2011

National Safe Schools Framework: Policy and Practice to Reduce Bullying in Australian Schools

Donna Cross
Edith Cowan University

Melanie Epstein
Edith Cowan University

Lydia Hearn
Edith Cowan University

Phillip Slee
Flinders University

Therese Shaw
Edith Cowan University

See next page for additional authors

10.1177/0165025411407456

Authors
Donna Cross, Melanie Epstein, Lydia Hearn, Phillip Slee, Therese Shaw, and Helen Monks

Consent paper outline - ANZJPH

Title:

Abstract

Objective: Increasingly, researchers are required to obtain active parental consent prior to surveying children and adolescents in schools. This study assessed the potential bias present in a sample of actively consented students, and in the estimates of associations between variables obtained from this sample.

Methods: 3,496 students from 36 non-government metropolitan schools completed an online baseline survey in 2010 as part of the Cyber Friendly Schools Project in Perth, WA. Students with active (35%) and passive (65%) parental consent were compared on a range of variables including demographic, bullying and social-emotional outcomes. The moderating effects of consent status on associations between the bullying and other outcomes were tested.

Results: The students with active parental consent were underrepresented among those students involved in problem behaviours such as bullying others, they were also more likely to have lower pro-social scores and academic scores and live with one parent who was older than other parents.. Consent status was found to be a significant moderator of the associations between bullying victimisation and certain social-emotional variables.

Conclusions and Implications:

Active only parental consent leads to biased samples and estimates of associations between outcomes of interest. Strategies to boost response rates to levels sufficient to warrant the conduct of the research are labour-intensive and costly, and the obtained samples are still likely to be biased. For low risk research, such as the completion of health surveys, rigorous active-?passive consent procedures which result in higher participation rates, lower costs and reduced burden on teachers and schools, are preferred.

Key words: parental consent, bias, ethics, student survey, bullying?

In 2013 in Australia all state government education departments and several non-government education sectors mandate that active parental consent is required prior to student participation in research conducted external to the school. Researchers are required to obtain signed consent from parents for their child to participate in a study, the equivalent of an "opt-in" system. Procedures which include a passive consent phase, where parents are required to "opt-out" and non-response is seen as implied consent, do not comply with these regulations. It is important to note that in most school-based evaluations of health programs, such as those addressing bullying or tobacco and drug use, consent from parents is only required for data collection as schools have the authority to implement programs deemed to be beneficial to students. This paper will explore the impact of required active parental consent when administering health-related surveys to students, particularly those aged between 10 and 16 years.

Educators and health practitioners are reliant on research evidence to determine the most effective policies and practices to implement to enhance health-related behaviours in young people. Many research studies utilise student surveys to collect health outcome data and evaluate program impact, and the participation of a representative group of? young people in such research is fundamental. The NHMRC National Statement on Ethical Conduct in Human Research (hereon referred to as the "National Statement") states that, in addition to obtaining consent from the minor whenever he or she has the capacity to grant it, parental consent is needed when surveying minors, particularly young people of "developing maturity" and children.[1] The National Statement does not, however, distinguish between active and passive forms of parental consent.

Consent procedures vary across studies from passive only to active only procedures and combinations of the two, with no or different degrees of follow-up. For example, typically in active-passive procedures parents are approached once or twice for active consent, followed by one to two further contacts seeking passive consent from non-respondents. Thus, parents are first asked to opt-in and then if they don't respond they are informed that consent will be assumed unless they opt-out and indicate their non-consent. Response rates vary widely according to the form of consent required, the extent and mode of contacts with parents and as well as other factors such as the use of incentives.[2]

Participation rates in health-related studies under passive consent conditions are often above 90%,[3-6] i.e. a minority of parents actively refuse permission for their child to participate. In comparison, in studies conducted in the last 10 years, participation rates under active consent conditions were between 27% - 76% [3-5, 7, 8] with higher rates of 80% [9] and 95% [10] achieved with considerable expenditure of resources to obtain consent information from parents. The financial cost for securing consent in one study was estimated at US$7 per participant[9].

