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The health promoting school: moving  
theory into practice : a case study

Philip Pearson  
University of Wollongong

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University of Wollongong



Faculty of Education

# **THE HEALTH PROMOTING SCHOOL: MOVING THEORY INTO PRACTICE**

## **A CASE STUDY**

**A dissertation submitted in partial fulfilment of the requirements  
for the degree of Doctor of Education**

**Philip Pearson**

**1998**

## ABSTRACT

Pearson, P. *The Health Promoting School: Moving Theory into Practice. A case study*. Doctor of Education dissertation, University of Wollongong, 1998.

Pentecost College, a Catholic coeducational secondary school was a pilot for the Health Promoting Schools (HPS) project. This was an initiative of the Department of Health, Department of School Education, Catholic Education Commission and the Association of Independent Schools in NSW. This research provides a case study of a school involved in trialing the *Towards a Health Promoting School* (Dept. of Health et al, 1996) document which provides guidelines in policy development and implementation for individual schools. The relationship between policy theory and practice was examined to determine barriers to successful health promotion initiatives and discover ways to make health promotion in schools more effective. A variety of qualitative and quantitative techniques were employed to document the initiatives as to what worked, what did not and why.

Extensive awareness raising of the HPS concept and school community health needs analyses were conducted at the college as part of the HPS process. A HPS committee was established which prioritised health promotion programs to be implemented at the college. These programs were designed to: enhance the physical environment; develop sun protective behaviours; increase physical activity and introduce a 25-hour personal development and health course for senior students. Initiatives were planned and implemented across the three areas of the HPS framework: curriculum, school ethos/environment and the school-home-community interface.

Major problems occurred in practice at Pentecost College with the policy process associated with funding, resources, time and support. The difficulty of involving parents in the secondary school, the risk-taking nature and belief systems of adolescents and competing commitments to priorities added to the problems for providing effective school health promotion initiatives. Whilst the HPS concept is high on the health sector's list of priorities, it appears that it does not receive reciprocal priority from the education sector. Policy support from the education sector at state and local levels needs to occur for the HPS concept to be successful in NSW secondary schools. The HPS project is in danger of faltering through poor interest, lack of enthusiasm and shifting priorities if further support for teachers in schools is not forthcoming.

### **Declaration**

*This thesis is my own work and has not been submitted for a degree to any other university or institution.*

Signed: \_\_\_\_\_

Date: 11/3/99

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I wish to thank all staff in the Faculty of Education at the University of Wollongong that have enhanced my education and assisted me to complete this study. Sincere thanks to Dr Jan Wright for her unequivocal support and direction throughout this study and to Professor John Patterson for his continual guidance.

To the students, staff and parents of the school where the research was based, my gratitude for your contributions. Thanks also to the Health Promoting Schools coordinators and project officers from the Illawarra Area Health Service whose enthusiasm and commitment to the HPS project has benefited all at the school.

Finally, I wish to express my appreciation to my family: my wife, Denise and children, Brendan and Jade, for their patience, understanding and support throughout the entirety of this research.

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# CHAPTER 1

## INTRODUCTION

### Background and context to the inquiry

This study examines the health promoting schools (HPS) policy implementation in a NSW secondary school. It provides a case study detailing the processes and outcomes of a school that has been involved in a HPS project which incorporated trialing the *Towards a Health Promoting School* (NSW Department of Health, Department of School Education, Catholic Education Commission & the Association of Independent Schools, 1995) draft document .

The health promoting school concept has been adopted by the NSW Government in response to a national and global health promotion strategy. The international goal of *Health for All by the Year 2000* (WHO, 1981) resulted in the Australian Government adopting numerous public health policies common to global initiatives. Many of these policies focused on health promotion, one of them being the development of health promoting schools. The World Health Organisation (WHO) has been instrumental in developing global initiatives in health promotion. Countries such as Australia have developed these initiatives into national health policies and guidelines to enable the implementation of health promotion programs. These have been developed to provide specific health promotion strategies that endeavour to cater for the community's health needs in various settings at the local level, such as schools. A key theme of health promotion is to provide for local and community needs. The Ottawa Charter (WHO, 1986) developed guidelines for health promotion which included specific principles for developing health promoting schools. The HPS concept is based on a holistic view of health which recognises the physical, social and emotional dimensions of health. The NSW Government has made a commitment to this national and international goal by launching *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996).

The health promoting school concept is by no means a new idea. Historically, cooperative planning among school and community leaders was deemed essential to the promotion of an effective school health education program. The 'comprehensive school health education' model (Johns, 1973; Killip, Lovick, Goldman & Allensworth, 1987; Stone, 1990) has been circulating for decades. Collaboration between school and community has recently been rediscovered as a fresh and promising way to improve school programs. Various developments in recent years have resulted in this rethinking.

One of the main developments has been the focus of health promotion on school programs as a means to achieve 'health for all'. The report, *Looking forward to better health* (Better Health Commission, 1986) states:

... given our changing and complex communities, the commission concludes that one of the most responsive and lasting ways to achieve good health is education for the young. Family learning and the mass media are much more uncertain than schooling. The commission takes very seriously the role that schools should play in promoting better health, a role which most education systems are not fulfilling. Many health objectives can be influenced directly by what does or does not occur in schools and by whether the approach is education or preventive ... (p.302).

Research (Smith, Roberts, Nutbeam & MacDonald, 1992) has shown that many adult health problems have their origins in childhood and adolescence. Health promotion programs directed at young people have therefore been seen as a possible way of reducing the incidence of risk factors for disease and of fostering positive attitudes, skills and behaviours for health. Schools offer the most systemic and efficient means available to improve the health of young people thereby enabling students through the development of knowledge and skills to avoid health risks (McGinnis & DeGraw, 1991). However, many schools have other educational priorities that have consumed the time and energies of key personnel who may have been committed to initiating a health promoting policy. As a result, if health promoting programs are to be successful, school communities must build partnerships with the school governing bodies and other relevant agencies such as the appropriate area health services, to support and maintain health promoting initiatives. Much planning by health and

education sectors still needs to be conducted if schools are to realise their health promotion potential.

School health no longer can be seen as an add-on but an integral part of the education program

(McGinnis & DeGraw, 1991, p.296).

Historically, the HPS movement began at the national level in 1991 with the formation of the 'Network for Healthy School Communities' with funding provided from 'The National Health Promotion' program. This network was formed to support schools in their endeavours to become what was termed a 'health promoting school'. This led to the formation of 'The National Council of the Australian Association of Healthy School Communities' which disseminated information with regards to 'best practices' required for improved health promotion to groups in both the education and health communities. More recently (1994), this association decided their title should be 'The Australian Health Promoting Schools Association', to firmly fix the association between schools and health within the global health promotion goals. The widespread recognition amongst educators of the health promoting schools concept in NSW has been supported by the following developments:

- \* the establishment of state associations in addition to the national association in Health Promoting Schools;
- \* the establishment of the National Centre for Health Promotion (Sydney University);
- \* the implementation of the mandatory Key Learning Area of Personal Development, Health and Physical Education (PDHPE) in NSW;
- \* the development of a National Health and Physical Education Learning Area focusing on student learning outcomes;
- \* the release of the *National Health, Goals and Targets* document (Nutbeam, Wise, Bauman, Harris & Leeder, 1993);
- \* adoption of 'Better Health Outcomes for Australians' report (Commonwealth Department of Human Services and Health, 1994a);
- \* National and State Health Promoting Schools Conferences (1995-1997); and
- \* the development of *Towards a Health Promoting School* document (1996) - a joint project of the NSW Department of Health, Department of School Education, Catholic Education Commission and the Association of Independent Schools.

Nutbeam et al (1993) in the *National Health Goals and Targets* document revised and refined the targets set in the *Health for All Australians* report (1988). This report recognised the need for a stronger intersectoral approach to health issues and clearly identified schools as places in which young people’s health can be promoted (Wass, 1995). In the PDHPE syllabus developed by the NSW Board of Studies (1991), emphasis was placed on promoting the health of students through school curricula, the school ethos and the school-home-community partnership. This framework can be represented by the following diagram (figure 1):

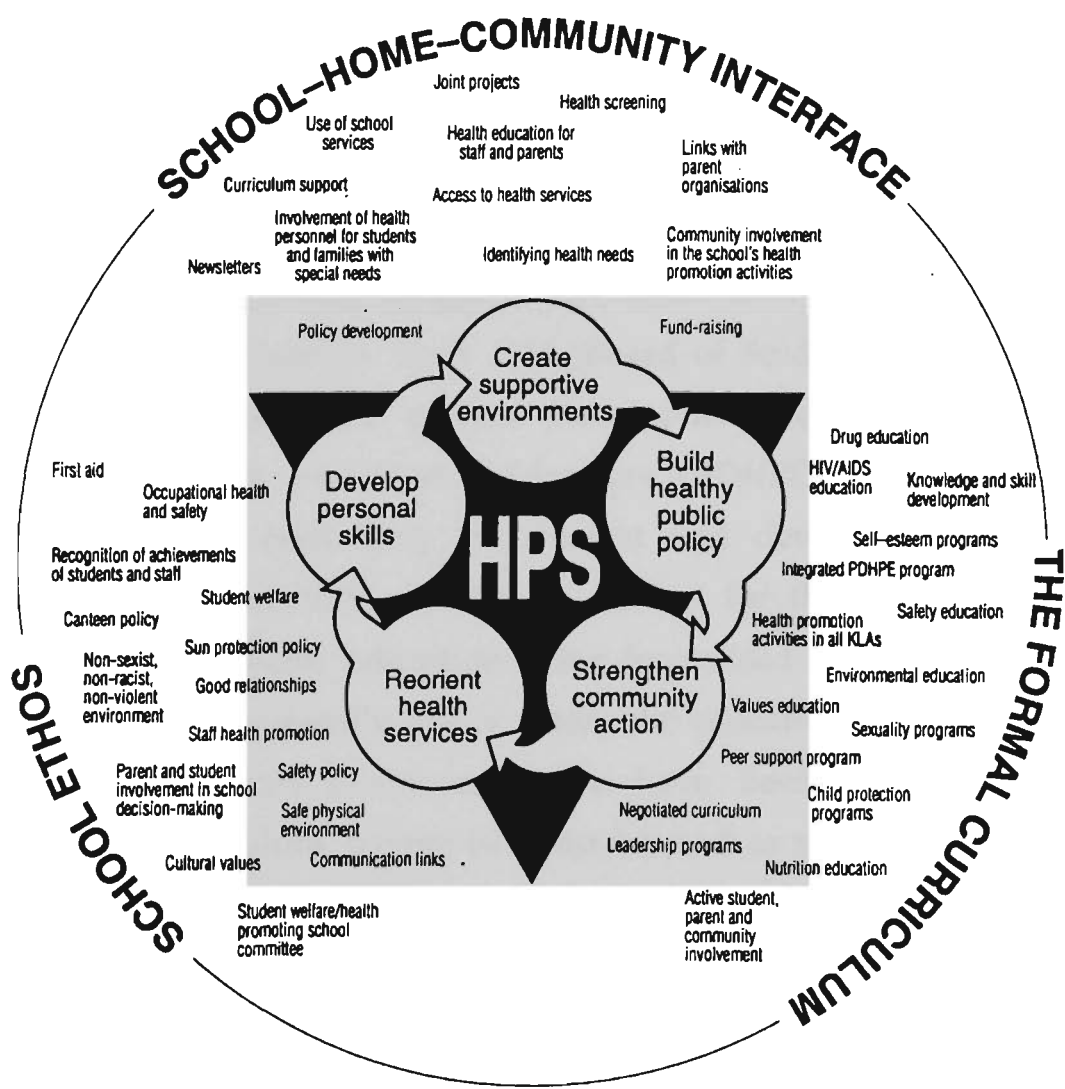


Figure 1. The Health Promoting School (NSW Department of Health et al, 1996, p.5).

The HPS concept is based on programs of health promotion occurring not only through the formal curriculum but in the school environment, the interface between school and community, and links with health and

welfare services. The health promoting schools concept which addresses these components is currently encouraged by the Board of Studies (BOS) for all NSW schools to adopt.

Since the early 1980s there has been unprecedented attention given to school health education and a dramatic increase in public concern about the health and education of the nation's young people. Consequently, programs in health and education such as the Life Education Unit, Pastoral Care and Welfare initiatives have expanded dramatically in nature and scope. In most Australian states, a more direct and formal approach to school health education has been one outcome.

Since 1992, mandatory hours for health education have become part of the curriculum in NSW schools. Such programs organised through the school curriculum are more likely to positively influence the health behaviour and lifestyles of students (Nutbeam, 1996). The development and implementation of the compulsory *Personal Development, Health and Physical Education Syllabus Years 7-10* (Board of Studies, 1991) into NSW secondary schools and the current development of the *K-6 Personal Development, Health and Physical Education (PDHPE)* syllabus has been a further catalyst for rekindling the interest and development of health promoting schools in NSW. A key ingredient for the health promoting schools concept is health education being formalised as part of the school curriculum and consequently this is where the concentrated efforts of those involved in secondary health education have been in previous years. Health in the curriculum, having been established to some degree in NSW, has resulted in further efforts by this group of health educators and those involved in health promotion to focus on the other components of school health promotion. The implementation of similar Health and Physical Education syllabi in other Australian states has set the platform for nation wide health promotion in schools.

However, there needs to be more than just a formal PDHPE curriculum in a school to make it 'health promoting'. The recognition of the 'hidden curriculum' in the school and the influence of the family and community are viewed as important elements in promoting health. An

obvious example of this 'hidden curriculum' operating in school is the issue where lessons taught in the classroom about smoking or nutrition can be undermined by the modelling of a teacher smoking or by school canteen food that does not conform to the principles of a healthy diet. These are insidiously contradictory to the concept of health promotion. The formal PDHPE curriculum must therefore be supported by what is witnessed in the school environment. This 'hidden' or rather 'parallel' curriculum of school organisation, policies, social and physical environments must reflect what students learn in PDHPE lessons. These health promoting practices then need to be extended further so reinforcement of these principles takes place in the home and community. Hurrelmann, Leppin and Nordlohne (1995) point out that a health promoting school should 'not only addresses children's and adolescents' cognitive development, but also consider the entire personal, emotional, social and ecological experience of the child' (p.121). Outside the immediate school environment there is the potential for involving parents in providing overt reinforcement of school health education and of integrating school activity with wider community programs:

These three elements of the school curriculum, the school environment (hidden curriculum) and the school interaction with home and the wider community (school outreach) have provided the basis for the health promoting school  
(Nutbeam, 1992, p.152).

In addition to the important interface between school and the home, the health promoting school framework provides a link between health and education through its focus on health promotion in school communities (NSW Department of Health et al, 1995).

Central to this notion is the close relationship between management, organisation and curriculum in schools, and the recognition of the school as a commodity within the context of the broader community. A healthy school community makes important connections between curriculum and ethos of school settings. These things which constitute health, be it at an individual or organisational level emerge from a wide range of interrelated issues  
(Ackermann, 1992, p.1).

According to McBride, Midford and James (1995), schools are an ideal setting for health promotion as they are able to provide a systematic and cost-effective way to reach a large section of the population. Schools can play a particularly important role in promoting healthy lifestyle practices



during these formative development stages of their students. The goals of the health promoting school as provided by NSW Department of Health et al (1995, p.5) are to:

- \* improve the health status of students;
- \* provide teaching and learning opportunities for all students to develop health skills and knowledge to equip them for life;
- \* provide safe school environments for teachers, students, parents and community members;
- \* create a health supporting school environment for children and families;
- \* increase the proportion of parents, care-givers and community members involved in a health school policy development and implementation.

Colquhoun (1996b) highlights the fact that schools have enormous potential to be used to promote health via HPS policy. However, he also adds that the diverse nature of schools and the attempt to address all the goals of health promotion policy often results in health promotion being spread across too broad a range of projects rendering it ineffective. It is important then for schools to analyse and prioritise their own specific needs to render programs that target and satisfy the whole school community.

### **Purpose of the inquiry**

The Health Promoting Schools (HPS) project, an initiative of NSW Department of Health, Department of School Education, Association of Independent Schools and the Catholic Education Commission, is one strategy adopted to bring the government's health promotion policies to fruition. Pentecost College, a coeducational secondary school was one of five secondary pilot schools involved in the HPS project. The literature relating to HPS predominantly focuses on the ideal description of what a health promoting school should be rather than investigations of actual practice. This study addresses the absence of such work through an investigation of the implementation of policy in one school from the point of view of a teacher involved with the health promotion initiatives. It examines how Pentecost College came to be involved in the HPS project and documents the procedures of policy development and implementation

of initiatives that occurred to promote health in the school community. The health promotion initiatives are evaluated in terms of how effective they have been for the school community. One of the main purposes of this study has been to assist the planning and process of implementing further health promotion initiatives within the school. In addition, the policy process of implementation from the global health promotion strategy, through national and state departments to local school policy development, is analysed as a critical factor towards achieving effective health promotion.

Initiatives have been and are being conducted in schools in relation to health promotion but have been fragmented for some time. Nutbeam (1992) highlights just how broad the gap is between the concept of the health promoting school and current practices in many schools. He concludes that the translation of the health promotion concept to the school environment is not one that is easily achieved. For this study then, it was paramount that a well developed health promoting school policy for Pentecost College be established to maintain the focus of the project. Such a policy was aimed to facilitate a structural framework that would enhance health, promote a healthy environment and encourage healthy lifestyles for all those associated within the school community. This process of developing a specific policy for Pentecost College identified priorities appropriate for the health promoting schools project. Once the priorities were established, collective working by interested members of the school community on the school's health initiatives incorporated those energies and resources that were deemed important to promote health in the school. The initial efforts in this research were to formally establish the school's priorities as a fundamental step in developing a health promoting school program.

Assessment of needs provides objective data to define important health problems, set priorities for program implementation, and establish a baseline for evaluating program impact. Likewise, assessment provides an opportunity for early involvement of community leaders in planning, evaluation, and determining priorities, which helps develop a sense of program ownership (Grunbaum, Gingiss, Orpinas, Batey & Parcel, 1995 p.54).

Reflecting on these theoretical considerations and practical implications, the following research statement and questions were formed to be the focus of research and an action plan at Pentecost College.

## Research Questions

### Research Statement:

An investigation of the process and outcomes of a secondary school's involvement in a health promoting schools project in the context of the school and the wider community.

### Research Questions:

- \* What health promotion initiatives have been implemented at Pentecost College?
- \* How was health promotion policy developed at the school?
- \* Which personnel were involved in policy development and implementation of health promotion initiatives?
- \* How were these initiatives implemented and what factors facilitated and/or constrained their implementation?
- \* How effective have these health promotion initiatives been on the school community?
- \* What are the school community members of students, staff and parents responses to health promotion initiatives in the school?
- \* What professional development and training were involved in the health promoting schools project?
- \* What makes health promotion initiatives successful or unsuccessful in a school?
- \* How can the school maintain and promote health status and awareness in the school context?
- \* What are the major barriers that health promotion faces within the school environment?
- \* What are the influences of local, community and societal factors on school health promotion?
- \* How does the health promoting school's project reflect wider community health promotion policy?
- \* What are the advantages and disadvantages that emerge from becoming a 'Health Promoting School'? What impact has the development and implementation of health promotion policy had on the school community?

## Significance of the study

In practice, there appears to be many barriers that exist when attempting to put the suggested health promoting schools framework and policy into practice. This research examines the processes involved in becoming a health promoting school, highlighting such barriers whilst attempting to find ways to overcome these obstacles. It examines the implementation of HPS policy at the local school drawing on theory surrounding policy development and implementation.

This study endeavours to document the factors that enhance or detract from effective health promotion in schools through a close and detailed observation of one particular school. Underpinning the decision to introduce HPS policy was the assumption that there were health benefits to the school community of becoming a health promoting school. Studies (Ackermann, 1992; Hurrelmann et al, 1995; Jackson, 1994) have already shown that if a school combines health in the formal curriculum, with improving school environment and developing the school-home-community interface, then the school community members will become healthier.

Major research efforts (Lalonde, 1974; Naidoo & Wills, 1994; WHO, 1996) have demonstrated that health promotion is viable and that risk factors can be altered such that individual health is increased. Research on comprehensive school health programs in the United States and Europe have shown to be effective in terms of health promotion than health education alone. Baseline data on the health of children are available, but there is still little available information on the nature and quality of health promotion programs in the environment of schools (O'Connor & Parker, 1995). The intention of this study therefore, was not to look at specific health outcomes, but to document the HPS policy process. It is the *process* of providing health promotion opportunities that is the issue of this research. This study follows this process at the local level and determines the factors which work for and against the implementation of a HPS policy.

Since its inception in 1983, Pentecost College has been implementing a number of health promotion initiatives and activities. However, it was only as recently as 1995 that a coordinated approach to become a 'health promoting school' was instigated by the PDHPE staff with the Area Health Service personnel, as part of the HPS project. Pentecost College was selected as a pilot school in 1995 to initiate the health promoting schools project. Initially, a Health Promoting School Committee was formed which included the principal, two deputy principals, guidance coordinator, PDHPE coordinator and five other interested staff members. Later the committee expanded to include interested parents and a group of students ranging from Years 7 to 12. The Promotions Officer for the Health Promoting Schools Project in the region was instrumental in assisting in the initial stages of determining the health issues that were a priority to the college. The focus was on assessing current programs, the direction in which to pursue these needs, how to promote the committee and possible ways to interest staff, students and parents so that they were willing participants and enjoyed their involvement on a community level.

Part of the process of becoming a health promoting school was to assess what the school had already been contributing towards promoting health. After assessment by members of the HPS committee and the project coordinator as to what Pentecost College had been doing in recent years, it was realised that the college had many traits of a health promoting school. Although a number of health initiatives had been implemented, it had been without coordination and leadership. Hence, the process and acceptance of health issues amongst staff and students had not been maximised.

The study is not only of immense importance to the Pentecost College community; the processes and associated problems which emerged will assist personnel from other schools to implement more effective health promotion initiatives. This study should also be of interest to any organisation involved in health promotion in schools or to those who have a general interest in developing and maintaining optimal opportunities for health.

## Structure of the thesis

This thesis is based on my documentation, as PDHPE coordinator and chief investigator, of Pentecost College's involvement in the HPS project. Chapter Two provides a review of literature which places the health promoting schools concept into a historical and policy context. The HPS project itself is discussed as a specific policy developed from national and international health policy. Health promotion theory is presented in terms of 'ideal' models and the development of *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) on which the HPS project is based, is examined.

Chapter Three explains the methodology of the case study, detailing the site and participants involved, including issues involved with participant research. Data collection and analysis procedures are discussed in terms of relevance to this particular study. The benefits of using a case study to research the phenomenon of health promotion in schools is explored.

Chapters Four, Five, Six and Seven follow the systematic processes involved in becoming a health promoting school as outlined in *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996). Chapter Four, entitled 'Awareness Raising', includes the processes involved in establishing a HPS committee; introducing the school community to the concept of a health promoting school; a review of the situation prior to the HPS project; and results from health needs assessments conducted with students, staff and parents of the college. Chapter Five examines the progression from the first stage of awareness raising to the planning process including how available resources were identified; how priority areas were determined; and the process of developing an action plan to achieve the goals and desired outcomes planned by the HPS committee. Chapter Six reports on how the health promoting plans were implemented at the college and the emerging issues that resulted from these initiatives. The focus of these programs was designed to enhance the physical environment, to develop sun protective behaviours, to increase physical activity and the

introduction of a senior personal development and health course. Chapter Seven provides an evaluation of these initiatives, determining the success of the programs and practices implemented. An examination of the processes underlying the theoretical and political framework of the HPS project is also undertaken.

Chapter Eight continues to provide a discussion of the overall case study of the HPS project conducted over the initial two and a half years at Pentecost College. It highlights the differences between the theory of health promotion and health promotion in practice in the school community. This chapter also explores some recommendations to improve health promotion in schools and provides concluding comments on the case study in relation to the future of the HPS concept.

## Definition of terms

AHPSA: Acronym for the Australian Health Promoting Schools Association (1994), a support network for schools in their endeavours to become a health promoting school.

CAHPS: Acronym for a Curriculum Approach to Health Promotion in Schools, a South Australian HPS project.

Health Promotion:

‘The process of enabling individuals to increase control over and to improve their health’ (Ottawa Charter, WHO, 1986).

Health Promoting School (HPS):

‘Health promoting schools are schools which display, in everything they say and do, support for and commitment to enhancing the emotional, social and moral well-being of all the members of their school community’ (NSW Board of Studies, 1991a, p.3).

Health Promoting Schools Project Officer (HPSPO):

Liaison person between Pentecost College and the local area health service.

HIPS: Acronym for Health in Primary Schools, a Victorian health promoting schools project.

NBHP: Acronym for National Better Health Program, established in 1988 by the Australian Federal Government.

NHMRC: Acronym for National Health and Medical Research Council.

NUDIST: Acronym for Non-numerical Unstructured Data Indexing Searching and Theorising. It is a computer package described to aid users in handling non-numerical and unstructured data in qualitative research.

Ottawa Charter:

A document for action to achieve ‘Health for All’ by the Year 2000 and beyond. Developed at the first International Conference on Health Promotion, 1986.



PDHPE: Acronym for Personal Development, Health and Physical Education, one of eight mandatory Key Learning Areas for NSW secondary schools.

PRECEDE-PROCEED:

A theoretical model of health promotion developed by Green et al (1991) consisting of a needs assessment phase called PRECEDE (Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis and Evaluation) and a developmental stage called PROCEED (Policy, Regulatory and Organisational Constructs in Educational and Environmental Development).

School-home-community interface:

Developed collaborative partnerships between the school, home and the community.

SPSS: Acronym for Statistical Program for Social Sciences used for analysing quantitative data.

TAHPS (1995):

Acronym for *Towards a Health Promoting School* draft document (NSW Dept. of Health et al, 1995) that was initially utilised by Pentecost College as a pilot school for the health promoting schools initiative.

TAHPS (1996):

Acronym for *Towards a Health Promoting School* final document (NSW Dept. of Health et al, 1996) that was distributed to all NSW schools in September, 1996.

TER: Acronym for Tertiary Education Rank derived from NSW Higher School Certificate results determining student places for University courses.

WASH: Acronym for Western Australian School Health program.

WHO: Acronym for World Health Organisation - specialised agency of the United Nations with primary responsibility for international health matters and public health. Coordinates the global endeavour to promote health.

## CHAPTER 2

### REVIEW OF RELATED LITERATURE

This thesis is concerned with the implementation of a policy, namely the NSW Department of Health's health promoting schools policy (1996), which has been developed from global and national health promotion and education policies. As pointed out in the literature, policy implementation is rarely smooth. Policy in practice reshapes original intentions of policy in theory to meet the needs and vicissitudes of particular contexts. This literature review explores:

- \* the development of health education in schools from a curriculum based emphasis to a more comprehensive health promotion approach;
- \* the broader concept of health promotion, placing the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) into a policy context;
- \* the new global public health movement which has led to significant developments in health promotion in Australia;
- \* health promotion policy development and implementation theory, in order to link this with what actually occurs in practice; and
- \* reasons for the differences between health promotion theory and practice in schools.

#### **Health education to health promotion in schools**

Schools have been identified by the World Health Organisation (1996) and the *National Goals and Targets* document (Nutbeam et al, 1993) as a priority for contributing to the creation of healthy environments. However, there has been a growing recognition over the last decade that health education alone is unlikely to have significant impact on health behaviour (Nutbeam, 1992). Health education in schools has been around for decades. It endeavours to provide a variety of learning experiences that favourably influence the health behaviour of students by assisting them to develop sound knowledge and positive attitudes about their own personal health. Health education has slowly developed from the 'traditional' model of classroom-based interventions to include the totality of health promotion which involves changes to the entire organisational structure of the school.

Such a development has given rise to the notion and entity of the Health Promoting School (HPS).

The evolving health promoting schools concept provided the framework for health and education to work together. This was in part, influenced by WHO (1996) evidence which indicated that schools could actively promote the health of students while at the same time not lose sight of their educational objectives. There was also the recognition that schools may not be able to do it all on their own and links with health services were recommended.

Current literature indicates that schools which adopt comprehensive health promotion programs integrating the three areas of curriculum, environment and health sector partnerships are more effective in encouraging students to adopt health-enhancing behaviours than schools which provide health education alone (McBride et al, 1995). Within the core business of schooling, the two main entry points for the health sector are in the PDHPE curriculum and the school management policy and practices (Kay & Robinson, 1995).

The development of the health promoting school concept and indeed, *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996), has been strongly influenced by the five principles of the Ottawa Charter applied to the school setting:

1. *Health Promoting Policy* by developing coherent curricula in education for health which bring biological, ecological and social dimensions to a process of environmental health;
2. *Creating Supportive Environments* by utilising the setting of the school to encourage reciprocal support between teachers, pupils and parents;
3. *Strengthening Community Action* by drawing on existing human and material resources in the community in which the school is set and involving that community in practical aspects of the decisions, plans actions pertaining to the project;
4. *Developing Personal Skills* by providing information, education for health and opportunities to enhance life skills in the setting of the school community;
5. *Re-orienting Health Services* by involving the school health service in project activities aimed at the promotion of health by utilising the skills of school health professionals on a broader basis than the traditional roles.

WHO (1991).

These five areas of action have become the foundation for the health promoting schools model developed by NSW Department of Health, et al (1996, see figure 1 on p.4). The concept of a health promoting school is broad and builds upon existing practices. For instance, the concept recognises the importance of having health education programs such as PDHPE within the school curriculum, the influence school policies can have on the school community and the role that parents and other members of the community can have on health. The concept of HPS takes schools beyond earlier views of students as captive audiences for simple advice on health behaviours (Kay & Robinson, 1995; Nutbeam, 1996). The health promoting school in theory addresses the issue of individual behaviour change not only through the school curriculum, but via the school environment, the interface between school and community, and links with health and welfare services. The report of the National Health and Medical Research Council (NHMRC), Health Advancement Standing Committee's Health Promoting Schools' Working Party titled *Health Promoting Schools* (1996) concludes that the available evidence suggests that school health programs which are comprehensive beyond the curriculum and the classroom, and integrated to involve these components are more likely to lead to advancements in the health of school students.

The challenge in this development has been to link health outcomes with educational and school outcomes (Davy, 1996; Lynagh, 1996). Schools' concerns are the improvement of student learning outcomes where outcomes are defined as 'knowledge, understandings, skills and attitudes students are expected to achieve within a course of study' (Board of Studies, 1996, p.4). On the other hand, health professionals are primarily concerned with health outcomes, commonly defined as 'changes in the health of individuals, groups or populations which occur as a result of a health service or intervention program' (NSW Dept. of Health, 1996a, p.17). Efforts to encourage health promotion in schools are problematic if they fail to contribute to the educational outcomes of the school (Davy, 1996).

Kolbe (1996) provides a model linking health promotion outcomes and education (see figure 2).

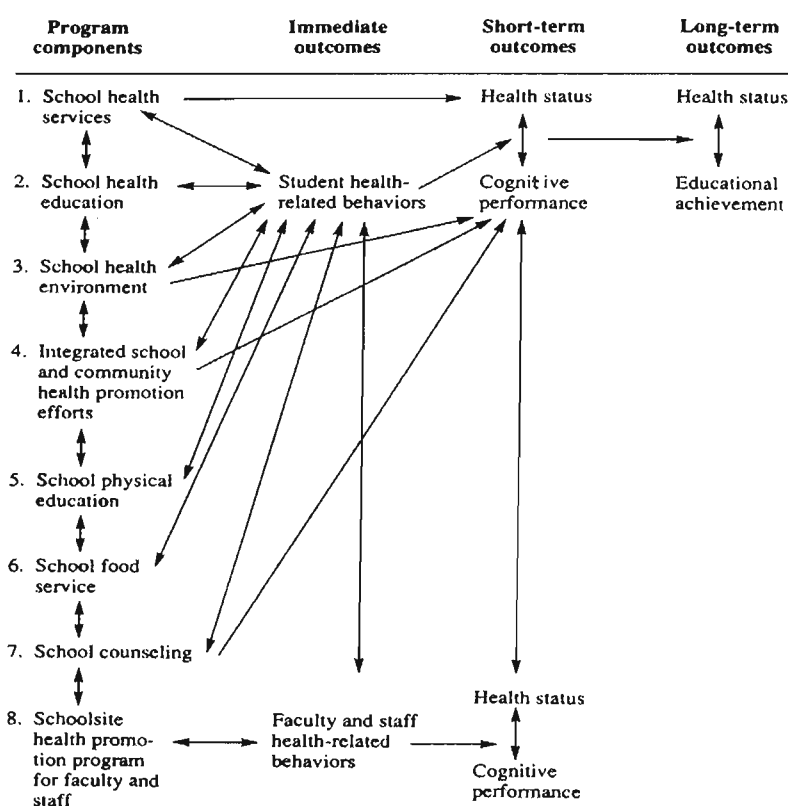


Figure 2. School health promotion components and outcomes (Kolbe, 1996, p.48).

Kolbe (1996) concludes that achieving a comprehensive educational and social experience for students which maximises the educational and health outcomes can only be done by:

- 1) creating a supporting environment for health;
- 2) providing a comprehensive and integrated health program for students;
- 3) adopting organisational practices which complement the teaching program;
- 4) offering a supportive social environment for students;
- 5) fostering links with health resources in the community;
- 6) creating a safe and secure physical environment.

The *Health Promoting Schools* (NHMRC, 1996) report has refined these processes to the three areas of: curriculum, teaching and learning; school ethos, environment and organisation; and partnerships and services.

From his fifteen years of research on what schools could do to assist in the health of young people and the involvement of the health sector, Nutbeam (1996) categorises three distinct phases of research and development. These phases demonstrate the changing approaches over time of the health sector working with the education sector in Australia.

Phase one began as the school, being a convenient venue, provided ready access for health researchers to young people. It involved the large growth in number, scope and sophistication of classroom-based education and intervention directed towards developing personal and social skills, that is, the traditional health education model. Through his analysis of these early programs, Nutbeam determined that behaviour outcomes were unlikely to occur solely from classroom based interventions. Whilst health education in the syllabus alone might provide awareness of health issues, it did not necessarily result in desired behavioural changes. Research during this phase (Arkin, Roemhild & Johnson, 1981; Coonan, Owen & Mendoza, 1990; Nutbeam, 1987) stressed the importance of peer and family influence, timing, content and methods of educational programs in relation to health issues.

Phase two saw schools as institutions ready for organisational development and incorporated the growing awareness of the influence of the 'hidden curriculum'. The impact of school structure, organisation and climate upon behaviour and effectiveness of interventions was realised by the health sector. School organisation, environment and policies were recognised as having significant impact on student health and well-being (Nutbeam, 1987 cited in Nutbeam, 1996).

Phase three was categorised as the period where schools were recognised as educational institutions working on common goals and common ground for both health and educational outcomes. After many years, finally there was acknowledgment that the health sector had to work with educationalists to incorporate curriculum and syllabi into an elaborated health promotion framework. However, the school's curriculum time is short and open to considerable competition across the curriculum and within subjects. The argument therefore has been that schools' primary responsibility is in education and social development of young people (Green, 1996), but to point out that the health of students can be a major factor in their capacity to learn.

You can't educate young people if they are unhealthy and you can't keep young people healthy if they are uneducated

(Nutbeam, 1996, p.5).

## Health promotion models

The various forms of the HPS concept implemented in Australia have drawn on a number of theoretical models of health promotion, in particular the Precede-Proceed model (Green & Kreuter, 1991). Most of these models have been developed from traditional disease prevention and health education models. As a starting point, Downie, Fife and Tannahill's (1991) model of health promotion (figure 3) brings together the three components of prevention, education and health protection.

Health promotion comprises efforts to enhance positive health and prevent ill-health, through the overlapping spheres of health education, prevention and health protection (p.59).

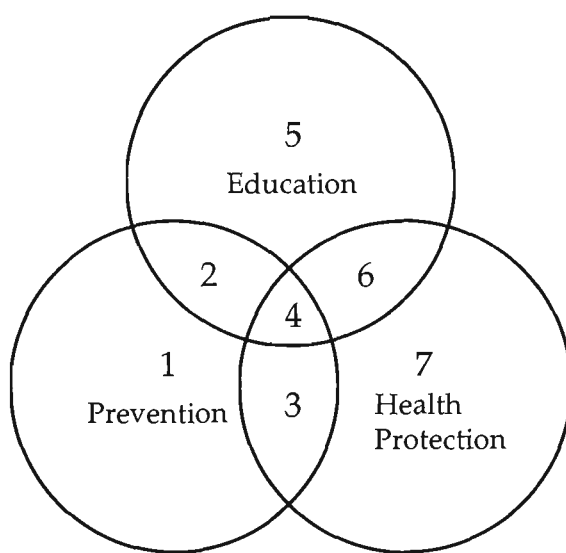


Figure 3. A model of health promotion (Downie et al, 1991).

This model presents the range of possibilities for health promotion by distinguishing seven domains as numbered.

1. Preventive services include immunisation and screening programs.
2. Preventive health education includes educational efforts to influence lifestyle in the interests of preventing ill-health as well as efforts to encourage the uptake of preventive services.
3. Preventive health protection: eg. fluoridation of water supplies to prevent dental cavities.
4. Health education for preventive health protection such as the intensive lobbying for seat-belt legislation.
5. Positive health education involves health education aimed at influencing behaviour on positive health grounds such as the encouragement of physical activity; and that which seeks to

- help individual's and communities to develop positive health attributes such as lifeskills and high self-esteem.
6. Health education aimed at positive health protection which involves raising awareness and securing support for positive health protection measures among the public and policy makers.
  7. Positive health protection such as implementation of a workplace smoking policy.

(Downie et al, 1991).

Such a model provides the framework to show why the overlapping areas of health education, prevention and protection need to work together for a comprehensive notion of health promotion to be effective. However, whilst it demonstrates the scope of health promotion, it offers limited planning and implementation suggestions.

Green and Kreuter's (1991) Precede-Proceed model is theoretically robust and addresses the major need in health promotion for comprehensive planning. It is robust in the sense that it applies to health promotion in a variety of situations. It has served as a successful model for much of the research in relation to the assessment of local needs, priorities, circumstances and resources in health promotion (see for instance: Downey, Virgilio, Serpas, Nicklas, Albert and Bereson, 1988; Kolbe, 1988; Floyd & Lawson, 1992; Schmerlaib, 1996). The model is intuitively appealing and logical, and despite the fact that it has been widely used for more than fifteen years, similar models continue to be developed today (Glantz, 1996). This is also the model which has underpinned most of the health promoting school projects in Australia (Green, 1996). It provides guidelines for making HPS policy specific to the school and promotes the necessity for thorough planning and evaluation of health promotion initiatives.

The Precede-Proceed Model for health promotion introduces two components of a health promotion planning framework: a needs assessment phase called PRECEDE (Predisposing, reinforcing and enabling constructs in education/environmental diagnosis and evaluation) and a developmental stage of health promotion which is called PROCEED (Policy, regulatory and organisational constructs in educational and environmental development). The strength of Green's definition of health promotion is that it encompasses all activities that improve health, including not only



‘health directed behaviour’ but also ‘the more pervasive and problematic web of health-related behaviour of individual ... whole families, groups, communities and organisations’ (Green & Kreuter, 1991, p.23).

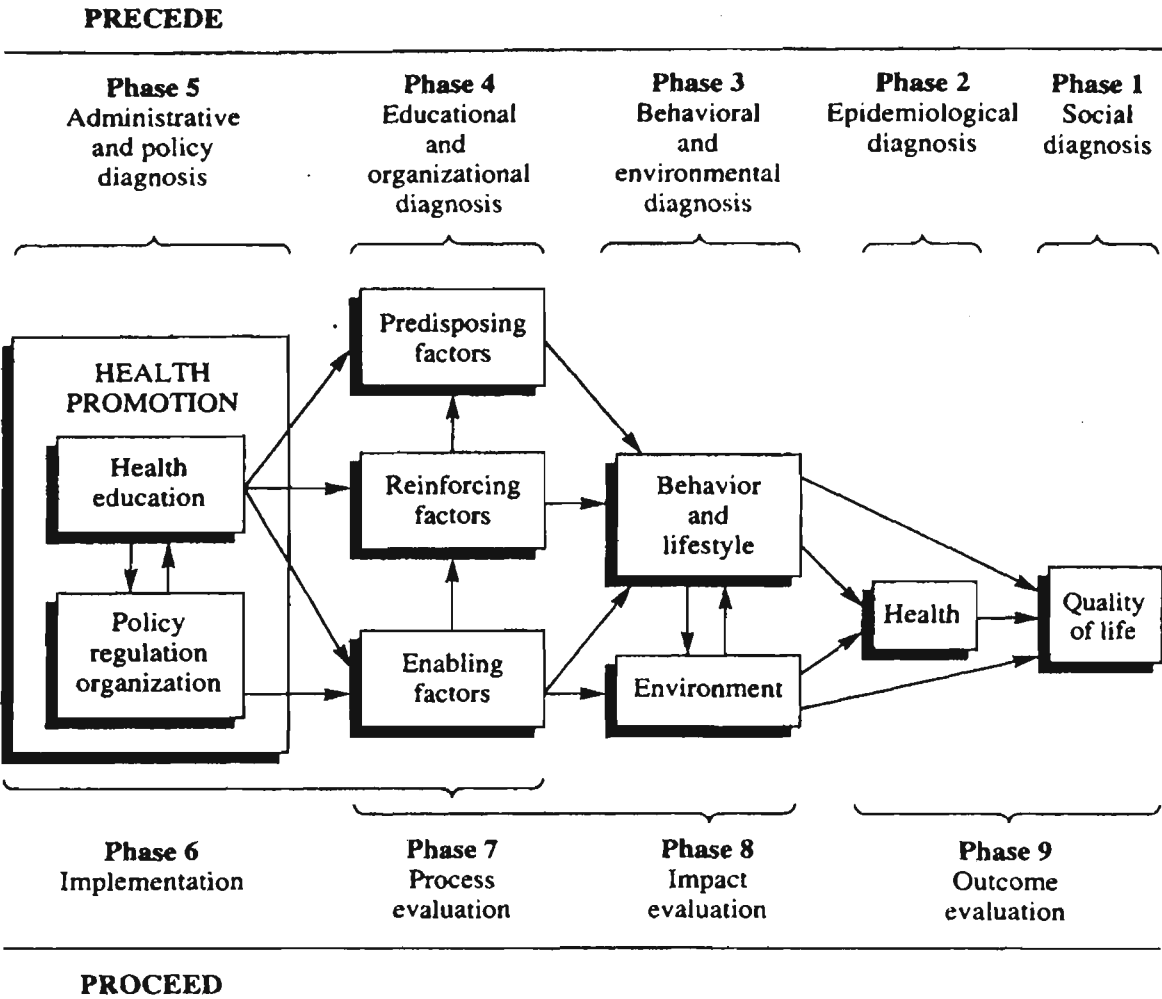


Figure 4. The PRECEDE-PROCEED model for health promotion, planning and evaluation (Green & Kreuter, 1991, p.24).

The Precede framework takes into account the multiple factors that shape health status and assists in developing specific targets for health promotion intervention. PRECEDE also generates specific objectives as criteria for evaluation. The Proceed framework provides additional steps for developing policy and initiating the implementation and evaluation process (see figure 4). The Precede framework begins the health promotion planning process from outcomes rather than inputs. The factors important to an outcome must be diagnosed before the intervention is designed; if they are not, the intervention runs the risk of being misdirected and ineffective.

Focusing specifically on the preparation stage or Green and Kreuter’s PRECEDE phases, Dijkstra, deVries and Parcel (1993) argue for a process of comprehensive planning for health promotion which involves all

stakeholders in not only planning and implementation, but in policy development. In addition, they argue that a process of 'diffusion' whereby health promotion programs are communicated through certain channels over time among members of the school community, must occur for initiatives to be successful. In the context of the HPS, the purpose of this diffusion process would be to ensure awareness and involvement in the program by students, staff and parents. One approach that helps improve diffusion is the 'linkage' approach to innovation-development and diffusion planning (Orlandi, Landers, Weston & Hayley, 1990). This approach suggests collaboration among three systems during implementation of an innovation: the resource system, linkage system and user system. The resource system in the case of the HPS project consists of the Area Health Services' personnel and the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) document and materials. The linkage system can include representatives from the resource system and representatives from the school community to form the HPS committee. The user system consists of individuals and the whole school community that are potential adopters of the innovation.

Health and educational researchers have examined such theoretical frameworks that help to interpret health risk situations and plan, implement and evaluate health promotion interventions. In Australia, the Precede-Proceed model has been influential in informing the various HPS projects concurrently being implemented across the states of Australia. The foci of these projects vary according to the priorities of the education and health sectors in each state. One state-wide initiative that involved a curriculum approach to health promotion in schools (CAHPS) was a pilot project funded by the South Australian Health Commission (Schmerlaib, 1996). The elements of the Precede-Proceed model were adapted and placed in a framework that was consistent with the process of change in education (see figure 5). Where the Precede-Proceed model has nine phases, these have been condensed to three by collapsing the PRECEDE phases into Phase 1: Building a shared understanding and the three evaluation stages into one single phase.

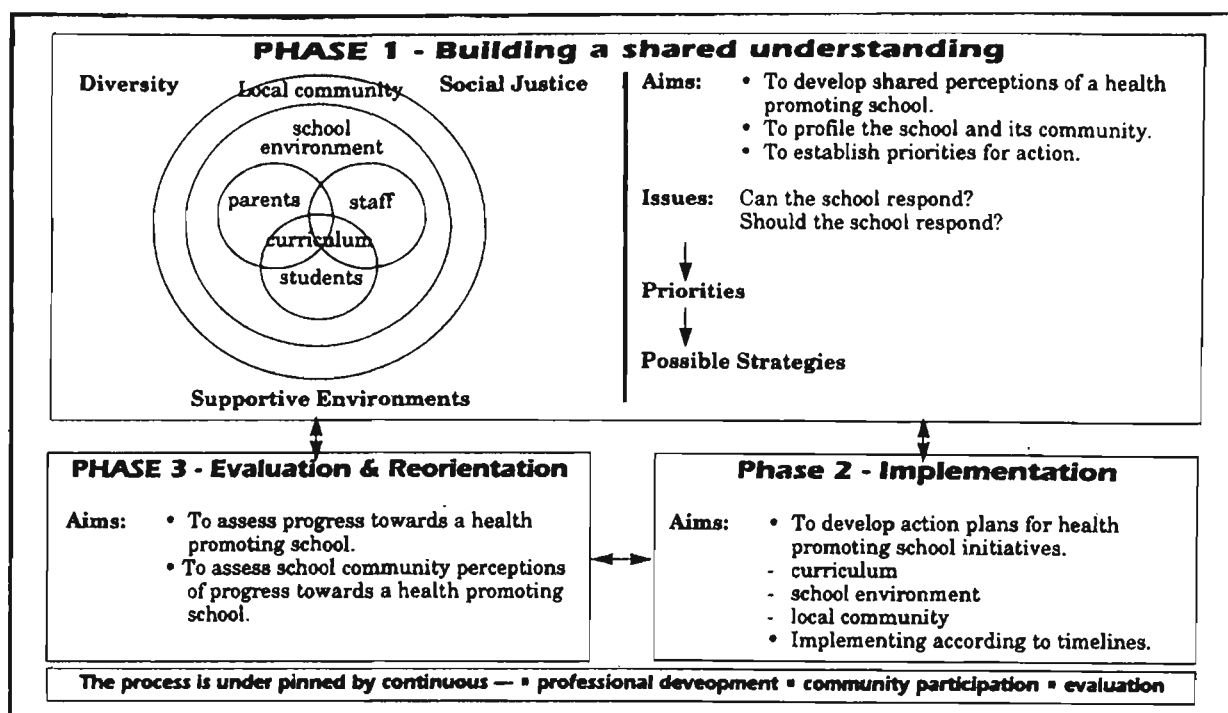


Figure 5. A Curriculum approach to health promotion in schools: A model for educational change designed to help schools become more health promoting (Schmerlaib, 1996, p.16).

Preliminary findings from the CAHPS project (Schmerlaib, 1996) indicate that the project was successful in terms of establishing health in the curriculum and receiving increased support from parents and the health sector. Other models of the HPS concept that have been launched around Australia include the Western Australian School Health Project (WASH) and Health in Primary Schools (HIPS) in Victoria.

In New South Wales, after reviewing previous models and guidelines and with collaboration between the health and education sectors, a slightly different model was developed to meet local needs. The *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) sets out a systematic process for planning, reviewing, implementing and evaluating health promotion in schools (see figure 6). This model represents a systematic process for becoming a health promoting school. Although evaluation is listed separately, monitoring and feedback should be viewed as important processes during each stage of the process. Such a process is something that requires coordination, planning, support, time, resources and suitable personnel who are committed to the philosophy and ethos of promoting health in schools.

# The health promoting school

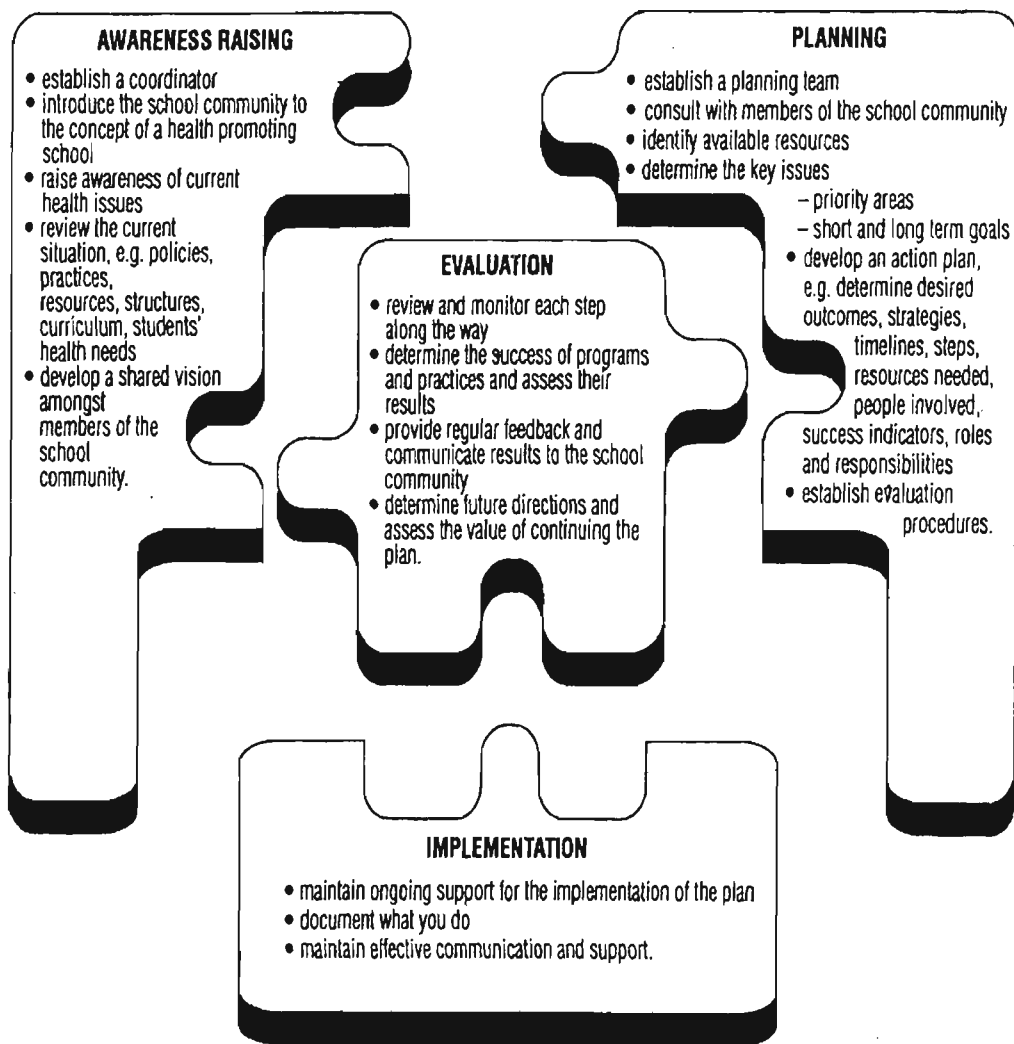


Figure 6. Stages in developing a health promoting school  
(Towards a Health Promoting School, 1996, p.13).

The commonality that emerges from these health promoting school models is that specific needs of students in the school must be determined and then prioritised. Following this, resources then should be mobilised and plans developed for reaching those particular goals that have been collectively set. Rather than having a standard set of criteria which presumes a similarity of context, schools have to set their own agendas within a policy framework of specific principles and processes based on the best available knowledge for health and education about sustainability. For school health promotion to be successful, there needs to be demonstrated in the school framework such important elements as: community

consultation; working partnerships; policies and programs; demonstrated student involvement; professional development; school budget allocation for health promoting school activities; and systems for tracking of school determined health behaviours (Rowling, 1994).

## **The health promoting school**

There are many definitions of health promoting schools due to the emergence of the HPS concept in different places at the same time and the individual response to the concept. Whilst the definitions vary from narrow to all encompassing views, they all basically agree that the HPS is a community effort. The document *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996), the joint project of the NSW Department of Health, the NSW Department of School Education, the Catholic Education Commission and the Association of Independent Schools, accepts the following two definitions:

A health promoting school is where all members of the school community work together to provide students with integrated and positive experiences and structures which promote and protect their health. This includes both the formal and informal curriculum in health, the creation of a safe and healthy school environment, the provision of appropriate health services and the involvement of the family and wider community efforts to promote health  
(WHO Regional Guidelines, 1996, p.3).

Health promoting schools are schools which display, in everything they say and do, support for and commitment to enhancing the emotional, social, physical and moral well-being of all the members of their school community  
(NSW Board of Studies, 1991a, p.3).

Guidelines for becoming a health promoting school are plentiful in the Australian literature (McBride et al, 1995; Nader, 1990; NSW Dept. of Health et al, 1995; Nutbeam, 1992). One such guideline from *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) is for schools to liaise with the Australian Health Promoting Schools Association whose role is to work with schools in identifying specific needs rather than present what might be a competing agenda. They assist schools by working collaboratively to form a sophisticated network basis, with the principles of equity and participation. This network draws attention to innovations and

practices already in place which are supportive of health outcomes. It seeks to build on these experiences by sharing resources and ideas. In developing health promoting schools, each school must focus on what is important to the school's particular cultural environment. Obvious priority areas are the health of their own student population, common causes of illness and death in the community such as skin cancer, cardiovascular disease, injuries and suicide; and to provide an environment that will contribute to the physical, social and emotional well-being of the school community. Three areas that the NSW Department of School Education prioritises are 'Teaching and Learning', 'Happy and Safe Schools' and 'Community Participation' which are directly linked to the categories formulated by the NHMRC outlined on page nineteen. Policies, programs, services and activities available to schools for developing a health promoting school in NSW are conceptualised using these three priority areas. The HPS concept is not new, but rather one of increasing awareness and of formally coordinating the responsibilities and resources to maximise the time, money and resources available. The concept of the HPS is international in its development, with many countries around the world working on similar programmes.

Governments have the responsibility to ensure that the conditions for schooling are the best they can be. This can be achieved through establishing health promoting schools which are a means of organising and linking all the crucial components which shape the health of children and young people  
(WHO, 1996, p.1).

