SCHOOL NURSES AND PARTNERSHIPS FOR HEALTH EDUCATION: TEAM TEACHING IN THE SECONDARY SCHOOL CURRICULA.

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Marguerite C. Sendall, Marylou Fleming, John Lidstone, Michelle Domocol

Abstract

The purpose of this research is to examine School Based Youth Health Nurses experience of partnerships for health education and team teaching. The School Based Youth Health Nurse Program is a contemporary model of school nursing in Queensland, Australia. The role of the School Based Youth Health Nurse consists of individual health consultations and health promotion. This research analyses a subset of qualitative data collected for a larger project about the experience of school based youth health nursing. The Health Promoting Schools model is used as a deductive framework.

The findings reveal five subthemes across the three areas of the Health Promoting Schools approach. There are two subthemes within the curriculum, teaching and learning area; *We were on the same page so to speak* and *I can go and do my reports or whatever.* There are two sub-themes within the partnerships and services area; *I had a beautiful science teacher who was just delightful and really just wanted to do things in partnerships* and *It's all airy fairy arty farty stuff that's not important.* There is one theme in the school organisation, ethos and environment area; *I just don't know how well the top of these organisations communicate with the bottom of those organisations.* Successful partnerships for health education and team teaching between school nurses and teachers are based on personal relationships based on rapport which lead to trust and reciprocity. Partnerships are limited by teachers understanding of the role of the school nurse and engagement with school nurses in the classroom. Administrative support from the top down is fundamental.

1. Introduction

This research, conducted in Queensland, Australia, explores school nurses experience of partnerships for health education and team teaching in a contemporary model of school nursing. In 1999, after a 6 month pilot project, the health department, Queensland Health (QH), in collaboration with the education department, Education Queensland (EQ) initiated the School Based Youth Health Nurse Program (SBYHNP). The SBYHNP was phased into state secondary schools in 5 stages over 4 years. The only mandatory qualification for a School Based Youth Health Nurse (SBYHN) position is registration as a General Nurse with the Australian Health Practitioner Regulation Authority (Queensland Government, Department of Education and Training, n.d., p. 3). The SBYHNP currently employs the equivalent of 115 full-time SBYHN (Queensland Government, Department of Education and Training, 2006). The strategic relationship between QH and EQ is outlined in *The Memorandum of Understanding* between QH and EQ (Queensland Health, 2006). The operational relationship between SBYHN and schools is outlined in the *School Based Youth Health Nurse Program General Guidelines* (Queensland Health, 2003).

The SBYHN role varies from other school nurse roles in Australia. The most significant difference is philosophical and the underpinning premise of the role of the SBYHN. This premise proposes SBYHN *belong* to the school community. This philosophical re-orientation adjusts the role of the school nurse from a visitor to an integrated member of the school community. The implementation of this new model of school nursing is supported by structural changes, for example, an increased presence of the SBYHN (usually two or three days per week in each of two schools) and designated office space. These changes increase the SBYHN profile and provide opportunities to develop relationships with other members of the school community.

The SBYHN role has two primary components: 1) individual health consultations and 2) whole school health promotion. The focus of this paper is the health promotion component. Health promotion in the school environment is guided by the Health Promoting Schools (HPS) approach. The HPS approach is endorsed by the World Health Organisation's (WHO) Global School Health Initiative 1995 to improve the health of students, staff, families and other members of the school community (WHO, 2012a). It is underpinned by the

fundamental concepts of health promotion articulated in the Ottawa Charter for Health Promotion (1986) and the Jakarta Declaration (1997). The Ottawa Charter identifies health promotion as 'the process of enabling people to increase control over, and to improve, their health' (WHO, 2012b). There are eight pre-requisites for health including education. The strategies to achieve these prerequisites are 'advocate, enable and mediate'. The Ottawa Charter identifies five action areas; 1) build healthy public policy, 2) create supportive environments, 3) strengthen community action, 4) develop personal skills and 5) reorient health services. The Jakarta Declaration re-iterated the principles of the Ottawa Charter and identified strategies to address the challenges for the twenty-first century; 1) promote social responsibility for health, 2) increase investments for health development, 3) consolidate and expand partnerships for health, 4) increase community capacity and empower the individual and 5) secure infrastructure for health promotion (WHO, 2012c).

