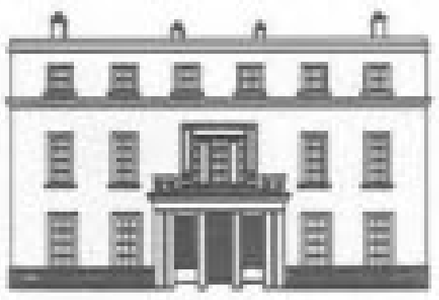
IRISH NETWORK OF HEALTH PROMOTING SCHOOLS



PROGRESS REPORT 1993-1996

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FOREWORD

The European Network of Health Promoting Schools promotes a philosophy of health promoting that reflects a holistic approach.

The progress of Irish schools, in the years 1993 - 1996, as a member of the European Network is described in two reports:

(a) The Irish Network of Health Promoting Schools - a Collaborative Report. (Saoirse Nic Gabhainn, Cecily Kelleher - Centre for Health Promotion, N.U.I., Galway and the Steering Committee of the Irish Network of Health Promoting Schools).

(b) The Implementation of the European Network of Health Promoting Schools in Different National Contexts (Parsons et al. Centre for Health Education and Research, Canterbury Christ Church College).

The enthusiasm generated at national and school level is highlighted in both reports. The importance placed on the development of school structures, the implementation of timetabled SPHE, staff development, teaching methods and parent involvement are all highlighted. The benefits of creating a supportive social and physical environment and developing community links are clearly visible.

It becomes apparent that changes in feelings, attitudes, values, competencies and health promoting behaviours is a long-term objective dependant on getting the school setting right.

Central to the success of the Irish Network of Health Promoting schools has been:

(a) The credibility given to health promoting activities by being part of the Irish and European Network of Health Promoting Schools.

(b) The support given by the National co-ordinating centre to assist schools in working towards goals which they have set for themselves

(c) The quality of inservice training provided at Summer Schools, National and school-based workshops.

The commitment of the 10 schools, and of key personnel within the schools, has been acknowledged as the foundation on which all other interventions to support health promotion depend.

We would like to thank these schools for their commitment and inspiration over the 3 years. Without them there would not be an Irish Network of Health Promoting Schools, or an Irish involvement in the European Network of Health Promoting Schools.

Owen Metcalfe
Chief Education Officer
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The Irish Network of Health Promoting Schools
- A Collaborative Report -

(**Saoirse Nic Gabhainn, Cecily Kellegher,**
Centre for Health Promotion, N.U.I., Galway /
Steering Committee of the
Irish Network of Health Promoting Schools)

THE IRISH NETWORK OF HEALTH PROMOTING SCHOOLS EVALUATION OF THE PILOT PHASE 1993 - 1996

Executive Summary

Saoirse Nic Gabhainn, Cecily Kelleher and the Steering Committee of the Irish Network of Health Promoting Schools

Introduction

This executive summary describes the Irish Network of Health Promoting Schools and covers the main findings from the various research strands designed to evaluate the pilot project. The results from the qualitative and quantitative investigations are discussed and the main recommendations provided. The quantitative investigations consisted of the collection of school level information through the Questionnaire for Health Promoting Schools and pupils' information through a series of self-completion questionnaires and the 'Draw and Write' activity. Other data were collected through a series of school visits and semi structured interviews with implementors, parents, teachers and pupils in all of the Health Promoting Schools in the project.

The Health Promoting School

There are three main elements in the health promoting school concept; (1) *the health education curriculum*, referring to the teaching methods and materials applied during classroom-based health instruction, (2) *the school ethos or 'hidden curriculum'*, referring to the physical, social, or pedagogical environmental conditions within the school, and (3) *the school-home-community relations*, referring to factors outside school which may or may not reinforce what students have learned within school. This may include active involvement of parents in curriculum planning, planning of congruent school-based and home-based activities, close collaboration between the school and local health agencies, and the like.

The health promoting school concept was originally developed by the World Health Organisation Regional Office for Europe as early as 1984 (Kickbusch, 1991), and was further cultivated through collaboration with the Council of Europe (CE) and the European Commission (EC). The concept of the health promoting school is closely aligned with ideas described in WHO Ottawa Charter for Health Promotion (WHO, 1986). Central to the strategies described in the Charter is a recognition of the fact that alongside the attention given to individual lifestyles, action also has to be taken to influence the underlying social and

economic conditions and physical environment which influence health behaviour choices. For schools this has meant that their role can be seen not only in terms of working directly with young people, but also in terms of the public policies which determine the role and functions of schools, the physical environment of schools, and the relationships between schools and the wider community.

The Irish Network of Health Promoting Schools.

Although Health Education or Promotion has never been mandatory in Irish primary or post-primary schools, the Education *White Paper* 'Charting our Education Future' (1995) identifies personal and social development of students as a central aspect of education. The departments of Health and Education agreed to undertake an initiative to foster the development of health promoting schools (Morrow 1994). The Health Promoting School initiative began in 1992, when discussions were undertaken with relevant bodies and seminars were organised. The pilot schools were invited to join the project in the Spring of 1993. This development coincided with the decision by CE, EC and WHO to establish the European Network of Health Promoting Schools (ENHPS) to encourage innovation and to disseminate good practice in health education and promotion. Ireland has been a participant in this Network since Autumn 1992. The Irish Network is supported by a Steering Committee which represents the Department of Education, the Department of Health and the Marino Institute of Education. The supports offered to the schools include in-service meetings for parents, principals and co-ordinators of the member schools, summer schools for teachers, school visits, specialist in-service workshops and the provision of resource materials (Lahiff, 1995). The 10 pilot schools (5 primary and 5 post-primary) attended the first induction workshop in May 1993 and committed themselves to a three year pilot programme. The specific supportive activities undertaken by the national co-ordinators and individual school reports are detailed in the Irish Network of Health Promoting Schools (INHPS) annual reports (Morrow, 1994; Lahiff, 1995; 1996). During the pilot phase, the steering committee of the Irish Network invited the Centre for Health Promotion Studies to undertake an evaluation of the INHPS.

The development of the Health Promoting School concept and its specific application in Ireland should be viewed within the context of other developments in Irish School Health Education and Promotion. This is an exciting time for those involved in this area, as the developments are many and varied. For many years the impetus behind post-primary school health education came from individual school parents and teachers and managers who saw the need to help pupils deal with what were considered to be new pressures facing adolescents. These focused on the topical issues of substance use, relationships and growth and development, and were in some cases supported by the Health Education Bureau, the Department of Health and the

Department of Education. During this time primary schools were expected to cover relevant topics under the physical education directives of the new curriculum (1970). At national level both the Departments of Education and Health became increasingly interested in youth and school health education and supported the development of a considerable number of educational packages designed for use in these settings (e.g. Drink Awareness for Youth, 1989; Aids Education Programme, 1990; Action for Life, 1992; Substance Abuse Prevention Programme, 1993). A number of regional Health Boards have been involved in training teachers in the new classroom methods required as well as in developing their own programmes with teacher packs, class plans and other resource materials. A more detailed chronology of this evolution can be found in Nic Gabhainn & Kelleher (1995). More recently the National Council for Curriculum and Assessment and the Department of Education have been developing the potential role of what is now called social, personal and health education (SPHE) and there are lobbies at local and national level supporting its inclusion on the curriculum of all schools. Informing this possible expansion has been the national health strategy (1994) and the white paper on education (1995).

