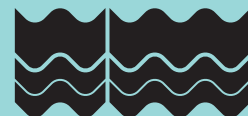




University of Brighton

East Sussex
County Council



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



Professor John Kenneth Davies
June 2015

LITERATURE REVIEW

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List of abbreviations

BEI	British Education Index
BME	Black and Minority Ethnic
CINAHL	Cumulative Index to Nursing and Allied Literature
DH	Department of Health
ERIC	Education Resources Information Centre
EMBASE	Excerpta Medica dataBASE
ESCC	East Sussex County Council
HPS	Health Promoting School
MEDLINE	Medical Literature Analysis and Retrieval System Online
NICE	National Institute of Health and Care Excellence
LGBT	Lesbian, Gay, Bisexual, and Transgender
PsychInfo	Psychology Database
PHE	Public Health England
SH	Sexual Health
SRE	Sex and Relationship Education
UoB	University of Brighton
WHO	World Health Organisation
WoS	Web of Science
WSA	Whole School Approach

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Executive summary

This literature review and synthesis constitutes an integral part of the primary research report by Sherriff, Coleman, and Cocking (2015) on engaging young people to inform health improvement commissioning and delivery in East Sussex. Prior to the engagement activities with young people, secondary research was conducted to support and contextualise the project. This involved desk-based literature extraction and a synthesis of key local/national or international research relating to the three topic areas under focus: whole-school health improvement approaches; emotional wellbeing and resilience programmes, and; sexual health improvement initiatives. Summaries from the literature concerning these three areas are provided to enable researchers and commissioners to ascertain how young people can be engaged effectively in health promotion/improvement initiatives, and in collaboration with the commissioning process.

Literature review protocol

The literature searches were carried out in two phases: Phase 1 was carried out in October and November 2014 and Phase 2 in February-March 2015. Phase 1 was completed by ESCC and focussed mainly on health literature. It involved searching databases such as MEDLINE, EMBASE, CINAHL, NICE, Cochrane Collaboration and PsychInfo. Phase 1 search results were assessed by UoB then extended, updated and complemented by additional searches of the following educational databases Web of Science (WoS); British Education Index (BEI); Education Resources Information Center (ERIC) and further specialist health promotion/health education literature. The latter involved reviewed reference lists, citation searches, hand searching key journals, relevant websites, and targeted internet searches.

As Phase 1 searches were comprehensive, there was some inevitable overlap with Phase 2 searches in particular areas; however, accessing the educational literature added a key dimension and perspective. In both phases the search protocol followed a similar procedure. The same inclusion criteria were used (i.e. literature since 2000; in English; from developed countries [mostly, the UK and Europe, USA, Canada, Australia and New Zealand]; and involving young people aged 13-16 years (extended to 24 years for the sex and relationships topic). The exclusion criteria omitted search studies from: developing countries; that discussed clinical conditions; that gave the views of parents, school staff or health professionals. Full details of the database search terms used and a detailed search history are provided in the full literature review report together with all references (see Davies, 2015).

In the following sub-sections a summary of the findings are provided.

Young people's views on the whole school approach

The whole school approach (WSA) internationally has many different names as well as the health promoting school (HPS), but all these approaches have the same core components of a healthy environment, healthy policy, and skills-based health education and services. However, research on measuring the HPS and/or WSA is rather limited.

Given it was beyond the scope of the review to consider all single topic health improvement programmes (e.g. obesity, smoking, drug and alcohol abuse, etc.), instead, particular attention was paid to the key project themes of mental health (emotional health and wellbeing), sexual health, and active engagement with young people. The principal finding from the review (and reflected in the findings from the primary data from Sherriff *et al.*, 2015) was that young people's key concern is that they are not listened to and that their views are not taken into account. The literature suggests that once young people can see changes being made as a result of being listened to, their self-esteem and sense of being valued improved.

Social relationships were of concern to most young people, who raised confidentiality issues, such as the need to have someone trustworthy they could talk to and consult, and who would listen to them and problem-solve. Confidentiality is crucial for effective youth-friendly programmes and services as far as young people are concerned.

A key issue in the literature was the need for young people to be actively involved in, what they saw as, relevant activities tailored to their own needs and concerns. The local context and characteristics of the school itself and the extent of student involvement in the life of the school were important factors. This is fundamentally important for commissioners, as any health improvement initiative must be tailored to the local context of the school.

Areas for further consideration

The evidence base for the effectiveness of school-based health improvement programmes is highly variable. Many studies rely on personal accounts from young people of their own behaviour and are unable to deduce clear conclusions regarding the effectiveness of the HPS or WSA. It is difficult to differentiate the relationship or complementarity between the many topic/one dimension health programmes within a whole school framework. More process research is needed to explore young people's engagement in this process.

There is a need for further research on the effectiveness of the WSA with respect to: young people's mental and sexual health; measuring the impact of interventions on academic achievement as well as on health; settings outside the USA; marginalised, disengaged and, 'hard to reach' young people; and process evaluations which can collect useful qualitative contextual data.

The local diversity of schools, as complex social systems needs further research. Better designed programmes are required to establish what actually does or doesn't work over time and in what circumstances, for whom, and why. Realist evaluation offers a potentially useful approach to evaluate complex interventions such as the whole school approach.

Young people's views on emotional health and wellbeing

Young people's emotional health and wellbeing influences their learning and cognitive development. The WSA and school connectedness are key factors in improving emotional wellbeing and resilience. The ethos and culture of the school is fundamental to building positive

mental health among young people. Therefore young people must be placed at the core of any intervention.

The HPS framework has demonstrated positive outcomes in building resilience among young people. There are many studies related to mental health within schools but very limited research findings on the views and opinions of young people regarding mental health promotion. Precise evidence of which interventions are most effective is limited.

A personal sense of belonging to the school environment and community is a positive protective component and is needed to endorse mental health by building competence and resilience. The context of each school needs to be considered and support strategies reflect their local needs.

Young people should be placed at the core of any intervention to promote emotional health and resilience. They should own and actively participate in initiatives to improve all aspects of their health and wellbeing.

Current mental health programmes often originate from the health sector and thus fail to consider how the educational, social, and cultural structures and processes in the school operate. Therefore a multi-agency strategy through a whole school approach needs to be developed taking account of the local context of the school or educational institution.

Key components to promote students' emotional health and wellbeing are:

- Strong school leadership – adopting the SAFE approach (careful sequencing, active learning, focussed on skills development and having explicit goals);
- A WSA – including adoption of evidence-based programmes based on thorough needs assessment involving students (and monitoring their needs over time);
- A whole person approach – linking physical, social and emotional health and wellbeing;
- Authentic and practical student engagement at the following levels: behavioural emotional and cognitive.

Areas for further consideration

There are many studies related to mental health within schools, but very limited research findings on the views and opinions of young people regarding mental health promotion. More research is needed on resilience programmes and in particular young people's views and experiences with regard to them to help ensure mental health promotion programmes are as effective as possible.

There is a dearth of robust evidence for the effectiveness of school-based mental health promotion initiatives in the UK. School-based mental health programmes are particularly difficult to evaluate. In particular, there is a need for clear outcome measures and a need to clarify the exact initiative under evaluation.

Young people's views on sexual health improvement

Sex education alone needs to be reinforced and complemented by much broader 'upstream' interventions that acknowledge the social context of sexual behaviour. Evidence shows that sex and relationships education (SRE) increases young people's knowledge and attitudes, but has limited impact on behaviours. Young people's views on what makes sex education effective, differs considerably from policy makers; something that commissioners should be aware of.

In their views on SRE, young people were often critical of information being too biological or 'scientific', and being presented in a didactic way, with little opportunity for interactive discussion. They wanted more focus on relationships and negotiation skills. SRE needs to be set firmly within the WSA. Numerous authors have endorsed the multi-model/whole school approach, as laid out in the HPS framework, as most effective in bringing about long term changes to students' knowledge, attitudes, and behaviours.

Outside of school, consideration should be given to engaging with young people's informal sources of sexual health information. Many disengaged students rely on these information sources in the absence of school or youth-based services.

Those developing, commissioning, and/or delivering sexual health improvement programmes for schools should engage with young people and staff to develop services in line with their needs. Fundamentally it is essential to establish on-going systems to listen to young people and prioritise their needs, preferences and interests, which can differ by gender, sexual orientation, ethnic origin, and so on. These will of course change with young people's sexual development, and appropriate programmes should be started early. Communication and assertiveness skills should be stressed and not just biological information. Consultation/needs assessment with young people should be carried out in advance of any programme and a feedback cycle built in.

SRE programmes should be tailored to consider local contextual issues, for example, sexual diversity and ethnic differences in beliefs and attitudes.

Competent, appropriately trained and trustworthy/non-judgemental teachers should form part of a multi-professional team comprising (as an example), a health professional (e.g. school nurse), an external specialist consultant, and others such as a youth worker involved/experienced in SRE delivery. They should create safe and secure environments that ensure appropriate confidentiality, privacy, accessibility and approachability and encourage open discussion of sensitive areas. They should treat sex as a positive contributor to individuals' lives and not as a bad/ embarrassing/ negative form of risk behaviour.

All young people's informal sources of sexual health information should be discussed, including peers, siblings, friends, parents, mass media, internet/websites/cyber world, dominant sexual discourses, for example. The internet and other contemporary electronic media have potential for contributing towards effective SRE for young people.

Areas for consideration

There were very few attempts in the literature to involve young people directly in the ownership and direction of methodology used to ascertain their views and needs regarding sexual health improvement. Further research is needed on:

- Targeting SRE into whole school/college approach, linking more effectively with youth-friendly sexual health services such as the C-Card scheme;
- Processes that move beyond information provision to skills training and follow-up, in terms of the evaluation of behavioural intentions/behaviour change;
- Carrying out more process evaluation as well as realistic outcome evaluation;
- Use of peer educators/mediators – although popular with young people, there is a need to establish their effectiveness, as there is currently mixed evidence;
- The role and function of sexual health improvement within the WSA.

Section One: Introduction

Engagement with young people and their active participation are key components in the development, implementation, monitoring and evaluation of effective health improvement initiatives. As part of a wider project on engaging young people to inform health improvement commissioning and delivery (Sherriff *et al.*, 2015), it was therefore essential to explore the literature regarding young people's views and experiences of health improvement initiatives specifically related to the three target areas of the primary research project:

- Whole school approaches (WSA) to health improvement;
- Emotional well-being and resilience programmes;
- Sexual health improvement initiatives.

The review provides an up-to-date contextual background to support the primary research work being carried out in East Sussex in relation to the project's specific research questions/approach.

Summaries from the literature concerning the above three areas are provided to help ascertain how young people can be engaged effectively in health promotion/improvement initiatives, and in collaboration with the commissioning process.

Section Two: Methods

The literature review comprised a two-phase process:

Phase 1

A review and synthesis of findings from the following evidence searches (which had been previously commissioned by East Sussex County Council and prepared by Brighton and Sussex NHS Library and Knowledge Service):

- Young people's views on the whole school approach to health improvement. Liz Rowan (30 October 2014) Brighton, UK: Brighton and Sussex (Appendix 1a);
- Young people and emotional wellbeing and resilience programmes. Liz Rowan (20 October 2014) Brighton, UK: Brighton and Sussex (Appendix 2a);
- Young people's views on sex and relationship programmes in schools. Liz Rowan (3 November 2014) Brighton, UK: Brighton and Sussex (Appendix 3a);
- Young people's views on availability and use of condoms. Liz Rowan. (4 November 2014) Brighton, UK: Brighton and Sussex (Appendix 3b).

Phase 2

The results of the Phase 1 synthesis, which were very comprehensive, were assessed and then extended, updated and complemented by additional searches through the University of Brighton Library:

1) Education literature in Web of Science (WoS) and British Education Index (BEI) and Education Resources Information Center (ERIC) databases to supplement the initial searches in Phase 1:

- Young people's views on the whole school approach to health improvement. Beth Hewitt (3 March 2015) University of Brighton, UK (Appendix 1b);
- Young people and emotional wellbeing and resilience programmes. Beth Hewitt (3 March 2015) University of Brighton, UK (Appendix 2b);
- Young people's views on sex and relationship programmes in schools. Beth Hewitt (3 March 2015) University of Brighton, UK (Appendix 3c).

2) Specialist health promotion/health education literature.

The above evidence searches were reviewed incrementally. See appendices for search strategy.

Inclusion/exclusion criteria:

- Types of studies: multi-purpose;
- Time period: 2000 onwards;
- Language/area limits: English/non developing countries/mainly USA, UK, Europe, Canada, Australia, New Zealand;

- Age of participants: whole school approach (11-16 year olds); emotional wellbeing and resilience (11-16 year olds); sexual health (13-24 year olds);
- Target of intervention: views of young people/not parents, school staff or health professionals;
- Type of intervention: whole school approach; emotional health and resilience; sexual health;
- Type of outcome: health improvement/non clinical conditions;
- Type of publication: peer reviewed articles and reviews; website material, grey literature.

Section Three: The whole school approach to health improvement

3.1 Introduction

In order to explore young people's views and experiences of various health improvement interventions there is a fundamental need to define such interventions and assess their effectiveness, including for example whole school or single topic approaches and their relationship. Particular attention is paid to the key themes of mental health and sexual health and to active engagement with young people.

School health programmes have evolved considerably over the past 50 years and the changing role of schools in society reflects their potential to make a substantive impact on the health and wellbeing of young people (Young 2005; Anderson *et al.*, 2014). In the last century, and, it could be argued at the current time, school health programmes have been driven from the health sector in many countries, including the UK. Their principal goal has been to improve health, although in recent times, coordinated school health programmes have attempted to influence young people's educational attainment (Murray *et al.*, 2007) and boost their academic learning (Bonell *et al.*, 2014).

3.2 Health education

Health programmes in schools have traditionally focussed on health education, which is defined as:

“...the continuum of learning, which enables people, as individuals, and as members of social structures, to voluntarily make decisions, modify behaviours and change social conditions in ways that are health enhancing.” (JCHET 1991 p105).

Health education is perceived as a form of education for health persuading young people to live more healthily by giving appropriate information, which sought to change their attitudes and, subsequently their behaviour. It adopts a perspective that assumes individuals are rational in their decision-making and can be persuaded, by giving ‘scientific’ information, to make the required ‘healthy choices’ and thereby bring about healthy behaviour change. Health education perceives health as absence of illness and thereby bases its activities on a model of preventive medicine that focuses on individual behavioural risk factors, for example, smoking, drug abuse, unsafe sexual practices, etc. This individual risk factor approach set the rationale for one-dimensional school programmes (St Leger *et al.*, 2007; Allensworth and Kolbe 1987). Schools have become the setting therefore for attempting to prevent a wide variety of health problems including obesity, smoking, drug and alcohol abuse, sexually transmitted diseases, and bullying, for example.

Within schools, health traditionally has been delivered as ‘health instruction’ within the curriculum, related primarily to physical health, for example being delivered as part of the biology or physical education syllabus, with little if any acknowledgement that health also had mental and social perspectives. It is important to highlight this, not only for historical reasons, but because, even contemporary approaches reflect limitations of relying on information transfer

within curriculum implementation alone – students aged 14-15 years in Canada gave mostly negative feedback on health programmes and highlighted limitations related to passive reception, routine delivery, and repetitive course content (Begoray *et al.*, 2009).

3.3 Health promotion

In the last quarter of the twentieth century the focus on the traditional bio-medical, individual risk factor model of health alone shifted towards health promotion, which embraced consideration of the wider socio-economic determinants of health based on a socio-ecological model of health (Wilkinson and Marmot 1999; WHO 2008; Marmot 2010). Individual health behaviour was recognised as being influenced by the contexts and settings in which people live. Health promotion was seen as a process that is enabling and empowering, combining individual lifestyle/behaviour with broader socio-structuralist approaches. The essential elements of health promotion relate to its core values, which are based on principles of social justice, equity, empowerment and self-determination. This is reflected within the World Health Organisation (WHO) Ottawa Charter (WHO 1986) in which health is conceived of as a complex interaction between social, political, economic, environmental, genetic and behavioural factors (Poland, Krupa and McCall 2009).

