Teachers as health promoters: factors that influence early career teachers to engage with health and wellbeing education

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Abstract

Factors that affect novice teachers' willingness to engage with health and wellbeing education are explored. An online questionnaire was sent to novice teachers in England (n=114) who had received pre-service training in health and wellbeing. Semi-structured

interviews were conducted (n=14) to support the questionnaire findings. Pre-service training appears to have some impact on new teachers. However, school ethos, attitudes of senior leadership, the level or extent of mentoring influence these novice teachers' identity as health promoters. Nurturing this nascent identity has policy and resource implications for senior leaders in schools and governments particularly where health and wellbeing is not prioritised.

Keywords: pre-service teacher education; teacher identity; health and wellbeing education; school ethos

[Main document]

> *Actually now having spent time in schools and seeing, perhaps, this kind of social education how important it is, almost I think more important than learning about Pythagoras' Theorem, I think social education is going to get you far further in life than actually knowing trigonomic ratios. (Secondary 62)*

As this teacher suggests, the importance of personal, health and social education cannot be underestimated in facilitating the life chances of pupils. Increasingly the teaching workforce worldwide is being recognised as crucial in promoting pupil health and wellbeing (Jourdan, McNamara, Simar, Geary, & Pommier, 2010; Tang, Nutbeam, & Aldinger, 2008; World Health Organisation [WHO], 2016). However, little is known about the effect of training in health at pre-service level, or what other influences may affect teachers at the start of their careers (Flaschberger, 2013; McNamara, Moynihan, Jourdan, & Lynch, 2012; Shepherd et al., 2013). This paper aspires to bridge that gap by presenting findings from a study in England about pre-service training in health and wellbeing and addresses the following research question:

What are the factors that affect new teachers' willingness and ability to engage with health and wellbeing education?

Throughout this paper, we have used the term ‘pre-service teachers’ to refer to those who are in training to become teachers (typically a one-year post-graduate course in England); with ‘newly qualified teachers’ we denote those who are in their first year of teaching after qualifying; and with ‘early career teachers’ we indicate teachers in the subsequent two years after qualifying.

Background to Health and Wellbeing Education

In English schools the main vehicle for delivery of health and wellbeing education is Personal Social, Health and Economic Education (PSHEe). This is a non-statutory subject; content and mode of delivery is at the discretion of each school (Department for Education [DfE], 2013). Consequently experiences of teaching health and wellbeing are highly variable (Dewhirst et al., 2014; Formby, 2011; Shepherd et al., 2013). Therefore opportunities to capitalise upon and cement pre-service training, or being supported as a new teacher of PSHEe, are likely to be inconsistent and may affect teachers’ commitment once qualified (Myers-Clack & Christopher, 2001). However, some countries have made statutory provision for health to be included in their curricula in order to maximise the benefits of the synergies between health and wellbeing and education (Välimaa et al., 2008; McNamara et al., 2012). In Finland, health and wellbeing is recognised as an independent subject (National Board of Education, 2003; 2004) and schools are regarded as prime settings to promote children’s health and wellbeing with training in health and wellbeing integral in pre-service teacher education (Välimaa et al., 2008). Health and wellbeing is a compulsory subject for children aged 12-15 years in Ireland, although little pre-service teacher education in health currently takes place (McNamara et al., 2012). In New Zealand health is taught as a dual subject with physical education (Sinkinson & Burrows, 2011). These international variations may impact on the level of commitment schools and teachers in different countries make with respect to

health and wellbeing education, and therefore affect how new teachers' engage with health and wellbeing education.

Influences on Novice Teachers' Identity as Health Promoters

Novice teachers are also subjected to a myriad of influences beyond their training, including the school environment and culture (Beauchamp & Thomas, 2009; Day & Gu, 2010), experiences in school (Flores & Day, 2006; Pillen, Den Brok, & Beijaard, 2013), encounters with significant others (Schatz-Oppenheimer & Dvir, 2014) including the level of support and mentoring (Fletcher, Strong, & Villar, 2008; Hobson, 2002; Izadinia, 2016; McIntyre & Hobson, 2016), inclusion in the community of practice (Cuddapah & Clayton, 2011; Lave & Wenger, 1991), previous life experiences (Friesen & Besley, 2013) as well as their choice of subject discipline (Beijaard, Meijer, & Verloop, 2004; Pellegrino, 2015; Varghese, Morgan, Johnston, & Johnson, 2005; Wrench and Garrett, 2012). These factors affect their nascent teacher identity and inevitably impact on beliefs and attitudes about health and wellbeing as a worthwhile subject to pursue (Beauchamp & Thomas, 2009; Jourdan, Simar, Deasy, Carvalho, & McNamara, 2016). How new teachers perceive their professional identity affects their self-efficacy, and as non-specialists in health and wellbeing, the opportunity to develop a confident health promoting identity may be lost (Mead, 2004).

The predominant socio-cultural environment of the school influences the evolution of new teachers' identity and moulds their attitudes (Day & Gu, 2010). As Green and Greive (2007, p. 34) noted, "Attitude does not arise in a vacuum; the beliefs and feelings that crystallize into the attitude are shaped by background factors". A school with an ethos that values health and wellbeing will induct new teachers into positive attitudes towards the subject and to emulate the good practice that they witness (Brown, Busfield, O'Shea, & Sibthorpe, 2011). Such schools are likely to have a philosophy of education that regards the development of the whole child as paramount and enables them to flourish (Norrish,

Williams, O'Connor, & Robinson, 2013). Amongst other factors this is commonly supported by a leadership team that advocates health and wellbeing for all staff and pupils, effective relationships with parents and carers, as well as good resources to teach health and wellbeing (Brown et al., 2011; Jourdan et al., 2016; Stolp, Wilkins, & Raine, 2015).

