One child in ten at school in the UK today suffers from a serious mental health problem. These are not minor difficulties; rather, they are enduring problems that interfere significantly with children’s ability to go out and have friends on a day-to-day basis. Moreover, as many children again are likely to be suffering some less disabling form of distress; their problems may not be so visible, but they could easily become so.

Or to look at these statistics another way, in a school of one thousand pupils, around 50 students will be seriously depressed with a further 100 suffering significant distress; and between five and ten girls will have an eating disorder. Of course, other children will have other problems.

These statistics will surprise people working in health promotion. Over the last decade, there has been a steady shift towards greater understanding of the importance of mental health. But the statistics also underline how vital it is for all agencies working with children to take seriously the promotion of emotional as well as physical well-being.

Breaking barriers

YoungMinds is the national charity committed to improving the mental health of all children and young people. We believe children’s mental health is everybody’s business, that the prevention and treatment of problems are the concern of a wide range of agencies and professionals.

Above all, we are committed to a broad definition of mental health – one that emphasises emotional and physical well-being, and children’s capacity to develop, learn and overcome problems. Our definition is based on that of the World Health Organization, which suggests health is much more than “merely the absence of disease or infirmity.”

Our work reflects our commitment to promoting mental health as a genuinely multi-disciplinary enterprise, and our unique, news-driven magazine is a key instrument in that. YoungMinds Magazine is committed to breaking down barriers between agencies and professional groups by communicating news and information in a lively, intelligent, informative and, above all, accessible way. Each 96-page issue is packed with 15 pages of news, extensive parliamentary coverage and extended features on research and innovative ways of working.

Recent features

Over the last six months, features have included researcher Cathy Street writing on girls and school exclusion. She described how many of the difficulties girls face are likely to be hidden from teachers and other professionals, leading to “unofficial exclusion.” A persistent theme was how the emphasis on helping boys at risk of exclusion has led to a dearth of provision for girls.

In a separate article, Julia Brannen and Ellen Hepworth of the Thomas Coram Research Unit summarised their research into how children view family life and parental responsibility. All children were clear that parents committed to spending time with them at the children’s home thought that having children in the children’s home, however brief.

Elsewhere, we have carried a cogent (if provocative) personal opinion piece arguing that all children should be allowed to learn at their own pace; in other words, anywhere but school. And in our most recent issue.

Reviews

Our lively reviews section has included Nick Hornby on Chris Ware’s White Teeth: Prize winning, Jimmy Corrigan: the Smartest Kid on Earth, as well as reviews of films, plays, exhibitions and a diverse range of books of interest to professionals working with children.

YoungMinds Magazine has received plaudits for the comprehensiveness and diversity of its coverage. Sir William Utting recently said: “YoungMinds Magazine is excellent. It is refreshingly eclectic in approach, providing authoritative coverage of all social topics and professional activities that are relevant to children. It is a source of invaluable information, attractively presented. Everyone concerned with children or with mental health ought to read YoungMinds Magazine.”

YoungMinds Magazine is published six times a year; annual subscription costs £25.

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A game, for parents and young people, is used as a resource for teaching Sex and Relationship Education, and, is described with reference to strategies to reduce teenage pregnancy rates.

Viv Crouch

Teenage pregnancy, better prevention and a sexual health game for young people

The role that the school nurse might play in reducing rates of pregnancy in relation to Government strategy.

In June 1999, the UK Government launched the Social Exclusions Report on Teenage Pregnancy.3 Teenage pregnancy rates have been a concern for UK Governments for the past two decades. In recent years these rates in the UK have remained consistently above most of our European neighbours, 3 times higher than France and 6 times higher than Scandinavia. The Social Exclusion Unit (SEU) undertook a detailed analysis of the problem and recognised that teenage pregnancy was both a cause and a consequence of social exclusion. Other evidence also suggested that teenage pregnancy had serious health and social consequences for teenage mothers.

The SEU has set an overall national target to halve the rate of conceptions among the under 18 years old by 2010. To achieve these goals a comprehensive cross Government Teenage Pregnancy Strategy was launched by the Teenage Pregnancy Unit. The action for achieving the goals falls into four categories: “a national campaign”, “joined up action”, “better prevention” and “better support”.

