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Welcome to the third issue for 2015. 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.

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**TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES**
Adolescence is often viewed as a time for experimentation and risk-taking behaviour. For instance, when I was a teenager, my friends and I used to occasionally play a game that we called ‘Headrush’ where we would have our breathing temporarily stopped by someone holding onto our chests after a deep expiration and hyperventilation (so that we could not breathe). It induced feelings of light-headedness and dizziness followed by temporary unconsciousness (usually lasting 10 to 15 seconds). I did it twice and on both occasions I felt as though I had lived a whole other life while I was unconscious. I cannot remember exactly why I had engaged in such a potentially life-threatening behaviour except that all my friends were doing it.

SARTB

This activity that I engaged in as a teenager is an example of self-asphyxial risk-taking behaviour (SARTB), and the game we called ‘Headrush’ is more popularly known in the academic literature as the ‘choking game’ or the ‘fainting game’ (but is also known by dozens of alternative names as listed in Appendix 1).

As an academic, I first became aware of this issue in a case study published by Shlamovitz et al. (2003) on ‘suffocation roulette’ (although reports of SARTB date back to the early 1950s in the medical literature [e.g., Howard et al., 1951]). Shlamovitz and colleagues reported the case of a 12-year-old boy admitted to hospital because of recurrent syncopal episodes (i.e., persistent fainting). The authors reported that the fainting episodes were due to SARTB. It also appears that what I did when I was an adolescent was a form of ‘self-induced hypocapnia’ (i.e., a state of reduced carbon dioxide in the blood). It has also been reported that these ‘games’ can be played alone and typically involve self-strangulation, or sometimes with others (Shlamovitz et al., 2003), and where like my own experiences, the cutting off of the oxygen supply was carried out by somebody else.

SARTB has been defined by Toblin et al. (2008) as self-strangulation or strangulation by another person with the hands or a noose to achieve a brief euphoric state caused by cerebral hypoxia. As with autoerotic asphyxiation (i.e., suffocation as a way of enhancing sexual arousal [Aggrawal, 2009]), the aim of SARTB is to intentionally cut off the oxygen supply to the brain to experience a feeling of euphoria (the only difference being that in children’s games, it is not done for a sexual reason). As the Wikipedia entry on SARTB notes:

“According to Dr. Steve Field, chairman of the Royal College of General Practitioners in London, the fainting game is pursued primarily by children and teens ‘to get a high without taking drugs.’ Children ‘aren’t playing this game for sexual gratification.’ It is frequently confused with erotic asphyxiation, which is oxygen deprivation for sexual arousal. Unlike erotic asphyxiation, practice of the fainting game appears to be uncommon in adulthood”.

There has been relatively little research into the practice although Drake et al. (2010) claimed that ‘thrill-seeking’ is risk factor in engaging in SARTB. Another paper by MacNab et al. (2009) said there was a perception among those who engaged in such games that inducing fainting was a low-risk activity. MacNab and colleagues attempted to determine the prevalence of knowledge about and participation in SARTB and how best to raise awareness of this risk-taking behaviour and provide preventive education. Their study collected data from children and adolescents (aged 9 to 18 years with

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**Mark D. Griffiths**

A brief review of self-asphyxial risk-taking behaviour in adolescents
an average age of 13.7 years) at eight middle and high schools in Texas (US: n=6) and Ontario (Canada: n=2). They also noted that there had been a recent death from playing the choking game in one of the Texas schools, and that two other fatalities had occurred within the state. Over 2,500 questionnaires were completed. They reported that 68% of children had heard about the game, 45% knew somebody who played it, and 6.6% had tried it (and 40% perceived no risk from the activity). The study found that the most respected source of a preventive education message was parents for pre-adolescents (43%) or victim/victim’s family (36%) for older adolescents.

### Other reasons to participate in fainting games

Neal (2008) noted other reasons that children participate in fainting games include curiosity (as to what the act of fainting might feel like), peer pressure (including a challenge or a dare or a rites of passage into a particular social group), and as an exploration of ways to ‘get high’ and intoxicated at no financial cost (compared to engaging in illicit drug use). Neal also noted that children that experienced self-induced hypocapnia blackouts may experience dreaming or hallucinations (albeit fleetingly), and may regain consciousness with short-term memory loss and involuntary movement of their hands or feet. Although full recovery is usually made within seconds, such activities can cause confusion, headaches, amnesia, permanent brain injuries, and in extreme cases, death (Urkin & Merrick, 2006). Advocacy groups have claimed that the number of fatalities due to SARTB is more than 1000 worldwide (GASP, 2008).

Fatalities of children engaged in SARTB have been reported in the clinical and medical literature. For instance, Egge et al. (2010) reported the case of a 12-year-old girl who was brought to the paediatric emergency department after her mother found her hanging from her bunk bed. She died five days after being admitted to hospital and it was eventually found that she had played the choking game.

The revalence of the activity is debatable as most of the academically published studies are case reports (usually when a problem – and in some cases, death – has occurred). However, a comprehensive systematic review of SARTB was recently published by Busse et al (2015). They attempted to assess the prevalence of engagement in SARTB and associated morbidity and mortality in children and adolescents (and up to early adulthood). Busse and colleagues examined every survey and case study that had been published on SARTB, and more specifically examining the behaviour among those aged 0–20 years (excluding any study where the motive was autoerotic, suicidal or self-harm). They reported that 36 studies had examined child and adolescent SARTB in 10 different countries (North America and France being the most common, but also reports in the UK).

### Risk factors

Risk factors for SARTB were hard to assess because most of the studies examining such risks did not control for other confounding variables. However, five of the studies reported an association between SARTB and a number of other risky behaviours including substance misuse, risky sexual behaviours, poor mental health, poor dietary behaviours, and engagement in risky sports. The review also reported that there did not seem to be any association between SARTB and engagement in physical activity, and experiencing accidents, and/or hospital admissions. It was also noted that a number of other behaviours increased the likelihood of engaging in SARTB including experiences of violence, being more impulsive, having a thrill-seeking personality, and having lower school achievement. However, only six of the 36 studies they reviewed reported the potential for SARTB to be associated with other risky behaviours. No consistent findings were found between SARTB and gender, age and other demographic factors (such as socio-economic status).

Examining the studies as a whole, Busse and colleagues reported that awareness of SARTB ranged from 36% to 91%, and that the median lifetime prevalence of engagement in SARTB was 7.4% (however, these were studies that used convenience sampling, therefore none of the studies were necessarily representative). In the SARTB literature, a total of 99 fatal cases were reported (and of the 24 detailed case reports, most of the deaths occurred when individuals were engaged in SARTB alone and used some type of ligature).

In a different analysis, Toblin and colleagues
(2008) used US news media reports to estimate the incidence of deaths from SARTB. Their report identified 82 probable SARTB deaths among youths aged 6-19 years during 1995 and 2007. Of these 82 cases, 71 (86.6%) were male, and the mean age of death was just over 13 years of age. The study also noted that deaths were recorded in 31 US states and were not clustered by location, season or day of week. Busse and colleagues assert the importance of education and prevention and more specifically note:

“As it has been suggested that knowledge and identification of symptoms and signs of engagement in [SARTB] could have possibly enabled early identification and possible prevention of fatal cases, we believe that clinicians, paediatricians, health professionals and teachers should receive education on the symptoms and signs of [SARTB]. The need to educate health professionals has been highlighted as awareness of [SARTB] will enable these individuals to identify symptoms and signs and to act as educators to young people and their parents...We further recommend that more research is carried out together with young people to develop appropriate education material. In line with recommendations from others, we further recommend removing existing videos about [SARTB] from the internet and ensuring that preventative website rather than promotional websites appear first on internet searches” (p.8).

This brief examination of the literature suggests that a significant minority of adolescents have engaged in SARTB and that in extreme cases it may lead to death. Despite being known about for over 60 years, the data concerning SARTB are still limited and relatively little is known about the associated risk factors. However, SARTB certainly appears to be an activity that parents and teachers should be made more aware of even if the prevalence of such activity among children and adolescents is low.

References


Appendix 1 (Source: Urban Dictionary, 2015)

According to the online Urban Dictionary, asphyxial games have many different names worldwide including: Airplaning, America Dream Game, Black Boxing, Black Out Game, Breath Play, Breathing the Zoo, Bum Rushing, California Blackout, California Choke, California Dreaming, California Headrush, California High, California Knockout, Catching Some Zs, Choking Game, Cloud Nine, CranK, Dream Game, Dreaming Game, Dying game, Fall Out Game, Flat Liner, Flatline Game, Flatliner Game, Funky Chicken, Getting Passed Out, Grandma’s Boy, Groobling, Halloween, Harvey Wall Banger, High Riser, Hoola Hooping, Hyperventilation Game, Indian Headrush, Knockout Game, Passing Out Game, Pass-out Game, Purple Dragon, Natural High, Neckies, Redline, Rising Sun, Rocket Ride, Sandboxing, Sleeper Hold, Sleepers, Space Monkey, Speed Dreaming, Suffocation Game, Suffocation Roulette, The Game, The Mysto World, Tingling Game, Trip to Heaven
In spring 2014, research was conducted evaluating the health benefits of outdoor Learning In Natural Environments (LINE). The Woodland Health for Youth (WHY) project (Aronsson et al., 2014) was a partnership project between Plymouth University (School of Nursing and Midwifery and Institute of Education), Plymouth City Council (Natural Infrastructure Team and Public Health), Plymouth Community Healthcare, Silvanus Trust (Good from Woods) and a local primary school aiming to measure the physical health benefits of LINE whilst exploring the potential for outdoor learning as a framework for ‘whole-school health promotion’ (Langford et al., 2014). A public health nurse was appointed as the practitioner-researcher; a role which involves clinical knowledge of the field as a means to develop appropriate methods for the study. This article describes this process, with a particular focus on accelerometry as a component in holistic evaluation of whole-school health promotion using natural environments.

