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Teaching health education: a thematic analysis of early career teachers' experiences following pre-service health training

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ABSTRACT

Purpose: To understand early career teachers' perceptions of the impact of a pre-service health education programme on their health promotion practice in schools and the contextual factors that influence this.

Design/methodology/approach: Semi-structured interviews were conducted with 14 primary and secondary trainee and qualified teachers who had trained at a university in England. Data were analysed using thematic analysis.

Findings: The teachers found the training to be a useful introduction, particularly when it was relevant to their practice. They valued gaining practical skills at university, on placement and in school once qualified. They reported that witnessing pupils' lives in school had increased their awareness that health education is important. Their personal qualities, life experience, the school's ethos, and competing pressures influenced their practice. Teachers considered that building relationships with colleagues, pupils and parents facilitated health promotion, and that health education needs to be relevant to pupils. Some teachers expressed that teaching about health could be a "minefield". They also discussed whether schools or parents are responsible for educating pupils about health issues and the place of health promotion within education's wider purpose.

Originality/value: Few studies have followed up trainee teachers once they are in teaching posts to explore the longer-term perceived impact of pre-service health education training. The findings suggest that teachers' development takes place via an interaction between training and practice, suggesting that training could particularly aim to provide teachers with a contextualised understanding of health issues and practical experience.

Keywords: health education; teacher training; PSHE.

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5 **Article classification**: Research paper.
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INTRODUCTION

School teachers can play a fundamental role in promoting the health and well-being of the children and young people they teach and support, and it is important that they are well prepared for this aspect of their job. Their role can involve teaching health and social education, the pastoral care of pupils and contributing to whole school health promotion initiatives. The central role of teachers and schools in health promotion has been recognised for some time. Internationally, since the 1990s, many schools have become health-promoting schools (World Health Organisation (WHO), 1998). In England, Government health and education policies over the past two decades have emphasised the role that schools play in promoting health (e.g. Department for Education, 2010; Department for Education and Skills, 2004; Department of Health, 2010).

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The distinction between health education and health promotion has been discussed at length but a consensus emerges that health education is a component of health promotion (Tones and Tilford, 1994; Whitehead, 2004). These authors argue that health promotion has been regarded as having a broad emancipatory scope that in the context of school health and wellbeing resonates well with the tenets of the health promoting school (WHO, 1998), whilst health education focuses on knowledge and teaching individuals the skills to lead a healthier lifestyle. Indeed good practice in school health education should encompass the development of skills and attitudes in order for individuals to lead a healthy life and thrive (DfE, 2013; PSHE Association, 2014). Therefore in this paper we have adopted the terms health promotion to mean managing and dealing with wider health and well-being issues at school level whilst health education is concerned with teaching about health, mostly in the context of specific lessons. However the landscape in English schools is complicated because one of the main mechanisms for teaching about and promoting health is through personal, social, health

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3 and economic education (PSHEe). Elements of health education may also be taught in other subject lessons and through the spiritual, moral, social and cultural (SMSC) development programme. We will therefore refer to PSHEe to mean both health education and health promotion as defined above.

PSHEe covers personal and economic well-being issues that children and young people may experience in life. It includes topics such as sex and relationships education (SRE), drug and alcohol education, healthy eating, emotional health and well-being, careers education and skills for managing personal finances (Department for Education, 2015). There is some evidence that PSHEe and other health promotion initiatives in schools can improve health outcomes (Department for Education, 2015; Lister-Sharp *et al*., 1999).

PSHEe is currently a non-statutory subject in England (Department for Education, 2013), despite calls for it to be made compulsory (Macdonald, 2009). Certain topics, though, are a statutory part of the wider curriculum, such as SRE, drug education and careers education (Department for Education, 2013, 2015). There is no prescribed curriculum and schools are encouraged to tailor their PSHEe programmes to their pupils' needs (Department for Education, 2013). Consequently, delivery is variable across schools (Formby, 2011; Formby and Wolstenholme, 2012).

In 2013, the Office for Standards in Education, Children's Services and Skills (Ofsted), which regulates education services in England, published a report finding that PSHEe was inadequately taught or required improvement in 40% of the 50 schools it inspected (Ofsted, 2013). It stated that teachers particularly lacked expertise in teaching sensitive issues, often due to limited training. The report recommended that all initial teacher training (ITT) courses should provide PSHEe training and that continuing professional development (CPD) opportunities should be promoted to qualified teachers. The House of

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Commons Education Committee (2015) has also emphasised this need for appropriately trained teachers.

A 2011 survey of ITT providers in England about the health content of their courses found that coverage of PSHEe topics was variable (Dewhirst *et al*., 2014a; Shepherd *et al*., 2013). Yet, as the Ofsted report highlights, comprehensive training in PSHEe and health-related issues is vital in ITT, and may contribute to more effective health promotion in schools. The international literature shows that such training is associated with increases in teachers' knowledge and confidence to teach health topics at the end of training and that it can help raise teachers' awareness of the importance of health and well-being (Shepherd *et al*., 2013). Less is known, however, about the influences of health and well-being training in ITT on teachers' practice when they have completed training and are working in schools with the many other competing factors that can affect their practice (Beauchamp and Thomas, 2009). A systematic literature review (Shepherd *et al*., 2013) identified only three studies that followed-up the effects of ITT in health education on teachers' practice once they were qualified (Bostock *et al*., 2011; Weatherby-Fell and Vincent, 2005; Evans and Evans, 2007). These studies focused on ITT in mental health (Bostock *et al*., 2011; Weatherby-Fell and Vincent, 2005) and in integrating PSHEe into English lessons (Evans and Evans, 2007). The review recommended further research is needed that includes both trainee and early career teachers to follow-up the effects of ITT in health education (Shepherd *et al*., 2013). In particular, no study has followed-up the impact of a broad health education programme delivered to whole cohorts of trainees.

