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Abstract

The wellbeing of young people is of considerable concern with many initiatives targeting the health behaviors of this population. Educators are amongst the professional groups being challenged to understand, evidence and enhance childhood wellbeing. Working with a case study UK school adolescent subjective wellbeing (SWB) was examined through the administering of the Personal Wellbeing Index – School Children (PWI-SC, 2005) ($n=840$) and focus group with pupils ($n=18$) PWI-SC results suggest significant differences in personal wellbeing between school years ($P < 0.001$). Focus group data indicate transitional periods associated with adolescence, feeling unsafe and anxiety over the future were linked to a lowering of SWB. Asset-based wellbeing strategies that promote health literacy and build on the resources of young people and local communities are considered as a means for schools to promote wellbeing.

Keywords: adolescents, subjective wellbeing, health literacy, asset-based strategies

66 2009, The Children’s Society, 2012). Consequently, the wellbeing agenda is moving on with
67 more attention focused on how to work with children to understand wellbeing from *their*
68 perspective and how to take local action to enhance it.

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

80 **Evidencing adolescent wellbeing**

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

90 Measurement of SWB is characterized by a range of single item and multi-item scales
91 covering global life satisfaction (i.e. an individual's satisfaction with their life overall) and
92 life domains (i.e. personal relationships, health, safety, material wellbeing and future
93 security). There is evidence these self-reported measures are stable over time and show
94 'reasonable convergent validity' with non-subjective measures (Diener & Ryan, 2010:391,
95 Sandvik, Diener, & Seidlitz, 1993). Consequently, there are advocates of using validated
96 indices for the measuring of life satisfaction amongst children to support needs assessments,
97 the formation of policy and the evaluation of programmes (Diener et al., 2008, NEF, 2009,
98 The Children's Society, 2012, Valois et al., 2003).

99 Evidence from studies utilizing a range of these scales (e.g. *Students' Life Satisfaction*
100 *Scale, The Good Childhood Index*) suggests schools do impact on life satisfaction. A positive
101 school experience can have a pivotal role in promoting a child's wellbeing. Fryenberg, Care,
102 Freeman and Chan (2009) examined the relationship between wellbeing, coping strategies
103 and school connectedness amongst secondary school pupils. Scandinavia research has also
104 shown how the school environment influences pupils' SWB (Konu, Lintonen, & Rimpelä,
105 2002) and demonstrated a relationship between health behavior, school satisfaction and SWB
106 (Katja, Päivi, Marja-Terttu, & Pekka, 2002). A child's perception of their social environment
107 (including their school, neighborhood and home life) has also been seen to have an impact on
108 wellbeing (Tisdale & Pitt-Catsuphes, 2012). The school as a 'space' as well as a social
109 setting can therefore be a significant influence on a child's transition through adolescence,
110 their emotional and social wellbeing and their engagement in activities inside and outside of
111 school time.

112 With behaviors and psychological skills and responses at the heart of wellbeing
113 schools will be acutely aware of how broader influences on the lifestyles of adolescents
114 impact on their pupils. Schools cannot be responsible for tackling all health and social issues

115 but they will be conscious of how health behaviors, peer relations, self-identity and feelings
116 of self-worth etc., impact on children. For example, physical activity and health outcomes are
117 associated with a child's wellbeing (Sleap, et al., 2007). Recent work concluded that children
118 who met the recommended guidelines for moderate to vigorous intensity physical activity
119 reported higher levels of wellbeing (Breslin, Gossrau-Breen, McCay, Gilmore, MacDonald,
120 et al., 2012). There has also been evidence of reduced life satisfaction amongst particular
121 race / gender groups in adolescent high school pupils associated with weight perception and
122 dieting behaviors (Valois, Zullig, Huebner, & Drane, 2003) and physical activity behaviors
123 (Valois, Zullig, Huebner, & Drane, 2004). Health-risk behaviors such as fighting, drug use,
124 smoking and alcohol consumption have also been shown to lower life satisfaction (Bergman
125 & Scott, 2001, Visser & Routledge, 2011).

