

The implementation of social, personal and health education in Irish schools

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Abstract

Purpose – Social, Personal and Health Education (SPHE) is mandated in all Irish schools. This study aims to illuminate the perceived value and quality of SPHE and to document facilitators of successful implementation.

Design/methodology/approach – A case study approach was taken, where 713 pupils, 968 parents and 49 teachers and other staff across a stratified random sample of 12 schools completed questionnaires and participated in interviews and focus groups. Data were integrated at the school level and subsequently across schools.

Findings – Stakeholders generally agreed on the worth of SPHE. However, its perceived value relative to other areas of the curriculum varied by school context. Facilitators for successful implementation included training for teachers, inclusion of SPHE in school planning and evaluation processes, and organisational support for SPHE via timetabling and resource management within schools.

Research limitations/implications – Case studies were useful for investigating implementation at school level, but replication with more schools, across contexts, is warranted. Parental knowledge was limited and response rates from parents were in general low.

Practical implications – During planning, implementation and evaluation it appears to be crucial to recognise and respond meaningfully to existing contexts within schools. Given the methodologies of SPHE, the delivery of innovation across the whole school curriculum could be led and supported by more fully embracing this compulsory development.

Originality/value – The paper illustrates the value of exploring implementation at school level through the involvement of a range of educational stakeholders. It documents crucial success factors for schools and health educators, particularly in the context of the introduction of compulsory health education.

Keywords Health education, Adolescents, Schools, Ireland

Paper type Research paper

1. Introduction

The Irish education system mandates health education for all students. Introduced as a compulsory subject in 2000, Social, Personal and Health Education (SPHE) comprises a syllabus and associated supports for all schools that was explicitly designed to be coherent with a whole school approach to health promotion (Department of Education and Science, 2000). The compulsory nature of this initiative means that schools at various stages of readiness were required to adopt SPHE and are inspected on the basis of their work in this area, with unsurprisingly mixed results (www.education.ie/insreports). Nevertheless, such a national context provides an opportunity for those in other jurisdictions to learn from the challenges posed, proposed solutions and lessons learned.



Health education for pupils in Irish schools has generally mirrored developments elsewhere in Europe. The transition from an ad hoc approach led by particularly motivated teachers or interest groups intent on using the vehicle of the education system to further their aims, to a structured, systematic partnership between the Education and Health sectors has been characterised by uneven development (Swain and McNamara, 1997; Friel *et al.*, 1999; Nic Gabhainn and Kelleher, 2000; Byrne *et al.*, 2005; Mayock *et al.*, 2007). Initially led by the health sector, a partnership approach between health and education has enabled the more widespread acceptance of school-based approaches to health maintenance and improvement. Ireland was an early adopter of the Health Promoting Schools (HPS) approach; a commitment to HPS was explicitly included in the 1991 White Paper on Education, and was enthusiastically supported during the pilot phases of the initiative (Nic Gabhainn and Kelleher, 1998; Lahiff, 2000). Subsequent developments were driven to some extent by concern about adolescent risk behaviours, but also substantially informed by the settings approach to Health Promotion (Dooris, 2006) and the principles of the European Network of Health Promoting Schools (WHO, 1997; Rasmussen and Rivett, 2000; Jensen and Simovska, 2002; Young, 2005).

Irish post-primary education is divided into two broad periods, the first three years of which is referred to as the Junior Cycle. The Junior Cycle is part of the compulsory period of education usually taken by students between the ages of 12 and 15: the Junior Cycle programme is based on the curricular principles of breadth and balance, quality, equity, relevance, coherence, continuity and progression (National Council for Curriculum and Assessment, 2004). The introduction of the Junior Cycle programme in 1989, heralded widespread curriculum change with the intention of developing a post-primary school system that aims to balance unity and diversity in an increasingly pluralistic Ireland. In line with the 1998 Education Act (Government of Ireland, 1998), the Department of Education and Science approved the Junior Cycle Social, Personal and Health Education (SPHE) syllabus in April 2000 (Department of Education and Science, 2000).

SPHE was designed to match with and facilitate the educational principles that underpin the Junior Cycle curriculum and all post-primary schools were advised by circular that SPHE must form part of the core curriculum of the Junior Cycle by September 2003. SPHE aims to enable the students to develop skills for self-fulfillment and living in communities, promote self-esteem and self-confidence, enable the students to develop a framework for responsible decision-making, provide opportunities for reflection and discussion and promote physical, mental and emotional health and wellbeing (SPHE Support Service, 2009). SPHE comprises a spiral curriculum with ten modules offered in each of the three years of the Junior Cycle:

- (1) belonging and integrating;
- (2) self-management – a sense of purpose;
- (3) communication skills;
- (4) physical health;
- (5) friendships;
- (6) relationships and sexuality;
- (7) emotional health;

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- (8) influences and decisions;
 - (9) substance use; and
 - (10) personal safety.