Therefore the aim of this study was to begin to address this gap in the research literature by examining the impact of a health education training programme on the practice of trainee and recently qualified teachers. We conducted a qualitative, thematic analysis to understand these new teachers' perceptions of the effect of a whole-cohort pre-service health

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education programme on their attitudes, competence and confidence to promote health, their practice in school and the contextual factors that influence this. The programme was developed and delivered at the Southampton University, England (Dewhirst et *al*., 2014b). The effects of the programme have been evaluated at the end of the trainees' courses (Byrne *et al*., 2012). This study was part of a larger, mixed-methods study that examines the impact of the programme on teachers' practice (Byrne *et al*., 2016; Pickett *et al*., 2015).

METHODS

Overall study design

In the wider study, one survey was sent in May to July 2014 (phase 1) and another in January to March 2015 (phase 2) to three whole cohorts of primary and secondary teachers who had trained at [university] between 2011/2012 and 2013/2014 on the Postgraduate Certificate in Education (PGCE) or School Direct (previously Graduate Teacher Programme (GTP)) courses. The cohorts were current trainee teachers at the end of their courses (in phase 1), and qualified teachers up to two or three years post-training (in phases 1 and 2, respectively). In phase 1, a sub-sample of the preservice teacher survey respondents were interviewed. In the final research phase (phase 3), a sub-sample of survey respondents from all three cohorts, who were all now qualified, were interviewed in March to July 2015. This paper reports on a thematic analysis of the phases 1 and 3 interview data.

Ethical considerations

Ethical approval to conduct the study was granted by the Southampton University Ethics Committee before the research began. Participants provided informed consent prior to the interview.

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The health education training programme

The Southampton health education training programme has been delivered to primary and secondary school trainee teachers on the PGCE and School Direct (formerly GTP) programmes since 2010. It is based on a constructivist model of learning (further described in Byrne *et al.*, 2016) and aims to raise trainees' awareness of PSHEe and the importance of health and well-being through a programme of active learning in the university and during school placements. The programme aims to furnish trainees with skills, knowledge and confidence to be able to teach about health issues and promote pupils' general health and wellbeing in school. It is also in a small part directed at trainees' awareness of their own health behaviours by supporting them in actively taking care of their health by providing them with information and practical strategies to do so. Therefore, while the programme is primarily focused on health education, it also touches on other aspects of health promotion. Trainees attend a whole-day 'Health Day' event (now called the 'ITE [initial teacher education] Health and Wellbeing Conference'), which is embedded in their whole teacher training course and consists of an introductory lecture, mandatory and optional interactive and practical workshops (e.g. on sex and relationships education (SRE), healthy eating, emotional first aid, the role of school nurses, and drug awareness) which focus on providing trainees with practical strategies for use in school, and an exhibition with stalls from public health and education agencies. People with health expertise from a variety of external agencies (including local authority public health and education departments, local and national charities and independent consultants) are involved in delivering sessions at the Health Day. Trainees are expected to complete follow-up tasks during their subsequent school placement, including finding out about the school's health policies, and observing, co-planning and delivering a PSHEe lesson. The teacher training course includes modules on

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special needs, diversity and equality and teaching PSHEe, as well as on social and emotional health and wellbeing which are also part of the trainees' health and wellbeing education programme. Trainees can additionally opt to complete a health portfolio to gain the UK PSHE Association's Chartered Teacher Certificate. The programme is described in detail in Dewhirst *et al*. (2014b).

Participant sampling

Phase 1 and 2 questionnaire respondents were asked if they were willing to be contacted about follow-up interviews. For the phase 1 interviews, all 27 preservice teachers who had expressed interest were approached to obtain a convenience sample. For the phase 3 interviews, the aim was to interview a variety of in-service teachers and so 21 prospective participants were purposively sampled. They were selected (using questionnaire data) to obtain good representation from: all three cohorts, both genders, different age groups, different attitudes and levels of confidence promoting health, schools with differing health education cultures, and from schools in different socioeconomic catchment areas. Only five teachers replied to the invitation. Therefore, all in-service teachers who had indicated their interest in the interviews were e-mailed, yielding one more interviewee.

Reminder e-mails were sent after the initial interview request. Overall, 21 teachers responded. Of these, 17 agreed to interviews and four declined. Of the 17, two were not contactable when phoned to do the interview and one did not respond to arrange a time and date. The final sample was 14 interviewees (eight preservice and six qualified teachers). None were interviewed in both phases 1 and 3 (i.e. there were no repeat interviews).

Interviews

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The two lead authors carried out semi-structured interviews, using piloted topic guides. The phase 1 and 3 topic guides included similar questions, asking participants about:

- their backgrounds and schools
- training aspects they found most or less useful
- how the training influenced their health
- further training needs
- attitudes towards and experiences of teaching and promoting health and their views on their competence and confidence to do this
- the role they saw themselves having in teaching and promoting health in the future
- barriers and facilitators to promoting health.