On the other hand, Colquhoun (1996b) noted that policies and guidelines on health promoting schools support the processes of 'governmentality' which involve the 'controlling and normalising of the behaviours of schools and school populations' (p.2). What Colquhoun (1996b) refers to as 'governmentality' here is not only the external forms of government but also self-governing bodies such as schools that carry out policing and regulatory activities. The concern is that schools may take the conservative approach to health promotion by setting agendas for students' health based on administrative decisions without taking into account the particular points of view or specific characteristics of the young people with whom schools are supposed to be working.

The health promoting schools concept has been adopted in North American and European schools well ahead of Australian schools (Nutbeam, 1996). However, it appears that the Australian school approach whilst being implemented later is indeed a truly integrated approach between the education and health sectors of the community (Langridge, 1996). The Australian studies available focus on primary schools with limited research at this stage into secondary schools. In many case studies, significant attention seems to be given to the physical environment such as safety measures, planting/greening, shade areas and the like which are readily visible, rather than the many 'intangible' health needs such as developing students' self esteem (Ackermann, 1992; NSW Department of Health et al, 1996).

McGuinnis and DeGraw (1991) suggest that successful school health programs represent a key to obtaining the *Health for All by the Year 2000* (WHO, 1996) objectives. Planned and sequential health education in the school setting is a critical component to the development of health promotion in schools. State and local departments can work with schools to provide a multi-dimensional program of school health that may include general school health education, school linked or school-based health services designed to prevent, detect and address health problems, a healthy and safe school environment, healthy school canteens, an integrated PDHPE program, psychological assessment and emotional health, school site health promotion for students and staff, and integrated school and community health promotion efforts. The health promoting schools' initiative enables schools to pursue this holistic approach to health where the curriculum, school policies and programs are integrated with local community resources to provide the school with a contextual view of health and the skills for sustaining better health. The initiative requires everyone to work together towards the common goal of improving health in schools. 'Given that teachers, principals and committees are already under such intense pressure to respond to a diverse range of demands, there is a need for consolidation - a drawing together of fragmented efforts' (Cummings, 1992, p.16).

*Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) follows the guidelines of a policy model where it is up to individual schools to appropriately implement their own developed health promotion policies. The implementation decisions made by school personnel are related as much to the issues embodied within the policy as they are an interpretation of the policy itself.

Implementing new policies in the school situation relies on changes for all concerned. A great majority of educational changes are not implemented in practice even when implementation is desired (Fullan, 1991). Some of the key factors of educational change management have been addressed in *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) by providing guidelines for awareness raising, needs assessment, leadership support, community consultation and developing a shared vision to assist in the planning, implementation and evaluation of health promotion in schools.

Like any policy, the implementation of *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) also needs to take into account the common barriers to change in educational institutions. For instance, teachers are often reluctant to change due to 'custom and practice' in their everyday roles. As it is, they report constantly experiencing a critical shortage of time and because of this are reluctant to be involved in further initiatives within the school (Fullan, 1991). As House (1974), explains:

The personal costs of trying new innovations are often high ... and seldom is there any indication that innovations are worth the investment. Innovations are acts of faith. They require that one believes that they will ultimately bear fruit and be worth the personal investment, often without the hope of an immediate return. Costs are also high. The amount of energy and time required to learn the new skills or roles associated with the new innovation is a useful index to the magnitude of resistance

(p.73).

Moreover, the nature of adolescents, the influence of peer pressure and acceptance within their social group often forms barriers against promoting changes in students' behaviours. There also exists the problem of involving all stakeholders in the policy process unless there is a strong consensus and firm commitment from all parties to the agenda of health promotion and the implementation of initiatives.



## Health promotion policy

So how does an issue such as health promotion become part of the policy agenda? Health and health promotion are deeply affected not only by political systems but also by plain politics (Rajala, 1995a). Hogwood and Gunn (1988) state that for an issue to receive priority on the policy agenda, one or more of the following circumstances must apply:

- 1) the issue has reached crisis proportions or threatening as a future crisis;
- 2) the issue has achieved peculiarity;
- 3) the issue has an emotive aspect or the human interest angle which attracts media attention;
- 4) the issue seems to have wide impact;
- 5) the issue raises questions about power and legitimacy in society;
- 6) the issue is fashionable.

Health and health promotion indeed fits all these criteria due to its emergence and development over the years.

Health promotion was conceived in the 1970s, born in the 1980s and matured in the 1990s

(Macdonald, 1992, p.71).

In the 1970s, preventable diseases and risk behaviours were tackled primarily through the distribution and dissemination of information and basic education within the community. In the 1980s, the emphasis was on the importance of complementary intervention approaches. In the 1990s, the value of reaching people through the settings and sectors where they live and meet, was acknowledged by the health sector as being vital for effective health promotion to be achieved (Nutbeam, 1996).

The Lalonde report (1974) conducted by the Canadian Ministry of National Health and Welfare outlined new perspectives on the health of Canadians. It emphasised that the determinants of health, via lifestyle, heredity, environment and organisation of health care, required different responses if action was to be fully health promoting. It also expressed the need for the active support of a wide range of agencies and professionals, as well as individuals themselves, in a truly collaborative venture for better health.

At the Thirtieth World Health Assembly in 1977, the attainment of 'Health for All' was accepted as one of the main social targets of governments and the World Health Organisation for the remaining years of this century. The strategy for *Health for All by the Year 2000* (WHO, 1986) began with the *Declaration of Alma Ata* (WHO, 1978). It was in this document that the 'health promotion' concept began as a movement and gathered in momentum over the next two decades. A global strategy was adopted in 1981 by the World Health Assembly from these beginnings (WHO, 1981). In 1986, the World Health Organisation formulated what is now known as the Ottawa Charter (see appendix 1) at the inaugural International Conference of Health Promotion. This charter encouraged and provided guidelines for countries to take action towards preventive health care and the promotion of health, where health promotion is defined as 'the process of enabling people to increase control over and to improve their own health' (WHO, 1986, p.3). This conference was primarily a response to the growing expectations for a 'new' public health movement internationally, which led to global health promoting policies and initiatives. This was based on the notion of decreasing the biomedical focus on health to one incorporating disease prevention and cost effectiveness. The Ottawa Charter was central to the development of the concept of the health promoting school (Kickbusch, 1992; Nutbeam, 1992).

Parallelling the growth in interest in health promotion in recent times has been a resurgence of interest in 'public health'. Health promotion emphasises the need for fruitful 'intersectoral collaboration' and is now treated as a substantial and vital component of public health (Tannahill, 1990). The development of the Ottawa Charter was an important landmark which gave health promotion 'legitimacy'. It is for this reason that *all* public policy, it is now argued by health personnel, should have a health promoting dimension. This has led to the development of new strategies for health promotion in the field of policy analysis and advocacy. This is evident in the global concept of 'Healthy Cities', healthy workplaces and the health promoting schools' initiative. The WHO's slogan 'think globally - act

locally' was taken to be an appropriate framework for developing health promotion policies, strategies and structures (Rajala, 1995a).

The acceptance of the benefits of health promotion and the health promoting schools concept has become widespread over the last few years (Catford, 1996). Journals solely on health promotion are now published: *Health Promotion International* and *The Health Promotion Journal of Australia* with other journals devoting whole issues to health promotion in schools, for example: *Journal of School Health* and *ACHPER Healthy Lifestyles Journal*. New associations have been formed; policies and guidelines developed. In addition, new textbooks on health promotion are appearing regularly and university departments and professors now offer specific courses in health promotion. Bachelor and Masters degrees in health promotion are also now available in Australia and state and national funding is increasingly being invested in health promotion programs.

The rapid changes in society in the first part of the 1990s present new challenges to health policy. The changes have made it necessary to revise national strategies. There has been a temptation for governments to concentrate on current problems where the consequences of inaction will not occur until the future, and perhaps affect a different political party (Rajala, 1995a). Health policy in Australia, including that related to health promotion is increasingly focused on evidence of health outcomes. Hall, Birch and Hass (1996) in their discussion on the role of health outcomes in creating health gains, suggest that '... it is important to shift the emphasis from funding and providing health services and institutions to providing care that improves health' (p.4). The HPS concept is part of the new public health movement which 'reemphasises the link between environment and disease' (Colquhoun, 1996b, p.3). The HPS concept is based on a settings approach where students can be exposed to healthy practices and develop positive health knowledge, skills and behaviours. The departure from traditional school health education focusing solely on formal curriculum based activities in the classroom, has through the HPS concept, resulted in a broader, more holistic approach to health in schools (Colquhoun, 1996b).

Building healthy public policy which extends into economic, social and political spheres is the initial requirement for health promotion action according to the Ottawa Charter (WHO, 1986). The Ottawa Charter states that health promotion policy:

... combines diverse but complementary approaches including legislation, fiscal measures, taxation and organisational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, and cleaner, more enjoyable environments. Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in the nonhealth sectors and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well (p.6).

Prior to the global *Health for All by the Year 2000* (WHO, 1981), Australia's health systems' organisational structures, legislative and policy frameworks, and resources were focused overwhelmingly on diagnosing and treating those who were ill (Wise & Nutbeam, 1994). Health promotion efforts were limited in scope, had access to limited resources and priorities were often set without a full understanding of the health needs of communities. By the early 1980s it was clear that growing investments in the health care system were not being translated into improvements in the health of the population. *Health for All by the Year 2000* (WHO, 1981) was not likely to be achieved without much more significant concentrated efforts by those in authority (Rajala, 1995b).

The Australian Government responded to the *Health for All by the Year 2000* (WHO, 1981) through the Better Health Commission, established in 1985, by developing the *National Better Health Program* (1988) whose objective was to provide funding and to support the implementation of programs in health promotion. National targets included reducing exposure to ultraviolet radiation, reducing cardiovascular disease, reducing the incidence of injury and other key issues concerned with nutrition, tobacco use, drug and alcohol use, sexual behaviour and physical activity. It is worthy to note that many of these factors contribute to the leading causes of morbidity and mortality for children and adolescents. It was the first concerted national effort to change the basic direction of health policy in Australia (Better Health Commission, 1986).

For the first time the potential health gains to be made from promoting health and preventing illness or injury were given political prominence. *The National Better Health Program (NBHP)* was intended to spearhead Australia's drive towards health promotion with emphasis on the development of national strategies in priority areas (Wise & Nutbeam, 1994). The *Health for All Australians* report (Health Targets and Implementation Committee, 1988) and the findings of the Better Health Commission (1986) have provided an important catalytic effect on health funding and in the developing of primary prevention and health promotion research and programs.

The original set of goals and targets from the NBHP were reviewed in a report *Goals and Targets for Australia's Health in the Year 2000 and Beyond* (Nutbeam et al, 1993). This presented a revised framework and structure for implementation along with further goals and targets. From this a further report, *Better Health Outcomes for Australians* (Commonwealth Department of Human Services and Health, 1994a) was developed. This report, together with the *National Health Policy* (Commonwealth Department of Human Services and Health, 1996), was set to improve health outcomes. Both of these processes incorporated extensive consultation with community and professional groups. These reports allowed health promotion to move beyond the narrow focus of disease to address common issues such as social justice, access and participation and healthy lifestyles. The Australian Health Ministers' Forum (Commonwealth Dept. for Health Services and Health, 1994c) agreed in its National Health Strategy to refocus the health system towards improved health status of the population rather than a disease focus. Baric (1992, p.6) outlines the 'settings' approach where health promotion takes into account context and environment involving a target population within a given setting, such as a school:

... it recognises that any population group will have a number of health problems, and therefore does not limit itself to one problem, it also accepts that the health problems presenting that population are the consequence of the functional relationship between the environment and personal factors associated with that population... it considers the interaction between these two groups of factors as being reflected in the lifestyle of the population and it takes into account the fact that the different aspects of a person's lifestyle are

associated with the different settings in which that person lives, reproduces, learns, works, utilises different services, and enjoys leisure, etc... It treats each of these settings as a system which is characterised by a certain structure, norms, participants, communication, interaction... it recognises that each of these settings is a part of a wider system and is interdependent with other parts of the system in terms of providing services or mounting interventions

(cited in Colquhoun, Goltz & Sheehan, 1996, p.16).

According to Rajala (1995b), health promoting programs are in most cases low cost and cost effective compared to costs involved in treatment of lifestyle diseases. However, the Australian Government has provided little funding for health promotion and prevention compared to treatment resources. Additionally, there seems to have been some inequity in the targeted areas for funding. According to Nutbeam (1996), priority should be given by policy makers to programs that address issues of greatest public health importance as determined by epidemiological data and use methods and strategies that are based on this evidence. However, the Australian Government has been reactive to public pressure which is often directed to funding issues with lesser public health importance but capture greater public concern. For example, more funding is designated for HIV/AIDS because it is an emotional issue, compared to Hepatitis B which claims more lives in Australia. Nutbeam (1996) and Rajala (1995b) both recommend diversified funding and policies which would increase flexibility and improve the ability of health promotion initiatives to withstand political changes.

Once national policy settled on objectives for health promotion in Australia, the necessity of adapting those policies to the state and community levels became inescapable. The health promoting schools project for instance, was developed in response to national health policy and created a 'political platform' which allowed for policy development and for interactive processes at the local, national and international levels (Cogdon & Belzer, 1991). Whereas state and national governments can formulate policies, provide leadership, allocate funding and generate data for health promotion, in the end it is the individuals and groups involved in implementing these which determine their success or failure. Therefore, decisions on priorities and strategies for social change affecting lifestyle

issues should be made collectively by all concerned if health promotion initiatives are to be successful. This principle assures that programs are relevant and appropriate for the people affected and that they are to be actively engaged in the planning process. The overwhelming evidence from research (Dijkstra et al, 1993) on the value of participation in learning and behaviour change indicates that people are more committed to initiating and uphold those changes if they assist in the design of these programs as they are suited to their own purposes and circumstances. This is the theme that has been adopted in *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) as an approach to health promotion in schools. This document supports international and national health promotion policy, focusing on the development and implementation of policy at the local school level. It provides processes for establishing specific school health promotion policies through a framework of awareness raising, planning and integration within existing school policy.

### **The issue of policy**

Since the main aspect of this thesis is concerned with policy implementation, it would seem useful to clarify the term 'policy' and to review the theory that has developed around policy implementation as these relate to the HPS concept.

Heclo (1972) states that policy is not a self-evident term but suggests that it 'may usefully be considered as a course of action or inaction rather than specific decisions or actions' (p.84). A policy can consist of what is not being done as much as what is being done. It is assumed that policy involves behaviour as well as intentions. From a public policy perspective, Anderson (1975) defines policy as 'a purposeful course of action followed by an actor or set of actors in dealing with a problem or matter of concern' (p.3). Goggin (1991), writing from an educational perspective, defines policy as being reflections of human interactions in a particular time, place and context. This suggests that policy is pertinent to a particular time and place in that what might be useful now, may not be relevant in the future. Such

a definition is very relevant for the dynamic nature of schools. Dye (1987) offers a simple definition of policy, '...whatever governments choose to do or not to do' (p.3). And the list goes on ...

Guba (1984) gives some indication of the complexity of policy by listing eight different perceptions of the term:

- 1) An assertion of intents and goals.
- 2) The accumulated standing decision of a governing body by which it regulates, controls, promotes, services and otherwise influences matters within its sphere of authority.
- 3) A guide to discretionary action.
- 4) A strategy undertaken to solve or ameliorate a problem.
- 5) The output of the policy making system: the cumulative effect of all the actions, decisions and behaviours of bureaucracies.
- 6) A sanctioned behaviour, formally through authoritative decisions, or informally through expectations and acceptance established over time.
- 7) A norm of conduct characterised by consistency and regularity in some substantive action area.
- 8) The effect of the policy making and policy implementing system as is experienced by the client.

(Guba, 1984, p.64).

Such vicissitudes in conceptual understanding of what policy is deemed to be creates a multitude of varying interpretations and responses to its implementation. The underlying commonality is that policy is a process that involves planning followed by intended action. Fuchs (1975) when defining policy, saw the need to include reference to major guidelines, rules, directions of efforts, future orientation and decision framework. Tefler (1983) used this when defining school policy as 'a set of major guidelines indicating the school's goals, objectives, values or ideals, and often prescribes the means for their accomplishment' (p.6). These two latter definitions seem to be more relevant to HPS policy as numerous guidelines and strategies have been developed with the intent of implementation in schools.

In Australia, school education policy is primarily the responsibility of the State Governments. The implementation of the document *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) was backed by the NSW government and launched by the Minister for Education, John Aquilina in August, 1996. From the collective definitions and perceptions



of policy it can be concluded that such a document is in fact, a policy document. This is because it provides guidelines, goals and prescribes various means to accomplish these. Whilst it is not a mandated requirement, all schools are encouraged to follow the guidelines in *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) to develop health promoting policies specific to the needs and culture of the individual school and adopt the suggested guidelines to move towards becoming a health promoting school. The NSW Government, by supporting such policy development, embraces national and international health promotion policies. Governments have a key role to play in the success of health promoting schools; they provide the strength and validation of such policies.

The *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) document contains Green and Kreuter's (1991) components of a policy. They identify three components to a policy as:

- 1) the clear statement of a problem or potential problem that needs attention;
- 2) a goal to mitigate or prevent that problem; and
- 3) a set of strategic actions to accomplish that goal.

*Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) addresses each of these components and also recognises the importance of school policy development for health promotion. While it provides a general framework, a whole school health promotion policy needs to be developed for the individual characteristics of each school and from this, specific policies such as a canteen policy, welfare policy and environment policy can be established. Such policy development concurs with Goggin's (1991) view that policy must be relevant in time and place to address the needs of the school community. The *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) points out that assessment of the greatest risks to health in the school is essential for development of policy that aims at reducing these risks. 'One way to approach health promotion policy is to focus on health risks' (Burns, 1996, p.59).

Ball and Bowe (1991) make a useful distinction between the cyclical and overlapping phases of 'actual policy', 'intended policy' and 'policy in

use'. 'Actual policy' is that document, report or piece of legislation, such as *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) whose intention is sanctioned by the government. Such policy documents 'written in relation to idealisations of the real world can never be exhaustive and cannot cover all eventualities' (Ball, Bowe & Gold, 1992, p.21). 'Intended policy' is what the various interest groups want where interest groups combine to implement the policy. Research literature on policy and program implementation (Pressman & Wildavsky, 1984; Rist, 1994) indicates that translating policy intentions into policy and program realities is a particularly difficult task to accomplish.

Our normal expectations should be that new policies will fail to get off the ground and that, at best, they will take considerable time to get started. The cards in this world are stacked against things happening, as so much effort is required to make them work. The remarkable thing is that new policies work at all

(Pressman & Wildavsky, 1984, p.17).

If policy is too new and different, then successful implementation is less likely. Health promoting schools' policy is more likely to be effective then, if it fits within existing school policy. 'Policy in use' is how those who have to implement the policy do so. Any policy document and any original intentions are always open for interpretation. This was evident at Pentecost College when HPS policy was often interpreted differently by the principal, teachers, parents and students.

## **Policy implementation**

Further to 'policy in use', policy can also be examined in terms of output and outcome, where output is the structures put in place to support the policy and outcome is what results from the output (Hogwood & Gunn, 1988). For example, a government policy to improve health may result in the output of more funds for medical facilities and more trained staff. The intended outcome from these increased resources is improved health which may, or may not be realised from this output. When examining policy, the policy making process also needs to be considered. Policy making and implementation is not a linear process, but one that can be seen as a cyclical

model where 'there is no point at which the policy making stops and implementation begins' (Walker, 1989, p.4).

Hogwood and Gunn (1988) describe the concept of 'policy space' as being the machinations of government and private agencies which eventually result in policy. 'Policy space typically tends to become crowded over time with more and more governmental interventions and increasingly complex interactions among them' (Hogwood & Gunn, 1988, p.13). Health promoting schools policy derived from the health sector but has had enormous impact on the policy space of the education sector. The concept of the HPS initially came through the health portfolios and seems to have received much more support from the health sector than from the education sector. According to Colquhoun (1996b), implementation of HPS policy has been thrust onto schools in a climate where the demands placed on teachers, students and school communities are increasing.

The National Health and Medical Research Council (NHMRC, 1996) recommends that the health sector continue to play an active role in supplying and advocating the HPS concept. Based on theory and research, the NHMRC provide clear direction for the development of health promotion policy in schools. The health sectors' commitment to working with schools remains a priority, but perhaps it is not an education sectors' priority. Commitment by both the health and education ministries is essential for the successful implementation of the HPS concept in schools (WHO, 1995). Rather than treating implementation as the transmission of policy into a series of consequential actions, the policy-action relationship needs to be regarded as a process of interaction and negotiation, taking place over time, between those seeking to put policy into effect and those upon whom action depends (Hogwood & Gunn, 1988). In addition, health is not the only sector attempting to increase its agenda within schools. Groups associated with the environment, science, family, technology, culture and industry are all demanding access to schools (Davy, 1996).

There is abundant literature on what is termed the 'implementation gap' between policy and 'policy in action' (Dunsire, 1978; Hogwood & Gunn, 1988; Nutbeam, 1992 and Kok, 1993 ). When analysing policy breakdown or

failure, Hogwood and Gunn (1988) suggest it is important to distinguish between non-implementation and unsuccessful implementation. Non-implementation is where a policy is not put into effect as intended. This may be because those involved in its execution have been uncooperative and/or inefficient, or because their best efforts could not overcome obstacles to effective implementation over which they had little or no control. Unsuccessful implementation is when policy is carried out in full but fails to produce the intended outcomes.

A simple model for the ideal policy implementation would be:



Hogwood and Gunn (1988) suggest that such 'perfect implementation' of policy is unattainable (p.198). They list the following ideals for 'perfect implementation' noting that these pre-conditions are rarely able to be satisfied and unlikely to be achieved in practice:

- 1) that the circumstances extended to the implementing agency do not impose crippling restraints;
- 2) that adequate time and efficient resources are made available to the program;
- 3) that the required combination of resources is actually available;
- 4) that the policy to be implemented is based upon a valid theory of cause and effect. That is, if 'x' is done at time '1', then 'y' will result at time '2'. It may be the underlying theory that is at fault rather than the execution of the policy;
- 5) that the relationship between cause and effect is direct and that there are few if any intervening links;
- 6) that dependency relationships are minimal;
- 7) that there is understanding of, and agreement of objectives;
- 8) that tasks are fully specified in correct sequence;
- 9) that there is perfect communication and coordination;
- 10) that those in authority demand and obtain perfect compliance.

Hogwood and Gunn (1988) present these as conditions for perfect implementation of policy. They by no means advocate that each of these, for example point ten, would be beneficial or attractive to our society. However, this set of conditions will serve as one means of analysing the implementation of the health promoting schools initiative and of determining factors that have contributed to the implementation gap in order to enhance further implementation of health promotion policy.

The cyclical policy model as described by Ball and Bowe (1991), is more successful when implementation is decentralised because it empowers more people to participate in the policy process. In the school context, policy can then reflect the specific needs and culture of the individual school. Decentralisation in NSW schools began in 1989 when the NSW Government began to dismantle the bureaucracy at a state level thereby empowering schools with policy development and implementation in certain areas (Crump, 1993). The curriculum, however, is still centrally determined by the Board of Studies for all NSW schools. The future directions of the education system in NSW were encapsulated in the recommendations in the White Paper, Excellence and Equity (1989), the Committee of Review (Carrick Report, 1989) and School Centred Education (Scott Report, 1990). It was the Scott Report (1990), based on devolving authority and decentralising responsibilities to a future system of self-determining schools with community participation, that was the blueprint for restructuring the school system in NSW. Emphasis was placed on decentralising responsibilities to principals and teachers, devolving power to school councils, and making school personnel more accountable to both their local communities through school councils, and to government through performance monitoring and auditing. However, when it comes to practice, there are a number of competing perspectives in developing local objectives: the school principal's and teachers' individual needs and priorities; the demands of parents, students, local community and employers and the overriding expectation that schools in NSW will teach to the set curriculum developed by the Board of Studies.

The Education Reform Act (1990) provided the legal framework for Excellence and Equity (White Paper, 1989), the Committee of Review (Carrick Report, 1989) and School Centred Education (Scott Report, 1990) to be implemented into NSW schools. These reports all have the common theme that school-based management should provide the structure to improve the quality of education. 'Making schools educationally effective and efficient is therefore the prime aim of the Review's strategy for reform' (Scott, 1990, Foreword). This has also resulted in individual schools being

responsible for such things as health promotion. The decentralisation process supports the HPS concept by allowing schools to develop specific health promotion policies according to the needs of the students and other members of the school community. This empowerment of schools recognises that policy will be interpreted and implemented differently across school systems but also allows schools to develop specific policies that best service their needs and interests.

### **Reasons for HPS policy 'slippage'**

Despite following specific guidelines for policy development and implementation, there have been many health promotion initiatives that have failed in the school setting. There appears to be many problems and barriers when implementing school health promotion models, guidelines and frameworks into practice. The health promotion policy or initiative in theory does not necessarily progress to policy in action. Reasons for this can be linked to the conditions outlined by Hogwood and Gunn (1988) that contribute to this implementation gap or 'slippage' between policy and policy implementation (see page 42). Other factors maintaining this gap include 'change management barriers' (Fullan, 1991), lack of school community interest, priority on the school agenda, lack of funding, and the nature of adolescents and cultures.

Research into health promotion and schools in Wales (Britain) conducted by Smith et al (1992) found that whilst the term 'health promoting school' had been in use for some time, the vast majority of school coordinators surveyed were unfamiliar with the term. Although many thought their school was 'health promoting', it did not satisfy the criteria for a health promoting school. In particular, the key part played by the school environment in the health promoting school concept did not appear to be fully appreciated. School coordinators in the study identified the major obstacles to becoming a health promoting school as smoking by teachers, school catering services, general staff attitudes, time and financial pressures. Smith et al (1992) concluded that school governing bodies need to

provide further leadership in achieving broadly based policies for health which include not only students, but staff and all other adults who use school premises.

Whilst Australian schools have made a great deal of progress in relation to the development of the health education curriculum, particular attention now needs to be directed at the other two main strands of the health promoting school concept: the school environment and links to the wider community.

Cameron and McBride (1995) and Hurrelmann et al (1995) whose work focuses on the school environment and school community links emphasise the need to form an integrated approach to health promotion. Such an approach assists in negating current contradictions that can exist between the curriculum and the social and ecological dimensions of the school community.

The health promoting school attempts to balance the health curriculum and classroom teaching with structural changes in the school environment. These changes promote health and improve the link between school, families, caregivers and the wider community

(Cameron & McBride, 1995, p.4).

Often there is a wide gap between the concept of the health promoting school and current practices in many schools (Nutbeam, 1992). Booth, Rowling, Nutbeam and Townsend (1996) conducted research into health related activity in NSW high schools to gain a clear understanding of current practice. The purpose of this research was to develop an informed, coordinated plan to foster and support the development of health promoting schools in NSW. Their report, *Healthy Schools?* (Booth et al, 1996) gives an overview of the reported health-related policies and practices in NSW high schools. They found that only twenty five percent of schools reported any organised approach to health promotion (an informed, planned strategy). Other issues to emerge from this study were inadequate teacher training, lack of involvement of parents in the school, lack of attention to environmental issues such as poor sun protection and the inadequacy of support programs for students.

Such research indicates that fragmentation and haphazard implementation frequently occurs in health promotion initiatives in

schools. Studies of the effectiveness of school health promotion practice demonstrate the need for schools to be more rigorous in the implementation of all components of the comprehensive schools approach (O'Connor & Parker, 1995). The common theme that emerges from the literature is that some form of overall organisational structure needs to be developed prior to implementing a health promoting schools program.

Although schools potentially are powerful agencies for social influence, including changing community health, they are limited by time and resources and compete with those forces negatively affecting community health. For example, the powerful influence of adolescent peer pressure to smoke and drink alcohol often oppose health promotion messages. Naidoo and Wills (1995) state that health promotion in schools is more likely to be effective where:

- \* it addresses the needs of young people and starts from where they are in terms of knowledge and experience;
  - \* it is supported by an institution which itself is health promoting;
  - \* it is supported by health promotion in the community in which young people's health choices are made;
  - \* it is delivered by committed and informed teachers with curriculum time and resources which reflect its importance.
- (p.78).

Floyd and Lawson (1992) give further guidelines that suggest that school-site health promotion programs that begin without a full appreciation of the size and complexity of the task, may do more harm than good. They present a chronological model for school health promotion projects in which planners initially assess the school personnel's receptivity. The planners then organise the project to ensure that it addresses all necessary audiences and shares 'ownership' with them. It is only then that members of the school community are motivated and initiatives are implemented into action. Lastly, the programs are monitored to ensure that they put the project's priorities into practice. If these four underlying principles cannot be achieved, the authors state that the initiators of any health promotion in schools are wasting considerable time and effort.



All coordinated school health promotion programs will not just happen because everyone agrees it is a good idea. The key players must do more than agree in principle; they must take concrete actions

(Cogdon & Belzer, 1991, p.10).

Such actions as suggested by Cogdon and Belzer (1991) might include providing time for inservice training for those who will implement activities; making public statements about support; and most importantly, providing a coordinator to take responsibility for harvesting health promotion efforts already being made by others in the school. In Sweden for example, people have been freed from other duties, in order to establish health promotion in their school (Kickbusch, 1992). Smith et al (1992) also stressed the importance of designating a teacher as a health promoting school coordinator. Cameron and McBride (1995) concluded from their research into health promoting schools in Western Australia that additional teacher training is required to facilitate the implementation of the health promoting schools initiative. Thyer's (1995) research into teachers' perceptions of health promoting schools in NSW also indicates a need for the inservicing of teachers in relation to children's health needs and available services.

From *Towards a Health Promoting School* (NSW Dept. of Health, 1996) it emerges that it is also important for successful programs that conditions are created in the formulation of a school health promotion policy that are in fact feasible and appropriate to the whole school community. Once the health promotion priorities for the individual school are set, ways need to be found to make the health promoting policy options possible to implement. For example, the HPS policy needs to be supported in real terms by allocation of human, structural and financial resources within the school setting. This, however, is not always an easy task. In establishing policy there can often be conflicts of interest from various groups within the school community. For instance, an issue such as timetabling can create discord between educational and organisational priorities within the school. Economic, political and cultural factors within the school environment may also exert strong influences over the specific initiatives selected as a health priority so that health promotion outcomes

may be at the mercy of the strongest and most influential interest group. Other necessities include time allocation to adequately plan, time for members of the community to adapt to planned or other changes and time for the health promotion concept to achieve results. Members of school communities need to be convinced that although the goals of health are elusive, as they are rarely quantifiable, school communities can positively impact on the health status of all its members.

In NSW schools in the past, and still the case in many schools, any health issue was regarded as the PDHPE faculty's responsibility. If the HPS concept is to be successful however, then it has to be encompassed by the whole school community based on their specific needs and interests. The Health Promoting Schools initiative has resulted in programs where *all* teachers are now expected to assist in the promotion of children's health as part of their increasingly demanding and complex role. If this is to work, the links between the health and teaching professions need to be strengthened. Furthermore, teachers need to be convinced of the benefits of a health promoting school and must be willing to take these on board and be supported by administrators. As McGinnis and DeGraw (1991) point out, 'health and public professionals will never be able to impose effective school health programs on unwilling school administrators and teachers who already feel overburdened and beleaguered' (p.296).

Few studies of the relationship between burnout and social support for teachers have been conclusive (Brenner, Sorbom & Wallis, 1985; Jackson, Schwab & Schuler, 1980). Whilst the measurement of this relationship has been clouded by methodological issues, Beehr and Bhagat (1985) claimed that the best the research can show is that social support and burnout of teachers are related, without attempting to explain any causality in this relationship. They go on to conclude that at all levels of education, there needs to be a promotion of policies which make the work of teachers less stressful and demanding. There is a close correlation between effective school management and a reduction of occupational stress. A school which effectively utilises the skills of its staff, has good morale, adequate communication systems, a caring atmosphere and procedures which are

decided upon collaboratively will not only be a school that operates efficiently, but is also likely to be one in which levels of stress experienced by staff and students will be significantly reduced.

Other Australian research into the causes of teacher occupational stress has uncovered a variety of stress factors. Included among these have been items relating to the administrative policies and practices in schools. Otto (1986), in reviewing literature which examined the causes of teacher stress, identified poor school administration as one of the stresses. She cites examples from previous research which included administrators being unsupportive and without understanding and sympathy of the problems of their staff, inaccessibility and failure to communicate unilateral decision-making without consultation, taking teachers' efforts for granted without recognition, making petty or unreasonable requests and being unpredictable and inefficient. For any lasting hope that the HPS concept can become an integral and sustained reality in schools, these issues for teachers and administrators need to be addressed.

Futhermore, if health promoting schools are to be successful, parents and communities also need to become committed to the potential benefits of a health promoting school. Once they have background knowledge of HPS and agree with the concept, they have the power to demand quality health programs the same way they expect and demand quality programs in relation to other school curricula. In this model of a HPS, health promotion complements the health education programs and policies already in existence in schools. The aim is that ultimately, with further planning, support, coordination and implementing activities with the whole community, students' health status will be improved.

Achieving these changes is not without difficulty. The importance of a health promoting school may not have a high priority given the many competing demands on time and resources

(Nutbeam et al, 1993, p.8).

Much of the research into HPS has focused on outcomes rather than documenting the process. For instance, evaluations of comprehensive school health promotion programs confirm that such programs where there is interaction between the health sector, staff, students and parents,

positive effects on student health behaviour have resulted (Nutbeam et al, 1993). Less well documented is *how* the health promoting schools concept can be realistically implemented. This is most likely because intensive and ongoing documentation is in itself a long and demanding process.

This is the challenge taken up in this study. It reports on the process of becoming a health promoting school using the suggested guidelines in the literature to move health promoting schools theory into practice. A case study was deemed to be the most appropriate method to analyse HPS policy development and implementation. The next chapter reports on the methodology used for the research. The characteristics of the case study are outlined and the advantages and disadvantages of being a participant researcher are discussed.

## CHAPTER 3

### METHODOLOGY

#### **Mode of inquiry**

My involvement at Pentecost College in the HPS project provided an ideal opportunity to use a case study approach for this research into health promotion in schools. The case was of personal interest as the HPS project was an initiative in which I was actively involved before formal study had begun. As a form of research for this project, the case study provided me with the opportunity as a participant observer, to capture the flavour of what it was like to be involved in the trials and tribulations, successes, constraints, challenges and day-to-day events of implementing HPS from within the school setting. I am the Personal Development, Health and Physical Education Coordinator at the college and have been teaching PDHPE for fifteen years in secondary schools, thirteen of those at Pentecost. My primary role as PDHPE coordinator is to provide effective management of the PDHPE KLA which includes assisting staff in the development of their teaching skills and processes; assessment of the effectiveness of programs; supervision of programs and registers; and provision and maintenance of PDHPE resources. This, added to my teaching duties and support for parents and students, provided me with a solid base and a motivation for examining the implementation of the HPS initiative at Pentecost College.

The case study is particularly useful when examining not only outcomes of a project but all the processes involved. 'A case study is both the process of learning about the case and the product of our learning' (Stake, 1994, p.240). Case studies require a detailed investigation of one site in its complexities and in depth. This particular case study involved studying the interactions of a variety of different groups: students, teachers, parents and other community members, both in and out of the school environment. My personal involvement allowed me to document a detailed reflection of the processes involved in this research. This case

study is generally qualitative, but quantitative data has been used to extend understanding of processes and outcomes. As a case study of a naturalistic site by a participant researcher, the study also has features associated with ethnography and action research.

These various approaches provided the opportunity for a more complex view of an environment in which there were both limits and opportunities that had to be taken into account when evaluating the global functioning of the school. In such a study, as a qualitative researcher I was willing to assume relatively little. This was an attempt to keep the investigation open-ended and to be sensitive to unanticipated features of the study, especially to the descriptions and explanations of events supplied by the participants involved. As a participant researcher, I have been able to immerse myself into the phenomenon of interest which allowed for a more concrete depiction of detail and a greater insight into the complexities of a health promoting school. Whilst this may have created some problems such as bias in the research, it allowed the case study to provide a comprehensive overview of the practices of health promotion in a secondary school which in turn facilitated my understanding of the health promoting schools concept in action.

As Glaser and Strauss (1979) point out, quantitative and other research methods by themselves fail to address the integral social construct and therefore miss a substantial part of the whole picture. The great advantage of qualitative research, I found, is that there is more likelihood that new information will emerge to help answer some of the concerns that quantitative research alone leaves unanswered. It can construct a picture of people's experiences and their interpretation of them.

Qualitative methods can be used to uncover and understand what lies behind any phenomenon about which little is known

(Strauss & Corbin, 1990, p.19).

Qualitative research is becoming increasingly recognised as a legitimate and important methodological approach within the field of health promotion. Qualitative health research has the potential to describe in depth the experiences of people's lives and the social contexts that strengthen, support and diminish health (Gifford, 1996). Small scale action

research projects and case studies are probably the best means of finding the obstacles to knowledge and motivation for healthy behaviour (WHO, 1988). There is now a need to reconsider epidemiological studies and move towards research on concepts of 'context' and 'meaning' (Colquhoun et al, 1996).

This case study deals systematically with a social process. As a participant researcher, I am an integral part of the school system and have an understanding and appreciation of the specific school culture. As a teacher in the school concerned, my accessibility and knowledge of school personnel, community and organisational structure allowed for this topic to be fully explored. It is the 'close-in' and intensive familiarity with the situation that comes from conducting qualitative work that allows the researcher to make judgements about the intricacies of change in schools (Rist, 1994).

A limitation of the study is that the research is only specific to this particular school at this particular time. The nature of this case study is indeed intrinsic in that it is specific to Pentecost College and the product will assist in the direction of health promotion at the school. However, it is also instrumental and should be of external interest to all schools and health promotion personnel as it aims to provide insight into the implementation of health promotion policy in schools. This is an aspect of health promotion rarely covered by the empirical research in the field so far (Stevens, 1993). This case study endeavours to investigate the development of health promotion policy with the purpose ultimately, of analysing what is happening within the school culture, make recommendations and be pivotal in implementing and maintaining positive health initiatives. It involves reflective enquiry in order to enhance the quality of education for the community at Pentecost College. In this sense it is action research as a dynamic process which is built on a foundation of working with people, enabling them to be the key developers of problem solving and change. Because action research is based on a recognition of the inextricable links between research and practice (Carr & Kemmis, 1993), it has a great deal to offer health promoters and researchers. It is an ideal approach to working

with the school community enabling planning, development and learning (Wass, 1995). It can also be used to provide a framework for good reflective practice. The social basis of action research is 'involvement; the educational basis is improvement' (McNiff, 1994, p.3).

The results from this current research would enable changes at Pentecost College to allow for more effective implementation of health promotion initiatives. However, such educational research does not necessarily need to lead to change, and according to Weiss and Buccavallas (1980) enlightenment alone is a legitimate outcome of the process. Enlightenment can help audiences to:

... understand the background and content of program operation, stimulate reverses of policy, focus attention on neglected issues, provide new understanding of the causes of social problems, clarify their own thinking, reorder priorities, make sense of what they have been doing, offer ideas for future directions, reduce uncertainties, create new uncertainties and provide re-thinking of the taken for granted assumptions, justify actions, support positions, persuade others, and provide a sense of how the world works

(cited in Owen, 1993, p.82).

There is support in the literature for participants being directly involved in research (Jorgensen, 1989; Owen, 1993; Stevens, 1993). Most qualitative investigators would agree that the researcher is the instrument. However, the degree of participation varies from external research where researchers have little impact on the actual study to a more internal involvement with the project. My involvement in the intervention and in this case study is central. I am researcher and a participating teacher in the HPS process. Research approaches oriented towards direct participant involvement have become more common place and more widely accepted, particularly in the field of education and health. Supporters of such practices involved Stephen Kemmis and Yolande Wadsworth in Australia, Robert Stake and Yvonne Lincoln in the United States and Barry McDonald and David Hamilton in the United Kingdom (Owen,1993). They agree though that a group commitment is vital in the whole process if the research is to be successful in gaining meaningful information. However, in this particular case, as with much research in schools, it is difficult to attain the commitment of all the participants to the research because of limited time and competing agendas.



Being a researcher who was actually a part of the social construct of the school and unobtrusive in everyday occurrences assisted in understanding the complexities of the study. Green (1996) discusses the benefits of participatory research as being the best chance of producing action or change through an educational process. It fits both the enabling and empowering goals of health promotion and the principles of participatory learning fundamental to health education. This case study involves process evaluation which is concerned with what actually happens in practice (Owen, 1993). Such an approach is used when stakeholders need to know about the actual delivery of an existing policy, program or initiative, either for the sake of improving it or when reviewing the process.

My experience with this form of research can be best summarised by the following quote : '... doing good qualitative research is not easy. It is not a soft option' (Gifford, 1996, p.58). This had become increasingly true for me. Many times I thought that perhaps I had taken the wrong path to data collection and analysis. I wished that I had remained in my more accustomed world of statistical analysis, punching data into 'Statview' or 'SPSS'. A question that I have often been asked from more quantitative oriented colleagues whilst conducting this case study has been: 'What about validity and reliability?' I have simply replied that it is a case study and that it is not appropriate to apply criteria of validity and reliability to such research. However, there is literature on issues of 'rigour' in qualitative research which generally agree that some type of triangulation should be included to increase rigour. Triangulation reduces the likelihood of misinterpretation by employing a number of different approaches to get at the same question. Triangulation has been generally considered a process of using multiple perceptions to clarify meaning, verifying the repeatability of an observation or interpretation. Triangulation serves also to clarify meaning by identifying different ways the phenomenon is being seen (Flick, 1992). Triangulation in this case study involved using a variety of data collection procedures ranging from informal observations to formal questionnaires and interviews to cross reference results.

Issues such as prejudice, personal values and attitudes bring up the inevitability of the researcher's subjective response or interpretation. Such components are inherent but not necessarily negative in a qualitative paradigm. Peshkin (1988) believes that researchers should actively seek out their feelings and emotions during their enquiry so not only to acknowledge them but to be aware of how subjectivity can effect their study, and thus act accordingly. It is important therefore, to mention my own position. I have been involved in health education in secondary schools for a number of years and have experienced the frustrations of conflicting agendas in schools. Teaching PDHPE to senior students and undertaking postgraduate study have resulted in the necessity for increased professional reading. This has further developed a personal interest in health promotion as an answer to many health problems. I sincerely believe that the theory behind the HPS concept must be put into practice to improve the health of our school community. I am passionate about and committed to the concept of the health promoting school and have been actively involved in the entire process of implementing this initiative at Pentecost College. I also have the desire to identify what is likely to facilitate or work against this process. In this case study, I did not look to document the effect of the initiative on the health of the members of the school community, but to document as objectively as possible as to what worked, what didn't and why.

I have been concerned to remain as objective as possible to alleviate bias in reporting the process. As an active participant in initiating the HPS concept at Pentecost College there were often times where I had to consciously stand back and attempt to view things more objectively. This process was assisted by using the variety of data collection methods and by conferring with other staff members involved and with other personnel outside the health promoting school situation. Occasionally my actions had to be justified to other staff members as to whether I was pushing a point as PDHPE coordinator or as a HPS initiator or as a researcher. During this case study it was difficult to distinguish between these roles as they had the common purpose of attempting to provide more effective health promotion strategies for Pentecost College. The personal question remains however:

'Would I have put as much time and energy into initiating the HPS project if I were not writing this thesis?' As a PDHPE teacher and coordinator, I would like to answer 'Yes', but realistically, the answer must be 'No'. It would be unlikely that I would have gone into as much detail into the needs assessment and data collection despite the suggestions in the *Towards a Health Promoting School* document (NSW Dept. of Health et al, 1996). This is because of the ever-increasing responsibilities associated with being KLA coordinator which already take up any available time. I have found that one of the challenges of qualitative research is being open to critical reflection.

A personal struggle at the beginning of this research was establishing a major research question. Unlike some quantitative research, many questions are not known in advance and emerge as the study progresses. Hence, a research statement was written along with a range of related research questions to which the data collected may provide answers.

This case study of the health promoting school has provided a perspective on the commitment of those involved, their belief in the worthiness of the effort, the amount of support that they are engendering and the receptibility of the school community to the initiative.

## **Site and participants**

Pentecost College, is a Year 7 to 12 coeducational Catholic secondary school comprising of approximately 800 students, 57 teaching staff, 15 secretarial and administrative staff and seven grounds, cleaning and maintenance staff. It is a Catholic community which aims to create a safe and caring environment, where all students feel valued, where parents are welcome and involved and where education is for the total person (College Prospectus, 1996). The College's mission statement is as follows:

Pentecost College is a Catholic school providing opportunities empowering all students to achieve their greatest potential in every aspect of life (p.1).

The curriculum offers a wide range of subjects within the eight key learning areas (KLAs) of Personal Development, Health and Physical

Education; Technical and Applied Science; Human Society and its Environment; Creative Arts; Languages other than English; English; Mathematics; and Science. Religious Education is a compulsory subject for all years. The college has a principal and two deputy principals, one having the responsibility for administration, the other, pastoral care. In addition to a coordinator for each KLA there is also a Religious Education coordinator, Special Education coordinator, Curriculum coordinator, Guidance coordinator and Year coordinators.

Prior to the commencement of this study approval was obtained from the principal of the college and from the Catholic Education Office, for the research to be conducted. An information letter to parents was also circulated to seek their support. The participants in the research included students, staff, parents and community members who have been involved in health promotion within the school.

### **Data collection procedures**

This case study makes use of multiple data collection methods. Such 'diverse slices of data' (Glaser & Strauss, 1979, p.66) ensure a wealth of available information and provide different perspective's for understanding social phenomena. The processes involved in this investigation were documented and analysed through a variety of methods such as observation, fieldwork notes, interviews with focus groups, individual interviews and participation with committees and in meetings. Surveys in the forms of questionnaires were also conducted to complement the qualitative data.

Observation, fieldwork notes and daily journal:

Observation consists of gathering impressions of the surrounding environment where researchers must actively witness the phenomena of interest they are studying in action (Adler & Adler, 1994). The object of this approach was to gather first-hand information about the processes of implementing health promotion initiatives in a naturally occurring

environment without any obvious intervention. An advantage of being a participant observer in this case study was that I was part of the school culture and somewhat unobtrusive as a researcher. It also allowed me to follow up other observations and read into the emotion of what was continually happening in the school. Throughout the process, observation of patterns of behaviour (such as physical activity participation according to gender, ethnicity and type of activity) were noted to assist in describing the social structure and the relationships that existed in the school.

One of the initial problems with being a participant researcher was 'information overload'. There was a certain naivety at the beginning of the study as I did not know what was going to emerge and everything that was happening around the school seemed to be related in some way to health promotion. After gathering as much detailed data as possible to analyse, it became a mammoth task to decipher what was meaningful and not meaningful. It was only after themes began to emerge from the data after an initial analysis that the collection of data could be streamlined.

Observations were recorded as fieldwork notes on any aspect of the health promoting school initiatives that were occurring in the college throughout the period of the study. Continuous documentation of events, processes and conversations, together with personal reflections, were recorded in a daily journal. Journals provide a means for in-depth documentation and a means of 'observing our observing' (Holly, 1989, p.143 cited in Rowling, 1996, p.147). Journal keeping can also provide the means for participants in a health promoting school project to identify their own development and to have a way of improving their own skills (Rowling, 1996). Other documentary evidence provided the context for information and was collected from minutes recorded from appropriate committees, letters, newsletters from Health Promoting Schools Project, HPS workshops and in-services, school newsletters, school policy documents, newspaper articles, photographs and other relevant information pertaining to health promotion at Pentecost College.

## Questionnaires:

A variety of questionnaires distributed to students, staff, parents and community members were used along with other instruments to facilitate discussion and to provide further data on the processes of implementing health promotion in schools (see appendices 2, 3 and 4). The questionnaires used were those suggested in *Towards a Health Promoting School* (NSW Dept. of Health et al, 1995) and provided informative data concerning participants' level of understanding of the concept and functioning of health promoting schools. These questionnaires designed to raise awareness and provide a health needs analysis for the school community, were given to every student, parent and staff member at Pentecost College. Other questionnaires included a Youth Health Survey (see appendix 5) conducted by the NSW Department of Health and a drug needs analysis conducted by the Catholic Education Office (see appendices 6 and 7). The Youth Health Survey provided quantitative data as to the current attitudes and behaviours of adolescents to health issues such as physical activity, sun protection and mental health. The drug needs analysis provided a report on the current status of drug use and drug education of students from years 7 to 12 at Pentecost College.

## Interviews and Focus Group Interviews:

Both individual and focus group interviews were used to augment formal observations and served to clarify the meanings participants attributed to a given situation.

Individual interviews were conducted with students, staff, parents and community personnel involved in health promotion within the school, with school administrators, HPS Committee members and health service personnel involved in the HPS project. An interviewing schedule consisting of ten open-ended questions was devised (see appendix 8). These were intended as focus questions that facilitated further discussion, insight and information about the issues at hand. Interviews were tape-recorded and transcribed. To facilitate analysis, notes were recorded throughout the interviews and correlated with transcripts from the audio-tapes. Data were

coded and analysed for emerging and recurring themes, trends and patterns in the participants' responses. Selected verbatim quotes that captured participants' sentiments, views and opinions are included in later chapters.

The focus group interview is a methodology used in qualitative research when there is an interest in the range of opinions of subjects. This approach is also useful in enabling a broad understanding of why participants think and act the way they do. Focus group interviews with students, staff and parents explored participants' responses on a more personal level. This technique provided explanations for responses which assisted in the investigation of respondents' attitudes, values and priorities towards implementing a health promoting schools program. Focus group interviews were conducted in groups ranging from four to eight. Selection of participants was based on an attempt to maintain representativeness of the school population. The difficulty in this process was that interviews were mainly limited to those interviewees who were interested and available for interviews. For example, most of the focus group interviews conducted with parents were with those who were involved with the school in some way such as helping with the reading program for students, canteen workers, Parents' and Friends' Association members and senior exam supervisors. These of course are parents who already have a vested interest in the school. The difficulty arose in communicating with those parents who have little contact with the school. Questionnaire responses and limited individual interviews with these parents overcame this to some degree. The focus group interviews were structured and had the advantage of discussing different points of view that emerged from participants. However, the effect of group dynamics in relation to power and influence was evident in some sessions where certain individuals dominated discussion whilst others contributed little.

Unstructured, informal interviews with students, staff and parents in everyday communication around the school yielded much meaningful information that assisted with the inquiry. Again, this reflected the advantage of being in a participatory researcher role. The value of the

personal rapport with students, staff and parents that has been built up over the years at Pentecost College cannot be underestimated.

## **Data analysis**

Data was analysed and presented in a descriptive style of reporting. All data collected was filed and coded into various categories. The analysis was a continual process of developing conceptual themes and of cross-checking data. Emerging patterns and themes resulted from the analysis of data and certain conclusions were derived. Interpretation was assisted by close reading of all data and by drawing on the collaborative network of all key personnel. My interpretations of what happened in relation to implementing the HPS initiative into the school were compared with the interpretations of others involved in the health promoting schools project so as to minimise bias and increase the trustworthiness of the data.

Qualitative data analysis, I have realised, requires a great deal of time. The sheer volume of data one collects in a study such as this needs organisation. Whilst initially tempted to use 'Nudist' (Non-numerical Unstructured Data Indexing Searching and Theorising) as a computer program to analyse the data, I found that I was spending far too much time categorising data rather than interpreting. Whilst coding and organising is an essential process of qualitative analysis, I found it more enlightening to perform this on a manual basis. Much time was spent reading and re-reading transcripts and actively searching for explanations, understandings and consulting with others on my interpretations of the data. Transposing from one manilla folder to another, adding information to computer files, darting from transcript to text, constantly up-dating diary entries on health promotion, a scribble here, writing a page; consumed my days. Although sounding somewhat disorganised, I found that this process greatly assisted me with my overall analysis of health promotion at Pentecost College and my understanding of the enormity of the issues and implications of what it means to be a health promoting school.



Findings and discussion from the case study are presented in four categories that form the systematic process for becoming a health promoting school (NSW Dept. of Health et al, 1996). These are:

1. Awareness Raising - which included introducing the school community to the concept of a HPS; conducting a health needs analysis; and developing a shared vision amongst members of the school community.
2. Planning - involved identifying available resources; determining priority areas; developing an action plan to achieve goals and desired outcomes; and establishing evaluation procedures.
3. Implementation - consisted of maintaining ongoing support for the implementation of the plan; documenting what was being done; and maintaining effective communication.
4. Evaluation - included reviewing and monitoring each step along the way; determining the success of programs and practices; providing regular feedback to the school community; and determining future directions and assessing the value of continuing the project.

Within each of these defined processes, the three interactive areas of the health promoting school's framework of curriculum, ethos/ environment and school-home-community interface is examined with the responses from students, staff, parents and other community members. The following chapters are not categorised into the various health promotion initiatives implemented at Pentecost College but in the order of the *processes* of awareness raising, planning, implementation and evaluation. While the processes appear somewhat sequential, the categories in practice are more integrated. For writing purposes, the processes have remained separated. Within these chapters, the health promotion initiatives are defined and addressed in terms of curriculum, ethos/environment and the school-home-community interface. Each chapter is represented as a piece of a jigsaw from the *Towards a Health Promoting School* document (NSW Dept. of Health et al, 1996); the aim being to discover how the jigsaw fits together.

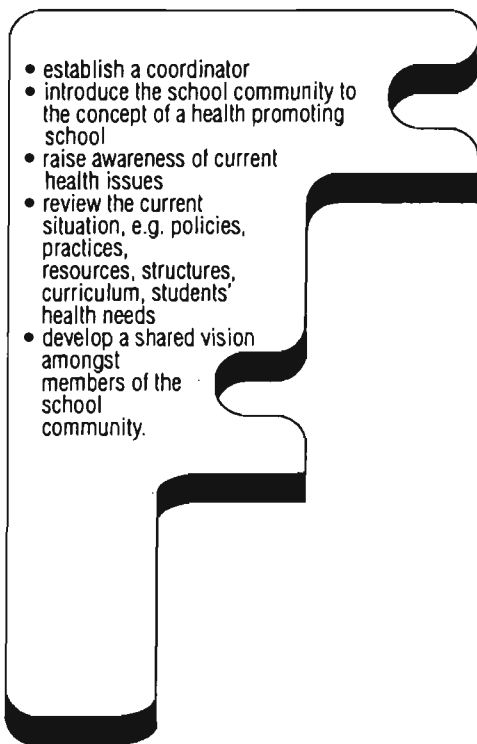
The case study researcher faces a strategic choice in deciding how much and how long the complexities of the case should be studied (Stake, 1994). It was a difficult decision for me to draw the line as to when to cease

data collection. This case study analyses data which was collected over a two and a half year period from May 1995 to October 1997. I rationalised that this period would allow time to get the project established in the school and for each of the outlined processes of becoming a health promoting school to be implemented to some extent. Whilst the HPS concept is ongoing at Pentecost College, this case study reports on the implementation of the health promoting schools project and the processes involved and outcomes attained in this initial two years plus period.

