The Berkshire health education project

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The HEC/LEA Project in Berkshire, 1984-86

We are pleased to have the privilege of publishing, in very abbreviated form, the final report of what has been described as 'one of the smallest projects ever funded by the HEC'. It may be modest in financial terms, but two specialist teachers working full-time in a group of secondary schools have succeeded in promoting large-scale curriculum review and development. Is there a case for similar initiatives elsewhere?

Most recent HEC projects have linked curriculum development to some form of in-service education. Individual teachers were encouraged to take project ideas and to develop them in their own schools, while critically examining their own roles in the school and the ways in which health education might be better developed alongside and within other curriculum areas. In developing health education to meet the needs of their pupils they are required to clarify their aims as members of staff, to be aware of all the resources available to them, and to identify their training needs. A daunting task for hard-worked teachers!

It was against this background that the HEC decided to set up a pilot scheme to promote curriculum development at local level. Since expenditure cuts had made it difficult for LEAs to appoint advisory teachers for health education, it was decided to fund the appointment of two project teachers, Laura Lindsay-Clift and Jenny Instone, who would spend two years working in secondary schools, offering advice and support, stimulating curriculum approaches, drawing attention to existing materials, and disseminating good practice.

A letter outlining the project from the Director of Education, Berkshire, was circulated to all secondary schools. As a result, five 'core' schools and seven 'associate' schools were selected. A review of the status of health education in the curriculum of each school was plotted on a grid, and these grids were used to identify gaps and overlaps in what was being provided.

Co-ordinating initiatives

One of the problems inherent in implementing new programmes of health education in secondary schools is that there is generally no existing management structure on which they may be based. The curriculum in most secondary schools may be described as 'collected' – that is, it is packaged and delivered to pupils as 'subjects' such as mathematics, history, biology, and so on. This subject structure is reflected in departmental structures: teachers' professional identities and careers are built round them. No such departmental structure exists for health education – it is cross-curricular. The implementation of new programmes thus has to be integrated into not one but many subject areas, and this integration requires co-ordination in the school.

Following the initial curriculum review, the project teachers worked on a one-to-one basis with teachers in their classrooms, promoting participatory, active, pupil-centred methods of learning. These methods are designed to develop decision-making skills based on currently-accepted knowledge about the consequences of health-behaviour choices. By building up self-esteem and confidence, these methods are also effective in enabling young people to deal with social pressures to behave in ways which they believe to be detrimental to their present and future health.

Support for the work in both core and associate schools was mobilised from a number of HEC national projects, for example the Smoking Education for Teenagers project, the Dental Health Study, the 12-19 project, and the Health Education for Slow Learners project. The project teachers also liaised and worked with a number of agencies in Berkshire to further develop health education and active learning methods in the county. These agencies included the Berkshire Pastoral Support Team, TRIST, curriculum guidelines working parties, the police, the county Road Safety officers, and the Educational Library Service.

Perhaps the best way of describing the impact of the introduction of these project workers will be to summarise the final account given by one of the core school co-ordinators. [Accounts from the other schools may be read in the project report – Ed.]

A project school's report

The initial information about the proposed Berkshire project arrived in May 1984 at a most opportune moment. The school was in the process of reviewing the curriculum, and there were at least three areas which contained elements of health education which we were currently developing: the revised tutorial work scheme, a newly-planned course in social education for all 4th and 5th-year pupils, and our sex education programme. The offer of 'more sustained support' in the form of project teachers with the brief to 'work in depth with existing schools to develop their health education programmes' was an exciting prospect. We were being offered time, ideas, resources, and an extra pair of hands!

Gaps in the system Consultations with the project workers established a priority; we needed a survey of what was being covered across the curriculum in health education. We had syllabuses for all subjects and we were aware that not all pupils were given the same opportunities: much depended on which teacher they had and which options they had chosen, and while some topics appeared on several syllabuses, others were not mentioned.

A large proportion of the staff went through interviews with the project workers, and we could then see the gaps in our existing programme. Often what we thought was being taught was not! The decision was taken to trial material in the following 4th and 5th-year health & social education topics: *Alcohol, road safety and traffic, family relationships, mental health and stress,* and *infectious diseases.*

A developing momentum By the beginning of the 1985 spring term our 'worker' had produced a document listing possible resources which could be trialled, and from that point the Head of RE & Social Education became the main contact for co-ordinating and trialling these materials, and the work developed a momentum of its own.

By this time the project worker had become very well known to staff through her enthusiasm, knowledge of resources (better than a computer!), and her obvious ability in the classroom during the process of trialling and evaluating lessons. Her work load increased considerably as more teachers went to her for help – the co-ordinator of the tutorial

work programme, her year co-ordinators and tutors, the science department, home economics, other members of the PSE team, and probably many others.

