successful programs specifically target academic achievement through individual interventions aimed at improving academic skills. Strategies included programs to help students with homework completion, after school remedial classes, and one-on-one or group academic tutoring. Characteristics of programs that appear to be effective are

theory-based, are well structured and implemented, and provide participants with intensive exposure to a variety of skill-based activities.

Engagement and retention are common issues for programs aimed at educationally disadvantaged youth. Typically, young people who have the highest need, with respect to education and vocational training, are the most difficult to engage and retain in these programs. One successful strategy is to use youth outreach workers who are able to connect with these young people and motivate them to join programs or engage with services. Another strategy used to improve uptake into programs involves incentives or stipends, but this is often not the prime motivating factor to join programs as incentives are generally quite small in monetary value.

Once participants are in programs, retaining them so that they gain benefits from their participation is crucial. Program factors that improve retention include supportive program staff, providing a sense of belonging, and providing tangible benefits for the participants in terms of skills gained. One example here is provision of outings and activities, in addition to education and training, that are fun (such as sports, trips and cultural activities). Another successful approach involves building relationships between participants and program staff.

Many of the most successful programs reviewed were multi-component and provided long-term interventions (up to two years). They often involved a range of community agencies, utilised intensive case management to address wider social issues and concurrent health concerns, and used community services alongside training and skill-building (Redd, Cochran et al. 2002).

For older young people at risk of education failure there are fewer educational opportunities. In New Zealand, approximately 10 to 15% of 15-19 year-olds are not participating in regular work, education or training. This is high by international standards and is driven in part by low participation in training and education and high teenage fertility rates. Outcomes for youth who are not in work, education or training for prolonged periods of time are poor and include lower earnings, higher rates of criminal offending and poor physical and mental health (Youth Transitions Report Series 2003). Most programs for older, educationally disadvantaged youth (aged 16 to 24 years) concentrate on increasing employment through improving work skills and/or job training. Components of programs for older, educationally disadvantaged youth that appear

to be effective include: linkages and referrals of young people to other community agencies; involvement in community work and projects; instruction that includes both practical job skills and basic academic abilities; and financial incentives to improve school attendance. Of interest, the effectiveness of the job training programs did not vary if the training was delivered on-the-job or in-class. Like programs for younger students, many were multi-component programs. For example one program targeted young mothers without educational qualifications and offered an intensive program of education, job skills and case management. Another program offered intensive case management through home visiting by nurses to young disadvantaged mothers. (Hair, Ling et al. 2003).

In general, programs aimed at improving educational achievement among educationally disadvantaged young people need to specifically target educational outcomes and deliver intensive exposure to a variety of skill based activities over a prolonged period of time. They also need to use strategies to improve uptake and improve retention, so that those young people who are most in need can benefit from these programs.

---

## Programs for Youth with Drug and Alcohol problems

Drug and alcohol use continue to be a major threat to the health and well-being of young people in New Zealand. Alcohol is the substance most commonly used by young people and many youth drink alcohol frequently and in high quantities. Almost 90% of high school students have consumed alcohol by the age of 15 years. About 40% of students have had an episode of binge drinking (five or more drinks in one session within 4 hours) in the past month and nearly 20% of students drink alcohol weekly or more often. Many students have also tried and currently use cigarettes, marijuana and other drugs (Adolescent Health Research Group 2003).

Programs designed to prevent drug and alcohol problems generally fall into two groups: targeted programs or universal programs. Targeted interventions are designed for individuals at high-risk for drug and alcohol abuse or individuals already engaging in drug or alcohol use. Universal approaches are commonly school-based and are designed to reach all of the students in the school. Historically, targeted interventions for drug and alcohol problems have focused on individual-based treatments such as pharmacological therapy, psychotherapy, and educational programs. A consistent finding from evaluations of treatment-based interventions is that without family involvement most interventions are ineffective (Catalano 1991). More recent targeted interventions that involve the family have been shown to be effective in preventing drug and

alcohol related problems, but only if they are intensive. This means they meet with the family on six to twelve occasions over a period of up to 6 months. A well evaluated example of family based treatment is multisystemic therapy (MST). MST delivers an intensive intervention program tailored to each families needs over a 6 month period.