The approval in 2000 of the SPHE curriculum for Junior Cycle rests within a suite of curriculum changes in the Irish education system (Kellagan and McGee, 2005).

In most education systems there has been relative neglect of curriculum innovations in personal and social education when compared with academic education (Fullan, 2001). In Ireland the origins of SPHE can be traced back to the pastoral care/tutorial system of the mid-1970s, and later more structured programme initiatives, for example Lifeskills for Health (SPHE, 1979), On My Own Two Feet (SPHE, 1991) and Relationships and Sexuality Education (SPHE, 1995). The introduction of the SPHE programme gave structure and coherence to that which was often informally in place in Irish schools; and this formalisation demanded space on the timetable. The development of the SPHE curriculum followed the main phases as other curricular developments, and should be interpreted within the framework of such innovations (Department of Education and Science, 2002; National Council for Curriculum and Assessment, 2004). There are, however, key differences in relation to the cross-curricular nature of the content and the need for specific training in the content and processes of SPHE for most post-primary schoolteachers (Burtenshaw, 2003).

As with similar developments in other jurisdictions (St Leger, 2000; Paulus, 2005; Young and Lee, 2009; Lee *et al.*, 2008), the SPHE programme challenges the more didactic methods of teaching, traditional classroom management and assessment and requires a commitment to facilitate the process by individual teachers, indeed “it challenges the traditional concept of the teacher as the ‘source of all knowledge’” (SPHE Support Service, 2004, p. 4). In recognition of these challenges a support structure for the SPHE programme was developed in September 2000. In order to assist schools and teachers to implement the new curriculum, the support service takes the form of a partnership between the Departments of Education and Science and Health and Children and the Health Service Executive (formally the Regional Health Boards), in association with the Marino Institute of Education with funding from the National Development Plan. The support service offers training opportunities to schools, including whole school training and courses for teachers, school co-ordinators and school management on a range of modular topics and teaching approaches. Assistance with health-related policy development and other in-school supports, such as programme planning and help with identifying locally appropriate resources, are also offered by teams of Regional Development Officers working in partnership with Health Promotion Officers throughout the country (see www.sphe.ie).

The implementation of SPHE should be considered within the wide range of educational change, particularly curriculum innovation, which has been on-going in Irish schools. While there is increasing evidence that school health education and promotion can work (e.g. Weare, 2000; Stewart-Brown, 2006; St Leger and Nutbeam, 2000), there have also been considerable advances in our understanding of the determinants of healthy and effective schools (Scheerens, 2000; Clift and Jensen, 2005; St Leger *et al.*, 2007). The centrality of the education partners to the process (St Leger, 2000; Blake, 2005; Nic Gabhainn *et al.*, 2007) has been clearly identified, as has the

importance of the socio-environmental context of the school for the introduction of such innovations (Whitman, 2005; Durlak and DuPre, 2008), and these factors deserve specific attention. Within Ireland, it has been acknowledged that the effectiveness of SPHE depends on continuously evaluating the needs of students as well as consulting with teachers, parents and school management to ensure that the content of the subject remains relevant (SPHE Support Service, 2004).

A number of studies have monitored and informed the development and implementation of the SPHE Curriculum (Millar, 2003a, b; Burtenshaw, 2003; Geary and Mannix-McNamara, 2003). All of these have provided vital information on the operation of the SPHE Support Service and the roll-out of SPHE in schools. Millar (2003a) reported data from a 2001 postal needs analysis of 489 schools indicating how many schools offered SPHE to students (64 per cent), the percentage of schools that had developed SPHE related policy (up to 95 per cent) and how many SPHE teachers had up to that point received dedicated SPHE training (54 per cent). He later reported on a review of the evaluations of 259 in-service training programmes provided by the SPHE support service between 2001-2003 (Millar, 2003b). These data were generated by 3,558 individual teachers and demonstrated that most considered the training received to be excellent (60 per cent) or very good (34 per cent). Burtenshaw (2003) focused on the views of the staff and partners of the SPHE support service. Her work comprised interviews and focus groups with the Regional Development Officers employed directly by the support service and their regional partners, Health Promotion Officers located within the Health Service, as well as interviews with the management teams for these partners in the roll-out and delivery of support to schools. The nature of the partnership and the challenges in supporting schools were explicated clearly and recommendations for the further development of the support service were outlined. Geary and Mannix-Macnamara (2003) reported on the most comprehensive assessment of SPHE implementation from the perspective of school Principals and teachers. Based on postal self-report questionnaires they examined the extent of SPHE provision, the perceived role of the SPHE support services and the challenges of implementation related to the curriculum itself, the choice of teachers and co-ordination of SPHE at school level.