However, regardless of the school ethos, some new teachers may be advocates of health and wellbeing education. Influences beyond school including life experience such as being a parent, having a positive experience of health and wellbeing education as a pupil, or having a strong sense of personal morality can increase novice teachers' self-efficacy and affect how they approach their professional duties, including promoting health and wellbeing as part of their wider pastoral role (Connelly & Clandinin, 1999; Hecimovich & Volet, 2011; Jourdan, Pironon, Berger, & Carvalho, 2012; McNamara et al., 2012; Mead, 2011).

Whatever their life experiences, training at pre-service and in-service levels has an impact on new teachers' willingness to engage with and promote health (Byrne et al., 2016; Jourdan et al., 2010). However, training in health and wellbeing at pre-service level in England is inconsistent and in-service training has been reduced, as priorities for schools and teachers have shifted towards academic subjects and achievement (Brown et al., 2011; Byrne et al., 2015; Formby & Wolstenholme, 2012; McNamara et al., 2012). The increasing emphasis on a vertical discourse in schools that has a highly prescribed curriculum, differentiated into traditional subject content areas is also likely be detrimental to including subjects like health and wellbeing with its more horizontal discourse and diffuse knowledge (Bernstein, 1999). Therefore, new teachers may have fewer opportunities to develop their knowledge and skills as health promoters. Furthermore, the focus on performativity within the educational landscape has resulted in a tendency towards instrumentalist approaches to teacher training that are diametrically opposed to the development of professional values, practitioner autonomy and an ethical self-concept (Ball, 2003; Mead, 2011; Turner-Bisset,

2001) that are regarded as crucial in dealing with health and wellbeing (Paakkari & Välimaa, 2013). As a consequence, having the self-efficacy to develop a confident health promoting identity may be at risk in schools with an ethos of high performativity (Mead, 2004).

Teachers' identities are negotiated through experience and how an individual makes sense of that experience (Sachs, 2005). Therefore the powerful vertical discourse of subject disciplines has the potential to affect how the identity of a new teacher is constructed, so that they see themselves as a teacher of English or Science rather than a pedagogue with a more holistic agenda including health and wellbeing (Beijaard et al., 2004; Day & Gu, 2010; McNamara et al., 2012).

However, identity is developed not only as a result of personal reflection but through interactions and conversations in a professional context that creates a joint narrative which reinforces that identity (Sfard & Prusak, 2005). As Beauchamp and Thomas (2009, p. 178) noted, "A teacher's identity is shaped and reshaped in interaction with others in a professional context". Effective mentoring both at pre- and in-service levels has been recognised as an important feature of ensuring new teachers stay within the profession and are empowered and motivated to develop their skills and knowledge, consequently increasing their self-efficacy as a professional and fostering positive attitudes towards the subjects they teach (Huizing, 2012; LoCasale-Crouch, Davis, Wiens, & Pianta, 2012). A supportive environment and experienced staff who are willing to engage in dialogue and share their wisdom and experience to lead and guide new teachers appears to be conducive for them to develop the professional knowledge and personal values to facilitate the process of change that is required to develop their identity as educators including how to teach health and wellbeing effectively (Mead, 2004, 2011; Thomas & Jones, 2005).

Paradoxically, as the global focus on academic achievement and the vertical discourse in schools is likely to reduce attention on health and wellbeing education, there is increasing

evidence of the connections between positive health outcomes and good educational attainment (Aggleton, Dennison, & Warwick, 2010; Brooks, 2014; Jourdan et al., 2012; Suhrcke & de Paz Nieves, 2011). It seems increasingly necessary to explore the factors that influence teachers to become promoters of health and wellbeing, as they transition from pre-service training to becoming qualified teachers.

Methods

Overall Research Design and Participants

The results reported here are part of a larger, mixed-methods longitudinal study that explored the effect of health education training among three cohorts of teachers trained at Southampton University to capture its impact on attitudes towards, and perceptions of confidence and competence to teach PSHEe along with the enablers and barriers to adopt a health promoting role. Table 1 provides details of the three phases of data collection and the participants who were post-graduate trained teachers. After data were analysed from phase 1 (see Byrne et al., 2016), responses to questions about experiences of and opinions about the enablers and barriers gave rise to changes in phase 2 and 3 that explored the effect of the school environment, including the ethos and culture, on new teachers' capacity to engage with, and employ their health education training. Using this iterative approach we hoped to examine in more detail factors that may influence new teachers in promoting health and wellbeing. We report on the new questions in the phase 2 questionnaire and both sets of interviews.