Health promotion has been operationalized through the ‘healthy settings approach’, which is rooted in the WHO health for all strategy (WHO, 1999). Healthy settings reflect the socio-ecological model of health promotion, a systems perspective and a whole organisational development and change focus (Baric 1993; Dooris 2004):

*“Health promotion interventions are inherently complex, often adopting a variety of approaches, involving multiple audiences and attempting to achieve several outcomes which may subsequently impact on health” (Holliday *et al.*, 2009).*

Within this holistic approach, health and well-being are considered integral resources for life where health promoting environments are created to enable individuals and groups to realise aspirations, satisfy needs, and cope with daily living (WHO 1986).

Health education’s traditional persuasive and coercive approach is in conflict with the democratic and participatory values of health promotion. However, a synergy between health education and health promotion has emerged and ideally both should work together to create informed and empowered young people (Weare 2002). Within the school environment health education is an essential component, but it is much more effective set within a supportive context, including both social and physical environments, to facilitate health improvement among young people. (Begoray *et al.*, 2009).

3.4 The whole school approach

3.4.1 Concepts and definition

One of the first settings adopted by the WHO to apply its model of health promotion in practice was the school (Young 2005). WHO, together with the European Union (EU) and Council of Europe (COE), initiated and supported the health promoting schools network (HPSN) during the late 1980's and 1990's in order to generate evidence for further investment (Barnekow Rasmussen and Rivett 2000; Denman, Moon, Parsons and Stears 2002; Clift and Jensen 2005; Cushman 2008; Bell and Dymont 2008). The health promoting school approach is used extensively across Europe (Senior 2012; Buijs *et al.*, 2013), currently under the title of the Schools for Health in Europe Network (SHEN) www.schoolsforhealth.eu. Adopting a similar approach, all institutions of further and higher education can work towards becoming health promoting colleges or universities (Tsouros *et al.*, 1998).

The health promoting school kick-started what is termed the 'whole school approach'. This approach emphasises that health and education are inextricably linked. The whole school approach internationally has many different names as well as the health promoting school, for example, the healthy school, universal school, and multi-dimensional school, as well as comprehensive school health education and the coordinated school health programmes (CSHP) (both in the USA) and the focussing resources on effective school health (FRESH) programme from the United Nations Educational, Scientific and Cultural Organisation (UNESCO). Yet all these approaches have the same core components of a healthy environment, policy, skills-based health education and services (Whitman and Aldinger 2009). Health promoting schools use "a whole-school approach to enhance the health and educational outcomes of children and adolescents through teaching and learning experiences initiated by the schools" (Nutbeam 2000; St Leger 2001; Markham and Aveyard 2003). More recently, in 2014 the Children and Young People's Mental Health Coalition carried out an extensive consultation with a wide range of educational stakeholders in England who endorsed the principles of the health promoting school approach as consistent with the whole school approach (PHE 2015b):

*"Health promoting schools offer an innovative and participatory way to increase the likelihood of the next generation becoming aware of the practical ways to positively influence their lifestyle and future wellbeing" (Macnab *et al.*, 2014).*

For the purposes of this review the term 'health promoting school' will be used to represent the whole school approach – this is because the literature mainly uses the term 'health promoting school' and rarely the term 'whole school approach'.

3.4.2 The health promoting school framework

The health promoting schools framework is:

"...a multifactorial approach that covers teaching health knowledge and skills in the classroom, changing the social and physical environment of the school, and creating links with the wider community" (Stewart-Brown 2006 p 4).

Developing a health promoting school involves facilitating a whole organisation approach to embed health, wellbeing and sustainable development into the ethos, culture, policies and daily processes of the institution. It requires long-term investment of time in order to develop the necessary relationships, partnerships and common synergy. (Macnab 2013). The establishment of a health promoting school “...requires changes in mind-set and refinement of educational investment rather than the provision of new resources ...” (Macnab 2013, p 78).

To be effective, this approach requires complex, multi-factorial planning, implementation and evaluation as well as ‘joined-up’ thinking and active engagement with key stakeholders – students, parents, teachers, health professionals, for example. Joint ownership of the endeavour, including ownership by students, is crucial to its effectiveness and sustainability. There are 6 components to the health promoting school framework (Deschenes *et al.*, 2003; Senior 2012):

- Healthy school policies;
- Physical environment of the school - a poor quality external environment can restrict learning. Alternatively students perceive that both their health and educational development can be enhanced if the environment of the school is enjoyable, clean and pleasant (Denman *et al.*, 2002);
- Social environment of the school;
- Individual’s health knowledge, skills and action competencies;
- Community links;
- School health services.

3.4.3 Effectiveness of the health promoting school

Numerous authors have endorsed the multi-model/whole school approach, as laid out in the health promoting school framework, as most effective in bringing about long term changes to students’ attitudes (Stewart-Brown 2006; IUHPE 2009a; IUHPE 2009b; AHPSA 2005; St Leger *et al.*, 2007; Senior 2012). Nevertheless research on measuring the health promoting school is rather limited (Lee *et al.*, 2013), extremely complex (Mukoma and Flisher 2004; Keshavarz *et al.*, 2010; Bonell *et al.*, 2013) and, in particular, well-designed studies of its implementation are scarce (Samdal and Rowling 2011; Rowling and Jeffreys 2006; Inchley *et al.*, 2007). The National Healthy Schools Programme in England was found to be a useful facilitator of change at school level but did not clearly influence student’s health-related behaviour (Arthur *et al.*, 2011). The health promoting school approach aims at breaking down barriers between health and education sectors and to avoid them working in silos. But there is little evidence that this has occurred and studies demonstrate the value of the approach for health but not yet for education (Langford *et al.*, 2014). It has been proposed that evaluation of health promoting schools should be based on the research literature on the educational dynamics of schools rather than primarily on health-related indicators (Lee *et al.*, 2005).

The evidence base for the effectiveness of school-based health promotion programmes is highly variable (Lister-Sharp *et al.*, 1999; Warwick *et al.*, 2009; Brown and Summerbell 2009). Many studies rely on personal accounts from young people of their own behaviour and are unable to

deduce clear conclusions regarding the effectiveness of the health promoting school approach (Langford et al., 2014).

Common cross cutting themes related to implementation tend not to be highlighted, as the systematic reviews that have been carried out are usually topic or problem specific – see earlier comments regarding health education (Pearson et al., 2012). Therefore evaluation of the whole school approach should not be limited to outcomes from single topic health education/promotion interventions (Simovska 2012b).

There is great variability in the effectiveness of different types of school programmes:

“School-based programmes that promote mental health, healthy eating and physical activity are the most effective, while programmes on preventing substance use and suicide are among the least effective of school health promotion programmes” (Stewart-Brown 2006 p 2).

The above findings from the WHO Health Evidence Network (HEN) synthesises a series of high quality systematic reviews including school programmes on healthy eating, physical activity, aggressive behaviour/bullying, mental health, and substance use/misuse, for example. It built on an earlier systematic review whose key finding was that:

“...school-based programmes that promote mental health are effective, particularly if developed and implemented using approaches common to the health promoting school approach; involvement of the whole school, changes to school psycho-social environment, personal skills development, involvement of parents and the wider community, and implementation over a long period of time” (Lister-Sharp et al., 1999 p16).

For example, analysis of the various pathways underlying the effects the school may have on drug use among students, support the whole-school approach to interventions to reduce drug use by acknowledging students’ achievements and encouraging a sense of belonging, reducing bullying, and making additional social support available (Fletcher et al., 2009). Such interventions should be piloted and evaluated in a range of settings to examine their effects on students’ drug use. Broader policies relating to secondary school targets, curricula, assessment, and streaming may also influence rates of adolescent drug use.

Yet the evidence base for many health programmes is limited to health sector research. Evidence is needed from other disciplines, in particular the education sector which has its own established research base (Rowling and Jeffreys 2006). There have been more recent attempts to expand the evidence base on policy and practice decision-making for health promoting schools, acknowledging the practical realities of both sectors (Lee et al., 2013). There are limitations within systematic review processes, in both the education and health sectors, because the studies they contain are based on research design and not on intervention quality, this can produce anomalous results:

“The limitations of relying heavily on systematic reviews based on controlled studies for decision making are being recognized ... in policy making and planning for health-promoting

schools, perspectives and findings of educational research are essential elements.” (Rowling and Jeffreys 2006 p 707).

This observation is endorsed by other researchers (Speller et al., 1997). Although there is some evidence, as above, of the effectiveness of health ‘topic’ programmes in schools, this is not perceived currently as the best way to influence young people’s overall health and wellbeing:

“Evidence about effective school health initiatives indicates that health is better viewed as a ‘whole school approach’ where it links with other components of the formal and informal curriculum” (St Leger and Young 2009 p 69).

Educational outcomes can also be more effectively achieved:

“...a whole school approach or using the Health Promoting School (HPS) framework is likely to achieve better health and education outcomes than a classroom-based topic approach” (St Leger and Young 2009 p 71).

Public Health England has also recently endorsed this approach:

“The evidence tells us that treating different, specific health issues separately will not tackle the overall wellbeing of this generation of young people” (PHE 2015a p 6).

Although they suggest not to forget the health aspects under consideration:

“Learning from what works, we have seen that an effective approach is to start with a holistic, integrated model of health and wellbeing, without losing focus on the importance of specific health outcomes” (PHE 2015a p 21).

The most comprehensive and high-powered review and synthesis of evidence on the health promoting school approach has set out the current state of play (Langford et al., 2014). They suggest the need for further research on the effectiveness of the whole school approach, in particular, regarding mental health and sexual health. They also highlight the need 1) to measure the impact of interventions on academic achievement as well as on health, 2) to carry out more research outside USA and in particular more process evaluations, which can collect qualitative, contextual data to elucidate what works, for whom, in what circumstances, and why. In an evaluation of the national healthy schools programme, successful interventions build upon student’s needs and interests; are related to their gender and age; are interactive and enable young people to gain new knowledge, clarify their values and try out new skills (Warwick et al., 2009). It is important that effective programmes are responsive to the current context and circumstances of the school or educational institution in question, intervene at different levels (building on the ‘spiral curriculum’) and involve students directly in their planning, implementation, monitoring and evaluation:

“Successful programmes are usually those that are relevant, resonate with students, and engage school communities so that they choose to ‘own’ and sustain their programme” (Macnab et al., 2014)

Work in Canada, where the term ‘healthy schools’ (HS) programme is prevalent, has explored the action mechanisms in its practical implementation:

“Because of its multifaceted, integrated and concerted nature, the HS approach is inherently complex from a practical point of view and a challenge with regard to its absorption within the core business of schools” (Deschesnes et al., 2014 p 209).

3.4.4 Participation of young people

It is recognised that the context in which people live their lives day to day are important in determining their health and wellbeing. Therefore healthy settings such as the health promoting school should be assessed as individual political endeavours that are negotiated among the local stakeholders involved, in this case by young people themselves. Youth participation is the key to ensure the development of healthy relationships (PHE 2015b). A systematic review of evidence points out that participation of students in terms of their acquisition of knowledge, skills and competencies in school health promotion is beneficial to their overall wellbeing (Simovska, 2012a). It has also been proposed that, given appropriate guidance, students can act as health promotion change agents (Paulus 2012).

After remaining in the shadow of adults for many decades, a reconceptualization of young people perceives them as being citizens in their own right and having their own opinions regarding their health and wellbeing (Smith et al., 2004; Smith et al., 2004). The more connected young people feel towards their school the better their educational attainment and emotional wellbeing (SHEN 2013). Yet recent surveys of young people’s involvement in local strategic health decision making in England is at best mixed and fragmented (OCC 2013).

In an evaluation of the National Healthy School Standard in England, a major factor was the contextual characteristics of the school itself (Warwick et al., 2005). These included the extent of student (and parent) involvement in the life of the school, the quality of teaching and of social relationships. The researchers highlighted the need to develop outcome measures including students’ views:

“Students can act effectively as agents for positive change in the ethos and health culture of the school” (Macnab 2013).

Student participation and empowerment is a key principle of the health promoting school approach (St Leger 2005). In his evaluation he asked students what they understood by health, what a healthy school ought to be and their views on healthy school activities. Respondents felt that tangible changes brought about, such as establishment of a new policy were noticeable, but there were a range of other issues, related to the ethos or their feelings about the school and its social environment, which were more intangible. It was unusual for students to refer to the whole school approach “...tending to talk of them instead as specific initiatives such as the ‘playground project’, ‘peer mediation scheme’ or simply changes to the canteen...” (Warwick et al., 2005 p 701). Respondents valued after school activities but this depended on their personal interests, such as sport, for example. The area of social relationships was of concern to many students, who raised confidentiality issues – the need to have someone trustworthy they could

talk to and consult, and who would listen to them and problem-solve, especially when bullied or isolated. Overall a key theme arising was the need for students to be directly involved in, what they saw as, relevant activities tailored to their own needs and concerns. This is endorsed recently by Public Health England:

“Understanding young people’s views on health and wellbeing and how they like to solve health problems is central to intervening successfully” (PHE 2015a p 21).

This raises the need for teachers and other relevant adults to take young people’s views and interests into account when designing school activities; in other words to ensure students are actively involved in learning:

“Rather than proscriptions and prescriptions, developing insights into the ‘real world’ were better generated by pupils’ informed decision-making” (Warwick et al., 2005 p 706).

Students stressed the value of discussion and the need to talk about real issues with other adults and not just teachers, for example, the school nurse. But even following discussion students realised that some issues were not resolved and they needed to see tangible results or improvements. Once they saw changes being made as a result of being listened to this improved their self-esteem and their sense of being valued. Students felt overall that there was still a great deal to do in improving their involvement (and that of their parents) in daily school life. In particular they valued the opportunity to build in regular times for reflection and feedback:

“Students need to talk about ideas, especially with knowledgeable, caring adults” (Begoray et al., 2009 p 40).

In this process confidentiality is of key importance to young people and is referred to “as a lynchpin to a youth-friendly service” (DH 2012 p39). Chase et al., (2006) found it important to create a confidential space and safe environment in schools to enable young people to access advice and support on a range of health issues. In 2006 they reported that few such services had been evaluated. The students interviewed by Begoray et al., (2009):

“...articulated for themselves the importance of the outside sources of health information, frequently admitting that they relied more on these rather than their disappointing and inadequate classroom experiences in health education” (p 41).

The health promoting school approach has to pay particular attention to the needs of marginalised/hard to reach groups:

“The whole-school approachmay fail to adequately address the experiences of marginalised and vulnerable groups of young people within schools, challenging and undermining the social inclusion agenda in which the programme is grounded ...” (Curtis 2008)

This applies for example to obese young people:

“Public health programmes that work at the population level (the ‘whole-school’ approach) can be responsible for unintended consequences for vulnerable subsections of the population, such as young people with obesity: rather than promoting social inclusion ... has the potential to exacerbate their marginalization” (Curtis 2008).

Concern is expressed that a lot of consultations with young people seem mainly to take place with those already involved with organisations.

Many young people thought the school nursing service was not ‘young people-friendly’, was not anonymous (as held in school) and would like a choice of places to go to seek help and advice (NCB 2011). Following consultation, young people felt the school nursing service should be accessible and be offered at times and places that were convenient for them, should have a confidential booking service by email or text, should encourage feedback from them and should ensure the nurse had appropriate skills in working with them (DOH 2012).

In an attempt to understand student’s views on encounters with school nurses, a survey in Danish schools found that 11-15 year olds felt the relationship was beneficial to their mental health when it was reciprocal, the student was able to shape what was being discussed and had enough time to do so (Borup 2000). In addition the school nurse listened and related advice that supported the student’s own thoughts and concerns. Young people expressed their need for adequate preparation time to actively participate and ensure the topics discussed were relevant to them (Maenpaa et al., 2007; Golsater et al., 2010). They also needed the aims of the encounter to be clearly stated by the nurse and in particular to include advice and information that they wanted to discuss. Confidentiality and privacy were key facilitators as young people often saw lack of them as a barrier (Gleason et al., 2002). Young people felt that the nurse should not be seen as too authoritarian and threatening (Loman 2008) and should take an empowering approach (Jolly et al., 2007).

