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Welcome to the second issue for 2014. 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. Keen followers of grammar will notice that this journal uses ‘wellbeing’ in the text and keeps ‘well-being’ if it is used in a reference.

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

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TO SUPPORT YOUR WORK WITH YOUNG PEOPLE TRY SHEU’S FREE RESOURCES
Recent research conducted into girl’s pressures and issues in an outer London Borough underpins and informs the development of a programme to support the wellbeing of girls. A group of girls and young women who were presenting with a range of behaviours which were felt to be putting them at risk – both emotionally and physically in a wide range of contexts – were identified by inclusion managers and SENCOs in schools. Staff were keen to explore the reasons and contributory factors and to also ensure that the girl’s views were elicited. The general discourse around these young women appeared to be one of negativity in that they were regarded as putting themselves at risk due to their daily behaviour and apparent self-harming behaviours.

Feedback from staff within the local authority had also highlighted concerns regarding early sexualisation of these students and a range of substance abuse which seemed to put them at risk from males and also engaged them in negative patterns of self-harming behaviours which mitigated against personal and educational progression and development. It was therefore felt appropriate to conduct a series of focus groups in order to elicit the girl’s views – what was it that they felt concerned about and what kind of intervention or support at a school-based level might they consider most helpful?

**Literature Review**

Although girls have been out-performing boys in terms of academic achievement for the last 20 years, there does remain a concern regarding the specific achievements of white working-class pupils from both genders. Nationally, it is this group who are less likely to stay on in education and training (DfES, 2003) or enter higher education (Archer, Hutchings, Ross, Leatherwood & Gilchrist, 2003). There are also increasing concerns regarding the challenges faced by girls from within this vulnerable group and the problems that they seem to face in today’s increasingly complex and highly sexualised society. Concerns have increasingly been raised regarding the sexualisation of girls and the impact that this has on self-esteem, attitudes and behaviour within relationships and academic performance and achievement.

**Impact of the media**

The media provide ample evidence of the sexualisation of women, including music videos, television, magazines, films, music lyrics, sports media, video games, Internet and advertising (Gow, 1996; Granerholz & King, 1997; Krassas, Blauw, Camp & Wesslink, 2001; Lin, 1997; Plous & Neptune, 1997; Vincent, 1989; Ward, 1995). Studies which focus upon the media indicate very strongly that women as opposed to men are more frequently portrayed in a sexual fashion and are also subsequently objectified. These media images also further emphasise a narrow and unrealistic notion of physical beauty which has evident implications for the development of self-esteem and self-image of girls and young women (O’Donohue, Gold & McKay, 1997).

**Pressure through interpersonal relationships**

Girl’s relationships can also be seen as a source of sexualisation. Parents/carers may present girls and young women with the message that being physically attractive is one of the most important goals for them to achieve and some will provide access to plastic surgery in the attempt to reach the ideal (Brown & Gilligan, 1992). Research also shows that teachers can encourage girls to play at being
sexualised adult women (Martin, 1998) or maintain the belief that girls from specific ethnic backgrounds are hypersexual and therefore unlikely to achieve any real academic success in school (Rolon-Dow, 2004).

It is also evident that male and female peers contribute to this process. Peer pressure from both genders has been found to contribute to girls conforming to standards of thinness or sexiness (Eder, 1995; Nichter, 2000). A key concern is also the particular ways in which the process encourages boys to sexually objectify and harass girls. This kind of behaviour is also ‘normalised’ by the girls themselves via the process of self-objectification – the process whereby girls and young women learn to think of and treat themselves as objects of other people’s (mainly boy’s and men’s) desires (Fredericks & Roberts, 1997; Mckinley & Hyde, 1996).

The impact of sexualisation

The unrealistic expectations on girls and young women to achieve the ‘ideal’ in terms of appearance has led to an increase in eating disorders and the number of young women having breast implants at an increasingly early age (Zuckerman & Abraham, 2008). Exposure to gender-stereotypical ideas and images also contributes to sexist attitudes and beliefs and sexual harassment and violence against women (Kilbourne & Lazarus, 1987). Sexual objectification can also be seen to enable and encourage a range of oppressions including employment discrimination and sexual violence alongside the trivialisation of women’s roles and accomplishments in the workplace (Fredrickson & Roberts, 1997).

The mainstreaming of the sex industry has also led to an increase in the number of girls and young women entering careers such as lap dancing or glamour modelling which require a ‘sexy’ image (Deeley, 2008) whilst the viewing of sexually objectifying images of young women has also been associated with more acceptance of violence within relationships (Kalof, 1999; Lanis & Covell, 1995). The increasing availability of pornography via advances in technology has also be seen as a contributory factor to the increase in acceptance of sexual aggression within relationships (Malamuth, Addison & Koss, 2000).

Possible implications

The report of the American Psychological Association’s (APA) Task Force (2007) on the sexualisation of girls concludes that it is vital for psychologists, educators, carers and community organisations to work together in order to encourage the development of curricula which enhance self-esteem based upon young people’s abilities and character as opposed to their appearance. The report also advocates increasing public awareness and the development of policy in this area in order to reduce sexualised images of girls in all forms of media and products and the development of positive portrayals of girls and young women as strong, competent and non-sexualised.

Rationale and Research Objectives

Such objectives formed the basis and the rationale of this current study in which a qualitative research paradigm that espoused an open-ended exploratory nature, using focus groups as a method of data collection, was employed.

Convenience sampling was used in relation to the schools and the selection of the participant students.

Participants

The characteristics of the participants are summarised in Table 1.

<table>
<thead>
<tr>
<th>Focus group</th>
<th>Number of participants</th>
<th>Ethnicity</th>
<th>Gender</th>
<th>Year group</th>
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<td>10</td>
</tr>
<tr>
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<td>Female</td>
<td>10</td>
</tr>
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<td>3</td>
<td>6</td>
<td>5 White British and 1 Black A/C* British</td>
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<td>6</td>
<td>4</td>
<td>White British</td>
<td>Female</td>
<td>6</td>
</tr>
</tbody>
</table>

* A/C Afro-Caribbean

Procedure

Focus groups were undertaken with the participants. A key function of focus groups is to gain views on products, programmes, services and institutions (Stewart & Shamdasani, 1998). They are basically semi-structured interviews with the added value of interaction in a group, with the discussion focussed around one identified theme (Kruger, 1994).
The questions posed were as follows:

- Do you think ‘girls’ are at risk?
- What does being at risk mean to you?
- Are they more at risk than boys? If so what are girls doing that is putting them at risk/in danger?
- When do things go wrong for girls? When do they need help?
- How could schools help young girls to be safer? happier?
- Is it important for women to work to have a career?
- Should girls have careers and should they progress?
- Are they equal to men?
- How important is school?
- Should women be financially independent of men?
- How do culture/media impact on you? How do the images you see in the press and on TV make you feel and think and behave?
- What’s important in life? Is life a quest for happiness? Are we entitled to be happy? What does being fulfilled mean?
- Who do you respect as a woman? Who wouldn’t you respect and why? Role models - who are they? Who are these people who have it all?
- Why do people engage in risky or self harming behaviours like taking drugs or belonging to gangs? What causes them to do this and what influences the way they do or do not cope?
- What do you think can be done to monitor, control or prevent bullying? What do you think would or does work?
- Do you ever feel lonely or stressed and what helps you?
- What is your definition of a good ‘girl friend’?

Findings

In this study, it has been possible to identify general themes, and to describe patterns across data via a ‘bottom up’ data-driven approach as described above. In brief, the themes identified were as follows:

**Theme 1: Safety issues**

It was recognised that girls were generally less safe and more vulnerable to crime than boys when they were on the streets and that they sometimes made themselves more vulnerable by dressing in revealing clothes which might attract attention.

The risk of being raped was mentioned in the majority of focus groups as was the difficulties faced by girls in trying to get home safely after drinking and socialising in general.

**Theme 2: Relationships**

The difficulties faced by girls from within their own relationships with each other were mentioned in all focus groups and peer pressure and relational aggression were described as key issues and concerns.

The pressure to have sex was also highlighted and also the concern around the fact that boys would expect girls to behave in the same way as women they had observed via pornographic material on the Internet.

Bullying of girls by both genders was perceived to be a major concern in all focus groups.

**Theme 3: Media pressures**

The pressure to look good and achieve the so-called ideal was highlighted in all focus groups and the fact that boys particularly were seen to expect girls to match up to such images was a real cause for concern.

**Theme 4: Valuing Education/careers**

The importance of education as a means of achieving success in the workplace was highlighted alongside the difficulties faced by girls feeling trapped in their own contexts and helpless in terms of breaking out and achieving real success.

The fact that the media tend to focus on celebrity culture and do not always show successful women who have and are working hard to achieve and be successful was also raised.

**Theme 5: Financial independence**

Being financially independent of men was deemed to be a good thing in terms of being
able to make your own choices and decisions and particularly important should there be a break down in the relationship.

**Theme 6: Happiness/Wellbeing**

Happiness was equated with feeling good about oneself, having positive relationships with significant others and enough money to live reasonably well and without too much stress.

Ways of coping with stressful relationships or events ranged from self-harm as a coping mechanism at one end of the continuum to strategies emanating from positive psychology at the other.

**Theme 7: Role models**

Many of the participants identified celebrities as being role models but generally in a negative sense. Those who had overcome or encountered difficulties were deemed to be more positive role models and the majority of participants cited their mothers or other significant female family members as role models for them.

**Conclusion**

The findings of this study have illustrated that there are a range of factors that impact upon girls and young women as they attempt to negotiate their roles within a complex and often challenging social context. Together, these factors pose challenges to both the girls and young women concerned and also to those who support them in both the social and learning contexts.

**Implications of findings and the development of the programme**

Most importantly for this publication, these findings also help to form the evidence-base for the development of a curriculum for girls and young women attending a range of educational contexts which focuses upon:

- Gender awareness and equality
- Positive peer relationships
- Confidence, self-esteem and safety of girls and young women
- Management of stress, peer pressure and relational and sexual bullying
- Awareness of sexualisation in both the media and social and learning contexts
- Skills and strategies to assertively highlight and tackle sexualisation and misogyny in both the social and learning contexts
- The promotion of positive role models
- Teenage relationship abuse
- Wellbeing and ‘happy habits’

**Establishing the programme**

**A child-centered model**

This girls curriculum aims to promote well-being by building positive relationships within a nurturing and child-centered approach. This builds upon resilience factors and protective factors within the school context.

Access to a supportive network can function as a protective factor, supporting and promoting resiliency within a community context, to combat severe risk factors such as homelessness. In a school context, protective factors such as having at least one significant and caring relationship with an adult; clearly being a school which demonstrates concern for and commitment to pupils’ self-esteem, wellbeing, independence, self-efficacy, and emotional health; and school teachers who freely offer time and space to listen, can impact positively upon the resiliency of young people.

These findings informed the development of a child-centred approach. The main tenets of the model adopted include taking into account the individual needs of each member, looking at the reasons behind different behaviours rather than reacting to the behaviours themselves, and promoting the right of the young person to choose and communicate, whilst accepting these choices and not basing judgements upon them.

**The practical application for school-based staff**

**Issues in multi-agency working and the development of a joint approach between clinicians and teachers**

When developing this programme, practitioners thought that there was potential for tension between the needs and expectations of the senior management team in terms of educational and behavioural boundaries and expectations and the clinical staff in terms of their therapeutic approach as described above. They felt that clear and open communication, trust and respect of professional expertise would be required to prevent conflict and achieve professionally appropriate approaches and outcomes.

The team at our pilot school originally identified two school-based counsellors and an Assistant Psychologist to work with the Consultant Educational Psychologist to develop the programme and agree the approach. The adoption of the child-centered approach as described above did subsequently result in some tension in the area of behaviour management.
and expectation. There was a sense that teaching staff were less comfortable with what they perceived to be an ‘unboundaried’ forum, with girls having the freedom to move around and express themselves in inappropriate language. This was seen by the clinicians as key to ensuring the development of confidence, self expression and feelings of ultimate safety within the clinical relationship. For school-based teaching staff the concerns remained, however, around how ‘in control’ the clinicians were of the process and ensuring the safety and behaviours of the girls in line with school-based expectations.

There was some evidence of a tension between those adhering primarily to a strong behaviourist tradition and those who were aiming to incorporate clinical and what they perceived to be more emotionally intelligent approaches. In effect, the challenge was how to make the clinical intervention ‘fit’ with the educational approach.

In order to attempt such innovative practice and to begin to ensure that staff could successfully work together in order to do this, it was agreed that the team be broadened to incorporate members of the care team – one of whom also had experience in teaching. The programme could then be developed and delivered by these members of staff working as a team.

Agreeing that the clinical principles and approaches would be maintained within a more boundaried context ensured that school expectations regarding behaviour were adhered to. The approach would therefore also incorporate the knowledge and skills base of care and teaching staff would then become the key objective. This would involve regular meetings to ensure the development of the programme and its sustainability with both younger and older groups of girls and young women being targeted in separate interventions. This on-going dialogue would then ensure agreed approaches and content of the sessions which ensured the wellbeing of girls within this context. It would also provide a forum for transparent working and approaches which would also ensure that all staff – both clinical and teaching/care staff could operate within a safe and purposeful framework agreed by all.