The phase 3 interviews additionally focused on how their teaching experiences had affected their attitudes, whether they could influence their school's health promotion approach and followed-up the participants' responses to the phase 2 survey about their schools' health promotion ethos.

The participants were interviewed at a time and location convenient to them (six face-to-face at the University, one at their school, and seven by phone). Interviews typically took between 30 to 40 minutes, were audio recorded and transcribed verbatim by a secretary. Researchers checked transcripts. Researchers considered that data saturation had been reached after 14 interviews.

Data analysis

The two lead authors analysed the data using inductive thematic analysis (Braun and Clarke, 2006), and discussed the ongoing analysis with the third author. Initially, the researchers read the transcripts, noted thoughts and then analysed the data using NVivo software, to generate initial codes. To enhance trustworthiness, multiple coding was carried

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out (Barbour, 2001): the researchers each initially independently coded the three same interviews and met to discuss and refine the codes they had generated to devise an agreed coding framework. They then split the remaining interviews to code between them. Once all data was coded, they each generated themes and met with each other twice to discuss and refine these to develop 14 agreed candidate themes. One researcher then further refined these into the five final main themes presented here. Some of the earlier identified themes became sub-themes.

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RESULTS

Participant characteristics

Table 1 summarises the characteristics of the interviewed teachers. Twelve (85.7%) were women and two (14.3%) were men. Most (71.4%) were aged 20 to 29 years. Ten (71.4%) had trained on secondary and four (28.6%) on primary level courses. In the questionnaires, three teachers (21.4%) described their school's catchment area's socio-economic status as a high, four (28.6%) as low, and seven (50.0%) as neither a high nor a low (medium status area). There was sufficient representation from all three cohorts in the sample.

In the questionnaires, 10 (71.4%) teachers 'strongly agreed' and four (28.6%) 'agreed' that it is very important for schools to teach PSHEe and to promote health. In the phase 2 questionnaire, respondents were asked to what extent they agreed that their current or most recent school prioritised PSHEe . Only four interviewees responded to the phase 2 questionnaire and so answered this question (which was not asked in phase 1). Two 'strongly agreed', one 'agreed' and one 'disagreed'.

[Insert Table 1 about here]

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Summary of themes

The five main themes were: 'Value and purpose of training', 'Influences on training, teaching and dealing with health issues', 'Value and purpose of PSHEe', 'Roles and purpose of education' and 'Teaching PSHEe is a minefield'. Each of the themes and the associated sub-themes are summarised in Table 2 and described below. After each presented quote, the teachers' experience level is indicated by "trainee", "1yr", "2yrs" or "3yrs" to indicate if they were trainees or one, two or three years post-training, respectively.

[Insert Table 2 about here]

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Value and purpose of training

The theme 'value and purpose of training' captured how useful the teachers had found the ITT as preparation for teaching PSHEe and promoting health, and what they felt is the purpose of ITT.

Gaining awareness

The University training helped the teachers gain awareness of the importance of PSHEe, the types of issues they may come across in school, resources they could use and that their role extended beyond teaching:

"I think it actually made me think more about my role and my responsibility, rather than just being a classroom practitioner." (P12, 3yrs)

Spending time in school during training and after qualifying, seeing issues first-hand, however, seemed to have particularly impacted on their views:

"It's interesting how my views have changed, even though I haven't seen any lessons on it [PSHEe]. That actually maybe just being more around children, more aware, and listening to their conversations and their concerns, stuff like that, that actually I've

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been… OK, actually, maybe this is more important than I had anticipated probably." (P04, trainee)

Training usefulness

The teachers were generally supportive of the value of ITT in PSHEe. It was commented that this could potentially have a "domino effect" (P07, trainee) on improving delivery quality in school.

Although many teachers said it was difficult to remember all the details of the training, they generally viewed it positively and felt it had been useful, interesting, and well-delivered. The majority felt it had prepared them for teaching PSHEe and promoting health, and had developed their knowledge:

"It's [the University training] definitely helped by giving me a much broader knowledge." (P05, trainee)

The teachers appreciated being confronted with real-life issues during talks at the Health Day, and felt they had obtained useful resources and future contacts:

"The fact that we've got the on-going contacts as well that we can go back to, or um, look at if we need to, is really helpful." (P05, trainee)

Some also felt that the training had had a positive impact on their teaching and felt inspired by the Health Day facilitators' teaching methods to use similar techniques:

"The way he delivered it [a Health Day workshop], it changed, in me, the way to deliver, I say academic, but sit-down-and-listen-to-me-type-lesson […] it was engaging and animated. […] and not only did I learn from the content of his [session], but the way he delivered." (P13, 2yrs)

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> "I think the PSHE did make me think more about different backgrounds that people come from and different issues that can arise […] it had a really big impact on the way that I think I approach teaching." (P12, 3yrs)

Others, however, felt that their training post-ITT had had more of an influence on their teaching:

> "I think more of my post-training […] since I qualified has been a bit more influential in that, and has given me practical ideas to use." (P11, 3yrs)

Some teachers found some training aspects less useful than others. Some felt the Health Day could have been more useful, as they were not satisfied with the workshops they attended. There were mixed feelings about the portfolio's usefulness. Some found it valuable for reflecting on their practice, but others felt it was another task to do within already limited time. Some teachers also felt that ongoing training throughout the ITT year would have been better than a one-off day so that they could integrate their University and placement learning more effectively. Improving the teachers' health was not a primary aim of the training and the teachers generally commented it had not affected their health, because they already led healthy lives and felt university could not influence this.