This reporting on process begins with a brief history of the school before being involved in the health promoting schools project. It outlines the roles of key personnel and associations involved in implementing the health promoting schools initiative and discusses the links with health and welfare services. Other specific areas that emerged during the course of the study such as professional development and training are included in the findings. An overall summary of the case study is provided with discussion of the findings and recommendations for the future.

## CHAPTER 4

### AWARENESS RAISING



#### The process

Raising awareness is the recommended first stage of the systematic process of becoming a health promoting school (NSW Dept. of Health et al, 1996). It introduces the concept of the health promoting school to the whole school community and establishes the framework and support for the remaining stages of planning, implementation and evaluation. This chapter discusses how Pentecost College became involved in the HPS project and examines the process of awareness raising for health promotion within the Pentecost community. It explores the initial naivety and limited understanding of those involved in the health promotion concept from the first point of application for funding by the PDHPE staff to the complex and broad issues faced by the members of the health promoting schools committee, school personnel and wider community. Added to these concerns are the resultant difficulties, obstacles and frustrations, along with the obvious interest and acquired knowledge from all sectors of the school cooperative, that gave premise to the general awareness of what a health

promoting school could mean. The difficulties in bringing health promotion awareness to the school community, developing an understanding of the broad and encompassing idea and integrating the health promotion philosophy into the day-to-day routine of the school are further considered.

The beginning:

Funding from NSW Health and Healthy Cities Project, together with support from the Department of School Education and Catholic Education Office, led to the introduction of the Health Promoting Schools Project in the local area in January, 1995. It is important to note that at this stage, all financial support for staffing of the NSW Health Promoting Schools Project had come directly from the NSW Area Health Commission. The previous Liberal government in NSW, who were firmly committed to the global concept of health promotion, were on the verge of committing substantial funds to the Health Commission. The Labour government responded to this commitment to increase health promotion in schools by issuing a statement that was solely limited to increasing physical activity in the school curriculum. They failed to take up the broad concepts of the health initiatives proposed under the Liberal Government so it is likely that there will be limited funding available whilst they are in power. Added to this is the fact that although school systems and their directors are theoretically in favour of promoting health in schools, they have not contributed any financial aid to date.

Each state in Australia is approaching the concept of Health Promoting Schools differently. Even within NSW, the local Area Health Services have different funding priorities. The Area Health Service, which covers Pentecost College, has demonstrated a commitment to health promotion in schools through the global context encompassing students, teachers, parents and the wider community. This has been in line with the European concept and has been based on health and education personnel working together for the school. Funding has been allocated within the Area Health Service to employ additional health personnel to assist schools

in establishing the HPS project. Sharing expertise and resources available in the local area was seen as the key for collaborative action. A HPS team was established within the Area Health Service and personnel from Healthy Cities, Water Board, City Council, Environmental Protection Authority, and local business organisations were enlisted to support the project.

Ten local schools, five primary and five secondary were invited to develop a health promotion initiative within their schools in the areas of physical activity, environment, sun-protection, safety, nutrition and personal development. Pentecost College applied for and was selected as one of these pilot schools in May, 1995. Later it was found that these schools were the only ones to have shown interest in the project by completing and returning an application form to the Area Health Service.

The initial interest in the project at Pentecost at this point in time came from a desire by the PDHPE staff to try and obtain any form of accessible and available funding. The PDHPE staff consisted of five full time teachers (three male and two female staff members). We saw the HPS project as a possible avenue that may have provided funds to improve the poor facilities and resources existing at Pentecost College. With very limited physical facilities for indoor PE lessons there was a certain naivety and a singular hope from the staff that if the school was successful in its application, it could possibly be the first steps towards building a multi-purpose hall or gymnasium. As PDHPE coordinator, after consultation with the PDHPE staff, the decision was made that Pentecost College's initial priorities should be an attempt to obtain funding for an indoor facility for physical activity and for the development of a senior (Year 11 and 12) personal development and health course. These priorities were included on the application form which was forwarded to the Health Promotions Officer at the local Area Health Service. At this stage no administrative personnel or other staff members apart from PDHPE staff were involved and the senior executive had little, if any, knowledge of the initiative.

Unknown to me at the time however, the principal had placed a copy of the HPS pilot school application form on all KLA Coordinators' desks for discussion at the next executive meeting scheduled the following week.

The principal's thought was that health promotion priority areas would be discussed by all KLAs and one application submitted accordingly. When I saw the item on the agenda for this meeting, I informed the principal that the application form was already completed by the PDHPE KLA staff and had been returned to the appropriate authority. I explained that I had assumed that the principal had only passed the application on to me for my attention, as any correspondence relating to health issues has traditionally been passed to the PDHPE department. The typical pattern of assuming that health in schools is the responsibility of the PDHPE KLA was evident. After this explanation, the principal did not seem too perturbed that the other KLA Coordinators had missed the opportunity to have input into the application. In practical terms for the principal, it meant one less item for an already overcrowded agenda. The principal accepted the PDHPE departments' priorities and it was mentioned at the following executive meeting that the issue had been addressed. No further discussion resulted as no-one at the meeting really had knowledge of the HPS concept and what it entailed. In retrospect, given the HPS aims and guidelines, consultation with representatives from all areas of the school community should have occurred at this stage of nominating priorities. However, because of the time line requirement, my limited knowledge of the HPS project and lack of any guidelines in these early stages of the project, this did not occur. I had no advanced knowledge that such a project was forthcoming and the timeframe for response was unrealistic. Insufficient time for consultation for the many issues that schools are asked to address is a common problem. For deadlines to be met, it is usually left to an individual who must respond to demonstrate an interest from the school.

The initial link:

The first meeting as a participating pilot school in the HPS project took place in June, 1995 between myself, another PDHPE staff member and the Health Promotions Officer (HPO) from the Area Health Service. It was then that Pentecost College was introduced to the HPS concept through the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1995) draft

document. It was stressed by the HPO that the first thing to do was to look at what we were already doing at Pentecost College in terms of promoting health in the school community.

When we came to review our initiatives, we realised that previous activities between the health and education sectors were often disorganised and short-term. 'One-off' health promotion days were the norm with no real collaboration between the school community and the health services. However, after assessing what the school had been doing collectively in recent years we came to the conclusion that the college was informally moving towards a health promoting school but without any definite guidelines or structure. Although a number of health initiatives had been implemented it had been without centralised coordination. Health promotion initiatives only occurred in the school due to the efforts of a few individuals that had personal interest in particular areas. From the point of view of HPS principles, the process and acceptance of health issues and health promotion amongst students, staff and parents had not been maximised. There was no ownership of health promotion by the whole school community, which in essence failed to address the specific health needs of its members. Coordination of the health promoting schools project was seen to be an important step in the process of increasing the health of the school community through meaningful health promotion strategies.

Prior to becoming a pilot school for this initiative there was a large number of processes, policies and programs already operating (see appendix 9) which could be incorporated into the health promoting school framework. *Towards a Health Promoting School* (NSW Dept. of Health et al, 1995) offered a checklist to determine what was happening in the school in the areas of the formal curriculum, school ethos and the school-home-community interface (appendix 10). This checklist was completed in a staff focus group session with members from other KLAs as well as PDHPE staff. Examples of some of the policies and programs identified as operating at Pentecost College in the areas of curriculum, school ethos/environment and the school-home-community interface were:

## Curriculum

- \* Provision of a curriculum which promotes the growth and development of the whole person
- \* Well developed PDHPE programs throughout years 7 to 12
- \* Opportunities for students to be involved in sport and recreational activities
- \* Provision for inservicing of staff, for example:
  - first aid and resuscitation
  - sexual abuse
  - individual learning strategies
  - grief and loss
- \* Catering for student with special needs (Special Education Unit and Gifted and Talented workshops)
- \* Co-operative learning strategies (Accessing Learning)

## School Ethos/Environment

- \* A pastoral care program which is designed to recognise and promote the dignity of each person in the school community. Every effort is made to challenge the students to critically reflect on their own behaviour and to mature through accepting responsibility for their actions
- \* Positive student discipline (Glasser approach)
- \* Merit and reward system
- \* The appointment of a second Deputy Principal in 1994 in charge of Pastoral Care of the school
- \* Provision of a Guidance Coordinator available for counselling of students, parents and staff on a one-to-one or small groups
- \* Counselling is also available to students of the college through the Catholic Family Life Centre (Centacare)
- \* Funding allocated for 'Students at Risk' (STAR) program
- \* The development of numerous policies, for example:
  - bullying and harassment
  - child protection and safety
  - critical incident management
  - critical incident management
  - supervision
  - healthy canteen
  - sun protection
  - QUIT smoking program
  - litter and the environment
- \* The formation of various committees, for example:
  - Occupational , Health and Safety
  - Gender Equity
  - Affirmative Action
  - Equity Education
  - English as a Second Language
  - Health Promoting Schools
- \* Peer support program which allows Year 7 students to adapt to their new way of life in high school whilst acknowledging and developing the leadership skills of the Year 11 students



- \* The formation of support groups for students with special needs:
  - C.O.Js' (Companions on a Journey)
  - Buddy system
  - Assertive Training
  - Social Skills Training
  - Relaxation and Meditation
  - Study Skills
- \* Access to a private room for staff who are ill or want to 'get away from it all'
- \* Weekly morning tea celebrating staff members' birthdays, welcoming outside visitors to the school
- \* Camps and retreats

#### School/home/community interface

- \* Appointment of a Parent-liaison person who regularly communicates and encourages parental involvement in the school
- \* Parent communication
  - reports
  - newsletters
  - information days
  - parent/teacher days
- \* An active Parents' and Friends' Association
- \* Establishment of a 'Foundation' group who works at bringing financial aid to the college
- \* Involvement of parents in the school:
  - reading programs
  - resource centre assistance
  - canteen helpers
  - exam supervision
  - annual fete day
- \* Community use of the college's sporting facilities
- \* Support groups use of school buildings such as:
  - Alcoholics Anonymous
  - Narcotics Anonymous
  - Parents Support Group
  - Computer literacy
- \* Health services and screening at school, for example:
  - regular visits by the Mobile Blood Bank
  - health checks, immunisation programs
  - Cancer Council Promotions - swimming carnivals, athletic carnivals.
  - scoliosis testing
- \* Police Liaison Officer
- \* Provision of 'Camp Quality' companions

- \* Involvement in community health promotion campaigns such as:
  - 'Jump Rope for Heart'
  - 'M.A.D.' (Melanoma Awareness Day)
  - 'CanTeen' fun runs
  - Salvation Army appeal
  - 40 Hour Famine
- \* As a catholic school there was already an established link with the catholic community of teachers, parents and students through the church.

The committee:

Initially, a Health Promoting Schools committee was informally organised from seven interested staff plus the administrative executive consisting of the principal and the two deputy principals. A coordinator for HPS was required to serve as a link between the school and the health sector to guide the school towards more effective health promotion. This is a role that fell to me at the time because of my role as PDHPE coordinator. However, I was somewhat reluctant because the HPS concept should not only be seen as the PDHPE faculty's responsibility. The entire school community must have input into the initiative and provide support for it to be effective. It was not until February 1996 that the Health Promoting School Committee was formalised and official election of a chairperson took place. It was important to me that the HPS project was not seen as merely the PDHPE faculty 'pushing their own barrow' so I declined nomination for the chair. The Guidance Coordinator took up the position and this was a positive step in raising awareness that the whole school community should be involved in the HPS initiative. The committee was then expanded to include other interested parents and student representatives as outlined in the HPS guidelines. As is suggested by policy literature (Hogwood & Gunn, 1988), policy is more likely to succeed if all stakeholders should have an active role in policy formation and implementation and in this way the committee became more representative of the community in which health promotion would become a focus.

Having documented what was already happening in the school, the HPS committee members agreed that most current policies and programs operating at Pentecost College needed to be reviewed. Naturally this was to be expected as any working program or policy needs to be continually reviewed and evaluated in order to be effective. Some of the emerging health promoting themes presented from the checklist demonstrated that the formal PDHPE curriculum was well established and satisfied the necessary requirements for a solid base for health promotion within the school. On the other hand, there were concerns from the committee members and PDHPE staff as to the effectiveness of the school sport program and whether or not it was meeting the needs of all students. It was also felt that although the school had made policies and developed procedures within the school ethos/environment area, many staff and students were unaware of them. In addition, whilst it was assumed by many that the school had policies developed for sun safety and a healthy canteen, they were not formally acknowledge in Pentecost College's handbook. Thus, such policies did not really exist; they were simply informal agreements developed through past practice. Committee members also expressed strong concerns about the menu of the school canteen and the lack of health promotion directed at staff. The improvement of the physical environment of the school emerged as a important priority that the HPS committee felt would not only beautify an already less than adequate surrounding but would also provide desperately needed shade areas for students and staff. It was noted at the time that Pentecost College was not a member of any health promotion associations such as the NSW Health Promoting Schools Association and that there was little emphasis on the awareness of health promotion issues through public forums such as school assemblies, staff meetings and school newsletters.

The school-home-community interface was already visible to some extent. Whilst Pentecost College had established links with parents in terms of their assistance in the school community with such activities as exam supervision, canteen work, assistance in the library, uniform shop, reading programs and working bees, it was agreed by the HPS committee

that parents really had little input into the procedures and practices of the school. In areas such as curriculum, policies and programming, parents were neither consulted nor encouraged to be part of the decision making processes within the school. The small group of parents who were regularly involved in the formally mentioned school partnerships, certainly did not represent the diverse range of cultural groups in the school community. Moreover, whilst there were traditional established links with community support services such as Centacare (Catholic Family Life Centre Counselling) and health care checks for students, fewer opportunities for staff, parents and other community members to access similar services were presented.

Despite these drawbacks however, the group discussions indicated that Pentecost College was in fact informally involved in health promoting activities and ideas. There were notable issues however, that needed to be publicly and formally addressed in order for the school to become more effective in promoting health for all its members.

The next move:

According to the guidelines in *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996), the first step in becoming a health promoting school is to introduce the school community to the concept of a health promoting school and to raise awareness of current health issues. However, without the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) guidelines, this vital stage had not been initially addressed by the Health Promoting Schools' Committee. Part of the problem of any committee is the immediate desire to be visibly active in the implementation of policy. The committee was enthusiastic and wanted to immediately implement health initiatives rather than spend 'valuable' time in discussing and developing at length a policy statement articulating the school health program vision and outlining the review and planning process. The group therefore had unknowingly ignored the initial stage of awareness raising advised in the HPS guidelines at this stage and escalated to the planning stage where key issues were determined through assessing

current policies and consulting with key groups. However, very little consultation was conducted with students, parents and others in the community. At Pentecost College the committee, after one meeting's discussion, decided by consensus that the priority areas at this time for the school were 'Sun Safety' and the 'Development of the Physical Environment'. The basis for this decision included the following reasons:

- \* the physical layout of the school presented unique problems;
- \* the distinct lack of cover/shade provision for students and staff;
- \* the problem of having a public thoroughfare running through middle of the school creating continuous vandalism of the school;
- \* lack of finance but with some community support available; and
- \* PHDPE and sport lessons often timetabled during the middle part of the day.

(HPS committee meeting minutes)

#### Action:

Liaisons with a representative from the City Council gave the HPS committee guidelines to solving the problems of the physical environment of the school and provided expertise in the form of technical advice and access to assistance through free labour programs. This liaison was established through the efforts of the HPS project officer and the commitment of individual HPS committee members.

The initial step suggested by the council representative was to attain the services of a landscape architect, who surveyed the school grounds and after consultation with the committee prepared a draft design for improving the physical environment for the college. Once the draft design was completed, opinions from various interest groups, students, teachers and parents were sought. All staff were presented with the plans at a staff meeting and provided with an opportunity to comment at the meeting or at later time. The plans were posted in the staffroom with a book for writing comments and suggestions. Students also had the same opportunity with plans being on display in the school foyer and library. Parents were invited through Parents' and Friends' Association meetings and newsletters to contribute their ideas. This process resulted in a collective 'wish list' and was viewed by the committee as a long-term project with the possibility of the year 2000 as an appropriate target for the school to work towards realistic

planned outcomes. As to which outcomes we wanted to work towards was unclear at this time because of the many and varied needs of the school community. However, it became evident from all interest groups, that one of the most supported needs was to provide an undercover shelter to provide protection from the elements large enough for the entire school population to utilise. This along with enhancing the total environment became the priority for the HPS committee. This initial process occurred towards the end of 1995 with the aim of the committee being to launch the HPS project at the beginning of 1996 with these specific goals in mind. At this point however, the process seemed to stagnate. Many projects in schools lose their momentum at the end of the year with the summer break approaching and the associated pressures of completing necessary tasks associated with teaching.

Back to the beginning:

At the beginning of 1996 I was keen to get the HPS project moving again. The HPS committee meeting held in the first week of the year began by examining what was feasible to achieve in the short term. It was apparent that the HPS committee was working in isolation from the wider school community. Many were unaware of what the HPS project involved or actually meant. The connection between the enhancement of the school environment and provision of an undercover area as part of the HPS project was not recognised by the school community. With the support of the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1995) draft document and later with the final *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) document and further advice from the Health Promotions Officer, the process thus far was evaluated by the HPS committee and a back-track to the first stage of 'awareness raising' and the second stage of 'planning' was necessary. According to *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) each step is vital in the total process so that students, teachers, parents and the wider community can take on the ownership of health issues that affect them directly. If people are able to internalise health concepts through such an approach, the

initiative then has the value of being proactive in its focus, enabling people to make positive lifestyle decisions. The HPS committee had bypassed this stage and a reassessment of the school's priorities for health promotion was required in order to provide *all* the school community members with knowledge of the HPS initiative.

Thus the 1996 school year began by introducing the school community to the concept of a health promoting school. This task was far more difficult than it first seemed. The enthusiasm of the committee was not necessarily that of the remaining staff or students. Other committees considered just as important and essential to the promotion and smooth running of the school competed for the involvement of the community members. The task remained, however, to encourage and empower other members to show a commitment to the initiative.

Raising the awareness:

One of the methods of raising awareness whilst simultaneously conducting a needs analysis was through providing students, staff and parents with information about the health promoting schools concept and asking them to complete questionnaires on what they saw as the specific needs of Pentecost to become more health promoting. These questionnaires for parents, staff and students were taken from the *Towards a Health Promoting School* (NSW Dept. of Health et al, Draft, 1995).

Fifty seven questionnaires (appendix 2) were given to staff members via their pigeon holes in the staffroom with follow up information presented at a staff meeting. Forty two of these were returned completed. As well as raising the awareness of the HPS concept and to give a staff's perspective on what the health needs were at Pentecost College, the questionnaire's purpose was to solicit support for the initiative. Selected staff members were also interviewed in four focus groups of five teachers and fourteen individual interviews as a follow-up to the questionnaire responses.

Information letters with a questionnaire (appendix 3) were mailed to 597 parents with 140 returns. A box was provided for parents or their

children to return the questionnaires to school. Six focus group interviews were initially conducted with parents with four to six parents in each group. These parents that were interviewed were those that I had easy access to in the school, that is, they were involved in some way within the school (Parents' and Friends' Association members, canteen workers, reader helpers and exam supervisors). Seven hundred and sixty students completed the student questionnaire (appendix 4). This questionnaire was administered by myself and the PDHPE staff in Years 7 to 10 in PDHPE lessons and to Years 11 and 12 students in Religious Education lessons. Two focus group interviews from each year level (Years 7 to 12) were conducted as a follow-up to the questionnaires. Student focus groups consisted of six students, three male and three female randomly chosen from volunteers to be representative of each year group.

The questionnaires used were taken straight from *Towards a Health Promoting School* (NSW Dept. of Health et al, Draft, 1995) with no alterations as part of the study involved trialing the complete HPS package. The staff and student questionnaires were relatively easy to complete and analyse and our experience produced only minor changes to these when they were revised for the final *Towards a Health Promoting School* document (NSW Dept. of Health et al, 1996). However, the parent questionnaire from the *Towards a Health Promoting School* (NSW Dept. of Health et al, Draft, 1995), was a poor instrument. In hindsight, it was difficult for parents to complete. A number of the open-ended questions were too abstract in meaning for parents to fully understand. Their responses in return were very broad, testifying that health promotion was viewed as an all encompassing concept but one which many parents believed was the responsibility of the school.

The parent questionnaire presented in *Towards Health Promoting School* (NSW Dept. of Health et al, 1996) has now been altered considerably partly due the difficulties encountered at Pentecost College acting as a pilot school. The format of the questionnaire is now written in more 'user-friendly' terms (see appendix 11). This meant more direct questions that required a 'yes/no' response with space for personal comment. Part of the



process of being a pilot school for the HPS project was to work with the draft document and provide feedback on its application.

The majority of staff and parents at Pentecost College acknowledged the notion of physical, social, emotional and spiritual aspects of health for their children but this was the limit of their understanding of what a HPS should be. Parents, particularly, wanted their child's health to be developed in all these areas but could not provide any concrete ideas of how this was to be accomplished. Generally, parents had few specific suggestions about how to promote health at school but certainly wanted policies and procedures to target the total well-being of each student which in turn would produce well adjusted young adults. For example, quotes from parents included: 'We would like the school to have a strict policy on drugs' (Year 9 parent), 'I don't want my son to feel threatened and bullied at school' (Year 7 parent) and 'Parents need to be aware of school policy and procedures on drug users in the school' (Year 12 parent).

Students' understanding of the HPS concept was more narrow. They concentrated more specifically on the development of their physical health and conceptually did not look beyond this definition. Typical quotes from students included: 'We should have more sport', 'A health promoting school is healthy food in the canteen', '...teaching us about our bodies' and 'looking after all aspects of the school environment - shade, food, sun shelters, rubbish'.

From the questionnaires and follow-up interviews with representatives of these three groups (students, parents and teachers), the general responses were very supportive of the health promoting schools initiatives that were to be implemented at Pentecost College. Whilst all three groups expressed support for the HPS concept, it was difficult to find individuals to help when *action* to promote the health initiatives was required. 'Anything to do with health should be the PDHPE KLAS responsibility' (senior male staff member).

In addition to these internal questionnaires and interviews to raise awareness of the HPS project, other questionnaires administered at the college included a Youth Health Survey (see appendix 5) conducted by the

NSW Department of Health and a drug needs analysis conducted by the Catholic Education Office (see appendices 6 and 7). The Youth Health Survey provided quantitative data as to the current attitudes and behaviours of adolescents to health issues such as physical activity, sun protection and mental health. The drug needs analysis provided a report on the current status of drug use and drug education of students from years 7 to 12 at Pentecost College. The remainder of the chapter will be devoted to reporting on the main concerns that emerged from the awareness raising process and the needs analysis at Pentecost College. These will be analysed in the context of the three interactive areas of the health promoting school's framework of curriculum, ethos/environment and school-home-community interface.

## **Curriculum**

### **Physical activity:**

Most students (67%) from the student questionnaire (appendix 4) suggested that there should be more time in the curriculum for physical activity and sport. Despite parents' given understanding of health, from their comments in the parent survey, which seemed to look to the development of the 'whole person', parents singled out the more specific need for physical 'fitness' rather than physical 'activity' to be increased in the schools' curriculum time. Seventy-eight percent of parents believed that physical fitness was essential to the well-being of a healthy person and that it needed to be a priority of the schools' administration when allocating time to each KLA. This sits next to a response from staff where they were opposed to providing more time in the curriculum for physical activity (76%).

Figure 7 clearly shows that whilst the majority of students and parents believed time for physical fitness/activity/sport should be increased in the curriculum, it was not supported by the majority of staff. The reason that emerged for the staff's response was that sufficient time was already allocated, but the problem was in the effectiveness of the time used for

physical fitness/activity/sport. As part of the health promoting school project at the college, the issue then became how to make the curriculum time already available for physical activity more productive to satisfy the needs of all concerned.

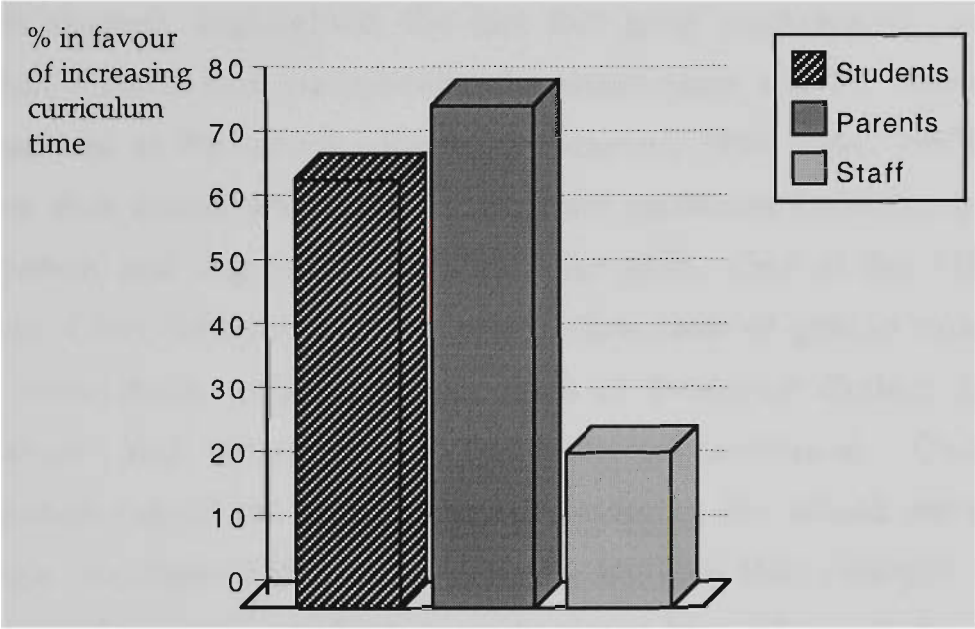


Figure 7. Provision of more curriculum time for physical activity.

The encouragement of physical activity requires a solid foundation deriving from the PDHPE curriculum. One of the priorities of the PDHPE staff over the past two years at Pentecost College has been the need for a greater input into the class structure and timetabling of PDHPE and sport classes.

Recently, one specific area concerning gender make-up of physical education (PE) classes has been identified as having potential to enhance participation and enjoyment in PE classes in order for parts of the curriculum to be more effectively implemented. Since the introduction of the Year 7 to 10 PDHPE syllabus at Pentecost College in 1992, there has been a general move away from single sex PE classes to a mixed sex coeducation, integrated approach to these lessons. This was phased in at Pentecost College over two years so that the majority of PDHPE classes became coeducational for both health and physical education classes. Prior to this, all PE classes were single sex. Historically, physical education has developed as a discipline on quite distinctive gender lines with different aims and

expectations (Scruton, 1990). Therefore, the introduction of coeducational PE classes resulted in significant changes to the PE program at Pentecost College.

Personal observation, PDHPE staff evaluation and discussions with students strongly highlighted the fact that girls' participation in physical education lessons had dramatically decreased since the PE classes became coeducational at the school. Research (Scruton, 1990; Cleal, 1993) supports the view that mixed sex PE classes generate problems concerning levels of participation and degrees of confidence for girls. One of the PDHPE staff members, Cleal (1993) compared participation rates of girls in mixed sex PE classes with those in a single sex class at Pentecost College by teacher observation and administering student questionnaires. Overall, the participation rate of the girls was much lower in the mixed sex class than the single sex class. Other disadvantages for girls that emerged from this study were that female students were harassed by the boys in the mixed sex class, the boys dominated game situations, the girls were ridiculed for their skills and were then too embarrassed to participate in many of the PE activities. The PDHPE staff in their day-to-day teaching experience at Pentecost College concurred with these results. They did report that whilst some mixed sex PE classes worked well, the overall view was that these classes were in the minority and that significantly, mixed sex PE classes were not successful, particularly in promoting physical activity for girls.

Comments from focus group interviews in this current study, reflected similar sentiments. Comments from the girls included: 'The boys just show off in front of us and won't let us do anything' (Year 9 student), 'We're not swimming with the boys - they're just out for the perve' (Year 8 student). Despite these problems, a number of Year 10 girls clearly preferred mixed sex PE classes. These girls reported enjoying the social interaction between the sexes which they did not have the chance to enjoy in other subject areas. It was noted however, that when the students were asked to move into groups during these classes they still produced single sex groupings. Many of the problems of coeducational PE classed did not seem to appear in the Year 7 groups. There were fewer differences in boys' and

girls' physical maturation so that they could compete equally, their socialising was more centred on friendships rather than 'girlfriend' and 'boyfriend', they were more compliant to teachers as authority figures and still maintained an active interest in their participation of physical activity.

Further problems resulted from the PDHPE classes being linked on the timetable to other subject areas such as Mathematics and English which were based on levels of ability, causing some PE classes to contain unbalanced gender groups. In Year 9 for example, where girls already felt anxious about participating in mixed sex PE activities, the lower classes were made up of 22 boys, 6 girls and 21 boys and 9 girls respectively (1996 classes). PE teachers were also unable to team teach because of timetabling restrictions, so that there was no alternative but to teach these classes in their coeducational format. Added to this was the complicating factor that some PDHPE classes were being taught by non-trained PDHPE teachers who had difficulty in dealing with basic PDHPE curriculum let alone having the experience to deal with difficult gender issues in PE classes. This only exacerbated the lack of participation or domination of students and often created discipline problems for the teacher and myself as PDHPE coordinator. The critical aspects of staffing, class structure and timetabling of PDHPE classes were thus issues that the PDHPE staff saw as essential to address in order to promote physical activity at Pentecost College.

In addition to allocated PDHPE lessons, Pentecost College operates an integrated approach to sport. This system which has been in place since 1990, is organised so that Years 7 to 10 have experience of two periods of sport per week; each year timetabled on separate days. This was originally introduced because the traditional sports afternoon where all students and staff were involved in sport or related activities, developed numerous problems both within the school and outside the school environment. The philosophy of participation and physical activity in sport and its desired outcomes were being eroded and a change from the administration in the structure of the school day resulted in this traditional afternoon of sport being abandoned. To provide opportunities for regular physical activity and skill development for all junior school students, integrated sport to

supplement PE classes was considered the most suitable solution. Initially, the PDHPE staff were able to staff the integrated sport lessons, however, as further elective classes were added to the PDHPE faculty, the staffing of sport drew more widely from the college's teaching staff. This combined with problems timetabling sport and the lack of regular sport for Year 11 and 12 students, was a further issue that the PDHPE staff identified as important if physical activity was to be promoted effectively.

25-hour personal development and health course:

One of the students' and PDHPE staffs' initial concerns, through questionnaires and interviews, was senior student opportunities to participate in the PDHPE curriculum. The Year 7 to 10 PDHPE program has been well established at Pentecost College and is mandatory for all students. However, prior to 1992, there was no mandatory PDHPE component in the senior curriculum for any student in NSW schools. Many students therefore were given no formal PDHPE during their important years of maturation in Years 11 and 12. Such education in this turbulent period of physical, emotional, social and spiritual growth is crucial in their adolescent years. Many students during this time employ high risk-taking behaviours as a response to their exploration and understanding of life's experiences (Curtis, 1992).

In response to this, in 1991, a 2 unit PDHPE syllabus became available to schools to implement in Year 11. One of the limitations of this initiative was that the course was offered as an elective senior program. As such, when faced with decisions of subject choice only a minority of students elected to study this course. Therefore, in an attempt to cater for all senior students health and social needs through the curriculum, the NSW Department of School Education (DSE) developed a 25-hour personal development and health course for Years 11/12. This course was implemented as a mandatory program in all NSW DSE schools in 1992.

In response to the community's grave concern over the harmful impact associated with drug use and infection with HIV on the lives of

young Australians, the course focuses on two particular issues, drug education and HIV/AIDS education.

This concern about drug use (including tobacco and alcohol) and HIV/AIDS infection is such that it was felt that an initiative was needed to provide a formal learning experience in the senior secondary school to assist young adults in Government schools to make and act upon informed health decisions both while they are at school and in the years to come

(Cowling, 1992 p.2).

A formal Year 11/12 PDH course is currently only mandatory in government schools in NSW. The HPS initiative provided the means to enlist the support of others for a similar course at Pentecost. One of the curriculum priorities for Pentecost College, then, initially identified by the PDHPE staff but now well supported by the HPS committee and the administration, was the development and implementation of some form of PDH course. The need for the introduction of a 25-hour PDH course had become particularly evident as a result of certain curriculum changes. Prior to 1994, all Year 11 and 12 students at Pentecost College were studying a compulsory school-based Religious Education Course (1 unit) as part of the curriculum. Encompassed in this course were numerous personal development and health topics designed to cater for the specific needs of the senior students. However, with the introduction of the Board of Studies course 'Studies in Religion', students now had a choice of Religious Education programs. The majority of senior students selected the Board Course rather than the school-based program as the 1 or 2 units of Religious Education studied count towards their Tertiary Entrance Rank (TER) score for their Higher School Certificate. This course however omits the personal development and health topics that were previously taught in the school-based Religious Education program. Many of these students, like their counterparts in Years 11 and 12 in government schools had previous to the introduction of the mandatory PDH course, had no formal PDHPE education during their important and formative years of maturation.

In this context, the HPS committee supported the move to develop and re-introduce a personal development and health course at Pentecost College to allow all students further exposure to this important aspect of

their education. This had the support of students, staff and parents at the college.

Drug education:

Two external surveys conducted at Pentecost College along with comments from focus group interviews with students indicated that drugs, both legal and illegal, were prevalent and used at an earlier age than was expected. The Youth Health Survey, (NSW Department of Health, 1996b) and the drugs needs analysis (Hetherington & Sparks, 1996) highlighted these issues as critical components of living that students face at Pentecost College. This supports earlier research (Pearson, 1993) that found drug use was prevalent at Pentecost College, but at the time, more specifically in the senior years.

Figure 8 shows the percentage of students that had used the drugs named. This graph was constructed using the results from Hetherington and Sparks (1996) who surveyed 524 students across Years 7 to 12 at Pentecost College.

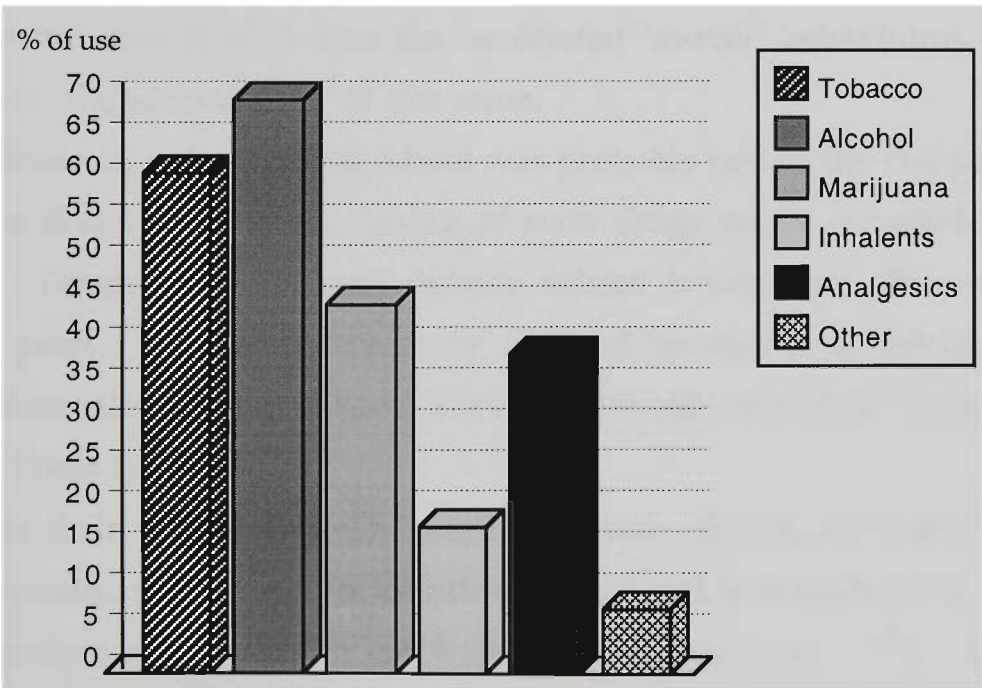


Figure 8. Drug use analysis of Pentecost College students.



'Other drugs' included amphetamines, hallucinogens, ecstasy, heroin and cocaine. These results from Pentecost College paralleled state-wide student drug use (Commonwealth Dept. of Human Services and Health, 1994b). Appendix 12 provides the drug summary report for Pentecost College students in 1996. Whilst most of the drug education that occurred in the Year 7 and 8 program concentrated on alcohol and tobacco, these results indicated that other drugs such as inhalants especially for girls were also an issue at this stage of the students' personal development.

In the HPS parent survey, ninety three percent of parents (130 out of 140) indicated their concern about drugs for their children at Pentecost College. In focus group interviews, the parents talked about their fear that their children might be being supplied with some form of illegal drug at school. They believed that if they didn't come into contact with drugs at school then their child was relatively 'safe' from the drug scene. The issue was raised at a Parents' and Friends' Association meeting where it was suggested by some parents that 'the school should conduct regular bag searches for drugs'. The fact that parents were more concerned by effects of illegal drugs but relatively unconcerned by the more socially accepted drugs of cigarettes and alcohol and the associated 'at-risk' behaviours, reflected their lack of understanding of this issue.

Students indicated that school was probably one of the last places they acquired drugs and that the taking of such drugs rarely occurred whilst at school. Drugs were obtained outside school hours and often not from school peers. Students were more inclined to arrive at school 'stoned' rather than take drugs at school: 'We're not stupid enough to bring drugs to school' (Year 12 male).

In their responses to the HPS awareness raising and needs analysis questionnaire, parents asked for relevant updated information on personal development issues with an emphasis on drug education. The majority of parents (78%), suggested evening-time workshops as a solution in helping them to understand the behaviours of their adolescent children. Parents wanted to be involved in discussions about the content of the PDHPE curriculum but were quick to decline access to the classroom where they

could listen or participate in the lesson with their child. Comments such as: 'My kids would freak out if I was in the class with them, discussing drugs' and 'I don't want my son to know that I really know very little about drugs and I don't have the answers for his questions. I want the school to teach him all about it'.

### **School Ethos/Environment**

Safety and well being:

All students, parents and staff were adamant that it was the school's responsibility to provide a safe and healthy environment for all the school community. Issues of bullying and harassment both in the school yard and to a lesser extent, in the classroom emerged as safety concerns in questionnaire responses and focus group interviews. A safe and healthy environment was seen to also encompass a school yard that sheltered the staff and students adequately from the sun, a healthier canteen, physical fitness programs that developed the mixed abilities of all students, more leisure activities/sport and a focus on teaching students to be resourceful by teaching them life skills. This included issues of decision-making, dealing with personal stress, improving self-esteem and building their confidence in themselves. Staff and parents believed that students needed to take advice of the 'experts', care for each other, respect individual differences, take a more active role in their nutritional needs at school, play more sport, have a daily exercise program, develop a school spirit and to take pride in Pentecost College.

Parents requested that teachers be consistent with policies and attitudes towards students and parents both in and out of the classroom, be seen in the community as positive role models, be positive with all students, encourage students as often as possible and respect the differences between students and other cultures. Some parents were concerned with inconsistencies in student disciplinary actions, for example, 'My daughter received an afternoon detention for having her shirt out when there was a hundred others with shirts out that didn't get detentions.' The feeling

emerged that parents wanted a written 'code of conduct' for students *and* teachers. From the teachers' responses, they wanted parents and caregivers to 'be there' for their children, give them as much time as possible, to help and encourage their child often, to be confident with them, to set strong moral examples, to foster positive communication, to work together as a family both in and out of school and to participate in school activities. Both parents and staff believed that the local community should be encouraged to be involved in the school by the school providing health information to parents through workshops, by inviting students to participate in activities within the community, by reporting positive happenings at school in the media and finally, by showing genuine care and support for our youth.

Self-esteem and confidence were important issues among students of all ages (results from the Youth Health Survey indicated that 14.6% of students surveyed rarely feel confident in themselves; 50% of students were unhappy with their body image and 28.4% of students reported feeling sad or depressed regularly throughout the past year). Forty-five percent of parents that completed the HPS needs analysis questionnaire believed this was an area that the Pentecost community could improve on for students.

As a teacher, it was surprising to hear students from years 7 to 10 in focus group interviews, actively ask for more teacher supervision in the playground. This, they implied, was to help reduce bullying and harassment. This clearly indicated that the 'Bullying and Harassment Policy' in place at Pentecost College is perceived as ineffective by many students. Students also reported harassment from teacher to student, often commenting on the fact that they were 'not treated fairly', were not encouraged but 'put down', teachers 'expected each student to be perfect', would not let students discover their own way of doing things or make their own decisions. The students wanted to be 'treated with respect', not like small children. They wanted both parents and teachers to stop worrying about them and for discipline to fit their age and circumstance. From each other, students wanted cooperation and tolerance of differences especially between the sexes and within the various cultural mix at the school. Other common requests included a clean and tidy playground, sun

protection, protection from violence and an understanding of the difficulties students face both at school and home.

The HPS committee with support from the staff at Pentecost College, concluded from survey results that the major issue for them regarding safety at school was the problems the public thoroughfare that passed through the middle of the school grounds created. The staff unanimously agreed that the thoroughfare must be moved in order for the students and staff to feel safe within the school grounds. As a result of public access to this pathway students and staff have suffered a history of verbal abuse, some physical assaults, school bags stolen by passers-by and countless acts of vandalism throughout the school. The staff felt that many of the aims of the HPS could not be achieved unless this problem was addressed first.

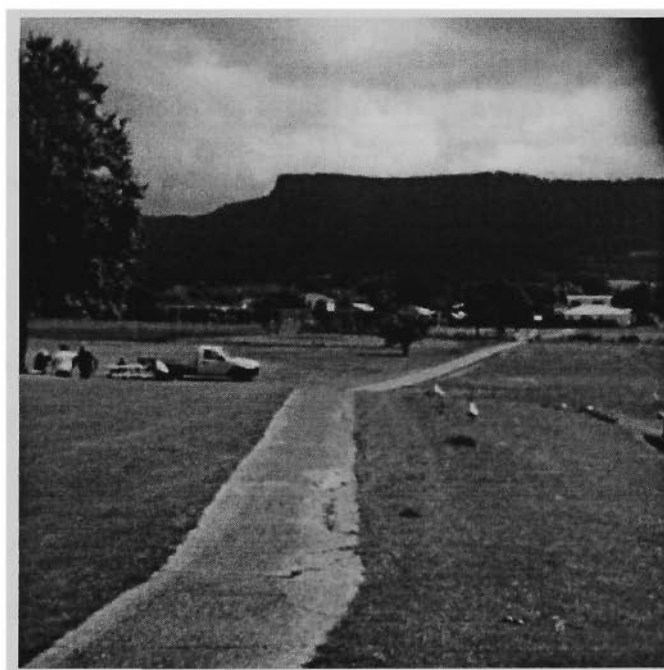


Figure 9. The public thoroughfare that passes through Pentecost College.

Strong support to relocate this pathway was evident from the entire school community. Many saw the pathway as a prohibitive factor to ground and building improvements due to previous incidences of vandalism. Efforts in the past such as extensive tree planting have been destroyed by some members of the public. These trees have been stolen, disturbed or simply uprooted. As a consequence, the efforts of interested teachers to give their own time to improve the school grounds have been diminished. It was the feeling of the HPS committee and other members of the school

community that if this path were to be relocated then support for other initiatives would be higher and therefore health promotion programs more successful.

#### Physical layout and sun protection:

Pentecost College is the result of an amalgamation in 1984 of two single sex schools located side by side. This in itself has resulted in difficulties of movement for teachers and students across the widespread campus. The school buildings, some of which are more than forty years old, are in constant need of repair and maintenance. The college is fortunate to have several ovals that provide ample space for physical activity. However, as indicated by students, staff and parents, the external aspect of the school is lacking in terms of shade areas for active and passive activity for staff and students. Trees are sparse and there is minimal undercover area. There is no undercover area or indoor facility that can house the entire school. Thus, regular whole school assemblies and other gatherings are held in the open.

Environmental issues such as increased shaded areas, tree planting, beautifying the school grounds and the development of the creek area became the stated priorities from the entire college community. 'We learn about sun safety in class but go outside and there is nowhere to sit in a shaded area . . . typical!' (Year 10 female student).

Youth Health Survey results (see appendix 5) indicated that students were more likely to protect themselves from the sun by staying in the shade, wearing hats, sunglasses and sunscreen outside school hours than at school. These results were supported by students' and parents' comments in focus group interview and behaviour at school.

Figure 10 shows the number of students who said they usually or always engaged in sun protective behaviours. This indicated that students exhibited different behaviour outside the school environment than at school. In this case outside school sun protection behaviour was more health promoting than in school sun protection behaviour so the reasons for this need to be identified and addressed.

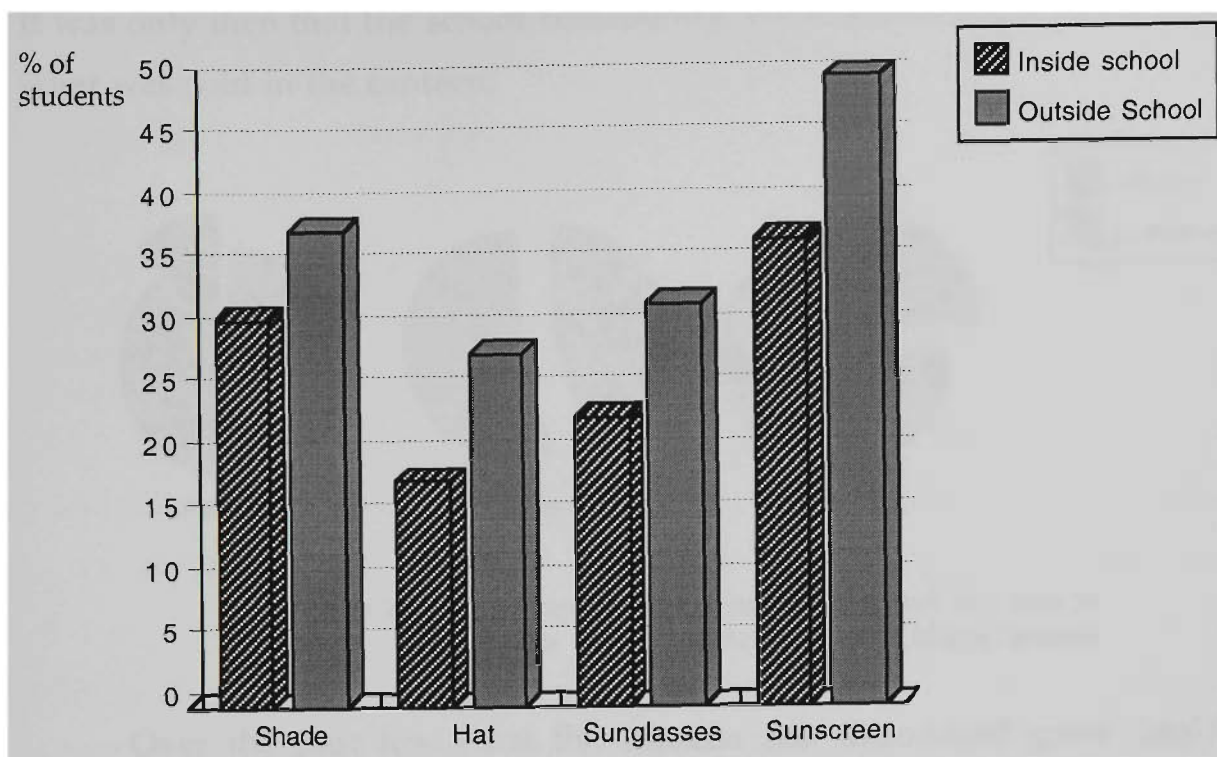


Figure 10. Sun protection behaviour of students

Comments from focus group interviews suggest that students would be more inclined to wear suitable hats if they were able to choose the style, colour and brand name. Parents felt they would then be able to reinforce sun safety behaviours and that their child would not be subjected to the negative influence of conforming to the peer pressure of wearing a 'trendy' hat, that is so strongly exerted in the school situation.

#### School canteen:

The issue of the school canteen provided a strong example of the different perceptions that various interests groups held concerning nutrition. Figure 11 depicts the disparity between staff, parents and students attitudes toward the current food offered at the Pentecost College canteen.

The issue of providing a healthier canteen menu at Pentecost began in 1985 when a campaign was launched by a small group of new staff members. However, at the time the canteen manager was well established and had full control of the canteen. Despite the serious efforts of the campaign staff, there were no changes to the school canteen until 1992 when changes in administration persuaded the canteen manager to retire.

It was only then that the school community were able to begin to influence what was sold in the canteen.

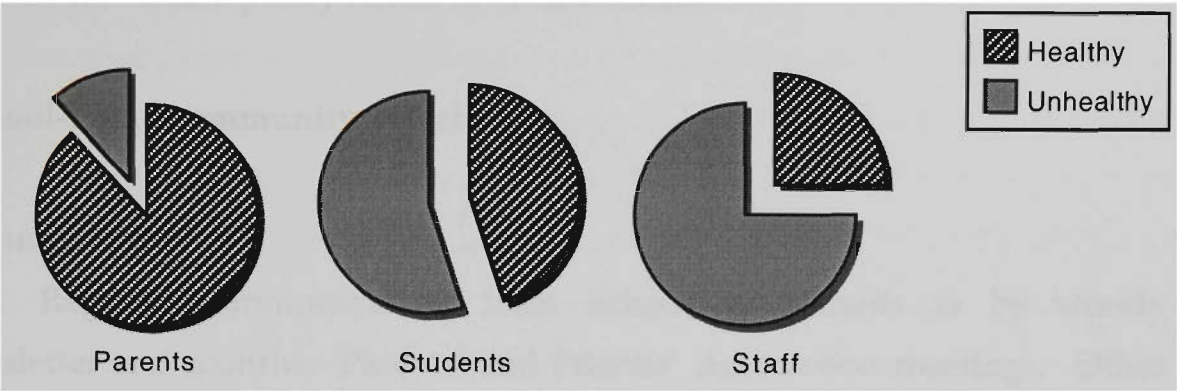


Figure 11. Percentage of parent, student and staff attitudes to the menu offered at the Pentecost College canteen.

Over the past few years the canteen has introduced more healthy choices such as wholegrain bread and rolls, selected health bars, fruit and packaged salads. Whilst this has been a positive move towards health promotion, the ‘profit making’ philosophy still underpins the canteen’s existence. Products such as lollies, chocolate bars, chips, pies, sausage rolls and aerated drinks with high sugar content dominate the offerings. The current canteen menu can be seen in appendix 13. The ‘Pepsi-Cola’ company for example provides the school with ‘free’ large display refrigerators for the canteen’s use provided the canteen sells ‘Pepsi’ drinks. This is seen as a satisfactory arrangement by the school administration as it saves them thousands of dollars on the purchase of refrigerators. What should be the responsibility of the HPS with respect to such promotions? I concur with Tinning (1996) that there are serious ethical issues that need to be addressed and such promotions should not be endorsed by schools until this occurs. This is a whole school issue that the HPS committee needs to work through with the school administration and explore alternatives to such an arrangement.

It is obvious from the staff and students surveyed, that the school community is not currently satisfied with the school canteen. Students’ comments suggest that some of the products on offer should be deleted from the canteen menu. They say that they would buy healthier food if it



was made available. Of the staff who order their lunch, the majority are supplied by an outside school vendor, a further indication that the school canteen menu and policy needs to be addressed.

**School-home-community interface**

**Communication:**

Regular communication from school to parents is by weekly newsletter and monthly Parents’ and Friends’ Association meetings. Other forms of communication include student reports, parent-teacher interview days and both verbal and written contact with parents when the need arises. Most parents and staff agreed that these were currently underutilised in terms of promoting issues of health and well-being of the school community. Figure 12 shows the percentage of staff and parents who completed the HPS questionnaire that felt that ‘open communication’ existed between the staff and parents at the college.

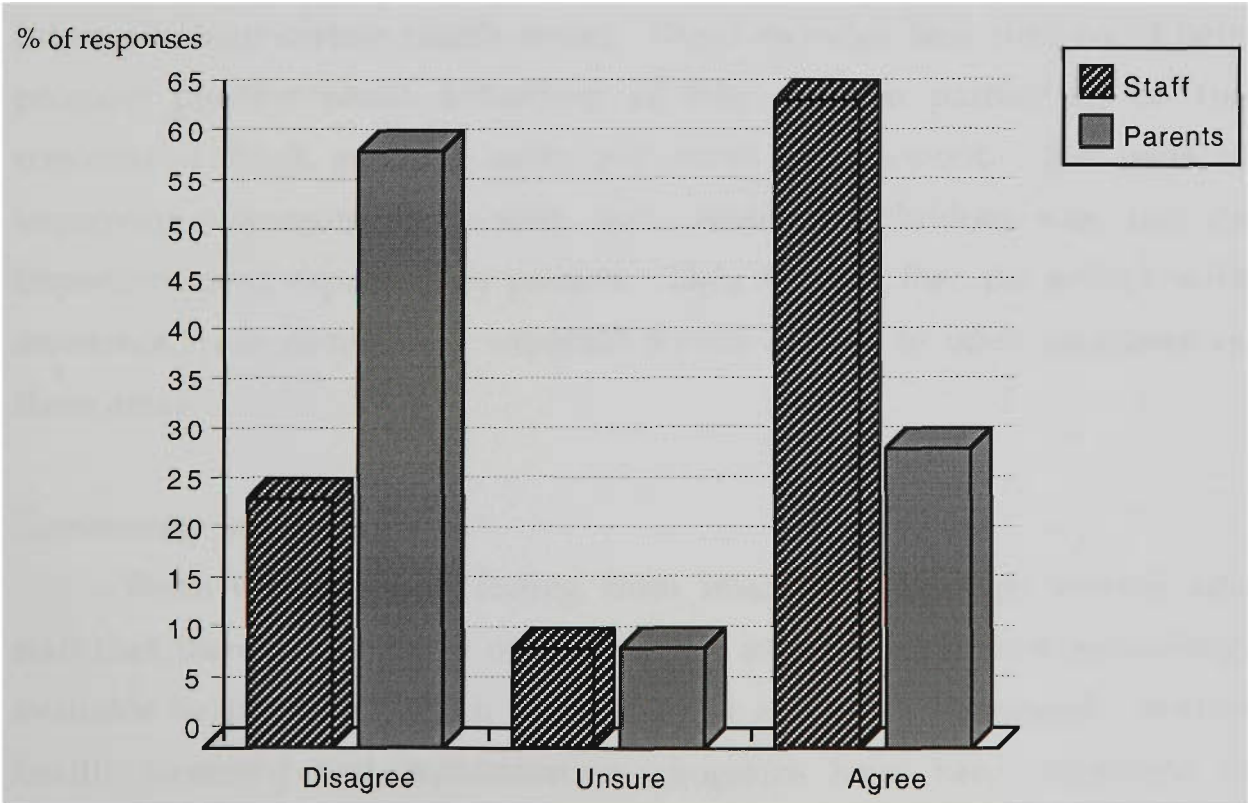


Figure 12. Perception of open communication at Pentecost College.



Figure 12 clearly demonstrates contradictions in the perceptions of staff and parents as to just how much open communication exists between the parents and the teachers at Pentecost College. Interestingly, staff believed that parents were openly welcomed to talk about issues concerning themselves or their children at the college. Parents on the other hand did not respond with reciprocal feeling and indicated that they were hesitant to approach staff members in the school community. It was obvious that if communication was to be open between all interested groups within the college, then the existing perceived barriers needed to be examined and improved so that community members could feel that issues including that of health promotion may be discussed and addressed.

