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Understanding, Evidencing and Promoting Adolescent Wellbeing: An Emerging Agenda for Schools

Introduction

Wellbeing is referred to frequently within public policy and it has become a common measure by which quality of life is judged (Coombs, 2006, OECD, 2009, ONS, 2011). However, it is a contested, multi-dimensional construct without an agreed definition (Conceição & Bandura, 2008, Diener & Suh, 1997, Ereaut & Whiting, 2008). This presents those wanting to promote wellbeing with the challenge of how to respond when 'one size does not fit all'. Research indicates an individual's life satisfaction or subjective wellbeing (SWB) can be enhanced through social, cultural, spiritual, educational and environmental interventions, alongside working to ameliorate economic conditions (Diener & Ryan, 2010, Diener, Kesebir, & Lucas, 2008, Spurr, Bally, Ogenchuk, & Walker, 2012). This complexity makes understanding adolescent wellbeing a salient health issue as many of the behaviors (i.e. being physical active) and psychological skills (i.e. resilience) associated with wellbeing track from adolescence into adulthood (Hoyt, Chase-Lansdale, McDade, & Adam, 2011, Sleaf, Elliott, Paisi, & Reed, 2007). With this in mind, this paper will firstly add support to the argument for the need to work more creatively with young people to further our understanding of adolescent wellbeing. Secondly, it will suggest that as sites for the promotion of wellbeing schools use the experiences of the young people to design asset-based approaches to their activities aimed at improving students' quality of life.

Since 1983, the Health Behaviour in School-aged Children (HBSC) research group has raised awareness of the social determinants of young people's health and wellbeing (Currie, Zanotti, Morgan, Currie, de Looze, et al., 2012). Furthermore, UNICEF (2007, 2011) has published reports on the quality of life of young people. In response professional groups and think tanks have started advocating more action to promote childhood wellbeing (NEF, 2009, The Children's Society, 2012). Consequently, the wellbeing agenda is moving on with more attention focused on how to work with children to understand wellbeing from *their* perspective and how to take local action to enhance it.

As part of a broader mix-method programme of research on childhood wellbeing this paper presents survey data and explores the views of a group of young people on what wellbeing is and what makes them happy. In line with contemporary studies, it uses the Personal Wellbeing Index-School Children (2005) and draws out children's experiences through participatory techniques (Anderson, McDonald, & Chesson, 2010, Crivello, Camfield, & Woodhead, 2009, de Rossi, Matthews, Maclean, & Smith, 2012, Kostenius & Ohrling, 2008). It seeks to show how schools can use collaborative work to ensure their efforts to promote health and wellbeing resonate with the realities of children's lives. By exploring the children's experiences schools can involve them in the design of programmes. Pupils, alongside school health practitioners, are then the 'co-producers' rather than the passive recipients of any initiatives.

Evidencing adolescent wellbeing

It is critical the foundations of lifelong wellbeing are laid early in life. Efforts to understand the SWB of adolescents can have long term value. Internationally, UNICEF sets the agenda and monitors the wellbeing of children against six dimensions: material wellbeing, health and safety, educational wellbeing, family and peer relationships, behaviour and risk and SWB (UNICEF, 2007). It also identifies additional indicators of wellbeing deemed likely to be influenced directly by government policy (e.g., environment, housing and quality of school life) (OECD, 2009). Whilst such monitoring reports have received criticism for the way data are aggregated (Statham & Chase, 2010), they do emphasize on the breadth of domains that impact on childhood SWB.

Measurement of SWB is characterized by a range of single item and multi-item scales covering global life satisfaction (i.e. an individual's satisfaction with their life overall) and life domains (i.e. personal relationships, health, safety, material wellbeing and future security). There is evidence these self-reported measures are stable over time and show 'reasonable convergent validity' with non-subjective measures

(Diener & Ryan, 2010:391, Sandvik, Diener, & Seidlitz, 1993). Consequently, there are advocates of using validated indices for the measuring of life satisfaction amongst children to support needs assessments, the formation of policy and the evaluation of programmes (Diener et al., 2008, NEF, 2009, The Children's Society, 2012, Valois et al., 2003).

Evidence from studies utilizing a range of these scales (e.g. *Students' Life Satisfaction Scale*, *The Good Childhood Index*) suggests schools do impact on life satisfaction. A positive school experience can have a pivotal role in promoting a child's wellbeing. Fryenberg, Care, Freeman and Chan (2009) examined the relationship between wellbeing, coping strategies and school connectedness amongst secondary school pupils. Scandinavia research has also shown how the school environment influences pupils' SWB (Konu, Lintonen, & Rimpelä, 2002) and demonstrated a relationship between health behavior, school satisfaction and SWB (Katja, Päivi, Marja-Terttu, & Pekka, 2002). A child's perception of their social environment (including their school, neighborhood and home life) has also been seen to have an impact on wellbeing (Tisdale & Pitt-Catsuphes, 2012). The school as a 'space' as well as a social setting can therefore be a significant influence on a child's transition through adolescence, their emotional and social wellbeing and their engagement in activities inside and outside of school time.

