

# Education and Health

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Published by SHEU since 1983

Volume 37 Number 2, 2019

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ISSN 2049-3665

**[The relationship between pedometer step counts and intermittent recess breaks for elementary students](#)**

**Alicia C. Stapp**

**[MindEd : A whole-school strategy on wellbeing - Tackling mental health stigma and promoting positive wellbeing in secondary schools](#)**

**Rebecca Baxter**

**[Goldilocks is online](#)**

**David Regis**

**[Mind and Body: an early intervention group programme for adolescents with self-harm thoughts and behaviours](#)**

**Veronica Roberts, Richard Joiner, Claire Russell, Richard Bradley, Mark Bowles, Aaron Bowes and Terence Nice**

**[Labelling the labia – a lesson in how to terrify teachers: Pedagogical obstacles to the introduction of compulsory Relationships and Sex Education \(RSE\)](#)**

**Emma Dobson**

# Education and Health

Editor

**Dr David Regis**

(e-mail: [david.regis@sheu.org.uk](mailto:david.regis@sheu.org.uk))

Welcome to the second issue for 2019.

We receive articles from many parts of the world and some do not make it into the journal. This is mainly due to our focus on young people and, although we do not specify an age range, most published articles are about those between the ages of 5-20 years old. There are exceptions and the Editor welcomes your contribution.

This issue continues with the proud tradition of independent publishing and offers an eclectic mix. The journal, published since 1983, is aimed at those involved with education and health who are concerned with the health and wellbeing of young people. Readers, in the UK, come from a broad background and include: primary, secondary and further education teachers, university staff, and health-care professionals working in education and health settings. Readers outside of the UK share similar backgrounds. The journal is also read by those who commission and carry out health education programmes in school and college.

Articles focus on recent health education initiatives, relevant research findings, materials and strategies for education and health-related behaviour data.

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Alicia C. Stapp is the Assistant Professor of Health and Physical Education, University of Mississippi.

For communication, please email: [acstapp@olemiss.edu](mailto:acstapp@olemiss.edu)

## Alicia C. Stapp

# The relationship between pedometer step counts and intermittent recess breaks for elementary students

Physical activity (PA) contributes to the overall well-being of a child and is noted as an integral component to improving the health of our future generation (Biddle, Mutrie & Gorely, 2015). While current national PA guidelines assert that children should obtain 60 minutes of PA each day, the Institute of Medicine [IOM] (2013) contends that 30 of the 60 minutes should occur during the school day. Despite this notion, the trajectory of PA in the form of physical education, free play, and recess at school has slowly diminished over the past two decades (IOM, 2013). It is estimated that over half of elementary school children (ages 6-11) in the United States do not meet the recommended 60 minutes of daily PA (Colley et al., 2011; Hallal et al., 2012) and approximately 23.8% are considered obese (Skinner & Skelton, 2014). However, it is important to note that participating in PA has the potential to decrease the onset of many prevalent chronic diseases for children, such as diabetes, cardiovascular disease, and asthma. A growing body of evidence also suggests that children who are physically active tend to lead physically active lifestyles as adults, perform better academically, and have decreased mental health issues (Chaddock, Kramer, Hillman & Pontifex, 2011; Fedewa & Ahn 2014; Rauner, Walters, Avery & Wanswer, 2013; Roberts, Freed & McCarthy, 2015).

### **Decline of Physical Activity at Home and School**

The benefits of PA at a young age are irrefutable (IOM, 2013). However, childhood during the past several decades has transitioned

from play time that resided solely outside to one that encourages sedentary behaviours inside. The emergence of technology, a decline in neighborhood safety, increased urban living, and the ability to access almost anything from home has contributed to this paradigm shift (Ewing, Meakings, Hamidi & Nelson, 2014; Rosen et al., 2014). Schools have also perpetuated an environment that de-emphasizes outside play, PA, and in some instances, even physical education (Slater, Nicholson, Chriqui, Turner & Chaloupka, 2012).

### **Paucity of Consistent Recess**

One reason for a de-emphasis on physical activity and reduction in recess is the unsurmountable pressure for schools to perform well on standardized testing and a limited number of states requiring allocated time for recess. Currently, only eight states (16%) require recess by law, and the consistency in effective implementation is not discernible within the research (National Association for Sport and Physical Education [NASPE], 2016). Additionally, a majority of states only mandate physical education, while minutes for daily or weekly PA are not always required.

Playground safety and behavioural issues have also precipitated a decline in recess (Beighle, 2006). However, this can easily be addressed with access to proper equipment, accessible playground design, and supervisory staff who consistently interact with children during periods of recess (Huberty, Beets, Beighle & Saint-Maurice, 2014). The Centers for Disease Control and Prevention (CDC) and SHAPE America even

developed a free *Strategies for Recess in Schools* document that outlines how to effectively implement recess (CDC, 2017).

Although the consensus remains, that there is a need for PA, policies regarding recess length and/or timing of recess have not been firmly instated across the United States. Thus inconsistencies persist. For example, recess periods may only be provided 20 minutes a day at one school, while another school may provide students with 60 minutes per day. In some schools, children may receive no recess whatsoever. Meanwhile, in other countries such as Japan, school children are afforded the opportunity to take a break once an hour. The justification for a break every hour is that the attention span is thought to wander every 40-50 minutes (Beresin, 2016). While scheduling PA in this manner is traditional in some European and Asian countries, the United States has yet to adopt the philosophy of providing recess breaks throughout the school day for all children.

### **A Case for Recess**

Despite the aforementioned reasons that have generated a decline in recess, it remains an essential component of the school day and provides an environment wherein students can obtain quality levels of PA (Massey, Stellino, Claassen, Dykstra & Henning, 2018). The current body of evidence most commonly correlates physical education and physical fitness with academic, social, emotional, and physical benefits (IOM, 2013). However, recess presents its own set of distinctive benefits. As a pause from the scheduled academic day, recess provides children with an unstructured period of time to rest, play, socialize, move, and imagine (National Association of Early Childhood Specialists in State Departments of Education, 2002).

#### **Physical benefits of recess**

The current body of literature contends that recess has a significant impact on a child's overall physical development (Esteban-Cornejo et al., 2017; Van Der Neit et al., 2017). One study completed a systematic review and found that playground had a significant impact on students' PA levels (Escalante, Garcia-Hermoso, Backx & Saavedra, 2014). Recess also provides children with opportunities to practice motor skills. Even small bouts of movement during recess can offset sedentary time at school and home to assist

children in achieving the recommended 60 minutes of daily physical activity. This standard is strongly supported by the American Academy of Pediatrics policy and has been noted as an antidote to obesity (CDC, 2008; NASPE, 2008).

#### **Social-emotional benefits of recess.**

Although the physical benefits of recess are perhaps the most documented, recess has the multifaceted potential to affect the whole child in ways that exceed physical benefits alone (Ramstetter, Murray, & Garner, 2010). In direct contrast to classroom activities in which children cannot make the choice to withdraw from an activity, at recess, children are free to join in or leave play situations according to their own discretion. This "open setting" that children encounter at recess allows them to engage in diverse and abundant social interactions that they might not experience otherwise (Jarrett, 2002, p. 3). Subsequently, recess provides time for children to "develop social skills that are not acquired in the more structured classroom environment" (Ramstetter, Murray & Garner, 2010, p. 519).

#### **Cognitive benefits of recess.**

Research also suggests that social interactions at recess have important cognitive implications (Pellegrini & Smith, 1993). Recess provides students a break from the rigorous academic schedule of a typical school day, which subsequently has the ability to affect students' focus, attention, and overall classroom behaviour (Donnelly & Lambourne, 2011).

Elementary students in Shanghai, China receive daily recess time that amounts to almost 40% of an entire school day. Even though these students are afforded more time away from academic work, their ability to perform well on academic tasks has not declined. In fact, these are some of the world's highest achieving students, receiving top honours in multiple areas on the Program for International Student Assessment (Chang & Coward, 2015).

#### **Single vs. Intermittent Recess Periods**

While the body of evidence on recess indicates positive implications for children, a majority of research on recess and its role in children acquiring daily PA has focused on singular recess periods. Thus, there is a lack of research addressing the quantity of recess – both in duration and number of periods – and its effect on children's PA levels. To counter this issue, a

recent study based on the Finnish education system aimed to increase overall recess time in four 15-minute intervals during the school day while simultaneously focusing on character development to address an increase in bullying behaviours. This program entitled LiINK (Let's inspire innovation 'N Kids) increased overall daily recess to 60 minutes, embedded character lessons into daily curriculum, and required training for teachers who wished to implement the program. 405 children in grades K-2 participated in the study. With a buy-in rate of 92% from teachers, results indicated that off-task behaviours decreased significantly and attention, based on listening skills, slightly improved with multiple recess periods allocated during the school day (Rhea & Rivchun, 2018). While this study implemented incremental recess breaks throughout the day for children to examine classroom behaviours, it did not address children's PA levels.

### Study Aims

For some children, school may provide the only opportunity to participate in PA. Thus, schools should continually evaluate ways to effectively provide and promote PA to aid in reversing the trajectory of physical inactivity. One way this can be accomplished in the school setting is through strategic planning of recess, which entails a re-evaluation of allocated time during the school day. For example, one 30-minute recess period may be divided into two 15-minute periods to allow for a break at different times of the day. Or, an additional recess period may be added during a transitional time of the school day. While research consistently indicates the contributions recess makes toward increasing children's PA levels (Bleeker, Burdumy & Fortson, 2015; Huberty et al., 2014) a deficiency in the literature still remains on the impact that adding multiple intermittent recess periods into the school day can have on children's PA levels.