Table 1

Research phases and data collection

Phase	Time period	Cohort		
		Pre-service teachers (PSTs)	Newly qualified teachers (NQTs)	Early career teachers (ECTs)
Phase 1 (online questionnaire and interviews with PSTs)	March -July 2014	Primary N=155; n=66 Secondary N=179; n=42 + Interviewees n=2 primary and n=6 secondary	Primary N=143; n=16 Secondary N=191; n=20	Primary N=172; n=7 Secondary N=174; n=13
			Former Pre-service teachers (PSTs – now in their NQT year)	Former Newly qualified teachers (now NQTs+1)	Early career teachers (ECTs – now in their NQT+2 year)
Phase 2 (online questionnaire)	December 2014 - March 2015		Primary N=154; n=17 Secondary N=175; n=20	Primary N=143; n=13 Secondary N=170; n=19	Primary N=170; n=10 Secondary N=164; n=25

Phase 3 (interviews)	March -July 2015	n=1 secondary	n=2 secondary; n=1 primary	n=1 primary; n=1 secondary

All the teachers for whom we had contact details in each cohort were invited to take part in the phase 2 questionnaire to gain as representative a sample as possible. Out of 976 invited teachers, 104 responded (11%). Interviews were conducted to provide in-depth qualitative data to complement the questionnaire findings. All phase 1 questionnaire respondents who volunteered to be interviewed and responded to an invitation were interviewed, yielding 8 interviewees; 6 secondary and 2 primary teachers. Phase 2 questionnaire respondents who volunteered to be interviewed were selected to provide a balance of length of time since qualifying, gender and age with a variety of backgrounds regarding their own and their schools' views of the importance of health education, and its socio-economic catchment. Of the 18 selected, 6 were available for interview. No participants took part in both interview phases.

Ethics

Ethical approval was obtained from The University of Southampton Education School Ethics Committee prior to the research commencing. All participants were given written information about the project, and assured of confidentiality of all collected data and anonymity of the questionnaire and interview responses and their right to withdraw from the research at any time. Participants completed a consent form to indicate their informed consent to take part in the questionnaire or interviews.

The Health and Wellbeing Training Programme

The programme consists of university- and school-based components and centres on an annual multi-disciplinary Health and Wellbeing Conference at the University. The programme aims to raise pre-service teachers' awareness of the importance of PSHEe/health

and wellbeing education and increase their knowledge, skills and confidence to teach the subject. The conference includes an introductory lecture, a range of inter-active workshops and an exhibition in which charitable and government organisations take part. Reflective tasks are completed after each workshop and this is followed up with compulsory tasks during school placement. For a fuller description see Byrne et al. (2016).

Questionnaire and Interviews

In another publication (Byrne et al, 2016) we report on the questionnaire items which were repeated across the two phases of the research and which focused on teachers' attitudes towards and experienced confidence and competence in teaching health and wellbeing education and dealing with health and wellbeing issues in school. The items we report on in this paper are the new items which were added in phase 2 after analysis of the phase 1 questionnaires including reflections on the influence of the pre-service training. They are:

Your involvement in teaching PSHEe and promoting pupils' health and wellbeing since you completed the initial teacher training course. These questions explored how the teachers felt the training they had received influenced their practice and self-efficacy as health promoters in school and whether they had taught PSHEe.

Your current school and its culture and environment. These questions explored the teachers' perceptions about the importance their current school placed on promoting health and wellbeing, their views about the delivery of PSHEe and what factors they felt had been influential in gaining competence to teach or deal health and wellbeing issues.

Association between teachers' perceptions of school culture and expressed attitudes. Through a multiple regression analysis described below, we examined how teachers' perceptions of their schools' environment and culture and their personal beliefs were associated with their expressed attitudes about the importance of teaching PSHEe and promoting health and wellbeing.

The interview questions provided more in-depth data by probing the interviewees' opinions and experiences of PSHEe since finishing their training course, these included:

- The facilitators and challenges in teaching PSHEe /dealing with health and wellbeing;
- What if any changes they would make to how the school promotes health and wellbeing and what influence they consider they have in the process;
- What has contributed to any change in confidence to teach or promote pupils' health and wellbeing;
- What affects the delivery of PSHEe and the school's approach to dealing with health and wellbeing?

Data Analysis

Questionnaire data were analysed in SPSS 20 using standard descriptive statistics (e.g. counts and percentages). All the percentages reported in the paper are the valid percentage. Inferential statistical analyses (Mann-Whitney U tests, as none of the variables were normally distributed) were employed to compare responses between cohorts. Responses were compared between the three cohorts and between the newly qualified teachers and the teachers who qualified at least more than one year ago. In order to identify themes in the qualitative data from open-ended response questionnaire questions a basic content analysis approach was used to categorise answers and to identify the most common categories.

A multiple regression analysis using the procedures outlined in Field (2000) was conducted to examine how the characteristics of the teachers' schools and their perceptions of the schools' culture and environment, as well as their personal beliefs (the independent variables), were associated with their attitudes towards the importance of teaching PSHEe and promoting health and wellbeing in school (the dependent variable). The variables were selected *a priori* through team discussion about which factors might impact on teachers' attitudes.

The interviews were transcribed and thematically analysed following Braun and Clarke's (2006) method and employed data analysis software (NVivo 10) to assist the process. Two researchers independently coded the same three transcripts, after which the team agreed the coding scheme. All transcripts were subsequently coded according to this coding scheme. Codes were then amalgamated and overarching themes were identified as a result of a team discussion.

