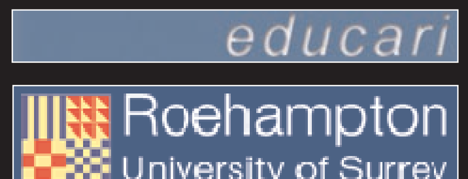
REPORT

CHILDREN, YOUNG PEOPLE AND HEALTH-RELATED DECISIONS:

A Review of the Research Literature and Discussion of the Implications for Health Education of Children and Young People

Literature Review prepared for Life Education by educari in association with Roehampton University of Surrey



REPORT ON THE CONSULTATION
CHILDREN, YOUNG PEOPLE & HEALTH-RELATED DECISIONS
21ST JULY 2004 AT PORTCULLIS HOUSE

Introduction

The event held at Portcullis House on the 21st July was based upon a review of research literature on those factors, which influence children's and young people's health-related decisions. It was prepared for Life Education by educari in association with Roehampton University of Surrey.

The review was presented for consultation with an audience of people and organisations with experience in health and drug education.

The key questions addressed by those attending were:

How much do we know about the factors that influence children's attitudes to health?
and
Against A background of many challenges to children's health, what more can we do to effect a change?

The results of this work and the experience gained during the consultation will inform the future development of Life Education's programmes and, it is hoped, will become an important reference point for others interested in developing health and drug education programmes on their own or in partnership with Life Education.

This report contains a summary of the consultation event, a fuller summary from the transcript of the event and a summary of the literature review, which informed the event.

During the course of the consultation a number of speakers were invited to comment on the review findings from their perspective. The speakers were:

Dr Richard Taylor MP	
Tony Baldry MP	
Stephen Burgess	National Director – Life Education
Louise O'Connor	Roehampton University of Surrey
Dr Peter Maguire	British Medical Association
Professor Mike Kelly	Health Development Agency
Simon Blake	National Children's Bureau

A list of those attending the consultation is attached to this report.

REPORT IN SUMMARY

There was a general consensus that the key issues in relation to children's and young people's health are: -

DRUGS	NUTRITION
EXERCISE	OBESITY
SMOKING	DRINKING
BULLYING	EARLY SEXUAL ACTIVITY

A range of other factors contributing to these issues were identified as:

- Health is often related to other social factors such as education, employment, transport and housing
- Nutritional status is an important influence on health generally
- The highest rate of binge-drinking among adolescents is in the UK
- Risky sexual intercourse is more likely when influenced by alcohol
- There is increasing evidence of a link between psychosis and drug misuse
- Family circumstances, performance at school and general attitudes to society are predictive factors for health problems
- The most vulnerable children include those whose parents misuse drugs, those who are young offenders, are homeless, or excluded from school
- People in different social positions respond differently to Health Education
- Smoking campaigns are generally more successful with the higher educated/higher social groups
- There is a link between early smoking and using other drugs later.
- Attitudes to health are formed early
- Parents with their own education deficits have the greatest problems in helping their children
- Improvements in public health are more likely to arise from primary prevention than from later medical interventions
- Some important public institutions (e.g. hospitals) set a poor example on smoking and healthy food

A number of desirable ways forward were the subject of discussion and included: -

- Early intervention with health messages, particularly to more vulnerable young people
- Reach children before the onset of experimental behaviour
- More strict law enforcement on sales to minors
- Properly funded dedicated services aimed at vulnerable adolescents
- Ban on smoking in public places (Irish experience proved successful)
- More carefully controlled access to harmful substances
- Using positive media messages to form adolescent opinions on health
- Healthy affordable food available to all
- Easy access to facilities for physical exercise
- Emphasis on targeting messages to the least well educated
- Promote partnerships in health matters between young people, their parents and education/health professionals
- Parents, particularly those with educational deficits of their own, to be helped with parenting and relationship education
- Promotion of healthy foods rather than bans on less healthy options
- Schools, hospitals and other public institutions to take a lead in promoting healthy lifestyles
- More controls on Corporations marketing their products to young people
- Easier access to information on health
- Effective collaboration between all those able to influence health choices – Government, schools, parents local communities and agencies with special knowledge and expertise

REPORT OF SPEAKER PRESENTATIONS AND DISCUSSION

I. Opening Remarks

Dr Richard Taylor MP

Dr Taylor was impressed with the Literature Review and identified the key issues with regard to children, which included:

Drugs
Sex/early sexual activity/teen pregnancy
Obesity
Exercise
The important role of Schools

He noted that education was capable of having an effect, citing improved knowledge of nutrition and the growing presumption against added sugar. He quoted the recent obesity report to government, which included…"To fail to address this problem would be to condemn future generations for the first time in over a century to shorter life expectancies than their parents". The Life Education consultation was an "extremely important" contribution to the debate.