Specific Activities of the Irish Network

The co-ordinators of the Irish HPS project have provided an outline of activities undertaken under its auspices. This is included here as specific examples of the programmes and actions undertaken and to provide a more detailed context to the sections that follow. In Ireland, the Health Promoting School concept is a philosophy of whole-school development. Each school is seen as a unique social organisation addressing its own needs and developments in the Project Schools reflect these differences. Each school identified its own priorities in the areas of SPHE Programmes; staff development; parent and community involvement; and school environment.

SPHE Programmes

All schools identified the need for timetabled SPHE, supported by cross-curricular and co-curricular activities. Most commonly, schools had and/ or developed a weekly timetable slot for SPHE. Elsewhere a modular approach was taken. The framework for SPHE was consistent with the European model of Me; Myself and Others; and Me in My Community. It aimed to develop personal and social skills and provide relevant information with a view to promoting healthy behaviours and lifestyles.

'Activity Weeks' were a common feature and focused on nutrition, safety, dental health, physical activity, and environmental issues. The display of students' work was a practice in

many schools. In some schools, surveys were undertaken to identify the curriculum needs of students.

The SPHE programmes were supported by school co-ordinators and at post-primary level, by year-head/ tutor structures.

Staff Development

Teacher in-service has been provided by the Network at school and national level.

The provision at school level has been in response to schools' identified needs, and has included half-day and full-day whole staff in-service. These seminars aimed to clarify the HPS philosophy and to develop facilitation skills and counselling skills for use in the classroom. Prefect training was provided in one school. Elsewhere, first-aid and cardio-pulmonary resuscitation were a focus.

Facilitation skills training has been provided for groups of teachers on request. In other instances, teachers have been encouraged to avail of such training as that provided by 'On My Own Two Feet' (The Substance Misuse Prevention Programme). Each Primary School had a day's in-service for the 'Action for Life' programme.

Schools have additionally been supported from the National Centre by the provision of resources for SPHE; school visits; telephone contact; and a regular newsletter.

At National level, two in-service days have been provided annually for the Principal, Parent Representative and HPS Co-ordinator from each school. Here the focus has been on clarifying the HPS concept and philosophy; examining roles and structures in schools; developing school policy; promoting good communication and networking ideas. A special in-service on the use of 'Circle Time' was provided by Jenny Mosley (Self-Esteem Consultant, U.K.) over 3 days.

Annual Summer Schools for teachers in the Network have been well supported and have addressed such issues as promoting self-esteem; art and drama in the classroom; bullying; substance misuse; relationships and sexuality education; SPHE programmes and skills development; physical education and leadership and counselling.

Parent Involvement/ Community Links

All project schools identified the need to involve parents in the life of the school. Schools responded in a number of different ways - open days, induction programmes for new pupils/

parents; parenting courses and parent involvement in supervising a range of co-curricular activities.

Schools have focused on the development of a structure for parent involvement through Parent Councils, Parent/Teacher Associations, etc. Parents' needs and priorities were surveyed in a number of schools; parents facilitated parent groups in some schools and parents have also been engaged in policy development.

In some schools parent training for facilitation work was a major focus. In the most developed example, a group of parents completed 150 hours training over 3 years and received certificates in facilitation skills from St. Patrick's College, Maynooth. These parents now facilitate groups of students and parents in the school and in the local community, with a focus on self-esteem, assertiveness, substance misuse prevention and bereavement.

At community level, schools have participated in Tidy Towns and Healthy Cities Projects. Students have participated in projects with senior citizens. In one school, a group of parents have learned to swim; another has been closely involved with the development of a community sports complex. All schools have invited visitors from the local community. These include representatives from Gardaí; fire service; sporting bodies; community drugs counsellors; local authorities; and interactive drama workshops.

School Environment

Attempts were made to make the schools more user friendly by the use of signposting. Some schools developed designated meeting points such as a room for parents. Awareness was raised for the need to maintain safety standards, including fire drills, in a busy school schedule. For some schools the physical limitations of the building presented difficulties.

Where schools provide catering facilities, the need for providing healthy alternatives was addressed. The issue was identified as the dilemma between the need to run these facilities to raise funds and the ideal of promoting healthy eating. One school, in particular, was successful in meeting both objectives.

The provision of school gardens and window boxes was a particular focus of some primary schools as was the development of health promoting school yards, with designs to promote games and activities included. Health messages included the display of student work as deemed appropriate.

The importance of promoting good relations between all members of the school community was stressed in the context of improving overall health and well-being.

Evaluating the Irish Network of Health Promoting Schools

The progress of each individual school should be documented against its own goals and internal criteria. Given the nature of the constructs inherent in the Health Promoting School concept, assessment of the progress towards these ideals should be assessed primarily through the perspectives of those constituencies the project was intended to develop, namely pupils, staff, parents and external community based bodies. Of particular interest is the documentation of particular factors assisting the progress of schools and indeed those issues which posed particular difficulties and may even have led to setbacks or slower progress than was desirable. However, the impact of the project on actual behaviour and health related attitudes is also interesting and for this aspect of the evaluation a more quantitative approach is warranted.

In order to illuminate the change process, to investigate the perceived impact on schools and to document factors influencing the natural history of the project, this section of the evaluation was approached from a qualitative perspective. Progress was assessed through semi-structured interviews. Principals, co-ordinators, teachers and students in each school were sampled and their opinions and experiences with the project investigated through interviews with personnel and students as well as observation conducted throughout the time spent in each school. Schools also provided the researchers with documents and supportive materials related to their involvement within the Health Promoting School Project. Issues around the impact of the HPSP on factors such as physical and social environment, involvement of the home and community and social and health curriculum were investigated using the data from the interviews and documentation garnered from each school and the project coordination centre throughout the duration of the project. In addition, factors that facilitated and factors that hindered the implementation of the project were also studied and documented.

The qualitative findings

Teachers, staff and pupils in all ten schools were very welcoming and open to the visiting researchers. Their co-operation facilitated the conduct of the evaluation. They were willing to communicate about all aspects of their involvement with the project and their candour allowed great confidence in the honesty of their responses. Representatives in all schools indicated that they were happy to be part of the network, had learnt from their membership and felt that overall, there had been a positive influence on the school and the pupils within it.

Most primary schools are doing well in striving towards their ultimate goal of being a Health Promoting School. School-home links appear strong with parents involved in a broad spectrum of school related activities. All schools have a social, personal and health education curriculum. In addition, they all put emphasis on physical education and physical activities. More importantly, the promotion of self-esteem has taken on a central role in many primary schools. It was reported that staff/pupil and particularly staff/parent relationships have improved. However, the provision of a health promoting physical environment has proved difficult for the 'old' schools who are constrained by the age and condition of school buildings. Structural factors such as inadequate classroom space and toilets do not advance the building of a health promoting environment. It should however, be remembered that improvements are often restricted by the age and structure of the buildings.

Similarly, most of the post-primary schools had made substantial progress towards being health promoting. One of the most difficult issues to be faced in interpreting the qualitative findings from the post-primary schools is the huge differences between them (e.g. gender composition, funding arrangements, location) which obviously influenced where they started from and the perspective they took on their involvement with the project. Support from principals and senior management is crucial to the development of the project within schools, without this support implementation becomes almost impossible. In schools where there was full support from the principal and an inclusive management style the project was developing well. For the full implementation of the project in schools, staff training and development is also extremely important. Staff development has occurred to a greater extent in some schools than others and where this has occurred it is of great benefit to the implementation of the project. Structural factors also influenced implementation, the newer schools having more physical resources to assist them in their work.

The major issues which were perceived as having influenced the history of the project in schools related to a number of factors. Training and support from the National coordinating centre were seen as vital and central. This included summer schools, in-service training and grant aid. The freedom for each school to set its goals was also frequently applauded. This also presented schools with their greatest challenge. Lack of prior training in the area, the perceived inaccessibility of in-service and lack of money were all factors which were seen as impacting negatively on project implementation. These rendered communication between schools and mutual support difficult.

