

A Health Promoting College For 16-19 year Old Learners.

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Healthy Colleges

Introduction

The National Healthy Schools Standard (NHSS) is part of the government's strategy to reduce health inequalities, promote social inclusion and raise educational achievement.

In 1999 the Department for Education and Employment (DfEE) laid out the standard of a healthy school as:

“...one that is successful in helping pupils to do their best and build on their achievements.

It is committed to on-going improvement and development.

It promotes physical and emotional health by providing accessible and relevant information and equipping pupils with the skills and attitudes to make informed decisions about their health

A healthy school understands the importance of investing in health to assist in the process of raising levels of pupil achievement and improving standards.

It also recognises the need to provide a physical and social environment that is conducive to learning”(Health Development Agency 2003).

The purpose of this report on healthy colleges for 16-19 year olds is to see whether a standard, such as the Healthy Schools Standard, would be useful, appropriate and achievable in the further education sector. The report examines:

- What literature exists that shows how colleges and health have been linked;
- The policy and research context which would affect the implementation of a healthy college standard;
- What young people want;
- Examples of good practice showing what colleges have done and how this has worked;
- What might a healthy college standard look like;
- What are the challenges and barriers that exist which might prevent the successful implementation of a standard, such as staffing concerns?

Defining Health

Throughout this report I have referred to health and well-being. I have used a wide definition of health and well-being to include positive health behaviours, appropriate access to medical services and information, social and emotional well-being such as self-esteem, confidence and satisfaction with life, as well as physical health and absence of illness and disease.

Methodology

I conducted a literature review of books and reports on healthy colleges, other relevant publications and reports on government policy, health promotion and youth social inclusion. A web search was also carried out. A search of OFSTED reports was carried out and telephone interviews conducted with a sample of colleges.

NIACE are currently conducting a survey of provision for people with mental health difficulties in all Further Education colleges in England. Where colleges had indicated that they provided specific support to young people with mental health difficulties, they were contacted and telephone interviews carried out.

Literature Review

The earliest report on the concept of a healthy college was written in 1993 by O'Donnell and Gray and entitled "*The Health Promoting College*". In acknowledging the untapped potential for health promotion in F.E. colleges the authors write

"During the past decade, it has been recognised that attention to health matters in the post-16 education sector has been largely non-existent. Yet this is at a time when colleges have become increasingly populated by young people and older adults whose school career may not have included a planned and co-ordinated programme of health education. Over the same period there has been increasing emphasis on the important role of schools in making children aware of both their own and the communities health needs.....in the post-16 sector nothing comparable has taken place."(O'Donnell and Gray 1993).

"*The Health Promoting College*" was written as a result of an action research project, 'Health Promotion and Health Education in Colleges of Further Education', which ran from April 1988 to July 1989. The pilot project was predominantly based in one college, Bourneville College of Further Education. To provide contrast of environment and curriculum, two associate colleges, Brooklyn College and East Birmingham College, were also involved. The main aim of the project was to develop a policy and strategy for health promotion and health education in Birmingham colleges of further education by:

- planning and implementing a college-based project that explores and exploits the advantages of a 'whole-college' approach;
- recording and analysing the progress achieved and processes involved in the conduct and delivery of the project;
- designing an appropriate and effective dissemination programme, suitable for implementation locally and nationally.

In September 2000, Further Education Funding Council Inspectors wrote a report on '*Further Education and Health Improvement*' (FEFC 2000). In recognising that further education colleges come into contact with over three million learners annually through a variety of activities, the report highlights the mechanisms by which colleges can make an impact on health. It identifies three main ways by which colleges can impact on health:

- direct teaching about health;
- health promoting activities;
- effective partnerships which impact on community health.

Focusing on all learners in FE, not just 16-19 year olds, the report:

- provides examples of effective partnership between health authorities and FE colleges;
- provides examples of good practice;
- contributes towards strategic thinking in the college sector about the link between learners health and their educational achievements;
- suggests ways of encouraging a growth of effective health promoting activities in colleges;

- encourages the health service to take further education colleges more seriously as a setting for health improvement.

The Further Education Funding Council ceased to exist in March 2001 and was replaced by the Learning and Skills Council with its 47 local arms. Within this major re-organisation the idea of a healthy college has yet to be taken forward.

During the 1999-2000 academic year, Kingsway College in London undertook a 'Healthy College' project (Kingsway College 2002). Kingsway College is a further education college that has 11,000 full and part-time students from a very ethnically and linguistically diverse community that has major disparities in wealth, employment and social opportunities. The Healthy Colleges project used the Healthy Schools standard to develop Personal, Social and Health Education (PSHE) programme. The PSHE programme aimed to

“Progress the colleges’ commitment to provide quality provision for all its students in the context of the colleges equal opportunities policy. As well as promote inclusive learning that improves retention and achievement by action planning and developing pastoral and academic support progressively through a college devised PSHE programme and facilities.”(Kingsway College 2000).

The college created a template of activity that was appropriate to the needs of most students, irrespective of age and mode of attendance, although could be contextualised to meet the needs of differing student groups, e.g. students with learning difficulties. The template activity was supported by resource packs. The project was evaluated. Student feedback was sought and responses were generally positive and informative.