Results

A. Opportunities to Become Involved with Health Education since Qualifying

1. The influence of training. Three quarters of the surveyed qualified teachers who had taught PSHEe, indicated that the pre-service training at Southampton had a positive influence on the way they taught the subject (Table 2). This is in line with comments from the pre-service teachers interviewed in phase 1, many of whom indicated that they felt prepared to teach PSHEe:

> *I think [the health training] will be good preparation. I think so. Yes, I'm pleased with it, yes, I'm well prepared. (Primary 76)*

The university part of the health training course including increasing subject knowledge were regarded as important by this teacher especially when the opportunity to observe or teach PSHEe in school was limited:

> *I think probably more in the university it was specifically, the subject specific knowledge has helped me to develop. Because I wasn't involved in any particular distinct PSHEe delivery in schools. (Secondary 71)*

Training also provided strategies to develop pedagogical skills and understanding about teaching PSHEe appropriately, including sensitive issues:

The main point I probably take about teaching things is to be open and you can't be shy about these things [SRE]… so just being open… that's what I've learned from ITE training. (Secondary 35)

Opportunities to consolidate what was learned during the university part of the course were also regarded as important and welcomed by respondents in helping them develop as a teacher of PSHEe. This involved observation of good practice and having a supportive mentor during their preservice year:

Just watching somebody take it, that has helped a lot. Just the way that she carried it out, because it was a discussion, everyone could say their points. (Primary 12)

I think helping me was definitely my mentor at my second placement… one of my students had an abortion and having my mentor around … giving me realistic expectations and that you probably can deal with [it], but there are also things that it's not for us to say…and that was really helpful. (Secondary 9)

The support of the school and continuing professional development was regarded as essential for further development:

I think to facilitate good PSHEe …you have to have the support of the school; the school has to see the importance of it, and to be behind you. And good subject knowledge, so that's where CPD comes in as well doesn't it? (Secondary 71)

However some teachers felt that the training had not been helpful and that CPD was a rare occurrence or non-existent:

I am teaching a subject for which I have not really been trained …how many people are trained to teach PSHE? (Secondary 25)

Table 2

Influence of training

To what extent do you feel the health education training you took part in at Southampton has had a positive influence on the way you have taught PSHEe?		
	n	Valid %
To a large extent	7	10.4
To some extent	43	64.2
Not at all	17	25.4
Total	67	100.0
(Missing–possibly because not yet taught PSHEe therefore couldn't answer)	(37)	

There were also differences in questionnaire responses between the cohorts in phase 3, with newly qualified teachers reporting a significantly greater positive influence of the health training on their teaching of PSHEe than the teachers with at least one year of experience (U=366.000; p=.021). The recent training for newly qualified teachers or lack of opportunity to put the training into practice once qualified may account for these differences, although it appears that as other priorities take over the training can be forgotten. In phase 3 many interviewed teachers reported that a multitude of other experiences had taken precedence since they took up their post:

> *Um … golly, that was a while ago! Two years …A lot has happened since then. I don't think I remember [the health training]… it's all been pushed, pushed to the back of my mind, sadly. I know I enjoyed it... but … I can't quite remember... So much has happened. (Secondary 102)*

Whilst formal training was valued by the majority of teachers in helping them feel confident in teaching PSHEe, some interview respondents thought that informal 'training' as

a result of life experience had given them the self-efficacy to manage health and wellbeing issues effectively:

> *I think being a parent of teenagers really helps, because you know how far you can take things, and you know when you have to say we need to get help with this. (Secondary 71)*

2. Seeking information and influencing PSHEe. The quantitative responses indicate that the training has raised the majority of these teachers' awareness about key school policies and procedures related to health and wellbeing and enabled them to take a proactive stance in seeking relevant information (table 3). Most often this involved seeking information about who to refer pupils' health and wellbeing issues to.

Table 3

Seeking information and influencing PSHEe

To what extent has the training you received influenced you in the school(s) you have worked in since completing your course to:				
	To a large extent n valid %	To some extent n valid %	Not at all n valid %	Total n
Seek information about who I should refer pupils' health and wellbeing issues to	32 31.7	47 46.5	22 21.8	101
Seek information about how the school delivers PSHEe	16 15.7	53 52.0	33 32.4	102
Seek information about the school's health and wellbeing policies	11 10.6	49 48.0	42 41.2	102
Become involved in making changes to the way the school approaches	10 10.1	27 27.3	62 62.6	99

PSHEe and / or the promotion of pupils' health and wellbeing

In contrast to seeking information, only just over a third (37%) of respondents had become involved in making changes to the way the school approaches PSHEe and promotes pupils' health and wellbeing. The possible alternatives with regard to what happened to the majority of respondents are that they had not actively engaged with making changes to pupil health and wellbeing, or they had not been encouraged to do so or there had been no opportunities available to them.

Interview responses were mixed with regard to the influence these new teachers felt they had in making contributions to the development of PSHEe. Some considered that their influence would be quite minimal, especially compared to senior management, and focused on their own practice rather than being able to affect school-wide PSHEe:

> *I don't think … I'd have very much impact at the moment. Only in my class, but school-wise I don't think I would be able to (…) I think if the head teacher told us all to do it then we'd have to do it, but if I'm asking them it's very different. (Secondary 102)*

Others felt that the school ethos determined what and how PSHEe was taught; this teacher recognised that decisions about PSHEe were taken at a higher institutional level and as a consequence the autonomy of the teaching staff was reduced:

> *Er, no, it's just not possible, so … probably minimal [my influence] … well it's a Catholic College, so it's all got to be approved by the Governors, … it's got to be strict; it's got to follow [the Catholic teachings]. (Secondary 7)*

However in some schools the ethos facilitated contributions from junior staff and these were thought to be welcomed by the senior leadership team:

Definitely [feel able to influence things]. Yeah, it's quite open to making sure that things can be the best that they can be. I think it's a very open school in itself, so the SLT [senior leadership team] are very approachable… curriculum leaders …are very approachable too, so if there was any shadow of a doubt that it [PSHEe] wasn't being delivered as best as it could be, the school are always very open to change. (Secondary 25)