Importance of practical experience and skills

The teachers particularly valued gaining practical experience and skills in the pedagogy of PSHEe. When the teachers perceived the training as useful, this was often because they felt they had learnt such skills:

> "I thought actually the, the health afternoon which we had to try and deliver in a school was the most useful part of [the portfolio] […] it forced us to really think about how we'd present that information to children" (P11, 3yrs)

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When the teachers viewed it as less useful, this was because the teachers felt this practical element was lacking:

> "So, I think with the Health Day […] there could have been a lot more that was more beneficial […] for example by showing us plans, or examples of how they would actually go about teaching certain things" (P07, trainee).

Some teachers would have liked more chances to observe and teach PSHEe lessons, to learn pedagogical approaches and practical strategies for dealing with issues, and to have received more resources. They suggested practical or observation experience could be more fundamental to or compulsory on the course. This sub-theme relates to the 'Relevance' sub-theme below, as, essentially, the teachers valued practical training that was relevant to practice.

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As part of the programme, the teachers were expected to teach PSHEe on placement. The teachers had variable experiences of this and commented that these opportunities depended on their placement school (e.g. how much it prioritised health or taught PSHEe). See the sub-themes 'Dealing with competing pressures' and 'Impact of school and its ethos' for more findings regarding this. Some acknowledged, though, that in retrospect they could have taken more initiative to seek these opportunities. This was related to having gained more awareness of the importance of PSHEe and having developed a greater sense of independence as a teacher. Two interviewees also mentioned that being a trainee limited how much you could become involved in health promotion in school and how not knowing your place as a trainee in school made it difficult.

Relevance

The teachers' perceptions of the relevance of the training to their learning needs, their school and their teaching practice also influenced how valuable they found it:

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"I think, I thought it [the Health Day] had no connection to teacher training." (P14, 1yr)

"Well I knew that the school I was going to be going into at this point was going to place a very big emphasis on PSHE, so I definitely thought it [the certificate] would help. […] So that was the main reason for doing it," (P07, trainee)

However, the qualified teachers commented that some of the training they had not considered relevant had become more relevant once they were working in schools:

"Because I didn't find the AIDS and HIV one [workshop] very relevant. […] At the time; but now it would be because I have taught all that about infections, disease, and resistance and mutations of diseases, and now if I could remember most of what they were saying that would be brilliant." (P13, 2yrs)

It's an ongoing learning curve.

The teachers generally viewed the ITT as a good introduction and they acknowledged that only so much could be covered in a one-year course. They felt fairly confident about teaching PSHEe and dealing with health issues, but more prepared to teach some aspects than others. They acknowledged that professional development is ongoing:

"I think it's something that really has to grow with your experience as a teacher, I think, and then perhaps um, address with CPD" (P05, trainee)

Further training needs generally related to practical aspects, including liaising with parents about health issues, tailoring teaching to pupils of different genders and ages, planning PSHEe lessons and how to talk to pupils about mental and social issues.

Some of the in-service teachers commented that their confidence in teaching and dealing with health issues had increased since qualifying, due to becoming more

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knowledgeable generally as a teacher, interacting with pupils, further training in school, increased subject knowledge and through dealing with issues:

> "[On how her confidence to promote health had changed since training] Um … just kind of general confidence in myself and how to deal with situations. So kind of learning from mistakes and seeing different situations and building up, a kind of a bank of how to deal with, with those and apply those to other children who've got similar problems." (P09, 2yrs)

Again, this incremental development seemed to be related to having gained more 'on the ground' experience in schools.

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Influences on training, teaching and dealing with health issues

This theme encapsulated the personal, training and school factors the teachers felt impacted on both their learning during ITT and also health promotion in schools.

Personal qualities and background.

The teachers said their life experience, previous work experience and personal qualities informed and influenced their teaching and promotion of health, as well as the opportunities they sought during training (e.g. such as their personal motivation to undertake the portfolio). The teachers' experiences of PSHEe when they were school pupils also influenced their teaching and their motivations for contributing to PSHEe now:

> "But I think because my PSHE was not brilliant either when I was at school, and I think it is quite important, so I figured that by completing the portfolio I might have a better understanding of how to make it interesting for when I have to teach it." (P07, trainee)

The teachers believed theirs and other teachers' personal qualities influenced their PSHEe teaching, their motivations to teach it, and the learning opportunities they sought.

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They mentioned the importance of qualities such as being open, approachable, and interested in health and well-being:

> "I don't know whether you can teach someone to teach PSHE. Or is it just the fact, like I, I, I consider myself to be approachable and open minded, […] and I think I do get on very well with kids, and there is … a mutual self-respect, but is that something you can teach? Or is that just something about the way you're made?" (P04, trainee)

Building or having relationships and communicating.