Considering that the current body of research reveals a majority of children do not meet the recommended daily PA guidelines, there is a definitive need to address the impact of allocating more than one traditional recess period during the school day on students' PA levels. Thus, this study sought to answer the following research question: What is the relationship between students' step counts and intermittent

recess periods during the school day?

## Methods

### Participants and Setting

The present study utilized a quasi-experimental design comprised of a single intervention group (n = 17). Participants were third-grade students at a school in Northwest Mississippi and were acquired through a convenience sample, as the researcher mentored the students' teacher and had a pre-existing relationship with the teacher. Twenty-four students were in the original study sample. However, three students were excluded from the study because they transferred to different schools and four students' data were withdrawn from the study due to low attendance. 53% of the participants were female and 48% percent were male. Demographics of the participants were 45% White, 30% Hispanic, 20% African American, and 5% Asian.

### Procedures and Instrumentation

Approval to conduct the study was received by the University's Institutional Review Board. Teacher and parental consent, and children's assent were also obtained. An additional 20-minute recess period was also approved by the school's principal and built into morning transitions between mathematics and English language arts.

Baseline data were collected for all participants via pedometers for six weeks (November 5, 2017 - December 19, 2017) from 7:45 a.m.- 12:45 p.m. – approximately 21% of a 24 hour day – with a daily 20-minute recess. During the intervention phase of the study, step counts were collected for an additional six weeks (January 16, 2018 - February 23, 2018) within the same time period with two 20-minute recess periods – one in the morning and one in the afternoon. The teacher required students to write down their individual steps at the end of each day in a daily step count worksheet.

Prior to the intervention phase of the study, the classroom teacher was trained on correct positioning of the pedometer – directly at the hip bone and in line with the kneecap. The researcher visited the third-grade classroom to provide a 'how to' session where students were taught how to wear, set and reset the pedometers. While much research has focused on the use of accelerometers to measure PA,

pedometers have become much more prevalent in PA research (McNamara, Hudson & Taylor, 2010). The Gopher FITstep Pro was utilized within this study to measure participants' daily step counts. Selection of the pedometer was based upon its level of accuracy even when not in the exact upright position (Gopher, 2015). This particular pedometer also has a delayed counting feature, which does not enable step count inflation.

### Data Analysis

Step counts for each participant were calculated and documented daily in a *My Daily Step Count* worksheet (See Figure 1). A worksheet was provided for the first six weeks (one 20-minute recess period) and a new one for the second six weeks (two 20-minute recess periods). At the end of each week, students totalled their weekly step counts. When all data were collected by the researcher from the teacher, each participant's overall daily step count was totalled both prior to (baseline) and after the additional 20-minute period of recess (intervention). A mean daily step count was derived without the additional recess period and with the additional recess period for each participant. The pair of mean step counts for each participant were then put into SPSS and a dependent paired *t*-test was conducted to determine if the additional twenty-minute recess period significantly increased students' average daily step count.

### Results

Findings revealed that all participants' average mean step counts increased with an additional 20-minute period of recess added to the school day (See Table 1). The overall mean increase in daily step count from baseline to intervention was 792.2 steps. Prior to testing for statistical significance between the two data sets, a Shapiro-Wilk normality test (Shapiro & Wilk, 1965) indicated that the data were normally distributed ( $p > .05$ ). A dependent paired *t*-test was then conducted to compare the daily step count mean of third-grade students with a 20-minute daily recess period and then again with two 20-minute recess periods. Findings revealed that there was a statistically significant difference in the daily mean step count with a 20-minute recess ( $M = 3399.47$ ,  $SD = 503.76$ ) compared to students' daily step counts with two 20-minute recess periods ( $M = 4191.65$ ,  $SD = 1079.84$ );  $t(16) = 3.96$ ,  $p < .05$

(See Table 2) during the school day.

### Discussion

The current body of evidence has addressed the benefits of recess for children in the school setting. However, most studies in the United States have only examined recess and its benefits from the context of one traditional recess period during the school day. Much less attention has been paid to the effect of an additional and/or multiple recess periods embedded into the school day, particularly in relationship to students' PA levels. While some countries already embed 15-minute physical activity breaks every hour during the school day, this practice is not commonplace in the United States. On the contrary, the mindset of schools to focus solely on improving academic achievement has perpetuated a decrease in time allocated for recess during the school day.

Findings from this study imply that a shift in mindset from only one recess period during the school day to implementing two intermittent recess periods during the day may provide the opportunity for students to receive at least half of the recommended 60 minutes of daily PA. Furthermore, implementing an additional recess period yielded a significant increase in students' step counts. In alignment with previous research that contends recess accounts for 17% - 44% of a child's step counts during the school day (Erwin et al., 2012), this study revealed a 23% increase in step counts from baseline to intervention. This is critical to the discussion of increasing children's PA at school, as many children do not receive daily physical education, may be limited in the PA they experience in the classroom, and/or do not receive any PA at home.

This study also adds to the breadth of research that aims to increase children's PA levels through recess in order to deter the impending trajectory of decreased PA opportunities in schools. The idea and structure of multiple recess periods, as opposed to the traditional single recess period provides a new way for school district leaders, administrators, teachers, and parents to examine the allocation of time for PA across the school day and its effect on students' well-being. While the benefits of recess are not a novel idea in the literature, shifting the paradigm to include multiple recess periods throughout the day proved to have positive PA outcomes for all children in this study.

Although positive results arose from this study, limitations include timing of recess periods during the study. Furthermore, while recess periods were consistent in time and duration throughout the study – one in the morning and one in the afternoon – the researcher did not have control over when the recess periods began and ended. Recess periods were also unstructured, yet supervised. This may have played a role in a decrease or increase of step counts. Future research may seek to examine the impact of more than two recess periods or how small incremental recess periods throughout the day affect children's overall physical activity levels. Different grade levels, geographic regions, and times of the year may also be examined.

## Conclusion

Children in the United States spend almost half of their waking hours in a school environment. Thus, schools provide a unique platform from which to address the health of our future generation. However, pressures to improve academic achievement have precipitated increased instructional time during the school day. Subsequently, time allocated for PA has decreased or diminished altogether. A reduction in allocated time for PA may prove to be counterproductive to not only developing positive physical and social-emotional health behaviours, but also to increasing academic achievement. Thus, schools must develop a balance that supports all of a child's developmental domains. Part of the physical domain must be fostered during play at recess. As we move further into the twenty-first century and the childhood full of free play that once existed begins to fade, it is imperative to keep in mind the physical, social-emotional, and cognitive benefits that recess provides. When schools begin to develop strategies that facilitate the aforementioned benefits, a paradigm shift may occur alongside a generation of healthier children.

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Table 1 Students' Daily Mean Step Counts

Student	Baseline	Intervention	Difference
S1	3875	4797	922
S2	3423	4148	725
S3	3531	4174	643
S4	3333	3786	453
S5	2278	3158	880
S6	3600	4448	848
S7	2895	3735	840
S8	4066	4866	800
S9	3908	4566	658
S10	3082	3640	558
S11	3233	4405	1172
S12	3238	3834	596
S13	3050	4238	1188
S14	3860	4796	936
S15	3240	4439	1199
S16	2893	3540	647
S17	4286	5213	1027
Group Mean	3399.4	4191.6	792.2

Table 2 Results of Dependent Paired *t*-Test for Students' Daily Mean Step Counts

Step Counts	20- Minute Recess Period		Two 20-minute Recess Periods		n	95% CI for Mean Difference	r	t	df
	M	SD	M	SD					
	3399.4	503.7	4191.6	1079.8	1	-1215.63,	.68*	3.96	16
	7	6	5	4	8	-368.72			

\*  $p < .05$ 

Figure 1 — Daily step count chart completed by third grade students during baseline and intervention

Name _____	Date _____					
	Monday	Tuesday	Wednesday	Thursday	Friday	Weekly Totals
Week 1 Jan 16-19	8939 <sup>X</sup>	3455	3916	2950	3576	25,166
Week 2 Jan 22-26	4083	2785	3304	3965	6367	21,104
Week 3 Jan 29-Feb 2	7626	4889	4086	4034	4845	25,480
Week 4 Feb 5-9	6717	2880	3387	2016	5374	20,374
Week 5 Feb 12-16	6992	7188	4470	6900	7535	35,195
Week 6 Feb 19-23	absent	4309	5225	4244	6738	20,571
Total Step Count- 6 weeks						147,840

## Education and Health

The journal, published by SHEU since 1983, is aimed at those involved with education and health who are concerned with the health and wellbeing of young people. Readership is worldwide and in the UK include: primary; secondary and further education teachers; university staff and health-care professionals working in education and health settings. The journal is online and open access, continues the proud tradition of independent publishing and offers an eclectic mix of articles.