School nurses played a key role advocating for school wide change in a school-based obesity prevention programme called ‘Health in Motion’ (Mauriello et al., 2006). The researchers developed an incremental process of obtaining student views by interviewing five focus groups of students to ascertain their perspectives, terminology and behaviour. This was then followed up by interviews with nine students to obtain their understanding of concepts and surveys of larger groups to obtain feedback on adolescent perspectives of the appropriateness of the programme, including their reading and academic levels. A dedicated questionnaire approach has also been used in other obesity prevention programmes to gauge what aspects young people feel are important to aid the design of bespoke programmes (Wilson 2007).

3.5 Summary and conclusions

The whole school approach (WSA) internationally has many different names as well as the health promoting school (HPS), but all these approaches have the same core components of a healthy environment, healthy policy, and skills-based health education and services. However, research on measuring the HPS and/or WSA is rather limited.

Given it was beyond the scope of the review to consider all single topic health improvement programmes (e.g. obesity, smoking, drug and alcohol abuse, etc.), instead, particular attention was paid to the key project themes of mental health (emotional health and wellbeing), sexual health, and active engagement with young people. The principal finding from the review (and reflected in the findings from the primary data from Sherriff *et al.*, 2015) was that young people's key concern is that they are not listened to and that their views are not taken into account. The literature suggests that once young people can see changes being made as a result of being listened to, their self-esteem and sense of being valued improved.

Social relationships were of concern to most young people, who raised confidentiality issues, such as the need to have someone trustworthy they could talk to and consult, and who would listen to them and problem-solve. Confidentiality is crucial for effective youth-friendly programmes and services as far as young people are concerned.

A key issue in the literature was the need for young people to be actively involved in, what they saw as, relevant activities tailored to their own needs and concerns. The local context and characteristics of the school itself and the extent of student involvement in the life of the school were important factors. This is fundamentally important for commissioners as any health improvement initiative must be tailored to the local context of the school.

3.5.1 Areas for further consideration

The evidence base for the effectiveness of school-based health improvement programmes is highly variable. Many studies rely on personal accounts from young people of their own behaviour and are unable to deduce clear conclusions regarding the effectiveness of the HPS or WSA. It is difficult to differentiate the relationship or complementarity between the many topic/one dimension health programmes within a whole school framework. More process research is needed to explore young people's engagement in this process.

There is a need for further research on the effectiveness of the WSA with respect to: young people's mental and sexual health; measuring the impact of interventions on academic achievement as well as on health; settings outside the USA; marginalised, disengaged and, 'hard to reach' young people; and process evaluations which can collect useful qualitative contextual data.

The local diversity of schools, as complex social systems needs further research. Better designed programmes are required to establish what actually does or doesn't work over time and in what circumstances, for whom, and why. Realist evaluation offers a potentially useful approach to evaluate complex interventions such as the whole school approach.

Section Four: Emotional well-being and resilience programmes

4.1 Introduction

Young people's learning and cognitive development is heavily influenced by their emotional health and wellbeing (Durlak *et al.*, 2011; PHE 2014). Educational institutions are seen as 'ideal settings' for programmes that promote health and wellbeing (Miller *et al.*, 2008). The school has an important role in promoting resilience for young people (Sellstrom and Bremberg 2006; Knight 2007; PHE 2014) and enhancing their mental health and social and emotional development into adulthood (WHO 2002; NICE 2009; DH 2013). Yet precise evidence of which interventions are most effective is limited (Kidger *et al.*, 2009). Young people understand wellbeing as a broad concept that encapsulates their views and experiences of everyday living including formal and informal learning (Awartani *et al.*, 2008). Both government policy and educational principles encourage young people to become active participants in their school and local community. Growing evidence, especially from the USA, suggests that the more connected young people feel to their school or educational institution the greater their educational attainment and overall wellbeing (Catalano *et al.*, 2004; Young *et al.*, 2013; Griebler *et al.*, 2012). The Centres for Disease Control (CDC) in the United States, based on current evidence, provides the following advice for head teachers to encourage school connectedness:

- Allow students and their parents to use school facilities outside of school hours for health/recreational purposes;
- Create opportunities for all students to interact, develop friendships and engage in team building;
- Involve all students in parent/teacher activities, curriculum committees and school health teams;
- Communicate values, expectations, and norms supporting positive health to the whole school community (Young *et al.*, 2013).

Young people who perceive themselves as having 'agency' may feel they have free choice to influence and change their lives or their environment – this may increase their resilience and adaptability to life challenges and empower them to promote their social and emotional wellbeing (Sharp 2014). Social and emotional wellbeing refers to:

"...a state of positive mental health and wellness ...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" (Weare 2015 p3).

The international literature uses various terms when discussing programmes related to student wellbeing, including 'social and emotional learning (SEL)' and 'resilience'. The skills of emotional and social competencies underlie young people's mental health (Weare and Markham 2005). Mental health programmes and social and emotional skills development improve both young people's health as well as their educational attainment (Blank *et al.*, 2009; HM Government 2011; Durlak *et al.*, 2011). Young people have demonstrated that they can make well-informed decisions

that make a contribution to their emotional wellbeing and mental health development (Harden *et al.*, 2001). A recent review summarises the ‘evidence informed approach’, which includes impact on students’ academic learning and connectedness and wellbeing (by enhancing social and emotional skills, reducing risk behaviour and preventing mental health problems) (Weare 2015). The two concepts of coordinated school health and school connectedness are keys to improving student emotional health, coping with stress and promoting wellbeing (Miller 2011).

4.2 Resilience programmes

There are many definitions of ‘resilience.’ One that is useful perceives it as a process:

“...that involves individuals being supported by the resources in their environment to produce positive outcomes in the face of challenge. Understanding the processes that lead to and support positive outcomes are the keys to understanding resilience” (GCPH 2014 p 4).

It also relates to all members of the community:

“Resilience is about all children (and adults), not just those who are considered vulnerable, and is therefore a whole school issue” (Young Minds in Schools 2015).

Studies have demonstrated that the health promoting school concept is effective in building resilience among students (Wong *et al.*, 2009; Macnab *et al.*, 2014). The health promoting schools framework offers a system-based approach that sets the individual in their wider ecological context:

“Avoid just putting in place a bolt-on programme that fails to recognise the context of diversity and challenge living in disadvantage may have on children and young people in the UK. Be careful about implementing programmes or approaches that are mainly focussed on the individual child as opposed to also considering the possible impact of macro-systems they live within may have upon them” (Hart and Green 2014 p 22).

See Hart and Green 2014 for a detailed review of the numerous resilience programmes available.

4.3 The whole school approach

Evidence points to the need to embed a whole school approach to emotional health and wellbeing (Langford *et al.*, 2014). The following ‘tiers’ of intervention have been identified in school-based mental health prevention models - universal (for all), targeted (for those at risk) and indicated (for those already experiencing difficulties) (Wells *et al.*, 2003). This approach can be seen in schools in the USA, Australia and England (Humphrey *et al.*, 2013). But ambiguous findings have arisen and therefore there is a need for further research into the inter-relationship between these tiers (Humphrey 2013).

School connectedness or a personal sense of belonging to the school community and environment is a positive protective component for young people’s emotional health and

wellbeing (Rowe and Stewart 2009). Evidence of expressions of pride by students who are part of a health promoting schools programme enhances their self-esteem and resilience (Lee 2009; Macnab and Kasangaki 2012). The whole school approach promotes connectedness and is needed to endorse mental health effectively by using positive health models emphasising competence, resilience and wellbeing (Weare and Markham 2005). The psycho-social climate of the school relates to students' perceptions of trust and opportunities for active participation and influences depression, truancy, and other physical and psychological factors (Virtanen *et al.*, 2009). The students' form tutor has a key role in enabling the interface between adolescents and services that provide support for mild emotional and behavioural problems (Farrand *et al.*, 2007).

The health promoting school has demonstrated a positive outcome in building resilience among young people (Stewart and Wang 2012; Langford *et al.*, 2014; Allen 2014). There is some evidence that more impact is made among primary school pupils early on in their life cycle than secondary school students; nevertheless all students' life satisfaction improved if their school comprehensively adopted the concept of the health promoting school (Lee *et al.*, 2006). Such multi-component approaches, such as SEAL (Social and Emotional Aspects of Learning) and TaMHS (Targeted Mental Health in Schools), have demonstrated impact on student wellbeing in preference to uncoordinated single-issue programmes (Banerjee *et al.*, 2014; NCMHIN 2011). Yet there is a pressing need to understand:

“...the many ways which children and young people receive emotional health support and services...work in this area is still in its infancy, but there are emerging examples of good practice” (Children’s Plan 2010 p 52).

These examples include whole school consultations within the Healthy Schools programme and establishment of dedicated groups of young people to increase students' participation. In the absence of the ethos associated with the whole school approach to support emotional health and wellbeing, it becomes more problematic to identify opportunities for students to air their concerns and this in turn means that those having problems are more difficult to identify and support (Young Foundation 2012).

A recent framework proposed by Public Health England (2015) recommends adopting ‘an asset-based’ approach to develop wellbeing and resilience by placing young people at the core of any intervention. They perceive the role of social relationships as the key to interlinking the physical and mental health of young people. (See Children and Young People’s Benchmarking Tool produced by Public Health England (www.fingertips.phe.org.uk). Students emphasise the need to consider the whole school environment in order to improve and increase activities that they feel enhance their emotional health (Kidger *et al.*, 2009). To create a whole school approach to positive mental health, emotional wellbeing and resilience, schools need to promote active listening cultures and an inclusive ethos (Aston 2014):

“Mental health promotion from a salutogenic theory of health promotion is used which considers a person in a holistic sense with a focus on social and cultural conditions that facilitate good mental-promotive behaviours, in contrast to health focussing on medical and pathogenic orientations” (Aston p 289).

Adversity and resilience are unequally distributed across society, and are related to broader social and economic inequalities, which shape people's lives and influence their experiences, relationships and opportunities (Allen 2014). The young people facing most adversity are those least likely to have the resources available to build resilience.

Six principles, which relate to building resilience among young people and that cross-cut health topics, have been identified (PHE 2015a):

1. Relationship-building as the core (reinforced by WHO 2014);
2. Coping strategies;
3. Reducing health inequalities;
4. Integrated services;
5. Changing health needs;
6. Accessible and youth-friendly services.

A whole school approach to mental health needs to consider socio-environmental factors with all relevant stakeholders including students (Weare and Markham 2005). Positive mental health is also advocated as a four level approach within a whole school framework (Atkinson and Hornby 2002):

- Whole school organisation, policies and procedures;
- Ethos of the school;
- Classroom practice;
- Pastoral provision.

The core tasks of the school should be linked to basic educational values, including democracy, inclusion, and participation, for example (Simovska 2012b).

EXAMPLES OF PROJECTS USING WHOLE SCHOOL APPROACHES:

Europe

European Network of Health Promoting Schools (<http://www.euro.who.int/ENHPS>)

USA, also in countries of Europe

Second Step (<http://www.cfchildren.org.uk/proginform/programs>)

PATHS (Promoting Alternative Thinking Strategies) (<http://www.prevention.psu.edu/PATHS/>)

Norway

Bullying Prevention (<http://www.gold.ac.uk/connect/reportnorway.html>)

Australia, also in countries of Europe

Mind Matters (<http://www.curriculum.edu.au/mindmatters>)

The latter is a whole school approach developed in Australia using the health promoting schools and the comprehensive school mental health models (Sheehan *et al.*, 2002). It places young people's wellbeing as the goal and works in a structured way by changing school organisation, policies, curriculum and building partnerships.

4.4 Participation and engagement with young people

Although there are many services in the UK at local level to enhance mental health (see Young Minds 2006), there are very limited research findings on young people's views and opinions on mental health promotion (Aston 2014). Very few studies have explored emotional health and wellbeing from young people's point of view (Coombes *et al.*, 2013). 13-14 year olds in five secondary schools felt mental health topics were neglected and depended on the enthusiasm of the teacher; they also were concerned about confidentiality and in many cases preferred to discuss emotional health and wellbeing issues with their friends (Coombes *et al.*, 2013). Further exploration is therefore needed to ascertain young people's views and concerns, particularly in relation to emotional and resilience programmes, so these programmes can be more effective and meet young people's real concerns (Aston 2014).

There is a need for young people to own and actively participate in initiatives to improve their health and wellbeing:

*“Genuine student participation allows for student ownership of the learning process”
(Jensen and Simovska 2005).*

Bullying behaviour has not been effectively influenced by short-term educational approaches (Hunt 2007). Secondary school students in the USA feel that bullying is an inevitable part of their school life and they often had to struggle to cope with bullying situations (De Lara 2008). They also reported that it was essential for their good mental health to accept and deal with a limited amount of personal mistreatment by peers. It is important therefore to understand bullying and harassment from young people's perspective and involve them in making systemic changes in their school environment.

Active participation by young people needs to be considered carefully in all aspects of the whole school approach (Dyson *et al.*, 2002). To be effective in building and retaining child or young person-friendly cultures, it is fundamental that students actively participate (Badham and Wade 2005; Aston and Lambert 2010). There is a greater need to involve young people in the planning, implementation and monitoring/evaluation of mental health interventions (Coombes *et al.*, 2013). Absence of involvement and low social engagement in schools are likely to increase the chances of students attempting suicide and committing self-harm (Young *et al.*, 2011). Involvement and participation of students is a key component of the SEL (Social and Emotional Learning) programme in schools in the USA, which highlighted universal whole school-based interventions as effective (Durlak *et al.*, 2011).

Young people feel that a positive school ethos and supportive teacher are essential to facilitate student participation and involvement in decision-making (Aston 2014). A key determinant is

empowering school communities and ‘being authentic’ in engagement of young people (Weist and Murray 2007; Aston 2014). Student engagement consists of:

“1) ... behavioural engagement shown through participation, punctuality, concentration and effort applied to tasks, 2) emotional engagement demonstrated when students are enthusiastic and keen to learn, and 3) cognitive engagement, whereby students are able to formulate their own learning goals, and believe in the importance of their academic achievements” (Cahill et al., 2014 p 4 ; from Van Uden et al., 2014).

Young Minds: the Voice for Young People’s Mental Health and Wellbeing carried out a consultation with 1,600 young people in the UK to seek their views on the top five mental health issues they identified (www.youngminds.org.uk). As a result they have created on-line campaigns involving young people on sexual pressures, anti-bullying, unemployment, school stress and access to counseling. Their Young Minds in Schools web-site focuses specifically on improving outcomes for children and young people with behavioural, social and emotional problems by means of on-line learning resources and training courses for teachers related to mental health and wellbeing in schools. Their programme seeks to meet the needs of these pupils but within the context of influencing the emotional wellbeing and mental health of the whole school community. Fundamental to these types of programmes is the need to build and maintain resilience among young people. Resilience works by basically by reducing risk factors and maximising assets or protective factors:

“... the capacity to ‘bounce back’ from adverse experiences and succeed despite adversity” (PHE 2014 p 6).

Attention needs to be paid to marginalised young people, who need to be enabled to have their voices heard, and not just focus on the most engaged and motivated (Weare 2015).