With behaviors and psychological skills and responses at the heart of wellbeing schools will be acutely aware of how broader influences on the lifestyles of adolescents impact on their pupils. Schools cannot be responsible for tackling all health and social issues but they will be conscious of how health behaviors, peer relations, self-identity and feelings of self-worth etc., impact on children. For example, physical activity and health outcomes are associated with a child's wellbeing (Sleap, et al., 2007). Recent work concluded that children who met the recommended guidelines for moderate to vigorous intensity physical activity reported higher levels of wellbeing (Breslin, Gossrau-Breen, McCay, Gilmore, MacDonald, et al., 2012). There has also been evidence of reduced life satisfaction amongst particular race / gender groups in adolescent high school pupils associated with weight perception and dieting behaviors (Valois, Zullig, Huebner, & Drane, 2003) and physical activity behaviors (Valois, Zullig, Huebner, & Drane, 2004). Health-risk behaviors such as fighting, drug use, smoking and alcohol consumption have also been shown to lower life satisfaction (Bergman & Scott, 2001, Visser & Routledge, 2011).

The insights into adolescent life satisfaction offered by studies focused on the relationships between indicators of wellbeing are important but these tools also need to be used in conjunction with other methods. UNICEF (2011) has for example undertaken ethnographic work with families to complement its large-scale monitoring activities. It is acknowledged that more needs to be done to track wellbeing through adolescence, understand what wellbeing means to young people and design child-centred wellbeing strategies (Pople & Solomon, 2011, Rees, Goswami, & Bradshaw, 2010, The Children's Society, 2012). This necessitates qualitative and longitudinal research to be undertaken. This work will offer a 'deeper assessment' of SWB which can be of value to decision makers (Diener et al., 2008:50). It has been recognized, for example, that participatory action research projects which supported the design of programs to enhance adolescent wellbeing were effectiveness in: increasing participants' competencies; supporting the development of social relations; and facilitating greater engagement in activities within their families and communities (Cook, 2008).

Asset-based health strategies and health literacy: framing the school wellbeing agenda

There is international agreement that more needs to be done to attend to health inequalities and improve health outcomes through the life course (OECD, 2009). However, the means of achieving better health outcomes is disputed (Wilkinson, & Pickett, 2009 Snowdon, 2010). The debate is often also overlaid with reference to ideologically opposed positions on who and what is responsible for a person's health (Birn, 2009). Education is inevitably drawn into the debate and schools resources for health will be influenced by political priorities.

Currently there is an interest in promoting asset-based approaches to health. The approaches are founded on three principles: a focus on the determinants of health rather than illness; consideration of the resources individuals and communities already have (protective factors); and a recognition of the importance of psycho-social factors in health outcomes (Harvey, 2013). This contrasts to deficit-based models of health improvement which focus on needs within communities. In these models public services and professionals

such as school practitioners fill gaps in competencies and are seen to simultaneously ‘treat’ problems and create dependencies. Morgan and Ziglio (2007) suggest the focus on ‘deficits’ in health programmes has ignored the resources that are potentially at an individual’s or community’s disposal. These protective factors cut across the range of health determinants from our own behaviors through to the provision of local health services. They operate at three levels: the individual (e.g. resilience to risk-behaviors); community (e.g. social networks); and institutional / population level (e.g. good housing and environmental conditions).

Morgan and Ziglio (2007) argued an asset model would revitalize the evidence-base for public health leading to a ‘positive and inclusive approach to action’ (p. 17). The result being a rebalancing of the mix of asset-driven and deficit-based health promotion programmes in community settings. Critics (Birn, 2009, Friedli, 2012) countered this by observing that any recognition of the positive attributes of individuals and social groups does little to counter the structural issues that underpin the distribution of health.

Where asset-models are adopted the ‘rebalancing’ of public health strategies promotes the importance of health literacy; an individual’s ability to make informed choices about their health and wellbeing. Health literate populations have the skills to attain and then maintain good health (Nutbeam, 2000, Peerson & Saunders, 2009). Improving literacy starts with children having access to age-appropriate messages concerning their health and wellbeing (Marmot, 2010). It is therefore important that children’s understandings and experiences of wellbeing are represented in these messages. This is best achieved through participatory means as advocates of health literacy conceive it as a personal health ‘asset’.

Interest in working *with* young people to enhance our understanding of adolescent wellbeing has coincided with these debates within public health and it taps into some of the same language: empowerment, choice, capacity building, self-efficacy, connectedness and resilience. Qualitative research looking at the application of the asset-based model for public health for practice associated with young people’s health is limited. However, the Search Institute (2013) has identified 40 ‘developmental assets’ that it argues promotes the capabilities and builds the resilience of young people and these have been tested extensively through quantitative measures. It is recognized that opportunities to experience the positive effects of ‘protective factors’ increases the likelihood of longer term wellbeing (Fenton, Brooks, Spencer, & Morgan, 2010).

