Opening Statement to Joint Oireachtas Committee on Education, Further and Higher Education, Research, Innovation and Science: Meeting on School Bullying and the Impact on Mental Health, June 8th, 2021

Dr Paul Downes, Associate Professor of Psychology, DCU Institute of Education and Affiliate Professor, University of Malta, Centre for Resilience and Socio-Emotional Health   paul.downes@dcu.ie

Based on publications for the EU Commission:

Downes, P. & Cefai, C. (2016). *How to tackle bullying and prevent school violence in Europe: Evidence and practices for strategies for inclusive and safe schools.* Luxembourg: Publications Office of the European Union/EU bookshop.

Cefai, C., Bartolo P. A., Cavioni. V., Downes, P. (2018). *Strengthening Social and Emotional Education as a core curricular area across the EU: A review of the international evidence.* Luxembourg: Publications Office of the European Union/EU bookshop.

And

Downes, P. & Cefai, C. (2019). Strategic Clarity on Different Prevention Levels of School Bullying and Violence*: Rethinking Peer Defenders and Selected Prevention. Journal of School Violence*, 18 (4) 510-521

1) **The Long-Term Impact of Bullying on Mental and Physical Health (as well as Educational Engagement) Makes Bullying in Schools a Child Welfare and Child Protection Issue of Trauma and Adverse Childhood Experiences**

2) **Early Intervention is needed to Prevent the Impact of Bullying on Mental Health and for Support Services for Perpetrators: This Requires Specialist Emotional Counselling/Therapeutic Supports in and around Primary and Secondary Schools**

3) **Increased Funding for Parenting Programmes and Family Support Services Linked with Schools**

4) **Peer Challenger Approaches such as those Advocated by the Finnish KiVa Programme are Psychologically and Legally Questionable**

1) **The Long-Term Impact of Bullying on Mental and Physical Health (as well as Educational Engagement) Makes Bullying in Schools a Child Welfare and Child Protection Issue of Trauma and Adverse Childhood Experiences**

Bullying in its various forms has been associated with various emotional, psychological as well as academic problems in children and young people. The harmful effects are most evident in victims of bullying, but the perpetrators and the perpetrators-victims, and to a lesser extent bystanders, are also liable to experience the negative impact of the bullying experience (Arbax, 2012; Arseneault et al., 2010; Ttofi et al., 2011). Victims are likely to experience low self esteem, anxiety, depression, and suicidal ideation (Gladstone et al., 2006; Klomek et al., 2007; Nansel et al., 2004; Radliff et al., 2015; Juvonen and Graham, 2014; Tfofi et al., 2011; Swearer et al., 2012; Bjereld, 2014). Victimisation has also been linked to lower academic achievement and other behaviours such as disengagement, absenteeism and early school leaving (Fried and Fried, 1996; Glew et al., 2005; Nakamoto and Schwartz, 2010; Brown et al., 2011; Green et al., 2010).

Fisher et al. (2012) reported that victimisation in the early years is three times more likely to lead to self-harm in adolescence amongst the victims when compared to non-bullied peers. They found that 50% of twelve year olds who harm themselves were frequently bullied, while victimised children with mental health problems were at greater risk of self-harm later on. Longitudinal studies have also shown that frequent victimization at age 8 predicted later suicide attempts and completed suicides for both boys and girls, while frequent bullying perpetration at age 8 also predicted later suicide attempts and completed suicides for boys (Klomek et al., 2009).

Tfofi et al. (2011) reported that the probability of depression up to 36 years later was much larger for victimised students when compared to non-bullied peers, even after controlling for other factors. In a large scale study with 14,500 participants in the UK, Bowles et al. (2015) reported that peer victimisation in adolescence is a significant predictor of depression in early adulthood; about one in three cases of depression among young adults may be linked to peer victimisation in adolescence. Out of 683 people who reported they had been bullied at least once a week at the age of 13, nearly 15 % were depressed at 18 years. In a comparative study on the long term impact of bullying on mental health, Lereya et al. (2015) used data from two longitudinal data bases, one in in the UK (4,026 children) and the other in the US (1,420 children). They reported that children who were both maltreated and bullied were at increased risk for overall mental health problems, anxiety, and depression according to both cohorts, and for self-harm according to the English cohort. Children who were bullied by peers only were more likely than children who were maltreated only to have mental health problems in both cohorts, including anxiety, depression and self harm.

Against the backdrop of these pervasive associations between bullying and mental health issues and early school leaving related risk factors, it is evident that bullying in schools is *both an education and a health issue*. It requires an integrated strategic policy response across both departments. **It is an issue of trauma and requires recognition as such**. The wide range of detrimental outcomes arising from bullying in school highlights that this is a serious issue for child and youth welfare. It is also a child protection issue (Farrelly, 2007; 8th European Forum on the Rights of the Child, 2013).

2) Early Intervention is needed to Prevent the Impact of Bullying on Mental Health and for Support Services for Perpetrators: This Requires Specialist Emotional Counselling/Therapeutic Supports in and around Primary and Secondary Schools

Given the seriousness of the long-term impacts of bullying, a prevention strategy needs to encompass not only prevention of the bullying but *prevention of the consequences* of bullying through a holistic focus on system level emotional, cognitive and social supports. This prevention of consequences approach needs a much firmer policy focus. From the following illustrative examples from qualitative research on the consequences of bullying in victims' experiences, such supports could intervene at an early stage to prevent the escalation of experiential processes, such as self-doubting and double victimising, described in a Swedish context (Thornberg et al., 2012). The concept of double victimising refers to an interplay and cycling process between external victimising and internal victimising. They internalised the socially constructed victim-image and acted upon this image, which in turn often supported the bullies' agenda and confirmed the socially constructed victim-image. Research examining cognitive perceptions in children who participate in bullying has found that many involved children experience cognitive distortions (Doll and Swearer, 2006).

Radliff et al. (2015) is the first study to examine hopelessness as a mediator within the context of bullying. In a sample of 469 US middle school students, victims reported the highest levels of hopelessness and significantly higher scores compared with students not involved in bullying. Hopelessness was a mediator for victims, but not for bully-victims. Thornberg's (2015) Swedish ethnographic fieldwork in two public schools was located in urban neighbourhoods of different socioeconomic statuses, representing both lower and middle classes, in a medium-sized city. In total, 96 students (50 boys and 46 girls) from four school classes (two classes in Grade 4 and two classes in Grade 5) participated along with four teachers. The children's age ranged from 10 to 12 years. Striving towards social acceptance appeared to be associated with efforts to change oneself and to socialise, perceiving the minority identity as unchangeable and inevitably causing bullying and social rejection appeared to be linked to resignation and a range of escape or avoidance behaviour, such as social withdrawal and avoiding others, as well as trying to be socially invisible in the classroom and other school settings. **This has implications for the potential role of emotional counselling/therapeutic supports in and around schools in helping students construe their reactions to bullying and to minimise self-blaming approaches.**

From their longitudinal study in Finland, Sourander et al. (2007) conclude, 'early crime prevention that focuses on bullying should be one of the highest priorities in child public health policy. Frequent bullying may serve as an important red flag that something is wrong and that intensive preventive or ameliorative interventions are warranted' (p.550). **This requires intensive individual emotional counselling/therapeutic supports in and around schools for early intervention (Downes 2020).**

The Irish Department of Education and Skills Procedures on Bullying 2013 a) does not adequately distinguish distinct levels of prevention of bullying and b) is weak on the indicated prevention level of intensive individual supports for both perpetrators and victims of bullying in and around schools. Neither NEPS nor generic programmed approaches offer individual intensive one to one emotional counselling/therapeutic supports needed at this indicated prevention level; Career

Guidance Counsellors are not suitable for the trauma and adverse childhood experiences level of indicated prevention. A continuum of need and risk requires recognition and not all bullying perpetrators or victims require referral to CAMHS (Child and Adolescent Mental Health Services) for clinical level or psychiatric supports. The clear strategic gap in system supports in schools is for specialist emotional counselling/therapeutic supports in and around schools to prevent problems of trauma accelerating into clinical levels of need.