4.5 Young people’s views of mental health programmes in schools

Young people in secondary schools in Scotland wanted more information on mental health topics, for example coping strategies, self-harm and suicide, bullying, and sex education (Woolfson, Mooney and Bryce 2007). They also wanted input from a range of professionals using a variety of techniques, including group discussions. In England students requested an increase in school-based help resources that were confidential, universal and empathetic to their needs (Kidger et al., 2009). The context of each school needs to be considered and support strategies reflect their local needs (Gugglberger 2011). Young people, particularly 14-16 year olds, are more concerned to be listened to and involved in co-shaping their learning, and to have support in times of stress, such as exam time (Children’s Commissioner 2011). An in-depth review of 12 studies involving 11-16 year olds indicated the following ways these young people wanted their mental health to be promoted – for example – better information designed by young people stressing what to do, not just focussing on problems, their need to be listened to, heard and understood (Oliver et al., 2007). They mentioned the following barriers – material or physical circumstances (unstable home environment, restrictions on their freedom, and bullying/violence from others, for example). Coping strategies included creating music; releasing stress and

tension through sport and dancing, attending raves; getting angry to avoid depression; self harm; and drug taking, for example. In a similar way, twenty six 13-19 year old adolescents, from various ethnic and cultural backgrounds in England, when relating their feelings and experiences, all wanted to be listened to in a confidential way led by trained professionals, such as psychologists or nurses (Aston 2014). These young people highlighted the importance of active involvement and participation and wanted their voices to be heard and acted upon by decision-makers in the school or local community. They saw the ethos and culture of the school as fundamental to their positive mental health, with having teachers available that listened and understood them in a non-judgemental way. Other issues raised by these young people included the desire for creative and flexible curricula with teachers devising teaching and learning strategies to meet their individual needs; the importance of the physical environment of the school, including clean toilets and the availability of good and healthy food choices. The young people felt it important to have a safe, friendly and enjoyable social environment, which was conducive to building and maintaining good relationships. Finally, they proposed having appropriate tools, such as questionnaires, being available to feedback and communicate their views.

4.6 Evaluating mental health programmes in schools

There is a dearth of clear evidence for the effectiveness of school-based mental health promotion initiatives in the UK (Pugh and Statham 2006). Such programmes can be difficult to evaluate (Wells *et al.*, 2003) – there are various reasons for this including that schools often use preventive and promotional initiatives without clarifying the outcome measures (Aston 2014). Whole school approaches can therefore be too vague and spread resources too thinly to demonstrate real impact (Durlak *et al.*, 2011; Lendrum *et al.*, 2013). It is often difficult to identify the exact initiative under evaluation (Pugh and Statham 2006):

“...interventions are interpreted as offering input ‘over and above’ what is available to all children as part of mainstream provision, with the increasing prevalence of whole school-based initiatives, it is hard to decide what is an intervention” (Aston 2014 p 291).

Current mental health programmes originate from the health sector and fail to consider how the (educational) structures and processes in the school operate (Rowling 2009). Therefore a multi-agency approach through a whole school approach is needed.

Examples of school-based programmes in Sweden have demonstrated that massage and mental training helped to boost 12-15 year old students’ sense of wellbeing related to stress (Haraldsson *et al.*, 2008). An education programme combining tai-chi with mindfulness-based stress reduction are suggested as ‘transformational tools’ for secondary school students (Wall 2005). Yet in these and numerous other school-based programmes more rigorous evaluation and better dissemination of good practice is needed to ensure student needs regarding their emotional health are addressed effectively (Kidger *et al.*, 2009).

Peer education

Peer education enables young people to become active participants in their own learning. It has been demonstrated to be effective in particular in teaching social and emotional skills by

imparting a real sense of engagement and ownership (Rones and Hoagwood 2000; Blank *et al.*, 2009). A common method of peer support in English secondary schools is peer mentoring which involves a one-to-one relationship between students. Those providing support gain interpersonal benefits, but further research is needed into the experiences of acting as a peer mentor (James *et al.*, 2014).

School counselling service

An evaluation of a Scottish secondary school-based counselling service for students aged 11 to 18 years found significant improvements in terms of functioning, problems and wellbeing. Participating students rated the services as helpful. An important factor is that if schools retain control of access to such services by referring on the basis of bad behaviour this can cause negative feelings among students (Spratt *et al.*, 2010; McKenzie *et al.*, 2011). They propose that students should be allowed to opt-in informally allowing them to decide whether to seek help, thereby building trust. In the 'Bounceback' programme though, teachers retained the power to identify and prioritise pupils' problems (Segrott *et al.*, 2013).

School counselling can be effective in helping those young people who have been bullied and should therefore form a core component of an effective whole school emotional health and wellbeing approach (McElearney *et al.*, 2013).

Prevention of mental health problems

There are numerous mental health-related programmes, which offer promising school-based strategies and which rely on young people's active participation, for example:

- Project Wings – a 14 session stress management/coping intervention used with 15-21 year old Latino girls (Garcia 2010);
- Teaching Kids to Cope with Anger (TKC-A) – used with rural adolescents in Pennsylvania (Puskar 2009);
- Creating Opportunities for Personal Empowerment (COPE)/Healthy Lifestyle TEEN (Thinking, Emotions, Exercise and Nutrition) used with Hispanic teens in south western USA (Melnik 2009);
- Web-based Stress Management in Schools in Australia (Van Vilet and Andrews 2009);
- Learning to Breathe Mindfulness curriculum in USA (Broderick 2009);
- School-based Meditation programme in Australia (Campion 2009).

4.7 Framework for emotional wellbeing and resilience in schools

A number of key elements of good practice in school programmes, from the international literature, show positive effects on students' emotional health and wellbeing (Connelly *et al.*, 2011). These elements include 1) strong school leadership (which adopts a SAFE approach to school programming ie carefully sequences, active learning, focussed on skills development and having explicit goals), 2) a whole school approach including adoption of evidence-based programmes based on a thorough needs assessment involving pupils, together with explicit tracking of students' needs over time, 3) a whole person approach. Barriers identified are the confusion over what constitutes students' emotional and wellbeing needs and expectations on

what the school can achieve in that regard; and lack of usable audit tools to monitor and evaluate practice (Connolly *et al.*, 2011). On the positive side, an evaluation of the SEAL (Social and Emotional Aspects of Learning) programme demonstrated significant increases in young people's 'feelings of autonomy and influence' (Humphrey *et al.*, 2010). Building on this approach, Aston (2014), from her grounded theory analysis, generated 3 key themes divided into the following 10 conceptual categories:

1) Macro-level (including influence of wider society):

- Listening/participation
- Mental health promotion

2) Meso-level (including whole school approach):

- Caring, knowledgeable adults skills, with appropriate knowledge and positive attitudes, non-judgemental, understanding pressures young people face
- Appropriate curriculum, teaching and learning
- Inclusive physical environment – clean, good facilities
- Positive friendly and safe/anti-bullying environment
- Good management and organisation – with flexibility
- Equality and fairness, social/cultural opportunities and partnerships

3) Micro-level (including resilience factors to building positive mental health development):

- An adolescent-centred approach to personal development – regarding each young person as a 'unique individual' with their own appropriate self-concept and identity, based on personal qualities and life experiences
- Understanding and maintaining good relationships with friends/peers, including healthy sexual development

The above conceptual levels approach is also supported by Atkinson and Hornby (2002) who suggest a framework for mental health promotion in schools having the following 3 levels – ethos, pastoral/class-based teaching and learning, and whole school organisation. Aston's (2014) findings regarding adolescent's views about mental health promotion are endorsed by other findings – adolescents wanted support staff and peers to be available with specialist input as necessary; safe and confidential places for supportive discussions; and an anti-bullying culture, for example (DFE 2011). A dedicated school-based website covering health information relevant to young people has been proposed to enable early self-identification of mental and emotional problems (Santor *et al.*, 2007). Fundamentally mental health education should reflect and seek to address the needs of young people themselves bearing in mind gender and age related preferences (Woolfson *et al.*, 2009; Gabhainn and Kelleher 2000).

4.8 Summary and conclusions

Young people's emotional health and wellbeing influences their learning and cognitive development. The WSA and school connectedness are key factors in improving emotional wellbeing and resilience. The ethos and culture of the school is fundamental to building positive

mental health among young people. Therefore young people must be placed at the core of any intervention.

The HPS framework has demonstrated positive outcomes in building resilience among young people. There are many studies related to mental health within schools but very limited research findings on the views and opinions of young people regarding mental health promotion. Precise evidence of which interventions are most effective is limited.

A personal sense of belonging to the school environment and community is a positive protective component and is needed to endorse mental health by building competence and resilience. The context of each school needs to be considered and support strategies reflect their local needs.

Young people should be placed at the core of any intervention to promote emotional health and resilience. They should own and actively participate in initiatives to improve all aspects of their health and wellbeing.

Current mental health programmes often originate from the health sector and thus fail to consider how the educational, social, and cultural structures and processes in the school operate. Therefore a multi-agency strategy through a whole school approach needs to be developed taking account of the local context of the school or educational institution.

Key components to promote students' emotional health and wellbeing are:

- Strong school leadership – adopting the SAFE approach (careful sequencing, active learning, focussed on skills development and having explicit goals);
- A WSA – including adoption of evidence-based programmes based on thorough needs assessment involving students (and monitoring their needs over time);
- A whole person approach – linking physical, social and emotional health and wellbeing;
- Authentic and practical student engagement at the following levels: behavioural emotional and cognitive.

4.8.1 Areas for further consideration

There are many studies related to mental health within schools, but very limited research findings on the views and opinions of young people regarding mental health promotion. More research is needed on resilience programmes and in particular young people's views and experiences with regard to them to help ensure mental health promotion programmes are as effective as possible.

There is a dearth of robust evidence for the effectiveness of school-based mental health promotion initiatives in the UK. School-based mental health programmes are particularly difficult to evaluate. In particular, there is a need for clear outcome measures and a need to clarify the exact initiative under evaluation.

Section Five: Sexual health improvement

5.1 Introduction

Sexual health improvement or sex and relationship education (SRE) has the following aims:

“... to equip children and young people with the information, skills and values they need to have safe, fulfilling and enjoyable relationships and to take responsibility for their sexual health and wellbeing” (Sex Education Forum 2015).

The importance of effective sexual education is well documented (DfEE 2000). Yet sexual health improvement, sexuality education or SRE is a controversial and often contested issue in relation to young people. Contemporary debates relate to its aims, methods, and outcomes. The 4th European Conference on HPS identified the need for a wider discussion of its role, particularly within the HPS framework. Delegates from many countries endorsed the need for consideration of positive socio-structural perspectives of health and wellbeing in relation to sexual health and for the issue to be addressed from a life course perspective (Simovska and Kane 2015).

Traditional health education in schools tended to deal with sexuality using a topic based rather than a holistic approach. It did not consider the life skills and relationship competencies necessary to build confident and assertive young people (St Leger and Young 2009). Therefore in adopting a WSA to sexual health improvement there is a need to understand young people's views on sexual health. This involves consideration of a wide variety of structural and cultural factors in relation to sexuality.

5.2 School as key location for sexual health and relationships education (SRE)

The majority of young people in the UK and Canada mention schools as a useful and/or preferred source of information on sexuality (Boyce *et al.*, 2003; Buston and Wight 2002, 2006; Coleman and Testa 2007; Selwyn and Powell 2006; Lester and Allen 2006; Reeves *et al.*, 2006). Given that it appears difficult for them to discuss sexual issues with their parents (Jerman and Constantine 2010), sex education in school has a very important role to play, and parent–school collaboration can be a fruitful way forward (Walker *et al.*, 2010). Yet there is no single dominant model of service delivery in UK schools:

*“...there have been no templates, no consistent sources of sustainable funding and no systematic approach to evaluation. This context has facilitated local innovation, but has also produced an uneven distribution of services and resources” (Owen *et al.* 2010).*

Sex education has been heavily criticized as not even meeting young people's needs:

*“...current provision of sexual health education in UK secondary schools does not adequately prepare young people to negotiate sexual relationships, which support the findings of the systematic review undertaken by DiCenso *et al.*, (2002)”. (Westwood and Mullan 2006)*

Over the last decade little seems to have changed (Haste 2013a). A recent qualitative study involving 32 teenage mothers in USA indicated that they had received little accurate information about sex from their schools or their parents (Dudley et al 2014). These teenage mothers also expressed widely varying views about contraception and pregnancy. This situation is endorsed by Hirst (2008) who found that young people's sexual health interests are not being covered by the content of sex education they receive. Young people also have mentioned the omission of topics they thought important as a negative factor (Shepherd et al., 2014). Self-completion questionnaires were completed by around four hundred predominantly working class 12-19 year olds in three secondary schools and six 'out of school'/youth settings in an urban area of South Wales (Selwyn and Powell 2006). The researchers followed this up with 57 young people in focus groups. These young people report school lessons as their most frequent source of information on sex and relationships. These lessons they felt were most useful for younger boys who were more educationally engaged. Overall the lessons were criticized by many young people as being overly focused on biological aspects and were non-participatory. As they moved through the school they reported a diminished commitment by their teachers to sex and relationships education.

5.3 Factors influencing young people's views on sexual health

A range of important factors that influence young people with regard to participation in sex education classes are highlighted in a study in 25 schools in the East of Scotland which were - class size and composition (age, gender, academic ability, and maturity), individual young people's interest in sexual health, the teacher's relationship with the class (in terms of teacher discipline and humour), the educational method/materials used, time of day, and the school catchment area (Buston and Wight 2004).

With regard to sexual health services, a systematic review identified 19 studies from either USA or UK that centred on the views of 11-18 year olds (Carroll et al., 2012). The researchers proposed the following principal themes arising from their review:

- Awareness and need;
- Confidentiality and disclosure;
- Perceptions of staff;
- Service location;
- Physical environment;
- Costs and types of services offered.

As a result young people felt that school-linked health services should ensure privacy, confidentiality, accessibility, and approachability if they are to be effective and influence behaviour. Results from a survey of young people in 15 secondary schools in New Zealand found they wanted:

“...more honesty, interactivity and practical work from sex and relationships education; they want subject matter that is more detailed and that engages with sexuality diversity, erotics and sexual pleasure; and they want teachers who are unbiased, comfortable and

competent in the subject matter. These are key criteria against with the appropriateness and effectiveness of sex and relationships education should be judged” (Allen 2005 p 306).

Secondary analysis of data from the Minnesota Student Survey, included 22,828 sexually experienced adolescents aged 13–20 years, found peers and siblings were the most commonly reported source of information about sex (Secor-Turner et al., 2011). They suggest that formal sex education programmes can be more effective by engaging informal sources of information about sex from people in adolescents' everyday lives. Cheetham (2013) interviewed 14-18 year olds in North East England about the social implications of the C-Card scheme, which is a common method throughout the UK of enabling access to condoms and sexual health advice. She highlights the practical and emotional benefits young people obtain from their chosen friendship networks and peer relationships and how these have potential to positively affect their sexual attitudes and behaviour. The scheme also provides support in alleviating the stigma and embarrassment young people face when trying to access sexual health advice. This indicates that there may be potential scope to maximise the opportunities for informal SRE initiatives linked to the C-Card scheme, building on young people's friendship networks. The Teen Prevention Education Program (Teen PEP) is a peer-led sexuality education programme designed to prevent unintended pregnancy and sexually transmitted infections (STIs), including HIV, among American secondary school students (Jennings et al., 2014). An evaluation of Teen PEP highlighted that such programmes, by including comprehensive education and training to peer educators, may improve sexual risk behaviour knowledge, attitudes and behaviours. In North Carolina, the Teen PEP curriculum was implemented during half of the school year. The young people involved felt that the sexual health information they received was both new and relevant to them and felt that the peer education approach provided better learning than their traditional classroom-based programme (Layzer 2014). The use of peer educators has been popular among young people, yet there is mixed evidence regarding its effectiveness (Audrey et al., 2006). In addition, details of what peer educators actually do, especially in informal settings, are scarce in the literature.

Young people don't always relate scientific or biological information to their own experiences and this causes them to disconnect from both school and parents when discussing sexual issues (McKee et al., 2014). Similar findings among 16-25 year olds, again from Australia, indicated that they thought programmes too didactic, non-engaging and clinical, and omitted relevant information especially on relationships; they highlighted for example the negotiation of condom use (Helmer et al., 2015).

Sex and relationships education (SRE) interventions are enhanced by ensuring that the information sources used, meet adolescents' preferences (Parker 2014). These preferences can differ by gender, school type and adolescent's needs (Turnbull et al., 2010). Their research findings indicated that young people in 8 community comprehensive schools in the North-East of England preferred to be taught by specialist sexual health workers, rather than teachers, school nurses, peers or parents. Almost half their respondents preferred websites, followed by magazines, and phone lines; drop-in centres were less preferred, along with youth clubs.