#### Seminars and workshops:

A high percentage (68%) of parents who completed the HPS questionnaire indicated that they wanted the school to provide seminars or workshops on health issues. This was reinforced from individual and focus group parent interviews where there were many requests from parents to be informed about certain health issues. These included how they could help promote positive health behaviour of their children particularly on the concerns of drugs, personal safety and stress management. The issue of improving communication with their adolescent children was also an important need expressed by parents. They believe that the school with assistance from community expertise would be able to offer assistance in these areas.

#### Community support:

There was a general feeling from interviews amongst parents and staff that there was a range of community support for health promotion available to the school which was not being effectively harnessed. Whilst health screening and immunisation programs have been conducted at Pentecost College, many other local health services such as drug and alcohol services, community nutritionists and dietitians, and other general health personnel were underutilised. Other community support services that were

highlighted by parents and staff which could assist promote health by playing a greater role in the school community included Centacare (Catholic counselling services), local police, local sporting clubs, local council and the Roads and Traffic Authority.

### **Needs analysis summary**

From the HPS awareness raising process and health needs analysis conducted at Pentecost College, it was evident that there was a wide variety of expectations from students, staff and parents. Obviously, not all of these issues could be addressed simultaneously. Priorities needed to be established and acted upon. The health needs for Pentecost College were derived from the most common responses from the HPS questionnaires completed by students, parents and staff and from focus group interviews. Figure 13 shows the six most supported needs for Pentecost College from each of these three groups.

The information in figure 13 indicates the dominant issues that emerged from a clear majority within the three groups surveyed. It must be taken into account that these are the needs according to those staff, parents and students who responded to the survey. Other data from the Youth Health Survey and the Drug Analysis conducted at Pentecost College supported these perceived needs but also indicated other student needs. For example, whilst students themselves did not indicate that they need to increase physical activity, other surveys suggest that students' participation in physical activity needs to be increased to improve their health. Also as a result of Hetherington and Sparks' (1996) survey, the drug education program needs to be changed to address students' current needs. This data together with observations and fieldnotes assisted the HPS committee to formulate priorities for health promotion at Pentecost College. Other issues raised by students, teachers and parents ranged from suicide prevention to preventing litter in the playground. The health needs were listed on poster paper and displayed in the staff common room and the school library to raise awareness and acknowledge the health issues that were of concern to

the school community. These were also presented to parents at a Parents’ and Friends’ Association meeting by the HPS committee.

Priority Health Needs for Pentecost College		
Staff	Parents	Students
* Safety - relocation of the public thoroughfare.	* Safety - students should be safe whilst at school.	* Safety - fencing of school; increased teacher supervision.
* Maintenance - buildings, covered walkways and concrete areas.	* Physical Fitness - needs to be improved for students.	* Self concept - many students have poor self-esteem and confidence.
* Sun safety - provision of shade areas; under-cover assembly area.	* Sun safety - provision of shade areas.	* Sun safety - provision of trees and covered areas.
* Senior Personal Development and Health program.	* Stress management for students - particularly for seniors.	* Senior Personal Development and Health program.
* School Canteen - needs to have a healthier menu.	* Drugs - education and control of availability.	* Seating - increase seating in the playground.
* Staff welfare - stress levels need to be reduced.	* Seminars and workshops provided for parents on specific health issues.	* Qualified supervision for sport classes.

Figure 13. Priority health needs for Pentecost College - Summary

For a more extensive list of perceived health needs for Pentecost College, see appendix 14. These issues express the enormity of the concept of health promotion in schools and highlight the fact that much of what happens in the school community can affect the health of individuals.

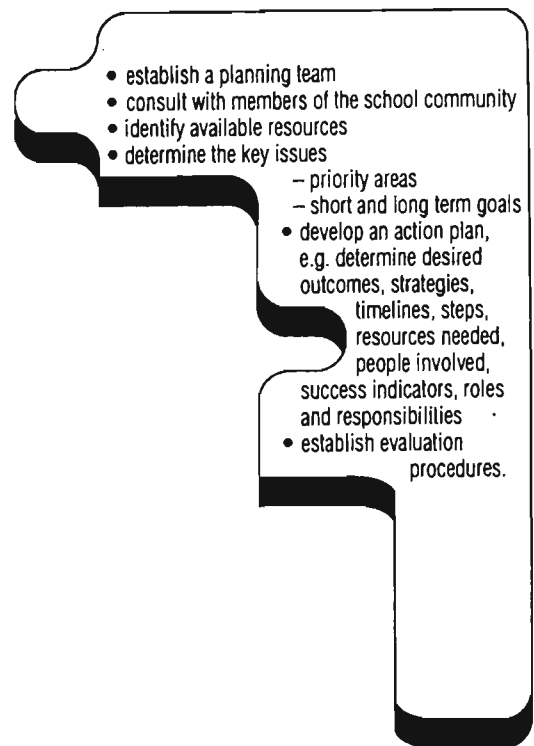
After examining the above priority health needs for Pentecost

College, the initial priority decided upon by the HPS committee as a result of awareness raising and needs analysis was enhancement of the physical environment. This was the original issue the committee decided to go with before this process had been carried out. So why go through the long arduous task of awareness raising and needs analysis? The entire awareness raising process, although taking longer than anticipated (over six months) was seen as being beneficial. It was felt that the entire Pentecost College community now had a much broader knowledge of the HPS concept and would now be more likely to support initiatives that were introduced to promote health. The questionnaires and interviews provided valuable information as to specific areas of the school environment that needed to be concentrated on and, more importantly, suggestions and ideas of how to improve the surrounds.

So where to from here? After this initial stage of awareness raising, the HPS committee and myself were determined to consolidate the project as an ongoing initiative that the whole school community could support. The following chapter examines the next stage of moving towards a health promoting school, that of planning how the priority of enhancing the physical environment of the college and other health promotion initiatives were to be implemented. Further chapters will examine the successive steps that Pentecost College followed to move health promotion policy into practice. The stages of implementation and evaluation will be discussed. It is realised however, that the stage of awareness raising does not finish here but needs to be ongoing.

## CHAPTER 5

### PLANNING



The previous chapter described the initial process that schools need to take when being involved in a HPS project. Awareness raising of the HPS concept incorporating a health needs analysis for Pentecost College provided the HPS committee with a base from which to work. This chapter frames the next stage of the HPS project which involved prioritising the issues that evolved in chapter four and developing specific plans for health promotion action. The chapter examines the progression of the HPS committee from the first stage of awareness raising to the planning process. As with the previous stage of awareness raising, this planning stage took some time. Having begun the HPS project early on in 1995, most of the year was involved in establishing HPS structures, awareness raising and the health needs analysis. It was only towards the end of 1995 (term four) that this specific planning process begun.

According to Dignan and Carr (1992) only the most carefully planned health promotion program can be assured of high level implementation. Effective health promotion planning requires communication, cooperation

and coordination between all stakeholders and an understanding of the initiatives and how they are intended to interact to produce an outcome. The driving force producing this understanding is theory. Much of this underlying theory was absent in planning HPS initiatives at Pentecost College. It was only since documenting the planning process that much of the theory had been revisited. The HPS committee, whilst utilising *Towards a Health Promoting School* (NSW Dept. of Health et al, 1995 & 1996), did not really adopt specific theories in the planning process. However, theory is useful to understand and analyse the processes of health promotion planning, implementation and evaluation conducted at Pentecost College. Green's PRECEDE-PROCEED model (Green & Kreuter, 1991), introduced in Chapter Two is valuable in health promotion planning because it provides a format for identifying factors related to health problems, behaviours and program implementation. Reflecting upon Green's model brings to this focus the links between planning, implementation and evaluation. Following the awareness raising and needs analysis conducted at Pentecost College (the 'PRECEDE' process), the following steps of developing policy and planning to initiate the implementation and evaluation process of health promotion initiatives occurred.

One of the first steps for schools to become health promoting, is to develop a HPS policy (O'Connor & Parker, 1995). To develop an effective policy it is necessary to understand the process of policy development and prioritisation. The HPS committee did not consciously go through the theory of policy making but realised that the key decision makers in the school setting had to be identified and their assistance enlisted. In this case, initial support was required from the principal in developing an effective HPS policy for it to have a chance of being successful. In reality, it is the principal that must commit the school to the HPS concept and support school decisions to implement health promoting initiatives. The principal initially supported the efforts of the HPS committee and involved himself in the planning and implementation of some of the HPS initiatives. The role of the principal is further discussed in Chapter Eight.

The HPS committee found it difficult to write a general health promotion policy for Pentecost College. No-one really knew what the 'policy' needed to contain. We were not sure whether to write a simple statement or a more complex one detailing specific initiatives, roles and responsibilities, and funding and resource requirements. It was agreed by the members of the committee at the time to follow the guidelines provided by the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1995) document and utilise the assistance of the health promoting schools project officer. She pointed out that the HPS policy must fit in with the general aims of the school and that the HPS concept was already incorporated into the school's mission statement: 'Pentecost College is a Catholic school promoting opportunities empowering all students to achieve their greatest potential in every aspect of life' (Pentecost College's prospectus, 1996). An extension of this statement was to incorporate support for and commitment to enhancing the emotional, social, physical spiritual and moral well-being of *all members* of the school community. As the mission statement was already in place and accepted by the college community it became the underlying orientation for Pentecost College's HPS policy.

After much deliberation and discussion between individual members of the HPS committee, the following general policy for health promotion at Pentecost College was agreed upon: 'Pentecost College will establish a supportive environment that promotes the health and well-being of all the school community' (HPS committee minutes, 1996). This policy in itself, means very little unless it is supported and acted upon by all members of the school community and more particularly, from those in positions of authority. It is the administration personnel who are able to release funds and time to support projects to endorse and make credible the health promotion policy. However, if in fact it remains a theoretical statement of what the college plans to do and there is little support from the principal, then the statement remains simply that and lies dormant with the other intended policies that are not acted upon.

Colquhoun, et al (1996) argues that in the health promoting schools initiative, it is important to stress that the *process* of policy development

may be more important than the actual policy itself. This is because for successful implementation of policy, it must be developed and understood by policy makers and be meaningful to all stakeholders. All stakeholders in the school community should be represented in the policy-making process which in itself forms the basis for involvement in the HPS project. Following the approval of the school's general HPS policy by the principal, the HPS committee set about elaborating on the policy by developing specific health promotion policies and formulating strategies for implementation. *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) recognises Green and Kreuter's (1991) components of a policy that included determining the areas that need attention, setting goals and then developing strategic actions to accomplish these goals.

In the first instance, we clarified the priority areas outlined in Chapter Four. It soon became obvious that the HPS committee could not achieve *all* the aims on its own. From the process of awareness raising and needs analysis described in Chapter Four, the following four priorities were set for Pentecost College to move towards becoming a health promoting school:

- enhance the physical environment;
- promote sun protection;
- increase physical activity of the school community members; and
- develop a Year 11 and 12 personal development and health program.

The aim was to begin planning initiatives for these four projects immediately and to have them implemented in 1997. We saw the HPS approach of involving all stakeholders (students, staff and parents) in the projects to be paramount for the programs to be successful. It was therefore realised that planning was going to take some time and much of 1996 was devoted to this process. The priority projects were divided up amongst individual members of the HPS committee who voluntarily selected an area based on their personal interests. The principal maintained the responsibility for enhancing the school environment as these decisions would involve substantial amounts of school funds and the deputy principal (welfare), the development of the senior personal development and health course. Another committee member took responsibility for sun



protection and the promotion of physical activity became my responsibility as PDHPE coordinator.

From this point, those who accepted the tasks gathered teams of interested staff, students and parents to assist in planning specific initiatives and establishing goals that would produce health promoting behaviours and a health promoting environment. This resulted in different groups of people working simultaneously on different projects, thereby broadening the base of activity and commitment. This was seen to be the most effective method of involving the whole school community on specific programs whilst maintaining awareness that were all linked to the whole school health promotion plan.

The assistance of the health promoting schools project officer in this planning stage was invaluable. The officer provided networking links for the HPS committee with other health agencies and provided considerable support for the school community during the process. This support came in the form of attending HPS meetings and providing new ideas and assistance in utilising resources.

In theory, the school's health promotion program was in action. However, at this stage, the members of the HPS committee were becoming frustrated with the lack of observable health promoting products or behaviours that they had hoped would be in operation. Again there was a strong temptation to spend as little time as possible in planning and just do something so all could see where our time and effort was heading. Time was becoming a critical factor and it was difficult even to collect the HPS committee members together for meetings. In addition, lack of support from other staff was becoming noticeable due to the time delay in achieving tangible outcomes. In an attempt to keep the team focussed on the health promoting goal and to maintain their flagging interest and enthusiasm towards planning health promotion initiatives, committee meetings were organised to become a 'breakfast affair'. Whilst this meant extra work and time in organising and preparing a healthy breakfast, it was also seen as an expression of thanks for members already giving their valuable time to yet

another committee. Support was also forthcoming from the principal as he financially covered the cost of the breakfast.

It became obvious as the school year progressed that there were already 'hidden agendas' or unspoken goals from particular members of the HPS committee. These included certain stakeholders focusing directly on the planning process, degree of involvement and support of one project at the expense of others. For instance, previous to the formation of the HPS committee, the Parents' and Friends' Association, PDHPE staff and students had been lobbying the principal for a much needed covered area so that the school community could be protected from the effects of the sun. Before the enhancement of the school environment became a priority for the HPS committee, only a few trees had been planted and nurtured by a interested science teacher but nothing had been discussed or implemented to be of use to the entire school community. Now with the local and state governments supporting the idea of health promoting schools and the emergence of health promotion units in the wider community, it appeared that the goal of establishing a large covered area had become a more fashionable idea to the principal. Hence, his energy and attention was concentrated on the planning and implementation of a covered area that would be visible evidence attributable to his efforts during his time at the college. It appeared that the principal saw the entire HPS project as the building of an undercover area. Many of the HPS committee members saw this a narrow view to health promotion, however in retrospect, it did not really matter. There were definite benefits to the school community by having an undercover area and indeed it was part of the HPS project. If the principal saw additional benefits, then so be it. At least he was part of the HPS committee and once the objective of completing the undercover area was realised, then maybe he could be convinced to focus on other goals of the HPS project.

Following then are the specific goals and plans of the priority areas that were agreed to by the HPS committee. At this stage there was no discussion as to the allocation of resources necessary to address these areas. The school

community was informed of these initiatives through school assemblies, staff meetings and parent newsletters.

## **Enhancing the Physical Environment**

The draft plans that had been drawn up by the landscape architect using the criteria based on comments from students, staff and parents during the awareness raising process, were displayed for a number of weeks at various locations such as the Student Services Centre, library, staff lunch room and Parents' and Friends' Association meeting room. These were again commented on verbally and in writing by the members of the school community and a final plan was designed. This plan diagrammatically represented a 'model for action' for enhancing the physical environment at Pentecost College (see appendix 15). This made it possible to select specific areas within the school environment, both passive and active, to focus on as initial priorities. By providing a visual representation, it enabled all stakeholders to grasp how the short term goals of developing small areas related to the long term project of beautifying and developing the overall physical environment of the college.

It was clear that the principal supported this process from the outset by funding the \$3000 cost for the landscape architect to complete the college plans for a health promoting environment. From these plans and the input from the whole school community, the HPS committee decided on two major short-term goals. One was the relocation of the public thoroughfare from the middle of the college grounds to the perimeter of the college. This priority addressed a number of concerns, particularly those of safety for the school community and the possibility of reducing the vandalism that regularly occurred with people accessing the college grounds. It was also felt that by removing the thoroughfare, any health promoting efforts and activities that beautified the physical environment had a stronger chance of remaining intact. The other priority was the provision of an undercover area which also addressed a number of long standing needs of all college members. It was anticipated that such an area would not only provide

adequate shelter from the sun for students and teachers but could provide a central area for assemblies and school masses and provide a much needed all-weather venue for physical activity in physical education classes.

#### Relocating the Public Thoroughfare:

The principal undertook the responsibility to pursue the avenues for the thoroughfare's relocation through local and state government bodies. After discussions with the local council about the concerns with the current pathway, a meeting was organised with a representative from the council, the state member for the area and the principal. After extended negotiations, support was offered to the college to assist in this matter.

If the college wanted immediate removal of the pathway (this in 1996), then the local council would fund half the cost with the college funding the other half. At this stage, the estimated cost of the relocation of the pathway was to be \$40,000. However, if the state government approved funding to change the walkway into a cycleway that would join an existing cycleway that ran near the college, then the project would be jointly funded by the state government and the local council. This process however, would take time with funding likely to be available in the 1998 budget. After lengthy discussions, the principal's proposal to the HPS committee was that he continue negotiations with government representatives and that we wait until funding was approved for a cycleway, thus saving the college a much needed \$20,000.

Other initiatives set in place to enhance the college's physical environment included brightly painting the garbage bins with caricatures or themes, landscaping the area and building a sandstone brick wall around the newly built toilet block, landscaping smaller areas such as the Art block that would encourage students to work in a passive area that was aesthetically pleasing and comfortable, improvement of the creek running through the school grounds, applying for grants for local and state bodies for funding to accomplish this task and turfing a large play area outside the sportshed. Some of these initiatives went ahead, some did not due to various reasons.

A number of problems were confronteded and these will be discussed in the next chapter on implementation.

#### Undercover Area:

As the major project for the HPS committee, much of the time and energy focused on this issue. Many planning decisions needed to be made in order for this project to come to fruition. The initial decision was to choose the most suitable location within the college setting. There were a number of possible sites outlined on the landscaped plan, all of which had certain advantages and disadvantages. After much deliberation between members of the HPS committee, which included student and parent representatives, an area in the central part of the school was dedicated as the preferred site. The reasoning supporting this decision was that the principal wanted the covered area to be in a central location. In addition, the existing surface was predominantly concrete, which would cut down the costs of beginning the project without a floor. Other decisions such as the structural design, material, cost and construction were debated at length.

The links established with the Area Health Service, through the HPS Project Officer, provided guidelines and photographic examples of the shade areas and undercover constructions that were already in existence in other schools and institutions. This resulted in many alternatives and suggestions from members of the HPS committee as to the design were many and varied. At the next HPS committee meeting, a draftsman from the Catholic Education Office responsible for the construction of buildings throughout all schools in the diocese, presented some possibilities in draft form. These were discussed and amendments made to finally arrive at a sketch of a construction that catered for the college's needs and was realistically possible to construct. From this point, the principal arranged three quotes from different companies and reported back to the HPS committee. The cost of providing an undercover area was in the vicinity of \$90-95,000. The intention at this time was for the money to be raised through the collaborative efforts of students, staff and parents following the HPS framework of the school interface of school and home. This would see the

school community working together for a common purpose and establish a sense of worth and ownership of the project. However, this was a mammoth task to coordinate and no-one was prepared to volunteer for the role. Each member had many other existing responsibilities other than those of the HPS committee.

A final sketch presented for the undercover construction depicted four main vertical supports in the centre in addition to the supports around the perimeter (see figure 14).

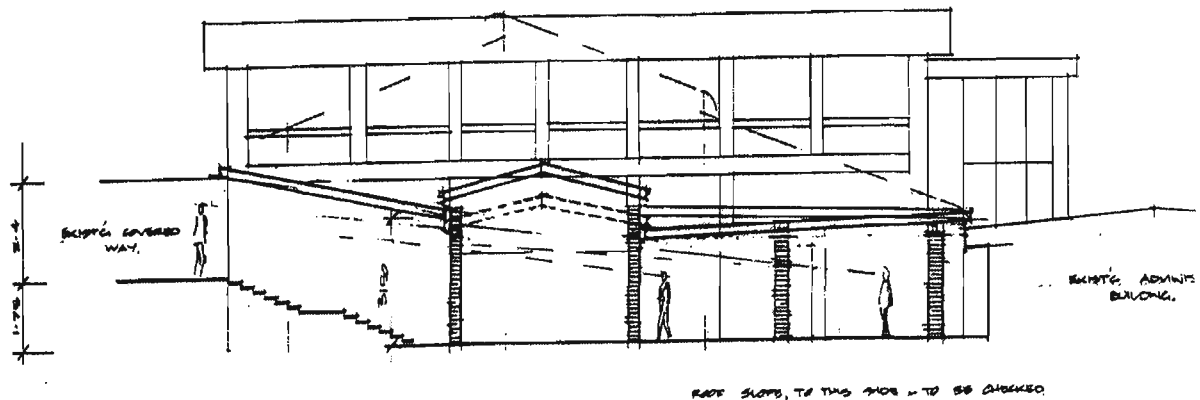


Figure 14. Sketch of the undercover area as presented to the HPS committee.

The PDHPE staff and myself believed that this would still enable the area to be effectively utilised for a number of physical activities both in wet and hot weather. However, we argued that because of the cost of such a structure, it may be possible to look further ahead and perhaps replan to build the infrastructure for a multipurpose hall where the walls and floor could be completed in future years. This suggestion was not taken up by the principal because of the time and effort that had already gone into the planned shelter to date, the cost of the proposed structure and perhaps his unclear vision of the potential plans for Pentecost College in the twenty first century. A tender was accepted and final plans submitted. The planned completion date of the undercover area was for the beginning of the new school year (1997). The principal unexpectedly announced at a HPS committee meeting that he had been able to secure funding for the project from surplus funds from other building projects that had been taking place in the college. This circumvented the grand community effort in raising funds for the project, but no-one complained.

## Sun Protection

The plans for the large undercover area were an important part of providing sun protection for the college community. However, after attending a HPS workshop coordinated by the Area Health Service for all pilot schools involved in the project, it was realised that much more could be done to promote positive sun protection behaviours amongst members of the school community. Teachers, students and parents were all invited to take part in this initial workshop on sun protection which was intended to provide the opportunity for members of different school communities to discuss promotion strategies and ideas, resources and support available for sun protection. Pentecost College was well represented with five staff members and one student in attendance. Unfortunately, at this first workshop, no parents from the college or any other pilot school attended. It was designed to motivate teachers and develop their skills and to provide them with new ideas to take back their schools. The workshop leaders suggested that sun protection strategies needed to be considered as part of a comprehensive program. It was pointed out that while programs which encouraged people to deliberately avoid exposure to the sun have had some impact, these are likely to be more successful if physical and social environments make it easier to avoid sun exposure (Sun Protection Workshop notes, 1996).

The teachers came back from this workshop willing to be involved in the planning and implementation of measures to promote sun protective behaviours at Pentecost College. The following plan was decided upon by the HPS committee after feedback from the staff that attended the workshop. The plan is outlined below, again categorised into the three interactive areas of the HPS framework of curriculum, ethos/environment and school-home-community interface.

### Curriculum:

Firstly, it was decided that the Year 7 to 10 PDHPE program should be reassessed in terms of the goals of sun protection and that the available

resources that existed within the school should be more effectively incorporated into the curriculum. For example, it was suggested that the resource kit provided by the NSW Cancer Council (1986) which contains excellent information could be used to develop skills of secondary students. Such kits now use a harm minimisation approach whereby risky situations that adolescents are confronted with are identified and addressed.

Secondly, it was suggested that 'curriculum mapping' (Smith et al, 1992; Colquhoun et al, 1996) across other KLAs such as Science, HSIE and Technology and Applied Science (TAS) be further developed. Issues related to sun protection should be addressed through different parts of the curriculum, such as designing and producing shaded seating in TAS lessons and following sun protection themes in other classes. Thirdly, the timetabling of physical education and sport classes in the morning was also examined as a possibility with plans to trial this strategy in 1997.

#### School Ethos/Environment:

Because the undercover area would not be available until 1997 and with warmer weather approaching, plans to provide immediate protection were put into action. These included purchasing large umbrellas that would fit into existing tables/seats for student use in the playground. It was also felt by the HPS committee that SPF15+ sunscreen should be provided free of charge for the members of the school community. The deputy principal (welfare) accepted the responsibility for purchasing and publicising the sunscreen's availability at the Student Services Centre in Pentecost College.

In addition, tree planting in two specific areas was planned so as to provide further shade areas for student use. It was also recognised in the discussion that this was not a short-term solution as the trees would take a long time to grow but the process needed to start in order to achieve the long term goal.

Sun protective clothing, hats and sunglasses were issues of great debate amongst members of the HPS committee. Prior to the HPS project, hats were encouraged but it was compulsory for students to wear the college cap which was a baseball style grey cap. After discussing the poor sun



protection benefits of such a cap and noting the contradictions in teaching students to wear a more effective hat for sun protection, the HPS committee decided to promote the use of hats with brims. The majority of the committee (70%) were in favour of allowing students to wear any coloured hat to college as long as it satisfied the sun protection standards of a wide brim. The principal supported by the two deputy principals agreed, but on the condition that the brimmed hat was one of the four college colours thereby limiting the personal choice for students. This issue was planned for open discussion at the ensuing staff meeting where it was supported by the majority of the teaching staff. Promotion of the new styles of hats was to take place at the school assembly after securing samples of the types of hats which would now be permitted at Pentecost College. An item in the college newsletter explained the reasons for the addition to the college uniform to parents. Staff and parents were also encouraged to be positive role models in wearing sun protective head gear.

At this stage it was also planned to promote the wearing of sunglasses for students whilst outdoors. The benefits of wearing sunglasses would be clearly outlined to students and staff and a sample of wrap around sunglasses would be provided at recess and lunch times for students to try on. It was suggested that optometrists, chemists and the NSW Cancer Council be approached to help promote the idea of wearing sunglasses by providing a discount to students, staff and parents for purchasing sunglasses that conformed to the sun protection standard. This was to be publicised and encouraged at college assemblies, through the college newsletters and by teachers and high profile students modelling sun protection sunglasses at the appropriate times.

A further measure to encourage sun protection was to provide a choice for students of a long sleeve sports collared shirt that provided block out from the sun's rays. This would complete a uniform that students could wear to help protect them from the sun. The local media were also informed of these sun protection initiatives and were encouraged to publicise what was planned for Pentecost College.

In addition, the changing of recess and lunch times were put forward to the HPS committee and in turn the whole staff. The idea of making recess forty minutes and lunch twenty minutes rather than the reverse was to reduce sun exposure to the students and staff in the middle of the day. It was agreed by the staff to trial this for four weeks in term four, 1996 after 'selling' the idea to the student population. At the completion of that term, it would then be formally evaluated by students, parents, staff and canteen workers as to the effectiveness and suitability of the reversed eating times.

A further plan to support these changes was to collect and place laminated health promoting posters around strategic areas of the school and in the staffroom. Provision of shade at school carnivals and sporting events was also planned by purchasing a large tent or portable shelter of some type. This would enable a number of people to have protection from the sun during these all day events.

#### School-home-community interface:

The sun protection workshop was an important link in planning sun protection initiatives at Pentecost College. The Area Health Service which provided expertise from members of the local community also established the beginnings of a network between the pilot schools involved in the HPS project. In addition to the HPS project officer, the Area Health Service employed a Sun Protection Officer whose role was specifically designed to assist schools in developing strategies to increase sun protection behaviours. Regular newsletters were sent to the pilot schools providing up-to-date sun protection information and strategies, competitions to promote sun protection and catchy phrases to motivate and instil enthusiasm in the members of the pilot schools.

Another way the school-home-community interface was developed was through the uniform committee that had representatives from staff, students and parents. The responsibility of this committee was designing and providing the proposed long sleeve sport shirt. Furthermore, the uniform committee was to identify and contact retail outlets where wide brimmed hats in college colours were available. A discount of 10% was

offered by certain stores as an incentive for students and parents to purchase these hats. A plan to invite a local retailer who was prepared to offer substantial discounts on his sunglasses to display here at the college was also supported. This came about because the students showed a strong preference for these sunglasses rather than those offered by the NSW Cancer Council. Brand names and the more expensive sunglasses appeared to have a greater appeal to students rather than the cheaper but effective wrap sunglasses available from the NSW Cancer Council.

Newsletters and Parents' and Friends' Association meetings provided platforms to promote awareness regarding sun protection. This was intended to provide parents with vital information and seek their support in terms of modelling appropriate sun protection behaviour and in promoting sun protection with their children. The involvement of students and staff in health community protection campaigns such as 'Me No Fry' and 'MAD' (Melanoma Awareness Day) were also planned as an integral and permanent part of the overall sun protection program rather than as isolated occurrences.

## **Physical Activity**

Whereas sun protection and enhancement of the physical environment had support from all members of the school community, plans for increasing physical activity time received less enthusiastic support. Staff and administration agreed instead that the curriculum time already available for physical activity needed to be used more productively. A recently released discussion paper entitled *Physical Activity in the School Curriculum* (NSW Government, 1996) supported this notion by revealing that the time and type of physical activity in schools needed to be reassessed.

As a member of the HPS committee and as PDHPE coordinator I undertook the responsibility for planning how to increase physical activity in the school community through the three interactive areas of curriculum, ethos/environment and the school-home community interface.

## Curriculum:

I argued firstly that the encouragement of physical activity required a solid foundation from the PDHPE curriculum. In NSW secondary schools, the Board of Studies mandates an indicative time of 300 hours PDHPE across Years 7 to 10. The period allocation for PDHPE at Pentecost College provided an indicative time of 375 hours, well above the mandatory requirement. The Board of Studies does not mandate any requirements for sport, leaving the responsibility for school sport in the hands of the various educational systems. The NSW Department of School Education's 1988 Sport Policy required government schools to allocate at least eighty minutes per week to sport in each year from 7 to 11. There is no single sport policy for non-government schools at present. The integrated sport structure at Pentecost College provided students in Years 7 to 10 with ninety minutes of sport per week, so that in terms of actual curriculum time for physical activity, Pentecost College was well supported. The plan was to use this time more effectively to promote physical activity. After consultation with the PDHPE staff, I advanced the proposal for all physical education classes to be based on single sex break-ups for Years 8, 9 and 10 lessons in 1997, leaving Year 7 coeducational. This was in an attempt to alleviate the problems of poor participation from girls in physical education lessons as discussed in Chapter Four (pages 81-83). All health classes were to remain coeducational. This decision required a timetable priority and the support of the administration. For this to be feasible, PDHPE classes could not be aligned with other subjects on the timetable as had previously been the case and in most instances would require the whole year group to be timetabled at the same time. This would allow Year 8 to 10 classes to be organised as single sex classes of reasonably equal numbers.

I also proposed to the principal that if the opportunity arose, an additional PDHPE teacher be employed in 1997 to alleviate the problem that some PDHPE classes were being taught by non-trained PDHPE teachers. This would also assist with the staffing problems associated with integrated sport. The staffing plan for integrated sport in 1997 was for each year group to have

at least two trained PDHPE teachers allocated with a selected team of other motivated staff members.

#### Ethos/Environment:

Pentecost College again is fortunate to have more than adequate outdoor facilities that promote physical activity within the college community. It has four playing fields, an athletics track, four asphalt basketball courts, four grass volleyball courts, two netball courts and three asphalt tennis courts. However, some of these surfaces are unusable because they are in need of immediate maintenance to ensure the playing surface is safe for students. For example, the tennis courts have deteriorated so much over the years the surface undulates and large cracks have appeared making them unplayable. This resource is now used as a bike storage area for approximately twenty bikes. Two of the ovals are poorly drained, have little grass and are often unplayable for weeks after any amount of rain. The area outside the PE storeroom where gymnastic lessons are taught was badly lacking in grass and was very dusty and dirty, making effective lessons difficult.

The college has three grounds and maintenance employees and with the assistance from the community it was initially planned to upgrade the grassed playing surfaces. Lunchtime sporting competitions were planned to encourage more students to be active at lunchtimes and make use of the school's facilities.

#### School-home-community interface:

The Area Health Service's health promotion unit provided an inservice entitled 'Active for Air' physical activity workshop. Pentecost College was represented by two staff members, two parents and three students. We accepted support and resources from a further staff member in the Health Promotions Unit employed to promote physical activity. Some suggestions from the workshop were to begin a walking group of students, parents and staff either before or after school or at lunchtimes. This had to

be carefully planned to optimise opportunities for parents to be included in the program.

The assistance of the local council and local Rugby League clubs was also requested to assist in the upgrading of the ovals. Council agreed to assist the college by turfing the gymnastics area outside the PE storeroom. A Rugby League club committed themselves to upgrading the two ovals by providing drainage, aerating, top dressing and turfing in return for allowing an afternoon junior school rugby league competition to be held at the college.

### **25-hour personal development and health course**

It was planned to implement a 25-hour personal development and health course for students in Years 11 and 12 at Pentecost College in 1997. At this stage, the course was being developed along the guidelines set for the mandatory 25-hour personal development and health course for Year 11 and 12 students that was introduced into NSW Department of Education schools in 1992.

Plans to involve as many personnel as possible in the development of this course were formulated. The Year 11 and 12 Coordinators were to play a role in coordinating the course. The PDHPE Consultant from the Catholic Education Office had experience in running such a course recently at another school and his experience was to be drawn upon.

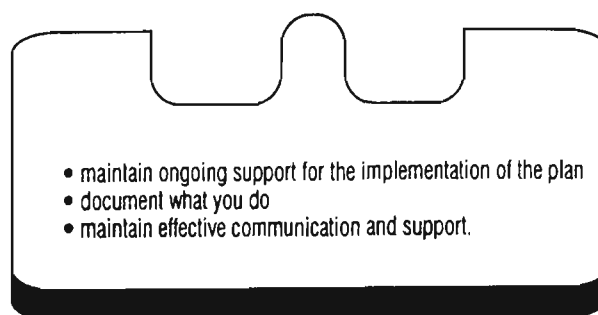
The use of community resources such as the police, drug and alcohol educators, RTA personnel and other health workers with experience in such issues as suicide and stress were to be approached. This course for both year 11 and year 12 students was not intended as a 'one off' approach but to continue such support within the school in areas of health promotion. The program was to consist of a two day workshop where students rotated in small groups through different themes of 'Suicide Prevention', 'Drugs and Alcohol Harm Minimisation', 'Sex Issues and HIV/AIDS' and 'Driver Education'. Stress management activities and time for discussion were also planned (see appendix 16).

Obviously, there were other areas of concern for the HPS committee in promoting health at Pentecost College. Issues such as improving the school canteen, enhancing students' self concept and confidence, conflict resolution and other mental health issues were also regarded as being of vital importance to the total well-being of the individual within the college setting. It was anticipated that these issues were already and would continue to be addressed through the existing policies, programs and practices established at Pentecost College. However, these issues may become the focus for the HPS committee once the current priority measures have been established. All health promotion programs need to be linked to other policies and practices that are already occurring in the college.

The next chapter examines how the health promoting plans of the HPS committee were implemented at the college and the emerging issues that resulted from these initiatives. The implementation of these initiatives began to take place during term four, 1996 and continued throughout 1997.

## CHAPTER 6

### IMPLEMENTATION



Implementation is the process of putting the planning into practice. The effort spent in awareness raising and planning finally came to fruition during this stage. Whilst Green and Kreuter's (1991) Precede-Proceed model can be used to analyse the implementation phase, Dignan and Carr's (1992) model will also be referred to as it breaks down the implementation phase into further components. Dignan and Carr (1992) suggested that for health promotion programs to be successful, they needed to be implemented in a series of five interrelated phases.

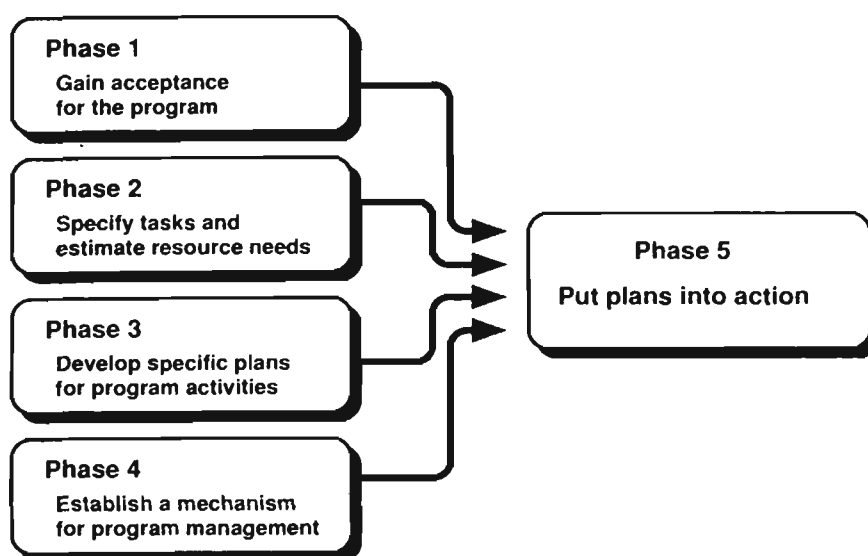


Figure 15. The five phases of implementation (Dignan & Carr, 1992, p.22).

As figure 15 illustrates, health promotion plans are not fully implemented until the final stage of the process. The majority of implementation involves expanding on the original planning and



supplying information needed to put the plans into action. The five phases represent the ideal situation. In reality, as this chapter will discuss, challenges to implementation comes from a variety of sources such as problems in securing resources, recruiting personnel and expanding political influences that are necessary to ensure time allocation, financial commitment and overall public promotion.

Dignan and Carr's (1992) model is used to reflect on the process that Pentecost College went through in the implementation of health promotion initiatives. The HPS committee did not consciously follow this model of implementation, notwithstanding, it is a useful model to assist in understanding the 'implementation gap' referred to by Hogwood and Gunn (1988). Both non-implementation and unsuccessful implementation of some of the health promotion initiatives occurred at Pentecost College. Non-implementation is where the policy or initiative is not put into effect as intended, perhaps because those involved in its execution have been uncooperative and/or inefficient, or because their best efforts could not overcome obstacles to effective implementation over which they had little control (Hogwood & Gunn, 1988). Unsuccessful implementation is when a policy or program is fully implemented but fails to achieve the intended outcomes. This chapter explores the possible explanations behind the 'implementation gap' between policy and practice of health promotion initiatives at Pentecost College.

As depicted in figure 15, the initial phase of implementation involved gaining acceptance for each initiative planned. Anything new in organisations often results in change both for individuals and the organisation at large. Change however, can also create anxiety, frustration, conflict and tension for people within the organisation which may well lead to some members resisting the changes simply because it is uncomfortable and the outcome unknown. Unless members are supported through change and encouraged to actively voice their opinions and concerns, changes are not integrated into the system effectively and the outcomes are predicably poor (Fullan, 1991). This was definitely a factor in implementing a number of health promotion initiatives at Pentecost College. For example, many of

the sun protection initiatives were unsuccessful due to people's reluctance to change.

Looking at the second phase of specifying tasks and estimating resource requirements, it was evident that there was a definite gap between planning and implementation. Many plans at Pentecost College had to be modified or abandoned altogether due to lack of personal time and financial resources required for these initiatives and the sometimes conflicting agenda of the administration. Phase three involved developing specific plans for program activities. At Pentecost this meant introducing the school community to the aims of the project and implementing the initiatives in the most effective way possible. This process was often overlooked at the college with some projects emerging through the initiatives of members of the HPS committee rather than consulting with members of the school community in a collaborative way. This led to phase four of program management which involved the responsibility of establishing the procedures of managing and sustaining the specific project. One of the major problems at Pentecost College was that at phase four there was no time assistance given by the administration to implement the HPS initiatives and as a result individuals were reluctant to take responsibility for a project. As this was too onerous a task for one person, the committee members worked together in sharing the responsibility for ensuring the project was workable and productive.

For successful health promotion initiatives, it is critical that there is a readiness for change and that there is a commitment of resources in terms of personnel, time, space and money (Dignan & Carr, 1992). However, the reality at Pentecost College, was this state of readiness was never really evident. Although awareness raising of health promotion was achievable for all vested groups at the college, it was only the HPS committee that had the passion and drive for brainstorming, planning and implementing the health promotion initiatives. This energy was generated out of a sincere and pastoral concern for the idea of a health promoting environment at the college. The committee's focus was to be proactive in motivating and sustaining health promoting behaviours for all the college members. The

remaining teaching staff and many students were passive participants in the initial two years of the health promotion project. The staff were generally happy for someone else to take on yet another worthwhile committee and many were prepared to give verbal support but had not internalised the philosophy of health promoting schools. For the HPS committee there was no time allocation given by the administration to adequately plan for new initiatives and their implementation and no financial support to begin projects or to offer incentives to students for such things as poster and slogan competitions. All the initiatives then came about purely on the good will and effort by the HPS committee members together with some interested students and parents.

Green and Kreuter's (1991) PROCEED component involves administrative and policy diagnosis and asks what political, regulatory and environmental constructs affect educational and environmental development. It is these factors that can assure that resources exist to implement acceptable and effective health promotion initiatives. Any change is more likely to be accepted if it has the support from the highest authority (Dignan & Carr, 1992; Hogwood & Gunn, 1988). In this case, the principal of Pentecost supported the HPS project and was a member of the HPS committee. His involvement on the HPS committee and his verbal support for the initiatives was unquestionable. However, it became obvious that his unilateral decisions on such things as the style of the sun shelter and the lack of time provided for the HPS coordinator to effectively coordinate the committee were based on his analysis of the school's financial constraints.

The remainder of this chapter examines the process of implementation of the health promotion initiatives at Pentecost College planned by the HPS committee as part of the HPS project. These initiatives were implemented from term four, 1996 to the end of term three, 1997 (a twelve month period). The four specific strategies to be discussed are programs designed to: enhance the physical environment; to develop sun protection behaviours; to increase physical activity; and the introduction of a senior personal development and health course.

## **Enhancing the Physical Environment**

### **Undercover Area:**

Construction of the undercover area began during the 1996-7 school summer vacation period. At some time between when the plans were shown to the HPS committee around the middle of 1996 and when building of the shelter began, changes were made to the structure. These changes were as a direct result of cost cutting measures made by the administration. The up-dated quote for the structure was \$100,000 so the decision was made by the assistant principal in charge, in consultation with the principal to reduce the span of support structures thereby reducing the cost of the undercover area by \$5-8000. Consequently, many more support poles were put into place for the undercover area. This completely defeated the original requests from the PDHPE Department for as few support poles as possible so that the area could also be utilised as a wet weather area for physical education lessons. The actual structure was completed early February, 1997 just after school commenced for the year. The PDHPE staff and myself were extremely disappointed with the result. In reality it meant that with so many support structures in place, the safety of students' movement during physical education lessons would be impeded and therefore unacceptable. What was even more frustrating was the fact that the principal and the two assistant principals had been at all the HPS committee meetings and were completely aware and supportive of the needs of the PDHPE staff and our requests. It was quite horrifying then to come back to school in 1997 and be faced with a completely unworkable PE wet weather shelter in addition to the visually cumbersome and unsightly structure that was to be a permanent part of the college. Mixed reactions from students, teachers and parents ranged from 'Yuk' (Year 7 male student), 'It's a complete eyesore on the environment' (Creative Arts KLA Coordinator), 'This is useless for wet weather activities in PE' (male PE teacher) to 'This is great to have assemblies together under a shelter' (Year 9 female student), 'It's good to be able to sit and have lunch in the shade' (Year 10 female student) and 'It's

about time the school did something practical about the lack of shelter' (canteen worker).



Figure 16. The construction of the undercover area.

Following the completion of the covered area, the principal ordered enormous amounts of concreting be poured to ensure the undercover area was practical for students and staff to shelter under during the day. Terracing of the banked area and landscaping of the surrounding area with sandstone walls and gardens added to the aesthetics of the area. Interestingly, the decision to beautify and to extend the concrete areas was made solely by the principal. There was no consultation with the HPS committee or discussions with any interested group as to where the \$30000 could be better spent. This of course raised the immediate question: 'Why spend so much money on the surrounds but scrimp on the undercover area making its capacity very much limited at school?' The logic of this decision caused much discussion amongst other staff members and the HPS committee, too late however, for any changes to take place.

As a result of this action many members of the college cynically felt that in reality it was only certain decisions that the principal would make collaboratively despite the fact that the HPS committee had been set up to specifically negotiate these issues. They felt that decisions were made to suit the administration's agenda at the time. Members of the HPS committee did not really feel empowered to make the 'big decisions' such as providing time for HPS initiatives to be developed or even on an issue concerning styles of

hats. Many of these decisions were ultimately dictated by the principal's philosophy on uniform and related issues. Developing collaborative partnerships between the school, the home and the community is the basis of the HPS concept (NSW Department of Health et al, 1996). Involvement of students, staff, parents and others associated with the school community in all initiatives is the central theme to successful health promotion programs. However, in reality, sometimes it is necessary and unavoidable that individual stakeholders approach the project independently. In this way at least some of the initiatives become active because of the personal interest of the stakeholders. This dilemma was faced on a continual basis. If someone was prepared to start the initiative with passion and energy, then at least some outcomes had a chance of being achieved. However, if all the stakeholders were not involved in consultation, then the support and ownership of the initiative was often absent.

#### Beautification of surrounds:

Funding was received from organisations such as 'River Care' and 'Stream Watch' for improvements and beautification to the area surrounding the creek that flows through the grounds of Pentecost College. A total of \$3500 was granted for the project. The Science teacher who applied and received the funding as part of the overall HPS committee plan of enhancing the physical environment took control of the project. Inadvertently, the project became isolated and as such became the domain of this particular teacher and a small group of students. No-one else in the college community was aware of what was happening with the project or even had the chance to be involved in the planning and implementation of this initiative. Despite this, as I write, the river area was being cleared of grass and rubbish resulting in that zone being replaced with mulch and trees, thereby regenerating the area and teaching the students about the care of the physical environment. Assistance in this area has also been given by the local council who supplied more trees and the commitment of the college's grounds and maintenance staff who dedicated time and effort to

this project. Colourful thematic bins painted by the students and placed round the school have also been introduced to promote a clean playground.

## **Sun Protection**

### **Curriculum:**

As planned by the PDHPE staff, in connection with the whole school initiative to promote sun protective behaviours, sun protection was the focus in PDHPE teaching units from Years 7 to 10 for the initial weeks of 1997. The changes being made around the school in relation to sun protection initiatives were issues raised in PDHPE classes. The HPS concept was discussed with students so they could understand how individual initiatives were combined to achieve a common purpose of both beautifying the environment as well as providing shelter for all the college's members on campus. While the aim was to involve all KLAs in curriculum changes to incorporate sun protective behaviours, the breakdown came when 'mapping across the curriculum' as suggested by Smith et al (1992) and Colquhoun et al (1996) outlined in the previous chapter, did not occur in practice. Whilst some KLA areas supported what the HPS committee was trying to achieve, they had their own agenda and a busy curriculum to follow. Some support came from the Creative Arts department where photography students took part in the local Area Health Service 'Sun Protection Art Competition'. This competition was open to all state and private schools in the area. Students from the college in Years 7-10 were active in designing sun protection postcards and the senior students presented their work in a thematic setting accompanied with a slogan. As a result, students from Pentecost College took out both first and second places with their entries whilst many other were applauded for their efforts. This in turn was publicised in the local paper, noting that the college's philosophy and current work commitment to sun protection. The students' photographs were then displayed in the local shopping centres and then sent as a travelling display to other centres. The school was also provided with a prize of an 'Enviroshade' tent which was to be utilised at sports carnivals.

Most physical education classes and sport lessons were timetabled in morning sessions between 9.00am and 11.30am in an attempt to reduce sun exposure to students during the middle of the day. Whilst this may have achieved a sun protective purpose there were associated problems. These problems related to students not getting changed after physical activity and a reduction of physical activity time in sport lessons.

In order to promote physical activity and make efficient use of allocated PDHPE and sport time, the policy of the school had been for students to wear their sports uniform to school when participating in physical education or sport lessons. Previous to 1997, most of these lessons took place in the afternoon and usually students went home shortly after the end of that lesson. A few members of staff expressed concern that because students were now physically active early in the day, they had to sit around in sweaty and often dirty clothes for the remainder of in-class lessons. The PDHPE staff argued that students run around before school and at recess times anyway, so that this issue should not be a major concern.

The other problem in the area of sport was where Year 9 and 10 students were often involved in activities outside the school grounds. When timetabled between recess and lunch, students previously were able to make best use of the time by travelling to the venue during recess and returning during lunch or when timetabled after lunch, to travel to the venue during lunch and make their way home at the conclusion of the activity. Now by having sport lessons in the morning block, this reduced the travel time available to the students, hence limiting the types of activities available in an area closer to the college. In addition, it eroded the actual time available to these students for physical activity. For example, if a venue took twenty minutes travel time for the students in each direction, it diminished the actual one and a half hours sport allocated time to fifty minutes. The feeling was that the any advantage gained from not being exposed to the sun inside peak times did not outweigh the disadvantages of reduced activity time. The PDHPE staff recommended that sport lessons not be held in morning sessions in 1998.



### School Ethos/Environment:

Whilst the construction of the undercover area was the major project for enhancing sun protection for the college community, a number of other supportive initiatives were introduced at the college at the latter end of 1996 and the beginning of 1997 to promote sun protective behaviour.

In term four of 1996, prior to the construction of the undercover area, a temporary measure of providing large umbrellas that fitted into the existing tables in the school yard were made available to students. The umbrellas were kept in an area accessible to interested students who were responsible for taking them out to the yard and bringing them in at the end of recess or lunch. An inherent problem with this system was that the umbrellas were often treated roughly or with little care or responsibility. As a result some of the umbrellas were broken or left in the playground for someone else to return to the Student Services Centre. These umbrellas were donated by 'Pepsi' and had a large logo printed onto the sleeves. This message was contradictory to the health message taught in PDHPE lessons concerning sugars but the practical need for the shelter was judged to outweigh the message for healthy foods. Students were also informed that sunscreen was now available from the office located near the canteen and were encouraged to use it if they were to be in the sun either for recreation or lessons. There was regular use of this sunscreen, particularly from female students.

The promotion of wearing wide brim hats began with the introduction of a variety of hats available to students to wear as part of the school uniform. A student 'fashion parade' took place at a whole school assembly towards the end of term three, 1996. Students were informed of the benefits of sun protection for these types of hats. Sunglasses and long sleeve sport shirts were also promoted at this 'showing'. This information was followed up with an article in the school newsletter informing parents and providing a list of local retailers assisting in the promotion by offering discounts to Pentecost College students. Some of the staff began to model the wide brim hats, sunglasses and long sleeve shirts whilst outdoors and in particular when teaching physical education lessons. The response from the

members of the college community to these sun protection promotions is discussed in detail in the following evaluation chapter.

The beginning of term four, 1996 also saw the reversal of recess and lunch times. Students and staff were aware that this trial was to take place after being informed about it towards the end of term three. There was hesitation from a number of students and staff prior to the trial as they did not like deviating from their daily routine: 'We've always had lunch later' and 'This is a stupid idea' were typical comments. Once again, a change to what has historically been the 'norm' for many years was particularly resisted by students, possibly because it was a change to routine. The change to recess and lunchtimes involved changing the hours of the canteen workers so that they could organise lunch orders for the earlier lunch. The canteen workers were quite encouraging about the change, reporting that it was more convenient for them to arrive earlier and to go home earlier in the afternoon. The trial lasted for six weeks and after feedback from staff and students, recess and lunch times were reverted back to their original time slot. Results of the evaluative process are reported in the next chapter.

#### School-home-community interface:

The Sun Protection Officer employed by the Area Health Service as part of the health promotion team assisted the HPS committee at Pentecost College by discussing what other schools were doing in terms of promoting sun protection. Monthly 'Sun Protection Newsletters' were distributed to the school providing up-to-date information on sun protection, various sun protection policies that were emerging in other schools and new ideas towards promoting sun protective behaviours in schools.

As has already been discussed, local community businesses were involved in providing hats and sunglasses and assisted in the promotion of sun protective behaviours. Parents were consulted through representation at Parents' and Friends' Association meetings and uniform committee meetings of the changes in hats, sunglasses and sports shirts. School newsletters and student assemblies provided avenues for the reinforcement of the initiative. However, the effect of what was happening in the school

and in the local community in terms of sun protection was often contradictory. Whilst some teachers at school were making a concentrated effort on role modelling desirable behaviours by wearing wide-brimmed hats, sunglasses and long sleeved shirts whilst teaching outdoors or on playground duty, they were in the minority. Students picked up on this and commented accordingly: 'If it is really that important, then why doesn't Mr X who has had skin cancers burnt off protect himself more?' (Year 9 female).

The problem of conflicting messages was also evident at the 1997 college swimming carnival, which was held at the local council swimming pool. Whilst some councils are now making a concerned effort to promote sun protective behaviours, they are only just beginning to back up policies with physical structures. The shade provision at the pool used for the swimming carnival could be best described as totally inadequate. As a result, the college borrowed two large tents, one from the Area Health Service and one from the Catholic Education Office in the diocese. Two smaller tents, one from another school sports association and one from the local council, were also erected to provide students with more areas to shelter from the sun. The PDHPE staffs' traditional responsibility for running school carnivals now took on the additional and arduous task of setting up the tents and areas for shade for a minority of people. Added to this was the time involved in booking, collecting and returning these shelters, all extra duties unrecognised and unpaid.

Whilst every attempt was made to provide some shelter for the students, four tents were obviously not enough shade for all students. Sunscreen was provided and encouragement for students and staff to keep hats and long sleeved shirts on were constantly broadcast throughout the entire day.

The college's philosophy however, on whole, school carnivals needs to be evaluated. At this stage, Pentecost College's swimming and athletic carnivals are whole school events. That is, if students choose not to compete in events they are to support their peers as spectators. Whilst the ideal is for every student to compete in events, realistically this isn't the case. Carnival statistics indicated that only 31% of students actually competed on

the day. It is reasonable to assume that we are placing some students unnecessarily at risk of sun exposure. A classic example was at the 1997 swimming carnival where some Year 8 students were sitting under a tree a small distance from the pool area, once deemed out-of-bounds, but on such a hot day providing a much needed shade area. These students were instructed by the assistant principal (welfare) who was also a HPS committee member, to go back near the pool and to sit with their 'house group' despite the fact that many students in these house groups were in the full heat and exposure of the sun. This was a complete contradiction of what the college was trying to promote in terms of sun protection behaviours. Added to this were telephone calls from irate parents of these students and others who were sunburnt during the day, complaining about the lack of sun protection for their children. Comments such as 'You insist the students participate in the carnival and yet provide little shelter for them when they are not swimming' (Year 9 parent), 'My son used sunscreen all day and was still unacceptably burnt by the end of the day' (Year 7 parent) and 'How can the college promote sun protective behaviours when the assistant principal thinks that keeping students in areas is more important than protecting their skins from the intense sun on that day?' (Year 12 parent). The whole school carnival approach in relation to sun protection and physical activity will be further discussed in Chapter Eight.

## **Physical Activity**

### **Curriculum:**

From the results obtained from the awareness raising and needs analysis surveys in regards to physical activity, the PDHPE staff made the decision for Year 8, 9 and 10 physical education lessons to be all single-sex classes in 1997, leaving Year 7 classes co-ed. All health classes were to remain co-ed. This decision required timetable priority and support by administration. PDHPE staff were able to make up all Year 7 to 10 PDHPE classes according to students and sex as PDHPE was not aligned with other subjects on the timetable. As a result:

- Year 8 PDHPE classes (six in each year) were timetabled at least in pairs to allow for splitting of classes into single sex PE groups;
- All Year 9 PDHPE classes (six classes) were timetabled together;
- All Year 10 PDHPE classes (five classes) were timetabled together.