According to Quinn (1991) to promote health in schools the three elements that need to be present in any school are attitude, involvement and time. A positive attitude and a feeling of

involvement by Principal, staff and parents towards the promotion of health combined with dedicated time on the curriculum for health education are the key factors which enable a school to become more health promoting. The 10 HPS schools included in this evaluation have all attained or improved their performance on at least one of these elements. Those with all three are clearly more advanced than the others. In general the nature of the schools and particularly their pre-project disposition towards this area of work could account for many of the inter-school differences.

The Questionnaire for Health Promoting Schools

Respondents from all schools were clear about and willing to complete the Questionnaire for Health Promoting Schools (Nic Gabhainn & Kelleher, 1995) *(see appendix 1)*. In both the primary and post-primary schools the pattern of their responses reflect what was later observed during the school visits. This reinforces the validity of the questionnaire. As there are so few schools involved it makes less sense to talk about patterns emerging, but it is clear that links with other schools and the community have provided member schools with challenges. The primary schools scored themselves as slightly more Health Promoting than the post-primary schools.

The comparison groups

In the absence of a dedicated control group for this study, an approximated comparison group was constructed from data collected for the Lifeskills evaluation (Nic Gabhainn & Kelleher, 1995). Great care must be exercised in any analysis utilising these separate data sets because they were collected 2 years apart and from different areas of the country. For the post-primary groups these consisted of samples from the school population of a single Health Board. Data were collected in these schools using exactly the same instrument and methods as in the current evaluation, that is by individual researchers in the classroom. The comparison group comprises all those sampled in this way who report not having received any health education and who are in the same year groups as those sampled in the HPS schools.

For the primary schools the comparison groups consists of 3rd and 4th class pupils in NWHB schools who had never been exposed to health education as reported by their class teachers. Again the methods used to collect the data were exactly the same as those employed here, with one exception. In the NWHB the only contact researchers had with the teachers who collected the data was through the post or by telephone. In this case school visits had been held although the researchers had not necessarily met with the teachers who later led the classes in the draw and write activity.

The Draw and Write activity

The paucity of a psychometrically sound instrument to measure health behaviour in primary school age Irish children resulted in the decision to adopt the 'Draw & Write' technique (Williams et al., 1989). This consists of teachers asking pupils to draw pictures of all the things they do to **Make them Healthy** and **Keep them Healthy**. These drawings are then coded according to a number of predetermined categories. A3 sheets of drawings were collected from 3rd and 4th classes in all 5 HPS primary schools. This comprised a total of over 1500 drawings from 195 pupils. Each individual drawing and its accompanying text was categorised as to whether it reflected any one of 16 possible categories and pupils were scored as to how many categories they covered, how many drawings they submitted in total as well as a variety of other dependent variables. The differences between the drawings of the various schools are likely to be related to various campaigns conducted within them, for example some schools concentrated over time on personal hygiene and others on safety issues. This is reflected in the drawings from pupils. Below are presented the overall findings for the primary HPS pupils

Table 1: Classification of drawings for HPS primary schools. Percentages covering each activity in their drawings are given.

Category	HPS %
% Exercise	73
% Doctor	2
% Food	71
% Fresh Air	13
% Safety	14
% Hygiene	46
% Medication	10
% Negative	22
% Play	25
% Relationships	27
% Rest	8
% Sleep	20
% Dental Care	35
% Temperature	3
% Work	15
% Nil	27
Total number of drawings submitted	8.25 (6.29)
Number of categories covered	4.12 (2.47)
Number of categories covered not including the Nil or inappropriate ones	3.86 (2.39)
Total N	**195**

It should be noted that pupils from the Health Promoting Schools drew pictures in a wide range of activities. Most categories were well represented including, for example, play, work and relationships. These topics are central to the concept of the Health Promoting School. Where significant differences were identified between the drawings of the HPS pupils and the comparison schools they were all in favour of the HPS pupils.

The post-primary school survey

A survey of senior pupils in each of the 5 post-primary schools involved with the project was conducted employing the core questionnaire from the WHO cross national Health Behaviour in School Children (HBSC) study. The HBSC questionnaire was initially developed by an International group of multidisciplinary researchers (Aaro et al., 1986), working with the support of the World Health Organisation - European Office. This instrument is being used by ENHPS evaluation teams in numerous countries and is recommended by the EVA project (Piette et al., 1995). Along with the HBSC core questionnaire all pupils were administered the Rosenberg Self-Esteem Scale (Rosenberg, 1965), the General Well being Questionnaire, with its two subscales uptight and wornout (Cox et al., 1983; 1984) the Mastery Scale (Pearlin & Schooler, 1978) and an assessment of their health related knowledge (Nic Gabhainn & Kelleher, 1995). The percentages of pupils in the Health Promotion post-primary schools engaging in various health behaviours varies considerably and care should be taken in interpretation. Because sample sizes are relatively low, straightforward comparisons between the schools would not be reliable, in any case statistical analyses reveal few significant differences between schools or between the post-primary HPS pupils and the post-primary comparison pupils. Below are presented the overall findings for the post-primary HPS pupils.

Table 2: Substance use among post-primary HPS pupils

Behaviour	Girls	Boys
% Currently Smokers	49	35
% Have ever had a drink	95	93
% Drink beer ≥ weekly	32	54
% Drink spirits ≥ weekly	15	27
% Have ever been drunk	74	80
% Been drunk > 10 times	12	36
Total N	**101**	**70**

From closer examination most of the elevated drinking rates were attributable to one HPS school. So particular care needs to be exercised in interpreting these data on drinking behaviour.

Table 3: Exercise participation among post-primary HPS pupils

Behaviour	Girls	Boys
% Exercising ≥ 4 times p.w.	17	55
% Exercising ≥ 4 hours p.w.	14	39
Total N	**101**	**70**

Table 4: Eating behaviour among post-primary HPS pupils

Behaviour	Girls	Boys
% Coffee ≥ daily	26	31
% Fruit ≥ daily	72	63
% Cola[1] ≥ daily	42	60
% Sweets ≥ daily	70	73
% Crisps ≥ daily	43	41
% Chips ≥ daily	19	27
% Burgers ≥ daily	8	9
% Brown bread ≥ daily	32	28
% Low fat milk ≥ daily	31	22
% High fat milk ≥ daily	59	71
Total N	**101**	**70**

Table 5: Dental Care among post-primary HPS pupils

Behaviour	Girls	Boys
% Brush teeth ≥ daily	98	87
% Floss teeth ≥ daily	9	3
Total N	**101**	**70**

[1]This refers to both cola and other fizzy soft drinks

Table 6: Safety behaviour among post-primary HPS pupils

Behaviour	Girls	Boys
% Always wear seat-belt	46	26
Total N	**101**	**70**

Table 7: Leisure behaviour among post-primary HPS pupils

Behaviour	Girls	Boys
% T.V. ≥ 4 hrs a day	12	23
% Video ≥ 4 hrs a day	8	22
% Computer ≥ 4 hrs a week	2	10
Total N	**101**	**70**

Table 8: General feelings among post-primary HPS pupils

Behaviour	Girls	Boys
% Very or quite healthy	67	87
% Very or quite happy	82	75
% Often lonely	14	15
Value Health[2] Mean (SD)	3.92 (1.00)	3.94 (0.98)
Total N	**101**	**70**

[2]This is measured on a five point scale and the means (standard deviations) are presented here, higher scores represent a greater value placed on health