In the summer term I was out on a secondment, and another senior member of staff took over my role as 'co-ordinator behind the scenes'. She commented:

The project developed new material and made the school look at the type and quality of health education on offer to students... The curriculum has definitely been strengthened and widened by the inclusion of carefully prepared health education material. It has made us aware of deficiencies in our programme of social and personal development. The teachers piloting the work have become a team.

One difficulty was the lack of time for staff to meet and discuss with the project worker and with one another. This problem is, of course, a recurring one for any curriculum development initiative, and we were fortunate that our worker seemed to manage to fit her arrangements around us – if we gave her a time, she would be there!

The 'extra resource' Staff at the school have worked hard for a project they could see was going to lead to an improved curriculum for the pupils. All staff have paid tribute to the project worker for her efforts – "she worked so incredibly hard"; "you only have to mention something and she knows a resource – and produces it"; "she seems to know everything that's been published on health education"; "she's done all that photocopying for me"; "we could not have done this without her".

The second year is now over, and our project worker has left us. During the past year we have reviewed, reorganised, and selected the materials and units to be used. Our 'social education programme' is there for all to see and use in Years 4 and 5. We are already having to look at our timing, as we have so many important and well-planned resources, but the need for constant evaluation and re-assessment is a positive aim which the project worker has left with us.

The development of a sex education programme for all pupils in Years 1–6 is well under way. Material has been trialled in various departments, and we now have a working party which is finalising its report.

We have enjoyed the two years of the project – we feel privileged to have been one of the schools selected. We are sorry the project has ended, and would like to think that other schools could benefit from a similar joint venture in the future. Although we intend continuing the work we have started, it will be more difficult without that extra resource – the project worker.

Team building

It will be seen that the initiative in this school came from senior management level. One finding of the project was that *take-up of initiatives was patchy in schools where the initiatives came at classroom level rather than from higher up,* indicating that strong support from senior and middle management is required if a successful team is to be built.

In the special circumstances of the project, team building proved difficult anyway. Because of the Teachers' Action it was not possible to hold meetings outside school time to plan programmes, select materials, or evaluate what was already being done. However, in schools where pastoral care is organised by year groups, tutors of a particular year group usually function as a team led by the Year Head. If time is set aside for tutorial work, it will often be organised through this team structure. In some schools, short meetings for tutors have been arranged while the pupils are in assemblies taken by senior members of staff. Co-ordinators and project teachers used these times to monitor the progress of the tutorial work and to introduce new ideas and materials for trial.

Experience with group work

The content of personal, social, and health education programmes is often sensitive, and, as explained earlier, one of the aims of the project was to encourage teachers in the use of group participatory

methods. The size of classes needs to be small, ideally about 20 pupils. In order to achieve such grouping, the subject needs to be given timetable priority.

If such priority is not given, the result can be classes which are extremely difficult to handle. For example, one experienced teacher, generally enthusiastic about group work, found her 5th-year Lifeskills class particularly trying. This group consisted of five girls and 25 boys, and the majority of the latter had learning difficulties. Yet with smaller groups of 5th-year pupils of mixed ability in which the numbers of boys and girls were equal, she found that the Lifeskills materials were successful.

Nevertheless, even with support, many teachers were hesitant about undertaking group work, and one section of the report is devoted to some specific comments from teachers involved in tutorial work with 2nd-year pupils, from which the following are taken:

Comment 1 "The course seems to be going well, and the children are generally keen to participate. My only criticism is with regard to the timetable, which sometimes makes it difficult for the teacher to organise a reasonable discussion, as the children come back 'high' after the lunch break. Changing the lesson to between 8.50–9.15 would solve both problems."

Comment 2 "Generally speaking, one-third cannot be roused from disinterest, one-third are too lively and looking for a good time. The rest are quite willing to co-operate but are often drowned in the noise. From my own point of view, each episode is a small battle, far more exhausting than any of my normal lessons, where I try to organise some sort of order to achieve some form of valuable gain at the end. Time always seems to be short, too.

"Perhaps they would respond better to some form of games or points system, with the class divided into teams or houses."

Comment 3 "Pupils have generally worked well in groups or as individuals when writing, discussing, or drawing. However, I have found class discussions very difficult. The pupils were not prepared to listen to each other and the ones with the loud voices like to shout out, so that the quieter ones are left out. I have tried just having one person reporting back from each group, but still the others were often not prepared to listen.

"Some of the less successful topics were those which did not just involve answering questions, but required some imagination and ideas. Either the pupils had no ideas, or they became very silly and stupid."

Comment 4 "I have found social education quite hard going. I feel part of this is due to the way I started the course, maybe not giving the children the impression of the importance that it should have. I have found discussion-holding very difficult. Basically I think things would have gone better if some sort of introductory talk had been available, especially as this was a new thing to all of us. I have found most ideas quite interesting, although I never felt at the end of a session that it was particularly well rounded. Maybe this was due to my own lack of experience."