The number of universal school-based programs has increased over the past 20 years and range significantly in their delivery and content. Several reviews have concluded that while there is ample research on changing student's attitudes about drugs and alcohol, there is a paucity of information on whether these attitudes translate into reductions in drug and alcohol use behaviours. It is now commonly accepted that resistance-training ("just say no") and information-only approaches are ineffective. For example, the DARE program (a popular program where police teach students in class on the dangers of drug and alcohol use) has been repeatedly shown to be ineffective (Ennett, Tobler et al. 1994; Dukes, Ullman et al. 1996). More recent research is beginning to show that effective school-based drug prevention programs use a range of interactive teaching styles that include: youth led sessions, role-playing and skill-based activities, social decision-making rehearsals, and class discussions based on student experiences (Cuijpers, 2002). A good example is the Australian School Health and Alcohol Harm Reduction Project (see case study).

**Case Study: The School Health and Alcohol Harm Reduction Project (SHAHRP)** (McBride, Farrington et al. 2004)

The SHAHRP program is a curriculum-based intervention conducted in secondary schools in Australia with a goal to reduce alcohol related harm among school students. It incorporates an evidence-based, harm reduction approach to deliver an intervention that uses: interactive skill based activities, individual and small group decision making rehearsals, and discussions based on student experiences. The program is delivered over two years, providing an initial 10 sessions in the first year and a further 12 activities in the second year. The evaluation of SHAHRP used a randomised design and has shown that compared to the control group, intervention participants had significantly lower rates of risky alcohol consumption and harm associated alcohol use, especially during the intervention phase of the study. By the 32 month follow-up assessment these differences were beginning to converge.

---

## **Programs for youth with mental health concerns**

Emotional health concerns are common among young people; approximately 18 % of female high school students and 9 % of male students in New Zealand have high levels of depressive symptoms (Adolescent Health Research Group 2003). Likewise, suicidal thoughts are common among high school students as approximately one quarter of all students have thought about killing themselves in the last 12 months. These rates are even higher among students in alternative education schools (Denny, Clark et al. 2003).

In the last 20 years there has been increasing recognition of protective factors such as competencies, skills, and caring relationships that may protect children and young people against maladjustment and mental illness. Accordingly there has been a shift in many primary mental health prevention programs towards mental health promotion.

Evaluations of universal programs designed to prevent emotional health concerns show that effective programs: target both risk and protective factors; teach specific strategies like cognitive strategies that improve social and emotional competencies; create changes in the school or home environment; and are long-term and intensive (Greenberg, Domitrovich et al. 1999). A number of programs focus on social and emotional skill-building, generally through class room activities. These programs teach listening, language and thinking skills, interpersonal skills and help students identify, understand and regulate their emotions. Other programs have looked to improve the school environment and make schools more supportive and less threatening for students. Findings from evaluations stress the need for long term interventions over years (rather than months) as most short term interventions appear to diminish with time.

**Case Study: RAP-Kiwi** (Merry, McDowell et al. 2004).

RAP-Kiwi is a New Zealand, school-based curriculum program designed to prevent depression among teenagers. The program took place over 11 regular class sessions during the school year. The program content was developed from the Resourceful Adolescent Program (RAP) and incorporates cognitive-behavioural and interpersonal therapy principles. The course content was delivered by trained teachers using a variety of delivery methods, including: interactive discussions, role playing and course material. Evaluation of the randomised RAP-Kiwi intervention showed that the program was able to improve depression scores among participants in the intervention groups, but these improvements diminished by the end of the 18 month follow-up period.