Focus of the research

The wellbeing of young people is the responsibility of a network of groups including extended families and carers, educators, health workers and the children themselves. And whilst education literature indicates that schools are already crowded policy spaces (Houlihan, 2000) this should not detract from their potential to enhance health literacy and contribute to adolescent wellbeing (Kilgour, Matthews, Christian, & Shire, 2013).

There are case studies of asset-based approaches working at a local (city) level (Wallace & Schmueker, 2012). However, there is potential to explore more fully how school-focused health practitioners can use participatory work with children to better understand the interplay of protective and risk factors and build on their capabilities and resources. The remainder of this paper describes a project aimed at helping a county borough (a tier of UK local government) support schools as they seek to: understand adolescent experience of SWB, identify those factors which influence its level; and consider how this information can be used to engage young people in programs to enhance wellbeing.

Method

Participants

Participants included pupils in Key Stage 3 (11-14 year olds) and Key Stage 4 (15-16 year olds) from a secondary school in South Wales, Hillview Comprehensive School; all names used are pseudonyms. Hillview Comprehensive School accommodates pupils from Year 7 to Year 11 (11-16 years old). The school had around 12% of students on the special education needs (SEN) register and about 60% of the pupils had reading ages close to their actual age. Approximately a fifth of children were eligible for free

school meals, indicating areas of significant social disadvantage. Unauthorised absenteeism was below the national average.

The research aim was to identify baseline data on the current SWB of the school population and then examine through qualitative means adolescents' perceptions of their health and wellbeing. Initially, all pupils at the school on a given day in the autumn term ($n=869$) were sampled to complete the *Personal Well-Being Index – School Children* (Cummins & Lau, 2005). Subsequently, pupils from Year 7 (age 11), Year 9 (age 13) and Year 11 (age 15) were sampled for a series of focus groups ($n=18$).

Procedure

A parallel mixed methods design (Teddlie & Tashakorri, 2009) was utilized by which the quantitative and qualitative data were collected during the same time period and addressed related elements of the research question, namely to further understand adolescent wellbeing and assess how this might shape school and community-level action to promote quality of life. Approval for the project was granted via the Faculty Research Ethics Panel at the lead researcher's institution. As the pupils were under the age of 18 years, formal consent was given by the Headteacher of the school, acting as *loco parentis*. This is in line with University's ethics policy when data are collected as part of standard school business. The study was conducted in two stages. Firstly, the PWI-SC (2005) was disseminated to all pupils. The Index contains eight Likert scale questions covering Happiness with Life as a Whole (HLW) [question 1] and Personal Wellbeing Index (PWI) domains [questions 2-8]. The PWI-SC was administered by class tutors as set out by Cummins and Lau (2005). The survey was self-completed during a morning registration period. After cleaning the data in line with the principles proposed by Cummins and Lau (2005) there was a final sample of 230 $n=840$.

Three focus groups were also conducted with groups of six pupils from three year groups ($n=18$). Groups were heterogeneous and balanced in terms of gender. The primary aim of the focus groups was to undertake exploratory work with the pupils to examine their understanding of health and wellbeing and explore adolescent health behaviors. The semi-structured discussion guide included eight prompt cards that included questions linked closely to the subjects and scales of the PWI-SC. Pupils were invited to discuss their thoughts on: the meaning of happiness and/or unhappiness; the importance of material possessions; what constitutes health; personal skill development and things they wanted to be good at; perceived barriers towards success; relationships; feelings of safety in different environments and perceptions of their own futures. The focus group facilitator wanted the groups to be inclusive and participatory. Graffiti walls (Mathers, Anderson, McDonald, & Chesson, 2010, O'Kane, 2008) were used to support the discussions, allowing pupils to express their views and respond to the view of others through drawings and brainstorming exercises. Veale (2005) argues such activity encourages 'non-hierarchical relationships and reciprocal learning' (p. 254) as the children become co-producers of knowledge rather than merely the source of data. The materials form part of the record of the focus groups and examples are considered later in this paper.

Semi structured interviewing methods were used to ensure flexibility in dealing with the responses of participants (Hennessy & Heary, 2005). All children were aware of the purpose of their involvement in the research and were given a project brief detailing the nature of the study (Flick, 2006, Marvasti, 2004). In addition the researcher informed each pupil of the confidentiality of the information provided and confirmed that they were free to leave at any time. In order to facilitate anonymity of all participants, pseudonyms were assigned. The group interviews were recorded digitally and lasted between 50 - 80 minutes and were transcribed verbatim.