**Overall aims of the programme**

Consequently, the aim of the 16 session programme is to build a therapeutic environment that allows and promotes autonomy, emotional resilience and open communication. This statement can be broken down into three main objectives:

1. Promote emotional resilience within the group members
2. Assist in the development of the skills associated with positive communication
3. Support group members with a view to further developing self-regulation

The contents of the sessions clearly reflect the concerns and themes arising from the focus groups.

**The session structure**

The sessions are generally structured as follows although there are some differences between the sessions:

- Welcome
- Group Rules
- Talk Time
- Ice Breaker
- Core Activity/Activities & Additional Activities
- Reflections and Feedback
- Target Setting
- Compliments to Close
- Relaxation

**A few points to note**

Having now delivered and trialled this evidence-based programme in both a special and mainstream context, it is very important to finally highlight a few points which may impact upon delivery by facilitators in the future. It is very important that the facilitator(s) make themselves aware of the contents and aims of each of the sessions in the programme so as to ensure that their selection (if they choose not to deliver all of the sessions in sequence) is entirely appropriate to the target group. It may be appropriate to select a more focused set which focus on key areas such as relationships or self-image. This will also need to be planned with time constraints in mind as some institutions may not be able to allocate sufficient time in any one or two term block to actually deliver all of these sessions in sequence.

It should also be noted that the images selected for the programme to date have been done so with groups of girls currently in mainstream and special education within the UK. These may well not be entirely suitable or appropriate in other
contexts and it may be necessary to source alternative images which have more meaning and relevance to the specific group of girls being targeted. The existing framework and contents of the sessions will remain pertinent, it is simply that the facilitator(s) will have to source some additional images at some points in the course of delivering the programme.

Overall, it is hoped that this evidence-based programme will provide a genuinely meaningful experience for the target groups of girls and young women in terms of really addressing their concerns and anxieties whilst also providing them with a range of tools and strategies to more effectively maintain and further develop their overall wellbeing and mental health.

References


Throughout adolescence, young people gain greater independence in many areas of their lives including increased responsibility for learning, employment and health behaviors. This transition is difficult for some young people, particularly those from disadvantaged backgrounds, who may not develop in the same way as those from advantaged backgrounds. Socio-economic status (SES) has a major impact on education and health and young people with low SES are less likely to graduate from high school and less than half has regular connections to school or employment (US, DOL, 1997). Health is also affected. For example, family income is inversely associated with obesity particularly in Whites (Freedman 2011; Kumanyakia, et al., 2008; O'Dea & Wilson 2006). Disadvantaged young have adversity that is difficult to overcome.

To assist low income young people, the US funds Job Corps (JC), a programme to educate low income young people (ages 16-24) to attain a high school diploma/General Education Development (GED) and vocational education. The programme is primarily residential to remove young people from less than optimal social environments and help them become educated, gain independence and skills toward productive adult lives. About 100,000 students are currently enrolled in 124 JC centres across six regions in the U.S. and must meet the poverty level published by the Department of Health and Human Services (HHS).

The purpose of this study was to determine the weight patterns of young people as they enter into the JC education programme. Additional aims were to determine if there were differences in overweight and obesity prevalence associated with age (computed into a new variable, adolescents (age 16-19) and adults (≥20) ethnicity, gender and health insurance status (insured or uninsured) as well as to provide demographic assessment of a JC centre population.

**Methods**

A retrospective longitudinal cross sectional study included data from all students entering into a JC education centre during a 16-month period. Variables included; age, race/ethnicity, gender and health insurance status. Also collected were height and weight measurements. The exclusion criteria for subjects included females who were pregnant upon entry since this can influence weight.

**Design and procedures**

This cross-sectional retrospective study was approved by the Institutional Review Board at the University of Massachusetts and the JC national office. All heights and weights were obtained on the same calibrated scale on the day of arrival. Body Mass Index (BMI) and percentile were calculated via the Centers for Disease Control (CDC) teen calculator for students ages 16-19 and adult calculator for those 20 and over. BMI categories were examined according to CDC standards: percentile age-specific BMI: ages 16-19 as underweight (≤5th percentile), normal weight (5th–84th percentile), overweight (85th–94th percentile), or obese (≥95th percentile) and by adult (age ≥20) as underweight (BMI≤18.5), normal (BMI=18.5-24.9), overweight (BMI=25.0-29.9), and obese (BMI≥30).

**Data Analysis**

Data were analyzed in SPSS 19 (IBM, 2010). Descriptive statistics (mean, standard deviations, and confidence intervals) for BMI stratified by four demographic variables, age (transformed to a new variable of adolescent: ages 16-19 and adult: ≥20 years of age), gender, and ethnicity and health insurance status were
calculated. Weight percentiles were analyzed as underweight, normal, overweight, obese and combined overweight and obese. Q-Q plot*, histogram and K-S** statistic revealed asymmetric distribution of the sample and, as such, violated model assumptions. Although the data were squared and log transformed for analysis, this was not clinically useful or meaningful.

Therefore, non-parametric tests were chosen to determine if there were significant between group differences. Kruskal-Wallis tests were used to determine differences in BMI by ethnic groups and Mann-Whitney tests were used to analyze differences in gender and health insurance status in the adolescent and adult samples. Regardless, the analysis techniques revealed similar results and therefore were left in non-parametric format for reporting.

## Results

The sample included 192 JC young people, ages 16-25. Although there were some Asian and Alaskan-Native American students in the population (n=6), these were omitted from the analysis because the sample size was too small to generalize, leaving 186 students for the final analysis. The majority, 65%, of the total population lacked health insurance and a disparate 79% of the adults (≥20 years of age) were uninsured compared to 55% of the adolescent population. The BMI range was between 14.6 kg/m² and 48.9 kg/m² with a median of 31.7 kg/m². The mean BMI was 27.5 kg/m², sd = 7.1. Population characteristics are described in Table 1 (above left).

### Age, Gender & Ethnicity- Overweight and Obese Young People

Table 2 (above right) illustrates unhealthy weight patterns for combined overweight and obese young people in the total population (N=186) that reveals over half, 56% (n=105), of the entire sample was either overweight (25%, n=48) or obese (31%, n=57).

There was no difference in adolescent overweight and obesity prevalence between females and male subjects with an almost equal prevalence of overweight and obese young people with 58% (n=53) of females and 55% (n=52) of males being either overweight or obese. Racial/Ethnic differences were not statistically significant (p=.28) with 57% of blacks and 62% Hispanic/Latino compared to only 54% of whites being overweight and obese. Overall, both female and male whites had a lower incidence of being overweight or obese than Hispanic/Latino and blacks, although not enough to be statistically significant (p=.54).

### Age, Gender & Ethnicity-Obese Only Young People

Approximately one-third (n=58, 31%) of the young people in this study were obese. Although not enough to be statistically significant (p=.35), overall the rate of obese females (36%, n=33) was 10 percent higher than males (26%, n=25). Ethnic differences were non-significant (p=.71); however, Black non-Hispanic overall had the highest percent of obese young people with 43% (n=18) compared to 29% (n=28) of whites and only 26% (n=12) of Hispanics being in the obese category. Overall, adolescents had a higher obesity rate of 34% (n=37) than adults 27% (n=21). Table 3 (next page) depicts the prevalence of obesity among different age, gender and ethnic groups and for the entire sample.

* Q-Q = quantile-quantile plot  ** K-S = Kolmogorov-Smirnov test
Insurance Status
For the total population, the majority, 65\% (n=120), was uninsured. Of the 108 adolescent students in the study, 45\% (n=49) were insured compared with only 21\% (n=17) of the adults in the study. A weak correlation was found (\(\rho(184) = .243, p < .01\)). Adolescents were insured at a significantly higher rate (mean = 84.31) than adults (mean = 106.23, U= 3219.00, \(p = .001\)). The relationship between weight status and insurance was not significant (\(\rho(184) = -0.024, p > .05\)) indicating insurance is not related to weight status in this population. Similarly, although descriptive statistics revealed that 60\% (n=58) of white students, 74\% (n=31) of black students and 64\% (n=30) of Hispanic students were uninsured, there were no significant differences (\(p=.42\)) in insurance status between ethnic groups. There was a significantly (\(p=.001\)) higher mean BMI and higher standard deviation (27.55 kg/m\(^2\), sd=7.02) in those without health insurance in contrast with those who were insured with a mean BMI (25.5 kg/m\(^2\), sd=3.18), although both would be classified as overweight.

Discussion
The young people from this centre came from across the country; therefore, to understand how this population compares to the general population, national estimates were reviewed. About one-third of U.S. adults are obese and approximately 17\% of children and adolescents are obese (Flegal, Carrol, Ogden and Curtin 2010; Kumanyika et al., 2008). For the adults in this population, there was a 27\% obesity rate, less than that of the US population. However, when reviewing the adolescent population, there was a 34\% obesity rate, which is twice that of the general youth population in the US. These findings echo those found by Bodenlos and colleagues (2010), where half of the JC students (N=641) in their study were overweight or obese. These results, while disturbing, are not surprising, given the correlation between low SES and obesity.

There were weight-related disparities among the adolescent youth in this JC population, in particular Hispanic young people who were more likely to be overweight or obese than their White and African American counterparts. Although Whites had the lowest prevalence overall for being overweight or obese and the second highest for obesity, the rates were still striking. This is in line with national trends that show obesity rate typically increase as income and parental education decrease in white children, although different patterns have been found for children from ethnic minority groups (Freedman, 2011). This finding elucidates the importance of including low-income whites in health disparity population research and practice.

U.S. estimates reveal that as many as one in five African Americans and one in three Hispanic individuals, compared with one in

<p>| Table 3. Prevalence &amp; percent of obese youth among age, gender and ethnic groups for the total sample |
|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|-----------------------------------------------|</p>
<table>
<thead>
<tr>
<th>Gender</th>
<th>Age Group</th>
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<th>Prevalence % (n)</th>
<th>Prevalence % (n)</th>
<th>Prevalence % (n)</th>
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<td>34% (n=37)</td>
</tr>
<tr>
<td></td>
<td>Adult (n=78)</td>
<td>26% (n=11)</td>
<td>38% (n=8)</td>
<td>14% (n=2)</td>
<td>27% (n=21)</td>
</tr>
<tr>
<td>Total (N=186)</td>
<td>(N= 186)</td>
<td>29% (n=28)</td>
<td>43% (n=18)</td>
<td>20% (n=12)</td>
<td>31% (n=58)</td>
</tr>
</tbody>
</table>
eight whites, lack health insurance (Mead et al., 2008). In this study, these were even higher than US estimates with three in four African Americans, three in five Hispanics and three in five white individuals having no health insurance. Similarly, there were major age related differences in insurance rates, especially between adolescents and adults. However, there were a significantly higher number of uninsured adults versus adolescents (79% vs. 55% respectively) and suggest a relationship between health insurance and age. In spite of this, there was a higher percentage of obese adolescents over adults (68% vs. 55%), although more adolescents were insured. The lack of care and individual clinician health education contributes significantly to health disparities. This period presents an important opportunity to prevent the health problems associated with being obese before they develop or while they are reversible. Study findings spanning over one and a half decades suggest that being overweight during adolescence predicts a broad range of adverse health effects that are independent of adult weight trends (Kumanyakki et al., 2008). Alterations in health associated with obesity are difficult to improve without health insurance. Young people enrolled in JC have educational goals that culminate in securing gainful employment. This may be problematic in those who are obese as national data (France) revealed that the percentage of time spent unemployed during working years is significantly higher for each kg/m² deviation from the mean body mass index (BMI) (Paraponaris, Saliba, Ventelou, 2005). Other studies examining the relationship between employability and obesity found discrimination among employers across all job selection criteria, such as starting salary, leadership potential, and likelihood of selecting an obese candidate for the job in those who are obese (O’Brien, Latner, Egneter & Hunter, 2012).

**Learning Environment**

The US Department of Health and Human Services (DHHS) task force found characteristics of the social and physical environments shape human experience and offer opportunities for health (Anderson et al., 2003). The time in which young people are enrolled in a vocational programme is a major transitional period and, as such, an ideal time in which the culture of school life can be optimally aimed at shaping health behaviors aimed at achieving wellness. This is an opportune time to educate them about healthy lifestyles and health-focused life skills (e.g. meal preparation and understanding basic nutrition). Since health promotion efforts implemented on a student community and cultural level may have a greater impact on behavior change than those with an individual focus, the environment should shape a culture of wellness and community support for health (Kumanyika et al., 2008).

Prior research conducted on JC education training students showed that students may not perceive their weight and associated health risks as problematic (Bodenlos et al., 2009). Since many JC students have not graduated from high school or have not attended school consistently, vocational education is a major portion of their secondary education and should include health education. The majority of this population is of unhealthy weight and education needs to occur on both a micro (individual) and macro (population) level to educate students about the need for maintaining a healthy weight. Further, curriculums should include health education that extends beyond occupational health and safety and includes work readiness thought employee wellness.