3) Increased Funding for Parenting Programmes and Family Support Services Linked with Schools

A review of research reveals strong grounds for interventions to include a parental dimension. Ttofi and Farrington's (2011) meta-analysis found that parent training was one of the program elements significantly associated with both a decrease in bullying and being bullied. Axford, Farrington et al.'s (2015) review of parental engagement and bullying suggests that there is good reason to involve parents in school-based bullying prevention. Given the parenting risk factors for bullying perpetration and victimisation, bullying prevention programmes could also usefully offer parenting education and support. **They highlight the findings of a systematic review by Lereya et al. (2013) involving 70 studies which concluded that both victims and bully/victims are more likely to be exposed to negative parenting behaviour, including abuse and neglect and maladaptive parenting**. Effects were small to moderate for victims but moderate for bully/victims

4) Peer Challenger Approaches such as those Advocated by the Finnish KiVa Programme are Psychologically and Legally Questionable

Ttofi and Farrington's metanalytical review (2012) offers a strong critique of peer support approaches that questions both their efficacy and harmful side-effects. Ttofi and Farrington (2012) observe that evaluations indicate the 'not encouraging' conclusions: although peer support schemes appear effective based on attitudinal surveys, these schemes are not related to actual levels of bullying or victimization and are quite often related to an *increase* in bullying and victimization. Their analysis was of programmes involving 'work with peers', if it included peer mediation, peer mentoring, or engagement of bystanders in bullying situations. Programmes were not included as work with peers if they only had role playing exercises and 'quality circles' for bullying awareness, but no formal engagement of peers in tackling bullying.

Referring to Canadian research (Hawkins et al., 2001), Ttofi and Farrington (2012) raise further concerns with peer defenders intervening in aggressive ways, 'peer interventions may reinforce the aggressive behaviour of school bullies and promote a cycle of violence' (p.456).

Forsberg et al.'s (2014) Swedish qualitative research involved 43 semi-structured individual interviews aged 10-13 years across 5 schools. It observed that social hierarchies exist among the students, which are kept in mind when observing bullying and guide their actions by evoking and mutually interacting with self-protecting considerations (e.g. the fear of retaliation, social disapproval, social blunders, getting bullied, losing friends or losing social status). Whereas bystanders with self-protection concerns avoid intervening when the bullies are older than they are, they see themselves as more capable of intervening if they are older

than the bullies. *A student's intuition about the risks of getting involved may not need to be challenged but rather listened to. Their fear of getting involved may be a rational fear, a reading of circumstances where intervening would place them also at heightened risk of being bullied, with potentially long-term damaging consequences that are now well-documented in the international research literature.*

From a national policy perspective, it may also be problematic legally to place a burden of support on peers to deal with potentially highly complex emotional issues and to encourage interventions to *defend* the victim against the perpetrator of the bullying; **interventions to defend may also be placing the child or young person at risk of themselves being bullied. At least it is a reasonably foreseeable consequence that this could occur and this potentially breaches a duty of care on the State to all its students not to encourage them into situations of harm for them.** This legal issue of negligence if the State promotes a peer defenders approach resonates also with the medical injunction, *primum non nocere*, first do no harm. This is not an argument against all aspects of peer support approaches but against peer challengers/defenders approaches.

See references in the longer formal submission below.

Invited Submission to Joint Oireachtas Committee on Education, Further and Higher Education, Research, Innovation and Science: Report on School Bullying and the Impact on Mental Health

Dr Paul Downes, Associate Professor of Psychology, DCU Institute of Education and Affiliate Professor University of Malta, Centre for Resilience and Socio-Emotional Health

Dr Carmel Cefai, Professor of Psychology, Director, Centre for Resilience and Socio-Emotional Health, University of Malta

February 2021

1) **The Long-Term Impact of Bullying on Mental and Physical Health (as well as Educational Engagement) Makes Bullying in Schools a Child Welfare and Child Protection Issue of Trauma and Adverse Childhood Experiences**
2) **Early Intervention is needed to Prevent the Impact of Bullying on Mental Health and for Support Services for Perpetrators: This Requires Specialist Emotional Counselling/Therapeutic Supports in and around Primary and Secondary Schools**
3) **Increased Curricular Time Needed for SPHE and for Integration of Social and Emotional Education Across the Curriculum**
4) **There is a Growing Consensus on the Important of Differentiating Universal (All), Selected (Moderate Risk – Group) and Indicated (Chronic Need –Individual, Intensive Supports) Prevention Levels: The Indicated Prevention level of Individual Intensive Supports in and around Schools is a Clear Gap in the Irish Action Plan on Bullying 2013**
5) **Increased Funding for Parenting Programmes and Family Support Services Linked with Schools**
6) **Peer Challenger Approaches such as those Advocated by the Finnish KiVa Programme are Psychologically and Legally Questionable**

Based on publications for the EU Commission:

Downes, P. & Cefai, C. (2016). *How to tackle bullying and prevent school violence in Europe: Evidence and practices for strategies for inclusive and safe schools.* Luxembourg: Publications Office of the European Union/EU bookshop.

Cefai, C., Bartolo P. A., Cavioni. V., Downes, P. (2018). *Strengthening Social and Emotional Education as a core curricular area across the EU: A review of the international evidence*. Luxembourg: Publications Office of the European Union/EU bookshop.

And

Downes, P. & Cefai, C. (2019). Strategic Clarity on Different Prevention Levels of School Bullying and Violence*: Rethinking Peer Defenders and Selected Prevention. *Journal of School Violence*, 18 (4) 510-521

1) **The Long-Term Impact of Bullying on Mental and Physical Health (as well as Educational Engagement) Makes Bullying in Schools a Child Welfare and Child Protection Issue of Trauma and Adverse Childhood Experiences**

Bullying in its various forms has been associated with various emotional, psychological as well as academic problems in children and young people. The harmful effects are most evident in victims of bullying, but the perpetrators and the perpetrators-victims, and to a lesser extent bystanders, are also liable to experience the negative impact of the bullying experience (Arbax, 2012; Arseneault et al., 2010; Ttofi et al., 2011). Victims are likely to experience low self esteem, anxiety, depression, and suicidal ideation (Gladstone et al., 2006; Klomek et al., 2007; Nansel et al., 2004; Radliff et al., 2015; Juvonen and Graham, 2014; Tfofi et al., 2011; Swearer et al., 2012; Bjereld, 2014). Victimisation has also been linked to lower academic achievement and other behaviours such as disengagement, absenteeism and early school leaving (Fried and Fried, 1996; Glew et al., 2005; Nakamoto and Schwartz, 2010; Brown et al., 2011; Green et al., 2010). Victims are more likely to experience worse concentration in class (Boulton et al., 2008) and more interpersonal difficulties (Kumpulainen et al., 1998). Beran (2008) concluded that preadolescents who are bullied are at some risk for demonstrating poor achievement, although this risk increases substantially if the child also receives little support from parents and is already disengaged from school. The Longitudinal Survey of Young People in England (Green et al., 2010) age 16 young people who reported being bullied at any point between ages 14-16 are disproportionately likely to not be in education, employment or training.