Tony Baldry MP

Mr Baldry saw parents in his surgery, concerned about the well-being of their children, and almost always mentioning the following issues:

Bullying
Health
Drugs, including binge drinking by young girls

He welcomed the fact that these and other issues were being addressed at Life Education's consultation. He also highlighted the importance of getting young people back into physical activity. He felt that Life Education's work was important in providing advice to parents, decision makers, MPs etc on one of the most important social issues of our time.

2. Welcome and Introductions: The Importance of the Consultation to Life Education's Strategic Review, Stephen Burgess

Adverse factors and trends affecting the health of young people were cited, noting that the comparison with Europe was not good. He explained that the consultation would:

Examine factors that influence children's choices/attitudes towards health
Look at what we could do to effect change

Communities and schools needed to be engaged and everyone should feel a responsibility for the health of children. What needed to be done would be based on the evidence of what worked best. This was the reason for the literature review and consultation. The goal was to improve the work of Life Education, but also to inform government and other agencies about children's healthy choices.

3. Purpose and Scope of the Literature Review: Summary of Findings, Louise O'Connor

The literature review was described as "work in progress". The purpose was to use the research to identify how to support young people in making healthy decisions. She suggested that Health Education was only one of a number of influences, which included schools and social partnerships, which together had an important influence on healthy behaviour. It was not enough just to have the defining characteristics of "good" Health Education - school structure and ethos needed to support this.

Close work with parents was important. Education and the involvement and work of key agencies (voluntary, public, private) were all needed to reinforce health messages. In order to enable children and parents to make those choices, the right conditions needed to be created. Research in the literature review showed what needed to be in place for children to make healthy choices - a multi-faceted approach was needed.

4. Presentation, Dr Peter Maguire, Deputy Chairman, Board of Science and Education, BMA

The BMA worked at the interface between the medical profession, government, and the public. They had commissioned a large literature review with research on the following adolescent health issues:

Nutrition
Exercise
Obesity
Smoking
Drinking

Dr Maguire summarised the Adolescent Health Report, which:

- Aimed to highlight the lack of services specifically targeted at adolescents and the need to fund these dedicated services
- Reviewed available literature which showed the need to target the most vulnerable groups of adolescents
- Demonstrated the general relationship of education, employment and housing to health
- Suggested that school-based education may fail to reach the most vulnerable adolescents.

The report had also highlighted nutrition issues:

- Diet of adolescents was very important
- Nutritional status contributed to obesity, susceptibility to illness, and general ill-health
- Food Deserts and Poverty played a significant role in nutrition in our society
- National Diet and Nutrition Survey 2000 showed adolescents ate excessive salt, sugar, and saturated fats.

In particular, areas of poor transport were more reliant on unhealthy fast food and convenience shops and there were problems of access to reasonably priced fruit and vegetables.

Ireland and Denmark had made efforts to decrease the high fat content of foods. Obesity was linked with diabetes and smoking also increased the risk of diabetes.

The smoking ban in public places in Ireland had helped to change views on smoking. It was now seen as "not normal" or socially acceptable. He hoped that this ban would be brought to the UK. Ireland had had a major fall in tobacco sales due to the smoking ban. The ban also sent a strong message to children by making it an "illegal" activity but an aggravating issue was problem of young girls associating smoking with thinness.

The highest rate of binge drinking was in the UK. It was important to make binge drinking, which was bad for health, socially unacceptable, as it would affect school performance and young people's futures.