Table 9: **Symptoms among post-primary HPS pupils - those who report having the following symptoms often**

Behaviour	Girls	Boys
% Headache	32	19
% Stomachache	26	10
% Backache	10	20
% Feeling low	29	15
% Lose temper	32	33
% Nervous	15	13
% Sleep problems	22	29
% Dizzy	9	14
% Tired in the am	8	14
Total N	**101**	**70**

Table 10: **Medication use among post-primary HPS pupils - those who report having used medication to help with these problems in the last month**

Behaviour	Girls	Boys
% Coughs	19	21
% Colds	30	28
% Headaches	59	40
% Stomachaches	45	9
% Nervousness	4	0
% Sleep problems	5	2
Total N	**101**	**70**

Table 11: Health related knowledge among post-primary HPS pupils

Behaviour	Girls	Boys
Knowledge Mean (SD)	17.84 (3.29)	18.61 (3.24)
Total N	**101**	**70**

The next table in this series presents the results from the analyses of responses to a series of psycho-social measures which were presented along with the core HBSC questionnaire. For each measure a mean score and a standard deviation is presented. Thus the first row contains the means and standard deviations for the HPS pupils on the Rosenberg Self-Esteem Scale. The subsequent rows contain the means and standard deviations for the Mastery scale, the subscales Uptightness and Wornout of the General Wellbeing Scale and the overall General Wellbeing Scale. In each case a higher score indicates a greater level of psycho-social well-being.

Table 12: Psycho-social health among post-primary HPS pupils

Behaviour	Girls	Boys
Self-esteem Mean (SD)	34.79 (6.71)	38.24 (7.81)
Self Mastery Mean (SD)	20.52 (3.40)	21.88 (3.87)
Uptightness Mean (SD)	34.04 (5.29)	35.67 (5.39)
Worn out Mean (SD)	27.65 (5.89)	29.74 (6.22)
General wellbeing Mean (SD)	61.81 (10.07)	65.39 (10.79)
Total N	**101**	**70**

Overall, few differences have emerged between the post-primary HPS pupils and the comparison pupils. On the whole there is no pattern in favour of either group and in general the

pupils seem fairly typical of their age range. It is likely to be some time before behavioural differences emerge and the present information serves as a baseline. Although the project does not appear to be impacting positively on the health behaviours there are a number of possible explanations for these findings. The most likely is that one should not expect significant behavioural changes over a short time period and particularly not in a project that did not specifically target behavioural change.

The focus of the project was broad and emphasised communication, structures and methodology rather than focusing narrowly on behaviour change. Thus it would have been very unlikely to actually effect health behaviour. It is rare that behaviour change would be identified in a short term intervention and this evaluation mirrors many such findings.

It is also known that other factors such as structural school differences and socio-demographic classifications determine many health behaviours and such factors were not within the scope of this project. However, it should be noted that 3 schools (1 primary and 2 post-primary) cater for pupils from urban disadvantaged areas.

Recommendations

Many of the following recommendations centre on communication and structures within the school and between the school co-ordinators and other parties. Others are related to project management and the conduct of the network. Given the recent expansion of the network, some of the following recommendations acquire even more significance and should render the current phase of the Irish Network of Health Promoting Schools even more effective.

• All teachers from all subject areas should be made aware of how they could contribute to the Health Promoting School Project in the school as well as how it could affect them and should actively be encouraged to participate. The Health Promoting School is a whole school philosophy and it needs the co-operation of all teachers and staff.

• The criteria for inclusion in the project should be more detailed and preferably formalised in order that selection procedures can be reviewed.

• Care should be taken to ensure awareness of the extent of the commitment needed from school management to ensure effective participation in the Network.

• Schools would benefit from pairing, matching or the provision of regional networks of similar types of schools. This would aid mutual assistance between schools and minimise their

reported isolation within the project. This might be a focus in the future development of the project.

• Individual needs assessment is required for each school and this would be best paired with realistic objective setting in each school. This is not only necessary when a school first joins the network, but may be of specific use after being involved for a period when the working and goals of the project are more completely understood.

• Staff development programmes should be supported in schools to enable teachers to be properly equipped to teach health education and especially how to deal with the more sensitive topics in this area.

• The way in which schools budget and allocate resources could be disseminated in a more systematic fashion across the network. Budgeting and activities should be documented, reported and disseminated in a systematic fashion across the network. This would assist the coordinators, funders and member schools in identifying other budgetary options.

• Schools policies must be made known to all students, parents and staff and in order to be of worth must be regularly reinforced within the schools activities.

• Specific and specialised assistance should be made available in response to particular identified needs. Resources and experienced helpers could be identified to facilitate this purpose.

• Given that the physical differences between schools appeared to influence the implementation of the project, more attention must be paid to physical resources. Special funding could be made available to those schools requiring specific alterations.

• Some schools would benefit from guidance on how to co-operate and forge links with their feeder primary schools or associated post-primary schools. This is one area which would enable schools to start working more widely within the community.

Acknowledgements

This project was supported by the Steering Committee of the Irish Health Promoting Schools Network. We acknowledge the assistance of representatives from all ten pilot Irish Health Promoting schools in the country. The information and data provided by the project co-ordinators Ruby Morrow and John Lahiff were also of considerable help to us. This work has been conducted by Saoirse Nic Gabhainn with the help of Olivia Carney and Ursula Diamond, both Masters students on the M.A. in Health Promotion in U.C.G., and under the supervision of Dr Cecily Kelleher, Professor of Health Promotion.

APPENDIX

Number of primary schools who agreed or strongly agreed with the HPS statements

Statement	N
Our school actively promotes the self-esteem of all pupils	5
Our school makes its social aims clear to pupils	5
Our school makes its social aims clear to staff	5
Our school promotes good nutritional practice	5
Our school provides stimulating challenges for all pupils through a wide range of activities	4
We actively encourage an exemplar role for staff in health related issues	4
We take every opportunity to enhance the physical environment of the school	4
We utilise the help of specialist services in the community for advice and support in health education	4
We have developed excellent home school links	4
We actively promote staff health and well-being	3
We have developed excellent community school links	3
We have developed good links with associated secondary schools to plan a coherent health education curriculum	0

Number of post-primary schools who agreed or strongly agreed with the HPS statements

Statement	N
Our school promotes good nutritional practice	5
Our school actively promotes the self-esteem of all pupils	4
We take every opportunity to enhance the physical environment of the school	4
We have developed excellent home school links	3
Our school makes its social aims clear to staff	3
We actively promote staff health and well-being	3
We have developed excellent community school links	3
We utilise the help of specialist services in the community for advice and support in health education	3
Our school provides stimulating challenges for all pupils through a wide range of activities	2
Our school makes its social aims clear to pupils	2
We actively encourage an exemplar role for staff in health related issues	1
We have developed good links with associated primary schools to plan a coherent health education curriculum	0

Number of primary schools who responded affirmatively to the policy subscale

Policy	N
A code of discipline	5
A policy on games and exercise	5
A policy about safety and supervision	5
A policy on litter	5
A policy on bullying	5
A properly maintained first aid kit	5
Well maintained school grounds	5
A policy on children with special needs	5
A schools achievement / award system for pupils	4
A policy about break time / snack foods	4
Proper hygiene and toilet facilities	4
A child abuse referral system	3
A policy about school lunches	3
A system of fire drill	3
A toilet routine	3
Programmes of staff training	2

Number of post-primary schools who responded affirmatively to the policy subscale

Policy	N
A policy on games and exercise	5
A policy on movement of students in school	5
Proper hygiene and toilet facilities	5
A policy on bullying	5
A properly maintained first aid kit	5
A system of fire drill	5
Well maintained school grounds	5
A health education programme	4
A policy about smoking	4
A policy on children with special needs	4
A policy on litter	4
Programmes of staff training	3
A policy about the tuckshop	2
A policy about school lunches	2

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The Implementation of the European Network of Health Promoting Schools in Different National Contexts

(**Parsons et al.,**
Centre for Health Education and Research,
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The Implementation of the European Network of Health Promoting Schools in Different National Contexts

A Summary

The Theoretical and Practical Background

This research was carried out by a team based at Christ Church College, Canterbury, England from April 1996 - March 1997 and took place in six countries. It was funded by the Technical Secretariat of ENHPS with allocations from EC, WHO, and voluntary donations.