**Contributors** (see a recent list) - Do you have up to 3000 words about a relevant issue that you would like to see published? Please contact the Editor

Rebecca came to St Albans School, Hertfordshire in 2009 as an English teacher having joined the teaching profession in 2008 after a brief spell working in the film industry. Since commencing her current role as Head of Middle School four years ago, Rebecca has established a holistic approach to pastoral care and developed an increasing interest in the wellbeing of both pupils and staff. As a culmination of her research and earlier initiatives, in September 2018 Rebecca launched MindEd, a campaign to tackle mental health stigma and promote positive wellbeing at St Albans School.

For communication, please email: [rjbaxter@st-albans.herts.sch.uk](mailto:rjbaxter@st-albans.herts.sch.uk)

## Rebecca Baxter

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# MindEd : A whole-school strategy on wellbeing - Tackling mental health stigma and promoting positive wellbeing in secondary schools

Recent research into young people's mental health in the UK supports what teachers and pastoral leaders have been witnessing in schools over the past decade: an exponential rise in the rates of reported mental health disorders. According to NHS Digital, the prevalence of 5-15 year olds experiencing emotional disorders (including anxiety and depression) has increased by almost a third - from 3.9% in 2004 to 5.8% in 2017 - and one in eight children and young people aged between five and 19 has a diagnosable mental health condition (NHS Digital, 2017). Additionally, mental health services, such as CAMHS, are vastly overstretched, with waiting lists of up to a year (Moore & Gammie, 2018), and less than a quarter of young people with mental health needs accessing professional support. The demands on schools, therefore, to support these growing numbers of young people with poor mental health are increasing year on year. However, it is not enough to simply be reactive; schools and local authorities are becoming increasingly aware of the need for a far greater emphasis on proactive mental health and wellbeing education.

One way to be more proactive in tackling mental health concerns is through the taught curriculum. As long ago as in 2011, the Centre for Economic Performance published the results of a long-term study into evidence-based PSHE focusing primarily on the provision of a Personal Wellbeing programme of study and the effectiveness of this study is leading to the development of a model curriculum in this area

(Hale, Coleman & Layardet, 2011). This is undoubtedly much needed, but, as the study acknowledges, schools also need to embed such programmes in their individual contexts and offer programmes such as these as just one part of a holistic whole school strategy if it is to really make a difference.

At St Albans School, we have been working during recent years to develop such a strategy and in September this year we launched MindEd, a programme designed to promote positive wellbeing and tackle mental health stigma amongst three core groups: pupils, staff and parents. We recognise that a triad approach is essential to ensure that every young person, and the support network around them, is resilient, equipped with healthy coping strategies, and knows how to access help when it is needed.

### MindEd: Pupils

In establishing the programme, we began by considering the challenges facing young people, which are undoubtedly more complex than ever: the rise in social media has changed the face of communication; globalisation of university education and employment has increased competition and thus the pressure to achieve top examination results; and young people today are constantly bombarded with a stream of often anxiety-inducing news and information. Moreover, despite increased technological connectedness and vastly improved access to global opportunities, this generation of teenagers are less genuinely attached to others, less likely to

take risks and, crucially, less happy (Twenge, 2017).

One of the most powerful impacts of the MindEd programme is its pupil-driven aspect; giving young people ownership of the solutions empowers them to take risks, build personal connections, and puts them at the forefront of tackling the taboo that still surrounds mental health issues. This year, a group of students in the Upper Sixth led the MindEd pupil team, organising monthly events and activities to bring the school community together and build relationships between students in different year groups. They also developed resources which form prefects or form tutors could deliver to younger pupils in Years 7 – 11 and delivered assemblies to younger year groups on eating disorders, coping with exam stress, and social media. Running alongside this, a mentoring programme with a focus on pastoral support has been established. Hearing older students sharing their own experiences with stress, anxiety, depression and eating disorders has been very powerful in beginning to tackle stigma, developing peer support, and encouraging others to come forwards and ask for help. Moreover, the mentoring programme develops the wellbeing of those working as mentors as well as their mentees; helping others and building connections is proven to enhance wellbeing.

### **MindEd: Parents**

It is important to acknowledge, however, that it is not only larger societal and technological changes that are affecting young people: parenting has changed too. According to Jean Twenge, so-called 'iGen' children are growing up "less likely to experience the freedom of being out of the house without their parents--those first tantalizing tastes of the independence of being an adult, those times when teens make their own decisions, good or bad" (Twenge, 2017), and this is resulting in the development of a generation for whom being outside of their 'safe-space' poses serious emotional risks which they are simply not prepared for. Over-parenting, it seems, leads to a too powerful desire for 'emotional safety' which can "include preventing bad experiences, sidestepping situations that might be uncomfortable, and avoiding people with ideas different from your own." (Twenge, 2017). When we combine this with the fact that,

for iGen, "the world is an inherently dangerous place because every social interaction carries the risk of being hurt" (Twenge, 2017), it is perhaps easy to see why today's young people are at risk of experiencing the greatest mental health crisis any generation has ever faced.

Parents, therefore, are absolutely key in improving wellbeing and tackling mental health stigma, yet often they are the hardest group to reach. However, through increasing the publicity of wellbeing events at school via the school website and social media, sending out termly PSHEE newsletters, and inviting parents in for talks from school staff and external speakers on important topics such as screen time, risk taking, and mental health, parents are enabled to understand more about the education their son or daughter is receiving about mental health and wellbeing at school and continue discussions at home about these issues. Additionally, we have developed a resource bank for parents giving them advice about how to support a son or daughter who may be struggling with a mental health disorder, helping to dispel myths around some mental health conditions and building their understanding of the issues their child may be facing. Moreover, we have developed materials which offer advice to parents on how to manage difficult aspects of adolescence, such as: sex and relationships; parties, drugs and alcohol; and social media. We have found that there is a real appetite for such advice and that parents feel more equipped to set clear boundaries whilst also having the confidence to allow their sons and daughters to experience some of the risks which are necessary for building resilience.

### **MindEd: Staff**

Education, support and training is also crucial for staff, and it is not only pastoral leaders who need to be able to offer help; all school staff, including teachers, school nurses and special educational needs co-ordinators must be equipped to respond to the growing mental health needs of young people in their care. Training programmes such as Mental Health First Aid offer excellent one and two day courses for education professionals in supporting pupils at the point of initial need; like triage nurses in hospitals, staff are able to listen, assess, and refer pupils on to appropriate support, either in or out of school. However, the majority of the training

for staff at St Albans School has been delivered in house; 'Wellbeing Forums', which run once a month, enable staff to come together over breakfast to disseminate training on wellbeing and mental health which they have undertaken out of school or share their experiences of supporting pupils in different capacities. Having a range of staff talking and discussing ideas at these events builds an open conversation around mental health and develops staff confidence in addressing issues they may previously have been unfamiliar with. In addition, we have found staff to have been very open about their own experiences with mental ill health in these sessions, which has been revolutionary in reducing mental health stigma amongst the staff body also.

Furthermore, we recognise that workload pressures across the teaching profession are increasing and that as adults we often feel the same pressures with social media and technology that young people do. We believe, therefore, that schools need to prioritise staff wellbeing and help their teachers to manage external stressors as well as the peaks and troughs of the school year to prevent stress and burnout. Professional training in pastoral care and mental health has, therefore, been combined with opportunities for staff to improve their own wellbeing. Free yoga and mindfulness sessions are offered to staff, social activities, such as book clubs and sketch clubs, have been promoted more widely, a counsellor is available in school two days per week, and a more open environment for staff to share their own experiences with mental ill health has been created through the celebration of national events, such as Time to Talk Day, led by the charity *Mind*.

## MindEd: The Future

Whilst this programme has undoubtedly been a transformative step for the School on our path towards building a community in which mental health is given parity of esteem with physical health, we recognise that there is still a long way to go. New challenges arise weekly and the rapidity with which the world young people are living in is changing can be almost impossible to keep up with. As educators, however, we have a responsibility to do all we can to avert the mental health crisis enveloping the nation. As we all know, young people are the future and if they are to build a world in which people are happier, it is up to us to give them the skills to do so.

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## Education and Health

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**Contributors** (see a recent list) - Do you have up to 3000 words about a relevant issue that you would like to see published? Please contact the Editor

Dr David Regis is the Research Manager at SHEU [Schools Health Education Unit].

For communication, please email: [david.regis@sheu.org.uk](mailto:david.regis@sheu.org.uk)

## David Regis

### Goldilocks is online

A year or so ago, there was a startling article by Jean Twenge in *The Atlantic*, asking, *Have Smartphones Destroyed a Generation?* (Twenge, 2017a).

There is a cynical rule of thumb which says, *any question in a headline can be answered in the negative* (Betteridge, 2009), but Twenge's article was based on her recent book, which was wide, deep, and scholarly, and associated the rise of smartphones with an increase in depression among young women, and I know from bitter experience that academics don't get the last say on a headline.

Many other commentaries have linked a rise in emotional health problems in young people to the rise of Internet use (including risks from online (cyber) bullying, 'sexting' and grooming) (Twenge & Campbell, 2018; O'Keeffe & Clarke-Pearson, 2011; Palmer *et al.*, 2016; Kelly *et al.*, 2018).

However, even if it can be firmly shown that adolescent emotional health is in decline (Collishaw, 2015; Keskin, 2015; Mental Health Foundation, 2016; Hagell, 2009; Potrebni, Wiium & Lundegård, 2017; NHS, 2018) it is difficult to distinguish processes of cause and effect (does poor wellbeing prompt more social media use?) and also to rule out confounding individual factors like disturbed sleep, or wider factors like social class and the effects of austerity (British Psychological Society, 2018; Etchells *et al.*, 2017; Twenge, 2017b; Cavanagh, 2017; Etchells, 2019).

