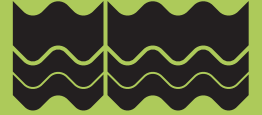




**University of Brighton**

**East Sussex  
County Council**



# Engaging young people to inform health improvement commissioning and delivery in East Sussex



**Nigel Sherriff, Lester Coleman,  
and Chris Cocking**

November 2015

**FINAL REPORT**





**University of Brighton**

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## Contents

|  |    |
|--|----|
| List of tables .....   | 3  |
| List of abbreviations.....   | 3  |
| Acknowledgements .....   | 5  |
| Executive summary .....  | 6  |
| Section One: Introduction.....   | 12 |
| 1.0 Introduction .....   | 12 |
| 1.1 Engagement objectives .....  | 12 |
| 1.2 Structure of the report.....   | 13 |
| Section Two: Methods of engagement and ethical issues.....                 | 14 |
| 2.0 Introduction.....  | 14 |
| 2.1 Engagement framework: participation in programme development .....     | 14 |
| 2.1.1 Involving young people .....   | 14 |
| 2.2 Recruitment strategy and sample.....                                   | 15 |
| 2.2.1 Sample characteristics.....  | 16 |
| 2.3 Methods of engagement.....   | 19 |
| 2.3.1 Participatory focus groups and/or individual interviews.....         | 19 |
| 2.4 Data management and analysis .....                                     | 22 |
| 2.4.1 Data preparation and analysis .....                                  | 22 |
| 2.4.2 Note on the use of data and interpretation .....                     | 22 |
| 2.4.3 Data storage and confidentiality.....                                | 22 |
| 2.5 Research governance and ethical approval .....                         | 23 |
| 2.5.1 Research governance.....   | 23 |
| 2.5.2 Ethical approval.....  | 23 |
| 2.5.3 Ethical issues and procedures .....                                  | 23 |
| 2.6 Timetable for reporting.....   | 24 |
| Section Three: Whole school approaches to health improvement .....         | 25 |
| 3.0 Introduction.....  | 25 |
| 3.1 Awareness and relevance of health in school.....                       | 26 |
| 3.2 Focus on health in school .....  | 27 |
| 3.2.1 ‘Everyone’s business’: health integration and delivery .....         | 30 |
| 3.3 School health-related initiatives.....                                 | 33 |
| 3.4 Making health better in school.....                                    | 37 |
| Section Four: Emotional wellbeing and resilience .....                     | 44 |
| 4.0 Introduction.....  | 44 |
| 4.1 Awareness of resilience .....  | 44 |
| 4.2 Constraints on resilience .....  | 45 |
| 4.3 Individual strategies to cope with stress and achieve resilience ..... | 47 |
| 4.4 Social and/or collective resilience strategies .....                   | 48 |
| 4.5 The role of schools/services in achieving resilience.....              | 50 |
| Section Five: Sexual health improvement.....                               | 53 |
| 5.0 Introduction.....  | 53 |

|   |     |
|---|-----|
| 5.1 Experiences of Sex and Relationships Education (SRE).....               | 53  |
| 5.2 Improving SRE in school: young people’s preferences.....                | 57  |
| 5.3 Views on the ‘Safe Around Sex’ (SAS) programme .....                    | 58  |
| 5.4 Opinions and experiences of using the East Sussex C-Card .....          | 63  |
| 5.5 Communications and campaigns (within and outside school).....           | 66  |
| 5.6 Ideas on positive sexual health and relationships .....                 | 68  |
| Section Six: Recommendations .....  | 70  |
| 6.0 Introduction.....   | 70  |
| 6.1 Recommendations for whole school approaches to health improvement ..... | 70  |
| 6.2 Recommendations for emotional wellbeing and resilience.....             | 73  |
| 6.3 Recommendations for sexual health .....                                 | 76  |
| References .....  | 79  |
| Appendix A: Topic guides.....   | 84  |
| Appendix B: Consent form.....   | 95  |
| Appendix C: Monitoring form .....   | 96  |
| Appendix D: Participant information sheets.....                             | 98  |
| Appendix E: Recruitment flyer.....  | 100 |
| Appendix F: Parental opt-out consent template for schools.....              | 101 |
| Appendix G: Project steering group membership .....                         | 102 |
| Appendix H: Safeguarding protocol.....                                      | 103 |
| Appendix I: Information for gate-keepers .....                              | 105 |
| Appendix J: Governance and ethical approvals.....                           | 106 |
| Appendix K: Thank you letters for recruitment sites.....                    | 108 |

## List of tables

|  |    |
|--|----|
| Table 1: IMD for recruitment sites based on postcode data .....                        | 17 |
| Table 2: Sample characteristics.....   | 18 |
| Table 3: Sample characteristic for whole-school approach topic area .....              | 19 |
| Table 4: Sample characteristic for emotional wellbeing and resilience topic area ..... | 20 |
| Table 5: Sample characteristic for sexual health topic area .....                      | 21 |
| Table 6: Timetable of activities and reporting .....                                   | 24 |

## List of abbreviations

|      |                                    |
|------|------------------------------------|
| BME  | Black and Minority Ethnic          |
| DH   | Department of Health               |
| ESCC | East Sussex County Council         |
| EWR  | Emotional Wellbeing and Resilience |
| HPS  | Health Promoting School            |
| IMD  | Indices of Multiple Deprivation    |
| PSG  | Project Steering Group             |
| PIS  | Project information Sheet          |

|      |  |
|------|--|
| NIHR | National Institute of Health Research            |
| LGBT | Lesbian, Gay, Bisexual, and Transgender          |
| PIS  | Participant Information Sheet                    |
| PSHE | Personal, Social, Health, and Economic Education |
| SAS  | Safe Around Sex programme                        |
| SH   | Sexual Health                                    |
| SRE  | Sex and Relationship Education                   |
| WSA  | Whole School Approach                            |

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## Executive summary

### 1.0 The project

- 1.1 The Centre for Health Research at the University of Brighton was commissioned by East Sussex County Council to: 1) conduct engagement and participation activities with young people across the county, and; 2) support and contextualise the engagement activities by conducting a targeted literature review and synthesis of relevant UK and international research.
- 1.2 Together these activities aimed to provide greater understanding and insight into the views and experiences of young people with regards to both existing and commissioning of future health improvement services and initiatives. The specific topics of investigation included the following three defined areas of health improvement commissioning and/or delivery: 1) Whole-school approaches to health improvement; 2) Emotional wellbeing and resilience programmes, and; 3) Sexual health improvement. This report presents the findings from the engagement and participation activities with young people. A separate companion report presents the findings from the literature review and synthesis (Davies, 2015.)

### 2.0 Methods

- 2.1 The project used qualitative participatory methods to generate primary research data with 97 young people during February-March 2015. A further four young people were engaged as members of the project steering group and another eight young people helped to co-produce the project recommendations. Participants were recruited from different sites (e.g. academies, youth centres, community schools) representing all five boroughs and districts of East Sussex. The sample included a mix of urban/rural sites as well as sites that varied by socio-economic profile. A combination of thematic analysis (focus groups, interviews) and content analysis was used to analyse the dataset.

### 3.0 Main Findings

- 3.1 Findings from the engagement activities on the whole-school approach (WSA) suggest that young people perceive the quantity and quality of personal, social, health and economic education (PSHE) in school as being unsatisfactory. Moreover, attention to health more broadly in school (e.g. school nurse, physical activity, healthy school meals) was perceived to be lacking with young people wanting greater opportunities and strategies to embrace, learn, take control of, access, navigate, try-out, contribute to, and feedback on, health improvement initiatives.
- 3.2 Findings from the emotional wellbeing and resilience (EWR) focus groups demonstrate that most young people are not familiar with 'resilience' as a concept or its potential benefits and/or limitations. Nevertheless, some young people appear to use individual and

collective strategies to achieve resilience in and out of school settings including informal support structures, ‘time-out’, and physical activities.

- 3.3 The main finding in terms of sexual health was that young people perceive Sex and Relationship Education (SRE) provision in school to be inadequate and suggest that it is not taken seriously by schools, teachers or pupils. These findings are particularly important given that trends over the past 20 years show a greater reliance on school lessons for SRE, alongside convincing evidence showing that sexual health education being mainly from school (as opposed to parents or ‘other’) is predictive of positive future sexual health outcomes.

#### 4. Recommendations for whole school approaches to health improvement<sup>1</sup>

- 4.1 Prior to commissioning, the **conceptual complexity of the WSA** approach must be considered along with the substantial short and longer-term challenges that implementing such an approach can raise (e.g. attention to the social and wider determinants of health). Adopting a **long-term commissioning** strategy to support WSA to health is required.
- 4.2 The quantity and quality of PSHE in school was perceived by young people to be unsatisfactory. As a priority, schools should be supported to conduct **whole-system reviews of their PSHE provision** (as well as how health more broadly is perceived, planned for, experienced, and delivered) considering areas such as: Alternative curriculum models for health; mixed modes of curriculum delivery; day-to-day delivery; staff training and development; a review of overt/covert conceptualisations of health; gender (in)equities regarding PSHE and SRE, and; participation in decision-making by young people.
- 4.3 **Traditional views of public health** are apparent in the way some health opportunities and/or initiatives are provided for young people. Attention should be paid to young people’s preferences for moving away from ‘static’ health education and prevention messages to more **health promoting principles** that facilitate young people to reflect, review, touch, experience, understand, debate, and ultimately use, strategies to take control and improve their own health in and out of the school context. This requires re-thinking how health is conceived by the school and its stakeholders as well as in terms of commissioned services.
- 4.4 Young people would like to see **increased opportunities for physical activity** in and out of school including less traditional activities such as opportunities for ‘a kick-about’, skateboarding, and cycling. Commissioning should consider how best to assist schools in realising these opportunities, for example, in extending and widening young person-led provision before and at the end of the school day.

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<sup>1</sup> All recommendations in this executive summary are abridged. Full recommendations are provided in Section 7.

- 4.5 Gender based restrictions on opportunities to participate in sport and physical activity were a barrier to health for some young people. **Gendered barriers to sport and physical activity are unfair**, unhelpful, and outdated and should be reviewed as a matter of urgency against school's gender equity policies.
- 4.6 The **school nurse provision is perceived as 'invisible'** and inaccessible to some young people. Young people reported wanting greater and more flexible availability in terms of access, increased engagement with students to develop relationships, and increased communications regarding location and the range of support offered from early on in their school careers. Improvements in these areas should be implemented before looking at increasing and widening the core school nurse offer.
- 4.7 Views were mixed regarding interest in co-developing **school health plans**. Some young people felt that their voices were not heard; in others where young people had already experienced participation in service development (or similar) and thus narratives were more positive. It will be important for all schools to develop a meaningful **participation agenda to help create a culture** where young people feel connected, are listened to, and believe that their input will make a difference (see 4.9 below).
- 4.8 Concerns over **privacy and lack of confidentiality are key barriers** for some young people in: 1) taking proactive steps to improve their own health, and; 2) accessing health and educational improvement initiatives at school. School policies and training for teachers and other staff may need to be reviewed and/or updated to ensure clarity over the extent of privacy protection possible and the extent and limits (e.g. child protection) of confidentiality when young people disclose/want to disclose.
- 4.9 Commissioning should consider how best to support all schools in East Sussex to develop and embed their own **Health Promotion School Council (HPSC)**. A health promotion initiative in its own right, such councils comprise young people, parent representatives, school staff, representative of the SHS, and where relevant outside agencies to adopt **'whole-school thinking'** to health ensuring that relevant parts of the school organisation work coherently together. HPSCs can help **identify local priorities, needs, develop actions and implement and evaluate change** thus potentially contributing to the required school health needs assessment and school health improvement plan for every school.
- 4.10 Young people did not want their **families involved in health issues**, mainly for fear of confidentiality being breached. However, as noted in 4.9 above, development of a HPSC may help to engage not only young people but also their families in a meaningful and acceptable way.
- 4.11 Given most young people reported being unsatisfied with their school's 'health offer', bringing external (youth-friendly) health professionals from **local community(ies) into school can help both widen and deepen provision** as well as motivate attention to, and reinforce messages, regarding health issues for young people. Whilst some schools already do this it should only be used as useful adjunct to a school's 'formal' health

curriculum and not as a replacement or solitary provision (e.g. drop-down days in some schools).

## 5. Recommendations for emotional wellbeing and resilience

- 5.1 Young people hold **varying degrees of engagement with the term ‘resilience’**. Schools should be supported to engage with the **utility of the concept** including its **potential benefits (and limitations)** located within broader practical, strategic, and conceptual frameworks (i.e. the WSA). This could be achieved as part of whole-system reviews for health in schools (see recommendation 4.2 above; see also Section 6.1 of the main report)
- 5.2 A shared social identity developed through **mutual peer support** appeared to be a strategy for resilience which some young people reported as being beneficial to help them de-stress and achieve resilience. Although the evidence for **peer-led schemes** are somewhat mixed, commissioning could consider how best to support schools in exploring such schemes (e.g. shadowing, mentoring, buddying etc.), and where possible, ensure these schemes are embedded within a WSA structure. Such schemes can be low cost, and may be especially useful in helping students through key transitions.
- 5.3 Schools should be encouraged to place greater attention on the role that **informal social support networks** can play in maintaining young people’s resilience, forming and maintaining social identities, and developing friendship groups to foster mutual support. Such networks may also consider how supportive adults outside of young people’s immediate teaching networks can be potential assets for young people’s resilience.
- 5.4 Where appropriate, schools should consider how to encourage young people to maintain links with **external peer groups and/or extracurricular activities** outside of the school environment that could then be linked into their existing school activities. This could be particularly useful for young people attending specialist schools such as PRUs who may feel disconnected from existing social networks in their former mainstream education).
- 5.5 Young people commonly desired a **physical ‘time out’ space** (or a ‘de-stress room’) that they could voluntarily go to if desired - and that this space should be separate from an exclusion room that they are taken to against their wishes (e.g. ‘isolation’ rooms or similar). However, such provision must be considered within broader support systems and processes of a WSA.
- 5.6 Many young people feel that they are **not listened to** in school environments. Schools should be supported to create meaningful dialogue with young people to help them develop and inform existing and/or future EWR initiatives. It is likely that implementation of a **health promotion school council** (see 4.9 above; see also Section 6.1) may assist in achieving such dialogue.
- 5.7 Young people recognised the importance of **physical activity as an individual strategy** to resiliently cope with stress and ‘self-soothe’. As also emerged in the WSA discussions,

young people report wanting greater opportunities for physical activity in school and that this should include non-traditional activities beyond the usual school gendered sports. This may **require some creativity** to facilitate such activity and ensure equity of access for all young people. However, the importance of such relatively simple and low cost strategies to support young people's individual resilience should not be underestimated.

## 6. Recommendations for sexual health improvement

- 6.1 Young people report wanting **greater attention to SRE in school**, particularly in terms of opportunities to explore the complexities of issues that they can't find out about easily. They also want these opportunities to be **age and gender segregated** as necessary. Schools should be supported to **review the status and emphasis given to SRE** within broader PSHE curricula as well as review links and sexual health opportunities from the school nurse. Linked to the WSA, this review could constitute part of the **whole-systems review** of PSHE provision as recommended in Section 6.1 of this report.
- 6.2 Linking with findings from the WSA, young people report experiencing traditional public health and/or health education approaches to SRE which focus unhelpfully on prevention, avoidance, and abstinence messages. Instead, a **cultural shift is required** which recognises positive individual and social responsibility for sexual health. Re-thinking how health is conceptualised by the school, its stakeholders, and commissioned services (e.g. school nurse provision) is required.
- 6.3 In many cases, young people appear to be aware of their own (sexual) health needs even if they are not sexually active. Young people report wanting **SRE input from when they start secondary school**, in part, to normalise the issues, and then to continue throughout their school career increasing in complexity and depth over time. **Spiral curriculums** for SRE/PSHE may assist in meeting these needs.
- 6.4 Data suggests that there is scope within schools to increase young people's participation in setting and reviewing the agenda for SRE. Convincing young people that their views are valued is a crucial first step. **Health promotion school councils** (HPSC) may serve as a useful mechanism to ensure both formal and informal health curriculums related to sexual health are relevant, up-to-date, appropriate, and informed by young people.
- 6.5 Similar to the WSA findings, some of the dissatisfaction with SRE was related to the specific facilitator and/or provider. Too few staff appear to have the **specialist knowledge required** to teach high quality SRE. As part of whole-school thinking (and review), staff's professional development needs (including their own health and welfare) need to be considered within any provision for young people.
- 6.6 Young people involved in the sexual health focus groups were mostly **not aware of the School Health Service (school nurse)**, its location, resources, or the range of support available. Commissioners could consider how opportunities to engage with the school nurse or an alternative outside of this core offer could be provided (e.g. via anonymous

text messaging service, trained school staff who are regularly on site to support the school nurse's remit). Young people themselves recommended better communication in school regarding the health opportunities available via the school nurse as well as reassurances regarding (and including limits to) confidentiality.

- 6.7 All young people spoken to were **unaware of any local or national sexual health campaigns**. Current communication channels targeting young people thus appear not to be working and ways to remedy this should be a priority.
- 6.8 Young people reported wanting **further information about the C-Card** and the female condom or femidom. Although the C-Card was perceived positively, young people felt that obtaining it was **unnecessarily complex**, and should be more easily available within school settings.
- 6.9 SRE and sexual health improvement initiatives for young people in school **require normalisation** and attention to **reducing associated stigma**. Young people in this study expressed strong preferences to engage in SRE from the very start of their secondary schooling to help reduce stigma and normalise positive sexual health, as well as to **increase their access** to initiatives and services including the school nurse provision.

Engaging young people to inform health improvement  
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# Section One

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## Introduction



## Section One: Introduction

### 1.0 Introduction

In November 2014 the Centre for Health Research at the University of Brighton (UoB) was commissioned by the Public Health department at East Sussex County Council (ESCC) to: 1) conduct engagement and participation activities with young people across the county, and; 2) support and contextualise the engagement activities by conducting a targeted literature review and synthesis of relevant UK and international research.

Together these activities aimed to provide greater understanding and insight into the views and experiences of young people with regards both existing and future health improvement services and initiatives. The specific topics of investigation included the following three defined areas of health improvement commissioning and/or delivery:

1. Whole-school approaches to health improvement;
2. Emotional wellbeing and resilience programmes;
3. Sexual health improvement.

For each of the above three areas, various aspects of young people's views were explored including: their experiences of existing services and potential service developments; what works and what doesn't in service implementation and design; as well as barriers that exist in enabling children and young people to achieve their health and wellbeing potential.

### 1.1 Engagement objectives

The overarching objectives of this project were to:

- Plan and deliver safe, effective, and meaningful engagement and consultation with young people about health improvement services and initiatives in East Sussex;
- Produce a synthesis of key national and/or international research regarding service and outcome areas to give context to the project;
- Produce a synthesis of up-to-date information about young people's views and experiences in relation to health improvement services and initiatives in East Sussex;
- Produce a report with robustly determined recommendations to help determine the acceptability of proposed developments in school settings and help inform the development of health improvement initiatives to be commissioned or provided in future in the context of limited resources.

In the context of health improvement programme development, the engagement activities focused on gathering the views of a wide range of young people attending schools and other sites (e.g. youth centres) regarding:



- The experiences of those currently using / not using services;
- Feasibility and acceptability of proposed/existing services;
- Ideas for potential service or system developments;
- Views on what is effective and important in service implementation and design;
- The barriers that exist in enabling children and young people to achieve their health and wellbeing potential;
- Potential for engaging young people in service design and delivery.

## 1.2 Structure of the report

This report presents the findings and recommendations from the engagement activities conducted with young people (the findings from the literature review and synthesis are provided in a separate companion report; see Davies, 2015).

This report is structured into six main sections as follows:

Following this introduction including the project's objectives, Section Two provides an overview of the methodological approach and specific methods used to carry out the engagement activities. Section Three focuses on the views and experiences of young people with regards to whole-school approaches to health improvement. In Section Four, the views and experiences of young people with regards to emotional wellbeing and resilience are presented. In Section Five, the views and experiences of young people with regards to sexual health improvement are outlined. Finally, Section Six presents the main recommendations of the report to inform commissioning linked to each of the three topic areas.



Engaging young people to inform health improvement  
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# Section Two

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## Methods of engagement and ethical issues



## Section Two: Methods of engagement and ethical issues

### 2.0 Introduction

In this section, details are provided of the methodological framework within which young people were engaged as well as details of how a diverse sample of young people was recruited including basic socio-demographic information on the final sample achieved. Details of the methods used to engage young people are presented alongside issues such as data analysis and storage, as well as governance and ethical issues.

### 2.1 Engagement framework: participation in programme development

The engagement activities in this project were underpinned by an interpretivist perspective using participatory qualitative methods and embracing realist conceptualisations (Pawson and Tilley, 1997) of ‘what works for whom, when, and under which circumstances’. Young people’s active participation in research and engagement is important because it has a number of advantages over more conventional methodologies where young people are frequently excluded. Participatory approaches represent a move away from young people as passive objects of enquiry, and instead move towards a view that young people are social actors with a unique perspective and insight into their own realities (NCB, 2011). Although it is beyond the scope of this report to lay out the benefits of involving young people in research, a participatory approach was appropriate for a number of specific reasons as follows (adapted from NCB, 2011):

- Participatory approaches can help address some of the power imbalances between the researcher and the researched which can be compounded for young people by the adult-child dynamic;
- Involving young people can help ensure that project outcomes and recommendations are more relevant to the issue under scrutiny, are more valid and robust, and can have a greater impact on dissemination of findings (for example being more persuasive for policymakers and practitioners);
- Young people can benefit directly from being involved in research and engagement (e.g. skills, valuable experience, and recognition);
- Young people can help to ensure that the project team remain focused on young people’s perspectives throughout the engagement process as well as offering invaluable insights into ways of collecting data, ensuring acceptability and relevancy of project materials and processes (e.g. information sheets, topic guides, etc.).

#### 2.1.1 Involving young people

Young people were invited to participate in one of three ways: 1) taking part in participatory focus group discussions; 2) being a member of the Project Steering Group (PSG); or 3) a single workshop on the co-production of the project’s recommendations. In terms of the focus groups, young people could participate in small focus groups (and/or individual interviews) during which additional and more creative approaches were also used (see Section 2.3.1 for details). With

regards the PSG, up to five young people over 14yrs could opt to participate as full members of the Project Steering Group (PSG) with decision-making authority. Young people were invited to take part by the University of Brighton (UoB) research team with assistance from ESCC. Invitations were extended to a diverse range of gatekeepers representing organisations including schools and colleges, ESCC and other youth advocacy groups and forums (e.g. East Sussex youth cabinet, Newhaven Youth Forum, ESCC Young Inspectors, LGBT youth groups), as well as other support services such as East Sussex Target Youth Support Service and ESCC Children in Care Council (see Appendix G for the PSG membership).

To ensure participation in the PSG was informed, a specific participant information sheet (PIS) for involvement in the PSG was devised (Appendix D) as well as a project recruitment flyer (Appendix E). Once identified, a member of the research team spoke with the young person directly prior to their confirmed membership. The purpose of this was to provide a 'briefing' on what participation was likely to mean. Based on the principles of the National Institute of Health Research (NIHR) Involve framework, this briefing outlined the following:

- The research process – An outline of the project stages, what is planned to happen, what the project can and can't deliver, and opportunity to answer any questions. This helps young people to be clear regarding what the research is about;
- Other members of the PSG – The names of people who will be at the meetings, what role they will play and why they have been asked to join the group (see Appendix G);
- The limits of what can and can't be changed – Clearly identifying up front what may be negotiable and explaining that the protocol cannot be changed at this stage;
- How decisions will be made in the group – For example explaining that all suggestions will be considered and discussed, but that not all ideas can be taken up.

The PSG met three times over the life of the project. To assist participation, funding was available to support involvement (travel and subsistence expenses alongside a £10 'thank-you' voucher) as well as the opportunity to bring along a worker (e.g. teacher, youth worker, parent etc.). Young people participating as a PSG member also received a certificate of achievement at the end of the project jointly from the University of Brighton and East Sussex County Council. Although not required, a procedure was in place to select members should more young people wish to participate in the PSG than was required. In total, four young people participated in the project as core members of the PSG (see Appendix G).

Finally, towards the end of data generation (March, 2015), young people were invited to participate in a single facilitated workshop on the co-production of the project's recommendations. This was limited to a maximum of eight young people for practical purposes.

## 2.2 Recruitment strategy and sample

Purposive sampling was used to recruit young people to participate in the engagement activities. This means that particular groups of young people were invited to participate based on certain relevant variables such as their age, school year group, gender, and so on. Working collaboratively with ESCC Public Health and other stakeholders (e.g. schools, ESCC partner organisations), attempts were made to ensure that the sample of young people recruited was

diverse; balancing as far as possible factors such as the rural/urban location of recruitment sites including consideration of the boroughs and districts of East Sussex (Eastbourne, Hastings, Lewes, Rother and Wealden), scores of multiple deprivation of recruitment sites, demographic characteristics of young people themselves (including gender, ethnicity, disability, age/year group, as well as where feasible, sexual identity/orientation<sup>2</sup>). A final consideration for the sexual health topic was to identify young people who had/had not attended the ESCC commissioned 'Safe Around Sex' (SAS) programme for targeted schools<sup>3</sup>.

## Recruitment strategy

In the first instance gatekeepers from schools and other services for young people across East Sussex were approached by ESCC during early December 2014 (see Appendix I). Schools/services who expressed an interest in participating in the project were then introduced to the UoB research team who followed up each expression of interest with an on-site visit during February 2015. Following a strategic mapping exercise by the research team to achieve the desired sample variations outlined above, gatekeepers distributed participant information sheets and recruitment flyers (Appendices D-E) to young people inviting them to participate.

As the engagement activities took place, 'young person friendly' monitoring forms were used (Appendix C) to help the research team identify the 'shape' of the sample as it developed. When required, additional strategies were deployed to maintain or increase the diversity of the sample e.g. by focusing sampling in targeted settings such as LGBT groups for young people, and working with school and other gatekeepers to invite alternative groups of young people to participate.

### 2.2.1 Sample characteristics

A total of 97 young people contributed to the engagement activities between mid-February and the end of March 2015 (see Table 1). A further eight young people were engaged through a dedicated workshop on the co-production of the project recommendations. However as these young people did not contribute to the data generated for the three topic areas, demographic are not included in the breakdowns.

Young people involved in data generation were recruited from multiple different types of sites (e.g. academies, youth centres, community schools etc.) representing all five boroughs and districts of East Sussex. The sample included a mix of urban/rural sites as well as sites that varied by socio-economic profile. In total, eight sites were accessed including an academy (30.9% of the sample), three community colleges or schools (45.4% of the sample), two youth centres (14.4% of the sample), a faith school (3.1% of the sample), and a pupil referral unit (6.2% of the sample). Postcode data of recruitment sites were analysed using the indices of multiple deprivation (IMD)

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<sup>2</sup> Although data on sexual identity/orientation was not specifically collected, one of the recruitment sites included an organisation supporting young people who identify as Transgender (Trans).

<sup>3</sup> The SAS programme is a targeted school-based teenage pregnancy prevention and SRE enrichment project. SAS aims to reach young people who are most vulnerable in order for them to access high-quality information in a small group format that raises self-esteem and which positively impacts on their personal lifestyle choices - reducing risky behaviour and increasing their own and others' personal safety.

from the Department for Communities and Local Government<sup>4</sup>. Almost one third (28%) of young people were recruited from coastal sites falling into bands 1 and 2; representing areas of higher than average social and economic disadvantage (Table 1; next page). The remaining proportions of the sample were recruited from bands 3 (41%) and 4 (31%) representing lower levels of deprivation.

|                | IMD Quartile              | Frequency (sites) | % of sample |
|----------------|---------------------------|-------------------|-------------|
| Most Deprived  | Band 1 (1-8120)           | 2                 | 11.3        |
|                | Band 2 (8120-16,241)      | 2                 | 16.5        |
|                | Band 3 (16, 242 – 24,361) | 3                 | 41.2        |
| Least Deprived | Band 4 (24, 362 – 32,482) | 1                 | 30.9        |
| <b>TOTAL</b>   |                           | <b>8</b>          | <b>100</b>  |

Table 1: IMD for recruitment sites based on postcode data

With reference to Table 2 (next page), most young people who participated in the engagement activities were male (n=54 males or 55.7% vs. n=38 females or 39.2%). Five young people identified as being Trans (5.2%). The vast majority of young people (n=85 or 87.6%) identified as White British. This is not surprising given that black and minority ethnic (BME) groups form a lower than average percentage of the population in East Sussex; the sample is thus broadly reflective of the county in this regard (ES-HWB, 2012). Few young people identified as having a disability (n=5 or 5.2%). Most young people were aged 14-15yrs (n=54 or 55.7%) followed by those 11-13 (n=22 or 22.7%) and those 16-17 years (n=19 or 19.6%). In terms of where young people live, partial postcode data revealed that young people were represented from across all five boroughs and districts of East Sussex. Most participants reported living in Wealden (37.1%), closely followed by Hastings (34.0%; Table 2). Further detailed sample break downs are provided by topic area in Section 2.3.1.