**Background**

We live in an obesogenic environment where sedentary lifestyles are accompanied by high-calorific food intake, putting the health of our children at risk. Preventing childhood obesity is a current national priority (Public Health England (PHE), 2014a; National Institute for Health and Care Excellence (NICE), forthcoming), with a strong focus on physical activity. In addition to reducing rates of childhood obesity, increased physical activity in children is associated with multiple positive health outcomes such as cardio-metabolic health, muscular strength, bone health, cardiorespiratory fitness, self-esteem, anxiety/stress, academic achievement, cognitive functioning, attention/concentration, confidence, and peer friendship (PHE, 2015). However, physical activity levels in English children are low, with around two in ten children aged 5-15 years meeting the national physical activity target of 60 minutes or more moderate-to-vigorous physical activity every day (PHE, 2014b). Furthermore, a social gradient exists, with children from the lowest income bracket more likely to report low levels of activity (PHE, 2014b).

Kriemler et al. (2011) undertook a systematic review of initiatives that increase physical activity levels in school-aged children, and concluded that school-based initiatives reach the greatest number and most diverse population of children, with a potential to increase physical activity and overall fitness in young people. However, schools have a busy timetable delivering the national curriculum, which hinders opportunities to offer health promotion initiatives. The WHY project evolved from a need to evaluate whether outdoor learning would allow for equitable access to physical activity interventions for school age children, without compromising school’s delivery of core subjects. The benefits of outdoor learning are well established and include educational attainment and child mental health and wellbeing indicators (Waite, 2011; Dillon and Dickie, 2012; Roe and Aspinall, 2012). There was a need to explore physical health outcomes in relation to outdoor learning.

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1 The Natural Connections Demonstration Project aims to increase the number of teachers and pupils experiencing the full range of benefits that come from Learning Outside the Classroom In Natural Environments (LINE) across the curriculum, in areas of high deprivation in the south-west of England (http://www.naturalconnectionsblog.wordpress.com).
learning. The specific aim of WHY was to evaluate the physical health benefits of Learning In the Natural Environment (LINE).

Methodology

Choosing an appropriate methodology is pivotal within research management, not only because a specific research problem is best addressed by a certain methodology; the methodology that is used or developed also dictates the structure and content of the inquiry (Brew, 2001). The WHY project aimed to evaluate health benefits within the educational sector with an emphasis on partnership working with the local authority (City Council). In practice, the practitioner-researcher was supported by two supervisors from health and education. This allowed expertise and learning to be shared to produce an innovative research outcome (Bossio et al., 2014). As the research problem was anchored in real world practice, an action research methodology was adopted. Action research concerns problem-solving in a specific context, and aims to improve practice through collaboration between researchers and practitioners (Robson, 2011). The WHY practitioner-researcher role included supporting the delivery of LINE whilst carrying out the research, which meant working closely with school staff. Such involvement requires reflexivity; an awareness of the researcher’s position within, and possible influence on, the research (Robertson, 2000).

Action research has the potential to employ both qualitative and quantitative methods to address the research question, allowing for multiple perspectives being incorporated through data triangulation (Mukherji and Albon, 2010). Fielding (2009) argues that this can extend the scope and depth of understanding. However, from a theoretical stance, such mixed methods research poses a clash between underpinning philosophies traditionally associated with quantitative and qualitative research. This is overcome by pragmatism, where knowledge arises from actions, situations, and consequences without being limited to any one system of philosophy and reality (Creswell, 2003). This lends itself to action research, which is a process that works in cycles of planning, acting, observing and reflecting, and is context specific (Mukherji and Albon, 2010). For the WHY project, quantitative data was collected through the measurement of physical activity and body mass index (BMI), and qualitative data was assembled via observations and reflexive diary notes written by the practitioner-researcher. The focus here will be on the development of accelerometry for the quantitative measurement of physical activity.

Accelerometry

An accelerometer is a device that measures acceleration of movement, which can be translated into physical activity (PA) levels. This provides a solid objective measurement of PA and has been used in a number of studies of children across diverse cultures around the world (Sherar et al., 2011). The decision to use accelerometry to measure PA within the WHY project crystallised through consultation and engagement with wider stakeholders for the project, including other researchers working with children in different educational and public health contexts. Two researchers independently recommended this data collection method, one of them offering to lend the accelerometers, which prompted the novel opportunity to pilot their use in the WHY project.

The WHY project used GENEActiv accelerometers (ActivInsights, Kimbolton, http://www.geneactiv.org/) which are wrist-worn accelerometers that are fairly new, yet well established as an objective and feasible measurement tool, comparable to other peer accelerometers (Esliger et al., 2011). Ethical approval for the study was obtained from Plymouth University in 2014. Ten children participated in this small-scale study following written consent from their parents/carers and oral consent from the children every morning of data collection. The participating children wore their accelerometers on their wrist of choice one day a week during school hours for five weeks, which in theory means 50 days of data collection; however due to absence of children on a few occasions the total number of data collection days amounted to 45. Comparison with the school timetable allowed data to be analysed according to PA levels during indoor and outdoor lessons and break times throughout the day.

Cut-points

Previously validated movement count cut-points
(Phillips et al., 2011) were used to determine the proportion of time spent in sedentary, light, moderate and vigorous activity. Cut-points are thresholds applied to the accelerometer 'activity counts' that are used to convert the accelerometer raw data into PA levels. To develop cut-points to use for children there are calibration experiments where children have participated in age-typical activities and accelerometry has been used to determine the activity count for an activity that is sedentary (e.g. sitting down) / light (e.g. walking slowly) / moderate (e.g. walking briskly) / vigorous (e.g. running). Different studies use different sets of activities when they conduct calibration experiments; the study by Phillips et al. (2011) was chosen for the purpose of this project because they used the GENEActiv accelerometers and looked at children close in age to the children participating in the WHY project.

**Epochs**

The accelerometry raw data were downloaded using the GENEActic PC software (version 2.2) and converted into epochs; units that summarise the data collected during a set time period. An epoch size of 60 seconds is conventionally used; however research has shown that children’s movements are more sporadic and intermittent than those of adults, and therefore collecting accelerometer data in shorter rather than longer epochs may capture the short bursts of activity in children more accurately (Colley et al., 2014; Rowlands et al., 2006). However, Schaefer et al. (2013) suggest that very short epochs may capture movements that are not purposeful, such as hand movement from reading. It was therefore thought that 5 seconds would be a suitable epoch length - short enough to capture children's energy burst without capturing movements of the wrist that are not purposeful. This was supported by the researcher’s observations in the field (school) whereby it was noted that some children used the arm with the accelerometer to enthusiastically communicate by raising their hands while sitting in the classroom. Thus, the use of accelerometry was largely informed by simultaneous triangulation with other qualitative and quantitative data collection methods (Plano Clark and Creswell, 2008) afforded by action research.

**Findings**

Statistical Package for the Social Sciences (SPSS) (IBM, Version 21) was used for all statistical analysis, using paired t-test to compare PA levels between LINE and classroom learning. The main focus of the study was to compare moderate-to-vigorous physical activity (MVPA) levels, as there is a national target for children aged 5-18 to spend 60 minutes or more a day in MVPA (Department of Health (DH), 2011). The results showed that children spent a significantly larger proportion of the time doing MVPA during LINE sessions (17.0% ± 6.7 SD) than during indoor lessons (6.2% ± 4.3 SD), p=0.000. The analysis also investigated if activity levels during LINE depended on if the lesson was held in the woodland or in the school ground, and found significantly higher proportions of MVPA in woodland LINE than in school ground LINE: 19.0% ± 7.1 SD in woodland LINE, 13.7% ± 4.8 SD in school ground LINE, p=0.01. Fjørtoft (2004) explains how rough surface, topography and vegetation in natural environments provide challenges for children, which enhances play, PA and motor development. Congruently, Passy and Waite (2011) identify a range of benefits to woodland LINE including greater freedom, wilder and more natural space, child-led learning, negotiated boundaries, created activities and managed risk. Figure 1 [below] shows the difference between the proportion of time children spent in MVPA depending on if they were engaged in woodland LINE, school grounds LINE, or an indoor lesson. This concurs with previous studies which have concluded that children who spend more time outside are more active (Stone and Faulkner, 2014; Cooper et al., 2010).