This article will focus on ‘better prevention’, the role of the school nurse and describe one resource used for Sex and Relationship Education (SRE).

Local pregnancy co-ordinator

Every local authority area in England has been given a specific reduction target to meet by 2010 and are required to appoint a local teenage pregnancy coordinator. The SEU recommended that both local authorities and health authorities should combine to develop a local strategy, and outline a plan showing how they are going to meet their specific target to reduce teenage pregnancies.

In some areas there may exist different opinions as to both the causes and the ideas for prevention surrounding teenage pregnancy, but the overriding consensus is that the trend in teenage pregnancy highlights a problem of socio-economic deprivation. This remains a key factor, both for understanding and tackling the issue.

SRE and promiscuity

Does Sex and Relationship Education encourage promiscuity? It is suggested that children are under increasing pressure to have sex at an early age, and, they are exposed to images and information of an adult nature. They can also be targeted by media campaigns which may contain sexual images that appear to normalise the idea that sexual experience occurs at an early age. However access to information about contraception and sexual health has not caught up with this early exposure to the message of sex.

It is also necessary that there is no empirical evidence to support the argument that SRE encourages early sexual relationships, instead most of the evidence points to the opposite.4 He promotes the premise that young people, who are sexually active before a SRE programme, are unlikely to change their sexual behaviour. He also suggests that parental attitudes can have a serious affect on young people’s sexual behaviour - the closed parental response and just
There is evidence to support the notion that schools who deliver high quality SRE, and have sexual health services available to young people within walking distance of school, have seen a marked reduction in teenage pregnancy. However, Allen suggests that young people’s experience of sex education was, “too late, too little, too biological and, does not address the emotional side.” Naylor strongly opposes all SRE. He is in contention with the findings from the SREU and believes the Unit is a political tool used to discredit family values. He also strongly recommends that parents withdraw their children from all SRE lessons. Naylor has based some of his argument on abstinence education in the USA, where Blake and Francis deduced that there is no clear indication that abstinence education makes any long term difference to young people’s sexual behaviour. They discovered that there has been no systematic evaluation proving the effectiveness of abstinence education, with many of the arguments for it based on moral grounds rather than research based. Statement however, supports the idea that abstinence education should be promoted as sex education and it should be delivered by parents and supported by doctors and not by schools. He also supports an American view that abstinence is the “greatest sexual health promotion behaviour available.” He suggests that the decline in teenage sexual behaviour is due to the availability of contraception and explicit sex education at an early age.

Sexual conduct among young people remains a vigorously debated issue. How should those concerned with sexual health education respond to the issues? Ingram suggests that there is a choice between advocating abstinence or promoting a greater openness in homes, schools, sexual services and other settings in order to improve individual knowledge and skills. The guidance from the DfEE maintains that SRE can and must be based on values of respect and mutuality. Effective SRE should enable young people to understand how to build stable relationships.

Strategy and the school nurse

How does the Government Teenage Pregnancy Strategy impact on school nurse practice? There are some straightforward implications for practice; the strategy recommended that clearer guidelines needed to be given to schools around SRE. The new SRE guidelines recommend that school nurses have much to offer in the delivery of the SRE module. There is also a clear indication that health professionals must maintain confidentiality and give individual advice about sexual health issues in a school setting. “Secondary schools should provide young people with information about the different types of contraception, at sex and how they can access local services for further advice and treatment.” This does give ample opportunity for innovation and scope to work with schools and parents and is an improvement on the previous guidance from the DfEE.

Confidentiality

Why is the uptake of sexual health services for young people so poor? There is some evidence to suggest that the reason they don’t use contraception is because it is in their power to find services, or trust professionals. According to Wardle and Wright, who suggest that regardless of the context in which contraceptive services are provided, young people often find such services inaccessible, unfriendly and lacking in confidence. This view was supported by Jones et al. when looking at how to meet adolescents health needs. The British Medical Association clearly recommends the concept of young people having access to confidential, individual advice and support within school premises. Confidentiality is an issue that is pivotal to providing services to young people, but so often they are let down by adults whom they believe they can trust. A study to discover the attitudes of 15-16 year olds to General Practitioner and nurse consultations and confidential services revealed that a quarter of the 4481 teenagers surveyed believed that their parents would be informed against their wishes. Sometimes the problem of confidentiality is made more complex by the fact that the adults concerned are unclear about their position. Teachers have long been unclear about confidentiality. The DfEE “Sex Education in Schools” (6/1994) circular states that if teachers believe that a child or young person is, or is about to embark on an action that is illegal, including undergoing sexual intercourse, the head teacher should be informed and then the parents.