<sup>4</sup> Based on postcode data, the IMD provides a score for a particular location. This score is a ranked overall measure of deprivation based on a number of factors such as income, employment, education, health, skills and training, barriers to housing and services and crime. A low score (e.g. 1) indicates greater deprivation whilst a higher score indicates the least deprivation (e.g. 32,482). For the purposes of this report, the IMD scores are categorised into four quartiles to give a simplified depiction of recruitment sites (rather than individual residence profiles).

| Age           | N (%)           | Gender      | N (%)           | Ethnicity               | N (%)           | Disability | N (%)           | Recruitment location* | N (%)           | Type of site             | N (%)           |
|---------------|-----------------|-------------|-----------------|-------------------------|-----------------|------------|-----------------|-----------------------|-----------------|--------------------------|-----------------|
|               |                 |             |                 |                         |                 |            |                 | Borough/District      |                 |                          |                 |
|               |                 |             |                 |                         |                 |            |                 | Town*                 |                 |                          |                 |
| 11-13         | 22 (22.7)       | Male        | 54 (55.7)       | White British           | 85 (87.6)       | Yes        | 5 (5.2)         | Eastbourne (3.1)      | 3 (3.1)         | Academy                  | 30 (30.9)       |
| 14-15         | 54 (55.7)       | Female      | 38 (39.2)       | White & Asian           | 2 (2.1)         | No         | 86 (88.7)       | Hastings (34.0)       | 22 (22.7)       | Community college/school | 44 (45.4)       |
| 16-17         | 19 (19.6)       | Transgender | 5 (5.2)         | White & Black African   | 1 (1.0)         | Unknown    | 6 (6.2)         | Lewes (17.5)          | 11 (11.3)       | Youth Club/Centre        | 14 (14.4)       |
| 18-19         | 2 (2.1)         |             |                 | White Irish             | 1 (1.0)         |            |                 | Lewes (1.0)           | 1 (1.0)         | Faith school             | 3 (3.1)         |
|               |                 |             |                 | White & Black/Caribbean | 1 (1.0)         |            |                 | Peacehaven (7.2)      | 7 (7.2)         | Pupil Referral Unit      | 6 (6.2)         |
|               |                 |             |                 | African                 | 1 (1.0)         |            |                 | Seaford (9.3)         | 9 (9.3)         |                          |                 |
|               |                 |             |                 | Unknown                 | 6 (6.2)         |            |                 | Rother (2.1)          | 2 (2.1)         |                          |                 |
|               |                 |             |                 |                         |                 |            |                 | Bexhill               | 2 (2.1)         |                          |                 |
|               |                 |             |                 |                         |                 |            |                 | Crowborough           | 1 (1.0)         |                          |                 |
|               |                 |             |                 |                         |                 |            |                 | Walden (37.1)         | 5 (5.2)         |                          |                 |
|               |                 |             |                 |                         |                 |            |                 | Unknown (6.2)         | 3 (3.1)         |                          |                 |
|               |                 |             |                 |                         |                 |            |                 | Uckfield              | 27 (27.8)       |                          |                 |
| <b>TOTALS</b> | <b>97 (100)</b> |             | <b>97 (100)</b> |                         | <b>97 (100)</b> |            | <b>97 (100)</b> |                       | <b>97 (100)</b> |                          | <b>97 (100)</b> |

\*Derived from first part of postcode provided by young people

Table 2: Sample characteristics



## 2.3 Methods of engagement

To maximise the potential for diverse groups of young people to engage and express their views, participatory methods were used including focus groups and/or individual interviews (the latter as an ethical alternative to focus group participation when required). In addition, during focus group engagements, additional more creative and interactive approaches were also used to maximise the potential for young people to be able to contribute their views.

### 2.3.1 Participatory focus groups and/or individual interviews

All data collection took place between mid-February and March 2015. Topic guides were developed and agreed with ESCC prior to data collection, and finalised through the PSG which included young people (Appendix A).

*Whole-School Approach (WSA) to health improvement:* Seven focus groups (n=35; or 36% of the total sample) were carried out with young people (aged 11-17yrs) from four recruitment sites across East Sussex lasting for up to a maximum of one hour each. The gender split for this topic area was 60/40 male and female respectively, and all were White British. Most young people were aged between 11-15yrs (n=28 or 80%; see Table 3).

| Age    | N (%)     | Gender | N (%)     | Ethnicity     | N (%)      | Disability | N (%)     | Recruitment Location*         | N (%)                                       | Type of site             | N (%)     |
|--------|-----------|--------|-----------|---------------|------------|------------|-----------|-------------------------------|---|--------------------------|-----------|
| 11-13  | 14 (40.0) | Male   | 21 (60.0) | White British | 35 (100.0) | Yes        | 2 (5.7)   | Borough /District<br>Hastings | 6 (17.1)<br>5 (14.3)                        | Academy                  | 11 (31.4) |
| 14-15  | 14 (40.0) | Female | 14 (40.0) |               |            | No         | 33 (94.3) | Lewes                         | 4 (11.4)                                    | Community college/school | 20 (57.1) |
| 16-17  | 7 (20.0)  |        |           |               |            |            |           | Wealden                       | 1 (2.9)<br>5 (14.3)<br>3 (8.6)<br>11 (31.4) | Youth Club/centre        | 4 (11.4)  |
| Totals | 35 (100)  |        | 35 (100)  |               | 35 (100)   |            | 35 (100)  |                               | 35 (100)                                    |                          | 35 (100)  |

\*Derived from first part of postcode provided by young people

Table 3: Sample characteristic for whole-school approach topic area

To facilitate the discussions and to ensure that they were age appropriate, where possible each focus group catered for a different year group ranging from Year 7 to Year 11. Each group explored the following indicative areas:

- Health topics and issues covered in school including identification of ‘gaps’;
- Health initiatives in-and-out of school, facilities and barriers to access;
- The School Health Service (school nurse provision);
- Ideas for what are the most effective features of service implementation and design (e.g. staffing, accessibility, privacy, location, topic area etc.)?
- Young people’s ideas for new services / initiatives they would most like to see at their school which could help to improve their health;
- The potential for engagement in whole school initiatives/services (e.g. design and implementation etc.).

**Emotional Wellbeing and Resilience (EWR) programmes:** Four focus groups were carried out with young people (aged 11-17yrs) and one individual interview (n=23; or 24% of the total sample) from three recruitment sites. The gender split for this topic area was 47.8% male and 30.4% female respectively; five young people were Trans (21.7%). The majority of young people were White British (n=17 or 74%) with the remainder (six cases) unknown. Most young people were aged between 11-15yrs (n=20 or 86.9%; see Table 4).

| Age           | N (%)           | Gender | N (%)           | Ethnicity     | N (%)           | Disability | N (%)           | Recruitment Location* |                       | N (%)              | Type of site             | N (%)           |
|---------------|-----------------|--------|-----------------|---------------|-----------------|------------|-----------------|-----------------------|-----------------------|--------------------|--------------------------|-----------------|
|               |                 |        |                 |               |                 |            |                 | Borough /District     | Town*                 |                    |                          |                 |
| 11-13         | 7 (30.4)        | Male   | 11 (47.8)       | White British | 17 (74.0)       | Yes        | 1 (4.3)         | Hastings              | Hastings St. Leonards | 1 (4.3)<br>2 (8.7) | Community college/school | 12 (52.2)       |
| 14-15         | 13 (56.5)       | Female | 7 (30.4)        | Unknown       | 6 (26.0)        | No         | 16 (69.6)       | Lewes                 | Lewes                 | 1 (4.3)            | Youth Club/Centre        | 5 (21.7)        |
| 16-17         | 3 (13.0)        | Trans  | 5 (21.7)        |               |                 | Unknown    | 6 (26.1)        | Rother                | Bexhill               | 2 (8.7)            | Pupil Referral Unit      | 6 (26.1)        |
|               |                 |        |                 |               |                 |            |                 | Wealden               | Uckfield              | 11 (47.8)          |                          |                 |
|               |                 |        |                 |               |                 |            |                 | Unknown               | Unknown               | 6 (26.1)           |                          |                 |
| <b>Totals</b> | <b>23 (100)</b> |        | <b>23 (100)</b> |               | <b>23 (100)</b> |            | <b>23 (100)</b> |                       |                       | <b>23 (100)</b>    |                          | <b>23 (100)</b> |

\*Derived from first part of postcode provided by young people

Table 4: Sample characteristic for emotional wellbeing and resilience topic area

As with the WSA focus groups, where possible groups catered for different year groups, and lasted for up to a maximum of one hour each. Each group/interview explored the following indicative areas:

- What factors help or hinder young people to cope, prevent stress and overcome difficult times?
- What are the factors and features of school that help or hinder young people to cope, prevent stress and overcome difficult times?
- What do schools do to help young people to cope, experience less stress and overcome difficult times?
- What are the most important things schools could do to help young people to cope, experience less stress and overcome difficult times?
- How do young people understand whether measures which seek to help them cope, experience less stress or overcome difficult times have been successful?
- What would coping better, being less stressed or overcoming difficult times look like? How would it be described by young people?

**Sexual Health (SH):** Eight focus groups (n=39; or 40.2% of the total sample) were carried out with young people aged between 11-19yrs from six recruitment sites across East Sussex lasting for up to a maximum of one hour each. One quarter of these young people had experienced the targeted ‘Safe Around Sex’ programme (n=10 or 25.6%). The gender split for this topic area was relatively even with 56.4% (n=22) male and 43.6% (n=17) female respectively. Most young people were White British (n=33 or 84.6%), and the majority were aged between 14-15yrs (n=26 or 66.7%; see Table 5).

| Age           | N (%)           | Gender | N (%)           | Ethnicity         | N (%)           | Disability | N (%)           | Recruitment Location* |              | N (%)           | Type of site             | N (%)           |
|---------------|-----------------|--------|-----------------|-------------------|-----------------|------------|-----------------|-----------------------|--------------|-----------------|--------------------------|-----------------|
|               |                 |        |                 |                   |                 |            |                 | Borough /District     | Town*        |                 |                          |                 |
| 11-13         | 2 (5.1)         | Male   | 22 (56.4)       | White British     | 33 (84.6)       | Yes        | 2 (5.1)         | Eastbourne            | Eastbourne   | 3 (7.7)         | Academy                  | 19 (48.7)       |
| 14-15         | 26 (66.7)       | Female | 17 (43.6)       | White Irish       | 1 (2.6)         | No         | 37 (94.9)       | Hastings              | Hastings     | 15 (38.5)       | Community college/school | 12 (30.8)       |
|               |                 |        |                 |                   |                 |            |                 |                       | St. Leonards | 4 (10.3)        |                          |                 |
| 16-17         | 10 (25.6)       |        |                 | White & Asian     | 2 (5.1)         |            |                 | Lewes                 | Peacehaven   | 7 (17.9)        | Youth Club/Centre        | 5 (12.8)        |
|               |                 |        |                 |                   |                 |            |                 |                       | Seaford      | 5 (12.8)        |                          |                 |
| 18-19         | 1 (2.6)         |        |                 | White & Caribbean | 1 (2.6)         |            |                 | Wealden               | Uckfield     | 5 (12.8)        | Faith school             | 3 (7.7)         |
|               |                 |        |                 | White & Black     | 1 (2.6)         |            |                 |                       |              |                 |                          |                 |
|               |                 |        |                 | African           | 1 (2.6)         |            |                 |                       |              |                 |                          |                 |
| <b>Totals</b> | <b>39 (100)</b> |        | <b>39 (100)</b> |                   | <b>39 (100)</b> |            | <b>39 (100)</b> |                       |              | <b>39 (100)</b> |                          | <b>39 (100)</b> |

\*Derived from first part of postcode provided by young people

Table 5: Sample characteristic for sexual health topic area

When engaging young people on sexual health issues the research literature is clear - mixed group settings can be an ‘unsafe environment’ for girls and should be conducted in single-sex groupings (Strange *et al.*, 2003; see also Sherriff *et al.*, 2014). Thus, all groups were age and gender differentiated both in terms of the young people and facilitators to ensure discussions were appropriate. Each group/interview explored the following indicative areas:

- What do young people think about the sex and relationships education (SRE) programmes and advice they have received from schools and other professionals?<sup>5</sup>
- What do young people think about the East Sussex ‘Safe Around Sex’ programme?
- What do young people think about the C-Card?
- Are young people aware of local sexual health campaigns that have been delivered in the past? What are their views about these campaigns?
- Where do young people go to get information about sexual health and local sexual health services?
- What are young people’s experiences of receiving information and advice relating to sexual health from professionals?
- What improvement could be made to the knowledge, skills and approaches used by professionals in providing information and advice on sexual health to young people?
- What else has been helpful to young people in looking after their sexual health and managing sexual relationships?
- What could be done better and what would help most?
- How would young people describe positive sexual health and relationship outcomes?

<sup>5</sup> SRE is a topic within the broader subject of PSHE and is defined by The Sex Education Forum (SEF) as “learning about the emotional, social and physical aspects of growing up, relationships, sex, human sexuality and sexual health”. The purpose of SRE according to the forum is to “equip children and young people with the information, skills and positive values to have safe, fulfilling relationships, to enjoy their sexuality and to take responsibility for the sexual health and well-being” (HoCEC, 2015).

## 2.4 Data management and analysis

### 2.4.1 Data preparation and analysis

All engagement activities using focus groups/interviews were recorded on a digital voice recorder (with young people's permission) and allocated a unique identifying number. Files were transcribed verbatim by an external University approved supplier who is experienced in dealing with sensitive and confidential data. All transcripts were anonymised by the research team using pseudonyms (including names of young people, schools, and any other identifying information). The following conventions were used for the transcription of the interview data: [ ] background information or any contextual note; ?? inaudible responses; M=male, F=female, I=Interviewer (where more than one interviewer or participant, I1 I2, F1, F2 etc.); FG=Focus Group, I.I. individual interview; [...] text removed for clarity but without altering the context or meaning within which it was said.

A combination of thematic analysis (focus groups, interviews) and content analysis (e.g. post-it notes, flip-charts, whiteboards, etc. from interactive activities) was used to analysis the dataset. For thematic analysis, following transcription data were inspected to quality check the transfer of information between the audio tracks and to begin the process of devising a preliminary coding structure as emerging themes were identified within and across the data set. Development of the final thematic categories were informed and guided by the project's key foci including topic guides, and also grounded from the data itself (i.e. whereby patterns, themes, and categories of analysis emerge out of the data). Finally, adopting a team approach, analytical processes were triangulated to increase the reliability and validity of the findings.

### 2.4.2 Note on the use of data and interpretation

Whilst epistemologically, qualitative methods can allow a real and meaningful way of generating data by gaining access to young people's narratives and analysing their use and construction of discourse; this is not to say that accounts given are necessarily taken as wholly factual (Mason, 2002). Indeed, experiences, knowledge, understandings are not simply represented; rather they become reconstructed in the telling. In other words, young people's experiences and understandings can only be constructed or reconstructed in collaboration with an interviewer/facilitator as such constructions involve an interaction with gendered, racialised, and class identities/positions, which are heavily dependent on the social context, as well as young people's abilities to verbalise, interact, conceptualise, and remember their experiences (Sherriff, 2005). It is therefore important not to treat understandings generated and presented in this report as though they are a direct reflection of understandings that exist outside of the research setting (Mason, 2002). Rather, young people's subjective accounts are taken within critical realism, as possible but not indisputable ways of gaining insights into the realm of the real (Sayer, 1992).

### 2.4.3 Data storage and confidentiality

All digital data were stored in the Centre for Health Research (CHR) at the UoB securely against unauthorised access using a password protected network and in compliance with data protection legislation. Hard copy materials derived from the engagement activities (e.g. print outs of

transcripts, flip charts used during the engagement activities etc.) were stored in a locked filing cabinet in the CHR and subjected to the same strict confidence as the digital data.

Only the research team and the transcriber had access to raw data and only anonymised data were presented to the PSG. To mitigate against the unlikely loss of data, copies of the digital files were backed up daily to University external (secured) servers. All original files (including recordings, field notes, and creative materials) will be destroyed 12 months after the end of the project (by May 2016). This time period is required to allow the re-visitation of data for dissemination purposes.

## 2.5 Research governance and ethical approval

### 2.5.1 Research governance

Preliminary approval for the project was received by ESCC Research Governance Panel (RGP) in November 2014 based on the initial commissioning specification. In December 2014, a full detailed governance proposal was submitted to the ESCC RGP for full consideration. Final approval to proceed with the engagement activities was received on the 8<sup>th</sup> January 2015 (Appendix J).

### 2.5.2 Ethical approval

Simultaneously with the governance process, a full ethics proposal was developed in November 2014 and submitted to the University of Brighton's Faculty of Health and Social Science, Science and Engineering Research and Ethical Governance Committee. Approval to proceed was received on the 26<sup>th</sup> January 2015 (Appendix J).

### 2.5.3 Ethical issues and procedures

Although full details of the ethical issues and procedures are available from the authors and are thus not reproduced here, some issues are nevertheless noteworthy. These are addressed below and include: informed consent, key risks and safeguards, and monitoring of risk(s).

#### Gaining informed consent

Gaining informed consent from young people to participate in the engagement activities was a staged process over time. The British Psychological Society ethical guidelines for research<sup>6</sup> state that although parental consent is needed for young people under 16, when potentially sensitive material is to be discussed, parental 'opt-out' (as opposed to 'opt-in') can be appropriate. In this project the exact process of gaining parental 'opt-out' consent varied slightly given each participating school/institution had different protocols for engaging their students in research and engagement activities. In most cases, schools sent a letter to parents providing information on the project and giving parents the opportunity to 'opt-out' via a slip that could be returned to the school (Appendix F). Other schools explicitly required parents to 'opt-in' by returning a signed slip to the school.

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<sup>6</sup> [http://www.bps.org.uk/sites/default/files/documents/code\\_of\\_human\\_research\\_ethics.pdf](http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf)

For young people themselves, explicit ‘opt-in’ was *always* required. In the first instance, young people indicated to gatekeepers whether they wanted to be involved at which point they were provided with a PIS (Appendix D) and any questions addressed by the gatekeeper. On the day of the engagement activities and just prior to commencing, the researcher checked again that the participant had read the PIS and in doing so, read out key information including issues of confidentiality, withdrawal and so on as stated in the PIS. At this point, if the participant still wished to participate they were then asked to sign a consent form (Appendix B<sup>7</sup>) and complete a short monitoring form (Appendix C). At the end of each engagement activity, consent was checked again to ensure participants were still happy for their data to be used. Finally, each participant was given a £10 voucher as a ‘thank-you’ for their participation. In all cases if either the young person or the parent was not willing to consent to participate, then recruitment did not proceed.

### Risk Assessment, safeguards, and monitoring

This study questioned vulnerable participants (children and young people) regarding sensitive topics (e.g. sexual health and issues of emotional wellbeing and resilience). Consequently, via the ethical review and governance process, a risk assessment and appropriate safeguarding procedures were put in place to support the study’s processes. Monitoring of risks and the procedures and protocols was ongoing and reviewed and/or revised where necessary by the UoB research team. Full details of these are available on request. See Appendix H for a copy of the safeguarding protocol used during actual engagement activities.

## 2.6 Timetable for reporting

Table 6 below provides a broad overview of the project timetable.

| Activities  | November 14 | December 14 | January 15 | February 15 | March 15 | April 15 | May 15 | June 15 |
|---|-------------|-------------|------------|-------------|----------|----------|--------|---------|
|   | M1- start   | M2          | M3         | M4          | M5       | M6       | M7     | M8-end  |
| Project start to end  |             |             |            |             |          |          |        |         |
| Informal review meetings with ESCC PH                         |             |             |            |             |          |          |        |         |
| PSG meetings  |             |             |            |             |          |          |        |         |
| Enhanced DBS submitted/updated/received                       |             |             |            |             |          |          |        |         |
| Ethics prepared, reviewed, approved                           |             |             |            |             |          |          |        |         |
| Governance prepared, reviewed, approved                       |             |             |            |             |          |          |        |         |
| Literature review outline plan, start, interim, and finish    |             |             |            |             |          |          |        |         |
| Invitations to schools and follow-up                          |             |             |            |             |          |          |        |         |
| Intensive data generation, transcription, and analysis        |             |             |            |             |          |          |        |         |
| Submission of interim ‘highlight’ report                      |             |             |            |             |          |          |        |         |
| Start, development, and delivery of final report              |             |             |            |             |          |          |        |         |
| Production of accessible summary for young people and schools |             |             |            |             |          |          |        |         |
| Thank you letters sent to recruitment sites (Appendix K)      |             |             |            |             |          |          |        |         |

Table 6: Timetable of activities and reporting

<sup>7</sup> As the consent form asks young people to sign their names, this obviously can identify a young person. Consequently, in some cases young people were offered the choice of making a simple ‘mark’ instead of a signature to prevent a potential breach of anonymity.

Engaging young people to inform health improvement  
commissioning and delivery in East Sussex

# Section Three

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## Whole school approaches to health improvement



## Section Three: Whole school approaches to health improvement

### 3.0 Introduction

In this section, findings from seven focus groups (n=35; or 36% of the total sample) with young people (aged 11-17yrs) recruited from four recruitment sites across East Sussex are presented. As a reminder, the purpose of these discussion groups was to seek young people's views and experiences concerning the WSA to health improvement initiatives including issues such as:

- The School Health Service (nurse provision);
- What is most effective and important regarding WSA service implementation and service design (e.g. staffing, accessibility, privacy, location, topic area etc.);
- The potential for engagement in whole school initiatives/services (e.g. design and implementation etc.), and;
- Young people's ideas for new services / initiatives they would most like to see at their school which could help to improve their health.

A WSA to health comprises 10 core components as follows:

- A. Leadership, management and managing change;
- B. Policy development;
- C. Curriculum planning and resources, including working with outside agencies;
- D. Learning and teaching;
- E. School culture and environment;
- F. Giving children and young people a voice;
- G. Provision of support services for children and young people;
- H. Staff professional development needs, health and welfare;
- I. Partnerships with parents/carers and local communities;
- J. Assessing, recording and reporting children and young people's achievement.

In turn, each of the above areas can be applied to the four themes which constitute the cornerstones of healthy schools work, namely:

- Personal, social and health education (PSHE)<sup>8</sup>;
- Healthy eating;
- Physical activity;
- Emotional health and well-being (EHWB).

In this project, a WSA to health is conceptualised as an approach that requires specific action to be taken within three broad areas (Langford *et al.*, 2014) including: **a formal health curriculum** (e.g.

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<sup>8</sup> The PSHE Association describes personal, social, health and economic education as “planned programme of learning through which children and young people acquire the knowledge, understanding and skills they need to manage their lives, now and in the future. As part of a whole school approach, PSHE education develops the qualities and attributes pupils need to thrive as individuals, family members and members of society.” ([www.pshe-association.org.uk/content.aspx?CategoryID=1043](http://www.pshe-association.org.uk/content.aspx?CategoryID=1043))



where health education topics are given specific time allocation within the curriculum to help students develop the knowledge, attitudes, and skills needed to make healthy choices); 2. **Ethos and environment of the school** (e.g. whereby the health and well-being of students and staff are promoted through the ‘hidden’ or ‘informal’ curriculum, which encompasses the values and attitudes promoted within the school, and the physical environment and setting of the school); and; 3) **Engagement with families and/or communities** (e.g. schools seek to engage with families, outside agencies, and the wider community in recognition of the importance of these other determinants on young people).

Analysed thematically but with reference to the WSA components, findings from engagement activities with young people are categorised into five main themes including: Awareness and relevance of health in school; the focus on health in school; ‘everyone’s business’ - health integration and delivery, and; making health better in school.

### 3.1 Awareness and relevance of health in school

To gauge young people’s awareness of health issues as well as identify the health issues that are important to them, all WSA focus groups began by an interactive exercise. Young people were asked to consider two items: ‘things that are healthy’ and ‘things that are unhealthy’ by writing down their ideas on ‘post-its’ and sticking on to a flipchart for discussion. This activity was useful in: 1) eliciting young people’s conceptualisations of health which may differ to those of the school and other health professionals (Buijs *et al.*, 2014), and; 2) generating issues for discussion to set the context for the remainder of the focus group; namely, staying healthy and promoting/improving their health in and out of school.

Once completed, young people were asked to rank their items from being the ‘most-healthy’ to ‘most-unhealthy’. As this activity operated across different schools, it was not possible to produce a combined ranking. However, young people’s views are shown below and demonstrate an awareness of a range of physical and psychological (including emotional) health matters relevant to young people:

| Things that are healthy                                      | Things that are not healthy                                   |
|--|---|
| Healthy food/eating / good diet                              | Stress  |
| Exercise and sport   | Abuse / domestic abuse  |
| Respect / kindness / polite                                  | Poor food quality/diet/fatty foods                            |
| Water/hydration  | Fighting and causing harm to others / violence                |
| Sleep  | Sweets and chocolate  |
| Hygiene  | ‘Bad state of mind’   |
| Health of family members and pets                            | Sexually transmitted infections                               |
| ‘Good state of mind’/ being happy                            | Bullying (including cyber bullying e.g. Facebook)             |
| Being well educated / attending school at all times          | Being aggressive / suicidal thoughts / depression / self-harm |
| E-safety   | Drug and alcohol abuse (including underage drinking)          |
| Safe sex   | Smoking/passive smoking                                       |
| Friends with the right people/ peer groups                   | Racism and discrimination                                     |
| Punctuality  | Misbehaviour in school and anxiety for those observing        |
| Being competitive without causing harm                       |   |
| Being talkative and socialising                              |   |
| Things going on in and after school                          |   |
| Smooth transition to sixth form and university/future career |   |

In general, young people's conceptualisations of health were mostly pathogenically based, in other words, focusing on conceptions of health as the absence of disease rather than more positive or salutogenic notions of health development. Furthermore and perhaps unsurprisingly, young people's views of health issues and being healthy were relatively simplistic tending to focus on the individual's prevention of physical health problems via abstinence (e.g. not drinking or smoking, not eating unhealthy foods, being active to prevent obesity etc.) rather than more multi-faceted and complex ideas about maintaining and actively improving their own health. Moreover, in the early discussions it was clear that for some young people, perceptions and/or awareness of their own health status and/or development was not particularly salient or embedded in their thoughts and behaviours within the context of their daily lives:

*M1: I don't know, they're young [other pupils], they don't need to worry about it [health] too much. I suppose, it's still something that's important.*

*M2: I don't think enough people care about it now as much as they should do. It is important but there are not enough people that understand that you need to be healthy at this age to stay with you. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

In the above quote, pupils imply that their (young) age combined with the relatively long-term nature of health decline and/or development is a possible determinant for their apparent lack of concern about health. In other words, health improvement for some of the youngest young people in secondary school, appears not to be a concern for them currently; although in the above quote, one male does astutely make reference to a link between healthy behaviours in childhood and health outcomes in later adult life (e.g. for obesity, type II diabetes, cardiovascular disease; Dietz, 1998). The issue of age influencing awareness of health was also referred to by pupils from one school who suggested that it was easier to be active when younger and that circumstances change as one ages raising the challenge of developing a long lasting culture and ethos of healthy physical activity through the early school years and life beyond:

*F: I think about how it [health] differs between age groups. When you're younger you tend to do a lot more exercise because you tend to have that motivation more and as you get older I think you stop doing as much as you did when you were younger. (School 2, female FG-WSA, Grp2, Yr 7)*

This notion is supported by evidence from the literature (e.g. Knowles *et al.*, 2011) showing that physical activity often declines as young people transition from primary to secondary school. Thus developing school structures and policies that empower young people to sustain engagement in health promoting behaviours over their school careers and lifecourse is important.