Data analysis

Data from the PWI-SC ($n = 840$) were treated according to the procedures described by Cummins and Lau (2005). First, all Likert data were converted to a percentage of scale maximum. Second, values from questions two to eight were averaged to calculate Personal Wellbeing Index (PWI). Data from all subscales were first checked for normality (Shapiro Wilk test) and all data sets differed significantly from normal ($P < 0.001$). Consequently, descriptive statistics are given as median (IQR) and non-parametric inferential statistics were utilized. The Happiness with Life as a Whole (HLW) [Question 1] and PWI data

were also tested for differences by sex (Mann-Whitney U test) and by year group (Kruskal-Wallis test).

The focus group transcripts were subjected to thematic content analysis, which took the form of identifying key, recurring themes from the data (Morse & Richards, 2007). The inductive analysis was an iterative process. Initially all transcripts were read and re-read in full and independently of one another to ensure familiarity with the data. Then each transcript was subject to in-depth scrutiny allowing for all meaningful data to be identified and attributed labels, initially in-line with the domains of wellbeing used in the focus group discussion guide. This phase of work was undertaken by two members of the project team. Researcher triangulation is often used to verify themes and enhance trustworthiness (Flick, 2006). In total over 40 issues were identified by the pupils under the eight domains. For example, under the domain of happiness / unhappiness issues such as family and friends, pets, hobbies, arguments, bullying, being left out, sports injuries, stress and self-image were raised. Finally, the transcripts were reviewed collectively and the labels assigned were reviewed, clustered and organised into broader conceptual themes (Teddle & Tashakkori, 2009).

Results and discussion

The PWI-SC scores support the idea of changes to wellbeing as young people progress through their secondary education. The thematic analysis of the qualitative data identified three discrete but interrelated themes: transient understandings of wellbeing; the influence of maturation on wellbeing; and the role of safety, marked by significant transitions through adolescence. The profile created through this mix of data confirms support for the breadth of factors known to influence wellbeing and offers some illustration of how young people interpret and respond to those influences.

Personal Well-being Index – school children

Descriptive statistics for Happiness with Life as a Whole (HLW) [Question 1] and PWI are presented in Table 1, by sex and year group. There were sixteen missing values for sex but no other missing data. Values are consistently above the normative range [70-80] (Cummins & Lau, 2005). As expected results from each question and PWI were all related (Spearman's rank correlation) to each other ($P < 0.001$ in all cases).

Table 1: Descriptive statistics (median [IQR]) for HLW and PWI by sex and year group.

		Year 7	Year 8	Year 9	Year 10	Year 11
HLW (%)	Male	90 (20)	80 (20)	90 (10)	90 (30)	80 (20)
	Female	90 (20)	80 (20)	80 (10)	80 (20)	80 (30)
PWI (%)	Male	89 (15)	81 (16)	87 (11)	87 (11)	84 (14)
	Female	87 (14)	83 (13)	86 (14)	83 (13)	79 (16)

The HLW and PWI data were further tested for differences by sex (Mann-Whitney U test) and by year group (Kruskal-Wallis test). The data for these analyses are presented in Figures 1 and 2 respectively. There was no sex difference for HLW ($P = 0.111$), but males scored significantly higher for PWI ($P = 0.002$). There were significant differences across year groups for both HLW ($P < 0.001$) and PWI ($P < 0.001$). The nature of the year group effect can be seen in Figure 2.

Figure 1: HLW and PWI by sex. Bars are median values and error bars are IQR.