Gaps remain in our knowledge and understanding of SPHE implementation. Burtenshaw (2003) indicated the need to know more about the degree of integration of SPHE at school level and the underlying mechanisms, both in terms of the outcomes of the training activities of the support services and the potential synergy between SPHE and other curricular activities. In addition, two of the key stakeholders in the SPHE process have not yet been involved or consulted: students and parents. The views of students and parents are critical to the whole process as they are often the ultimate targets of health education; their responses to interventions are important in determining successful outcomes and also act as motivators for teachers and school management (Leurs *et al.*, 2007). However, stakeholders such as parents and children hold their own expertise and both want and are able to contribute to the process (Blake, 2005; Kirby *et al.*, 2003). Such a voice is safeguarded for children by one of the key goals of the Irish National Children's Strategy, which aims to give children a voice in matters that affect them (Department of Health and Children, 2000). It is therefore timely to include a broader range of educational stakeholders in the current investigation; children and their parents should be considered as the partners of school staff and

school management. The views and perspectives of all are considered concurrently, with none taking precedence over the other in coming to a whole-school perspective.

This paper reports on a study that was commissioned by the SPHE Management Committee to examine the contribution of SPHE to the experience of Junior Cycle students and to the Junior Cycle curriculum. The aim was to investigate and document the responses of educational partners to two research questions:

RQ1. Is SPHE valuable or worthwhile?

RQ2. What are the facilitators of successful SPHE implementation?

2. Methods

2.1 Sample

A case study approach was adopted with 12 schools acting as cases. All 731 post-primary schools in the country formed the sample frame from which participating schools were randomly selected using a modified Latin-Squares design (Maxwell and Delaney, 1990). The sample frame was stratified by the key dimensions of Irish post-primary schools (see www.education.ie) that have been demonstrated to be important for the SPHE implementation (Millar, 2003a); school size, location (urban/rural), student gender (boys only, girls only and co-educational), disadvantaged status (yes/no) and school type (secondary, vocational and community/comprehensive). Individual schools were randomly selected from within stratification levels of the sampling frame.

2.2 Measurement and method

Following agreement to participate from Principals, a range of data collection methods was employed in each school. Pairs of data collectors first liaised with, and then visited, each school over a one or two day period, depending on the scheduling of interviews and focus groups.

Individual semi-structured interviews were held with the Principal, the SPHE co-ordinator, two SPHE teachers and another member of staff who was involved with the pastoral care aspect of the school. The latter included Home-School Liaison Officers, Chaplains and Guidance Counsellors. Interviewees were asked about their perception of the role of SPHE in the school, the contribution that SPHE made to student learning, educational experiences and health, and their experiences of structures, policies and roles that supported SPHE implementation. The interviews were audiotaped with the permission of participants and all followed the same protocol. In one school, the Principal did not consent to be taped. Two schools had no SPHE co-ordinator and in a third the co-ordinator was the only SPHE teacher. In all schools the SPHE teachers and pastoral care staff were selected on the basis of their availability on the day of data collection. Interviewees were also asked to complete a paper and pencil task in order to facilitate the production of a whole school perspective on key issues. This involved interviewees rating various aspects of the implementation process and the school as a setting for learning and health on a five-point Likert-type scale. The items in this task were drawn from the suite of items in the questionnaires given to students and parents. All interviewees agreed to and participated in this exercise.

A focus group, planned according to the guidelines provided by Litoselliti (2003) was conducted with parents to explore the issues in a consensus building fashion. The main areas for discussion focused on their knowledge, experience and expectations of SPHE, and their perceptions of the support available for SPHE. School administrators assisted in distributing invitations to parents via notes home from Junior Cycle varied; the times of the focus groups varied and were organised after liaison with the SPHE co-ordinator or Principal. In total, nine focus groups were held in the 12 schools. In one school no parents participated in the scheduled focus group and in two schools no focus groups were scheduled on the advice of the Principal.

Self-completion questionnaires were administered, during class time, to students in all three years of the Junior Cycle. The questions were primarily closed, with a limited number of open-ended questions. In order to maximise the reliability and validity of the questions some were drawn from other studies, specifically the Health Behaviour in School-aged Children (HBSC) questions on school culture and settings (Samdal *et al.*, 2000). Questions about SPHE were also included, specifically around the areas of the curriculum they had covered, their views on how important, interesting, relevant and useful they found SPHE and the degree to which they and their parents had been involved in SPHE developments in their school.

Questionnaires for parents were developed and were analogous with those for students; they were sent to all parents whose child was attending SPHE classes (i.e. all first, second and third year students). Schools were also given a large freepost envelope and parents were advised they could either post their own questionnaire back or have it delivered to the school where the SPHE co-ordinator (or other nominated staff member) would collect and return them to the research team.

All data collection protocols were approved by representatives of the SPHE Management Committee. In addition all data collection methods were pilot tested within the context of a full pilot case study. Active parental and student consent was obtained for all data collected from students, and assent procedures applied to all face-to-face data collection exercises.