An additional PDHPE teacher was employed to alleviate the problem that some PDHPE classes were being taught by non-trained PDHPE teachers. This was made possible with a change in staffing formula where the principal gained permission from the catholic education Office to have an additional staff member at Pentecost College. This decision made it unnecessary to staff PDHPE classes with untrained teachers who had difficulty in dealing with basic PDHPE curriculum as well as not having the experience to deal with difficult gender issues in PE classes. This was seen as support from the administration towards improving the quality of physical activity at Pentecost College.

#### Ethos/Environment:

Basic to effective teaching in physical education is the need for the college to provide adequate facilities to promote physical activity. Resources provided for such lessons need to be continually maintained. The local council assisted in the turfing of the PE lawn used for gymnastics and other activities in term four, 1996. This area was fenced off and out-of-use for at least six months. At the point where the grass had germinated and was growing well, indicating that the area was ready for use, further building projects near the centre of the school necessitated heavy traffic. Concrete trucks, workers' vehicles, transportation of building materials and the like traversed the grassed area making much of it unusable again. Because of the lack of forward planning, the area now will need to be returfed, this time at the school's expense.

The employment of two new ground maintenance staff, one with landscaping and horticulture experience has greatly assisted in the maintenance of the college grounds. Maintenance work on the two ovals that were also used for community use finally began in term two, 1997 after being promised for twelve months. This required the principal to

continually remind the relevant community parties about their commitment to the college. The work was finally undertaken by a local construction business under the direction and support of the local rugby league club in gratitude for their use of training and playing grounds.

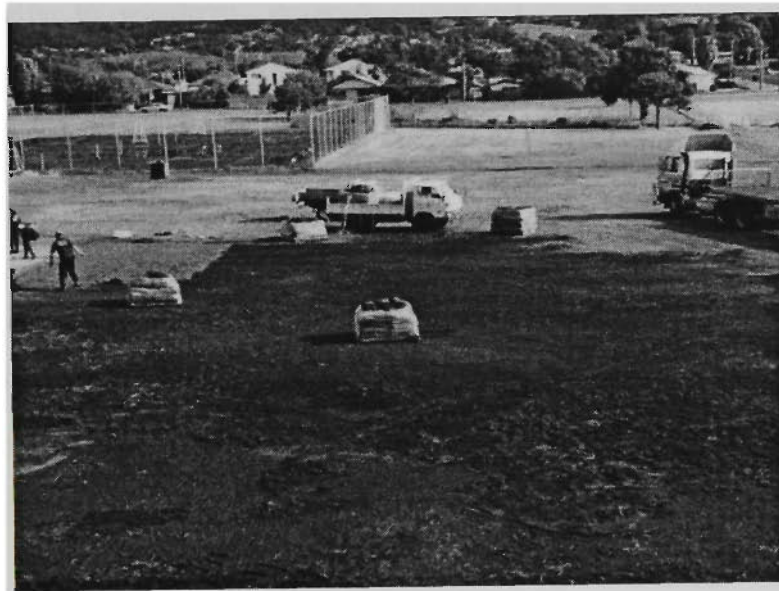


Figure 17. Turfing of the gymnastics area.

The dilapidated tennis courts have been unusable for tennis for many years and currently house approximately twenty of the students' bikes. They have recently been checked by the principal with the building consultant from the Catholic Education Office with the view of having the courts resurfaced. While this is a first step towards their restitution along with support from members of the school community, the exorbitant cost of resurfacing the area seems to be beyond the college's budget.



Figure 18. The current use of the tennis courts.

### School-home-community interface:

Once again the HPS committee utilised the human resources available through the Area Health Service to assist with Pentecost College's promotion of physical activity. After attending the Area Health Service's 'Physical Activity Workshop' provided for all pilot schools, it was arranged for the physical activity coordinator and the migrant coordinator employed by the Area Health Service to attend a HPS committee meeting at Pentecost College. From this meeting, the concept of a 'Walkers' Club' was promoted at staff meetings, student assemblies and Parent's and Friends' Association meetings. The 'Walkers' Club' did not eventuate because although it was supported in theory, it lacked coordination and support. The PDHPE staff were also responsible for coaching teams before or after school and often at lunchtime and those who might have assisted, could not physically participate in this project. To make it work, other interested staff members needed to give up their lunchtime and most were not willing to do so. Morning or afternoon sessions were not a practical alternative for staff, students or parents and interest in the 'Walkers Club' dwindled.

After discussion with the migrant coordinator regarding the problem of encouraging some specific ethnic groups of girls into physical activity, she offered assistance in this area. However, once again it was up to the teachers at Pentecost College to find the time to establish and coordinate such a program. The recurring problem of having assistance from outside the school community available for many projects, yet being unable to harness this expertise due to inadequate time and other priorities, was a common factor for the failure of many health promotion initiatives at Pentecost College.

Encouragement of active modes of transport to and from school were promoted through whole school assemblies and newsletters. The conflict between safety and physical activity became evident when the decision was made by the school's administration that students would not be allowed to ride home if they were not wearing a bike helmet. A letter was sent home to parents informing them of the bike helmet policy and a contract for each student to sign, verifying that each one would wear a helmet to and from

school. Intensive random checks on students took place over a four week period. Some students were found to have their helmets on but not secured, others had the helmets swinging from the bike's handlebars, some did not have a helmet at all. The majority of students, however, wore helmets in the correct manner. Similarly, the encouragement of students walking to and from school met with safety concerns from parents and caregivers in relation to traffic dangers and personal safety issues. The popularity of skateboard riding resulted in many students, mostly male, using this mode of transport but safety concerns led to the deputy principal (welfare) to ban skateboards from school. The issue between safety and physical activity is one that needs to be addressed by the HPS committee.

### **25-hour personal development and health course**

Lack of support from Year 11 and 12 teachers hindered the implementation of the senior PDH course. Other KLA coordinators did not see the course as necessary: 'There is no time in the curriculum to give these students personal development or health lessons. Besides, they had all that in the junior years' (English KLA coordinator). This can be directly attributed to the pressures of completing the work to be covered in the Higher School Certificate (HSC) year. The majority of staff could see the benefits of such a program but were concerned with placing extra time commitments on senior students, taking away 'valuable curriculum time'. There is a strong contradiction here with the rationale behind the implementation of a senior PDH course:

The emergence of issues relating to independence and identity, together with the rigours of preparing for the HSC present a challenge to students in Years 11 and 12. Tension often exists because of the individual's concern for personal and social well-being and parental and social expectations for high achievement and preparation for adult life

(Cowling, 1992, p.2).

The importance of a PDH course for senior students is unequivocally agreed on in the literature (Cooney, Dobbinson & Flaherty, 1993; Frydenberg & Lewis, 1994; Wragg & Fazelli, 1994). However, because of the HSC



requirements, this course is at odds with elements of the curriculum timeline.

After the decision was made to provide the course over two days for Year 11 and Year 12, that was the end of the support from the administration. The planning and implementation of the course became the responsibility of the respective year coordinators neither of whom had any expertise or experience in such programs. An understanding and commitment to the area in itself is crucial to effective implementation of a senior PDH course. While teachers are central to the implementation process, several factors influence classroom implementation: teacher training, presence of supportive administrators and school format (Smith McCormick, Steckler & McLeary, 1993). Obviously, teachers who receive training are more likely to use curriculum appropriately, than teachers who do not receive such training. Administrative support and encouragement is also crucial:

Presence of supportive administrators to champion a curriculum also exerts a positive effect on curriculum implementation. Supportive administrators help locate and provide resources for implementation, answer questions about how a curriculum was intended to be taught, help with scheduling problems, and act as advocates in promoting new curriculum to higher school district administrators (Smith et al, 1993, p.349).

This was not the case with the introduction of the 25-hour PDH course at Pentecost College. Administrators appeared to give the course little priority. No matter how dedicated, enthusiastic or prepared a teacher may be, administrative and structural mechanisms must support classroom activities. Boggiano, Flink, Shields and Barrett (1994) suggested that a major reason for ineffective implementation of any senior health program was the inadequate time given to teach the curriculum because of mandated testing in other subject areas or not receiving needed curricular materials.

Whilst the 25-hour PDH course was developed to cater for the needs of students in Years 11 and 12, it was only in 1997 that the course was directed to both years 11 and 12. In future years it will be restricted to implementation in Year 11. This is because the principal and the majority of senior staff members consider this the least obtrusive way of initiating the PDH course, without placing extra time commitments on students in their

final year. The only reason it was implemented in Year 12 in 1997 was to ensure that these current students would not miss out on this course. This came as a result of the interest of the Year 12 coordinator at the end of 1996 and the beginning of 1997. It was then timetabled in the school calendar and accepted by the staff as an important addition to the Year 12's focus for the year. Unfortunately, this teacher took another position in a different school and left without informing anyone else at the college of his preparations and ideas for this particular group of students. The responsibility for the course was picked up in 1997 by the new Year 12 coordinator whose role was to provide students with a course that would be both worthwhile and rewarding. Assistance was also offered by the PDHPE Consultant from the Catholic Education Office who had prior experience in presenting similar courses in other secondary schools. Students from Pentecost College were not involved in the consultation process and the course followed a similar format to that of other systemic high schools.

The 25-hour course was implemented for Year 12 just after their trial Higher School Certificate exams midway through term three, 1997. The course consisted of a two day workshop where students were rotated through different themes of 'Suicide', 'Drug Taking' and 'Sex issues and HIV/AIDS' and 'Driver Education'. The Year 11 program was similar and was conducted at the end of term three, 1997. An evaluation of the 25-hour course implemented for Year 11 and 12 is discussed in the next chapter.

On reflection, there was sufficient lead up through the stages of awareness raising and planning for the implementation of health promotion initiatives at Pentecost College. The main difficulty, however, was that once the initiatives were implemented, that was the end of the process. There was no mechanism established for program management as required in Dignan and Carr's (1992) model outlined at the beginning of this chapter. According to this model, once an initiative has been implemented, there needs to be ongoing commitment to maintain support for the idea and to sustain the project. In the awareness raising and planning stages, HPS committee meetings were regular and supported by members' attendance at

a number of workshops provided by the Area Health Services' Health Promotion Unit. However, since the various initiatives have been implemented, HPS committee meetings have virtually come to a standstill and the sense of unity among the members has diminished.

It was suggested in *Towards a Health Promoting School* (NSW Department of Health et al, 1996) that all health promotion initiatives needed to be documented throughout the process. Whilst regular HPS committee meetings were occurring, this documentation was recorded in the minutes of the reports of committee members involved in the various health promotion projects taking place at the college. Other than this, the only ongoing documentation that was continued were my notes from personal observations and interviews for the writing of this thesis. If this was not the case then I would suggest that there would have been little, if any, further documentation of the process of implementation of health promotion initiatives at the college.

Staff changes at schools present a serious impediment to sustaining health promotion programs. Health promotion initiatives can often be motivated by personal objectives where no-one else knows what is going on and when that person leaves, the whole project leaves with them. It is essential then that steps, stages and processes are documented (like KLA registers and programs) so anyone else can come in, recognise what has happened and what has been planned for the future. The process belongs to the school not the person, therefore there is a need to ensure that it does not become what others see as 'empire building'. The whole school community must share in the philosophy and commitment to the project.

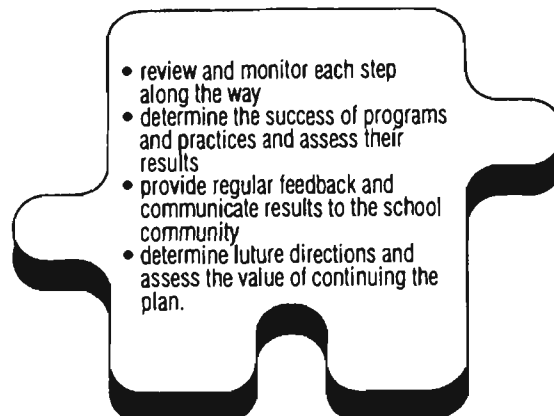
There is always the lurking danger of 'volunteer burnout'. All individuals involved in the HPS project, staff, students and parents, have a range of personal, family, career, community and study commitments. At times, these other demands slowed the HPS project down, creating frustration and draining mental and physical energies of those involved in its application. Often it was difficult to regain the momentum of the project, to reharness the interest and motivation of people so that the public profile of health promotion remained a priority. This is why it is necessary to

involve as many individuals and interested groups as possible in the project which in turn will better sustain the health promotion process.

The next chapter on evaluation will examine the success of each of the health promotion initiatives implemented at Pentecost College during the first two and a half years of its involvement in the HPS project.

## CHAPTER 7

### EVALUATION



‘Evaluation encompasses a broad range of activities’ (Dignan & Carr, 1992, p.144). Evaluation for health promoting school projects involves monitoring all the decisions made and the decision-making process itself (Rowling, 1996). Evaluation of health promotion is difficult. Evaluation implies some sort of measurement and comparison with a criterion or standard that is considered an indication of good performance. The nature of the HPS project and the fact that health cannot be readily quantified makes evaluation a complex task. The definition of evaluation that underpins this case study comes from Suchman (1967) who states ‘evaluation is the process by which we judge the worth or value of something’ (p.6). How it is judged depends on expectations, past experience, observations and what is thought to be important or not important. Evaluation procedures used in this case study have included documentation, questionnaires, interviews with parents, staff and students, to provide an overview on the effect of the HPS project at Pentecost College. Ultimately, the purpose of this evaluation was to determine whether the time and effort put into the implementation of the health promotion initiatives had been worthwhile. This meant recognising the strengths and weaknesses of the processes involved in the HPS project in order to make future implementation of health promotion initiatives more effective.

At Pentecost College ongoing monitoring and evaluation was conducted to some extent throughout the early stages of awareness raising,

planning and implementation. Although this chapter stands alone, evaluation does not exist as a singular phase, but as an integral and ongoing part of the whole HPS process. Nearly all that has been written so far has in some way been an evaluation of the HPS process.

This chapter goes further to evaluate the specific health promotion initiatives that were implemented at Pentecost College over the years 1995-1997. An evaluation of the four priority areas for the initiatives was conducted. These were the health promotion programs designed to: enhance the physical environment; develop sun protective behaviours; increase physical activity and introduce the 25-hour PDH course for senior students. Each of these are examined in terms of responses from students, staff and parents and the problems encountered in implementation. In addition, an evaluation of the HPS workshops, conferences and network meetings together with an evaluation of the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) document is presented.

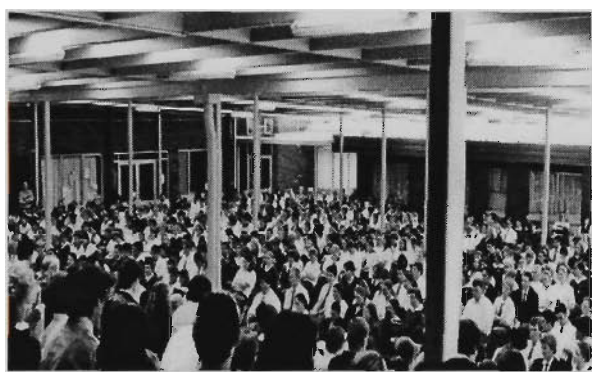
## **Enhancing the Physical Environment**

### **Undercover area:**

Chapter Six described the problems in construction of the undercover area and the initial negative comments by a number of members of the school community. Despite these problems, the undercover area is now well utilised. In terms of sun protection, having whole school assemblies undercover has been a positive step in health promotion. The area has also proven to be very popular at recess and lunchtimes for students as it provides much needed seating, a shaded play area for handball and general protection from the elements. Positive feedback from parents and other members of the school community following functions such as family barbeques, Year 10 graduations, presentation nights, college dances and the college fete, revealed they all made use of the undercover area.

The undercover area has therefore been useful for the college on one level. It has not, however, alleviated the need for a school hall or indoor facility that could cater for the whole school population and for indoor

physical education classes. In wet weather, it is still unsatisfactory for school assemblies as the noise of the rain on the roof and the unsatisfactory drainage for the surrounds makes it impossible to utilise the area. As an undercover area for physical activity, it has also been inappropriate. Safety issues are of concern because of the myriad of poles used in the construction, and the fact that the area may only be used at selected times during the day because of its location within the school setting. It is attached to the existing hall which is used regularly for exams and other functions. This makes it unsuitable for potentially noisy classes when a quiet environment is required.



Assemblies



Lunch

Figure 19. The undercover area at Pentecost College in use.

Enhancing the school environment by building the sandstone walls which surround the undercover area was aesthetically pleasing rather than a functional necessity for the school community. Many questioned whether the \$30,000 for this project could have been better spent. With an extra \$5-10,000 allocated to the undercover area, the number of support poles could have been reduced to allow a larger area free of obstructions where students could play and physical educators could teach in a safer environment.

Beautification of the surrounds:

Beautification of the surrounds was a priority of the HPS committee as a further strategy to enhance the physical environment of the college. The relocation of the public thoroughfare was seen as essential by the committee in order to ensure any beautification of the college's grounds

were not vandalised by individuals passing through the school. To date this project has not commenced. Council surveyors however, have been involved in surveying an alternate route on the perimeter of the school for the walkway/cycleway. This occurred at the end of term three 1997, and the possibility of the project commencing sometime in 1998 now appears feasible. The principal stated that whilst there had been no official word on the relocation, he was hopeful of its inclusion in the local council's 1998 budget. If this does not occur, negotiations must continue to get this project underway in the future. Previous chapters have discussed the issue of safety in regards to this thoroughfare and the fact that members of the school community have indicated that they would be more motivated to put effort into beautifying the grounds if the pathway was relocated. The benefits to Pentecost College, in these terms, to enhance the physical environment would certainly be worth the persistence of further negotiation.



Figure 20. Mulching in readiness for tree planting on the creek embankment.

The beautification of the creek embankment area is currently taking shape. The trees are beginning to grow and will add to the natural surrounds of the school. However, the project has been confined to a small group of students. Such projects have the potential to involve more of the school community and the possibility of expanding this project to other parts of the creek and school grounds needs to be examined for it to become a whole school initiative in the context of the HPS project.



The project undertaken by the Creative Arts KLA in painting the bins around the school and murals on some of the school walls has been beneficial in enhancing the image of the playgrounds. Unfortunately, this has had little effect in promoting a clean playground. Students at Pentecost College still have a major problem with placing rubbish in garbage bins. This appears to be a common problem in secondary schools. For the development of the HPS concept, it is important to look at health in a wider environmental context. Students must take on responsibility of a healthier environment for all. However, for many adolescents this does not seem to be a priority when it comes to their own health and their own environment. From an adult perspective, students do not seem to understand health in this wider context. Different belief systems between adults and adolescents certainly need exploring when attempting to implement effective health promotion programs in schools. The nature of adolescents in regards to their risk-taking behaviour and belief systems will be explored in detail in the following chapter.

## **Sun Protection**

The linking of sun protection in PDHPE lessons to what was occurring in the physical environment was intended to make PDHPE lessons more meaningful for students. The college's commitment to sun protection by providing more shade, promoting hats, sunscreen, sunglasses and long-sleeved shirts for students and teachers reinforced the theory and practice of sun protection within the curriculum. Many students indicated that these lessons had more relevance now they could see that school structures supported what was being discussed in class.

The attempt at timetabling more sport and physical education classes into morning sessions before 11.30am to reduce sun exposure to staff and students during the middle of the day had numerous logistical problems. The number of classes involved and the staffing combinations realistically had to be spread across the timetable. The time lost in not being able to use recess and lunch to travel to different sport venues had a detrimental effect

on physical activity time. Prioritising morning sport and physical education classes in the timetable will not be pursued in 1998, instead the sun protection emphasis is to shift the responsibility for sun safety back to the students to protect themselves from the environmental conditions at the time. If the philosophy underlying health promotion is empowerment for the individual to make decisions that are health promoting, then students need to take responsibility to protect themselves from the sun. Ways need to be found to assist students to do this through the interactive areas of curriculum, environment and the school-home-community interface. Schools must provide opportunities for students to develop health enhancing skills so that they take responsibility for their own health now and in the future. The school has sunscreen available and has promoted long-sleeved shirts, hats and sunglasses. The use of the sunscreen made available from the Students' Services Centre was initially used by a small number of students on a regular basis. However, it was found that more students would use it in physical education and sport lessons if the teacher offered it to the students at the commencement of the lesson.

The sun protection uniform changes met with mixed results. Although there was an immediate increase in the number of students wearing wide brim hats, it was still limited to a small percentage of students (approximately five percent). Whilst the choice of hat was extended to include any wide brim hat and any logo, the students' choice was restricted to four set colours which represented the school colours. Students reported that the main reason for not wearing the wide brim hats was 'Because we can't wear any hat we want ... nearly everyone would wear a hat if we could wear them outside school' (Year 12 male student). Figure ten in Chapter Four (p.92) supports these responses. From the analysis of sun protection behaviour by students at the college they are more inclined to wear hats outside of school than whilst at school. Another problem related to the wide brim hats were that they were often without a drawstring around the chin which was not particularly effective or suitable in many forms of physical activity. As a result these hats were constantly falling off during the lesson and therefore did not protect the students from the sun. Other

reasons that students gave for not wearing the hats revolved around image and looks: 'I've got long hair to protect me from the sun' (Year 11, male student), 'They just don't look good' (Year 11 female student), and 'It would mess up my hair' (Year 10 female student). The reasons students gave for wearing hats included: 'I'm glad I at least have a choice in the type of hat I wear' (Year 11 male student), 'It's cool to wear a hat, even if it is to school' (Year 7 male student) and 'I want to protect my skin as I burn easily' (Year 9 female student).

The sunglasses promotion provided evidence that this apparel was far more appealing to the students and as a result, they were willing to wear them around the college campus. A large number of students wore sunglasses whilst outdoors and during physical activity. The promotion of sunglasses was supported by a local retail outlet providing samples to the school for students to try on to 'see what they looked like'. In conjunction with the college and in support of the sun protection philosophy, the retail outlet offered substantial discounts to the students from the college if they purchased sunglasses from that outlet. A number of similar outlets also contacted the college to offer a discount on all purchases through their stores. The ability for students to choose any style and brand of sunglasses provided them with a sense of individuality which captured the 'cool' image.

It was also interesting to note that the NSW Cancer Council was approached to assist the promotion of sun protection by supplying on approval, a selection of wrap sunglasses to sell in the college canteen. However, the Cancer Council would not agree to such an arrangement and would only provide sunglasses to the college if they were paid on the initial order. There seems to be a contradiction between the Cancer Council's philosophy and practice. The original non-profit making health promotion venture appears now to be very commercial and business-like. This philosophy also needs to be questioned.

The introduction of the new long-sleeved sports shirt was not accepted by the majority of students. To date, sales in the twelve month period from the college uniform shop since the initial promotion have

totalled thirty-five shirts. The slow acceptance of the long-sleeved shirt seemed to be linked to factors such as resistance to change and to self-image. For instance, students made comments such as 'Just don't like it! (Year 11 male student), and 'No-one else is wearing them' (Year 8 female student). The usual adolescent concerns and cultural influences were at work here once again. The majority of students who have purchased the long-sleeved sport shirt have done so not for the designed purposed of sun protection but because the shirt keeps them warmer in winter under their track suit tops.

An evaluation of the practice of reversing recess and lunch times resulted in the times being shifted back to their original time slot after the six week trial in 1996. All staff and students had the opportunity to respond to the changes in a brief questionnaire (see appendix 17). The results by students were overwhelmingly against continuing the reversal of recess and lunch times. However, the staff were more positive with these changes, citing reasons such as students being more settled in the afternoon lessons.

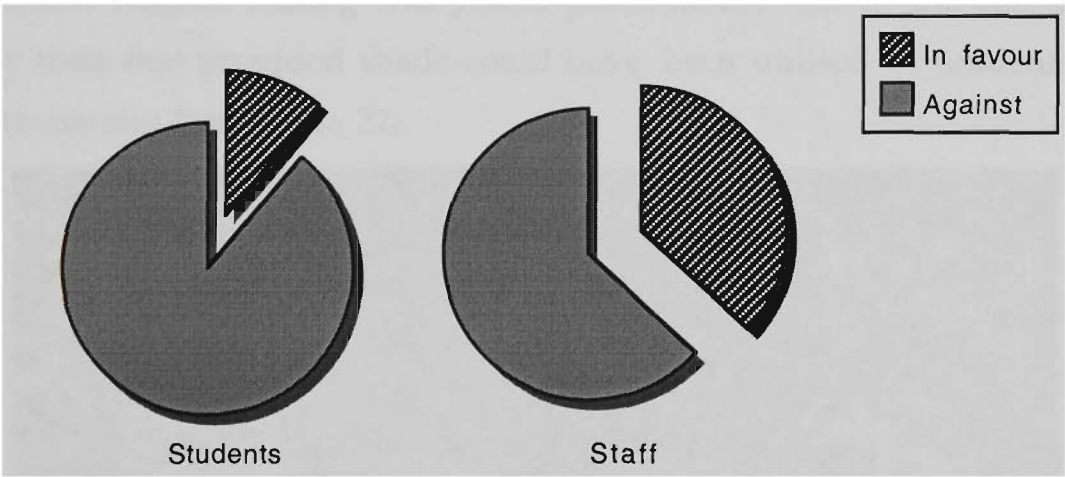


Figure 21. Student and staff response to the continuation of reversal of recess and lunch times.

Comments from students such as: 'The days felt a lot longer', ' ... need the longer break later in the day' and 'I don't really want to play sport at the early lunchtime' were typical. Positive responses from students included: 'I liked it ... I never have breakfast, so the earlier lunch suited me' and 'I ate better food at lunch than I did before'. Interestingly, most of the responses focused on nutrition aspects with no comments related to the benefits of sun protection which the initiative was targeting. The Canteen Coordinator

reported less sales of 'junk' foods and increased sale of healthier foods. Some parents in focus group interviews reported that children were hungrier than 'normal' at 4.00pm. This sometimes proved difficult for working parents who were not at home to ensure a healthy afternoon tea and instead found that some students would then elect to eat more junk food at home. Other parents reported that they were able to eat dinner earlier which had a positive effect on the family routine and allowed more time together after the meal was eaten.

Overall, the variety of initiatives to promote sun protection that were introduced to the Pentecost College community met with some success. However, it was evident that students were still receiving mixed messages from within the school. The problem of conflicting messages from teacher role-modelling and provisions of shelter were discussed in the previous chapter. Adding to this problem was the recent location of tables and chairs provided by the Student Representative Council (SRC) for senior students. This much needed seating was placed permanently out in the sun whilst nearby trees that provided shade could have been utilised by students in a similar manner (see figure 22).



Figure 22. Location of permanent seating away from a shaded area.

The SRC had responsibility for this project (two members of which are on the HPS committee) but gave little thought to the philosophy and practice of sun protection. The idea of providing umbrellas for the tables came as an afterthought, one which the college has already found to be

problematic. They suffered the ravages of westerly winds and were usually left abandoned at the end of the lunchtime break. This is yet another example where groups within the school community need to work together if health initiatives are to be successful.

## **Physical activity**

Now is the ideal time to promote physical activity within NSW schools. The emergence of HPS projects across the state, the discussion paper entitled *Physical Activity in the School Curriculum* (NSW Government, 1996) and the 'Fitness and Physical Activity' study undertaken across NSW schools in first term 1997 are integral in elevating and advocating the cause. The promotion of physical activity within the HPS framework can provide the opportunity for students to develop skills that they can use in their leisure time activities.

One of the initiatives to increase the physical activity of girls at Pentecost College was to revert to single-sex physical education groups. Observations of these single-sex physical education classes have indicated an increase in girls' participation in physical activity. PDHPE staff reported at faculty meetings that the girls are more relaxed in the single-sex classes and increased enjoyment was evident. Teachers had remarked that many girls appeared more willing during class to become involved and wear the PE uniform whereas previously they were trying to cover up their bodies, particularly evident in co-ed swimming classes. From the point of view of the PDHPE staff, there has been a greater response from girls for representative sport teams and a willingness to 'have a go' in team games. There have been no noticeable changes in the participation rate for boys. There is still a need to reevaluate the PE program as to the *type* of activities we are offering so as to further increase participation in physical activity for all.

Student reports for PDHPE have become a little more time consuming. Teachers need to work together to provide combined marks from the different PE and health classes as PDHPE is reported on as one

integrated subject. PDHPE staff felt that this was a small price to pay for the advantages of single-sex PE classes. Although segregation has provided one solution to the poor participation of girls, it has not really challenged the dominance of masculine attitudes in PE classes. It was an expedient answer to the problem for PDHPE teachers but not necessarily for the students because we have not provided the opportunity for boys to develop skills to interact with girls in PE lessons, nor addressed issues of harassment within the boys group. Their attitudes are maintained, the only difference being within an all boys group. To provide relationship development opportunities, social interaction between males and females is maintained in coeducational health classes and sport lessons.

The staffing of integrated sport however, was still an area of concern. The 'promise' from the principal that staffing of sport was to be a priority for 1997 did not come to fruition. As had been the case in the past, staffing for integrated sport for 1997 was derived from teachers who were short on lesson allocation so that their teaching load was made up with sport periods. In some year groups, this has resulted in these students being taught sport without any trained PDHPE teachers. Also the existence of many 'split' classes, that is classes where two or more teachers shared the one class week about, added to the problems. In some cases, four teachers shared one sport class that resulted in students having a different teacher for each of their four sport lessons per fortnight. Problems such as different teacher expectations, discipline and lesson preparation gave students an ideal opportunity to manipulate the situation.

The entire issue of sport at school needs to be explored. The positive aspects of sport in schools are well recognised and documented and few would dispute their value (Clifford, 1996). Most members of the school community agree that sport as an aspect of the school curriculum is an integral part of an individual's development, requiring as it does, physical involvement in organised games and activities played within accepted sets of rules. However, there are currently many problems with school sport, not only at Pentecost College, but in many schools both public and private. Those in charge of school sporting activities battle an ever increasing flow of

hindrances, organisational difficulties, discipline problems and apathy from disinterested teachers. For instance, representative teams usually take up those staff members who are willing to coach, leaving the majority of students who really need assistance and motivation to participate, to their own devices. It is these students that a school sports program really needs to target. There is a desperate need to alter this negative attitude by many students and teachers to sport in schools. What alternatives are there? How do we change habits and well entrenched negative attitudes? These are questions that must be explored if sport in schools is to become effective for the promotion of physical activity. It is unfortunate that if a facet of education such as sport is assessed negatively, there is a danger that it will be eliminated from the system. If sport in schools is to become more meaningful then a total reassessment and appropriate changes need to be made if it is to achieve its aim of promoting physical activity. It is important to cater for the students' needs and interests, which may involve evaluating the appeal of current team sports and exploring alternatives to achieving the benefits of physical activity.

To address the sport issue and as part of the HPS physical activity initiative, as PDHPE coordinator, I proposed changes to sport for 1998. During a KLA Coordinators' planning session in the last week of term three, 1997, the principal indicated that a total of seven extra periods per two week cycle over Years 7 to 10 would need to be allocated to meet the required hours for the new Board of Studies (BOS) approved Year 7 to 10 Religious Education Course. I proposed that these forty-five minute periods could come from sport providing that the remaining sport periods be reallocated to PDHPE. This resulted in Years 7 and 8 moving from five periods PDHPE plus four sport lessons per two-week cycle to seven periods PDHPE; Year 9 from seven periods PDHPE plus four sport lessons to nine periods of PDHPE and Year 10 from seven periods PDHPE plus four sport lessons to ten periods of PDHPE. The only stipulation was that PDHPE classes were to be taught by qualified PDHPE teachers. The philosophy behind this decision was that time for promoting physical activity could be more effectively utilised if the PDHPE staff had two periods to teach what was currently being



achieved in four periods of sport taught by unqualified and uninterested teachers. The proposal was accepted by the principal and supported by the majority (90%) of KLA Coordinators. It was planned that this proposal go ahead for the 1998 school year timetable. This of course necessitated a complete overhaul of the current Year 7 to 10 PDHPE program. A number of new alternatives are now possible in the teaching and timetabling of PDHPE for 1998. Teacher specialisation in different physical activities, triple periods and modified vertical streaming are initial possibilities for timetabling. Whatever the outcome, I believe that a greater opportunity to promote health and physical activity exists within the school community because of this initiative.

These changes do not mean Pentecost College no longer has any sport. The students will continue to have the opportunity to be involved in representative teams at Diocesan sports carnivals, in athletics, swimming, cross country and numerous 'Gala Days' throughout the year. In addition, the school also competes against other schools in a number of state-wide knock-out competitions, both during school time and after school.

School sports carnivals were another area targeted for attention on two fronts: sun safety and the promotion of physical activity. The 'whole school' sports carnival approach in relation to sun protection and promotion of physical activity needed to be evaluated at Pentecost College. Traditionally the whole school population had attended swimming and athletic carnivals. Participation was always encouraged for all students but only thirty percent of students competed. As a school aiming to promote physical activity, it was necessary to examine what we were doing for the majority of students who do not participate on these days. The swimming and athletic carnivals at Pentecost College whilst attempting to encourage all students to compete were in effect, designed to select elite athletes to represent the college at Diocesan Championships. In reality, if all students were to compete, the carnivals would never be able to be completed on the day allocated. Previously, a trial 'competitor's only' swimming carnival took place in 1995 after a push from the PDHPE faculty. The carnival ran very smoothly for those in attendance. Those that were not involved had

classes as normal. As part of the HPS project to promote physical activity for all students, it was suggested that the students not participating at future swimming carnivals be involved in an alternative carnival/sports day at a separate venue. This would offer a variety of non-competitive novelty events in which each student could participate. Such a day would do more to promote physical activity than one where seventy percent of students remained inactive. While the PDHPE staff took responsibility for the competitors' carnival, unfortunately no other staff members would take on the organisation of the alternative carnival for the remainder of the school population. In addition, after complaints from a small influential group of parents and some members of staff who were suddenly interested in attending such days, the principal made the decision that future school carnivals would continue to be represented by the whole school population.

Another aim of the HPS committee was to increase the use of the school grounds by improving the condition of the ovals. Overall, the oval use for physical activity has increased since the initiation of the HPS project. This was mainly due to the efforts of the two grounds maintenance staff employed coincidentally at the beginning of the HPS project. Grass cover cutting and line-marking has resulted in a much more efficient use of the grounds. However, the work commenced by the local rugby league club as part of negotiations for use of the playing fields was left unfinished at the end of the 1997 season. This again highlights one of the problems of using 'outside' assistance in schools. Someone needs to have the time and persistence to constantly chase up each of these commitments.

Similarly, it has been extremely difficult to organise and motivate parents, students and teachers to participate in the 'Walkers' Club'. Firstly, the college population is drawn from a wide spread geographical area and for people to participate in after school activities meant participants travelling home on late trains and buses. Secondly, the majority of families had both parents working which worked against their involvement at any time of the day. Thirdly, there was effectively thirty minutes for lunch and students and teachers were not prepared to give up this time to participate in physical activity. Fourthly, no-one who wasn't already heavily involved

in the HPS committee was prepared to be a leader in the 'Walkers' Club'. Their commitment to other committees, marking work, preparing lessons or simply enjoying their lunch was a higher priority at this time. This project still needs to be prioritised for discussion at a school staff meeting to encourage the involvement of others and to brainstorm other ways of implementing the program effectively. It is also important to link in with other health promotion initiatives that are occurring in the wider community. For example, the local 'No Ifs, No Buts' National Heart Foundation promotion aimed at adults over forty (which includes most secondary teachers and parents) could be harnessed to promote physical activity in the school community.

### **25-hour personal development and health course**

A 25-hour personal development and health course was implemented in Year 11 and Year 12 for the first time in term three, 1997. This was not effective for a number of reasons. Firstly, the amount of time spent on the course was really only six hours. Six one hour sessions: four rotational sessions on the topics of 'Drug and Alcohol Harm Minimisation', 'Suicide', 'Road Wise', and 'Sex and HIV/AIDS'; and two whole group sessions comprised of 'Stress Management' (meditation) and a question/discussion hour.

Secondly, the significance of any personal development course is that it is current, relevant and sensitive to the needs of the students. It is imperative for all students to have an input into the development of the program but this did not occur. The findings from the interviews with students on their experiences of being involved in the program clearly indicate that they view the program as irrelevant and ineffective in this present form. Many students just did not see the course as being related to their lifestyles even though the content areas address the general areas in which adolescents will be making important life decisions. Consultation with students about their relevant needs in terms of the course content is

vital for the students to accept the course and it will be more likely that students will commit themselves to the outcomes.

The use of guest speakers and outside personnel for their expertise was looked upon favourably by students. However, whilst the majority of students indicated in a Likert scale evaluation sheet (see appendix 18) that they thought most of the presentations were 'good' to 'excellent', follow-up interviews with students suggested that this did not reflect what they felt about the entire program. After conducting a number of questionnaire surveys and following them up with individual and focus group interviews, it appeared that students often fill out questionnaires with the aim 'to please' or what they feel is expected from the evaluator, rather than portray their true feelings. Interviews with forty Year 12 students immediately following the two day workshop indicated that whilst they enjoyed the break from classes, many did not really get anything out of the presentations. 'It was shit'; 'It was fun and interesting, but won't affect what I do'; 'I would have rather done something active like a sports day'; and 'It was boring' were common comments. A strong sense of invulnerability was expressed along with the feeling that they had 'heard it all before'. Such feelings were not obvious from the Likert scale evaluation sheets.

Whilst schools need to be cautious and discerning in their selection of guest speakers, the novelty for students of new strategies, current information and the availability of discussion whilst keeping a sense of anonymity *can* promote positive input. Students suggested that it was preferable to have a variety of speakers rather than just teachers presenting the sessions. The personnel used for the workshop at Pentecost College were all received positively except the presenter of the suicide session which was presented in an analytical format with little student interaction.

Thirdly, the program was implemented with minimal in-servicing and professional development, with limited time allocation and little administrative support to develop the course adequately. As a result, the implementation of the course suffered. The course was block programmed for two days in the timetable because it carried the least interruption to the 'real' senior curriculum. Previous research (Pearson, 1995; Spence, 1993)

into the effectiveness of the 25-hour PDH course in other secondary schools had shown this method of implementation to be ineffective.

The feasibility of the course implemented following this structure needs to be examined in terms of effectiveness and in relation to covering areas specific to the needs of current students. Rather than abandoning the course, it needs to be assessed and revitalised to promote safe health behaviours amongst senior students. There is a strong need to implement a program that students can identify with and relate to in a meaningful way. The purpose of the 25-hour PDH course is to provide students with knowledge and understanding, skills and attitudes which will motivate them to adopt healthy, positive lifestyles both while at school and throughout their lives.

Schools can assist young people by providing them with relevant learning activities within a familiar trusting environment which allows them to explore personal issues. Students need to be supported in assessing their current level of health risks and making appropriate behaviour changes accordingly  
(Cowling, 1992, p.2).

It is imperative that support from administration and time be allocated to effectively develop and implement a re-vamped PDH course for senior students at Pentecost College. Teachers need to be trained in PDH education and have up-to-date information to undertake such a task. Such a program cannot afford to be fragmented into a token one period per fortnight, nor treated as a 'one-off' occurrence. From our assessment, the time of twenty five hours for the course was not sufficient for it to be implemented effectively. This time needs to be increased substantially if the course is to address the personal development and health issues that effect adolescents at this time in their lives. The course should also be developed within the context of an ongoing program of personal development and health. Personal development and health incorporates aspects from a number of KLAS of the curriculum. A more holistic approach encompassing personal skills such as communication, decision-making, calculated risk-taking and necessary protective behaviours is required. Dryfoos (1990) in addressing successful prevention programs found that experts from different fields agree that there is no single 'magic' bullet program; high-risk behaviours are interrelated; a package of services is

required within the community; interventions should be aimed at changing institutions, not just the individual; the timing of interventions is critical; and continuity of effort must be maintained.

The senior PDH course needs to continue to involve Year 12 students in addition to Year 11. My personal recommendation would be that a continuation of the Years 7 to 10 PDHPE program be extended to become a Year 7 to 12 PDHPE program incorporating aspects of physical education rather than merely an 'tacked-on' PDH course for the sake of fulfilling requirements. This would be seen by teachers and students as part of a continuing process and also provide an avenue for senior students to be involved in regular physical activity at school which has of late become available only to those students choosing to study an elective one or two unit PDHPE course.

### **Other HPS initiatives**

The HPS project has had an influence on established health promotion initiatives that have existed at Pentecost College for some time. The number of staff and students, for example, donating blood to the Mobile Blood Bank which comes to the college once a year has increased dramatically since the HPS committee have organised and advertised the days well in advance. Students have demonstrated a change in behaviour from curiosity to a commitment to donating their blood to the Mobile Unit, perhaps due to a greater awareness brought about by being part of the HPS project.

Other smaller scale projects that are currently in action are the provision of more seating and the beautifying of specific areas in the school such as the outdoor chapel area and the TAS passive outdoor education area. Annual community health promotion days such as Melanoma Awareness Day (MAD), Amnesty International, Red Nose Day and Yellow Daffodil Day for Cancer Awareness have been well supported by both students and staff and are now an integral part of the overall HPS concept at Pentecost College.

### Parental involvement/Drug Information Evening:

A workshop on minimising harm for adolescents was held in term three, 1997. All parents and students from Pentecost College were invited to this evening meeting where they were to participate and listen to how Pentecost College's PDHPE program, the HPS Committee and the Catholic Education Office work towards reducing and minimising drug problems for students at the college. The responses by students from Pentecost College to the Diocesan Drug Survey (Hetherington & Sparks, 1996) were discussed in relation to the curriculum and current policies of the school.

Detailed planning and advertising went into this opportunity for parents to learn and discuss the many issues concerning students and drugs. The evening was promoted as one of significant importance for all families with students attending the college. Thirty-five parents attended the workshop along with four current and three ex-students. Positive feedback was received from these parents and students in regards to the format of the workshop and the process that the school was undertaking in attempting to draw all sectors of the school community together to confront the drug problem that was evident at the school. It was recognised by all that this was only an initial meeting and the expression of interest for follow-up workshops was high. One of the problems with workshops and meetings such as these are that we are usually 'preaching to the converted'. The parents who attended were predominantly those already involved in the school community. I have already mentioned that the lead-up work and effort by teachers for such an evening is immense. If we are not attracting the parents that we are targeting to get more involved in the school, then perhaps the time and effort is not worth it. However, such workshops do get parents talking amongst themselves and some information passes on to others through 'word of mouth'. Alternative methods to reach parents must be explored. The results of the drug survey were also presented to staff in a full staff meeting on harm minimisation in an attempt to get other staff apart from PDHPE teachers involved in an across curriculum approach to drug education.

## **HPS workshops, conferences and network meetings**

The workshops provided for participating schools in the HPS project were held each term and provided health promotion ideas and resources as well as developing local health promoting schools' network groups.

Obviously, the available workshops for the health promotion initiatives dictated to some degree what health promotion took place in the pilot schools. Workshops on 'Sun Protection', 'Enhancing the Physical Environment' and 'Physical Activity', for example, led to the school attempting to implement new initiatives in these areas.

The original workshop in 1995 was on 'Sun Protection'. Pentecost College was the only school that had a student representative along with several interested teachers. Even though other schools were encouraged to bring along student representatives, this did not occur. As a result, the student from Pentecost College felt rather 'out of place' amongst a room full of teachers, but to his credit he made a considerable contribution. We did not, however, see him again at further workshops.

Pentecost College was represented by five staff at this workshop indicating the high interest and commitment to the project. In later workshops, however, numbers dwindled until at the fifth there was no-one to represent the college. The workshops were held after school from 4.00pm to 8.00pm. This in itself required a certain commitment after teaching all day and with family responsibilities to meet. The lack of time, support and incentives for teachers to be involved in such workshops and indeed the entire HPS concept will be discussed in the next chapter.

Lowe (1995) argues that academic health promotion professionals need to collaborate with 'real world' practitioners to conduct workshops which provide continuing education and training at the local level. Whilst this did occur in the local area of Pentecost College, it appears to be only beginning in other areas around the state. At state and national 'Health Promoting Schools' conferences that I have attended, it was disappointing to note that the delegates were predominantly health personnel with a poor representation from the education sector. This is an issue that needs to be



addressed and will also be discussed in the next chapter in regards to limited funding from schools and the education sector generally.

Network meetings were planned by the HPS project coordinator from the Area Health Service for all participating high schools. The networks for HPS are viewed by the local Area Health Services as a key strategy for consolidating and providing support for teachers, students and parents willing to advocate for the concept of the health promoting school (Schmerlaib, 1996). The first network meeting's agenda in term three, 1997 was to share ideas, gain information, and provide support and inspiration for school health promotion programs. From the fifteen schools affiliated with the HPS project in the same network group as Pentecost College, representatives from only two primary schools and one secondary school from four secondary and eleven primary schools were in attendance. There were four health personnel in attendance, further emphasising that the HPS project seems to have a higher priority in the health sector compared to the education sector. Similar statistics were evident from the other network meetings. The second planned network meeting set for term four, 1997 for the Pentecost College network group was cancelled due to even less support from the education sector.

Further to this, at the 1997 NSW PDHPE Head Teachers' Conference during term four, a workshop offered in relation to the HPS concept was poorly attended. In the first session it was conducted, only myself and one other head teacher attended. This was extremely disappointing for the three presenters from the health sector. In the second time allocated for this workshop to run, not one teacher attended. This clearly indicates that the HPS concept is not a high priority for secondary teachers across the state. If this is true for PDHPE head teachers, then little hope can be held for stimulating interest amongst other secondary teachers. There is far more priority given to the concept from the health sector than the education sector, but for health promotion to be effective in the school setting, the motivation must come from *teachers*. Until it does, then it does not matter how much more time, effort and personnel are provided for the health service, the HPS concept will not become a reality across NSW schools.

Clearly, we have a difference between policy and practice. Too often policies enacted at national or state levels are never implemented locally. Without school community involvement and support, the HPS policy cannot be successfully implemented. Many of the requirements we place on our school systems and teachers are unreasonable and unworkable if the resources and support for carrying them out are not also provided at the school site. The many support issues such as funding for teacher training and inservices, curriculum development and community involvement programs will be discussed in detail in the following chapter.

### **Towards a health promoting school?**

*Towards a Health Promoting School* (NSW Department of Health, et al, 1996) was launched in August, 1996 and copies distributed to every school in NSW. This document has been instrumental in developing guidelines for Pentecost College's involvement in the HPS project. I felt that an evaluation of the use of *Towards a Health Promoting School* (NSW Department of Health, et al, 1996) in other secondary schools was necessary to add to the political perspective of this study. While each school in the state has a least one copy of the document, this does not necessarily mean that school communities will adopt health promotion policies and implement initiatives. The document must be backed up with action and support within the school community if it is to be successful. The commitment of a key facilitator within each school is *essential* from the beginning of the program. The HPS project requires interested, organised and committed personnel from all sectors of the school community to begin to explore opportunities for health promotion in the school.

However, many teachers do not even know of the *Towards a Health Promoting School* document's existence, let alone are acting on it. Others have not encountered the concept of HPS at all (Colquhoun, 1996a). Results from telephone and personal interviews conducted in August, 1997 with PDHPE head teachers from twenty secondary schools in the same region as Pentecost College revealed this discrepancy of theory and action. The results

indicated that the principal in each school passed the document onto the PDHPE head teachers. Often it progressed no further than this and other staff members were unaware of the document's existence and of the HPS concept. From the twenty PDHPE head teachers surveyed in Catholic, Independent and Government systems in the local area, one was not aware of its presence, three had copies but had not read it, six had given the document cursory attention, that is, flicked through the pages and filed it. Three others had been involved as pilot schools in the HPS project along with Pentecost College and had a working knowledge of the document. The remaining six PDHPE teachers had discussed the HPS project further at school staff meetings. They had also been in contact with the health promoting schools coordinator from the Area Health Service in regards to becoming a participating school in the HPS project in the region.

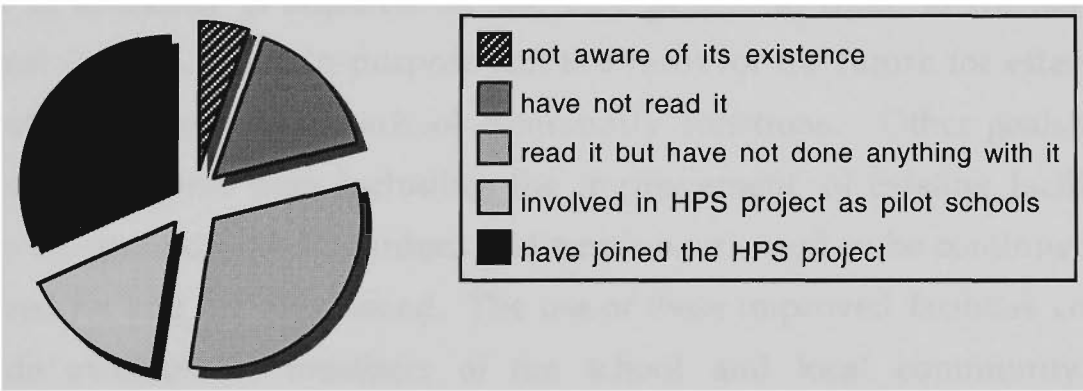


Figure 23. Results from telephone interviews of PDHPE Head Teachers concerning *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) document.

A total of sixty-two schools were affiliated with the local area HPS project at the commencement of term two, 1997. Fifty-three of these were primary schools with only nine secondary schools. There were a number of reasons for this inequality of representation between primary and secondary schools including both teacher and student acceptance of the project. The differences between secondary schools and primary schools in relation to HPS will be discussed further in the next chapter.

*Towards a Health Promoting School* (NSW Department of Health et al, 1996) provides no indication of when a school can be called 'a health

promoting school'. Perhaps one reason is because a school never attains this ideal stage as the process is never-ending and the school is always moving *towards* a health promoting school. As such those involved in school health promotion need to constantly view and plan towards the long term perspective. At Pentecost College, the forward vision necessary for many projects was lacking in the overall plan for ensuring a health promoting environment. The expensive plan for providing a vision for improving the environment at Pentecost College created much interest amongst members of the school community at the beginning of the HPS project. However, once it became apparent that this was a very long-term proposition many people lost interest. A number of students, staff and parents realised that they would not be around to see any of the benefits and were reluctant to get involved. Gradually the interest in this plan withered and it is now tucked away in a cupboard somewhere in the school. A long-term vision by a person in authority is required for the HPS project to come to fruition at Pentecost College. A multi-purpose hall is a must for the future for effective practical lessons and whole school community functions. Other goals that were on the original plan including the improvement of existing facilities such as the grounds, creek, gardens and tennis court need to be continued to be strived for and not abandoned. The use of these improved facilities could be made available to members of the school and local community to develop many aspects of the HPS concept.

Being a pilot school for the HPS project gave Pentecost College its best chance of utilising the resources offered from the Area Health Service. The school was in a selective group of ten schools with little competition for available resources. However, now the project has been in progress for more than two years and the health promotion programs in each of the pilot schools are somewhat established, a similar offer has been made to other schools in the area. Currently, there are over sixty schools competing for the same limited resources, making each schools' 'cut of the pie' smaller. In these times of diminished resources, more collaborative ways of working with health, education and other agencies will benefit all concerned.

Overall, involvement in the HPS project at Pentecost College has I believe been a positive influence on the health and attitudes of those in the school community. At the very least, there has been an increased level of awareness of health issues, which in itself is health promoting. The importance of evaluation is that it forms a foundation for reflection and further action. The following chapter discusses common barriers that were confronted in the HPS project. It also examines possible ways of overcoming these problems and what else can be done to establish the HPS concept in all schools.

## CHAPTER 8

### DISCUSSION

This final chapter concentrates on the HPS concept as a viable concern within a specific educational setting. It attempts to draw together and discuss all that has happened at Pentecost College during the initial years of moving towards a health promoting school. This case study demonstrates the potential of the HPS project whilst keeping in mind what is achievable in practice. Having been involved in the HPS project since 1995, I now realise the enormity of the initiative. It is important, however, not to let the concept seem too daunting, even though everything we do in schools from landscaping to the mathematics curriculum can fall under the HPS umbrella. The process must be broken down into manageable parts whilst still keeping a focus on the bigger picture.

At the outset, the benefits of becoming a health promoting school were taken for granted by those involved in health promotion at Pentecost college. That is, it was assumed that enhancing the environment, promoting sun protection and physical activity and other such initiatives would lead to the college community displaying healthier attitudes and behaviour towards themselves and their environment. It was the *process* of making these opportunities a reality that this case study attempted to document.

I believed, with enthusiasm and optimism two years ago, that more would have been achieved. There have been times when I felt very cynical and frustrated with the many delays in implementing the various initiatives at the college. I had expected the same level of commitment from other school community members in initiating and maintaining the health promoting initiatives that would benefit all those in the school community. On one level I recognised that within the existing curriculum and practices already in place, our members were exposed to various health promoting programs and that attitudes and behaviours from some students and staff had moved towards more positive health. However, I felt that if

taken seriously and owned by all members of the community, the health promoting concept had unlimited potential. It could become an integral part of the school community and the platform for holistic educational practices that could propel education into the next millennium. As time progressed and the problems emerged, I had doubts that the process was worth the effort. In retrospect however, there have also been many positive aspects that have emerged from being involved in the project. For instance, there were the unintended and unexpected consequences such as the high degree of community spirit that was generated when the school members and the wider community worked together on a health promoting project.

The remainder of this chapter re-examines the models and policy development of the health promoting schools concept, highlights the barriers to the HPS project and discusses major issues that arose from the case study at Pentecost College. Recommendations to increase the effectiveness of health promotion in schools are discussed in an attempt to provide some guidance to those involved in health promotion in secondary schools.

### **Health promotion policy revisited**

As Beckinsale, Foster, Gay, Peppard and Smith (1996) argue, health promotion policy development can no longer separate health and education. The agendas of health and education need not be viewed as being in competition with each other and have moved to being seen as complementary. Health promotion needs to be part of education; education needs to be part of health promotion. For health and education to achieve best outcomes for students' health, education needs to include the health promotion concept where the interface of school-home-community can be utilised as an important link in facilitating change in attitudes and behaviours. For instance, improving the attitudes to food for children with poor dietary habits who are experiencing difficult economic circumstances, are less likely to be successful in terms of learning outcomes. This is evidenced if the health education curriculum at school does not recognise

the value of support services in the area or the benefit at school of a healthy canteen or breakfast service for students. The association between health and poor learning outcomes for students are now well documented (Beckinsale et al, 1996). It is because health is a necessary means to virtually all other educational ends that the HPS project needs to be considered as an integral part of all school systems.

Changes to both the health sector and the education sector have involved social, political and economic action (Ackermann, 1996). The links between education and health in Australian schools vary across the nation both between and within states and territories. There has been a political commitment from the health and education sectors at state government level in NSW to launch the Health Promotion Schools project. There have been significant HPS projects developed in other states - WASH (Western Australian School Health), HIPS (Health in Primary Schools, Victoria) and CAFHS (Child, Adolescent and Family Health Services Schools Program, South Australia). In NSW, the HPS project has enjoyed considerable success in bringing together the education and health sectors. There has been support for schools as the HPS concept has been written into curriculum documents and policies. However, other states in Australia have not received this type of support (Colquhoun, et al, 1996). Further to this, the twenty PDHPE consultants who were appointed by the NSW Department of School Education in 1997 across the state have as part of their brief the support of PDHPE priorities, including the HPS project. Similarly, Catholic Education Office PDHPE consultants have HPS included in their portfolios. The Catholic Education Commission has also incorporated the Year 7 to 10 PDHPE syllabus into the document *Towards Wholeness* (Catholic Education Commission, 1992) which aims at developing students in a holistic way.