A study of over 26,000 Finnish adolescents found that involvement in bullying was associated with a range of mental health problems such as anxiety, depression and psychosomatic symptoms (Kaltiala-Heino et al., 2000). Jantzer et al. (2012) studied the relationship between victimisation and mental health among 300 students (aged 10-14 years) in ten schools in southern Germany. They found that bullying victims (21 % of the sample) had significantly higher risks for developing emotional difficulties than those who were not bullied. Perpetrators are likely to exhibit other oppositional and antisocial behaviours and to leave school early (Nansel et al., 2003; Nansel et al., 2004; Sourander et al., 2011; Kokkinos and Panayiotou, 2004). The worst off group however, appears to be the bully-victims, who experience higher levels of both internalised (depression, anxiety, psychosomatic symptoms) and externalised (behaviour problems, delinquency) difficulties than either the victims or the bullying perpetrators (Nansel et al., 2004; Ivarsson et al., 2005; Kokkinos and Panayiotou, 2004; Houbre et al., 2006; Swearer et al., 2012). Bully-victims are also more likely to come from dysfunctional families or have pre-existing conduct, behaviour or emotional problems and it has been suggested that these factors, rather than bullying per se, may explain adult outcomes (Sourander, Ronning et al., 2009). Bullying perpetrators and bully/victims had the lowest connection to school and poorest relations with teachers (RasKauskas et al., 2010).

Fisher et al. (2012) reported that victimisation in the early years is three times more likely to lead to self-harm in adolescence amongst the victims when compared to non-bullied peers. They found that 50% of twelve year olds who harm themselves were frequently bullied, while victimised children with mental health problems were at greater risk of self-harm later on. Longitudinal studies have also shown that frequent victimization at age 8 predicted later suicide attempts and completed suicides for both boys and girls, while frequent bullying perpetration

at age 8 also predicted later suicide attempts and completed suicides for boys (Klomek et al., 2009).

Tfofi et al. (2011) reported that the probability of depression up to 36 years later was much larger for victimised students when compared to non-bullied peers, even after controlling for other factors. In a large scale study with 14,500 participants in the UK, Bowles et al. (2015) reported that peer victimisation in adolescence is a significant predictor of depression in early adulthood; about one in three cases of depression among young adults may be linked to peer victimisation in adolescence. Out of 683 people who reported they had been bullied at least once a week at the age of 13, nearly 15 % were depressed at 18 years. In a comparative study on the long term impact of bullying on mental health, Lereya et al. (2015) used data from two longitudinal data bases, one in in the UK (4,026 children) and the other in the US (1,420 children). They reported that children who were both maltreated and bullied were at increased risk for overall mental health problems, anxiety, and depression according to both cohorts, and for self-harm according to the English cohort. Children who were bullied by peers only were more likely than children who were maltreated only to have mental health problems in both cohorts, including anxiety, depression and self harm. Van der Wal et al.'s (2003) research on 4,811 children aged 9 to 13 in schools in Amsterdam, observed that depression and suicidal ideation are common outcomes of being bullied in both boys and girls; direct physical bullying had a significant effect on depression and suicidal ideation in girls, but not in boys. Relational bullying including exclusion bullying had a stronger effect than physical bullying on depression and suicidal ideation in both boys and girls.

The Finnish population based, longitudinal birth cohort study of 2551 boys from age 8 years to 16-20 years (Sourander et al., 2007) found that frequent bullies display high levels of psychiatric symptoms in childhood. Sourander et al. (2007) observed that frequent bullies with conduct and hyperactivity problems and not the bullies per se are the ones at elevated risk for later criminality. Correlational studies cannot demonstrate causality, only associations of varying strengths. In contrast, longitudinal studies can provide stronger inferences about causal relations, when controlling for other factors.

In their systematic review of 28 longitudinal studies, Tfotfi et al (2011b) and Farrington et al. (2012) reported that bullying perpetrators are likely to offend and to engage in violent behaviour six years later, while victims were likely to manifest symptoms of depression seven years later, in both instances even after controlling for other risk factors in childhood. Boys who are bullying perpetrators have been reported to be in particular at increased risk for later offending (Sourander et al., 2011). Ttofi et al.'s (2011) meta-analysis found that bullying perpetration was related to later offending, but the size of this effect decreased as more confounders were included in the analysis and follow-up periods increased.

Rodkin, Espleage and Hamish (2015) argue that the evidence for the link between bullying perpetration and long term negative outcomes, holds only for incidental models of bullying perpetration, namely that perpetration is the result of some underlying disorder, but not for causal models, suggesting that perpetration itself contributes actively to psychopathology later on in adult life. In a review of the literature on peer victimisation, McDougall and Vaillancourt (2015) analysed prospective studies tracking children and adolescents into young adulthood. They use the construct of 'multifinality' in their analysis, suggesting that the impact of childhood victimisation on adulthood adjustment may follow different, multiple pathways,

varying according to the systemic context of the individual. The authors suggest that while there is longitudinal evidence that victimisation in childhood and adolescence, particularly at the ages of 8 to 14, is linked to poor adjustment in academic, social, self, physical, internalising and externalising areas, there are still doubts whether the effects of victimisation are contained within the school years or follow into adulthood. The authors reviewed 17 prospective studies and concluded that there is a direct path between childhood peer victimisation and poor long term outcomes in adulthood. Studies which controlled for related symptoms and behaviour in childhood suggest suicide for men and women and aggression and heavy smoking for men, but in a number of cases the association between peer victimisation and adjustment in adulthood did not hold when it was controlled for earlier adjustment. McDougall and Vaillancourt (2015) identified various factors which mediated and moderated victimisation, acting as protective or risk factors, leading to different pathways in adulthood adjustment; these include the classroom context, the timing of victimisation, *the presence or absence of support*, and the role of self evaluations. The authors conclude that at least some victimised children, especially those experiencing other mental health difficulties, are more prone to adjustment problems in adulthood. However, there are multiple pathways involved in the process, and the impact of early victimisation is greater when combined with other risks. Using a systematic review of prospective longitudinal studies which focused on internalizing and externalizing adjustment in the case of peer victimisation in childhood, Ttofi et al. (2014) found that a number of factors, including individual factors such as social skills and academic achievement, family factors as stability and healthy relationships and peer social support operated as protective factors against later adulthood problems.

Wolke et al (2013) in Western North Carolina longitudinal study examined 1400 people regarding their reported experiences of bullying perpetration, victimization, or both between ages of 9-16. Follow up at ages 19, 21 and 24-26 indicate that those who were bullied were more likely to have a diagnosable anxiety disorder in adulthood, while both perpetrators and victims were more susceptible to depression. Perpetrators were more at risk of later antisocial personality disorder. Gender differences were observed, where both female perpetrators and victims were increasingly likely to experience adult agoraphobia, in contrast to males who were more at risk of suicide. This study controlled for premorbid childhood psychopathology, so an implication can be made that these were consequences of the bullying experiences and not simply antecedent to them. In this study, victims and particularly bully-victims differed from children not involved in bullying by growing up more often in marginalised families and having more mental health problems in childhood.

As Rinehart and Espelage (2015) highlight, homophobic name-calling is correlated with an increase in anxiety, depression, personal distress, suicidality, and other mental health problems. LGBT students are more than twice as likely as their peers to be depressed and think about or attempt suicide (Russell and Joyner, 2001). In one of the main studies which examined the negative impact of homophobic bullying with 9,188 American 9th to 12th grade students, which included 315 LGBT young people, Bontempo and D'Augelli (2002) found that LGBT students who experienced high levels of bullying, reported higher levels of substance use, suicidality, and sexual risk behaviours than heterosexual peers who also reported high levels of victimization.

Against the backdrop of these pervasive associations between bullying and mental health issues and early school leaving related risk factors, it is evident that bullying in schools is *both an*

education and a health issue. It requires an integrated strategic policy response across both departments. **It is an issue of trauma and requires recognition as such**. The wide range of detrimental outcomes arising from bullying in school highlights that this is a serious issue for child and youth welfare. It is also a child protection issue (Farrelly, 2007; 8th European Forum on the Rights of the Child, 2013).