Participation rates dropped from over 90% to below 40% when consent procedures were switched from passive to active in the International Study of Asthma and Allergies in Childhood (ISAAC).[3] A

comparison of mixed and active only consent procedures in the 1999 Australian Secondary Students' Alcohol and Drug Survey (ASSAD) amongst Year 7-10 students in Victoria, yielded rates of 84% and 70% respectively.[11] In the Australian Covert Bullying Prevalence Study (ACBPS) the mean consent rates were 36% when active consent was required and 96% when using an active-passive procedure[12].

Comparisons of students with active only to students with other forms of parental consent found the active consent group constituted a biased sample under-representing students who were male[7, 8, 13], older[7], less academically competent[8, 14], from minority groups[6, 8, 13], absent more often from school[10, 14], less involved with their parents and less likely to live with both parents[13]. Students of non-responding parents were also more involved in and more at risk of involvement in problem behaviours such as aggression, tobacco use and alcohol and other drug use[6-8, 11, 13], and more likely to be overweight or at risk of being overweight[5].

While limited information is available on the characteristics of non-responding parents, available research shows that 87% of non-responders to a passive consent process had received and understood the materials, and had consciously decided to allow participation. Thus, non-response was more likely to indicate consent than refusal.[15] While non-responding parents were more likely to be employed, their attitudes to research were more similar to consenting parents, than those who refused consent.[16]

Passive or opt-out consent procedures are typically recommended for low-risk research to avoid non-response bias.[17-19] Research is defined in the National Statement as "low-risk" if the "only foreseeable risk is one of discomfort".[1] However, limited studies have assessed the impact on young people of completing health surveys. In a study by Langhinrichsen-Rohling and colleagues[20], 4.4% of students often felt upset while completing a survey which included questions on sensitive topics such as suicidal behaviour and physical and sexual abuse. Having experienced the sensitive events in their lives was a predictor of level of emotional response to completing the survey. However, no adverse consequences were observed or reported during data collection in the three years of the study. Furthermore, the passive consent group were no more likely to report feeling upset than the active group indicating no increased risk for students without active parental consent. In a two-year smoking prevention trial no harm to students from participation was observed, and no parent complaints of negative outcomes were received as a result of their child's participation.[21]

Motivation and aim of this study

Two studies conducted by the Child Health Promotion Research Centre (CHPRC) at Edith Cowan University investigating bullying behaviours in schools in Western Australia recruited students in government schools using active parental consent procedures (as mandated by The Department of Education in Western Australia[22]). Parental consent rates for government school students were 15% and 18% respectively, with 5% and 7% of parents respectively refusing permission.[23, 24] These low

response rates were obtained despite using numerous strategies to increase parental participation in the consent process, such as up to three rounds of follow-up, the provision of small incentives and reply paid envelopes for the return of consent forms and multiple methods of contacting parents, including information letters and consent forms being sent directly to home addresses by the schools.[23, 24] Given these low rates, we explored the potential for bias in samples recruited under active only consent conditions on a range of demographic, bullying and social-emotional variables to somewhat similar students from non-government schools, recruited for the Cyber Friendly Schools project using the active-passive consent procedure. We also assessed the potential impact of these biases on the associations between bullying and other outcomes.

While the focus in this study is on parental consent, the need to ensure the young person's participation is voluntary and as informed as possible, and to obtain their consent is also fully recognised.

Methods

Procedure

The Cyber Friendly Schools Project was a group-randomised intervention trial conducted in secondary schools in Western Australia in 2010-2012.[25] All Perth metropolitan non-government secondary schools were approached for participation and 36 (68%) agreed. Most of the participating schools were co-educational (n=25), with 7 girls only and 4 boys only schools, whilst 16 were Catholic and 20 other non-government schools. All Year 8 students in recruited schools were eligible for participation and the recruited cohort was followed until the end of Year 10. The baseline 2010 data were analysed in this paper.

