School problems
There has been a marked rise in worry about school work since 1996. Mother and father are the most common source of support.

Money problems
Around 50% would talk to their mother and father.

Health problems
Almoast half the males would turn to mother and father, but mother is the most frequent choice of the females.

Career problems
Mother and father are the most likely source of support and the school teacher plays a stronger part for older pupils. 20% of females would turn to their mother.

Friend problems
Gender differences are pronounced. More males say mother and father, or "would keep it to myself." More females say mother. A similar proportion, however, would share the problem with another friend.

Family problems
Females are twice as likely than males to turn to a friend. Males are more likely to go to mother and father or "keep it to myself."

Gambling problems
Around 25% would keep it to themselves.

Self-esteem
The level of self-esteem tends to increase with age. The "high" group included more males than females.

Control over health
The majority feel they are in control of their health. At least a quarter do not think they can influence their health by their own efforts.

Getting on with adults
Up to 55% see "getting on" with both parents. Older pupils have a more mature view of parents. Roughly 60% of the 16-17 year old males say "no" or "not sure".

Life satisfaction
Males are more satisfied than females. This difference is in line with evidence that males worry about more things than females.

Transmitting HIV
Sharing needles and unsafe sex are correctly seen as the top risks. Within each year group, the females' "knowledge is more accurate than the males."

Information about HIV
TV programmes and school lessons are the most widely mentioned useful sources.

Precautions against HIV
More males than females say they will not take care of getting infected with the HIV virus. Nearly 20% of the 15-17 year old males say "no" or "not sure."

Birth control services
42% of the 16-17 year old females know about the service for young people, and knowledge grew with age. 59% of the older males did not know of a source of free condoms whereas two-thirds of the females said they did know.

Lifting the Lid on Underage Drinking
Recent research about underage drinking has been released by the Home Office. 'Underage Drinking: Findings from the 1998-99 Youth Lifestyles Survey' involved a sample of 1,790 young people aged 12-17. The 'Social Contexts of Underage Drinking' involved a sample of 135 young people. The findings showed that frequent drinking was more common amongst offenders aged between 12 and 17. Also, among parents with the highest level of drinking (three or more times a week), 31% had children who drank frequently. Among parents who had never drunk, only 10% had children who drank frequently. Other findings revealed that ethnic minority teenagers were less likely to say they drink alcohol. Drinking behaviour, amongst one sample of 180 young people, was found to be dependent on a number of factors, including age, gender, local culture, family background, religion and ethnic identity. Further details from the Home Office Press Release 29H2000. For copies of the reports telephone 0207 273 2084

The primary and secondary school HRBQ have evolved since 1976. Data from 530,000 pupils between the ages of 6 and 18 are stored in the databanks.

John Balding
The Health Related Behaviour Questionnaire
What are you people in your area up to?

The Health Related Behaviour Questionnaire (HRBQ) was first developed in 1976 as an outcome of researches within the Department of Community Medicine at Nottingham University.

My research in Nottingham led to the development of a curriculum planning method called 'Just One Minute', through which schools could consult parents, teachers, and the children to discover priorities for the social education programme in their schools. The Open University later adopted this as part of one of its courses, and in the early 1990s the method was revised and updated to form 'Just A Tick', which was used also with governors and health care professionals.

I have always felt great sympathy and admiration for the large number of teachers who care so much for the wellbeing of their pupils. They are so keen to guide them away from dangerous pitfalls. My observation has been that the motivation for much of their efforts has often arisen from the distorted media reporting of excessive behaviour. This 'bad news' takes on the status of what is normal, and not only do teachers have a distorted view, but so do the youngsters.

The Health Related Behaviour method arose from my belief that if teachers could be more accurately and reliably informed of their pupils' behaviours, they would be better equipped to support them in their classes. What is now "knowledge" is that from the earliest surveys in the late 70s and early 80s, the data returned affected timing, content, and existence of health-related lessons.

First developed in 1976 in Nottingham

Today the HRBQ is used widely across the UK and provides baseline data to identify priorities for health education planning, assessments and intervention programmes. The funders of the surveys are usually Health or Local Education Authorities. Survey results are returned to the funding authority as well as individual schools following their own report.

Secondary schools
The HRBQ has been used in nearly three thousand surveys in secondary schools in the UK. It has also been used overseas. Across a period of more than 20 years the method surrounding its use, together with its content, have evolved against the demands of the users. In the early years these were mainly teachers, but within the last decade the medical profession has
became more and more involved in shaping the content against the demands of ‘Our Healthier Nation’ White Paper and to meet the concerns of the National Healthy School Standard. Similarly, from within schools there has been the pressure to produce information that can fit within National Curriculum targets when fed back as results.