The teachers talked about the importance of building relationships with pupils and parents to teach PSHEe and to promote health effectively. They felt it is important to get to know pupils and to create a comfortable, open and non-judgemental atmosphere in class:

> "The main point I probably take about teaching things is to be open and you can't be shy about these things. Um, and, yeah, so just being open about it; I think that's what I've learned from ITE training." (P03, trainee)

They felt getting to know pupils also offered the benefit of learning about the issues they faced, and therefore what guidance they needed. They felt that PSHEe could also be a part of this relationship building, as teaching it could help break down barriers between pupils and staff – it could help them to relate to and trust each other more through the sharing of experiences.

The teachers also emphasised the importance of knowing, learning from and having supportive colleagues in school for the effective delivery of PSHEe and health promotion and for their skill development:

> "In your school if you, if you know the teacher who is responsible for the subject, and er, if you get to know the colleagues involved in teaching the subject as well, I think

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good relationships with these people and being able to communicate with them and ask them for support, I think is very important." (P06, trainee)

Dealing with competing pressures

The teachers reported that competing pressures both in school and during training presented challenges to PSHEe delivery, to their skill development (e.g. finding time to complete the voluntary portfolio) and also to maintaining their personal health. They felt that due to time pressures in schools and the need to cover other subjects, creating space for PSHEe could be a challenge:

"I don't think we get an opportunity to build them as people, as civilians, as lovely people – we're too busy trying to shove information into their heads, and we're not building or developing the person that maybe we should." (P13, 2yrs)

They commented that there was variation in how schools delivered and prioritised PSHEe. They felt this affected both access to observation and teaching opportunities during placement and how much they could engage with and influence PSHEe once qualified:

"A lot of the Wednesdays [on placement] were taken up – 'cos Wednesday is the day we should do it [PSHEe] – were taken up, 'cos it's Year 9, with their options and all that kind of stuff, so actually I didn't see as many [PSHEe lessons] as I probably could have done." (P04, trainee)

Impact of school and its ethos

The teachers mentioned how the school's ethos and catchment area affected the extent to which PSHEe was delivered, prioritised or embedded in the school, the focus on particular health-related issues in the school, training opportunities and how supported the teachers felt to deliver PSHEe:

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"It's one of those classed as a Healthy School, so we very much promote healthy living and so it's play, er, at play time children are allowed to bring vegetables or fruit in, and they're encouraged at lunchtime not to eat rubbish, really." (P09, 2yrs)

"Because the ethos is so strong and so embedded it, it kind of it sets the standard so people are expected to deliver high quality health education, and if they don't feel able to then they're … you know, it makes it clear that there is support available." (P11, 3yrs)

Teachers working in schools that they considered had a strong health-related ethos, felt that this increased or reinforced their attitudes about the importance of health promotion:

"The ethos is kind of my ethos too, so I think it's just supported me in the way that I still value it and think it's important." (P12, 3yrs)

One facilitator to PSHEe the teachers identified was having a teacher responsible for it who brought structure to PSHEe in the school, which ensured it was delivered well. Conversely, where there was a lack of structure, the teachers felt PSHEe was not delivered well and was less cohesive.

Value and purpose of PSHEe

The theme 'Value and purpose of PSHEe' related to how important the teachers viewed PSHEe and health promotion, the value they felt it is currently given in schools and the purpose it could or does serve in children and young people's education and lives.

All the teachers stated it was important to teach PSHEe. This was because pupils spend much time in school and because some pupils may not learn about health and social issues at home. They stated that pupils' needed to know about these aspects of life and that classrooms provided opportunities to talk about this. They felt PSHEe was useful for pupils'

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future lives, for getting pupils thinking and making informed decisions, and could contribute to 'building the person' and good citizens:

> "I think it is a big part of school, and I've recently been thinking about that second school, and they didn't seem to do anything other than teach academic lessons. I thought that's, that's not, to me, what school is; it's more building the person and to do that I think you need the PSHE to teach them the health information" (P03, trainee)

The teachers also felt that PSHEe could be beneficial to schools and teachers: one commented that teaching PSHEe could positively influence pupils' behaviour, and another that teaching it helped her understand her pupils' lives better:

> "I think it's important for um, me to try and see things in their eyes as well. And I think PSHE can help you do that, as a teacher." (P12, 3 yrs)

The teachers, however, recognised that there was a mismatch between their views and the value placed on PSHEe in schools: that is, they felt it is often under-valued and not prioritised. They commented that PSHEe needed to be made more valuable in schools for it to achieve more. To do this, they felt it needed to be better integrated into the curriculum, taught in discrete lessons, properly taught and given equal importance to other subjects:

> "So doing it the way that it is being done, there is no importance to it because it is not achieving anything, but, if it was integrated properly, and if it was about things that kids themselves want to know about, then I think it is incredibly important because they might not learn that at home." (P07, trainee)

Making PSHEe relevant to pupils

The teachers also felt that good PSHEe needs to be relevant to pupils' lives, what they want to know and be timely in their development. They commented that the content and resources used to teach it needed to be up-to-date. Some teachers said that when they had observed

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PSHEe not being relevant to the pupils' lives, the pupils did not engage in it as well as when they felt it was more relevant:

> "I think it can be a very enjoyable subject if done in a proper manner, and if it's engaging, and if you can really make it er, um, relevant for the students" (P06, trainee)

Roles and purpose of education

This theme encapsulated what the teachers felt the overall purpose of education is – their views on the importance of health promotion were often embedded within this overall philosophy. The theme also captured where the teachers felt pupils should be taught about health issues (i.e. at home, school or by peers), who was best placed to teach them and how these different contexts complemented each other.