2) **Early Intervention is needed to Prevent the Impact of Bullying on Mental Health and for Support Services for Perpetrators: This Requires Specialist Emotional Counselling/Therapeutic Supports in and around Primary and Secondary Schools**

Given the seriousness of the long-term impacts of bullying, a prevention strategy needs to encompass not only prevention of the bullying but *prevention of the consequences* of bullying through a holistic focus on system level emotional, cognitive and social supports. This prevention of consequences approach needs a much firmer policy focus. From the following illustrative examples from qualitative research on the consequences of bullying in victims' experiences, such supports could intervene at an early stage to prevent the escalation of experiential processes, such as self-doubting and double victimising, described in a Swedish context (Thornberg et al., 2012). The concept of double victimising refers to an interplay and cycling process between external victimising and internal victimising. They internalised the socially constructed victim-image and acted upon this image, which in turn often supported the bullies' agenda and confirmed the socially constructed victim-image. Research examining cognitive perceptions in children who participate in bullying has found that many involved children experience cognitive distortions (Doll and Swearer, 2006).

Radliff et al. (2015) is the first study to examine hopelessness as a mediator within the context of bullying. In a sample of 469 US middle school students, victims reported the highest levels of hopelessness and significantly higher scores compared with students not involved in bullying. Hopelessness was a mediator for victims, but not for bully-victims. Thornberg's (2015) Swedish ethnographic fieldwork in two public schools was located in urban neighbourhoods of different socioeconomic statuses, representing both lower and middle classes, in a medium-sized city. In total, 96 students (50 boys and 46 girls) from four school classes (two classes in Grade 4 and two classes in Grade 5) participated along with four teachers. The children's age ranged from 10 to 12 years. Striving towards social acceptance appeared to be associated with efforts to change oneself and to socialise, perceiving the minority identity as unchangeable and inevitably causing bullying and social rejection appeared to be linked to resignation and a range of escape or avoidance behaviour, such as social withdrawal and avoiding others, as well as trying to be socially invisible in the classroom and other school settings. **This has implications for the potential role of emotional counselling/therapeutic supports in and around schools in helping students construe their reactions to bullying and to minimise self-blaming approaches.**

From their longitudinal study in Finland, Sourander et al. (2007) conclude, 'early crime prevention that focuses on bullying should be one of the highest priorities in child public health policy. Frequent bullying may serve as an important red flag that something is wrong and that intensive preventive or ameliorative interventions are warranted' (p.550). **This requires intensive individual emotional counselling/therapeutic supports in and around schools for early intervention (Downes 2020).**

3) Increased Curricular Time Needed for SPHE and for Integration of Social and Emotional Education Across the Curriculum

Influential international meta-analysis points to a range of benefits from curricular approaches to social and emotional education (SEE). SEE embraces a range of holistic approaches to wellbeing, emphasising awareness of emotions, caring and concern for others, positive relationships, making responsible decisions, resolving conflict constructively and valuing students' thoughts, feelings and voices (see also Weissberg et al. 2015; Brackett et al. 2015). A study of more than 213 programmes found that if a school implements a quality SEE curriculum, they can expect better student behaviour and an 11 point increase in test scores (Durlak et al., 2011). Durlak et al. (2011) review found most success for those SEE approaches that incorporated four key combined SAFE features: Sequenced step-by-step training, active forms of learning, focus sufficient time on skill development and explicit learning goals. Another key finding, echoed also by another meta-analysis by Sklad et al. (2012), was that classroom teachers and other school staff effectively conducted SEE programmes so these can be incorporated into routine educational activities and do not require outside personnel. A limitation acknowledged in Durlak et al. (2011) is that nearly one third of the studies contained no information on student ethnicity or socioeconomic status. 56 % were delivered to primary school students, 31 % to middle school students. A further limitation is that most of the reviewed studies took place in a US context and may not directly transfer to European contexts. Nevertheless, Sklad et al.'s (2012) meta-analysis which includes more European studies (11 out of 75 studies, i.e. 14.7 %) found no significant variation between US studies and other parts of the world in effect size for social skills (though there was only one non-US study for antisocial behaviour).

Durlak et al. (2011) highlight a range of SEE benefits indirectly related to bullying and school violence, for outcomes on SEE skills, Attitudes, Positive Social Behaviour, Conduct Problems, Emotional Distress and Academic Performance. Questions still remain about change to bullying behaviour, as distinct from attitudes. A recent review for the EU Commission emphasizes the need for a whole school approach to promoting SEE and wellbeing as part of a focus on developing inclusive systems in schools (Cefai, Downes & Cavioni 2021). This is resonant with a focus on connective relational spaces in school microsystems for bullying prevention (Downes 2009, 2020).

Sklad et al.'s (2012) meta-analysis of recent, school-based, universal programmes concentrated on ones that promote development rather than prevent specific problems such as bullying. However, it is strongly resonant with Durlak et al. (2011). The review of Sklad et al. (2012) found that SEE programmes showed statistically significant effects on social skills, antisocial behaviour, substance abuse, positive self-image, academic achievement and prosocial behaviour. Programmes had moderate immediate effects on positive self-image, prosocial behaviour, academic achievement and antisocial behaviour, improving each by nearly one half a standard deviation.

The increased emphasis given to personal and social development given in the new EU Key Competence for Lifelong Learning 2018, the Personal, Social and Learning to Learn Key Competence needs concrete impact in the Irish education system at primary and postprimary level. It is a concern that curricular time given to SPHE at primary level has been reduced in the past decade in Ireland (see also Ó Breacháin & O'Toole 2013) after the Literacy and Numeracy Strategy 2011.

4) There is a Growing Consensus on the Important of Differentiating Universal (All), Selected (Moderate Risk – Group) and Indicated (Chronic Need –Individual, Intensive Supports) Prevention Levels: The Indicated Prevention level of Individual Intensive Supports in and around Schools is a Clear Gap in the Irish Action Plan on Bullying 2013

There is 'a growing emphasis on the use of multi-tiered approaches' (Rivara & Le Menestrel, 2016, p. 19), specifically this three-tier level of prevention. For mental health services generally, distinctions can be made between universal intervention as school-wide positive behavioural supports, school climate promotion, targeted interventions for students at risk (e.g. social skills and anger management groups, classroom management strategies), and intensive individualized interventions with community support (e.g. therapy, implementation of behaviour intervention plans) in schools (Suldo, Friedrich, & Michalowski, 2010).
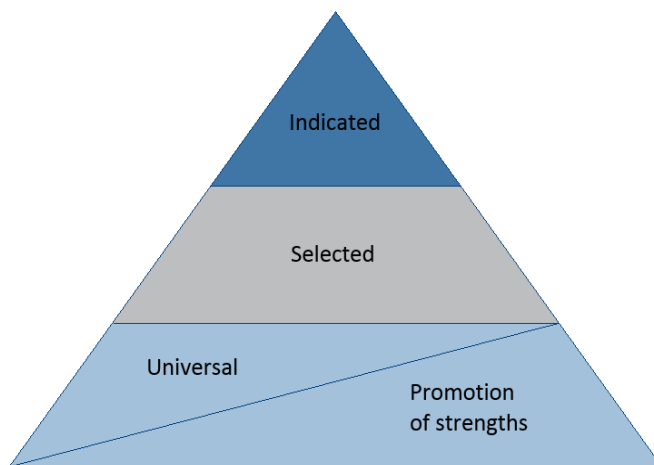
Universal – *All*

Selected – *Some, Groups, Moderate Risk*

Indicated – *Individual, Intensive, Chronic Need*

Another account of the three-tier public health model envisages selected prevention as more intensive social skills training and emotion-regulation approaches for small groups of youth at risk for becoming involved in bullying (Bradshaw, 2013). In a 'A Call for More Effective Prevention of Violence in Response to the Shooting at Sandy Hook Elementary School', a Position Statement 2012 of the Interdisciplinary Group on Preventing School and Community Violence (Astor, Cornell, Espelage, Furlong, Jimerson, Mayer, Nickerson, Osher & Sugai 2012) supported a three-tier approach, operating at universal (school-wide), targeted (for students who are at risk), and intensive (for students who are at the highest levels of risk and need) levels. A US-wide three-tier model for providing a continuum of supports for positive behavioural interventions and supports (PBIS) estimates that 10% to 15% of students will not respond to universal school-wide interventions, but will benefit from increased structure and contingent feedback (Reinke, Splett, Robeson, & Offutt, 2009). The PBIS model across a range of over 6000 US schools, albeit focusing on disruptive behaviour rather than bullying, estimates that 5% of students do not respond favourably to universal or selected interventions and thereby require intensive intervention support – that is, indicated prevention (Reinke et

al., 2009). It is important to acknowledge that the percentages for each target group for selective and indicated prevention can be expected to vary considerably across different countries.

