A new direction for health educators in schools and colleges

Gill Williams

Introducing the Professional Development of Teachers Diploma

Sit back, close your eyes, and imagine a course which . . .

- Offers a postgraduate professional qualification for teachers.
- Values and makes use of a range of past experiences, in and out of school.
- Encourages participants to negotiate content and assessment criteria.
- Involves the school or college in the development and progress of the teacher and, in turn, the professional development of colleagues.
- Responds to the needs of the workplace for support in the health education curriculum and in allied cross-curricular themes.
- Helps teachers to develop skills and competencies which will enable them to be an INSET resource, increasing their value to the school and enhancing their own career prospects.
- Ultimately enhances the development of the "healthy school" and the children who are its pupils.

No — not a dream, nor just wishful thinking, as about thirty teacher-students and their tutors do now. All these, and a range of other outcomes, characterise the intentions of a number of new, specialist Postgraduate Diploma courses which are either already in existence or are being developed in selected centres around the country. Such "aims and objectives" grew out of needs which were identified by teachers, Heads, and LEA Directors during the initial, research phase of the Professional Development of Teachers (PDT) Project; these needs were then used as guidelines in the second phase of the project, which developed a framework on which individual courses could be built.

Mismatch

The impetus for the project arose out of concern about the significant number of teachers who were applying for places on the Certificate in Health Education courses, validated by HED.

These courses, aimed at health professionals for whom health education is an important — though not necessarily major — part of their work, focus on the development of communication skills and elementary curriculum planning (for example the planning of content, method, and evaluation of health education with individuals or small groups of clients); health knowledge is taken for granted. For teachers on such courses, therefore, the work focuses on areas with which they are already familiar, and has little time to spend on the knowledge which they often need.

In those cases where teachers did attend Certificate courses this mismatch was clearly demonstrated, and though the teachers enjoyed (and gained considerable insights from) the opportunity to work with other professionals, the overall investment of their time could not be justified in terms of their own professional needs.

Worrying

When teachers were asked why they attended these courses, their answers indicated either that there were no other courses available or, where there was provision, it was not seen to meet their needs. Since there did appear to be numerous health education courses on offer, provided through a variety of sources, such criticism was worrying.

In an effort to find out whether there was a need for something more specifically for teachers, and to investigate the range of courses and their context already in existence, the Health Education Authority agreed to fund a two-year project to be known as the Professional Development of Teachers (PDT) Project. The intention was to find out if gaps existed and, if so, what and where they might be; in the second phase of the project an appropriate response to any identified needs would be developed.

Details of the research phase have already been published by the HED (1) and need not be repeated here. But except to illustrate the main issues which became the basis for planning.

- Teachers reported that courses often lacked a "school focus".
- It was difficult — given the range of topical areas which are encompassed by health education — to get any real sense of direction, or to develop confidence in facing the curriculum choices inherent in such a diffuse area.
- Teachers were unable to see many of the courses as parts of a coherent academic structure.
- Criteria for choosing to go on a particular course tended to be subjective and, in some cases, were reduced to straightforward convenience of location and timing.
- Provision of courses over the country was patchy — some areas had no provision whilst others appeared to have almost an embarrassment of riches.
- Some courses were award-bearing, whilst others merely rated attendance certificates.
- Once back in school, many teachers reported lack of opportunity to make use of new skills and knowledge — in some cases this amounted to positive discouragement — and a sense of isolation.

Beyond constraints

Equally valuable, in the planning phase, was our ability to work outside "institutional constraints". Normally, course planning in colleges and universities has to be carried out with regard not only to an appropriate theoretical base but also with an eye to facilities which are available, and to the limitations of staffing already in post. Thus, many courses have a bias which reflects the expertise available but which may only partially reflect students' needs.

In our case, although the planning phase was based in the Health Education Unit within the Education Faculty at King's College, London, we were not constrained by the particulars of the system of staffing or organisation therein. Because of HEA funding and the aims of the project, we had the rare opportunity to develop our response free from such problems; the challenge was to pro-
Five skill areas

Since the overall aim of the courses is that teachers, tutors, and lecturers who successfully complete the course will be able to initiate and enhance the professional development of colleagues in their own workplace and to act as in-service resources in Health Education and Health Promotion, all courses offer guidance and skill development in the following five areas:

1. Planning, monitoring, and assessment in curriculum development.
2. The organisation of school-based resources (including human resources and cross-curricular co-ordination).
3. Skills to support PSHE initiatives, including curriculum selection and delivery, assessment, record keeping, and profiling.
4. Inter-professional co-operation, the use of community-based agencies, the development of ‘Health Alliances’.
5. Leadership in INSET and the development of the Health Promoting School/Institution.