**Limitations**

The author recognizes the bias of limited representation associated with the geographically-limited convenience sample used in this study. The results may not be representative of the general JC population, all vocational training students or all young people living with low SES and thus limits the external validity of the findings.

**Conclusion**

The intent of this study was to understand the weight patterns of young people as they enter into a JC centre. Since a significant economic and social investment is being made in all students engaged in career vocational education, not only those enrolled in JC and in the US, curriculum should focus on a holistic approach that includes healthy lifestyles and education for these young people. Further research aimed at understanding the connection between student employability and weight patterns should be explored. These are young people who offer valuable service to society.
with their vocations and have the potential for a promising future.

Acknowledgements

The author would like to acknowledge the staff for their dedication and students of Job Corps for their pursuit of success that lasts a lifetime despite significant challenges. Also, the United States Department of Labor for allowing the use of the data in this report. Special thanks to Elizabeth Chin and Judith Mitiguy for their thoughtful considerations regarding this manuscript.

Bibliography


"The (named) Children and Young People's Partnership has benefitted from the results of the SHEU survey locally for many years now, and we should like to continue to do so in future."

Consultant in Public Health Medicine

For more details please visit http://sheu.org.uk
Dr David Regis is the Research Manager at the Schools Health Education Unit. This paper is based on a presentation given at the Mentor ADEPIS seminar “Understanding your pupils’ needs”. For communication, please email: david.regis@sheu.org.uk

David Regis
Drug and alcohol needs assessment with young people

The Health-Related Behaviour Questionnaire (HRBQ) is a widely-used lifestyle survey instrument offered by the Schools Health Education Unit (SHEU). The original purpose of the HRBQ was needs assessment, curriculum and service planning in schools, but it has found uses in public health monitoring and needs assessment at local authority level.

In 2012, the survey was used in more than 500 schools in 28 local authorities, and completed by nearly 100,000 pupils; in 2013, an almost entirely different set of schools and authorities took part. Over the years, millions of questionnaires have been processed by the Unit, contributing to a unique databank of young people's behaviour which is both wide – having in it many different topics – and long – going back to the early 1980s.

An early example of the HRBQ being used in deciding curriculum priorities for a school was from a city in the South West.

“I had a call from a teacher, who explained in some anxiety that there was a dreadful alcohol problem in her school. We talked for a while about this, clarifying, for example, whether in her view the problem was among the staff or the students…

There had been a recent incident. A third-year pupil (Year 9) has been found on the morning of her fourteenth birthday, unconscious, and lying in a neighbour’s front garden. She had left for school that day carrying supermarket bags containing bottles of Martini, vodka, cider and perhaps other drinks. She sat on the wall and drank until she collapsed. The bags were a birthday present from, I believe, her mother.

To say the least, this incident had created for the school, and the community it served, something of a focus on young people’s use of alcohol (if not an actual panic). We went in to support doing a survey, not just about alcohol, but including many other topics in health and social education. The findings showed a number of important things:

- Yes, there were some young people going over the top on alcohol. But they were few. Most young people’s use of alcohol was occasional, moderate and also – an important point in the story above – in the presence of, and/or supported by, their parents.
- When you looked across the whole picture presented in the results, there was some justification for reviewing the timing and content of the alcohol component of the PSE curriculum. There was also a lot of other information given by these young people which caused as much if not more concern – about their worries, their diets and so on.

The overall effect of doing the survey in this school was to go beyond a confusion of incidents and anecdotes to give some detailed evidence on which to base all their decisions about the PSE curriculum – certainly including alcohol, but including a wider context of discussions about peer pressure, decision making and so on. Furthermore, the survey also provided a more balanced and moderate picture of young people’s consumption, and calmed down a community which had reacted so strongly to an incident that, we can say in hindsight, was not typical.”

Variety of topics

The questionnaire includes a variety of topics, including drugs and alcohol, and can be offered to young people in primary and secondary schools, FE colleges and Universities. Repeated use can also show changes in knowledge, attitude, behaviour and social norms among young people in a community.

Examples (below) from one set of questions currently in use in secondary schools regarding alcohol and drug use:

How many cigarettes have you smoked during the last 7 days?
If you have smoked recently, where did you get/buy your last cigarettes?
Have you ever bought cigarettes with foreign writing on the packet?
How many people smoke on most days indoors in your home?
Have you had any alcoholic drink at all during the last 7 days?
On how many days did you get drunk, in the last 7 days?
During the last 7 days, (which) of the following alcoholic drinks did you drink, if any?
Total number of units of alcohol
If you ever drink alcohol at home, do your parents know?
What do you know about these drugs? (Detail)
Have you ever been offered cannabis?
Have you ever been concerned about someone else’s drug use?
Have you heard of or used any of these services? % responding ‘I have used this service’
Have you ever taken more than one type of drug listed in the above question, on the same occasion?
Have you ever taken drugs listed in (the above question) and alcohol on the same occasion?
Have you ever been concerned about your own drug use?
How much do you worry about the problems listed below? % responding ‘quite a lot’ or ‘a lot’ [inc. Alcohol]
Where would you go first for help or info. about the following? [inc. Drugs]
How useful have you found school lessons about the following? [inc. Drugs]
Examples of the sort of results obtainable for each question include:

**EXAMPLE SECONDARY SCHOOL RESULTS**

77: How useful have you found school lessons about the following? (Year 10 only, N=247)

<table>
<thead>
<tr>
<th></th>
<th>Can't remember any</th>
<th>Not at all useful</th>
<th>Some use</th>
<th>Quite useful</th>
<th>Very useful</th>
<th>(Missing)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>35%</td>
<td>11%</td>
<td>26%</td>
<td>18%</td>
<td>6%</td>
<td>3%</td>
</tr>
<tr>
<td>Puberty and growing up</td>
<td>10%</td>
<td>12%</td>
<td>34%</td>
<td>31%</td>
<td>9%</td>
<td>3%</td>
</tr>
<tr>
<td>Other sex education</td>
<td>12%</td>
<td>14%</td>
<td>34%</td>
<td>27%</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Education about drugs</strong></td>
<td><strong>11%</strong></td>
<td><strong>14%</strong></td>
<td><strong>30%</strong></td>
<td><strong>30%</strong></td>
<td><strong>11%</strong></td>
<td><strong>3%</strong></td>
</tr>
<tr>
<td>Citizenship</td>
<td>21%</td>
<td>24%</td>
<td>28%</td>
<td>15%</td>
<td>8%</td>
<td>4%</td>
</tr>
<tr>
<td>Careers education</td>
<td>21%</td>
<td>14%</td>
<td>27%</td>
<td>24%</td>
<td>10%</td>
<td>3%</td>
</tr>
<tr>
<td>Physical education (PE)</td>
<td>7%</td>
<td>8%</td>
<td>20%</td>
<td>32%</td>
<td>29%</td>
<td>5%</td>
</tr>
</tbody>
</table>

**EXAMPLE LOCAL AUTHORITY RESULTS**

Currently, work in schools is usually paid for by local authorities (previously also Primary Care Trusts). Schools and sponsoring organisations will get a detailed profile of their community, for these questions and all the others. The schools and authorities are then left with the task of deciding which of the many hundreds of results are the most important and can be responded to most productively.

To assist them with this, we offer each school an analysis of how their school population might differ from the picture across the authority, as a list of statistically significant differences. Where a school has taken part in a study before, we will also give them a list of differences between the recent and previous set of results.
Here is an extract showing each type of analysis (I’ve picked out the drugs and alcohol items from a longer list, using the report from a school chosen at random):

**EXAMPLE SCHOOL REPORT: Comparison results**

<table>
<thead>
<tr>
<th>School</th>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yr 8</td>
<td>Yr 10</td>
</tr>
<tr>
<td>Yr 8</td>
<td>Yr 10</td>
</tr>
<tr>
<td>Boys</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sig** | **School** | **Auth** | **Question**
---|---|---|---
*** 30% | 48% | pupils responded that they have found school lessons about smoking education ‘quite’ or ‘very’ useful.  
*** 44% | 27% | pupils said they have smoked in the past or smoke now.  
*** 30% | 47% | pupils responded that they have found school lessons about alcohol education ‘quite’ or ‘very’ useful.  
*** 18% | 9% | pupils reported that they have taken at least one of the drugs listed in the questionnaire.  
*** 11% | 4% | pupils responded that they have taken at least one of the drugs listed during the last month.  
*** 17% | 9% | pupils responded that they have smoked outside in a public place in the last 7 days.  
*** 15% | 7% | pupils responded that they have taken at least one of the drugs listed during the last year.  
*** 32% | 47% | pupils responded that school lessons are their main source of information about drugs.  
*** 12% | 5% | pupils responded that they have smoked on the way to or from school in the last 7 days.  
*** 29% | 18% | pupils responded that they have been offered cannabis.  

**Sig** | **2012** | **2010** | **Question**
---|---|---|---
*** 37% | 23% | pupils responded that they have found school lessons about drugs ‘quite’ or ‘very’ useful.  
*** 32% | 19% | pupils responded that school lessons are their main source of information about drugs.  
*** 30% | 19% | pupils responded that they have found school lessons about alcohol education ‘quite’ or ‘very’ useful.  
*** 64% | 75% | pupils responded that they have heard of FRANK or ‘Talk to FRANK’.  
*** 29% | 19% | pupils responded that they have been offered cannabis.  
* 12% | 17% | pupils responded that they drank beer or lager in the 7 days before the survey.  

Tests: Chi-squared ($\chi^2$).  
**KEY:**  
* $p < 0.05$ (5%)  
** $p < 0.01$ (1%)  
*** $p < 0.001$ (0.1%)  

I don’t know what this particular school did in response to this set of results, but it is hard to resist the temptation to read off a set of recommendations from what we are told here: there is progress that has been made but more still to be made in providing an alcohol education curriculum which is seen as useful by pupils.  

Yet resist, we must.  A school that relies on our recommendations, ignorant of local history and context, to tell them what to do, is not as likely to do it well; a school that takes ownership of and responsibility for its own results is likely to think through and believe in and implement properly a response.  So, even though that school might decide to do something I wouldn’t do, the fact that they believe in it might mean that it works anyway.
And to call back to the earlier reference to social norms, here are some results from a local authority who did some work on young people's perceptions of the behaviour of their peers between two waves of a survey:

Social Norms Trends in a Local Authority

Significant differences between 2013 and 2011 data

Below we have listed some statistically significant differences between the data collected in the 2013 survey and that collected in 2011.

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>1145</td>
<td>1075</td>
</tr>
<tr>
<td>Girls</td>
<td>1241</td>
<td>962</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sig</th>
<th>2013</th>
<th>2011</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>***</td>
<td>52%</td>
<td>34%</td>
<td>of pupils responded that they think 0-10% of people in their class drink alcohol regularly</td>
</tr>
<tr>
<td>***</td>
<td>69%</td>
<td>53%</td>
<td>of pupils responded that they think 0-10% of people in their class at school smoke regularly</td>
</tr>
<tr>
<td>***</td>
<td>40%</td>
<td>55%</td>
<td>of pupils responded that they think over half of the people in their age group in England drink alcohol regularly</td>
</tr>
<tr>
<td>***</td>
<td>10%</td>
<td>21%</td>
<td>of pupils responded that they think more than half of the pupils in their class drink alcohol regularly</td>
</tr>
<tr>
<td>***</td>
<td>65%</td>
<td>51%</td>
<td>of pupils responded that they think 0-10% of girls in their year group have had sexual intercourse after drinking alcohol</td>
</tr>
<tr>
<td>***</td>
<td>70%</td>
<td>56%</td>
<td>of pupils responded that they think 0-10% of boys in their year group have had sexual intercourse after drinking alcohol</td>
</tr>
<tr>
<td>***</td>
<td>60%</td>
<td>49%</td>
<td>of pupils responded that they think 0-10% of boys in their year group have had sexual intercourse</td>
</tr>
</tbody>
</table>

What were the outcomes (whether it facilitated the implementation of specific intervention programmes)?

It is not easy to generalise about actions based on surveys. One school's or one authority's set of actions in response to their results will be very different from the next, not just because their results are different, but also their history of recent programmes and capacity to innovate will be different to the next, and to some extent their beliefs and values. If you've just put in place a set of anti-smoking initiatives for young people, the topic is unlikely to be a priority for action following a survey, almost no matter what your results are. So we do seek feedback and commentary from schools and authorities about every step of the process, it's not easy to generalise.