126 The insights into adolescent life satisfaction offered by studies focused on the
127 relationships between indicators of wellbeing are important but these tools also need to be
128 used in conjunction with other methods. UNICEF (2011) has for example undertaken
129 ethnographic work with families to complement its large-scale monitoring activities. It is
130 acknowledged that more needs to be done to track wellbeing through adolescence, understand
131 what wellbeing means to young people and design child-centred wellbeing strategies (Pople
132 & Solomon, 2011, Rees, Goswami, & Bradshaw, 2010, The Children's Society, 2012). This
133 necessitates qualitative and longitudinal research to be undertaken. This work will offer a
134 'deeper assessment' of SWB which can be of value to decision makers (Diener et al.,
135 2008:50). It has been recognized, for example, that participatory action research projects
136 which supported the design of programs to enhance adolescent wellbeing were effectiveness
137 in: increasing participants' competencies; supporting the development of social relations;
138 and facilitating greater engagement in activities within their families and communities (Cook,
139 2008).

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

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

148 Currently there is an interest in promoting asset-based approaches to health. The
149 approaches are founded on three principles: a focus on the determinants of health rather than
150 illness; consideration of the resources individuals and communities already have (protective
151 factors); and a recognition of the importance of psycho-social factors in health outcomes
152 (Harvey, 2013). This contrasts to deficit-based models of health improvement which focus on
153 needs within communities. In these models public services and professionals such as school
154 practitioners fill gaps in competencies and are seen to simultaneously ‘treat’ problems and
155 create dependencies. Morgan and Ziglio (2007) suggest the focus on ‘deficits’ in health
156 programmes has ignored the resources that are potentially at an individual’s or community’s
157 disposal. These protective factors cut across the range of health determinants from our own
158 behaviors through to the provision of local health services. They operate at three levels: the
159 individual (e.g. resilience to risk-behaviors); community (e.g. social networks); and
160 institutional / population level (e.g. good housing and environmental conditions).

161 Morgan and Ziglio (2007) argued an asset model would revitalize the evidence-base
162 for public health leading to a ‘positive and inclusive approach to action’ (p. 17). The result
163 being a rebalancing of the mix of asset-driven and deficit-based health promotion
164 programmes in community settings. Critics (Birn, 2009, Friedli, 2012) countered this by

165 observing that any recognition of the positive attributes of individuals and social groups does
166 little to counter the structural issues that underpin the distribution of health.

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

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

185 **Focus of the Research**

186 The wellbeing of young people is the responsibility of a network of groups including
187 extended families and carers, educators, health workers and the children themselves. And
188 whilst education literature indicates that schools are already crowded policy spaces

189 (Houlihan, 2000) this should not detract from their potential to enhance health literacy and
190 contribute to adolescent wellbeing (Kilgour, Matthews, Christian, & Shire, 2013).

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

199 **Method**

200 **Participants**

201 Participants included pupils in Key Stage 3 (11-14 year olds) and Key Stage 4 (15-16
202 year olds) from a secondary school in South Wales, Hillview Comprehensive School; all
203 names used are pseudonyms. Hillview Comprehensive School accommodates pupils from
204 Year 7 to Year 11 (11-16 years old). The school had around 12% of students on the special
205 education needs (SEN) register and about 60% of the pupils had reading ages close to their
206 actual age. Approximately a fifth of children were eligible for free school meals, indicating
207 areas of significant social disadvantage. Unauthorised absenteeism was below the national
208 average.

209 The research aim was to identify baseline data on the current SWB of the school
210 population and then examine through qualitative means adolescents' perceptions of their
211 health and wellbeing. Initially, all pupils at the school on a given day in the autumn term
212 ($n=869$) were sampled to complete the *Personal Well-Being Index – School Children*

213 (Cummins & Lau, 2005). Subsequently, pupils from Year 7 (age 11), Year 9 (age 13) and
214 Year 11 (age 15) were sampled for a series of focus groups ($n=18$).