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The teachers felt education is not just about subject knowledge, but about building the person, good citizens, developing social responsibility and well-rounded individuals who understand others' points of view:

> "I'm very much for the holistic development of the child […] we as teachers, as educators are producing, trying to produce, well-rounded holistically developed young people, and um, the emotional content, the PSHE content, is a massive part of that" (P05, trainee)

They saw pastoral care as an integral part of education, however, they felt that educational bureaucracy often overshadowed this more overarching purpose.

Some teachers felt it was mainly parents' or carers' responsibility to educate children and young people about health matters. However, as mentioned above, some acknowledged not all parents or carers would do this, and they felt delivery at school was therefore important. Yet others saw health education as a partnership between the home and school:

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> "I feel quite strongly that that is … it's not just the school's responsibility, it should be parents' as well, but that it can be a partnership, and um, that's what we're trying to work on." (P11, 3yrs)

Some also commented pupils benefited from opportunities to discuss these issues with peers.

Some of the teachers saw a role for themselves in teaching PSHEe and also commented that it was important for teachers to be healthy role models. The teachers were generally supportive of people from external agencies delivering some PSHEe instead of teachers and felt this complemented teachers' input. External agency input was valued as parents sometimes found this more acceptable (stated by one teacher working in a faith school) and because it gave pupils a fresh perspective:

> "When we have people come from outside it's easier and the parents accept it er, maybe better; they prefer that it's, if it's someone else that talks about some areas in the subject, not the teacher" (P06, trainee)

> "I think it's just gives the children a different angle" (P09, 2yrs)

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Teaching PSHEe is a minefield

The theme 'Teaching PSHEe is a minefield' referred to the challenges teachers had experienced or observed in teaching PSHEe. It was felt to be a difficult and uncomfortable subject to teach:

> "I do think though that PSHE is a really difficult topic as whole to deliver. I think it's really important, vital, um, but I think the, the whole issue of how to teach it, when to teach it, what to teach is a minefield." (P05, trainee)

There were two other particular difficulties that the teachers raised in the interviews. One was that it was challenging to know where the boundaries lay: the teachers had experienced some conflict within themselves about what to say in lessons. They felt you had

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to be careful about this and about regulations, including pupil-teacher boundaries when dealing with health and well-being issues:

> "Through my experience that I've had so far I feel more confident. But in terms of, I would act this way, or would react this way to this situation, I don't know. I still feel like there are boundaries that I don't quite know how to cross." (P07, trainee)

The second issue was perceived tensions between what and when parents and schools wanted pupils to learn about sensitive issues:

> "SRE, because we're a faith school it's, it's very tricky, so we don't really talk about it, much. And when we do we have to be very careful, and um, and I know some parents don't want their, er, their children to be, to take part er, in PSHE lessons because of that." (P06, trainee)

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DISCUSSION

This qualitative analysis offers insights about the impact of health training on new teachers' practice and as such adds to a small body of evidence about the value and effectiveness of such programmes. The results highlight what new teachers perceive as useful and not so useful in ITT health promotion training and the factors that influence their teaching and promotion of health. Despite the rhetoric surrounding the benefits of reflective practice trainee teachers sometimes do not appreciate the importance of more abstracted training and prefer to learn in an active and experiential manner (Hobson, 2002). Therefore some of the aspects of the training at Southampton that are regarded as less useful may have been due to the teachers, as they stated, not seeing its relevance to their learning needs or their teaching practice at the time. The analysis also suggests that some viewed the training programme as less useful because they felt they had not sufficiently learnt about practical

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strategies for teaching and dealing with health issues. This was despite the Health Day and other aspects of the training being designed to be as interactive and practical as possible. Novice teachers have a multiplicity of things to master such as behaviour management, lesson planning, curriculum and subject knowledge, and these challenges can create cognitive overload, resulting in them preferring pragmatic strategies that 'work' in order to survive in the classroom (Hobson, 2002; Pollard, 2005). The systematic review of studies about health training in ITT (Shepherd *et al*., 2013) also identified that training may need to include practical experience and skills and be relevant to individual needs and practice in schools to meet trainees' needs. Indeed teachers often identify school-based, practical experiences as the most useful part of their ITT and it would seem that training in health is no different (Byrne *et al*., 2016; Hobson et al., 2009). Therefore despite the emphasis on active learning and acquiring practical strategies and experience in both the university- and school-based elements of the training programme these new teachers appear to require further opportunities to develop these skills.

The findings of this qualitative analysis suggest the relevance of the training to practice in schools could be made more apparent during the training. As the study found, though, some teachers may realise the relevance in retrospect when they encounter issues in school. Teachers' development in this area seems to be founded on their own experience. Nonetheless, ITT both at Southampton and elsewhere may need to aid teachers in gaining this more contextualised understanding so that teachers are able to relate the theory they learn to practice.