### 3.2 Focus on health in school

Following on from the interactive activity on awareness of health issues, young people were asked about which health topics they had learnt about/discussed in school. In response to this question, many young people from across the focus groups felt that little attention had been paid to health across the school curriculum, and reported dissatisfaction with the health issues/topics they had engaged with so far. For instance, in several groups focusing on WSA to health improvement (but also in the focus groups on SRE; see Section 5.1), young people felt that the ethos and culture of the school prioritised educational outcomes and results (e.g. GCSEs) rather than health issues:

*I: Do you think your school cares about health issues?*

*M1: No not at all.*

*ALL: No.*

*M3: They couldn't care less.*

*M4: If we get the grades they care but not if we don't (Youth Centre, male FG-WSA, Yr 9)*

Most young people talked animatedly about their dissatisfaction regarding the 'formal health curriculum' including both the quantity and quality of PSHE and health more broadly in school settings. On the whole, and in line with recent evidence from Ofsted (2013), PSHE was viewed by young people as being inadequate. At one targeted school for example, young people from Year 11 made reference to their (total) health experience of a single PSHE 'drop-down' day<sup>9</sup> which included as examples, sessions on drugs and alcohol, fair trade issues, personal finance, healthy eating and sexual health (including contraception, STI prevention, and the C-Card). Recall of any learning (impact) from this day was unsurprisingly limited:

*I: Have you ever had any sessions on what healthy means and how to keep healthy?*

*M1: Not for a couple of years ago since we changed to an academy.*

*I: What did you have a couple of years ago?*

*M2: Just a whole day off...*

*M4: There was writing things like starting off some people would learn about drugs but then it'd be like sexual health, then bullying, different things like a wide variety but it didn't go into too much detail (School 1, male FG-WSA, Grp2, Y11)*

*M1: ... some people would learn about drugs but then it'd be like sexual health, then bullying - different things like a wide variety but it didn't go into much depth.*

*M2: There would be several people coming into the classroom and periods on like crime like there was a police officer came to talk to us.*

*M3: There was quite a lot on sexually transmitted diseases. [But] that was it really. (School 1, male FG-WSA, Grp1, Y11)*

In a recent enquiry on PSHE (including SRE), the House of Commons Education Committee (HoCEC, 2015) draws attention to the inadequacy of such drop-down days, particularly as they are often delivered late in the school year not giving young people time to reflect, internalise, and question their teachers. Moreover and somewhat worryingly, according to the Sex Education Forum (SEF), in some schools a drop-down day is used exclusively to teach SRE. As indicated in both of the above quotes from two focus groups, a key concern for young people experiencing such a drop-down day was that there were simply not enough opportunities to discuss the health issues deeply; instead a broad range of topics were covered superficially. Similarly, even in the schools in our sample that did not utilise a drop-down day approach, young people nevertheless felt attention to PSHE issues (e.g. in dedicated lessons and/or less formal input such as tutor time) were not sufficient to explore the complexity of the issues and thus were perceived mostly as ineffective information giving sessions:

*M: I don't think that they give us enough detail... one lesson a week is not enough to go in depth about the [health] subjects that you're learning about. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

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<sup>9</sup> Dedicated time off the normal curriculum.

This information giving was particularly prevalent with regards sex and relationship education (SRE). In line with the findings from the literature review (Davies, 2015), young people reported that the biological bases of sex and reproduction dominated their experiences in school. This was perceived as not being particularly useful as it was factual information that they could get easily from other sources. Instead, young people wanted more (quantity and quality) opportunities (specifically in school settings) to explore some of the deeper complexities of health and social issues beyond factual information gathering (see also Section 5).

In several schools and settings, narratives indicated that many young people are exposed to quite traditional health education approaches in school. However, such health education messages (e.g. not smoking, eating healthily, and not drinking alcohol or taking drugs, consent and underage sex and/or sexual abstinence etc.) have been shown to have limited evidence of sustained changes in student health behaviours as they tend to assume simple causal pathways between and do not pay attention to social and wider determinants of health (e.g. Langford *et al.*, 2014). Young people from one school drew attention to the drawback of such traditional approaches to teaching about health issues, in that focusing briefly (without depth or complexity) via pathogenic and deficit models of health does not empower young people to learn, try, evaluate, and adopt effective strategies to take control over their own health:

*M: They would just say it's wrong instead of saying, it's wrong but here's how you can stop it or here's some help. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

*M1: They show you shock images and try to scare you... Like, this is what a smoker's lungs look like and this is what normal ones.*

*M2: Yeh but it's a problem, it's like saying 'don't touch the button', you want to touch it more. Just like trying to scare you out of it doesn't work as much as explaining it. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

Following these discussions, young people in a further interactive exercise were asked about which health topics or issues they wanted to know more about in order to improve their health over time. This was a useful exercise to consolidate young people's thoughts and to also refer back to later in the discussion concerning how best young people can be supported to maintain and improve their health in and out of the school context. In no particular order, the following are indicative examples from across the data set:

- Sexual health with less focus on biological bases and more emphasis on relationships;
- Opportunities to discuss sexuality issues including non-heteronormative views not just biological sex (e.g. safer sex for all sexual and/or gender orientations);
- Opportunities for discussion of important recent events as they might relate to health (e.g. disasters, terrorism);
- Drugs including issues regarding progression from use of 'gateway' drugs;
- Masculinities – what it means to be a man;
- Healthy eating;
- Mental health including anxiety, depression, stress;
- Self-harm;
- Life skills (paying bills, employment, training);

- Bullying (including cyber bullying through popular social media and sexting);
- Peer pressure;
- More health topics and opportunities in general.

### 3.2.1 'Everyone's business': health integration and delivery

An effective WSA to health improvement necessitates that health and wellbeing is 'everyone's business' including the meaningful involvement of staff, pupils parents, outside agencies and so on (Weare, 2015, p.5; Department for Education [DfE] 2015a). Moreover, *inter alia*, it requires appropriate curriculum planning and resources (often with outside 'specialist' agencies), and high quality learning and teaching. However, it was evident from the data (and literature) that for many young people, their experiences did not match these central tenets of a WSA. For instance, young people gave examples of school staff (teachers, teaching assistants, and school nurses as examples) not taking their views/worries about health (and other related issues) seriously, being unapproachable and grumpy when asked questions about health, and referring young people on to someone else rather than engage with the issue/person presenting. This latter point was emphasised particularly strongly by one participant who felt let-down that the teacher he went to talk to immediately sent him onto the school nurse rather than engage with him as the 'chosen' adult:

*M1: ... say you go there [school nurse] not often but more than regular because you have something wrong with you, if you keep going to the same person they [other teachers] will always take you to that person ... as soon as you talk to someone else about it [a problem], they will just take you straight to her. It's like I've come to you to talk about it, if I wanted to talk to her I'd talk to her? (Youth Centre, male FG-WSA, Yr 9)*

This signposting of students to staff members identified as 'the health person' is problematic in that it moves responsibility for health away from 'everyone' to particular individuals. Whilst of course a balance is required (see next paragraphs) between identified specialist trained and competent staff with regards health issues, equally, such targeted 'professionalisation' of health can be a barrier to whole-school/whole-systems working; it also means the power relations remain relatively hierarchical with the 'health provider' as a representative of the system and the young person as a passive recipient of health.

#### **Training and competence**

Following from the discussions on health topics and issues of quality and quantity of PSHE/health in school, the majority of students raised concerns over the expertise and competence of staff engaging young people in health issues via PSHE and other means such as tutor time (see also Buston and Wight 2004; Formby *et al.*, 2011; Ofsted, 2013; Westwood and Mullan, 2007). This was also found in the focus groups with young people on sexual health (see Section 5). This perceived lack of expertise was particularly highlighted with regards to sensitive or controversial topics relating to health such as sexuality and diversity (including homophobia and transphobia), mental health, and domestic violence:

*M: It's because it's [health] not usually their main subject. You don't have PSHE teachers, there's teachers that teach other subjects, so it's obviously not going to be their forte in the sense that, yeh it's not their favourite subject to teach. I just think that they don't put enough effort in but then again nor do the students. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

Linking with the findings on sexual health (Section 5.1) narratives suggest that this lack of specialist (training for) staff may have contributed to the culture of PSHE lessons for some young people not being taken seriously and seen as a 'bit of a laugh':

*M: I feel everybody in our form takes PSHE as a joke lesson, where you didn't have to do very much and the students didn't really want to be there and the teachers didn't really want to be there teaching it either... (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

Discourses regarding lack of teacher competency for delivering PSHE in schools are not new (Formby et al., 2011; Ofsted, 2013; SEF, 2008). Ofsted for example note how lack of teaching expertise in some schools across England resulted in 'difficult' topics (e.g. sexuality, domestic violence etc.) being omitted from the curriculum. Moreover, the recent House of Commons Committee for Education report (2015) recommends that the DfE make PSHE (including SRE) statutory and that each primary and secondary school have at least one teacher who has received specialist training (HoCEC, 2015, p. 55). In our view however, these recommendations do not go far enough. For WSA approaches to health to operate effectively, health must become 'everyone's' business. In other words, although improving PSHE is important and indeed necessitates staff with specialist skills, it also necessitates a much larger cultural and ethos shift in schools facilitated by strong leadership that works towards providing the conditions for the empowerment of staff and pupils (and wider stakeholders such as parents and other caregivers) to take responsibility and control to improve their own health within a supportive environment.

### **Learning materials**

In addition to perceptions of 'unsatisfactory' teaching of PSHE, other comments by young people (as with sexual health), related in some cases (but not all) to the poor quality of support materials. For example, audio visual tools for health were considered as dated, 'cringey' and generally poor; however these views were not always consistent with some pupils positive about their experiences:

*M: If they're going to do videos I think it should be more serious because when it was kind of comedy videos no-one took it seriously. Like it was stupid things, like this kid who was in the toilet, goes to the toilet and he screams ah, I have HIV and then has a really weird face.*

*M: Yeh with the videos and stuff it's never real to life (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

*F: They're [DVDs] sort of quite good because you can tell what it feels like because usually it's like, when we watched the dementia one we were imagining we were like a person.*

*F: It gave you lots of information about it, like you said, it makes you imagine what that person would feel like so they kind of, so yeh it's very good videos. (School 2, female FG-WSA, Grp2, Yr 7)*

## Integration

Young people from one school reported quite different experiences indicated the school had integrated health with learning and teaching by offering a formal and comprehensive (PSHE) curriculum that ‘meshed’ with subject specific curriculums – and in doing so, allowing dedicated health topics to be addressed, other health issues to be embedded in subjects (e.g. measuring physical activity in maths), as well as engagement with wider health issues as they emerged opportunistically<sup>10</sup>.

*F1: We’ve been doing it [healthy diet] in food technology and I also did it in science*

*F2: I’ve done it in science, well we’re doing smoking at the moment [in science] but we’ve done like what smoking does to you. You can build up tar in your lungs and stuff and how that affects you. (School 2, female FG-WSA, Grp2, Yr 7)*

This same school also appeared to embrace a broad view of health and well-being by operating a timetabled ‘buddy’ system which allowed new students into the school (Year 7) to interact with older (Years 10) students to assist in their transition from primary to secondary school:

*F1: On... Tuesday we see our mentors which are like a buddy.*

*F2: So you can talk to if we need to.*

*F3: We’ve all got one each. Some people share them though if the numbers are odd.*

*I: What kind of things can you talk about with them?*

*F: You can do what you want.*

*F: They can help you with your homework and stuff.*

*F: You talk about what we’ve done in our lessons.*

*F: Well like in the weekend.*

*F: Play a game.*

*I: What about stuff like bullying if that happened?*

*F: Yeh and they’re all really nice.*

*F: They [Year 10 buddies] do quite a lot on like i-pad safety in assemblies. (School 2, female FG-WSA, Grp1, Yr 7)*

*F: It’s a bit of fun to have and we communicate with people from other years.*

*F: ... Cos they’ve [Buddies] had more experience throughout the years, cos we’re only just into year 7. They’ve started from all the way from the bottom so they’ve had experiences that they can tell us about and how to avoid them or help us with them. (School 2, female FG-WSA, Grp2, Yr 7)*

There is a large body of educational literature noting the health, social, educational, cultural, and personal impacts transition to secondary school can have on various aspects of young people’s lives including levels of physical activity (e.g. Knowles et al., 2011), mental health and sense of belongingness (e.g. Allen, 2014; Vaz et al., 2014), self-concept (e.g. Gniewosz et al., 2012), bullying (Pellegrini and Long, 2002). Given these kinds of impacts can combine and be experienced in different, complex, and unpredictable ways the use of supportive systems such as guided

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<sup>10</sup> As noted in Section 2.4.2, it is important to recognise that young people’s experiences, knowledge, and understandings presented in this report are not necessarily taken as wholly factual. Consequently, it is possible that other schools may actually integrate health with learning and teaching but that this was either not recognised (e.g. not seen as PSHE if non-topic based or when not set within PSHE lessons) or was simply not recalled by young people.

‘buddying’/mentoring by older young people, is to be commended along with further appropriate scaffolds to support those identified as in need (e.g. learning support, welfare, or similar).

### 3.3 School health-related initiatives

#### **School Health Service/School Nurse**

Awareness of the various health initiatives and facilities available in schools by young people was poor. For example, similar to a recent consultation on the development of the school nurse programme by the British Youth Council (BYC, 2011; see also DH, 2012), young people demonstrated little awareness of the school nurse<sup>11</sup> provision in their respective schools. Moreover, there was little awareness of how they could access the school nurse (e.g. knowledge of availability and role/remit of the nurse), the range of services and/or opportunities for health that were available, or the physical location of the school nurse. Young people commonly recounted that they did not know who their school nurse was or where he/she was located:

*I: Do you think the school nurse is the best person [to answer questions about health]?*

*M1: I don't even know who she is.*

*M2: I don't know who she is.*

...

*M1: I don't think we ever had it explained at assembly who our actual school nurse was.*

*M2: I think there are a couple of school nurses but I'm not sure when or what they specialise in or if they specialise in something. (School 1, male FG-WSA, Grp1, Y11)*

*I: Do you care about seeing the school nurse, would you want to see them more?*

*M1: It would be nice to know she was there.*

*M2: Who here knows [sounds like where she lives/what she looks like]?*

*M4: I don't know.*

*M3: I never even knew we had one. (Youth Centre, male FG-WSA, Yr 9)*

Furthermore, many young people were not aware of the range of health opportunities available to them via the school nurse (such as the C-Card) viewing provision rather pathogenically as somewhere to go if injured, feeling unwell, or to be inoculated (jabs); rather than as an opportunity to actively improve and promote health (e.g. via advice, information, and strategies on key health issues such as healthy eating, anxiety, alcohol, sexual health, relationships etc.):

*I: What about, in terms of school facilities, you talk about health through school but-*

*F1: School nurse.*

*F2: We've only got one so if somebody's being sick or something and you come in and say, I've got a headache, they're like oh you'll be fine and send you away. (School 3, mixed FG-WSA, Grp 1, Yrs 8-9)*

*I: The condom card, C-Card did you know that you can get that from her [school nurse]?*

*M2: I didn't know you could get it from her. [M1: You can.]*

*M4: I didn't know you can. (School 1, male FG-WSA, Grp1, Y11)*

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<sup>11</sup> Since January 2015, re-named the School Health Service.



The apparent lack of visibility and awareness of the school nurse provision (and non-use) is also reflected in the literature with estimations that around half of young people in school do not know who their school nurse is (BYC, 2011; Westwood and Mullan, 2009). However, it is of course possible that of the 35 young people who engaged in the focus groups discussing this issue, participant's awareness and views were influenced by their perceived need; in other words, some young people may not have paid attention to knowledge and/or communications about the school nurse simply because they felt they did not have need to. Nevertheless, this lack of visibility and poor awareness of the range of health opportunities available through the school nurse was also present in discussions with young people engaging in the sexual health focus groups. Thus it is perhaps likely that visibility and awareness are real issues that need to be addressed.

One way this has been attempted recently, and building on the Department of Health's (DH, 2012) call to action on maximising the contribution of the school nursing team, has been via a small-scale pilot study on setting up a text messaging service to counter this lack of visibility and increase young people's access to health. Through a small scale evaluation of the intervention in two secondary schools, France (2014; see also BYC, 2011) reports that the initiative appeared to be successful from young people's perspectives covering a range of topics (in decreasing order of frequency) such as sexual health (including puberty and relationships), emotional health, human papilloma virus (HPV), physical health, and healthy eating. Interesting, this idea was also raised by a year 10 male focus group from a targeted school when talking about managing positive sexual health and relationships:

*I: So what would be helpful to you in terms of managing your own sexual relationships? So when the time is right if you're not active already, what would you need to help you?*

*M1: Maybe like 'Embarrassing Bodies' but an anonymous thing so you can text in your questions and they just send you a text back...*

*I: So something like that maybe in school where you could text questions and get a response.*

*M1: Yeh, just like a text back.*

*M2: Even if it's anonymous, you could just type it and they could type back and then you know it's you but other people just think-*

*M5: It needs to be anonymous yeh because otherwise people would be like, I'm not typing anything. (School 1, male FG-SH, Grp1, Y10)*

The lack of visibility of the school nurse in some cases meant that young people did not feel connected to the service meaning that they were less likely to access it even if they felt they needed to:

*I: If you wanted help, or advice on health in school say on a sexual matter... What is the best way of getting that dealt with that the school could help with? It might be going to the school nurse?*

*M1: No. I think in that situation you wouldn't go to the school nurse, you just wouldn't feel comfortable, because we don't know who she is like properly... our school nurse is literally just there, we're not feeling well, can you call our parents to come and pick us up. That is all I've ever had to do with the school nurse.*

*M2: Yeh same. I think if you had anything like that you would automatically go to your doctor rather than someone at school. (School 1, male FG-WSA, Grp1, Y11)*

Visibility and ‘knowing’ the school nurse thus appear to be barriers for young people. However, privacy was also raised as a further concern:

*M: It's kind of awkward because her [school nurse] office is in reception so she works with, like she's around everyone else so it's not really the person you want to talk to considering there's all the gossip going on and they're on their computers. (School 3, mixed FG-WSA, Grp 1, Yrs 8- 9)*

The notion of privacy was also raised in a mixed focus group where several young women reflected on the process of receiving their HPV vaccination<sup>12</sup>. Although the quote below is lengthy, it is important because whilst recognising the constraints on school nurses to deliver large numbers of vaccinations to young people, as well as privacy it also raises issues of consent, lack of information and understanding for/by young people, as well as issues of power whereby young people have little control over their own health or bodies. For example, in the first instance, young women drew attention to not really understanding the vaccination (although parents had consented) and desiring more information about what would happen and why. Their narratives moved on to highlight the lack of physical privacy the process had afforded in terms of having to remove clothing in front of (too many) others, as well as lack of psychological privacy when being asked sensitive questions (about pregnancy) in front of other people:

*F1: Year 8 have them [HPV vaccination], they didn't really tell us much about it they just said you're having it and there was a letter saying you're having this and then you and your parents had to sign*

*F2: Cervical cancer.*

*F3: And it really hurt.*

*F1: Most of the year 8s were worried about it and they didn't really tell us that much about it, whether it would hurt, what would happen, because they... didn't tell us much about it we were worried.*

...

*F1: We went for the needle [HPV vaccination]... some girls had to take off their blouses*

*F2: They shut the curtains but you still have to take our tops off in front of everybody.*

*F1: Yeh cos obviously we thought you'd go in and you'd have something covering up...*

*F3: ... you had to sit and wait in the middle of everyone.*

*F1: ... and then lots of girls had to wait and they were watching.*

*F: I think it was waiting didn't help. There's a lot of people and I think it could have been organised a bit better... it was the waiting and watching everyone.*

...

*F: My friend, she was really worried about it and the nurse asked her loads of questions and I was next to her, I could hear them and one of them was, are you pregnant and if she was it would be hard to her to tell them in front of everyone. (School 3, mixed FG-WSA, Grp 1, Yrs 8-9)*

This notion of privacy also emerged with regards the physical location of the school nurse across both the WSA and sexual health focus groups. Young people expressed the view that they didn't necessarily want to be seen accessing the nurse or other location for fear of being stigmatised by their peers. However, as also noted later in Section 5, arguably providing health initiatives that allow such discrete access can perpetuate stigma (e.g. regarding sexual and mental health) and actually work against other school systems and policies attempting to normalise health

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<sup>12</sup> All girls aged 12 to 13 are offered HPV (human papilloma virus) vaccination as part of the NHS childhood vaccination programme. The vaccine protects against cervical cancer. It's usually given to girls in year eight at schools in England (NHS website, 2015)

improvement. In other words, health initiatives and services such as the school nurse *should* be highly visible to young people both physically (e.g. appropriate publicity and marketing such as signage, post-cards, reading materials setting out what is being offered, how to access, what will happen when they access the service, etc.; see DH, 2007) as well as cognitively (e.g. knowledge of opportunities for health, self-efficacy, esteem, and confidence to empower young people to access support as and when needed/desired).

### **Confidentiality**

Evident in the literature review (Davies, 2015) and raised across both WSA and sexual health [Section 5]) focus groups, were concerns and worries regarding confidentiality (e.g. see AYPH 2014; BYC, 2011; DH, 2007, 2012; Carroll *et al.*, 2012; Mitchell and Wellings, 1998). Young people did not always feel that they could confide in school staff about health (and other) matters because of worries that their disclosure(s) would not be kept confidential from parents, teachers, their communities, or peers:

*I: If there's something [health related] you wanted to talk to somebody about, who would you talk to?*

*M1: I wouldn't feel comfortable talking to teachers... I've talked to like so many social workers ... talking to people that are in an actual organisation [not a school] so that you know [they] are going to keep everything safe.*

*M2: Yeh but then there's school and then somehow everyone would know.*

*M1: A different teacher would come up to you and talk about something that you've talked to a different teacher about and you'd just be like, well I didn't speak to you about that... I was talking to [name of teacher] about something that I was confused about and then she was like 'ok I won't talk to anyone about it' and then when I walked into a lesson three days later a couple of people were like, 'oh you've done that to that kid'. (Youth Centre, male FG-WSA, Yr 9)*

In contrast, in one school young people's narratives provide a particularly good example of where attention to confidentiality in groups settings and ensuring all understood the concept and its boundaries, meant a 'safe psychological space' could be provided to discuss health issues during (form) tutor time.

*F: In the form, you can have that freedom to speak...*

*I: Do people ask questions and things like that?*

*F: Yeh, you'd say something, people do ask questions about that so it's like, it's very discussable in there, you could say anything, you have that freedom again of having that confidentiality of not knowing that everyone else, that not everyone knows about what-*

*I: Nothing leaves those four walls. Does [name of tutor] say to you 'right whatever you say in this class...'*

*F: Yes we did, we did ground rules and everyone said, 'right we've got to have confidentiality in this room'. (School 2, female FG-WSA, Grp2, Yr 7)*

Most young people across both WSA and sexual health topic areas, talked about confidentiality as one of the major concerns and barriers to help-seeking behaviours. It is likely that some staff probably are not clear themselves about the complexities of confidentiality (either in line with school policy frameworks or more broadly in working with young people). Furthermore, staff may not always make clear to young people the limits or boundaries of confidentiality in school and

other youth settings (i.e. safeguarding). Moreover, it is of course also likely that even if this has been explained, that young people either do not understand what this means in practice and/or need reminding frequently. In a review of reasons for use/non-use of sexual health services, Carroll *et al.*, (2012) note that young people's satisfaction with perceived confidentiality of a service was an important reason for using it. Ideally, schools need to ensure that confidentiality (and consent to access health initiatives) and any limitations are communicated effectively and understood by young people as well as their parents/guardians, and staff.

### 3.4 Making health better in school

To generate a quick snap-shot of young people's views on ideas for how they could stay healthy and improve their health in school settings, an interactive exercise was conducted using post-it notes and flip charts. Young people were asked to list what they thought would make health work better in school by envisioning an 'ideal' health improvement scenario for their school and other young people. Subsequent discussions then narrowed down on some of the suggestions including increased attention to **health in the curriculum** (e.g. via PSHE, better use of 'free' time for older young people) including topic based ideas for health in school (e.g. focus on bullying, mental health, and physical activity) as well as more **ethos and environmental notions** such as changes to the way young people access support (including the school nurse) and potential discrepancies in messages and structures/provisions.

#### **Health in the curriculum**

The most common message from young people across the WSA focus groups (but also sexual health focus groups) was that young people would like to extend the depth and frequency of their engagement with health issues in school via PSHE and other means, and that this needed to include appropriately trained and specialist staff. Moreover, young people felt that delivery of health issues/topics/messages in school needed to be informed by young people themselves, and to move away from simple information provision:

*M1: PSHE is the way to go but there needs to be either more than one lesson or you need to cover the subjects in more depth...*

*M2: Specific teachers for PSHE in school who know what they're talking about...*

*M5: Yeh I think there needs to be teachers who are specialised in the subject but there aren't at the moment. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

Other ideas included rethinking how PSHE is delivered. Some young people talked about the need for the delivery of PSHE provision and other opportunities for health in school to be considered differently; such as utilising 'free' periods for older young people and increasing after-school provision. A further idea posed by several groups included moving away from health education approaches delivered through assembly formats with large numbers of pupils, to a mix of more interactive approaches appropriate to the issue which might include one to one sessions and/or opportunities for small group sessions (single sex and mixed depending on the issue/topic/preference) to allow depth, complexity, as well as emotionally 'safe' and confidential discussions on particular 'difficult' health issues or topics:

*M: You just said about the discussion thing in like smaller groups, that'd be better for the lower level [lower Year groups] making it more normal if you have those discussions with your peers, that's the first step really I think. If they do it in school, don't have these whole year assemblies where they tell you not to smoke drugs or whatever or have sex, just do it in smaller groups, I think that's better. (School 1, male FG-SH, Grp1, Y12)*

In the above quote, the young person also hints about normalising discussions about health through focusing on health issues early on in school careers. Other groups of young people focused more on topic based ideas for improving health and the removal of barriers to participation. For example, in one school, young women's narratives referred to gender stereotyped opportunities for physical activities (including sports) in school. In the quote below, Year 7 girls talked about how they were restricted in the type of activities they could participate in, and that they wished for a broader range of opportunities to be available to them:

*I: ... Are there other things that stop people from wanting to do healthy things like sport and activities?*

*F1: There's something that annoys me about sport is that the girls have to do all their more like stereotypical girly sports like netball and stuff-*

*F3: Yeh we're not allowed to do football...*

*F2: We do like dance and gymnastics and things.*

*F1: A lot of us want to do rugby and football and cricket.*

*I: Is that something you'd like to see changed?*

*F1: Yeh cos it really bugs me.*

*F2: My sister does street surfing on a little board thing. You have to wriggle on it, so it's like skate boarding. That sounds quite fun. (School 2, female FG-WSA, Grp1, Yr 7)*

Gender based restrictions on opportunities to participate in sport and physical activity have no place in contemporary schooling. Gendered views on physical activity are entrenched historically, socially, and politically in many school and wider systems and need to be challenged (e.g. Cox et al., 2006; Sherriff and Tungatt, 2007). Arguments against widening opportunities for young people (often from the media) claim that competitive 'traditional' sports and activities in school somehow foster team spirit and help prepare pupils for adult life. However, there is no evidence to support such out-dated notions or to suggest that non-traditional sports and activities in school are not capable of fostering such so-called team spirit and future life preparations.