Programs specifically targeting violence prevention or conduct problems in young people show similar characteristics to programs aimed at reducing emotional health concerns. Components of successful and effective violence and conduct disorder prevention programs target risk and protective factors, have multiple components that intervene with the individual, their home-life and school settings, and are based over the long-term (Greenberg, Domitrovich et al. 1999). The intensity of these programs is a critical factor in changing the trajectory for children who come from high risk backgrounds or are already showing early signs of conduct problems. Delineating prevention programs from treatment approaches is sometimes difficult in this area; both approaches use similar tools and interventions. Recognising this, prevention researchers have developed interventions that span the continuum of universal prevention through to treatments in a school setting.

**Case Study: Fast Track** (The Conduct Problems Prevention Research Group 2002)

Fast Track is an ongoing school-wide program that incorporates universal, selective and targeted treatment components for the prevention and treatment of conduct disorders and associated adolescent problem behaviours. The program starts in pre-school and screens for high-risk children to provide a multi-component intervention package including home visits, parental training, case management, academic tutoring, and social skills training. In conjunction with the targeted intervention, Fast Track also provides a classroom program to all students that focus on self-control, emotional awareness and understanding, peer-related social skills, and social problem solving to increase social competence. While the long term results for this program are not yet available, initial results show promising reductions in conduct problems among the participating students.

---

## Programs designed to prevent unwanted teenage pregnancies

While parenthood can be a positive and fulfilling experience, early unwanted pregnancy is often associated with serious and negative consequences for young parents and their children. In New Zealand, approximately half of all students have had sex by the time they leave high school and about 40% of those who are sexually active do not regularly use contraception to prevent pregnancy (Adolescent Health Research Group 2003). While all sexually active students are at risk for an early unwanted pregnancy, some students are at increased risk due to environmental characteristics such as community disadvantage, family disruption, low socio-economic status and lack of service availability. Individual characteristics such as detachment from school, emotional distress and sexual beliefs, and attitudes and skills place some youth at even greater risk of getting themselves or their partner pregnant (Kirby 2001).

Programs to prevent early unwanted pregnancies generally identify and try to modify one or more of these antecedents. Programs range from increasing sexual knowledge and skills of students in school-based settings to improving access to reproductive health care, services and contraception. Other programs focus on youth development without specific reference to sexual health knowledge or skills and some incorporate all of these approaches. Disappointingly, of the many programs

designed and implemented over the past 20 years, few programs have been effective. Some programs have even resulted in detrimental outcomes; one review found that abstinence – based programs increased pregnancy rates among partners of male participants (DiCenso, Guyatt et al. 2002). What is more certain is that sexual health education programs *do not* increase sexual activity and many do appear to increase contraceptive use and decrease unprotected intercourse. Characteristics of effective sex education programs include: clear and consistent messages about safe sexual behaviours, accurate and basic information, teaching methods that involve participants, activities that address the social pressures that influence sexual behaviours, and length of sufficient duration and intensity (Kirby 2001). Increasingly, programs are focusing on the wider determinants of sexual behaviours and many are using a youth development model to help young people develop skills and abilities to improve their education and vocational opportunities. Examples of these programs include: service learning programs which involve voluntary service by participants in the community, vocational education programs where participants receive education or employment related training, and multi-component programs that provided a range of interventions to participants, their families and in their schools.

**Case study on teen pregnancy prevention: The CAS-Carrera Program**

(Philliber, Kaye et al. 2002)

The CAS-Carrera Program is a long-term and intensive program that recruited youth aged 13 to 15 years from New York City for an after-school program (5 days a week) during their high school years. Participants spent an average of 16 hours per month in the program during the 3 years, with many spending considerably more time in the program. Cas-Carrera provided a multi-component youth development program that combined job training, academic tutoring, arts and sports with comprehensive sexual health education. The program was guided by the following principles: staff treated the participants as if they were their own children; each young person was viewed as a resource having potential; multiple services and activities were available to meet the various needs of participants; services aimed to involve families and parents; services were offered from one location; and the environment was supportive, non-punitive and safe. Results from a randomised evaluation showed that female participants were less than half as likely to get pregnant during the 3 years of the study compared to students in the control group.