In September 2002, NIACE completed a report for the Department of Education and Skills on how further education colleges can promote health and well-being for all learners (Escolme et al 2002). Using the experience of five general FE colleges the report uses evidence of health promoting practice within each college against the Healthy Schools Standard. The report acknowledges that health promotion in colleges is patchy and unco-ordinated and lacks a theoretical basis. However the huge potential of health promotion in colleges is recognised, since widening participation strategies have increased access to learning for those deemed to be vulnerable to, or to already have, poor health status. The report makes a number of recommendations and concludes overall that the remit of further education to widen participation in learning and raise achievement levels are compatible with an aim to reduce health inequalities. The report states

“The connections between learning and health need to be expanded. The development of a model of a ‘healthy college’, and the promotion of this is a key way forward.”(2002)

Beattie in his chapter ‘Education for Systems Change: A Key Resource for Radical action on Health’ provides an overview of how education as been a vehicle for health improvement. Beattie looks at the lessons learned from the health promoting schools, such as:

- projects must be more than health promotion ‘based in schools’ but must be school wide and strategic;

- projects are more successful when activities are run in parallel and are simultaneous (with parents, ethos, curriculum, environment);
- it must go beyond information giving and focus on health related skills such as assertiveness, problem-solving;
- equal attention must be given to emotional/mental well-being as physical well-being and priority must be given to debating and negotiating goals of health promotion and strategies for achieving them;
- most projects were successful in focussing on the health of pupils but greater focus needs to be given to the needs of staff and the school as a work environment;
- projects are more successful where there is involvement in the planning by pupils and parents. Projects need to take a bottom up partnership approach;
- all those involved in the project need to fully appreciate the link between health promoting school and effective school;
- all those involved in the project need to be aware of the theoretical basis of their interventions (Beattie 2002).

However, the value of his chapter is in his exploration of the effect of ‘emancipatory learning’ rather than ‘didactic teaching’ methods. Such theories of learning as a vehicle for social empowerment have a history in adult and community education, and in some sections of further education. Beattie cites the health promoting college initiative of O’Donnell and Gray and the health promoting universities as having learnt from the healthy schools initiative and as beginning to develop programmes through active, co-operative learning and campus wide consultation and participation.

Summary Points

- There have been some initiatives in colleges to promote health but the effect is piecemeal
- Colleges have potential as places for health promotion as widening participation strategies have increased the number of learners with poor health, or vulnerable to poor health, into learning.
- Colleges have the potential to be places for health promotion as they have a history of adult and community learning to draw upon. Traditions of adult and community learning are based on consultation, and learner-led curriculum which have resonance with health promotion as a vehicle for personal development, self-directed change and empowerment.

Key questions

Several isolated examples of health promotion existed in colleges:

- What are the factors that encourage some colleges to address health promotion and not others?
- How do they measure success and what outcomes do they look for?
- How do they fund the work they do?

Some projects have sought to disseminate their work and there have been intentions to implement the work nationally.

- Why has this not happened?
- What are the barriers to national implementation?

Previous projects have concentrated on health promotion for all learners regardless of age.

- Should a healthy college standard target 16-19 years or relate to all learners?

Current Policy and Initiatives

Educational Inequality

The current policy initiatives in post-16 education must be seen within the context of the learning divide that exists within this country.

Socio-economic factors have an impact on the potential of young people in initial schooling. In 2001, approximately 30% of children from Caribbean, Bangladeshi and Pakistani backgrounds achieved 5 or more good General Certificates of Secondary Education (GCSE) against a national average of 50% (LSC 2003). Furthermore, by the time some children are 15 there are substantial differences between the attainment levels of those from higher than from lower social backgrounds – for example, 81% of children living in social housing fail to achieve 5 or more A*- C grade GCSE's, compared with 43% of those from higher social backgrounds (DfES 2001).

This impacts on participation in learning as an adult. Success and engagement in post-16 learning are influenced by individual's prior attainment at age 15. In 1999 NIACE conducted a survey of 5054 adults about their participation in learning. Age, class and experience of initial education affect access to learning and the confidence to participate in learning (Sargant 2000).

Half (50%) of all upper class and middle class respondents to the survey were current or recent learners, compared with just over one-third (36%) of all skilled working class and nearly one-quarter (24%) of the unskilled working class and people on limited incomes. The length of initial education is another indicator of participation in learning. Those who left school at age 16 or earlier had participation rates of 25%, compared with participation rates of 61% among those who stayed on in education post- age 20 (Sargant 2000).

There is also a divide in participation rates for 16-19 year olds. Recent statistics from the Department for Education and Skills show that only 22% of those with fewer than five A* - C GCSE's were in school sixth forms and only 7% were in sixth form colleges. Whereas more than 70% of young people with fewer than 5 A* - C GCSE's attend general FE colleges on a full-time basis and 7% attend FE colleges part-time.

Stanton (Guardian 29.4.03) writes that within these figures there are some telling distinctions. For example, while colleges provide for 34% of white 16 year olds, with state schools providing for 27%, the colleges provide for 57% of black 16 year olds and schools only 22%. This may reflect the underachievement of black children at GCSE, but it does not explain why more girls than boys are educated in colleges rather than schools post-16. The study also shows that the less well educated the parents, the more likely their children are to be in colleges than elsewhere.

Stanton notes, that achievement and retention rates in colleges are lower than for other learning providers. Though many young people attend FE colleges for positive reasons, Stanton wonders whether

“On the other hand, some students may enrol at the FE college feeling rejected and separated from their peers who have ‘succeeded’.”

This ‘selection’ process at 16 may have long-term effects on confidence to learn.

Against this background of education inequality the government has declared a commitment to raise standards, improve achievement and widen participation in learning.

Success For All

Recognising the role of further education in achieving the government aim to raise standards, improve achievements and widen participation, the government have published the White Paper “*Success for all – Reforming Further Education and Training – Our Vision for the Future*” (2002). The White Paper states

“Further Education and training is important to the achievement of the governments twin goals of social inclusion and economic prosperity. Over 6 million learners choose further education and training which is funded by the LSC, with public funding of over £7 billion in 2002-03.”

“Success for All” also highlights the needs of 14-19 year old learners and states:

“The sector must ensure that 14-19 learners have greater choice and higher standards, with a wide range of academic and vocational programmes providing clear opportunities to progress to higher education and skilled employment.”(DfES 2002).

“Success for All” sets out to do this by:

- supporting and improving collaboration between schools and colleges;
- establishing and rolling out of the Connexions Service across England by April 2003;
- rolling out the Educational Maintenance Allowance on a national basis in September 2004;
- introduction of the Connexions Card for all 16-19 year olds aimed to encourage and motivate young people to continue in learning post-16 by rewarding attendance and application;
- supporting structural change or by expanding existing successful provision for 16-19 year olds in college;
- identification and development of best practice for teaching and training of young people;
- developing the leaders, teachers, trainers and support staff of the future;
- developing a framework for quality and success.