Comment 5 "I think social education has been badly timetabled, and would prefer to see it first thing in the morning. I should like to see a reduction in pieces of work that requires the movement of children around the room. This gives them too much scope to be noisy and in some cases lazy – allowing others to do the work for them.

"I am still not sure why this is a part of the school week. Does research show that we produce children who are better socially adapted than those who miss out on this opportunity during school?"

An 'agent of change'

The project was an 'agent of change' in the schools, and change was brought about by meeting the needs identified by the schools. The report summarises some of these:

1. *Curriculum time* Only one school has made a major change in the allocation of

curriculum time to allow for further development of health education. A management-led model was used. Another school made minor adjustments to the timetable and established 'protected' time for tutorial work within which health education has been developed.

2. *Curriculum content* There has been considerable change in the course content in each of the schools. Introduction and development of health education topics has taken place in traditional areas of the curriculum, particularly in science, home economics, parentcraft, religious knowledge, and 6th-form general studies. In three schools, social education common-core courses for 4th and 5th-years have been reorganised to include modules of health education.

In another school, a new common-core 4th and 5th-year PSE course has been planned, resourced, partly implemented and evaluated. The course comprises 10 modules, of which seven may be described as health education. These are personal relationships, contraception, lifestyles, health decisions, marriage, the family, and a caring community.

Health education has been introduced into existing programmes of tutorial time in one school. In three other schools, new tutorial programmes which contain a major health education component have been developed. Thus, in *all* project schools *all* pupils participate in a structured health education programme.

3. *Methodology* In health education, process is as important as giving information. The project teachers worked continuously in the classroom alongside teachers experimenting with active methods, not imposing new techniques, but encouraging their use.

An important area of development was the use of structured group discussion. The presence of a project teacher in the classroom to share the teaching facilitated the transition from 'teacher-led' activities to group activities. Role play seemed to be a threatening activity for many teachers. The project introduced simple role play, often in pairs, into health education programmes in each of the schools. Discussion with teachers afterwards indicated that they found role play to be a useful classroom experience.

4. *Attitudes towards health education.* In the early stages of the project, health education was seen by some teachers as prohibitive and restrictive ('thou shalt not'), and they looked to the project for free resources. As work progressed, however, an increasing number of teachers recognised that health education was concerned with promoting a positive healthy lifestyle and recognised the value of the project teachers' time as a resource. More teachers expressed a desire to be involved in the programmes, which were no longer seen as the preserve of the specialist teacher.

Perhaps the most important change in attitude has been the growing awareness that health education is the concern of teachers across the curriculum and the inter-departmental co-operation that has taken place in several schools.

5. *Pupil groups* Initially, some schools provided health education courses for selected groups of pupils (e.g. in minority 4th and 5th-year options, parentcraft, human biology, 'design for living' courses). At the end of the project, all pupils in the project schools had experienced a substantial health education programme.

6. *Resources* The appointment of co-ordinators in the schools led to a more effective use of existing resources. The project schools were prepared to allocate further cash to support the project, thereby extending the range of published resources. Co-operation with the Educational Library Service has provided a further wide range of published materials. The project also made extensive use of video recordings, and each school has extended its range of recorded schools' programmes. In addition they are aware of the wide range of videos available from a number of agencies.

Published resources do not always meet the needs of schools: selection and adaptation are necessary. A major part of the project has been involved with experimental work with teachers devising materials to suit their courses.

Other comments from the schools

1. All of the Heads agreed that the project had *raised the awareness of staff to the importance of health education for all pupils,* and that it had created a climate and a way of working in which change could be brought about.

2. *Time* was always a problem, both for staff contact and for the teams to develop an effective style of work.

3. All the co-ordinators agreed that a *key person* is essential to developing organised programmes of health education. In two of the schools, such appointments have already been made.

4. All the schools had established *important community links* as a result of the project.

5. Two of the core schools now have established *policies for health education,* and the other three are evolving them.

6. Co-ordinators would value the following:

   Meetings with other co-ordinators to *share experiences and ideas.*

   Release of co-ordinators to *work in new schools* as the project teachers did in theirs.

   Better opportunities to be informed about and preview *new resources and materials.*

   Continued support from *advisory staff.*

Recommendations from the project

Many of these recommendations, although specific to Berkshire, have implications for schools health education nationwide:

1. The project handbook should be printed and circulated, supported by some school-based in-service work.
2. A larger pastoral support team should be established, which is able to work with individual schools.
3. Active learning methods should be promoted.
4. Better preview facilities for new resources are needed.
5. Closer links should be formed between schools and local Health Education Units.
6. Develop work with existing county structures supporting health education (road safety, police, social services, etc.).
7. Encourage parental involvement and community projects.
8. Take advantage of new initiatives, such as TACADE *Skills for Adolescence,* HEC projects *16–19* and *Health education and lifeskills.*
9. Link health education with the work of the county Drug Co-ordinator.
10. Consider the appointment of an advisory teacher jointly funded by the LEA and the District Health Authority.