![Figure 1.](image-url)

**Figure 1.**

**Percentage of time spent in MVPA**

The Standard Deviation (SD) measures the amount of variation from the average value in the study sample.
While emphasising the importance of increased MVPA levels, the national recommendations (DH, 2011) together with evidence from research (Stone and Faulkner, 2014) also highlight the value of minimising sedentary behaviour. The WHY project compared the proportion of time spent in sedentary phase during outdoor lessons compared to indoor lessons and found that children spent a significantly smaller proportion of their time being sedentary during LINE sessions (44.2% ± 11.6) than during indoor lessons (60.4% ± 11.0 SD), p=0.000.

The highest levels of PA seen in this study were during break time and lunch (33.0% ± 17.3 SD), which concurs with previous studies exploring physical activities during the school day (Fairclough et al., 2008; Rauh, 2013). However, great variations were noted between individual children within the WHY project, presumably due to greater individual choice of activity during free time. Fairclough et al. (2008) noted more gender differences in activity levels during recess, and Rush et al. (2012) found that the gap in PA levels between the most active children than the least active children was bigger during recess than during the rest of the school day.

The gender imbalance related to physical activity is well-established, with a clear tendency for males to be more active than females at all ages (DH, 2011; PHE, 2014c). National statistics demonstrate that 79% of boys and 84% girls aged 5-15 years in England are not meeting the current physical activity recommendations (PHE, 2015), thus prompting policy to acknowledge the importance of increasing PA levels for girls in particular (Department for Culture, Media and Sport, 2015). Boys tend to participate more than girls in formal sports (Health and Social Care Information Centre, 2015; PHE, 2014c), and engage in more active games than do girls at school break times (Fairclough, 2008). Thus, introducing active curricular activities through outdoor experiential learning may be a more equitable way to increase PA levels for both genders. Indeed, the WHY study found that both boys and girls were more active outdoors compared to indoors. However, boys were generally more active than girls outdoors; boys spent 20.6% ± 6.5 in MVPA compared to 14.7% ± 7.1 for girls, p=0.09.

Limitations

The main limitation of the WHY project is the small sample size, which limits the external validity of the findings. Nevertheless, though the triangulation of quantitative and qualitative data, the results can be transferable to other schools in similar circumstances. The lack of a control group is another limitation, which needs to be addressed in future research.

An additional limitation is that PA was only measured during the course of a day during the five data collection days. It could be that children are less active after a school-day where they have had LINE, because they are physically tired. However, evidence extracted from the WHY reflective log suggests that children spend time in the woodland with their family after school, which would entail being physically active (walking to and within the woods, and probably engaging in activity through playing in the woods). This may be due to families increased interest, knowledge and confidence in accessing the woodland through LINE. Research has shown that children who are active during the school day are also more active after school (Rauh, 2013). This study suggests that children may in fact be inspired by LINE to spend more time outdoors outside of school, consequently increasing the total amount of PA.

Discussion and conclusions

Accelerometry proved to be useful as a component in holistic evaluation of whole-school health promotion using natural environments. Within the action research context, the WHY project dedicated considerable time to the methodology associated with accelerometry, assessing the suitability and deciding on appropriate cut-points and epoch lengths for children. The GENEActiv accelerometers offered an easy way of obtaining an objective measurement of PA and were well accepted by the participating children. This was an important contribution since the GENEActiv accelerometers are relatively new on the market.

The interdisciplinary action research design was found valuable as it allowed for emergent reflections to feed into the research cycle and inform the process. This flexibility enhanced the experience of partnership, as previously described by Richardson and Grose (2013), to become the lens...
though which the WHY project was observed. Additionally, the interdisciplinary element brought valuable aspects into promoting a whole-school approach to health, in line with the Odense Statement on health-promoting schools, which stipulates that health-promoting schools offer “concrete and well-evaluated examples of effective links between education and health that support “health in all policies” in the European Region” (Schools for Health in Europe, 2013, p.3). This study suggests that public health nurses can usefully lead practitioner-informed research for interdisciplinary practice.

The WHY project linked school-based initiatives and access to green space with increased physical activity levels, which suggests possible positive long-term health outcomes. The participating children were significantly more active during outdoor LINE sessions than during indoor lessons, and were especially active when LINE was held in the nearby woodland as opposed to the school grounds. These findings were triangulated with other methods of data collection not described here, namely BMI measurements and observational data/reflective log entries, to suggest that LINE may be associated with positive health outcomes for school age children.

Further research on a larger scale and over a longer period, with appropriate use of accelerometry, coupled with an exploration of the leadership role in promoting physical activity, would enable robust evidence to be gathered to develop and inform wider partnership approaches to whole-school health promotion.

Acknowledgements

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References


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**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
Angela Balding and David Regis

‘Young People into 2015’: The health related behaviour questionnaire results for over 78,000 young people

The Schools Health Education Unit [SHEU] is an independent research, survey and publishing company and the ‘Young People into 2015’ report is the 29th in the series. SHEU provide reliable baseline data for local needs assessment to inform plans in health, education and care.

‘Young People into 2015’, is a "unique contemporary archive" of young people. Each year, since 1977, SHEU carry out healthy lifestyle surveys with young people and, in 2014, this involved over 110,000 youngsters. This report contains over 100 health-related behaviour questions and answers from over 78,000 pupils between the ages of 10 and 15. They tell us about what they do at home, at school, and with their friends. The data have been collected from primary and secondary schools across England.

What's new and different in ‘Young People into 2015’?

Some of the differences are not new – they are continuations of trends that we have seen going on for some time.

Dr David Regis, Research Manager of the Schools Health Education Unit, says, “This report provides a snapshot of our young people as they were approaching 2015 and also offers some trends where we are able to look back over the last 30 years and more of our research. We have seen a further decline in young people's reported involvement with tobacco, alcohol and cannabis. We saw a peak for all these figures in the mid-1990s, and since then there has been a general decline.”

"Recent news reports have carried stories about mental health awareness (YoungMinds, 2015)\(^1\). In 2014, SHEU reported on some trends indicating that young people, perhaps particularly older girls, were less confident than were their peers a decade ago. We are still not sure why that is, but we have looked a little closer into our sample for this report. We found, for example, some links between use of social media ('talking and messaging online') and both risky behaviour and poorer emotional well-being.

The table 1 below is from p.44 of the report. It shows differences in the responses of Year 10 females, depending on whether they were light or heavy users of social media.

<table>
<thead>
<tr>
<th>Percentages among Year 10 females in one authority</th>
<th>Light social media use (&lt;1h) on the evening before the survey</th>
<th>Heavy social media use on the evening before the survey (3h+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low self-esteem</td>
<td>33</td>
<td>50</td>
</tr>
<tr>
<td>Worry about their own mental health</td>
<td>26</td>
<td>40</td>
</tr>
<tr>
<td>Worry about the mental health of someone in their family</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td>Know a trusted adult to talk with about worries</td>
<td>67</td>
<td>58</td>
</tr>
<tr>
<td>Follow e-safety advice 'always'</td>
<td>77</td>
<td>60</td>
</tr>
<tr>
<td>Ate '5-a-day' yesterday</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>Ever smoked</td>
<td>22</td>
<td>50</td>
</tr>
<tr>
<td>Ever drink alcohol</td>
<td>59</td>
<td>85</td>
</tr>
<tr>
<td>Ever offered cannabis</td>
<td>14</td>
<td>38</td>
</tr>
<tr>
<td>Believe most in their age group have had sex before 15</td>
<td>16</td>
<td>31</td>
</tr>
</tbody>
</table>

\(^1\) YoungMinds, 2015. “Headteachers say children’s mental health is most worrying concern”. Accessed 1\(^{st}\) September 2015 http://www.youngminds.org.uk/news/blog/2929_headteachers_say_children_s_mental_health_is_most_worrying_concern
There is a very plain association between heavy social media use and poor emotional wellbeing. But the statistics don't tell us anything about cause and effect – for example, it could be that youngsters who are feeling down then spend more time online, maybe to feel better.

"It's a real dilemma – young people want to be fully involved with everything their peer group is doing online, of course, and I would have really loved to see all the great things on the Internet when I was young. But we do worry if so much is good for them."

"Perhaps the standout result for me is the proportion of all of these young women who don't say they have an adult that they trust whom they can talk to if they are worried about something."

Angela Balding, Survey Manager at the Schools Health Education Unit, says, "We mentioned last year that the rising trend of self-esteem from 1997-2007 stopped in 2008, and the figures we are seeing for high self-esteem in 2014 have fallen again since last year especially for girls (p.94). The 2008 date coincides with the economic recession, so that's a plausible explanation of what we see – but we are also aware of new pressures about being online and spending so much time on social media."

"Social media can be a source of social anxiety and of course cyberbullying and other dangers. For example, the Year 10 Girls who spent 3+ hours messaging online were more likely to say someone they didn't know in person had asked to meet with them, and they report more exposure to other undesirable online behaviours."

Dr Regis adds, "The range of topics we have been asked to look at with schools continues to expand, but that hasn't made the production of our annual report any easier! We have seen some items dropped from the report, as too few clients chose those questions for their surveys, while a few items have been added to the reports. We have published this year for the second time results about e-safety; second-hand smoke; perceptions of drugs; barriers to exercise; responses to problems and sexuality and we have had another look at religion and belief (p.100)."

"As regards the aggregate data sets from which we publish this series of reports, they have become more complex and busy. Are the figures still representative? We reported last year that the characteristics of the schools in the SHEU data sets are reasonably well-matched to the national population of schools, and that is still true in 2015."