“Excellence and Opportunity 14-19”

This Green Paper acknowledges that nearly half of pupils leave school without 5 good GCSE’s and that a significant minority drop out altogether, that in this country there is low level participation in education for 17 year olds and socio-economic inequalities in progression to Higher Education still exists (DfES 2003).

The Green Paper states:

“Teaching in the 21st Century must serve 3 functions: the transmission of knowledge for a society built on information, the broadening of horizons in a country still scarred by socio-economic disadvantage, and the development of learning skills so students can go on to learn more in adulthood, as they respond to the demands of social and economic change.”

The paper proposes to do this by:

- creating more flexibility at 14-19, so that every young person can choose programmes of study suited to their ability and interests;
- motivating learners by engendering a sense of ownership of and commitment to the studies in which they are engaged;
- creating a system suited to the needs of the individual, not the institution.

The Learning and Skills Council

The Learning and Skills Council was established in April 2001 to transform the educational and training performance above 16 years and to tackle the skills gap that is undermining the country’s economic performance. The Learning and Skills Council has responsibility for the funding of all post-16 education with the exception of higher education.

Speaking in support of “Success for All”, John Harwood, Chief Executive of the Learning and Skills Council said:

“Success for All is an ambitious change programme, which will affect thousands of education and training providers and their learners. Unprecedented levels of investment by Government back this policy, which means to reform radically further education and training. I want the principles and values of trust in FE to underpin the LSC’s relationship with our colleges and providers.”(LSC 2003).

Local planning to address local needs, support and resources to improve quality, funding stability and real partnerships working in the best interests of learners are seen as the strategies by which the LSC will meet this change programme. To this end the LSC have signed a “Memorandum of Understanding” with the Local Government Association (LGA). The Memorandum of Understanding sets out the principles for partnership working between the two organisations on projects such as ensuring continuity and structured learning in post-16 education and the promotion of coherent learning 14-19 year olds. The memorandum will also help to ensure that local education authorities and the 47 local Learning and Skills Councils work together effectively. John Harwood stated

“We (LSC) have key synergies with local authorities which are responsible for the administration of secondary education, economic development and regeneration and of course the underlying social health and well-being of their local communities. All of these are important areas for us too.”(LSC 2003)

Connexions

The Connexions service was set up by the DfES to replace the Careers Service and to provide a more holistic approach to supporting young people aged 13-19 years old to make a smooth transition into adulthood. Personal Advisers offer advice, guidance and practical help to young people on matters such as planning a career and appropriate qualification routes. Support is also given on benefits, housing or personal and family life where it may be affecting school, college or work.

Health Inequality

In 1980 *Inequalities in Health* (Black 1980) was published, followed in 1998 by *The Health Divide* (Black et al 1998). Both these reports highlighted the extent of health inequalities in the UK and revealed that the biggest determinant of health and mortality is social class. While life expectancy rates have risen across the social spectrum, they have risen unevenly. For example, professional men in social class 1 can expect to live 9.5 years longer than unskilled manual working men in social class V. There are also inequalities in 'healthy life expectancy' – the measure of average length of life free from ill-health and disability. People in manual, semi-skilled and unskilled occupations have higher rates of chronic disease and disability than non-manual groups. People in lower socio-economic groups also have poorer fitness scores and register a lack of psychological well-being, evidenced by lack of energy, pain, sleep disturbance, physical immobility, emotional distress and social isolation.

Young people have their own health needs. Mental health difficulties are a growing cause for concern among young people indicating growing levels of emotional distress. A study conducted by the Mental Health Foundation (cited in Alyward 2003) found that 6% of young men and 16% of young women aged 16-19 experience mental health difficulties. Suicide is the most common cause of death for young men. Since 1982 the incidence of young male suicide has increased by 75% reaching 1,300 per year in 2002. In the UK, approximately 20,000 young adults are admitted to hospital each year as a consequence of self-harm.

Evidence exists which shows that young people also have health behaviours that are posing risks to their health in the short and longer term. For example, by the age of 14-15 years, 38% of young women take no physical exercise and 15% of girls smoke regularly by the age of 15 (Home Office 1999). Furthermore, among 16-24 year olds in England and Wales in 2000, 29% had used drugs in the last year and 18% in the last month. In total 9% had used Class A drugs in that year (DoH 2002).

Saving Lives

The Government White Paper "*Saving Lives: Our Healthier Nation*" is based on belief that poor health can be attributable to social, economic and environmental factors and that:

“individuals can make decisions about their and their families health which can make a difference.”(DoH 1999)

The Government recognises that there are inequalities in health, just as there are in education and housing and that there is link between many of the factors that contribute to poor health: poverty, low wages, unemployment, poor initial education, crime and fear of crime, and a polluted environment. The White Paper stresses the importance of education in particular:

“Education is vital to health. People with low levels of educational achievement are more likely to have poor health as adults..... By improving education for all we will tackle one of the main causes of inequality in health.”(DoH 1999)

Multi-disciplinary and cross-sectoral partnership working is seen as the key to addressing the wider determinants of health (including education and social inclusion), and as a way of tackling particular aspects of ill-health (such as coronary heart disease, cancer, mental health and accidents).

The White Paper required Health Authorities to develop and implement health improvement plans to address local health and social problems and health inequalities, and to involve local stakeholders in carrying these plans forward. In 2000, the NHS Plan further strengthened the policy emphasis on tackling inequality by requiring the development of Local Strategic Partnerships, involving Local Authorities, to forge greater links between health, education, employment and housing.

National Service Framework

In 1999 the Government launched the National Service Framework for Mental Health. This is a key document for those running mental health services and providing mental health support. The NSF has seven standards, of which Standard One is mental health promotion. Mental Health Services are encouraged to work in partnership with schools and educational providers to promote positive mental health and the social inclusion of people with mental health difficulties.