An active-passive consent process was followed to obtain consent from the Year 8 students' parents and caregivers for the students to complete a survey. Each school was provided with stamped, pre-packaged envelopes for school staff to attach address labels and mail to the students' home addresses. The parent/carer envelopes contained an information letter describing the study and requesting active consent for their child to participate, a consent form and a reply paid envelope. Parents who had not responded after two weeks were mailed a follow-up letter requesting passive consent for their child to participate in the study, a consent form and a reply paid envelope to return their response if they did not want their child to participate.

Student consent was obtained just prior to the survey administration, where students were informed of the purpose of the survey and that their participation was voluntary.

Students completed online surveys in Term 2, 2010 in controlled conditions during their normal classroom lessons. The surveys were administered by trained research staff according to a strict procedural protocol. Students were assured of the confidentiality of their responses. At the completion of the survey, all students were encouraged to speak with an adult they trust and received information regarding help they could access confidentially should the survey raise any concerns for them.

Ethics approval for the study was obtained from the Human Research Ethics Committee at Edith Cowan University and the Catholic Education Office of WA. Independent schools affiliated with the Association of Independent Schools of WA independently provided consent.

Measures

Demographic variables: Individual demographic variables included gender, age (12, 13, 14), self-reported academic performance, living with one parent or two parents/adults (used as a proxy measure for family socio-economic status). School variables included school sector (Catholic, Independent) and school type (co-educational, girls only, boys only).

Social-emotional outcomes:

Symptoms of depression and anxiety were assessed using the 14 item Depression Anxiety Stress Scale (DASS). Items had four response options ranging from 'Does not apply to me' to 'Most of the time'. The validity of DASS scores have been shown previously.[26, 27] Mean scores were calculated, with higher scores reflecting greater symptoms of depression (α = .92) and anxiety (α = .82).

The five subscales of the Strengths and Difficulties Questionnaire (SDQ) assessed emotional symptoms, conduct problems, peer problems, hyperactivity and pro-social behaviour.[28] Each subscale comprises five items with response options 'Not true', 'Somewhat true', 'Certainly true'. Means were obtained for each subscale, with higher scores representing greater levels of emotional symptoms (α=.73), conduct problems (α=.55), peer problems (α=.54), hyperactivity (α=.68) and pro-social behaviours (α=.72) and a total difficulties score was calculated using four of the subscales (α=.80).

The peer support scale (11 items, e.g. "How often would other students invite you to do things with them") was adapted from the Perceptions of Peer Social Support Scale.[29] The response options were 'Lots of times', 'Sometimes', 'Never'. The higher the mean score the greater the respondent's perception of support from his/her peers (α=.86).

Connectedness to school was measured using a five item scale (e.g. "I feel close to people at my school") adapted from the scale of Resnick and McNeely[30], with response options ranging from 'Never' to 'Always'. Mean scores corresponded to higher connectedness (α=.78).

Bullying outcomes:

Involvement in different forms of bullying victimisation and perpetration were measured using the respective versions of the Forms of Bullying Scale (FBS)[31] and cyberbullying victimisation and perpetration using two 11 item scales. Definitions of different forms of traditional bullying and cyberbullying, including examples and illustrations, were provided to students prior them completing the scales. The bullying and cyberbullying definitions were adapted from those developed by Olweus[32] and Smith[33] respectively, The response options correspond to the frequency of bullying within the previous 10 weeks at school: 'This did not happen to me/I did not do this'; 'Once or twice'; 'Every few weeks'; 'About once a week'; and 'Several times a week or more'. Higher mean scores represented greater involvement (victimisation: α=.87; perpetration: α=.85; cybervictimisation α=.86; cyberperpetration α=.91).

Consent status:

Students were categorised as having active parental consent if their parents returned a written consent form agreeing to their child's participation, or having passive parental consent if their parents did not return a form indicating either consent or non-consent (after being informed that non-response represents consent).