So, also in 2017, Przybylski and Weinstein (2017) published a large-scale analysis of the UK Government's *What About Youth?* (WAY) data set, finding that the highest wellbeing scores were found for modest amounts of time spent online. Lots of online time was associated with poorer wellbeing, but those who spent no time online also had lower wellbeing scores than those spending a bit of time online. The results suggest

that a middling amount of involvement with social media might be most desirable – neither too little, nor too much, but just right – as Goldilocks might have concluded.

The WAY sample was a postal self-report study of 15-year-olds, and produced oddly low figures for smoking, but it was large, nationwide, carefully designed, and the authors did their best to control for confounding effects, so I don't see any reasons there for rejecting the idea. In fact, I was interested recently to explore it with a large sample of young people from a SHEU study in one local authority, and found that Goldilocks is online there too: the highest average wellbeing scores (SWEMWBS, Stewart-Brown *et al.*, 2009) are seen for those spending modest amounts of time online (see page 45). Indeed, Twenge (2017c) found much the same.

It's not so easy to rule out confounding factors in our data sets. The same 'humped' pattern is seen if we select from the sample just those students who live with both parents at home. We also see the same pattern in different deprivation quintiles, although some of the samples become rather small and thereby wobbly.

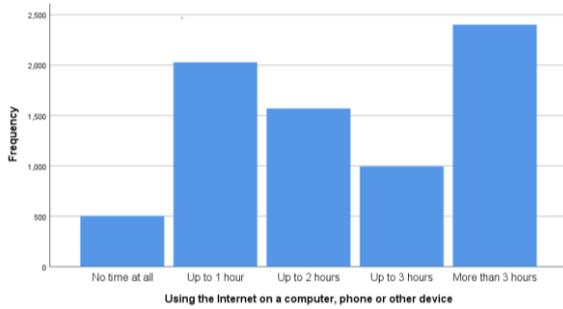
In any event, the direct contribution of online time to mental ill-health often appears slight at worst (Przybylski, 2019; Przybylski & Weinstein, 2017; Young Minds and Ecorys, 2016; Orben, & Przybylski, 2019; Orben, Dienlin & Przybylski, 2019); the difference between the highest and lowest mean scores on the chart (p.45) is about 2 points in 20. It's even possible to analyse the same data sets as Twenge and find a much more sanguine picture (Orben & Przybylski, 2019b).

It must also be recognised that there are opportunities provided by the Internet as well as risks (Centre for Mental Health, 2018), and there are several studies linking online activity to positive outcomes (for example, Education Policy Institute, 2017).

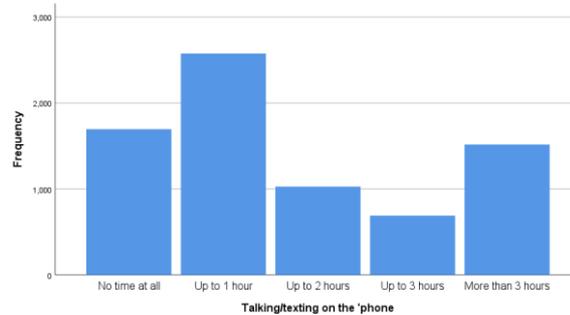
There is little doubt that, across the country, accessible mental health care services are insufficient to meet the needs of adolescents (Gunnell, 2018; Pulse, 2018; Pulse, 2019), particularly of those living in poverty (Children's Society, 2016), and this may be a more useful focus for attention than worrying about 'screen time' as such.

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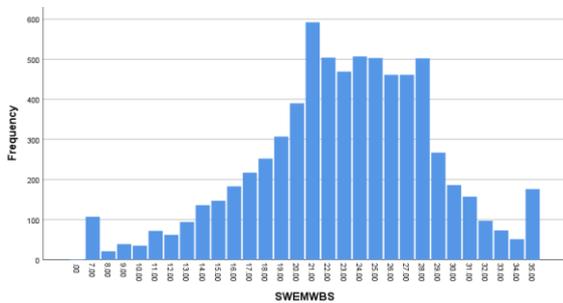
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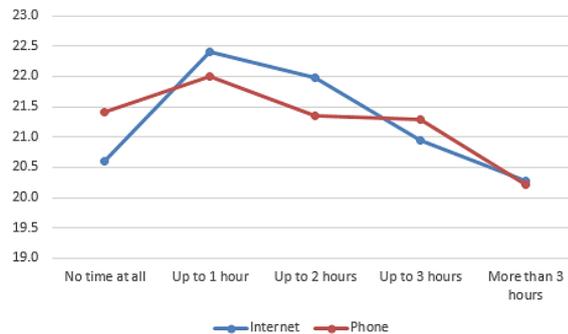
Time spent last night on the Internet among Year 10 females in one local authority, 2018 (N=7498)



Time spent last night on the phone among Year 10 females in one local authority, 2018 (N=7509)



Wellbeing scores (SWEMWBS) of Year 10 females in one local authority, 2018 (N=7069)



Mean wellbeing scores (SWEMWBS) of Year 10 females in one local authority, 2018, by time spent the previous evening on the Internet (on any device) or using a 'phone' (for talking/texting). (N=7027). Differences in both sets of wellbeing results significant at  $p < 0.001$  using ANOVA ( $F=46.6$ ,  $F=43.5$ ).

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Dr Veronica Roberts is an Independent Educational Psychologist and Research Associate. Professor Richard Joiner is Professor of Educational Psychology. Claire Russell is an Honorary Lecturer. All three are at the Department of Psychology, University of Bath. Richard Bradley is the Head of Organisation Design and Development at Addaction, UK. Mark Bowles is the Director and Aaron Bowes is Senior Project officer at The Training Effect, UK, [www.thetrainingeffect.co.uk](http://www.thetrainingeffect.co.uk) Dr Terrence Nice is a lecturer in psychotherapy at the Centre for Professional Practice, University of Kent.

For communication, please email: [veronica@drvroberts.co.uk](mailto:veronica@drvroberts.co.uk) and [r.joiner@bath.ac.uk](mailto:r.joiner@bath.ac.uk)

## Veronica Roberts, Richard Joiner, Claire Russell, Richard Bradley, Mark Bowles, Aaron Bowes and Terence Nice

### Mind and Body: an early intervention group programme for adolescents with self-harm thoughts and behaviours

Mental health difficulties amongst children and young people (C&YP) in the UK are on the rise (NHS, 2018). In particular, emotional disorders have increased from 3.9% in 2004 to 5.8% in 2017 (NHS, 2018). In the same survey, self-harm and suicide attempts were reported by 25.5% of 11-16 year olds, and 46.8% of 17-19 year olds with a mental health condition (NHS, 2018). Such stark prevalence rates for those with a mental health condition, alongside the association between self-harm and suicide, identify a significant public health concern (Brent *et al.*, 2013; Campbell, 2016; 2018). In addition, the survey found that 3% of 11-16 year olds *without* a disorder, had also self-harmed and considered suicide (NHS, 2018). Previous studies exploring community samples suggest that lifetime prevalence rates for self-harm amongst adolescents is much higher - between 13-45% (Nock, 2010, p344). This suggests there is perhaps a 'hidden demographic' of adolescents who engage in self-harm but are unknown. This group is of particular concern due to the likelihood that they are *not* accessing appropriate support services. Indeed, research suggests that between a third and one-half of adolescents who self-harm do *not* seek help for this issue (Rowe *et al.*, 2014; Deliberto & Nock, 2008).

Self-harm is a complex behaviour existing along a 'continuum of self-destructiveness' (Nock, 2010). At one end of the spectrum the individual's intent may be to end their own life, whilst at the other it may be to maintain it (Rae, 2016). It involves intentional and direct self-

poisoning (e.g. overdose) and/or self-injury (e.g. cutting) with methods being diverse and often conducted privately (Hawton *et al.*, 2012).

The effective identification and treatment of this group therefore poses a considerable challenge and suggests that early, preventative and community-based interventions are needed. However, research into psychosocial interventions for adolescents, primarily focuses on higher-tier clinical support provided post hospital admission. The treatments considered most effective are intensive, long term, tend to support the family as well as the adolescent (Glen *et al.*, 2015; Ougrin *et al.*, 2015) and therefore have significant cost implications.

Research into community-based support for self-harm is limited but preliminary findings have suggested that programmes based within schools and/or that involve peers and non-familial supportive adults such as teachers, could be beneficial (Brent *et al.*, 2013). This approach is further supported by evidence that interpersonal factors play a crucial role in self-harm and that the behaviour is strongly associated with peer relationship problems and peer victimisation (Giletta *et al.*, 2012; Brunner *et al.*, 2014). Having a friend who self-harms is also recognised as risk factor for self-harm behaviour (King & Merchant, 2008). Therefore, addressing self-harm within a peer group context has the potential of tackling key contributing social causes or maintenance factors. Preliminary evidence has suggested such programmes could be highly beneficial for adolescents (Nock, 2010, p355; Wood *et al.*, 2001,

p1247). Conversely though, concerns have also been raised regarding a 'social contagion' effect (Jarvi *et al.*, 2013) potentially undermining the efficacy of group interventions. Therefore, further research into community-based early intervention group programmes is required.