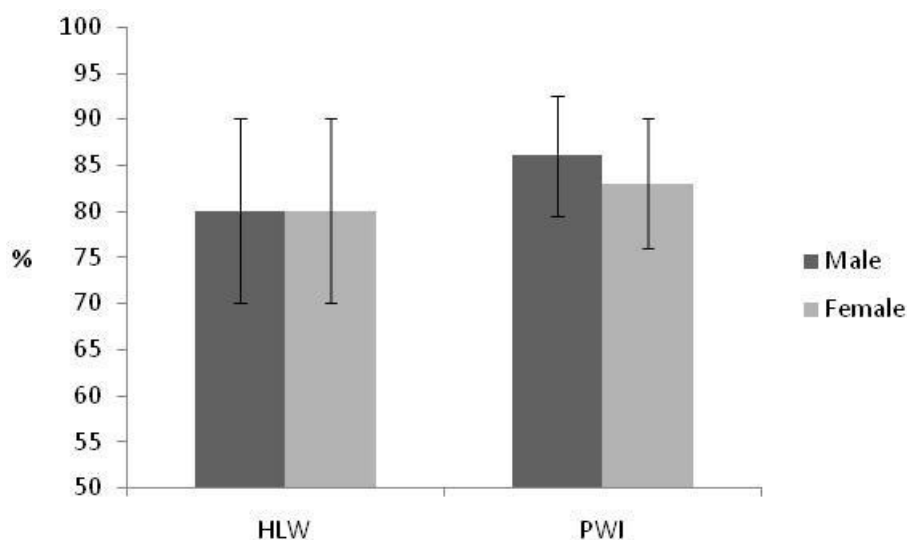
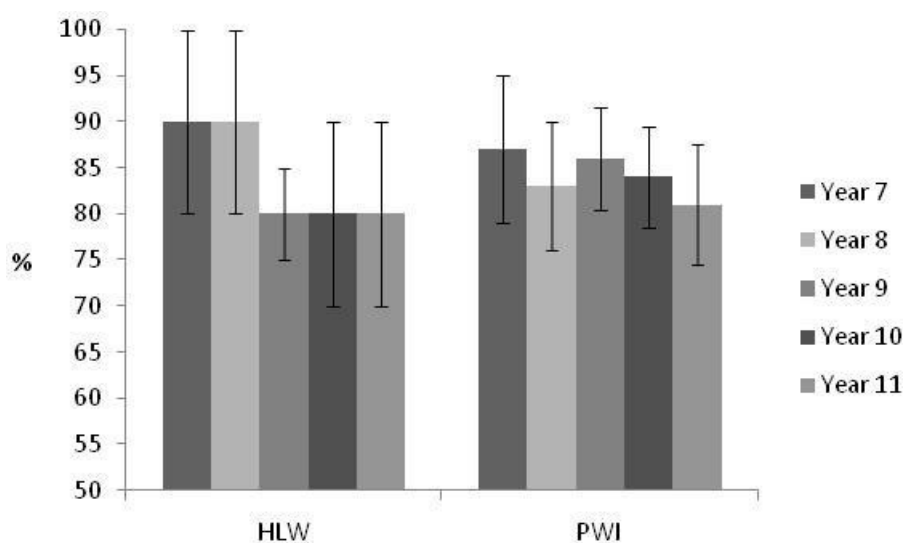


Figure 2: HLW and PWI by year group. Bars are median values and error bars are IQR.



The analysis highlights that both male and female pupils across all year groups are consistently happier and rate their wellbeing as considerably higher than is the norm within this population. Males reported higher levels of wellbeing across year groups in comparison to females. However, females reported consistently higher values than the norm in relation to personal wellbeing, so this is not to say that the female population is dissatisfied with their wellbeing. HLW was highest in Years 7 and 8, and levelled off in Years 9, 10 and 11. Satisfaction with personal wellbeing fluctuated, but was highest in Years 7 and 9. Overall, this population has high levels of HLW and PWI.

The qualitative data help to contextualize these scores. The students' views are used to illustrate how capturing the experiences of young people can support asset-based wellbeing strategies. An important starting point for this analysis is to recognize that if a deficit-based perspective was adopted then the fact the school services an area of high social deprivation might be the focus. Yet wellbeing is generally higher than the

norm for this population; borne out also by low absenteeism. This suggests potential to build on the skills and resources that appear to exist within the children and their community rather than looking to address deficiencies.

Adolescent subjective wellbeing: an assets approach

The focus group data generated over 40 items under the domains of wellbeing covered. These are summarized in Table 2. These are considered at the level of the asset (individual, community or population) (Morgan & Ziglio, 2007). Furthermore, the Search Institute's (2013) development assets framework is used as a means to categorize the 'building blocks' that could support adolescent health and wellbeing. These categories include: support, empowerment, boundaries and expectations, constructive use of time, commitment to learning, positive values, social competencies and positive identity.

Table 2. Indicators of adolescent wellbeing generated by focus group participants

Theme	Level of Asset (Morgan & Ziglio, 2007)	Illustrative Protective / Risk factors	Illustrative Developmental Assets (Search Institute, 2013)
Happiness / Unhappiness			
Family, friends, family and friends returning from war, pets, hobbies, cosiness, sleeping	Individual, community and population	Connectedness, external support system, social competence	Support, constructive use of time, social, boundaries and expectations
Family and friends at war, arguments, crime, drugs, sports injuries, bullying, being left out, stress, Facebook, people nagging you, lack of social life, self-image	Individual, community and population	Attitude to risk-behaviors, alienation, poor resilience, poor social network	(e.g. adult role models, positive family communication, positive peer influence)
Material Possessions			
Money, games consoles, pets and mobile phones	Individual Population	Positive values Poverty	Positive values (i.e. equality / social justice)
Health / Unhealthy			
Diet, exercising, socializing,	Individual and community	Engagement in activities, attitude to health-behaviors	Constructive use of time; positive values, social (e.g. engage in youth programs; restraint; resistance skills)
Stress, lack of socializing, sitting at the computer and watching TV, nowhere to go, alcohol consumption in early teens	Individual, community and population	Attitude to risk-behaviors, poor social support	
Skills, personal development and barriers			
Sticking up to people, accepting other people's opinions Managing workload, revising and being more academic, sports	Individual and community	Coping and positive values, commitment to school, social problem solving skills	Social, positive identity, commitment to learning, constructive use of time (e.g. friendship skills, conflict resolution, school engagement, youth programs)
Levels of concentration and effort, parents and other people, prioritizing, lack of jobs, pressures and stress, workload, where I live	Individual, community and population	Lack of social support, lack of community resources, and cohesion	
Relationships			
Friends and family at war, boyfriends and girl friends, role models Good when teachers follow the rules, social networking sites	Individual and community	Social competence, school ethos, external support network	Expectations and boundaries, Social (e.g. positive peer influence; neighborhood and school boundaries; resistance skills)
Changes to relationships, clash of personalities, hierarchies of social groups	Individual and community	Poor resilience, peer alienation	