The HPS framework contributes to health promotion in schools by identifying the framework for action. The HPS framework consists of three interconnected areas: 1) curriculum, teaching and learning, 2) partnerships and services and 3) school organisation, ethos and environment (Australian Health Promoting Schools Association (AHPSA), 2010). Globally recognised, the HPS approach has been adopted with vigour in some regions, for example, the European Network of HPS (ENHPS) has been active for three decades and in some countries, for example, Finland (Tururen, Tossavainen, Jakonen and Vertio, 2006) and China (Aldinger, Xin-Wei, Li-Qun, Jun-Xiang and Jones, 2008). The adoption of the HPS approach in Australia has been piecemeal because it has relied on individuals within the school environment such as an enthusiastic Principal or Health and Physical Education (HPE) teacher. Schools may have adopted an HPS approach before the inauguration of the SBYHNP and the SBYHNP was not instigated solely because of this issue. The HPS approach is not a program which begins and ends, it does not rely on one particular person or group of persons and one size does not fit all. It is a whole school approach; it is pervasive, sustainable and contextualised to promote better health outcomes for the whole school community (WHO, 2012).

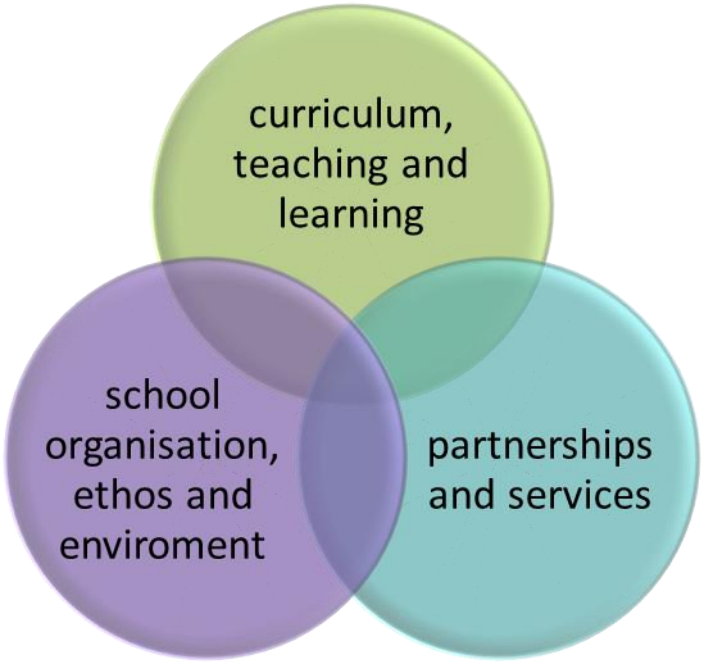

Figure 1: The Health Promoting Schools framework (AHPSA, 2010).

Health promotion includes health education. The three areas of the HPS framework encompass six key features: '1) engaging health and education officials, teachers, students, parents, and community leaders in efforts to promote health, 2) providing a safe, healthy environment, both physical and psychosocial, 3) providing effective skills-based health education, 4) providing access to health services, 5) implementing school policies and practices that support health and 6) striving to improve the health of the community (WHO, 2000d, p. 2-3). Health education in schools has traditionally been planned, developed and delivered by trained HPE or Home Economic teachers. Patton, Bond, Butler and Glover (2000) suggest most school based interventions use health education within the HPE curriculum to address specific health issues. According to Barnes, Courtney, Pratt and Walsh (2004), one of the main roles of the SBYHN is health education in the classroom. However, Carlsson (2005) found most SBYHN identify teaching practices and curriculum content is the most challenging to effect. Operationally, anecdotal evidence suggests many teachers are eager to engage SBYHN in partnerships for health education and team teaching. Other curricula embrace guest speakers in the classroom, for example, local accountants or businessmen support classroom lessons in Business Education and Studies of Society and Environment embrace opportunities by local cultural groups and representatives from the Electoral Commission. Many SBYHN are eager to oblige because they consider partnerships

for health education and team teaching as a strategy to increase their profile, a way to link with other health-related activities and an opportunity to foster their *belonging* in the school community.