In order to achieve all this, the courses are organised in four linked sections, which can be described as ‘preparation’, ‘development’, ‘investigation’ and the final ‘application’.

Preparation

In the preparatory stage, interviewing and selection are accompanied by the negotiation of agreements. These are concerned with ensuring that the school (or other employer) understands the nature of the commitment and is prepared to support the ‘student’. Work during the course depends on such support, and it would not be possible for the student to complete the course successfully without it.

A second set of agreements is negotiated between student and tutor, and is concerned with selecting appropriate out-of-school experience which will serve as an integral part of other professionals concerned with health. In some cases teachers have spent time with Health Promotion Officers or Environmental Health Officers, but the choice is wide and the selection depends on students’ needs and experience.

Development

The second section of the course is concerned with theory and planning, and focuses on the skills, competencies, and knowledge which are needed by health educators if they are to lead in-service training with colleagues in the workplace. The content will again depend on a negotiated agreement reflecting students’ needs and experience. The use of knowledge and skills within the group is supplemented, where necessary, by support from the tutors and others with relevant expertise.

Investigation

During this time, there will normally be work-based practice. This can take many forms, but since it will be used to provide a basis for the final assessment phase it is likely to investigate the needs of the school and staff. On previous courses students have undertaken a range of activities, from questionnaires to staff about present and future involvement in health education to whole-school audits of the present health education curriculum (i.e. where, what, and how much health education is taking place).

Application

The final assessment takes place in the school, since this is the appropriate place to judge the success or failure of a course which aims to help the teacher to become an effective and valued INSET resource. A programme to enhance some aspect of the health education abilities of colleagues is planned in the light of the previous study, and of negotiations with the head, or designated member of the management team, who will also write a report on the activities. Students and managers are encouraged to discuss both content and methods with tutors, as well as which assessment criteria will best serve the aims of the programme. A final, reflective report, which also includes future plans for continuing development within the school, is submitted by the student.

Course structure

Around such a framework colleagues develop their own organisation; some courses are offered on a modular basis, some are as an integrated course. Attendance may be the traditional evening pattern, but can be long days plus distance learning or even weekends only, depending on the negotiations between students and tutors. All the four validated courses have direct links to Masters programmes for those who wish to go along that path and whose results meet the entry criteria. In a number of cases the PTT Diploma needs only the addition of a dissertation to achieve the Masters award; in others...

John Balding & Carolyn Shelley

A health-related peep at 7,852 very young people

The Health Related Behaviour survey method, which has been in use in secondary schools and is now in its 16th version, began life in the Department of Community Health, Nottingham University, in 1975. It has been in ever-increasing use as a method of gathering baseline data (a) for healthcare planning by DHAs, and (b) for curriculum review in schools since that time. In 1994 alone it will be completed by over 80,000 young people from 300 schools, representing 47 DHAs from around the UK.

The method evolved in 24 schools, and from the outset primary school heads were putting pressure on us to provide a complementary method for use by them. Currently we are using Version 16 (secondary), which complements the Version 16 (secondary) in use through secondary schools. The primary version is becoming more and more widely used. It is quite common now for the survey in the secondary school to be carried out at the same time as the complementary survey is carried out in its feeder primary schools. The opportunity to bring staff together and link programmes is enhanced through the collection of relevant, and very interesting, lifestyle data.

The maturation process that can be discovered across this break in the schools is very illuminating. In general the reported behaviour, attitudes and aspirations by the older, more experienced secondary-school pupils fit nicely in step with those recorded by the younger primary children.

The results from the secondary Health Related Behaviour surveys have been published in regular annual reports, under the title Young People in... since 1986. We have been aware of the widespread interest in the primary results, and were determined to publish a similar report as soon as we had enough data available. The result is Very Young People in 1991–2, and this article looks at some sample tables from this report, which is in course of publication.

It will be noted that over half of the 7,852 pupils surveyed were in Year 6, with progressively fewer in the younger year-groups. Where there is overlap with the questions in the secondary questionnaire we have included the Year 7 data from our 1992 databank to show how behaviour compares across the primary-secondary divide.