2.3 Data management

The data collected from the questionnaires were primarily quantitative and were analysed using SPSS version 12.0. The responses from the parents and students were not matched, as this may have compromised the confidentiality of both. The qualitative interview and focus group data were transcribed and analysed according to guidelines for content analysis from Strauss and Corbin (1990). All collected data were analysed first at the level of the school, and subsequently thematically. In keeping with the intention to consider each school as a unique context or case, data from all sources were first considered at the level of the school. The questionnaire data from the students and parents, and the paper and pencil ratings given by the interviewees were first combined to facilitate a quantitative whole-school perspective; specifically using questionnaire items on whether participants viewed SPHE as interesting and important. The qualitative data were then employed to help elaborate and further specify and explain the nuances underlying these views. Observations that were expressed more frequently, accompanied by specific examples, repeated and those that used stronger language (i.e. more emotional, more emphasis) were given greater weight.

This paper focuses first on data collected regarding the perceived importance and worth of SPHE and second on its value relative to other subject areas. The second section of the results presents data collected on the facilitators of successful implementation of SPHE at the school level, including; teacher confidence and competence, the inclusion of SPHE in school planning and supports for SPHE. Data from all schools and from the various data collection methods employed are presented by theme. In most sub-sections the perspectives of school staff are presented alongside that of the other education stakeholders involved. However, there were some topics where views were not elicited from students and parents, for example, on the school planning process. Where quotes are given, they were chosen for their representativeness of the views expressed and for their clarity, simplicity and brevity.

3. Findings

3.1 Responses

Of the 12 participating schools, drawn from all over the country, two were girls-only, one was boys-only and the remaining nine were co-educational. Six schools had 600 or more students, three had 300-599 students and three had less than 300 students. Four schools were located in cities, seven in small towns and one in a rural area. Six schools were designated as disadvantaged, while six were not; and one was a vocational school, five were community or comprehensive schools and six were secondary schools. Overall, 49 members of staff in the 12 schools were interviewed and 57 parents participated in the nine focus groups. In addition, 713 students and 911 parents completed and returned questionnaires. Overall, three parents refused consent for their children to participate and two students withdrew themselves. The parental response rate ranged from 64 per cent to 7 per cent, and overall was 27 per cent. Percentages reported refer to the percentages of students ($n = 713$) or parents ($n = 911$), who indicated a particular perspective via their questionnaire responses. Findings related to the two main research questions are detailed below.

3.2 Is SPHE important or worthwhile?

School staff. Generally, the level of SPHE provision was viewed highly by staff. In ten of the 12 schools SPHE was regarded as a subject that is both challenging and worthwhile. Where various social and health education initiatives and lifeskills' programmes had previously been implemented, staff members viewed the introduction of SPHE as an obvious progression in the development of student wellbeing through education.

Enthusiasm for SPHE was evident in several schools. A Home-School Liaison teacher expressed this: "... the highest status you can give it is to assign a person's whole post to it and it's given the time, it's allocated the time every week...". A number of interviewees identified a teacher's commitment to the subject as a necessary ingredient for success. One co-ordinator commented: "... Some teachers ... make sure they deliver, others see it as a bit of a doss class and if something needs to be done instead of it, they'll do it ..."

Concerns raised about SPHE provision in the schools related mainly to the tensions between assigning sufficient time to the subject and the difficulty of curriculum overload. In many schools the view was that too little time was given to SPHE provision. Since SPHE is a relatively new subject on the curriculum, in a number of

schools it was recognised as needing much time and effort before reaping satisfactory results. One teacher commented that: “we are not where we want to be yet”. In some schools SPHE was reportedly not well accepted by members of staff who do not teach it. A co-ordinator stressed the point that, for SPHE to be successful, there is a need for: “... a whole school approach to SPHE. It’s really vital, that it’s not just the SPHE teacher trying to bring forward these ideals...”

Students and parents. The students expressed a wide variety of opinions with almost two thirds (65 per cent) agreeing that SPHE is interesting. Similarly, a majority of parents (59 per cent) agreed that their child finds the subject interesting. Among the suggestions for improvement from the students was allowing for more discussion time: “more open debates on the topics”, to learn: “more about things that are important in our lives and learn information that I could use in the future” and to deal with issues that arise regularly such as: “how to deal with exam stress and subject/college choices”. Some were unclear as to the relevance of the subject: “I would like SPHE to be taken out of schools ... a waste of time”. A 2nd year girl commented: “we don’t learn anything anyways”. It was evident from the open-ended questions that there are a number of students who feel the classes were worthwhile but could be improved: “what we’re doing in SPHE is everything I think I need to know, but I’d like more activities in it”.

A widespread view held by parents was that they have insufficient information on SPHE. Of those who completed questionnaires, many stated that they could not comment on the subject due to their lack of knowledge. One parent remarked: “until I received this questionnaire I knew nothing about the content of SPHE class”. Both parents and students concurred with school staff that the teacher plays a pivotal role in ensuring successful delivery. One parent believed that the quality of delivery was reduced due to lack of funding: “teachers are not given enough resources to teach the subject ... [it] needs more financial backing”.