The need for a more differentiated approach to bullying research has been highlighted: "We think it is time for researchers to move beyond investigating whether program A works or not (i.e., main effects studies) to testing what works, for whom, and under what circumstances" (Smith, Salmivalli, & Cowie, 2012, p.438). Weare and Nind's (2011) European Union Dataprev project analysed reviews on mental health promotion and problem prevention in schools, to extract key evidence-based principles, approaches and interventions relevant to European contexts. Over 500 review studies were identified of which 52 reviews met the inclusion criteria. The scope of this review was much wider than simply antibullying programmes. Weare and Nind's (2011) review of reviews generally endorses a focus on universal prevention approaches, though subject to important caveats. Universal approaches on their own were not as effective as those that added a robust targeted element.

The Irish Department of Education and Skills Procedures on Bullying 2013 a) does not adequately distinguish these three distinct levels of prevention of bullying and b) is weak on the indicated prevention level of intensive individual supports for both perpetrators and victims of bullying in and around schools. Neither NEPS nor generic programmed approaches offer individual intensive one to one emotional counselling/therapeutic supports needed at this indicated prevention level. A continuum of need and risk requires recognition and not all bullying perpetrators or victims require referral to CAMHS (Child and Adolescent Mental Health Services) for clinical level or psychiatric supports. The clear strategic gap in system supports in schools is for emotional counselling/therapeutic supports in and around schools to prevent problems of trauma accelerating into clinical levels of need.

> 5) **Increased Funding for Parenting Programmes and Family Support Services Linked with Schools**

A review of research reveals strong grounds for interventions to include a parental dimension. Ttofi and Farrington's (2011) meta-analysis found that parent training was one of the program elements significantly associated with both a decrease in bullying and being bullied. Axford, Farrington et al.'s (2015) review of parental engagement and bullying suggests that there is good reason to involve parents in school-based bullying prevention. Given the parenting risk factors for bullying perpetration and victimisation, bullying prevention programmes could also usefully offer parenting education and support. **They highlight the findings of a systematic review by Lereya et al. (2013) involving 70 studies which concluded that both victims and bully/victims are more likely to be exposed to negative parenting behaviour, including abuse and neglect and maladaptive parenting**. Effects were small to moderate for victims (g= 0.10 to 0.31) but moderate for bully/victims (g= 0.13 to 0.68).

A developmental focus on aggression recognises that coercive exchanges co-occur with harsh parental discipline and conflictual family dynamics, and all are associated with later bullying (Espelage et al., 2013). Bolger and Patterson (2001) highlighted a significant association between parental maltreatment and pupil aggression in a US sample. This all points to the need for **increased a) parenting programmes on positive communication approaches across age**

ranges to develop a culture of emotionally empathic communication and **b) funding for family support services with stronger links between these and schools**

The question whether the systemic scope of whole school approaches would be strengthened by adding a parental involvement dimension was directly addressed in an Australian study by Cross et al. (2012). Cross et al.'s (2012) Australian study included a range of components, including whole-school, classroom, family and individual targeted (both selected and indicated levels), across all grade levels from 1 (5–6-year olds) to 7 (12–13-year olds). The family level activities worked in partnership with parents by building their awareness, attitudes and self-efficacy to role model and help their children to develop social competence and to prevent or respond to bullying. These activities also encouraged school and parent communication and parents' engagement with the school to reduce student bullying. *The high intensity intervention (wholeschool, capacity building support and active parent involvement) is somewhat more effective than the moderate intensity intervention which comprised whole-school and capacity building support only*, and substantially more effective than the low intensity intervention (the standard school program with no capacity support). The effectiveness of the high intensity intervention was evident among both the Grade 4 cohort tracked to Grade 6, and the Grade 6 cohort followed to Grade 7.

Cross et al. (2012) suggest more targeted parental engagement over and above that typically provided in a comprehensive whole-school program to reduce bullying. While their study focused on actively informing parents about bullying through and with their children, they acknowledge that limited training was provided for parents. While information may be needed for parents in some contexts, there is a need for a much wider strategy for parental engagement on this issue. It is notable that a feature of many approaches to parental involvement for bullying prevention are reliant on top-down, information based approaches rather than on ones that actively include the parents in constructing meaning and policy, and developing their parenting and communication skills (Downes & Cefai 2016).

6) Peer Challenger Approaches such as those Advocated by the Finnish KiVa Programme are Psychologically and Legally Questionable

Debate in the international literature on the role of peer supports for bullying prevention has tended to focus on the empirical efficacy or otherwise of such interventions. However, this needs to be more strongly combined with a legal focus that includes the maxim, *primum non nocere*, first do no harm. The negative unintended effects of interventions have tended to be neglected in international research on health promotion more generally (Langford et al. 2014).

The role of peer supports has tended to focus on fellow classmates as bystanders. Bystanders may occupy a range of participant roles. They can act as (1) assistants, who join the bully and begin to bully; (2) reinforcers, who provide support to bullies; (3) outsiders, who remain passive bystanders or leave the situation; and (4) defenders, who help the victim (Salmivalli, 1999). In Salmivalli and Poskiparta's (2012) words, 'The indicated actions involve discussions with victims and bullies, as well with selected prosocial classmates, who are challenged to support the victimized classmate' (p.295).

Ttofi and Farrington (2012) offer a strong critique of such peer support approaches that questions both their efficacy and harmful side-effects. Ttofi and Farrington (2012) observe that evaluations indicate the 'not encouraging' conclusions: although peer support schemes appear

effective based on attitudinal surveys, these schemes are not related to actual levels of bullying or victimization and are quite often related to an *increase* in bullying and victimization. Their analysis was of programmes involving 'work with peers', if it included peer mediation, peer mentoring, or engagement of bystanders in bullying situations. Programmes were not included as work with peers if they only had role playing exercises and 'quality circles' for bullying awareness, but no formal engagement of peers in tackling bullying.

Referring to Canadian research (Hawkins et al., 2001), Ttofi and Farrington (2012) raise further concerns with peer defenders intervening in aggressive ways, 'peer interventions may reinforce the aggressive behaviour of school bullies and promote a cycle of violence' (p.456).

Forsberg et al.'s (2014) Swedish qualitative research involved 43 semi-structured individual interviews aged 10-13 years across 5 schools. It observed that social hierarchies exist among the students, which are kept in mind when observing bullying and guide their actions by evoking and mutually interacting with self-protecting considerations (e.g. the fear of retaliation, social disapproval, social blunders, getting bullied, losing friends or losing social status). Whereas bystanders with self-protection concerns avoid intervening when the bullies are older than they are, they see themselves as more capable of intervening if they are older than the bullies. *A student's intuition about the risks of getting involved may not need to be challenged but rather listened to. Their fear of getting involved may be a rational fear, a reading of circumstances where intervening would place them also at heightened risk of being bullied, with potentially long-term damaging consequences that are now well-documented in the international research literature.* The position of Salmivalli and Poskiparta (2012) that such peers need to be 'challenged' to intervene requires much further consideration and caution, as does any such role proposed for 'Student Anti-Bullying Anbassadors'.