Cross-Government Initiatives That Link Education and Health

The National Healthy Schools Standard

The National Healthy Schools Standard (NHSS) is a partnership between the DfES and the DoH. The aims of the NHSS are:

- To help raise pupil achievement;
- To help reduce health inequality;
- To help reduce social exclusion.

The NHSS sets out to do this by encouraging partnerships between schools and health agencies. The work is supported regionally by NHSS co-ordinators who offer support and guidance to individual schools and agencies within the community in order to enhance the health and well-being of pupils, staff and parents. NHSS co-ordinators help to initiate, monitor and maintain programmes. The specific themes covered by the NHSS are: local priorities, school priorities, PSHE, drugs education (including alcohol and tobacco), emotional health and well-being (including bullying), healthy eating, physical activity, safety and sex and relationship education.

Teenage Pregnancy Unit

The Teenage Pregnancy Unit was set up in 1999 in response to the report on Teenage Pregnancy carried out by the Social Exclusion Unit. Located within the DoH, it receives joint funding from the DfES, Department for Transport, Local Government and the Regions, the Department for Work and Pensions and the Home Office.

The aims of the Unit are to work with all these departments to develop strategies designed to cut rates of teenage parenthood, particularly underage parenthood and reduce the risk of social exclusion for vulnerable teenage parents and their children by making education, training and employment more accessible.

The strategy is managed by a network of teenage pregnancy co-ordinators. These co-ordinators work at a local level and are supported by 8 regional co-ordinators.

Skilled for Health

The DoH and the DfES have jointly launched the Skilled for Health project in January 2003. Skilled for Health is part of the Skills for Life strategy launched by the DfES in March 2001, which now has the aim of improving the literacy, language and numeracy skills of 1.5 million adults by 2007. By working in partnership with the DoH, the DfES hope to reach more of the priority groups which Skills for Life aims to help, whilst the work will also contribute to DoH targets to reduce ill-health and health inequalities. Skilled for Health aims to promote the concept of health literacy and build awareness of adult basic skills in the National Health Service. In addition to building awareness, the project will design and generate a number of health related curriculum programmes, supported by health related learning and assessment materials. The aim is that adults will gain a better understanding of their own health

and how to make the best use of the NHS as well as improving their literacy, language and numeracy skills.

The Skilled for Health project is now looking for national demonstration sites to help develop the project. Funding will be available to demonstration sites to explore the links between basic skills and health among specific groups, assist in the developing and testing new teaching materials, and build awareness of the issue amongst NHS employees and the general public.

Much of current government policy and initiatives are compatible with the concept of a health promoting college. Current government policy aims to tackle health inequality, raise achievement levels and promote social inclusion by linking issues such as learning and health. A Healthy College could help to achieve those key government aims.

Summary Points

- There is acknowledgement at government policy level that education impacts on social inclusion, social cohesion, social health and well-being.
- There is acknowledgement at government policy level that success in initial education impacts directly on individual's long-term health status.
- Cross government initiatives such as the National Healthy Schools Standard, Teenage Pregnancy Unit and the Skilled for health project all seek to tackle health inequalities by addressing the wider determinants of health.
- Cross government initiatives aim to maximise the impact of their strategy locally through the appointment of regional coordinators with a network of support and guidance to providers and establishment of standards and challenging but realistic targets.

Key Questions

Government policy is centred on widening participation in and raising achievement from learning and on tackling health inequality. A health promoting college would help achieve both these government aims. Participation in learning improves health.

- What evidence is there that shows that improved health improves learning and achievement?
- How can the concept of a health promoting college be tied into other cross-government initiatives such as the Teenage Pregnancy Strategy and the Skilled for Health project to avoid duplication of effort and to maximise effect?

Research on Learning and Health

The Centre for Research on the Wider Benefits of Learning

In 1999 the DfES funded the Centre for Research on the Wider Benefits of Learning (WBL) based at the Institute of Education. The Wider Benefits of Learning Centre is looking at the links between learning and a number of areas, one of which is health.

The research conducted at the Centre points to the contention that lifelong learning contributes to psychological, mental and physical health. Learning is seen to impact on health through five groups of mediators such as:

- economic factors such as income and work conditions;
- health related behaviours through mediators such as awareness, future oriented thinking, social effects and self-efficacy;
- resilience and ability to deal with stress;
- access to medical services; and
- healthy societies are the most egalitarian whereas those characterised by material inequality are also characterised by inequality in educational opportunities as well as access to health and other welfare services (Hammond 2002).

The effects of learning on health seem to generate immediate psychosocial outcomes (such as well-being, efficacy, communication skills, a sense of social responsibility) that have lasting effects upon mental health and cumulative effects on physical health. However crucially, evidence from the WBL Centre suggests that if lifelong learning is to improve health at national levels, it will be more effective if it targeted so as to reduce inequalities in education (Hammond 2002).

More recent research evidence from the WBL has shown direct correlations between low level of educational attainment and poor health. Evidence has shown that, taking into account childhood abilities, health and family background factors, it is estimated that the effect on the probability of depression for women going from no qualifications to level 1 is a reduction in the likelihood of depression of between 6 and 10 percentage points. For men, the effects are weaker although significant (Feinstein 2002).

Summary Points

- Research conducted by the Wider Benefits of learning Centre has increased our understanding of how participation in learning impacts on health beyond the socio-economic determinants. Mediators through which learning impacts on health also include increased resilience and ability to deal with stress, access to medical services and information, health- related behaviours and through creating a more equitable society.

Key Questions

- If participation in learning is seen to be health promoting in itself, what else can a health promoting college do to increase health outcomes?
- Could a healthy college curriculum build on those mediators by which learning impacts on health by focusing on self-esteem raising, problem solving, assertiveness training and stress management as well as understanding and acting on health information?

Who is in Further Education?

The Learning and Skills Council has a statutory duty to drive up participation, especially among young people.

Latest statistical data released by the Learning and Skills Council show that as of the 1st November 2001 there were 2.35 millions learners enrolled on Council funded courses.