Dr Maguire reviewed some known characteristics of adolescent behaviour:

Alcohol Use:

- UK adolescents had one of the highest rates of binge drinking (more than 5 consecutive drinks) and alcohol misuse in Europe
- 24% of 11 – 15 year olds had had an alcoholic drink during the past week with an average weekly consumption of 10.5 units amongst those who drank
- Excessive drinking was associated with physical and mental health problems
- School performance was affected
- Young people were having more risky sexual intercourse when under the influence of alcohol, often without use of contraception

Drug Use:

- Over 20% of 15 and 16 year olds had admitted using drugs in the previous month
- Over 11% of 11 to 15 year olds had admitted using drugs in the previous month
- Cannabis was the most common substance but stimulants and volatile substances were also common.
- The peak time for experimentation with drugs occurred towards the end of adolescence
- There was increasing research on the links between psychosis and drug misuse

Predictive Factors:

- Poor family and social support
- Having been in trouble with the police
- Perceived poor academic performance
- Lack of religious belief
- Coming from a non – intact family
- Favouring peer over family opinion
- Having been suspended from school

Effective Interventions:

- Controlled access to substances
- Law enforcement on sales to minors
- Increase price of tobacco / alcohol to make it uneconomic for adolescents
- Ban smoking in all public places (Ireland / Norway / Malta and Sweden following).
- School-based education and intervention
- Using mass media campaigns in a positive manner - the media could do a lot to help spread healthy messages

The biggest health crisis in the UK was smoking as it resulted in severe health problems. Health messages to children about eating and smoking would have a beneficial impact later, reducing the cost of health problems in adulthood.

Recommendations were listed:

- Targeting most vulnerable adolescents
- Early intervention in all areas of adolescent health
- Health services provided in an age-appropriate, user-friendly environment
- Well-resourced STI clinics to minimise waiting times for assessment and treatment
- Assured professional confidentiality for adolescents using health services
- Strong relationship between adolescent health and housing education and employment
- Healthy, affordable food available to all
- Access to facilities for physical exercise
- Positive use of media role in forming adolescent opinions on healthy life-styles

- Ban on alcohol advertising
- Reinforcement of dangers of smoking
- Education on need for healthy eating in youth as it impacted on later life
- More radical intervention strategies to prevent the growing crisis in obesity - failure to do so would result in epidemic of later adult heart and lung diseases and metabolic diseases such as diabetes
- Further education programmes to promote awareness of mental health problems
- Screening should be considered to detect asymptomatic infections such as Chlamydia in youth-oriented Clinics

5. Presentation, Professor Mike Kelly, Director of Evidence and Guidance, Health Development Agency

The Health Development Agency evaluated evidence to apply to practice and worked to support findings/develop evidence to address inequalities of health.

Three questions applying to Public Health were cited:

- What was effective?What was ineffective?
- What was harmful or dangerous?

The "Health Inequalities Conundrum" was explained:

- The unintended consequences of health policy and health delivery
- Regressive population health
- Widening inequalities

There had been year-to-year improvements in Public Health from the mid-1960s, but with small but increasing gaps between those who were well off having the best levels of health and those who were worst off having worse levels of health.

Understanding social position was important:

- Social differences in the population
- Different dimensions of social difference
- Differential responses to interventionsPopulation changes revealed since the 1911 Census were described: fewer farmers/labourers, immigration trends and the growth of single parents heading households had affected the composition of society. People in different social positions responded differently to Health Education, Health Promotion and Public Health interventions.

The Public Health campaign regarding smoking had been generally successful with a 40 - 45% decline in smoking across the population as a whole. However, it had been

most successful with the best educated/higher level social groups. It had not been effective with the poor and we needed better- targeted messages to reach them.

The HDA produced "Evidence Briefings" on various Public Health measures. They looked at scientific information in five question areas:

- Strengths and weaknesses of the evidence
- Identification of gaps
- Implications for practice and policy
- Recommendations for future research
- Comprehensive, systematic and up-to-date maps of the evidence

Overall lessons were summarised:

- Importance of tailored and targeted approaches
- Multi-level and multifaceted approaches
- Theoretically well-informed policies
- Clear unambiguous information
- Self-efficacy
- Integrated services/ integrated communities

He highlighted vulnerable young people and groups most at risk:

- The probability of a young person developing problems through drug use increased directly with the number of risk factorsChildren whose parents misuse drugs
- Young offenders
- Looked-after children
- Young homeless
- School excludees/truants
- Sex workers

Schools did not have all of the young people at risk, so both universal and specific approaches were needed to reach everyone.