Current secondary version

Since its origin, the HRBQ has been regularly revised and improved, and is now in its 21st version. It contains the following sections:

1. Personal background: age, family structure, ethnicity, home background, self-esteem, feelings of control, personal safety, height and weight
2. Nutrition: lunch and breakfast, frequency of consumption of list of foods
3. Drugs: Smoking, alcohol, other drugs
4. Hygiene: medication/ dental, frequency of use of medication, relationship with GP, dental hygiene, health problems
5. Relationships: mental health, HIV, ‘never say never’, problems and sources of support, HIV knowledge & precautionary intentions
6. Leisure and money: leisure activities, income, money spent, National Lottery, Instant scratchcards, money saved
7. Exercise: frequency of involvement, feelings about fitness & exercise, cycling training & safety, accidents

Primary schools

The primary-school version of the HRBQ was introduced in 1988 after many requests by primary school teachers for an inquiry instrument similar to that available in secondary schools, but appropriate to the primary school age range. It is well known that several important health-related issues (such as diet, physical activity, self-esteem, drinking and smoking) have their roots in the early years. Primary school children are often highly receptive to ideas presented by their teachers. However, the staff may have little idea where intervention is needed and at what age it is most appropriate. Introducing the questionnaire also raises interest in the topics and can begin to generate a health education agenda even before the results are returned.

Current primary version

The primary-school HRBQ is now in its 9th version, having gone through a process of evolution and thorough scrutiny from teaching and medical professionals alike, similar to that received by the secondary-school version.

Pupils aged 7-11 anonymously complete the questionnaire in school. It consists of 50 questions within 12 short sections:

1. You and your home
2. Your health
3. The food you eat
4. Feelings
5. Your money
6. Hygiene
7. ‘Balances’
8. Alcohol
9. ‘Stranger danger’
10. Smoking
11. Leisure time
12. Growing up

The questionnaire has been used by groups of schools supported by LEA or Health Authority funding. Collective study of the results by teachers from the schools is particularly valuable, and repeated surveys can track trends and changes.

Many of the 50 questions are directly compatible with those in the secondary school version. This makes possible a unique longitudinal study, whilst maintaining continuity of the data across the primary-secondary age ranges.

After the Survey

The Health Authority or LEA funding the survey will receive a bound volume of the combined results, together with a number of other services. These include comparing the combined survey data with SHEU’s unique databanks which hold HRBQ results from nearly 300,000 pupils. Individual schools involved in the survey also receive a bound volume of results together with a number of other services.

- ‘After the Survey’ is a substantial volume of information on the potential, for schools, staff, parents and government, use of the survey results. This collection of examples of good practice is the outcome of 20 years of evolution and repeated use of the method in schools. The manual shows how specific questions link with National Curriculum requirements, and gives examples of the use of the data in health education programmes across the curriculum.
- The ‘School Report’ presents the principal findings from the survey, with commentary on selected questions.
- The ‘Health Risk Appraisal’ shows the results of the Health Risk Appraisal calculations for individual boys and girls. PINs are used to ‘feed back’ data to individuals, so protecting their identity.

‘Pyramids’

The pyramid model involves co-ordinating HRBQ surveys in secondary schools with HRBQ surveys in their ‘feeder’ primary schools. Each secondary school, together with its cluster of feeder primary schools, is termed one ‘pyramid’. Much of the resulting data may be linked, revealing patterns in health related behaviours of young people between the ages of 9 and 16 within their shared communities. Schools can reach out for help with health issues, and the opportunity is provided for outside agencies to offer support.

The pyramid model provides a detailed evaluation of current health related behaviour of pupils in primary and secondary schools, placed in the context of their social environment. Survey data can also be separated into GP practice for analysis at local level. Pyramid surveys provide opportunities for linked schools to work collaboratively, and enable the tracking of pupils from primary school into secondary school.

Repeat surveys

Strategic planning of repeated HRBQ surveys provides information whereby potential partners may monitor changes in health related behaviour patterns for their area. A sampling strategy which aims to achieve a repeat survey after an interval of two years requires that alternative years groups are sampled, so that the repeat survey will catch the same groups at a later stage of their development.

Using HRBQ data

The survey data enables schools to review the content and timing of their current PSHE curriculum. This enables them to target appropriate teaching according to need to correct age groups. Current advice on good practice in PSHE programmes stresses the need that teachers must begin with what pupils already know. Although they will be able to gain a sense of this through discussions with pupils, the HRBQ is confidential and anonymous and undoubtedly will elicit information which would not offer within an open discussion.

The Schools Health Education Unit has developed and published a set of primary school classroom resources entitled ‘Preparing for Life after Primary School’. These materials have been developed in consultation with primary school teachers, they have benefited from responses from advisers and inspectors, and they have undergone much trialling within primary classrooms. They are designed to enable teachers to begin with pupils’ current knowledge and experience, through looking at survey data and discussion, and then develop appropriate attitudes and life skills to prepare them for the years ahead.

The HRBQ has seen many developments and remains a rich instrument. Health Authorities and schools continue to use it, resulting in a greater understanding of young peoples’ health-related behaviour. Many positive outcomes have been achieved including the establishment of behaviour levels of defined groups of young people at any particular time, and effective intervention programmes. The continued use of the HRBQ ensures that this important work carries on.