Of this 2.35 million, 27.2% were aged under 19 years. This is equivalent to 639,200 students. Learners under 19 years are studying for 49.7% of the qualifications aims funded by the council. Each learner under 19 will be studying for an average 3.49 qualifications each. 78.5% will be enrolled on full-time, full-year programmes.

Students under 19 were studying for a total of 2.10 million qualifications of which

- 4.5% were GNVQ precursors
- 6.9% were GNVQ's or VCE A/AS level
- 3.8% were NVQ's
- 5.7% were GCSE's
- 29.9% were GCE A/AS level.

No indication is given as to whether these are being studied in FE colleges, Sixth Form colleges or specialist colleges.

Overall the number of 16-17 year olds in full-time education has increased. In 2000 over 70% of 16/17 year olds were in full-time education compared with just under 50% in 1984. Government Policy is that all under 18's should be in education or training, and it has sought to achieve this by introducing encouragement in the form of the Educational Maintenance Allowance, Youth Cards and the Connexions Strategy. If more young people are remaining in education or training then a healthy college standard could provide continuity to any PHSE type education they may have had at school.

In 1999-2000 the Learning and Skills Council made additional funding available for providers to work with students from deprived areas or within certain social groupings, such as refugees, people with literacy, language or numeracy needs. This was called the Widening Participation uplift. Statistics show an increase in the number of students from Widening Participation uplift areas and groups to be accessing learning. In 1997-1998 25.1% of all council funded students were eligible for WP uplift. In 1999-2000 this figure had increased to 33.1%. For learners in the 16-18 age range the increase in students eligible to attract the WP lift rose from 25% to 32.2% from 1997-98 to 1999-2000. The percentage of learners attracting WP uplift in Further Education has risen from 25% to 33.2%.

No other data on was available to show any further effects of the WP uplift. From current data it can be assumed that there is increasing participation in FE among learners from deprived areas and from social groups vulnerable to poor health or with poor health.

Who Is Missing From Further Education?

In his study *“Finding the Missing”* Merton looks at the disaffection and the non-participation of young adults in education, training and employment in three areas of England and Wales (Merton 1998). Merton makes the point that it is vitally important for any policy initiative to take account of the prior experience, needs and wishes of the intended beneficiaries if it is to have any chance of success. Merton also points out that it is difficult to measure disaffection and non-participation. Reports quote non-participation of 16-18 year olds as between 9% and 16%.

While acknowledging that disaffected young people are not an homogenous group, Merton points to some common characteristics, including:

- predominantly male;
- disproportionate representation from African-Caribbean backgrounds;
- disproportionate representation of children looked after by local authorities;
- high proportion of young offenders;
- many from difficult and disrupted family backgrounds;
- those with literacy, language and numeracy needs;
- many have emotional or behavioural difficulties;
- a high prevalence of risk-taking behaviour; and
- frequently lack confidence and self-esteem(Merton 1998)

In looking at the reasons for non-participation Merton found the following reasons to be the most prevalent:

- pressures and diversions of unstable family backgrounds;
- psychological difficulties such as depression, stress or mental illness often derived from low levels of self-esteem;
- a revolving door syndrome of unemployment, government schemes, casual low-paid jobs and involvement in the informal economy;
- unawareness or lack of confidence to approach services and agencies that are there to help;
- lack of a friendly supportive adult to whom they can refer as a point of stability;
- a range of barriers and difficulties that are interconnected but are approached holistically by the agencies set up to support them; and
- financial barrier, with younger people (16-18) wanting to earn money for social and entertainment reasons and 19-25 year olds needing money for food, rent and other essentials.

Many young people choose not to participate in learning after age 16. However, changes in the labour market, erosion of benefits to under 18's and the abolition of the minimum wage for under 18's have left these young people very vulnerable. A polarisation is occurring between those young people who leave school at 16 and those who continue in education. Post-16 qualifications are the powerful influence on earnings. Alternatives to academic success such as craft apprenticeships have all but disappeared to be replaced by training schemes. This has affected those without qualifications and from low income households in particular, as they are more likely to experience early unemployment which in turn has longer-term impacts (Jones 2002).

Summary Points

- There is increasing participation in education among 16-18 year olds therefore it would be sensible to continue PHSE education in college under a healthy college standard.
- Initiatives such as the WP uplift have increased the number of learners from deprived areas and from social groups with poor health or vulnerable to poor health.
- There exists a core of young people who are missing from post-16 education, these young people are particularly at risk of experiencing poor health and well-being.

Key Question

- Should the concept of a health promoting college be one that reaches out to non-participant learners?
- Could non-participant learners be encouraged back into learning through their concerns for their health and well-being?

What Young People Want?

If a healthy college standard is to be successful then it must be meaningful to the young people that it attempts to engage and work with. It must address what young people think is what they want and what they need.

There has been some research into how young people feel about their situations and what they want. Listening to what young people want is important. Involving young people in the consultation process is important if projects and initiatives are to have any chance of success.

Evidence from various studies show that there are common themes. These themes are relevant to the concept of a healthy college.

Family life

Many young people said that their family was the most important thing in their life (Home Office 1999), and that their family was essential to their sense of identity (Bentley and Oakley 1999). Many young people reported being deeply affected when things went wrong in their family life (Home Office 1999) and that for many, unstable family life created pressures and diversions that distract them from learning and education (Merton 1998).

Young people want:

- more support for teenagers affected by divorce or family breakdown;
- better opportunities to return to education and training;
- more education on what it is like to be a parent;
- quality information for parents about building self-esteem. (Home Office 1999)

The role of parents in supporting their teenage children, is suggested by Jones, who talks about public education programmes on parental responsibility for children aged 16-18. She also stresses the importance of building cultural capital in families – educating parents by promoting lifelong learning for adults, so that their educational aspirations are raised for themselves and their children (Jones 2002). Such programmes could be part of a healthy college standard.