The evidence was described together with some cautions as to what the evidence did not reveal:

Evidence:

- School-based interventions aimed at adolescents could delay the start of substance misuse by non-users and reduce use by some users
- Universal prevention programmes were more effective for lower risk adolescentsInteractive education programmes using peers were more effective than non-interactive interventions.

- Information-based programmes led by police did not seem to be particularly effective.
- Some limited evidence of the effectiveness of teacher-led programmesIn peer-led interventions the people delivering the programme seemed to benefit most.
- Evidence about parent-oriented programmes was equivocal.
- Effective programmes had tended to use booster sessions
- Intensive programmes had been shown to be effective

What the Evidence did not reveal:

- How to do it
- Process data
- Implementation problems
- Local infrastructures

He pointed out that there were other pressures on schools with a busy curriculum and consequently how important it was to get Head Teachers and staff on side.

He described two different aspects of how things work:

- Plausibility: a scientific assessment – biologically, organisationally, socially, psychologically.
- Likelihood of success: the nature of local conditions married to tacit knowledge of practitioners

He pointed out that it was important to combine scientific evidence with what people did in everyday life. Primary prevention was important. For example, improvement in coronary heart disease was due to primary prevention (just over 60%), and medicine/medical interventions (less than 40%).

6. Simon Blake, Assistant Director, Children's Development, National Children's Bureau

Mr Blake posed the first underlying question - did we as a culture like children? It was important to keep in mind issues such as self-image, self-esteem, emotional well-being in the context of our approach and beliefs about young people.

Research by Luca in the USA regarding teen-pregnancy found that we got what we expected from young people - expectations could determine outcomes!

He summarised key messages from the review:

- Education must take account of wider experiences and vulnerabilities
- We must start early, be progressive, co-ordinated and holistic with a focus on core skills
- There must be a partnership between children, young people, their

families and professionals

- Agreed values were crucial if children and young people were to experience consistent and congruent messages

It was important to address the special needs of groups of more vulnerable young people. There was a need to see the problems facing them in particular. Macro and micro approaches were needed. Children's knowledge needed to be built upon and teaching should not be boringly repetitive.

The importance of involving all of the community was stressed. Questions to ask included - who needed to do what, and at what point should things be done?

It was essential to reinforce in the environment what was taught to children (e.g. have healthy food available when teaching nutrition). Young people heard about the negative effects of drugs but they/their peers had "positive" experiences of drug use. This needed to be addressed in practice.

Parents wanted to do the best and to do the right things. Their own backgrounds and experience needed to be considered. Schools could help parents' confidence and empowerment.

He described some implications and issues to be addressed:

- The language we use – what it told us and what we understood by itWhat did we mean by evidence and effectiveness? What were we searching for?
- The five national outcomes for children provided the context for this work
- Life skills, participation and emotional health and well-being lay at the core of good PSHE and Citizenship
- Schools and communities must coordinate their efforts and reinforce and support one another
- Creative approaches were needed to engage those who were vulnerable

Expanding on these, he outlined the need for a commonly understood language (for PSHE, for example) so that everyone was aware of what was meant and misunderstandings based upon language avoided. Evaluation was of different things and effectiveness measures/outcomes needed to be defined. Balancing education and health priorities represented a lot of work in addition to the standard curriculum. He listed the five desirable national outcomes for young people:

Keeping healthy

Staying safe

Enjoying and achieving

Participating

Having economic and social well-being

He highlighted the importance of enjoying and achieving for youth, often through play and creativity. With the most vulnerable, creative approaches e.g. through art - could be the means to increasing self-esteem outside mainstream education, where they might not be successful. Young people could be motivated to achieve and build confidence and skills.

In education topics need to be built around a skill-based curriculum with young people themselves helping to define Drug Education. We needed to know what were the opportunities to help children feel good about themselves?

7. Questions/Comments and Discussion Points

The following is a brief summary of issues raised in questions to the speakers and points made by delegates.