215 **Procedure**

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

231 Three focus groups were also conducted with groups of six pupils from three year
232 groups ($n=18$). Groups were heterogeneous and balanced in terms of gender. The primary
233 aim of the focus groups was to undertake exploratory work with the pupils to examine their
234 understanding of health and wellbeing and explore adolescent health behaviors. The semi-
235 structured discussion guide included eight prompt cards that included questions linked
236 closely to the subjects and scales of the PWI-SC. Pupils were invited to discuss their thoughts
237 on: the meaning of happiness and/or unhappiness; the importance of material possessions;

238 what constitutes health; personal skill development and things they wanted to be good at;
239 perceived barriers towards success; relationships; feelings of safety in different environments
240 and perceptions of their own futures. The focus group facilitator wanted the groups to be
241 inclusive and participatory. Graffiti walls (Mathers, Anderson, McDonald, & Chesson, 2010,
242 O’Kane, 2008) were used to support the discussions, allowing pupils to express their views
243 and respond to the view of others through drawings and brainstorming exercises. Veale
244 (2005) argues such activity encourages ‘non-hierarchical relationships and reciprocal
245 learning’ (p. 254) as the children become co-producers of knowledge rather than merely the
246 source of data. The materials form part of the record of the focus groups and examples are
247 considered later in this paper.

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

256 **Data Analysis**

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

263 utilized. The Happiness with Life as a Whole (HLW) [Question 1] and PWI data were also
264 tested for differences by sex (Mann-Whitney U test) and by year group (Kruskal-Wallis test).

265 The focus group transcripts were subjected to thematic content analysis, which took
266 the form of identifying key, recurring themes from the data (Morse & Richards, 2007). The
267 inductive analysis was an iterative process. Initially all transcripts were read and re-read in
268 full and independently of one another to ensure familiarity with the data. Then each
269 transcript was subject to in-depth scrutiny allowing for all meaningful data to be identified
270 and attributed labels, initially in-line with the domains of wellbeing used in the focus group
271 discussion guide. This phase of work was undertaken by two members of the project team.
272 Researcher triangulation is often used to verify themes and enhance trustworthiness (Flick,
273 2006). In total over 40 issues were identified by the pupils under the eight domains. For
274 example, under the domain of happiness / unhappiness issues such as family and friends,
275 pets, hobbies, arguments, bullying, being left out, sports injuries, stress and self-image were
276 raised. Finally, the transcripts were reviewed collectively and the labels assigned were
277 reviewed, clustered and organised into broader conceptual themes (Teddlie & Tashakorri,
278 2009).

279 **Results and Discussion**

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

287 **Personal Well-being Index – School Children**

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

293 <Insert Table 1 here>

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

300 <Insert Figure 1 here>

301 <Insert Figure 2 here>

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

310 The qualitative data help to contextualize these scores. The students' views are used
311 to illustrate how capturing the experiences of young people can support asset-based wellbeing
312 strategies. An important starting point for this analysis is to recognize that if a deficit-based

313 perspective was adopted then the fact the school services an area of high social deprivation
314 might be the focus. Yet wellbeing is generally higher than the norm for this population; borne
315 out also by low absenteeism. This suggests potential to build on the skills and resources that
316 appear to exist within the children and their community rather than looking to address
317 deficiencies.

318 **Adolescent subjective wellbeing: an assets approach**

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

326 <Insert Table 2 here>

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

331 **Transient Understandings of Wellbeing**

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

336 Across the year groups pupils recounted positive and negative aspects of wellbeing.
337 Positive dimensions were of happiness, health and relationships. Happiness was

338 characterized by social factors (people, e.g. *family* and *friends*) and material factors
339 (possessions, e.g. *games consoles*, *phones* and *pets*). These findings suggest schools need to
340 be sensitive to, and work towards promoting awareness of the range of factors that can
341 enhance subjective wellbeing especially during difficult economic times. The work of
342 UNICEF (2011) on materialism and wellbeing demonstrated the negative impact economic
343 inequalities and materialism can have on children and their families. The participants
344 recognized *diet* and *exercise* as fundamental to wellbeing. They also identified sedentary
345 practices such as *playing computer games* and *sitting watching TV* as being unhealthy, which
346 is promising, as recent research indicates that a sedentary lifestyle is on a par with health risk
347 factors such as smoking (Blair, 2009).