Statistical analyses

Logistic regression was applied in Stata 12.0 to identify the predictors of consent status to determine differences on the demographic, social-emotional and bullying variables between the consent groups. The impact of consent status on associations between the bullying and social-emotional variables was assessed by testing for interaction effects between consent status and the social-emotional variables on the bullying outcomes using tobit regression, as the bullying variables were highly skewed with percentages of 28% or more at the minimum value. Random intercepts were included in all models to account for school level clustering.

Results

At baseline, 7% of parents of the Year 8 cohort returned forms indicating they did not consent to their child's participation. In total, 3,496 students completed surveys (91% of those with consent), 35% with active parental consent and 65% passive consent. The sample comprised 52% female students, most were 13 years of age (85%), lived in a household with two parents/adult care-givers (86%) and attended co-educational schools (72%). About half attended non-Catholic non-government schools (51%). A minority perceived themselves to be academically less competent than their peers (9%). Table 1 describes the percentages of students with active consent within each demographic group.

Table 1: Active parental consent rates by demographic group

Demographic variable	Active consent rate
Gender	
Male	34%
Female	37%
Age	
12 years	42%
13 years	35%
14 years	25%
Family structure	
Single adult family	31%
Two adult family	36%
Academically compared to peers	
Worse	30%
Same or better	36%
School type	
Co-educational	34%
Girls only	40%
Boys only	39%
School sector	
Catholic	31%
Other non-government	40%

Note: Sample size varies between 3,433 and 3,495 due to missing values

Consent status was not predicted by gender or school type, but the parents of older students, students living with one parent/adult care-giver, attending Catholic schools and who reported they did not perform as well as their peers at school, were less likely to provide active consent (Table 2). Age and sector remained as independent predictors in multivariable analyses, and academic status was on the border of statistical significance.

Table 2: Demographic predictors of active parental consent

	Unadj. OR	(95% CI)	Adj. OR[a]	(95% CI)
Girl	1.16	(0.99-1.36)		
Age				
12 years	1.00	*p*=.014	1.00	*p*=.023
13 years	0.78*	(0.63-0.96)	0.81	(0.66-1.00)
14 years	0.51*	(0.30-0.88)	0.50*	(0.29-0.87)
Single adult family	0.80*	(0.65-0.98)		
Academically worse than peers	0.76*	(0.58-0.98)	0.77*	(0.59-0.997)
School type				
Co-educational	1.00	*p*=.127		
Girls only	1.29	(0.97-1.73)		
Boys only	1.26	(0.89-1.79)		
Catholic school	0.70*	(0.57-0.85)	0.71*	(0.58-0.87)

[a] Multivariable model including age, academic status and school sector; 'Single adult family' dropped as not significant in multivariable model.

No association was found between measures of mental health (depression, anxiety or emotional symptoms) and consent status (Table 3). Students who reported higher levels of conduct problems and

those who reported having bullied others, had significantly lower odds of active parental consent. In comparison, the odds of active consent increased with higher scores on the pro-social scale. Only pro-social skills remained as clearly significant after controlling for the demographic variables identified as independent predictors in the multivariable model reported in Table 2.

Table 3: Socio-emotional and bullying variables as predictors of active parental consent

	Unadj. OR	(95% CI)	Adj. OR[a]	(95% CI)
Social-emotional variables				
Depression	1.02	(0.90-1.16)		
Anxiety	1.01	(0.84-1.22)		
SDQ Emotional symptoms	0.92	(0.79-1.08)		
SDQ Conduct problems	0.76*	(0.61-0.95)	0.79	(0.63-1.00)
SDQ Hyperactivity	0.95	(0.81-1.12)		
SDQ Peer problems	0.93	(0.74-1.15)		
SDQ Pro-social	1.37*	(1.13-1.65)	1.38*	(1.14-1.67)
SDQ Total difficulties	0.81	(0.62-1.06)		
School connectedness	1.11	(0.99-1.26)		
Peer support	1.02	(0.85-1.24)		
Bullying variables				
Victimisation	1.00	(0.88-1.14)		
Perpetration	0.68*	(0.50-0.94)	0.72*	(0.52-0.999)
Cyber victimisation	0.90	(0.67-1.21)		
Cyber perpetration	0.72	(0.40-1.28)		