## **Summary of Effective Youth Development Interventions**

---

Contemporary strategies to help young people avoid problems and experience success focus on reducing risk factors and enhancing protection using a youth development framework. Based on public health models of reducing risk factors for disease and enhancing factors that buffer or protect against disease, recent reviews have identified positive youth development models as essential and effective strategies for both preventing problems and improving positive outcomes for young people (Catalano, Hawkins et al. 2002). Several key concepts underlie the youth development framework. First, there are a range of risk factors that place young people at greater risk for developing a range of poor outcomes, including emotional health concerns, alcohol and drug use problems, delinquency, poor academic achievement and early unwanted pregnancy. These risk factors are not specific to one problem area and a single risk factor may place a young person at greater risk for a range of poor outcomes (Catalano, Berglund et al. 1998). Furthermore, adolescent health concerns and behaviours often cluster. That is, if a young person is engaging in harmful drug or alcohol use, they are more likely to take part in risky sexual behaviours. Young people who are depressed are also likely to have an anxiety disorder or use drugs or alcohol. This means

that interventions to improve youth health outcomes do better when they intentionally target one or more risk factors, rather than focusing on specific health areas of concern (Zaff and Moore 2002). Second, youth development models identify protective factors that reduce the risk of poor outcomes and enhance positive outcomes. This means that successful interventions aim to enhance protective factors in the lives of young people. These protective factors are important for all youth and not just those at risk of poor outcomes. While risk and protective factors are inter-linked and vary across individual, family and environmental domains, it is clear that healthy communities have low levels of risk factors and high levels of protective factors across all domains. This means that enhancing positive youth development requires community level approaches in coordination with prevention efforts. Lastly, it is increasingly being recognised that positive and holistic approaches to youth health are more effective than negative-based strategies such as reprimanding young people about their behaviour. Positive youth development programs aim to build competencies and strengths in young people. They view young people as resources to be nurtured, not problems to be fixed (Pitman).

---

## Promoting close and caring relationships with parents

Numerous studies have identified that positive relationships with parents promotes adolescent health and well-being (McLaren 2002). Throughout the teenage years, positive parenting means providing age appropriate care and support, setting clear expectations, monitoring behaviour, and role-modeling acceptable behaviours for their teens. Research has consistently shown that young people who grow up with parents demonstrating these characteristics are more likely to be emotionally healthy, be successful at school and have positive self-esteem. They are also less likely to engage in behaviours that could harm their health such as drug use and unsafe sex and they are less likely to experience mental health problems (McLaren 2002). Overall, it appears that the warmth and quality of the relationships between young people and their caregivers is the single strongest predictor of adolescent well-being.

Programs that aim to improve outcomes for young people by promoting relationships with parents and caregivers can be classified as parental training programs or parental involvement programs. Parental training programs teach parenting strategies directly to parents to improve relationships between adolescents and their caregivers. Parental involvement programs bring parents into the program through involvement in events or activities. Other programs may indirectly influence the relationships between parents and adolescents by attending to family stressors

such as housing or socio-economic strains by referral to appropriate social agencies. These programs often use an intensive case management approach to help young people who are at risk or experiencing emotional or other health concerns. The research is unclear on which strategy is the most effective strategy for improving relationships between adolescents and parents; what is clear is that effective programs often attend to the needs of parents and families, thereby improving the health and well-being of young people in those families.

---

## Providing supports and interventions in schools

Much attention has been given to the role of school in nurturing the health of adolescents as most young people spend a considerable amount of their waking hours in school settings. Research has found that providing a supportive school climate can improve the health and well-being outcomes for its students (McLaren 2002). Schools that provide supportive environments have teachers who relate well and positively with students. Likewise, schools that promote mastery and effort over competition achieve better outcomes for their students. Extracurricular

activities also play an important part in improving outcomes for students. Students who engage in activities like sports, clubs and music are more likely to complete their schooling and less likely to experience problems than students who are not involved in extracurricular activities. Overall, doing well at school is a particularly strong predictor of adolescent health and well-being; students who drop out of school are more likely to have poor health, including significant emotional health concerns, drug taking behaviours and violence related concerns.