From the point of view of those in health, it is recommended that the concept of the HPS must be implemented as an 'umbrella' policy under which all other policies fit (NSW Dept. of Health et al, 1996). If health promotion policy is overarching and all embracing then it increases the likelihood for the continuation of the project. 'One-off health promotion



projects will not work and will never work in schools' (Colquhoun, 1996a, p.20). Perhaps the problem is further exacerbated because health and education continue to produce different outcomes for their particular clientele. Despite this, the value of better health for all is undeniable and the project provides a viable vehicle in attaining the best possible health outcomes. If this premise is accepted, the HPS project then needs to address all relationships that exist in schools and must strive to unite the 'decision-makers' and work on gaining their support and available resources. Health is, and should be, appreciated as an important issue in most policy and planning processes in all schools. Unfortunately, it is too often neglected for other popular or more pressing concerns.

Health promoting schools policy has developed from national and international health promotion policy. It is very important that there is 'top down' support for health promotion in schools (Cameron & McBride, 1995). The fact that the HPS concept is supported by national and state policy gives it public recognition. However, if the principal of each school ignores or gives little attention to the importance and place of health promotion within the school setting, it has little chance of becoming a reality. This 'top down' approach with regards to providing adequate funding, training and policy guidelines, is important for a commitment to the HPS project from the health and education sectors. More importantly, to bring the HPS concept to fruition, it must also flow from a 'bottom up' approach. This means gaining support from all members of the school community at each of the stages of the HPS project. However, ideas and support from the community will not eventuate without structural support. In retrospect, the decision by the principal to completely fund the covered area at Pentecost, instead of the original plan to have a community fund-raising effort, was pivotal. This was indeed a 'lost opportunity' for the HPS committee to work on raising awareness within the school community for the HPS initiative. The initial plan of engaging the school community in raising funds for the project would have provided a widespread base of awareness that is difficult to achieve through the 'hit-and-miss' method of relying on students to take newsletters home for parents to read. Working

together like this could have been used as a focus for the HPS project and helped students, staff, parents and other community members to internalise the concept and gain support and understanding for future initiatives.

The mandated policy, that secondary school students in NSW receive an integrated PDHPE program of 300 hours in Years 7 to 10, has firmly established health in the curriculum. However, other components of the HPS concept rely totally on individuals within each school. The development of other health promotion policies depends on the priorities to which these individuals commit themselves. From my involvement in the HPS project at Pentecost College, I have come to understand policy as being dependent on commitment from individuals: *Policy is people*. It is the commitment of individuals, which translate policy intentions into policy and program realities. Research in health promotion (Green & Kreuter, 1991; Smith et al, 1992; Hurrelmann et al, 1995; Colquhoun et al, 1996) highlight the importance of the teacher's skill, experience and motivation for the success of health programs. Added to this, the equally important role of students and parents in the HPS project support the fact that it is individuals who 'make or break' policy in schools.

While governments may provide funding and resources, public statements on policy do not always support health promotion in schools. Government priorities seem to change from one government to another and from one crisis to another. For instance, a short time after launching *Towards a Health Promoting School* (NSW Department of Health, et al, 1996), Mr Aquilina, the NSW Minister for Education and Training appeared to marginalise health concerns in schools. In a statement to the media with regards to curriculum in NSW schools, he stated that 'schools have to cope with two main things and that is literacy and numeracy. Some schools are offering driving courses. I am not knocking them, but there are already so many things crowding the school area' (Brennan, 1997, p.13). Courses such as driver education can be an important initiative in the HPS project for some schools. Such statements from Mr Aquilina frustrate those involved in health promotion in schools who have spent much time and energy developing and implementing HPS programs. This demonstrates the lack

of comprehension of, and support for, the HPS concept at state government level, which makes it extremely difficult for schools to seek continued support for such programs with local community. The lack of 'top-down' support helps to partly explain the limited success of the health HPS concept in NSW.

In examining the traditional health promotion models (Downy et al, 1991) it is noted that they are derived from the long-term fixation on the medical model of disease aetiology. However, health models have moved beyond this narrow notion to a broader understanding of the many and significant components that promote health in our society. New models have developed as a positive reaction to epidemiological research which established individual behaviours as risk factors associated with major chronic diseases such as cardiovascular disease. Two major components of these 'health belief' models suggest that a person's belief in personal susceptibility to disease and their perception of the barriers to action are partially responsible for determining behaviour.

Health promotion now encompasses action for health in which knowledge, communication and understanding play major roles (Rajala, 1995b). Although it is not always clear, it is important to know what is good and what is harmful to health. However, for health promotion in schools we also need to understand adolescent behaviour and the functioning of the school. Many health promotion initiatives are still unsuccessful because they fail to appeal to the concepts adolescents hold of life in general and health in particular. These ideas are less oriented toward medical prophylaxis than toward the satisfaction of much more urgent expressive and social needs. These concerns include social recognition, self-acceptance and a sense of meaningful achievement as well as the longing for exciting and profound experiences (Rajala, 1995b). Any efforts at health promotion must take into account these basic necessities and enable adolescents to deal with them in a constructive and non-threatening manner.

According to Hurrelmann et al (1995), health promotion can no longer afford to downplay the ecological and social living conditions of health maintenance. It is evident from this case study that for health

promotion initiatives to be successful they must be embedded in a structural context that takes into account the dependency of health on environmental and cultural conditions without exclusively focusing on the behavioural dimension of adolescent students. In building healthy policies, creating supportive environments, strengthening community action, developing personal skills and reorienting health services (Ottawa Charter, WHO, 1986), we have to more fully understand the culture including all relevant subcultures, circumstances and values in the whole school community. For health promotion programs to be successful they need to take into account self-efficacy and social support as important influences on health behaviour (Anderson, Davies, Kickbusch, McQueen & Turner, 1988). The functional importance of a good theoretical foundation in health promotion programming lies in its ability to break down the complex determinants of behaviour. Health promoters need to guide policy and program development to ensure that these important influences are addressed in an intervention (Love, Davoli & Thurman, 1996).

Many school policies fall into Ball and Bowe's (1991) categories of 'actual' or 'intended' policies in that while there are numerous policies written into school documents, only a very few of these are actually implemented in the school community. Hogwood and Gunn's (1988) preconditions for 'perfect implementation' of policy, outlined in Chapter Two, are simply not achievable in schools. The lack of consensus on priorities, the poor communication and the lack of adequate time and resources associated with the HPS project at Pentecost College were likely ingredients for less successful implementation. As happened at Pentecost, a common failing was that the HPS committee expected too much too soon, especially when changing attitudes and behaviours of community members. It may have been the underlying theory that was at fault rather than the execution of the policy. New methods to investigate school health promotion from different perspectives and to develop concepts and models, which place students' health in broader social contexts need to be explored.

Evaluation is extremely important to test the underlying theory of the policy against problems of practice observed at all stages in the process.

For example, policy theory suggested a sequencing of tasks. However, it was impossible to perfectly sequence the tasks to be performed by each participant involved in the HPS process. Attainment of 'perfect implementation' was not possible within the real-life organisation of the school as many groups had their own values, goals and interests to protect. Added to this was the school community's resistance to change and the various stages of the individual's readiness to internalise the importance to adopt more health promoting behaviours (Fullan, 1991). Time was needed to plan, promote, and adapt to these changes to achieve the desired outcomes of the health promoting school community. The goal of health is elusive; not concrete or quantifiable and is often inferred from people's attitudes and behaviours. Furthermore, as Hogwood and Gunn (1988) suggest, for an issue to receive priority on the policy agenda, the issue needs to have reached crisis proportions. This is rarely the case with school health issues. The consequences of lack of shade, not wearing a hat, eating junk food from the canteen and so forth are long term and not immediately observable. There have been concerns from parents about students reportedly smoking drugs outside school, or isolated issues of bullying, harassment of students and some ethnic-based violence but these issues have been addressed on a whole school level through the implementation of ongoing programs through the Pastoral Care portfolio. There has not been a major 'critical incident' that has been strong enough to make these or other health promotion initiatives an immediate priority.

Schools have the capacity to develop policies that enhance health and reinforce classroom activities by the creation of supportive environments. However, the HPS policy needs to become an integral part of school policy and the policy itself must retain an integrated purpose. So far this has not happened at Pentecost College. The HPS policy has really only become a conglomerate of different policies under the HPS umbrella and has not been infused into overall school policy. For the HPS initiative to maintain momentum, it requires a different way of thinking about the purpose of the school and a commitment by staff to this purpose. This is a major

challenge, given the many competing demands on schools by parents, politicians, teachers, lobby groups and students.

What has been outlined so far are the general issues associated with the implementation of HPS policy in schools. The following sections of this chapter discuss specific issues that contributed to the effectiveness/ineffectiveness of health promotion initiatives at Pentecost College. These issues include: the role of teachers in the health promoting school; the problem of attaining parental involvement; the risk-taking nature of adolescents and their belief systems; the difficulties faced in secondary compared to primary schools; and competing commitments to priorities influencing health promotion in schools. Examining these issues and associated barriers to effective health promotion initiatives (see appendix 19 for a summary of barriers) will help identify the specific components that could be useful in achieving the best practice for health promotion at the college and other sites.

### **Teachers in the health promoting school**

The first priority when embarking on a HPS project is to establish an in-school coordinator (NSW Department of Health et al, 1996). This is supported throughout the HPS literature (Cogdon & Belzer, 1991; Smith et al, 1992; Schmerlaib, 1996). The concept of HPS 'transforms several solo performers into an orchestra' (Resnicow & Allensworth, 1996, p.60). A school coordinator is the essential unifying element in the HPS model. The coordinator's responsibilities include administration, integration of personnel and programs, evaluation and direct intervention. The difficulty for most schools is finding someone to take on this extra role in the school. The position requires skills from multiple disciplines including organisation and management, school administration, group facilitation, social marketing, health education, counselling, teacher training, program evaluation, accounting and financial planning, fund raising and grant writing (Resnicow & Allensworth, 1996). Few teachers are trained formally in most of these areas and they may seem beyond the capacity of any one

individual, but for the successful implementation of the HPS project in schools this role needs to be filled. It is essential that someone in the school with motivation, goodwill and a dogged preparedness to face the many challenges of health promotion, be appointed to oversee the project.

Crucial to the development of the HPS concept in Europe has been the appointment of a full-time school coordinator in each school who has the responsibility to bring to fruition health promotion initiatives (Hurrelmann, et al, 1995). There has been varying degrees of support for this in Australian schools. Given the current political and economic climate where schools are trying to make their funding go further, any time allocation or funding for a HPS coordinator is rarely a priority. Teacher release time was seen as essential and helped gain maximum cooperation in the South Australian school health promotion projects (Beckinsale et al, 1996), however, in NSW schools, there seems to be no such incentive available. Indeed, at Pentecost College all coordination of activities involved in the HPS project were done in my own time both at school and at home. Teacher inservicing, participating in workshops, attending HPS committee meetings, evaluation and documentation were completed in addition to an already full teaching timetable. When I attended a Health Promotion Schools' conference that was on in school time, I was required to take leave without pay for the two days of the conference. This was in contrast to the personnel from the Area Health Service who were compensated either financially or with time in-lieu for their attendance at the conference. Health promotion conferences and time spent in schools are part of their employment practices, whereas teachers attending meetings and workshops do so out of goodwill and without remuneration. There is no incentive system for teachers to be involved in the HPS project; it simply relies on the personal commitment and motivation of interested teachers. For the HPS project to be firmly established in NSW schools, it is important that such conferences be given equal recognition by the education sector as it has been given by the health sector.

An important factor in the instigation of the HPS project at the college has been the teacher involvement in the process. A knowledge and

interpretation of the culture of the school and its operational procedures make it imperative for a teacher in the school to be responsible for the program. In addition, classroom teachers are vital links in the running of a successful school health promotion program. It cannot be assumed, however, that teachers will automatically incorporate this role into their current responsibilities. The pressure of implementing such new programs can be very stressful both mentally and physically. School systems must begin to provide the time and necessary resources for teachers to gain further expertise and to address these stresses.

Teachers in today's schools are increasingly taking on responsibility for developing curriculum and programs that promote health and lifestyle issues. The continuing success of such incentives will depend on wider community recognition and their importance and a commitment of resources by schools and system authorities

(Hemmings & Plotnikoff, 1996, p.29).

The case study of Pentecost College supports the literature's conclusions that the success of HPS projects rests with the enthusiasm and sincerity of the school and teachers responsible (Plotnikoff, Williams & Higginbottom, 1996; Schmerlaib, 1996). The HPS concept will not happen just because everyone thinks that it is a good idea. There must be direct action taken by the key stakeholders to ensure that HPS strategies become a reality.

Health promotion in schools is not only about the health of students, but should be concerned in promoting health to all members of staff. The irony is that if staff are stressed and indicate signs of poor health then this filters through the entire school community, negating efforts of some student health promotion initiatives. The school must be seen as any other workplace and also provide for the 'health' of the staff. It follows that it is essential to establish an Occupation Health and Safety Committee that works closely with the HPS committee to promote the well-being of staff. Initiatives need to be developed to enhance and sustain all aspects of health within the school community. Staff are then more likely to model better health practices to the students. Teaching is a very stressful occupation and for the development of the HPS model, stress management for staff is a vital ingredient, often lacking in schools. Burns (1996) points out:



Schools as workplaces for large numbers of adults should provide a variety of clearly identified support structures that match the many demands, academic, personal and pastoral, that are placed on teachers and staff in schools. Stress management strategies including support for changing staff roles should be seen as a natural part of school management plans and policies (p.53)

Health promotion in schools can only be successful if *all* stakeholders can reap some profit. This includes the teachers involved in the HPS project. At Pentecost College, a number of individual teachers started out on the task with a high degree of enthusiasm and idealism, but after a number of delays and frustrations, unexpected difficulties and time restraints, gave in to cynicism and indifference.

### **Parental involvement**

One of the key elements in the HPS concept is that of developing the school-home-community interface. However, from the Pentecost College case study, these partnerships were clearly the most difficult to strengthen. Collaboration between the health and education sectors has indeed occurred in this project and was the basis for developing the HPS notion. Committed staff have been directly involved in the day-to-day procedures of promoting health with some students taking the health agenda as part of their responsibility within the school context. The difficulty lies, however, in collaboration with parents and other community members.

Most parents still remain passive in their involvement with the college. One-way communication through newsletters and personal letters suit the busy daily schedules for most parents. From the Parents' Survey results, parents at Pentecost College generally are reticent about their involvement or appearance at school and at best, see the traditional parent contribution of fund-raising (school fete, selling raffle tickets, attending fund-raising functions) as fulfilling their 'duties' to the school. The feeling of 'teacher knows best' is still evident from conversations with parents. We need to move parents' participation from passive to active participation, to further assist in the collaboration of ideas and programs suitable for the specific needs of the school.

The problem of involving parents in the communication process is multifaceted. It is especially difficult to reach parents from ethnic minority backgrounds who often need special encouragement and support before they are prepared to become involved in any way with the school. Some parents reported in the survey that they often felt inadequate and isolated because of their language difficulties and would not be able to communicate well enough to either understand or be understood by a teacher. A Lebanese mother with limited English of a Year 9 female student continually wrote permission notes for her daughter to be excluded from PE lessons. Written and verbal communication from the school to the student's home received little response. When the school elicited the assistance of an interpreter to explain to the parent the health benefits of physical activity, however, the student began to participate in regular PE lessons. Beckett (1996) also found problems with parental involvement in schools from parents with ethnic minority backgrounds and less privileged social backgrounds: '... Only a small number would accept an invitation to the school's parent/community information meetings about PDHPE, or awareness nights, much less become involved in the planning and implementation of school programs' (p.110).

Parents will become involved in school matters only if they feel emotionally 'safe' and if they consider that there are not too many risks involved: 'My child is going alright . . . no problem' and 'Last time I came to the school, I felt as though I was intruding', were common comments from parents regarding their acceptance and involvement at Pentecost College. The difficulty in developing collaboration is that adolescents also do not want their parents at school and in reality neither do most teachers. Involving parents often slows down the decision-making processes, increasing time for things to happen and developing further conflicts of interest. As a consequence, many parents feel alienated from the school and rarely come further than the school gates.

The way to help overcome this is to involve parents from the outset; the school needs to encourage parents to become involved from the beginning of Year 7 and to foster their continual support throughout the

remaining years. Students in this way would become accustomed to the presence of their parent or other adults as a natural part of the school environment. There is an obvious need to involve parents in any school-based health promotion program, not only to inform them of what is going on in the school but to help educate parents about the issues that are affecting their children's lives. Wragg and Fazeli's (1994) research highlighted the importance of this process. By encouraging parents to take part in the curriculum process, it also promoted positive communication for family discussions on health issues.

Even though the majority of parents at Pentecost College agreed that they were responsible for their child's health education, most (90%) reported that they never became involved in any of the health promotion initiatives at the school. The school must continue to work diligently to provide *opportunities* for parents to be involved and to participate in any form. Exam supervision, working-bees, sports coaching, library assistance, book covering and canteen helpers were just some of the initial ways of involving parents at Pentecost College. Once parents feel a valued part of the school they are more likely to become involved in other areas such as curriculum planning, decision-making and initiatives such as the HPS.

### **The risk-taking nature and belief systems of adolescents**

One of the dominant issues for health promotion that emerged from the surveys conducted with students at Pentecost College was the propensity of many adolescents to be involved in behaviour that carry risks to their health. In developing effective health promotion strategies and programs for secondary students the social and psychological aspects of risk-taking behaviour need to be taken into consideration. Many studies (Gonzales, Field, Yando, Gonzales, Lasko & Bendell, 1994; Ho, 1994; Wragg & Fazeli, 1994) have tried to determine why adolescents engage in risk-taking behaviours. The general consensus is that if adolescents are aware of the risks, which they appear to be according to student interviews conducted throughout this case study, they must be either purposely seeking this

behaviour or prevented from perceiving its severity by their own sense of invulnerability or simply see the situation very differently from adults. Lipsitt and Mitnick (1991) suggest that adolescents purposely seek out risks so as to permit them to:

- 1) take control of their lives;
- 2) express opposition to adult authority and conventional society;
- 3) deal with anxiety, frustration, inadequacy and failure;
- 4) gain admission to peer groups and demonstrate identification with a youth culture;
- 5) confirm personal identity; and
- 6) affirm maturity and mark a developmental transition into adulthood.

The need for risk-taking has also been explained as a function of pleasure or fun-seeking behaviours (Gonzales et al 1994; Lipsitt & Mitnick, 1991). The need for change, variety and intensity of stimulation manifests itself in sensory, social and thrill-seeking behaviours. The assumption that adolescents seek out new and exciting experiences has generated considerable research.

Invulnerability, 'short sightedness', curiosity and substance experimentations are trademarks of adolescence (Smith et al, 1993). The search for and possible resolution of identity issues highlight adolescence. Risk-taking behaviours, the questioning of authority, widening social contexts, greater responsibility and increased personal and social freedom are features of many students in this age group. It is time of heightened awareness of sexual needs and sexual identity, of increasing independence from parents and family, of growing interdependence on peers and friends, and a time of career-directed decision-making.

Smoking, excessive use of alcohol and other drugs and being sexually active are common behaviours amongst senior students and sometimes are responses to the influence of peers, parents and the media (Cowling, 1992, p.2).

Cooney et al (1993) stress the importance to increase efforts in drug education, particularly in reference to senior male students. They also call for further efforts to direct health warnings towards students about tobacco use. Many students participate in further risk-taking behaviours because of the disinhibiting effect and widespread use of alcohol and drugs, mainly marijuana (Cooney et al 1993; Hetherington & Sparks, 1996; Pearson, 1993;

Wragg & Fazeli, 1994). The media also help to create an atmosphere of acceptability regarding behaviour that can be a powerful influence in determining the way people act. For example, alcohol advertising campaigns stressing drinks as associated with status, wealth and power can effectively entice adolescents in making decisions to drink alcohol before of legal age. Being an 'accepted' and part of the 'scene' is an important part of adolescent development and the media can have an enormous influence on adolescents' decision-making. Health promotion programs in schools need to recognise the media's presence and its powerful influence within our society. Teaching strategies need to be designed to assist students in identifying and evaluating media messages. It is also vital that if health promotion is to flourish across all sectors of the community then media campaigns that promote health-enhancing messages are the norm rather than the exception. In this way, students may more readily accept health promoting initiatives and learn to minimise their health risk, thereby better facilitating their own health safety.

It was also evident from the case study that attitudes towards health promotion in schools must be recognised as multidimensional in nature. An adolescent is unique because of his/her 'own biology, set of experiences, gender identity and social-cultural background' (Gallois & Callan, 1990, p.163). Understanding adolescent development and understanding the world from the point of view of adolescents and their health behaviour can help in selecting appropriate health promotion intervention strategies. As a Year 12 girl commented, '... no one I know has died from smoking marijuana ... or been killed in a car crash... no one sees the risks involved'. A Year 12 male commented further by stating: '... we like to take risks anyway'. It is important that schools assist adolescents to develop strategies that help them recognise the consequences of risk-taking behaviours.

Changing adolescent behaviour in ways perceived to enhance health is not always easy. One explanation as to why this is the case is that the health threatening behaviour that is part of every adolescent's life fulfils functions such as identity formation, coping with stress or gaining acceptance into certain peer groups (Hurrelmann et al, 1995). Curtis (1992)

argues that 'intervention programs to shape health-enhancing behaviours also must ensure that those behaviours serve the same psychological functions as the risk behaviours they tend to replace ... consideration of the sociocultural meanings accorded the behaviours, both health-enhancing and risk-taking, is necessary to determine what strategies will have the greatest influence during adolescence' (p.418). Adolescents also seem to see themselves as invulnerable where adults see risk and adolescents do not. The way forward is to listen to young people and to develop strategies which connect with the way they see the world. Teaching skills to help adolescents understand self-concept and to develop positive coping mechanisms to deal with the stressors of *their* lives have shown that adolescents are less likely to abuse substances or use other unhealthy strategies as a means to deal with whatever difficulties that confront them (Ho, 1994). Health promoters must recognise that what we prioritise may not be the same for adolescents. Current arguments are that we must provide opportunities for adolescents to reduce their risk-taking behaviours by focusing on a harm minimisation approach (Goltz, Colquhoun & Sheehan, 1996). This is really all we can do.

As teachers we often fall into the trap of identifying what we as adults see as a problem for students and what we believe to be an effective solution to their difficulties. Students and others however, may hold very different views as to whether there is a problem as well as varying ideas about its cause or solution. For example, teachers often interpret students' apparent refusal or disinclination to wear a hat as irresponsible and sometimes a deliberate challenge to our authority. Their not wearing a hat instead may be merely one of many plausible meanings rather than one of defiance. Concerns or restrictions in their family such as extra financial limitations over the cost of sun glasses and sun cream may be the student's reason for not adopting sun glasses and hats with wide brims. Our interpretation then, is based on *our* beliefs and assumptions that, providing we construct the environment to cater for sun safety, teach students sun protection strategies and model the sun safety behaviour ourselves, that students will naturally progress to positively changing their behaviour and attitudes. We become disappointed and disenchanted with students' behaviours, as they have not

conformed to what we believe is best for their sun protection and future well-being. Perhaps a better approach may be to acknowledge that solutions to the problem do not necessarily relate to causes and that changing one part of an interaction, such as a few other students adopting sunglasses and hats, may gradually change other students and parents' values and attitudes towards sun protection. Behaviour and attitude change may involve helping people think differently (which usually leads to them behaving differently), or it may more directly involve helping people to act differently (which will usually lead to their developing a different view) towards sun protection.

The difficulty for the HPS committee, teachers and school personnel is that the apparent causes of the problems of health promoting behaviour are often things over which the school can have no or limited influence. Perhaps it is more appropriate to find further productive ways to help students, teachers and parents solve the problems of poor health behaviours. Allowing students more flexibility in their choice of hat or offering second hand sunglasses may be more sensible than being caught up in the necessity to follow school uniform rules and discipline students for their non-compliant behaviour. If we focus on the idea that as a HPS, we can make small changes, and that these can lead, almost inevitably, to larger changes, as people behave differently, experience others responding and behaving differently, and so begin to think differently themselves. Therefore having achieved some change, such as a number of students correctly wearing sun glasses and wide brim hats or staying in shaded areas during lunch, the important question becomes that of how to encourage the change to continue. In fact, changes that occur are not always appreciated, so we need to highlight these changes no matter how small. It is also important to affirm the positive health behaviours of students either publicly or privately so that new behaviours might be sustained.

As a HPS we need to celebrate changes in the behaviour and attitudes of students, parents and teachers who are exhibiting change or keep data about the noted changes in behaviour so that it may be acknowledged that Pentecost College is in fact, evolving in the health promoting process.

Ultimately it must be for individual students to assess their health risks and decide appropriate action. We must endeavour to empower students, as much as possible, to be responsible for their own health.

Schools can foster development of self-efficacy through two social learning theory techniques: modelling and skill training (Ho, 1994). These form the basis behind the health promoting schools concept. Schools need to pursue this holistic approach to health promotion where the curriculum, school policies and programs are integrated with local community resources and supported by the whole school community to provide students with a contextual view of health and the skills for sustaining better health.

Whilst health promotion in schools primarily aims at all students, there also needs to be specific programs for targeted students. For example, some students that are to be seen as 'high risk-takers' may require further intervention. Such behaviours include chronic drug-taking, suicide ideations and promiscuous activities (Catholic Education Commission, 1997).

It seems that interventions, which offer a personalised counselling service often, succeed. This is particularly the case with high risk youth  
(Hemmings & Plotnikoff, 1996,p.31).

Pentecost College was involved in the Students at Risk (STAR) program provided by Centacare, the Catholic Family Welfare Services. This program offered a range of professional services to identified students with the objectives of the program to:

- identify students involved in high risk-taking behaviours;
- provide intervention for 'STARS' especially through groupwork; and
- foster motivation, involvement and goal setting towards continuing schooling.

Particular attention was given to the needs of students having difficulty fitting into the school social structure. This included students who displayed high risk-taking behaviours, had poor social skills, aggressive behaviour and anger management that contributed to their difficulties within and outside the school setting. Unfortunately, funding for the STAR program finished at the end of 1996. In consultation with the Catholic Education Office, Centacare and Pentecost College a limited amount of



funding was made available to continue some workshops for the special needs of these students during 1997. The concern was that the funding for such programs in schools has decreased and the continued support for these students was uncertain.

### **Secondary schools versus primary schools**

The case studies presented in the literature on health promoting school projects have predominantly focused on primary schools. There are very few reports on what is happening with health promotion in secondary schools. Indeed, the HPS project appears to have been very successful in primary schools in the local area.

Some of the reasons attributed to the HPS initiative being more widespread in primary schools included policy implementation issues and a student population who with ages ranging from five to twelve years are more amenable to authority figures such as teachers (Ackermann, 1992). It could be argued that primary school teachers are also more likely to share common goals than secondary teachers do. There are no defined subject biases amongst primary school teachers compared to secondary school teachers where they can become quite isolated in their own subject area.

In perusing *Towards a Health Promoting School* (NSW Department of Health, 1996), one cannot but help be struck by the childlike images and colour of the document which would usually be associated with primary school students. Several of the secondary teachers who received copies of the book commented that they had only glanced at the contents because they believed it to be primary school based. The HPS seems to have, intentionally or unintentionally, promoted itself to primary schools, perhaps at the expense of secondary schools. On analysis, out of the fifteen case studies provided in the HPS document only two were from secondary schools. The HPS concept has definitely gained more acceptance in the primary school sector judging by the number of primary teachers compared to secondary teachers that have attended HPS network meetings and workshops. At recent local PDHPE, Welfare and HPS network meeting I

was the only teacher from a high school amongst fourteen primary school teachers interested in promoting the concept. The results from the telephone calls to both private and state secondary schools teachers (see p.161) reflected the lack of support for the HPS initiative in their schools.

Primary school students also seem to be far more accepting and responsive to health promotion initiatives. For example, a 'No Hat, No Play' policy will see the majority of primary students abiding by this school rule whereas this is far less likely to be the case with secondary students for whom the rule has far less relevance. Parental involvement in the primary schools is also much higher than in secondary schools because the younger students still expect their parents to be an integral part of their lives which include the school environment. If the HPS project is to be successful in secondary schools then it is important to understand and take account of the changing and various needs and interests of the students and staff.

### **Competing commitments to priorities in schools**

The HPS concept must be viewed as a long-term project, eventually incorporating all aspects of school living. The adoption of a holistic HPS project is not achievable overnight. A school needs time and support to work towards becoming a health promoting school. To increase the school's ability to meet the criteria for health promoting schools, WHO (1991) suggests that no less than three consecutive years should be allocated to effectively implement school health promotion. After almost three years the project at Pentecost College has established a firm base in the school. With a number of supportive structures and policies developed, it should make it easier for new health promotion initiatives to be implemented and serve to maximise their impact. The HPS project is ongoing and as with any other policy implementation, it involves continual planning and evaluation to be successful.

At this stage of the project, further professional development for all staff at Pentecost College needs to occur to make HPS policy a continuing possibility. The workshops and network meetings organised by the Area

Health Service need to continue with increased support from the school's administration. As well as providing resources for teacher inservicing in health promotion, the challenge exists for universities to provide a working knowledge of the HPS concept and to develop skills of leadership and implementation of this project in all graduating teachers, not just those undertaking PDHPE courses. The signs that HPS is here to stay make this an immediate priority that universities need to include in the content of teacher education courses.

There is now a consensus in the literature (Resnicow, Cherry & Cross, 1993) that for the HPS concept to be successful it must span Kindergarten to Year 12. Indeed, it needs to begin in the early years of schooling, but must be maintained throughout the student's whole school lifetime. Thus the importance of the implementation of the K-6 PDHPE syllabus and the reassessment of Year 11 and 12 personal development and health courses is essential. Health behaviour and attitudes then have a stronger chance of being part of an individual's life throughout adulthood. This leads to less stress on the current health system, providing more funding for future health promotion programs, that is, it becomes proactive rather than reactive.

The next step in the HPS project at Pentecost College is to move from visible outcomes to incorporating the more challenging 'intangible' health issues evident in the school. *Towards a Health Promoting School* (NSW Department of Health et al, 1996) does not provide a 'quick fix' or uniform approach to becoming a health promoting school. However, it provides a support structure and numerous suggestions as to how schools can provide opportunities for health promotion in schools. The focus of the HPS project in most cases, including the case study at Pentecost College, has been on 'tangibility'. Changes in the curriculum, the planting of trees, developing playing fields, building of shade areas and the like are readily observable and therefore quantifiable in terms of commitment to the philosophy of health promotion. It is these short-term, observable changes once established, that attract support and funding for further initiatives. For example, the college received further funding from 'Streamwatch' and 'Rivercare' once there was

physical evidence that work had been conducted on the creek embankment.

The initial priority at Pentecost College focused on enhancing the physical environment. I believe that this was an excellent starting point for the school to introduce the HPS concept. The physical environment of the school effects the day-to-day health and well-being of those who interact with it. Improving the physical environment helps to achieve optimal health, safety and well-being (Rowe, 1987). This, however, is only the 'tip of the iceberg'. It is the often neglected 'intangible' issues such as boys' participation in cultural activities at school, confidence building and students' self-esteem issues that are now critical to address in the HPS project. I have come to realise through being involved with the project that the HPS concept involves much more than the immediately discernible activities such as changing the curriculum and developing the physical environment. The challenge now involves a whole change in the way we teach and encourage students to learn. There must be a paradigm shift from a focus on teaching skills in isolation to a focus on teaching generic skills identified to promote health-enhancing behaviours. Generic personal and social skills include refusal skills, problem-solving, decision-making, media analysis, assertiveness skills, communication, coping strategies for stress and behavioural contracting (Jackson, 1994). These skills need to become part of the repertoire of all individuals if better health behaviours are not to remain elusive.

Attending school is not always a healthy experience for students. Some students are made to feel intellectually or physically inadequate, some experience severe anxiety over a number of issues, some are bullied, others injured and many exposed to drugs and risk-taking behaviours. Student welfare policy is currently receiving immense support in NSW schools. This must include the promotion of broader holistic health issues as its aims and outcomes for the total well-being and safety of the student, interlocked within the philosophy of health and welfare.

I believe that the health promotion initiatives implemented at Pentecost College so far have merely provided a foundation for the HPS concept. The future success of the project lies in addressing these

'intangible' health priorities and devoting as much support, time, resources and enthusiasm towards these issues as with any other school program.

There are a number of priorities and structures of schools that appear to work against the implementation of HPS policy. It is important to recognise these and to provide alternative structures for action if the HPS vision is to be achieved. Schools, led by principals, characteristically are managed in a hierarchical fashion which in itself is contrary to the philosophy of achieving a health promoting school as suggested in *Towards a Health Promoting School* (NSW Department of Health et al, 1996). If indeed the HPS is to become the focus, it must be accepted by the whole school community as the umbrella under which all other facets of school life gather. It is vital that the health promoting concept is inculcated into the school and community life and not simply a short-term 'piecemeal' attempt which suits the vested interests of a few. This may appear somewhat idealistic but the HPS concept has always involved this as a central premise in developing health promotion initiatives in schools.

In a hierarchical structure, decision-makers and professionals tend to squeeze the maximum short-term gains in each position they hold as they move through the ranks (Kok, 1993). In doing so they frequently sacrifice important long-term goals, which are fundamental in health promotion. For the HPS concept to become a long-term proposition, one needs to accept the 'total package' and not use parts of the initiative when it suits the short-term vested interests of a few individuals. For instance, the principal at Pentecost College was very enthusiastic with his support of the HPS project on occasions when it would produce something tangible such as the undercover shelter. Short-term projects in response to pressure from active parents and teachers also tended to take precedence over the long-term goals of the HPS project. It seemed that the principal's vision for the school did not truly engage with the HPS concept.

There is also the problem that many people measure school success by HSC results and Tertiary Education Ranks (TERs). However, there are no such TERs for combating drug use, being physically active and managing life without employment in today's world. From the surveys conducted with

parents and teachers, there is an evident conflict between teachers and parents wanting to decrease stress for students but at the same time, expecting high level performance in the HSC.

PDHPE teachers may have contributed to this conflict by introducing grading for PDHPE for the NSW School Certificate. Grading appears to be totally contradictory to the basic philosophy of PDHPE and indeed the HPS concept. A complete re-evaluation needs to be conducted with regards to assessment practices in PDHPE. The question remains: What are we as health educators trying to achieve?

For the HPS concept to achieve its potential, it requires a radical rethinking of the purpose of education. The school curriculum continues to expand. As educators take on new responsibilities, the time spent in the traditional assigned curriculum must decrease to allow new initiatives to be implemented. There needs to be a reassessment of the total school curriculum. More responsibility cannot continue to be put onto schools without making other issues less of a priority for the school year. This presents a dilemma for those supporting the HPS concept. Perhaps it is time that a number of these changes need to happen in order to fully realise the HPS project. Questions on the philosophy of education need to challenge the purpose of education in the new millennium and how the existing structures with their conflicting demands can limit and restrict students' potential education. This can be seen as a difficult and daunting task for educators but nevertheless must be addressed if we are to see the HPS concept become incorporated under the banner of education.

Perhaps health promotion in the context of the HPS project is unlikely to occur in many schools unless the concept is mandated in some way by the NSW Department Of School Education and the Catholic Education Commission for schools to implement policy changes. For example, health educators had lobbied for decades for health education to become a part of the formal curriculum in NSW schools. However, widespread implementation did not occur until the NSW Board of Studies (BOS) mandated it for Years 7 to 10. Likewise this occurred when the NSW Department of School Education mandated the 25-hour PDH course for

Years 11-12. Many of the goals of the HPS concept may not become a reality unless mandated policy is introduced with regards to such issues as the type of food and beverages that can be sold in a school canteen, the amount of shade area required per capita and the number of hours for physical activity provided at school.

### **The HPS project at Pentecost College - a final comment**

Schools have for a long time recognised their capacity to influence student health behaviours is not determined solely by the curriculum, but also by their structures and services. The HPS concept is reflected to some degree in most schools around the country. The establishment of health canteens, sun protection policies, student welfare and counselling services are common in many schools. What the HPS project offers is a holistic approach to all of these issues. It is now self-evident that effective health promotion, even through the HPS approach, cannot be achieved on its own; it must be supported by a comprehending and sympathetic wider community.

Much has been written about the philosophy and conceptual framework underlying the health promotion concept. The last few years have witnessed an increasing investment of energy and resources into the health promoting schools' approach by both health and education sectors. Health promoting schools associations have been established at international, national, state and local levels, and a number of schools have embarked on projects incorporating the principles of a HPS into their agendas.

The challenge for Pentecost College now lies in the maintenance or sustainability of programs and hence behaviour change; the increase community participation which will increase the likelihood of commitment to programs; the strengthening networks and collaborations between community sectors; and the empowerment of the school community to better able to deal with other health problems or issues in the future.

The health promoting schools concept has been able to achieve something unique by bringing health and education together in a way that has the potential to provide sustainable benefits to the entire school community. There has been many other opportunities to involve other organisations and agencies into this network. Local councils, Department of Sport and Recreation, Area Health Services, Environment Protection Authority, Roads and Traffic Authority, and the National Heart Foundation are examples of other agencies who, as part of their core business, aim to service and enhance local communities. Each of these agencies has been only too willing to assist Pentecost College in harnessing resources and assistance in the planning and implementation of the health promotion initiatives.

This case study has been extremely insightful to me, both personally and professionally. One major benefit has been the HPS agenda that is occurring *now* at Pentecost College. Every day, I have been able to witness, discuss, teach, make modifications and be an integral part of this interesting process. Many of the initiatives introduced at Pentecost College are considered useful by the school community in the promotion of health and warrant continuation.

Has the project enhanced the health of the Pentecost College community? Some members of the school community have displayed more health promoting behaviours than others but even so, it is not possible to establish their future health behaviours without a longitudinal study to follow students once they leave school and progress with their lives. The HPS project at Pentecost College has indeed closed the gap between health promotion theory and practice. However, I believe that the HPS project at Pentecost College will not continue with the same amount of vigour and enthusiasm that it has experienced over the last three years. The project is in danger of faltering through poor interest, lack of enthusiasm and shifting priorities of staff and the school administration. If the project is to continue, the base of health promotion ownership must be broadened so that other individuals and interested groups become actively involved. Whilst belief and interest in the HPS concept remains strong, there is just



not enough time with the other curriculum and extra curricula activity demands on teachers, to maximise the effectiveness of the project. Some observable outcomes have already been achieved due to the efforts of members of the HPS committee and some feel that they have already 'done their bit' and the project no longer warrants further efforts on their part. This again underlines the importance of involving as many people as possible from the whole school community in the project. One would hope that the HPS project at Pentecost College has not reached its climax, but with a broadened interest from others will continue to gradually progress through future years into the realms of effective health promotion.

*Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) as a package to introduce schools to the HPS concept, provides a means to move along the health promoting schools continuum. The document outlines appropriate processes that may assist in developing appropriate policies that have the potential to enhance the school's ability to be health promoting. The questionnaires and other pro-formas that are included in the document are helpful in establishing awareness raising and needs analysis specific to individual schools. *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996), however, provides no indication as to when a school can be called 'a health promoting school'. A school is seen to be continually moving *towards* the ideal of a health promoting school. WHO (1996) presents a model award system which takes such checklists used in the *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) document a little further. WHO (1996) propose a three-tiered award system based on set criteria to enable schools to gain recognition for progress towards the goal of becoming a health promoting school. The criteria for this award structure is outlined below. The six areas referred to include school health policies, school physical environment, school social environment, community relationship, personal health skills and health services.

#### *The bronze award*

To attain this level schools need to demonstrate that they:

- have developed a 'Charter for a health promoting school';
- have been active for over one year in the six areas;
- meet the minimum requirements for the Bronze level.

#### *The silver award*

To attain this level schools need to demonstrate that they:

- have developed a 'Charter for a health promoting school';
- have been active for two years in the six fields;
- meet the minimum requirements for the Silver level.

#### *The gold award*

To attain this level schools need to demonstrate that they:

- have developed a 'Charter for a health promoting school';
- have been active for three years in the six fields;
- meet the minimum requirements for the Gold award;
- supported another school to become a health promoting school  
(WHO, 1996, p.25).

So, is a school deemed a health promoting school once it achieves a 'gold award'? Colquhoun (1996b) suggested that set checklists and award structures are potentially detrimental to the HPS concept because such a universal scheme may result in schools not developing their own checklists to suit their own context. This form of 'governmentality' as Colquhoun (1996b) puts it, can lead to a more conservative agenda and detracts from the broad concept of HPS. This is especially evident in today's culture when schools have entered the competitive marketplace.

Do we subscribe unquestionably to this set criteria or is the fact that Pentecost College *is* evolving and making a concerted effort to improve students', teachers' and the wider community's behaviours and attitudes towards health enough to accept, that indeed we are a health promoting school? Guidelines supporting the HPS concept emphasise the need to involve the school community to cooperate and actively participate in the HPS policy making process by exploring their *own* needs, developing initiatives and forming their own criterion references. The aim is not to become entrapped with the power of government and health agencies' agendas, but to have a sense of ownership and belonging to the HPS concept. Needs and opportunities are then context bound for the school and wider

community. To date, Pentecost College has not received any notification from the Area Health Service or the NSW Health Promoting Schools Association in regards to the WHO award scheme. However, the NSW Health Promoting Schools Association has recently undertaken a feasibility study of the award scheme and have recommended its implementation in NSW (NSW Department of Health, 1997).

## **Recommendations**

Both health and education personnel must be realistic in what they might expect of schools to achieve as settings for health promotion. Health promotion efforts must be directed towards all areas of the daily life of adolescents and not be delegated to schools alone.

Schools definitely cannot counteract all stressors and tensions originating in other life spheres such as unfavourable economic conditions, dysfunctional families or lack of supportive friends. Above and beyond that, school in and of itself bears a considerable risk potential for the healthy development of the young

(Hurrelmann, et al, 1995, p.124).

Making the HPS concept a reality in *all* schools does not only mean changes in national, state and local school policy, but further developments in the support structures for the HPS project in terms of funding and training. *Towards a Health Promoting School* (NSW Dept. of Health et al, 1996) was launched into schools with little financial commitment from the government. There was no funding support in schools for resources and little professional development provided for staff to contemplate taking on a HPS project. Schools need to be provided with a total support package comprising of not only implementation ideas but also staff development procedures and parent brochures. Such a package is proposed from the 'Fitness and Physical Activity' project, which focuses on 'how' to promote physical activity within the time constraints of the 'normal' school curriculum. This also needs to be followed through with the HPS concept.

One must not lose sight of the fact that central to the health promoting school is the integrated PDHPE curriculum which requires adequate time, staffing and resources to form a solid base for coordinated

efforts of the whole school community to complement programs and move towards a health promoting school. Sixty percent of secondary schools in NSW have someone outside the PDHPE faculty teaching the subject (Booth et al, 1996). Curriculum priority is an initial concern for the HPS concept to come to fruition. It is necessary to have qualified teaching staff members of PDHPE in both primary and secondary schools. The push for specialist PDHPE teachers in primary schools or training and inservicing for primary teachers in health issues needs to be continued.

An in-school coordinator is of utmost importance for the HPS project to continue. This person requires time and funding for resources to take responsibility for the project. Acknowledgment for individual effort and time in the HPS project also needs to be taken into consideration by the school's administration so that the health promotion personnel feel supported in their efforts to maintain programs. The establishment of the HPS committee becomes the responsibility of the coordinator and it is vital to entice administrative staff 'on board' to be involved in the decision-making processes. The number of people involved with the HPS committee also needs to be broadened but it may be that teachers need incentives to become involved in any new school project that is added onto their already busy school schedules. Acknowledged is the fact that with high stress of teachers the volunteer burnout is inevitable. Therefore, a large number of committed personnel is paramount to ensure that the responsibility of the project is shared and that its continuation is more likely to be sustained.

Of equal importance is the notion that the HPS project is an ongoing cycle. It must provide for continual needs assessment, awareness raising, planning and evaluation of and by all members of the college. It is important to address the intangible health needs in the school community and further research is required in this area. This, along with exploring structural changes to teaching and learning, changes to curriculum and sport in schools and long-term vision for the HPS concept, must occur for it to become a reality in practice.

Where to from here? Further development is needed in a number of areas, particularly specific strategies for adolescent students that are in line with their belief systems, support from the school's administration, and strategies for *sharing* responsibility for health promotion across the school community. For Pentecost College, the entire project needs to be evaluated. The current health needs of the school community must be reassessed, awareness raising maintained and the project continually explored for successful implementation of future health promotion initiatives. The HPS concept has not become an integral part of the school as new students, staff and parents appear to be unaware of the` project. However, the problem remains to find the time and personnel required for this continual evaluative process to be sustained.

## **Conclusion**

Pentecost College's involvement in the HPS project has achieved a number of positive health outcomes. The enhancement of the physical environment has contributed towards promoting sun protective behaviours and increasing physical activity of students. Uniform changes, media contact and student, staff and parent workshops have assisted health promotion in the school. Curriculum changes and further links with community services have also encouraged healthier lifestyles. The PDHPE program is currently being rewritten to incorporate changes derived from the drug survey results, and changes are being made to period allocations for sport and PDHPE in an attempt to further promote physical activity. The principal has recently received plans from the local council for the proposed cycleway, suggesting that the relocation of the public thoroughfare that runs through the school will become a reality in 1998. Work on this project has already commenced.

Some of these issues may have been addressed without being included in the HPS project. By the school being involved in the project, it brought the attention of many health issues to the forefront of the school's agenda. A committed effort by a small number of people has demonstrated

the potential of the HPS concept. However, a structural framework for the continuation of health promotion in the school has not been successfully achieved. Although health programs have been implemented, it has relied on the efforts of a few committed teachers to maintain its continuity. If those staff who have been heavily involved in the project left the college, there are few teachers who would be prepared to commit similar amounts of time and effort with all interested groups. Programs with step-by-step instructions have been written for others to follow but with little response. In addition, the school's HPS policy has little credibility. Its implementation has been limited, firstly by the administration in not adhering to some health promotion principles, then by the whole school community participating in an ad hoc fashion in health promotion initiatives. As such the HPS policy has not become an integral part of education in the school. Until this is realised, health promotion will remain the determined efforts of committed individuals to raise the profile and continue the HPS project in the school. Health issues in the school appear to have remained a PDHPE faculty responsibility rather than a whole school community project. Like all schools, it was difficult to accommodate all social, academic, cultural and sporting commitments at Pentecost College into any one single school year. The introduction of a HPS project needs to be recognised as the umbrella or social structure for the whole school and practices must be designed within this framework which will translate health promotion into constructive health challenges. An integral part of a health promoting school is its dynamic nature. School communities are developing and living entities, responding to changing situations both within and without the confines of the school's enclosures. Thus, it requires a continuing process of developing innovations and assessment and evaluation of existing procedures for health promotion to be sustained.

The HPS project at this stage seems to be a positive concept due only to a considerable number of initiatives made by individual schools or teachers rather than a joint and coordinated effort to introduce systemic change within the school system as a whole. This was recognised by Colquhoun (1996b) when he acknowledged the paradigm shift from

traditional school health education of a formalised curriculum to a broader and more holistic approach to health in schools. The additional responsibilities and burdens (as seen by some) of the changing demands placed on schools and teachers may mean that any initiative such as HPS may be construed by teachers and parents as further demands placed on the already over crowded curriculum and programs within the school. It is little wonder then, in such a climate, that health promotion programs often remain the passion of a few. Time and administrative support to integrate the HPS concept are critical as colleagues meet and work through the transitional phase of this paradigm shift.

Realistically, the HPS concept for NSW schools is still a distant reality. Certainly there is a long way to go at Pentecost College but the ideal is to make the school physically and psychologically safe as possible and to continually promote the health and well-being of the entire school community. If this is to be achieved then, there must be a strong commitment to continuing consultative dialogue with all groups in the school-home-community interface. Meaningful opportunities need to be provided and administrative support is essential for the effectiveness of the HPS committee and for the health promotion project to continue. Health promotion in schools is an ongoing process that needs to become an focal part of the culture of the school for the lifetime of the school. Maintaining the motivation of interested students, teachers and parents involved in the process in addition to the commitment of the education and health sectors to the health promoting schools concept is the challenge for the future. 'Health promoting schools need to be set up in a way which ensures that positive changes are sustained' (WHO, 1996, p.2). Policies, practices and structures must be further developed to embed the fundamentals of the HPS into a school's everyday operation.

There are no simple answers to the challenges of becoming a health promoting school. 'The struggle to be health promoting is never won - there are always challenges and barriers to be overcome' (Colquhoun, 1996b, p.3). However, it is crucial that schools accept the challenge and cope with the frustrations and set backs as well as be encouraged and pleased with the

positive outcomes that are achieved. It is important to be aware that change in schools or any organisation occurs gradually. The HPS agenda must contain the key elements of the curriculum, school environment and the interface between school and community. Continual awareness raising and planning, a developed understanding of the health needs of school students, increased teacher training and support, and increasing school-home-community links are essential ingredients for health promotion to be sustained at Pentecost College. At the same time there is also a need to be creative and open-minded about the range of possibilities for health promotion that may be unearthed through collaborative discussion of all interested parties. We must continue to strive for the ultimate aim of improved health for the whole school community. To do so, health promotion policies must be incorporated into the existing goals of the school rather than be portrayed as an additional responsibility.

The HPS concept can play a major role in achieving the objectives in *Health for All by the Year 2000* (WHO, 1986). Quality health promotion programs that address and integrate education, skill development and motivation on a range of health problems and issues from Kindergarten through to Year 12 are required. These programs must also be delivered to students at their appropriate psychosocial readiness. In doing so, there is a stronger chance that the information is relevant and therefore more likely to be internalised and understood by students so that more appropriate attitudes and values are formed. Such health promotion dilemmas that are evident in schools today are complex and challenging. Health promotion initiatives must be specifically tailored according to the needs of the school community. A school has tremendous potential to touch on the current and future health of students, staff, parents and the wider community. Let us continue the challenge to move along the health promoting school continuum.



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## Appendix 1 - The Ottawa Charter (WHO, 1986)

*The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November, 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.*

*This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialised countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma Ata, the World Health Organisation's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.*

### HEALTH PROMOTION

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being.

#### Prerequisites for health

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites.

#### Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health

#### Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

#### Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organisations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programs should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organisation of health services, which refocusses on the total needs of the individual as a whole person.

## **MOVING INTO THE FUTURE**

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

### **Commitment to health promotion**

The participants in this conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
- to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being.
- to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and most importantly with people themselves;
- to recognise health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The conference urges all concerned to join them in their commitment to a strong public health alliance.

### **Call for international action**

The Conference calls on the World Health Organisation and other international organisations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programs for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organisations, governments, the World Health Organisation and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

## Appendix 2 - HPS staff questionnaire

16th May, 1996

Dear

Attached is a survey exploring your ideas and priorities concerning '**Health Promotion**'. The committee is interested and keen to know how you feel about aspects of health promotion that may affect you. With parents and students we have conducted surveys which have focused on their particular needs and interests. After the results are collated we will be disseminating relevant information to all parties surveyed with the aim of prioritising each group's concerns.

We appreciate that you are very busy with the end of term rush. We hope that you acknowledge the importance of health issues in our school and so will see your way clear by completing this survey.

Completed surveys can be returned either to my pigeon hole or a box labelled '**Staff Health Promotion Surveys**', on top of my pink cabinet.

Many thanks for your time, effort and co-operation.

**Health Promoting Schools Committee**



**Staff perception of health in a health promoting school: Values continuum**

Each staff member is asked to respond to the following statements by making a decision on the continuum. Respond by choosing from the following, strongly agree (SA), agree (A), disagree (D) or strongly disagree (SD).

Our school is responsible for providing an environment which protects and promotes health for the whole school community.

SA	A	D	SD
_____			

It is the responsibility of the whole school community to provide a green, clean and tidy environment.

SA	A	D	SD
_____			

Parents, caregivers and community members should work with the school in educating students.

SA	A	D	SD
_____			

The safety and welfare of our school community is a priority not just for the school but for the wider community.

SA	A	D	SD
_____			

We provide students and staff with adequate opportunity to participate in physical activity.

SA	A	D	SD
_____			

Staff are actively responsible for acting as role models of healthy behaviours.

SA	A	D	SD
_____			

Environmental issues need to be actively promoted and addressed in our school community.

SA	A	D	SD
_____			

The school canteen should provide staff and students with healthy food choices irrespective of profit margins.

SA	A	D	SD
_____			

Our school actively promotes good relationships between all members of the school community.

SA	A	D	SD
_____			

Parents, caregivers and community members should participate in curriculum development.

SA	A	D	SD
_____			

Our school is responsible for making visitors and community members feel welcomed.

SA	A	D	SD
_____			

Our school is responsible for establishing communication networks for keeping the whole school community informed.

SA	A	D	SD
_____			



**FOLLOW UP OPEN-ENDED QUESTIONS:**

a)     What do you understand and suggest should be health promoting school?

.....

.....

.....

.....

.....

b)     How broad are the issues relating to a health promoting school?

.....

.....

.....

.....

.....

c)     What has this activity highlighted for you?

.....

.....

.....

.....

.....

d)     What issues would you like to address at your school?

.....

.....

.....

.....

.....

Thankyou for your participation.

## Review of staff perception of health: Health promotion

Complete the sheet by circling a response to each of the statements.

### Health promotion is:

- |  |     |    |
|--|-----|----|
| • caring for the environment   | Yes | No |
| • developing anti-litter campaigns in school   | Yes | No |
| • highlighting the impact of smoking and alcohol on people   | Yes | No |
| • providing safe access to and from schools and school activities  | Yes | No |
| • reducing hazards in play areas and classrooms  | Yes | No |
| • organising a school community safety committee   | Yes | No |
| • participating in fund raising campaigns for charities  | Yes | No |
| • parents, caregivers and teachers working collaboratively on policy and curriculum issues                           | Yes | No |
| • the way in which school communities work with and influence the wider community                                    | Yes | No |
| • providing a variety of healthy food choices for students and staff   | Yes | No |
| • providing school community members with the opportunity to influence canteen practices                             | Yes | No |
| • helping to alleviate stress for students and staff   | Yes | No |
| • helping students to develop their self-esteem  | Yes | No |
| • using interpersonal skills to promote health in others   | Yes | No |
| • providing school community members with the opportunity to develop positive and meaningful relationships           | Yes | No |
| • developing positive relationships with the whole school community by acknowledging the value of their contribution | Yes | No |
| • providing opportunities for staff and students to keep fit and active  | Yes | No |
| • encouraging physical activity as an important part of a healthy lifestyle.   | Yes | No |

**Staff health and well-being**

In our school to what extent do we:	Low	→	High
• plan collaboratively?	1	2	3 4 5
• share materials and ideas?	1	2	3 4 5
• openly discuss problems with students, parents, caregivers?	1	2	3 4 5
• involve others in sharing special activities and experiences?	1	2	3 4 5
• take responsibility for keeping others informed when meetings or professional activities are missed?	1	2	3 4 5
• report back to the whole school when we have attended a course or conference?	1	2	3 4 5
• informally discuss professional concerns?	1	2	3 4 5
• support others who may not be feeling well or who are experiencing difficulties?	1	2	3 4 5
• give and receive compliments on professional matters and personal qualities?	1	2	3 4 5
• hold regular morning teas or luncheons to celebrate important milestones during the school year?	1	2	3 4 5
• hold staff, grade or faculty meetings away from the school?	1	2	3 4 5
• meet in pleasant, non-threatening surroundings for social interactions?	1	2	3 4 5
• recognise the achievements of staff?	1	2	3 4 5
• celebrate special events such as birthdays and graduations?	1	2	3 4 5
• seek help when feeling stressed or overcommitted?	1	2	3 4 5
• communicate the positive things that are happening at school?	1	2	3 4 5
• model "healthy" choices, e.g. wearing hats, eating healthy food?	1	2	3 4 5
• allow ourselves time to reflect?	1	2	3 4 5
• other _____	1	2	3 4 5

**follow-up questions:**

What are the three most positive aspects of staff health and well-being at our school?