Strategically, there has been resistance to SBYHN participation in the delivery of the health education curriculum. The SBYHNP does not recommend SBYHN participate in the delivery of the health education curriculum based on two grounds; 1) SBYHN do not have formal teaching qualifications and 2) there is a lack of empirical evidence related to behaviour change and improved health outcomes from health education, especially one-off sessions. One-off sessions are health education lessons which are not embedded in curricula and therefore are not contextualised to a topic. This creates juxtaposition between the strategic recommendations and operational reality of the SBYHNP. SBYHN may consider health education as the 'face' of health promotion and a way to increase their profile and gain credibility in the school environment. SBYHN may consider teachers expect them to undertake health education. This creates ongoing tensions for school nurses and teachers on the ground.

This inquiry is about SBYHN experience of partnerships for health education and team teaching in the school community. This inquiry is important because it will shed light on the nexus between SBYHN and the third key feature of the HPS framework, *providing effective skills-based health education*, within the context of the three interconnected areas: 1) curriculum, teaching and learning, 2) partnerships and services and 3) school organisation, ethos and environment. In order to examine this inquiry, the authors analysed a subset of raw data collected from a larger research project about the experience of SBYHN.

The purpose of this research is to understand SBYHN experience of partnerships for health education and team teaching. Insights gained from this research will contribute to a small body of evidence and reframe understandings about school nurses role in partnerships for health education and team teaching. The rationale for this research is twofold.
The authors are keen to challenge assumptions associated with partnerships for health education and team teaching and promote the potential outcomes, for example, enhancing the perception of SBYHN as trusted people in the school community.

2. Literature Review

The literature about partnerships for health education and team teaching in the school environment is broad and diverse because it comes from a variety of professions and sectors. Most literature is from primary, secondary and tertiary education and some literature is from health and other disciplines.

Definition of team teaching

Critics and practitioners of team teaching find several challenges stem from its mutable definition. In various teaching contexts, educators and school nurses view definitions as flexible guides. As a result, teaching arrangements are unclear and complex, differ significantly among teams and are on a scale from interdependency to autonomy (Bessette, 2008). Without an established definition, team members disagree about the operational framework of team teaching, for example, options, characteristics and logistics (George and Davis-Wiley, 2000; Murawski, 2006). Researchers define team teaching as two or more professionals delivering lessons to a class of students (Minnett, 2003; Piechura-Couture, Tichenor, Touchton, Macisaac and Heins, 2006). Others, such as Stivers (2008) and Gayton (2010) specify the collaboration extends from class instruction through to the design and evaluation of the curriculum. Jacob, Honey and Jordan (2002) emphasise team teachers must equitably distribute decision making power in student instruction, assessment, and the learning objectives. Game and Metcalfe (2009) reiterate team teachers can only succeed with reciprocal feedback and constructive evaluation. Open communication can help teachers diminish teaching-related reservations and worries (Bessette, 2008). With proper collaboration, engaged team teachers can radically transform the learning and teaching experience (Game and Metcalfe, 2009). In contrast to this expected transformation, many school administrators anticipate team teaching will decrease the schools workload in general and add an extra perspective. These schools do not expect an added resource could engage and transform the classroom dialogue (Minnett, 2003).

Types of team teaching

In most cases, Shapiro and Dempsey (2008) find teachers and visiting experts practice a continuum of team teaching methods from modularising the curriculum to embracing subject and pedagogy to maximise collaboration between teachers. Other authors highlight common types of team teaching. Six commonly used teaming approaches include: 'one teaching-one observing, one teaching one circulating, team teaching, station teaching, parallel teaching, split class, small group pull out'. Each approach involves various 'exchanges of leadership roles' within the classroom (Hanusch, Obijiofor and Volcic, 2009). In other contexts, Carpenter, Crawford and Walden (2007) note team-teaching ranges from the serial to the collaborative approach. Serial team teachers divide the teaching into 'lecture blocks' and teach individually. Each team teacher operates like an 'alternate solo performer' who deliver with different styles, goals and objectives (Shapiro and Dempsey, 2008). Whereas collaborative teachers continually plan, present, and evaluate lectures together (Carpenter, Crawford and Walden, 2007). School nurses, visiting experts and instructors ideally choose a level of collaboration which meets students' learning styles, needs, content areas, and instructional goals (Dieker and Murawski, 2003; Hang and Rabren, 2009). Ideally, for team teaching to support the lesson, each instructor should clearly understand their roles and classroom relationships (Shibley, 2006).