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

355 Through their words and contributions to the graffiti walls the children were
356 demonstrating their own understanding of the biopsychosocial model of health which
357 emphasizes the links between mind and body. It proposes health is not confined to physical
358 wellness rather it emphasizes connections between the physical, psychological, emotional and
359 social aspects of health. This resonates with the asset approach which Marks and Ziglio
360 (2007) argues challenges the dominant positivist / biomedical model of health underpinning
361 much of the evidence base in health.

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

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

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

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

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

383 Year 7 pupils expressed more anxiety relating to physical bullying, this may be
384 indicative of their transition to secondary school, the associated 'unfamiliar' surroundings,
385 and the realization of being the 'new kids on the block'. The prevalence of cyber-bullying
386 specifically is a contemporary phenomenon school practitioners accept reluctantly is out of

387 their control and therefore challenging to address and manage via the school context
388 (Kidscape, 2010). However, working with children to enhance social competences, resilience
389 and restraint skills would contribute to their capacity to deal with such scenarios.

390 **Maturation and Wellbeing**

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

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

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

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

412 early adulthood). The Search Institute talks about this in terms of positive identity, personal
413 power and a sense of purpose.

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

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

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

432 **Safety – Use of Space and Wellbeing**

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

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

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

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

456 This has led to young people and adults disconnecting with outdoor environments, the
457 impact of which is twofold. First, the benefits of outdoor activity which are documented
458 widely are negated. This means the benefits to mental health, which would serve to enhance
459 SWB are not harnessed (Barton & Pretty, 2010, Hine, Pretty, & Barton, 2009, Thompson,

460 2011). Second, longer term health benefits accrued by an engagement with open spaces are
461 lost (Brymer, Cuddihy, & Sharma-Brymer, 2010). If people are habitually connected to
462 outdoor environments from an early age it has been demonstrated that they are likely to feel
463 more empowered and safe and are less likely to have feelings of vulnerability (Thompson &
464 Thomas, 2004).

465 **Conclusion**

466 There is significant international interest in assessing a nation's wellbeing in terms
467 beyond economic wealth. Diener and Chan (2011) suggest there is 'compelling' evidence
468 that SWB can contribute to longevity in healthy populations. In an earlier paper Diener et al.
469 (2008) argued its role in enhancing social relationships, career success, health and citizenry.
470 It epitomizes the idea that health includes physical, psychosocial and cultural components
471 (Marks, Murray, Evans, & Vida Estacio 2011). The role for schools in promoting wellbeing
472 is born out of international agreement that more needs to be done to improve health outcomes
473 throughout the life course (Pickett & Wilkinson, 2009, OECD, 2009, UNICEF, 2011). The
474 argument for adopting an asset based approach is grounded in the suggestion that deficit
475 models have not delivered (Morgan & Ziglio, 2007); though this is contested (Birn, 2009,
476 Friedli, 2012).

477 The task at the local level is to translate concept of asset building into actions. For
478 example, within this study it has confirmed for health practitioners within the County
479 Borough the importance of fostering and formalizing work with children and young people to
480 promote subjective wellbeing, through extra curricula activities/programmes. This is
481 particularly salient for Year 6 and 7 pupils (i.e. transition initiatives) and for Year 11 (i.e.
482 future post compulsory education). The Borough and school might also work in conjunction
483 with local partners (e.g. parks, business, voluntary groups) to promote use of community
484 spaces. They would however need to attend to the concerns young people articulated

485 regarding safety (i.e. buddying schemes) in order to capitalize on the children’s interests.
486 This could increase the time spent by young people in their local environment and, more
487 widely, encourage the utilization of green spaces and other resources by the whole
488 community.

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

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

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

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

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

529 Future research in this area must include more studies that track adolescent wellbeing
530 over the duration of their school life. More participatory action research projects as reported
531 by Cook (2008) and greater use of creative and participatory techniques as advocated by
532 Crivello *et al.* (2009) would also further support health and schools practitioners understand,
533 evidence and promote adolescent wellbeing.