Other young people's narratives however, showed this gendered barrier to some physical activities did not exist in all schools. For instance, pupils in one mixed focus group reflected on doing both 'boys' and 'girls' sports in school although interestingly the notion of gendered sports (e.g. 'girls' sports') was still apparent. In the example, below the discussion moved on to discuss swimming sessions which were currently mixed although single-sex was preferred:

*F: When you go into year 9, the girls do the boys sports but then the boys do the girls' sports, like hockey and netball for girls and like rugby and football for boys.*

*[Discussion follows about choice of physical activity and sport]*

*I: You're talking about wider choices as well, so it's not just about choosing rugby or football, it's about different kinds of activities?*

*F: Yeh. And I think it should be throughout the year so that each time we get to choose what PE you do. If you're doing something you enjoy you're going to get more out of it rather than.*

*F: ... I'm in a mixed PE group on a Monday for swimming... and you feel a bit self-conscious if you're in a swimming costume.*

*I: If it's mixed, so it would be better to have swimming as all girls or all boys?*

*F: Yeah it's awkward because all the boys are around looking, it's really awkward. (School 3, mixed FG-WSA, Grp 1, Yrs 8-9)*

In several focus groups, mental health was raised by young people as being an important and overlooked topic/issue in school that they would like to see redressed. Two examples below reflect this point from Year 7 and Year 12 pupils respectively:

*F1: It would be beneficial for us to know what you could do if someone had a mental health problem... because if you had a friend or a family member you would know what to do or what help you could get.*

*F2: Yeh they should do bullying but more, they should put more focus into mental health things. (School 2, female FG-WSA, Grp2, Yr 7)*

*M1: ... stress levels are so high for GCSEs for A levels, mental health is just getting more and more, like there's an increase in mental health problems, I think that having a counsellor that everyone gets to go and see would be a real benefit.*

*I: There's not one here then for students?*

*M1: Well that was what the school nurse said, oh come to us if you're feeling depressed.*

*M2: No the school nurse just seems like a one off thing that you'd occasionally go to her... (School 1, male FG-SH, Grp1, Y12)*

In the above quote, the idea of a counsellor or similar is also raised in another school as having 'someone to talk to' who is trustworthy, on their 'wavelength', and unlike a 'normal teacher':

*M: Around school definitely we should have a young counsellor, someone who's psychologically trained to be able to communicate with younger people because I feel like if I had a mental problem or something that I needed help and support with, I wouldn't be able to go to my head of year because they haven't been in this generation to really understand as much. So I feel we should have the help of a younger counsellor, someone to talk to who would be able to give help and therapy. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

### **School ethos and environment**

Across several focus groups, young people's narratives commonly highlighted a preference for being able to access health advice, support, and/or information when they needed to (e.g. drop-in style) rather than having to wait via appointment, for example to see the school nurse. This need for 'immediacy' and/or flexibility is found frequently in literature around young people's support needs, particularly for those vulnerable young people who may experience chaotic lives:

*F1: If you were having a problem and it was sort of, it was a long term problem and you sort of were dealing with it and it suddenly got dramatically worse, you wanted just to speak to someone immediately rather than leave it for a couple of weeks where it could get even worse, I think that you should have someone you could go to straight away.*

*F3: Having someone to go to like you know they're always going to be there and they're going to be in the same place and they would always be free to talk to. (School 2, female FG-WSA, Grp2, Yr 7)*

Other suggestions relating to support from/with the school nurse included the notion of more flexible and anonymous opportunities for access (e.g. booking of appointments), asking questions by text messaging, and the use of telephone ‘helplines’ to assist immediacy:

*M: Anonymous help because the teachers always say, if you’ve got a friend who’s got a problem please tell us but it’s kind of, it’s your friend isn’t it, if they don’t want you to tell someone, it’s harder to tell somebody. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

Ideas from two schools for improving health concerned healthy eating and the management of healthy weight. In doing so, young people referred to several issues including the poor quality of food for school lunches, low pricing of unhealthy foods, and the influence of convenience and peer pressure regarding making healthy choices:

*M1: The vegetables are disguised as pizza and manky and soggy...*

*I: So school dinners not great.*

*M1: They’re quite healthy, they’re good meals but they’re rubbish (quality)*

*M2: The broccoli looked like it had been left in the pan for about two days.*

*M3: It’s just microwaved isn’t it? ...*

*M4: And at lunch they just got pizzas, paninis, sometimes like a bacon bagel and-*

*M1: Trouble is it’s all tastes nice. That’s the thing, they make it unhealthy but they make it cheap but they also make it taste nice.*

*M2: It looks appealing.*

*M3: It looks very appealing.*

*M4: That’s the thing though they encourage you to buy it but you probably shouldn’t.*

*M3: What’s healthy doesn’t look nice at all, what’s unhealthy looks nice. (Youth Centre, male FG-WSA, Yr 9)*

Similarly, in a second group, young people note health messages about healthy eating but also the common discrepancy with the food choices then available to young people in some school settings:

*F: You know schools [??] all healthy eating and everything? Yeh, [??] go on about healthy eating when they’ve got pizzas, and chips and bacon butties...*

*F: It’s nice [the good] but like they go on about it [healthy eating].*

*F: They could add a little bit more fruit.*

*F: And like main things to eat as well, there’s only that or the fruit.*

*F: Well just a few things, there’s fruit and that but they could do more healthy things like stuff like paninis like main things to eat. (School 3, mixed FG-WSA, Grp 1, Yrs 8-9)*

A number of issues are raised here for schools to consider including pricing, sourcing, and availability of unhealthy foods as well as looking more closely at convenience issues that make it more difficult for young people to make healthy choices, e.g. presence of sugary drinks and snack vending machines in some canteens and other social spaces. This latter point was raised in one particular discussion where young people drew attention to convenience and peer group pressures impacting on their decisions and health behaviours. For example, in the quote below, young people indicate that convenience is an important influence over healthy food decisions and go on to highlight the power of peer groups in conforming to popular modes of health damaging behaviours (e.g. smoking, drinking).

*F1: There's fast food restaurants and things like that around... so it seems like the easier option to go and get a McDonalds rather than eating a salad cos it's quicker in some ways. As teenagers today we don't care as much because of the easier option.*

*M1: I think people that have fast metabolisms think that they're already healthy enough to not do anything about it so they're like, they eat what they want and the peer pressure at this age like with the whole smoking and alcohol thing, there's quite a lot of people do it and don't see what will happen to them through it.*

*I: Is there pressure to smoke and drink and things like that?*

*M1: Yeh there is a lot of it about. (School 3, mixed FG-WSA, Grp 2, Yrs 7-8)*

## **Participation in design and delivery of health initiatives**

Young people were asked about their interest in participating in the design and implementation of school policies relating to health such as the school health plan. Responses were generally mixed across schools. For example, in three schools, young people from Years 7, 8, 9, and 11 were keen on getting involved in the commissioning and implementation (e.g. design) of new initiatives (see also Association for Young People's Health [AYPH], 2014):

*I: Would you be interested in helping to design health initiatives in school?*

*F1: Yeh cos our new library, some students helped design the spaces and we've now got some really nice chairs and it's really welcoming. So maybe students could get more involved ...*

*...*

*F2: Yes because it would be nice if we had an input into it [health initiatives] after they listened to what we think about it. (School 3, mixed FG-WSA, Grp1, Yrs 8-9)*

*I: If young people were asked to come together and help develop health initiatives, is that you would be interested in. Do you think your views would be taken seriously?*

*F: Yeh, that would be a good idea. (School 2, female FG-WSA, Grp2, Yr 7)*

*I: Do you think young people would be interested in that [developing a school health plan and informing service design]?*

*M3: I kind of already do... but we don't do it with the school - I'm part of the [name] Youth Council so we do that a lot. I don't think there's an opportunity to do it at school.*

*I: Would you and or others like it if there was?*

*M1: Yeh. (School 1, male FG-WSA, Grp1, Y11)*

In the above quote from School 1, the young person refers to participation in a local youth council. He draws attention to the fact that the school does not currently have a mechanism for young people to get involved in the design/development and/or implementation of health or other initiatives in school and states that if the opportunity was available, he and perhaps other young people might be interested. Given a core principle of the WSA and/or HPS movement is enabling young people to gain more control over determinants of health one of the key issues to be addressed is how can schools provide an appropriate space for young people to genuinely and meaningfully participate in decision-making processes in health promotion and/or improvement? Like youth forums, health promotion school councils (HPSC) can provide one such space and mechanism. Embedded appropriately into a school's organisational culture, such councils can contribute to the promotion of mental, social, and physical health and wellbeing, improve interactions between different school stakeholders (teachers, pupils, parents, administration,



communities, school nursing, specialist health providers etc.), as well as develop the culture and ethos of a school (e.g. see Griebler and Nowak, 2012).

However, not all young people were so positive about getting involved in the commissioning and implementation (e.g. design) of health initiatives. In line with other engagement activities with young people (e.g. AYPH, 2014) as well as the findings from the literature review and synthesis (Davies, 2015) there was a clear sense young people felt that even if they did get involved, their voices would not be heard. This was also reflected by young people in the emotional wellbeing and resilience focus groups (Section 4):

*M1: The school takes your opinion [but]... your opinion doesn't really count because nothing gets changed. (School 1, FG-WSA, Grp2, Y11)*

*M2: ... I think that for some people in our year, it would be*

*M1: A joke to them.*

*M2: ... it wouldn't be their kind of thing because in their kind of thinking, quite a lot of people won't be here next year so it won't actually be relevant to them. So we'll be designing it for it to be better for someone else. (School 1, male FG-WSA, Grp1, Y11)*

*I: So, would young people be interested in actually designing and delivering some of this stuff [health initiatives], getting involved?*

*M: Yeh but it won't happen.*

*M: It's coming from the voice of a pupil, of course we don't know anything do we?*

*M: Yeh but it's not like anything's going to be done about it no matter how much we express our opinions, nothing ever gets done about it.*

*M: The school's always right when I'm wrong. They're always right, we're always wrong.*

*M: It's working for them, they're getting money out of it, they're not going to change it.*

*M: They don't care about us.*

*M: The school, literally they say yeh we've got a student voice, just so they're put in a positive light, we don't have any choice.*

*I: So you're worried about getting involved in something you won't get listened to anyway?*

*M: We don't get listened to anyway, what's the point? (Youth Centre, male FG-WSA, Yr 9)*

In one group, young people discussed about ways their views could be heard through private means such as via questionnaires, anonymous texting, suggestion boxes etc., but nevertheless, remained sceptical that involvement in such ways would be meaningful or taken on board by the school.

### **Engagement with families**

Given the WSA advocates the need for schools to engage families, outside agencies, and the wider community in recognition of the importance of these other determinants on young people, young people were also asked about whether they would be interested to have their parents or other family members involved in their health issues at school (such as informing the school health plan, linking with schools to raise awareness and reinforce health messages at home). If done appropriately, this generated a positive response:

*I: What about your parents working with people in the school to deliver a plan, do you think that would be useful or not useful?*

*M: You could get the mick taken out of you as well so if she came in everyone would recognise that she's my [parent] and I'd get the mick taken out of me.*

*I: What about them working with the teachers, not in front of you lot but just developing a health?*

*M: That would be ok, yeh. (School 1, male, FG-WSA, Grp1, Y11)*

However, in general, most young people were clear – they did not want their family members involved in issues relating to health at school. Reasons for this once again appeared mostly to be due to concerns over lack of confidentiality regarding disclosure but this time with regards peers rather than staff:

*I: That was an emphatic no [to parents being involved in health issues] but why not?*

*M1: It's because we're all 15, 16 and if you find something out about someone you normally try and use it against them in a funny way.*

*M2: Spread around.*

*M5: You can't really guarantee that the information's going to stay confidential.*

*M3: Cos you have certain friends like best friends who you think you tell something and they don't tell anyone else but then you have other friends that will hear something and they'll spread it on to someone else and it will then just become bigger and bigger. (School 1, male FG-WSA, Grp1, Y11)*

Engaging young people to inform health improvement  
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# Section Four

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## Emotional wellbeing and resilience



## Section Four: Emotional wellbeing and resilience<sup>13</sup>

### 4.0 Introduction

Data for this topic was generated from 23 participants (11 male, 7 female, and five who identified as transgendered) from four focus groups and one individual interview at three different locations: a mainstream school; a youth club, and; a Pupil Referral Unit (PRU<sup>14</sup>). There was a broad demographic variety within the sample meaning that some issues that emerged were specific to a particular location or demographic (such as the PRU and Trans youth group), but there were also interesting commonalities that emerged from the data. Therefore, the findings are categorised into five main overarching themes: awareness of resilience; constraints on resilience; individual strategies to achieve resilience; social and/or collective resilience strategies; and the role of schools/services in helping young people to achieve resilience.

### 4.1 Awareness of resilience

Initial conversations focussed around what young people found stressful and what helped them cope with such stressors and achieve greater resilience. Recognition of the term ‘resilience’ was by no means universal during the interviews, with most participants being unfamiliar with it when asked. For instance, in the school and PRU interviews, only one participant was explicitly aware of the term, and this was only because he had been introduced to it at his previous mainstream school:

*I: Do you know what resilience is?*

*M: Yeah... I know what it is. We used to talk about it in my old school like it was something massive.*

*I: What did they say?*

*M: They said it was the ability to bounce back.*

*I2: That’s almost the classic definition.*

*M: It’s annoying though...*

*I2: Because?*

*M: ... People continue talking about it like we don’t know what it means. Teachers talk to us like we’re stupid when obviously we’re not...*

*I: Would you say, was it useful or not?*

*M: No not at all. (PRU, mixed FG-EWR, KS4)*

Interestingly, whilst this near text-book definition of resilience shows a clear awareness of the term, the participant who mentioned it rejected any utility it may have had because of the way in which he felt it was presented to him. This suggests that it wasn’t the term itself that he rejected, but how the concept was perceived to have been delivered at school (e.g. in a patronising way) that caused him to disengage with it. However, this did then generate some discussion of the topic amongst others who showed an understanding of what being resilient might look like:

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<sup>13</sup> Weare (2015, p.3) provides the following definition of social and emotional well-being; “a state of positive mental health and wellness. It involves a sense of optimism, confidence, happiness, clarity, vitality, self-worth, achievement, having a meaning and purpose, engagement, having supportive and satisfying relationships with others and understanding oneself, and responding effectively to one’s own emotions”.

<sup>14</sup> PRUs provide education to young people who have been excluded or cannot attend mainstream schools because of emotional, social, and/or behavioural difficulties and may be more likely to exhibit challenging behaviour.

*I: The reason we ask is that it's a real buzz topic and ... it's talking about the ability to bounce back. ... so we're really interested in finding out more about what you think about it.*

*F: Like when you said bounce back, does it mean it'd be like getting back and that.*

*M: On track like turning your life round, it's never too late. (PRU, mixed FG-EWR, KS4)*

However, in the group interview with participants who identified as Trans, there was a much greater sense of awareness and engagement with the term 'resilience':

*I: Have you ever been told about the concept of resilience? ...have any of you ever heard that word?*

*T1: Yeh.*

*T2: Mm.*

*I: Does it mean anything to you or have any relevance?*

*T1: Strong willed.*

*T2: I think we're quite resilient, we have to be resilient to be ourselves.*

*T1: I remember an activity about it, because [name] was talking about it...*

*T2: We do all have to be resilient every time we walk out of our front door, that is when we have to start being resilient because you don't know what's going to come from where, like it is difficult but to be ourselves it's what we've got to do.*

*...*

*T1: It's useful. Just like it's like a protection word. If you call yourself resilient then you're going to get confidence from it because you know you're stronger than some people who would put you down because in a sense you're better than them because you can take it on a daily basis whereas maybe they wouldn't be able to cope with it. (Youth Club, Trans FG- EWR, Yrs 9-10)*

Trans young people thus appeared to find it easier to engage with the term resilience than other participants interviewed, perhaps because it had more practical utility for them as it helped them develop a sense of psychological protection to deal with the external pressures they face. This finding complements evidence recently reported by the 'Engaging Communities Staffordshire' (2015)<sup>15</sup> study, which highlighted that transgendered people may have additional health and well-being needs to the general population as "feeling uncomfortable or confused about their identity can affect their mental well-being in many ways" (p.7). Therefore, there is perhaps a greater need for those who identify as Trans to be resilient in the face of societal stigma.

## 4.2 Constraints on resilience

### **Physical environment**

Participants reported a variety of different possible barriers to dealing with stress and achieving resilience, many of which were specific to the particular educational context in which they were situated. For instance, participants from the PRU frequently reported feeling physically constrained by such an environment (there is a large perimeter fence around the PRU and classrooms are locked when not in use), but also how certain cultural norms have developed that set PRUs apart from mainstream schools, which could increase their stress levels, and make resilience less likely. For instance, there was a general perception that the PRU setting had a custodial feel:

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<sup>15</sup> <http://temp.ecstaffs.co.uk/wp-content/uploads/2015/02/SCC-Redesign-of-Sexual-Health-Services.pdf>

*F: We're kept in prison in these classrooms so we can't get out. Oh yeh, no we can in these classes, but the teachers stand in front of the door, like guards... At like a fucking zoo.*

*I: If you could change one thing about this place, what would it be?*

*M: To not have locks on any of the doors. It's so annoying.*

*F: Yeh.*

*I: How does that make you feel?*

*M: Literally like I'm in prison. (PRU, mixed FG-EWR, KS4)*

However, the impact upon resilience that a PRU's physical environment could have was not universally seen as negative, and some participants also recognised possible benefits. For instance, some reported experiencing less stress when compared to their mainstream school, because of the smaller classroom sizes and consequently fewer potential distractions from other students:

*I: Would you say it's more or less stressful than the schools you were at before, or no different?*

*M1: More.*

*M2: Less.*

*M3: Less.*

*I: Those of you who said less, can you give us a bit more detail why is less stressful?*

*M2: Less students to kick off, less noise in classrooms sometimes. (PRU, mixed FG-EWR, KS4)*

## **Bullying**

Bullying was a common theme mentioned by participants in the mainstream school discussions, and in both focus groups this was discussed in detail as a possible barrier to achieving resilience. However, there was also a general perception in this group that their school did not address bullying adequately:

*I: So what can the school do around bullying?*

*F1: ...I've recently joined choir club and I didn't mean to audition for the solo but my friend was too scared to do it in front of everyone so they left and ...then so I did but I didn't do an audition so I got the part and it was too late to back out and some of my form found out and they're apparently going to come so they can hear me sing so they can make fun of me ...*

*F2: I find that pretty harsh because-*

*F1: -that is harsh and because they judge me for who I am that I'm not going to be any good at singing so they bully me.*

*F2: - yeh but bullying is completely out of order...*

*F1: But this school does nothing, nothing. (School 3, mixed FG- EWR, Yr9)*

Homophobic bullying was also cited as a common stressor and potential barrier to resilience amongst participants from the Trans group, and this was compounded by the perception that their schools did not address the issue adequately:

*T1: I go to an all-boys school so you always hear around school, you hear oh 'gay' or 'faggot'... When I was in year 7, 8 and 9 ... I was called it everywhere I went, 'oh he's gay' or... 'he's queer' and it really put me down. The school did nothing over it, it was like 'oh we'll deal with it don't worry' and then just slid it under the rug. Then ever since I came out they stopped saying it, which is quite weird.*

*I: Did you say they stopped saying it when you came out?*

*T1: Yeh. ... it was kind of like they were shocked. They kept saying it and then I came out and they kind of went 'oh'. They kind of paused for a minute... because... the definition of an insult*

*is taking away someone's identity so if you're calling someone gay and they are, it's not even an insult, it's just pointing out the obvious. So I think that's what happened at my school and they kind of just went 'oh we can't call him that now what do we do'. I was left on my own. (Youth Club, Trans FG- EWR, Yrs 9-10)*

Interestingly this extract also illustrates a resilient (even if possibly unforeseen) outcome for this participant in response to the bullying, as once he had come out, the homophobic taunts seemed to lose all their power against him, and so the bullies stopped using them as they no longer had any effect.

### 4.3 Individual strategies to cope with stress and achieve resilience

Some participants showed an interesting degree of insight into what they found stressful and the various strategies they used to try and cope. For instance, the following participant from the PRU talked about his experiences at his previous school and then compared them to his current environment:

*M: At my mainstream school ... I used to be the one that kicked off and then I think the reason I started being naughty in the mainstream school was because everyone else was and then I came here I started being better behaved but now I keep on seeing people kicking off and that so it makes me think oh like that reminds me is I used to find it quite fun cos it's like doing whatever you want really, just going on a little nutty one. But now every time, that's what stresses me out other people reminding me of what I was like and that and it just makes me want to do it again. (PRU, male I.I.-EWR, KS3)*

So, he openly admitted that 'kicking off' used to be 'fun' for him, and perhaps a personal strategy for resilience, albeit a problematic one, as the consequences of such actions could result in interventions that could compromise his resilience in the long term (behavioural sanctions, timeout, exclusion from mainstream schools etc.). However, he also seemed to distance himself somewhat from such behaviour now, and also mentioned that seeing others do it can be stressful because it reminded him of what he used to be like. He later described how even within the physical limits of a PRU, he could negotiate with staff to explore more creative ways of achieving resilience:

*I: What other things help when you're hyper?*

*M: Er, I don't know, just running around.*

*I: Do you get a chance to do that here?*

*M: Yeh earlier I was going absolutely mental sprinting up and down this corridor, sprinting all around the school, like jumping everywhere and like just until I got worn out and I couldn't run any more, they just let me run up and down the corridor, they just let me sprint up and down until I was worn out. (PRU, male I.I.-EWR, KS3)*

Participants from the mainstream school focus groups reported perhaps more traditional methods of trying to achieve resilience, such as engaging in physical sports as a tactic to deal with their anger by distracting them from whatever it was that was bothering them:

*M: Well the rugby which I play more, say you're angry, it's easier to take your anger out because you're just throwing people across the floor...*

*I: What purpose does it serve? How does sport, does it help with coping or?*

*M: More like if you enjoy it you'll be more focused on that than you'll let all your other, say you're worrying about something, you'll forget about that for the time you're playing sport because you're enjoying that rather than focusing on your worries. (School 3 mixed FG-EWR, Yr 9)*

Participants from the youth club also reported a variety of different individual strategies to achieve resilience, and also showed a degree of insight into the possible benefits resulting from such approaches:

*M1: I know how to meditate... like someone taught me a weird way of how to relax, it's quite a personal way, the gist of it and he was like yes, it releases loads of endorphins and I was like ok.*

*M2: I guess we do like a lot of activities and stuff, we do stuff here like art and that but then... I take that home and if I'm feeling upset or whatever, then I'll do some drawing or some painting or just write down how I feel and that helps quite a lot if I'm feeling stressed. Or like doing exercise and stuff like that. (Youth Club, Trans FG- EWR, Yrs 9-10)*

#### 4.4 Social and/or collective resilience strategies

The influence that others could have on young people's resilience was a common theme in the discussions, and participants revealed some interesting observations of such influence, with a shared sense of identity, mutual trust and social support being significant resources from which they drew upon to help enhance their resilience. This links with the social psychological literature (e.g. Jetten et al., 2012) which demonstrates that mental and physical well-being can be improved by people having a strong sense of identity and hence connection with their social group, and also supports recent advice for schools on well-being that emphasised the role pupils' peers could play in supporting them (e.g. Weare, 2015, p.7). Although the sources of such social support could vary, young people were often explicit about the role they felt that mutual peer support could play, as illustrated in the following extract from the PRU focus group:

*I: Do you find people help each other when people get stressed?*

*M: Yeh ... like say another student is getting stressed, I think like being how close that they are I think another student would be able to help that other student that's getting stressed more than the teachers will on certain situations.*

*I: Do other people, have you found that that other students can help each other out in different ways than say the teachers?*

*M: Yeh. (PRU, mixed FG-EWR, KS4)*

However, this shared sense of social identity and consequent mutual support could also result in unintended consequences that could impact negatively upon young people's resilience. For instance, this participant from the PRU explained that seeing others with whom he was close (and so had a shared sense of identity with), 'kick off' could result in him becoming agitated too-something that didn't happen if he didn't identify with the other young person involved:

*M: It's weird, sometimes when someone's kicking off I can either find it funny but if I'm close to the person then I kick off as well. Like if someone was doing it to like, like my mate [name], when she used to kick off in the school and like the teachers tell her to stop and say that she's getting sent home then that's when I start kicking off but when I started kicking off and they*



*said I was going to get sent home, that's when [name] would start kicking off. It's just like when one of us argues, all of us argue really.*

*I: Is it different if they're your friends or not?*

*M: If they're not my friends and I saw them getting restrained, they'll probably stand there and laugh at them because it's funny just watching. (PRU, male I.I.-EWR, KS3)*

Participants from the Trans youth group were also very forthright in their descriptions of the sense of support they derived from their peers, reporting that they felt a strong bond of mutual trust, and likened this closeness to being in a family:

*M1: We all get along here.*

*M3: Yeh, everybody just accepts each other.*

*M1: There's no secrets or an air of mystery, we're all very close like family in a sense, so we can trust each other.*

*CC: Do you feel supported by each other?*

*SEVERAL: Yeh. Definitely. (Youth Club, Trans FG- EWR, Yrs 9-10)*

Trans young people continued in this vein describing how their involvement in the youth group gave them a common identity derived from their shared identification, and also a sense of mutual support in a non-judgemental environment that gave them increased confidence and enhanced resilience to face the outside world.

*I: Do you find being involved in groups like this... help you with your resilience?*

*M3: Yes. Definitely, it helps to know how to be able to hold heads high and just go, you know, we're not going to pretend to be anyone we're not.*

*I: Can you think why that might help you be resilient being involved in things like this?*

*M3: Because everyone helps you to feel more confident in being yourself when you're here but also if you've got problems ... you can talk to other young people, you can talk to the staff and they help you to know how to be resilient outside of the group as well.*

*CC: Do you feel any shared sense of common experience with people?*

*M3: Yeh.*

*I: Can you explain that - any examples?*

*M3: You just meet people that are ... going through the same... difficulties as us, it's like we're all different... but we're sort of grouped... into a different group if you know what I mean and... we all just have a laugh, we all get on, we know we can talk about anything with each other and we're not going to get judged for it. (Youth Club, Trans FG- EWR, Yr 9-10)*

The sense of mutual support that these participants reported from their common experience of negative events (such as suffering social stigma from their identification as transgendered, homophobic bullying etc.), can also illustrate how resilience may emerge from initial adversity. Similarly, evidence from the literature (e.g. Cocking, 2013) has shown how collective resilience can emerge from a common identity that results from shared experience of adverse events (such as disasters, mass emergencies etc.). However, such processes are not unique to life-threatening emergencies, and the following extract shows how more mundane (but perhaps similarly stressful to the young people who are experiencing them!) adverse events can encourage the emergence of a sense of collective resilience:

*M1: I've become friends with people I thought I would never have become friends with. Because of exams we'd always rely on each other and I think it's brilliant that even something that's so*

*intimidating can just bring people closer together and shows that humans in general - in a time of need - will band together like our natural instincts would. (Youth Club, Trans FG- EWR, Yrs 9-10)*

#### 4.5 The role of schools/services in achieving resilience

When asked about the support they received from teachers and other professionals, young people were more circumspect. This is perhaps not surprising given that research (Jetten *et al.*, 2012) has found that social support is more likely to be perceived as being effective when coming from one's own social group (e.g. one's peers). In such circumstances, teachers and other adults will be more likely to be perceived as an 'outgroup' and so may be less able to provide meaningful social support- however well-intentioned such attempts may be. The following extract illustrates the ambivalence some participants had about their school teachers' attempts to support them to become more resilient:

*I: At this school, do you feel supported in helping to deal with your stress?*

*SEVERAL: No.*

*I: Does anyone feel supported?*

*F1: Sometimes.*

*I: Can you think of any examples when you do feel supported?*

*F1: When you have like a problem, like with another student or anything, you can go to the Head of Year or [staff member] and the Deputy Head of Year and they do help but they talk you through it to calm you down but they don't necessarily do anything about that problem.*

*F2: They can only help you to a certain extent.*

*F1: Yeh they can only help you understand the situation more but they don't actually do anything about it, just help you cope. (School 3, mixed FG- EWR, Yr9)*

This extract highlights potential limitations with individual resilience frameworks that have been raised by recent reviews of the literature (e.g. Cocking, in press). For instance, the young people here highlight the possible limitations of the support that school staff can offer them, and feel that this support tends to focus on merely helping them cope with the stress (as opposed to resolving the situation that is the cause of their stress). This illustrates quite well the need to also consider possible broader social perspectives when looking at strategies to improve individual resilience. For, if such contexts are not considered, then there is a risk that the concept of resilience could become little more than 'sociological Prozac' (Cocking, in press, p.7) if it does not challenge the broader structural inequalities that could impact upon young people's resilience, and instead expects them to simply adjust to adverse circumstances. There were also more specific sub-themes that emerged from the over-arching theme of young people's perceptions of institutional support, and these will be addressed in turn.