### Case Example: The Gatehouse Project

The Gatehouse Project commenced in 1997 as a randomised controlled trial to determine if the implementation of a school-based intervention, that included both individual and environment-focused components, could improve students' emotional well-being. Twenty-six schools (12 intervention, 14 control) in the greater Melbourne area agreed to participate and worked with the Gatehouse Project team from 1997 to 2000. The intervention involved three key areas of action including building a sense of security and trust; enhancing communication and social connectedness; and building a sense of positive regard through valued participation in aspects of school life. Using the Health Promoting Schools framework the intervention schools introduced relevant and important skills through the curriculum; made changes in the schools' social and learning environments; and strengthened links between the school and its community. Results have shown that students attending the intervention schools had reductions in cigarette smoking and alcohol and cannabis use compared to students attending the control schools. To date, The Gatehouse Project has not been able to show an effect on depressive symptoms or other common emotional problems.

---

## **Improving connection with peers, adults and family**

Young people who experience a caring and connected and positive relationship with peers, adults and other family members have better outcomes than young people who lack these supports (Garmezy 1985; Jenkins and Smith 1990; Resnick, Bearman et al. 1997). Peer friendships buffer the effects of parental divorce, improve emotional well-being, retain young people in extra-curricular activities and help young people develop pro-social behaviours (McLaren 2002). With peer friendships, the nature and quality of the activities friends do together is important, as friends can also influence behaviours in a negative way. This is true of adult relationships with young people as well; adults who model positive behaviours and attitudes have constructive and healthy influences on young people's lives (Zaff and Moore 2002).

Mentoring programs seek to improve outcomes for young people by providing caring and positive relationships to young people. Evaluations of mentoring programs have shown that close, long-term relationships can

improve outcomes for young people, including emotional health concerns, drug and alcohol use and improved academic outcomes (Jekielek, Moore et al. 2002). Key lessons from research on mentoring programs emphasise that mentoring relationships need to last more than 12 months; short-lived mentoring relationships may in fact be harmful to participants. Mentors and youth also need to have frequent contact (more than several times a month) to have a positive impact on the youth involved in these programs (Jekielek, Moore et al. 2002). Both of these characteristics mean that programs that wish to use mentoring relationships to improve outcomes for youth need to ensure that the appropriate structures and support for mentors are in place. Special considerations should be given to pre-match training, supervision and education of mentors to promote the best outcomes for young people in these types of programs (DuBois, Holloway et al. 2002).

Case study: Big brothers/ Big sisters(Tierney, Grossman; et al. 1995)

Big brothers/ Big sisters is a large mentoring program for youth aged 5 to 18 years who desire an adult mentor. The mentor is usually recruited from the community and must commit to a minimum of 3 to 5 hours a week for at least one year. The goal of this program is to provide a caring and supportive relationships for children and youth at risk of poor outcomes. Volunteers are interviewed and screened prior to selection and selected mentors get orientated and trained to ensure that their relationship with the participant is a positive one. Randomised evaluations have shown that after 18 months, participants were less likely to engage in drug and alcohol use, less likely to get into a fight and had better school attendance than youth in the control group.

---

## **Opportunities to contribute and participate**

Youth involvement in community activities is linked to a range of positive health and well-being outcomes. Participation, through extracurricular activities at school, community organisations, sports teams or volunteer activities, improves long term health and well-being and decreases the likelihood of poor outcomes in youth who engage in these activities. Moreover, participation in community service or volunteer activities impacts in a positive way on future citizenship, with increased involvement in community activities and responsibilities like voting (Zaff and Michelsen 2001). Involvement in community activities improves outcomes for young people by enabling young people to be effective and valuable participants in their communities, while also gaining skills,

knowledge and experiencing success (McLaren 2002).