Health Education:

- Attitudes were formed early; an early start was important since it was harder to change people later when behaviours were completely formed. It was not only Education, but also a variety of factors that worked together in forming healthy attitudes.
- Early information was important along with restrictions on smoking. If it was more difficult or inconvenient, this helped decrease rates of smoking.
- It was essential to get to children before the onset of experimental behaviour.
- Research had shown the link between early smoking, and decisions to use other drugs later. All young people had different personalities/individuality. They needed to develop an understanding of themselves, their own personalities, as part of effective Health Education.
- There were transition points in life where people were more amenable to messages about health. Not just age-specific messages: local, cultural, geographic features of groups needed to be considered. Differences needed to be understood.
- The climate of society outside school issues was vital. The language used was important in effectiveness, so we needed to be careful. We also needed to realise that the single greatest control factor was young people themselves. They could reduce/eliminate unhealthy behaviours. We needed to give credit for good decision-making and achievements.
- We needed to think about the underlying issues - desires, pleasures of alcohol, etc. We needed to get parents on board. This would take time, but we needed Public Health policies to support parents. Parents also needed access to healthy options.
- The temptations of the environment needed to be mentioned. The educational focus was important for young people -

protecting/empowering them, giving them skills, helping in practicing skills and gaining confidence for adult life.

- Useful information on Health Education had become more difficult to access. DfES, who used to send documents to read, now invariably use on-line methods, which were harder to access. Sometimes it is difficult even to know what is available on-line.

Social Environment:

- This debate had been going on for the last 25 - 30 years because the underlying, oldest philosophical questions had not been asked: What was the nature of a good society? How could we bring this (a good society) about? Personal growth needed to be optimised, avoidable risk minimised, profit for corporations limited and skills needed to be provided to survive. We were not challenging the government about a "good society". Tackling one problem could cause other unintended problems if interventions were not well thought-out. There were limitations of education for social engineering. We needed to accept and cope with Capitalism and the inequalities that occur.
- Hospitals even set a bad example with smoking areas and unhealthy food easily accessible.
- Lifestyles today relied on convenience foods. Food labels/nutrition information was hard to understand even if parents wanted to look for healthy food. Bans were not always the answer - incentives were needed. Less unhealthy food available should be the goal - not bans.

Public Policy:

- There were big corporations behind alcohol, tobacco, and junk food and these corporations were making money off poor people by selling quick fixes. There were public policy issues concerning large corporations and government needed to control their powers. How realistic was this?
- Consider curtailing large corporations and banning smoking in all public places in the UK.

Media/Advertising:

- Cigarette advertisements targeting the young, poor and minorities were an issue including marketing to vulnerable people
- Marketing products directly to children was an issue. Parents were concerned about this. Young people needed to be aware of advertising.
- In marketing, there needed to be a link to the public health agenda, with control of marketing, especially regarding children. Children were exposed to a high volume of advertisements. OFCOM needed to address the whole climate of advertising, not just the content of each advertisement.

- The media needed to promote different messages about risk-taking behaviour of young people. Major headlines regarding the decreasing ages of drug use/sexual activity contributed to “norms” that children and parents saw/believed. Research showed that “perceived norms” were actually higher than reality. It would be very difficult to get the media to present a more realistic picture. Local press might be easier to change as they aimed to present a better picture of local communities.
- Soap operas were a problem too, presenting alcohol misuse as “normal”. These programmes should introduce educational messages

Schools:

- Schools needed to set a good example by having healthy food vending machines, no staff smoking rooms; using the partnership with the BMA, which provided Health Education information and having a specific Health Education programme. Life Skills had some effect but needed supportive measures for greatest success.
- Teachers could not be expected to handle all the necessary work of health education.
- Head Teachers must be engaged, as well as parents. Pressures on Head Teachers on all the health issues had to be accommodated with the general education emphasis. The effects of Health Education were hard to measure.
- We needed to look at current curriculum opportunities outside of PSHE, including cross-curricular opportunities. DfES would not be revising the curriculum again since they had done so recently.
- There needed to be coherence among all areas in the curriculum.