#### **'Nobody listens to us'**

A sub-theme that was also common in the data was the perception amongst participants that staff did not listen to them (or even if they did listen, nothing of substance would change anyway), and this negatively impacted upon their ability to deal with stress and achieve resilience. This concurs with findings from the WSA (Section 3) as well as the literature review and synthesis by Davies (2015) who found that not being listened to, is among the top concerns of young people, despite

the necessity of placing young people at the core of interventions to improve well-being and resilience. Participants kept returning to this issue throughout the discussions, with the topic also being used as an example of why participants felt that their views were not being considered in a meaningful way, as illustrated in this extract with young people at the PRU:

*I: So is it being listened to do you reckon?*

*M: Yeh. But then I see it as like also you're being listened to for literally no reason, because nothing's going to happen, nothing of what you're saying is actually going to be taken into consideration and like actually being made into a change. So it's just like pointless. (PRU, mixed FG-EWR, KS4)*

Furthermore, the following extract from a school focus group illustrates the potential difficulties young people felt were inherent in talking to staff about threats to their resilience (especially if they felt the teachers were responsible for such threats), and their desire to be able to talk to other adults who weren't involved in teaching them:

*F: If you're in a bad mood you can't really, and the teacher's caused it, that's kind of what it revolves around, you can't really talk to other teachers about it because they might get annoyed with you because you might have said something about the teacher.*

*I: Do you find there might be other things that could deal with the stress that aren't teachers?*

*M1: Get people in that aren't your teachers so you can slag them off.*

*I: Like me?*

*M1: Yeh. (School 3, mixed FG- EWR, Yr9)*

Therefore, perhaps having adults available that young people could talk to in less formal settings, and who are perceived as more 'neutral', could encourage greater trust and foster more opportunities for resilience to emerge (although there would still need to be clear guidelines about disclosure and safeguarding issues to prevent possible divisions between these informal arrangements and the existing formal support networks that are already in place in schools).

### **Taking a lead**

Data emerged from the interviews suggesting that schools need to provide strong leadership if they are to promote young people's resilience more effectively; something that is explicitly stated in the NICE guidelines on social and emotional well-being in schools (see NICE, 2009, 2013) although there was also recognition of the possible associated complexities in this area. For instance, in the discussion with Trans young people, participants felt teachers needed to take a lead in dealing with homophobic bullying, but also recognised that there were risks associated if this involved leading by personal example:

*T: I just think if teachers can't deal with it then kids aren't going to deal with it, you know*

...

*T2: The teacher has to be very brave themselves because teenagers, especially in year 10 and 9 can be really quite vicious, with their comments so it can ruin a teacher's career. Like in a sense that they came out but then they might not have control of the class because the class can be very homophobic to them which is why I think some teachers are afraid to come out.*

*T3: It takes a very confident person to come out.*

*T2: We've got a couple of openly gay teachers at our school and they get teased about it all the time outside of class. (Youth Club, Trans FG- EWR, Yrs 9-10)*

In one of the school based focus groups, participants also expressed frustration at what they felt was not only a failure to set a good example, but also the perceived inconsistencies in the teachers' approach to the pupils, as illustrated in the following extracts:

*F1: Everybody should follow the same rules including the teachers because they don't set a good example at the moment and it just encourages us to do the same. So if they did it, if they follow the same rules maybe it would encourage us to as well.*

...

*F2: They teach us to be independent and be ourselves but then they go along the road where we're not allowed to express ourselves, so [name] I'm very sorry, taking nails as an example but that's what [name]'s into so that's what she does whereas me I wore bright lipstick to school and I got an after school detention for it but they teach us to be independent. (School 3, mixed FG- EWR, Yr9)*

### **A resilient space**

A final theme that emerged was of a more practical nature although still of significant importance to participants - that of a 'safe space' where young people could go to if they felt their resilience was compromised. This notion has been recognised in previous work on resilience in schools (e.g. Hart and Green, 2014<sup>16</sup>), as well as DfE (2015b) guidance for school staff on mental health and behaviour in schools both highlighting the need for 'stress/relax room' where young people can retreat to when necessary. Availability of such a space sometimes depended upon the physical environment of the educational establishment that young people were situated. For instance, participants in the PRU felt that such spaces were absent<sup>17</sup>, meaning that the female pupils resorted to creating their own 'safe space' in the toilets:

*F: What they do here is, say that you're stressed; they don't really give you any time like... 'go and try to calm yourself down'. They're literally just in your face.*

*I: Do you get a space like a physical space, a chill out space, a time out space that you can go to?*

*M: No.*

*F: No*

*I: Do you think that would be useful?*

*F: Yeh.*

*M: But to be honest there probably isn't anywhere*

*F: Yeh I know because we don't have anywhere, like... if the girls are stressed they just tend to go to like the girls' toilet. (PRU, mixed, FG-EWR, KS4)*

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<sup>16</sup> [www.boingboing.org.uk/index.php/component/content/article/14-static-content/our-research/145-schools-projects](http://www.boingboing.org.uk/index.php/component/content/article/14-static-content/our-research/145-schools-projects)

<sup>17</sup> The PRU did have an isolation room, but there was a perception that this was somewhere that young people were taken to when they became agitated or distressed rather than a space that they could voluntarily seek out and go to.

Engaging young people to inform health improvement  
commissioning and delivery in East Sussex

# Section Five

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## Sexual health improvement



## Section Five: Sexual health improvement

### 5.0 Introduction

Eight focus groups with young people (n=39; or 40.2% of the total sample) between 11-19yrs were conducted from six recruitment sites across East Sussex. The sample comprised a proportion of young people who had experienced the East Sussex 'Safe Around Sex' (SAS) programme<sup>18</sup> for targeted schools. Findings from these focus groups were categorised into the following six main themes:

- Experiences of Sex and Relationships Education (SRE);
- Improving SRE in school – young people's preferences;
- Views on the 'Safe Around Sex' programme<sup>19</sup>;
- Opinions and experiences of the East Sussex C-Card;
- Communications and campaigns (within and outside school);
- Ideas on positive sexual health and relationships.

### 5.1 Experiences of Sex and Relationships Education (SRE)

Young people from different settings (targeted and non-targeted schools as well as those attending youth settings) expressed considerable dissatisfaction with the amount and quality of SRE they had experienced whilst at school. The views of young people in East Sussex about the lack of provision and poor quality echoes the national perspective (e.g. fpa, 2007; UK Youth Parliament, 2007; Brook, 2011), that is thought to be consistent throughout at least the last two decades (DiCenso *et al.*, 2002). Moreover, the reality of young people's experiences appear to contrast with the ambitions of the Departments of Health and Education for children and young people to receive high quality sex and relationships education (Brook, PSHE Association, and the SEF, 2014):

*M1: No SRE*

*M2: We've had literally nothing for the past 5 years that I know. (School 1, male FG-SH, Grp2, Y12)*

*I: What advice have you been given about sex and relationships?*

*F: Nothing.*

*F: Well no, sex ed.*

*F: Yeh but they don't really go personal, they just go the overall topic.*

*...*

*F: Yeh, you learn like the basics but to be honest most people know that by the time anyways. (School 3, female FG-SH, Yrs 7-8)*

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<sup>18</sup> The SAS programme is a targeted school-based teenage pregnancy prevention and SRE enrichment project for young people at risk of relatively poor sexual health outcomes (e.g. teenage parenthood). Aimed predominantly at Year 10 students aged 14/15, SAS is conducted in small group settings that aims to raise self-esteem and impact positively on lifestyle choices, thus reducing risky behaviours and increasing their own and others' personal safety.

<sup>19</sup> Although the findings from the focus groups with young people who had experienced SAS are presented in a separate them, where relevant, data from these groups are also presented in other themes to support, compare, expand, or refute particular points.

Although the views from the young people within this East Sussex sample are far from unique, more positively, their experiences provide valuable insights and a clear rationale towards their own recommendations for improvement (see 5.2).

Many young people felt that their school did not take SRE (and more broadly) PSHE seriously suggesting, in one example, that this was because schools are judged by exam success which takes priority over sexual health promotion and education matters (see also Section 3.2 on the WSA for similar findings). In one all-female group at a local youth centre, young women's narrative reflected this view:

*F1: I think the thing is, schools are based on exam results cos that's all they get judged on-*

*F2: They just want a good image.*

...

*I: So you think they don't provide more on this sort of subject because it's not tested?*

*F: We already have that in science. The school don't care about it unless you're tested on it because they need results. (Youth Centre, female FG-SH, Y9)*

These perceptions are likely to be a consequence of government policy of PSHE not being a statutory requirement within schools. Although SRE is a requirement for all maintained secondary schools (through the National Curriculum Science rather than PSHE) to include work on STIs including HIV/AIDS, those that do not deliver or provide limited PSHE may rarely align sex education to the broader context of health and well-being and relationships. This current context, essentially allowing schools to adopt a diverse range of delivery models (Owen *et al.*, 2010), is imperative in understanding some of the strong views and experiences held by the young people who participated in this study.

Young people expressed views that both supply teachers and 'normal' classroom teachers often lacked the specialist knowledge or training to teach SRE appropriately (see also Section 3.2.1 on the WSA). Evidence from the literature shows that this also resonates with teachers themselves who report not having sufficient knowledge to provide young people with adequate sexual health education, and that when they do not feel prepared to teach, in many cases they prefer not to teach these programmes; see Westwood and Mullan, 2007). In their narratives, young people in this study thus viewed staff as not being credible and a sign that the school does not value the issues/subject. These perceptions appeared relevant for males and females, across different settings (targeted school, non-targeted school, youth setting), and age groups. These views are particularly significant given that the teachers' relationship with the class is one of the core predictors of young people's engagement with the subject matter (see Buston and Wight 2004):

*M1: You can't take it seriously so you'd have a supply teacher cover the lesson.*

*M2: Or they don't know what they're talking about... if the teachers don't know what they're talking about, you get... like geography teachers and they are trying to teach us how to put a condom on... they should just get a dedicated teacher to do it if you're going to get it at all. (School 1, male FG-SH, Grp1, Y12)*

*I: ... You said I think that you were going to be shown tomorrow how to put a condom on?*

*F: ... it's probably just going to be a joke because the teacher's probably not going to be able to keep control - the teachers can't, they just give up, oh yeh they show us and then people are doing it and then they start chucking it [the condom] about and messing around.*

*F: Especially cos the teachers aren't properly trained...*

*F: ... It just turns into a massive joke and I think it's unfair on the people who actually want to learn.*

*F: You laugh when you're there but you realise afterwards you probably should be paying attention. (Youth Centre, female FG-SH, Y9)*

Given the nature of the SRE, the laughter/disruption in the above quote is probably not surprising and most likely does not indicate disinterest, with the interplay between humour and discipline seen as an effective strategy within this context (see Buston and Wight 2004). Indeed, laughter can of course help create a more relaxed environment, but may also as is implied above, be a psychological reaction to feeling uncomfortable and in doing so, prevent open and constructive discussion by alarming other young people with serious questions to pose.

Overwhelmingly and in line with the literature (e.g. Hilton, 2003), young men reported unanimously that the gender of the person delivering SRE did not matter. Rather, young people tended to have a strong preference towards information received from a specialist facilitator, alongside a 'youth friendly' approach (in conjunction with the teacher not being 'too old'); a good teacher-relationship with the young people; capable of normalising issues; and not presenting SRE as embarrassing. The preference for a specialist approach matches the evidence generated through other research (e.g. see SEF, 2008; Turnbull *et al.*, 2010):

*I: What about gender of the person that's doing it [delivering SRE]? Does it matter, do you have a preference?*

*M1: As long as they know what they're talking about... I don't think it particularly matters. If you've got a question that you want to ask then you do just have to ask it.*

*M2: They need to present it as something that isn't embarrassing, like the students don't want to be fearful of, 'ooh I don't want to ask this question about sex'. It doesn't matter what the gender is because if they're trained enough they'll be able to answer. They've got to be approachable to the students. (School 1, male FG-SH, Grp1, Y12)*

In terms of delivery, the focus groups generated lively commentary about the school nurse and their role. While some described the nurse-teacher interaction within the drop-down stay as 'spot-on', the majority of responses were critical. Similar to the WSA findings (Section 3.3), issues were raised around uncertainty whether there was a nurse within the school; their availability; their location within the school; and their overall manner. This opinion is reflected in the national perspective with the Department of Health (2012) publishing from the views of young people, a need to make the school nurse more accessible (including a confidential booking service), visible, able to offer early help, and more convenient in terms of place and time, and facilitate means by which young people can offer views about the service they receive (BYC, 2011; DH, 2012). This is an important viewpoint, given that the role of the school nurse has been considered an important support for teachers as well as to (particularly younger) students themselves (Westwood and Mullan, 2009).

*M: Well she's [nurse] here on Thursdays, the problem is though even though we can go to her, the problem is we don't know her that well to go and, say if [name], he thought he had an STI and he wanted to go and speak to the school nurse, I don't think he'd be that willing to try and show her because he doesn't know her that well and to him she's an outsider, she's a stranger, we never see her. (School 1, male FG-SH, Grp2, Y10)*



## Content of SRE

Within the context of the mixed delivery models, young people shared a variety of approaches to their SRE. As raised by young people in the WSA, in the sexual health focus groups some young people also talked about experiencing a ‘drop-down’ day which included a variety of different ‘stalls’ around the school for hour long sessions of around 20-30 young people each time (see also Section 3). The session on sexual health was run by the school nurse and included contraception, condom use (including how to put one on using a condom demonstrator), the influence alcohol can have on decision making, STIs etc. However, young people reported that such a ‘drop-down’ day had had little impact on them (not least to students who did not attend school on that particular occasion). This is in line with the conclusions of Ofsted (2005, 2013) who described these as “*limited because they do not connect with pupils’ prior experiences or meet their needs and there is no effective follow-up*” (Ofsted 2005, p.16), even if they were described on occasions as rather ‘in-depth’ (first quote):

*M: ... we had a big day where we went round and had, I learnt how to, well how to put condoms on plastic models and had STI talks and stuff like that so that was quite an in depth one. (School 1, male FG-SH, Grp2, Y10)*

*I: Do you think it’s had any impact on you [SRE at school including the drop-down day]?*

*M: I know how to put a condom on but that’s probably more from not in this school, it’s from going to the C-Card lady at the [location] - really not anything at school.*

*M: They end up teaching you the basic messages you know, don’t get STIs, how to put a condom on but they don’t... [trails off]*

*M: Well obviously they don’t because look at the teen pregnancy ratings in bloody [name of town]! (School 1, male FG-SH, Grp1, Y12)*

Reasons why young people saw the ‘drop-down’ day and SRE more broadly as having limited impact, was that it was recalled as being exclusive to a single school day and that SRE issues were interwoven within a whole host of additional health and well-being behaviours which diluted the detail:

*M: It was just anything and everything.*

*M: One part was healthy eating, one part was smoking, we spent 20 minutes in each.*

*M: They were just trying to go for a broad approach.*

*M: So one bit was healthy eating, one bit was smoking, one bit was drugs. (School 1, male FG-SH, Grp2, Y12)*

With existing SRE covering a wide range of issues such as contraception (including the correct usage of condoms) and STIs, there were instances of some informative additions such as consent for sex and legislation regarding age at which sex is permitted, sexting<sup>20</sup>, the femidom, and some relationships information. These instances of additional information, beyond the statutory guidance of contraception alongside STIs were, however, in the minority:

*M: Yeh we had a police officer come in and give us a lesson about consent and we watched a video about it and it pointed out when consent is given and when it isn’t.*

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<sup>20</sup> Sexting is the act of sending sexually explicit messages, primarily between mobile phones.

*M: It made it more official when the police officer came in.*

*I: Describe to me in that situation what is a situation where consent is given, how do you know consent is given?*

*M: If they say like no, then that's that so if you want to carry on there are serious consequences. (School 5, male SAS FG-SH, Grp 2, Yr 11)*

## 5.2 Improving SRE in school: young people's preferences

Young people offered numerous ideas on how SRE provision could be improved in school settings which were categorised into a number of distinct suggestions. The vast majority of participants form across the eight focus groups on sexual health (as well as the seven focus groups on the WSA; see Section 3.2) wanted greater provision of SRE and within the curriculum, along with opportunities to develop age-appropriate knowledge and skills over time (as opposed to single drop-down days).

*M: I think the big ['drop-down' day] was good but in a way I think we should almost have done it, like do one in year 7 and then one in maybe like year 9 and then year 10 just to make sure that's always fresh in your memory. (School 1, male FG-SH, Grp2, Y10)*

Starting SRE at the earlier age was also seen as an opportunity to intervene early, before any detrimental consequences could occur:

*M: I would say earliest as possible, even though there's going to be maturity issues and some people are not going to want to take part because they don't like hearing it, it is, the sooner you hear about it the sooner you can prevent it being you. (School 1, male FG-SH, Grp2, Y10)*

In terms of a provider, and in light of the criticism raised earlier, the strong preference was towards an expert provider of an appropriate age ('not too old'), and ultimately someone students could relate to and trust (gender was not an issue). This was thought to be a useful means of overcoming the evident awkwardness among teachers when delivering such potentially sensitive matters:

*M: Because some of the teachers we had were referred to as maybe teachers that everybody didn't like or found a bit awkward. I remember some of the teachers we had were very awkward how they taught it because they didn't really want to teach it but they had no choice in it. (School 1, male FG-SH, Grp2, Y12)*

In general, when students were asked about preferences about future content of SRE, they tended to repeat topics that they already covered in school. This supports the notion that the overarching recommendation was for more sexual health education providing greater *detail* on the key topics of contraception, STIs and relationships (particularly with reference to harassment and respect). Although not explicitly mentioned, it is intuitive that the request for more detail includes not just the 'facts' but also the necessary skills (such as negotiating condom use – see Helmer *et al.*, 2015) replicated in various sexual health interventions such as SHARE (see Wight, 2011) and the consequences (see next) of less than favourable sexual health outcomes. Further detail for more information within these topic areas is consistent with research reported elsewhere (e.g. Buston and Wight, 2006).

These experiences shared by young people suggest that the omission of specific topics, seen as a leading indicator of people's negative expressions towards sex education (see Shepherd *et al.*, 2014), was not particularly applicable in these focus groups. The isolated exceptions to this were recommendations for more information on sexting; the consequences of not following sexual health advice (for example, becoming pregnant at a young age); and managing the often gender stereotypes of some young people bragging over sexual exploits (e.g. Ringrose *et al.*, 2012) by, for example, using the C-Card for status more so than for condom use:

*F: Cos some boys like you're going to have sex with them and they'll be, they'll go to their mates and go, oh yeh I've done this you know and immediately take it not seriously. And some people will just take it [C-Card] and say things that are not true just to make them look cool. (School 3, female FG-SH, Yrs 7-8)*

Preferences towards more information on the positive aspects of sexual health and feelings and emotions were rarely expressed (see Section 5.6), possibly because they were seldom mentioned (if at all) as in other schools nationally (SEF, 2008).

Finally, in tune with the research literature, it was unsurprising that there was a strong preference for single sex groups, generally more important for girls than boys (e.g. Strange *et al.*, 2003; this gender issue is addressed in more detail in the next section (Section 5.3)

*I: Would you like more sex education?*

*F: Yeh more sex education yeh if girls are split off from boys cos they'll just be like [LAUGHS MOCKINGLY]. (School 4, female SAS-FG, Yr10)*

### 5.3 Views on the 'Safe Around Sex' (SAS) programme

One quarter of the young people who engaged in the series of focus groups on sexual health promotion (n=10 or 25.6%) had participated in the East Sussex 'Safe Around Sex' (SAS) programme. Issues presented here include: participant selection and group characteristics and delivery; and programme content and influence.

#### **Participant selection, group characteristics, and delivery**

The two schools in the sample presented the SAS programme to young people subtly whereby young people were 'chosen' specifically to participate in small single-sex 'health groups' to make their voices heard on important issues and messages around sexual health. For example, in one group, SAS was offered to the students as a 'men's health group' where young people felt they had been selected as those who 'voiced' their opinions rather than those in particular need in terms of risks from STIs or unplanned pregnancy:

*M1: Mr [teacher] asked us.*

*M2: ...he chose people that could voice an opinion on a matter like this. We had to get our parents to get a letter home to see if it was ok for us in particular. And he was like you don't have to do it but he just thinks it would be good...*

*M1: I think he chose the people that he chose because either things they've heard or like people who are able to talk and voice their opinion sort of thing. (School 5, male SAS FG, Yr 11)*

Similarly in an all-female group who had experienced SAS, a comparable approach was adopted by the school:

*I: Have you heard of Safe Around Sex? Where did you hear about it?*

*All: Yes.*

*F: In our little group, Miss.*

*I: What is that little group?*

*F: Health group.*

*I: ... Does everyone in your year get that?*

*F+: No.*

*F: No just a little group... Cos we're special [LAUGHS]. (School 4, female SAS-FG, Yr10)*

Such a careful approach to selection by the schools is to be commended in reducing the potential for enrolment into SAS to be stigmatising. Moreover, in both SAS groups there was a sense that young people felt proud to have been chosen to participate.

In a related issue, male students also commented on the formation, size, and functioning of the group suggesting that recruiting by 'friendship' group rather than being randomly brought together, was a useful protective factor against embarrassment and worries regarding potential breaches of confidentiality. Moreover, the small size of the group (and in line with the SAS programme ambitions) appeared to empower young people to interact with the facilitator more and ask questions that would normally be seen as a potential source of embarrassment in the usual whole tutor SRE groups:

*M1: It [SAS] ... because there was a much smaller group of us rather than 30 in the class, there was more focus on certain people at a time... With it being a smaller group it wouldn't be such an embarrassment to ask more questions cos we were all quite friends, we were all friends before and I think it's just a bit less embarrassing and not really much of a fear of having people laughing at you.*

*...*

*M2: Yeh and like because we all know each other as well, it felt more comfortable.*

*M3: And there was only a small group of like five or six guys so.*

*M1: I think if you picked six people from six different schools and put them in a room together I think it would be much more awkward to answer some of the questions or ask a question of your own.*

*I: Why?*

*M: Because you don't know who they are and you don't know if they'd like... go and tell people or something, you don't know. (School 5, male SAS FG, Yr 11)*

This implies that the SAS group in this case was successful in creating a strong group identity with shared norms and values, and in which a safe shared space for discussing sensitive issues can be created contributing to building of self-esteem and self-efficacy (e.g. Hilton 2003; Worchel et al., 1998; Turner et al., 1987). Interestingly, other young people who had not experienced SAS, commonly reported that they also wanted SRE to be delivered in small group settings to facilitate the creation of such psychological and emotional safe spaces. As noted in the educational and health literature (e.g. Strange et al., 2003; Sherriff et al., 2014), single sex groupings are particularly important for girls to create such 'safe' spaces preventing and denying boys opportunities to use

sexual language to denigrate girls, victimise, and harass them (sometimes physically). This view was reinforced by girls in the SAS focus group when commenting on the delivery of SRE in school:

*I: When you have your classes about SRE are they just you girls on your own?*

*F: No.*

*F: And boys so it's really embarrassing.*

*F: But then if you're sat next to a boy it's really awkward because they get like really like.*

*F: They get really sexually into it.*

*F: They're like oh yeh I've done that before.*

*F: I'd do that with you, no.*

*F: And they're like, do you want to touch my willie, it's like no, no.*

*I: Would you like those classes to be separate.*

*ALL: Yes. (School 4, female SAS-FG, Yr10)*

The above quote highlights not only the importance of providing opportunities for single-sex SRE sessions in schools (albeit for slightly different reasons for girls than boys), but that adequate attention also needs to be paid in SRE to broader issues around relationships and gender (e.g. empathy for others values, attitudes to women and sexual embodiment, harassment, gender identities and problematic deployment of certain types of hegemonic masculinities and femininities etc.; e.g. see Jackson and Sherriff, 2013; Sherriff, 2005, 2007). Moreover, it is well evidenced that young women, more so than young men are likely to link sexual activity with emotional attachment, whereas the latter tend to have a greater focus on the physical triggers for sexual activity, and articulate a competitive 'need' for sexual experience which is often distinct from any overt association with emotions and relationships (fpa, 2007). This is not to say that mixed groupings should not still be offered as they can be valuable for helping young people to consider, compare, contrast, and challenge each other's assumptions about the opposite gender. Rather mixed groups should be complemented with single-sex groups as part of SRE provision.

In terms of delivery of the SAS programme, sessions at both participating schools took place once a fortnight during the time in which their peers received PSHE lessons. At one school, the programme was delivered by a member of the pastoral (rather than teaching) staff and at the other by a teaching assistant with responsibility and expertise in working with disaffected students. In terms of the latter, one of the major contributors to the overall positive view of the programme by young people was the facilitator. Positive aspects were related to her specialist knowledge, age as someone they could 'relate to', and the fact they were not a regular teacher. Notably as with data from other focus groups, the gender of the facilitator was rarely raised as an issue:

*M: She was good at getting her stuff across because she's quite young... and she knew how to put across in our terms.*

*M: I feel more comfortable doing it with her than doing it with like a... like one of the teachers, yeh.*

*...*

*M: I think [the facilitator] who taught it was really good, like cos she sort of understands us. I don't think anyone could have taught it any better than she what she done. Cos obviously like in a big class, there's more chance of people messing around and not taking it seriously but cos it was just a small group of us. (School 5, male SAS FG, Yr 11)*

## Programme content and influence

Young people were asked a variety of questions about the content of the SAS programme. For example, whether they remembered any of the advice they were given, how it might differ from other SRE they had experienced in school, and whether participation influenced their knowledge, thoughts or behaviours. Of the 10 young people who had experienced SAS, views of the programme were entirely positive and clearly match some of the previous evaluations of SAS within East Sussex (SEF, n.d.). In their narratives, young people recounted some of the interactive exercises that took place during the programme which focused on attitudes and values (e.g. respect for selves and others, understanding sex within the context of relationships, attitudes to women, influences of pornography, and so on), as well as STI symptoms. For the young male group, these exercises were not only formative in developing new knowledge and attitudes, but were also memorable and enjoyable:

*M: There was like a game we played, it was to do with values and it was sort of like a money game and we'd all bid and say which values we think are important to have in a partner.*

*M: It was a good game ... she [SAS facilitator] gave her opinion as well on certain values which obviously is important. It's not just like, you can't just be stereotypical... and so on, yeh.*

...