The range of serious associations with being bullied, recognised in a range of cross-cultural contexts and with potentially long-term effects, illustrate that this is a child welfare and child protection issue (Farrelly, 2007; 8th European Forum on the Rights of the Child, 2013). Against this backdrop, it raises questions for approaches that rely centrally on peer supports, including to challenge the passive bystander effect. Approaches that encourage student peers to intervene to defend the child or young person being bullied, or to offer supports to such a student are usually interrogated in terms of the efficacy or otherwise of these approaches. Salmivalli and her colleagues, in the KiVa national antibullying intervention in Finland, point to sizeable reductions in bullying (behaviour and not only attitudes) through a range of school system approaches that also centrally involve a peer support component with challenges to passive bystanders for them to intervene. From a child welfare and protection perspective, it is however problematic that a system response centrally relies on other children and young people's responses and involvement. Defenders who intervene may or may not be putting themselves at risk of being bullied, depending on the motivations and power of the child/children who are perpetrators of the bullying. A system response to emotional supports risks being negligent, if it relies centrally on children and young people to provide these supports for situations with such serious longterm consequences.

From a national policy perspective, it may also be problematic legally to place a burden of support on peers to deal with potentially highly complex emotional issues and to encourage interventions to *defend* the victim against the perpetrator of the bullying; interventions to defend may also be placing the child or young person at risk of themselves being bullied. At

least it is a reasonably foreseeable consequence that this could occur and this potentially breaches a duty of care on the State to all its students not to encourage them into situations of harm for them. This legal issue of negligence if the State promotes a peer defenders approach resonates also with the medical injunction, *primum non nocere*, first do no harm. This is not an argument against all aspects of peer support approaches. For example, Salmivalli (1999) makes an important distinction between the role of peers in refusing to reinforce a bullying process and in encouraging them to actively defend someone. Refusing to support a bullying process is a key role for peer support that differs from the unknown risks of actively defending someone.

The KiVa approach assumes the perpetrator's motivation is fundamentally to be interpreted in behaviourist and social learning theory terms of Bandura (1989), so that the reward patterns for bullying become changed through the social context of the peers' reactions: 'Bystanders maintain the bullying behaviour in part by assisting and reinforcing the bully, because such behaviours provide the bullies the position of power they seek after. On the other hand, if bystanders defend the victim, this turns bullying into an unsuccessful strategy for attaining and demonstrating high status. These views imply that a positive change in the bystanders' behaviours will reduce the rewards gained by bullies and consequently their motivation to bully in the first place' (p.797) (Kärnä et al., 2011b). Building on social-cognitive theory of Bandura (1989) (Kärnä et al., 2011a), according to Kärnä et al. (2011b), the KiVa program locates its theoretical background in the social status of aggressive children in general. It is assumed that bullies demonstrate their high status by harassing their low-status victims and that bullying is actually a strategy for gaining a powerful position in the peer group. In the KiVa program, bullying is viewed as a group phenomenon.

Yet a diversity of motivations for bullying and aggression needs further recognition here. Even within social learning theory, the bullying may be imitative, for example as an entrenched pattern from home or the local community, thereby going beyond aggression as simple reinforcement (see Bandura et al.'s 1961 well-known Bobo doll study). Again, even internal to a framework of social status theory, the motivational path is open to the bullying perpetrator to seek to sustain a high status through challenging threats to his/her authority such as that offered by a peer defender – this challenge obviously could include attempts to bully also the peer defender. Beyond the frameworks offered by Kärnä et al. (2011 a, b), issues of bullying and aggression linked with attachment issues arising from early childhood (Golding et al., 2013), sadistic aggression (Fromm, 1977) and emotional trauma may be more enduring; they may not be responsive to peer negative reinforcement and even be hostile to peer defenders. A social reinforcement framework assumes a level of extraversion (i.e., adjustment to the external social world, Downes, 2003) and empathy that may not be a feature of at least some perpetrators of bullying. While the KiVa explanatory framework is an important one, it is not an exhaustive explanation of motivations of perpetrators of bullying and violence. Exceptions to this framework need to be envisaged in a strategic approach.

A role for other children as support to victims in situations of bullying that are child welfare and child protection issues must not be an abdication of responsibility or displacement of responsibility onto children to cope with difficult, complex and emotionally fraught issues. It might be argued that once parental consent and student consent is given to engaging in a structured role of peer defender that this would be adequate. However, the issue is also one of *informed* consent with knowledge of the risks, and currently even such informed consent would

be problematic, based on a limited understanding available on the complexity of this issue in international research.

References

Action Plan on Bullying, Report to the Anti-Bullying Working Group to the Minister of Education and Skills 2013

Arbax (2012) *Report on inter-ethnic relations, school bullying and adolescent violence. Arbax General Report 9/2012* Last retrieved on 15th July 2015 from: http://www.schoolbullying.eu/

Arseneault, L., Bowes, L., & Shakoor, S. (2010). Bullying victimization in youths and mental health problems: 'Much ado about nothing'? *Psychological Medicine*, 40, 717–729.

Astor, R.A., Cornell, D.G., Espelage, D.L., Furlong, M.J., Jimerson, S.R., Mayer, M.J., Nickerson, A.B., Osher, D., & Sugai, G. (2012). *A call for more effective prevention of violence. In Response to the Shooting at Sandy Hook Elementary School*. Position Statement of the Interdisciplinary Group on Preventing School and Community Violence. Endorsed by 183 organizations and more than 200 prevention scholars and practitioners.

Axford, N., Farrington, D P., Clarkson, S., Bjornstad, G., Wrigley, Z and Hutchings, J. (2015). Involving parents in school-based programmes to prevent and reduce bullying: what effect does it have? *Journal of Children's Services,* in press.

Bandura, A., Ross, D., & Ross, S.A. (1961). Transmission of aggression through imitation of aggressive models. *Journal of Abnormal and Social Psychology*, 63, 575-582.

Bandura, A. (1989). Regulation of cognitive processes through perceived self-efficacy. *Developmental Psychology*, 25, 725-739

Beran, T. (2008). Consequences of being bullied at school. In D. Pepler and W. Craig (Eds.) *Understanding and addressing bullying: An international perspective* (pp. 44–66). Bloomington, IN: Authorhouse

Bjereld, Y., Daneback, K., Hrafnihildur, G, & Petzold, M. (2014) Mental health problems and social resource factors among bullied children in the Nordic Countries: A population based cross-sectional study. *Child Psychiatry and Human Development,* 46, 2.

Bolger, K. E., & Patterson, C. J. (2001). Developmental pathways from child maltreatment to peer rejection. *Child Development,* 72, 549-568.

Bontempo, D.E. & D'Augelli, A.R. (2002). Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behaviour. *Journal of Adolescent Health,* 30, 364-374.

Boulton, M. J., Trueman, M. & Murray, L. (2008). Associations between peer victimization, fear of future victimization and disrupted concentration on class work among junior school pupils, *British Journal of Educational Psychology,* 78, 473–489

Bowles, L, et al (2015). Peer victimisation during adolescence and its impact on depression in early adulthood: prospective cohort study in the United Kingdom. *British Medical Journal,* 350:h2469 doi: 10.1136/bmj.h2469

Brackett, M.A., Elbertson, N.A., & Rivers, S.E. (2015). Applying theory to the development of approaches to SEL. In J.A. Durlak, C.E. Domitrovich, C.E., R.P. Weissberg & T.P. Gullotta (eds.*), Handbook of social and emotional learning: Research and practice* (pp.20-32). London & New York: Guilford Press.