### Evaluation focus

This study evaluated Mind and Body (MAB), which is an early intervention group programme for adolescents at risk of, or engaging in, self-harm behaviours. It was delivered within secondary schools and community-based clinics by Addaction. This evaluation therefore contributes to the preliminary research into community-based interventions for self-harm in adolescents.

Specifically, the programme was evaluated for its:

1. Identification, referral and support of young people at risk of, or engaging in self-harm behaviours.
2. Impact on young people's awareness and management of thoughts, feelings and behaviours related to self-harm.
3. Impact on mental health and emotional well-being.

### Method

#### Students

8440 students (13-17 year olds) completed a screening survey. 1573 students (18.6% of the screened population), were identified at risk of self-harm and had one-to-one sessions with an Addaction professional to determine the programme's suitability. In addition, school

staff could highlight students of concern and adolescents were also able to self-refer to the programme. 622 students participated in the programme between March 2016 and April 2017 (13.6% of the total screened population). We collected data from 299 young people who undertook and completed the programme. See Table 1 (below) for a geographical breakdown.

#### Procedure

The MAB programme was delivered in three pilot sites across England: Kent, Cornwall and Lancashire within secondary schools and community centres, by Addaction professionals. We obtained ethical approval from the Psychology Department's ethics committee at the University of Bath. The parents were informed that the programme was being delivered in their child's school and they were told to notify the school if they did not want their child to participate. The programme involved 8 weekly group sessions and 3 one-to-one sessions (See Figure 1 below). Group sizes were between 6-8 students.

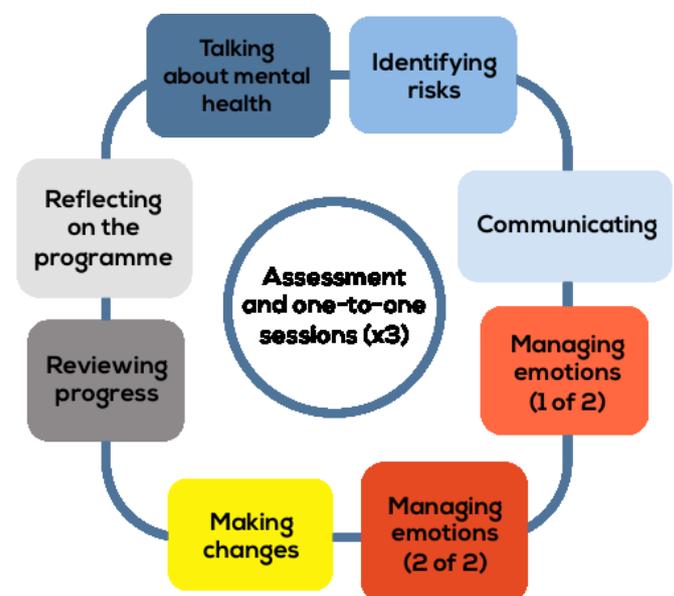
Baseline assessments were conducted one-to-one with the students prior to their participation in the programme and post-intervention.

In addition, we conducted semi-structured focus groups with key stakeholders at the start of the programme delivery and six months later in each area, except for Lancashire, where following an initial focus-group, feedback questionnaires were completed by stakeholders 6 months later.

Table1: Screened and participating sample figures

Area	Number screened	Number identified as at risk	Number engaged in programme
Cornwall	914	203	107
Kent	6039	1115	421
Lancashire	1487	255	94
Totals:	8440	1573	622

Figure 1: Programme structure and core themes



## Measures

### *i. Screening survey*

We used a bespoke online screening survey developed by The Training Effect, to identify adolescents at risk of, or engaging in, self-harm. The questions explored emotions, life-focus, peers and family, alcohol, smoking, self-harm and school support.

### *ii Pre and post-intervention measures*

We evaluated the effectiveness of the programme before and after the programme using measures of mental wellbeing and a self-harm risk assessment.

*The Short Warwick Edinburgh Mental Well-being Scale* (Stewart-Brown, 2009) a 7-item scale to assess and monitor students' mental health and well-being

*The Strengths and Difficulties Questionnaire* (SDQ) a 25-item questionnaire exploring emotions, behavioural conduct, attention/distractibility, peer relationships and prosocial behaviour; providing a quantitative measure of behavioural change (Goodman, 1997).

*Self-Harm Risk Assessment* – a 7-question protocol exploring the frequency of self-harm behaviour, thoughts of self-harm, nature of self-harm behaviours and presence of suicide ideation.

All the above measures are of known validity and reliability.

## Quantitative analysis

The quantitative analysis we conducted compared students' pre- and post-intervention scores on the Short Warwick Edinburgh Mental Well-being Scale, the Strengths and Difficulties

Questionnaire and the Self-Harm Risk Assessment. Non-parametric statistical tests were used in keeping with the ordinal nature of the questionnaire data.

## Qualitative analysis

We took notes during the focus groups and the transcripts were circulated to attendees for accuracy and perspective checks. Thematic analysis (Braun and Clarke, 2006) was conducted to explore core themes regarding the MAB programme delivery, impact and outcomes.

## Findings

### Quantitative findings

We found a significant reduction in the number of self-harm thoughts after the programme, for students who disclosed self-harm thoughts before the programme; 67% reported a reduction in self-harm thoughts after the programme, 24% reported an increase and for 9% there was no change (Wilcoxon signed ranks test,  $z = 5.00$ ,  $p < 0.05$ ). We found a similar pattern for self-harm actions: 64% of students reported a reduction in the number of self-harm actions; 27% reported an increase, and there was no change for 10% of students (Wilcoxon signed ranks test,  $z = 2.44$ ,  $p < 0.05$ ).

We compared the students' scores on the Short Warwick Edinburgh Mental Well-being Scale and the Strengths and Difficulties Questionnaire before and after the intervention (see Table 2 below).

There was a significant improvement for students on the Short Warwick Edinburgh

Table 2: Changes in psychological well-being following participation in the MAB programme

	Deteriorated	Stayed the Same	Improved
Short Warwick Edinburgh Mental Well-Being Scale	21.4%	5.8%	72.8%
Strengths and Difficulties Questionnaire			
Emotional	11.8%	40.3%	48.5%
Conduct	13.6%	56.0%	30.5%
Hyperactivity	25.9%	43.2%	30.9%
Peer Problems	24.2%	42.8%	32.9%
Prosocial	18.0%	67.9%	14.0%

Mental Well-being Scale (Mann-Whitney,  $z = 10.37$ ,  $p < 0.05$ ), with 73% of students improving over the course of the programme. In addition, significant improvements occurred on the Strength and Difficulties Questionnaire, for emotional problems (Mann-Whitney,  $z = 7.42$ ,  $p < 0.05$ ), conduct problems (Mann-Whitney,  $z = 12.24$ ,  $p < 0.05$ ) and peer problems (Mann-Whitney,  $z = 2.45$ ,  $p < 0.05$ ). There was no significant improvement in terms of hyperactivity (Mann-Whitney,  $z = 1.28$ ,  $p > 0.05$ ) or prosocial behaviour (Mann-Whitney,  $z = 1.19$ ,  $p > 0.05$ ).

We further explored whether there were any differences between those students who improved and those who did not (see Table 3 below). Those who improved on the Short Warwick Edinburgh Mental Well-being Scale, scored significantly lower before the programme, than those who did not improve (Kruskal-Wallis, Chi-squared = 27.79,  $p < 0.05$ ). Those who improved on the Strengths and Difficulties Questionnaire had significantly higher ratings on emotional problems (Kruskal-Wallis, Chi-squared = 32.41,  $p < 0.05$ ), conduct problems (Kruskal-Wallis, Chi-squared = 118.96,  $p < 0.05$ ), hyperactivity (Kruskal-Wallis, Chi-squared = 66.59,  $p < 0.05$ ), peer problems (Kruskal-Wallis, Chi-squared = 57.19,  $p < 0.05$ ) and lower scores on prosocial behaviour (Kruskal-Wallis, Chi-squared = 116.70,  $p < 0.05$ ). Therefore, students who benefitted the most from the programme were those who had the greatest difficulties

before the programme.

### Qualitative findings

We organised emergent themes from stakeholder focus groups around the key objectives of the MAB programme. Themes and the number of stakeholders contributing to the theme are summarised in Table 4 (see next page).

### Identification, referral and support of young people at risk of, or engaging in self-harm behaviours

#### Under the radar

The screening survey was a powerful tool to identify 'at risk' students. In one stakeholder's view, it had saved the life of a student who had been completely unknown to them as at risk.

*"It pulled out students who I would never have come across. They would never have got support...but doing that survey, it identified those students. It was a real eye opener."* Stakeholder, Lancashire.

The high number of students identified was a surprise and led to concerns regarding how to support students who could not participate in MAB and did not meet the threshold for Child and Adolescent Mental Health Services (CAMHS).