[a] Adjusted for age, academic status and school sector

Consent status was found to be a significant moderator of the associations between three predictors and victimisation, with significant interactions identified in the tobit regressions between consent status and school connectedness (z=2.46, *p*=.014), emotional symptoms (z=2.67, *p*=.008), and the SDQ total difficulties score (z=2.21, *p*=.027) respectively. The associations between each of school connectedness, emotional symptoms and the SDQ total difficulties scores and victimisation were significant within each consent group but stronger, in terms of larger regression coefficient values, in the group of students with active consent than those with passive consent. No moderating effects were found for the other bullying outcomes, namely perpetration, cybervictimisation or cyberperpetration.

Discussion

In accordance with the findings of others[6-8, 11, 13, 14] this study's results demonstrate that students with active parental consent differ systematically from the larger student population. Students involved in problem behaviours and with lower pro-social scores were less represented in this group, as were older and less academically competent students, as well as those living with one parent/adult care-giver. Students in single parent families may be less likely to have forms returned due to the increased

pressures on these households, while parents of older students may be less engaged with their child's school. More pro-social students presumably belong to families where these attitudes are valued, hence a parent is more likely to return consent forms.

The reason for parents of students in Catholic schools being less likely to return consent forms than other non-government schools is unclear, although the high socio-economic status of several of the non-Catholic schools may be a possible explanation. School SES has been found to be a predictor of active consent rates[9]. The lower participation of students engaged in problem behaviours, implies the exclusion of students most at risk who are likely to benefit from these research efforts.

Stronger associations were present in the active consent group between bullying victimisation and school connectedness, emotional symptoms and the SDQ total difficulties score, than in the group with passive consent. This has implications for studies aimed at estimating associations and effects, as the estimates may be biased[9]. Although the effects based on the active consent group were overestimated in this study, it is unclear in which direction the bias may operate for different outcomes. However, when assessing the effects of health programs, if students engaged in the at risk behaviours targeted by the program, i.e. those with the most potential to shift their behaviours as a result of the program, are under-represented in the sample, it is likely that the impact of effective programs will be underestimated. Further information on the impact or otherwise of active versus passive parental consent on study findings in health-related studies will be provided by a Cochrane review which is currently underway[34].

Ethics committees and school authorities need to be cognisant that requiring active consent has consequences and costs which need to be weighed against the potential harm completing surveys may have on young people, as well as the benefits gained from utilising consent procedures where passive parental consent is sufficient.

Research and anecdotal evidence indicates a low probability of harm to students as a result of completion of health surveys.[20, 21] This is the experience of the research team at the CHPRC, with no adverse outcomes to students from survey completion observed or reported in the conduct of ten large-scale projects in schools within the last 12 years. Whilst it is important to implement adequate measures to assist the small number of students who may be impacted negatively, current evidence suggests that completing health surveys (especially those which do not include highly sensitive items) is unlikely to lead to distress or other harm to students, and that this type of research can be viewed as low-risk[1].

The benefits of allowing passive parental consent are increased participation rates, often above 90% [3-6], thus avoiding the biased samples resulting from active only consent procedures[6-8, 11, 13, 14]. Lack of bias adds to the validity of the research and confidence in the findings. Given the potential for

response rates lower than 40%, the conduct of research under active consent conditions becomes impracticable. The use of active-passive procedures enables the conduct of research which provides more valid evidence on which to base health policy and practice.

The costs of mandating active only parental consent include the financial and organisational resources required to achieve response rates which justify the conduct of the research, as well as increases to the burden on research participants. All of these issues have implications in terms of research rigour and viability.