The training may also benefit from the inclusion of more practical content. Similarly, in the context of ITT in physical education, Velija *et al.* (2008) found that teachers placed more importance on learning practical skills and placement experience than on theoretical sessions at the University, which they considered irrelevant to their practice. As stated above,

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the ITT health education programme at Southampton is grounded in practical skills and tasks (Byrne *et al*., 2012), but this content may need to be made more apparent and increased. Teaching or observation experience of some PSHE-related practical teaching skills could be made mandatory, as suggested by some interviewees. This and other studies (e.g. Shepherd *et al*., 2013), however, suggests that variability in how PSHEe is delivered and prioritised in schools can be a barrier to trainees gaining practical experience, which could make it challenging for ITT providers to make this experience mandatory. This is not an issue with other subjects (Shepherd *et al*., 2013). To overcome this, providers could communicate an expectation to school mentors that trainees should have this opportunity, or could arrange for trainees to have a one-off visit to a different school if PSHEe is limited in their school.

The findings of this study underline the value new teachers place on gaining direct, concrete experiences of teaching health education and promoting health in school for their development in this area. The University training was found to have raised awareness of the importance of health to some extent and some of the teachers felt they had developed useful skills and knowledge to use in practice, but the teachers perceived their development was more greatly influenced by their experiences in school both during and after training. Whilst this may be less surprising for those trainees on the school-based programmes such as GTP or School Direct it is also apparent for those on a more traditional university-based training route. School is therefore a major influence on the development of these new teachers as health educators and promoters and any further development of the training programme needs to take this into account.

As the teachers in this study pointed out developing these skills is a learning curve and it comes from an interaction between training and practice, of which ITT is only the first step. More recently CPD has focused on a more contextualised approach where teachers' knowledge and skill are developed 'in situ' with the support and guidance of accomplished

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practitioners whilst emphasising the need to reflect on their own practice, their classroom roles, and student outcomes (Townsend, 2010; Vescio *et al*., 2008). This is in line with thinking about teacher development as a dynamic process that evolves over time - this perspective emphasises the impact that situated learning experiences and the learning social context have on professional development (Herold and Waring, 2011). One of the challenges to new teachers obtaining the situated learning they value, though, is that schools can vary in their health education and health promotion expertise, as well as the priority they place on this (Mead, 2004; Shepherd et al., 2013).

This study partly aimed to identify the contextual factors that influence teachers' health promotion practice in school. The findings show how ITT does not occur in a vacuum, but can be mitigated and supported by the wider context of what occurs in schools. The findings show how competing pressures, teachers' personal qualities, schools' ethos, the priority placed on PSHEe, the general discomfort with PSHEe and uncertainty about boundaries can be a hindrance to or support skill development and later teaching. Some of these themes have arisen in the literature. Brown *et al*. (2011) identified that a school's ethos is a strong determinate of whether or not PSHEe is provided. Therefore a supportive environment is essential if these new teachers are to continue to develop as health promoters (Thomas and Jones, 2005). Studies also suggest that while ITT educators prioritise the holistic development of the child, this is in conflict with an educational culture in some schools and government educational policies that increasingly focus on performativity (i.e. academic development and teaching to the test) (Adams *et al*., 2015; Shepherd *et al*., 2013). This instrumentalist approach to teaching and learning is diametrically opposed to the holistic development of the child that teachers in this study suggest is the purpose of education. Ball (2003) notes these struggles are often highly personal and challenge teachers' values and their autonomy. As a consequence the identity of these new teachers as health promoters may

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be precarious in a situation where personal values are in conflict with the school's ethos of performativity (Mead, 2004). The focus on performativity also means that training providers feel they have to prioritise preparing teachers to teach their subject over preparing them to promote pupils' health, and trainee teachers may feel they have to prioritise being ready and technically competent to teach their subject (Shepherd *et al.*, 2013). The priority, or lack of, given to PSHEe and the school's ethos were perceived by the teachers in this study to impact on their opportunities to learn about and deliver health education. Therefore in the absence of statutory PSHEe it might seem appropriate to consider how PSHEe is integrated into the whole of the curriculum so that both pre and in-service teachers can learn how to include aspects of health and wellbeing into their subject specifc lessons. With respect to the specific training programme more attention should be focused to the profound impact the school can have on these new teachers. Greater integration of school and university-based aspects of the training as well as acknowledging the important role mentors can play may go some way to mitigate the possibility of negative outcomes.

As a positive counter balance to these constraining aspects of some schools' ethos the findings also underscore the importance of a collegiate atmosphere in school where new teachers have good relationships with and support from colleagues, so that these new teachers can flourish (Thomas and Jones, 2005). Furthermore the teachers in this study recognised the need to develop positive relationships with pupils and create a comfortable atmosphere in class for learning about or promoting health. This is encouraging, as this is one of the UK PSHE Association's principles of good PSHEe practice (https://www.pshe-association.org.uk/curriculum-and-resources/resources/ten-principles-effective-pshe-education).

Although many of these issues are primarily school-based, an implication of the findings for ITT generally is that teachers could be made aware of the importance of

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communicating well with relevant others including tutors, mentors and health professionals during ITT for health promotion and supported to develop these communication skills where possible. This includes awareness of the expertise available on specific health issues within and external to the school, which may increase new teachers' understanding of, and to what extent they should be dealing with particular issues themselves as teachers and at what point they should be handing over to these experts. The health education training at Southampton addresses this by bringing in various experts to come and talk to trainee teachers at the yearly 'Health Day' as well as offering specific workshops about the roles of various people in and out of school in promoting pupils' health. However, in-depth experience of and skill-building in communication with relevant experts can arguably only be gained in the reality of a school context.