Programs have used a range of activities and strategies to foster participation and contributions from participants in their communities. Community service or other volunteer activities give youth opportunities to contribute to their communities in positive ways. This demonstrates a fundamental shift away from viewing youth as problems, but rather viewing youth as assets and as resources to be developed. Other service learning programs actively involve youth in decision making, organising events and other leadership opportunities. Evaluations of these programs have shown a range of benefits, from improved academic performance and employment outcomes to less delinquency and lower pregnancy rates (James and Jurich 1999).

---

## **Healthy youth development takes time**

The development of a person as an adult takes place over a number of years. In recent times this period is being extended into young people's twenties and thirties as the demands of education, training and employment delay the onset of adult roles and responsibilities. It is not surprising then that young people need consistency and commitment from caring adults and family to be fully prepared for the

responsibilities and demands of adulthood. Programs which offer long-term commitment and follow-up appear to be the most promising in preparing youth for these responsibilities. Programs that offer services for an extended period build trust in their participants as there is time to develop strong and enduring relationships with adults in these programs.

---

## **High standards and expectations**

Across all contexts of youth development, at home, school or in communities, young people need to be held to high standards and expectations of their behaviour. This means holding young people accountable for their behaviour and challenging young people to achieve their best. For example, in the home, young people require a caring and nurturing relationship with their parents along with clear

boundaries with firm but fair consequences (McLaren 2002). Likewise, successful programs should aim for high standards and strive to help students to achieve those high standards. For example, teachers who give students clear and accurate feedback on their learning have been shown to improve academic outcomes beyond their prior achievement history.

## **Ways forward**

---

### **Form alliances and partnerships with other agencies**

This report has documented numerous approaches to improving the health and well-being of young people. Successful approaches are often multi-component and require cooperation between sectors and agencies. No one service (generally) has the capability or capacity to meet all the needs of young people to ensure their optimum health and well-being.

### **Look for existing programs that have been well evaluated and have clear implementation procedures**

Programs need to be well structured and implemented to be effective. This is best achieved through the use of well established programs that have been successfully evaluated. Along with using existing programs, try to provide intensive exposure to a variety of program activities over the long-term

### **Attract and engage hard to reach young people**

The young people who are most in need of intensive and prolonged interventions often miss out. Factors such as socio-economic disadvantage, family disruptions and stressors, or previous poor education or vocational experiences may mean that these young people are difficult to engage. When services face such difficulties engaging these young people, they often turn their attention to 'less risky' young people. Providers of successful services realise that they need to work hard at engaging the young people with the highest needs and utilise resources such as youth outreach workers who have the ability to relate well to young people in their environments.

### **Involve young people in the planning and running of the program**

Without youth participation, programs risk becoming inappropriate and irrelevant. Having young people involved in the planning and running of programs means that programs are more likely to remain dynamic, changing and responsive to the needs of the young people. Many programs struggle to retain young people for the duration of the program. Program factors that encourage youth to stay are: meeting young people's needs, providing a sense of belonging and providing high quality relationships with staff.

### **Build evaluation into programs**

There is limited evidence to what works to promote healthy youth development, especially among youth most at risk. Any new efforts or programs need to provide evidence that they are effective. Resources are too scarce to be wasted on ineffective interventions. As new efforts or programs are demonstrated to be effective by rigorous research, then the effective components of the program should be available to guide future refinements and advance what we know on 'what works' in promoting health youth development.

## References

---

Adolescent Health Research Group (2003). "A health profile of New Zealand youth who attend secondary school." *N Z Med J* **116**(1171): U380.

Catalano, R. F., M. L. Berglund, et al. (1998). *Positive Youth Development in the United States: Research findings on evaluations of Positive Youth Development Programs*. Report to the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and National Institute for Child Health and Human Development. Seattle, Washington, Social Development Research Group.