Young People into 2015
Summary

Chapter 1 - Food choices & weight control
In the sample, 64% of 14-15 year old females, 51% of 12-13 year old females and 31% of 10-11 year old females 'would like to lose weight'. This compares with 29% of 14-15 year old males, 32% of 12-13 year old males and 25% of 10-11 year old males who 'would like to lose weight'.

Less fresh fruit and vegetables are eaten as pupils get older and up to 55% report eating 1-3 portions of fruit and vegetables. 16% of 14-15 yr. olds and 27% of 10-11 yr. olds report eating 5 or more portions of fruit and vegetables yesterday.

Up to 72% of 12-15 year olds reported drinking less than 1 litre of water.

Chapter 2 - Doctor & Dentist
Up to 30% of the 12-15 year old females, reported feeling 'quite uneasy' or 'very uneasy' on their last visit to the doctor.

Chapter 3 - Health & Safety
Most 12-15 year olds report sleeping 8 or more hours 'last night'. There is a strong relationship between sleep patterns and a number of variables. For example, for 14-15 year old females, the more sleep they get they are less likely to: want to lose weight.

As pupils get older fewer say schools take bullying seriously. Up to 88% say they have been advised how to stay safe while chatting online.
Chapter 4 - Family & Home

As they get older, fewer pupils report living with both parents [59% 14-15 year old females in this sample report living with Mum and Dad together].

More females than males did homework on the evening before the survey, and they tended to spend longer at it.

Up to 80% of males played computer games after school 'yesterday'.

Chapter 5 - Legal & Illegal Drugs

Since the mid-1990s there has been a general decline in the percentage of 14-15 year olds who smoke regularly. Around 97% of 10-11 year olds say they have never smoked. This figure drops to 71% (males) and 66% (females) by the time they are 14-15 years old.

18% of 14-15 year old girls reported smoking and 26% reported drinking alcohol 'in the last 7 days'.

12% of 14-15 year olds report taking cannabis and, as they get older, fewer pupils think that cannabis is 'always unsafe'.

Chapter 6 - Exercise & Sport

Over 91% of the sample of 10-15 year olds report exercising at least on one day 'last week'. Around 67% of all males and 64% of 10-11 year old females report exercising vigorously on 3 or more days 'last week'.

Chapter 7 - Social & Personal

'School-work problems' are a worry for 14-15 year old females and 'the way you look' remains the main worry for 12-15 year old females.

64% of 14-15 year old females, compared with 49% of 14-15 year old males, want to continue with full-time education after Year 11.

Statements from the 'Every Child Matters' section show a marked difference between the positive responses from primary and secondary pupils e.g. responses to, 'The school helps me work as part of a team' drop from around 63% (10-11 year-olds) to around 36% (14-15 year-olds).

Younger (12-13 year-old) males continue to be the most satisfied group when 12-15 year olds are asked about how they feel about their life 'at the moment'.

Chapter 8 - Some responses from primary-age children that are not contained in Chapters 1-7

Up to 24% of 10-11 year olds report being picked on for 'the way they look'.

20% of 10-11 year olds report being approached by an adult who scared them or made them upset.

Wire bound edition £25 [including p&p] and can be purchased via this link Young People into 2015
NHS England’s recent report *Child Adolescent Mental Health Services (CAMHS) Tier 4 Report*, (2014), shows that, on average, approximately 360 children and young people were admitted to a Tier 4 service in England each month during 2013 with over 60 units providing care for adolescents across England.

**Inpatient Tier 4 services are inpatient services for the most unwell children and young people whose mental health problems cannot be managed on an outpatient basis** (House of Commons Health Committee, 2014, p.52).

Within CAMHS Tier 4 adolescent in-patient units good quality, relevant educational provision is vital for all young people throughout their admission. The provision of education for young people with health needs stemmed from information in the Education Act 1993 charging Local Authorities with a ‘duty’ to provide an appropriate education for this vulnerable group. In addition to this, the Department of Health research *The Welfare of Children and Young People in Hospital* (1991) supported the establishment of education provision. Subsequent legislation has clarified the form and importance of this provision culminating in the most recent guidance *Supporting Pupils at School with Medical Conditions* (Department for Education, 2014). This key document sets out the schools’ responsibilities in terms of gathering appropriate information to understand and support each individual young person and their specific health needs to ensure disruption to education is minimal. The process for gathering this information requires efficiency and consistency by education staff working in collaboration with service users thereby empowering them and giving them a degree of control over their experiences whilst an in-patient. In addition, the process provides information to the education staff to devise recommendations in collaboration with the young person, their school, family and clinical team, for alterations to their courses taking into account their career aspirations as well as the implications of their diagnosis and treatment plans.

**Evaluation project**

This evaluation project was conducted within a CAMHs Tier 4 adolescent unit in Northamptonshire to establish the effectiveness of the information gathering process already in place. The current process involves an informal one-to-one discussion, supported by the completion of a pro forma document, between a member of the education team and the newly admitted young person. The purpose of this is to collect information about their current education experiences and their career aspirations to enable the education team to support them in creating an Individual Learning Programme (ILP) to structure the support offered whilst an in-patient. Education staff also liaise with the parents/carers of the young person as well as their school/college to enlist support in providing encouragement and resources to support the ILP.

These young people, or service users, can provide pertinent information to the education team staff to aid in the development of ILPs in addition to retaining involvement in the provision and continuation of their learning. A degree of personal control is essential as it will have an impact on their subsequent success academically and enable them to be more effective and instrumental in achieving their ambitions (Ross and Broh, 2000). This
involvement of service users is of as much value to the education team as it is to the young people. Systems developed, in conjunction with them, should prove to be more successful and engaging. Studies relating to ‘pupil voice’ in education discuss the complexity of this process. Busher (2012) identifies issues of power between teachers and pupils and May (2005) identifies a lack of balance between the actions of pupils and teachers instigating participation. Other studies identify concerns relating to the frequency with which pupils’ ideas are implemented and the consequential devaluing of the process (Flutter, 2007 and Robinson and Taylor, 2007). Telford and Faulkner (2004) and Worrall-Davies and Marino-Francis (2008) discovered a lack of published literature relating to good practice where service users, particularly adolescents, participated in studies relating to mental health provision.

Methods

To discover the effectiveness of the initial information-gathering process, education staff and a member of the clinical team were involved in reflecting on its value to discover what they thought and felt about the intervention and its effects. These results would then be evaluated and, if necessary, recommendations made to improve the process. Øvretveit (2002) uses the term ‘action evaluation’ and explains that this process enables users to achieve ‘informed decisions’.

Service users were recruited through an information-sharing session of the plans for the evaluation and issues relating to confidentiality. They were given the opportunity for one-to-one discussions to clarify their understanding of the purpose of the evaluation and their involvement. Advice was sought from clinical staff about the suitability of the service user and their participation given their mental health presentation in terms of capacity to consent before the information gathering session. Suitable participants were then included in a focus group discussion based on their consent to participate and the consent of their parents/carers and the agreement of basic ground rules for the session. This session was managed by the evaluator and clinical staff as participants were known to them and they would be able to intervene if they felt the service users were finding it difficult to cope.

The session was led by an independent evaluator who had an unbiased approach to the questions asked and subsequent discussion.

An open-ended email questionnaire was used to provide opportunities for members of the education team and a member of the wards clinical team to provide feedback on the current process. This allowed the participants a greater sense of empowerment and control, time for reflection, greater anonymity and opportunities for editing responses. This process was again facilitated by an independent evaluator to ensure anonymity for respondents as most were line managed by the evaluator.

Data from notes, the transcription of the focus group discussion, and information in emails from the open-ended questionnaire were studied to identify common themes to enable the evaluation of the information gathering process. Inductive thematic analysis was used to analyse these data.

Results and Discussion

The analysis of the data generated several themes and the evaluator found areas of commonality, difference and relationships between the elements and identified two main themes from the data relating to the information gathering process:

- Understanding the purpose of the information gathering process
- Understanding the timing of the session

Purpose

The young people in this evaluation accepted that education was part of their treatment whilst in hospital and that information needed to be gathered to facilitate continuing this:

‘It’s part of your treatment programme here so yea it does work.’

‘It does work…’

‘...it’s one of those things you have to do…’

They understood that the information gathering process enabled the education staff to personalise the learning to their individual needs during their stay:

‘I think it is good how it like works to everyone individually so like depending on the situations that people come in there is always like education is offered to them…’

‘cos they want the best for you because they care so they know what’s most suitable.’

Staff also expressed the same purpose for the
process;
‘...the form can help tailor, engage and target supported learning.’
‘After this meeting there is a plan for the young person re their education needs.’
‘You get a clear full picture directly from the service user and then you can start to plan a programme for them and obtain the right support and work.’

Personalised, or individualised, learning appeared as part of the government’s agenda in the mid 2000’s where the focus was on giving every young person an equal chance of success through participation and fulfilment (Department for Children, Schools and Families (DCSF), 2008). More recently, schools have a responsibility to ensure the needs of young people with medical needs are properly met through the development of an Individual Healthcare Plan (IHP) (DfE, 2014). The purpose of the IHP ‘should be to capture the steps which a school should take to help the child manage their condition and overcome any potential barriers to getting the most from their education.’ (DfE, 2014, p.10).