#### Filling a gap in services

Stakeholders identified that the MAB programme bridged an important gap in services for students with self-harm behaviours who

Table 3: Students' mean pre-test scores and standard deviations

	Deteriorated Mean (SD)	Stayed the Same Mean (SD)	Improved Mean (SD)
Short Warwick Edinburgh Mental Well-being Scale	21.05 (3.18)	21.3 (2.95)	18.77 (3.77)
Strengths and Difficulties Questionnaire			
Emotional	2.21 (0.74)	3.18 (1.27)	3.38 (0.78)
Conduct	1.39 (0.56)	1.43 (0.92)	3.07 (0.85)
Hyperactivity	1.71 (0.77)	2.15 (1.33)	3.24 (0.80)
Peer Problems	1.92 (0.86)	2.79 (1.30)	3.43 (0.74)
Prosocial	2.59 (0.70)	1.19 (0.67)	1.41 (0.66)

required support beyond school staff expertise, but did not meet the criteria for CAMHS involvement.

Some stakeholders also identified how the programme filled a gap in the *form* of service offered to young people. The ease of access due to the programme being school-based, flexibility/responsiveness of approach, and availability during the school holidays were cited as reasons the programme had been so effective for many of the students.

*"The other advantage is that access to the MAB practitioners is on the young person's terms."*  
Stakeholder, Cornwall.

### **Young people's awareness and management of thoughts, feelings and behaviours related to self-harm**

#### **Not alone**

Stakeholders highlighted how the group sessions had increased students' awareness that they were 'not alone' with their experiences,

Table 4. – Qualitative Themes from Stakeholder Focus Groups

Theme	No. of stakeholders	Cornwall	Kent	Lancs.
<b>Identification, referral and support of young people at risk of, or engaging in self-harm behaviours</b>				
<i>Under the radar</i>	10	3	4	3
<i>Filling a gap in services</i>	14	4	8	2
<b>Young people's awareness and management of thoughts, feelings and behaviours related to self-harm</b>				
<i>Not alone</i>	5	-	3	2
<i>Reduced stigma and stereotyping</i>	10	-	7	3
<i>Increased awareness in staff</i>	11	1	8	2
<i>Increased support seeking</i>	7	2	4	1
<i>Independent coping strategies</i>	8	3	4	1
<i>Self-sustaining peer support</i>	10	2	7	1
<b>Impact on students' mental health, emotional well-being and behaviour</b>				
<i>Communication skills</i>	7	1	5	1
<i>Confidence and empowerment</i>	6	-	5	1
<i>Increased participation in school life</i>	6	2	4	-
<b>Additional key themes</b>				
<i>Skill of MAB practitioners</i>	15	4	8	3
<i>Parent and family support</i>	4	3	1	-

reducing their sense of isolation.

*“Every single one of the students has acknowledged that there is support from the shared experience of their situations” Stakeholder, Lancashire.*

### **Reduced stigma and stereotyping**

Several stakeholders indicated that the programme led to a reduction in students’ stereotypes and stigma around mental health. In some instances, this had led to increased mental health awareness within the school.

### **Increased awareness in school staff**

Stakeholders’ felt introductory assemblies had raised awareness for staff and students who attended, but that the impact could have been enhanced by presenting it to the whole-school and fostering a more supportive whole-school ethos. It was felt this would have helped overcome some teachers viewing students missing lessons for MAB as “a nuisance”.

### **Increased support seeking**

Several stakeholders observed increased communication between MAB students and school staff, including coded communications and seeking additional support from school personnel when needed.

*“Some YP...have initiated a system where they wear wrist bands to identify risk feelings or vulnerabilities” Stakeholder, Kent.*

### **Independent coping strategies**

Stakeholders indicated that the students were now more able to independently and effectively use appropriate coping strategies. One stakeholder felt that the extended time frame of the programme made it more realistic that young people would be able to develop and use these techniques.

### **Self-sustaining peer support**

Stakeholders indicated that students had formed self-sustaining peer networks that provided support after the programme concluded. This was viewed as a particularly powerful and unanticipated outcome generated by the group format of the programme.

*“I certainly think that the group aspect helps...young people are learning from one another without being judged.” Stakeholder, Kent.*

*“Because it’s a small group, the ethos is that the students will stick together. They may not be best friends but there*

*is a support network based on shared experience” Stakeholder, Lancashire.*

## **Impact on students’ mental health, emotional well-being and behaviour**

### **Communication skills**

Stakeholders reported that participating in MAB had supported students’ communication skills towards peers, school staff and/or their parents. One stakeholder felt this helped reduce their sense of isolation whilst others reported it had helped some students to talk to their parents.

*“We do an exercise where we support young people to identify their communication styles. This really opens their eyes so that they can take different perspectives...Young people were able to change their communication styles.” Stakeholder, Cornwall.*

### **Confidence and empowerment**

Some stakeholders reported that many participating students had noticeably improved confidence. Four stakeholders felt that the group sessions provided a safe space to be ‘heard without judgement’ and that this had led to a lasting sense of empowerment.

### **Increased participation in school life**

Some stakeholders had observed improvements in the students’ engagement and participation in school life including reduced absences, behavioural incidents and lateness, and improved attitude to learning. Two stakeholders reported some students had volunteered for events that previously they would not have put themselves forward for. One stakeholder reported that some students had improved so significantly that they were no longer on the school’s intervention list.

## **Additional key themes**

### **Skill of MAB Practitioners**

MAB practitioners’ skills were viewed as a key factor supporting the effectiveness of the programme. This included their ability to communicate clearly with school staff, their relationship with the students and flexibility in responding to the students’ needs within programme delivery. Their ability to do this was linked by stakeholders to the level of prior experience and expertise practitioners had, as well as extensive training in the MAB programme and being external to the school

organisation.

*"Having an independent person seemed to promote honest and authentic disclosure."* Stakeholder, Cornwall.

*"Because the practitioner was empathic, the students felt they could really trust her"* Stakeholder, Kent.

### Areas for further development

A few stakeholders indicated that there was a potential gap in the provision of support to parents/families of students attending MAB.

*"Parents are crying out for support when they don't know what to do to help their children."* Stakeholder, Cornwall.

## Discussion

The Mind and Body programme was developed in response to the need for preventative and early interventions for young people who engage in or, are at-risk of engaging in, self-harm behaviours. MAB aimed to support students in addressing thoughts and actions associated with self-harm and to increase mental well-being. The screening tool identified 1573 students at risk of or, engaging in, self-harm – 18.6% of the screened population. This included many "under the radar" students, who were not known by the school or local mental health services to be experiencing any difficulties. Follow-on interviews with all identified students indicated that this level of identification was valid and therefore the screening tool was effective at identifying young people at risk of or, engaged in self-harm behaviours. The potential of this instrument for nationwide identification of young people at risk of self-harm is therefore worth further investigation.

Quantitative analysis indicated that the MAB programme was effective in improving mental well-being for the majority (72.8%) of students. In addition, significant improvements were found for students in emotional (48.5%), conduct (30.5%), and peer problems (32.9%). Furthermore, of students completing the self-harm risk assessment, 67% reported a reduction in self-harm thoughts and 63% reported a reduction in self-harm actions. These results are therefore supportive of the efficacy of the MAB programme for providing an effective school-based group intervention for students at risk of or, engaging in, self-harm behaviour.

Qualitative observations from stakeholders also supported the view that the MAB

programme had a positive impact on young people's awareness, thoughts, feelings and behaviours relating to self-harm:

- There was a reported increase in young people's appropriately seeking and accessing support from school staff
- There was a reported increase in young people's coping skills/strategies
- There was a reduction in stigma about self-harm, aided by the group sharing experiences, understanding, empathy and compassion
- There was an increase in young people's well-being and a broadening of their social networks
- There was also an observed improvement for some young people in their attendance and contribution in classes

Given these findings regarding the impact of the MAB Programme, there is strong emerging evidence for the effectiveness of the programme.

However, whilst these findings are very promising, they need to be considered within the limitations of the evaluation. There was no control group and so it is not possible to show categorically that these improvements would not have happened without the programme. In addition, data were not collated for all of the students who completed the programme and so may not be fully representative. Furthermore, follow-up data are not available and so it is unclear whether these improvements were maintained over time. In addition, it is notable that a sizable minority of young people deteriorated during the course of the programme, and more exploration of the factors that may have contributed to their deterioration is needed.

In conclusion, both the screening tool and MAB programme demonstrate considerable promise in providing an effective way of identifying and supporting young people at risk of or, engaging in, self-harm behaviour, as a form of early and community-based intervention. However, further research is required to build upon the current evaluation's findings.

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Emma Dobson is a post-doctoral researcher at the School of Education, Durham University.

For communication, please email: [e.s.dobson@durham.ac.uk](mailto:e.s.dobson@durham.ac.uk)

## Emma Dobson

# Labelling the labia – a lesson in how to terrify teachers: Pedagogical obstacles to the introduction of compulsory Relationships and Sex Education (RSE)

Current 'Sex and Relationship Education Guidance' (DfEE, 2000) has been widely criticised. With almost twenty years having passed since its publication, and following the recommendations of various committees and inquiries (OFTSED, 2013; House of Commons Education Select Committee, 2015; House of Commons Education Committee, 2016), legislation passed in Section 34 of the *Children and Social Work Act* (2017) introduced Relationships and Sex Education (RSE) as a statutory requirement in schools in England. From 2020, Relationship Education will be compulsory in primary schools (age 4-11) and RSE will be compulsory in all secondary schools (age 11-16). This is cause for celebration. After committed campaigning and vigorous debate, young people will now be entitled to receive an education that will support their transition into adulthood by preparing them to engage in healthy, consensual, and fulfilling relationships. Despite this achievement, during a study of RSE curriculum implementation, a number of pedagogical constraints were identified as posing potential barriers to the introduction of the compulsory RSE curriculum in 2020.