What suggestions could you make to improve staff health and well-being?

### **Appendix 3 - HPS information letter and parent questionnaire**

Dear parents/guardians,

Pentecost College is working towards becoming a better health promoting school. It has been selected as a pilot school for the Health Promoting Schools Illawarra. This is an initiative of the Illawarra Area Health Service, Healthy Cities Illawarra, South Coast Department of School Education and Wollongong Catholic Education Office.

The process involves a review of the:

- Personal Development, Health and Physical Education curriculum
- school ethos or climate
- links between the school-home and community

These areas can include aspects of: knowledge and skill development; school health services; the school environment; school physical education and fitness; the school canteen-nutrition; health promotion for staff and parents; counselling programs, student welfare; safety; recycling; and school community health events.

The health promoting school should reflect the needs and interests of the school community. So that we can establish the needs and interests of our students and the school community in general, we are seeking the opinion of parents/guardians and local community members on what areas should receive emphasis in our health promoting policy.

The school is now in the process of writing a health promotion school policy and we invite you to be involved in this task by completing the attached questionnaire.

On behalf of the school community I would like to thank you for your interest and involvement. If you wish to discuss this matter with me, please phone the school on the number shown above.

Yours faithfully,

Phil Pearson  
PDHPE Coordinator  
for Health Promoting Schools Committee



PARENT SURVEY: HEALTH PROMOTION

Please answer the following questionnaire concerning health promotion:

1.

What do you understand by the term 'health promotion' as applied to this school?
2.

What do you consider to be the most important health needs of parents and caregivers at this school?
3.

What do you see as your three main barriers for achieving optimal health?
4.

What do you consider to be the most important health needs of your children (or the children of our local community) and the lifestyle they lead?
5.

What concerns you most about your children's health and safety?

(i)

Now

(ii)

In the future

6.

What do you think could be done to ensure the happiness and well-being of your children (or the children of our local community)?
7.

How could our school help to develop a healthier and safer community?
8.

How can members of the local community help to ensure the health and safety of our children? .....
9.

What suggestions can you make for our school community, to ensure it is more supportive of the health and well-being of all its members?

Students:

Staff:

Parents/Caregivers:

Community:

Appendix 4 - HPS student questionnaire

Complete the following questions:

- 1. A health promoting school to me means .....
- 2. The three things that give me the greatest happiness are .....
- 3. The three things I worry about most are . ....
- 4. The one thing I would like to change in my life would be .....
- 5. My friends would say that I am a health/unhealthy (cross out one) person because.....
- 6. When I am 25 years old I expect that I will be healthy/unhealthy (cross out one) because .....
- 7. When I am 65 years old I expect that I will be healthy/unhealthy (cross out one) because .....
- 8. I think my school could be healthier and safer place if .....
- 9. I think my local community could be a healthier and safer place if .....
- 10. I think my family could make my life healthier and safer if .....
- 11. I think my school could help my family to have healthier and safer lives by .....
- 12. Any other comments you would like to make concerning health promotion in our school .....



# Rating scheme:

Evaluating the school environment

This activity allows you to evaluate aspects of the school environment by using a five star rating scheme. One star would indicate a low rating (i.e. in need of significant improvement) and five stars would indicate a high rating.

## School environment evaluation

Environment	Rating					Suggested improvement
Our school has:	☆	☆☆	☆☆☆	☆☆☆	☆☆☆	
1. adequate designated play areas						
2. playground supervision at all necessary times of the day						
3. adequate safety rules which are enforced in the playground						
4. adequate fencing of the playground						
5. safely designed equipment and sport areas						
6. adequate levels of qualified supervision for sporting activities						
7. suitable wet weather areas for students						
8. any hazards clearly marked						
9. effective procedures for dealing with hazards						
10. ongoing and regular maintenance (cleaning, repairs, etc.)						
11. adequate sun protection (shade, hats, SPF 15 sun screen)						
12. adequate seating available in good condition						
13. procedures to ensure safe travel to and from school by students						
14. adequate storage space for bikes and bike helmets						
15. safety policies which are actively implemented and regularly reviewed						

Appendix 5 - Youth Health Survey and results  
(NSW Department of Health, 1996)

Page 1

1. What is your sex? (Please tick one box).

- ☐ Boy
- ☐ Girl

2. What age did you turn on your last birthday? (Please tick one box).

- |                             |                             |                             |
|-----------------------------|-----------------------------|-----------------------------|
| <input type="checkbox"/> 10 | <input type="checkbox"/> 13 | <input type="checkbox"/> 16 |
| <input type="checkbox"/> 11 | <input type="checkbox"/> 14 | <input type="checkbox"/> 17 |
| <input type="checkbox"/> 12 | <input type="checkbox"/> 15 | <input type="checkbox"/> 18 |

3. What suburb or town do you live in?

---

4. What language do you speak at home? (Please tick one box).

- ☐ English
- ☐ Other
- ☐ English + other

If you regularly speak a language other than English, please write which language.

---

5. Outside school hours: How many times a week do you usually exercise in your free time so much that you get out of breath or sweat? (Please tick one box).

- ☐ Every day
- ☐ 4-6 times a week
- ☐ 2-3 times a week
- ☐ Once a week
- ☐ Once a month
- ☐ Less than once a month
- ☐ Never

6. Outside school hours: How many hours a week do you usually exercise in your free time so much that you get out of breath or sweat? (Please tick one box).

- ☐ None
- ☐ About 1/2 hour
- ☐ About 1 hour
- ☐ About 2-3 hours
- ☐ About 4-6 hours
- ☐ 7 hours or more

7. Outside school hours: How many hours a week do you usually spend walking for recreation, exercise or to get to and from places? (Please tick one box).

- ☐ None
- ☐ About 1/2 hour
- ☐ About 1 hour
- ☐ About 2-3 hours
- ☐ About 4-6 hours
- ☐ 7 hours or more

8. How many hours a week do you usually play computer games? (Please tick one box).

- ☐ Not at all
- ☐ Less than 1 hour a week
- ☐ 1 - 3 hours
- ☐ 4 - 6 hours
- ☐ 7 - 9 hours
- ☐ 10 hours or more

9. How many hours a day do you usually watch TV or videos? (Please tick one box).

- ☐ Not at all
- ☐ Less than half an hour a day
- ☐ 1/2 - 1 hours
- ☐ 2 - 3 hours
- ☐ 4 hours
- ☐ More than 4 hours

10. Inside school hours: What do you feel about your physical education lessons at school?

- ☐ I like them very much
- ☐ I like them
- ☐ I neither like or dislike them
- ☐ I dislike them
- ☐ I dislike them very much
- ☐ I do not attend them

11. Inside school hours: When you are outside between 11am and 3pm (daylight savings time, or between 10am and 2pm at other times) on a sunny day, how often do you: (Please tick one box for each line).

	Always	Usually	Sometimes	Occasionally	Never
Stay in the shade?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear a broad-brimmed or legionnaires hat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear wrap around-style sun glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear sunscreen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover your skin with clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Outside school hours: When you are outside between 11am and 3pm on a sunny day, how often do you: (Please tick one box for each line).

	Always	Usually	Sometimes	Occasionally	Never
Stay in the shade?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear a broad-brimmed or legionnaires hat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear wrap around-style sun glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear sunscreen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cover your skin with clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. How often do you brush your teeth? (Please tick one box).

- ☐ More than once a day
- ☐ Once a day
- ☐ At least once a week, but not every day
- ☐ Less than once a week
- ☐ Never

14. Do you control what food you eat to: (Please tick one box for each line).

	Never	Rarely	Sometimes	Often	Always
Put on weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lose weight?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other - Why?_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. Last week how often did you: (Please tick one box for each line).

	Every day	Almost every day	2-3 times	Once	Rarely or never
Eat breakfast?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat lunch?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat dinner?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat between meal snacks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take lunch to school?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buy lunch from a shop?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buy lunch from a school canteen?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. In the last week how often did you eat or drink the following? (Please tick one box for each line).

	Every day	Almost every day	2-3 times	Once	Rarely or never
Bread	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cereal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pasta or noodles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cheese	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Yoghurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice-cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meat eg sausages, chops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chicken	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish - fresh or tinned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cakes or biscuits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lollies or chocolates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chips or nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft drink or cordial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea or coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low fat dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wholemeal or wholegrain foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vitamin pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain killer pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takeaway food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. How often do you use a seatbelt when you sit in a car? (Please tick one box).

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom or never
- ☐ Usually there is no seat belt where I sit

18. How ofter do you wear a helmet that's done up when you ride a bicycle? (Please tick one box).

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Seldom/ never (or don't have a helmet)
- ☐ Don't ride a bicycle

19. How healthy do you think you are? (Please tick one box).

- ☐ Very healthy
- ☐ Quite healthy
- ☐ Not very healthy

20. How do you feel about school at present? (Please tick one box).

- ☐ I like it alot
- ☐ I like it a bit
- ☐ I don't like it very much
- ☐ I don't like it at all

21. Please read each statement about your school carefully. Tick one box for each statement.

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
In our school the students take part in making rules.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The students are treated too severely/ strictly in this school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The rules in this school are fair.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our school is a nice place to be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel I belong at this school.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our school is clean.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Please tick one box for statements about the students in your class.

	Always	Often	Sometimes	Rarely	Never
The students in my class(es) enjoy being together.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most of the students in my class(es) are kind and helpful.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other students accept me as I am.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Please tick one box for each of the statements about your teachers. If you have only one teacher, think of this person when you answer the questions.

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
I am encouraged to express my own views in my class(es).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Our teachers treat us fairly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When I need extra help, I can get it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My teachers are interested in me as a person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. How many close friends do you have? (Please tick one box).

- ☐ None
- ☐ One
- ☐ Two or more

25. Do you feel confident in yourself?

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

26. In general, how do you feel about your life at present? (Please tick one box).

- ☐ I feel very happy
- ☐ I feel quite happy
- ☐ I don't feel very happy
- ☐ I'm not happy at all

27. Do you think your body is: (Please tick one box).

- ☐ Much too thin
- ☐ A bit too thin
- ☐ About the right size
- ☐ A bit too fat
- ☐ Much too fat
- ☐ I don't think about it

28. During the past year have you: (Please tick one box for each of the questions)

	Not at all	A little	Quite alot	Alot
Felt too tired to do things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble going to sleep or staying awake?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt unhappy, sad, or depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt hopeless about the future?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt nervous or tense?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worried too much about things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt lonely?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Felt left out of things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Found it hard to make new friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Have you ever smoked tobacco (including cigarettes) even if it was a puff or two?

- ☐ Yes
- ☐ No

**If NO, please go to question 35 on page 8 - skip the questions in the shaded box .**

**If YES, how old were you when you first smoked tobacco? \_\_\_\_\_ years**

30. How often do you smoke tobacco at present? (Please tick one box).

- ☐ Every day
- ☐ At least once a week but not every day
- ☐ Less than once a week
- ☐ I don't smoke

31. How many cigarettes do you usually smoke in a week? (Please tick one box).

- ☐ Less than 1
- ☐ 1 to 9
- ☐ 10 to 19
- ☐ 20 or more



32. How old were you when you began to smoke every day?

I was \_\_\_\_\_ years old.

☐ I do not smoke every day

33. Where do you usually get your cigarettes from? (Please tick one box).

- ☐ Cigarette machine
- ☐ Petrol station
- ☐ Corner store
- ☐ Take away food store/ milk bar
- ☐ Supermarket
- ☐ Club/ pub
- ☐ Bottle shop
- ☐ Friends
- ☐ Brother or sister
- ☐ Parent
- ☐ Other (Please write it down): \_\_\_\_\_

34. Why did you, or do you continue, to smoke? Please tick one box for each statement.

	Yes	No
It helps me stop feeling bored	<input type="checkbox"/>	<input type="checkbox"/>
It's relaxing	<input type="checkbox"/>	<input type="checkbox"/>
Advertisements make smoking look good	<input type="checkbox"/>	<input type="checkbox"/>
Friends put pressure on me	<input type="checkbox"/>	<input type="checkbox"/>
To look tough	<input type="checkbox"/>	<input type="checkbox"/>
To be part of a gang	<input type="checkbox"/>	<input type="checkbox"/>
To look older	<input type="checkbox"/>	<input type="checkbox"/>
Other reason: Please write it down:	<input type="checkbox"/>	<input type="checkbox"/>

35. In five years time, do you think you will smoke? (Please tick one box).

- ☐ Yes
- ☐ No
- ☐ Don't know



36. How easy do you think it would be for you to get cigarettes from each of the following? (Please tick one box for each line).

	Never tried	Very hard	Hard	Easy	Very easy
Cigarette machine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Petrol station	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corner store	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk bar/ take-away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supermarket	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Club/ pub	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bottle shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

37. How often do other people smoke inside your house? (Please tick one box for each line).

- ☐ Every day
- ☐ At least once a week but not every day
- ☐ Less than once a week
- ☐ Never

38. Have you ever tasted an alcoholic drink? (That means beer, wine, coolers, cider, or spirits like whisky).

- ☐ Yes
- ☐ No
- ☐ Don't know

**If NO, please go to question 46 on page 11 - skip the questions in the shaded box .**

39. If YES, at present how often do you drink anything alcoholic? Try to include even those times when you only drink a small amount. (Please tick one box for each line).

	Every day	Every week	Every month	Less than once a month	Never
Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wine/ coolers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spirits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



40. Have you ever had so much alcohol that you were really drunk? (Please tick one box).

- ☐ No, never
- ☐ Yes, once
- ☐ Yes, 2 - 3 times
- ☐ Yes, 4 - 10 times
- ☐ Yes, more than 10 times

41. On a day when you have had a whole drink of beer, wine, coolers, cider or spirits, how many whole drinks would you usually have? (Please tick one box).

- ☐ I don't drink alcohol
- ☐ A sip now and then
- ☐ Two drinks or less
- ☐ 3 - 4 drinks
- ☐ 5 - 6 drinks
- ☐ 7 drinks or more

42. Think back over the last two weeks. How many times have you had five or more alcoholic drinks in a row? (Please tick one box).

- ☐ None
- ☐ Once
- ☐ Twice
- ☐ 3-6 times
- ☐ 7-9 times
- ☐ 10 or more times

43. If you have ever drunk alcohol, why did you (or do you still) drink alcohol? Please tick one box for each statement.

	Yes	No
It helps me stop feeling bored	<input type="checkbox"/>	<input type="checkbox"/>
To drink at home with my family	<input type="checkbox"/>	<input type="checkbox"/>
It's relaxing	<input type="checkbox"/>	<input type="checkbox"/>
Advertisements make drinking look good	<input type="checkbox"/>	<input type="checkbox"/>
I feel I'm at my best when I'm drinking	<input type="checkbox"/>	<input type="checkbox"/>
People have more fun when they are drinking	<input type="checkbox"/>	<input type="checkbox"/>
It helps me not feel so shy	<input type="checkbox"/>	<input type="checkbox"/>
I am more fun to be with when I'm drinking	<input type="checkbox"/>	<input type="checkbox"/>
Friends put pressure on me	<input type="checkbox"/>	<input type="checkbox"/>
To look tough	<input type="checkbox"/>	<input type="checkbox"/>
To be part of a gang	<input type="checkbox"/>	<input type="checkbox"/>
To look older	<input type="checkbox"/>	<input type="checkbox"/>
Other reason: Please write it down:	<input type="checkbox"/>	<input type="checkbox"/>



44. Where do you usually get your alcohol from? (Please tick one box).

- ☐ I don't drink alcohol
- ☐ Buy it from a pub, bottle shop
- ☐ Get it/ buy it from other people
- ☐ Friends give it to me
- ☐ Get it from home
- ☐ Other way: Please write it down: \_\_\_\_\_

45. Has anyone ever refused to sell you alcohol because you were under age? (Please tick one box.)

- ☐ No, I have never tried to buy alcohol
- ☐ No, I have never been refused service
- ☐ Yes, I have been refused service once or twice
- ☐ Yes, I have been refused service frequently \_\_\_\_\_

46. How likely is it that someone like you would be refused service if you tried to buy alcohol? (Please tick one box).

- ☐ Very likely
- ☐ Fairly likely
- ☐ Fairly unlikely
- ☐ Very unlikely

Many young people get injured at places such as the street, at home, playing sports, or during a fight with others. The next questions ask about accidents or injuries that might have happened to you during the last year.

47. During the last 12 months, were you injured and had to be treated by a doctor or a nurse?

- ☐ Yes
- ☐ No

If NO, you do not need to answer any more questions - thank you for completing this questionnaire.....

If YES, how many times? Number of times \_\_\_\_\_

Now we would like you to think about THE ONE most serious injury or accident that you had during the past 12 months.

48. Did this one injury need medical treatment such as the placement of a cast, stitches, surgery or staying in a hospital overnight?

- ☐ Yes
- ☐ No



49. Did this one injury cause you to miss at least one full day of school or other usual activities?

- ☐ Yes
- ☐ No

50. Which of the following conditions best describes the main result of this one injury?

- ☐ Broken or dislocated a bone
- ☐ Sprain, strain or pulled a muscle
- ☐ Cuts or puncture wounds
- ☐ Concussion or other head or neck injury
- ☐ Bruises or internal bleeding
- ☐ Burn
- ☐ Poisoning
- ☐ Another type of injury (please specify): \_\_\_\_\_

51. Which of the following places best describes where this one injury occurred?

- ☐ In your home or garden
- ☐ In someone else's home
- ☐ At school
- ☐ At a sport facility
- ☐ In the street/ road near your home
- ☐ In the street/ road not near your home
- ☐ In a park or recreational place
- ☐ On a farm
- ☐ At work
- ☐ In some other place: \_\_\_\_\_

52. Which of the following best describes what happened when you got injured?

- ☐ Riding a bicycle
- ☐ Roller skating or using a skateboard
- ☐ Riding in a car or other vehicle
- ☐ Got hit by a car or other vehicle
- ☐ Got a sport injury during training or playing
- ☐ A school-playground injury during free time
- ☐ Accidentally tripped over or fell down
- ☐ Accidentally got struck/ hit or cut by an object
- ☐ During a fight with another person
- ☐ Fell off something
- ☐ Some type of other event (please specify): \_\_\_\_\_

**Thankyou for completing the questionnaire.**



95 students completed the survey -Year 8- 43 (m=25 f=18)  
-Year 10 -50 (m=30 f=20)

Language

Year 8 25.6 % speak English and another language at home, 2.3% ( 1 student) speaks only a language other then English at home.  
Year 10 20% speak English and another language at home, 2% (1 student) speaks only a language other then English at home  
Languages spoken include Greek, Italian, Spanish, French, Croatian, Vietnamese,Polish (over 50% of those with a 2nd language speak Italian).

Exercise Outside School Hours (20minutes or >)

Frequency

Year 8 25.6 % exercise daily	Year 10 -16 % daily
58.1% 2-6 times a week	44% 2-6 times week
11.6% once a week	8% once a week
4.6 % less than once a month or never	10 % less then once a month or never

Duration

Year 8 37.2% spend 1 or < 1 hours per week	Year 10: 26%
62.8 % spend 2 or > hours a week	74% 2 or > hours per week

Walking

Year 10

51% spend 1or < 1 hours walking a week  
49% spend 2-7 hours walking

Year 8

27.9 % 1 or < 1  
72.3 % 2-7 hours

## Computer Game Playing

### Year 10

46% do not play every day  
46% spend 1 or less then 1 hour a day  
8 % (4 students) spend 2-4 hours a day

### Year 8

7% (3)do not play every day  
69.8% spend 1 or less then 1 hour a day  
18.6% spend 2-4 hours  
4.7 % (2) spend >4 hours

## TV\video watching

### Year 10

6% Do not watch it at all or less then 1/2 a day  
26% watch it 1/2 -1 hour a day  
48% watch it 2-3 hours  
20 % 4 hours or more

### Year 8

16.3% 1/2 -1 hour a day  
51.2% (22) 2-3 hours a day  
18.6 % 4 hours a day  
14% (6)>4hours

## Attitude to School Physical Education Lessons

### Year 10

50% like them  
35.4 % neither like or dislike  
10.5 % dislike them  
4.2 % do not attend them

### Year 8

53.5% like them  
37.2% neither like or dislike  
7% dislike them  
2.3% (1 student) does not attend them

## Sun Protection Behaviour during 11am and 3pm

### Inside school Hours

Stay in shade : Year 10 : 38% Year 8: 23.8% usually or always  
: " " 18% Year 8: 23.8% occasionally or never  
: " " 44% Year 8: 52.4% sometimes

Wear a hat : usually or always Year 10 :12% Year 8: 23.8%  
: sometimes Year 10 : 6% Year 8 : 16.7%  
: occasionally or never Year 10 82% Year 8 59.5%

Sunglasses always or usually Year 10: 28% Year 8 : 17.1%  
occasionally or never Year 10 52% Year 8 73.2%  
sometimes Year 10 20% Year 8 9.8%

Sunscreen always or usually Year 10 48% Year 8 : 24.4%  
occasionally or never Year 10 30% Year 8 41.5%  
sometimes Year 10 22% Year 8 22%

### Outside of School Hours

Shade usually or always Year 10 46% usually Year 8 28.6%  
occasionally or never Year 10 10% Year 8 23.8%  
sometimes Year 10 34% Year 8 47.6%

Hat Year 10 16% usually Year 8 usually or always 38.1%  
Year 10 72% occasionally or never Year 8 45.3%  
Year 10 12% sometimes Year 8 16.7%

Glasses Year 10 34% usually or always Year 8 30.9%  
Year 10 54% occasionally or never Year 8 59.2%  
Year 10 12% sometimes Year 8 14.3%

Sunscreen Year 10 53% usually or always Year 8 47.6%  
Year 10 34% occasionally or never Year 8 33.3%  
Year 10 14% sometimes Year 8 19%

### Dental Care

Year 10 92% brush teeth 1or >1 x a day Year 8 95.4%  
Year 10 4% at least once a week but not every day Year8 4.7%  
Year 10 2% less then once a week  
Year 10 2% never



### Control of Food Intake

Year 10 To put on weight 36% Year 8 50%  
" " to lose weight 46.9% Year 8 41%

### Seatbelt

Year 10 84% always wear Year 8 86.7%  
" " 12% often or sometimes Year 8 8.9%  
" " 4% (2) no belt where they sit 4.4% (2)

### Helmet wearing (done up)

Year 10 44% always Year 8 60%  
" " 30% often and sometimes Year 8 28.9%  
" " 4% seldom or dont have a helmet Year 8 16.7%  
" " 8% dont ride a bike Year 8 4.4%

### Perception of Own Health

Year 10 Very Healthy 20.4% Year 8 15.6%  
" " 63.3% quite healthy Year 8 68.9%  
" " 16.3% not very healthy Year 8 15.6%

### Attitude to School

Year 10 6.1 % like it alot Year 8 11.1%  
" " 38.8 % a bit Year 8 51.1%  
" " 34.7 dont like it very much Year 8 26.7%  
" " 20.4% dont like it at all Year 8 11.1%

### Confidence

Year 10	22.4%	always feel confident in themselves	Year 8	6.7%
"	"	32.7% often do	Year 8	46.7%
"	"	24.5% sometimes do	"	37.8%
"	"	10.2% rarely do	"	4.4%
"	"	10.2% never do	"	4.4%

### Happiness

Year 10	28.6 %	feel very happy	Year 8	30.2%
"	"	44.9% feel quite happy	Year 8	53.5%
"	"	12.2% dont feel very happy	Year 8	11.6%
Year 10	14.3%	arent happy at all	Year 8	4.7%

### Body Image

Year 10	36 %	think their body is the right size	Year 8	57.8%
"	"	22% too thin	"	8.9%
"	"	28% too fat	"	40.1%
"	"	14% dont think about it	"	2.2%

### Tiredness

Year 10	34%	felt too tired to do things in the last year quite alot or alot	Year 8	11.4%
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### Sleeping difficulties

Year 10	80%	report some problems sleeping or staying awake (a little - alot)
Year 8	77.8%	

### Unhappy

Year 10	49%	report feeling a little unhappy	
		sad or depressed in the past year	Year 8 67.4%
	26.6 %	(14 students) report it quite a lot or alot	30.2 %

### Future Concerns

Year 10	48%	do not feel hopeless about the future	Year 8	50%
	32%	do a little		34.1%
	12 %	do quite alot		11.4%
	8%	alot		4.5%

### Nervousness

Year 10	16%	have not felt nervous or tense at all	Year 8	13.6%
	48 %	a little		59.1%
	24%	quite a lot		20.5%
	12%	alot		6.8%

### Worried

Year 10	18.4% have not felt they worried too much about things	Year 8	13.3%
	34.7 % a little		57.8%
	30.6% quite alot		13.3%
	16.3 % alot		15.6%

### Lonely

Year 10	40.8% have not felt lonely at all in the past year	Year 8	55.6%
	40.8% have a little		28.9%
	18.3 % have quite alot or alot		15.5%

### Leftout

Year 10	26% have not felt left out at all	Year 8	33%
	30% have a little		48.9%
	14 % have quite alot and alot		17.8%

### New Friends

Year 10	61.2% have not found it hard to make new friends	year 8	57.8%
	38.6% a little hard		31.1%
	4.1% quite alot		6.7%
	6.1% alot		4.4%

### Smoking

Year 10	73.5% have tried smoking (36 students)	Year 8	42.2% (19)
	69.5 % of these ( 25 students) no longer smoke	Year 8	47.4% (9) students no longer smoke

### Frequency of smoking

year 10	16.7% smoke every day	Year 8	31.6 %
	11.1% at least once a week but not every day		15.8%
	11.1% less than once a week		5.3%

### Amount smoked

Year 10	61.5% less then 1 a week	Year 8	52.9%
	11.5% 1-9 a week		41.2%
	3.8% 10-19 a week		
	23.1% (6) 20 or more		5.9% (1)

### Source of Cigarettes

Year 10	cigarette machine 5.3%	Year 8	
	Petrol Station 5.3%		
	corner store 5.3%		
	Friends 63.2%		
	brother or sister 10.5		

### Intention to Smoke in future (five years time)

Year 10 13.3% do not think they will smoke in the future	Year 8 56.8%
57.8 % dont know	31.8%
28.9 % think they will	11.4%

### Alcohol

Year 10 87.8% had tried alcohol	Year 8 86.7%
---------------------------------	--------------

### Frequency of Drinking

Year 10 (42 students) Year 8 (39)

Beer - 7.1 % 2.6% drink it every day ,11.9 %15.4% drink beer weekly, 15.4% monthly 40.5%,41% less then once a month 16.7% 25.6% never do

Wine 7.3% daily, 9.8 % 12.8% every week, 19.5 %17.9% every month, 41.5%33.3% less than once a month and 22% 35.9% never do

Spirits 4.9% daily 4.9%7.9% every week 24.4% 5.3%every month 41.5% 18.4% less than once a month 24.4% 68.4% never

### Drunkedness

Year 10 28.6 % (12 students ) have never been drunk	Year 8 69.2%
14.3% once	17.9% (7)
23.8% 2-3x	5.1%
16.7% 4-10x	7.7% (3)
16.7 % (7 students ) > 10x	

### Quantity

Year 10 37.2 % of students who have tried alcohol dont drink now, just have a sip or two or have <2 drinks at a time	Year 8 86.5%
44.2 % have 3-6 drinks	13.5%
18.6% have 10 or more drinks at a time	

### Hazardous Drinking

year 10 32.6% (of 43) in the 2 weeks prior to the survey had drunk 5 or more drinks in a row at least once (4.7% 2 students had 10 x or more) Year 8 23.1% (2.6% (1) had 10x or more)

### Reasons for drinking

People have more fun when their drinking

It helps me not feel so shy

Just to try/taste

### Injuries

Year 10 49% had an injury in the last year requiring treatment by a doctor or nurse  
45.8 % had 3 or more injuries Year 8 52.3% 13.6% >3

Year 10 47.8 % missed a day a school because of an injury Year8 56.5%

Injuries included broken and dislocated bones, sprains, strain or pulled muscle, bruises or internal bleeding, cuts and puncture wounds, concussion or head injury

Year 10 45% at a sporting facility, 15% of injuries occurred at a park or recreational place, 10% at a road near their home, 5% at home, at school, at the snow, 10% at beach /surf Year 8 31.8% school 27.3% sporting facility, 9.1% street or road not near home 4.5% road street near home, on a farm, park

Year 10 (Year 8) 35% (47.5 % ) got injured at a sport facility training or playing, the rest riding bicycles 10%(9.5%), 5% falling off something, getting hit or cut by something, in the playground (5% -1 student). riding in a car/vehicle, hit by a car, accidentally tripped over or fell down

Appendix 6 - Drug education survey for teachers  
(Hetherington & Sparks, 1996)

Question 1. What is your position on staff? \_\_\_\_\_

Question 2. What is your sex? Male ☐ Female ☐

Question 3. What is your age in years? \_\_\_\_\_.

Question 4. How long have you been teaching? \_\_\_\_\_.

Question 5. In which of the following KLA's is drug education taught?

(please tick a box)

- |               |                          |
|---------------|--------------------------|
| PD/H/PE       | <input type="checkbox"/> |
| Mathematics   | <input type="checkbox"/> |
| Science       | <input type="checkbox"/> |
| English       | <input type="checkbox"/> |
| LOTE          | <input type="checkbox"/> |
| Creative Arts | <input type="checkbox"/> |
| TAS           | <input type="checkbox"/> |
| HSIE          | <input type="checkbox"/> |

Question 6a. Are all students at your school receiving drug education?

Yes ☐ No ☐ Unknown ☐

Question 6b. Are year 11 and 12 receiving any drug education?

Yes ☐ No ☐ Unknown ☐

If Yes which groups?

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**Question 7** Place a tick next to the KLAs that cover/teach drug education?

PD/H/PE	--
Religion	--
Science	--
English	--
LOTE	--
Creative Arts	--
TAS	--
HSIE	--
Special education	--

**Question 8.** How many of your staff have been inserviced in drug education?

PD/H/PE	-----
-----	-----

(Other Departments PLEASE PRINT)

**Question 9.** What sort of priority does your school have to incorporate drug education into the school programming?

(Place an x on the line where you think the priority lies)

Low-----High

**Question 10.** Does your school conduct a peer support programme?

Yes    ☐       No    ☐

If yes in what ways does this programme contribute to the drug education programme in the school?

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**Question 11.** Are there any students who do not receive drug education at this school?

Yes    ☐       No    ☐                      Unknown    ☐

**Question 12.** Is there a teaching programme for drug education for years 7 to 12?

Yes    ☐       No    ☐                      Unknown    ☐

**Question 13.** What is your general focus of lessons in drug education for the following years?

YEAR	Focus of lessons
7	Eg. Analgesics
8	Eg. Tobacco
9	
10	
11	
12	

**Question 14.** Are you familiar with the Harm Minimisation approach to drug education?  
Yes    ☐        No    ☐

If you have answered Yes please explain how.

If you have said no what approach do you use in your drug education programme?



Question 15. When formulating your drug education programme at your school which groups were consulted?

PD/H/PE teachers	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Drug committee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Library staff	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Students	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Parents &Friends.	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Drug Education Committee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Religious Education Coordinator	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Principal	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
School Executive	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Others ( please state) _____				

Question 16. Has there been an evaluation done on your drug education programme?

Yes ☐ No ☐

If Yes when? \_\_\_\_\_

How was this evaluation done?

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Question 17. On the following graphs how would you rate your school's resources in the drug related areas? (Please Circle answer).

DRUGS

Alcohol	poor	inadequate	Adequate	Excellent
Tobacco	poor	inadequate	Adequate	Excellent
Marijuana	poor	inadequate	Adequate	Excellent
Illegal Drugs	poor	inadequate	Adequate	Excellent
Medications	poor	inadequate	Adequate	Excellent
legal Drugs	poor	inadequate	Adequate	Excellent
Other drugs	poor	inadequate	Adequate	Excellent

Question 18. List five of the best resources that you have used?

1 \_\_\_\_\_.

2 \_\_\_\_\_.

3 \_\_\_\_\_.

4 \_\_\_\_\_.

5 \_\_\_\_\_.

Question 19. Who is responsible for the choice of drug resources in your school?

Teachers PD/H/PE	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
A Parent/Teacher Committee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Library	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Drug Education Committee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
S.R.C	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pastoral Coordinators	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Others_____				

Question 20. Who is responsible for ordering drug resources?

Teachers PD/H/PE	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
A Parent/Teacher Committee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Library	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Drug Education Committee	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Pastoral Coordinators	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Others_____				

Question 21. Has your school developed a plan to spend money on drug resources?  
Yes ☐ No ☐

If yes please explain.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Question 22. Does your school have a drug education policy?

Yes    ☐       No    ☐       Do not know    ☐

Question 23. If Yes does the policy include the following areas?

PD/H/PE	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
Mathematics	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
Science	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
English	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
LOTE	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
Creative Arts	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
TAS	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>
HSIE	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Do not know	<input type="checkbox"/>

Question 24. Who is aware of the policy?

Question 25. Who initially formulated the policy?

Question 26. What inservices related to drug education has your department received?

Department	No Inservices	List of Inservices Attended
PD/H/PE		
Mathematics		
Science		
English		
LOTE		
Creative Arts		
TAS		
HSIE		

**Question 27.** Have any professional development courses or days in drug education been organised and held for the following groups?

Teaching Staff

Yes



No



If yes please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Ancillary Staff

Yes



No



If yes please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Parents

Yes



No



If yes please explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Students

Yes



No



If yes please explain:

\_\_\_\_\_

Community

Yes

9

No



If yes please explain:

---

Question 28. Have you referred students with drug problems?

Yes ☐ No ☐

If Yes to whom have you referred the student ? \_\_\_\_\_  
Did you follow up the students progress?

Yes ☐ No ☐

If No Why?

-----  
-----  
-----  
-----

Did you receive adequate feedback on the student?

Yes ☐ No ☐

If No Why?

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-----  
-----  
-----

Question 29. Are all the staff informed about all students with drug related problems?

Yes ☐ No ☐

If No Why?

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-----  
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29b. When dealing with drug education problems with students when do you know you are out of your depth?

-----  
-----  
-----  
-----



**Question 33** What would be the main drug concerns for your students in the following years?

School year	Drug concern
Year 7	
Year 8	
Year 9	
Years 10	
Year 11	
Year 12	

**Question 34.** Do you think that you know the current facts about drug education ?

Yes ☐ No ☐ and

**Current approaches**

Yes ☐ No ☐

**Question 35.** Does your drug education program meet the needs of your students? ( School make up ie. boy girl split, culture, religious beliefs)

Yes ☐ No ☐

**If yes please state how**

**If no please state why not?**



**Question 36.** How effective is your drug education programme in meeting the needs of both boys and girls at your school?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5 \_\_\_\_\_  
Not effective Very effective

**Question 37.** What part do the following people and organisations play in the drug education of your school?

(place an x on the line)

**Principal**

High level of assistance \_\_\_\_\_ very little assistance

**Assistant principal**

High level of assistance \_\_\_\_\_ very little assistance

**Parents**

High level of assistance \_\_\_\_\_ very little assistance

**Drug Education consultant**

High level of assistance \_\_\_\_\_ very little assistance

**Catholic Education office**

High level of assistance \_\_\_\_\_ very little assistance

**Pastoral Carers**

High level of assistance \_\_\_\_\_ very little assistance

**Subject Coordinators**

High level of assistance \_\_\_\_\_ very little assistance

**Year Coordinators**

High level of assistance \_\_\_\_\_ very little assistance

**Staff**

High level of assistance \_\_\_\_\_ very little assistance

**Religious education department**

High level of assistance \_\_\_\_\_ very little assistance

**Community groups ( Centacare , drug agencies, police etc)**

High level of assistance \_\_\_\_\_ very little assistance

Question 38. Could your drug education program be improved?  
Yes    ☐        No    ☐

Question 39. What needs to be done to carry out any improvements?

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Question 40. What can your CEO Drug consultant do to help?

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**EVALUATION OF QUESTIONNAIRE**  
Do you see anything that could be added to or taken away from this questionnaire?



## Appendix 7 - Drug education survey for students (Hetherington & Sparks, 1996)

1. I am a ☐ Male ☐ Female ( please tick)
2. I am in year 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐
3. My age is 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐

# TOBACCO SURVEY

4. Which members of your family smoke? (please tick)
- ☐ Father      ☐ Mother      ☐ Brother      ☐ Sister  
☐ No family members smoke?
5. Have you ever smoked, even once?
- Yes ☐      No ☐  
If yes go to 6      If no go to 14
6. Only once ☐      Less then 10 times ☐      More then 10 times ☐  
Day before this survey ☐ Week before this survey ☐      Month before this survey ☐
7. Do you smoke on a regular basis?      Yes ☐      No ☐
8. If yes how many per day (please tick)
- less than 5 ☐      5-10 ☐      10-20 ☐      more than 20 cigarettes ☐
9. If yes, Do your parents know you smoke?
- Yes ☐      No ☐      I do not know ☐
10. Do your parents approve of you smoking?
- Yes ☐      No ☐      I do not know ☐
11. At what age did you start to smoke tobacco? \_\_\_\_ years.

a) To get a reputation ☐ b) To be accepted ☐  
c) To fit in with a group ☐ d) Because friends did it ☐  
e) To see what it was like ☐ f) The fun of trying it ☐  
g) Because I enjoy it ☐ h) It feels good ☐  
i) Because it's cool ☐ j) To handle family problems ☐  
k) To help with stress ☐ l) Because of the image ☐  
m) Other reason \_\_\_\_\_

If yes have you ever tried to stop?    Yes ☐                      No ☐

What have you tried/what helped?

place an x on the following graph at the danger level.

no 0 1 2 3 4 5 extremely  
danger dangerous

## ALCOHOL SURVEY

16. When was the last time that you had a drink?

Day before this survey ☐      Week before ☐      Month before. ☐

17. If you have consumed alcohol in the last week how many times? (please tick).

1-2 ☐                      3-5 ☐                      6-9 ☐                      10 plus ☐

How many drinks would you drink on average each time?

1-2 ☐                      3-5 ☐                      6-9 ☐                      10 plus ☐

---

Mon ☐    Tues ☐    Wed ☐    Thur ☐    Fri ☐    Sat ☐    Sun. ☐

a) To get a reputation ☐ b) To be accepted ☐

c) To fit in with a group ☐ d) Because friends did it ☐

e) To see what it was like ☐ f) The fun of trying it ☐

g) Because I enjoy it ☐ h) It feels good ☐

I) Because it's cool ☐ j) To handle family problems ☐

k) To help with stress ☐ l) Other reason \_\_\_\_\_

If you said no, why did you give it up?

If you said yes, have you ever tried to stop/what helped?

Yes ☐ No ☐

no 0 1 2 3 4 5 extremely  
danger . dangerous

Yes ☐ No ☐

Only tried once ever ☐ Only a few times ☐ use weekly ☐ use Monthly ☐ .

25. How much do you smoke on average per day?(please tick)

1-2 ☐

3-5 ☐6-9 ☐

10+ ☐

26. Why did you start smoking marijuana?

a) To get a reputation □

b) To be accepted ☐

c) To fit in with a group ☐

d) Because friends did it ☐

e) To see what it was like □

f) The fun of trying it ☐

g) Because I enjoy it ☐

h) It feels good ☐

i) Because it's cool □

j) To handle family problems ☐

k) To help with stress ☐

1) Other reason \_\_\_\_\_

27. Do you still use marijuana? Yes ☐

No ☐

If you said no, why did you give it up?

---

\_\_\_\_\_

If you said have you tried to stop/what helped?

---

---

28. Do you see marijuana as being dangerous?

Yes ☐

No ☐

place an x on the following graph at the danger level.

no 0 1 2 3 4 5 extremely  
danger dangerous

29. Which of the following drugs have you ever used? (Not medically prescribed) even if you have used them only once.

a) Deliberately sniffed or inhaled from spray cans, (glue, petrol, thinners.)

Yes ☐No ☐Weekly ☐Monthly ☐

Occasionally  $\square$

Once only ☐

b) **Amphetamines** ( also known as speed, "go-ee", "whizz")

Yes ☐No ☐Weekly ☐Monthly ☐Occasionally ☐

Once only ☐

c) **Hallucinogens** ( also know as Acid, LSD, Magic mushrooms)

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

d) **Analgesics** ( Legal painkillers eg cough syrups, aspirin, panadol )

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

e) **Ecstasy**

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

f) **Steroids**

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

g) **Heroin**

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

h) **Cocaine**

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

i) **Trocanol**

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

j) **Diet pills**

		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>

k) **Others** please specify

---

Weekly <input type="checkbox"/>	Monthly <input type="checkbox"/>	Occasionally <input type="checkbox"/>	Once only <input type="checkbox"/>
---------------------------------	----------------------------------	---------------------------------------	------------------------------------



30. Have you received drug education classes at your school?

Yes ☐ No ☐

If yes have you learnt about ( please tick as many as you require.)

Alcohol ☐ Tobacco ☐ Marijuana ☐ Amphetamines ☐  
Heroin ☐ Steroids ☐ Inhalants ☐ Others \_\_\_\_\_.

31. Do you think that the information given to you at school in drug education classes will stop you from using drugs?

Yes ☐ No ☐

32. Do you think that the information given to you at school in drug education classes will help you to make sound decisions on your own drug use?

Yes ☐ No ☐

33. If you had a drug problem to whom would you talk to about it?  
(please tick answer)

- Parent ☐
- trusted teacher ☐
- Partner ☐
- pastoral care teacher ☐
- Friend ☐
- other students ☐
- PD/H/PE Teacher ☐
- Priest ☐
- No one ☐
- Other \_\_\_\_\_

34. How do you think drug education should be taught to you at high school?

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All INFORMATION IS CONFIDENTIAL.

## **Appendix 8 - Interview focus questions**

- What do you understand by the term 'Health Promoting School'?
- What things happen in this school (inside and outside the classroom) to promote health?
- What other things would you like to see around the school?
- What do you consider are your most important health needs?
- What can be done to ensure these health needs are addressed at Pentecost College?
- Comment on any health promotion initiatives in which you have been directly involved. For example: Sun Safety - Melanoma Awareness Day, QUIT, STAR, Blood Bank, Immunisation, Bullying and Harassment.
- What do you see as the barriers to optimal health?
- Do you have any suggestions as to how to overcome these barriers?
- What opportunities have you had to provide input into the promotion of any health initiative?
- How can you get involved in promoting health within the school?



**Appendix 9 - Pentecost College handbook outline showing existing health promotion policies and programs**

PHILOSOPHY					
Emblem, Motto, Vision Statement, Marist/Josephite Link, Liturgies CEO.					
ADMINISTRATION	PASTORAL CARE	CURRICULUM	STAFF DEVELOPMENT	COMMUNITY	EVALUATION
Staff List Role Descriptions Executive KLA Co-ordinators Year Co-ordinators Staff Communication Bulletins Meetings Timetable Daily Routines Bells Rooming Subject Selection 3/4 Unit Classes Staff Attendance Staff Appointments Calendar Office Management Copyright Book Hire Maintenance & Buildings Printing Finance Security Casual Teachers Student Teachers	Pastoral Care System Detention Awards Leadership SRC Peer Support Camps & Retreats New Students Enrolments Year 7 Orientation Student Communication (Assemblies) Student Attendance (Roll Marking) Uniform Transport Student Supervision Aids Centacare Child Abuse Harassment Drugs Weapons Illness/Injury/First Aid Critical Events Student Health Canteen Sun Protection	Writing Reading Spelling Homework Excursions Assessment Exam Procedures Exam Supervision Study Skills Students With Special Needs Special Education ESL Equity Education Gifted & Talented Remediation Equal Opportunity Multicultural Aboriginal Gender Equity Environment Technology Occupational Health & Safety Resource Centre Sport Houses Post Compulsory Education Extra Curricular Year Book Drama, Calas etc. Work Experience	Staff Development Days In-servicing Staff Meetings Beginning Teachers Experienced Teachers Promotions & Appointments Staff Appraisal	Parent Communication Newsletters Reporting Parent Liaison Parents & Friends College Foundation Parish Links Feeder Schools Links Catholic Education Office Community Participation Visitors Charities	Executive Meetings KLA Meetings Year Meetings Staff Meetings Specific Committees Co-ordinator Interviews Surveys Annual Report



## Appendix 10 - HPS checklist

Tick the box which best describes your school's situation.

Yes: if the school has an existing policy or program in this area

**Review needed:** if the existing policy or program needs updating

**Priority (1,2,3):** whether the priority given to the review should be:  
1 (high) 2 (medium) or 3 (low)

**No:** if no policy or program currently exists, or it is not appropriate

## 1.The formal curriculum

### 1.1 The PDHPE curriculum

*Indicate whether your school's PDHPE program shows the following features.*

A vision and rationale for the PDHPE program is clearly stated, widely accepted and commonly shared by staff

The PDHPE program reflects the priorities of the school community with input from students, staff, parents, caregivers and community members

The PDHPE program is comprehensive, sequentially developed and includes a variety of health content

The PDHPE program includes a balance of health knowledge, skills and values relevant to students' needs

Teachers use a variety of PDHPE process skills in the classroom such as: esteem building, communicating, interacting, decision making, problem solving, moving and performing

Regular PDHPE inservice courses are conducted to update and increase teachers' knowledge and skills

All K-6 students participate regularly in PDHPE activities  
or All 7-10 students receive at least 300 hours of PDHPE

Senior students are able to choose a PDHPE course or related area of study

Parents and caregivers are informed of the PDHPE content to be taught, including sensitive issues

The school has a procedure to regularly review the school's PDHPE program which is coordinated by a nominated person or persons

The PDHPE budget is sufficient to provide a range of resources to support a comprehensive, integrated approach to teaching in this key learning area

Yes  
Review Needed  
Priority (1,2,3)  
No

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--	--	--	--

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--	--	--	--

--	--	--	--

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1.2 Other aspects of the school curriculum

Indicate any other significant features of your school's curriculum.

	Yes	Review Needed	Priority (1,2,3)	No
All students participate in meaningful daily physical activity, e.g. walking, lunch time activities, planned fitness program				
The school sport program balances competitive and recreational activities and reflects the needs of students				
Support staff (e.g. counsellors, itinerant teachers ) provide assistance to class teachers for students with special needs				
Peer leadership programs are organised to give student training and support for peer intervention health programs				
Health promotion activities are identified in all key learning areas, e.g. leadership skills, social skills, self-esteem				
PDHPE is regularly integrated with events outside the classroom, e.g. class activities with the school canteen				
The curriculum is supported by school policies, procedures and practices, e.g. staff as role models, sun protection policy				
Other (please list) _____				
_____				
_____				
_____				
_____				
_____				

2.School ethos

2.1 School policies and procedures

Indicate whether your school has the following policies and procedures.

	Yes	Review Needed	Priority (1,2,3)	No
The school has a formal planning team that meets routinely to monitor and initiate programs to promote health within the school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time is provided to allow the planning team to meet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health promotion is a continuing priority component of the school's management (or strategic) plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The school has a written action plan of health promotion activities, e.g. heart week activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School administrators are well informed of health promotion activities and issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Students are involved in the planning and implementation of whole school health events, e.g. through the SRC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The school is a member of health promotion associations e.g. NSW Health Promoting School and NSW School Canteen Associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The school has a critical incident policy to deal with issues such as death, suicide, fire and accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug and alcohol guidelines are implemented, e.g. tobacco, alcohol, legal and illegal drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The school has an anti-violence strategy in place to deal with discrimination, bullying and sexual harassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The school has first aid procedures and policies in place to deal with: injuries; HIV positive students; staff or students with special health needs; and the administration of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The school demonstrates an awareness of environmental issues, e.g. the school recycles, uses environmentally friendly products, controls litter, provides curriculum support, has introduced a greening program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



	Yes	Review Needed	Priority (1,2,3)	No
Guidelines for sports safety are in place, e.g. playing surfaces are well maintained, protective equipment is provided, sport coaches are accredited in first aid				
The school has a sun protection policy, e.g. no hat —play in the shade, shelter is provided, restructuring of the timetable for outside activities during peak times of ultra-violet radiation				
The school canteen implements a healthy canteen policy				
The school has implemented policies for child protection, e.g. mandatory notification procedures, professional development for staff				
The school’s plans and policies address occupational health and safety issues				
The school demonstrates an awareness of other safety issues e.g. safe routes to and from school, tap water does not exceed 50 degrees C, safe storage or removal of all medications and noxious chemicals, maintenance of all play equipment				
Other (please list) _____				
_____				
_____				

## 2.2 The social environment

*Indicate the main features of your school’s social environment.*

Positive relationships amongst staff, students, and staff and students, are encouraged				
Positive relationships amongst school personnel, parents, caregivers and the community are promoted				
Social, sporting and academic success for all students and staff is promoted				

2.3 The physical environment

Indicate the main features of your school's physical environment.

The school has access to both outside and covered facilities for PE lessons

Yes	Review Needed	Priority (1,2,3)	No

Regular monitoring procedures are in place to review safety aspects in the following areas:

- Sanitation
- School buildings
- Lighting
- Heating or cooling systems
- Rubbish removal
- Noise control
- Attractiveness and cleanliness
- Landscaping
- Playing fields and grassed areas
- PE and sporting equipment


Regular monitoring procedures are in place to review and assess the playground area, for example:

- Adequate soft fall undersurfacing (300mm if over 600mm high)
- Safe fall zone (3m from equipment to hard surface)
- No exposed bolts, sharp edges
- Terrain checks, e.g. asphalt surfaces, paths, grass


The school involves members of the school community in activities to enhance the physical environment

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Other (please list)


	Yes	Review Needed	Priority (1,2,3)	No
The school reflects the cultural values of the school community				
The school displays students' work and recognises all the achievements of students and staff				
The school newsletter contains regular items about its progress towards a health promoting school				
The school provides a safe, stimulating and welcoming environment				
Teachers and students act as role models of healthy behaviours				
The school encourages and values contributions by students, staff, parents, caregivers and the community to the life of the school				
Maximum opportunities are taken to interact with students outside the classroom				
The school actively promotes the health and well-being of staff in the workplace by providing:				
Healthy food choices in the canteen, at catered functions, school development days				
Access at school to smoking cessation classes				
Opportunities to take part in programs of physical activity, weight loss or weight gain				
Routine programs for health screening of staff and for referral, counselling and rehabilitation				
Talks by guest speakers on health issues as required, e.g. stress management				
Other (please list) _____				
_____				
_____				

3.The school-home-community interface

3.1 School, home and community health promotion partnerships

Indicate the main features of health promotion partnerships amongst the school, the home and the community.

	Yes	Review Needed	Priority (1,2,3)	No
The school has regular communication links with community support services, e.g. local community health centre, local council, police				
Students are regularly informed and have the opportunity to participate in community activities				
Community support services, such as the school nurse, are routinely involved in health promotion programs, e.g. classroom activities, inservice courses, seminars, school development days				
Parents are regularly informed and have the opportunity to participate in school activities				
Partnerships reflect and represent the diverse range of cultural groups in the local community				
Resources are shared between the school and community				
Parents and community members are encouraged to be involved in decision making and policy development within the school				
Local newsletters, radio and TV are used to communicate and promote school activities to the community				
Health personnel work closely with school staff and parents to meet the special health needs of students				
The school regularly liaises with parents, caregivers and the community				
Other (please list) _____				
_____				
_____				

3.2 School health support services

Indicate the main features of your school's health services.

The school has procedures for the identification and referral of students with specific health needs, for example:

	Yes	Review Needed	Priority (1,2,3)	No
Divorce and family problems				
Drug and alcohol use by students				
Teenage sexuality and relationships				
Family planning and pregnancy counselling				
Anxiety and depression				
Suicide				
Students' concerns about their friends				
Neglect and sexual, emotional and physical abuse				
Career counselling				
Learning disabilities				
Academic counselling				
Grief and loss counselling				
Behaviour problems				
Youth employment				
Non-attendance at school				
 The school encourages and supports the ongoing follow-up of students and families with specific health needs				
 Community support services are involved in the inservice of the school community on specific health needs				
 The school involves community support services in the development of policies and procedures relating to specific health needs				
Other (please list) _____				
_____				
_____				

Adapted from: Western Australia School Health Project-Healthy School Index  
ACHPER Project, 1994.

Appendix 11 – Updated HPS parent questionnaire  
(NSW Dept. of Health et al, 1996)

Health promoting school questionnaire

In your opinion how important are the following activities in our school for developing the health and well-being of students?

PDHPE programs about:

Fitness and lifestyle

e.g. balancing exercise, nutrition, physical fitness, relaxation, rest and recreation, practical fitness activities

Very important	Important	Not important	Don't know

Growth and development

e.g. physical, social and emotional change, healthy eating, sexuality, illness and disease

--	--	--	--

Interpersonal relationships

e.g. family life, friendships, nature of relationships and the development of effective interpersonal skills

--	--	--	--

Personal awareness

e.g. the way individuals see themselves, self-esteem, communication skills, stress management, goal setting

--	--	--	--

Personal health choices

e.g. making decisions about lifestyle behaviours, nutrition, drug use, sexuality

--	--	--	--

Physical education

e.g. fitness testing and developing skills in aquatics, games, gymnastics, dance, athletics

--	--	--	--

Promoting health

e.g. lifestyle diseases, environmental issues, health promotion campaigns, community health issues

--	--	--	--

Safe living

e.g. injury prevention, water safety, road safety, child protection, first aid, survival skills

--	--	--	--

A healthy physical environment

e.g. improving the school grounds, developing a safe environment, recycling, reduced packaging

--	--	--	--

A healthy social environment

e.g. promoting good relationships, recognising the achievements of students and staff, anti-violence procedures

--	--	--	--

**Student participation in school decision making**

*e.g. student representatives on committees, SRC, leadership programs*

Very important	Important	Not important	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Participation by parents, caregivers and the community in school decision making and activities**

*e.g. parent representatives on committees, parent groups, parent education, use of local health services*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

**School policies and practices which support health promotion**

*e.g. No hat—play in the shade, healthy canteen, first aid officer, injury prevention, road safety procedures*

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------

*What benefits do you think would result from the introduction of "health promoting school" activities?*

Healthier children

Yes	No	Don't know
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

We would know where to get help

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

It would be good for parents to hear speakers on health issues

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

We would know that the students, staff and parents are working together for better health

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------

*Any other comments:* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What type of health activities would you like to be involved in?**

*Please rank the activities in order of preference.*

- 1 - being the activity you would be most likely to attend and  
10 - the activity you would be least likely to attend.