An unedited collection of some school responses, to our impact assessment question, is given below (spots separate individual responses):

School Improvement Planning • To plan PSHE for next year and to help signpost actions where a problem lies • Healthy Schools Plus targets, Feedback for PSHEE conference mornings- suggested • Topics • To evidence information for the Annual Audit Healthy Schools • We use the information to develop our school Health Improvement Plan. • Informs planning, areas of development • Identifies issues that need to be explored further in school. • To inform planning, particularly for PSHE and to help us identify issues which need to be dealt with and the views of the children. • To complete our development plan for a healthy school. • It supports our Self Evaluation and PSHE • anti bullying / healthy schools / attendance / SRE / drugs education / assemblies • We are quite a small school which means that staff have very heavy workloads so we decided to look at the data in a staff meeting and identified four areas to be covered in school through the normal curriculum if possible with assemblies to support. • To sort out priorities and training for cohorts of children. • To look at the gaps in knowledge and understanding of our children • It was interesting to compare our results to others and so put them in context. • Inform SEF and SRE and behaviour policy. Useful information for governors. • PSHE planning Pastoral Team aware of potential issues Deputy Head addresses issues with appropriate subject areas/ pastoral staff • Linked to our healthy school's agenda, PSHE and informing our SDP and action plans. • As evidence for the SEF and setting actions for areas we need to improve • As part of our school evaluation and improvement process, we use the survey to identify areas of concern for the children, or those which indicate we could improve, and draw up action plans. We have also used the report data to draw up our Healthy Schools submission. • Identifying areas of weakness/need • To develop PSHCEE within school • For self-evaluation • Data for OFSTED etc. and school improvement on ECM issues which aren't easily collected in other ways. • Report to parents and governors, LA and as resource for Healthy Schools; data for OFSTED …
Teachers don't have a lot of time to tell us what they do with their findings, so these are quite brisk summaries. You have to peer to find the one specific mention of drug topics, but many of the actions shown here are, or may be, relevant e.g. "Informed PSHE coordinators' focus for next year". Among the few longer responses we found the following:

“I was involved in taking part in a city-wide health and wellbeing survey over a period of six years. Completing the survey every two years grew in importance year-on-year, with the final cycle having a major impact on our SDP, PHSE curriculum, OFSTED outcomes and Governor understanding. Over the six-year period, we moved from a small sample in two tutor groups filling in a paper survey to two year groups completing an online survey. The reports produced give graphical analysis of a wide range of issues. As a result of the survey, we increased the number of PSHE workshop days for students to address issues such as smoking, drug and alcohol awareness, anti-bullying workshops. The surveys helped Governors make a positive informed decision to allow Brook Advisory Clinic nurses on site to support students.”

“It was very, very useful. It gave us reassurance we weren't missing a trick. For example, not many pupils in the sample year groups were taking illegal drugs, which re-enforced our opinions. But the survey also raised issues and flagged some things up. We discovered that some of our girls weren't eating enough – the percentage of girls in our school not eating lunch the day before the survey was higher than the county average. There were other concerns too, specifically around cigarettes, alcohol and attendance.”

Authorities also seem rather better at doing the work than documenting it – a charge that may also fairly be levelled at us, I fear. I can pick out one or two examples from client feedback...

“The data for (us) are very useful ... This is especially important when evaluating the impact of interventions regarding alcohol or other areas, as the survey data are likely to provide an earlier indication than routine data sources.”

…but I'm sure you are familiar with the distinction between anecdotes and data.

One Authority recently took the trouble to collate a list, possibly partial, of actions they had undertaken following a SHEU survey:

“Involving pupils in the identification of key priorities and actions • Development and further guidance for provision mapping in schools, to meet the needs of vulnerable pupils • Use of the Inclusion Passport to improve information sharing and strategies to improve pupil outcomes for individual vulnerable pupils, particularly on transition • More in-depth monitoring of variance within social identity groups, for example Gypsy/Roma travellers and new arrivals within the ethnic minority social identity group • Targeted pupil voice to follow up emerging key issues, for example interviews with Gypsy/Roma travellers, testimonials including young people’s accounts of their experiences to further exemplify perceptions. This will inform planning of provision • Workshops at the Inclusion Conference focussed on SEN and disability key issues e.g. risky behaviours, anti-bullying • Suite of guidance materials for schools and settings including new guidance on tackling homophobia in schools and supporting Lesbian, Gay, Bisexual (LGB) young people, and a free school meals toolkit • Bespoke work with individual schools in addressing local/school based equalities issues • Sharing the service family findings with the local Ministry of Defence Garrison and with the PCT • Sharing the service family findings at a children and young people’s multi-agency conference looking at the education and welfare of Armed Forces children, attended by school leaders, Integrated Services, Adult Learning Services, Educational Psychology Service, Army Welfare Service, Army Families Federation and the Soldiers, Sailors & Airmen Families Association (SAFA) • Publishing a CYPS guidance leaflet aimed at Armed Forces parents outlining how they can help schools support their children at times of exercise, deployment or posting: Helping us to help you and your family • Continued support from the Quality & Improvement Service for an LA funded project aimed at supporting pupils from Armed Forces families.”

Nothing there on alcohol or drugs? Well, the focus on LGB young people was motivated in part by their relatively high alcohol and drug use. Year 10 students in that LA may have tried smoking (45%), drank alcohol last week (49%) or ever tried illegal drugs (18%), but use among LGB pupils in the same year group is rather higher in each case (61%, 64%, 47%).
Authority Needs Assessments concerning Drugs and Alcohol and mentioning SHEU results include:

Preventing Drug and Alcohol Misuse by Young People (BaNES)
Worcestershire Drug and Alcohol Needs Assessment
Health Needs Assessment of University students studying in Newcastle
Bedford Borough JSNA
Bristol Alcohol Strategic Needs Assessment 2012
Essex Joint Strategic Needs Assessment
Cornwall & Isles of Scily Alcohol Needs Assessment
Alcohol Health Needs Assessment - Bradford
Alcohol Harm Reduction Strategy for Swindon 2011-2014
Needs Assessment 2009 - Sunderland Children’s Trust

Substance Misuse Needs Assessment 2013/14 – Wiltshire
Joint Strategic Needs Assessment Director of Public Health – Derbyshire
The alcohol health needs assessment - Greater London Authority
Joint Strategic Needs Assessment – Cumbria
Alcohol Protection (Young People and Families) – Manchester
Alcohol strategy – Dudley
Solihull Joint Strategic Needs Assessment - Solihull NHS
Wakefield JSNA
Joint Strategic Needs Assessment Gateshead
Joint Strategic Needs Assessment for NHS Swindon

How it was used by local authorities, how it was used by schools?

If that all sounds a bit top-down, we have many examples of survey results being taken back to young people for comment and suggestions.

For instance, here is an account of an ad hoc group of pupils being a major pathway for deciding on responses to results in a school:

“Two focus groups of sixteen mixed-ability, mixed-gender, mixed background students in Years 9 and 11 were established. Using their responses to the HRBQ, a senior youth worker plus colleague and school nurse then interviewed these students to ‘erase out’ more substantive opinions from them … A report on the findings was then produced by the Youth Service.”

For an Authority-level example, one client asked us to produce an A4 poster for each headline figure from the County results (extract below), and then worked through a thorough consultation exercise with many groups of young people, involving setting priorities and then inviting comments and suggestions. Substance use topics were two of the four most commonly prioritised topics from the survey.

Involving pupils in the identification of key priorities and actions for the 2010 ECM-HRBQ county report

Following the reporting of the survey data in October, there were a number of ECM-HRBQ Pupil Consultation activities held in secondary schools/pupil referral services, and with the North Yorkshire Youth Council to inform the key priorities and actions. Among the resources for the activity were:-
- The draft County report - useful to show pupils, especially the sections where the key priorities and key actions would be inserted, and to answer any questions that arose about the broader data
- 2010 Pupil questionnaire - this was helpful to remind pupils of the questionnaire that they had completed in the previous May.
- Pie charts with key data

Introductory Activity: 15 mins
Using the current ECM-HRBQ statements, pupils were asked to match the percentages. The correct answers were shown to the pupils to support discussion and allow the facilitator to give the background to the questionnaire in terms of content, size of county, number of pupils/schools taking part and the importance of their input.

Main Activity:
Stage 1 - 15 mins
- Pie charts were displayed around the room. Pupils were asked to place a Post-it sticker on the ones they feel are the most important to them or pupils in their school.
- Pupils were asked to identify the most commonly marked (max 5 pie charts) and asked to discuss these briefly on their tables: were they what they expected and why they think they have received the most Post-Its

- Pupils were told what would happen to their feedback – that it was collated and taken to next LA meeting to inform key actions and priorities together with feedback from other services.

ECM-HRBQ matching exercise – answer sheet

<table>
<thead>
<tr>
<th>% young people using Internet chat rooms</th>
<th>% young people with high self esteem scores</th>
</tr>
</thead>
</table>

Feedback from pupil consultation
The top issues emerging from pupils were:
- Bullying - How schools deal with bullying (example below)
- Drinking - Drugs and Alcohol on the same occasion
- Smoking
- Sex and contraception

Example of actions identified during the pupil consultation
Table 3 (below) shows an example of actions, following the pupil consultation, relating to bullying.

Table 3. Example of actions identified during the pupil consultation

<table>
<thead>
<tr>
<th>Most popular priorities</th>
<th>Reasons for choice</th>
<th>What should be done</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullying</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of pupils who think they are picked on or bullied for the way they look and for their size or weight.</td>
<td>Has major impact on pupil confidence and lowers self-esteem and affects attendance. Also reflects badly on the school. Leads to eating disorders. Worries about figures and think they should look like models. Boys get bulked up.</td>
<td>Act quickly as schools should not wait until it gets bad. Sit pupils down and encourage them to talk. Restorative justice but only when pupils are ready. Take personal responsibility for appearance. Promote that everyone is different and it does not matter how you look. Staff to tackle bullies - more sanctions. Have staff available to talk to pupils affected. Encourage people to feel good about themselves by putting more average people in magazines and newspapers. Education about healthy eating, involvement of school nurse.</td>
</tr>
</tbody>
</table>

Use of the 2010 ECM-HRBQ
The 2010 data has been used in a variety of ways to inform service planning, provision and evaluation.

- Stranded through the 2011-14 Children and Young People’s Plan – measurable outcomes.
- Providing evidence to inform inspection: Local Authority e.g. service family inspection, Children’s Centres and school inspections.
- Informing targeting of resources – for example the LA Performance Reward Grant - Risk Taking Sexual Health Services Project - identification of schools and integrated into measurable outcomes on the school project action plans.
- Used widely in training.

Table 2. Use of the ECM-HRBQ

<table>
<thead>
<tr>
<th>Reason for choice</th>
<th>What to be done</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using the current ECM-HRBQ statements, pupils were asked to match the percentages.
It might be asked – in fact, it has been asked – do you need to do the survey in the first place, why not just consult locally on priorities? I think the reason to answer yes was demonstrated decades ago by Doreen's school down in Plymouth – that is, while a community may come to a view about a topic like alcohol or drugs, it may be basing that view on at best a partial understanding of the local picture, and in some cases a greatly distorted one.

So, we can see that the HRBQ:

- Can be used as a drugs and alcohol needs assessment in schools
- Has the potential to be a rich and potent source of change in schools and communities
- Can also be used to monitor change

**Any feedback from schools?**

As part of our routine quality assurance processes, we ask schools: Would you recommend doing the survey to another school, and why? Again, some unselected schools' comments are offered:

```
It gives vital information about pupil voice • Useful to collect data and use in whole school planning • It highlighted areas of strength and weakness • certainly - it has given my PSHE team a clear view of what we are doing right as well as the gaps that we need to plug. An excellent, user-friendly resource we will certainly use again. • Think the survey is very worthwhile in informing us about our pupils attitudes and awareness of social pressures around them. • Allowed an overview of the health of our students and able to focus curriculum and extra curricular activities on areas they need help and support. • Our school is fully committed to healthy schools issues - can't really speak for others • It is very useful to read the survey to find out exactly what your pupils feel/think. It highlights areas that need developing in your school that you may be unaware of. • It was quite time consuming & difficult for the younger child ten to understand & therefore give an honest answer. For KS2 colleagues I would recommend it. • Results showed some interesting trends and pinpointed issues to address • Helps identify issues and needs of the school which need to be addressed. Helps provide action plan within PSHE for school priorities. Good evidence for SEF of what is going well in school and issues which have improved for the children. • Yes I would recommend it because it gives such a wide overview. • Quick, simple and a clear and accurate piece of data about your school • It enables staff to deal with training and understanding the issues in related areas from a child's point of view • Yes - see above • Yes - it is another way of finding out the viewpoint of our children. • It gives you proof that you are doing a good job and brings to your attention areas where you need to do a better job • It gives an overall idea of students' attitudes and perceptions to the issues that we cover in different areas of the curriculum. • Really helpful and useful evidence for school self evaluation. • HRBG gives our school specific data on areas which are not easy to assess and comparisons with other schools. This is really useful in action planning. • Useful to show OFSTED and make positive changes in school. • Feedback helps to improve the service • Very useful data • Yes - provides good information for self evaluation • Useful data for OFSTED which you cannot gather another way. • When we had OFSTED a year ago we used the data effectively. • Yes, good way of collecting additional data; easy to fill in for pupils; reports clear and self explanatory • Easy to partake in, good results and can be used effectively for students • Yes. Because a school can use the information to deal with issues. • Gave us further information to support the children in need • the survey helps to provide a taylored educational plan that meets the childrens needs at that time. • These surveys used over time provide invaluable data • It raises discussion and promotes knowledge of pupil views • Gives statistical information for impact of health and wellbeing strategies. • Useful information which can be used to support pupils and their learning as well as teaching. Excellent presentation. Lots of support. • Yes. Feel that the work is valuable and informative. • Very useful information to use for school improvement and SEF, which would be hard to acquire ourselves. • Found it beneficial • Useful for highlighting areas of concern or areas for informing discussion or future teaching • Useful for identifying areas of concern / informing future discussions or planning • For highlighting concerns; for informing discussions with children and for informing planning • It is a very useful way of looking at opinions and behaviours in the school • Encourages reflection on many of issues covered in questions. • Yes. Some data has been helpful in PSHCE planning • A useful survey providing measurable data. The LA support was also extremely crucial in order to interpret the data. • It is a good way to identify areas of concern with regards to the wellbeing of every child. • The process is straight forward and the data recieved is useful. • The amount of information returned is trackable over time. You can see if school strategies are working. • Yes, very efficient. • Yes, great service. • It is very useful to collect data for children in Year 5 and Year 6. • Good information to inform planning and provision • Valuable insight into needs of class / school • Yes as it is beneficial for the school to move forward in aspects that are relevant to their children, allowing the creation of a personalised curriculum."
```
There is growing literature on possible ways of reducing alcohol consumption and alcohol-related harm among university students (Larimer and Cronce, 2002; Siegers and Carey, 2010). However, interventions with this aim might be made more effective by information on students’ readiness to change their drinking behaviour (Carey et al., 2007a), where an assessment of readiness to change might influence the kind of approach that is thought most likely to be successful. For example, it has been found that readiness to change moderated the effects of a brief intervention among heavy-drinking students (either brief motivational intervention or alcohol expectancy challenge) such that high readiness to change made an expectancy challenge relatively more effective in reducing drinking (Capone and Wood, 2009). This study also reported an association between higher readiness to change and greater reductions in alcohol consumption in the overall sample, thus supporting previous findings (Fromme and Corbin, 2004; Carey et al., 2007b).