5.4 Views about teachers

16 years and older boys wanted teachers to be empathetic and non-judgemental; they should have the ability to create and maintain a secure and 'safe' environment, which allowed appropriate confidentiality and encouraged open discussion of sensitive areas (Hilton 2003). Most boys felt the gender and age of the teachers was not important but they should be able to build trust and be respected; in relation to the latter boys felt teachers should have specialist training. There was no agreement on whether the teacher should be from outside the school or not. Teachers often receive negative feedback but, by realizing that a student's behaviour is a result of emotional and internal anxiety related to their developing sexuality, they can better lead discussion and avoid confrontation (Gilbert 2007). It is important that teachers retain enthusiasm, knowing that most students are keen to learn about sex and they rely on his/her authority as a teacher (Haste 2013b).

5.5 Gender and mixed classes

Analysis of data from a survey of 3355 young people (aged 15/16 years), carried out in 13 co-educational English secondary schools (as part of the RIPPLE study), found that the majority of girls, and about one-third of boys, would like some or all of their sex education to be delivered in single-sex groups (Strange et al., 2003). Data from 15 focus groups were analysed to examine the reasons for these preferences. The way in which sex education lessons are 'gendered' was explored. These young people wanted more sex education with girls to be delivered in single-sex groups.

Gender is an important variable that influences young people's attitudes to knowledge and information on sexual matters:

“Home and intimacy with parents, especially mothers, is important for many, although not all, girls in a way it is not for boys. This indicates a picture of boys learning about sex and sexuality in ways that by and large do not include adults, or more especially trusted adults, and where there appears to be some elements of exclusion from the family. This has important implications for sex education programmes, and may offer us insights into why the boys resist school sex education work”. (Measor 2004).

Key gender differences were reported by O'Higgins and Nic Gabhainn (2010) from their work with Irish students – boys wanted information on condoms, whereas girls required more knowledge on all aspects of contraception and more opportunities for sexual confidence building. Male and female stereotypes seem to prevail:

“Stereotypical preferences of boys and girls outside SRE seem to be perpetuated in SRE, and special needs and mainstream adolescents' preferences are consistent with their communication and education outside SRE.” (Turnbull et al., 2010).

Young men in Ireland prioritized the skills and practical guidance that would give them the confidence to take the lead physically in sexual encounters (Hyde et al., 2005). Research among

16-year-old and 17-year-old boys has indicated that their needs are not being met in sex education programmes, particularly regarding the issues they want to know about (Hilton 2007):

“Feelings and emotions, sexuality, sexual techniques, sexually transmitted infections, pornography and the effects of the ‘boy culture’ are not being addressed sufficiently, or in some cases at all. Boys also called for smaller class groups, and for more active methods of teaching and some of them asked for time away from girls to express themselves without censure. They called for more education at an earlier age and that their desire for a safe, non-critical environment should be met”.

It has been proposed that sex education in schools is too dominated by public health outcomes and a rather negative/risk view of sexual relations. In other words, the positive and pleasurable aspects of sex are ignored:

“While it may be unacceptable in most cultures to suggest that teaching young people how to achieve sexual pleasure is valuable, there are increasing indications... that public health outcomes may benefit from a greater acceptance of positive sexual experiences. It is suggested that greater comfort with one's own body will enable greater ability to communicate wishes to others, and to be less "pressured" into unwanted sexual relationships” (Ingham 2005).

In a survey among male pupils in secondary schools in the East of Scotland, they reported that the sex education they received in school was the only major source of information they received and that it was not explicit enough (Buston and Wight 2006). It is important therefore to focus on helping boys discuss feelings, emotions and coping skills, actively in a way that maintains their ‘street cred’ and includes the following issues from a male perspective – STIs, masturbation, pornography, for example. The class size should be limited to no more than 15 and more interaction and freer discussion will occur by allowing boys to discuss in pairs (Hilton 2007). There is a need to include information on accessing local health services, as boys are not as likely as girls to use these on a regular basis. A key dilemma faced by boys and young men in relation sex education is that:

“Secondary school sex education in England seems to be regarded by boys as incompatible with the stresses and strains placed upon them to express a burgeoning masculinity” (Forrest 2000 p 257-8).

Boys and young men have a wide range of ‘positive attributes,’ which should be used productively in the classroom setting, these include “...humour, athleticism, directness, being principled, being supportive and generosity” (Biddulph 2007). In relation to pornography, there is a divide between the issues teachers are willing to address and the issues pupils must deal with in their daily lives. However, even in the most sensitive areas, both in terms of practical and behavioural challenges, there are still real opportunities to address boys' concerns (Haste 2013b).

5.6 Lesbian, gay, bi-sexual, and trans-gender (LGBT) young people

Data drawn from focus groups and questionnaires undertaken by 16–19 year-olds suggest that young people's preferences reflect, in complex ways, dominant discourses in sexuality from

within their own culture and social norms (Allen 2007). These dominant discourses often reinforce and perpetuate social inequalities. This needs to be considered when working within the context of young people-centred approaches. The need for the promotion of social justice within sex education programmes has also been emphasized (Allen 2007). A systematic review of studies exploring sexual health services for sexual minority youth (lesbian, gay or bisexual young people) demonstrates that limited and inaccurate information is often given which needs to be rectified to address the health concerns of this specific population (Rosea and Friedman 2013). Three small-scale studies, which sought to collect young people's views on sexual health and relationships education, included young people who identify themselves as lesbian, gay, or bisexual (Formby 2011). They highlight the influences on sexual activity, knowledge and understanding of sexual health and safer sex, which determine dominant 'sexual cultures'. Research engagement with LGBT young people has clearly identified a need for specialist training for teachers and other practitioners working with sexual minority youth (Sherriff *et al.*, 2011).

5.7 Black and minority ethnic (BME) young people

There is limited evidence available among 13-17 year olds from black and ethnic minorities with regard to their preferences and experiences of sex and relationships education. There are wide variations reported between different ethnic groups and genders in terms of their sexual concerns and experiences (Newby *et al.*, 2012). Poorer sexual health knowledge among BME groups, especially in comparison with white British, is reported in a survey of secondary schools in London (Coleman and Testa 2007). It also highlights distinct ethnic differences in attitudes, risks and behaviours in relation to sexual health.

5.8 'Hard to reach' groups

Young people identify the potential for using a performance-based drama regarding sexual health promotion, and perceive it as empowering, meaningful, and engaging in terms of their sexual-health skills development (Orme *et al.*, 2007). This positive response was particularly encouraging from hard to reach or disengaged young people. It emphasized that when working with young people in sensitive areas full consideration needs to be given to both group as well as individual contexts. Ingram and Salmon (2010) provided detailed feedback from young people on sexual drop-in clinics in 16 secondary schools in the South West of England. These attracted 'hard to reach' as well as less academically able young people. Barriers identified by these young people included confidentiality, embarrassment and various cultural issues. The latter cultural issues included, for example, the sex education needs of young Muslim women, for whom alternatives needed to be offered. This reflects the wider, diverse and often competing needs of all different religious groups and the need for further research to ascertain sensitive sex education methods to respond appropriately to their preferences (Coleman 2008). The forthcoming challenge is to research the ways in which this potential for sex education can be harnessed in a sensitive manner. On a more positive level, the importance of establishing a school drop-in service was highlighted, especially in schools in deprived communities, as large numbers of more vulnerable young people attended who had indicated that they would not go elsewhere to seek sexual advice and support.

5.9 The internet

Many teenagers use the internet to seek information on sexual issues as they do not get their questions answered by the school or their parents (Goldman and McCutcheon 2012). Increased access by young people to on-line sexual content has made the Internet a key setting for sexual experimentation (DeHaan *et al.*, 2012). The link between parents' attitudes and young people's online sexual activities appears to be mediated by parental rules (Sorbring *et al.*, 2015). These are factors influencing young people to use the Internet and phone lines to obtain sexual information, to learn about sexual issues and therefore online sex may be the only learning source available to some of them (Turnbull *et al.*, 2010; McKee 2012). The Internet, through high quality websites, has great potential for improving the effectiveness of sex education.

5.10 Participation and active involvement of young people

In their analysis of 10 sex education programmes (which included relationships education as well as pregnancy and Sexually Transmitted Infections (STI) prevention) in different locations in the USA, Cushman *et al.*, (2014) found few programme developers had consulted young people and carried out a comprehensive needs assessments before developing their programmes. Many had also struggled with programme evaluation. In assessing the level of participation in schools:

“Classes with the highest level of participation tended to be comprised predominantly of girls, were older, were headed by a teacher with a strong sense of humour and a tight disciplining style and who was new to the class that year, used material which the pupils appeared to find interesting and made use of methods with which they were comfortable, and were in schools with a mixed catchment” (Buston and Wight 2004 p 285).

The ‘Our Lives: Culture, Context and Risk’ project, explored sex and decision-making in the context of the daily lives of Australian young people aged 16-25 years (Helmer *et al.*, 2015). These young people felt that their needs could be met if they were listened to and, for example, they requested more information on first sexual experience and condom use, and healthy relationships. In their review of nine process evaluations, Shepherd *et al.*, (2014) identified student engagement, relevance and appeal to young people as important positive factors. Health Education for Youth (HEY), a comprehensive sexuality education programme, actively engages with young people by incorporating anonymous questions about sexual issues that they input into the curriculum themselves, thereby creating sexuality education that is youth-centred and youth-driven (Stevens *et al.*, 2013).

5.11 School nurses/sexual health clinics

School nurses play a key role in developing and delivering school-based sexual health clinics. Ways of involving young people in developing and evaluating services was explored using a qualitative design (Hayter *et al.*, 2012). They recommend that sexual health services should be branded and marketed and highlight some of the barriers and facilitators for developing successful school-based or school-linked sexual health clinics. Their study concluded that systems for incorporating young people's participation were still evolving, and highlighted the importance of using routine feedback processes rather than discrete planning or decision-making

initiatives. In a questionnaire survey of 1959 pupils and 155 teachers from secondary schools in the UK Westwood and Mullan (2009) found that teachers valued school nurses more positively than pupils did. Older male students valued them least and these findings suggest the contribution of school nurses to sex education may not be very effective:

“Being more proactive, more available, and seen more frequently by students and staff would enhance their role as sexuality educators in secondary schools” (Westwood and Mullan 2009 p 293.)

Ways of involving 13-16 years old from the Trent region of the UK in developing and evaluating school-based or school-linked clinics was explored (Wilson and Williams 2000). They found that major barriers were lack of awareness of the range and location of services, accessibility, fears of embarrassment, especially among females, and confidentiality/ anonymity. They devised an appropriate leaflet, with help of a local youth group, which was widely disseminated. This leaflet included details and information about services and attempted to counter the above barriers. There may be value in reinforcing school-based sex education with sexual health services, but the outcomes are poorly understood and therefore combining school-based sex education and sexual health clinics has a limited impact. Young people viewed the privacy of the service location as critical. A study in Sussex highlighted the difference between the views of the young people and professionals regarding the understanding of privacy (Sherriff et al., 2011).

Interventions that address the upstream causes of poor sexual health, such as a detrimental sociocultural environment, represent promising alternatives. These should target and prioritise the most vulnerable young people (Elliott et al., 2013).

5.12 Major school-based SRE programmes in UK

A synthesis of the following three large-scale school-based sex education programmes in the UK has been carried out (Wight 2011):

- SHARE = a teacher-led sex education programme aimed at 13-15 year olds; using active skills development, interactive role-play, and video, for example. An outcome evaluation and follow-up was carried out; also a process evaluation reviewing programme quality and context, included pupil responses (Wight and Dixon 2004).
- RIPPLE = a peer-led sex education programme using 16-17 year olds but aimed at 13-14 year olds (teachers are not present). An outcome evaluation and extensive process evaluation was carried out (Stevenson et al., 2004; Oakley et al., 2006). Information based with little skills development (Strange et al., 2006). Many pupils were embarrassed by mixed class settings (Wight and Buston 2003). Both SHARE and RIPPLE were preferred by pupils to traditional sex education in the control schools. In both cases young people favoured single sex sessions some of the time (Strange et al., 2003; Buston and Wight 2004). There was some evidence that boys preferred the peer-led approach due to laxer discipline, but girls came up with more problems mainly related to comfort/safety (Strange et al., 2003).
- HEALTHY RESPECT 1 and 2 = used an extended version of SHARE (applied to more age

ranges and more pupils). It was carried out in Scotland and funded by the Scottish Government. Healthy Respect 2 linked sex education with youth-friendly sexual health services, media campaigns/branding, and partnership working between NHS, local government and voluntary organisations. A key aim was to reduce inequalities. Pupils related well to the teacher-led SHARE aspects of the Healthy Respect programme and reported good communication and improved confidence, but no change in behaviour. The drop-in services were well received by young people. Peer-led aspects were not as sustainable. Before and after surveys were carried out (Tucker *et al.*, 2006; Elliot *et al.*, 2010). Boys and, to a lesser extent, girls, sexual health knowledge was improved, but no change in behaviour (e.g. condom use, level of sexual activity, age of first intercourse) (Henderson *et al.*, 2002) or sexual health inequalities (Elliott *et al.*, 2013). The link between school input and drop-in clinics proved useful in terms of up-take of services (e.g. condoms), but had disappointing effects in terms of actual sexual behaviour: “The broader social factors shaping behaviour seem too influential” (Wight 2011 p 72).

An analysis of findings from SHARE, RIPPLE and HEALTHY RESPECT suggests that 1) skills-based interventions need highly motivated young people ie those who should opt-in as a link to self-motivation 2) sexual health interventions need to relate to critical change points in the young person’s sexual development and experiences to be most effective 3) untargeted interventions across large groups of pupils will reach very few - for some being too early and others too late (Wight 2011).

Other evaluations of large-scale sex education programmes in the UK have found little or no impact on young people’s sexual behaviour. As well as the major programmes discussed above, APAUSE demonstrated improved knowledge and attitudes among young people, but limited effect on behaviour (Blenkinsop *et al.*, 2004). This has also applied in Australia where although there was a high level of knowledge of safe-sex practices among young people they did not apply this in terms of their actual behaviour (McKee *et al.*, 2014).

It is important to point out that young people’s views on what makes sex education effective differs considerably from policy makers – the latter wanting to see reductions in unplanned pregnancies or sexually transmitted infections (Allen 2005).

5.13 The whole school approach setting

A study of marginalised and at-risk young people in out-of-school environments in Western Australia highlighted the importance of adopting a holistic approach to promoting positive relationships and sexual health (Brown *et al.*, 2012). This approach should include demonstrated trust and confidentiality within a safe environment, and be complemented by peer-led programmes and community youth agencies. These were particularly important in reaching out to disengaged young people who may not be contacted through school-based programmes.

A synthesis of evidence indicates commonalities about sexual education services that are important to young people. Broad-based holistic service models which are not only limited to sexual health seem to provide the confidentiality and privacy aspects valued by young people (Owen *et al.*, 2010). There is some evidence, from this systematic review, to suggest that

comprehensive, holistic service models are preferred by young people and maximize service uptake. These service models are delivered by a multi-professional team, offer a wide range of services not restricted to sexual health, offer the strongest basis for protecting young people's privacy and confidentiality, counter perceived stigma, and offer the most comprehensive range of products and services. However:

"... neither these service models nor narrower ones have been rigorously evaluated in terms of their impact on the key outcomes of conception rates and sexually transmitted infection rates, either in the UK or in other countries" (Owen et al 2010).

There is a pressing need for discussion and additional research regarding the role and function of sex education within the whole school approach (Simovska and Kane 2015).

5.14 Need for targeted sex education.

From the findings of their qualitative research with 14-16 year olds in Australian schools, McKee et al., (2014) recommended the following outcomes for sex education programmes:

- Sex should be acknowledged, at the appropriate time, as a positive contributor to people's lives;
- Discussing sex is a positive activity and should be handled in ways that do not cause embarrassment among young people;
- Communication and assertiveness skills should be included as well as biological information - as young people perceived 'scientific' too irrelevant to them.