Safe / Unsafe			
School, home, during the day, with friends and family	Individual, community and population	Peer and neighborhood cohesion	Empowerment, social, boundaries and expectations (e.g. community values youth, feeling safe in a neighborhood)
On own, groups on the street, being followed, at night, perceptions of 'young people', social networking sites, other people's houses	Individual, community and population	Lack of community solidarity, self-identity, self-esteem	
The Future			
Excited, independence, university, fresh start, working hard	Individual and community	Positive values, commitment to school, self-efficacy, sense of purpose	Empowerment, commitment to learning, positive values, positive identity (e.g. youth as resources, achievement motivation, responsibility, sense of purpose, self-esteem)
Being away from family and friends, pressure from parents, unprotected, jobs, finance, single parents being on their own, exams, no where to go and nothing to do	Individual, community and population	Poor coping skills, academic failure, poor neighborhood spaces	

The potential to identify particular development assets or protective / risk factors is helpful but factors do not operate in isolation. There are inevitably connections between individual, community and population level assets. The interplay is reflected in the focus group data.

Transient understandings of wellbeing

The contested nature of wellbeing as a construct is borne out of the qualitative data. The pupils offered differing interpretation of what wellbeing meant to them. This diversity is pivotal to understanding the potential for SWB amongst young people to be influenced by important but transient issues.

Across the year groups pupils recounted positive and negative aspects of wellbeing. Positive dimensions were of happiness, health and relationships. Happiness was characterized by social factors (people, e.g. *family* and *friends*) and material factors (possessions, e.g. *games consoles*, *phones* and *pets*). These findings suggest schools need to be sensitive to, and work towards promoting awareness of the range of factors that can enhance subjective wellbeing especially during difficult economic times. The work of UNICEF (2011) on materialism and wellbeing demonstrated the negative impact economic inequalities and materialism can have on children and their families. The participants recognized *diet* and *exercise* as fundamental to wellbeing. They also identified sedentary practices such as *playing computer games* and *sitting watching TV* as being unhealthy, which is promising, as recent research indicates that a sedentary lifestyle is on a par with health risk factors such as smoking (Blair, 2009).

This finding is of value in the context of health behavior research, using the Health Belief Model (Becker & Maiman, 1975). This suggests that adolescents and young adults have a tendency to dismiss generic health related advice because they believe it is not relevant to them (Biddle & Mutrie, 2009). However, these young people appear to be engaging with these messages suggesting a level of health literacy amongst this population which schools should capitalize on through curriculum-based and extra-curricular programmes; laying the foundations for better health outcomes through the life course.

Through their words and contributions to the graffiti walls the children were demonstrating their own understanding of the biopsychosocial model of health which emphasizes the links between mind and body. It proposes health is not confined to physical wellness rather it emphasizes connections between the physical, psychological, emotional and social aspects of health. This resonates with the asset approach which Marks and Ziglio (2007) argues challenges the dominant positivist / biomedical model of health underpinning much of the evidence base in health.

While *physical activity*, *friends* and *family* defined happiness and health, *arguments*, *bullying*, *unrest* and *family* issues were cited as the main sources of unhappiness. The younger respondents articulated *current family concerns* as important whereas older adolescents were looking ahead to *changes to family relations* post-compulsory education.

You've gotta make the person who you are; you've got to choose who you want to be... At the minute I don't care about life I just get on with things just ignore everything, ... but as soon as I leave it's my life and... it's what I want to do, it's my future... (David, Year 11)

The value of positive personal relationships for childhood wellbeing is highlighted consistently (Currie et al., 2012, HBSC, 2009, Statham & Chase, 2010). Equally, the negative impact of bullying on wellbeing is also apparent and it comes in many guises. This appears to reflect the changing physical and virtual environments that young people 'inhabit', with *school settings* featuring more in the thoughts of the Year 7 pupils and *social networking sites* being the focus of concerns for older adolescents. The latter 'setting' was not mentioned by those in Year 7.