Having a wider influence however seems to go hand in hand with taking on responsibility for PSHEe, as noted by some participants:

Other than maybe taking over the PowerPoint and ... scheme of work for my Year 8s; that's probably the maximum I can do unless I um, hold my hands up and say: I want to take over PSHEe. (Secondary 17)

Whilst taking on responsibility for PSHEe and coping with the demands as well as being able to influence what is taught was reported by two interviewees during phase 3:

I've just taken over as the PSHEe co-ordinator.... they're [Senor Leadership] very open to my suggestions and things. The staff are really open to ideas; so that's given me the confidence to suggest things. The difficulty was … there wasn't a coherent thread; so people were kind of taking their favourite bits and it was very difficult to ensure that the children were getting a balanced approach. … I've spent some time putting them into a plan that [is] consistent across the year groups. (Primary 85)

3. Teaching PSHEe. Approximately two thirds of questionnaire respondents (66.3%) had taught some PSHEe since completing their preservice training but 33.7% said they had no opportunity to put into practice the training even after they had been in school for more than a year. There is a high risk that the training is forgotten by these teachers and a health-promoting identity is never allowed to develop.

Similarly some of the interviewed pre-service teachers reported limited opportunities to become involved in PSHEe during placement, and this often depended on the priority given to PSHEe by the school, or opportunistic experiences such as happening to be on placement when PSHEe was taught:

The tutor group I followed …were supposed to do a certain topic from (…) the SEAL, PSHEe thing…. every week and they were a bit blasé about it frankly... it always wasn't happening, or something else would get in the way …so it didn't feel like it followed on very well, 'cos other things got in the way…In my first school placement I wasn't there for the health days, it didn't fit in the timetable. (Secondary 62)

Accounts also suggested that school ethos and attitudes towards the importance of PSHEe impact on pre-service teachers' experience and appear to act as an impediment to professional development:

My first placement school was a very religious school… so they were very, very spiritual; I mean it was all about spiritual development. However in terms of PSHEe, they didn't really do it. (Secondary 69)

I haven't really had much opportunity to teach it, so that would be a barrier… the opportunities just weren't there. (Secondary 71)

Once qualified, experience of teaching PSHEe for some still seems to be limited, even though, as this early career teacher states, they can become responsible for overseeing its delivery which could place them in potentially tricky situations:

I haven't [taught PSHEe], not once...I don't deliver it now … I've been appointed Deputy Head of Year 8… I don't personally deliver it, which is interesting, but I do oversee it being delivered and… making sure that it is being delivered. (Secondary 17)

B. School Environment and Culture and Other Influences on Teachers

1. The importance of PSHEe in respondents' schools. The school was regarded to consider PSHEe as important by 62.2% of questionnaire respondents who either 'strongly agreed' or 'agreed' to that and similarly, 69.7% 'strongly agreed' or 'agreed' that pupils' health and wellbeing was at the heart of everything the school aims to achieve. However this stands in stark contrast to the 81.6% who 'strongly agreed' or 'agreed' that academic attainment was prioritised over other elements of a pupil's education and that 40.4% 'strongly agreed' or 'agreed' that PSHEe was not taught well (Table 4).

Adding to this rather mixed picture just under half (49.5%) of the questionnaire respondents 'strongly agreed' or 'agreed' that senior management did not support high quality PSHEe or help staff to promote pupil health, and even fewer (44.4%) 'strongly agreed' or 'agreed' that staff health and wellbeing was thought to be a priority in school.

Factors other than the priority given to PSHEe seem to militate against the autonomy and development of a health promoting identity including the cultural and religious ethos of the school as commented by one of the interviewed teachers:

> *I suppose it's made [my own teaching of PSHEe] more restrictive because of the Catholic side of it… it's so strict, they've got such strict guidelines on what they can and can't do, and what they should and shouldn't talk about… by the time they [pupils]get to 15 – 16 they're obviously becoming sexually active and they have no idea of the dangers of sex, and unprotected sex, and all the stuff that goes with it…it's difficult here because obviously we have to stick to what the church says. (Secondary 7)*

PSHEe is not necessarily a priority in many schools, however where it is taken seriously respondents indicate that it benefits both staff and pupils, especially when the approach permeates the whole school:

> *The ethos [of the school] 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. (…) Yeah, the highest regard for the students, and what affects them, and you know, you respect them and they respect you. (Secondary 25)*

Table 4

The importance of PSHEe in schools

To what extent do you agree with the following statements about your current or most recent school's environment or culture? In my school…					
	Strongly agree n Valid %	3 n Valid %	2 n Valid %	Strongly disagree n Valid %	Total n (missing)
Academic attainment is prioritised over other elements of pupils' education	30 30.6	50 51.0	15 15.3	3 3.1	98 (6)
Pupils' health and wellbeing is put at the heart or centre of everything the school does	29 29.3	40 40.4	27 27.3	3 3.0	99 (5)
PSHEe is seen as important	25 25.5	36 36.7	30 30.6	7 7.1	98 (6)
PSHEe lessons in my school tend to be well structured and have clear objectives	19 20.4	34 36.6	28 30.1	12 12.9	93 (11)
The senior leaders support staff to promote pupils' health and	15 15.5	34 35.1	34 35.1	14 14.4	97 (7)

wellbeing and teach high quality PSHEe					
Teachers' and other staff's health and wellbeing is prioritised	11 11.1	33 33.3	39 39.4	16 16.2	99 (5)
The quality of the PSHEe is not high	9 9.1	31 31.3	33 33.3	26 26.3	99 (5)
It is not seen as acceptable to talk about sensitive issues such as sex and taking drugs	3 3.0	14 14.1	27 27.3	55 55.6	99 (5)

What appears to be important in developing high quality PSHEe and enabling new teachers to adopt these good practices consists of a combination of factors including a coordinated pastoral system, good communication between staff, good resources and an environment that supports and encourages a community of practice (Table 4).