*M: We did one [game], we played like, when we learnt about the STIs and that we each had an individual card with a different disease on it and we all had symptom ratings, effect ratings and we all played a game like Top Trumps with them so we'd all get to know which ones aren't as bad as such and such and such and such. (School 5, male SAS FG, Yr 11)*

Similarly from the girls SAS group, narratives reflected enjoyment of the activity designed to simulate the challenges of using condoms correctly when under the influence of alcohol or 'beer goggles'. Interestingly, in a previous evaluation of support for young people (Sherriff et al., 2011), this particular activity was also perceived as a notable and a valuable learning opportunity:

*I: Did you learn how to put a condom on?*

*F+: Yeh.*

*F: We had to put it on a dildo.*

*F: We had to put masks on... just in case we were drunk when we had to do it [use a condom].*

*F: And under the covers.*

*I: I was wondering what the glasses were, so they were beer goggles and they were trying to see if you could still put it on.*

*F: If you could still see the date on it.*

*F: I could do it.*

*F: I could.*

*F: I couldn't open the condom so it was hard - I had to use my teeth. I was like- right, right, I didn't like it. (School 4, female SAS-FG, Yr10)*

As part of the programme, young people (with parental permission) were offered the opportunity to visit a local sexual health clinic. For both the male and female SAS groups, it was clear that young men knew where to go if they needed to, and felt confident in their ability to access it (although no visit was actually arranged among the males):

*M1: The group was good for like if you were to get any like when you're older, get any sexual diseases, now we know where to go which is good to have that knowledge.*

*I: Where would you go?*

*M1: If I got a sexual disease I'd go to that [name of sexual health clinic] place.*

*I: It's nothing to do with the school... it's a young person's?*

*M2: It's just a walk in clinic. (School 5, male SAS FG, Yr 11)*

*I: Where do you get that information [about contraceptive aside from condoms] from?*

*F: The doctor's.*

*F: Sex clinic.*

*F: Here, there.*

*F: You can get them from school, you can get them from sex ed, you can get them from the doctor's, you can get them from hospital. (School 4, female SAS-FG, Yr10)*

However, for the female SAS group, girls appeared less positive and rather than the visit encouraging young people to go in the future if they needed to, the visit seemed to have the opposite effect. In this particular group, girls' narratives moved on quickly to other topics and so it was not clear why this was the case:

*F: Yeh we went to a sex clinic.*

*F: Yeh.*

*I: As a group or on your own?*

*F: Yeh as a group.*

*F: I'm never going again. (School 4, female SAS-FG, Yr10)*

Young people were also asked about what they thought they had learnt from participating in the SAS programme. Narratives from the young men's SAS group revealed that some were sceptical of the programme at the outset because they felt they already knew many of the issues. However, reflecting on the development of their knowledge over time via repeated evaluation questionnaires, this demonstrated that knowledge development had taken place:

*M: We did a few questionnaires when we first got there and when we did our last one... it was the same questionnaire on both and the first thing we filled out there were some things that we didn't really know and then at the end we could tick yes and then it was obvious that we'd learnt such and such. (School 5, male SAS FG, Yr 11)*

When asked to reflect on any parts of the programme they would change or did not like, young people did not have much to say and instead were overwhelmingly positive in their views on structure (e.g. single-sex, small group), content (topics, time for content, interactivity), and delivery (facilitator age, specialist knowledge, and respectful approach to working with young people). Notably however, when thinking about future developments of the SAS programme, participants were asked whether they would want their parents or other family members involved either to some extent in the programme, or more generally in talking about sexual health. The findings were less than favourable and could reflect the age (aged 14-16) of the SAS sample where information from parents is deemed more 'awkward' or difficult (see Balding, 1999; Tanton *et al.*, 2015) as well as young people's overarching preference for school-based information (e.g. Coleman and Testa, 2007; Kesterton and Coleman, 2010):

*I: Your parents, you wouldn't want your parents to be involved more than they are in that sort of thing?*

*F: No.*

...

*I: Why would you not talk to your mum for example?*

*F: I don't trust her, everything I tell my mum she tells my nan, and she tells everyone, they have their little old people meetings, like [FUNNY VOICE] my granddaughter.*

*F: It's embarrassing. (School 4, female SAS-FG, Yr10)*

As noted in other parts of this report, concerns about personal disclosure being kept confidential (in this case family members) appears to be a key barrier for young people in seeking advice/support to maintain or improve their sexual health.

## 5.4 Opinions and experiences of using the East Sussex C-Card

Across the focus groups where young people had not experienced SAS, participants were generally aware of the C-Card<sup>21</sup> although this was often through 'word-of-mouth' and few young people had actually used one or knew someone who had used one:

*I: Do you know what a C-Card is?*

*F: It's a condom thing, you go to your pharmacy and they just give you condoms don't they.*

*F: If you give it to them they like give you some. (Youth Centre, female FG-SH, Y9)*

However, in contrast, young people who had experienced the SAS programme were all aware of the C-Card and all possessed one. Moreover, they were also aware that femidoms could also be accessed through the card<sup>22</sup>:

*I: Have you heard of the C-Card?*

*ALL: Yes [LOUDLY].*

*F: We've all got one.*

*F: The pharmacy and then they'll give you condoms.*

*F: Whatever condoms you want, like female condoms.*

*I: The Femidom.*

*F: Plastic bags basically. (School 4, female SAS-FG, Yr10)*

Most young people recognised the potential benefits of being able to access condoms easily and free of charge. In one school, one male student draws attention to the acquisition of a C-Card and its association with 'laddishness'. This implies that for boys who perform hegemonic versions of masculinity in school as indicated by the deployment of laddish behaviours, acquiring and possessing a C-Card hints at being sexual active whether this is a reality or not. A large body of literature notes how some boys survey and regulate girls behaviour in schools through the boasting of sexual exploits, which as Francis (2000) notes, can have severe repercussions for girls

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<sup>21</sup> The East Sussex C-Card scheme is a confidential co-ordinated condom distribution network which allows young people to access condoms and lube free of charge from a range of outlets across East Sussex. Available to under 25s (but excluding under 13yrs), the service is supported by evidence based, contraceptive and sexual health information, and sign posting to comprehensive contraceptive and sexual health services.

<sup>22</sup> At the time of data collection (April, 2015), femidoms were not actually available by the C-Card. However, this particular group of girls had just completed their SAS programme and therefore may have been informed by the group facilitator that femidoms would soon be available via the C-Card.



named or inferred in such boasts. If the C-Card scheme is being used as a tool by some boys to confirm their 'proper' masculinity, whilst it is arguably positive that young men are able access condoms, this is also potentially problematic and needs to be explored further:

*M: Well it is a good idea cos obviously STDs, being able to prevent STDs... but, like in this school, in a way it's sort of seen as slightly, forgive me, a laddish thing to go and do, to get a C-Card... (School 1, male FG-SH, Grp2 Y10)*

### **Barriers to use of the C-Card**

Several young people in the focus groups (who had not experienced the SAS programme) were unclear about the C-Card and how the scheme functions:

*I: Has anyone in school ever mentioned the C-Card scheme, or how did you hear about it?*

*M1: Friends.*

*M2: The odd mate had one.*

*M4: It gets mentioned but never explained.*

*I: It gets mentioned in what way?*

*M4: I'm fairly certain it has been mentioned a few times when we have had talks and things but it just says, if you had a C-Card or you should go and get a C-Card and then like, ok it's a C-Card but what is a C-Card? (School 1, male FG-SH, Grp2, Y12)*

*I: Ok so none of you have had a C-card and you're a bit vague on where you might find one.*

*F: Yeh where would you get it? (Youth Centre, female FG-SH, Y9)*

In most focus groups, young people reported practical and psycho-social difficulties with accessing C-Cards. For example, due to lack of knowledge about how they work (process), where to get them and when, as well fears about being judged for accessing too often.

Young people discussed a number of additional concerns over accessing the C-Card. For instance, in one female focus group, participants were mixed on whether they felt able to use the card:

*I: If you wanted to, would you feel able to go and use that C-Card to get some condoms?*

*F: No.*

*F/F: Yes.*

*F: I have done once but that was like a dare.*

*F: Did you really?*

*F: Oh no me and [name] have got them and then we blew them up. I put them on my hand.*

*[TALKING TOGETHER]*

*F: You're not allowed to play with them. (School 4, female SAS-FG, Yr10)*

*F: There used to be a lady called [name] who came in on Monday lunchtimes at the youth centre and she used to give out C-Cards which is where you get free condoms, but then we were told that we weren't allowed to go and see her any more cos the boys used to mess around with the condoms so now we don't have any way of getting anything, so. (School 3, female FG-SH, Yrs 7-8)*

The above extracts are important because in both cases, young people are convinced that condoms via the C-Card are not to be played with or explored. In one of the non-targeted schools,

several young people reported that the school had to withdraw C-Card access via the school nurse because too many condoms were being ‘wasted’. This exploration and ‘play’ with condoms has important ramifications in a number of ways. Negotiating condom use effectively requires people to have confidence in how to use them, alongside forming strong implementation intentions (see Gollwitzer, 1999; Sheeran *et al.*, 1999) to enable them to plan and practise how to use them when the situation arises. This preparation and ‘rehearsal’ (or a ‘plan to do X when situation Y occurs’) is a key contextual cue that bridges the gap between a person’s intention to use a condom and their actual ability to execute this, which may often become clouded by the arousal of the situation or a partner’s opposing contraceptive preference. Given the C-Card guidance acknowledges the importance of familiarisation with condoms, it is thus possible that some staff/practitioners may require some refresher training.

In the male SAS focus group, boys also talked more specifically about barriers in obtaining/using a C-Card from a local clinic. This is significant in that the C-Card aims to remove the stigma from obtaining and ultimately using condoms (Cheetham, 2013), whilst the access via a clinic or pharmacy seemingly operates as a potential barrier. Further, obtaining C-Cards and condoms in this manner opposes young people’s overall preferences (in this study and reported elsewhere e.g. Coleman and Testa, 2007) that the school is the most suitable place to receive SRE, including methods of contraception that do not require medical approval. In illustration, young people reflected on how for some (other) pupils, entering such premises can be frightening and anxiety provoking. However, they also note that the environmental structures of the clinic (specifically, placement of reception and a waiting room) impact on their own worries about privacy, alongside feeling ‘judged’ which could be overcome with school-based provision:

*M: ... It was awkward in a way because there’s people waiting to be seen right there because reception’s there, like [?] whispering to everyone. (School 5, male SAS-FG, Yr 11)*

*F: They judge you though, they’re not allowed to judge you but they do, everyone judges you no matter what they’re job is.*

*F: They look at you like...*

*F: They think oh they came in there last week. If I was the pharmacist I’d laugh if someone came in and asked for one.*

*I: Is there another way of making that better?*

*F: Do it in the school with like [staff member] or [staff member]*

*F: I wish we had a little room where they had condoms and then we can go in there. (School 4, female SAS-FG, Yr10)*

Nonetheless, for those who already aware about how to obtain a C-card, the element of embarrassment by being clearly visible in a clinic setting was often overcome by being seen in a separate room, although the preference for obtaining condoms at school still predominated:

*M: There’s a walk in clinic in the train station and you go in and apply for one and then obviously you have to wait and then the doctor takes you in and says, she’d advise you to wait until you’re 16 because obviously she can’t control it, she’d like you to be safe, then they give you condoms for free.*

*I: How was that process for you?*

*M: They took us into a different room to everyone else. (School 1, male SAS FG–SH, Yr 11, LC)*

Furthermore, young people were asked about their views on potential changes to the C-Card, such as an electronic version similar to the London C Card<sup>23</sup> which has been described as being a “more convenient free condom service for young people... easier for voluntary outlets to run, and provide real time data for service monitoring and analysis.” However, young people were not particularly interested and did not really see the point or that it would make much difference to them:

*I: What about having something [the C-Card] more electronic would that be of interest?*

*M: I don't know if it would make any difference cos it's not going to need something fancy.*

*I: There's been ideas about having some sort of electronic card instead of, I don't know if your C-Card's like a paper card? (School 5, male SAS-FG, Yr 11)*

Nonetheless, with the possibility of a new electronic card there remains an evident query regarding young people's acceptance of this. Such an innovation can only be assessed through a piloting scheme to see whether the concept of an electronic card is favourable and/or ultimately improves uptake.

Finally, young people were asked about whether the branding of condoms influences their decisions to use condoms or select certain types of condoms. Across all focus groups, young people were consistent in their views that branding made no difference in influencing either their use or selection of a certain type.

*M1: It's [branding] a waste of time. Oh yeh, look how crazy this condom is, who cares, it's a condom, it's going in the bin. (School 1, male FG-SH, Grp2 Y12)*

## 5.5 Communications and campaigns (within and outside school)

In terms of communications regarding sexual health such as where to go for sexual health information, in line with the empirical literature most young people saw the school as being the most appropriate arena (e.g. Buston and Wight, 2002; Selwyn and Powell, 2006) despite concerns regarding the accessibility of the school nurse and other barriers around accessing the C-Card.

Most young people were aware of the existence of local sexual health clinics (but not necessarily how to access them) but raised concerns about being seen by others, particularly if it was in the local area. Consequently, discussions focussed instead on alternative means of accessing information and advice in school such as leaflets, and as noted in Section 3.3 (WSA), opportunities to have individual anonymous questions and answer service by text. Unsurprising, a number of young people on internet services as means of accessing information when required available 24/7 and in an anonymous manner:

*F: I know I think that's just a place where you can go where you don't have to broadcast to everyone that you want to know more. Some people might feel really self-conscious about asking about it or they don't like talking, then they might just be able to access their computer at home or just go on there with a friend that they want to and just have a look at it with someone if they want to. (Youth Centre, female FG-SH, Y9)*

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<sup>23</sup> See [www.comecorrect.org.uk](http://www.comecorrect.org.uk)

However, in one female focus group, young women expressed their irritation at the difficulties they experienced in accessing online information regarding sexual health (via PCs, phones and apps, or tablets) due to controls by the school or their parents; either in terms of blocking access (e.g. use of family internet safety filters) or monitoring usage (e.g. internet history). Moreover, one young person raises the issue of trust with regards legitimate websites:

*F1: The only problem is if you research on the internet is that it can always get traced back.*

*F2: I always worry that if there's something on the internet, you never know if it's legitimate.*

*I: How would you, is there some site that you know of that you trust that you would like a link to?*

*F2: My mum's put a cap on the internet so if anything sexual comes up gets blocked cos I've got a younger sibling and he's got an i-pad so my mum's put a cap on the internet so if there's anything that she doesn't want him to see, he can't see it.*

*I: Is there access to that sort of thing [sexual health] at school?*

*F4: No.*

*F4: Like I was researching drugs for clarification, I was researching cannabis and other stuff and [??]-*

*F3: But I think researching that kind of stuff at school isn't the best idea-*

*F1: The school can trace back the research as well. I sent [name] a google docs that was like the menstrual cycle and I got my account locked out and it was because of a child development essay (School 3, female FG-SH, Yrs 7-8)*

Thus although some have argued that the use of technology should be embraced to support young people accessing information (e.g. BYC, 2011; DH, 2012), recognition of the online restrictions many young people experience at school or home needs to be recognised (see McKee, 2012; Sorbring et al., 2015; Turnbull et al., 2010).

In terms of trusting website information on sexual health, this is clearly important and could be addressed by exploring the use of the Information Standard certification programme<sup>24</sup> for websites endorsed/developed/hosted by ESCC. Furthermore, it may be useful for schools to re-visit their internet safety policies and consider exploring whether certain sanctioned and 'trusted' websites (e.g. Connexions 360, Free 2Bme, the circle room) could be made available to young people in school – perhaps via a dedicated space such as welfare area, student support, school nurse location, or similar.

Finally on this issue, in the female SAS focus group, young people also stated strongly that they did not want to use social media (such as Facebook) to access sexual health information and/or advice mostly due to privacy concerns:

*I: Would you like there to be a Facebook page [for sexual health information]?*

*ALL: No.*

*I: Just with information about this sort of thing for young people in East Sussex?*

*F1: No.*

*F2: Cos it comes up with everything if you use it. (School 4, female SAS-FG, Yr10)*

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<sup>24</sup> [www.england.nhs.uk/tis/about/the-info-standard](http://www.england.nhs.uk/tis/about/the-info-standard)

### **Local or national campaigns related to sexual health**

Young people were asked whether they were aware of any local or national campaigns related to sexual health outside of school as well as any communications or campaigns inside school. In one school, aside to the occasional poster (notably references to anti-homophobic messages and testicular cancer), no participants were aware of any campaigns either within or outside of the school setting:

*M: Apart from that poster stuck up in the odd classroom [Stonewall Poster ‘Some people are gay, get over it!'], nothing. (School 1, male FG-SH, Grp2, Y12)*

This lack of awareness extended to young people in a youth centre focus group, as well as (perhaps surprisingly) those enrolled on the SAS programme:

*I: ... have you been aware of any campaigns about sexual health, safe sex around or outside the school or anything like that?*

*M: No*

*M: No there's not really been anything put up. (School 5, male SAS FG, Yr 11)*

Similarly when asked about Chlamydia campaigns on testing (including postal kits), although young people were aware of Chlamydia, none could articulate any details and none had either heard of, or accessed, online postal kits.

### **5.6 Ideas on positive sexual health and relationships**

Towards the end of the focus group discussions on sexual health, young people were asked what they thought might be helpful in supporting them to take control over their own sexual health and manage (existing or future) relationships, as well as asking them to reflect on what positive sexual health means to them. These were difficult question to answer and probably something young people had not really considered before, particularly for those in younger age groups. This is not least given they were unlikely to be taught about such issues, based on what is known from national surveys (SEF, 2008). Nonetheless, although rarely acknowledged in SRE, there is an argument that a greater focus on positive sexual health such as how to achieve sexual pleasure, alongside the avoidance of sexual ill-health, may lead to improved public health outcomes (Ingham, 2005). Further, positive sexual experiences may contribute to greater comfort with one's own body, in turn contributing to increased communication capabilities and feeling less pressurised to have unwanted sexual experiences (Ingham, 2005).

The responses concerning positive aspects arose only in two female focus groups (including a SAS group) that discussed issues around trust, love, mutual respect for sex and the delaying of sex:

*I: If you're thinking about your own sexual health ... what would positive sexual health relationships mean to you? What is a positive sexual relationship?*

*F1: ... somewhere where you're with someone you trust and love and you both want the same.*

*F2: Pretty much what [F1] said, if you're in a relationship and you feel comfortable with them and you feel ready, then I think it should be ok. (School 3, female FG-SH, Yrs 7-8)*

Responses about the positive aspects of sexual health in other groups tended to revert to the more traditional means of avoiding sexual ill-health. In one male group, young men felt that positive sexual health was involved being armed with appropriate knowledge to help understand possible risks and knowing how to be safe (implying health development), but also where to go if something went wrong:

*M: Yeh like just knowing about the issues in case cos you always need to be better safe than sorry or something so if they just teach you what to do with condoms and femidoms and all that. And then the dangers of it, the outcomes, where you can go if you get an STI or something. (School 1, male FG-SH, Grp1, Y10)*

Engaging young people to inform health improvement  
commissioning and delivery in East Sussex

# Section Six

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## Recommendations



## Section Six: Recommendations

### 6.0 Introduction

In this final section of the report, recommendations are provided which draw on the primary research data generated with 97 young people who contributed to the participatory engagement activities, the dedicated literature review and synthesis (Davies, 2015), as well as the views of a further eight young people who participated in a workshop to co-produce the recommendations.

The purpose of these recommendations is to support ESCC in the development of health improvement initiatives to be commissioned or provided in future in the context of limited resources. Where relevant, the recommendations also refer to how young people can potentially be involved in the design and ongoing delivery of health improvement initiatives.

### 6.1 Recommendations for whole school approaches to health improvement

The whole-school approach (WSA) to health promotion is ingrained within the WHO health promoting schools global movement and underpinned conceptually by the settings approach to health promotion. Although definitions of the WSA vary and are sometimes used interchangeably with health promoting schools, the same core components apply including creating and sustaining a healthy environment (e.g. developing an ethos and environment that supports learning and promotes the health and wellbeing of all), supporting the creation, implementation, and evaluation of healthy school policies, and creating, implementing and evaluating skills based health education and associated services which can help empower students as well as inform them.

Prior to commissioning, it is important that the conceptual complexity of the WSA approach is considered along with the substantial short and longer-term challenges that implementing such an approach can raise; for example, school policy shifts, staff training and re-organisation, school culture, environmental (e.g. building and other definitions of space and location), as well as paying attention to the social and wider determinants of health in the school context (e.g. use of vending machines, school lunch providers, impact of local and national educational and health policies, re-visitation of all external service contracts ensuring a health in all policies approach is adopted in any renegotiations etc.). Nevertheless, given that many long-term health-related attitudes and behaviours are determined (or influenced strongly) in childhood and adolescence and are strongly associated with educational and social outcomes, adopting a long-term strategy to commissioning to support WSA to health is required.

As noted previously (see Section 3.0), a WSA to health is conceptualised as an approach that requires specific action to be taken within three areas including: 1) a formal health curriculum; 2) Ethos and environment of the school, and; 3) Engagement with families and/or communities. Thus, recommendations presented here for action are organised around these three areas:



## Formal health curriculum

- In line with recent evidence from Ofsted (2013), the quantity and quality of PSHE received in school was perceived by young people to be unsatisfactory. Young people are aware that school is probably the best setting for them to explore the complexities of sensitive, embarrassing, or otherwise difficult subjects relating to health and related social issues (beyond factual information gathering) and are surprised that this is often recognised by the school. As a matter of priority schools should be supported to conduct **whole-systems review of their PSHE provision** for young people which includes a focus more broadly on how health is perceived, planned for, experienced, and delivered. Informed by the primary data, such whole-systems reviews could include considerations of areas such as (but not limited to):
  - Alternative curriculum models for health (e.g. a spiral curriculum);
  - Mixed modes of curriculum delivery (e.g. use/limits of drop-down days, specialist external providers, integrated curriculum with subjects);
  - Day-to-day delivery (e.g. mixing whole class with one-to-one and single-sex small group sessions to facilitate opportunities for in-depth engagement on particular ‘difficult’ or sensitive health issues or topics);
  - Staff training, professional development, and welfare;
  - A review of overt and covert conceptualisations of health (deficit vs asset of salutogenic models and their implications);
  - Gender (in)equities regarding differentiated experiences of PSHE and particularly SRE;
  - Opportunities for different types of feedback and participation in decision-making by young people (e.g. anonymous, health promotion school council; see ‘ethos and environment of the school’ below).

Such whole-system reviews are often ‘invisible’ work. However, they are also essential if step-shifts in the way health improvement is experienced by young people in schools are to occur.

- In some schools, traditional views of public health are apparent in the way that health opportunities and/or services are provided. Attention should be paid to young people’s preferences for moving away from ‘static’ health education and prevention messages to more health promoting principles that facilitate young people to reflect, review, touch, experience, understand, debate, and ultimately use, strategies to take control and improve their own health in and out of the school context. This requires re-thinking how health is conceived by the school and its stakeholders as well as in terms of commissioned services.
- Young people appear to recognise the pressures on schools relating to academic achievement. Nevertheless, young people want **increased opportunities for** physical activity in the school curriculum **and externally** (e.g. local sports and physical activity provision) as well as opportunities for more **informal and less (school) traditional** activities such as ‘a kick-about’, skateboarding, and cycling. Commissioning should consider how

best to assist schools in realising these opportunities, for example, in extending and widening young person-led provision before and at the end of the school day (e.g. see Sherriff and Tungatt, 2007).

- In some schools the existence of **gender based restrictions on opportunities to participate in sport and physical activity** were a barrier for some young people. Such gendered barriers to sport and physical activity are unfair, unhelpful, and outdated and should be reviewed as a matter of urgency against school's gender equity policies (e.g. Equality Act, 2006).

### **Ethos and environment of the school**

- The school nurse provision is perceived as 'invisible' and inaccessible to some young people. Young people reported wanting greater and more flexible availability in terms of access, increased engagement with students to develop relationships, and increased communications regarding location and the range of support offered from early on in their school careers (see also BYC, 2011).
- In terms of ESCC's interest in extending the range of provision by the SHS (school nurse) for 2015/16, in light of the above, it appears **unlikely that this would be the best delivery mechanism** for additional health improvement initiatives and messages in schools beyond what is set out in the current SHS service specification. Instead, it might be better to first look to improve the **delivery of core provision** (and re-consider young people's views as a result) before considering a phased **longer-term transition** to increasing and widening provision.
- Linked to the above point, young people's views were mixed regarding their interest in co-developing their **school health plan** with the SHS. In line with the findings from the literature review (Davies, 2015), in some schools young people felt that their voices were not heard; in others where young people had already experienced participation in service development (or similar), narratives were more positive. It will be important for all schools to develop a meaningful **participation agenda to help create a culture** where young people feel connected (e.g. Rowe and Stewart 2009) are listened to, and believe that their input will make a difference (e.g. in development of a school health plan).
- Concerns over **privacy** (e.g. young people not wanting to be seen entering a location for health that might stigmatise them) and **confidentiality** (treatment of disclosed information with the expectation that it will not be divulged to others without permission in ways that are inconsistent with the understanding of the original disclosure) are key barriers for some young people in: 1) taking proactive steps to improve their own health, and; 2) accessing health and educational improvement initiatives at school. **School policies and training** for teachers and other staff may need to be reviewed and/or updated to ensure clarity over the extent of privacy protection possible and the extent and limits (e.g. child protection) of confidentiality when young people disclose/want to disclose. The 'You're Welcome' criteria for youth friendly services from the Department of Health which may provide a useful reference point in this respect (DH, 2007, 2011, 2012).

- Commissioning should consider how best to support all schools in East Sussex to develop and embed their own **Health Promotion School Council (HPSC)**. Considered a health promotion initiative in their own right due to their positive contributions to student and staff's health as well as the cultural ethos of school (Griebler and Nowak, 2012), such councils comprise young people, parent representatives, school staff, representative of the SHS, and where relevant outside agencies (e.g. specialist providers, ESCC etc.). HPSCs have been used successfully in some European countries helping to bring relevant stakeholders together into a school's decision making process regarding health. HPSCs are strategically useful to help schools adopt '**whole-school thinking**' to health ensuring that relevant parts of the school organisation work coherently together (for example, helping to prevent unintended policy conflicts and consequences). Moreover, they can help identify **local priorities, needs, develop actions and implement and evaluate change** thus potentially contributing to the required school health needs assessment and school health improvement plan for every school. Finally, health initiatives delivered via school nursing and traditional health education initiatives are often conceptually at odds with health promotion and/improvement as they tend to emphasise a deficit model of health which is characterised by assessing problems and needs rather than identifying the conditions required by individuals and communities to maximise their health potential. HPSCs can help schools to assert a more **asset model of health** which provides a systematic approach to identifying a set of key assets for health and the most effective approaches to promoting health and development (Currie *et al.*, 2012).

### Engagement with families and/or communities

- In general terms, young people **did not want their families** involved in health issues, mainly for fear of confidentiality being breached (e.g. family members disclosing personal information about young people without their knowledge and/or agreement). However, as noted above, developed of a **HPSC may help to engage not only young people but also their families** in a meaningful and acceptable way.
- Linking back to the formal health curriculum where most young people reported being unsatisfied with their school's 'health offer', bringing **external (youth-friendly) health professionals** from the local community(ies) into school can help both widen and deepen provision (Buijs *et al.*, 2014) as well as motivate attention to, and reinforce messages, regarding health issues for young people. Whilst some schools already do this it should only be used as useful adjunct to a school's 'formal' health curriculum and not as a replacement or solitary provision (e.g. drop-down days in some schools).

## 6.2 Recommendations for emotional wellbeing and resilience

It has long been recognised that the mental health needs of young people are neglected in a multitude of arenas (e.g. Weare, 2015; Wells *et al.*, 2003). In the context of schooling, this is important given that promoting physical and mental health can reinforce children's attainment and achievement; which, in turn, can improve their well-being (Brooks, 2012). Evidence from the literature suggests that: 1) schools can occupy a key place to build resilience among children and

young people; 2) there is a need to embed a whole-school (multi-level) approach to emotional wellbeing and resilience (DfE, 2015b; Langford *et al.*, 2014; Marmot, 2010; Weare and Markham, 2005), and: 3) that there are a range of ways in which local authorities can support and encourage schools to take action (Allen, 2014).

It is important to acknowledge that recent advances in resilience theory and research (e.g. Cocking, *in press*) have suggested that popular individual resilience frameworks need to consider the broader social and collective contexts in which resilience occurs. This is important because adopting individualistic approaches can mean that there is not only a danger of ‘blaming’ the individual for their own adversity but also that the key emphasis is on enabling them to cope in an adverse environment rather than tackling the social and wider determinants of health. Such advances support the notion that specific initiatives to promote emotional wellbeing and resilience (EWR) in school, need to be perceived as a useful addition to, not in place of, complementary health improvement initiatives adopting WSA that look at creating healthy settings, ethos, policies, and environments for all (e.g. Weare, 2015). Moreover, although it is common for resilience programmes to be targeted to those most in need, set within the context of reducing health inequalities (and equity), they should also be universally available to all young people (Allen, 2014; Marmot, 2010).