Mixed message

Even the latest DfEE guidance is ambiguous about this teacher confidentiality problem. It is suggested that schools should have in place a clear and explicit confidentiality policy, which both pupils and parents understand. Many head teachers are still concerned about the implications and it remains their policy to inform parents if they are aware of an under 16 who is sexually active. The guidelines clearly state that “teachers cannot offer or guarantee absolute confidentiality”, this is one of the concerns that teachers have. However, these guidelines also confirm that health professionals can give individual advice about contraception and maintain confidentiality. This mixed message is very confusing for young people to understand.

The issues surrounding confidentiality and the under 16’s appear complex in the school setting, but for health professionals it should be more clear-cut. Joint guidance issued by the Royal College of General Practitioners and, states that, “any competent person, regardless of age, can independently seek medical or nursing advice and give valid consent to medical treatment.” However, this guidance is not clear. Many pupils and young people are confused about whom they can trust when seeking services. A survey of GPs showed that, when asked, “would you routinely inform a 14 year old attended your surgery and asked for emergency contraception,” eight GPs said that they would routinely inform a parent.

The Teenage Pregnancy Strategy document makes it clear that confidentiality is of paramount importance for young people to know that they trust health professionals, including those on school premises. Turnin goes even further by commending to the Cabinet Office, that confidential advice, including full contraceptive and sexual health services, should be available to teenagers on secondary school premises.

Emergency contraception

Is there a need for school nurses to be involved in the issuing of emergency contraception? If the services intentions for a reduction in teenage pregnancy then schools are going to be called on to play a more of an active part.

Conversely members of the Parent Truth Campaign are outraged by the idea that young girls might be given emergency contraception and other contraceptive advice without parents knowing. This group see it as, “an example of the medical profession intruding into the lives of young children, using unacceptable

nurses to dispense dangerous abortifacient and contraceptives.” The campaigns cite the controversy over a school in Derbyshire allowing the school nurse to dispense emergency contraception without parents being informed. They claim that this practice will, “encourage experimentation and say that it seems to mean that schools are making it acceptable to sponsor underage paedophilia.”

This dilemma is also apparent in a debate that has taken place in the House of Commons on July 2001, within the cross-parliamentary pro-life group who have expressed the horror at the widespread availability of the emergency contraception for school age children.

The way forward

Young people’s sexual health appears to be a political ‘hot potato’. If the goals, set by the Government Teenage Pregnancy Strategy, are to be realised, then the research findings must be taken into account and faced head on. Teenage pregnancy is not an easy issue for any government to tackle. It touches on very strongly held beliefs but, according to the SHD, the cost of neglecting the issues are too high.

Barlow suggests that, despite the findings of a recent survey about an increase in the use of condoms, the change is not apparent in attitudes of young people to sex. Teenage people continue to be a climate of fear almost taboo, which acts as a barrier to sensible debate. Despite the prevalence of sexual imagery in the media, society adopts a moral and disapproving tone on sexual matters and frowns upon discussion on sex. Young people quickly learn that the subject is taboo.

Furedi suggests that policy makers and health professionals must decide whether it is young people having sex that we disapprove of, or the adverse consequences of young people having sex, such as teenage pregnancies. She goes on to say that it is important to get that straight and tell young people, ‘if you are having sex have it safely’. From a practice point of view, if that is the message then we must provide the means for young people to be able to do that.
and are more able to contribute to a team situation.
I have been teaching SRE for many years and was always looking for a really good resource to use with year 10 groups knowing that games appear to go down well. Usually in a classroom situation, board games can only be used with a small group and there was a need for something that could be used with a whole class and which still had a competitive element. The game was developed around the use of a dice creating 6 categories, one for each number on the dice. The game takes into account the complexities surrounding young people's sexual health needs and the difficulties that many young people find in being able to express what they want in a relationship. The game involves young people discussing dilemmas, resolving situations as well as working out the consequences of certain behaviours. The class work in groups, which means that individuals don't feel exposed and they can have an opt-out clause.