Team teaching and teaching and learning outcomes

For the past twenty five years, various health education proponents promoted team teaching as a successful pedagogical tool. As facilitators in health education, school nurses use team teaching to manifest both teaching and learning outcomes (Shapiro and Dempsey, 2008). When integrated properly, team teaching can engage students in a dynamic, interactive learning environment (Dyrud, 2010). Through team-taught classes, school nurses 'model collaboration techniques' with teaching staff (Carpenter, Crawford and Walden, 2007). Simultaneously, team teaching exposes students to specialised, evidence-based knowledge from a variety of experts and fieldworkers (Hanusch, Obijiofor and Volcic, 2009). In turn, collaborative and interdisciplinary teaching fosters critical thinking and productive discussion of crucial public health topics (Hang and Rabren, 2009). Critics suggest the organisational features of team-taught classes can negatively affect the performance of teachers, for

example, control issues between teachers and students, for example, student confusion (Murawski, 2006; Piechura-Couture, Tichenor, Touchton, Macisaac and Heins, 2006). However, little empirical evidence evaluates the results of team teaching in health education contexts (George and Davis-Wiley, 2000). Most research praises team teaching for learning outcomes which benefit students (Dyrud, 2010). Team teaching is assumed to provide ideal professional relationships and classroom dynamics. Collaborative teaching holds the promise of innovative teaching methodologies.

Other cases suggest team taught classroom dynamics are transformative. Teachers and visiting experts find students attain improved self-confidence, academic performance, social skills, and peer relationships (Austin, 2001; Cramer and Nevin, 2006). Wenger and Hornyak (1999) find multiple teachers can encourage a cooperative effort in which students and teachers are engaged in a critical intellectual exchange. Druyd (2010) finds teachers share multiple perspectives and interdisplinary debates and students follow these behaviours to share unique intellectual insights. This normalises a discursive and rational debate useful in all learning contexts. Game and Metcalfe (2009) claim students and teachers develop intellectual debates which enhance self-efficacy, creative, articulate meaning-making in a dialogic community where both teachers and students are both teaching and learning.

Team teaching and professional relationships

In terms of professional relationships, Hanusch, Obijiofor and Volcic (2009) claim team teaching provides an opportunity for colleagues to 'model learning for students'. During the teaching process, colleagues exchange valuable techniques and research. Likewise, Dryud (2010) explains team teaching fosters synergistic relationships with educators and school nurses. Within teams, trusted colleagues can commit and build towards innovative and enriching educational outcomes (Carpenter, Crawford and Walden, 2007). For instance, Hang and Rabren (2009) found teachers divide roles to enhance their teaching capability. In many cases, one co-teacher provided accurate responses to the class while the other co-teachers served as assessors and witnesses. The authors suggest then witness role can observe how the teaching style and presentation engages students. In particular, the witness teacher can easily support the active teacher who may provide inaccurate answers due to anxiety, self-consciousness or those who may 'have difficulty withholding preconceptions'. This research

study shows teachers in interdisciplinary and multidisciplinary teams feel less isolated and more supported. Similarly Game and Metcalfe (2009) found 'the presence of other teachers as witnesses allows the teacher to get out of themself' and adopt another lens.

Team teaching and common conflicts

Common conflicts can block the desired teaching and learning outcomes. Organisational processes and classroom execution are not always ideal and produce negative effects for school nurses, academic staff, and students, for example, no significant improvement in student achievement (Carpenter, Crawford and Walden, 2007). Shapiro and Dempsey (2008) cite barriers stem from staffs inadequate orientation and training of team teaching concepts. Challenges also develop when organisational and visiting experts and students are coerced to adopt team teaching methods. Ideally, team teaching programs should only involve organisational and visiting experts who want to adopt the methodology. Those who engage in team teaching should be psychologically secure and professionally competent, and easy with spontaneous discussion (Hoover, Jacobs Anderson and Hoover, 2000; Gayton, 2010).