I get beaten up by all the Year 8's ... 'I said they can't play because they're too old and [...] then they started arguing with me and then they keep on beating me up in school now. (Mike, Year 7)

You have a lot of people who say stuff on social networking website(s) and then you come to it in person and then they wouldn't say nothing, they just wouldn't... (Ben, Year 11)

Year 7 pupils expressed more anxiety relating to physical bullying, this may be indicative of their transition to secondary school, the associated 'unfamiliar' surroundings, and the realization of being the 'new kids on the block'. The prevalence of cyber-bullying specifically is a contemporary phenomenon school practitioners accept reluctantly is out of their control and therefore challenging to address and manage via the school context (Kidscape, 2010). However, working with children to enhance social competences, resilience and restraint skills would contribute to their capacity to deal with such scenarios.

Maturation and wellbeing

Life stages appear integral to adolescent wellbeing. All pupils cited anxiety relating to what are interpreted as 'transitional' phases or periods of change associated with adolescence. Year 7 pupils reported feelings of anxiety manifested in their *move to secondary school*. Year 9 and 11 pupils' concerns were centred on impending *exams* and *their future* once they completed their compulsory education.

I know a lot of people are thinking 'well it doesn't matter if I don't get my GCSE grades 'cause I'm not going to get in anywhere anyway' ... You get all the way through Uni, you got all that debt and then...there still might not be a job at the end of it. (Heather, Year 11)

I'd rather do something that I enjoy doing and have enough money to sort of get by than have loads of money and do something I just really didn't enjoy doing... I want to be remembered so people knew who I was and they knew what I was there to do. (Finlay, Year 9)

In spite of anxiety in terms of their futures, pupils purported feeling excited, particularly in relation to the *independence* they would gain from *leaving school* and/or *home*. Statham and Chase (2010) suggest that wellbeing can be characterized as having a developmental perspective (i.e. preparation for adulthood) and that this can distract from the importance of understanding childhood wellbeing in the 'here and now'. The latter promotes children's rights and the immediacy of enhancing quality of life issues for children rather than being future-oriented. However, it is an important challenge for schools to promote wellbeing over the short and longer term (i.e. as a pupil moves from their school career into early adulthood). The Search Institute talks about this in terms of positive identity, personal power and a sense of purpose.

Money and *finance* were central to discussions with Years 9 and 11, with anxieties related to leaving home, going to University and getting a job. These are significant risk factors. Worries over financial security are ubiquitous given the current economic climate, rising costs of living, unemployment and lack of disposable income. Pupils sensed the financial pressures faced by their parents or carers daily and maintained the outlook as 'bleak' in terms of future employment or struggling financially as an undergraduate student.

It's like hearing about people not getting jobs ... [who] can't pay off the debt and stuff like that...you think 'oh why should I be bothered'. (Ben, Year 11)

These data support this notion that SWB is shaped, to some degree, by economic prosperity and having financial security may negate some feelings associated with negative SWB, such as anxiety and unhappiness. Whilst schools cannot control external environment it is important that they work with young people to promote the potential of other social, environmental and activity-based resources for wellbeing to lessen the effects of an economic downturn on life satisfaction. Critics of the asset-approach would contest that the structural inequalities in the distribution of health and wealth (a challenge at the population level) makes it difficult for individual or communities to do this. However, mapping local physical, cultural and organisational assets (e.g. voluntary clubs) can highlight opportunities to counter this claim.

Safety – use of space and wellbeing

Further significant aspects of adolescent wellbeing were *feelings of safety* and, specifically, *personal safety*.

I don't think you can ever feel safe outside your home, there's always something that makes you feel unsafe... when you see things on telly it just puts stuff in my head where I don't want to be on my own. (Fiona, Year 11)

There were nuances between the Year groups but also shared experiences with regards to feeling safe or unsafe. Feeling safe was portrayed through *everything familiar*, for example being with *family* and *friends*, to their *local community* and knowing people there, from being *in and around home*, to *being at school* (addressed by all three year groups). Temporality was also instrumental to feelings of safety with '*daytime*' and the lightness brought by daytime regularly cited, supporting previous research conceptualizing safety (Kilgour, 2007).

Conversely, pupils' vulnerability or feeling unsafe were defined through *being on their own* (all year groups). For Years 9 and 11 feeling of being unsafe were *being outdoors after dark*, and, in those contexts, *encountering groups or 'gangs'* of people not known to them. For example, Josie (Year 9) explained "I don't like [it when] big groups of older people start to walk passed. I get my phone out and start running faster." Yet again, spatiality and temporality aspects inherent in risk and fear research, specifically with children and young people are apparent (Kilgour, 2007, Valentine, 2004). These findings support evidence suggesting that a social trend has emerged where children's use of outdoor spaces is controlled by parents' own fears regarding their children's safety, and the notion that this is deeply embedded once they become adolescents (Thomas & Thompson, 2004, Valentine & McKendrick, 1997).