The ENHPS is a concept born of international idealism and is supported by the World Health Organization, the Council of Europe and the Commission of European Communities. The Technical Secretariat of ENHPS is the originator of what is a package of innovations disseminated to countries by inviting their involvement. By December, 1996 37 countries were involved. The Health Promoting School has been defined in the following terms:

> The Health Promoting School aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing environment.
>
> (WHO/EURO (1995) The Overall Progess of the ENHPS Project January - December, 1994)

It is a holistic and empowering definition and schools participating in the network are expected to address twelve criteria:

- active promotion of the self esteem of all pupils by demonstrating that everyone can make a contribution to the life of the school;
- the development of good relations between staff and pupils and between pupils in the daily life of the school;
- the clarification for staff and pupils of the social aims of the school;
- the provision of stimulating challenges for all pupils through a wide range of activities;
- using every opportunity to improve the physical environment of the school;
- the development of good links between the school, the home and the community;
- the development of good links between associated primary and secondary schools to plan a coherent health education curriculum;
- the consideration of the role of staff exemplars in health-related issues;
- the active promotion of the health and wellbeing of school staff;
- the complementary role of school meals (if provided) to the health education curriculum;
- the realisation of the potential of specialist services in the community for advice and support in health education;
- the development of the education potential of the school health services beyond routine screening towards active support for the curriculum.

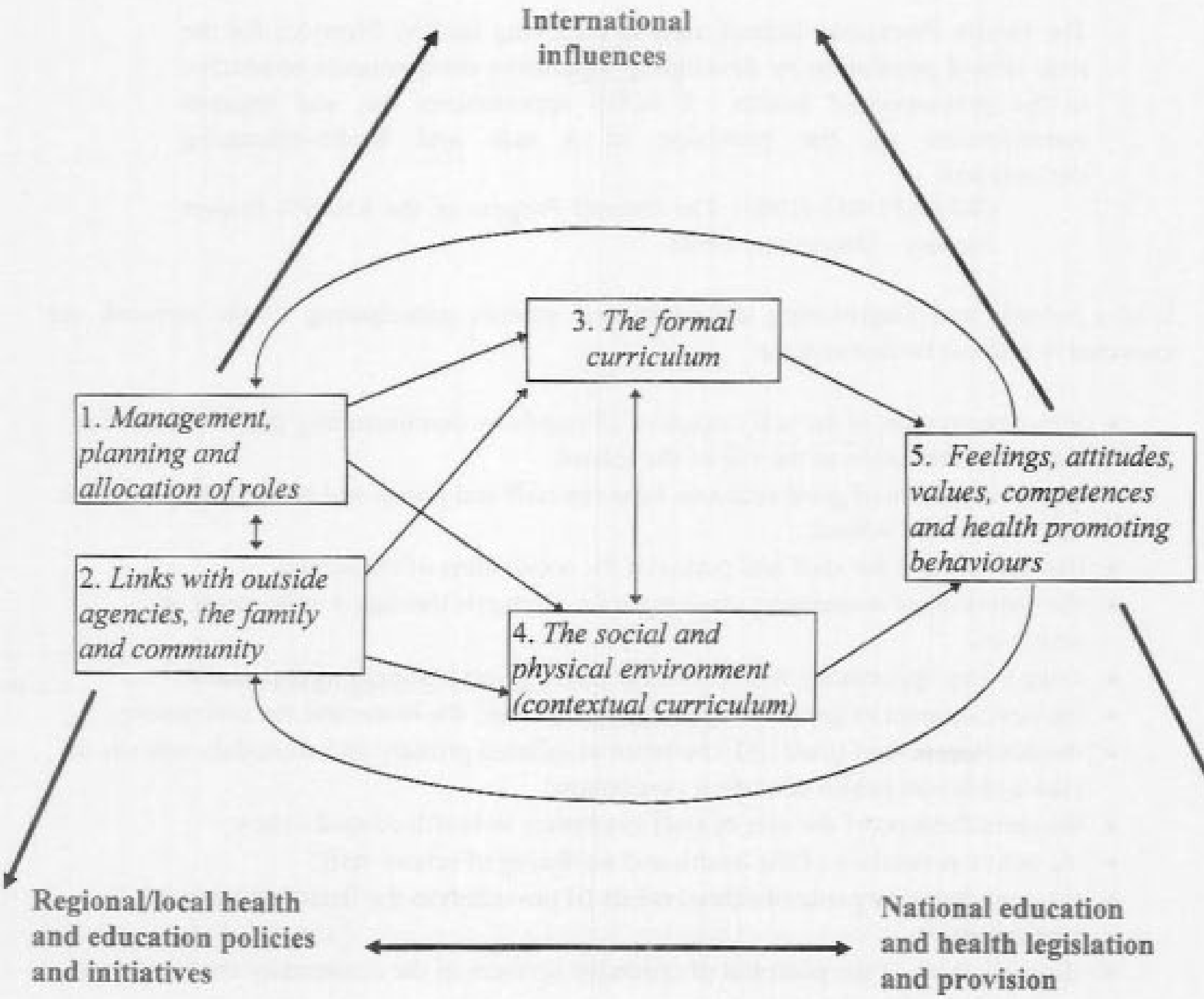
> (WHO, CEC, CE (1993) The European Network of Health Promoting Schools: A Joint WHO-CE-CEC Project, p1)

The Models and Methods of the Research

The research team has worked with a model in which account must be taken of three major sets of factors which might be expected to influence the reception of ENHPS: the first set is to do with previous experience of health promotion and the "stage of development"; the second set is to do with national policies and priorities; the third is concerned with environmental pollution, absolute levels of wealth, and practical needs and possibilities in the promotion of health.

The diagram below is a representation of the main contemporary features within the Health Promoting School, the interaction amongst those features and elements of the external contexts. This model guided the data gathering, analysis and reporting.

The Eco-Holistic Model of the Health Promoting School



ENHPS exists in a context of international influences, national, regional and local policies and provisions. *Management, planning and the allocation of roles* (1) are part of the context which supports both the *formal curriculum* (3) - the explicit health promoting process - and *the social and physical environment* (4), the contextual or parallel curriculum. Much of the official writing on the HPS concerns these areas. The argument, theoretical and empirical, is that if you get these right the desired impact - changes in *Feelings, attitudes, values, competences and health promoting behaviours* (5) - will happen with those inhabiting the school - pupils, teachers and other staff.

The links with the community, families and outside agencies (2) are important since the school is not insulated from them. The feedback loops and interactions may not be set out in the diagram in their full complexity and will vary from school to school.

The research is a macro formative evaluation conducted to serve the international partners and participants in the Network, European and national agencies supporting the programme, and schools. The objectives of the research were to investigate:

1. the extent to which the working practices and the structures established are consonant with the aims of the European Network for Health Promoting Schools;
2. models of health promotion and health education being used to develop work in European Schools;
3. the political, social and managerial influences on schools affecting their health promoting ethos;
4. support for schools in their management of institutional change in relation to health promotion.