It is important to build in feedback from young people, particularly regarding the support they need from schools (and parents). Young people become disengaged if schools (and parents) don't listen to their concerns. Basically listening to the needs of young people would significantly improve SRE programmes (Helmer et al., 2015).

5.15 Summary and conclusions

Sex education alone needs to be reinforced and complemented by much broader 'upstream' interventions that acknowledge the social context of sexual behaviour. Evidence shows that sex and relationships education (SRE) increases young people's knowledge and attitudes, but has limited impact on behaviours. Young people's views on what makes sex education effective, differs considerably from policy makers; something that commissioners should be aware of.

In their views on SRE, young people were often critical of information being too biological or 'scientific', and being presented in a didactic way, with little opportunity for interactive discussion. They wanted more focus on relationships and negotiation skills. SRE needs to be set firmly within the WSA. Numerous authors have endorsed the multi-model/whole school approach, as laid out in the HPS framework, as most effective in bringing about long term changes to students' knowledge, attitudes, and behaviours.

Outside of school, consideration should be given to engaging with young people's informal

sources of sexual health information. Many disengaged students rely on these information sources in the absence of school or youth-based services.

Those developing, commissioning, and/or delivering sexual health improvement programmes for schools should engage with young people and staff to develop services in line with their needs. Fundamentally it is essential to establish on-going systems to listen to young people and prioritise their needs, preferences and interests, which can differ by gender, sexual orientation, ethnic origin, and so on. These will of course change with young people's sexual development, and appropriate programmes should be started early. Communication and assertiveness skills should be stressed and not just biological information. Consultation/needs assessment with young people should be carried out in advance of any programme and a feedback cycle built in.

SRE programmes should be tailored to consider local contextual issues, for example, sexual diversity and ethnic differences in beliefs and attitudes.

Competent, appropriately trained and trustworthy/non-judgemental teachers should form part of a multi-professional team comprising (as an example), a health professional (e.g. school nurse), an external specialist consultant, and others such as a youth worker involved/experienced in SRE delivery. They should create safe and secure environments that ensure appropriate confidentiality, privacy, accessibility and approachability and encourage open discussion of sensitive areas. They should treat sex as a positive contributor to individuals' lives and not as a bad/ embarrassing/ negative form of risk behaviour.

All young people's informal sources of sexual health information should be discussed, including peers, siblings, friends, parents, mass media, internet/websites/cyber world, dominant sexual discourses, for example. The internet and other contemporary electronic media have potential for contributing towards effective SRE for young people.

5.15.1 Areas for consideration

There were very few attempts in the literature to involve young people directly in the ownership and direction of methodology used to ascertain their views and needs regarding sexual health improvement. Further research is needed on:

- Targeting SRE into whole school/college approach, linking more effectively with youth-friendly sexual health services such as the C-Card scheme;
- Processes that move beyond information provision to skills training and follow-up, in terms of the evaluation of behavioural intentions/behaviour change;
- Carrying out more process evaluation as well as realistic outcome evaluation;
- Use of peer educators/mediators – although popular with young people, there is a need to establish their effectiveness, as there is currently mixed evidence;
- The role and function of sexual health improvement within the WSA.

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Appendix 1 a

Search Strategy: Young people's views on the whole school approach to health improvement.

Liz Rowan (30th October, 2014). Brighton, UK: Brighton and Sussex.

Sources searched: EMBASE (32); MEDLINE (42); PsycInfo (40); Evidence Search (1); National Institute for Health and Care Excellence (NICE) (1)

Date range used (5 years, 10 years): 2009-2014

Limits used (gender, article/study type, etc.): English language

Search terms and notes (full search strategy for database searches below):

whole school, school wide, school based children, adolescents views, opinions, attitudes OR perspectives OR perceptions, satisfaction/dissatisfaction OR engagement OR experiences OR impressions.

Results were selected from the searches numbered: 29, 46 and 62. Excluded studies from developing countries, and studies that discussed therapy, clinical conditions and oral health.

Search History

Source	Criteria	Results
1.	MEDLINE (whole adj3 school).ti,ab	196 results.
2.	MEDLINE (school adj3 wide).ti,ab	245 results.
3.	MEDLINE "school based".ti,ab	8119 results.
4.	MEDLINE 1 OR 2 OR 3	8456 results.
5.	MEDLINE 1 OR 2	435 results.
14.	MEDLINE (opinion* OR view* OR attitude* OR perspective* OR perception*).ti	236451 results.
15.	MEDLINE (satisf* OR dissatisf* OR engage* OR experience* OR impressions).ti	217227 results.
16.	MEDLINE 14 OR 15	448637 results.
17.	MEDLINE 4 AND 16	579 results.
19.	MEDLINE *ATTITUDE/ OR *ATTITUDE TO HEALTH/ OR *PERSONAL SATISFACTION/ OR *CONSUMER SATISFACTION/ OR *PATIENT SATISFACTION/ OR *PATIENT PREFERENCE/ OR *PERCEPTION/	102611 results.
20.	MEDLINE 4 AND 19	247 results.
24.	MEDLINE *FOCUS GROUP/	1010 results.
25.	MEDLINE 4 AND 24	8 results.
26.	MEDLINE "focus group*".ti	1812 results.
27.	MEDLINE 4 AND 26	15 results.
28.	MEDLINE 17 OR 20 OR 25 OR 27	709 results.
29.	MEDLINE 28 [Limit to: English Language and Publication Year 2009-2014]	316 results.
30.	EMBASE (whole adj3 school).ti,ab	260 results.
31.	EMBASE (school adj3 wide).ti,ab	252 results.
32.	EMBASE "school based".ti,ab	8470 results.
33.	EMBASE 30 OR 31 OR 32	8860 results.
34.	EMBASE (opinion* OR view* OR attitude* OR perspective* OR perception*).ti	263146 results.
35.	EMBASE (satisf* OR dissatisf* OR engage* OR experience* OR impressions).ti	258760 results.
36.	EMBASE 34 OR 35	516227 results.
37.	EMBASE 33 AND 36	636 results.
38.	EMBASE *ATTITUDE/ OR *ATTITUDE TO HEALTH/ *PERCEPTION/ OR *ATTITUDE TO ABORTION/ OR *ATTITUDE TO BREAST FEEDING/ OR	59373 results.
39.	EMBASE *ATTITUDE TO DISABILITY/ OR *ATTITUDE TO ILLNESS/ OR *ATTITUDE TO LIFE/ OR *ATTITUDE TO PREGNANCY/ OR *ATTITUDE TO SEXUALITY/ OR *STUDENT ATTITUDE/	26895 results.
40.	EMBASE *STUDENT SATISFACTION/ OR *SATISFACTION/ OR *PATIENT SATISFACTION/ OR *EXPERIENCE/ OR *PERSONAL EXPERIENCE/	24050 results.
41.	EMBASE 38 OR 39 OR 40	108127 results.
42.	EMBASE 33 AND 41	346 results.

Source	Criteria	Results
43. EMBASE	"focus group".ti	1285 results.
44. EMBASE	33 AND 43	6 results.
45. EMBASE	37 OR 42 OR 44	843 results.
46. EMBASE	45 [Limit to: English Language and Publication Year 2009-2014 and (Human Age Groups Preschool Child 1 to 6 years or School Child 7 to 12 years or Adolescent 13 to 17 years)]	268 results.
47. PsycINFO	(whole adj3 school).ti,ab	791 results.
48. PsycINFO	(school adj3 wide).ti,ab	1210 results.
49. PsycINFO	"school based".ti,ab	10023 results.
50. PsycINFO	47 OR 48 OR 49	11793 results.
51. PsycINFO	(opinion* OR view* OR attitude* OR perspective* OR perception*).ti	196847 results.
52. PsycINFO	(satisf* OR dissatisf* OR engage* OR experience* OR impressions).ti	93766 results.
53. PsycINFO	51 OR 52	283711 results.
54. PsycINFO	50 AND 53	1064 results.
55. PsycINFO	*ADOLESCENT ATTITUDES/ OR *ATTITUDES/ OR *CHILD ATTITUDES/ OR *CONSUMER ATTITUDES/ OR *FEMALE ATTITUDES/ OR *HEALTH ATTITUDES/ OR *MALE ATTITUDES/ OR *STUDENT ATTITUDES/	75752 results.
56. PsycINFO	50 AND 55	632 results.
57. PsycINFO	*PERCEPTION/ OR *SATISFACTION/ OR *CONSUMER SATISFACTION/ OR *DISSATISFACTION/ OR *EXPECTATIONS/ OR *STUDENT ENGAGEMENT/	38432 results.
58. PsycINFO	50 AND 57	169 results.
59. PsycINFO	"focus group*".ti	1199 results.
60. PsycINFO	50 AND 59	15 results.
61. PsycINFO	54 OR 56 OR 60	1515 results.
62. PsycINFO	61 [Limit to: English Language and (Age Groups 18o School Age age 6 to 12 yrs or 200 Adolescence age 13 to 17 yrs) and Publication Year 2009-2014]	350 results.

Appendix 1 b

Search Strategy: Young people's views on the whole school approach to health improvement.
Beth Hewitt (3rd March, 2015) University of Brighton, UK.

Sources Searched: British Education Index (EBSCO); Education Resources Information Centre (ERIC) (EBSCO); Web of Science

Date range used (5 years, 10 years): 2009-2014

Limits used (gender, article/study type, etc.): English language

Search terms and notes (full search strategy for database searches below):

whole school, school wide, school based children, adolescents views, opinions, attitudes OR perspectives OR perceptions, satisfaction/dissatisfaction OR engagement OR experiences OR impressions

Search History

British Education Index and ERIC Search strategy

Searched 10.02.15

Results selected from sets 19, 21.

S21	S19 AND S20	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Basic Search 99 Database - British Education Index;ERIC
S20	uk or united kingdom or britain or england or wales or scotland or "northern ireland" OR ireland	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Basic Search 266,012 Database - British Education Index;ERIC
S19	S17 AND S18	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 52 Database - British Education Index
S18	S2 OR S5	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 4,910 Database - British Education Index
S17	S15 AND S16	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 379 Database - British Education Index
S16	S3 OR S4 OR S9 OR S12	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 2,809 Database - British Education Index
S15	S6 OR S7 OR S14	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 31,947 Database - British Education Index
S14	S1 AND S13	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 31,947 Database - British Education Index
S13	"young people*" OR teen* OR adoles* OR youth OR pupil* OR "secondary school" OR "high school" OR boy* OR girl* OR student*	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 73,914 Database - British Education Index
S12	DE "HEALTH education"	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases Search Screen - Advanced Search 1,430 Database - British Education Index
S11	S8 AND S10	Search modes Boolean/Phrase	Interface - EBSCOhost Research - Databases 122

			Search Screen - Advanced Search Database - British Education Index	
S10	S3 OR S4 OR S9	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	1,684
S9	"health* promot* school*" or "coordinated school* health program*" or "co-ordinated school* health program*" OR "comprehensive school* health program"	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	58
S8	S2 OR S5	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	4,910
S7	DE "STUDENTS -- Attitudes"	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	Display
S6	DE "TEENAGERS -- Attitudes"	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	Display
S5	DE "COMPREHENSIVE school reform"	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	Display
S4	DE "HEALTH promotion"	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	Display
S3	(DE "HEALTH programs")	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	Display
S2	("whole school" OR "school based" OR schoolwide OR "school-wide") OR ("school environment" OR "school* climate" OR "school ethos" OR "school culture")	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	Display
S1	(attitude* OR "attitude to health" OR opinion* OR view* OR perspective* OR perception* OR experience*) OR (satisf* OR dissatisf* OR engage* OR impression* OR preferen*)	Search modes Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - British Education Index	

Web of Science Search strategy

Searched 02.15

Results selected from set 22.

- # [26](#) #18 OR #17
22 **Refined by: COUNTRIES/TERRITORIES:** (USA OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR IRELAND OR WALES OR UK) **AND TOPIC:** (england OR ireland OR scotland OR wales OR UK OR united kingdom)
Timespan=All years
Search language=Auto
- # [Approximately 314](#) #18 OR #17
21 **Refined by: COUNTRIES/TERRITORIES:** (USA OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR IRELAND OR WALES OR UK)
Timespan=All years
Search language=Auto
- # [Approximately 373](#) #18 OR #17
20 Timespan=All years
Search language=Auto
- # [Approximately 14](#) #11 AND #10 AND #9 AND #6
19 **Refined by: RESEARCH AREAS:** (PEDIATRICS OR PSYCHOLOGY OR HEALTH CARE SCIENCES SERVICES OR

EDUCATION EDUCATIONAL RESEARCH OR PUBLIC ENVIRONMENTAL OCCUPATIONAL HEALTH OR BEHAVIOURAL SCIENCES OR SOCIOLOGY OR NUTRITION DIETETICS OR DEMOGRAPHY OR INFECTIOUS DISEASES OR PSYCHIATRY OR SOCIAL ISSUES OR SOCIAL SCIENCES OTHER TOPICS OR COMMUNICATION OR CULTURAL STUDIES) AND **COUNTRIES/TERRITORIES:** (USA OR IRELAND OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR WALES OR UK) AND **LANGUAGES:** (ENGLISH) AND [excluding] **DOCUMENT TYPES:** (MEETING OR EDITORIAL OR ABSTRACT) AND [excluding] **PUBLICATION YEARS:** (1994 OR 1993 OR 1995 OR 1992 OR 1999 OR 1998 OR 1997 OR 1989 OR 1996 OR 1988) AND **TOPIC:** ("whole school")

Timespan=All years

Search language=Auto

[Approximately](#) **TOPIC:** ("whole school" AND health promotion)

18 [92](#) Timespan=All years

Search language=Auto

[Approximately](#) #11 AND #10 AND #9 AND #6

17 [290](#) **Refined by: RESEARCH AREAS:** (PEDIATRICS OR PSYCHOLOGY OR HEALTH CARE SCIENCES SERVICES OR EDUCATION EDUCATIONAL RESEARCH OR PUBLIC ENVIRONMENTAL OCCUPATIONAL HEALTH OR BEHAVIOURAL SCIENCES OR SOCIOLOGY OR NUTRITION DIETETICS OR DEMOGRAPHY OR INFECTIOUS DISEASES OR PSYCHIATRY OR SOCIAL ISSUES OR SOCIAL SCIENCES OTHER TOPICS OR COMMUNICATION OR CULTURAL STUDIES) AND **COUNTRIES/TERRITORIES:** (USA OR IRELAND OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR WALES OR UK) AND **LANGUAGES:** (ENGLISH) AND [excluding] **DOCUMENT TYPES:** (MEETING OR EDITORIAL OR ABSTRACT) AND [excluding] **PUBLICATION YEARS:** (1994 OR 1993 OR 1995 OR 1992 OR 1999 OR 1998 OR 1997 OR 1989 OR 1996 OR 1988)

Timespan=All years

Search language=Auto

[Approximately](#) #11 AND #10 AND #9 AND #6

16 [336](#) **Refined by: RESEARCH AREAS:** (PEDIATRICS OR PSYCHOLOGY OR HEALTH CARE SCIENCES SERVICES OR EDUCATION EDUCATIONAL RESEARCH OR PUBLIC ENVIRONMENTAL OCCUPATIONAL HEALTH OR BEHAVIOURAL SCIENCES OR SOCIOLOGY OR NUTRITION DIETETICS OR DEMOGRAPHY OR INFECTIOUS DISEASES OR PSYCHIATRY OR SOCIAL ISSUES OR SOCIAL SCIENCES OTHER TOPICS OR COMMUNICATION OR CULTURAL STUDIES) AND **COUNTRIES/TERRITORIES:** (USA OR IRELAND OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR WALES OR UK) AND **LANGUAGES:** (ENGLISH) AND [excluding] **DOCUMENT TYPES:** (MEETING OR EDITORIAL OR ABSTRACT)