Education and Post-16 Opportunities

Studies show that on the whole young people were quite negative about post-16 opportunities and support. There is a culture within organisations and agencies that see young people as ‘problems’ to be managed (Merton 1998). Careers guidance only happened once or twice, that many careers officers seemed to have narrow views and that overall there was little preparation for employment (Home Office 1999). Research conducted by the Learning and Skills Development Agency into what young people think about the guidance and support services they receive show that many are still unaware of the Connexions Service (LSDA 2003).

Young people want:

- access to help when they perceive they need it;
- access to independent help that is confidential and unbiased;
- to be trusted by those who are supposed to be helping them;
- role models they can identify with and who have been through the system themselves and made some mistakes;
- safe non-threatening environments;
- more taster courses, probably starting around May each year; (LSDA 2003)
- improved teaching, a chance to learn practical ‘real life’ skills, improved counselling services, life skills and peer education; (Bentley and Oakley 1999)
- more flexibility in post-16 education and training;
- support for those who are pregnant, or are parenting, so that they can return to education and training;
- something done about gender stereotyping in education and training;
- ways through financial hardship (Home Office 1999);
- cultural issues to be acknowledged – identity and difference between ethnic groups, religious and cultural differences and respect for different cultural groups (Kingsway College).

Health and Health-Risk Behaviours

On the whole young people were aware of the arguments for a healthy lifestyle. Health-risk behaviour, such as smoking, drinking and drug-taking, is related to the behaviours of close friends and adults. Peer pressure is an important factor, but young people also talked about smoking, drinking and taking drugs as away to ease the stress and pressure of the problems they were going through. Young women also talked about using cigarettes, alcohol and drugs because they were unhappy about the way they looked or for dieting (Home Office 1999).

Young people want:

- accessible and confidential health services;
- greater involvement of young people in planning services;
- health education that reflects their experiences, especially about drugs and alcohol;
- provision of diverse and accessible mental health services and informal counselling;
- inclusion of anti-bullying strategies in all institutions;
- a curriculum that focuses on positive mental health, advice on combating depression and eating problems;
- focus in the PHSE curriculum on communication of feelings (Home Office 1999);
- help in dealing with stress, handling conflict and coping with personal problems such as absent parents;
- advice on contraception, dealing with pregnancy, relationships, homosexuality, all matters related to ‘being a man’;
- advice on making the most of yourself (Kingsway College).

Common themes also emerged about how young people wanted to be supported and to learn. Young people want:

- to receive support on a one-to-one basis, or in groups (sometimes single sex groups and sometimes mixed, as appropriate);
- to have visiting experts, adults who know what they are talking about and who are not embarrassed about personal or sexual matters;
- presented in a way that is interesting and not boring, and led by people who are confident and non-judgemental;
- allowed to express opinions, and be consulted in planning and evaluation;
- the right to opt out;
- peer education schemes;
- better information on services;
- information on websites;
- campaigns in colleges followed up by tutorials;
- different teaching methods and approaches to accommodate different learning styles;
- creative and different ways to express their views (through photography, rap, artwork and dance, for example);
- learning that acknowledges cultural diversity;
- supportive adult role models;
- to feel they have been heard and taken notice of.

Summary Points

- Young people express a wish and a need to have access to health information and services.
- Young people also express a wish and a need for more support in coping with emotional and social difficulties;
- Young people want support and learning opportunities about health and well-being which is non-judgemental, creatively and interestingly delivered and in which they are involved at all levels.

Key Questions

- How best and by whom could support and a curriculum be delivered?
- What resources would need to be put in place to development a support and learning programme for young people?
- What materials currently exist that support this work?
- How far could a programme developed for young people be adaptable for adults?

Staff and Staffing Issues

If the idea of a healthy college is to be developed it must include staff. All college staff, not just teaching staff, will be responsible for delivering a 'healthy college'. To achieve a healthy college staff health and well-being is crucial.

In 1994, NATFHE, the university and college lecturers union, commissioned the National Foundation for Educational Research to undertake an investigation into lecturers workload and factors affecting stress in further and higher education.

In the years preceding the report Further Education had undergone many changes, including:

- incorporation in 1993;
- introduction of new qualifications;
- modularisation of qualifications and new assessment methods;
- pay restraint and changes in condition of service;
- increase in student numbers;
- new styles of management.

Since 1994 Further Education colleges have undergone even more changes, including:

- mergers and subsequent reorganisations;
- new funding regimes;
- new inspection regimes;
- increase of new and different learners, including increase of learners with differing needs such as mental health difficulties, homelessness, refugee and asylum seekers low level literacy, language and numeracy needs;
- new initiatives to improve achievement, raise standards and widen participation have resulted in many initiatives and administrative systems to get to grips with.

No further studies could be found since the research was carried out in 1994. However, NATFHE and the Association of Colleges have since issued joint guidance on work related stress in recognition of the seriousness of the matter.

Summary Points

- Further Education has undergone a period of change over the past ten years and many demands have been put on staff, including increased workloads.

Key Questions

- Will a healthy college initiative be perceived as 'yet another thing to do'?
- How receptive will staff be to a Healthy College Standard?
- How can a Healthy College Standard be used to promote the health and well-being of all staff in colleges?

What Makes a Healthy College?

As yet no model of a healthy college exists. This section of the report explores what models have already been used and what work is currently being carried out in colleges.