The information-gathering process within the CAMS Tier 4 unit in Northamptonshire was developed with meeting the needs of individuals in mind and providing a bespoke package of support and advice whilst an in-patient and when returning to an educational provision. The evaluation data shows an understanding of the purpose of the process as providing personalised learning packages.

Data from both the young people’s focus group and the staff email questionnaires showed an understanding of the purpose of the information gathering meeting. Staff describe the process as a way:
‘to initiate the continuation of their education’
‘ascertain what the young person is doing in school’
‘explain how we [education staff] will be working with them during their stay’
‘gain valuable information directly from the service user’.

The young people showed a similar understanding:
‘you know the teachers here seem to kind of... know individually what we need to do for work’
‘It’s kind of like to get you started’
‘I think it is good how it like works to everyone’

‘Although you’re thrown into being asked like responding to all these questions that’s just like a general idea of what you would like to gather information’.

The Department for Education (DfE) (2014) statutory guidance states that
‘They [young people] should be fully involved in discussions about their medical support needs and contribute as much as possible to the development of, and comply with, their individual healthcare plan’ (p.13)

By involving the young people in this information-gathering process they are enabled to receive the support and teaching that they need during their admission ensuring that any disruption to their studies is kept to a minimum. This involvement on an informal one to one basis gives the young person an opportunity to voice their perceptions of what is working well and what is challenging to them in relation to their current education provision. Listening to the young people and acting upon the information they provide often leads to positive developments in their education (Robinson and Taylor, 2007) in the form of recommendations about the content of their education to their schools to ensure academic success alongside an improvement and stabilisation of their mental health issues. This process of listening and implementing changes based on the voices of the young people supports the views of Worrall-Davies and Marino-Francis (2008) who state that it ‘is essential to delivering the government’s vision of a modern effective CAMHS’ (p. 9).

The young people involved in the focus group did, however, highlight some uncertainties about the full purpose of the process:
‘...they could have found out ... without actually having to talk to us.’
‘I don’t know whether they were asked because they didn’t already know that information’
‘I think knowing why they are doing it in a more kind of focussed way it might be useful.’

The process is undertaken by a variety of education staff members each approaching the meeting in their own way. This has led to the process being introduced with the emphasis on different aspects of the education provision in the unit. The young people would benefit from a consistent approach from staff to ensure a complete understanding of this process. Training
or guidelines could be developed to ensure a reliable approach.

**Timing**

The young people made many references during the focus group to the timing of the one-to-one information-gathering discussion:

‘...it was like my second day and I just got all these questions thrown at me...’

‘It’s not your main concern at the time.’

‘Well maybe wait a while like not your first education session...’

‘Yea when you first come in it’s so surreal and then you are like thrown into so much of a change and you are asked so much you don’t really want to you can’t even think.’

The information-gathering process commences as soon after admission as possible to ensure programmes can be developed in consultation with school/college. It is a difficult time for the young people as they are coming to terms with an admission which is often unexpected and feel their health is more important than their education at that time. Their comments show how unsettled they are and struggling to focus on anything other than the admission. Education staff are conscious of this but often find the young people can benefit from thinking about a different part of their life and being reassured that the admission need not have a negative impact on their education:

‘It is important to reassure they can carry on their studies...’

‘...reassure the client [service user] that they will have the opportunity to keep up with their school work...’

‘Sometimes the client [service user] enjoys talking about the person to contact in school and it can be reassuring for them to know that they will be advising us whilst they are in hospital.’

As education is part of the treatment programme it is more meaningful for the young people if they are completing work that their peers are covering in school in their absence. In addition to this some young people may have missed periods of schooling and can use the opportunity to catch up with some of the work they have missed. To motivate the young people relevant programmes of work are created in consultation with schools/colleges to minimise the impact of admission on their attainment as well as their emotional and general wellbeing (DfE, 2014).

Education staff are aware of the importance of discussing education as soon as possible after admission and commented that:

‘Students often worry about falling behind...’

‘...you get a clear full picture directly from the service user and then you can start to plan a programme for them and obtain the right support and work.’

During the focus group the young people had time to reflect on the comments of other service users and towards the end of the discussion they were able to show that they did understand why the meeting was held so quickly after admission and appreciated the informality of the discussion:

‘I don’t remember anything formal like, it wasn’t like a meeting or anything we just sat down like in the classroom to the side someone just asked you a few questions...’

‘...because if they don’t ask these questions or if they asked us like a month later then we would be doing nothing in our education session for like a month.’

‘...they like to say it informally to make people feel more comfortable.’

‘I suppose if you like delayed doing the form or not like two days or maybe a week later it’s still going to be tricky to like answer and fill out so it’s just one of those things that you have to kind of do.’

The comments from the young people have again highlighted the need for clarity and consistency from the education staff when approaching young people to gather information. Guidelines and training for staff would be useful to ensure all young people are approached sensitively in the first few days of their admission to discuss their educational needs and reassured that this conversation is relevant to their treatment programme.

**Concluding Remarks**

The information-gathering process by education staff offers the young people an opportunity to have direct input and some control over their education provision. In collaboration with the young person, education staff are able to make recommendations to families and schools/colleges about adaptations to their courses to support their recovery as well as enabling them to achieve well. Administration guidelines, additional training for staff and regular updates will ensure all young people have access to the same experience to ensure they are offered the best individualised advice about the possible impacts of their in-patient stay on
their education. Staff need to be consistent, clear and reassuring when gathering information to enable the young people to share their thoughts at an unsettling time.

References
The experiences of children and young people in their early and developing years are critical to health and educational outcomes, in that they set the course for adult life (Department of Health, 2011a). The Department of Health paper, ‘Healthy Lives, Healthy People: Update and Way Forward’ clearly identified school nurses and their teams as central to the delivery of the public health agenda through setting down strong foundations for good life chances and supporting children and young people in the choices they make about their health (Department of Health, 2011b). School nursing teams consist of specialist public health nurses, qualified staff nurses and health care assistants, who work in partnership with several primary and secondary schools to provide a service to children and young people. In England, the school nursing service is commissioned locally by public health professionals, within Local Authorities (LAs).

Patient and public involvement

In public health, patient and public involvement (PPI) is “the active participation of patients, carers, community representatives and groups, and the public in how services are planned, delivered and evaluated” (NHS, 2008, p. 9). The basis for involving patients and the public with regard to commissioning healthcare services is to deliver real benefits, on the basis that by listening to those who use the services, and also those who do not, it is possible to develop more effective services (NHS, 2008).

Public and patient involvement during the service development stage can help healthcare professionals to understand the lifestyles and choices of the target population, so that the service can be designed in a way that is most appropriate and engaging (NHS, 2008).

In addition, involving service users in service development ensures that those, whose views may go unheard, such as hard-to-reach young people, are involved. Involving patients in all aspects of health is a government priority. ‘Liberating the NHS’ (Department of Health, 2010) talks about; ‘building partnerships for service changes and priorities’. Furthermore, the Marmot Review (2010) emphasised the need to; ‘Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people’.

Young people involved

It is clear, therefore, that young people need to be actively involved in the development of the school nursing service, rather than seen solely as recipients of the service. However, despite this, services are often designed in isolation using a “top-down” approach (i.e., practitioner-driven), with little or no input from the service users (Thackeray & Neiger, 2000). Indeed, the British Youth Council (BYC) (2011) reviewed the existing literature regarding the school nursing service, and found a lack of research regarding the engagement of young people in the development and design of school nursing. This identified great potential for commissioners to actively seek the voice of young people with regards to the school nursing service and its future vision (BYC, 2011).

A broad consultation was therefore conducted with service users of the school nursing service in a Yorkshire town; including the views of children and young people, and parents and teachers, from both primary and secondary schools. The current paper describes one element of this consultation, which engaged 292 children and young people (CYP) aged 11 to 18. The aim...
of the research was to replicate the BYC consultation, that is, to identify the thoughts and needs of the CYP regarding the role of school nurses in improving health in the local Borough; and to identify how school nurses’ skills and resources can be used in the most effective way. The findings from the consultation will build on the existing literature and inform the development of school nursing services both locally and nationally.

Method
An online survey was constructed using SurveyMonkey.com. Using the British Youth Council (2011) consultation as a framework, the survey consisted of quantitative questions about the school nursing service (these are available on request). In addition, one qualitative (free response) question was included to allow extra information to be derived. A further six questions collected equality monitoring information (e.g., gender, ethnicity, disability etc.)

Ten local secondary schools (all with sixth forms) were sampled from (out of the total 17 mainstream schools in the Borough), using a random number generator in Microsoft Office Excel (2007). The link to the survey was then shared with key people within these ten settings (e.g., Head teachers, pastoral staff, PSHE Leads) for dissemination amongst all CYP for completion.

At the end of the survey period, the data were downloaded into Microsoft Office Excel (2007); frequency counts and percentages are reported for quantitative data, qualitative data were content analysed to identify themes.