Timespan=All years

Search language=Auto

[Approximately](#) #11 AND #10 AND #9 AND #6

15 [350](#) **Refined by: RESEARCH AREAS:** (PEDIATRICS OR PSYCHOLOGY OR HEALTH CARE SCIENCES SERVICES OR EDUCATION EDUCATIONAL RESEARCH OR PUBLIC ENVIRONMENTAL OCCUPATIONAL HEALTH OR BEHAVIOURAL SCIENCES OR SOCIOLOGY OR NUTRITION DIETETICS OR DEMOGRAPHY OR INFECTIOUS DISEASES OR PSYCHIATRY OR SOCIAL ISSUES OR SOCIAL SCIENCES OTHER TOPICS OR COMMUNICATION OR CULTURAL STUDIES) AND **COUNTRIES/TERRITORIES:** (USA OR IRELAND OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR WALES OR UK) AND **LANGUAGES:** (ENGLISH)

Timespan=All years

Search language=Auto

[Approximately](#) #11 AND #10 AND #9 AND #6

14 [351](#) **Refined by: RESEARCH AREAS:** (PEDIATRICS OR PSYCHOLOGY OR HEALTH CARE SCIENCES SERVICES OR EDUCATION EDUCATIONAL RESEARCH OR PUBLIC ENVIRONMENTAL OCCUPATIONAL HEALTH OR BEHAVIOURAL SCIENCES OR SOCIOLOGY OR NUTRITION DIETETICS OR DEMOGRAPHY OR INFECTIOUS DISEASES OR PSYCHIATRY OR SOCIAL ISSUES OR SOCIAL SCIENCES OTHER TOPICS OR COMMUNICATION OR CULTURAL STUDIES) AND **COUNTRIES/TERRITORIES:** (USA OR IRELAND OR AUSTRALIA OR ENGLAND OR CANADA OR SCOTLAND OR WALES OR UK)

Timespan=All years

Search language=Auto

[Approximately](#) #11 AND #10 AND #9 AND #6

13 [1,146](#) **Refined by: RESEARCH AREAS:** (PEDIATRICS OR PSYCHOLOGY OR HEALTH CARE SCIENCES SERVICES OR EDUCATION EDUCATIONAL RESEARCH OR PUBLIC ENVIRONMENTAL OCCUPATIONAL HEALTH OR BEHAVIOURAL SCIENCES OR SOCIOLOGY OR NUTRITION DIETETICS OR DEMOGRAPHY OR INFECTIOUS DISEASES OR PSYCHIATRY OR SOCIAL ISSUES OR SOCIAL SCIENCES OTHER TOPICS OR COMMUNICATION OR CULTURAL STUDIES)

Timespan=All years

Search language=Auto

[Approximately](#) #11 AND #10 AND #9 AND #6

12 [1,277](#) Timespan=All years

Search language=Auto

[Approximately](#) #8 OR #7

11 [6,665,739](#) Timespan=All years

Search language=Auto

- # [Approximately](#) #5 OR #4
10 [27,556](#) Timespan=All years
Search language=Auto
- # [Approximately](#) #3 OR #2 OR #1
9 [26,218](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: (satisf* OR dissatisf* OR engage* OR impression* OR preferen*)
8 [2,018,108](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: (attitude* OR "attitude to health" OR opinion* OR view* OR perspective* OR perception* OR experience*)
7 [5,036,176](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: ("young people*" OR teen* OR adolescen* OR youth OR "high school" OR "secondary school" OR pupil)
6 [2,381,902](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: ("school environment" OR "school* climate" OR "school ethos" OR "school culture")
5 [5,803](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: ("whole school" OR "school based" OR schoolwide OR "school-wide")
4 [22,344](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: ("health promot*" NEAR/5 school)
3 [2,615](#) Timespan=All years
Search language=Auto
- # [Approximately](#) TOPIC: ("comprehensive school* health program*")
2 [93](#) Timespan=All years
Search language=Auto
- # 1 [Approximately](#) TOPIC: (health* promot* school* or coordinated school* health program* or co-ordinated school* health . program* OR comprehensive school* health program)
[26,218](#) Timespan=All years Search language=Auto

Appendix 2 a

Search Strategy: Young people and emotional wellbeing and resilience programmes. Liz Rowan (20th October, 2014). Brighton, UK: Brighton and Sussex.

Sources searched: Association of Public Health Observatories (1); ChiMat (8); Public Health England (1); Google (10); Department for Education (1); Gov.uk (1); National Institute for Health and Care Excellence (NICE) (1); The Children's Society (1); Ofsted (1); Children and Young People's Mental Health Coalition (1)

Date range used (5 years, 10 years): 2000-2014

Limits used (gender, article/study type, etc.): English language, studies in developed countries

Search terms and notes (full search strategy for database searches below):

"children and young people's views" "wellbeing in schools" wellbeing OR "well being" OR "mental health" OR stress OR resilience opinion* OR view* OR attitude* OR perspective* OR perception* satisf* OR dissatisf* OR engage* OR experience* health improvement OR health promotion OR health education healthy schools OR health promoting schools
Results were selected from searches numbered 91 and 136.

Search History

	Source	Criteria	Results
1.	PsycINFO	WELL BEING/	26206 results.
2.	PsycINFO	exp MENTAL HEALTH/	42773 results.
3.	PsycINFO	"RESILIENCE (PSYCHOLOGICAL)"/ OR COPING BEHAVIOUR/ OR EMOTIONAL STABILITY/ OR PSYCHOLOGICAL STRESS/	52302 results.
4.	PsycINFO	STRESS/ OR SOCIAL STRESS/	45501 results.
5.	PsycINFO	(wellbeing OR "well being" OR "mental health" OR stress OR resilience).ti,ab	299621 results.
6.	PsycINFO	1 OR 2 OR 3 OR 4 OR 5	339427 results.
7.	PsycINFO	SCHOOLS/ OR BOARDING SCHOOLS/ OR ELEMENTARY SCHOOLS/ OR HIGH SCHOOLS/ OR JUNIOR HIGH SCHOOLS/ OR MIDDLE SCHOOLS/	35886 results.
8.	PsycINFO	school*.ti	99444 results.
9.	PsycINFO	7 OR 8	112112 results.
10.	PsycINFO	6 AND 9	8728 results.
11.	PsycINFO	HEALTH PROMOTION/	15779 results.
12.	PsycINFO	exp HEALTH EDUCATION/	14539 results.
13.	PsycINFO	("health impro*" OR "health promot*" OR "health educat*").ti,ab	17641 results.
14.	PsycINFO	(health adj3 improv*).ti,ab	12193 results.
15.	PsycINFO	(health adj3 promot*).ti,ab	15353 results.
16.	PsycINFO	(health adj3 educat*).ti,ab	15197 results.
17.	PsycINFO	11 OR 12 OR 13 OR 14 OR 15 OR 16	56343 results.
18.	PsycINFO	10 AND 17	915 results.
19.	PsycINFO	*SCHOOL BASED INTERVENTION/	8332 results.
20.	PsycINFO	6 AND 19	1436 results.
21.	PsycINFO	17 AND 20	346 results.
22.	PsycINFO	("health* school*" OR "health promot* school*").ti,ab	538 results.
23.	PsycINFO	(school* adj3 health*).ti,ab	5874 results.
24.	PsycINFO	22 OR 23	5874 results.
25.	PsycINFO	6 AND 17 AND 24	615 results.
26.	PsycINFO	18 OR 21 OR 25	1197 results.
27.	PsycINFO	ADOLESCENT ATTITUDES/ OR ATTITUDES/ OR CHILD ATTITUDES/ OR CONSUMER ATTITUDES/ OR FEMALE ATTITUDES/ OR HEALTH ATTITUDES/ OR MALE ATTITUDES/ OR STUDENT ATTITUDES/	93807 results.
28.	PsycINFO	26 AND 27	61 results.
29.	PsycINFO	PERCEPTION/ OR SOCIAL PERCEPTION/ OR SATISFACTION/ OR CONSUMER SATISFACTION/ OR LIFE SATISFACTION/ OR DISSATISFACTION/ OR EXPECTATIONS/ OR STUDENT ENGAGEMENT/	79825 results.
30.	PsycINFO	26 AND 29	22 results.
31.	PsycINFO	(opinion* OR view* OR attitude* OR perspective* OR perception*).ti	196326 results.
32.	PsycINFO	(satisf* OR dissatisf* OR engage* OR experience*).ti	92116 results.

Source	Criteria	Results
33. PsycINFO	31 OR 32	281642 results.
34. PsycINFO	26 AND 31	62 results.
35. PsycINFO	26 AND 32	38 results.
36. PsycINFO	28 OR 30 OR 34 OR 35	148 results.
37. PsycINFO	27 OR 29 OR 31 OR 32	389288 results.
38. PsycINFO	6 AND 24	2498 results.
39. PsycINFO	10 OR 20 OR 38	10090 results.
40. PsycINFO	37 AND 39	1686 results.
41. PsycINFO	40 [Limit to: (Classification Codes 3365 Promotion and Maintenance of Health and Wellness or 3370 Health and Mental Health Services)]	45 results.
42. PsycINFO	exp MENTAL HEALTH SERVICES/	33365 results.
43. PsycINFO	MENTAL HEALTH PROGRAMS/	4165 results.
44. PsycINFO	42 OR 43	36677 results.
45. PsycINFO	9 OR 19 OR 24	118675 results.
46. PsycINFO	6 AND 37 AND 44 AND 45	103 results.
47. PsycINFO	"focus group*".ti,ab	20596 results.
48. PsycINFO	26 AND 47	34 results.
49. MEDLINE	(wellbeing OR "well being").ti	8211 results.
50. MEDLINE	*MENTAL HEALTH/ OR *RESILIENCE, PSYCHOLOGICAL/	14642 results.
51. MEDLINE	STRESS, PSYCHOLOGICAL/	91823 results.
52. MEDLINE	ANXIETY/	55844 results.
53. MEDLINE	(wellbeing OR "well being" OR "mental health" OR stress OR resilience).ti,ab	596891 results.
54. MEDLINE	49 OR 50 OR 51 OR 52 OR 53	683224 results.
55. MEDLINE	exp SCHOOL HEALTH SERVICES/	19291 results.
56. MEDLINE	("school health service*" OR "school nurs*").ti	2022 results.
57. MEDLINE	(school adj3 health OR school AND adj3cent OR school adj3 nurs*).ti	3721 results.
58. MEDLINE	(health* adj3 school* OR school adj3 clinic* OR school adj3 dentist*).ti	501 results.
59. MEDLINE	55 OR 56 OR 57 OR 58	21844 results.
60. MEDLINE	(opinion* OR view* OR attitude* OR perspective* OR perception*).ti	236065 results.
61. MEDLINE	(satisf* OR dissatisf* OR engage* OR experience*).ti	213487 results.
62. MEDLINE	*ATTITUDE/ OR * ATTITUDE TO HEALTH/	57191 results.
63. MEDLINE	*PERSONAL SATISFACTION/ OR *CONSUMER SATISFACTION/ OR *PATIENT SATISFACTION/ OR *PATIENT PREFERENCE/	35900 results.
64. MEDLINE	*PERCEPTION/	11205 results.
65. MEDLINE	60 OR 61 OR 62 OR 63 OR 64	505418 results.
66. MEDLINE	54 AND 59 AND 65	104 results.
67. MEDLINE	MENTAL HEALTH/ OR RESILIENCE, PSYCHOLOGICAL/	24724 results.
68. MEDLINE	49 OR 51 OR 52 OR 53 OR 67	687600 results.
69. MEDLINE	59 AND 65 AND 68	108 results.
70. MEDLINE	SCHOOLS/ OR STUDENTS/	54469 results.
71. MEDLINE	school*.ti	82149 results.
72. MEDLINE	70 OR 71	118481 results.
73. MEDLINE	exp HEALTH PROMOTION/	57082 results.
74. MEDLINE	exp HEALTH EDUCATION/	140021 results.
75. MEDLINE	("health improv*" OR "health promot*" OR "health educat*").ti	16920 results.
76. MEDLINE	(health adj3 improv*).ti	5891 results.
77. MEDLINE	(health adj3 promot*).ti	9865 results.
78. MEDLINE	(health adj3 educat*).ti	13043 results.
79. MEDLINE	73 OR 74 OR 75 OR 76 OR 77 OR 78	199189 results.
80. MEDLINE	65 AND 68 AND 72 AND 79	79 results.
81. MEDLINE	("health* school*" OR "health promot* school*").ti,ab	1516 results.
82. MEDLINE	65 AND 68 AND 72 AND 81	7 results.
83. MEDLINE	FOCUS GROUPS/	17937 results.
84. MEDLINE	"focus group*".ti	1812 results.

Source	Criteria	Results
85. MEDLINE	83 OR 84	18260 results.
86. MEDLINE	68 AND 72 AND 79 AND 85	10 results.
87. MEDLINE	59 AND 68 AND 85	23 results.
88. MEDLINE	68 AND 81 AND 85	0 results.
89. MEDLINE	65 AND 68 AND 81	11 results.
90. MEDLINE	69 OR 80 OR 86 OR 87 OR 88 OR 89	192 results.
91. PsycINFO, MEDLINE	Duplicate filtered: [28 OR 30 OR 34 OR 35], [40 [Limit to: (Classification Codes 3365 Promotion and Maintenance of Health and Wellness or 3370 Health and Mental Health Services)]], [26 AND 47], [69 OR 80 OR 86 OR 87 OR 88 OR 89]	419 results.
92. EMBASE	WELLBEING/	34539 results.
93. EMBASE	COPING BEHAVIOUR/	35505 results.
94. EMBASE	STRESS MANAGEMENT/	2421 results.
95. EMBASE	STRESS/ OR SCHOOL STRESS/	100802 results.
96. EMBASE	SOCIAL STRESS/	2656 results.
97. EMBASE	PSYCHOLOGICAL WELL BEING/	6861 results.
98. EMBASE	*MENTAL HEALTH/	23007 results.
99. EMBASE	(wellbeing OR "well being" OR "mental health" OR stress OR resilience).ti,ab	690660 results.
100. EMBASE	92 OR 93 OR 94 OR 95 OR 96 OR 97 OR 98 OR 99	758987 results.
101. EMBASE	SCHOOL/ OR HIGH SCHOOL/ OR MIDDLE SCHOOL/ OR PRIMARY SCHOOL/	57182 results.
102. EMBASE	HIGH SCHOOL STUDENT/ OR MIDDLE SCHOOL STUDENT/	3857 results.
103. EMBASE	SCHOOL HEALTH EDUCATION/	472 results.
104. EMBASE	exp SCHOOL HEALTH SERVICE/	18174 results.
105. EMBASE	("school health service*" OR "school nurs*").ti	1931 results.
106. EMBASE	(school adj3 health OR school AND adj3cent OR school adj3 nurs*).ti	3612 results.
107. EMBASE	(health* adj3 school* OR school adj3 clinic* OR school adj3 dentist*).ti	455 results.
108. EMBASE	school*.ti	84014 results.
109. EMBASE	("health* school*" OR "health promot* school*").ti,ab	1726 results.
110. EMBASE	101 OR 102 OR 108	121426 results.
111. EMBASE	103 OR 104 OR 105 OR 106 OR 107 OR 109	22484 results.
112. EMBASE	exp HEALTH PROMOTION/	70674 results.
113. EMBASE	exp HEALTH EDUCATION/	236214 results.
114. EMBASE	("health improv*" OR "health promot*" OR "health educat*").ti	17461 results.
115. EMBASE	(health adj3 improv*).ti	6420 results.
116. EMBASE	(health adj3 promot*).ti	10820 results.
117. EMBASE	(health adj3 educat*).ti	12863 results.
118. EMBASE	112 OR 113 OR 114 OR 115 OR 116 OR 117	246850 results.
119. EMBASE	(opinion* OR view* OR attitude* OR perspective* OR perception*).ti	262799 results.
120. EMBASE	(satisf* OR dissatisf* OR engage* OR experience*).ti	255224 results.
121. EMBASE	*ATTITUDE/ OR * ATTITUDE TO HEALTH/	59261 results.
122. EMBASE	*PERSONAL SATISFACTION/ OR *CONSUMER SATISFACTION/ OR *PATIENT SATISFACTION/ OR *PATIENT PREFERENCE/	34279 results.
123. EMBASE	*PERCEPTION/	23976 results.
124. EMBASE	ATTITUDE/ OR ATTITUDE TO ABORTION/ OR ATTITUDE TO BREAST FEEDING/ OR ATTITUDE TO DISABILITY/ OR ATTITUDE TO HEALTH/ OR ATTITUDE TO ILLNESS/ OR ATTITUDE TO LIFE/ OR ATTITUDE TO MENTAL ILLNESS/ OR ATTITUDE TO PREGNANCY/ OR ATTITUDE TO SEXUALITY/ OR STUDENT ATTITUDE/	141185 results.
125. EMBASE	PERCEPTION/	64198 results.
126. EMBASE	STUDENT SATISFACTION/	603 results.
127. EMBASE	SATISFACTION/ OR PATIENT SATISFACTION/	114374 results.
128. EMBASE	EXPERIENCE/	30567 results.
129. EMBASE	PERSONAL EXPERIENCE/	13114 results.
130. EMBASE	119 OR 120 OR 121 OR 122 OR 123 OR 124 OR 125 OR 126 OR 127 OR 128 OR 129	784411 results.
131. EMBASE	100 AND 110 AND 118 AND 130	162 results.
132. EMBASE	100 AND 111 AND 130	191 results.
133. EMBASE	"focus group*".ti,ab	27463 results.