This has led to young people and adults disconnecting with outdoor environments, the impact of which is twofold. First, the benefits of outdoor activity which are documented widely are negated. This means the benefits to mental health, which would serve to enhance SWB are not harnessed (Barton & Pretty, 2010, Hine, Pretty, & Barton, 2009, Thompson, 2011). Second, longer term health benefits accrued by an engagement with open spaces are lost (Brymer, Cuddihy, & Sharma-Brymer, 2010). If people are habitually connected to outdoor environments from an early age it has been demonstrated that they are likely to feel more empowered and safe and are less likely to have feelings of vulnerability (Thompson & Thomas, 2004).

Conclusion

There is significant international interest in assessing a nation's wellbeing in terms beyond economic wealth. Diener and Chan (2011) suggest there is 'compelling' evidence that SWB can contribute to longevity in healthy populations. In an earlier paper Diener et al. (2008) argued its role in enhancing social relationships, career success, health and citizenry. It epitomizes the idea that health includes physical, psychosocial and cultural components (Marks, Murray, Evans, & Vida Estacio 2011). The role for schools in

promoting wellbeing is born out of international agreement that more needs to be done to improve health outcomes throughout the life course (Pickett & Wilkinson, 2009, OECD, 2009, UNICEF, 2011). The argument for adopting an asset based approach is grounded in the suggestion that deficit models have not delivered (Morgan & Ziglio, 2007); though this is contested (Birn, 2009, Friedli, 2012).

The task at the local level is to translate concept of asset building into actions. For example, within this study it has confirmed for health practitioners within the County Borough the importance of fostering and formalizing work with children and young people to promote subjective wellbeing, through extra curricula activities/programmes. This is particularly salient for Year 6 and 7 pupils (i.e. transition initiatives) and for Year 11 (i.e. future post compulsory education). The Borough and school might also work in conjunction with local partners (e.g. parks, business, voluntary groups) to promote use of community spaces. They would however need to attend to the concerns young people articulated regarding safety (i.e. buddying schemes) in order to capitalize on the children's interests. This could increase the time spent by young people in their local environment and, more widely, encourage the utilization of green spaces and other resources by the whole community.

An asset-based approach within schools has the potential to ensure local agendas are set in collaboration with young people and that these look beyond deficits amongst the population. Scales (1999) observed that those working within school health could 'impact on about half of the [developmental] assets and an indirect effect on most of the rest' (p.117). The approach identifies attributes and works to build on those 'protective' resources. In doing so it responds to recent shifts in public health discourses which favor responsibility and capacity building over rights and dependency.

This study offers an insight into some of the determinants of health and wellbeing of group of young people. The findings support the extant literature on the importance of personal relationships, feeling safe and managing the transitional phases of adolescence into early adulthood in promoting wellbeing amongst young people (HBSC, 2009, Statham & Chase, 2010, The Children's Society, 2012).

There is a complex relationship between adolescent wellbeing and the environments and agents young people interact with and these data support the need for wellbeing issues to be given 'space' in the school context. Schools increasingly have to monitor and sustain activities that promote wellbeing. Given the challenges that are faced by young people the role of the school should not be underestimated. Educational settings can promote wellbeing within taught curricula and extra-curricular activities. Schools can also work with local communities to encourage young people to utilize their surroundings, in some cases reclaiming public spaces.

A limitation of the present study is the cross-sectional nature of the data. There is a call for more longitudinal studies that can track wellbeing. The autumn term (the data collection period) is a time of transition for Years 7 and 11 (starting a new school and preparing to leave school, respectively). This may be reflected in the concerns expressed by focus group participants. Furthermore, the gender differences highlighted by the PWI-SC are worthy of additional consideration through qualitative research. The exploratory nature of the qualitative phase of the work meant the focus was on year groups rather than other individual differences. This was in keeping with an exploration of a 'whole school approach' to wellbeing. Previous cross sectional studies have presented results on the basis of gender (Valois, *et al.*, 2003, 2004) and there is potential to examine in more detail how gender might influence perceptions of wellbeing. Knies (2012) however notes that in the UK there was no 'general association' between gender and life satisfaction, though girls aged 10-12 years were the most satisfied with their lives. Diener and Ryan (2010) further suggest that amongst adults gender differences in SWB are not significant although more women live at the 'extreme ends' of the SWB scales (p. 396).

The case study nature of the project might further limit the utility of the findings. The study does not claim to offer insight into the wellbeing of a whole population but rather it responds to the call for research that examines wellbeing from the perspective of young people. The use of graffiti walls was considered a valuable addition to the data collection and did offer a more inclusive experience for the children involved.

Future research in this area must include more studies that track adolescent wellbeing over the duration of their school life. More participatory action research projects as reported by Cook (2008) and greater use of creative and participatory techniques as advocated by Crivello *et al.* (2009) would also further support

health and schools practitioners understand, evidence and promote adolescent wellbeing.

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