Various strategies have been proposed for improving response rates under active consent conditions[2, 6, 10], but these have been costed at between US$7 and US$32 (usually US$20-25) per completed survey [6, 9]. Whilst rigorous passive consent procedures also incur costs, high response rates are only achieved for active processes which include strategies such as telephoning non-responding parents, repeated visits to each school by researchers and large expenditure on incentives.[8-10] Researchers, especially those conducting intervention research requiring large samples of schools and students, will have difficulty funding these additional costs within limited research budgets. Furthermore, expenditure of the limited resources within research projects on costly measures to improve response rates limits the funds and time available for the development of health interventions and assisting schools in the implementation of health strategies.

Apart from the added financial burden, some of the identified strategies may not be possible in the Australian context. For example, researchers are unlikely to be provided with parents' contact details to follow-up non-responding parents by telephone. The incentives to participation provided by others, may not be approved by research ethics committees as they could be seen as inducements beyond reimbursements of the costs of participation to participants.

Even when extensive costly measures are taken to improve response rates under active only consent requirements, these rates are still not comparable with those obtained in studies which include a passive component and samples may still be biased with participation rates of 79% [9] and 76%.[8] Thus, relatively high response rates may not guarantee representative samples. At issue is the extent to which participation is associated with the outcomes of interest in the study[7], the stronger this association the greater the likelihood of a biased sample. In addition, samples of actively consented students were found to be more homogeneous than those sampled based on less strict consent procedures.[11] The resultant stronger clustering effects (higher intraclass correlations) imply larger sample sizes may be needed whenever active consent is required to ensure studies are sufficiently powered and avoid too liberal tests of significance.[35]

The National Statement refers to the need for the research burden to be equitably distributed.[1] Under active only consent conditions, an added burden may be imposed on certain schools to be involved in

research projects as research is found to be impracticable in others. There may also be an added burden on certain students for data collection. Further, increased time and effort is often asked of teachers as their role is critical in the intensive efforts required to obtain consent forms from parents. Indeed, White and colleagues reported certain schools chose to use passive consent procedures as they were reluctant to implement active processes due to the extra time and effort that would be required by school staff.[11]

Despite the cautions against mandating active only consent presented here, the aim is not to promote the use of passive only procedures, i.e. where parents are approached once and asked to return the consent form only if permission is refused. Instead an active-passive approach is recommended with rounds of active consent followed by passive. Three to four rounds are recommended as limited benefits are gained beyond three follow-ups.[36] Given the available evidence that non-response to a passive consent process most likely indicates consent rather than refusal[15], an opt-out process which provides adequate means for parents to indicate their non-consent allows for informed individual decision making and maintains parents' autonomy.

It is imperative that all procedures which include a passive component are appropriately designed and implemented to meet the requirements of ethical research of voluntary participation based on sufficient information.[1] Interpreting non-response as consent assumes parents have received and understood the information, have had multiple opportunities to refuse their child's participation and the methods of returning forms indicating non-consent are as infallible as possible. Researchers should therefore make every effort to ensure parents not only receive, but engage with and understand the information[15], and are provided with the opportunity to? discuss the research[1].

This study is subject to limitations. Only non-government metropolitan schools in Western Australia were included, however the results are likely to be broadly generalisable to other contexts. The data are self-reported, and bias will be introduced into the results if the validity of the self-reported data differs between the actively and passively consented groups. Whilst statistically significant, the observed effects are small. However, they are in accordance with biases reported in the literature and could be expected to be larger in samples with lower active consent rates than observed here. Further research on a range of health outcomes is required to gain a better understanding of the biases resulting from active only consent procedures, the consent status of non-responding parents and the impact on young people of completing health surveys.