Current Practice in Promoting Health in Colleges

A sample of colleges were identified that had either been noted in OFSTED reports as having good learner support or had confirmed that they provided targeted support for young people with mental health difficulties. A total of seventeen colleges were contacted. This sample of eleven colleges reflects the range of work being carried out. The sample showed that while there were pockets of good practice, there were varying degrees of commitment. Some colleges demonstrate a strategic commitment, others embed health education in tutorials or in the general curriculum. Other colleges have designated health staff with a remit to promote health.

| | Health strategic plan | Partnerships | Learners targeted | Campaigns and health | Health checks | Health in tutorials | Integrated into | Specific health curriculum | Designated staff | Support for health of staff | Notes |
|--|-----------------------|--------------|---|----------------------|---------------|---------------------|-----------------|----------------------------|--|-----------------------------|--|
| Lewisham College | | | All & mental health | Yes | | Yes | Yes | Enrichment | Mental health worker | | Use of learner produced theatre workshops Millennium Volunteers programme |
| South Cheshire College | | Yes | All | Yes | | | | Yes | Health and Welfare Manager | Yes | |
| York College | | Yes | Mental health | | | | | | | | |
| Scarborough 6 th Form College | Yes | | All | | | Yes | | | College Counsellors & Youth Worker | Yes | |
| Thomas Danby College | | | | Yes | Yes | Yes | | Enrichment | Health adviser/nurse | | |
| Cirencester college | Yes | Yes | All, including mental health and young mother | Yes | | | In some areas | | | | Promotes healthy eating in canteen and use of exercise facilities |
| Wakefield College | | Yes | | | | | yes | | | | |
| Salford College | | | | | | Yes | | Stress Management | | Work-life balance courses | |
| North Lindsey College | | Yes | All | | | Yes | | | | | |
| Tower Hamlets College | | | | | | Yes | | Yes | Youth Worker. Mental Health Worker. College Counsellor | | |
| Kingston College | | | All | Yes | | | | Yes | None | | |

This sample provides a flavour of the type of work being done already in colleges to promote health and well-being among 16-19 learners. This is not a comprehensive list, but would, I suspect be fairly typical of the range of activity.

Models for Promoting Colleges

O'Donnell and Gray

O'Donnell and Gray developed a model as a result of the action research they carried out in Birmingham colleges (O'Donnell and Gray 1993). The model sets out a framework with four key institutional determinants. Each determinant is inter-connected but also stands alone with key features within each determinant.

| Determinant | Key Features |
|----------------------------|---|
| The Institution | <ul style="list-style-type: none"> • Clear and consistent processes for policy and decision making that are open and represent all sections of the college • Support available to encourage and enable all staff to contribute to innovation • Organisational procedures and management strategies geared to recognise and reduce stress • Cultural values that reflect concern for the well-being of college members |
| The Environment | <ul style="list-style-type: none"> • Attractive, cared for surroundings • Good quality working conditions • Health and safety requirements positively observed • Facilities: quiet room, recreations and exercise, religious observance, group and individual study • Smoking-free environment • Wide-ranging catering provision • Creche and play scheme available • Removal of graffiti that contravenes equal opportunities policies |
| The Curriculum | <ul style="list-style-type: none"> • Health education across courses and integrated into the curriculum • Effective tutorial systems, including development of personal effectiveness and health skills • Negotiated objectives, person-centred learning and recognition of achievement • Balanced workloads • Equal opportunities reflected across the curriculum • Recreational and exercise options • Staff development programmes to enable delivery of the above |
| Staff-student relationship | <ul style="list-style-type: none"> • Counselling services • Staff/student contact beyond teaching related commitments • Accessible health guidance • Student involvement in policy making • Effective internal communication for and with students and staff • Good support services in sufficient quantities to enable student-centred learning and problem-solving learning to take place • Happy atmosphere of respect and responsibility • Commitment to active learning strategies |

Many of the key features identified by O'Donnell and Gray have synergy with the key questions asked by the Adult Learning Inspectorate and OFSTED in their inspection of further education. Colleges who address these key questions would find themselves satisfying many of the key features of a health promoting college.

O'Donnell and Gray also highlight the different approaches to health promotion:

- Health-risk advice
- Educational/rational
- Self-empowerment

- Action-for-change

The different approaches are applied to the determinants of a health promoting college to provide a much more useful framework to support health promotion in colleges and shows how health promotion could work in a college.

An example of using the framework and how to work through different approaches to deal with stress. This gives an example of how a ‘template’ of health promotion could be developed within a college.

| | Institution | Environment | Curriculum | Staff-student relationship |
|-----------------------|--|--|--|--|
| Health-risk behaviour | Stress management advice in induction programmes for staff and learners | Provide information on the importance of learning to cope with stress | Provide sessions to raise awareness of stress, and of coping mechanisms | Ensure that stress is featured in events and health campaigns |
| Educational/rational | Induction programme for staff and students to cover good time management | Identify parts of the environment that may contribute to negative experiences | Explore causes and manifestations of stress. Practice stress management techniques | Promote extra-curricula programmes in stress management |
| Self-empowerment | Encourage self-help groups | Encourage college members to contribute to maintaining high quality physical environment | Develop the skills of stress management and prevention | Encourage staff and students to expect and give respect and consideration from/to each other |
| Action-for-change | Establish a regular practice of reviewing workloads | Prioritise and schedule a programme to upgrade the physical environment | Encourage students to plan and participate in programmes on stress management | Review communication channels between staff and students, develop strategies to increase communication |

O’Donnell and Gray also identified the key factors for success in achieving a health promoting college. These were:

- the appointment of co-ordinators- with sufficient time and status;
- support from senior management – so that decision could be made, funding secured and for giving the work credibility;
- cross-college support – so that it felt like a whole college owned initiative and touched as many people as possible;
- receiving external support – including contact with other health promotion co-ordinators in colleges and professional from health promotion services;
- setting realistic targets – creating a sense of achievement when milestones were reached;
- getting ‘health’ on the agenda – where health co-ordinators had senior management support, health was put on the agenda of academic board and other senior management meeting, giving it the support of college governance.

In conclusion the work of O’Donnell and Gray provides some useful insights into how a healthy college standard could be developed.

Kingsway College

Kingsway college provide another example of how health promotion in colleges can be approached.