3.3 The value of SPHE relative to other curricular areas

School staff. Of the 12 participating schools, eight asserted a positive view of the relative value of SPHE provision. Timetabling pressures and lack of status, however, were regarded as the two main challenges that confront almost all schools. Many members of staff regarded the subject as less important than examination subjects and the fact that it has to compete with these subjects in terms of time and resource allocation was seen as problematic. Thus, some members of staff reported that its value is diminished because it is not an examination subject. A recurring view was that it also takes valuable time away from these “more important subjects” as one SPHE teacher highlighted: “I think it’s great we have it but it’s where do you fit it in”. There was one notable exception where SPHE was considered to be a core subject in the school. The Principal confirmed this: “... it can be the only place for some students where certain issues can be spoken about and expressed and where there is time to give to these issues”. The co-ordinator concurred and also considered that the perception of value of SPHE within the school filters down to the students: “... belief in the subject and the importance of it. I think that comes across to the children as well because they do take it seriously and they know”.

It was acknowledged by four of the participating schools that the perceived value of SPHE is low. One Principal, newly appointed, admitted to having little knowledge of what SPHE entails and disagreed that SPHE is as important as other subjects: “... my

initial reaction would be no, I suppose...”. Yet another Principal observed: “... it wouldn’t just be your biggest priority ... It’s not fundamental to the timetable, definitely not ... It’s an added extra that you want to safeguard you know ... if something had to go it probably would be SPHE unfortunately”. Similar responses were frequent among members of staff in many schools; one co-ordinator reiterated: “do I think this is critical core stuff they should be doing as students in this school? I’d say yes, but do I think it’s as important as Irish, English, Maths, French? No”.

As was evident in the views on of the level of provision, the relationships between teacher and students were regarded as vital in assessing the value of SPHE provision. One Principal observed regretfully that: “... a teacher will have a class for first year ... by it’s nature it tends to be the last item in the timetable and it just might not be possible to give that teacher that class [group] next year”. Two SPHE teachers in the same school were unenthusiastic about the attitudes among staff: “. . . there’s a kind of a negative attitude from certain teachers ... generally, older teachers don’t want to teach it...”

Students and parents. Students and parents also expressed a range of views on the value of SPHE. In the student questionnaires slightly less than half (49 per cent) considered that it was an important part of what they learn or that it was as important as other subjects (41 per cent). On the other hand, a substantial majority (71 per cent) believed that SPHE classes are not too long and many observed that they would like the class period extended or to have more classes: “I’d prefer to have more than one SPHE class a week and spend more time at it since it’s important”. Many robust views, both positive and negative, were articulated by students, for example: “I think it is very important for us to learn the harmful effects of smoking, drinking, eating badly etc. so that we can make informed decisions”. Another participant disagreed with this view: “It’s so boring. It doesn’t help at all. It’s the worst subject ever because it’s useless”. Almost three quarters (74 per cent) of parents regarded SPHE as being as important as other subjects. Several parents commented positively, for example: “I think it is a very worthwhile subject and is as important as academics as it prepares the student for life both in school and outside”. Parents were asked if they ever discussed SPHE with their child, and almost half of the respondents (49 per cent) said that they did, as reflected in the following view: “I think this is a great programme which helps children and their parents to talk about health issues as well as growing up and drugs etc. together and discuss what they are being told in these classes”. Another respondent advocated that parents: “. . . be more involved with the school so that parents and teachers can act as mutual support in these very important aspects of the children’s lives”.

3.4 Facilitators of successful SPHE implementation

Teacher competence and confidence

School staff. Most SPHE teachers interviewed had attended SPHE training, as offered by the SPHE support service, and the vast majority of these, particularly those who volunteered to be part of the SPHE team, expressed confidence, enthusiasm and enjoyment in teaching it. In the schools where some teachers had no training interviewees expressed more negative views. Of the 12 schools, there were four schools where the teachers chose to teach SPHE, in the others teachers were timetabled to teach the subject.

Many co-ordinators conveyed strong views on the importance of on-going training: "... we went on every course available ... so I'd see that as a huge thing because there's no point asking teachers to take a subject if they've no training". The lack of value, which some SPHE teachers hold for the subject, and the training, is an issue that was expressed by some interviewees. One Principal commented: "... I suppose if there's an in-service that they can cut out, they'll cut out their SPHE". Generally, teachers in the schools where there is little in-service training expressed a lack of confidence and interest in the subject. One teacher with no SPHE training commented: "I wouldn't have been that thrilled with it [being timetabled with SPHE] because I don't know certain areas of it, there would be certain areas I wouldn't feel comfortable teaching...".