In team teaching, interdependent team members may 'perceive incompatibility in multiple forms (Carpenter, Crawford and Walden, 2007; Bessette, 2008). In many cases, conflict arises from unclear team teaching format, designated roles and responsibilities. For instance, in a state-wide survey general and special education co-teachers, reported instructional and behavioural management was disproportionately distributed in their teams (Hang and Rabren, 2009). Conflicts may arise from competitive instructors. Team teachers may resist a "backseat" role in their own classrooms. Competing for limited resources and using conflicting methodologies may build dysfunctional classroom relationships and unachieved learning outcomes. In other cases, teams collapse when individual teachers have considerably diverse personality types, fixed teaching styles and there is a power struggle for authority (Shapiro and Dempsey, 2008). Other barriers elevate from scarce funding and inadequate professional development seminars intended to support team teaching programs (Gayton, 2010).

Team teaching and effectiveness

Shared goal-setting, pedagogy, planning, and assessment are hallmarks of effective team teaching. Researchers recommend a wide array of solutions to counter any potential barriers to effective team teaching. Each solution aims to improve processes in pre-planning, curriculum planning, teaching, and evaluation (Shibley, 2006). During the preplanning stage, students who are used to lecture-based instruction may resist the team-teaching approach. To help combat this resistance, educational institutions should familiarise students with the dynamics of team-taught courses prior to registration (Shapiro and Dempsey, 2008). Alternatively, the educational institution should provide workshops with concepts and methods in effective planning, design, delivery, and assessment (Sargent, Allen, Frahm and Morris, 2009).

Prior to curriculum planning, teachers and incoming experts must develop a working, trusting relationship. Camaraderie and bonding is essential. Through comprehensive orientation, team teachers can comfortably share teaching experiences, teaching skills, philosophies, worldviews, and perspectives. Piechura-Couture, Tichenor, Touchton, Macisaac and Heins (2006) recommend the identification of each party's philosophy (i.e., essentialism, progressivism, existentialism), learning style, leadership strengths. This orientation will help each educator 'recognize and value the uniqueness of each teacher... complementary relationships' (Game and Metcalfe, 2009). Preplanning allows teachers to capitalise on their individual strengths to form and functioning collaboration. Once a team is formed, they must plan and divide responsibilities. In the curriculum planning stage, 'frank discussions' and establishment about classroom expectations are imperative.

Shibley (2006) finds these continual pedagogical negotiations improve the collaborators' teaching and lesson preparation. Hang and Rabren (2009) recommend an ongoing weekly co-planning period to discuss 'instructional issues, behaviour management, teachers roles and responsibilities, and students'. Once the course begins, educators must very clearly explain the format of the class and learning outcomes associated with classroom activities. Team teachers should continually build mutual support and avoid competitive delivery. During classes, they should be open to constructive debates and modelling rational discourse to students. Each teacher should continually evaluate and guide each other to improve the

overall teaching performance (Minnett, 2003). Administrative support is essential for continued success of a team teaching model. Administration should also provide funding for comprehensive evaluation programs. The professional support will enhance the performance of both students and teachers (Minnett, 2003; Stivers, 2008).

3. Methodology

The data used for this research is part of a larger data set collected for the first author's doctoral thesis titled *Title* (Author, 2009). The findings from this thesis are published elsewhere (Author, 2011). The first author conducted in-depth interviews which consisted of five open-ended questions with SBYHN. This data set was extracted because it is clearly defined by the third open-ended question, *Can you tell me about your experience of working with teachers when doing health promotion/education?* in each in-depth interview. The authors believe it is important to consider this data set separately from the original data because of the strategic recommendations and operational reality of the SBYHNP and the tensions this creates for school nurses and teachers. The authors suggest the SBYHNP assumes evidence about one-off education sessions can be extrapolated to team teaching by school nurses and teachers and have overlooked other benefits associated with SBYHN participating in health education.

Ethics approval was given by the University Human Research Ethics Committee at Queensland University of Technology: Ethical approval number 070000 0505.