> *[B]ecause the school has such a strong ethos … I think it's just, put it [PSHEe] into the forefront of my mind. I'm always ready to take any opportunity to teach about healthiness… I think because the ethos is so strong and so embedded 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 … there is support available…So, that's the whole ethos of the school is really important for that delivery. (Primary 85)*

2. Life experience. The teachers' questionnaire responses concerning influences other than training in gaining competence to promote health and wellbeing complement earlier answers (Table 5). The interviews showed that personal life experience was regarded as highly influential and appears to have provided these new teachers with an increased level of

self-efficacy so that they are looking forward to teaching and dealing with health-related issues:

> *Yeah, bring it on …I quite like that pastoral side of things… I'm a bit older than other [trainees]… I mean I've got a bit more life experience than most people… I don't have a problem with talking about any issue whatsoever in a very frank way. (Secondary 62)*

Table 5

Influences on teachers

How influential have the following factors been in you gaining competence to teach PSHEe or deal with pupils' health and wellbeing issues?					
	Very influential n Valid %	3 n Valid %	2 n Valid %	Not at all influential n Valid %	Total n (missing)
Your life experience	49 51.6	38 40.0	6 6.3	2 2.1	95 (9)
The practical experience of teaching PSHEe/managing health issues you have gained from your training or teaching	40 42.6	35 37.2	11 11.7	8 8.5	94 (10)
Mentoring and support you have received in the schools you have worked in since completing your initial teacher training course	24 25.8	41 44.1	16 17.2	12 12.9	93 (11)
Access to good resources	19 20.2	40 42.6	24 25.5	11 11.7	94 (10)
In-service, external or self-directed training you have undertaken since completing your course	12 12.9	37 39.8	29 31.2	15 16.1	93 (11)
The training, support and mentoring you received on	12 12.6	33 34.7	29 30.5	21 22.1	95 (9)

your school placements during your initial teacher training course					
The training and support you received at the University during your initial teacher training course (e.g. the 'Health Day' at the beginning of the course, taught sessions, the health portfolio)	7 7.4	34 35.8	28 29.5	26 27.4	95 (9)
Opportunities to observe PSHEe lessons and/or shadow the PSHEe coordinator in the school(s) you have worked in since completing your initial teacher training course	11 12.1	17 18.7	29 31.9	34 37.4	91 (13)

Opportunities to 'have a go' and be supported in school were also regarded by the interviewees as key factors in helping new teachers gain competence to teach and deal with health and wellbeing. The level of influence these factors have is likely to be related to the school ethos including the priority given to PSHEe and responses indicate that new teachers' competence is nurtured in schools that have a positive climate towards PSHEe:

> *[I have had] Loads and loads of support, especially from um, the members of staff who are in charge of it…from people who create the resources and I think [that] has really helped build confidence and sort of ability to teach that. (Secondary 25)*

C. To What Extent Are Teachers' Perceptions of Their School's Culture Associated with Their Expressed Attitude?

The independent variables (Table 6) explained 24% of the variance in how important the surveyed teachers felt it was to teach PSHEe and to promote health and wellbeing in the sample (question item: 'It is very important for schools to teach PSHEe and to promote the

health and wellbeing of children and young people'), and 18% of the variance in this variable in the population. The multiple regression model was statistically significant (R^2 = .24, adjusted R^2 = .18, F (6, 74) = 3.90, p = .002). The results (Table 6) show that the teachers' perceptions of the level of support that senior leaders' give to promoting health and wellbeing, and their own beliefs about the link between health and educational attainment, whilst not being statistically significant at $p<0.05$, were positively associated with how important they felt it was to teach PSHEe and to promote health and wellbeing. Although not statistically significant senior leadership support had a slightly greater association with the teachers' attitudes about the importance of these activities than the teachers' beliefs about the link between health and education. The type of school teachers worked in, their perceptions of its socio-economic status and ethos and how important they felt it was to help pupils lead healthy and happy lives were not statistically significantly associated with their perceptions of the importance of PSHEe. Regarding school ethos this may be a consequence of the lack of influence and efficacy these new teachers feel they have in shaping the school environment.

Table 6

Unstandardised and standardised coefficients from the multiple regression analysis

Predictor/independent variable	Type of variable	β	SE	Standardised β	*t*	*p*
Type of school they work in (LA, free school, academy, private, other)	School's characteristics	0.06	0.04	0.15	1.45	.15
How would you describe the local catchment area of your school? (High socio-economic status area; low socio-economic status area;	School's characteristics	0.05	0.07	0.09	0.83	.41

neither a high nor low socio-economic status area.)						
Pupils' health and wellbeing is put at the heart or centre of everything the school does	School's environment and culture	0.80	0.06	0.14	1.26	.21
The senior leaders support staff to promote pupils' health and wellbeing and teach high quality PSHEe	School's environment and culture	0.15	0.06	0.29	2.56	.01
Helping pupils to live healthier lives and be happy and well is NOT important to me	Personal beliefs	-0.09	0.07	-0.13	-1.29	.20
Healthy and happy children are more motivated to learn and have better attainment	Personal beliefs	0.25	0.13	0.21	2.02	<.05

Discussion

The impact of the pre-service training to promote health and wellbeing in school appears to extend into the early years of this small sample of new teachers' careers but unsurprisingly, factors beyond the control of the training programme seem to influence how this is sustained and maintained or allowed to decline. These facilitators and barriers include the nature of school ethos and culture towards promoting health, the level or extent of support from experienced members of staff and their impact on the novice teachers' sense of efficacy, autonomy, developing identity and professional values.