Conclusion

Education authorities and ethics committees who mandate active parental consent prior to the participation of minors in research, principally to avoid the risks of harm to the minor, need to be

cognisant of the consequences and opportunity costs of this requirement, relative to the benefits of allowing procedures including passive consent, particularly for low risk research. Researchers need to factor in the additional resources, both financial and time, of the measures required to get good response rates if active parental consent is required. Funding bodies need to recognise and approve the additional costs required to obtain good response rates. Passive consent procedures result in higher participation rates, lower costs, more representative/valid findings and reduced burden on teachers and schools, and are preferred when parental consent is sought for minors to complete health surveys.

References

1. National Health and Medical Research Council, Australian Research Council, Australian Vice-Chancellors' Committee. National Statement on Ethical Conduct in Human Research. Canberra: Australian Government.; 2007.
2. Wolfenden L, Kypri K, Freund M, Hodder R. Obtaining active parental consent for school-based research: a guide for researchers. Australian and New Zealand Journal of Public Health. 2009;33(3):270-5.
3. Ellwood P, Asher MI, Stewart AW, ISAAC Phase III Study Group. The impact of the method of consent on response rates in the ISAAC time trends study. The International Journal of Tuberculosis and Lung Disease. 2010;14(8):1059-65.
4. Frissell KC, McCarthy DM, D'Amico EJ, Metrik J, Ellingstad TP, Brown SA. Impact of consent procedures on reported levels of adolescent alcohol use. Psychology of Addictive Behaviors. 2004;18(4):307-15.
5. Mellor JM, Rapoport RB, Maliniak D. The impact of child obesity on active parental consent in school-based survey research on healthy eating and physical activity. Evaluation Review. 2008;32(3):298-312.
6. Tigges BB. Parental consent and adolescent risk behavior research. Journal of Nursing Scholarship. 2003;35(3):283-9.
7. Courser MW, Shamblen SR, Lavrakas PJ, Collins D, Ditterline P. The impact of active consent procedures on nonresponse and nonresponse error in youth survey data. Evidence from a new experiment. Evaluation Review. 2009;33(4):370-95.
8. Unger JB, Gallaher P, Palmer PH, Baezconde-Garbanati L, Trinidad DR, Cen S, et al. No News is Bad News. Characteristics of adolescents who provide neither parental consent nor refusal for participation in school-based survey research. Evaluation Review. 2004;28(1):52-63.
9. Esbensen FA, Melde C, Taylor TJ, Peterson D. Active parental consent in school-based research. How much is enough and how do we get it? Evaluation Review. 2008;32(4):335-62.
10. Secor-Turner M, Sieving R, Widome R, Plowman S, Vanden Berk E. Active parent consent for health surveys with urban middle school students: Processes and outcomes*. Journal of School Health. 2010;80(2):73-9.
11. White VM, Hill DJ, Effendi Y. How does active parental consent influence the findings of drug-use surveys in schools? Evaluation Review. 2004;28(3):246-60.
12. Cross D, Shaw T, Hearn L, Epstein M, Monks H, Lester L, et al. Australian Covert Bullying Prevalence Study (ACBPS) 2009. Available from: http://www.deewr.gov.au/Schooling/NationalSafeSchools/Pages/research.aspx.
13. Dent CW, Galaif J, Sussman S, Stacy A, Burtun D, Flay BR. Demographic, psychosocial and behavioral differences in samples of actively and passively consented adolescents. Addictive Behaviors. 1993;18(1):51-6.
14. Henry KL, Smith EA, Hopkins AM. The effect of active parental consent on the ability to generalize the results of an alcohol, tobacco, and other drug prevention trial to rural adolescents. Evaluation Review. 2002;26(6):645-55.