3.1. Methods

Participants

There are 16 participants in this research. Participants are SBYHN who are no longer employed in the SBYHNP because the researcher and the SBYHNP could not agree how to conduct the research. All participants are Registered General Nurses and come from an array of nursing experiences.

Data collection

The researcher conducted 16 in-depth interviews. The researcher was previously employed as a SBYHN and telephoned three SBYHN who were known personally. Participants were given a brief overview of the research and all participants agreed to an in-depth interview. Snowball sampling was used to recruit further participants. At the end of each in-depth

interview, the researcher asked participants to forward contact details to other potential participants. When potential participants made contact with the researcher, an overview of the research was provided before verbal consent was gained. A convenient date and time for was agreed for the in-depth interview. Most in-depth interviews took place in a public space such as a coffee shop. A few in-depth interviews took place at the participant's home. Before the in-depth interview commenced participants signed a consent form which re-enforced anonymity and confidentiality. All in-depth interviews except one were audio-recorded with the consent of the participant. The researcher took notes for this in-depth interview. In-depth interviews lasted from 45-70 minutes. Participants were asked five questions. Participants responses to the third question, *Can you tell me about your experience of working with teachers when doing health promotion/education?* is the focus of this inquiry. Participants were also asked a probing question; *Can you tell me about your experience of working in a team in the school setting?* The researcher ceased snowball sampling when there was no new information. The researcher collected demographic data at the end of each in-depth interview. Demographic details of participants are published elsewhere (Author, 2011).

Data analysis

Data analysis is deductive. Deductive analysis allows researchers to answer specific questions by analysing the data according to an existing framework (Patton, 2002, p. 453). The HPS approach was used as the deductive framework because it aligns with the 'whole school approach' which underpins the SBYHNP. The data was analysed for subthemes within the three areas of HPS framework – 1) curriculum, teaching and learning, 2) partnerships and services and 3) ethos and organisation (AHPSA, 2010). The first and second authors began data analysis by reading the transcripts several times. Significant statements were identified, transferred in context to an Excel spread sheet and allocated an initial code. Two hundred and thirteen significant statements were cut into paper strips and placed in groups, according to codes, on the desk. Each group was allocated another code (T&L, P&S and E&O) to represent an area of the HPS framework. This process allowed the researcher 'thinking time' to ensure the true meaning of each statement had been established. The researcher moved some statements to other groups and removed other statements. The researcher ensured internal validity (all statements represent the meaning of the group) and external validity (each group represents a significant concept) by not rushing to finalise data

analysis. Once the groups, now sub-themes, had settled, the researcher labelled each sub-theme with descriptive labels. The first and second authors conducted inter-rater reliability and reached 97% agreement for coding and theming. Wang (2010) suggests inter-rater discrepancies cannot be eliminated completely.

3.2. Limitations.

There are several limitations to this research.

1. The research question was formulated after the data was generated within the context of larger study.
2. The researcher knew some participants which enhanced rapport but may have limited objectivity.
3. Participants have moved to other nursing positions so may harbour grudges or forgotten details.

4. Results

The data reveals two subthemes within the curriculum, teaching and learning area of the HPS framework. The first subtheme is *We were on the same page so to speak.* The second subtheme is *I can go and do my reports or whatever.* The data reveal two sub-themes within the partnerships and services area. The first subtheme is *I had a beautiful science teacher who was just delightful and really just wanted to do things in partnerships.* The second subtheme is *It's all airy fairy arty farty stuff that's not important.* There was only one theme in the school organisation, ethos and environment area; *I just don't know how well the top of these organisations communicate with the bottom of those organisations.* A visual representation of the findings presented in Diagram 2: Five subthemes which represent SBYHN experience of partnerships for health education and team teaching. A description of the findings follows.