- An overarching theme that emerged from the focus group discussions was that the young people hold **varying degrees of engagement with the term ‘resilience’**. Participants from one focus group were broadly familiar with the term and reported possible benefits from utilising the concept (Trans young people who had most likely experienced adversity in the form of transphobia, stigma, and discrimination). However, this was not the case for most other young people. Schools should be supported to engage with the **utility of the concept** including its **potential benefits (and limitations)** although this should be located within broader practical (e.g. strategies for young people to achieve resilience), strategic (e.g. school ethos, leadership, systems and structure) and conceptual frameworks (i.e. the WSA) to ensure the concept does not become overused and meaningless. In Section 6.1 (WSA), it is proposed that schools should be supported to conduct whole-system reviews of their PSHE provision and broader engagement with health. Part of this process could include this examination of the concept of resilience as it applies to the particular school in question.
- A shared **social identity** developed through **mutual peer support** appeared to be a strategy for resilience which some young people reported as being beneficial to help them de-stress and achieve resilience. Although the evidence for **peer-led schemes** are somewhat mixed, commissioning could consider how best to support schools in exploring such schemes (e.g. shadowing, mentoring, buddying etc.), and where possible, ensure these schemes are embedded within a WSA structure. Such schemes can be low cost, and may be especially useful in helping integrate students into new and potentially alienating environments (such as the transition from primary to secondary school and from mainstream schools to more specialised environments such as PRU settings; DfE, 2015b).
- Evidence from the literature suggests that creating an ethos and environment within school that values all pupils and facilitates them to feel a **sense of belonging**, can help to

- create the conditions in which young people feel able to talk about their problems in a non-stigmatising way (e.g. DfE, 2015b; Rowe and Stewart, 2009; Weare, 2015). Schools should therefore be encouraged to place greater attention on the role that **informal social support networks** can play in maintaining young people's resilience, forming and maintaining social identities, and developing friendship groups to foster mutual support. Such informal networks may also consider how supportive adults outside of young people's immediate teaching networks (whilst operating within safeguarding protocols) can be potential assets for young people's resilience.
- Where appropriate, schools should consider how to encourage young people to maintain links with **external peer groups and/or extracurricular activities** outside of the school environment that could then be linked into their existing school activities. This could be particularly useful for young people attending specialist schools such as PRUs who may feel disconnected from existing social networks in their former mainstream education.
- Young people commonly referred to a desire to have a **physical 'time out' space** (or a 'de-stress room') that young people could voluntarily go to if desired - and that this space should be separate from an exclusion room that they are *taken* to against their wishes (e.g. 'isolation' rooms or similar). However, such provision must be considered within broader support systems and processes of a WSA, for example ensuring that routes to escalate and/or refer to a range of support services (both within and beyond the school) are available.
- Data from young people suggested that many did not feel that they had a voice and were **not listened to in school environments**. Schools should be supported to create **meaningful dialogue with young people** to help them develop and inform existing and/or future EWR initiatives. For instance, this may involve expressing ideas for how resilience can be made relevant for young people within the specific cultural ethos and/or physical context and of their educational environment. Part of this dialogue should also include how young people feel they can be empowered to not only cope with the stressors they may face, but to also address the reasons why they may face such adversity and how they might take control and challenge it. It is likely that implementation of a health promotion school council (Section 6.1) may assist in achieving such dialogue.
- In the focus groups, young people recognised the importance of **physical activity as an individual strategy** to resiliently cope with stress and 'self-soothe'. As also emerged in the WSA discussions, young people report wanting greater opportunities for physical activity in school and that this should include non-traditional activities beyond the usual school gendered sports (see also 6.1). For some schools and settings, this may **require some creativity** to facilitate such activity and ensure equity of access for all young people. However, the importance of such relatively simple and low cost strategies to support young people's individual resilience should not be underestimated – particularly given the time allocated to physical activity within school's formal curriculums continues to be squeezed.

### 6.3 Recommendations for sexual health

In general, young people **perceive SRE provision to be inadequate** and suggest that is not taken seriously by schools, teachers or pupils. These criticisms and resultant recommendations are particularly important given trends over the past 20 years showing a greater reliance on school lessons for sexual health education (Tanton *et al.*, 2015), alongside convincing evidence showing that sex education being mainly from school (as opposed to parents or ‘other’) is predictive of positive sexual health outcomes such as delayed sex, safer sex, and lower likelihood of STI diagnosis (Macdowall *et al.*, 2015).

- Overwhelmingly in the primary data and supported by the literature (e.g. see Davies, 2015) young people participating in the sexual health focus groups showed preferences for **greater attention in school to SRE**. Linking with findings from the WSA regarding PSHE more broadly, young people want greater opportunities to explore the complexities of issues that they can’t find out about easily. Moreover, young want these opportunities to be **age and gender segregated** as necessary. Specific ideas included: sexualities, pornography and expectations, sexual exploitation, sexting, homophobia, sex and religion(s), gender identities, acceptance of others (e.g. LGBT), and sexual harassment. Schools should be supported to **review the status and emphasis given to SRE** within broader PSHE curricula as well as review links and sexual health opportunities from the school nurse. Linked to the WSA, this review could constitute part of the **whole-systems review of PSHE provision** as recommended in Section 6.1.
- Linking with findings from the WSA, young people report experiencing traditional public health and/or health education approaches to SRE which focus unhelpfully on prevention, avoidance, and abstinence message. Instead, a cultural shift is required which recognises **positive individual and social responsibility for sexual health**. This means that rather than seeking services, support, or advice when **‘something is wrong’** young people are empowered (e.g. to make informed choices, self-esteem and self-efficacy, understand risk reduction etc.) to seek out, be prepared, maintain, and/or improve their (sexual) health as and when they are ready. As noted previously (6.1), this requires re-thinking how health is conceived by the school, its stakeholders, and commissioned services (e.g. school nurse provision).
- Linked to the two previous points, young people appear to be aware of their own (sexual) health needs even if they are not sexually active. Young people report wanting **SRE input** from when they **start secondary school** and to continue throughout their school career increasing in complexity and depth over time (see also UK Youth Parliament, 2007). **Spiral curriculums for SRE/PSHE** may assist in meeting these needs.
- As noted above, there is scope within schools to increase **young people’s participation** in setting the agenda for SRE. Convincing young people that their views are **valued** is the first step. High quality SRE (as set out by Brook, the PSHE Association, and the SEF, 2014, p.5), *“ensures children and young people’s views are actively sought to influence lesson planning and teaching”*. Health promotion school councils (HPSC) may serve as a useful mechanism

to ensure both **formal and informal health curriculums** related to sexual health are relevant, up-to-date, appropriate, and informed by young people.

- Similar to the WSA findings, some **dissatisfaction with SRE** (and PSHE more broadly) as well as other sexual health improvement opportunities in school (e.g. school nurse) were related to the **specific facilitator and/or provider** (e.g. teacher, teaching assistant, student guidance tutor, form tutor, external specialist, school nurse etc.). Too few staff appear to have the **specialist knowledge required to teach high quality SRE** (HoCEC, 2015; Ofsted, 2013; SEF, 2008, 2014; UK Youth Parliament, 2007). Young people reported that whilst the gender of the ‘teacher’ did not matter, specialist knowledge was important. As part of whole-school thinking (and review), **staff’s professional development needs** (including their own health and welfare) need to be considered within any provision for young people.
- Young people were mostly **not aware of the School Health Service (school nurse)**, its location, resources, or the range of support available (DH, 2012; BYC, 2011). Moreover, the school nurse was not someone young people felt they could approach over sexual matters mainly because they did not know ‘her’ as contact was so limited. It is unlikely that the current offer of ‘as a minimum a weekly drop-in service’ for targeted schools and ‘two sessions monthly’ for non-targeted schools will be adequate. However, ESCC could consider how opportunities to engage with the school nurse or a substitute **outside of this core offer** could be provided (e.g. via anonymous text messaging service, trained school staff who is regularly on site to support the school nurse’s remit). In addition, young people themselves recommended **better communication in school** regarding the health opportunities available via the school nurse as well as reassurances regarding (including limits to) **confidentiality** (e.g. see Carroll *et al.*, 2012).
- Linked to the above point, all young people spoken to were unaware of any **local or national sexual health campaigns**. Current **communication channels** targeting young people thus appear **not to be working**. Although **online/internet technologies** are popular means to engage young people, recognition of the **online restrictions many young people experience** at school or home needs to be recognised by providers (see McKee, 2012; Sorbring *et al.*, 2015; Turnbull *et al.*, 2010). Consequently, blended approaches regarding sexual health communications may be appropriate.
- Young people reported wanting further **information about the C-Card and female condom** or femidom. Although the C-Card was perceived positively, young people felt that obtaining it was **unnecessarily complex**, and should be more **easily available within school settings**; particularly in those schools where access via the school nurse was restricted and young people were ostensibly discouraged from exploring, ‘playing’ and familiarising themselves with condoms. In terms of the latter, it may be appropriate for schools to review this position.
- SRE and sexual health improvement initiatives for young people in school require normalisation and attention to reducing associated stigma. Young people in this study expressed strong preferences to engage in SRE from the very start of their secondary

schooling to help **reduce stigma and normalise positive sexual health**, as well as increase their **access to initiatives and services** including the school nurse provision. This is important as stigma can (amongst other things) create fear/reluctance to seek help or information early, reduce testing (e.g. for HIV and STIs), impact on mental health, and increase the chance of unintended pregnancy (e.g. DH, 2013). As part of a larger whole system review on health, schools should be supported to consider specifically, how sexual health stigma can be tackled which may also mean re-thinking how the sexual behaviour of young people is perceived (e.g. a *developmental* issue rather than a risky behaviour per se; see DH/DCSF, 2009).



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## Appendix A: Topic guides

### Facilitator preparation and guidance notes

#### Equipment

Flipchart paper and pens

Digital recorder (spare batteries)

Blu-tack

Post-it notes

Labels (name badges)

Other materials, specify \_\_\_\_\_

#### Facilitator (information only)

- Focus more on general thoughts rather than those relating to personal circumstances
- Involve all members in the group for response – e.g. ‘does anyone agree with this?’, ‘disagree? Encourage ‘quieter’ participants.
- Reach consensus or dissimilar views where appropriate
- Appreciate value at *all* responses
- Maintain independence of all views – we are not representing the school, youth centre etc. or East Sussex County Council but on behalf of the University of Brighton
- Probe for more responses to explore the importance of the ‘how’ and ‘why’ to fully research the topic of interest, and look for case examples.

#### Introductions and information

*Thank young people for coming, introduce selves*

- Thank you all for offering to take part in this group discussion which we expect to last up to an hour, but this can be flexible depending on how people feel and how much you have to say
- My name is [name] and I am working on behalf of University of Brighton (not the school or the council). So please remember that there are no ‘right’ or ‘wrong’ answers, and I’m interested in your own truthful thoughts and opinions. Please feel free to say you agree or disagree with what others have to say – I want this to be a relaxed and fun experience!
- There are some drinks and snacks available so please help yourself if you would like something (you don’t need to ask!)
- Can I check that everyone has read the participant information sheet – are there any questions?

#### Recording

- To make sure we capture all the interesting things that are said, we would like to record this discussion but, please be aware again that this will only be used by the research team and not used to identify anyone. Recordings will be deleted once we have finished with them.

*Ground rules (see hard copy version to be visible during all discussions)*

- Before we start it is important we agree a ground rule that any discussions within the group should remain within the group and not be discussed with anyone outside of the group. This is a standard procedure and respectful of the group’s boundaries and individual participant’s responsibility to the group. Please also note that all things that are said in this group will be anonymous and kept as confidential as possible - however, please understand that we are obliged to inform another professional if you disclose to us that either you, or someone you know, is at risk of harm.
- Show the ground rules card and read each out. Is everyone happy with these ground rules? Any questions?

### Consent and 'thank you's'

- Finally, it's important that I ask everyone to read this short consent form and sign their names at the bottom if you agree with what is said (*read through these points once the forms are handed out*). At the end of the discussion I will check again that you are still happy to contribute to the study and that you can still withdraw this consent at any time - if you do this, none of the data you have provided will be used.
- At the end of each focus group, a £10 voucher will be given to you as a 'thank-you' for taking part.
- Does anyone have any questions – are we happy to start?
- Please write your first name on these labels so I know who I'm talking to when I ask a question. Please also complete this (monitoring) form which is confidential and anonymous, and just tells us a little more about you.

Ground rules for use with focus groups

#### Ground rules for use with focus groups

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## Ground Rules

- Listen to each other, take turns to speak, don't all speak at once
- Respect each others opinions
- No name calling, bullying etc
- You don't have to answer questions if you don't want to
- Please ask if you don't understand anything
- Confidentiality
- HAVE FUN

## Whole school approaches (WSA) to health improvement

This topic guide has been informed by the Whole School Approach (WSA) to the National Healthy Schools Programme<sup>25, 26</sup> as well as the service specification for this project set out by ESCC<sup>27</sup>. It has also been informed by the PSG. The purpose of this discussion group is to seek young people's views and experiences (11-16yrs) concerning the WSA to health improvement initiatives including issues such as:

- The School Health Service (nurse provision);
- What is most effective and important regarding WSA service implementation and service design (e.g. staffing, accessibility, privacy, location, topic area etc.);
- The potential for engagement in whole school initiatives/services (e.g. design and implementation etc.), and;
- Young people's ideas for new services / initiatives they would most like to see at their school which could help to improve their health.

In this project, a WSA is seen as an approach that<sup>28</sup>:

- Aims to develop an ethos and environment that supports learning and promotes the health and wellbeing of all;
- Consults and encourages participation of all within the school community, and;
- Is an extremely effective, evidence-based school improvement mechanism that brings about and embeds cultural change in schools.

The 10 components of the WSA are as follows:

- A. leadership, management and managing change
- B. policy development
- C. curriculum planning and resources, including working with outside agencies
- D. learning and teaching
- E. school culture and environment
- F. giving children and young people a voice
- G. provision of support services for children and young people
- H. staff professional development needs, health and welfare
- I. partnerships with parents/carers and local communities
- J. assessing, recording and reporting children and young people's achievement

### 1. Introductions and ice-breakers

Introductions/ice breakers to be decided by the facilitator as needed.

### 2. Health in general

- In pairs using flip chart paper, to kick things off we would like to start this discussion with thinking about your ideas of things that are healthy and those things that are not healthy. We will then have a look at what they are and do a quick ranking exercise to put them in order of importance in terms of either being most likely to damage your health through to those that are most likely to help promote or improve your health. We will then think about the different ways we can stay healthy and actively improve our health.

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25 DCSF (2007). Whole School Approach to the National Healthy Schools Programme. Department for Children Schools, and Families, and the Department of Health.

26 Where relevant in the text, reference is made to one or more of the 10 key elements comprising the Whole School Approach (WSA). For example, with regards to how to involve young people in service development and provision, the following reference will be included in parenthesis (WSA: F - giving children and young people a voice).

27 ESCC (2014). Engagement with young people to inform health improvement commissioning for children, families and schools in East Sussex. East Sussex County Council, October 2014.

28 [www.cornwallhealthyschools.org/about-healthy-schools/the-whole-school-approach](http://www.cornwallhealthyschools.org/about-healthy-schools/the-whole-school-approach)



- Following the activity, what do you think most young people think about issues related to health? Is it important to them?
- Do young people care about their health? What would encourage people to do more things to promote/help their own health?

### 3. General health initiatives/facilities/services in school

This is likely to touch on the school health service (SHS) which is explored in more detail in the following section but is intended to look more at the range of initiatives in and out of school that are available, that YP may or may not have accessed, and their views on these initiatives including potential barriers and facilitating factors.

#### *Inside school*

- Thinking about lessons you have in school, where have health issues/topics been covered? Does this seem the right place for you? Are things covered in enough detail? Would you like more detail in certain areas? Would you like less detail in some areas? (cross-ref to topics outlined in Q2).
- Are there any things (e.g. facilities/services/before or after school clubs/lunch-time sessions etc.) in school that help you to be healthy? What sort of things? (e.g. lessons, DVDs, sport, teachers, etc.). Can you tell me about them? (knowledge, awareness, range) How do you find out about these kinds of things? (communication)
- Have you used these initiatives/services etc.? (note numbers used/not used)
- What do you think about them? What's good/not so good about them? (facilitating factors)
- What aspects might stop or prevent some people from using them? (barriers)
- Can you tell us about the people in school who help with things related to health? (e.g. school nurse, , teachers, assistants etc.; WSA: E, G). What do you think of them? (WSA: E, F). Can you think of anything they could do to improve things that they help people with – e.g. are they approachable? Any concerns over anonymity? Where their room/space is situated?

### 4. School Health Service (SHS) (WSA: E, F, G, I)

#### *Background for facilitators*

The school health service provides health services to children and young people of school age, in order that they are given the very best chance to achieve good health. Its practice is based upon public health principles with a preventative emphasis to promote child health and tackle inequalities. Examples of expected SHS outcomes include (as examples): better health and wellbeing for all children and young people; increased resilience and empowerment to make good, responsible lifestyle choices; decrease in STIs, unintended pregnancy, self-harm and substance misuse, tooth decay, smoking etc. As part of this process, school nurses (SN), are required to work with schools (including young people directly) to produce a school health needs assessment and a school health improvement plan for every school. This will help schools create a 'school health profile' which will identify priority health improvement areas. SN will then be encouraged to work with schools to address the needs identified via the development, and implementation of, an action plan.

On top of this core expectation, ESCC are interested for 2015/16 in looking at whether the SHS could be an effective delivery mechanism for additional health improvement initiatives and messages in schools beyond what is set out in the current SHS service specification. It could thus be helpful for the engagement activity to obtain views of young people on acceptability/perceived effectiveness of the School Health Service as a delivery mechanism for health improvement initiatives and messages in schools. It's expected that young people's involvement will be vital in facilitating the development of the school health profile/identifying need. It could be helpful to explore how young people feel they would be able to best contribute to this process.

We have already touched on (previous questions) some of the services provided by the SHS in school (and possibly out of school where relevant) to help you stay healthy and actively improve your health. We would now like to talk about the SHS in a bit more detail:

- Thinking about nurse involvement in providing health support in schools, what do you know about the School Health Service? Have you heard about the SHS? Are you aware of what it is, where it is, and what it offers? (knowledge, awareness, range)
- What do you think of the service? Have you used the SHS? What did you like/not like? (facilitating factors/barriers)
- Thinking about the nurse involvement, is this the best person to provide support about health, to talk to about health? Any other people (inside or outside of school) that would be better including peer support?

- How useful (effective) do you think the SHS is in providing health improvement initiatives and health messages in school? What would you change or like to see done differently?
- (WSA: I) Do you think parents should be involved in your health-related matters? Would you want your parents involved in your health-related matters? If so, how would you want this to happen? What about other family members (cousins, brother, sister, etc.)?
- What are the ways in which people delivering the health initiatives in your school as part of the SHS, communicate with you and your parents? (e.g. how do you find out about things? text message, letters home, email to self and parents etc.). How effective do you think these methods of communicating with you and your parents/family are? Are there other ways you would prefer?

## 5. Service ideas for the future of SHS

- What services / initiatives would you most like to see in your school which could help to improve health? Let's think about some health **topics** that could be good to know about (write on flip-chart) – healthy eating, self-esteem, smoking, alcohol, sexual health, emotional health, stress, body image, bullying, physical activity and sport (any missing for you?) – which ones do you already get advice about (tick) and which ones are most/least important? (rank from most to least)
- Thinking about the above, what would work best for you in terms of how these kinds of initiatives are **provided**? For example, a quiet/safe space where people can chill out, a tutor you could go to for advice, individual, single-sex vs group (or whole tutor group), drop-in, location, in or outside school?, FB/social media, privacy, anonymity etc. (idea here is to identify the features and qualities that would make support work best for young people and therefore enable young people to improve their own health and wellbeing).
- What about **staffing** (teachers, youth workers, outside agencies)? All delivered by nurse or teachers or topics separated into those provided by nurse and teacher? If so, which topics? Would you like one person to go to or more than one? Who should this be? Nurse or teacher(s)?
- What about receiving health advice or information through text, phone, email? Prefer this to face-to-face? What other ways could 'services'/information be delivered/ accessed? (e.g. social media, personalised messages via dedicated smart apps, email, school website etc.).
- Thinking generally, how much do you think the school makes health issues important? Given to health on a scale of one to ten where 1 is low importance and 10 is very important? Why? What could be done to make it 10 out of 10?

## 6. Health provision outside school

- What about outside of school? Any things/facilities/services/people that help you to be healthy (knowledge, awareness, range)? What sort of things? (e.g. youth club with themed/guided activities such as sexual health, physical activities, C-Card access etc.). Can you tell me about them? How do you find out about these kinds of things? (communication)
- Have you used these services/things outside school? (note numbers used/not used).
- What do you think about them? What's good/not so good about them? (facilitating factors)
- What things might stop or prevent some people from using them? (barriers)
- The things/facilities/services/people outside of school, are these linked to the school (WSA: C) or are they separate from anything to do with school?
- Thinking overall about using things/facilities/services/people to improve your health 'in-school and 'out-of-school'. Do you prefer 'in-school or 'out-of-school' services and why?

## 7. New initiatives /culture – designed by you! (WSA: F, G)

- Think about being in charge of [a selected choice of initiative from above] – your role is to design this new initiative to help improve health - what sort of things would be really important to encourage people to use it (several prompts such as staff, opening times, design of facility, what support is on offer, etc.)
- What kind of things would you do to make others more aware of these services?
- What kind of things would you do to make it easier for young people to use these services?
- Do young people get involved in designing health facilities in schools? How can we encourage more young people to get involved? E.g. surveys, speaking to staff, school council, other ideas?

- How would you feel about working with the school nurse/teachers in developing a health plan for the school i.e. what should be covered and how?

Any further comments? Re-check consent. Thank you to everyone.  
Hand out vouchers and sources of further support.

## Emotional well-being and resilience

This topic guide has been informed by the ESCC Service Specification, elements from the Whole School Approach, the 5 over-arching concepts from Hart and Blincow's (2007) Resilience Framework (RF)<sup>29</sup> and other resilience models. It has also been informed by the PSG. The purpose of this discussion group is to seek young people's views and experiences concerning the following issues:

- What factors help or hinder young people to cope, prevent stress and overcome difficult times? (i.e. achieve greater resilience);
- What are the factors and features of school that help or hinder young people to cope, prevent stress and overcome difficult times? (i.e. achieve greater resilience);
- What do schools do to help young people to cope, experience less stress and overcome difficult times? (i.e. achieve greater resilience);
- What are the most important things schools could do to help young people to cope, experience less stress and overcome difficult times? (i.e. achieve greater resilience)
- Do young people deal with stress on their own or seek out support from others? (individual or collective strategies for resilience);
- How do young people understand whether measures which seek to help them cope, experience less stress or overcome difficult times have been successful?;
- What would coping better, being less stressed or overcoming difficult times look like / how would it be described by young people? (i.e. desired outcomes).

### 1. Introduction and ice-breakers

Introductions/ice breakers to be decided by the facilitator as needed.

### 2. Existing services at school (WSA- E&G; RF- B,C&D)

- How do you cope at school when things stress you out? E.g. Deal with it yourself, look for support from friends, family, teachers you like etc.?
- What are your reasons for using (or not using) each source of support mentioned above & how effective do you find them? (use flip chart to make visual table differentiating different forms of support and gauge uptake/ effectiveness of each strategy)
- On the whole, do you feel supported at school or not? What support (if any) does school offer in helping you and your friends deal with stress & cope with life? Is it useful or not?
- Any specific examples of what they offer- Individual: relaxation, exercise, school pet etc.; Collective – e.g. group relaxation/mindfulness sessions, peer support schemes etc.
- Are there any other things that your school does that helps you to feel like you fit in, and that helps you to cope when times are difficult?
- Are these activities popular with you and your friends or not?
- Is there anyone else you feel you can get support from?
- Do you feel you fit in/belong at school?
- Do you have a safe space you can hang out in if you need it? (e.g. library access at lunch times, teacher monitored classroom at lunch/breaks etc.)
- Do you feel like your interests and talents are encouraged?

### 3. Achieving resilience (RF in general)

- How many of you have heard of the concepts emotional well-being & resilience? What (if anything) do they mean to you? Do you find them as relevant/useful terms?
- Does your school have well-being & resilience programs? Are they useful? Why/why not?
- What more could your school do to help you to feel like you fit in or belong?
- What more could your school do to help you to cope when times are difficult?

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<sup>29</sup> These 5 concepts are: A) Basics; B) Belonging; C) Learning; D) Coping, and; E) Core Self and are cross-referenced at relevant points in the text as above.  
See p.11 of ESCC (2014) Service Specification for the full Resilience Framework table.

- What more could your school do to encourage your interests and talents and help them to flourish?
- Any there any things that influence how people use coping strategies (age/ gender etc.?) E.g. do girls support each other more than boys; do younger students seek support from teachers/parents more than older ones etc.?
- How do you understand whether measures which seek to help you cope, experience less stress or overcome difficult times have been successful?

Depending on time:

- Any recent events that may have affected students' stress/ resilience levels (could be one-off incident- e.g. adverse weather, accident etc.; or ongoing issue-e.g. bullying)? How did people cope? Did people come together to support each other, or get pulled further apart; How did school help (or not) in this process? Did you notice any change in how people got on/ dealt with each other once incident was over & things got back to normal?

#### **4. Ongoing involvement in possible future resilience schemes (WSA- F; RF- C &E)**

- Is there anything else you think could be improved at school that would promote your emotional wellbeing and resilience?
- If you could wave a magic wand and change one thing in the way your school supports you, what would it be?
- Would you like to be involved in any ongoing efforts to improve well-being/resilience services at your school?
- Any projects you can think of that you would like to be involved in?
- What things (if any) do you think could get in the way of such schemes being introduced & being successful? Any ideas of how to try & overcome these challenges?

Any further comments? Re-check consent. Thank you to everyone.

Hand out vouchers and sources of further support.

## Sexual Health

This topic guide has been informed by the Safe Around Sex Programme<sup>30</sup> as well as the service specification for this project set out by ESCC, and informed by elements of the Whole School Approach. It has also been informed by the PSG. The purpose of this discussion group is to seek young people's views and experiences (13-24yrs) concerning issues relating to sexual health including:

- Young people's views and experiences of SRE, advice received from schools and other professionals, and where relevant, the East Sussex 'Safe Around Sex' programme and the C-Card;
- What is most effective and important regarding sexual health service implementation and service design (e.g. staffing, accessibility, privacy, location, topic area etc.)
- Young people's ideas for new sexual health services / initiatives they would most like to see at their school which could help to improve their health including
- Views on awareness and local communications activity relating to young people's sexual health improvement (e.g. campaigns, websites and other sources of information).

### 1. Introduction and ice-breakers

Introductions/ice breakers to be decided by the facilitator as needed.

#### **Before we start**

A quick reminder that because we are talking about sexual health which can be difficult to talk about for some people, it is important everyone talks in general terms rather than personal disclosures (e.g. to avoid feeling pressured into saying things you would prefer not to)- especially important with Year 9 group. You don't have to answer any questions you don't want to, and remember that you can leave at any time without giving a reason. Please respect and value other people's contributions and remember that what is discussed within this group should remain confidential.

### 2. Sex and relationships education (SRE) programmes in schools

Those who **HAVE** experienced the 'Safe Around Sex' programme which is delivered mainly to Year 10 (but sometimes Years 9 and 11 too)

- Have you heard of the 'Safe Around Sex' (SAS) programme? (knowledge, awareness)
- Have you participated in the 'SAS programme? What did you think of it? How is it different to other SRE you've had in school? Did you miss any SRE because of SAS?
- How did you feel about being invited to participate in the SAS programme?
- Who delivered it? (school nurse, youth workers, teachers)? What did you think about the staff that delivered it? (were they the right people, if not who would you have preferred?)
- Do you remember any of the advice you were given? (knowledge)
- Do you think the SAS programme has helped you think differently about some of the issues around sex (e.g. perceptions of social norms around sex, STIs, pregnancy, orientation)? (attitude)
- Do you think the programme influences young people's behaviour? If so how? Which behaviours? (behaviour)
- Did you visit a local sexual health clinic/contraception provider? (part of the SAS) What did you think about this? What did you learn from the visit? Should all pupils have a chance to do this? Has it influenced your thoughts about future behaviours (e.g. help-seeking)
- Did it cover how to get condoms from outside as well as within school?
- Do you think you are more likely to access contraception at school (SN) now you have experienced SAS?
- Which parts did you like/didn't like and why? (facilitating factors/barriers)

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<sup>30</sup> ESCC (2014). Safe Around Sex (SAS): East Sussex sex & relationship education (SRE) enrichment programme. Group Workers' Course Guidance. ESCC

- If you could change any part of the SAS programme, what would you change and why? (e.g. topics, delivery method such as gendered specific delivery, frequency, location, single sex groups, etc.) (facilitating factors/barriers and future provision)
- Finally, do you think parents should be involved in the SAS? Have they been in any way? Would you want your parents involved in your sexual health-related matters? If so, how would you want this to happen? What about other family members (cousins, brother, sister, etc.)?