The Kingsway College Healthy College project used the National Healthy Schools Standard to develop an appropriate Personal Health and Social Education curriculum for 16-19 learners at the college. The curriculum was delivered over two terms in tutorials and included the following elements:

- Action planning – including setting targets for improvement and monitoring grades;
- Personal and social education – with particular focus on working with the rights and responsibilities of living and working in a diverse community;
- Careers Education – include job search and careers information;
- Learning development – the skills the learners need to succeed on their programme e.g. study skills, internet search skills

Evaluation of the project shows that it was well-received by 16-19 learners, with the majority of learners reporting that the course had met their needs. A working group attached to the project felt that if the project was to develop, the following resources would need to be available:

- more materials to access in the Learning Resource Centres;
- in-depth subject-based training;
- clear guidelines, dissemination of best practice, work and resources;
- staff training;
- involvement of learner and welfare services in these issues;
- expansion of student welfare services;
- use of visitor expertise on sex education, drug use etc;
- training to be given on dealing with issues such as bullying, racism and homophobia in a culturally sensitive way.

These provide useful pointers in ensuring success and could form the basis of a ‘how to do it’ support materials. However, the Kingsway College project did not attempt to work to the other Healthy Schools Standards criteria.

NIACE

Escolme et al (2002) in their report on healthy college also used the National Healthy Schools Standard as a framework to assess the health promoting impact of work being carried out in five randomly chosen general further education colleges. The NHSS was chosen as a standard to judge work going on in colleges because it is comprehensive and covers all aspects of a health-promoting organisation. Whether the NHSS is the most appropriate standard remains to be seen. Again, there was found to be incidences of good practice and varying degrees of commitment, but the research clearly showed that colleges could at that time achieve a health promoting standard, in some of the criteria, if not all. Indeed many colleges already are doing very positive health promoting work. Given incentive and encouragement their health promotion work could be expanded. Training and support would need to be available a theoretical understanding to underpin the health promotion work that is carried on.

If resources and material were made available to colleges, similar to those produced by the National Children’s Bureau, the Health Development Agency and the Mental Health Foundation for the NHSS which lay out clearly the standards, ideas for

achieving them and how to assess the impact, more colleges might be persuaded to adopt a more coherent approach and become truly health promoting colleges.

Summary Points

- Models for a health promoting college exist and could be adapted to create a Healthy College Standard.
- There are examples of ‘templates’ of health promotion used within the college environment.
- Colleges would need the support to develop a theoretical understanding of the work they are doing, to develop a curriculum and policies, to develop resources and materials.
- There are identified factors for success in achieving health promotion in colleges such as resources, appointment of key people and importantly the support of college management.

Key Questions

- How can the concept of a health promoting college be ‘sold’ to colleges, including the management of colleges?
- What resources currently exist that would support a healthy college standard?
- What resources and materials would need to be made available to colleges to support the development of a healthy college standard?
- What training would need to be made available to college staff? Would this training be the same for all staff, or differentiated according to need?

Summary and Recommendations

Government policy seeks to address low levels of participation in learning among 16-19 year olds by reforming further education and extending the support available to young people through services like Connexions. More young people are remaining in education and training for longer and colleges have sought to widen participation in learning among those who would not have traditionally have accessed post-16 learning. Low levels of qualifications and poor experience of initial education have an impact on the long-term health status of young people and increase their vulnerability to factors associated with social exclusion. Remaining in learning and gaining qualifications has been shown to have a protective influence on health by improving life chances but also to increase the potential for adopting positive health behaviours. Colleges could be said to already have a health promotion role by virtue of the fact that participation in post-16 learning improves health chances.

The National Healthy Schools Standard has supported schools to make Personal Health and Social Education available to their pupils and for pupils and staff to work in a health-promoting environment. Healthy Schools have also impacted on child health by involving parents and the wider community. Concerns over child health and learning have often been the hook by which parents are encouraged back into learning.

Young people report that they need and would like better access to health information and services. Young people also express a need and a wish to have support with concerns about their well-being and emotional health. Continuing to have health and social support through a healthy college standard would provide a forum for this to happen. As more young people remain in education and training this would increase the chances of more young people benefiting from health, social and emotional support. The potential for involving parents and the wider community needs to be explored. Equally the potential for using the healthy college standard for engaging non-participant youth must also be explored.

Many colleges have recognised the health promotion role that they can play, and the support they need to provide to their learners. Colleges may be doing this because of the effects it has on achievement and retention, but these have an indirect effect on health by improving employment and life chances, and need to be applauded. However, we need to take the idea of a healthy college further if it is to have impact. To develop a healthy college initiative, several things need to happen. It would be necessary to:

- explore different models and approaches in order to build up training materials for staff involved with a implementing a healthy college standard;
- existing resources need to be shared and disseminated and new resources developed where nothing suitable exists;
- identification of factors that ensure success so that barriers and challenges to making a healthy college project work can easily be overcome;
- development of a healthy college ethos by which staff in colleges begin to gain a theoretical understanding of their health promotion role and how it might impact on learning and achievement;
- development of strategies to ‘sell’ the concept of a healthy college to all staff and managers and create a sense of whole college ownership.

This report recommends that a number of demonstration projects be developed to pilot a standard. It is recommended that the National Healthy Schools Standard is adapted because it is comprehensive in approach and includes all aspects of a health-promoting organisation. Demonstration projects could test out the relevance and appropriateness of the standard to Further Education Colleges.

This report recommends that the demonstration projects are evaluated according to two criteria. Firstly, they should be evaluated on their effectiveness in implementing a Healthy College Standard and the effectiveness of the various activities and strategies undertaken. A Healthy College Standard needs to be meaningful to the staff and learners within a college and is seen to be relevant to their experience. Secondly, they should be evaluated on the impact that their work has on the learning and health of project participants. A Healthy College Standard needs to be successful in addressing the key government agendas of tackling health inequality, raising achievement and widening participation in learning. Evaluation needs to show if a Healthy College Standard can do this.

Finally the report recommends that the experiences of the demonstration projects and the evaluation findings are written up and disseminated widely. Previous projects and colleges currently involved in health promotion work have developed in isolation and have not been able to benefit from the experience of others. This has led to an uncoordinated and undeveloped strategy and the full potential of health promotion within colleges has failed to be recognised.

While there are challenges to implementing a healthy college standard, such as demands on staff, there is a huge potential for using colleges to promote health and well-being and to investigate how far this impacts on achievement and participation. This urgently needs to be capitalised on.

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