Source	Criteria	Results
134. EMBASE	100 AND 110 AND 118 AND 133	30 results.
135. EMBASE	100 AND 111 AND 133	33 results.
136. EMBASE	131 OR 132 OR 134 OR 135	340 results.

Appendix 2 b

Search Strategy: Young people and emotional wellbeing and resilience programmes. Beth Hewitt (3rd March 2015) University of Brighton, UK.

Sources Searched: British Education Index (EBSCO); Education Resources Information Centre (ERIC) (EBSCO)

Date range used (5 years, 10 years): 2000-2014

Limits used (gender, article/study type, etc.): English language, studies in developed countries

Search terms and notes (full search strategy for database searches below):

"children and young people's views" "wellbeing in schools" wellbeing OR "well being" OR "mental health" OR stress OR resilience opinion* OR view* OR attitude* OR perspective* OR perception* satisf* OR dissatisf* OR engage* OR experience* health improvement OR health promotion OR health education healthy schools OR health promoting schools

Results selected from sets 25,27,37.

Search History

British Education Index and ERIC Search strategy

S37 S27 AND S32	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 21 Database - ERIC
S36 S32 AND S35	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 250 Database - ERIC
S35 S5 AND S13 AND S14	Limiters - Date Published: 20050101-20151231 Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 6,372 Database - ERIC
S34 S29 AND S32	Limiters - Date Published: 20050101-20131231 Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 27 Database - ERIC
S33 S29 AND S32	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 38 Database - ERIC
S32 S30 OR S31	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 31,060 Database - ERIC
S31 AB UK OR United Kingdom OR Britain OR England OR Scotland OR Wales OR Ireland	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 29,266 Database - ERIC
S30 TI UK OR United kingdom OR Britain OR England OR Scotland OR Wales OR Ireland	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 7,064 Database - ERIC
S29 S15 AND S24	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 1,267 Database - ERIC
S28 S5 AND S13 AND S14	Limiters - Date Published: 20050101-20151231 Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 6,372 Database - ERIC
S27 S15 AND S22	Limiters - Date Published: 20050101-	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search 317

	20151231 Search modes - Boolean/Phrase	Database - ERIC
	Limiters - Publication Date: 20050101-	Interface - EBSCOhost Research Databases
S26 S5 AND S13 AND S14	20151231 Search modes - Boolean/Phrase	Search Screen - Advanced Search 1,427 Database - British Education Index
S25 S15 AND S24	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search 42 Database - British Education Index
S24 AB ("mental health" OR resili* OR "well being" OR well-being OR wellbeing OR coping OR cope OR "self esteem") N2 (promo* OR service* OR scheme* OR program*)	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S23 S15 AND S22	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S22 S16 OR S17 OR S18 OR S19 OR S20 OR S21	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S21 DE "MENTAL health services"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S20 DE "SCHOOL mental health services"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S19 DE "HEALTH programs" OR DE "IMMUNIZATION" OR DE "MENTAL health services" OR DE "NATIONAL school lunch program" OR DE "SCHOOL breakfast programs"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S18 DE "HEALTH education"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S17 DE "HEALTH promotion"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S16 "health promotion" OR "health improvement" OR "health education" OR health* promot* school* OR "healthy schools"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S15 S5 AND S13 AND S14	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S14 S7 OR S8 OR S9 OR S10 OR S11 OR S12	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S13 S1 OR S2 OR S3 OR S4	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Display Database - British Education Index
S12 DE "MENTAL health"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Display Database - British Education Index
S11 DE "EMOTIONS (Psychology)" OR DE "AUTONOMY (Psychology)" OR DE "BELIEF and doubt" OR DE "BURNOUT (Psychology)" OR DE "CRYING" OR DE "EMOTIONAL conditioning" OR DE "EMOTIONAL maturity" OR DE "EMPATHY" OR DE "FEAR" OR DE "GRIEF" OR DE "HELPLESSNESS (Psychology)" OR DE "INTIMACY (Psychology)"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S10 DE "RESILIENCE (Personality trait)"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display

			Database - British Education Index
S9	DE "STUDENT well-being"	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S8	Resilien* OR happiness OR coping OR cope OR "mental health"	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S7	(wellbeing OR well-being OR "well being") N2 emotion*	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S6	wellbeing OR well-being OR "well being"	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S5	"young people*" OR teen* OR adolescen* OR youth OR pupil* OR secondary OR "high school" OR student*	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S4	DE "STUDENTS -- Attitudes"	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S3	DE "HIGH school students -- Attitudes"	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S2	DE "TEENAGERS -- Attitudes"	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index
S1	attitude* OR opinion* OR view* OR perspective* OR perc* OR experience* OR feeling* OR engage* OR satisf* OR dissatisf* OR preferen* OR evaluat* OR impression* OR engage*	Search modes Boolean/Phrase	- Interface - EBSCOhost Research Databases Search Screen - Advanced Search Display Database - British Education Index

Appendix 3 a

Search Strategy: Young people's views on sex and relationship programmes in schools. Liz Rowan (3rd November, 2014) Brighton, UK: Brighton and Sussex.

Sources searched; EMBASE (11); MEDLINE (3); BNI (6); CINAHL (5); PsycInfo (23); HMIC (1); Google (2); Department for Education (3); Gov.uk (3); National Children's Bureau (3); Ofsted (1) House of Commons Library (1); Family Planning Association (3)

Date range used (5 years, 10 years): 2009-2014

Limits used (gender, article/study type, etc.): English language

Search terms and notes (full search strategy for database searches below):

sex and relationship(s) education, relationships and sex education views, opinions, impressions etc. In Google: views "sex and relationship education"

The results were selected from search number 65 of the search strategy.

Search History

Source	Criteria	Results
1. MEDLINE	"sex and relationships education".ti,ab	13 results.
2. MEDLINE	"sex and relationship* education".ti,ab	28 results.
3. MEDLINE	sre.ti,ab	1496 results.
4. MEDLINE	3 and relationship*	148 results.
5. MEDLINE	3 and sex*	34 results.
6. MEDLINE	SEXUAL BEHAVIOUR/ OR SEX EDUCATION/ OR INTERPERSONAL RELATIONS/	105156 results.
7. MEDLINE	3 AND 6	6 results.
8. MEDLINE	*SEX EDUCATION/	4890 results.
9. MEDLINE	INTERPERSONAL RELATIONS/	58021 results.
10. MEDLINE	8 AND 9	123 results.
11. MEDLINE	"sex* and relationship* educat*".ti,ab	32 results.
12. MEDLINE	("sex* and relationship*" adj2 edcat*).ti,ab	0 results.
13. MEDLINE	("sex* and relationship*" adj2 educat*).ti,ab	48 results.
14. MEDLINE	1 OR 2 OR 11 OR 13	48 results.
15. MEDLINE	*INTERPERSONAL RELATIONS/	23568 results.
16. MEDLINE	8 AND 15	47 results.
17. MEDLINE	3 AND 9	1 results.
18. MEDLINE	("relationship* and sex*" adj2 educat*).ti,ab	24 results.
19. MEDLINE	13 OR 18	68 results.
20. MEDLINE	19 [Limit to: Publication Year 2009-2014]	34 results.
24. MEDLINE	(sex* ADJ relationship*).ti,ab	2219 results.
25. MEDLINE	*HEALTH PROMOTION/ OR *HEALTH EDUCATION/	64159 results.
26. MEDLINE	24 AND 25	36 results.
27. MEDLINE	("sex* and relationship*" adj2 educat*).ti,ab	48 results.
28. MEDLINE	("relationship* and sex*" adj2 educat*).ti,ab	24 results.
29. MEDLINE	sre.ti,ab	1496 results.
30. MEDLINE	SEXUAL BEHAVIOUR/ OR SEX EDUCATION/ OR INTERPERSONAL RELATIONS/	105156 results.
31. MEDLINE	29 AND 30	6 results.
32. MEDLINE	27 OR 28 OR 31	73 results.
33. BNI	("sex* and relationship*" adj2 educat*).ti,ab	49 results.
34. BNI	("relationship* and sex*" adj2 educat*).ti,ab	3 results.
35. BNI	sre.ti,ab	14 results.
36. BNI	33 OR 34 OR 35	54 results.
37. CINAHL	("sex* and relationship*" adj2 educat*).ti,ab	54 results.
38. CINAHL	("relationship* and sex*" adj2 educat*).ti,ab	12 results.
39. CINAHL	sre.ti,ab	95 results.
40. CINAHL	SEXUAL BEHAVIOUR/ OR SEX EDUCATION/ OR INTERPERSONAL RELATIONS/	21566 results.

Source	Criteria	Results
41. CINAHL	39 AND 40	18 results.
42. CINAHL	37 OR 38 OR 41	74 results.
43. AMED	("sex* and relationship*" adj2 educat*).ti,ab	0 results.
44. AMED	("relationship* and sex*" adj2 educat*).ti,ab	4 results.
45. AMED	sre.ti,ab	5 results.
46. AMED	44 OR 45	9 results.
47. HMIC	("sex* and relationship*" adj2 educat*).ti,ab	38 results.
48. HMIC	("relationship* and sex*" adj2 educat*).ti,ab	4 results.
49. HMIC	sre.ti,ab	24 results.
50. HMIC	47 OR 48 OR 49	48 results.
51. EMBASE	("sex* and relationship*" adj2 educat*).ti,ab	75 results.
52. EMBASE	("relationship* and sex*" adj2 educat*).ti,ab	36 results.
53. EMBASE	sre.ti,ab	2097 results.
54. EMBASE	SEXUAL BEHAVIOUR/ OR SEX EDUCATION/ OR INTERPERSONAL RELATIONS/	160862 results.
55. EMBASE	53 AND 54	10 results.
56. EMBASE	51 OR 52 OR 55	109 results.
57. PsycINFO	("sex* and relationship*" adj2 educat*).ti,ab	110 results.
58. PsycINFO	("relationship* and sex*" adj2 educat*).ti,ab	45 results.
59. PsycINFO	sre.ti,ab	206 results.
60. PsycINFO	INTERPERSONAL RELATIONSHIPS/	12777 results.
61. PsycINFO	SEX EDUCATION/	2886 results.
62. PsycINFO	60 OR 61	15610 results.
63. PsycINFO	59 AND 62	40 results.
64. PsycINFO	57 OR 58 OR 63	153 results.
65. MEDLINE,BNI, CINAHL, AMED,HMIC,E MBASE	Duplicate filtered: [27 OR 28 OR 31], [33 OR 34 OR 35], [37 OR 38 OR 41], [44 OR 45], [47 OR 48 OR 49], [51 OR 52 OR 55]	367 results.

Appendix 3 b

Search Strategy: Young people's views on availability and use of condoms. Liz Rowan (4th November, 2014) Brighton, UK: Brighton and Sussex.

Sources searched; MEDLINE (1); UNICEF (1); ChiMat (4); Google (4); Google Scholar (2); Gov.uk (1) National Children's Bureau: Sex Education Forum (2)

Date range used (5 years, 10 years): 2009-2014

Limits used (gender, article/study type, etc.): English language

Search terms and notes (full search strategy for database searches below):
c-card scheme, c card scheme

Search History

Source	Criteria	Results
1. MEDLINE	"c card scheme".ti,ab	1 results.
2. MEDLINE	CONDOMS/td [td=Trends]	46 results.
3. MEDLINE	*CONDOMS/ut [ut=Utilization]	2282 results.
4. MEDLINE	"c card".ti,ab	2 results.
5. MEDLINE	1 OR 4	2 results.
6. MEDLINE	3 AND 5	1 results.
7. MEDLINE	1 OR 6	1 results.
8. MEDLINE	"kinsella k*".au	51 results.

Appendix 3c

Search strategy: Young People's views on sex and relationship programmes in schools. Beth Hewitt (3rd March, 2015) University of Brighton.

Sources Searched: British Education Index (EBSCO); Education Resources Information Center (ERIC) (EBSCO)

Date range used (5 years, 10 years): 2009-2014

Limits used (gender, article/study type, etc.): English language

Search terms and notes (full search strategy for database searches below):

sex and relationship(s) education, relationships and sex education views, opinions, impressions etc. In Google: views "sex and relationship education"

Results selected from set 24.

Search History:

British Education Index and ERIC Search strategy

S24 S14 AND S22	Limiters - Date Published: 20000101-20151231 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 243 Database - British Education Index;ERIC
S23 S14 AND S22	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 287 Database - British Education Index;ERIC
S22 S19 AND S21	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 1,688 Database - British Education Index;ERIC
S21 S9 OR S20	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 6,331 Database - British Education Index;ERIC
S20 S6 OR S7	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 4,091 Database - British Education Index;ERIC
S19 S12 OR S13 OR S18	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 273,739 Database - British Education Index;ERIC
S18 S16 AND S17	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 264,413 Database - British Education Index;ERIC
S17 S10 OR S11	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 426,899 Database - British Education Index;ERIC
S16 S3 OR S4 OR S5 OR S15	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 872,014 Database - British Education Index;ERIC
S15 S1 OR S2	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 867,521 Database - British Education Index;ERIC
S14 uk or united kingdom or britain or england or wales or scotland or northern ireland	Limiters - Date Published: 19950101-20151231 Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 157,543 Database - British Education Index;ERIC
S13 DE "STUDENTS -- Attitudes"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 12,671 Database - British Education Index;ERIC
S12 DE "TEENAGERS -- Attitudes"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 1,080 Database - British Education Index;ERIC
S11 AB opinion* OR attitude* OR view* OR "attitude to health" OR perspective* OR perception* OR	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search 379,005 Database - British Education Index;ERIC

	satisfaction OR engagement OR experience* OR impression*				
	TI opinion* OR attitude* OR view* OR "attitude to health" OR perspective* OR perception* OR satisfaction OR engagement OR experience* OR impression*	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	113,979	
S9	DE "SEX education"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	3,955	
S8	"sex and relationship* n5 education	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	0	
S7	AB "sex and relationship* education" OR sex education OR SRE	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	3,419	
S6	TI "sex and relationship* education" OR sex education OR SRE	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	1,526	
S5	DE "ADOLESCENCE"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	295	
S4	DE "TEENAGERS"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	4,843	
S3	DE "YOUNG adults"	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	11,152	
S2	AB child* OR "young adult" OR "young people" OR adolescen* OR teen* OR girl* OR boy* OR youth OR pupil OR student OR "secondary school" OR high school	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	804,973	
S1	TI child* OR "young adult" OR "young people" OR adolescen* OR teen* OR girl* OR boy* OR youth OR pupil OR student OR "secondary school" OR high school	Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Basic Search Database - British Education Index;ERIC	344,178	



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