Children’s own perceptions:

- Self-image was important for Health Education. Focus on young children’s positive self-image as the foundation for healthy choices regarding food, drugs, sex etc. Research supported this. If schools supported children academically, socially and emotionally, this was correlated with better health decisions.
- Protection (taking away vending machines) versus empowerment of young people was an issue. However, some research showed that young people with increased self-esteem might be more likely to try drugs.
- Children did want to be healthy and fit; they just ate what they were used to eating (e.g. sweets). This needed to be changed to healthier things like fruit.
- The UN had a “Rights of Children” charter. This was intended to empower/involve them. It seemed we were quite selective about when we recognised children’s competence. There was a lack of therapeutic services for children.

Parents:

- It was apparent that some parents had educational deficits (e.g. low reading levels) and these were an issue for Health Education.
- Rowntree research showed that parents were the biggest influence on self-esteem. We needed to increase education and support for parents, as "Blueprint" did. Start before the school years by working with parents. There was too little support for parents. Parenthood and relationship education was needed throughout the school years to break the cycle of bad parenting.
- It was important to address poor parenting. Research had shown the damage of "high criticism/low warmth" parenting. Parents' previous abuse also had an impact.

THANK YOU

Life Education would like to thank all who so generously contributed to the consultation event.

Whilst more work on the evidence of what works needs to be done it is hoped that we can continue to work together to arrive at a shared position statement in order to influence future policy.

Name	**Organisation**
Deborah Allen	British Heart Foundation
Tracy Allen	Neil Stewart Associates
Tony Baldry MP	
Emilie Bennetts	5 A Day
Helen Bird	DfES
Simon Blake	National Children's Bureau
Maria Carlton	National Council of Parent Teacher Associations
Donna Castle	British Lung Foundation
Mary Cowley	Parenting Education Support Forum
Preeti Ghelani	Educari
Richard Ives	Educari
Margaret Jones	Ofsted
Ruth Joyce	Blueprint Team
Professor Mike Kelly	Health Development Agency
Natalie Law	BUPA
Helen Lee	Tacade
Carol Lock	Mentor UK
Susannah Lovatt	Porter Novelli
Cara MacDowell	The Learning Trust
Mary MacLeod	National Family & Parenting Institute
Dr Peter Maguire MP	British Medical Association
Jane Mallick	Roehampton University of Surrey
Jenny McWhirter	Drugscope
Gill Morris	Camden LEA
Abigail Morris	Children in Crisis
Louise O'Connor	Roehampton University of Surrey
Jack O'Neill	St. Vincent De Paul School
Neera Sharman	Barnados
Sarah Smith	Boots
Dr Richard Taylor MP	
Lucy Thorpe	NSPCC
Cressida Wakeley	5 A Day
Chris Williams	Save The Children
Katherine Wilson	Neil Stewart Associates
Kate Winstanley	The Portman Trust
Jenny Woolfe	Food Standards Agency

Aim of the Literature Review:

- To critically review relevant literature which examines the significant influential factors on children's and young people's health-related decisions, drawing mainly on UK sources, but with additional key selected sources from the USA, Australia and Europe

Outcomes of the Literature Review:

- The production of an independently produced and scrutinised report which will assist in the revision and adaptation of Life Education's strategy, programmes and provision
- To inform an expert consultation event (Portcullis House, July 21st, 2004) which will examine the findings and implications of the review, for Life Education and potential strategic partners to explore possible collaborations on areas of mutual interest*.
- The report is also intended to inform the national debate on effective health education policy and practice for children and young people; and support national and local organisations and individuals working within the PSHCE fields.

Scope and limitations of the Literature Review

A preliminary search of the literature to inform the brief for this review, suggested that a number of factors are instrumental in influencing the health careers of children and young people. These factors broadly fall within the following categories:

- Family/parents/carers
- Social/Community (peers/friendships, neighbourhood, statutory/voluntary agencies)
- School - informal and formal curriculum
- Media

Such influences on children and young people will vary in their importance depending on the developmental stages and life experiences of individuals.

There are several evidence sources in the literature which allow some generalisation of findings which have implications for policy makers and practitioners in health education. Given that this is an extremely broad and extensively researched area, a decision was made by the authors, to concentrate on key papers and seminal reviews which draw on meta-analysis of the relevant research studies.