School Priorities

From this study, involvement in teaching PSHEe seems to be highly dependent upon the priority the school gives to the subject. Whilst this appears to be obvious it is unlikely that

new teachers would find themselves in such a situation with respect to any other curriculum subject. Unlike countries such as Finland or Ireland the non-statutory status of PSHEe in England means that many schools do not give it much time or attention and that like other cross-curricular subjects there is the danger that it can 'get lost' (Formby & Wolstenholme, 2012). If schools and senior management do not support the provision of health and wellbeing education, but give precedence to other areas of school life, new teachers are unlikely to regard it as an important aspect of their role that will negatively impact on their attitudes about the subject (Day & Gu, 2010; Green & Greive, 2007; Jourdan et al., 2016). Despite the training they have received, the strong influence of the school environment and its systems is likely to reduce new teachers' willingness to take up opportunities, however minimal, to teach health and wellbeing (Brown et al., 2011; Myers-Clack & Christopher, 2001).

However, schools in England do have to attend by law to certain aspects of health and wellbeing such as safeguarding and Sex and Relationships Education (DfE, 2013). Raising awareness during training about key school policies and procedures meant that many of these new teachers had the confidence to seek out relevant information but a substantial number had not. Omissions in their training may have resulted in a lack of confidence or efficacy to seek out necessary information, but given the inconsistency of PSHEe provision reported it is possible that they had not been encouraged to do so, or opportunities were not available. The dearth of PSHEe in some schools seems to have militated against these new teachers' ability to engage with and develop a health promoting role to the extent that even statutory requirements are left unattended.

Impact of Training

Pre-service training appears to have raised awareness in this sample of teachers about the importance of health and wellbeing and yet opportunities to influence curriculum

development or teach PSHEe do not appear to be a regular occurrence. This indicates a potential risk that the training could lose its impact as teachers become embroiled in the day-to-day business of school life, and juggle other competing priorities such as developing the pedagogical skills and knowledge required for effective academic subject teaching. Whilst this may be true for many new teachers including the pre-service teachers in this study, an alternative is possible. For example, rather than focusing on the instrumental aspects of teaching, providing opportunities for new teachers to consider the broader purpose of their work may encourage them to develop the self-knowledge, personal growth and clarification of values they need to effectively manage health and wellbeing and foster positive attitudes about their wider pastoral role (Paakkari & Välimaa, 2013; Stenberg, 2010). As Mead (2004) indicates, teachers need time to reflect on their practice and critically engage with what they are doing and why in order to develop their professional knowledge and values, but in the hurly burly of school life opportunities to do so seem to be rare particularly with respect to health and wellbeing.

Whilst influencing at whole school level what happens in health and wellbeing education might not be expected of a new teacher, there were some who reported that they had been given such responsibly early on in their career. This is not unusual, as the subject is often ‘gifted’ to a newly qualified teacher because it falls into the horizontal discourse of the curriculum and is not considered to have a strong body of sacred knowledge associated with it. There is a pervading view that little expertise is required and someone without much experience can undertake this role (Formby, 2011; Whitty, Rowe, & Aggleton, 1994). They may of course accepted this role as either mature people, women or primary teachers who appear to be inclined to regard health and wellbeing education favourably (Jourdan et al., 2012). However the training seems to have been beneficial for these new teachers as they seem to have gained the confidence to take on responsibility for health and wellbeing and

cope with the demands this creates, and this is likely to improve their self-efficacy as health promoters. For others, life experience and a set of personal values seems to have provided a positive attitude and sense of efficacy to teach PSHEe. Despite unpromising circumstances these teachers have continued to promote health and wellbeing, albeit within their own sphere of influence such as their classroom (Hecimovich & Volet, 2011; Jourdan et al., 2016; McNamara, et al., 2012). It may be worth capitalising upon these teachers' experience and considering how they may facilitate less confident others to improve their self-efficacy through schemes such as peer mentoring during training in order to enhance and develop the professional knowledge and values needed to promote health effectively (Mead, 2011; Stolp et al., 2015; Thomas & Jones, 2005).

Barriers to Promoting Health and Wellbeing

At the other end of the spectrum about one third of the teachers said that they had not had an opportunity to teach PSHEe and the learning gained during training is in danger of being lost. Findings also indicate that a high proportion of schools prioritise academic subject teaching to improve attainment despite increasing evidence of the links between good health and educational outcomes (Brooks, 2014). The culture of performativity and academic achievement that prevails in many schools, in England and elsewhere, will inevitably affect how new teachers view their role, and has the potential to erode their nascent health promoting identities and compromise their autonomy and professional values, particular where personal values are in conflict with the school's ethos of performativity (Ball, 2003; Beijaard et al., 2004; Day & Gu, 2010; McNamara et al., 2012).