Although high readiness to change may increase the chances of successful brief intervention among heavy-drinking students, it has been found that, even among individuals referred to a university-based alcohol intervention programme, there was limited acknowledgement of a drinking problem or interest in changing behaviour (Caldwell, 2002; Vik et al., 2000). Such research has been conducted mainly in the USA and, with the exception of one study (Hosier, 2001), it is unknown whether a comparable lack of concern about heavy drinking is true of students in England. Moreover, there is limited understanding of the different factors associated with, and predictive of, readiness to change in heavy-drinking students.

The aims of this paper are therefore (i) to assess levels of readiness to change among heavy-drinking students and (ii) to identify variables predictive of readiness to change among heavy-drinking students and (iii) to generate hypotheses that could be tested in further research.

Method
Sample
The wider aim of this study was to examine the association between university sport participation and alcohol consumption. Therefore, universities were purposively sampled to represent varied participation and success in sport, and a range of degree types and geographical locations, both by area within England and proximity to city centres. 770 students completed questionnaire batteries. However, data from only 439 students who were classified as heavy drinkers were analysed.

Procedure
Ethical approval was granted from each institution and data collection took place between March, 2008 and March, 2009 during periods of typical drinking behaviour. All participants provided informed consent and completed a questionnaire booklet either at the start or end of a lecture.
Measures

Demographic information. Students provided information on their sex, age, ethnicity, term-time accommodation status, degree course, and year of study.

Alcohol Use Disorders Identification Test (AUDIT; Saunders et al., 1993). The AUDIT is a 10-item screening tool for the detection of alcohol use disorders (World Health Organization). Scores of 8+ on the AUDIT are classified as AUDIT-positive (drinking at least hazardously and, for the purpose of this study, heavy drinking). Support for the use of the AUDIT for detecting high-risk drinking has been found (Kokotailo et al., 2004). In our data; Cronbach’s alpha for the AUDIT was 0.70, indicating acceptable internal consistency.

Readiness to Change Questionnaire (RCQ; Heather et al., 1993; Rollnick et al., 1992). The RCQ is based on the Transtheoretical Model (Prochaska and DiClemente, 1986) and was developed as a 12-item tool to assess readiness to change among individuals who may be drinking excessively but who were not seeking help for an alcohol problem. It provides scores for precontemplation, contemplation and action subscales, with stage of change designated by the subscale on which the respondent scores highest. Evidence of various types of validity has been reported (Heather et al. 1993; Rollnick et al., 1992), along with the following Cronbach alpha coefficients: Precontemplation = 0.73, Contemplation = 0.80, Action = 0.85 (Heather et al., 1993).

Drinking Expectancy Questionnaire (DEQ; Young and Knight, 1989). This instrument measures both positive and negative outcome expectancies for alcohol consumption including: assertion, affective change, dependence, sexual enhancement, cognitive change, and tension reduction. Adequate Cronbach alpha coefficients have been found for all DEQ subscales (Range = 0.70 - 0.86) other than cognitive change (0.58; Young and Oei, 1996).

Statistical analysis

Variables predictive of stage of change were identified through the use of a multinomial logistic regression (MLR) with three-level stage of change (precontemplation/contemplation/action) as the dependent variable. Regression analysis was seen as especially relevant because associations between stage of change and predictor variables might have been due to the fact that both were independently related to AUDIT score. It was therefore necessary to extract the effects of AUDIT score in order to identify independent predictors of stage of change. The precontemplation stage was used as the reference category. Potential predictor variables were total AUDIT score and all other variables showing first-order associations with stage of change at the p < 0.1 level.

Results

Sample characteristics

Characteristics of the whole sample by stage of change are presented in Table 1 [p.23]. Significant between-group differences and associations are also highlighted (p < 0.1).

Gender ($\chi^2 = 11.501, df = 2, p < 0.01$), age (F(2,431) = 6.742, p = 0.001), year of study ($\chi^2 = 12.990, df = 4, p <0.05$), term-time accommodation ($\chi^2 = 16.754, df = 6, p < 0.05$), assertion (F(2, 396) = 3.840, p < 0.05), affective change (F(2, 396) = 6.843, p = 0.001), dependence (F(2, 396) = 7.174, p = 0.001) and tension reduction (F(2, 396) = 2.516, p < 0.1) were all associated with stage of change at the 10% level and were therefore included in the MLR.

Predictors of stage of change

Assertion, affective change, dependence and tension reduction outcome expectancies and gender, term-time accommodation and age were not found to be independent predictors of stage of change. However, total AUDIT score and year of study were predictive and were included in the final regression model shown in Table 2 [p.23]. Overall, the final model significantly predicted stage of change ($\chi^2 = 49.171, df = 6, p <0.001$), with 56.6% correct identifications. Pseudo $R^2$ values showed that 10.8% to 12.4% of the variance in stage of change was explained by the model. Owing to the inclusion of the continuous total AUDIT score in the MLR there were 50 (28.7%) cells with zero frequencies. As a consequence goodness of fit data are not presented (Chan, 2005).

Total AUDIT score was predictive of whether students were in the precontemplation or contemplation stage of change ($B = 0.134$, Wald $\chi^2 (1) = 31.157$, $p <0.001$, OR = 1.143) but not whether they were in precontemplation or action. More specifically, as total AUDIT score increased the chance of being in contemplation
### Table 1: Characteristics of the whole sample and by stage of change

<table>
<thead>
<tr>
<th></th>
<th>Precontemplation</th>
<th>Contemplation</th>
<th>Action</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>224 (51.9%)</td>
<td>122 (28.2%)</td>
<td>86 (19.9%)</td>
<td>439 (100%)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>138 (55.2%)</td>
<td>76 (30.4%)</td>
<td>36 (14.4%)</td>
<td>254 (58.0%)</td>
</tr>
<tr>
<td>Men</td>
<td>85 (47.0%)</td>
<td>46 (25.4%)</td>
<td>50 (27.6%)</td>
<td>184 (42.0%)</td>
</tr>
<tr>
<td><strong>Age (Mean, SD)</strong></td>
<td>20.1 (2.6)</td>
<td>21.2 (3.9)</td>
<td>21.4 (4.4)</td>
<td>20.6 (3.4)</td>
</tr>
<tr>
<td><strong>Degree studied</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Science</td>
<td>55 (57.3%)</td>
<td>28 (29.2%)</td>
<td>13 (13.5%)</td>
<td>96 (21.9%)</td>
</tr>
<tr>
<td>Arts</td>
<td>69 (50.7%)</td>
<td>42 (30.9%)</td>
<td>25 (18.4%)</td>
<td>137 (31.2%)</td>
</tr>
<tr>
<td>Sport</td>
<td>100 (50.0%)</td>
<td>52 (26.0%)</td>
<td>48 (24.0%)</td>
<td>206 (46.9%)</td>
</tr>
<tr>
<td><strong>Year of study</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>127 (52.5%)</td>
<td>65 (26.9%)</td>
<td>50 (20.7%)</td>
<td>245 (55.9%)</td>
</tr>
<tr>
<td>Two</td>
<td>52 (47.7%)</td>
<td>27 (24.8%)</td>
<td>30 (27.5%)</td>
<td>112 (25.6%)</td>
</tr>
<tr>
<td>Three</td>
<td>44 (55.0%)</td>
<td>30 (37.5%)</td>
<td>6 (7.5%)</td>
<td>81 (18.5%)</td>
</tr>
<tr>
<td><strong>Term-time accommodation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>71 (59.7%)</td>
<td>29 (24.4%)</td>
<td>19 (16.0%)</td>
<td>122 (27.8%)</td>
</tr>
<tr>
<td>On-campus</td>
<td>74 (53.6%)</td>
<td>39 (28.3%)</td>
<td>25 (18.1%)</td>
<td>140 (31.9%)</td>
</tr>
<tr>
<td>Off-campus</td>
<td>72 (50.0%)</td>
<td>43 (29.9%)</td>
<td>29 (20.1%)</td>
<td>145 (33.0%)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (22.6%)</td>
<td>11 (35.5%)</td>
<td>6 (7.5%)</td>
<td>32 (7.3%)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>205 (53.4%)</td>
<td>106 (27.6%)</td>
<td>73 (19.0%)</td>
<td>389 (88.6%)</td>
</tr>
<tr>
<td>Black</td>
<td>6 (40.0%)</td>
<td>5 (33.3%)</td>
<td>4 (26.7%)</td>
<td>17 (3.9%)</td>
</tr>
<tr>
<td>Chinese</td>
<td>1 (33.3%)</td>
<td>1 (33.3%)</td>
<td>1 (33.3%)</td>
<td>3 (0.7%)</td>
</tr>
<tr>
<td>Mixed</td>
<td>6 (46.2%)</td>
<td>4 (30.8%)</td>
<td>3 (23.1%)</td>
<td>13 (3.0%)</td>
</tr>
<tr>
<td>Asian</td>
<td>5 (38.5%)</td>
<td>5 (38.5%)</td>
<td>3 (23.1%)</td>
<td>13 (3.0%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (25.0%)</td>
<td>1 (25.0%)</td>
<td>2 (50.0%)</td>
<td>4 (0.9%)</td>
</tr>
<tr>
<td><strong>Total AUDIT score</strong></td>
<td>13.2 (4.2)</td>
<td>16.4 (6.1)</td>
<td>14.0 (4.9)</td>
<td>14.2 (5.1)</td>
</tr>
<tr>
<td><strong>DEQ (Mean, SD)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assertion</td>
<td>3.5 (0.6)</td>
<td>3.7 (0.6)</td>
<td>3.5 (0.5)</td>
<td>3.6 (0.6)</td>
</tr>
<tr>
<td>Affective change</td>
<td>1.9 (0.5)</td>
<td>2.1 (0.6)</td>
<td>2.2 (0.6)</td>
<td>2.0 (0.6)</td>
</tr>
<tr>
<td>Dependence</td>
<td>2.0 (0.6)</td>
<td>2.3 (0.6)</td>
<td>2.1 (0.6)</td>
<td>2.1 (0.6)</td>
</tr>
<tr>
<td>Sexual enhancement</td>
<td>3.5 (0.6)</td>
<td>3.5 (0.7)</td>
<td>3.5 (0.6)</td>
<td>3.5 (0.6)</td>
</tr>
<tr>
<td>Cognitive change</td>
<td>2.1 (0.6)</td>
<td>2.0 (0.6)</td>
<td>2.1 (0.6)</td>
<td>2.1 (0.6)</td>
</tr>
<tr>
<td>Tension reduction</td>
<td>2.8 (0.9)</td>
<td>3.0 (0.8)</td>
<td>2.7 (0.8)</td>
<td>2.8 (0.8)</td>
</tr>
</tbody>
</table>

a = significantly different to action (p<0.05), b = significantly different to contemplation (p<0.05), c = significant association with stage of change (p<0.1), NB tension reduction significantly different at <0.01 but follow up Bonferroni corrections not significant.