Results
A total of 292 young people aged 11 to 18 took part in the survey, which ran from January to March 2015. The mean age of participants was 13.3 years. Just over half of participants were female (54.6%), 107 were male (42.6%), 5 preferred not to say (5%) and 2 identified as transgender (0.8%). The majority of participants defined their sexual orientation as straight (80.2%). The majority of participants were White British (61.6%), although other ethnicities were represented; see Table 1.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White English/British</td>
<td>180 (61.6)</td>
</tr>
<tr>
<td>White Scottish</td>
<td>2 (0.7)</td>
</tr>
<tr>
<td>Gypsy Traveller</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Polish</td>
<td>9 (3.1)</td>
</tr>
<tr>
<td>Latvian</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Slovakian</td>
<td>4 (1.4)</td>
</tr>
<tr>
<td>Lithuanian</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Other European</td>
<td>7 (2.4)</td>
</tr>
<tr>
<td>Black African</td>
<td>8 (2.7)</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>3 (1.0)</td>
</tr>
<tr>
<td>Chinese</td>
<td>3 (1.0)</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Pakistani</td>
<td>23 (7.9)</td>
</tr>
<tr>
<td>Other Asian</td>
<td>7 (2.4)</td>
</tr>
<tr>
<td>Indian</td>
<td>2 (0.7)</td>
</tr>
<tr>
<td>Mixed - White and Black African</td>
<td>9 (3.1)</td>
</tr>
<tr>
<td>Mixed - White and Black Caribbean</td>
<td>5 (1.7)</td>
</tr>
<tr>
<td>Mixed - White and Asian</td>
<td>5 (1.7)</td>
</tr>
<tr>
<td>No response</td>
<td>55 (18.8)</td>
</tr>
</tbody>
</table>

The majority of pupils did not consider themselves to be disabled (94%). Of those who did, their conditions are presented in Table 2.

<table>
<thead>
<tr>
<th>Impairments</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility impairment (wheelchair user)</td>
<td>4 (8.2)</td>
</tr>
<tr>
<td>Learning disability</td>
<td>4 (8.2)</td>
</tr>
<tr>
<td>Sensory impairment - blind/visually impaired</td>
<td>2 (4.1)</td>
</tr>
<tr>
<td>Sensory impairment - deaf/hearing impaired</td>
<td>2 (4.1)</td>
</tr>
<tr>
<td>Long term illness/health condition</td>
<td>3 (6.1)</td>
</tr>
<tr>
<td>Mental health condition</td>
<td>2 (4.1)</td>
</tr>
<tr>
<td>Prefer not to say</td>
<td>37 (75.5)</td>
</tr>
</tbody>
</table>
At the beginning of the questionnaire, it was emphasised that school nurses were not first aiders and that they wore an NHS nurses’ uniform. When asked “In the last school year, have you seen a school nurse around your school?” the responses were evenly split between Yes (36.6%), No (36.3%) and Not sure (27.1%). It could be assumed, however, that those who responded Not sure had not seen a school nurse; this would increase the percentage of those who had not seen a school nurse to 63.4%. When asked “Do you know the name of the school nurse who visits your school?” almost all of the pupils responded No (95.9%). When the pupils were asked “If you want to see a school nurse would you know what to do?” the majority responded No (57.7%).

When asked “In the last school year, have you visited a school nurse? (This is not your school’s first aider, school nurses wear an NHS nurses’ uniform)” the majority responded that they had not (77.9%); with 13% reporting that they were not sure. In total, 84 of the 85 pupils who had visited their school nurse responded, when asked “Thinking of the last time you visited a school nurse, which of the below best describes them? Select as many as apply”. The majority of these pupils described their school nurse positively (see Table 3).

Table 3. Characteristics of the school nurse

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly</td>
<td>66 (78.6)</td>
</tr>
<tr>
<td>Listened to me</td>
<td>52 (61.9)</td>
</tr>
<tr>
<td>Approachable</td>
<td>39 (46.4)</td>
</tr>
<tr>
<td>Made me feel comfortable</td>
<td>30 (35.7)</td>
</tr>
<tr>
<td>Gave me lots of time to talk</td>
<td>23 (27.4)</td>
</tr>
<tr>
<td>Rushed me</td>
<td>7 (8.3)</td>
</tr>
<tr>
<td>Didn’t treat me with respect</td>
<td>5 (6.0)</td>
</tr>
<tr>
<td>Made me feel uncomfortable</td>
<td>4 (4.8)</td>
</tr>
<tr>
<td>Didn’t listen to me</td>
<td>4 (4.8)</td>
</tr>
<tr>
<td>Unapproachable</td>
<td>3 (3.6)</td>
</tr>
<tr>
<td>Unfriendly</td>
<td>2 (2.4)</td>
</tr>
<tr>
<td>None of the above</td>
<td>2 (2.4)</td>
</tr>
</tbody>
</table>

Of those who had visited a school nurse in the last year, three quarters found the advice given to them to be helpful (75%).

The pupils were given a list of possible services that the school nursing service could provide and were asked whether they knew the school nurse did this in their school or not. “Vaccinations or jabs” was the most commonly known service among pupils (N = 152) (Figure 2 below). There was poor knowledge among pupils around the rest of the services that school nurses could provide.
From the same list, the pupils were asked if they thought the school nurse should offer these services. “Advice on healthy eating and weight management” was the most popular service (N = 206) followed closely by “Vaccinations or jabs” (N = 204) (Figure 15). “Counselling” was the least popular service (N = 121) closely followed by “Advice on relationships” (N = 145). Overall, the pupils were supportive of all the services listed (Figure 3, below).

The majority of pupils said they would prefer the school nurse to offer a mixture of both appointments and drop-ins (59.7%), as opposed to either appointments or drop-ins alone (23.3% and 17.1% respectively). When making an appointment, pupils would prefer to do this by visiting the school nurse’s room; this option ranked highest, followed by: “Through staff at reception”; “Through a teacher”; “Email”; “Text messaging”; “Phone call”. When the pupils were asked, “Where would you like to visit your school nurse?” the highest ranked option was “In School”, followed second by, “At a doctor’s surgery” then: “At a youth club”; “At home”; and “In a private area of a shopping centre”. When asked when they would like to see their school nurse, the most preferred option was at “Break time”, followed second by “During lessons” then: “Lunchtime”; “After school; “In school holidays”; “At weekends”.

In terms of communication, when pupils were asked “How would you like to find out about school nurses and the services offered?” the highest ranked option was “Face-to-face e.g., in assemblies”. This was followed by: “Leaflets”; “Posters”; “Student email”; “Social media”; “School planner”; then lastly “Text message”.

There was one free response question, which asked for suggestions and comments as to what the school nursing service should provide. The qualitative data were content-analysed and three main themes emerged; unfortunately the characteristics of the respondents were not captured by SurveyMonkey.com.

### Access

Pupils would like the school nurses to be available more around school and offer private access, for example:

- “They should be able to be reached privately and anonymously if wanted. If pupils don’t want to speak face to face they should be able to talk over the phone or messages.”
- “Provide people with more private places”
- “If it is something personal, it should always be private”

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**Figure 3. Support for school nursing services**

<table>
<thead>
<tr>
<th>Service</th>
<th>I don’t think school nurses should offer this</th>
<th>I think school nurses should offer this</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSHE lessons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height and weight checks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health promotion activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccinations or jabs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual health service (e.g., STI testing, condoms,…)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Help for pupils with Long Term Conditions/Illnesses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on stress and anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on family issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on bullying (including cyber bullying)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on healthy eating and weight management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on sexually transmitted infections (STIs)</td>
<td></td>
<td></td>
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<tr>
<td>Advice on pregnancy</td>
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<tr>
<td>Advice on contraception</td>
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<td></td>
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<tr>
<td>Advice on relationships (including same-sex relationships)</td>
<td></td>
<td></td>
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<tr>
<td>Advice on stopping smoking</td>
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<td>Advice on alcohol</td>
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<td>Advice on drugs</td>
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<td>Advice on alcohol</td>
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<tr>
<td>Advice on drugs</td>
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</tr>
</tbody>
</table>
“I think it would be good if she was in school every day so I could see her as soon as I need her”
“Maybe if they were around a bit more.”
“You can talk to her all the time”
“I think the school nurse should offer appointments throughout a school day”
“I think that the school nurse should come in more”

Awareness
There was a general lack of awareness about who the school nurses are, for example:
“We don’t even know we have a school nurse”
“I have no clue who the school nurse is so I don’t know what they cover”
“To know who she is”
“They should make themselves more known around school, so that pupils know they have the opportunity to go to the school nurse.”
“To be more known around school”

Visibility
Pupils would like their school nurse to be more visible around school, for example:
“They should appear more in around school.”
“She/he [should] walk round at break time”
“They also never seem to never be around.”
“Why can’t I see them often”
“They could also make sure that people know that they are here I have only ever seen them in school when I got my jab done”

Recommendations
Pulling together the quantitative and qualitative data from the secondary school consultation, three key themes emerged from the children and young people who responded:

1. School nurses need to be visible and well-known in and around school
   • Over half of the respondents (63%) had not seen or were not sure if they had seen a school nurse around their school in the last school year.
   • Nearly all (96%) responded that they did not know the name of the school nurse who visits their school.
   • Over half of the respondents (58%) would not know what to do if they wanted to see a school nurse.
   • Only 29% of the young people had visited a school nurse in the last school year.