### Teaching RSE in Secondary Schools

12 secondary schools in the catchment area of the Local Education Authority participated in a study of RSE. Approximately 30 teachers received training, resources and a comprehensive curriculum guide to support their delivery of a sexual health and wellbeing programme to Year Nine (13-14 years) students. The curriculum consisted of six broad subject areas: puberty and reproduction, sexuality and gender identities, healthy relationships, communication and consent, STIs and contraception, and sex,

pornography and the media. During the course of curriculum design and delivery, several issues arose which may have negative implications for the roll-out of compulsory RSE in secondary schools. These are described in more detail below and include: teachers' reluctance to take responsibility for RSE delivery; the exclusion of female external genitalia from educative materials; the omission of experiences other than the biological act of reproduction, and censoring 'inappropriate' questions and answers.

### 'Other professionals' are preferable

Upon learning of the content they would be responsible for delivering, many teachers asked whether an external educator, such as a nurse, health practitioner, or peer educator, could be 'brought in to do the tricky bits'. An example of a 'tricky bit', thought to be best addressed by an external educator, was that of the condom demonstration. Teachers did not want to be seen holding condoms or demonstration models and referred to 'hiding' materials or 'locking them away in cupboards'. Teaching staff also requested that all condoms be counted out and counted in again upon their return by students due to concerns about misbehaviour. Any wrappers were to be removed from classrooms and disposed of outside of school grounds or wrapped in tissue paper to disguise on-site disposal, preventing 'silliness or students messing round with them'. This is an example of 'condom phobia' reported by Formby *et al.*, (2010), where the presence of condoms or their packaging in classrooms is associated with problematic youth sexuality; raising concerns around damage to a school's reputation. On the whole, teachers were happy with the content of

the proposed curriculum, so long as they were not the ones responsible for its delivery. When teachers *were* responsible for teaching the curriculum, a number of subject areas were identified as presenting considerable difficulties for classroom-based discussion.

### **Visuals of the vagina are vulgar**

The unit on puberty and reproduction included a PowerPoint presentation with diagrams of both the male and female reproductive systems. These were to be labelled by teachers and/or students. The male illustration included an internal and external representation of the genitalia, whereas the female illustration was limited to an internal view of the ovaries, fallopian tubes, and uterus. Previous studies spanning a period of thirty years have noted the tendency of sex education to neglect parts of female anatomy and sexuality related to pleasure (Fine, 1988; Measor, Tiffin & Miller, 2000; Pound *et al.*, 2017). To rectify this within the current programme, an illustration of female external genitalia was included alongside the 'traditional' diagrams present on teaching slides. Whilst teachers had initially been comfortable with the content of the reproduction and puberty unit, the addition of this new illustration caused considerable consternation. Teachers did not feel comfortable using material that included an image of female external genitalia; asking for the illustration to be removed from slides as it was 'too rude to show pupils in the classroom'. Teachers also refused to label the image. There was particular anxiety surrounding the identification and discussion of the labia and clitoris. These anxieties were not present when labelling external parts of the male reproductive system such as the penis, scrotum or foreskin.

### **Teachers can't talk trans**

Many teachers had identified students within their classrooms who were questioning their gender, in the process of transitioning, or experiencing homophobic bullying after disclosing their sexuality. Staff felt strongly that these students should be given greater support and believed RSE was the best method to dispel myths and discourage stereotyping and prejudice within their school. Despite this, teachers were reluctant to discuss transgender issues with their students. This was often identified as being due

to the fear of 'getting it wrong' or 'using the wrong label', potentially upsetting pupils in the classroom who may be transitioning. Teachers frequently described feeling ill-equipped to disseminate accurate information, claiming that students 'already know more about the labels and the process than we do from watching stuff on YouTube'. Some staff did not wish to discuss any content that could be linked to Lesbian, Gay, Bisexual or Transgender (LGBT) issues. There were concerns that subject matter relating to the sexual health and wellbeing of LGBT students would be 'too mature to discuss in school'. This was based on the notion that talking about homosexuality would necessarily lead to 'taboo' discussion of alternatives to vaginal penetrative sex such as oral and anal sex. These subjects were deemed to be beyond the educative remit of the classroom, an 'inappropriate' discussion to hold with students. The promotion of vaginal penetrative sex as the accepted, proper or normal practice excludes the experience and education of LGBT students (Formby, 2011; Hirst, 2013), and is an example of how teachers can uphold heteronormative RSE (Abbott, Ellis & Abbott, 2015). Furthermore, sexual practices such as oral and anal sex are not solely confined to homosexual relationships. The refusal to acknowledge these behaviours in RSE limits the sexual knowledge and repertoire of *all* young people (Allen, 2008; Hirst, 2008). The inclusion and acknowledgement of sexual diversity in RSE frequently presents difficulties for teachers (Kehily, 2002). This is not a consequence of teachers' disinclination to educate their students. As highlighted above, staff *wanted* to include this content in the curriculum but felt unable to personally discuss subject material due to a lack of knowledge or confidence, and a fear that discussion of this nature would be reported, leading to complaints.

### **Questions will not be tolerated**

Attempts to restrict curriculum content in this manner led to many teachers limiting or censoring student-led questioning through cautioning pupils to 'stick to appropriate topics'. As part of the programme, participating pupils were invited to submit anonymous questions about curriculum content. These would be answered by the researcher and returned at the end of the programme in the form of a

'Frequently Asked Questions' booklet. Booklets were to be given to each student so they could find the answer to their question at a time of their choosing; in private, with family, or amongst friends. They could also read questions that had been submitted by their peers; reinforcing the notion that no one 'knows it all' and providing answers to queries common amongst the peer group. Schools requested that submitted questions and proposed answers be subject to approval by staff before their return to students. Several questions and topic areas were redacted from the booklets upon review by teaching staff. Examples of these questions are given below:

*What happens when you have a sex change? How much does it cost?*

*What is lesbian sex?*

*How do you have anal sex?*

*Do lasses cum like lads?*

*Why do girls have more ways to masturbate than boys?*

*What does sperm taste like?*

*Do old people have sex? Can they still do it?*

*Can you get pregnant from animals?*

Teachers often justified this censorship by arguing that these questions were examples of students 'messaging around', deduced from phrasing or subject matter. It could be argued however that these questions serve to demonstrate the vast and increasingly complex sexual landscape young people today are trying to navigate. Restricting questioning in RSE limits pupil agency as: 'In order to have questions answered, pupils not only have to know *what* to ask... they must know *what is appropriate* to ask and *how to ask appropriately*' (Corteen, 2006, p89). This 'grey area' around question acceptability discourages participation, resulting in an RSE programme that does not adequately address the concerns of young people (Forrest *et al.*, 2004; Maxwell, 2006).

Furthermore, as these topics had been prohibited within classroom-based discussion, pupils would have been forced to look elsewhere to find answers to their questions. There is no way of knowing whether the information they will find will be accurate or reliable, or whether students will continue to search for answers at all. After having their question removed from the 'approved' list, there is a worrying possibility that students may decide that their question was too naughty, silly or abnormal to be worthy of a response; encouraging pupils to view their

gender/sexual identity in a negative manner (Abbott, Ellis & Abbott, 2015), and thereby dissuading them from asking for help or support in future.

### Where does the reluctance to teach RSE originate?

Difficulties inherent in teaching RSE have been widely documented (Abbott *et al.*, 2016). Given the historical context of sex education, previous legislative threats, negative media reporting, and an absence of teacher training, it is not surprising that teachers are sometimes reluctant to engage in the delivery of RSE.

#### Historical context

Historically, the focus of RSE has been preventative; presenting young people as vulnerable to and thus dutifully arming them against the threat of AIDS/HIV, teenage pregnancy, and soaring STI rates. In an analysis of English policy, Kidger (2005) identifies two dominant discourses: harm reduction and moralism. In this way, RSE serves to prescribe appropriate behaviour (Allen, 2001), portraying student sexuality as a problem to be managed or contained (Allen, 2007). To this extent, teachers educate *against* student sexuality, rather than educating *for* sexual health and wellbeing.

#### Legislative threats

Those responsible for teaching RSE have been subject to a number of legislative threats such as the infamous 'Section 28', which encouraged teachers to censor the sex education classroom (Nixon & Givens, 2007). Whilst these are no longer in effect, their influence remains. As Section 28 was only repealed in 2003, there will still be staff teaching in schools who recall and are mindful of repercussions. Despite OFSTED (2002) reporting that less than 1% of parents remove children from RSE, these fears will have been exacerbated recently by the parental response to LGBT curriculum materials used in Parkfield Community School in Birmingham. Teachers may continue to self-censor in order to avoid similar situations in future.

#### Moralistic media

Not only are teachers wary of parental disapproval, the media have also played a large part in encouraging public condemnation of RSE

curricula. Positive press coverage of the APAUSE<sup>1</sup> programme for example, was overshadowed by highly critical, graphic headlines accusing the programme of promoting 'oral sex lessons for under-16s' (Kingori, Wellings & French, 2004). Perhaps more seriously, in 2005, The Telegraph published an article entitled 'Outrage over explicit sex lessons' in which a specific school, head teacher, and the individual responsible for delivering what was deemed to be an 'offensive' RSE programme, were publicly 'named and shamed'. Accordingly:

*'the most prominent external factor cited as a barrier to service development or provision was fear of the media. High-profile cases of schools and individuals being targeted by a sensationalistic or antagonistic press appeared to have left the majority of service providers with feelings of fear or trepidation in relation to potential negative media coverage'.* (Formby *et al.*, 2010, p430).