### Table 2: Final regression model for the prediction of stage of change

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>SE</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Precontemplation vs. Contemplation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>-2.148</td>
<td>0.400</td>
<td>28.781</td>
<td>1</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Total AUDIT score</td>
<td>0.134</td>
<td>0.024</td>
<td>31.157</td>
<td>1</td>
<td>0.000</td>
<td>1.143</td>
</tr>
<tr>
<td>Year of study: 3</td>
<td>-0.619</td>
<td>0.303</td>
<td>4.183</td>
<td>1</td>
<td>0.041</td>
<td>0.539</td>
</tr>
<tr>
<td>Year of Study: 2</td>
<td>-0.327</td>
<td>0.349</td>
<td>0.876</td>
<td>1</td>
<td>0.349</td>
<td>0.721</td>
</tr>
<tr>
<td>Year of study: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Precontemplation vs. Action</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intercept</td>
<td>-2.446</td>
<td>0.555</td>
<td>19.421</td>
<td>1</td>
<td>0.000</td>
<td></td>
</tr>
<tr>
<td>Total AUDIT score</td>
<td>0.037</td>
<td>0.028</td>
<td>1.786</td>
<td>1</td>
<td>0.181</td>
<td>1.038</td>
</tr>
<tr>
<td>Year of study: 3</td>
<td>0.980</td>
<td>0.470</td>
<td>4.336</td>
<td>1</td>
<td>0.037</td>
<td>2.663</td>
</tr>
<tr>
<td>Year of Study: 2</td>
<td>1.428</td>
<td>0.492</td>
<td>8.412</td>
<td>1</td>
<td>0.004</td>
<td>4.171</td>
</tr>
<tr>
<td>Year of study: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
rather than precontemplation increased.

Year of study was found to be predictive of whether students were in precontemplation or contemplation, with those in year three more likely to be in contemplation than precontemplation than those in year one ($B = -0.619$, Wald $\chi^2 (1) = 4.183$, $p < 0.05$, OR = 0.539). In contrast, those in years one ($B = 0.980$, Wald $\chi^2 (1) = 4.336$, $p < 0.05$, OR = 2.663) and two ($B = 1.428$, Wald $\chi^2 (1) = 8.412$, $p < 0.01$, OR = 4.171) were more likely to be in action than precontemplation than those in their third year.

**Discussion**

In relation to the first aim of the study, to assess levels of readiness to change drinking behaviour in this sample, it was found that 52% of heavy-drinking students were in the precontemplation stage of change, indicating that many students whose drinking is endangering or actually harming their health and welfare fail to acknowledge that there is a problem with their alcohol consumption. This is broadly in line with previous research in the USA (Shealy et al., 2007; Vik et al., 2000). A further 28% of the sample were in the contemplation stage of change and therefore concerned to varying degrees about their drinking but only 20% of this sample were in the action stage and reported taking action to cut down drinking. Despite this overall lack of concern with the negative consequences of heavy drinking in the sample, there was an association between the seriousness of the alcohol use disorder and stage of change, such that those with higher total AUDIT scores were more likely to be in advanced stages of change. Total AUDIT score was a strong predictor of stage of change (precontemplation versus contemplation) after the effects of other variables had been taken into account. Year of study predicted the contrast between both precontemplation and contemplation, and precontemplation and action. Those in year three were more likely to be in contemplation relative to precontemplation than those in year two. In contrast, first and second year students were more likely to be in action relative to precontemplation than third year students. It should be noted that year of study predicted stage of change independently of age. It is possible that, despite being concerned about their alcohol consumption, third year students are less likely to take action to cut down their drinking than those in earlier years because of a preoccupation with preparing for final year examinations. It is also prudent to report that third year students had lower total AUDIT scores than those in years one and two (data by request from the first author). Thus third year students may be less likely to take action to cut down their alcohol consumption simply because they drink less than those in years one and two.

Our findings have implications for interventions aimed at changing students’ alcohol consumption. The majority who are in the precontemplation stage of change may benefit most from interventions designed to raise awareness of the negative consequences of heavy drinking (Caldwell, 2002; Connors et al., 2001; Gretchen et al., 2000; Shealy et al., 2007). While fewer heavy-drinking students in our sample were in the more advanced stages of change with regard to their alcohol consumption, those in contemplation may benefit more from motivational techniques and strategies based on motivational interviewing (Miller and Rollnick, 2002). Those already in action may benefit more from cognitive behavioural interventions aimed at changing behaviour (Conners et al., 2001; Gretchen et al., 2000). A recent overview of stage-based interventions (Heather and Hönnekopp, 2013) concluded that the ‘expert system intervention’ for smoking cessation (Velicer et al., 1993) was supported by robust evidence of effectiveness (eg, Prochaska et al., 2001). This intervention could be adapted for alcohol use disorders and tested among the heavy-drinking student population.

The medium in which these interventions are
delivered warrants consideration. A recent systematic review by White and colleagues (2010) suggests that online alcohol interventions might be particularly useful for groups, such as women and young people, who are less likely to go to alcohol-related services. Online interventions among students have already been evaluated, with promising results (Bewick et al., 2010; Carey et al., 2009; Hustad et al., 2010; Kypri et al., 2013). A refinement of these interventions would be the development and testing of a stage-tailored online intervention programme among heavy-drinking students.

Although this research adds to the knowledge base on readiness to change drinking behaviour among students in England, it is not without limitations. First, owing to the wider aims of the study, the sampling method used in this study was not random and so the obtained sample cannot be considered representative of the student population in England. As such, findings cannot provide a true picture of readiness to change alcohol-related behaviour in the student body in England as a whole. Secondly, although we included a measure of alcohol outcome expectancies in the study, there was no measure of efficacy expectancies, the other crucial variable for predicting movement through the stages of change (Dijkstra et al., 2006). Thirdly, although the Readiness to Change Questionnaire is widely used, it has been suggested that it may be inappropriate for younger drinkers (Carey and Hester, 2009). We propose to investigate this issue by psychometric exploration of the RCQ using data collected in this project and this will form the basis for a further communication.

Acknowledgements
This research was funded by the Alcohol Education Research Council (Grant R07/04).

References

Schools are charged with a responsibility to shape the lives of young people so that they are capable of making responsible and informed decisions which will affect their lifestyle. In the past, schools had taken pride in achieving ‘Healthy Schools Status’ – a nationally-accredited award scheme which rewarded schools’ work on delivering a curriculum embedding pupils’ Personal Social and Health Education with particular work focusing on the core themes: healthy eating, physical activity and pupils’ emotional health and wellbeing.

The impact of the programme was based on a whole-school approach which involved working with children, young people, their families and Governors to provide a solid foundation for improvement. The scheme prided itself that ‘Schools tell us that the National Healthy Schools Programme has brought sustained improvement in behaviour, standards of work and school management.’ (The National Healthy Schools Programme, 2008, p. 4).

When that programme was disbanded in 2011, schools were left in a quandary. Those underlying principles were still held in high regard by many practitioners. Sadly, the national recognition and qualifications schools had worked hard to achieve were no longer recognised or valued. As a practitioner myself, working in a London school in which children came from poor socio-economic backgrounds, I witnessed so much work that had been done to educate families about the importance of the aforementioned four core areas and how this could affect pupils’ learning potential.

Supported by funding from the Local Authority to run healthy eating workshops, we were able to invite nutritionists to work with families – a resource they may not have had access to without the school.

Healthy School’s London

I was delighted to hear, in April 2013, that a programme titled ‘Healthy Schools London’ would be sponsored by the Mayor of London. It echoes similar messages to the previous scheme, but with a slightly heavier emphasis on sports; (unsurprisingly, given the Olympic legacy). The Healthy Schools London scheme sets out to:

- Increase opportunity and participation for children and young people to be physically active in and out of school
- Improve links between schools and communities that promote physical activity
- Increase school meal uptake, including for pupils entitled to Free School Meals
- Improve access to healthy packed lunches and snacks.

Healthy School’s London awards

There are three tiers to the Healthy Schools London award:

Bronze - Supports schools to carry out an analysis of pupils’ needs, to identify actions to help pupils maintain a healthy weight, lifestyle and positive wellbeing.

As part of the Bronze application, seven areas are audited, namely: Leadership, Management and Managing Change, Policy Development, Learning and Teaching, Curriculum Planning and Resourcing, School Ethos, Culture, Environment and SMSC development, Provision of Support Services for children and young people, Staff Continuing Professional Development (CPD), Health and Wellbeing and Partnerships with parents/carers, local communities, external agencies and volunteers to support pupil health and wellbeing. This audit is reviewed by the local Healthy Schools Lead – an effective way of providing an additional point of contact and support for schools. The audit supports schools to identify the need for an underpinning framework (e.g. support from Senior Leaders, policies and staff responsibilities) for this whole-school approach to be effective, as well as acknowledging other schemes with which the schools may be involved (such as: School Travel Plans and Eco
Awards. The audit tool also helps practitioners to identify areas for development which form the basis of the School Action Plan, required for subsequent award qualifications.

Silver - Schools must undertake a needs analysis that identifies action that will help pupils to achieve or maintain a healthy weight, healthy lifestyle and wellbeing. These actions should include one universal action (i.e. that will affect all the pupils in the school) and one targeted action that is aimed at a particular group of pupils in the school. Schools would also need to develop an action plan for how they could deliver these actions, making clear the outcomes that they are aiming for and including milestones by which they will be able to measure progress made.

Gold - Requires schools to evaluate the impact of changes, demonstrate sustainability of the programme, as well as working with the wider community to achieve a healthy weight, lifestyle and/or positive wellbeing.

Themed weeks

Themed weeks, during which pupils are presented with short projects to support them to develop strong cross-curricular links, reinforces the whole-school approach and demonstrates sustainability of the Healthy Schools programme. Examples of themed weeks, held at the School in which I work, have included: Sports Week (linked with the Olympics and our Sports Day), Healthy Eating Weeks, and Environmental Weeks (linked with national events such as World Water Day).

Sports Week - This was a particular success for many reasons. The Olympic Games were being hosted in London and as such many of the children were interested in the news and developments in the preparation for the games. We asked the children to research the values represented by the Olympic rings and looked at the countries participating in the games. We are lucky to have a diverse school community and many of the children were able to recognise flags from different countries, as well as being able to tell us about their memories of their home country. The older children researched the Olympic Games as begun in Ancient Greece and compared the games then and now. The work culminated in a special Opening Ceremony (which was attended by a local member of the community who had been a Torch Bearer) and the children then participated in sports similar to those included in the Olympic Games.

Using our cross-curricular approach to teaching, the PSHE, PE, History, and Geography links are clear. In order to incorporate Literacy into the curriculum, the younger pupils wrote invitations and made posters inviting their family members to come and watch our Games. Some of the older pupils wrote rules for the various sports played, made leaflets about the history of the Games and persuading people to come to our events. The older pupils also wrote scripts for the Opening Ceremony and acted as commentators during the Games.

Similarly, the pupils covered their Numeracy objectives by buying tickets for the Games, working out the number of spectators that could be accommodated on benches (incorporating various calculations), measuring (e.g. the distance javelins were thrown etc.), ordinal numbers used to rank the order of runners in races and recording the number of medals won by each team in tables using tally marks and so forth.

Healthy Eating Week - This was linked with the school kitchens changing the lunch menus. Pupils considered a healthier lifestyle, focusing on healthy eating. The children were asked to design a healthy packed lunch box, building on their work on the food groups, as well as designing a bag in which to carry their lunch. Given that the pupils lunches are often made by a family member, a Coffee Morning Workshop was held to share the work done with pupils during the week. Families were also invited to food tasting opportunities in order for the children to taste the school meals on offer. This helped the school to boost the number of pupils opting for school lunches.

Raising awareness

As far as possible, we try to raise awareness of national days and events, such as World Water Day. We arranged for our Environmental Week to coincide with that date. The children had access to clean drinking water in their classes and in the playground, but we had found that children were wasting water unnecessarily and so education around water wastage was important.

Fortuitously, at a similar time, the local Borough
was introducing a fuller recycling scheme for residents so that food waste, cardboard and garden waste would be collected separately for recycling.

As part of our Environmental Week, we asked the children to consider the importance of recycling, reducing waste (e.g. opting to buy fruits etc. without packaging) and re-using (i.e. re-using items that could have been considered ‘rubbish’ for other purposes). We also invested in a school compost bin and children were encouraged to put their organic waste (from lunch and fruit times) in the compost bin. We re-used empty barrel boxes to collect rainwater which was then used to water the vegetable patch.

Each of these events related back to the standards set out by Healthy Schools London and although the school had not arranged the themed weeks with those standards in mind, they clearly fulfilled the requirements for the awards and most importantly provided a relevant and engaging curriculum.

Visitors are also invited to work with pupils across the school on a regular basis as they help to reinforce and reiterate key messages to pupils in a slightly different medium (e.g. through song-writing sessions, theatre groups who perform shows and lead workshops differentiated to each year group and sports groups (e.g. after-school clubs).