Fieldwork

Members of the research team visited each of the six countries and interviewed ENHPS national team members and officials at the national and regional levels and examined relevant documentation. Schools were visited, interviews were conducted, both with teachers and local agents involved with health promotion and there was some opportunity to observe lessons.

Draft sections of the report were returned to identifiable individuals for comment on accuracy and the whole report was then sent to the six national project directors. This is an important safeguard for reasons of diplomacy, ethics and accuracy. Information received as a result of this process was most helpful in finalising the report. The countries and schools visited are set out below.

Countries and Schools Visited

Country	Dates of visit	Schools visited
Lithuania	11–18 May 1996	• Jablonskis Secondary School, Kaunas • "Rasa" Gymnasium, Kaunas • Radvilenai Secondary School Kaunas • Radviliskis Grazina Secondary School • Vilnius Primary School, "Gama"
Ireland	27–30 May 1996	• St Thomas' Senior National School, Tallaght, Dublin • Killinarden Community School, Tallaght, Dublin • Caherline National School, Caherconlish, Co. Limerick • St Mary's College, Arklow, County Wicklow
Poland	10th–13 June 1996	• Primary School no. 21, Stanin • Primary School no. 2, Augustow • Primary School no. 5, Ostrowiec Swietokrzysk
Portugal	7–11 October 1996	• A consortium in Gouveia. (Kindergarten, Primary School & Preparatoria) • Amadora School.
Romania	18–21 November 1996	• Mahmudia School, Tulcea • School no. 13, Galati • Primary School no 17, Bucharest • Technical School, Baia Sprie • Primary School, Branesti • Sanitary High School, Gheorghe Marinescu, Targu Mures
Sweden	9–13 September 1996	• Kärsbyskolan, Norsborg • Tallbohovskolan, Järfälla • Vivallaskolan, Orebro

Main Findings

1. ENHPS is seen by member states as an internationally credible vehicle for developing public health policy, forging healthy alliances and stimulating community action.

2. The Network has become a major influence on the development and enhancement of health education and health promotion in schools across Europe.

3. ENHPS has potential to foster internationalism and equality of opportunity in the field of health promotion on a scale which has yet to be realised in other areas of health promotion.

4. The network has evoked a high degree of enthusiasm amongst personnel at macro, meso and micro levels of operation, management and control of school-based health promotion.

5. ENHPS has operationalised, in the school setting, a philosophy of health promotion which reflects an eco-holistic approach. As a project, necessarily short-lived in stimulating and testing ideas and practices, it has laid a foundation for deeper and wider developments.

Issues and Recommendations

	ISSUE	RECOMMENDATION
1	The devolved nature of ENHPS means that there is freedom for national projects, to interpret the twelve criteria for the HPS and devise health promotion plans according to diagnosed needs.	The devolved nature of ENHPS is one of its strengths and needs to be preserved.
2	The Technical Secretariat, is small with an IPC member working part-time, two Consultants and limited support staff. Further developments are possible in a number of areas to enhance still further the effectiveness of the 'centre' in developing the network and promoting change. Staff may need to be contracted to enable these developments to take place.	Expenditure at the centre should be kept low but consideration should be given to increasing resourcing and staffing for particular tasks and developments.
3	Communication with national projects is not evenly spread. The effectiveness and frequency of communications are dependent on technology, office arrangements of national project centres and equipment in schools. Most national project centres have telephone and fax. E-mail is still available to only a minority of national projects and to very few schools. Post is variable in delivery time and reliability.	To increase internationalism and the networking character of ENHPS improvements need to be made in terms of equipment, contactability and response time.
4	There are many projects in the area of Health Promotion and Health Education and also NGOs and charities which are active in supporting projects at national and school level. There is no cohesion amongst them or collation of them so that national projects or schools would be able to contact them.	The central Technical Secretariat should produce a portfolio of active projects, agencies and European information centres potentially available for national projects and project schools to establish contacts or collaborations.
5	Some countries have received a great deal of communication, information and training sponsored by the Technical Secretariat of ENHPS. However, there is a feeling that the 'internationalism/ Europeanism' of the project is limited; the only consistent pattern of networking at an international level which exists is the series of national coordinators meetings.	A phased programme of networking should be established at a) National Coordinator level, b) Project Team level and c) school level.
6	The variation in international networking is related to the degree of external funding thus creating inequalities between ENHPS national projects in Eastern and Western European countries.	Personnel and funding should be specifically allocated to support networking between all countries.
7	International workshops have been well received and much valued by those able to attend at whatever level in the project. Travel is expensive and there may be advantages to more subgroup staff development sessions on a regional basis.	Effort needs to be made to maximise the effect of the high quality inputs at conferences, workshops and meetings. Workshops for regional groupings of national projects should be arranged.
8	There is a need to develop ways of making contact between teachers and pupils in different countries. Language presents the largest barrier to a free exchange of information between national projects and schools emphasised the need to focus on translation and use of translators.	A policy is required on the use of core language(s) to exchange information at a national coordinator level and encourage use of different languages and culturally appropriate interpretation between schools in different countries.
9	Network News is important. It can celebrate success, disseminate ideas and stimulate contacts. A deeper and wider coverage of national projects and individual school initiatives would facilitate this further.	There should be more issues of Network News, perhaps supplements which are less glossy, which have a particular focus or theme and are practical in nature.
10	In some countries there has been a wish to have more information about methods that have been successful at school level and on how programmes have been implemented at national and regional level.	There should be more dissemination of good practice in Central, Eastern and Southern European countries through EHNPS News and conferences/workshops for national coordinators, parents and teachers.

	ISSUE	RECOMMENDATION
11	In schools where health education in the curriculum is supported by legislation ENHPS has a more receptive environment.	National project teams need to continue to lobby for support and collaborative working relationships at policy making and operational levels. It is vital that there is sustained commitment from Ministries of Health and Education to health promotion in schools.
12	Some projects are working on many fronts where they are promoting new relationships and new styles of learning and working towards self-empowerment, compared with other countries where open learning, a democratic style and notions of self-empowerment are well established.	National project teams need to continue to assess and identify the theoretical and practical basis of their respective national projects with a view to a) monitoring development of the health promoting school 'ideal' in their country and b) highlighting the cultural significance and individuality of their particular project.
13	Advantages result where both national coordinators and schools associate themselves with other health education and health promotion developments in their own countries.	The Technical Secretariat should construct a database of international school based health education curriculum resources and national project teams should seek to disseminate information on such resources to schools.
14	Different countries have different opportunities available for financial support. In Eastern Europe much effort is successfully expended in obtaining funding from NGOs whilst in western European countries much of the support comes from official agencies.	All national projects should seek to establish a plural system of support involving NGOs and official agencies.
15	Prescriptive curriculum and national legislation for education had a strong influence on the organisation and the teaching of health in the curriculum. It was found that time for teaching health education was restricted in some situations.	When schools have restricted allocated time-tabled time for health education, they need to consider ways of integrating health education into other subjects to overcome this restriction and to locate this within a health promoting school strategy.
16	The mode, focus and style of published curriculum resources available to schools in different countries influenced both the teaching styles adopted and the skills and concepts to be developed by children.	School project teams need to consider how published resources can be used flexibly and adapted to include a range of teaching approaches to develop pupils' independence and communication. Schools should consider devising their own materials for health promotion and collate these in a central resource bank.
17	Schools which were successful in disseminating good ideas and ensuring commitment to action valued staff development and training. This helped to establish health promotion activities throughout the school. When parents were involved, this further promoted enthusiasm for the project throughout the school community.	The School Project Coordinator needs to be committed to the training of school staff in health promotion. Wherever possible the use of external agencies at local, national and international levels should be used to provide information on health and teaching methods.
18	The schools in every country were committed to the development of the internal and external school environment to support the learning about health topics in the curriculum.	Schools need to seek the active support of parents and members of the local community to raise funds, assist in teaching, participate in training and extramural activities, help to improve the school environment and lobby officials for support.
19	Teachers, non-teaching staff, governors, pupils, parents, members of the local community and health and welfare professionals need to work together to improve the health of the school community. Sending newsletters to parents to inform them of the health promoting school, and to celebrate the success of health promotion activities may be a useful starting point.	The arrangement of informal parents' meetings and social events may help to encourage parents into the school. Alternatively these meetings could take place in the local community. Schools also need to work with parents when dealing with pupils' problems. Parents should be encouraged to carry out health promotion at home.