15. Ellickson PL, Hawes JA. An assessment of active versus passive methods for obtaining parental consent. Evaluation Review. 1989;13(1):45-55.
16. Baker JR, Yardley JK, McCaul K. Characteristics of responding-, nonresponding- and refusing-parents in an adolescent lifestyle choice study. Evaluation Review. 2001;25(6):605-18.
17. Lacy K, Kremer P, Silva-Sanigorski A, Allender S, Leslie E, Jones L, et al. The appropriateness of opt-out consent for monitoring childhood obesity in Australia. Pediatric Obesity. 2012;7:e62-e7.
18. Stubbs JM, Achat HM. Individual rights over public good? The future of anthropometric monitoring of school children in the fight against obesity. Medical Journal of Australia. 2009;190(3):140.
19. Junghans C, Feder G, Hemingway H, Timmis A, Jones M. Recruiting patients to medical research: Double blind randomised trial of "opt-in" versus "opt-out" strategies. BMJ. 2005;331(7522):940.
20. Langhinrichsen-Rohling J, Arata C, O'Brien N, Bowers D, Klibert J. Sensitive research with adolescents: Just how upsetting are self-report surveys anyway? Violence and Victims. 2006;21(4):425-44.
21. Leakey T, Lunde KB, Koga K, Glanz K. Written parental consent and the use of incentives in a youth smoking prevention trial: A case study from project SPLASH. American Journal of Evaluation. 2004;25(4):509-23.
22. Department of Education. Western Australia. Research conducted on Department of Education sites by external parties. Perth: The Government of Western Australia.; 2009.
23. Hall M, Cordin T, Bruce K, Paki D. *Strengthening pastoral care to reduce secondary students' harm from tobacco. Final report to Healthway.* Perth, Western Australia: Child Health Promotion Research Centre, Edith Cowan University2011.
24. Cross D, Brown D, Epstein M, Read M. *Strengthening school and families' capacity to reduce the academic, social, and emotional harms secondary students' experience from cyber bullying*. Perth, Western Australia: Child Health Promotion Research Centre, Edith Cowan University2009.
25. Child Health Promotion Research Centre. An empirical intervention to reduce cyber bullying in adolescents. Annual report to Healthway. Perth, Western Australia: Edith Cowan University, Child Health Promotion Research Centre2010.
26. Lovibond P, Lovibond S. The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. Behaviour Research and Therapy. 1995;33(3):335-43.
27. Szabó M. The short version of the Depression Anxiety Stress Scales (DASS-21): Factor structure in a young adolescent sample. Journal of Adolescence. 2010;33(1):1-8.
28. Goodman R. The Strengths and Difficulties Questionnaire: A research note. Journal of Child Psychology and Psychiatry. 1997;38(5):581-6.
29. Ladd GW, Kochenderfer BJ, Coleman CC. Friendship quality as a predictor of young children's early school adjustment. Child Development. 1996;67(3):1103-18.
30. Resnick MD, Bearman PS, Blum RW, Bauman KE, Harris KM, Jones J, et al. Protecting adolescents from harm. Findings from the National Longitudinal Study on Adolescent Health. The Journal of the American Medical Association. 1997;278(10):823-32.
31. Shaw T, Dooley JD, Cross D, Zubrick SR, Waters S. The Forms of Bullying Scale (FBS): Validity and reliability estimates for a measure of bullying victimization and perpetration in early adolescence. Psychological Assessment. Under review.
32. Solberg ME, Olweus D. Prevalence estimation of school bullying with the Olweus Bully/Victim Questionnaire. Aggressive Behavior. 2003;29(3):239-68.
33. Smith PK, Mahdavi J, Carvalho M, Fisher S, Russell S, Tippett N. Cyberbullying: its nature and impact in secondary school pupils. Journal of Child Psychology and Psychiatry. 2008;49(4):376-85.
34. Priest N, Duncan R, Yap MBH, Redmond G, Anderson A, Wade C. Active versus passive parental consent for improving participant recruitment and outcomes in studies targeting children (Protocol). The Cochrane Library. 2012.

35. Shaw T, Cross D. The clustering of bullying and cyberbullying behaviour within Australian schools. Australian Journal of Education. 2012;56(2):142-62.
36. Ji PY, Pokorny SB, Jason LA. Factors influencing middle and high schools' active parental consent return rates. Evaluation Review. 2004;28(6):578-91.