The timetabling of teachers is a thorny issue and was seen by many interviewees, including Principals, as problematic. One co-ordinator expanded: "... you're plonked with it you see, it's on your timetable, you're given the job". One of the Principals reflected on some of the difficulties encountered in organising timetables: "there are occasions when slots appear vacant on a timetable and you have people available and consequently you may have to slot them in". The Principals of some schools believed that asking a new member of staff if they would teach SPHE was a reasonable option: "I suppose, you'd be looking at new teachers coming in, you would ask them if they are willing to teach SPHE, and of course they would say yes ...". In one such school an SPHE teacher pointed out that: "it's literally random, timetables, you don't get any say. Well, that's here anyway; it's just given to you".

The issue of continuity was raised by some staff members, the importance of teaching the same class over a period of years and where possible the teaching of another subject as well as SPHE to the same class group. This was reflected by one SPHE teacher:

I thoroughly enjoy the subject, especially with a group that works well and in a way I've been spoiled in that way because the group that I teach I also have them for Geography and CSPE [Civic, Social and Political Education] so I know them very well ... I would think it's more difficult with a class that size if you only had them one day a week.

Students and parents. As mentioned earlier almost two thirds of students (65 per cent) agreed that the subject appealed to them. The following is a typical comment from students: "most of the things we do in SPHE is the stuff I would like to do ... there is nothing else really. Classes should be a lot longer than thirty five minutes..." Another student remarked: "I don't mind – just not any of the things we done, because it's kind of similar every week and it gets boring". Less than half of the students (46 per cent) thought that their teachers really like teaching SPHE.

The majority of parents (59 per cent) reported that their child finds SPHE interesting. One respondent reported that:

[...] from what my daughter has told me, the school at present are covering a wide range of topics ... she seems happy with what they are doing and I'm sure as she progresses through her years in her school, she will gain from the benefit of these classes.

Some parents (26 per cent) felt that the SPHE teachers need more training. Many communicated strong views on the requirements for a successful SPHE teacher:

I think professional teachers should be working in the school who know how to talk and answer students' questions in the best way as possible and not just any teacher that just tries to teach SPHE.

Mirroring the comments from school staff, another commented that SPHE is: "sometimes given to junior teachers with inadequate training".

3.5 SPHE in school planning processes

In over half of the schools SPHE was not included in the formal school plan but three schools were integrating the subject into the planning process. One Principal stated: "we haven't actually gone into all that yet. We're only starting". Another Principal noted: "...we have had in-service on whole school planning ... we haven't really got it completed yet". In a third school the Principal expanded on the plans for the school: "... we're just more or less embarking on the subject planning aspect of school planning ... the first meeting [was] for SPHE planning but there's a lot of work to be done on all the subject planning but SPHE would be one of those". In three other schools the Principals were strong in their commitment to SPHE and its assimilation into the planning policies and processes. This was reflected in a comment from one Principal who regards its integration as an essential part of validating the subject: "... it is part of the school. So the plan for the school would be rather to integrate SPHE, rather than SPHE looking for the integration, it is part of the school plan ..."

3.6 Support for SPHE implementation

School staff. In five of the 12 schools, the SPHE co-ordinators had shared posts of responsibility[1]. In one school the co-ordinator had a full post of responsibility. There was no post given to the SPHE co-ordinator in four schools and there was no co-ordinator at all in two schools. Only one school stated that they had no structures or policies in place to help support the SPHE programme. The measures that were in place in the rest of the schools included policies on bullying and behaviour, drugs, healthy eating and Relationships and Sexuality Education. In the majority of schools there were informal meetings to assist the SPHE team and in two schools there were weekly formal meetings. These meetings, both formal and informal, were for the purpose of discussing any difficulties that might arise in class, as well as issues such as in-service, information sharing, procedures and resource allocation.

A number of SPHE staff voiced their dissatisfaction with the lack of help and assistance available to them within their school. One teacher noted: "it's very much you're left to your own devices really...". In another school an SPHE teacher commented: "I suppose, there's no real support as such ... I just get on with it". In many schools there were no arranged meetings, they are conducted on an *ad hoc* basis. As one Religion teacher explained: "I mean there's no set time, but that happens, through break time if the need arises, or if there's an issue ..."

However, some schools were keen to put more formal structures in place. One SPHE teacher suggested a plan for improvement: "if we had some sort of a kind of an internal school in-service on SPHE where the SPHE teachers were may be given an afternoon off time so they could sit down and plan ...". Frustration was clear in the schools where there was little support given to the SPHE team. This was in stark contrast to schools where SPHE was regarded highly. In one school, for example, a specific classroom was used to deliver the SPHE classes. There, SPHE resources were stored and project work

displayed. The co-ordinator also had a generous budget, and a time allocation for co-ordination of two class periods per week. The Principal explained that: "... on a weekly basis resources are shared, difficulties are discussed and if there's an adjustment to be made it's made. But the policy is there so they pretty much go with the policy and recently they reviewed their policy and were happy ..."