The teachers' life experience and own experience of PSHEe also influenced their teaching and approach to health promotion. Indeed, in the phase 2 survey, 91.6% of the teachers stated their life experience had been influential in developing health promotion skills (Pickett *et al*., 2015). This again emphasises the perceived value of real-life experience, but raises questions about to what extent life experience is beneficial for teaching or complements formal training.

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Strengths and limitations

A strength of this study is that it is one of few (Bostock *et al*., 2011; Weatherby-Fell and Vincent, 2005; Evans and Evans, 2007) to recruit in-service teachers to follow-up the effects of ITT in health education on teachers' later practice. A limitation, however, is the small number of teachers who agreed to be interviewed, which perhaps limits variability in attitudes and experiences in the sample. Indeed, the questionnaire data showed that all the teachers felt health promotion in schools was important; therefore the interviewed teachers

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may have held more positive attitudes towards health education and promotion than the general population of new teachers. The findings may not therefore be transferable to new teachers who hold less positive attitudes. We attempted to purposively sample some teachers with less positive attitudes towards PSHE and health and well-being (based on their questionnaire responses), but in the end, due to a low response from the teachers to the interview invitation, we had to opt for a convenience sample. It is likely to be challenging to recruit teachers with less interest in health and well-being into studies about health promotion. Other studies following up the effects of pre-service training in health education on teachers once they are working in schools have experienced similar participant recruitment difficulties. For example, Evans and Evans (2007) found that only 21 in-service teachers replied from over 120 surveys sent out in their study of the effects of PSHE training in ITT.

Conclusion

The findings suggest the training model at Southampton has been successful in achieving its aims of raising trainees' awareness of PSHEe and the importance of health and well-being and, to some extent, providing them with skills, knowledge and confidence to be able to teach about, and deal with, health issues in school. In a small part, it also aimed to support teachers in living healthy lifestyles themselves, but the teachers did not perceive it to have an impact on their health behaviours. The training was generally valued by the teachers who took part in the study. There is some evidence that it has positively influenced their practice in the longer-term. Thus, this study adds to the existing literature by showing that such training programmes may be associated with some longer-term perceived effects on skills, knowledge and teaching practice. The findings suggest that teachers' development takes place via an interaction between training and practice, and that to better meet its aims the ITT at Southampton could particularly aim to provide teachers with a greater

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contextualised understanding of health promotion, and more practical experience and training in skills in the pedagogy of PSHEe. The findings also suggest that ITT training programmes elsewhere could prioritise the development of practical skills for promoting health to meet trainee teachers' needs. There is, however, only so much that ITT can achieve and it is clear that the school is a catalyst for change in the development of these new teachers as health promoters or not. School contextual factors as well as the attributes of teachers themselves can support or mitigate the effects of university ITT. Therefore the ITT training as part of professional education to increase knowledge and skills should be seen as only one part of a much needed wider professional development programme in health and wellbeing education.

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Table 1

Participant characteristics (N = 14)

Participant code (years' post-training, if applicable)	Cohort (course), primary or secondary teacher[1]	Gender (M/F), age category (years)	School type[2]	Socio-economic status of school catchment area[3]
Phase 1 interviews with pre-service teachers				
P01	2013/14 (PGCE), primary	F, 20-29	Local authority	Medium
P02	2013/14 (PGCE), secondary	M, 20-29	Local authority	High
P03	2013/14 (PGCE), secondary	F, 20-29	Academy	Low
P04	2013/14 (PGCE), secondary	F, 30-39	Academy	High
P05	2013/14 (PGCE), secondary	F, 40-50+	Local authority	Medium
P06	2013/14, secondary	F, 20-29	Local authority	Medium
P07	2013/14 (School Direct), secondary	F, 20-29	Local authority	Medium
P08	2013/14 (School Direct), primary	F, 30-39	Local authority and academy	Medium
Phase 3 interviews with in-service teachers				
P09 (2 years)	2012/13 (GTP), primary	F, 20-29	Local authority	High
P10 (2 years)	2012/13 (PGCE), secondary	F, 20-29	Local authority	Medium
P11 (3 years)	2011/12 (PGCE), primary	M, 20-29	Local authority	Low
P12 (3 years)	2011/12 (PGCE), secondary	F, 20-29	Academy	Medium
P13	2012/13	F, 20-29	Academy	Low

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(2 years)	(GTP), secondary			
P14 (1 year)	2013/14 (PGCE), secondary	F, missing	Missing	Low

Note. F = female; GTP = Graduate Teacher Programme; M = male; PGCE = Postgraduate Certificate in Education.

[1]Whether teacher trained as a primary or secondary school teacher

[2]For the pre-service teachers, this refers to the type of school in which they had their first and second training placements. Only one school type is mentioned where both placements were in the same type of school.

[3]Teacher's perception of the socio-economic status of the catchment area of their school, as they reported in the questionnaire.

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Table 2

Summary of themes and sub-themes generated from the thematic analysis

Theme	Sub-themes
Value and purpose of training	Gaining awareness
	Training usefulness
	Importance of practical experience and skills
	Relevance
	It's an ongoing learning curve
Influences on training, teaching and dealing with health issues	Personal qualities and background
	Building or having relationships and communicating
	Dealing with competing pressures
	Impact of school and its ethos
Value and purpose of PSHEe	Making PSHEe relevant to pupils
Roles and purpose of education	(None)
Teaching PSHEe is a minefield	(None)

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