Bradshaw, C. P. (2013). Preventing bullying through positive behavioural interventions and supports (PBIS): A multitiered approach to prevention and integration. *Theory into Practice, 52*(4), 288–295. doi:10.1080/00405841.2013.829732

Brown, V., Clery, E., & Ferguson, C. (2011). Estimating the prevalence of young people absent from school due to bullying. *National Centre Soc Res* 1-61

Cefai, C., Bartolo P. A., Cavioni. V., Downes, P. (2018). *Strengthening Social and Emotional Education as a core curricular area across the EU: A review of the international evidence*. Luxembourg: Publications Office of the European Union/EU bookshop.

Cefai, C. Downes, P. Cavioni.,V. (2021). *A formative, inclusive, whole school approach to the assessment of social and emotional education in the EU*. Luxembourg: Publications Office of the European Union/EU bookshop.

Cross, D., Waters S. Pearce, N., Shaw, T., Hall M., Erceg E., Burns S., Roberts C., Hamilton, G. (2012). The Friendly Schools Friendly Families programme: Three-year bullying behaviour outcomes in primary school children. *International Journal of Educational Research*, 53, 394–406.

Doll, B., & Swearer, S. M. (2006). Cognitive-behavioural interventions for participants in bullying and coercion. In R. Mennuti, A. Freeman, & R. W. Christner (Eds.), *Cognitive behavioural interventions in educational settings: A handbook for practice* (pp. 183-201). New York: Routledge

Downes, P. (2003). The new curriculum of Social, Personal and Health Education in Irish primary schools: Self-awareness, introversion and the role of the teacher. *Kwartalnik Pedagogiczny*, 190 (4), 93-112.

Downes, P. (2009). Prevention of bullying at a systemic level in schools: Movement from cognitive and spatial narratives of diametric opposition to concentric relation. In S.R. Jimerson, S.M. Swearer, and D.L. Espelage (Eds.), *Handbook of Bullying in Schools: An International Perspective*, (pp.517-533). New York: Routledge.

Downes, P. (2020). *Reconstructing agency in developmental and educational psychology: Inclusive Systems as Concentric Space.* New York/London/New Delhi: Routledge

Downes, P. & Cefai, C. (2016). *How to tackle bullying and prevent school violence in Europe: Evidence and practices for strategies for inclusive and safe schools.* Luxembourg: Publications Office of the European Union/EU bookshop.

Downes, P. & Cefai, C. (2019). Strategic Clarity on Different Prevention Levels of School Bullying and Violence*: Rethinking Peer Defenders and Selected Prevention. Journal of School Violence*, 18 (4) 510-521

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D. & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development,* 82, 405–432.

Espelage, D. L., Low, S., Rao, M. A., Hong, J. S., & Little, T. (2013). Family violence, bullying, fighting, and substance use among adolescents: A longitudinal transactional model. *Journal of Research on Adolescence.* 1-13.

European Forum on the Rights of the Child (8th) (2013). *The role of child protection systems in protecting children from bullying and cyberbullying.* Background paper for Session 3. Brussels, December 17-18.

EU COUNCIL RECOMMENDATION of 22 May 2018 on Key Competences for Lifelong Learning

Proposal for a COUNCIL RECOMMENDATION on Key Competences for Lifelong Learning (Text with EEA relevance) {SWD(2018) 14 final} Brussels, 17.1.2018 COM(2018) 24 final 2018/0008 (NLE)

Farrelly, G. (2007). Bullying and Social Context: Challenges for Schools. In Downes, P & Gilligan, AL (Eds) *Beyond educational disadvantage* (pp.429-440). Dublin: Institute of Public Administration.

Farrington, D,P., Losel, F.,, Ttofi, M., & Thoedorakis, N. (2012). *School bullying, depression and offending behaviour in life. An updated systematic review of longitudinal studies.* Stockholm: Swedish National Council for Crime Prevention.

Fisher, H.L, Moffitt, T.E., Houts, R.M., Belsky, D.W., Arseneault,L. & Caspi, A. (2012). Bullying victimisation and risk of self harm in early adolescence: longitudinal cohort study. *British Medical Journal*, 344:e2683.

Forsberg, C., Thornberg, R. and Samuelsson, M. (2014). Bystanders to bullying: fourth- to seventh-grade students' perspectives on their reactions. *Research Papers in Education*, 29 (5), 557-576

Fried, S., and Fried, P. (1996). *Bullies and victims: Helping your child through the schoolyard battlefield.* New York: M. Evans.

Fromm, E. (1977). *Anatomy of human destructiveness.* Harmondsworth: Penguin.

Gladstone, G. L., Parker, G. B & Malhi, G. S. (2006). Do bullied children become anxious and depressed adults?: A cross-sectional investigation of the correlates of bullying and anxious depression. *Journal of Nervous and Mental Disease, 194,* 3, 201-8.

Golding, K.S., Fain, J., Frost, A., Mills, C.,Worrall, H., Roberts, N., Durrant, E. & Templeton, S. (2013). *Observing children with attachment difficulties in school: A tool for identifying and supporting emotional and social difficulties in children aged 5-11.* London, Philadelphia: Jessica Kingsley

Green, R., Collingwood, A. & Ross, A. (2010). *Characteristics of bullying victims in schools.* Department Education, London.

Hawkins, D.L., Pepler, D. J and Craig, W. M. (2001). Naturalistic observations of peer interventions in bullying. *Social Development,* 10, 512–527.

Houbre, B., Tarquinio, C., Thuillier, I., & Hergott, E. (2006). Bullying among students and its consequences on health. *European Journal of Psychology of Education*, 21(2), 183-208.

Ivarsson T, Broberg AG, Arvidsson T, & Gillberg C. (2005) Bullying in adolescence: psychiatric problems in victims and bullies as measured by the Youth Self Report (YSR) and the Depression Self-Rating Scale (DSRS). *Nordic Journal of Psychiatry*, 59, 365–373.

Jantzer, V., Haffner, J., Parzer, P. & Resch, F. (2012): Victims of bullying at school: Depression, suicidality, and self-harm in German adolescents. *Kindheit und Entwicklung*, 21, 40-46

Juvonen, J., & Graham, S. (2014) Bullying in schools: The power of bullies and the plight of victims, *Annual Review of Psychology*, 65, 159-185.

Kaltiala-Heino, R., Rimpela, M., Rantanen, P., & Rimpela, A. (2000). Bullying at school: An indicator of adolescents at risk for mental disorders. *Journal of Adolescence*, 23, 661–674

Kärnä, A., Voeten, M., Little, T., Alanen, E., Poskiparta, E., & Salmivalli, C. (2011a). *Effectiveness of the KiVa antibullying program: Grades 1–3 and 7–9. Journal of Educational Psychology*, 105, 535-551.

Kärnä, A., Voeten, M., Little, T.D., Poskiparta, E., Erkki Alanen, E. & Salmivalli, C. (2011b) Going to Scale: A Nonrandomized Nationwide Trial of the KiVa Antibullying Program for Grades 1–9. *Journal of Consulting and Clinical Psychology* 79(6), 796-805.

KiVa (2015). http://www.kivaprogram.net/is-kiva-effective. Last retrieved, October 2015.

Klomek AB, Marrocco F, Kleinman M, Schonfeld IS, Gould MS. (2007).Bullying, depression, and suicidality in adolescents. *J Am Acad Child Adolesc Psychiatry*., 46:40–49.

Klomek, A. B., Sourander, A., Niemelä, S., Kumpulainen, K., Piha, J., Tamminen, T., Gould, M. S. (2009). Childhood bullying behaviours as a risk for suicide attempts and completed suicides: A population-based birth cohort study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 48, 254-261.

Kokkinos, C. M., & Panayiotou, G. (2004). Predicting bullying and victimization among early adolescents: Associations with disruptive behaviour disorders. *Aggressive Behaviour, 30*, 520 33.
Kumpulainen, K., Rasanen, E., Henttonen, I., et al. (1998). Bullying and psychiatric symptoms among elementary school-age children, *Child Abuse and Neglect,* 22(7), 705–717.