2. School nurses need to offer choice to young people in order to be accessible
   • The majority of respondents would prefer a mixture of appointments and drop-ins.
   • Young people preferred to visit the school nurse in school at break times but should still have the option to visit them at other places and times, with the most important thing to young people being privacy.
   • Despite the rise of new technology among young people, they would prefer to make contact with their school nurse by visiting a designated school nurse room and seeing them face-to-face.
   • The majority of respondents who had accessed their school nurse reported that they had a positive experience; 75% of young people said they thought the advice they were given was helpful.

3. School nurses need to offer a wide range of services and promote these face-to-face as well as using leaflets/posters
   • Overall, there was a lack of awareness of what services school nurses could offer.
   • The young people thought it would be helpful for school nurses to promote their services at assemblies, PSHE lessons and after school clubs.
   • Face-to-face communication to promote the service was preferred over written communication.
   • The top five services that respondents thought all school nurses should offer were: Advice on healthy eating and weight management; Vaccinations; Height and weight checks; Health promotion activities; and help for pupils with long term illnesses and conditions.

The findings of the current consultation corroborate those of the BYC (2011) report, whereby four key themes emerged from the CYP regarding the school nursing service:
1. School nurses need to be visible and well-known amongst school-aged children and young people.
2. School nurses need to offer early help to support young people.
3. School nursing services need to offer choice to young people in order to be accessible and confidential.
4. Young people want to be able to offer their views about the service they receive.

These themes are also reported in ‘Getting it right for children, young people and families’ (Department of Health, 2012), which also highlights the importance of understanding and considering the views of the parents/carers in the review and redesign of school nursing.

Strengths and Limitations
As mentioned in the introduction, school nursing services are commissioned locally by the local Council. As such, different LAs have different school nursing services, from varying providers with various different models. A limitation of this research is therefore the extent to which it can be generalised to other LAs. However, the results from the BYC consultation were very similar, suggesting that the views are consistent across England.

Since the consultation was concerned with school nursing across schools, and not within individual schools, the survey failed to capture the distribution of pupils from the ten different schools. Thus, it may be that some schools had greater participation than others but we cannot tell. However, the random sampling method used to identify schools for recruitment adds a strength to the consultation, by reducing bias.

The mean age of respondents was 13.3 years, thus the sample was relatively young. This may have an effect on the types of services that students may have accessed the school nurse for and/or think that the school nurse should offer. The questions had a set time frame (i.e., last school year) to reduce the effect that the amount of time that a pupil had been attending a school would have on their use of the service. For example, whether they had been at the school five months or five years, the questions specifically referred to the last school year. As mentioned in the introduction, this article reports only part of a wider consultation (including primary age children, as well as parents and teachers) and the totality will be considered when designing the new school nursing service.

Conclusion
This consultation sought to explore secondary school children’s experiences of their current school nursing service and views of what the priorities for school nursing should be, in a Yorkshire town.

The findings highlight key elements of improvement that can help shape the school nursing service model in order to deliver a service that: meets the needs of children and young people aged 11 to 18; a service that is visible, accessible and well-promoted. Engaging CYP in this way ensures they have a voice and enhances the likelihood of developing and delivering a service that is both relevant and effective.

Acknowledgement
The author would like to thank all the schools, and especially their pupils, who took part in this consultation.

References
British Youth Council (2011). Our school nurse; Young people’s views on the role of the school nurse.
Department of Health (2010). Liberating the NHS. London: DH.
In 2010, the World Health Organisation identified obesity as a global epidemic finding that the worldwide prevalence of obesity had almost doubled between 1980 and 2008. In high-income countries, such as the United Kingdom, lower socioeconomic status is associated with a higher prevalence of obesity (World Health Organisation, 2010).

There is no magic formula to address this epidemic. Unhealthy weight often begins in childhood. Many children are identified as overweight or obese, through the National Child Measurement Programme (NCMP), when this information is shared with parents, they consider it a criticism of their parenting and are hard to engage.

A study from University College London involved fifty-two parents of overweight and obese children aged 4-5 years and 10-11 years enrolled in the NCMP programme in England in 2010-2011. The research showed that parents who received NCMP written feedback, informing them that their child was overweight, disregarded the results because they viewed 'health and happiness as being more important than weight' (Syrad et al., 2015).

People are reluctant to raise the issue of obesity with friends and family and health staff are reluctant to raise the issue of obesity with patients. Nevertheless, there is a pressing need to address the public health challenges of poor diet, including the overconsumption of food, especially those foods high in fat, salt and sugar, sedentary lifestyle and poor levels of physical activity.

For some years now there has been a trend toward ‘convenience’ foods and of eating ‘on the go’; the nutritional content of processed and take away food is of concern. Commercial and media influences on children and parents are strong so public health messages need to be high impact and complemented by accessible interventions and easy-to-use information.

Public Health messages regarding healthy eating and physical activity are universal and, because of the complexity of obesity, a range of interventions are needed based on: improving attitudes and knowledge; limiting unhealthy cues and irresponsible retailing practices; and creating opportunities and support for changed behaviour. Interventions need to have the dual aim to directly protect children and young people and to help parents and carers make healthy choices (BMA, 2015).

Local action, through interventions, and regional and national action on reducing unhealthy content in processed food, will benefit everyone. In the current recessive environment, unhealthy food choices are made by families on low income as these are cheap, easily accessible and heavily promoted. Individuals on low income and vulnerable groups can face food poverty and there are significant challenges and barriers to overcome to provide healthy eating for themselves and their families. The Living Wage Commission, cited in the ‘Getting By?’ report (Liverpool City Council’s Action Group on Poverty, 2015), stated that “Low pay is closely linked with food poverty and unhealthy diets.”

The Church Poverty Action Group found that at least four million people in the UK do not have access to a healthy diet. Parents involved in the ‘Getting By?’ report identified that trying to ensure children have a healthy diet is a serious concern. Many families accessed food banks to ‘get by’.

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**Annette James**

**Unhealthy weight : Changing the attitude and behaviour of Liverpool’s children and young people**
Involving children, young people and their families in bringing about changes in attitudes and behaviours is really important. In Liverpool, the Schools Parliament gave us some clear advice on language they were unhappy with. They said that the term ‘obesity’ was stigmatising and unhelpful. Because of this we use the term ‘unhealthy weight’ however, clinicians still prefer the term ‘obesity’ as this is clearly understood and has set parameters.

What is the evidence

There is a wealth of evidence from research, insight and screening programmes that unhealthy weight is an issue for children, young people and their families in the city. For children and young people in Liverpool, weight is something they are concerned about – ‘Insight with 16 – 19 year olds’ in 2012, identified weight as one of the key concerns for children and young people (Liverpool City Council, 2015).

The ‘National Child Measurement Programme’ (NCMP) results for Liverpool (Public Health England, 2014), reveal that in their reception year 24% school-aged children are either overweight or obese and, by year 6, almost 40% of children are overweight or obese. Interim figures for 2014/15 show that there has been little change in these figures.

What are we doing about it

Liverpool recognises that we need a city-wide approach through media campaigns and through all systems and interventions with children and young people and their families if we are to effect levels of unhealthy weight in the city (Liverpool Primary Care Trust, 2012). A strategic healthy weight network meets regularly and is in the process of writing a strategy. Social marketing campaigns such as: ‘Give Up Loving Pop’ (Food Active, 2015); the ‘Change4Life, Sugar Swaps Campaign’ (NHS England, 2015a) and the ‘Ten Minute Shake-Up’ (NHS England, 2015b); and a local ‘Drop a Drink size Campaign’ (Liverpool City Council, 2014); are promoted by public health and well supported by those who provide for children and young people.

The city has a range of other initiatives which contribute to this agenda, these include the ‘Play Healthy Scheme’ funded through the Liverpool Play Partnership, the Mayor, Public Health and the Clinical Commissioning Group. This initiative provides breakfast, lunch and an afternoon activity around healthy food during school holiday times for children and young people across the city through a network of playschemes (Liverpool Play Partnership, 2013).

‘Hearty Lives’, funded through the British Heart Foundation and Liverpool City Council work with looked-after children, foster carers and residential staff to reduce the risk of cardiovascular disease for children in care. (Hearty Lives Liverpool, 2015).

Across the city we have three ‘Trussell Trust’ (2015) food banks and a range of other outlets for food. The large venture ‘Hope Foodbank Plus’, involves a number of churches across the city and other community and school outlets serve their local community.

Liverpool has been at the forefront of the ‘Think Family’ agenda (Social Care Institute for Excellence, 2012), and this has been an important feature of developing public health services from pregnancy and through children’s services. Building on the Marmot principle, services have been developed across the life course. Pregnancy provides a window of opportunity to bring about behaviour change learning from the ‘Fit for Birth’ study (Weeks, 2012), has enabled us to shape a perinatal programme of physical activity and healthy eating; ‘Mamafit’ (Diverse Health and Fitness Liverpool, 2015). Women are referred to ‘Mamafit’ in the ante-natal period mainly through the collaboration with Children’s Centres and attend a 6-week programme. Once their baby is born, from 10 weeks post-natally women can attend a short course with their baby and then there is an opportunity to continue with drop in sessions.