	ISSUE	RECOMMENDATION
20	Links between project schools in each country and between countries varied. This was often confined to meetings between project school staff at workshops and conferences organised by national project coordinators	As accessibility was limited due to expense and distances between schools, schools need to consider carefully who will attend meetings and ensure that opportunities are provided for the dissemination of information. School staff meeting at these conferences could be encouraged to establish 'buddy' systems with staff from other schools. Once the Project Coordinator has concentrated on establishing the project throughout the school, teachers could seek to collaborate with willing teachers from neighbouring schools to generate ways of teaching health education throughout the curriculum and to improve community health.
21	The efforts to promote connections with regional and local providers of healthcare and education is vital and proceeding vigorously in many areas.	There is a need at the national and at the international level for a sharing of guidance and on the dissemination of good practice with regard to working with parents and the community.
22	The nature of health promotion embodied within the national project needs to be framed in a national context of known health problems, national aspirations and optimum means of addressing these. There is a need for three levels of focus with regard to work in schools: generic teaching, learning and relationship skills; materials, guides and activities; specific health focuses. National projects, in the relatively early stages of such a complex development, may be operating in a way which is more opportunistic than systematic.	It is important that debate continues within and across national projects about the nature of health promotion and the need to operationalise rationally health promotion philosophy, taking account of national and local cultures, constraints and priorities.

This Report was delivered to the 1st Conference of the European Network of Health Promoting Schools, 1 - 5 May, 1997, Thessaloninki, Greece.

Case Study: Killinarden Community School, Tallaght, Dublin, Ireland.

Details of School:	student numbers:	927
	staff:	63 teachers plus support staff
	age range:	Secondary – 12-18 years

Distinctive features of the Health Promoting School

* Very positive relationships in the school servicing a socially deprived area.
* A well embedded and widely supported Development Social Studies programme
* Strong links with parents including a Home-School liaison project within which there is now a trained Health Promotion Group.

Context and Background to the School

Killinarden Community School is one of the ten national project schools in the Republic of Ireland which are affiliated to the ENHPS. The school serves the Killinarden district of Tallaght which is a socially deprived area with an unemployment rate of approximately 78 per cent. The School receives additional support from the Department of Education because it serves a recognised socially deprived area. The 3,500 school-aged children in the area have no swimming pool, sports hall or similar recreation facilities, just a small community hall.

Two key Department of Education initiatives have influenced Killinarden and all other schools in Ireland with respect to health promotion and health education. The first was the White Paper *Charting our Education Future* which laid emphasis on health promotion in schools. The second was a new national curriculum for *Relationships and Sexuality Education*. All schools in Ireland had received the discussion document on the latter and were awaiting the National Council for Curriculum Assessment's definitive document on the subject.

The current Killinarden Community School buildings, officially opened 13 years ago, are modern and extremely well cared for. A meeting room had been made available for parents and the notice board in the main entrance hall had a large poster on it advertising the latest course on stress management classes for parents. The walls of the school corridors displayed examples of the pupils' art and project work. Toilets, classroom and staff rooms are clean and well maintained. The teachers' common room was comfortable, furnished with armchairs and coffee tables and had its own kitchen area. The grounds of the school were laid to green fields and covered approximately six acres. The backdrop behind the school is of hundreds of white, semi-detached, municipal houses and beyond them the soft flowing hills of the Irish countryside.

The school reflects visually the views expressed by several of its staff — 'a place which is set aside, both environmentally and socially, from the community which it serves'. The contrast is stark and serves as a reminder of the ever-expanding gap between perceived middle status of the school and its staff and the lower social class values and expectations of the majority of the local community.

Teaching staff gave vivid examples of how unemployment and dis-empowement in the area had separated, socially, parents from their children. The large majority of parents were between 30 and 40 years of age and had experienced periods of long term umemployment. They were unskilled and some were barely able to read or write. In contrast, their children are educated and employable. The parents were a generation that has been 'left out'. This had led to a situation where some parents had nothing to even get out of bed for in the morning, leaving some pupils to get themselves up in the morning and out to school with no support whatsoever.

Killinarden Community School in the staff's own words is a "tough school to teach in". Most teachers are in their 20s, 30s or early 40s — few are over 50 on the staff. "You have to be fairly lively to teach in a school like this", (a teacher's comment), with the few staff leaving the School over the last five years,all cases of promotion. Not only is staff morale very high at Killinarden Community School but staff respect for one another for who they are and what they offer the institution.

Teachers are referred to by pupils as 'Sir' or 'Miss'. They would, however, know teachers' first names. Pupils had respect for the teaching staff. One teacher explained that she had given a lift by car to one pupil who had left the area but who had managed to get transferred back to Killinarden to finish her secondary education. When the teacher asked the pupil why she had wanted to come back she replied "Well Miss it was the teachers in the other school". When asked what she meant the girl said "Well Miss they were only teachers!" This was thought to summarise the kind of relationship that exists between the majority of pupils and staff in the school.

School uniform is compulsory! Staff felt uniforms are remarkably well kept. The pupils have 'uniform checks' every morning and if they forget their tie they have to hire one for 10p from the Library. The pupils apparently appear to enjoy this order in their lives. In terms of personal, social and health education Killinarden CS is the envy of many schools in Ireland. This point is exemplified by its leadership; when the President of the Republic of Ireland visited the school she made reference to the Principal, Aidan Savage's reputation as a prominent educationalist.

Specific Health Promoting Activities

The schools has two Vice Principal. One of them, Mary Keane, had been responsible for developing a comprehensive programme of Personal, Social and Health Education. Mary and the School had reputations throughout the Republic of Ireland for inservice training in the area of social education. The School's social education programme had acted as a spur to the school becoming a health promoting school within the ENHPS project.

The School's health education policy is integrated into what is referred to as the Developmental Social Studies programme (DSS). This programme had been formulated to meet the particular needs of local young people, who come from a socially deprived area. Unemployment, an acute local drug abuse problem and a recent rapid increase in teenage pregnancies within the school had forced staff to make certain modifications to the DSS programme. The staff found that they could not concentrate on any one part of the health education programme. Health education had to be integrated into the whole DSS programme Group work is used as one of the teaching approaches within the DSS programme. The DSS

teaching team continually review and monitor the programme in order to ensure relevance to the pupils' immediate health and social needs.

The main health education elements of the DSS programme are:

Development of Self Esteem (core of the programme)

↓

Drugs Education)
Education in Sexuality)
Communication Skills) Topics
Nutrition/Eating Disorders)
Exercise and Leisure)

The school has developed a very sound and well tested sex education programme which will now link with the new 'Relationships and Sexuality Education' programme of the Department of Education. Exercise and Leisure however, is difficult to follow up because the PE staff have very poor indoor facilities. The three Physical Education teachers currently teach in the small school hall while pupils and staff have to cross through the path of their lessons on their way from one part of the school to another. The school has no showers. However, a new sports hall is planned for 1997/98. This should provide a great boost to the promotion of physical health within the school.