534

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

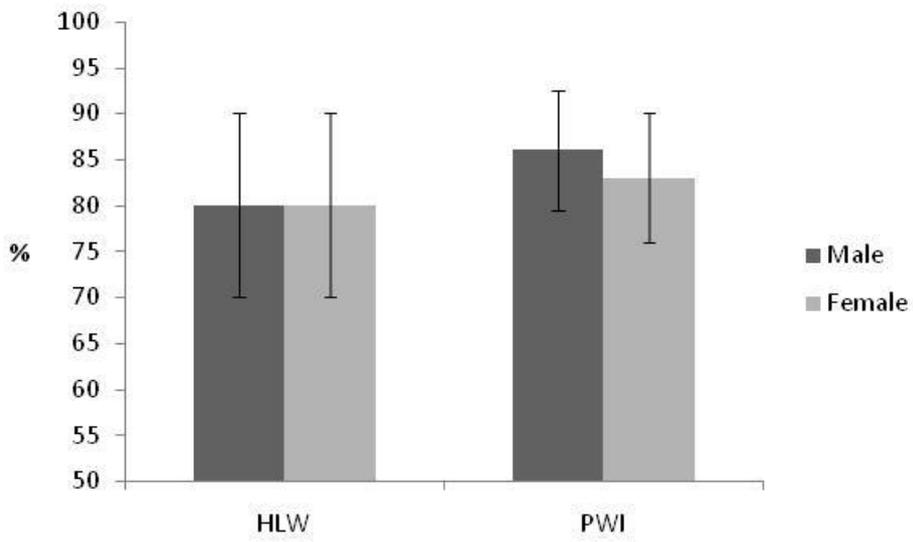
		Year 7	Year 8	Year 9	Year 10	Year 11
HLW (%)	Male	90 (20)	80 (20)	90 (10)	90 (30)	80 (20)
	Female	90 (20)	80 (20)	80 (10)	80 (20)	80 (30)
PWI (%)	Male	89 (15)	81 (16)	87 (11)	87 (11)	84 (14)
	Female	87 (14)	83 (13)	86 (14)	83 (13)	79 (16)

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

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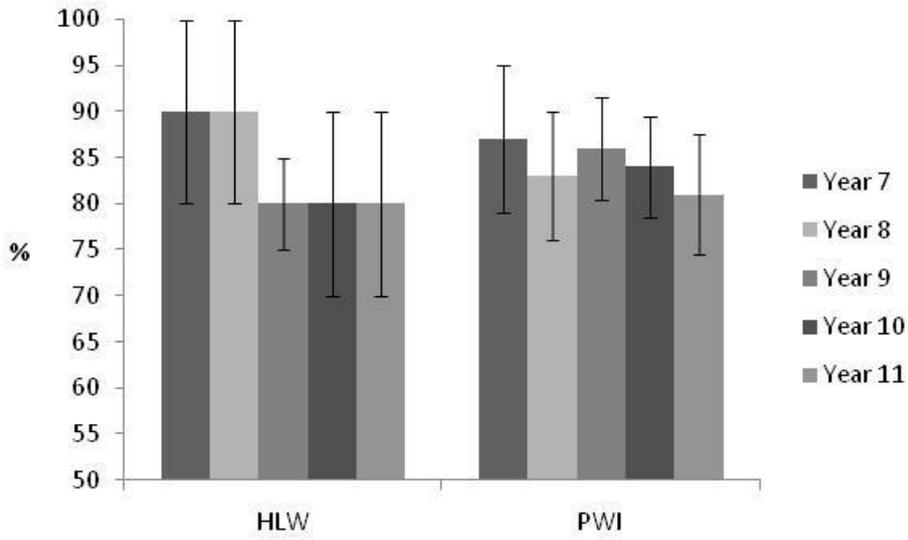
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738 Figure 2: HLW and PWI by year group. Bars are median values and error bars are IQR.

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742 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	