Children’s centres across the city have a ‘whole family approach’. They are supported to offer health promotion through healthy eating, physical activity and specific family support programmes such as ‘Bambi’s’ a peer support programme for women who have initiated breastfeeding. Every woman is contacted face-to-face by the ‘Bambi’ service in hospital within hours of delivery and after discharge the ‘Bambi’s’ community service contacts the family by telephone within 48 hours to offer 1:1 support as appropriate. Babies who are breastfed are less likely to become obese in later life but only 53% of women in Liverpool choose to initiate breastfeeding and by 6 – 8 weeks this has fallen to
33% of women fully or partially breastfeeding their baby.

Health Visitors weigh and measure babies and young children at key points in their growth and development, which provides another window of opportunity to raise the issue of weight with families and to bring about a change in eating and physical activity behaviours.

The National Institute for Health and Care Excellence recommend a role for school health in identifying unhealthy weight, offering ongoing advice and support to children in schools and making appropriate referrals (NICE, 2013). In Liverpool, the school nursing staff measure the height and weight of children in reception and year 6 and this is submitted to the NCMP. A recent research report identified that school health staff in Liverpool felt unable to provide the level of care they would like to have offered. The report identifies barriers of capacity and competing priorities, lack of training and poor knowledge of protocols or pathway for onward referral (Turner et al., 2015).

This year every school that participates in the NCMP will be provided with an analysis of the results for their school in relation to the city wide and national results.

Liverpool have retained the Healthy Schools Team through the Liverpool School Improvement Ltd, and it is reported that 90% of schools in the city meet the criteria for Healthy Schools Status, which is reviewed on a three-year rolling programme. Healthy schools promote positive health and wellbeing in schools including physical activity and healthy eating, and work with head teachers to develop whole school approaches (School Improvement Liverpool Ltd., 2015).

Over the last decade Public Health Liverpool has commissioned a city wide, multi-disciplinary, neighbourhood based weight management programme for children aged 3 – 16 and their families. Initially this was a research programme with Liverpool John Moore’s University. The ‘Getting Our Active Lifestyles Started’ (GOALS) project was begun in 2003 in response to growing local concern regarding provision for children who were already identified as an unhealthy weight but there was no service available. Concern was also expressed about the volume of families seeking medical support for their child’s obesity, which in the majority of cases required a lifestyle solution. The research project adopted a ‘bottom-up’ approach to develop an intervention and supporting evidence began to emerge in the academic literature for a multidisciplinary family-based lifestyle change approach to child weight management (Watson, 2015).

In 2014, Liverpool Public Health commissioned a new service to address the issue of unhealthy weight in children and young people – this programme took learning from a range of evidence including the ‘GOALS’ programme and the national ‘Healthy Weight: Healthy Lives’ framework (Cross-Government Obesity Unit et al., 2008). Some of the key issues in addressing healthy weight are: the time between identification and the initial engagement of children; young people and their families; motivation to change and keeping that motivation between the initial assessment and the beginning of the intervention; and sustainability of the relationship over the twelve week intervention and follow up over two years.

‘Healthy Families’ programme

The ‘Healthy Families’ programme, (Liverpool Community Health NHS Trust, 2015), began with the recruitment of a co-ordinator who was already experienced in delivering a similar service in another area. He then worked with the provider to appoint a team of health advisors. Referrals are invited from health, education and social care staff. At present, there is no opportunity for self-referral. When referrals are received by the service, each family is contacted by telephone and a home visit planned. The health advisor aims to make contact, listen to the family story and motivate children, young people and their families to engage with the programme. In the mobilisation phase an initial ‘participation course’ was run with a small number of families in a youth centre in one of the lower super output areas (LSOA)*. The aim of this was to pilot the process and develop a service that was appropriate and acceptable to children and families within the parameters of the commissioners; agree a name for the service; test out the structure of the programme and to engage children and their families in developing materials to promote and deliver the course. The aims of the ‘Healthy Families’ programme are to:

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*LSOA : The English Indices of Deprivation measure relative levels of deprivation in small areas of England called Lower-layer Super Output Areas
engage with children and their families; to change knowledge and attitudes towards healthy 
eating and physical activity; bring about behaviour change; and to assist children and 
young people, who are an unhealthy weight, and their families to reach and maintain a healthy weight.

‘Healthy Families’ work with a wide range of partners including primary care, children’s 
centres, schools and colleges, foundation trust’s and acute or specialist health service providers. 
They work to ensure child and family-centred interventions are embedded in service provision 
for the promotion of change management, healthy eating and increased physical activity for 
all children and families. They specifically target overweight and obese children and their families. 
Referral processes are easily accessible visible and clear.

‘Healthy families’ is multi-component, addressing motivation, change management, 
healthy eating and physical activity. The programme builds on the learning from the 
‘GOALS’ programme and other studies: that interventions involving parents, carers, siblings 
or peers, with similar weight issues, could prove more successful than those that target individuals 
alone. Parents or carers are encouraged to consider whole family behaviours, recognise they 
are role models for their children, and take responsibility for lifestyle changes with 
overweight and obese children and young people. ‘Healthy Families’ take an age 
appropriate approach, taking into account the levels of maturity and acknowledging the 
differing preferences, cultures and circumstances of child, adolescent and family. The emphasis is 
on solution-focussed asset-based working, encouraging positive changes in behaviour that 
can be maintained over the long-term.

The programme takes account of protected 
characteristics of individuals, children and families as outlined in the Equalities Act 2010 
(Gov.UK, 2015). Interventions are tailored to the 
target populations and use a ‘healthy foundations’ type process using different 
approaches for different populations.

Courses of twelve weekly sessions are 
delivered in schools, church halls, youth and 
community or children’s centres. For young 
people, aged 13 – 16 years of age, it is more 
appropriate (with parental permission) to 
facilitate group sessions without parent/carers 
presence. The programme identifies short- and long-term outcome measures with children, 
young people and their families and follow-up is 
over two years.

The ‘Healthy Families’ programme began it’s 
first ‘pilot’ group in October 2014. From this 
developed an engaging, evidence-based 12-week activity programme. Commitment to the 
programme is gained through a mutually-agreed goal-setting pledge. The programme also 
supports families to be aware of what is available 
within their own communities to sustain change, 
and aims to create synergy between the proposed 
programme and other local services.

Early results

Parents of children who are shown to be 
overweight or obese by NCMP data are sent a 
letter informing them of their child’s weight 
status and a programme leaflet designed by 
children and families in the pilot phase is 
enclosed.

Four family courses have completed to date 
and four more are currently in progress. The first 
two adolescent courses have recently completed 
and we await the outcome from those.

The outcomes over the first two quarters of the 
‘Healthy Families’ programme have been 
positive. Referrals have come from a range of 
disciplines top referrers being school nurses, the 
‘Alder Hey’ Children’s Hospital and GPs. 80% of 
families referred have engaged with the 
service. 3.7% of families in the last quarter did 
not attend due to travel issues.

Attendance at courses has been very good with 
an 84% retention rate. A small number of families 
declined to engage with the programme. If 
families agree to an initial assessment visit by the 
health advisor and then decline to engage these 
families are given advice on healthy eating and 
physical activity and signposted to other services 
such as ‘Walk and Cycle for Health’ and the 
school nursing service.

73% of families who attended a course either 
maintained or reduced their weight and 
abdominal circumference. One family was 
highlighted where the father reduced his weight 
substantially – follow-up will show if this has 
been sustained.

25.2% referrals were for children aged 5 – 9 years 
and 24.8% for young people aged 10 – 14 years.
Emotional health and wellbeing is measured using the ‘Sinclair’ or the ‘Warwick and Edinburgh Mental Well Being Survey’ (Liddle and Carter, 2015; NHS Scotland, 2015), the last quarter’s summary is impressive as it indicated that 85% children and 78% adults reported an increase in self-esteem.

The service is progressing well and it continues to develop and embed in communities across the city.

**Conclusion**

Obesity and unhealthy weight are national and local priorities and key priorities for children and young people themselves. Liverpool has learned from evidence and practice and takes a life-course and city-wide approach to unhealthy weight. When the public health staff worked alongside Liverpool John Moore’s University to set up the ‘GOALS’ programme there was scant research evidence regarding what would work. Over the years, much has been shared about raising the issue of unhealthy weight, engaging and motivating families, delivering a multi-disciplinary intervention and retaining the interest of children and families across a 12 week intervention and follow-up over two years. Bringing about a change in weight is a long-term process and outcomes may not be evident at the end of a 12 week intervention; the aim is to bring about a sustainable change in behaviour for the whole family.

The ‘Healthy Weight: Healthy Lives’ framework provided an overview of validated programmes and guidance for commissioners that was helpful for us when commissioning our services. We found that a local community approach to be the most helpful in Liverpool. Any intervention for children and young people has to have parental support and has to be fun. ‘Healthy Families’ is a multi-disciplinary community-facing programme steered by those organisations that already provide a face-to-face service for children and young people.

Much has been achieved but there is more that can be done. Sport and physical activity are key priorities across the city at present as well as healthy eating; emotional health and wellbeing must sit alongside if we are to make a difference to our population’s unhealthy weight. Food is an emotive issue and there are huge complexities in addressing this in a time of recession where austerity measures rather than stimulation policies are prevalent.

**References**


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