Currently the Sixth Form receive no physical education at all. The PE staff believe they can only teach one tenth of the programme they are trained for, and want to teach. There is parental support for some of the physical education activities. For example some parents help with sporting activities.

A Pastoral Care System is integrated across the whole curriculum so that pupils believe and understand that every member of staff in the school is interested in their welfare. The DSS Programme is an important part of this framework. The focal point of the programme is the development of self esteem.

One teacher paid tribute to the successful tutorial system which was operated within the school. Each pupil identifies with one personal tutor. Their personal tutor would remain with pupils right through the school and they spend 40 minutes every day with them. Year group tutors progress through the different years with their tutees.

The pupils have 80 minutes per week for DSS in Years 1 to 3 and Health Education is integrated on a spiral curriculum basis into this part of the timetable. In Years 3–5 Health Education is part of two options: a) a 40 minute class period for Standard Leaving Certificate course and b) two class periods (80 minutes) for a one year vocational preparation and training programme and c) two class periods (80 minutes) for the Transition Year classes. Within the DSS programme thematic weeks are used to emphasise specific topics, which involve a cross-curricular approach. For example, they have looked at communication skills recently. Pupils had received sessions on 'good manners'. This was part of the DSS programme which had looked at good manners in the home, good manners in school, good manners in the world. For example, simple things like how to greet their teacher in the morning!

The School was also tackling drug education. Fourteen years ago drugs abuse was a minor problem in the local community but over the last five years the problem has escalated rapidly. A special Drug Task Force has recently been set up to tackle the problem.

Certain staff would not necessarily wish to teach DSS, but every teacher gave 100 per cent support to the programme in other ways. For example subject teachers in the school are happy to let the DSS team overlap their timetabled lessons in order to allow a workshop utilising the services of an outside speaker to take place.

The school researches every outside speaker — this is the Principal's policy. Sometimes it is necessary for the DSS teacher to stay in the classroom with the visiting speaker. It is usual for the visiting speaker to know exactly where their session fits into the DSS programme and teachers sit in so they will know,what it is the pupils are receiving so they can follow up the session.

In the last two years the school has had to review the DSS programme and team. It has been necessary to train some new staff for the revised programme and re-establish contacts with outside speakers. This has been due to a number of the previous team gaining promotion and taking on different roles within the school. Mary (the Vice Principal) made the point "there is no such thing as having a permanent and trained team; it's a dynamic situation".

Most parents, and in particular fathers, wanted little to do with supporting activities in the school, seeing it as an alien place. Staff commented that parents saw teachers "as middle class with a different accent". However, the Vice Principal suggested that this situation was changing "parents, mostly mothers, were starting to attend meetings and the school has had a great breakthrough with the parents' Health Promoting Group".

The Home-School Liaison Project, funded by the Department of Education, has been established in schools across Ireland which serve socially deprived neighbourhoods. At Killinarden Community School support for this project has been supplemented by money drawn from the Irish HPS project enabling 11 parents to be trained as facilitators of health promotion. These parents are called the Health Promotion Group and now run sessions for the Sixth Form and parents within the community. There is little doubt that the success of the Home-School Liaison Project at the School is due, in large measure, to the enthusiasm and hard work of Kathy Bradley (the project coordinator). She had made great progress in forging links between the school, parents and local community.

ENHPS funding enabled 11 parents to join parents from the other Health Promoting pilot schools at summer schools and special training weekends run by John Lahiff and staff from the Department of Education. Additionally, the 11 parents had decided to undertake a Facilitators Certificate course at Maynooth University. They all graduated from this course in 1996.

So far the Health Promotion Group has run courses on drug education, assertiveness training and parenting. Currently they are working with sixth form pupils of the school. A Primary Drug Prevention Programme has been established in the primary school and a community helpline is also in operation.

External Links

The School had received a great deal of help from John Lahiff (National HPS Project Co-ordinator) and the Psychological Services of the Department of Education.
Ruby Morrow and Anne-Marie Sheehan had been responsible for putting together the key Irish drugs education and life skills package *On my own two feet* and because of this the staff knew them very well. Teachers just have to telephone the Department and one of the staff from Psychological Services will turn up to assist them. The Department of Health's Health Promotion Unit had also been very supportive with resources.

Support also comes from the Church and in particular from Father Finton the School Chaplain. Ita Garvey, one of the DSS team teachers, summed up his support role:-

> "Father Finton is a very strong link between the school and the community and a mine of information. He lives in the parish and even the toughest students identify with him. He doesn't preach the gospel to the pupils, he just treats them all like a friend."

Father Finton had formed a club for troublesome pupils. Apparently he approached every year tutor and asked them to send him the most difficult pupil in their year group. Each Friday afternoon these pupils attend his 'club' to take part in extra-curricular activities, such as horse riding, bowling, swimming, which are designed to give them challenges they can look forward to. The Chaplain is well aware and supportive of the HPS project the School is involved in and although his 'club' is part of the health promoting activities of the School his initiative was set up independently of the HPS project.

International Links

One of the DSS team members thought Mary Keane (the Vice Principal) had been way ahead of her time in setting up the DSS programme in the school long before PSHE had been taken seriously in other Irish schools. Mary had visited schools in other countries, coming home laden down with resources she had collected on her travels. She would then sit down with staff and put together the various units of the DSS course.

The school has recently introduced an Incentive Programme to reward and encourage effort and achievement by the students at all levels. The Incentive Programme came about through links with schools in Scotland and England.

Killinarden Community School has also established an Educational/Behavioural Support Unit within the school. The main aim of this unit is to provide a safe, secure environment for very behavioural disruptive students who are learning to react differently to individual and group situations.

The contribution and success of the National Health Promoting School Project

The whole staff were aware of the ENHPS and its relationship to the National HPS project. The school had received £2,000 over 3 years from the Irish HPS Project Centre and this had gone into staff development, in-service training and support for the parents' Health Promoting Group.

Staff and parents thought the project had contributed greatly to improvements in parent/teacher/school relationships. The National HPS project, and by implication the ENHPS project, has led to the development of a specific drug education programme for the community run by parents (The Health Promoting Group).

The success of the HPS project in motivating and involving parents is set against a backdrop of the different categories of pupils in the school. There are those who have very committed parents who support their son/daughter. There are those pupils who are self-motivated and 'want out'; sadly this often results in them leaving the area. Then there are those pupils who drop-out and don't attend.

Success has also come from the emphasis placed upon the physical environment of the School by the Irish HPS project. Graffiti is removed from school walls as soon as it appears. The Vice Principal thought the staff assume Peter and John (the caretakers) are part of the HPS. However, they have not been fully included in the planning process of HPS at Killinarden Community School. She thought they "just take a pride in making the school look good" but wasn't sure whether they were aware of the HPS project or not. It was interesting that the National Evaluator of the Irish HPS Project from the University of Galway had interviewed both caretakers during one of her visits to the school but the caretakers could not understand why she wanted to talk to them.

Senior management and teachers thought time was the biggest barrier to the development of the health promotion within the school. Trying to find time to meet to plan initiatives was a growing problem, and training now has to take place after school.

There is little doubt that Killinarden Community School epitomises much that is positive about the Irish HPS Project. Even within an area as challenging as West Tallaght, the project schools are displaying outstanding achievement in the development of health promoting environments. The Irish project schools and Killinarden Community School in particular have made real progress by involving the enthusiasm of parents and their local community within the developmental process of establishing the health promoting school.