Meeting of a parent group with a visiting speaker	<input type="checkbox"/>	Day	<input type="checkbox"/>
		Night	<input type="checkbox"/>
Assisting in developing a school policy	<input type="checkbox"/>		
Explanation of the Personal Development, Health and Physical Education syllabus	<input type="checkbox"/>		
A specific health day <i>e.g. Accident Awareness Day, Children's Day</i>	<input type="checkbox"/>		
Classroom activity <i>e.g. PE or nutrition lesson, class luncheon</i>	<input type="checkbox"/>		
Serving as a member of the school health committee	<input type="checkbox"/>	Day	<input type="checkbox"/>
		Night	<input type="checkbox"/>
Courses for parents	<input type="checkbox"/>	Day	<input type="checkbox"/>
		Night	<input type="checkbox"/>
Working bees to improve the school environment	<input type="checkbox"/>	Weekday	<input type="checkbox"/>
		Weekend	<input type="checkbox"/>
School canteen food expo	<input type="checkbox"/>	Weekday	<input type="checkbox"/>
		Weekend	<input type="checkbox"/>
Health promoting school expo	<input type="checkbox"/>	Weekday	<input type="checkbox"/>
		Weekend	<input type="checkbox"/>

Any other comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Child's Class (If more than one child, record each class)**

First Child \_\_\_\_\_ Second Child \_\_\_\_\_ Third Child \_\_\_\_\_

*Thank you for taking the time to fill in this questionnaire.*

*Adapted from: A school community questionnaire, Health Promotion Unit, Eastern Sydney Area Health Service.*





## Appendix 12 - Drug use summary report (Hetherington & Sparks, 1996)

The drugs survey conducted at College surveyed 524 students 270 males and 254 females. The age of the students ranged from 12 to 19 years covering Year 7 through to year 12.

### Tobacco Survey

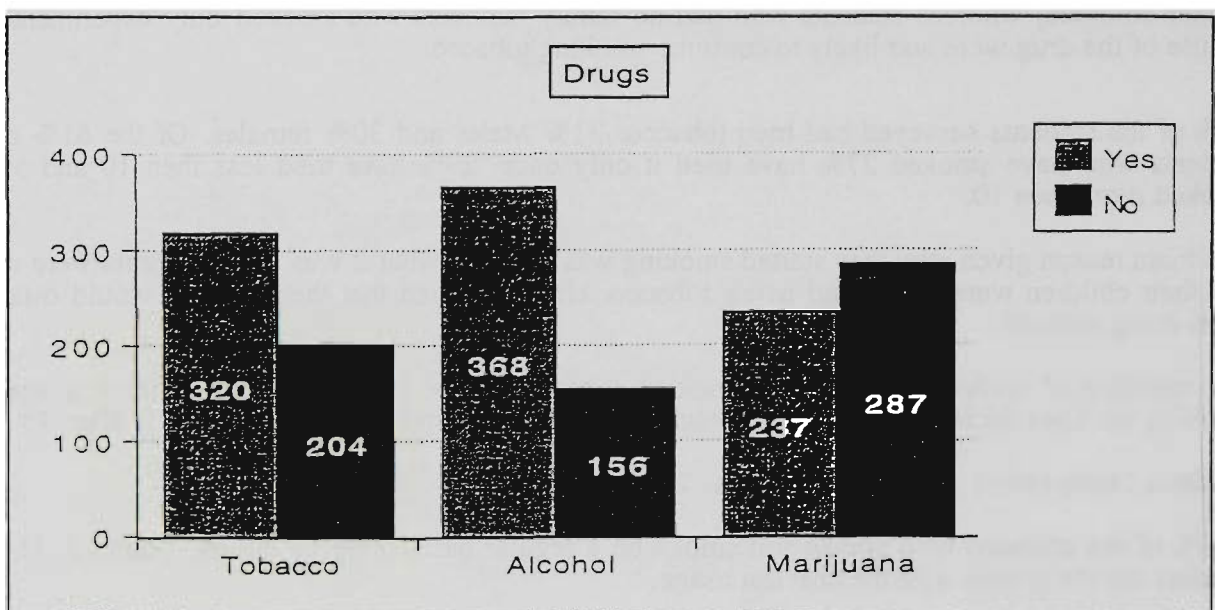
- The survey revealed that students who had parents who smoked were more likely to continue to become regular smokers, whereas students who had no family members who smoked only experimented with the use of the drug were less likely to continue smoking tobacco.
- 61% of the students surveyed had tried tobacco. 31% Males and 30% females. Of the 61% of those students who have smoked 27% have tried it only once, 29% have tried less than 10 and 5% have smoked more than 10.
- The main reason given why they started smoking was "To see what it was like." Parents were unaware that their children were trying and using tobacco. children stated that their parents would disagree with them using tobacco.
- The majority of students commenced smoking tobacco at 13-14 years of age. After this age group smoking for boys declined rapidly, girls reached a peak at 15 years and declined rapidly after 15 years.
- Students commenced smoking as young as 7 years of age.
- 35.9% of the students who smoke still smoke on a regular basis. Year 10 males, Years 10, 11 and 12 females are the groups with the heaviest usage.
- Students viewed the danger level of smoking as 4-5 out of 0-5 scale.

### Alcohol

- 70.2% of the students surveyed have tried alcohol making it the most commonly used drug.
- Binge drinking starts in year 8 and continues through 9, 10, 11 and 12. Heaviest binge drinking occurs year 10 boys, year 11 boys and year 12 girls.
- Beer most commonly used alcohol in years 7 to 10, spirits were most common alcohol in years 11 and 12.
- The most popular days to consume alcohol were Friday and Saturday nights.
- The main reasons given for trying alcohol were "To see what it was like" and "The fun of trying it."
- Students viewed the danger level of alcohol as 4 out of 0-5 scale.

## Marijuana

- 45.2% of the students surveyed have tried marijuana.
- Females used the drug more than males. Seniors more than juniors.
- Majority of students who used the drug used it monthly sighting cost the main reason.
- The main reasons given for trying the drug were “To see what it was like”, “The fun of trying it” and “It feels good.”
- Students viewed the danger level of marijuana as 4-5 out of 0-5 scale.



## OTHER DRUGS

- 18.7% of the students surveyed have used inhalants.
- 3.6% of the students surveyed have used amphetamines.
- 2.4% of the students surveyed have used hallucinogens.
- 39.5% of the students surveyed have used analgesics.
- 0.5% of the students surveyed have used ecstasy.
- 0.1% of the students surveyed have used steroids.
- 1.1% of the students surveyed have used heroin.
- 1.5% of the students surveyed have used cocaine.
- 0.9% of the students surveyed have used diet pills.

## HOW DO YOU THINK DRUG EDUCATION SHOULD BE TAUGHT? - WHAT THE STUDENTS SAID!

It should be taught to show the bad (side) affects. They should be taught to far outweigh the good. Hence making people stop or not start.

Not being so pushy and telling you what to do, just advise you on what to do.

The way that I think drug education should be taught at school is by telling the students the effects that can happen, the dangers, how to make the right decision and to say no to people that sell drugs.

Perhaps to show the effects of over usage in a way that will interest students and not bore them. To teach about drinking in moderation and not to abandon drinking altogether.

Firstly kids should be told it's their own choice, or often they do it simply because they are not allowed. Try to scare kids from an early age, even try to make the good side of drugs scary. e.g. with hallucinogens "when you're high you start to see scary things and you may not know where you are", or "two out of three who smoke pot before they are 18 become schizophrenic".

It should be taught so that it tells teenagers that it is bad for their health and could kill them, so teenagers think twice before taking it.

Teenagers are going to experiment no matter what you tell us. So you may as well teach us how to do it SAFELY!! Ignoring drugs, alcohol and sex problems won't make them go away.

Taught by you people who have had drug problems in the past.

The way it is now. We are taught of the dangers of drug use and of the importance of safe drug use if you're going to do it.

I feel that the drug education programs taught at schools should be updated and in a format that kids can relate to and feel comfortable with. Not only should there be formal drug education lessons in PD/H/PE classes, but I think that a concept of "students helping students" should be developed. Senior students should be used to help educate younger students and their peers feel free to ask question which directly relate to them. Educational programs such as the Anna Wood Foundation should be used.

In a way that shows people the consequences of taking drugs. A bit of alcohol doesn't hurt, it's those who abuse it that give it a bad name. People should be told what drugs do to your brain and state of health

You shouldn't say not to take it because people will. Kids only take drugs because they are told not to.

I think there should be a greater awareness of drugs, cigarettes and alcohol. I know a lot of people who smoke and drink under age. Videos and activities will get some kids attention and drugs should be dealt with in a serious manner.

People who have experienced these situations and have overcome them should educate us because it is first hand information.

They should show you what actually happens to drug users, how much they change. They should just basically tell the truth about how drugs effect people.

Teach adolescents that alcohol, if used in moderation can be nice. But don't give in to peer pressure. It should be taught by giving examples of incidents that have occurred by using the drug.

It should be taught throughout the whole year because I have learnt about it in PE/PD/Health and not everyone does this subject.

I think that most of it is right, but how marijuana is talked about so badly is wrong. If you use it in moderation it does not affect you at all. More emphasis should be on the worse drugs which can kill you or stuff your brain up.

Yes they should tell you about the drugs so at least you know what it is doing to your system. I don't think drugs are bad, I think they have to be handled properly though.

Just like sex education (but without parents).

I think the students should be given the facts and the decision that drugs are good or bad should be left to the individual.

Get people to come and talk to us, e.g. people who have been affected by alcohol, drugs etc.

We should be taught what drugs are being consumed in the society that we will grow up in, so that we know what to avoid and what's harmless. If we get a better understanding of these drugs and alcohol in society we'll know how to react when we're offered.

To actually have a person who has converted from being a drug addict to a healthy, responsible person come in and give their testimony would certainly change decisions by students who are under that pressure to conform to drugs or regular intakes of alcohol.

Should be talked about on a regular basis. Should use real life videos on what happens and the effects it has on the person taking them.

Talk to reformed addicts, don't soften it, and teach the street names otherwise kids can be tricked into it.

It should be taught as early as possible and be as truthful and factual as possible. Plus there should be occasional reteaching in case information is forgotten and also to reinforce what has been taught. It should cover all types of drugs not just the well known illegal ones.

More lessons, with maybe videos/demos, they can tell us not to do it, but you don't know what it does until you see it happen in real life.

Basically how bad it is. But not to stress that you should never do it. Because that will just make people more determined to try them.

Yes, it should be less preached to us, everyone just turns off. It should be taught to us in such a way that catches out interest and attention. The program they have at school is so boring no one really pays attention - it's just writing definitions and the causes and results - nothing that really connects with us personally.

Yes definitely but they need to pay more attention to the harmful effects and generally say that it's no good. But there is always going to be people - teenagers wanting to experiment and find out and use different and dangerous drugs.

I think Marijuana should be more targeted against. It is a very commonly used drug, and through programs at school I have not really learnt why marijuana is bad, only not to use it. I think we should be told why it is bad. We have only really learnt about the effects of harder drugs. These could still be elaborated on.

I think that a comprehensive education on drugs should be given. The format doesn't really matter, because everyone will listen, but it should be comprehensive, covering ALL drugs.

The system now being used I think it is effective and I see no need to changing the way it is taught.

Make it fun to learn but at the same time look at the really serious side of things so that students get shocked and that's the only way they will learn.

I think drug education is a serious thing but because it is always taught boringly, you don't get interested and so switch off and do something else.

Presentations e.g. Higher Ground. They are entertaining and informative.

My school, College, has taught me nothing about Drugs like Marijuana, Heroin, Cocaine etc. It has only taught me things about alcohol and smoking (which I knew anyway). I think we should get told about all the drugs. Each one specifically. What they look/smell like, and the effects they have on you - long term and short term. I have been thinking about trying marijuana to get a high, but I don't know anything about it, so I don't want to endanger myself because for all I know 80% of people that try it could have allergic reactions to it and die - I don't know!! I want to be educated - before I leave high school!!

Videos, real life stories, being able to look at the real drugs, seeing is believing, lots of facts and harmful evidence.

I think it should run over all the years you are at high school and each year increase as you're older because with each year you become more in contact with drugs and alcohol. In the senior years the information should be in greater depth.

In a relaxed way where there is no pressure or no demands that drugs are wrong because students will only put their guards up. The teacher should also come up with ways to give students ways in which to control or limit their drug use just in case one of the students does have a serious problem.

They shouldn't hide the truth. Tell all the reasons why teenagers try it, and why they don't. Don't just say "don't do it" because that's not enough to stop them from trying it.

Pretty much in the sense of using students our age, like skaters and hip hoppers, so we can relate to people who we connect to.

### CONCLUSIONS AND RECOMMENDATIONS

The role of school education in promoting health and well-being is a complex one particularly in the area of Drug Education. The potential exists within the key learning area of Personal Development, Health and Physical Education to look at the issues of Drug Education specifically within the content strands of personal choice, promoting health and safe living.

Drug Education however should not be isolated to this one key learning area. The responsibility of such an important and relevant issue requires a shared partnership between all teachers, parents and students focusing on mutual support, involvement and participation.

*'When there is partnership within a school community, there is a richness flowing from diversities present, culminating in a wholistic development of each student.'* (Towards Wholeness Pg 23)

The utilisation of outside agencies such as Centacare and the Youth Drug and Alcohol Service are also essential to this partnership providing expertise that schools themselves may be lacking.

The major findings of the Needs Analyses for College were:

- The most commonly used drug was alcohol with 70.2% of students surveyed having tried it. The concerning factor over use of alcohol was that binge drinking (4 or more drinks in the one session) started as early as year 8 and progressed steadily through to year 12.
- 35.9% of students surveyed still smoke on a regular basis with year 10, 11 and 12 being the heaviest users. Marijuana has been tried by close to half of the respondents (45.2%) with females once again being the biggest users of this drug.
- Students despite using alcohol, tobacco and marijuana still rated all of these as highly dangerous when asked to place them on a danger scale.
- The two other drugs of concern were the use of analgesics (39.5%) and inhalants (18.7%) by respondents. Analgesic use that was not medically prescribed was an issue in need of response.
- All drugs of highest use are legal drugs except for marijuana and certainly should demand the most time as far as programming in schools.
- The illegal drugs such as ecstasy, heroin, cocaine, amphetamines etc. reported minimal usage and although still important in terms of education the teaching of these should not dominate curriculum time.
- The most common reasons for students in years 7 and 8 for using alcohol, tobacco and marijuana was to 'see what it was like'. This tended to be a common response for all year groups although from year 10 onwards the reasons started to push toward 'because I enjoy it' or 'the fun of trying it'.
- The majority of students indicated that they had received drug education at school with over 88% of students being exposed to lessons by senior school. The majority of students also reported that the information presented in drug education lessons would help them make sound decisions regarding their own drug use.
- Year group responses tended to decline from year 7 when asked if drug education lessons would stop them from using drugs. Year 7 (75.8%) would stop, Year 8 (65.8%), year 9 (40%), year 10 (28.8%), year 11 (23.7%) and year 12 (39.5%).

#### WHAT THE STUDENTS SAID ABOUT DRUG EDUCATION

The students wanted to know the facts about Drug Education, the consequences and effects of taking drugs. They emphasised the need to teach Drug Education on a regular basis with effective lessons involving guest speakers, videos and people who are streetwise about drugs.



## WHAT THE TEACHERS SAID ABOUT DRUG EDUCATION

The teachers emphasised the need for professional development opportunities particularly non PDHPE teachers such as Pastoral Care Coordinators. They highlighted the need for continual resourcing in this area and the importance of linking existing programs to match the students' needs. Also coming out was the uncertainty about referring students with problems and their role in the counselling process. The need for Drug Education Policy was also raised to provide guidelines and structures within the school and even the Diocese. Other issues raised included the concern that formal drug education stopped at year 10 and limited opportunities were provided to our senior students.

Drug Education Programs at \_\_\_\_\_ College should reflect an understanding of the student population and be sensitive to gender and age differences. The programs should focus on the drugs of most common use which in this case are alcohol, tobacco and marijuana. There is also a need to provide relevant information on all other drugs without heightening curiosity toward these drugs.

The programs at \_\_\_\_\_ should encompass the strategies of harm minimisation which have the aim to reduce harmful or hazardous drug use by young people. Harm minimisation aims to influence student behaviour by focusing on safe, responsible drug use (in terms of legal and over the counter use) and non use of illegal drugs.

Harm minimisation is a central theme behind strategies incorporated into resources received by \_\_\_\_\_ College. The quality of the educational experience is vital to the success of Drug Education and is summed up by the following strategies from the research of Jeff Wragg from the University of Wollongong.

*'Successful Drug Education Programs should incorporate strategies to:*

- increase student knowledge and skills of health-enhancing behaviours and to develop and reinforce attitudes favourable to a healthy lifestyle. The latter should include social support and raising the accessibility of health-enhancing activities;*
- enlarge a student's repertoire of skills in decision-making, coping refusals and assertiveness; and*
- increase students' commitment to minimal, safe drug use.*

There is a need to commence Drug Education prior to year 9 where drug use begins to expand. This also has greater implications for primary schools who need to look at sequential programs for students before they enter the secondary school environment.

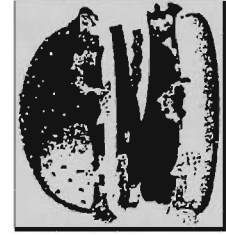
The programs at \_\_\_\_\_ College should involve all teachers and look to parent evenings to keep all parties informed on the latest developments as well as providing an arena for discussion and clarification.

It is hoped that this needs analysis has provided specific insight into the current use and non-use of drugs coupled with student and teacher feedback about program effectiveness. It is now open to the school community of \_\_\_\_\_ College to use this information, resources and professional development opportunities to enable all students to make positive health decisions regarding drugs.

Appendix 13 - Pentecost College canteen menu

SANDWICHES	ROLL	SALAD PLATE	HOT FOOD
Vegemite	.80	Salad Plate	Chicken Burger
Peanut Butter	.80	Extras Ham, Chicken, Egg, Salmon	Vegetarian Burger with Lettuce & Mayo
Baked Beans	.80		Pizza Ham & Pineapple
Tomatoe	.80		Pizza Supreme
Egg	.90		Rounders Pizza Chicken
Ham	1.00		Beef
Cheese	.80		Lasagne
Salmon	1.30		Lge Spinach Rolls
Chicken	1.20		Lge Ham, Cheese & pine
Egg & Lettuce	1.20	Available every day	Sausage Rolls
Tomatoe & Lettuce	1.20	Seasonal Prices	Meat Pie
Vegetarian Salad	1.30	Fruit Salad (Summer)	Potato Pie
Chicken Salad	1.60	Seasonal Prices	Ham & Cheese Pie
Salmon Salad	1.80		Corn on the Cob
Lavash Salad	1.60		Hot Dogs (MONDAYS)
			Tomato Sauce
			Spoons (extra)

SANDWICH EXTRAS	CAKES	DRINKS
Coleslaw	Custard Tarts	Plain Milk
Cheese	Finger Bun	Flavoured Moove (300ml)
Lettuce	Chelsea Bun	Flavoured Moove (600ml)
Mayo	Sultana Scones	Oak Milk
Sprouts	Plain Bread Rolls	Milo (300ml)
Cucumber	Cheese Top Roll	Dare
Onion	Big Bites	Water
Tomatoe	Chips	100% Orange Juice
		35% Juice
		Orange
		Orange/Mango
		Passio Nect
		100% Berri Popper
		Cans
		Sml Bottles
		Lge Bottles
		Mineral Water
		Gatorade



Lunch orders to be placed in the box BEFORE 10.30am. Late orders can be brought to the Canteen at Recess. Lunches are to be collected from the front door of the Canteen.

**PRICES SUBJECT TO CHANGE**



## **Appendix 14 - Perceived health needs for Pentecost College (Parents, Students and Staff)**

### **Responses from 140 parents**

#### **1. Health Promotion as a definition:**

Parents understanding of the concept covered a broad but limited range of responses. This may have depended on the experiences and the education of parents at the time.

##### **Quotes:**

- To develop an awareness, both personal and global.
- It is a feature, event or ongoing information of health and healthy foods.
- Choice of healthy foods and to be able to exercise.
- The school needs to set an example - healthy looking, 'clean' teachers, healthy food and living (no smoking, drugs etc.) and to encourage sport activities at lunchtimes.
- The mental, emotional, physical, social and spiritual growth of students.
- Stress Management courses to equip children with life skills.
- AIDS prevention and up-to-date information.
- Schools providing lockers to students to prevent/ease back injury and pain.
- Global health and a stable and caring environment.
- A curriculum and school spirit which provides a solid foundation for a metaphysical, spiritual and personal development which will in turn give the students the beginnings of cultural formation in line with the Christian philosophy, promoting healthy living.
- Workshops for helping parents deal with adolescence, suicide prevention, eating disorders, common illnesses and child abuse - the issues which affect parents and children today.
- We need to include the wider community in health promotion.
- The unique worth of the individual, providing rest and recreational places for students within the school community and promoting peace and order.
- Effective discipline process that teachers and students know how to modify their behaviour.
- Safe sex programs.

#### **2. Most important health needs of parents and caregivers:**

Responses again covered a wide range of health concerns. Generally parents agreed that programs, resources, expertise and funding needed to be allocated to ensure that the students' needs were addressed. Issues such as developing

stress management strategies, regular exercise, wider choice of healthy foods in the canteen and workshops for parents and students together were noted as important.

#### Quotes:

- The school needs to address the issue of personal stress for students of all ages.
- Mental health issues are just as important as the physical - perhaps even more so!
- Good leadership from teachers in health matters.
- Use students of non-English speaking families to inform them of diseases and how to promote healthy lifestyles.
- Continually identify students' changing needs at school - consult with parents and have the parents take on the responsibility of their children.
- Counselling needs to be made available to students and parents - someone with whom to debrief after difficulties at home.
- Structured exercise rather than simply playing games such as pool or bowling.
- Develop positive attitudes in students and to also provide some peace and safe space for students.
- Workshops/expert talks on relating with teenagers, drug and alcohol education.
- Spiritual development.
- Reduce the weight of school bags.
- School health services, knowledge and skill development for students with regards to their health needs.
- Healthy eating patterns which are developed from what is available in the canteen.
- Conflict resolution skills for all ages. We also need a 'Time-Out' area for students to help them think through their difficulties.
- A sound philosophy - 'Health is not a passive state of freedom from disease but an active condition of being. That is, the potential of the individual is developed in a balanced way to enable him/her to cope'.
- Adequate and comfortable seating and highlighting, programs to cope with anger, peaceful place to escape to, less noise in the classroom for learning.
- Face the problem of ethnic factionalism and drug use.
- Regular cholesterol checks - prevention checks.

### 3. Barriers for achieving optimal health:

Parents responded well to this question with a strong emphasis on stress, money, time, motivation, physical fatigue from working and the instant availability of junk foods. The majority of parents acknowledged they

understood health issues but because it has not been life-threatening at this stage, did not prioritise it very highly.

**Issues:**

- Cultural differences, ongoing monitoring, drug abuse
- Parents lack of knowledge of health issues, laziness on the part of parents
- Time management, effect of advertising promoting junk food
- Cost of health food - fruits not in season that kids like
- Lack of information, attitude of parents, peer pressure, local pollution
- Little support of parents when school identifies health problems
- No resolution to student/school/parent relationship on definition of required program
- Unhealthy foods readily available, pace of life, materialism
- Far too much stress at home and word to monitor health needs of students and parents, heavy demands on work and family
- Priorities - parents tend to put themselves last, tiredness, lack of resources
- Students' not committed to Sport because of the school's current sport policy
- Student stress due to teachers' attitudes and vice-versa
- Ignorance unrelieved by a medical profession that does not teach health but provides remedies for ill health - self-serving profession
- Motivation, lack of genuine interest in cooking and a worry that health issues aren't being instilled in children at home, poor eating habits established a long time ago
- Lack of communication between sports associations and schools

**4. Most important health needs of children and the lifestyle they lead:**

- Adequate sleep and rest, hygiene, exercise, management of emotional stress
- Healthy eating habits, balanced view of diets, knowledge of diseases
- To keep themselves safe in the environment and to have a safe environment
- Reasonably priced health foods with no chemicals or preservatives
- Limit time in front of computer and television
- Encourage students to occupy leisure time by using the natural resources around us such as the beach, walking
- Counselling services for students at school to talk over their concerns when they happen and to help parents when needed
- Emotional stability, time to exercise and relax, clean water and clean air
- Experience positive influences and opportunities at school
- Positive role models from the teachers, how to cope with peer pressure
- Education on drug and alcohol issues, positive reinforcement for healthy choices

- Spiritual health and mental health are important, develop high self-esteem and self confidence skills in students
- To enjoy life but to know how to resolve conflicts when they occur
- Involvement in after-school sports to promote a lifelong interest in the benefits of exercise
- Critical analysis of advertisements, to respect life at all stages
- Assertiveness skills, stress relief and conflict resolution skills
- Strategies to deal with anything that has the potential to destroy their physical, social and mental well-being
- Safety zones in which to play, to recreate and enjoy the company of others
- A discipline regime - firm but fair
- Recognition of achievements to enhance self-esteem and to encourage the individuality of others
- A stable and loving family, limit junk food in the canteen
- PE and Sport timetabled in the coolest part of the day

## 5. **Concerns about children's health and safety**

### **Now:**

- Discarded needles and availability of drugs, environment
- Students' poor attitudes towards healthy lifestyles, binge drinking
- Increased levels of violence, sex on television, pollution, availability of junk food, availability of drugs
- Time spent in front of television and computers, safety and peer pressure
- Knowing the moral boundaries that meet acceptable standards of behaviour
- Eating the right types and qualities of foods for a healthy body
- Being aware of the dangers of poor decision making
- Exposure to activities which are in conflict with a healthy lifestyle
- Heavy school bags, safety, excessively competitive sport
- Positive attitude towards themselves and others, lack of work - boredom
- Development of self-esteem, accurate drug information
- Fad diets, drink-driving, slipping standards at school
- Community acceptance towards the abuse of drugs and alcohol

### **Future:**

- Fear of the possibility of legislating certain drugs, environmental issues
- Sexually transmitted diseases, making the right decisions
- Legacy we leave our children, violence, education, devaluing parents' role
- Road safety, peer pressure and maintaining a certain lifestyle
- To be able to make moral choices, have confidence and a conscience

- Pressure of work, train safety, gang violence, stranger danger
- Heart disease and cancer from earlier lifestyle patterns
- To be able to communicate well - establish and maintain friendships and relationships with family and friends
- Negative attitudes towards authority, work, school and self
- The information revolution, the general lowering of standards/values of our society

## **6. What could be done to ensure the happiness and well-being of children**

- Instil confidence in students, give credit where credit is due
- Develop an understanding and enjoyment of the outdoors in preference to television
- Present students with healthy options, teachers set a healthy example
- Keep the school environment safe, feel safer in the streets
- Listen to students - if home is unhappy, provide a 'Teen-line' with a full time counsellor
- Lots of health education - important if parents have limited knowledge
- Full parental support to both students and teachers
- Chances for individual growth of interests, academic, music, sports, drama, creativity, leadership, communication
- A collective consciousness about life and pursuing a healthy safe and happy life. Providing positive alternatives to those offered by mainstream society
- Encourage better parent/child communication, time for relaxation
- Develop a sense of union with God, self-worth and community
- Teach students to plan their time well
- A safer school environment (bullying) and free from drugs and alcohol
- Parents need to ensure that their children eat healthy foods, exercise and need to set a good example to them (smoking, drinking, recreational drug use)
- Definitely need programs for mental health issues
- A better community where there are activities for the young and a change in attitude towards the young - respect for all
- Health promotion a great idea - parents, teachers, students and health workers working together for the common good
- Giving children time and take an interest in their lives, support and understanding, communicate with parents and teachers
- Provide areas where adolescents can socialise after hours, where it is safe and supervised
- Relay information regularly to parents about current health news

## **7. How can the school help to develop a healthier and happier community?**

- Provide school lockers so there is less spinal damage to students



- Provide better shelter for all types of weather
- 'Conservation Club' run by students, whole school recycling: compost, whiz bins and control of waste
- Student run workshops on sexually transmitted diseases
- Make the canteen healthier - offer ethnic foods that are healthy
- Give the students more choice in physical activities
- Promote age appropriate health education lessons
- More media releases such as 'Higher Ground'
- The continual teaching of self-respect, self-esteem, self-reliance, recognition of the needs of others and accepting of responsibility for others, programs allowing for creative, physical, academic and individual needs (within reason)
- A commitment to the Australian ethos and this way of life
- School that actively supports the promotion of health values, foods, ensuring time for physical exercise, time and stress management
- Provide a safe environment, free of influences which conflict with a healthy lifestyle including the physical, emotion, social, spiritual and mental health of students
- More parent education workshops on health and adolescent issues
- Ensure that the Christian philosophy is soundly based and expounded with due regard for individual differences
- Study is important but there are many other equally important things in life
- Listen to pupils' problems, relieve peer pressure, promote nutrition, promote awareness of drugs, alcohol, family violence and rape
- Discuss and form a health promoting school policy and act on it
- More community involvement and awareness of adolescent issues
- More trees, shade, hats, sun hats as part of the school uniform
- Skills to function in society, promote the Ten Commandments
- Continually strive to raise the standards and values within the school
- Recognise achievements and reward acceptable behaviour
- Provide a caring and cooperative approach to all students that is in line with existing school policies

## 8 **How can the local community help to ensure the health and safety of our children?**

- Share knowledge, experiences and provide assistance whenever possible to the teaching staff, be supportive of the school's efforts
- Ask students how the community could be of assistance to them
- If they see children in dangerous situations they should intervene and provide them with genuine help, promote safety houses
- Be a good role model- drinking, smoking, bullying
- Provide areas where young people can go, play areas or recreation areas which are drug and alcohol free, dob in drug dealers
- Police to be more visible, talk and teach NOT preach!

- Health workers constantly pushing health initiatives
- Supermarkets to have special days where they reduce the prices on targeted health foods, provide safe, clean areas such as public toilets, playing fields, shopping centres, frequent cleaning of the streets, garbage bins and no backyard burning

## 9. **Suggestions made to help our school community**

### **For students:**

- Make them responsible for themselves by allowing them to run workshops - interest base with health themes
- Maintain peer support at school, more sport, exercise during homeroom
- Develop a school spirit not based on competition, positive feedback
- Develop skills and strategies to cope with problems they encounter
- Join support groups that deal with family and relationship problems if they are experiencing difficulties
- Have students involved in discussions/ committees for health and safety
- Survey their own eating habits for two weeks then reappraise the types and quantities of foods eaten, respect for peers, teachers and parents

### **For staff:**

- Principal needs to relate with students at all levels of schooling - leadership
- Have guest speakers, teaching and promoting a healthy lifestyle
- Maintain regular communication through the newsletter
- Compulsory teacher supervision of sport during and out of school hours
- Learn and develop new skills to deal with changes in society and adolescents
- Be happy, forgive and forget, treat all students equally, give students time to obey, patiently listen to their gripes, anxieties and praise their good behaviour
- Self-assessment, staff development, support and debriefing
- More personal involvement with any student perceived to be at risk, to build one-to-one trust and therefore influence them in a better way
- Need knowledge and up-to-date information, use common sense
- Respect the differences in students, be positive, good role model
- Consistency of policy with action and behaviours
- Be alert and compassionate with their work colleagues

### **For parents/caregivers:**

- Not to be placed with unrealistic goals, good role model, guidance and support
- Encourage their children to eat properly and exercise sufficiently

- Be confident with children, support prayer, be open-minded sense
- Love, encouragement - know when to let go and give children independence
- Maintain liaison between school and home, take a more responsible attitude instead of expecting the school to be the major educator of health and safety of our children
- More interaction with staff if any problems arise, information on programs being followed at a school so they can be reinforced at home
- Attend P & F meetings and contribute ideas, parents contribute expertise

#### **For the community:**

- Be considerate and not vandalise or litter the school grounds
- Recognise that our youth need support in encouraging a healthy lifestyle
- Kids are the number one priority so their needs are the needs of the community
- Support the school in revenue raising activities
- Set a good example for our young people, continually striving for higher standards and reject those who continually work against the community
- Give the young a voice in planning for the community
- Provide them with opportunity to gain skills relevant to introduce them to the world such as budgeting, employment interviews and techniques and employment opportunities
- Community organisations to continue to provide awareness and education programs. This also needs media and government support in the areas of publicity and funding
- Keep media in check, restrict alcohol, drugs and pornography by keeping them out of the reach of our youth
- More money spent on media promotion of good healthy foods and exercise
- More positive reporting in the media about the positive things our youth do
- Make a real stand on violence - make justice a real thing
- Increase penalties for misbehaviour, encourage family activities
- Continual education for students, staff, parents and the wider community

#### **9. Other Suggestions:**

Set up a 'Class Parliament' to discuss issues. This might comprise a Minister for Education - educate peers, parents and the community, Minister for Media - to advertise, Minister for Environment - recycle, compost, anti-pollution - all based on the school needs, Minister for Health and Safety - road, street and travel safety, AIDS education and organise guest speakers.

## Responses from 42 staff members

1. Overwhelmingly, teachers agreed that the school was responsible for providing opportunities for students and parents to feel valued
  - It was the responsibility of the whole school community to provide a green, clean and tidy environment
  - Parents and the wider community need to work with the school in educating students
  - Safety and welfare are priorities within the school
  - Environment issues need to be promoted and addressed at school
  - Visitors and communities members feel welcomed at school, although sometimes parents are hesitant to visit
2. **School provides students and staff with opportunity for physical activity:**
  - The majority of respondents agreed that students were given ample opportunity to participate in physical activity however, there was limited if any opportunity for staff to participate on a regular basis
3. **Keeping students physically fit is the school's responsibility:**
  - Half of the teachers agreed that this was primarily the school's responsibility but the other half disagreed and believed the school's responsibility was limited to the curriculum only
4. **School canteen provides nutritional food choices for students and teachers:**
  - 25% noted that the canteen had improved its standards of nutritional food however in their written responses they commented on the availability of foods such as chips, soft drinks and lollies
  - The remaining 75% agreed that health choices were available at school
5. **Students travel safely to and from school:**
  - The majority agreed, 10% disagreed as there have been reported incidents on buses of bullying and harassment and students regularly rode home on bikes without their helmets on or secured
6. **Parents feel comfortable and included in school decision making processes:**
  - 60% of teachers felt that parents did not experience this, 40% were undecided or did not know whether they did or not

**7. Open communication readily exists between staff and parents and students and staff:**

- 25% disagreed, noting that 'readily' was too subjective, 10% were unsure and the remainder agreed

**8. For staff, health promotion is:**

- To care for the environment -100%
- To develop anti-litter campaigns in school-100%
- To highlight the impact of smoking and alcohol-100%
- To provide safe access to and from school and school activities-90%
- To reduce hazards in play areas and classrooms-100%
- To provide a variety of health food choices-100%
- To provide students, parents, staff and the wider community with an opportunity to influence canteen practices-90%
- To help students develop self-esteem-95%
- To use interpersonal skills to promote health in others-95%
- To provide students with opportunities to keep fit and active-99%
- To encourage physical activity as an important part of lifestyle-100%
- To participate in fund raising campaigns for charities-10%
- To develop positive relationships with the school community, acknowledging the value of their contribution-90%
- To provide staff, parents and students with the opportunity to develop positive and meaningful relationships-75%
- To influence the wider community-85%
- To work collaboratively with parents on policy/curriculum issues-65%
- To organise a school safety committee-90%

**Open-ended questions:**

**1. What do you understand and suggest should be a health promoting school:**

- The majority of teachers agreed that food, physical environment, emotional, psychological and physical health and positive role modelling by teachers and parents need to be in a health promoting school
- Other responses included sunglasses, shade and exercise outside school
- Safety for students and staff
- Self-respect and respect for the community
- Practise what we as teachers preach
- Positive relationships and communication between students and teachers
- Target the whole person
- Clean and protected environment

**2. How broad are the issues relating to a health promoting school:**

- Mental, physical and social issues are all encompassing
- Everything that relates to the person including the environment and the community
- All agreed that health promotion covers most issues in one way or another

**3. What has this actively highlighted for you, the teacher:**

- The majority of teachers recognised that there were a vast array of areas that need to be addressed and a wide range of topics to cover
- Everyone needs to be involved
- This is much broader than just healthy foods
- Enormity of the task and therefore needed to prioritise the school's needs
- Need to examine the relationship between parents and the school
- Need to address the issue of unhealthy foods sold through the canteen
- Questioned just how much influence a school can really have in the community
- Stronger awareness of the focus that needs to be placed on health promotion
- Re-ignited awareness of the healthy school project
- It is important to involve the whole school community
- Health is mainly the responsibility of the home - school is only a back up and should not take on the entire responsibility for health promotion
- Different people place different emphasis on health issues
- Very broad concept but what can be realistically achieved at this school?

**4. What issues would you like to address at school:**

- Physical environment at school needs improving
- Physical and mental health of the entire school community
- Issues of self-worth including suicide rates of young people
- Competitive sport and an opportunity for all staff to be involved in weekly sport
- A buddy system for train travellers
- Bike safety, driver education, fitness/nutrition and time management programs
- Availability of counsellors at school
- Develop a positive attitude to litter in the school
- Guidelines for beach swimming activities at school
- Community awareness - what can we put back into the community?
- 'Health Profile' for students highlighting areas of concern
- Healthier canteen food
- Self-respect and respect for others

- Parent involvement at school - made feel welcomed and comfortable
- Promotion of racial harmony and justice for all
- Open communication for each person within the school community
- Learning about making healthy lifestyle choices
- Sun-safety practices in the school by both students and teachers
- Safe playing areas around the school
- Time, on a rotational basis for each year group on the basketball court
- Extension of the 'Sun-Safe' program
- Breakfast available for students, highlighting the importance of this at the start of the day
- Increase the amount of shelter and trees in the school yard

## **Responses from 760 students**

### **1. A health promoting school means:**

Generally students offered a narrow view of a 'health promoting school' but stressed healthy foods, plenty of sport and shaded areas to shelter from the sun and wet weather. The senior students commented on eliminating drugs and alcohol from school, learning about growth and maturation, self-esteem, assertiveness, relationships, sexuality, Harm Minimisation, First Aid and available counsellors to help with problems.

### **2. Three things that gave the students happiness:**

- Food, money, playing sport, good marks at school, family, friends, having fun
- Television, exercise, drawing, pets, learning about themselves, love, God
- Activities with family, entertainment, computers, shopping, swimming
- Movies, socialising, being Australian, independence, drinking, drugs, sex
- Celebrations, helping friends, being liked by others

### **3. Issues students worry about:**

- Overwhelmingly students worried about failing exams, success at school, uncertainty of their futures, employment and death
- Other issues to worry about were family, losing at sport, parents dying
- Making friends, making a good impression, war, crimes such as murder
- Being embarrassed in front of others, parents' smoking habits, illness
- Body image, dealing with 'bad' things in life, sex, girls, boys, racism
- Public speaking, pollution, boring life, rejection, getting into trouble
- Reputation, violence, parent/teacher interviews, sexual harassment
- Sexual, physical or emotional abuse, danger, missing opportunities
- Conflicts between friends, alcohol, drugs, driving whilst drinking
- Proving oneself, depression, suicide, being abducted and
- Being stabbed at school or approached by gangs

**4. One thing students would change in their life:**

- Better at sport, physical appearance, become more popular, more money
- Acceptance of others, health status, weight, to be more intelligent
- More positive attitude to life and school, parents quarrelling, reunite parents
- Happiness of parents, personality, school, procrastination, anger management
- Fighting with siblings, communication with parents and/or teachers

**5. Perceived health by others:**

- The majority of students believed others perceived them as 'healthy' as they played sport, rode bikes, swam, walked and generally ate fruit and vegetables
- Of those students who believed that others would perceive them as 'unhealthy', their reasons included overeating, overweight, did not like exercise and didn't worry much about the types of foods they ate
- All students were aware of the necessary components for healthy living

**6. Future health perception at 25 years and 65 years of age respectively:**

- At 25 years and 65 years of age, the majority of students felt they would be fit and healthy as they would still be exercising and eating the correct foods for healthy living
- Students generally were unable to perceive their future health and understood they would simply have to repeat their current health behaviour patterns to ensure a healthy lifestyle free from disease

**7. Suggestions to make school a healthier and safer place:**

- Improve the cleanliness of the grounds, provide shade in the playground
- Prevent bullying and harassment both in the classroom and playground
- Harsher punishments for students who do the wrong thing
- More garbage bins, more sport at school, closer supervision in the playground
- Health food in the canteen, protect students from the public walking through the school grounds
- Condom machines, safe place, quiet place
- Teachers treat students fairly and genuinely care about students
- Treat senior students differently to juniors, car spaces for seniors
- QUIT smoking program at school, more seating
- Activities other than sport to do at lunchtimes and after school like Computer, Craft, Movie/Video, Chess, Fiction Clubs



**8. Suggestions to make the community a healthier and safer place**

- Reduce pollution, clean environment, drug and alcohol programs
- More shelter and seating in the environment, more shaded areas
- People caring more about one and another, better public transport
- More facilities available to students after school and at night
- Police more visible in troubled areas and more friendly to the public
- Harsher punishments for those breaking the law
- Eliminate racism, safety houses, safer roads, increase cement footpaths
- Healthy promotion on billboards and more street lights

**9. Suggestions to make the student's family healthier and safer:**

- Reduce the amount of junk food we buy, parents stop smoking
- Play sport and socialise together and more often
- Promote health by exercising together
- Less pressure concerning school, lower expectations for achieving at school
- Increase parent/teacher nights where issues can be communicated effectively

**10. Suggestions for school to help families have a healthier and safer lives:**

- Run programs at school to educate parents on issues like drugs, sex, alcohol, HIV/AIDS, communication with adolescents and stress on adolescents
- Communicate issues through regular newsletters
- Designate special health days at school, make sports equipment available at lunch times even if students have to hire it out
- Where possible, have parents participate in school activities and be part of the school life

**11. Further comments:**

- More programs at school informing the community of the effects of drugs and alcohol
- Health Promotion needs to begin in Kindergarten and progress to Year 12 so that all students accept and understand this concept
- More formalised PDHPE lessons, mandatory 25 Hour Health Course in Year 11/12
- Awareness raising days at school dealing with sensitive issues as well as themes of sun safety and healthy foods

**12. Students' rating of the school environment:**

**Highly Rated (5-6 stars)**

- Adequate safety rules are enforced in the playground
- Safe design of equipment and play area
- Ongoing and regular maintenance

**Medium Rated (3-4 stars)**

- Adequate designated play area
- Playgroung supervision provided at all necessary times of the day
- Level of qualified supervision in relation to sport activities
- Hazards identified throughout the school
- Safe travel to and from school

**Lowly Rated (1-2 stars)**

- Fencing of the playground
- Bike helmet use by students and staff
- Suitable wet wether areas provided for students
- Action procedures for dealing with hazards
- Condition and availability of seating
- School safety policies are regularly reviewed and recommendations for changes made
- Adequate sun protection (shade, hats, SPF broad spectrum)

**13. Suggested improvements to the school environment:**

- School needs to have a teacher on duty for every physical activity
- Need a quiet area where those students who don't like sport can sit
- We need to plant lots of trees and shrubs to enhance the beauty of school
- Have students paint and decorate walls with health messages
- In winter we need heaters in the classrooms and more protection against wet and windy weather in playground
- Teachers need to supervise bus duty more closely
- More play areas that aren't dominated by older students
- Recycling area and support to run it during the school day







# Appendix 16 - 25 hour PDH course outline

THURSDAY 21 / 8		12.1	12.2	12.3	12.4
9.00 - 9.10	Introduction	Gilmartin			
9.15 - 10.15	Session 1	Drugs & Alcohol Harm Minimisation (Gilmartin)	Sex, HIV etc (Room 36)	Road Wise (Room 6)	Suicide (Language Lab)
10.30 - 11.30	Session 2	Suicide (Language Lab)	Drugs & Alcohol Harm Minimisation (Gilmartin)	Sex, HIV etc (Room 36)	Road Wise (Room 6)
11.30 - 12.00	Recess	BYO			
12.00 - 1.00	Session 3	Road Wise (Room 6)	Suicide (Language Lab)	Drugs & Alcohol Harm Minimisation (Gilmartin)	Sex, HIV etc (Room 36)
1.00 - 2.00	Lunch (supplied)	Hall			
2.00 - 3.00	Session 4	Sex, HIV etc (Room 36)	Road Wise (Room 6)	Suicide (Language Lab)	Drugs & Alcohol Harm Minimisation (Gilmartin)
FRIDAY 22 / 8					
9.00 - 9.30	Introduction Meditation	Gilmartin			
9.30 - 10.30	Question Time	Gilmartin			
10.30 - 11.00	Recess	(BYO)			
11.00 - 12.00	Grad/End of yr meeting	Gilmartin			
12.00 - 1.00	Lunch	(BYO)			
1.00 - 3.00	Job Interviews	Careers Room			



Appendix 17 - Evaluation questionnaire for the reversal of recess and lunch times

Do you wish to continue the new times for recess and lunch?

☐

YES

☐

NO

Why/why not?

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Other comments:

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Thankyou for your assistance (HPS Committee).





## Evaluation

**Instructions:** Could you please answer as honestly as possible. Circle the most appropriate response.

**ROAD WISE : fatigue, speeding, drink driving, occupant restraint etc  
(Fabian Blattman)**

A. Content Presented										A. Content Presented									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
POOR										POOR									
EXCELLENT										EXCELLENT									
B. Value of Content										B. Value of Content									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
POOR										POOR									
EXCELLENT										EXCELLENT									
C. Standard of Presentation										C. Standard of Presentation									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
POOR										POOR									
EXCELLENT										EXCELLENT									

**SUICIDE: issues**  
**(Rachel Yerbury)**

A.	Content Presented										A. Content Presented									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	
POOR								EXCELLENT		POOR								EXCELLENT		
B.	Value of Content										B. Value of Content									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	
POOR								EXCELLENT		POOR								EXCELLENT		
C.	Standard of Presentation										C. Standard of Presentation									
1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	
POOR								EXCELLENT.		POOR								EXCELLENT		

MEDITATION  
(Margaret Kierse)

1	2	3	4	5	6	7	8	9	10
POOR								EXCELLENT	

GENERAL COMMENTS

.....

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QUESTION TIME  
(John Sparks, Marg Kierse, Peter Vaughan-Reid)

1	2	3	4	5	6	7	8	9	10
POOR								EXCELLENT	

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.....

MOCK JOB INTERVIEWS  
(various persons)

1	2	3	4	5	6	7	8	9	10
POOR								EXCELLENT	

.....

.....

.....

.....

THURSDAY'S LUNCH

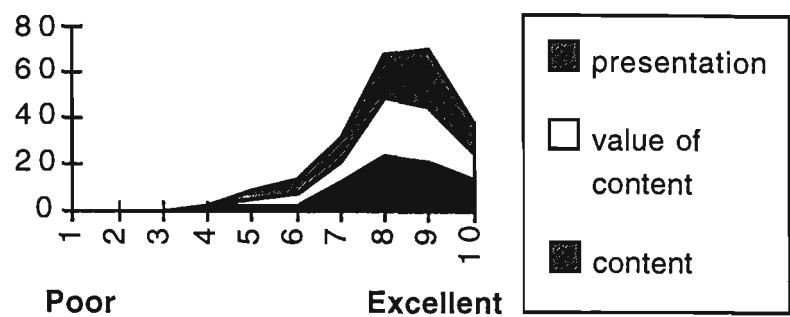
1	2	3	4	5	6	7	8	9	10
POOR								EXCELLENT	

Thankyou for your time and effort.

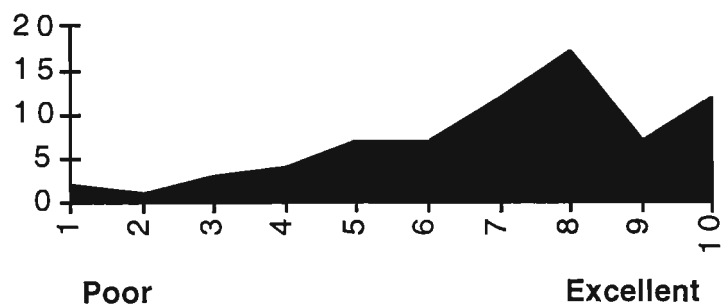
ORGANISATION OF THE 2 DAYS

1	2	3	4	5	6	7	8	9	10
POOR								EXCELLENT	

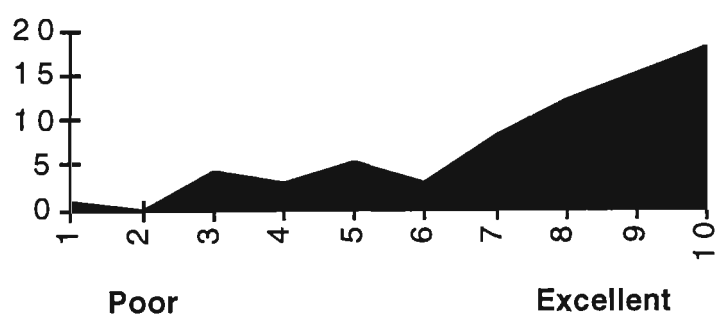
Drugs & Alcohol



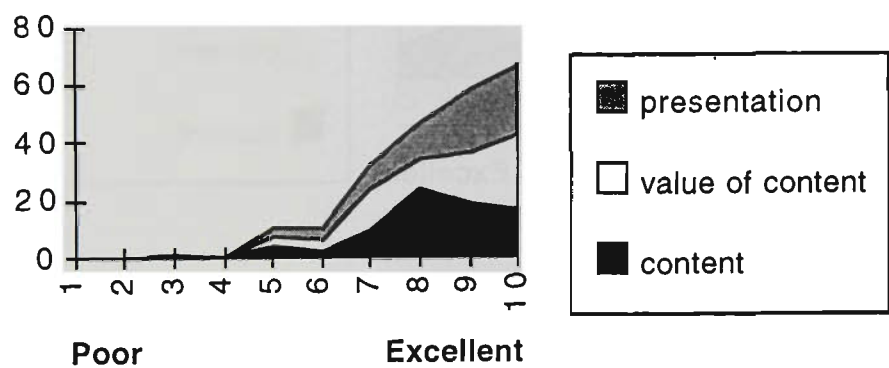
Meditation



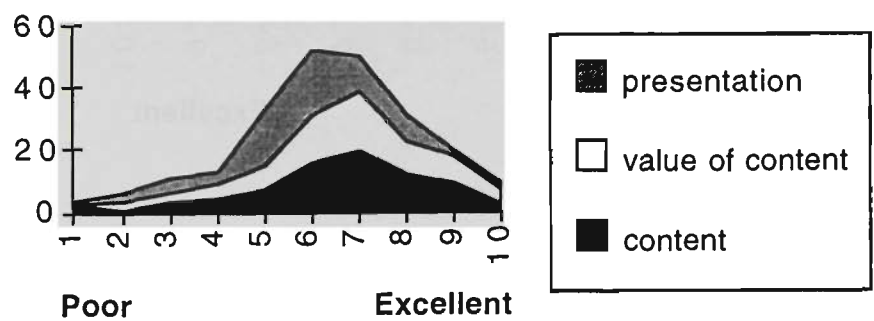
Lunch



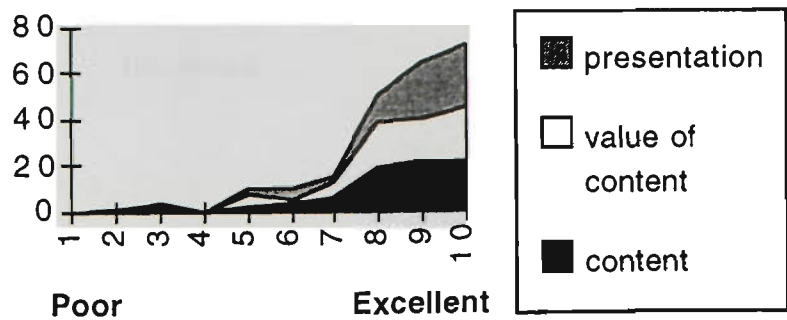
Road Wise



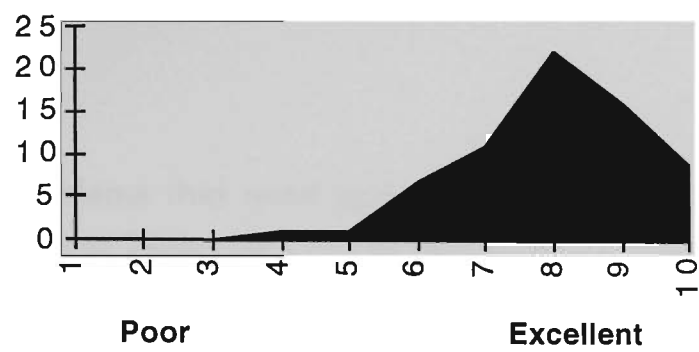
Suicide



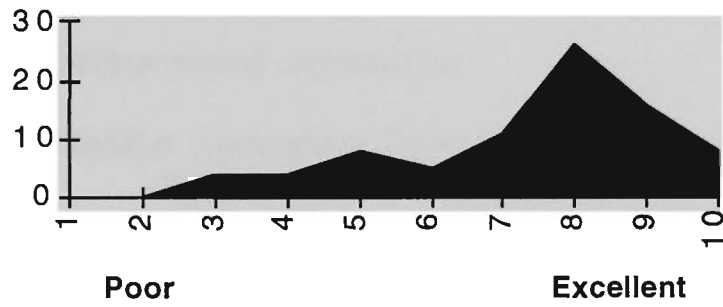
Sex/HIV



Organisation Of Course



Question Time





## **Appendix 19 - A summary of barriers to the effectiveness of the HPS project at Pentecost College**

The problems that were faced in developing structures and practices for the HPS project at Pentecost College included:

- \* Funding dollars - for the implementation of initiatives.  
- for teacher inservicing.
- \* Administration priorities.
- \* Adequate time for planning and coordinating the program.
- \* Teacher overload - so much to do already - burn out of volunteers.
- \* Overcrowded curriculum.
- \* 'Hidden curriculum' gives mixed messages about health:
  - Lack of healthy role modelling by adults.
  - Supportive and correct procedures must be agreed to by the whole staff to provide consistency and security for the student.
- \* Consensus as to priorities in terms of the school's needs. Lack of clear direction with a need to focus on one issue that can be effectively implemented.
- \* Reallocation of school resources to fund health promoting schools program.
- \* Students, parents have not been as actively involved in the process as they need to be.
- \* Poor communication between teachers and parents.
- \* Change is very slow and time consuming and support is sometimes difficult to obtain.
- \* Students' risk taking behaviour and belief systems.
- \* School is under pressure to improve student performance such as the Higher School Certificate results rather than focusing on the development of the whole person.