Development of the game was made possible by an award from the Queen's Nursing Institute which led to extensive use in the class-room and led to it being used successfully with a group of 20 parents at a Sex Education Workshop. With a little adaptation the game can be a useful tool when working with groups of disaffected young people or young offenders. It has now been adapted for use in puberty and growing up sessions in primary schools.

Research & Guidance
When considering the complex nature of the issues surrounding teenage sexuality, it is easy to see why previous efforts to reduce teenage pregnancy have largely been unsuccessful. The research evidence has now influenced the findings of the Teenage Pregnancy Strategy (T75) with its more liberal attitudes. This has, for many workers in the sexual health fields, been a great step forward, but it is recognised for others that it might cause some personal conflict. However, if the T75 is going to be effective then it is vital that all government departments are giving the same message. For schools and teachers, better, less ambiguous guidance needs to be given, as well as a clear statement to health professionals, unless this happens young people will still receive the mixed messages that adults in the past have given. It has become apparent whilst researching this article that to do the TPS justice warrants a much larger piece of work. Poverty, deprivation, low educational attainment, religion and children's rights are issues which are integral, but not mentioned. At some future date this author would like to address these issues and the impact they have on teenagers in Britain today.

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Does sex education in primary schools currently pay too little attention to gender differences in pupils' values and attitudes?

Professor Mark Halstead currently works at the University of Oxford. Department of Educational Studies. Sue Waite is a Research Assistant at the University of Plymouth.

Worlds Apart: the Sexual Values of Boys and Girls

Case studies show remarkable gender differences in the attitudes of 9 and 10-year-olds to reproduction, parenthood, relationships, contraception, and the value of the family.

When the two sexes meet, it is almost like two alien species meeting, very different are their ideals and expectations. So says Jane Root about young adults, and her observations will strike a chord with many of us. But where do these differences come from?

At what age do they develop? And what should sex educators do about them?

This article discusses some of the gender differences which come to light during a small-scale ethnographic research project carried out into the developing sexual attitudes and values of children.

What makes our findings so interesting is that we were not looking for them. The focus of our research was not gender difference, but children's values and the extent to which the values of sex education programmes take account of the existing values and attitudes of children. So we were ourselves surprised at the Gulf which became apparent between the girls and boys even at the age of nine and ten in terms of their developing sexual attitudes.

Background
The research was part of a larger project on ‘Values and Sex Education’ carried out at the University of Plymouth. It involved two primary schools in socially disadvantaged locations in the south-west of England, one a large city school and the other a smaller school on the outskirts of a generally fairly prosperous town. Despite the differences in size and location, we found no significant differences between the responses from the two schools.

We interviewed Year Five pupils (aged 9-10) who had not yet been taught sex education in school. Three or four visits were made to each school, and on each visit meetings took place with several groups of children, each containing six to eight pupils. In the first school all eight classes were involved, and one mixed group were chosen at random from the register. However, the mixed group appeared to be far less willing to discuss issues freely, and at the second school the teacher allocated four single-sex groups. The groupings remained constant throughout the visits to help build up a relationship of trust with the pupils. Each meeting lasted about 45 minutes.

Research Method
An ethical code was devised which clarified issues of confidentiality and anonymity, the provision of information to parents, the obtaining of permission to carry out the research, the right of the child to confines in their class teacher about any issue that was raised, the right to withdraw from the research at any time, and the responsibilities of the researchers if revelations of abuse occurred. In the event, no child withdrew from the research. Detailed advance planning of the activities and research techniques was a further way of reassuring parents, teachers and children about the research, so that they knew precisely what information we wanted, why we wanted it and how we intended to gather it.

Children were seen in groups because this was probably less threatening and would enable them to take a greater lead in the discussions with less input from the researcher. We