### Lack of teacher training

Efforts to provide good quality RSE have also been hampered by limited opportunities for teacher training. Despite opportunities increasing with successive governments, the House of Commons Education Committee wrote in 2015 that 'there is a mismatch between the priority that the government claims it gives... and the steps it has taken to improve the quality of teaching in the subject' (Life Lessons, p3). This is to the detriment of RSE as inadequate teaching will negatively impact the subject knowledge of students. Teacher training for RSE is not compulsory. Whilst figures vary, it is estimated that 20% of teachers have not received any RSE training (OFSTED, 2013). This is supported by a 2018 survey conducted by the Sex Education Forum which reported that 6% of teachers had not covered RSE in Initial Teacher Training (ITT), and 29% had never had any training at all. Consequently, teachers report feeling unsure, embarrassed and underconfident when delivering RSE (Gordon & Gere, 2016; Wight & Buston, 2003).

### Implications for the Introduction of a Compulsory RSE Curriculum

Taking account of the difficulties outlined above, it is questionable whether legislative change in itself will be enough to improve RSE. It may guarantee provision, but this does not guarantee quality. 'Guidance can provide the

foundations for good quality provision, teachers' key role in its delivery affects its efficacy' (Abbott, Ellis & Abbott, 2016, p689). Whilst it is important that young people receive RSE, within this educative context it is the teachers that need guidance as well as their students. Without support, teachers will continue to deliver content based on personal notions of comfort and appropriateness (Abbott *et al.*, 2015). Thus by neglecting to support teachers, we also neglect to support their students, who will receive restricted lesson content as a result. Observations suggest that as it stands, teachers are not only unprepared but are also unwilling to deliver parts of the RSE curriculum. This may hinder the introduction of a compulsory curriculum in 2020. There is still much confusion and debate surrounding the provision of RSE. This is due to conflicting notions of morality, normality and the family; complicated by the curriculum's lack of clarity in defining and identifying 'age-appropriate' content; and compounded by limited opportunity for teacher training. A survey conducted by the National Confederation of Parent Teacher Associations, National Association of Head Teachers and National Governors Association stated that 80% of respondents did not feel trained and confident to deliver RSE, with only 9% rating available teaching materials as useful. Similarly, Westwood & Mullen (2007) reported that one third of teachers disliked teaching RSE. The majority did not feel they had adequate resources to teach the topic and didn't feel sufficiently prepared to teach the subject. As such, this article recommends four key areas that need to be addressed before the roll-out of the compulsory curriculum in 2020: 1) invest in teacher training, 2) define age-appropriateness, 3) identify age-appropriate materials and 4) celebrate sex educators.

### Investing in teacher training

'An area often overlooked in the planning of any health education programme is the development of the capacity of individuals to deliver the programme' (Walker, Green & Tilford, 2003, p321). Teachers are regarded as the most sustainable source of RSE as they are already employed within schools. The new RSE

<sup>1</sup> APAUSE is an acronym for Added Power and Understanding in Sex Education. One of the project aims was to help teenagers in areas reporting a high incidence of teenage pregnancy to identify appropriate 'stopping points' in the build-up to penetrative sex to avoid unplanned pregnancy.

Guidance (2019) places heavy emphasis on teachers' responsibility for the delivery of RSE: 'Use of visitors should be to enhance teaching by an appropriate member of the teaching staff, rather than as a replacement for teaching by those staff' (p18). Yet teachers currently receive very little training in preparation for this role. Consequently, preparing teachers to deliver RSE has been identified as 'the most significant delivery challenge' (Government Response to the Report by the Sex and Relationships Education (SRE) Review Steering Group, Department for Children, Schools and Families, p7). Despite this, the availability of training is limited. The Sex Education Forum commendably delivered preparatory training days in readiness for the launch of the compulsory curriculum. Sessions were at a cost of £200 however and held in London. These may not be accessible for schools with budgetary constraints or those based outside the South of England. 'Taking staff out of school... places great pressure on schools, in relation to maintaining staff levels, and the alternative solution of providing training at weekends transfers pressure to individual team members' (Walker, Green & Tilford, 2003, p327). Currently the majority of training is in the form of Continuing Professional Development (CPD). This is provided via external agencies at considerable cost and there will necessarily be variation in quality between programmes. A standardised form of training at least during ITT may be required to ensure the consistency of future provision. Whilst it is good that RSE guidance will be reviewed every three years to respond to emergent trends, training programmes and resources will also need to be regularly updated. This represents considerable CPD cost for schools. The Secretary of State for Education has announced £6 million of funding to support this process, however this sum has been critiqued as equating to approximately £250 per school (Rayner, 2019) – covering the cost of just one ticket for an SEF training day.

### Defining age-appropriateness

Having minimal prescriptive content within the RSE curriculum can be viewed positively as it gives schools the flexibility to 'respond to local public health and community issues, meet the needs of their community and adapt materials and programmes to meet the needs of pupils'

(SRE Guide, 2019, p41). Whilst it is important that schools consider the context in which they will deliver RSE, it is also worth considering that RSE is valued by some students from ethnic or religious minorities precisely because it provides an opportunity to learn about issues not discussed within their community (Selwyn & Powell, 2007; Orgocka, 2004; Yu, 2007). Moreover, determining when it is most appropriate for students to learn about specific aspects of sexual health and wellbeing is a daunting task for teachers, who fear they may overstep the professional boundaries of their role as an educator and cause offense. This may account for teachers' reluctance to label diagrams of the female genitalia or discuss LGBT content with students. New guidance often refers to schools including content *if* and *when* it is appropriate for the needs of their pupils – but who has the right to decide which content is appropriate and at what age? This responsibility is currently passed down to schools, but the lack of clarity surrounding *when* content is appropriate (and therefore by inference, when it is *not*) will serve to perpetuate teachers' delivery of a narrow and restrictive RSE curriculum. Guidance should present curriculum content progressively, year by year, making clear statements about when content can be deemed 'acceptable' to be passed on to students. This will alleviate teachers' fears that they may have presented a topic prematurely and potentially exposed themselves to critique.

### Identifying age-appropriate materials

Teachers delivering RSE are predominantly concerned with teaching methods and resources (Walker, Green & Tilford, 2003). Westwood & Mullen (2007) report that the majority of teachers do not feel they have adequate resources to teach RSE and the scarcity of funding meant resources were not replaced or updated. Even if excellent, free curriculum materials were distributed to teachers alongside or as part of RSE Guidance, as observations from this article would suggest, 'the success of those materials would depend in very large part upon the educator delivering them' (Pound, Langford & Campbell, 2016, p12). An SEF survey (2018) reported that 70% of teachers would find it very helpful to have guidance on how to choose and use reliable resources when delivering RSE. Instead, RSE Guidance (2019)

places the responsibility for identifying sources and determining their appropriateness on teachers. It states that 'schools are free to determine how to deliver content' (p8) and to support this process:

*'There are a lot of excellent resources available, free-of-charge, which schools can draw on when delivering these subjects. Schools should assess each resource that they propose to use to ensure that it is appropriate for the age and maturity of pupils'*(p13).

What criteria should teachers use to support this endeavour? Where are the best resources? Is there a checklist of items that could be used to corroborate teachers' classification of retrieved materials as high-quality and, age-appropriate? Without this, individual schools/teachers may face having to justify their decision to the press or parents without sufficient support. When compiling the *Life Lessons* (2015) report on PSHE, the House of Commons Committee received correspondence from 'a large number of parents... expressing their concerns about inappropriate teaching materials being used' (p25) in RSE. Whilst RSE guidance does include a list of 'good' websites from which resources can be downloaded, this is no guarantee of their acceptability or appropriateness. For example, the *Times Educational Supplement* (TES), a common port-of-call for teachers looking for educational materials, was recently condemned by LGBT+ groups for including a link to a classroom resource from a critical pressure group *Transgender Trend*.

Another example is that of sexual health charity *Brook*, who were widely criticised in the media (The Telegraph, 2014; BBC News, 2014) and in a sitting of the Commons Education Select Committee for schools' use of their 'Traffic Light Tool'; despite this being featured in supplementary guidance on sex and relationships education that was endorsed by the Department for Education and produced by the SEF and the PSHE Association (currently on the 'approved' RSE Guidance list of websites). Given this background, teachers will need more support in sourcing and scrutinising self-selected resources for RSE. It is not enough to merely direct them to websites without first giving them the appropriate training and guidance to justify their selection and utilisation of materials as it has been the case in the past that individual teachers or schools have been 'put on trial' by the media

for the 'inappropriateness' of their RSE programme.

## Celebrating sex educators

Finally, to further bolster the confidence of those teachers responsible for delivering RSE in schools, awards such as those given by the SEF to recognise outstanding examples of innovation or practice should be widely publicised: the reporting of which should help to shift media rhetoric to a more positive appraisal of the sex education curriculum, its content, and the beneficial impact it can have on the lives of young people.

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