Parents. Over half of the parents (52 per cent) thought that schools needed more support in order to deliver SPHE successfully. One parent observed: "I think it is a very important subject and should be given as much emphasis as other subjects. Teachers are not given enough resources to teach the subject".

4. Discussion

As the data indicate, the issues of perceived importance, worth and relative value cannot be divorced from issues around implementation. Where SPHE was considered to be of value it was more likely to be considered by participants as being well implemented and subsequently perceived to be of greater importance and worth, and vice versa. Nevertheless, the majority of members of staff, parents and students perceived the SPHE provision positively. There was, however, considerable variation in perceptions of some aspects of provision between stakeholders in each of the 12 schools involved in this study. Most members of school staff interviewed believed their school is providing a worthwhile SPHE programme. As with other curricular areas, the importance of the teaching was stressed as the essential ingredient for successful delivery of a quality programme. The other significant issue repeatedly emphasised was the need to allocate sufficient time to the subject. A considerable majority of students were interested in SPHE, an attitude that was also reflected by parents. However, the lack of understanding and knowledge of SPHE that a large number of parents demonstrated militates against them being able to give an informed opinion on the quality of SPHE provision or indeed to be meaningfully engaged in the process.

The majority of parents, students and members of staff perceived the relative value of SPHE provision in the schools to be high, and endorsed the worth of SPHE provision. This finding provides an important basis on which to build greater parental involvement in SPHE and the need to develop mechanisms that will facilitate more active engagement of parents and students in the whole process of SPHE planning and delivery. The challenge for schools in promoting and valuing SPHE within a given school ethos, particularly one focused on academic successes, cannot be underestimated. The most frequent challenges for staff were dealing with timetable overload and ambivalence as to the value of SPHE when compared to examination subjects. Nevertheless the perceived value and importance of SPHE was reflected in the many positive contributions from parents and students, albeit with some reservations. Importantly, most students enjoyed learning the subject and their parents reported that they do so too; likewise, most teachers liked teaching it.

The most important facilitators of SPHE implementation were clear. Teachers who chose to teach SPHE were generally more enthusiastic and dedicated than those who have been timetabled, without consultation, to teach the subject. The training and the Support Services were considered to be of great benefit in the delivery of a successful SPHE programme. Many SPHE team members felt supported in their position, and the role of the SPHE co-ordinator was seen as pivotal in the successful integration and

delivery of the programme. It is the SPHE co-ordinator who supports the SPHE team in the school, organises meetings of the team, allocates the SPHE budget, and sees that training needs are met. School health policies and appropriate timetabling with time for planning were also highlighted as important systemic supports for SPHE. The situation in relation to the inclusion of SPHE in school planning processes is more ambiguous, though there was support expressed for this development. In a few schools there was a sense of dissatisfaction at the perceived lack of structures and support and a little over half of the parents who responded would like to see SPHE getting more assistance. These findings underscore the need for supportive organisational policies and practices at the individual school level in order to ensure the sustainable integration of the SPHE programme into the school curriculum.

As Fullan (2001, p. 69) points out “Educational change is technically simple and socially complex”. For curriculum changes to be successfully established more is required than mandatory statements of intention. Even when change is acknowledged as being necessary, resistance from within the system is inevitable (Walsh, 1997). Many writers acknowledge that change should not be considered as a discrete event but as a difficult process (Lawton, 1996; Fullan, 2003). On one level it is a political process involving the many actors in the educational system, among who there may well be some conflicts of interest. However, change is also a cultural process (Walsh, 1997; Fullan, 2001), with an element of “conversion” for the participants who gradually adapt their understanding, beliefs, practice and relationships in order to work through the change successfully.

The process of curriculum change can be divided into three phases:

- (1) initiation;
- (2) implementation; and
- (3) continuation.

Whether an initiated change actually happens in practice depends on more intricate factors such as the local characteristics, including the specific school characteristics, and external factors. For an innovation to become embedded in the whole school the continued support of the Principal, the existence of a critical mass of teachers who are trained and committed to the change, and procedures for training new staff are all necessary (Fullan, 2001; Walsh, 1997).

Ongoing teacher education and training is a key component of a good and effective school (Scheerens, 2000); it is particularly important during processes of curriculum change but becomes an acute need when also introducing new subjects and teaching methods as in the case of SPHE (St Leger, 2000; Greenberg *et al.*, 2003). The differences identified between schools according to the extent of teacher training, or number of teachers trained by the SPHE support service, illustrates the difficulty that individual or small groups of teachers have in introducing quality innovation (Whitman, 2005), even when mandated, and further underlines the added value of whole school training (Weare, 2000; Burtenshaw, 2003; SPHE Support Service, 2004).