As part of the Bronze application, seven areas are audited, namely: Leadership, Management and Managing Change, Policy Development, Learning and Teaching, Curriculum Planning and Resourcing, School Ethos, Culture, Environment and SMSC development, Provision of Support Services for children and young people, Staff Continuing Professional Development (CPD), Health and Wellbeing and Partnerships with parents/carers, local communities, external agencies and volunteers to support pupil health and wellbeing. This audit is reviewed by the local Healthy Schools Lead – an effective way of providing an additional point of contact and support for schools. The audit supports schools to identify the need for an underpinning framework (e.g. support from Senior Leaders, policies and staff responsibilities) for this whole-school approach to be effective, as well as acknowledging other schemes with which the schools may be involved (such as: School Travel Plans and Eco Awards). The audit tool also helps practitioners to identify areas for development which form the basis of the School Action Plan, required for subsequent award qualifications.

The Healthy Schools London programme continues to be rolled out to schools across the City of London. Healthy Schools London advertise that, “The benefits go beyond health. Participating schools have also reported reduced incidents of bullying, improved behaviour and improved attendance. Headteachers have said that they found the Healthy Schools Programme helpful as a general school improvement tool.”

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**Contributors** (see a recent list) - Do you have up to 3000 words about a relevant issue that you would like to see published? Please contact the Editor
Mindfulness derives from Buddhist practice and is described as “the process of engaging a full, direct, and active awareness of experienced phenomena that is spiritual in aspect and that is maintained from one moment to the next” (Van Gordon, Shonin, Zangeneh, & Griffiths, 2014). In a previous issue of *Education and Health*, we briefly reviewed research findings and discussed the growing interest amongst educational stakeholders into the applications of mindfulness for improving both the health and learning environment of school-aged children (Shonin, Van Gordon, & Griffiths, 2012). For example, mindfulness has been shown to improve levels of anxiety, depression, somatic distress, self-esteem, and sleep quality in schoolchildren with and without a psychiatric history (Biegel, Brown, Shapiro, & Schubert, 2009; Burke, 2010). Mindfulness has also been shown to improve children’s problematic responses to social stress (e.g., thought rumination, intrusive thoughts, emotional arousal, etc.) (Mendelson et al., 2010) as well as teacher-rated classroom social competent behaviours (Schonert-Reichl & Lawlor, 2010). Additionally, there is preliminary evidence to suggest that mindfulness can enhance metacognition and executive functioning in schoolchildren (Flook et al., 2010).

Ten practical tips

Following on from our more research-focussed article, this article provides ten practical tips for the effective teaching of mindfulness by teachers and/or mindfulness tutors to school-aged children.

(1) Make use of meditative anchors: Integral to the success of mindfulness programs for schoolchildren is to familiarise children with the principle and use of meditative anchors. The most commonly taught meditative anchor is that of observing the breath. Full awareness of the in-breath and out-breath helps children to ‘tie their mind’ to the present moment and to regulate thought rumination (Shonin, Van Gordon, & Griffiths, 2013a). Given that concentration capacity is still developing in school-aged children, teaching children to count their breath (i.e., from 1 to 10 and then back again) is normally beneficial. Similarly, children generally find it easier if they are guided using simple and gently spoken phrases such as “breathing in, I am fully aware of my in-breath” and “breathing out, I am fully aware of my out-breath”. Other examples are “breathing in, I am here; breathing out, I am now” and “breathing in, there is nowhere I need to be; breathing out, I am already home”.

(2) Demonstrate how to breathe correctly: When using breath awareness as a meditative anchor, it is very important to discourage schoolchildren from forcing their breathing. In other words, the breath should be allowed to follow its natural course and to calm and deepen of its own accord (Shonin, Van Gordon, & Griffiths, 2014). Forced breathing runs contrary to the general principle of meditation which is that tranquillity and wisdom are naturally present in the mind and will arise of their own accord when the correct conditions come about (Dalai Lama, 2001). One of these ‘correct conditions’ is simply observing and nourishing the mind through mindful awareness (Shonin & Van Gordon, 2014). A metaphor that might be used to help explain this principle to schoolchildren is that of a garden fish pond – every time the garden pond is stirred or interfered with, the water becomes muddy and unsettled. However, if a
person sits quietly next to the pond and simply observes it, the water becomes perfectly still and clear again.

(3) Use appropriate metaphors: At first glance, many principles relating to meditation might appear to be very complicated and/or abstract – especially to schoolchildren. Indeed, in just the last few years, hundreds of scientific papers have been published attempting to analyse, dissect, and define the mindfulness construct (and mindfulness is in fact only one small aspect of Buddhist meditative practice) (Van Gordon et al., 2014). Despite this, mindfulness (and meditation more generally) is actually a very simple practice that is best understood by utilising a more intuitive rather than academic intelligence. Thus, by applying some imagination, it shouldn’t be too difficult to formulate metaphors that are appropriate for schoolchildren. Examples of metaphors that schoolchildren generally respond well to include likening the practice of mindfulness to: (i) the sun that causes the flowers to grow by simply watching and shining on them, (ii) cats that tend to be more careful and deliberate in their movements as opposed to dogs that are often less gentle and composed, (iii) a graceful swan that is confident and elegant in the way it moves and that glides effortlessly through the water without disturbing it too much, (iv) the gatekeeper to a city who lets those with good intentions in (i.e., wholesome thoughts and emotions) but asks troublemakers (i.e., negative/maladaptive thoughts and emotions) to pass on by, and (v) a baby that having just put down a toy or another object, picks it up again a few seconds later and treats it as if it is an entirely new and fresh experience. Of course, a metaphor that is suitable for one group of children may not work well for another group. However, the ability to formulate suitable methods of explanation for schoolchildren will certainly be helped by teaching mindfulness from an experiential standpoint rather than solely from a manual.

(4) Teach mindfulness from an experiential standpoint: In our teaching and research of mindfulness and meditation, something that we have continuously observed is that children (and adults too) are sensitive to the extent to which the teacher is able to impart an embodied authentic experience of mindfulness. Put simply, if the person teaching mindfulness is on some kind of spiritual trip, or their mindfulness experience is limited to information they have derived from reading a handful of books or attending a few mindfulness retreats, then children tend to notice this and become less receptive. Conversely, a teacher who is ‘well-soaked’ in meditation is able to teach from a more experiential standpoint. They naturally exert a reassuring presence that helps schoolchildren to relax and connect with their own capacity for cultivating meditative awareness.

(5) Introduce children to mindfulness at an early age: In our previous mindfulness article in *Education and Health*, we touched upon an ongoing debate amongst scientists regarding the most appropriate age to teach mindfulness to children. For example, some scholars believe that children (from a developmental ability standpoint) can be taught mindfulness from around 7 to 8 years of age. Others are of the opinion that a child’s concentration span is too underdeveloped at this age and that mindfulness should not be taught to children until they are in their early teenage years (see Burke, 2010). These different scientific standpoints offer interesting perspectives on the most appropriate time to introduce children to the practice of mindfulness. However, consistent with the pedagogic approach used as part of traditional Buddhist practice, the best time to teach mindfulness to children is right now. In other words, the earlier a child is introduced to mindfulness the better. Rather than the extensive use of instruction manuals, our own view is that the most effective means of introducing schoolchildren to mindfulness is for the teacher to simply be mindful. When a teacher is mindful of their being, when they walk around the classroom and school practicing full awareness of each and every breath and of each and every step, research indicates that the calming presence they emanate helps to improve children’s levels of wellbeing and classroom behaviour (Singh, Lancioni, Winton, Karazsia, & Singh, 2013). As a child observes the teacher having time for life and for other people, and not rushing their lives away, it appears that they begin to understand intuitively what it means to live in the present moment. Thus, although there is undoubtedly a
need for children to receive age-appropriate oral and written instructions on how to practice mindfulness, due to teachers ‘practicing what they teach’ and allowing their own mindful presence to establish an atmosphere of awareness, there may be less of a requirement for mindfulness teaching curricula that are heavily theoretically orientated.

(6) Focus on the integration of mindfulness into everyday life: Although it is unquestionably beneficial for children to meet with the mindfulness teacher regularly, emphasis should be placed on empowering children to introduce mindfulness into all aspects of their lives. Many children find a CD of short, guided meditations to be invaluable in this respect. Where a child’s living situation allows, another effective life-integration strategy is to work with children’s parents and/or caregivers in order to establish a program of at-home mindfulness practice that the entire family can engage with. Our personal preference is do this on a case-by-case basis (i.e., rather than prescribing a blanket amount of formal meditation practice time for all people), and we generally encourage people to try and adopt a dynamic meditation routine. In this manner, children and their parents are dissuaded from drawing divisions between mindfulness practice during formal seated meditation and practice during everyday activities. The purpose of this is to reduce the likelihood of dependency on the need for formal meditation sessions (Shonin, Van Gordon, & Griffiths, 2013b).

(7) Use mindfulness reminders: In addition to the use of a CD and involving parents and/or caregivers, ‘mindfulness reminders’ are a further strategy for helping children maintain mindful awareness during everyday activities. An example of a mindfulness reminder is an hour chime (e.g., from a wrist-watch or mobile phone), that, upon sounding, can be used as a trigger by children to gently return their awareness to the present moment and to the natural flow of their breathing. Depending on their levels of development, some children are able to cope with (or even prefer) a less sensory reminder such as a simple acronym. For example, in the eight-week secular mindfulness program known as Meditation Awareness Training (MAT), children are sometimes taught to use a three-step SOS technique to facilitate recovery of meditative concentration by ‘sending out an SOS’ at the point when difficult thoughts and feelings arise (Box 1).

Box 1. The three-step SOS technique

<table>
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<tr>
<th>Sending out an SOS</th>
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<tr>
<td>1. Stop</td>
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<tr>
<td>2. Observe the breath</td>
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<tr>
<td>3. Step-back and watch the mind</td>
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(Adapted from Shonin et al., 2013b)

(8) Encourage children to assume a correct meditation posture: Although the focus of mindfulness practice should be directed towards its maintenance during everyday activities, short formal daily seated-meditation sessions are an essential aspect of mindfulness training. As part of seated meditation practice, a good physical posture helps to facilitate the cultivation of a good mental posture. The most important aspect of the meditation posture is stability and this can be achieved whether sitting upright on a chair or on a meditation cushion (Shonin et al., 2013b). In the aforementioned eight-week MAT teaching program, the analogy used to explain the most appropriate posture for meditation is that of a mountain; a mountain has a definite presence, it is upright and stable but it is also without tension and does not have to strain to maintain its posture – it is relaxed, content, and deeply-rooted in the earth (Van Gordon, Shonin, Sumich, Sundin, & Griffiths, 2013).

(9) Make things enjoyable and stimulating: As with most activities involving schoolchildren, stimulating and enjoyable teaching methods are integral to effective cognitive development and knowledge acquisition. Accordingly, the following exercises – adapted from our work with children using MAT – are examples of how to cultivate an engaging learning environment for mindfulness education:

(i) Make use of sensory devices such as a meditation gong or singing bowl – the sound can be used to help guide the meditation,

(ii) If the classroom set-up allows, try a game of “alternative musical chairs” – when the music is paused, children stop wherever they are and take a few conscious breaths (in and out) before
walking slowly and in silence towards an unoccupied chair,

(iii) Practice mindfulness outside and/or in nature – invite children to be silent and to become aware of and relax into the sights, sounds, and smells around them,

(iv) Practice walking meditation – invite children to walk silently and at a very slow pace (e.g., 20 steps per minute) whilst paying attention to their breath and bodies, as well as to all of the muscles that are used during the everyday process of putting one foot in front of the other, and

(v) Don’t turn periods of seated meditation into an endurance exercise (i.e., guided meditations of around 2-10 minutes seem to work well for school-age children).

(10) Encourage teachers to practice mindfulness ‘on the job’: Several of the foregoing practical tips have made reference to the importance of teachers coming to some kind of experiential appreciation of the benefits and subtleties of mindfulness practice. However, from the teacher’s perspective, maintaining a regular practice of mindfulness does not have to encroach into busy work schedules. In fact, rather than ‘taking time out’, mindfulness practice really begins when a person gets up from their meditation cushion (or chair) and continues with work and daily tasks (Shonin et al., 2014). So the practice of mindfulness is less about finding the time to practice, and more about simply remembering to engage a mindful attention-set during whatever activity one happens to be engaged in. For example;

- As you read this article, are you fully aware of your breathing?
- As you breath in and out are you aware of the rise and fall of your chest?
- Can you feel the weight of your body on the chair you are sitting on?
- Do you know how you are sitting – is your posture that of somebody who is awake and fully participating in the world or are you slumped right back in your chair?
- Are you fully present as you read this or is your mind already jumping to whatever you will be doing next?

- In short, are you fully aware of each precious moment of your life as it passes?

Developing childrens’ competence in mindfulness requires patience, regular practice, and a teacher with a firmly-embedded and experiential knowledge of mindfulness. With these essential ingredients in place, we believe the above practical suggestions will help to foster a teaching environment conducive to children cultivating aptitude and an authentic understanding of mindfulness practice.

References


Melonie Syrett

PSHE teaching in primary schools: The past, present and the future

I became a Personal, Social, Health and Economic Education (PSHE) co-ordinator in 2003, after completing my NQT year. Like many, I was thrown into the position because it was the only subject leader role going and I was given no support whatsoever. I didn’t know much about it; there had not been any PSHE in my teacher training degree (and there still isn’t now). Speaking to the staff, it seemed that there was no real system for PSHE within the school. There was no prior co-ordinator, no scheme of work, no…well, nothing. At this time, Curriculum 2000 was in place. There was a Programme of Study (POS) PSHE. There was even a Qualifications and Curriculum Authority (QCA) scheme for PSHE. Yet this school, and later I found most schools, had nothing of quality in place.