Catalano, R. F., J. D. Hawkins, et al. (2002). "Prevention science and positive youth development: competitive or cooperative frameworks?" *J Adolesc Health* **31**(6 Suppl): 230-9.

Cohen, M. A. (1998). "The monetary value of saving a high-risk youth." *Journal of Quantitative Criminology* **14**(1): 5-33.

Denny, S. J., T. C. Clark, et al. (2003). "Comparison of health-risk behaviours among students in alternative high schools from New Zealand and the USA." *J Paediatr Child Health* **39**(1): 33-9.

DiCenso, A., G. Guyatt, et al. (2002). "Interventions to reduce unintended pregnancies among adolescents: systematic review of randomised controlled trials." *Bmj* **324**(7351): 1426.

DuBois, D. L., B. E. Holloway, et al. (2002). "Effectiveness of mentoring programs for youth: a meta-analytic review." *Am J Community Psychol* **30**(2): 157-97.

Garnezy, N. (1985). *Stress-resistant children: The search for protective factors*. Recent Research in Developmental Psychopathology. J. E. Stevenson. New York, Elsevier Science: 213-233.

Greenberg, M. T., C. Domitrovich, et al. (1999). *Preventing Mental Disorders in School-age Children: A review of the effectiveness of Prevention Programs*, Prevention Research Center for the Promotion of Human Development. College of Health and Human Development. Pennsylvania State University.

James, D. W. and S. Jurich (1999). *MORE Things That DO Make a Difference for Youth: A Compendium of Evaluations of Youth Programs and Practices, Volume II*. D. W. e. James. Washington, DC, American Youth Policy Forum.

Jekielek, S., K. A. Moore, et al. (2002). *Mentoring programs and Youth Development: A Synthesis*. Washington, D.C., Child Trends.

Jenkins, J. M. and M. A. Smith (1990). "Factors protecting children living in disharmonious homes: Maternal reports." *Journal of the American Academy of Child & Adolescent Psychiatry* **29**(1): 60-69.

Kirby, D. (2001). *Emerging answers: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, D.C., National Campaign to Prevent Teen Pregnancy.

- McBride, N., F. Farrington, et al. (2004). "Harm minimization in school drug education: final results of the School Health and Alcohol Harm Reduction Project (SHAHRP)." *Addiction* **99**(3): 278-91.
- McLaren, K. (2002). *Youth Development Literature Review: Building Strength*. M. o. Y. Affairs, Ministry of Youth Affairs.
- Merry, S., H. McDowell, et al. (2004). "A randomized placebo-controlled trial of a school-based depression prevention program." *J Am Acad Child Adolesc Psychiatry* **43**(5): 538-47.
- Philliber, S., J. W. Kaye, et al. (2002). "Preventing pregnancy and improving health care access among teenagers: an evaluation of the children's aid society-carrera program." *Perspect Sex Reprod Health* **34**(5): 244-51.
- Redd, Z., S. Cochran, et al. (2002). *Academic Achievement Programs and Youth Development: A Synthesis*. Washington, D.C., Child Trends.
- Resnick, M. D., P. S. Bearman, et al. (1997). "Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health." *JAMA* **278**(10): 823-32.
- The Conduct Problems Prevention Research Group (2002). "Evaluation of the first 3 years of the Fast Track prevention trial with children at high risk for adolescent conduct problems." *Journal of Abnormal Child Psychology* **30**(1): 19-35.
- Tierney, J. P., J. B. Grossman, et al. (1995). *Making a Difference: An Impact Study of Big Brothers Big Sisters*. Philadelphia, Pa., Public/Private Ventures.
- Zaff, J. F. and E. Michelsen (2001). *Background for Community-Level Work on Positive Citizenship in Adolescence: Reviewing the Literature on Contributing Factors*. Washington, D.C., Child Trends.
- Zaff, J. F. and K. A. Moore (2002). *Promoting Well-being Among America's Teens: An Executive Summary of Adolescent Development Research Reviews Completed for the John S. and James L. Knight Foundation*. Washington, D.C., Child Trends.