*A similar expert consultation event for Life Education Parent Programmes/Provision was held at the BMA (London) on June 24th.

However, other indicative and recent research is also included where relevant. The focus is on UK literature, but research from other English-speaking countries is used to support and enhance topic areas discussed. UK government reports and policy guidance are also examined in relation to the national policy context and impetus for health education practice within the United Kingdom.

In attempting to draw out the critical factors to inform health education policy and practice, this review has limited itself to the key areas of young people's health related behaviour of most concern to public health policy (see Sections 3 and 4) and where national and local resources are most concentrated.

Thus this review focuses on the following aspects of Children and Young People's health:

- Legal and illegal drugs
- Sexual behaviour
- Overweight and obesity
- Exercise
- School disaffection and exclusion

Space precludes an exhaustive examination of all the relevant literature, therefore aspects such as gambling, and accidents and road injuries are not included. However, they are acknowledged here as worthy of additional research to further inform the debate.

The review is also weighted in favour of a drugs perspective, to reflect the research which indicates that smoking, alcohol and drug misuse are positively correlated with less healthy lifestyles and problem behaviour (see Section 4).

In summary, the Introduction leads into the following Sections:

- Section 1: Health Behaviours and Health Education Models
- Section 2: Definitions of Health and Related Terms
- Section 3: Mapping Health Behaviours of Children and Young People
  - a) Drug and Alcohol use
  - b) Sexual Health
  - c) Overweight and Obesity
  - d) School Disaffection and Exclusion
- Section 4: Risk and Protective Factors
- Section 5: Public Health Priorities: Government Reports
- Section 6: School Health Education – Effectiveness Research

- Section 7: BME Communities and Diversity Issues
- Section 8: Commentary, Discussion and Conclusions.

The sections above set out the research evidence base for the summary findings presented in Figure 1 (overleaf), which sets out the positive influences on the health promoting decisions of young people. These influences are located within the social environments of families, schools and communities, and their interaction may strengthen the positive influences on health promoting behaviour.

Evaluation Issues arising from the review

In terms of accumulating a credible evidence base on which to formulate public health policy and education interventions, the research literature shows that properly implemented and followed-through programmes are very rare, and long term follow-up (longitudinal) studies are rarer still (see Sherman *et al,* Section 4). Whilst accepting there are methodological and practical difficulties with such research, the lack of empirical studies which can stand up to expert external scrutiny, is a problem for policy makers and practitioners in forming clear conclusions around resource allocation to public health policies and prevention activities.

Nevertheless, the literature reviewed here has allowed the presentation of Figure 1 below, which summarises the influences on positive health-promoting decisions and behaviour of young people. The Figure is presented as a basis for discussion, and for consideration by those in the public, private and voluntary sectors engaged in health promotion and education activities.

Fig. 1: CHILDREN, YOUNG PEOPLE AND HEALTH-RELATED DECISIONS

Positive influences on health-promoting decisions of young people

Family and Parenting

- Good parenting skills including setting clear boundaries for behaviour
- Secure and stable family environment
- Good models of constructive social and educational values including high aspirations for personal fulfilment and good citizenship
- Intellectual stimulation
- Loving and supportive relationships
- Good communication between parents and children
- Parental involvement throughout pre-school and school experience
- Responsible Parental modelling around alcohol, smoking and illicit drug use

School

General

- Positive attitudes towards school
- Academic achievement
- Regular attendance
- School effective at supporting academic, social and emotional development, including those pupils with special needs
- School engages parents in children's progress
- Schools provide a safe and orderly environment for children to engage in learning
- Safer School Partnerships (SSP) and/or similar initiatives to promote school safety

School-specific Health Education

School health programmes which incorporate research findings on effectiveness namely:

- are evidence based, effectively teacher managed and co-ordinated, supported by coherent policies (Healthy Schools, Drugs, Citizenship, Anti-bullying, Behaviour management
- are developed through pupil involvement and needs-analysis, incorporating both primary and secondary prevention as appropriate in the case of drugs and sex education
- use well trained, credible and competent educators, who empathise with pupils, and send coherent messages aligned to pupil needs
- use life skills approaches based on the effectiveness literature
- start before experimentation with drugs and sexual behaviour, and provide sustained, developmentally appropriate provision throughout school career
- use interactive teaching approaches which address normative perceptions of drug and sexual behaviour
- are culturally sensitive, for example, incorporating needs analysis/consultations with BME pupils
- provide targeted interventions for at risk pupils appropriate to their needs
- engage parents in school and health education initiatives
- have effective partnerships with parents, agencies and individuals in the community, to support positive values around health
- use Media interventions to support school and community messages around young people's health
- include evaluations which inform on-going programme provision

Communities

- Strong social cohesion
- Clear behaviour expectations of young people within neighbourhood communities
- Buoyant local economy
- Few (and controlled) alcohol outlets
- Low levels of crime in local area
- Illegal drugs not easily available
- Good housing
- Low tolerance of anti-social behaviour, street drinking, graffiti, criminal damage, intimidating (bullying) behaviour
- Majority of peer and friendship groups engaged in legitimate recreational activities as opposed to - legal/illegal drug use, vandalism, neighbourhood disturbance, gang memberships
- Positive engagement by police with young people and communities through Safer School Partnerships and Public Reassurance schemes in addition to other social controls exerted

Conclusions and Implications for Health Educators

In summary, this literature review has demonstrated that impacting on children and young people's health behaviours can is most likely to happen through a coherent and planned approach which engages significant components known to have an influence on the process. Figure 1 presented on page 4, puts the school at the centre of such endeavours, acknowledging current national and local policy imperatives which see schools as crucial for co-ordinated provision. Further research to test whether the multi-faceted approach illustrated here, and recommended from the literature, has the greatest impact on young people's health related decisions (in contrast to single faceted approaches) would add to the evidence base.

In conclusion, the implications of the Literature Review (see Figure 1) for the Health Education policy and practice of organisations and individuals are as follows:

- Health education programmes should take account of the context in which they operate – ensuring consistency and coherence with organisational values, management structures and educational provision. School health education programmes are delivered within complex environments, which need to be connected at all levels to health education messages delivered in the classroom. The research suggests that schools which are effective in supporting pupils' academic, social, and emotional development, will also positively influence their health related decisions.
- The above point suggests that the overall expertise base in schools to support health education is critical to effectiveness. This means that investment in effective teaching and learning approaches, and measures to support pupils at risk of school exclusion (Behaviour and Education Support Teams (BEST) and Safer School Partnerships (SSP) may all prove effective. The National Healthy Schools Standard and DfES support of accredited Teacher In-Service Training in PSHCE are also moves in the right direction. However, not all schools are yet committed to becoming Healthy Schools, or to investing in the appropriate training for teachers. Training key teachers in all schools to a nationally agreed standard, could move good practice into the mainstream.
- Integration of external and internal health educators within overall school efforts to address health issues for children and young people is crucial, but partnerships and collaborations with parents and other key community agencies across the broad areas of child welfare and health will maximise impact.
- Monitoring and evaluation of *single-faceted* programmes have proved problematic, applying monitoring and evaluation procedures and related Quality Control measures to *multifaceted* interventions suggested by the review, would provide further challenges to those working within partnerships and collaborations. Nevertheless, the accumulation of such evidence could support investment in the best strategies and approaches. The BLUEPRINT evaluation should help in this regard.

- The elements of the review pertaining to effective health/drug education programmes (Figure 1: School-specific Health Education) suggest that there are core principles and factors which relate to effective programmes. It follows that health educators providing health and drug related programmes should endeavour to incorporate best practice principles derived from them. External funders making decisions on supporting a range of programmes provided for children and young people, might usefully take into account whether such programmes incorporate evidenced best practice, and the comparative costs of programmes which do so.
- Overall, the review suggests that there are some key research findings which can inform principles for health education policy and practice. It is important that realistic expectations are set for education programmes in schools, which the research indicates will have modest effects at best. However, if these are strengthened by the multi-faceted components presented in Figure 1, the potential for positive impact is significantly increased.

Finally, the importance of parental influences on children's and young people's health related decisions and overall life choices, is identified strongly across all aspects of the literature. Therefore all those concerned with the healthy development of children and young people, would wish to consider how parent involvement, education and support might be integrated as a core component of their work.