Those who have **NOT** experienced the ‘**Safe Around Sex**’ programme’

- What SRE and/or advice have you received in school so far? Who was it delivered by? (knowledge)
- Do you remember any of the advice you were given? Do you think this has changed what you do (behaviour) or how you think (attitude)?
- Which parts did you like/didn’t like and why? (facilitating factors/barriers)
- Were there any barriers to stopping you from learning what you wanted to during SRE sessions? Which ones? How could things be changed? What would make it better for you? (facilitating factors/barriers)
- Overall, what do you think would have made the talks or discussions around SRE better?
- What could the school do to improve their SRE provision? What would make the biggest difference for you? (e.g. single-sex sessions, sexual orientation discussion, chance to talk about homophobia etc., location, timing of sessions, topics covered, who delivers it etc.) (facilitating factors/barriers and future provision). What about the shift from biological aspects to other issues like resilience, emotions, peer pressure, relationships, etc.
- What about how to get sexual health support (e.g. finding out more about contraception and accessing condoms?) in school – school nurse role?

### 3. Young people’s views on availability and use of condoms including the C-Card

All year groups involved in this part of the study (Years 9-11 plus older young people) are eligible for the C-Card.

- Do you know where you can get condoms for free? (e.g. C-card for under 25yrs, sexual health clinics, GP, SAS programme in school etc.). Have you heard about the C-Card Scheme (note how many are aware)? (knowledge/awareness)
- Do you know how to get a C-Card? (usually get youth worker or school nurse to register it and choose types of condoms most appropriate). Do you know how to use a C-Card? (any point with c-card logo e.g., youth centre, GP, chemist, college etc.) (knowledge/awareness). How was this experience of getting hold of the C-Card generally?
- What do you think about using the C-card? What do you like/dislike? (facilitating factors/barriers)
- What would (or did) stop you from using the C-Card Scheme? (e.g. being anonymous (no name on it), knowing where to use it? (facilitating factors/barriers)
- What would make using the C-Card Scheme easier for you? Electronic availability? (facilitating factors/barriers)
- Do you think condoms are important? (attitude/knowledge of condoms and perceived risk of pregnancy or STI transmission etc.). What can happen if you decide not to use a condom?
- What *influences your decision* to use a condom? (decision-making) - could have some listed on a flip chart and ask YP to identify which ones by circling (or use a post-it note to write them down and stick them on a board – group can then discuss each of them)

Possible influencing factors:

| Worries over the effectiveness of condoms | The availability/cost of condoms                           | Awareness of available services giving out free condoms                     | Views of and trust in the professional  | Acceptability, facilitators and barriers to carrying condoms   |
|---|--|---|---|--|
| Embarrassment of obtaining condoms        | Experience of obtaining condoms before from a service      | Acceptability of accessing the service and accessing different outlet types | Ability to access the C-Card service (service location, transport links, and opening times) | The acceptability of different types of condom, range of condoms/products available through the scheme |
| Skills using condoms                      | The context of the sexual encounter (planned or unplanned) | Their relationship with their partner                                       | Self-esteem   | Drug or alcohol use  |

- Does how services are **marketed or branded** influence your decision to use condoms? E.g. branding of condoms as ‘sexy’ or ‘fun’ (influences)
- Finally, the government now recommend that young people can also access **female condoms** freely in the same way as you can get normal male condoms. Have you heard about or used female condoms? What do you think about them? (look, ease of use, branding etc.). What might influence your decision to use one?

#### 4. Sexual health campaigns and other communications

- What sexual health campaigns, communications, projects, websites etc. have you seen (in or out of school) aimed at young people (YP write on flip chart)? (knowledge/awareness)
- What do you think about them? What did you like/dislike? What would you change/improve? (facilitating factors/barriers)
- Did they impact on you in any way? Did it change the way you think/view (attitude) or behave regarding sexual health? (impact/change)
- If you wanted to get information about sexual health, where would you go? Why there? Do you think these are the best places to go for information? Where do you go to find out more information about local sexual health services? Is this information on where to go useful or could it be improved? What would help you most to get information easier?
- What about chlamydia testing? E.g. through postal kits or using other services? Good idea? Has anyone used/ordered a kit like this?


#### 5. General issues

- Is there anything you can think of that might be helpful to you in looking after your own sexual health and managing sexual relationships?
- When thinking about your own sexual health, what would positive sexual health and relationships mean for you?

Any further comments? Re-check consent. Thank you to everyone  
Hand out vouchers and sources of further support.



## Appendix B: Consent form

  
**University of Brighton**

### Consent Form

*For young people participating in focus groups*

Name of the researcher:.....


Please tick the boxes to show that you agree to take part in this study

- I agree to participate in this focus group on [date]
- I agree that the researcher has explained the purpose of the focus group, I have read the information sheet and I understand how the information will be used.
- I understand that taking part is voluntary and I can change my mind and stop taking part at any point without giving a reason.
- I agree for the research team to record the focus group and understand that the recording will be destroyed when no longer needed.
- I understand that my name will not be used in any report or any other materials written as a result of the focus group.
- I understand that any confidential (private) information will be heard only by the research team (including a transcriber) at the University of Brighton. However, I also know that if reveal that I, or someone I know, is at risk of harm, the researcher may have to inform another person.
- I agree not to talk to others outside the group about what is said during the focus group discussion.

|                                    |      |           |
|------------------------------------|------|-----------|
| Name of participant (please print) | Date | Signature |
| Researcher                         | Date | Signature |

**Thank you!**

## Appendix C: Monitoring form

  
University of Brighton

### Monitoring form

We would like to know more about you. Please can you fill this in for us? Information you provide will remain private.

1. Are you  Male or  Female  Transgender

2. How old are you? Please tick one box only

|                                |                                |
|--------------------------------|--------------------------------|
| <input type="checkbox"/> 11-13 | <input type="checkbox"/> 18-19 |
| <input type="checkbox"/> 14-15 | <input type="checkbox"/> 20-24 |
| <input type="checkbox"/> 16-17 |                                |

3. Which of these describes your background the best? Please tick one box only

|  |  |
|--|--|
| <b>Asian or British Asian</b>                                    | <b>Mixed/dual heritage</b>   |
| <input type="checkbox"/> Indian?                                 | <input type="checkbox"/> White and Black Caribbean?                      |
| <input type="checkbox"/> Pakistani?                              | <input type="checkbox"/> White and Black African?                        |
| <input type="checkbox"/> Bangladeshi?                            | <input type="checkbox"/> White and Asian?                                |
| <input type="checkbox"/> Other Asian background, which is: _____ | <input type="checkbox"/> Other mixed heritage background, which is _____ |

|   |   |
|---|---|
| <b>Asian or British Asian</b>                                   | <b>White</b>  |
| <input type="checkbox"/> African?                               | <input type="checkbox"/> British?                               |
| <input type="checkbox"/> Caribbean?                             | <input type="checkbox"/> Irish?                                 |
| <input type="checkbox"/> Other Black background, which is _____ | <input type="checkbox"/> Traveller of Irish heritage?           |
|   | <input type="checkbox"/> Gypsy/Roma?                            |
|   | <input type="checkbox"/> Other White background, which is _____ |

4. Do you consider yourself to have a disability?

Yes  No

*Please turn over*

5. Can you tell us the first part of your postcode where you live? *For Example: TN22*

\_\_\_\_\_

6. Would you like to receive any information about the findings of this research?

Yes\*     No

**If yes, please let us know how you would prefer us to reach you.** *For Example: email, home address, text message, Twitter, Facebook*

How to reach me: \_\_\_\_\_

**THANK YOU!**

## Appendix D: Participant information sheets

### Tell us what you think!

We are inviting you to take part in a [small focus group or paired discussion](#) to talk about health improvement initiatives in your school. Before you decide whether you would like to or not it is important to understand why the research project is being done and what it will involve. If you do not understand anything, please just ask us.

### Who are we?

Our names are Nigel Sherriff, Chris Cocking, Lester Coleman, Liz Cunningham and Kay Aranda. We work for the University of Brighton.

### What are we doing?

We have been asked by East Sussex County Council to find out young people's views and experiences of health improvement initiatives in your school. The Council would like to know what you think of these services, and to also think about which other services might be useful. We will be talking to young people who have and have not used school health improvement services.

### What will you have to do?

In a [focus group or paired discussion](#), we would like to ask you about your opinions on the health improvement initiatives in your school. It will take about an hour and will be conducted in your school. You can choose whether you want to take part and you can leave at any time without having to tell us why.

### What will we ask you about?

We are interested in lots of things. Here are some of the things we would like to talk with you about:

- Your experiences of using (or not using) health services or initiatives in school
- What things might prevent you from using health services or initiatives in school
- What health initiatives you would like to see in school and why?
- What are the most important things to you in a school health initiative?



### Will you get anything for helping?

Yes. We will make every effort to help you feel comfortable. We will give you a snack, a drink, and a £10 shopping voucher to say 'thank-you'.

### How will we record what you say?

We would like to record the [focus group or paired discussion](#) but we will ask you if this is ok first. This is so that we don't forget what you have said. Only us and the person who types up the recording will hear it and it will be destroyed afterwards.

### Will anyone find out what you have said?

No. We will not use your name in anything we write.

### What will happen to the information we collect from you?

All your views and experiences will be put together with other information we have collected from other young people. The report we write will then go to the East Sussex County Council so they can use it to plan services for the future. We will also make sure that everyone who wants it will receive feedback on the results of the project.

### But what is something goes wrong?

We hope nothing does go wrong, but if it does you can leave the [focus group or paired discussion](#) at any time and without giving us a reason. If you have a complaint about the research, you can also talk privately to someone at the University who will be able to help you. Her contact details are:

Ann Moore  
University of Brighton  
Tel: 01273 64 3766  
E-mail: [A.P.Moore@brighton.ac.uk](mailto:A.P.Moore@brighton.ac.uk)

### If you would like to ask any questions at all about the project you can get in touch with me here:

Nigel Sherriff  
University of Brighton  
Tel: 01273 64 4539  
E-mail: [n.s.sherriff@brighton.ac.uk](mailto:n.s.sherriff@brighton.ac.uk)



**University of Brighton**

## Get involved and tell us what you think!

### Tell us what you think!

We are inviting you to take part as a member of the [project steering group](#) and work alongside the research team! Before you decide whether you would like to or not it is important to understand why the research project is being done and what it will involve. If you do not understand anything, please just ask us.

### Who are we?

Our names are Nigel Sherriff, Chris Cocking, Lester Coleman, Liz Cunningham and Kay Aranda. We work for the University of Brighton.

### What are we doing?

We have been asked by East Sussex County Council to find out young people's views and experiences of health improvement initiatives in your school. The Council would like to know what you think of these services, and to also think about which other services might be useful. We will be talking to young people who have and have not used school health improvement services.

### What will you have to do?

We would like you to work with the research team as a member of the [project steering group](#). This will mean attending up to a maximum of 3 meetings for about two hours each time. Your role will be to help the research team make decisions about how the project should be run as well as things like express your opinions on the planned activities.

### Can I bring someone with me?

Yes. We will make every effort to help you feel comfortable. If you would like an adult to accompany you such as a family relative/guardian, teacher, youth worker, then please just let us know.

### How will I get to the meeting?

[Project steering group](#) meetings will be held either at your school or at the University of Brighton. Don't worry as we will make sure you either have someone to travel with (such as a parent/teacher/worker), or we will send you very clear and easy instructions with a map on how to get to the meeting.

### Will you get anything for helping?

Yes. We will make every effort to help you feel comfortable. We will give you a snack, a drink, and a £10 voucher every time you participate in a [project steering group](#) to say 'thank-you'. You will also receive a certificate of achievement at the end of the project, and any public transport expenses will be reimbursed.

### Will anyone find out what you have said?

Yes. In a [project steering group](#) meeting, notes are written (called minutes) so that everyone involved in the meeting can later remember what was said. However, only the other members of the [project steering group](#) will see these notes.

### But what if something goes wrong?

We hope nothing does go wrong, but if it does you can leave the [project steering group](#) meetings at any time and without giving us a reason. If you have a complaint about the research, you can also talk privately to someone at the University who will be able to help you. Her contact details are:

Ann Moore  
University of Brighton  
Tel: 01273 64 3766  
E-mail: [A.P.Moore@brighton.ac.uk](mailto:A.P.Moore@brighton.ac.uk)

If you would like to ask any questions at all about the project you can get in touch with me here:

Nigel Sherriff  
University of Brighton  
Tel: 01273 64 4539  
E-mail: [n.s.sherriff@brighton.ac.uk](mailto:n.s.sherriff@brighton.ac.uk)



**University of Brighton**



## Appendix E: Recruitment flyer

### Tell us what you think!

We want to explore the views and experiences of children and young people in relation to initiatives that promote health and well-being in your school. If you do not understand anything, please just ask us.

### Who are we?

Our names are Nigel Sherriff, Chris Cocking, Lester Coleman, Liz Cunningham and Kay Aranda. We work for the University of Brighton.

### What are we doing?

We have been asked by East Sussex County Council to find out children and young people's views and experiences of health improvement initiatives in your school. The Council would like to know what you think of these services and initiatives, and also to think about which other services might be useful.

### How can I be involved?

There are **three ways** in which you can get involved. You can choose one or all three. If you decide to take part, you can leave at any time without having to tell us why.

### 1. Small group or one-to-one discussion

We will run some small group discussions. We do this so that young people can tell us in detail what they think about the health improvement initiatives in your school. We will hold focus group or paired discussions in your school and will make every effort to make you feel comfortable. We will give you a snack, a drink, and a £10 shopping voucher to say "thank-you".



### 2. Activity workshops

We will also run some activity workshops. We do this so that we can collect the views of young people on different health campaigns and resources that are available to you. We will hold the activity workshops in your school and will make every effort to make you feel comfortable. We will give you a snack, a drink, and a £10 shopping voucher to say "thank-you".



### 3. Be part of the project steering group!

If you are *really* interested in this project, you could become one of our project steering group members.

You would receive a briefing, and you would help us to make decisions about the project. This could provide you with some great experience and some new skills.



As a project steering group member, you would be asked to participate in up to 3 meetings on this project between January and April 2015. We will hold the meetings either at a school or at the

## Appendix F: Parental opt-out consent template for schools

✳  
University of Brighton



[School letter head]

[Date sent]

Dear [Parent/Guardian]

The University of Brighton has been commissioned by East Sussex County Council's to conduct some engagement and participation activities with young people. They have asked [name of school] to participate in the project which will find out children and young people's views and experiences of health improvement initiatives in the school. The researchers would like to know what young people think of these services and initiatives, and also to think about which other services might be useful.

This will be achieved through small single-sex focus group discussions lasting up to an hour in relation to one of the following defined areas of health improvement commissioning/delivery:

1. Whole-school health improvement approaches (young people aged 11-16)
2. Emotional wellbeing and resilience programmes (young people aged 11-16)
3. Sexual health improvement initiatives (young people aged 13-24)

All young people who participate will receive a £10 thank-you voucher and light refreshments during the focus group activities (water and healthy snack). All young people's responses will be confidential and anonymous, and all young people will be asked whether they would like to take part before beginning. If they do not wish to participate, they will just continue normal school activities.

If you are happy for your child to take part, **you do not need to do anything**. Unless we receive a signed copy of the slip below by [DEADLINE FROM SCHOOL], we will assume that you are happy for your child to take part. If you have any further questions please do not hesitate to contact me on [EMAIL ADDRESS AND/OR PHONE NUMBER]. Thank you for your cooperation.

Yours

A handwritten signature in black ink, appearing to read "Nigel Sherriff".

[signature of head]  
Head teacher

Dr Nigel Sherriff,  
Principal Investigator



### Engaging with young people to inform health improvement commissioning in East Sussex


I understand that Dr Nigel Sherriff and/or members of his research team will be conducting the above study at my child's school.

I **do not** wish my son/daughter to be included in this study.

Signed \_\_\_\_\_ (Parent/Guardian)

Please return this form to [school contact] as soon as possible if you **do not** wish your son or daughter to take part in the study

## Appendix G: Project steering group membership

  
**University of Brighton**

### Project Steering Group

*Membership*

Membership of the project steering group (PSG) is subject to change and not all members will attend every meeting. Membership is as follows:

**University of Brighton**

- Dr Nigel Sherriff (Principal Research Fellow, Centre for Health Research, School of Health Sciences)
- Dr Lester Coleman (Visiting Fellow, Centre for Health Research, School of Health Sciences)
- Dr Chris Cocking (Senior Lecturer, School of Health Sciences)
- Liz Cunningham (Senior Lecturer, School of Applied Social Science)
- Dr Laetitia Zeeman (Senior Lecturer, School of Health Sciences)
- Dr Kay Aranda (Principal Lecturer, School of Health Sciences)

**East Sussex County Council (ESCC) Public Health team**

- David Bishop (Health Improvement Specialist [sexual health], East Sussex County Council, Public Health team)
- Nicola Blake (Health Improvement Specialist [Children, Schools and Families], East Sussex County Council, Public Health team) or Graeme Potter
- Beverley Amaechi (Participation Manager, East Sussex County Council)

**Young People**


- Odhran O'Donoghue (East Sussex Youth Cabinet member)
- Dan Quinnell (Student, Ark William Parker Academy)
- Frazer Beaton (Student, Ark William Parker Academy)
- Ethan Barnes (Student, Ark William Parker Academy)

**Representation from schools and other linked organisations (to date)**

- Kay Park (PSHE Lead, College Central) or a representative
- Collette Iglinski (Ark William Parker Academy) or a representative



## Appendix H: Safeguarding protocol

  
**University of Brighton**

**Safeguarding protocol**

This protocol has been designed by Dr Chris Cocking who is a Band 5 qualified RMN registered with the NMC. Chris has worked in Child and Adolescent Mental Health Services with clients with emotional and behavioural difficulties, and has experience of monitoring and managing situations where distress and/or agitation in young people can happen, as well as an awareness of recognised procedures for dealing with possible safeguarding issues that may arise.

Each member of the research team involved in data collection has been trained to use the protocol which sets out signs to look out for and actions to take, should participants become distressed and/or agitated during the focus group and/or individual interviews as well as the activity workshops.

**Mild distress:**

*Signs to look out for:*

- 1) Tearfulness
- 2) Voice becomes choked with emotion/ difficulty speaking
- 3) Participant becomes distracted/ restless

*Action to take:*

- 1) Ask participant if they are happy to continue
- 2) Offer them time to pause and compose themselves (if in a focus group, they will be given the opportunity to sit outside of the group to collect their thoughts in private).
- 3) Remind them they can stop at any time if they become too distressed

**Severe distress:**

*Signs to look out for:*

- 1) Uncontrolled crying/ wailing, inability to talk coherently
- 2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack

*Action to take:*

- 1) The researcher will intervene to terminate the interview (if in a focus group, the participant will be excluded from the focus group and the session paused while the situation is managed).
- 2) The distressed participant will be debriefed immediately
- 3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
- 4) If any unresolved issues arise, accept and validate participant's distress, but suggest that they discuss with school health professionals and/or their local GP. Provide details of how to access the counselling/therapeutic services available, but remind participant that the interview is not intended to be a therapeutic interaction.
- 5) Upon resolution of the situation, the remaining members of the focus group will be asked if they wish to continue or to exercise their individual right to withdraw from the study. Interview will only recommence once all members have stated they are happy to do so.

**Mild agitation:**

*Signs to look out for:*

- 1) Young Person becomes restless/ irritable.
- 2) YP may express boredom/ unwillingness to engage in interview.

*Action to take:*

- 1) Ask YP if they are OK, attempt to involve them in discussion & negotiate whether there is anything the researcher/group can do that would help ease their agitation and re-engage with the session.
- 2) Remind them that they are free to withdraw participation at any time they choose without giving a reason.

**Severe agitation:**

*Signs to look out for:*

- 1) YP may show signs of anger/ frustration and become disruptive.
- 2) In extreme cases of agitation the YP may become verbally and/or physically aggressive to other participants and/or the researcher, or display other forms of challenging behaviour

*Action to take:*

- 1) Researcher will temporarily terminate interview and use recognised verbal de-escalation and anger management techniques gained from their experience of working with YP.
- 2) Participant will be reminded that they are free to leave the session at any time they wish, and the researcher will also reserve the right to request that the YP leave the session if their behaviour is considered too challenging, or is a risk to themselves or others.
- 3) If the YP refuses to respect a request to leave the session and/or becomes verbally/physically aggressive to others, outside help from others will be sought.
- 4) Once the situation has been resolved, the researcher will check that other participants are OK, and the session will only recommence once all remaining participants confirm that they are happy to do so.

**Safeguarding Issues- Action to take:**

If a young person discloses information during the group or individual discussions that leads the researcher to believe that there are possible safeguarding concerns (such as child protection issues), then the researcher will temporarily suspend the discussion and inform the young person who made the disclosure that they will need to consult with the research team and relevant gatekeepers to decide on whether this information needs to be passed on to the appropriate body (such as Social Services and/or the Police) for investigation. Permission will also be sought from the participant to inform their parent and/or carer (unless it was considered that by doing so this could place the young person at increased risk). The young person will then be asked if they wish to continue their participation and requested not to make any further personal disclosures. Researcher will confirm that other participants present have not been unduly affected by such disclosure, and discussions will only continue if all participants have stated that they are happy to do so.

## Appendix I: Information for gate-keepers



### Engagement with young people to inform health improvement commissioning for children, families and schools in East Sussex

#### Overview

The University of Brighton has been commissioned by East Sussex County Council to conduct engagement and participation activity which will provide greater understanding and insight of the views and experiences of young people in East Sussex in relation to health improvement services and initiatives that are deliverable within a context of limited resources. Critical to this project is to involve a wide range of young people who are attending schools and other sites (e.g. youth centres). This information sheet provides more information about the activity and why such support is so central to its success.

The overarching objectives of the project are to:

- Plan and deliver safe, effective and meaningful engagement and consultation with young people about defined health improvement services and initiatives in East Sussex;
- Collate and analyse the outputs of engagement and consultation activity in order to produce a synthesis of up-to-date information about young people's views and experiences in relation to defined health improvement services and initiatives in East Sussex;
- Produce a report with robustly determined recommendations that will help commissioners determine the acceptability of proposed developments and help inform the development of health improvement initiatives to be commissioned or provided in future in the context of limited resources.

#### Topics and planned activities

The engagement activities will involve gathering local information in relation to children, schools & families and sexual health improvement commissioning. This will be achieved through focus groups, interviews and additional participatory approaches such as workshops. The main topics of investigation will be in relation to the following defined areas of health improvement commissioning/delivery:

1. Whole-school health improvement approaches (young people aged 11-16)
2. Emotional wellbeing and resilience programmes (young people aged 11-16)
3. Sexual health improvement initiatives (young people aged 13-24)

#### Who will be engaged and when?

A variety of young people based on certain relevant variables (e.g. age, gender, postcode etc.). In total, the project plans to involve up to 80 young people from areas such as Eastbourne and Hastings as well as Hailsham and its surrounding areas. Young people will receive a £10 thank-you voucher for their participation. Activities are planned to take place from January 2015 to March 2015 inclusive. The project team will require assistance in making arrangements to conduct engagement activities with young people on school sites.

#### Next steps and action points

If your school, youth group/organisation or service is interested in supporting this project and would like young people to have the opportunity to be involved, ESCC will put you in touch with the project team at the University of Brighton who will be able to let you know more about the project, answer any queries, and fine tune dates for this engagement activity.

Thank you for reading this information sheet.

## Appendix J: Governance and ethical approvals



David Bishop  
Health Improvement Specialist (Sexual Health)  
Public Health  
East Sussex County Council  
County Hall  
Lewes  
East Sussex BN7 1UE

8 January 2015

Dear David,

**Research Governance Approval – proposal for engagement with young people on health improvement commissioning**

Further to our email correspondence on this matter, I am writing to confirm that the research governance proposal for engagement with young people on health improvement commissioning has received approval from the ESCC Research Governance Panel.

Yours sincerely

A handwritten signature in black ink, appearing to read "Sally Hepburn".

Sally Hepburn, Development Manager  
Planning, Performance & Engagement  
Adult Social Care & Health

T: 01273 481214

E: [sally.hepburn@eastsussex.gov.uk](mailto:sally.hepburn@eastsussex.gov.uk)

[eastsussex.gov.uk](http://eastsussex.gov.uk)  
eastsussex.gov.uk

## Health and Social Science, Science and Engineering Research Ethics and Governance Committee

### Decision Letter (REGC-14-074.R1)

**From:** J.Scholes@brighton.ac.uk

**To:** c.cocking@brighton.ac.uk

**CC:** N.Sherriff@brighton.ac.uk

**BCC:**

**Subject:** Health and Social Science, Science and Engineering Research Ethics and Governance Committee - Decision on Manuscript ID REGC-14-074.R1

**Body:** 26-Jan-2015

Dear Dr. Cocking:

It is a pleasure to approve your application entitled "Engagement with young people to inform health improvement commissioning for children, families and schools in East Sussex" which has been approved by the Health and Social Science, Science and Engineering Research Ethics and Governance Committee. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Please notify The Chair of FREGC immediately if you experience an adverse incident whilst undertaking the research or if you need to make amendments to the original application.

We shall shortly issue letters of sponsorship and insurance for appropriate external agencies as necessary.

We wish you well with your research. Please remember to send annual updates on the progress of your research or an end of study summary of your research.

Sincerely,

Prof. Julie Scholes

Chair, Health and Social Science, Science and Engineering Research Ethics and Governance Committee

J.Scholes@brighton.ac.uk

**Date Sent:** 26-Jan-2015

 Print  Close Window

## Appendix K: Thank you letters for recruitment sites



**University of Brighton**

Centre for Health Research (CHR)  
College of Life, Health, and Physical Sciences  
School of Health Sciences  
Mayfield House, Falmer,  
Brighton  
BN1 9PH  
Direct Line: 01273 644539  
[www.brighton.ac.uk/healthresearch/index.aspx](http://www.brighton.ac.uk/healthresearch/index.aspx)

[Date]

**Re: Engaging young people to inform health improvement commissioning**

Dear [name]

We would like to express our gratitude to [name of school/recruitment site] for its participation in the above project. Specifically, we would like to thank [name of gatekeeper] for assisting us in engaging with young people from the school.

The [number of] young people who participated in the engagement activities were enthusiastic, polite, articulate, and made a valuable contribution both to the project and more broadly for health improvement commissioning across East Sussex. We would therefore like to extend our thanks to those young people.

The research team from the University are now working to analyse the findings along with data generated from other schools and sites across the county. We will be producing a report for East Sussex County Council setting out these findings and providing recommendations for future health improvement commissioning. On completion of the project at the end of May 2015, a hard copy and electronic copy of this report will be made available to all participating schools and other sites. In addition, we will produce a short accessible executive summary which may also be of interest.

If you have any questions about any aspect of the project, please contact either Dr Nigel Sherriff from the University of Brighton at [n.s.sherriff@brighton.ac.uk](mailto:n.s.sherriff@brighton.ac.uk) or 01273 644539 or David Bishop from East Sussex County Council at [david.bishop@eastsussex.gov](mailto:david.bishop@eastsussex.gov) or 01273 336228.

Our thanks again to [name of school/recruitment site]

Yours sincerely

A handwritten signature in black ink, appearing to read "Nigel Sherriff".

Dr Nigel Sherriff  
Principal Investigator  
University of Brighton

A handwritten signature in black ink, appearing to read "David Bishop".

David Bishop  
Health Improvement Principal  
East Sussex County Council





## **University of Brighton**

Centre for Health Research (CHR)  
School of Health Sciences  
College of Life, Health, and Physical Sciences

University of Brighton  
Mayfield House (M256)  
Falmer  
BN1 9PH, UK  
Tel: +44 (0)1273 644539

[www.brighton.ac.uk/healthresearch/index.aspx](http://www.brighton.ac.uk/healthresearch/index.aspx)