A further barrier to engaging with health and wellbeing appears to be the myriad of quotidian obligations teachers face. Our findings show that the impact of the training appears to be greater for newly qualified teachers than those who have been in school for more than a year. This suggests that pre-service training gets forgotten as the daily pressures of teaching

and other influences take precedence. These more experienced teachers are subjected to a range of other factors in their day-to-day teaching, possibly rendering pre-service training less relevant in teaching about health and wellbeing as they will have gained increased knowledge and understanding of their pupils and their lifestyles. That said, these teachers did not seem to be more engaged with PSHEe than their newly qualified colleagues which might suggest that ongoing professional development is appropriate in order for teachers to benefit from and capitalise on preservice training (Byrne et al., 2016; Jourdan et al., 2010).

Empowering new teachers through professional development to adopt good practice in health and wellbeing education may increase their self-efficacy and autonomy particularly where they may feel at odds with the prevailing school ethos, and help them, even in the busy school day, to consider how they can include aspects of health education in their teaching. The guidance and support of more knowledgeable practitioners within a situated learning experience as part of a community of practice is crucial to the further development of these new teachers' professional knowledge and values, and as a consequence their ongoing health promoting identity. A challenge to overcome is therefore the schools' ethos and the value they place on health and wellbeing. The support of the senior leadership team in creating a school climate that promotes health and wellbeing health is crucial if teachers are to maintain a health promoting role (Jourdan et al., 2016).

Facilitators to Promoting Health and Wellbeing

An environment in which new teachers are supported and nurtured to teach health and wellbeing appears to have facilitated them to develop their skills effectively and enabled them to capitalise on their pre-service training. This included supportive mentors who modelled good practice and engaged in constructive dialogue with their mentee to empower and motivate them to develop their teaching character as autonomous practitioners with professional values-based knowledge (Carr, 2007; Izadinia, 2016; McIntyre & Hobson, 2016;

Mead, 2011; Thomas & Jones, 2005). The importance of a nurturing environment is clear. When a new teacher has a sense of solidarity with their more experienced colleagues and they are included in the community of practice that promotes health and wellbeing, their self-efficacy is increased and they are able to flourish as a teacher of PSHEe (Cuddapah & Clayton, 2011; LoCasale-Crouch et al., 2012).

Similarly where the school culture and ethos is conducive to health and wellbeing and a whole school approach is adopted, new teachers appear to thrive as health promoters (Brown et al., 2011; Hecimovich & Volet, 2011). However, our findings indicate that some new teachers faced difficulties in teaching health and wellbeing due to the cultural norms and values of the school, for example religious beliefs. Decisions about the health education policy and what is included in the curriculum are made at institutional level and therefore beyond the authority of individual teachers. Senior leadership sets the tone and overall ethos of a school and this influences how teachers respond and behave (Brown et al., 2011). The positive association shown from our data between teachers' perceptions of the level of support senior leaders give staff to teach high quality PSHEe and the teachers' own attitudes about how important they felt it was to teach the subject suggests that senior leadership should embrace a holistic approach to promoting health and wellbeing as this is likely to positively influence new teachers' attitudes towards health and wellbeing education. A positive environment conducive to promoting health and wellbeing does appear to encourage the continuation and development of positive attitudes and beliefs about health and wellbeing (Jourdan et al., 2010). In such a climate new teachers will be encouraged to develop a teacher identity that includes and recognises the importance of health and wellbeing, and they are likely to become advocates for health education throughout their careers. This augurs well for the future of these new teachers and the children they teach. However, access to high quality health and wellbeing education should be a universal right for all children and training in

health at pre-service level is only a start. Whilst continuing professional development will facilitate access to health and wellbeing education for more children those who manage schools should ensure that the ethos of the school encourages and promotes health and wellbeing so that the barriers to teaching the subject are removed. Furthermore policy makers at local and national level should consider developing policies that enhances the status of the subject so that all children can not only improve their wellbeing but also flourish academically (Aggleton et al., 2010; Brooks, 2014; Suhrcke & de Paz Nieves, 2011).

Conclusion

The training the small sample of pre-service teachers in this study received does appear to have had an impact on some new teachers and generally influenced them positively towards their role as health promoters. Nevertheless the findings indicate that there are factors beyond pre-service training that influence new teachers to adopt a health promoting role or not. Our findings clearly show that support from senior leaders is essential to create an ethos within the school that supports health and wellbeing and thus enable a community of practice to develop that facilitates early career teachers' positive attitudes towards health promotion and their nascent teacher identity. Nurturing and developing this nascent identity has resource and policy implications particularly where health and wellbeing education is not currently prioritised. This will require commitment on the part of senior leaders in schools and Governments if they are serious about improving educational outcomes and enabling pupils to achieve their full potential. As the teacher at the beginning of this article notes they should also consider pupil health and wellbeing as integral to achieving this aim.

Finally, some caution is needed with respect to these findings as the teachers who responded may have more interest and positive attitudes towards health and wellbeing education and thus create bias in the results. It should also be noted that in the multiple-regression analysis the dependent variables only explained a small proportion of the variance

in teachers' attitudes (18% in the population) and so it is likely that other factors not included in our multiple regression analysis may be associated with teachers' attitudes about the importance of PSHEe and promoting health and wellbeing in schools, in addition to the factors we identified. This warrants further investigation. We did not have enough information about the sample to analyse non-responders' demographics against that of the responders to analyse of how they may have been different in terms of age, gender, type of course, attitudes to health and wellbeing, etc. To prevent response bias in the questionnaire we have used forced-choice items and reverse questions. We also believe the questions are fairly neutral and therefore not likely to be susceptible to socially desirable responding.

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