Thus, while these developments in Ireland have included the crucial commitment of the State and the development of support services, both of which have been recognised as important broader contextual factors for educational innovation, school ethos and context remains central to the adoption and implementation process (Whitman, 2005; Durlak and DuPre, 2008). Their relevance is not attenuated by such a national

commitment. Practical issues at the level of the school emerged as important during this study, most clearly resource availability, timetabling and teacher allocation to class groups. To some extent the approach taken by school management will be substantially informed by the value they attribute to SPHE and the extent to which they are committed to delivering a quality experience for students. Engaging the interest and commitment of the school principals in bringing about a supportive school ethos and organisational practices is critical to this process. This in turn is related to the national frameworks, training experiences, teacher commitment and enthusiasm, parental interest and student response. In the Irish context, given that SPHE is not an examined subject, although compulsory, the system of school inspection remains central to the process. The inclusion of SPHE on individual student reports to parents and more broadly the consideration of the quality of SPHE provision on national school inspection reports are key to increasing the perceived value and relevance of SPHE to students, parents and schools. In addition, and given the national commitment to continued educational innovation, the learning derived from the introduction of SPHE could be embraced to support the delivery of innovation across the whole school curriculum.

However, it is vital to acknowledge that supports for child and adolescent health, like the ethos of SPHE, do not “begin or end in school” (INTO, 2005). Full partnership between all the stakeholders within a school community, ensures that parents will also be fully involved in the process; they can actively participate in curriculum development and; learning can be supported and enhanced within the home and wider community. Parent and community involvement is an essential component of a health promoting school. Parental involvement in school health education and promotion has proved one of the most challenging of all components of these innovations, and this is not unique to Ireland (e.g. Inchley *et al.*, 2006). Nevertheless, positive values, attitudes and behaviours in relation to health need to be replicated in the home and community if they are to be effective in the long-term (Denman, 1999). Denman also noted that the values, attitudes and behaviours learned by the students are the most important influences on their education and health. If health-promoting practices are to be effective they must be designed to relate to the home and community environments. As St Leger (1999, p. 56) points out, it has been claimed that:

Linking the curriculum with the school environment and the community, a greater range of factors which affect students’ health will have a better chance of being addressed, than if explored through classroom curriculum.

Parental influence may be particularly important. Parcel *et al.* (2000) have argued that parents act as role models for their children. Parents provide both opportunities for, and barriers to health in the home and they influence the determination of their child’s peer group that in turn influence their child’s health. It is, therefore, appropriate that the school acts to strengthen these links, seeking support and reinforcement within the home and community settings for effective health promotion.

However, although built on the principles and processes of the HPS movement, it is important to recognise that efforts to integrate the implementation of SPHE in Ireland more closely with the development of the health promoting school process have been hindered by a lack of clarity on the abstract concepts and practical applications involved (Burtenshaw, 2003). The term “healthy schools” is frequently used

interchangeably with health promoting schools. It is important to recognise the convergence between the principles and practice of “good” or “effective” schools and those of “healthy” or “health promoting” schools, indeed in many conceptualisations the two are interchangeable (Nic Gabhainn and Clerkin, 2004). The importance of language should not be underestimated. The potential for squandering resources by not fully considering the position of teachers and school management, in terms of the paradigms they work within, and the language they use to explain and describe them, is substantial (St Leger, 2000; Young, 2005; Smith *et al.*, 2005). Thus, a true partnership between the health and education sectors is a necessary condition for further advances. Such partnership is a complex and long-term process, and could be facilitated by moving the focus from the differences between health and education to a broader commitment to child wellbeing and well-becoming, and a focus on the child (Earls and Carlson, 2001; Ben-Arieh, 2005; Hanafin *et al.*, 2007).

Case studies can provide a useful approach to investigating the implementation of initiatives such as SPHE at the school level, and for replication purposes in examining this topic in different schools, and across different contexts. While the reliability and validity of this study rests on the faithfulness of the participants and the researchers to the process, the inclusion of a broad range of informants could be conceptualised as a form of triangulation that maximises the external validity of the data collected. The response rate from parents varied considerably by school, however. This was generally disappointing, and because many who did respond indicated clearly their lack of knowledge in relation to SPHE, these factors should be taken into account when interpreting the data. Nevertheless, the present case study methodology facilitated the observation of important patterns at the individual school level that can influence SPHE uptake and application (i.e. within school associations between the views of various educational partners).

When planning the implementation of any intervention, and specifically one that is compulsory, it is important to recognise and respond meaningfully to the school context particularly in terms of ethos and training opportunities within schools, and to appreciate that stakeholders are likely to vary in terms of their definitions of success. Thus multiple and flexible approaches are necessary. Particular supports for school management in terms of timetabling, planning and teacher allocation to classes must be addressed. In addition, evidence-based approaches to the development of more meaningful partnerships between teachers, pupils and parents in planning and evaluating school health education are required.

Note

1. A senior teaching post with a higher level of responsibility, status and remuneration.

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