Langford R, Bonell CP, Jones HE, Pouliou T, Murphy SM, Waters E, Komro KA, Gibbs LF, Magnus D, Campbell R (2014). *The WHO Health Promoting School framework for improving the health and well-being of students and their academic achievement*. Cochrane Database of Systematic Reviews , Issue 4.

Lereya, S. T., Winsper, C., Heron, J., Lewis, G., Gunnell, D., Fisher, H. L., & Wolke, D. (2013). Being bullied during childhood and the prospective pathways to self-harm in late adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52, 608 – 618. e2.

Lereya, S.T., Copeland, W.E., Costello, E.J. & Wolke, D. (2015). Adult mental health consequences of peer bullying and maltreatment in childhood: two cohorts in two countries. *The Lancet Psychiatry,* 2 (6), 524-531.

McDougall, P., & Vailliancourt, T. (2015). Long-term adult outcomes of peer victimization in childhood and adolescence: Pathways to adjustment and maladjustment. *American Psychologist, 70,* 300–310.

Nakamoto, J. & Schwartz, D. (2010). Is peer victimization associated with academic achievement? A meta-analytic review, *Social Development*, 19, 221- 242.

Nansel, T. R., Overpeck, M.D, Haynie, D. L., Ruan, J., Scheidt, P.C. (2003). Relationships between bullying and violence among youth. *Archive of Pediatric Adolescent Medicine,* 157, 348-353.

Nansel, T. R., Craig, W., Overpeck, M. D., Saluja, G., & Ruan, W. J. (2004). Cross-national consistency in the relationship between bullying behaviours and psychosocial adjustment. *Archives of Pediatric and Adolescent Medicine*, 158, 730–736.

Ó Breacháin, A. & O'Toole, L. (2013). Pedagogy or politics?: Cyclical trends in literacy and numeracy in Ireland and beyond. *Irish Educational Studies*, 32 (4), 401-419.

Radliff, K.M., Wang, C. & Swearer, S.M. (2015). Bullying and Peer Victimization: An Examination of Cognitive and Psychosocial Constructs *Journal of Interpersonal Violence* 1–23

RasKauskas, J.L., Gregory, J., Harvey, S.T., Rifshana, F., & Evans, I.M. (2010). Bullying among primary school children in New Zealand: Relationships with prosocial behaviour and classroom climate. *Educational Research*, 52, 1-13.

Reinke, W.M., Splett, J.D., Robeson, E.N. and Offutt, C.A. (2009). Combining school and family interventions for the prevention and early intervention of disruptive behaviour problems in children: A public health perspective. *Psychology in the Schools,* 46(1), 33-43.

Rinehart, S. J., & Espelage, D. L. (2015). A multilevel analysis of school climate, homophobic name-calling, and sexual harassment victimization/perpetration among middle school youth. *Psychology of Violence*. Online first.

Rivara, F., & Le Menestrel, S. (Eds.). (2016). *Committee on the biological and psychosocial effects of peer victimization: Lessons for bullying prevention; national academies of sciences, engineering, and medicine*. Washington, DC: National Academies Press (US).

Rodkin, P.C., Espelage, D.L., Laura D. Hanish, L.D., (2015). A Relational Framework for Understanding Bullying Developmental Antecedents and Outcomes. *American Psychologist*, 70, (4), 311–321.

Russell ST & Joyner K. (2001) Adolescent sexual orientation and suicide risk: evidence from a national study. *American Journal of Public Health*, 91(8), 1276–1281.

Salmivalli, C. (1999). Participant Role Approach to School Bullying: Implications for Interventions. *Journal of Adolescence,* 22, 453–459.

Salmivalli, C. & Poskiparta, E. (2012). KiVa antibullying program: Overview of evaluation studies based on a randomized controlled trial and national rollout in Finland. *International Journal of Conflict and Violence*, 6 (2), 294-302.

Sklad, M., Diekstra, R., Ritter, M., Ben, J and Gravesteijn, C. (2012). Effectiveness of school-based universal social, emotional, and behavioural programmes: Do they enhance students' development in the area of skill, behaviour, and adjustment? *Psychology in the Schools*, 49 (9), 892-909.

Smith, P., Salmivalli, C & Cowie, H. (2012). Effectiveness of school-based programmes to reduce bullying: a commentary. *Journal of Experimental Criminology,* 8, 433–441.

Sourander, A., Jensen, P., Ronning, J.A. et al. (2007). Childhood bullies and victims and their risk of criminality in late adolescence: The Finnish from a boy to a man study. *Arch Pediatr Adolesec Med,* 161, 546-552.

Sourander A, Ronning J, Brunstein Klomek A, Gyllenberg D, Kumpulainen K, Niemelä S, Helenius H, Sillanmäki L, Tamminen T, Moilanen I, Piha J, Almqvist F. (2009). Childhood Bullying Behaviour, and Later Psychiatric Hospital and Psychopharmacological Treatment Findings From the Finnish 1981 Birth Cohort Study. *Arch Gen Psychiatry,* 66(9), 1005–1012.

Sourander A, Brunstein Klomek A, et al. (2011). Bullying at age eight and criminality in adulthood: findings from the Finnish Nationwide 1981 Birth Cohort Study. *Social Psychiatry and Psychiatric Epidemiology*, 46(12), 1211–1219.

Suldo, S.M., Friedrich A & Michalowski, J. (2010). Personal and systems-level factors that limit and facilitate school psychologists' involvement in school-based mental health services. *Psychology in the Schools,* 47,(4) 354-373.

Swearer S.M., Wang C., Maag J.W., Siebecker A.B., Frerichs, L.J. (2012). Understanding the bullying dynamic among students in special and general education. *Journal of School Psychology*, 50 (4), 503-20.

Thornberg, R. (2015). School bullying as a collective action: Stigma processes and identity struggling. *Children & Society* 29, 310–320.

Thornberg, R., Tenenbaum, L., Varjas, K., Meyers, J., Jungert, T., & Vanegas, G. (2012). Bystander motivation in bullying incidents: To intervene or not to intervene? *Western Journal of Emergency Medicine,* 13, 247-252.

Ttofi MM & Farrington D P. (2011) Effectiveness of school-based programmes to reduce bullying: a systematic and meta-analytic review. *Journal of Experimental Criminology.* 7(1):27–56.

Ttofi MM, Farrington DP, Friedrich, L and Loeber, R. (2011). The predictive efficiency of school bullying versus later offending: A systematic/meta-analytic review of longitudinal studies. *Criminal Behaviour and Mental Health.* 21(2):80–89

Ttofi, M.M. & Farrington, D.P. (2012). Bullying prevention programmes: The importance of peer intervention, disciplinary methods and age variations. *Journal of Experimental Criminology*, 8, 443–462

Ttofi, M.M., Bowes, L., Farrington, D.P., & Lösel, F. (2014). Protective factors that interrupt the continuity from school bullying to later internalizing and externalizing problems: A systematic review of prospective longitudinal studies. *Journal of School Violence*, 13, 5 - 38.

Van der Wal, M. F., de Wit, C. A. & Hirasing, R. A. (2003). Psychosocial health among young victims and offenders of direct and indirect bullying. *Pediatrics*, 111(6), 1312–1317.

Weare, K. & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say ? *Health Promotion International,* 26, 29-69.

Weissberg, R.P., Durlak, J.A., Domitrovich, C.E., & Gullota, T.P. (2015). Social and emotional learning: Past, present and future. In J.A. Durlak, C.E. Domitrovich, C.E., R.P. Weissberg & T.P. Gullotta (eds*.), Handbook of social and emotional learning: Research and practice* (pp.3-19). London & New York: Guilford Press.

Wolke,D.,Copeland, W.E., Angold,A. & Costello, E.J. (2013) Impact of Bullying in Childhood on Adult Health, Wealth, *Crime and Social Outcomes. Psychological Science,* 24 (10) 1958–1970.

■■■