New to the role and not one for just leaving something, I signed up to a PSHE co-ordinator course. I was instantly inspired by the passionate consultant who ran the sessions. She spoke with such drive, modelled sessions so clearly and communicated the life skills PSHE teaches so profoundly. As I drove home I vowed to improve PSHE in my workplace.

Over the next few years I set to work. I called an amnesty on resources and plans and audited what the school had (which like most schools turned out to be a huge amount of resources) and tried to create something for the school to follow. I introduced a scheme, made it to meet an individual’s needs and able to link the National Curriculum 2000 POS to the topics the school had in place. I made every effort to make it easy to turn into quality units of work rather than blindly following QCA. “Here we go!” I thought. “This is the beginning of the PSHE revolution!”

Deaf ears

Bless me and my youthful outlook! It fell on deaf ears. People just were not interested. All I heard was; “PSHE is NOT statutory.” “PSHE is NOT SATS.” “PSHE is hard to assess and has NO levels attached to it.” “PSHE only has to be reported in the end of year report and that’s basically just a behaviour comment isn’t it?” “PSHE is at the bottom of our list.”

Even faced with such apathy my motivation didn’t waver. I enrolled on the Continuing Professional Development (CPD) accreditation programme (now run by Babcock 4S) and took a module on Sex and Relationships Education (SRE) within the accreditation. This helped me further understand PSHE, the objectives and the theory. I learned a range of teaching techniques such as distancing, grouping, making the session impersonal, using real situations and having clear rules. I was observed by outside agencies and at the end I had a qualification underwritten by Roehampton University, to prove my knowledge, skills and understanding.

I left that school realising that PSHE, at that time, was there, somewhere: usually lurking about in wonderful county-run courses and qualifications far away from classrooms. The school co-ordinator, however, needed the rest of the staff on board for it to be anywhere near the type of quality-first teaching that would make a difference to young people’s lives. There were people in the Local Authority championing it, but really only the co-ordinators in schools seemed interested.

Huge gaps

As I moved on, I strengthened my resolve. It was now 2008. I had joined an ‘Outstanding’ school. Surely a school with a great OFSTED rating would have everything in place! On the surface yes, things ticked along nicely. But once I started digging and looking for all the things a co-ordinator needed I found huge gaps. The behaviour system was excellent. The morale of the children was brilliant. There were many celebrations, religious group visitors and
reflection times. Here and there bits of Social Emotional Aspects of Learning (SEAL) were going on but no one really seemed to understand its relevance and SRE was taught by those who dangerously used humour to mask their lack of subject knowledge.

When you looked at the provision you could see many great things. There was a whole school ethos. PSHE as an atmosphere was great! But there was also a distinct lack of discrete PSHE teaching. The teaching that was going on was littered with subject knowledge faults and teachers used to laugh off questions that children asked. When it was opened up, the raw picture of PSHE provision was actually quite distressing! Also at this time the money set aside for Local Education Authority PSHE courses had been taken away. You were lucky if there was still a consultant that you could speak to when in need.

**Overhaul**

Once again, I tried to overhaul the subject. I introduced a new scheme that was ‘the best available’ following guidance from the PSHE association. I taught the SRE sessions (utilising the BBC’s excellent but now dated Living and Growing DVD) while Year 6 teachers observed, and then over the years we team-taught them. I took over the parent meetings for SRE, which were quite ridiculous affairs, and made them into something that satisfied parent’s curiosity and calmed their fears. I turned PSHE from something that (as all too often was the case) people paid lip service to and made it into something of some stature.

Finally there were lessons being taught in each class using a spiral scheme and Sex Education went on really well, in Year 6. But it still wasn’t a whole-school, quality approach. SRE didn’t run through the school. People were far too scared for that to happen. Assessment for learning didn’t really take place. Teachers taught the given lessons but they didn’t look at their classes needs and personalise the learning. Why? Because PSHE wasn’t statutory. There was no need. People just didn’t give their time to PSHE. They didn’t even have the skills and knowledge to teach it well themselves. I watched in dismay as literacy and numeracy lessons using the new frameworks were being delicately crafted by teachers. I attended In-Service Educational Training (INSET) on Assessment for Learning, on meeting your children’s needs, on differentiation, on targeting… all geared just to the core subjects.

By now, I had been in charge of PSHE for 9 years. In each school I had worked in, and when talking to other co-ordinators, the picture had been similar. In fact, the schools I had been in had been better than other colleagues’ provision and that is scary! When I joined my current school in 2011, an inner London school in Special Measures, I instantly noticed something completely different to my previous experience. In my summer holiday, I was contacted by the previous co-ordinator. She wanted to share her action plan, tell me her provision and show me the assessment procedures the school used! There was a scheme in place! SRE ran through the school! There was also a complicated assessment tracking system, but a tracking system no less! I held a little flutter of excitement in my heart but didn’t allow any more than that. I knew what I was likely to find.

**PSHE as a core subject**

This time my pessimism was unwarranted! Gradually, as I met with the headteacher, I began to notice that she regarded PSHE as a core subject. She had turned the school around from being in special measures by firstly implementing PSHE across the school. She looked at the relationships the staff had with the children, parents and each other. She looked at how conflicts were resolved, how difficult situations were approached and how people spoke to each other. She created a whole-school approach. A kind of PSHE-based atmosphere. She implemented a yearly programme of SEAL at the school! There was a scheme in place! SRE ran through the school! There was also a complicated assessment tracking system, but a tracking system no less! I held a little flutter of excitement in my heart but didn’t allow any more than that. I knew what I was likely to find.

I set to work. There was already a spiral SRE scheme in place (from reception to Year 6!), so I introduced the spiral scheme I had used for other themes in PSHE. I led INSET and modelled teaching sessions. I showed how to plan for PSHE, how to assess PSHE and how to provide personalised learning. I taught SRE at Year 6 and provided support to others. I taught teachers how to use distancing techniques if they didn’t know an answer or were worried about answering questions. I wrote a clear
policy for both PSHE and SRE that detailed exactly HOW we taught and WHY we taught that way. The difference here was that the headteacher wanted this to happen and actively, publicly supported it.

We decided to sign the PSHE Association’s School Charter for PSHE. (PSHE Association, 2014) We displayed it prominently in the reception, announced it in the school newsletter and used the logo on our website and letter heads. During INSET, I explained the impact that signing the charter would have on the school. How it meant we were a school that was working towards outstanding PSHE provision. It gave me extra ‘oomph’ in developing provision school wide.

Knowing full well that PSHE was fully supported in this setting, I approached the headteacher about going for the PSHE Association Chartered Teacher award. I researched the standards that I needed and recognised that I had much of the knowledge and evidence to hand. She agreed! I took time to collect evidence from files and observations I already had and did a little extra research in areas I needed updating. I built my file and presented it to the Head. She asked me questions to check my understanding and asked me to talk her through different pieces of evidence. She then booked a time to observe me to see this theory in practice. We then signed the forms and sent it off to the PSHE Association.

Chartered Teacher

Since receiving the Chartered Teacher award, my personal PSHE career has gone from strength to strength. The PSHE Association announced my achievement on their website and Twitter and also the school celebrated the award. Shortly afterwards, we were invited to present to the All-Party Parliamentary Group for Children at the House of Commons. There were over 20 people in the public gallery, many of importance to PSHE in schools and in the wider community. People began to ask me questions to find my professional opinion! I later returned to the House of Commons after being invited by an MP, present at that meeting, to pick my brains on PSHE.

Since 2011, PSHE has evolved in my current workplace. It is no longer something teachers ignore. PSHE is everywhere. Our whole school assemblies focus on a PSHE theme each half-term. There are displays around the school. PSHE is assessed at the beginning and end of each unit at least. Lessons are scheduled per week, in half-termly themes through a spiral curriculum, from Reception upwards! Year on year, our children build on their knowledge. Staff are more knowledgeable. INSET and training takes place. Teachers know who to go to and they know that they are getting good advice. They have the opportunity to see good practice in action and have their lessons jointly planned if they feel less than comfortable. We have parent meetings each year for SRE at their child’s maturity. They know they are listened to. The parents know what we are teaching. I am visible as the co-ordinator; people have a face that they can go to. Our PSHE goes wider than just the school – we have links with the local library, we have celebratory assemblies and put on productions and enterprise fairs which are open to the local community.

We have had many visits to view our PSHE provision and to discuss what can be done to improve PSHE in schools. I’ve hosted a Baroness, an MP, the curriculum leader of the DfE and the subject leads from the DfE. I’ve supported other school teachers in their provision. We have a CPD programme of observations of quality-first PSHE teaching. I’ve also developed resources for the PSHE Association.

Joining a school with PSHE at its heart and becoming a Chartered Teacher of PSHE has enabled me to bring PSHE out into the open. It is a visible subject in the school. Being the co-ordinator has changed. Rather than slowly making a tiny difference to the provision in my workplace and facing an uphill struggle, I am now co-ordinating an active subject. My knowledge and skills are valued and respected by a growing community. I am part of a wider community of people passionate about PSHE and my work has been greatly enhanced.

But I am one drop in the ocean. I have fallen on my feet in a place that puts PSHE on a pedestal and realises the effect that a whole school PSHE approach and discrete, tailored, quality first PSHE teaching can have on an institution. There are more of us out there. I know this from the workshops and meetings I attend. There are people who value PSHE.
Similarly, there are teachers on that first step, just where I was, 10 years ago. They still fight to have their voices heard. They still push to get time in a staff meeting or to get a PSHE scheme taught in their school and in some cases PSHE provision has not moved forward in a decade.

**The future**

And what about the future? Well our Education Secretary has managed to take us down from having guidance in the National Curriculum 2000 to having the measly phrase ‘All schools should make provision for personal, social, health and economic education (PSHE)’ (DfE, 2013). Well thanks for that, Mr Secretary. We ‘should’ be teaching PSHE and SRE. We don’t actually ‘HAVE’ to, but just should.

Confusingly, OFSTED will actively look for it in their inspections. In a report published in 2013, it was stated that there was ‘a close correlation between the grades that the schools were awarded for overall effectiveness in their last section 5 inspection, and their grade for PSHE education… All but two of the schools graded outstanding at their last section 5 inspection were also graded outstanding for PSHE education and none were less than good’ (PSHE Association, 2013).

So, what do we do? In a world where social media seems to be cultivating cyber bullies, alter egos, ridiculously posed or Photoshopped selfies and grooming, in a world where terrorism is always on the tip of people’s tongues, in a world where 11-year olds become pregnant and keep it secret until it is far too late (Daily Mail, 2014), in a world where we are constantly barraged with sexual references, images, storylines and vocals, in a world where pregnancy is disposable in the pursuit of fame (Metro News, 2014), in a world where gang culture is on the rise, in a world where readily disposable credit and payday loans are on the uptake… in this world, today’s world, where Personal, Social, Health and Economic Education ‘should’ be being taught. It just does not add up.

I worry for the state of PSHE. I worry that it will take something horrendous to wake up those that rule our education system. We are just not literacy and numeracy drones. We interact with people daily. We meet people, we fall in love, we might have children, and we need to budget and save and interact with others. We need to know who to turn to for help. We need to care about ourselves. PSHE should be statutory. It isn’t a soft subject of skills that you can learn by osmosis. It needs to be actively taught and taught well.

In the wider scheme of things – even if the government won’t give us new guidance on PSHE, there are now new POS developed by the PSHE Association (PSHE Association, 2013a). Resources exist for people to bring their PSHE teaching into the 21st century. DfE 2000 guidance is just not relevant anymore. It’s 14 years old.

**In an ideal world**

Looking to the future, in an ideal world PSHE in schools would be statutory. It would make it something that HAD to be taught in schools. But by no means does that create the conditions for amazing PSHE education. It needs to have high status in schools. Co-ordinators need to have training by passionate PSHE trainers so that they come away with fire in their bellies ready to share the importance of PSHE with their staff. Headteachers need to see the impact high-quality, school-wide, PSHE has on their students and to cultivate this with their staff.

There should be an expert in each school or at least in each cluster of schools that can support, model and help craft PSHE in each environment. Every school needs someone on the ground who works tirelessly to improve PSHE in their workplace; someone who can train, motivate and monitor PSHE throughout the school, making changes where necessary. Each school needs someone who meets with parents and helps them to understand the curriculum and can help to quell their fears and understand that it is maturity relevant content for their children.

If this was the case….and it started tomorrow, in 7 years’ time some really confident, knowledgeable young people would be going to secondary school, ready to face the pressures of teenage life and adulthood. They would be ready for the next stage of PSHE and if the same kind of passion went with the children to the end of their educational days we would have wonderful young adults being let loose in society. They would assess risk, resist peer pressure, and know who to go to when they needed help. They would value themselves and
Attracting contributions from around the world, 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 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