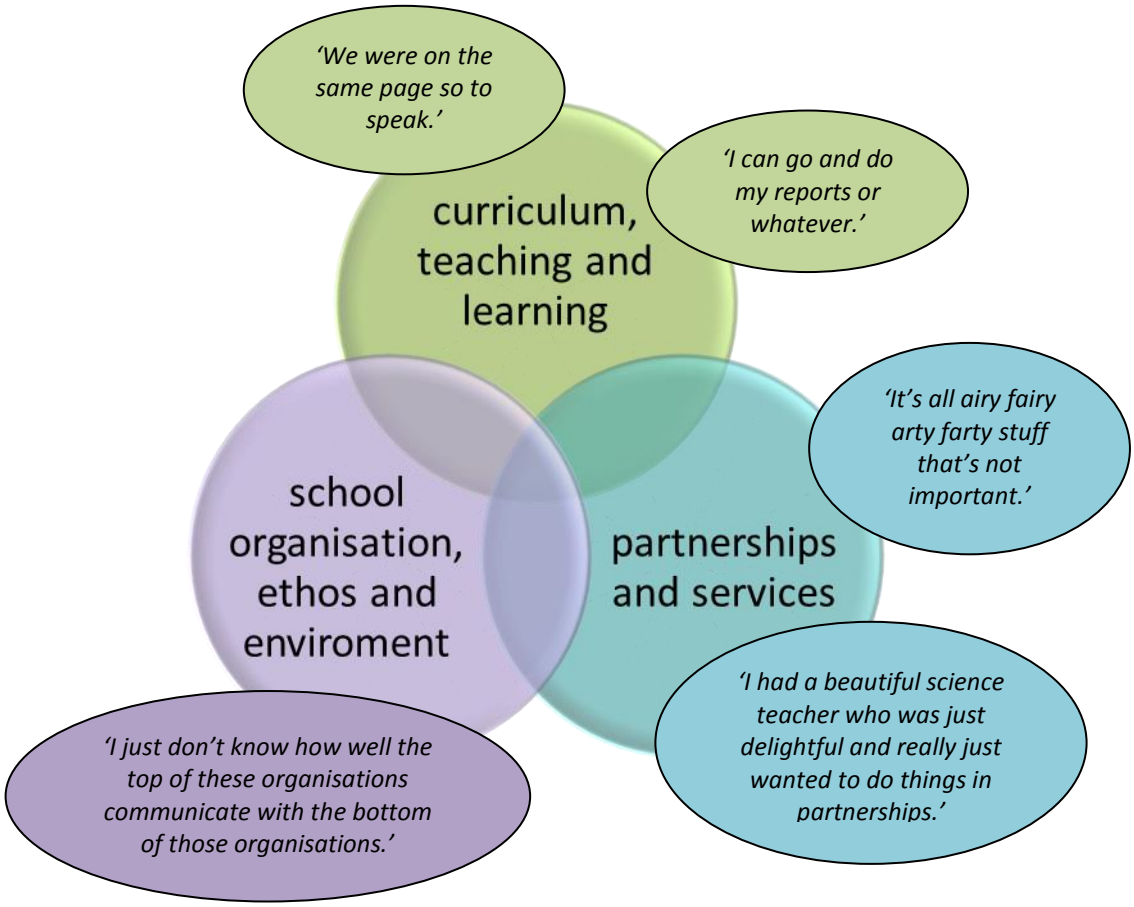

Figure 2: Five subthemes which represent SBYHN experience of partnerships for health education and team teaching.

4.1. Curriculum, teaching and learning

The context of this theme is the relationship between participants and the curriculum, teaching and learning component of the HPS framework. Participants' suggest the premise of this theme is participating in health education in the classroom. Participants feel they are experts in health and have knowledge which can be incorporated into health education. Participants suggest some health education is not be conducted by teachers because they are not trained or do not feel confident. The following quote is representative of many quotes from participants who spoke about the premise of the relationship before telling stories about their experience.

> *ES4: So you'd almost be asked in as, like - you know, to provide supplementary information or expert advice as to what - around what they couldn't give in regards to a whole range of health issues that might be identified in the school system, but they really knew nothing about how they could be addressed or what happened in the community.*

Participants' experience of curriculum, teaching and learning fell into two strong and divergent sub themes. The first subtheme is *We were on the same page so to speak.* The second subtheme is *I can go and do my reports or whatever.*

4.1.1. *We were on the same page so to speak.*

This subtheme represents participants' experience of being included in the curriculum, teaching and learning component of the HPS framework. Participants feel teachers are open to inviting them to participate in health education in the classroom. Participants consider teachers allow them scope to do health education in the most appropriate and relevant way. Participants feel they are afforded the freedom to use a variety of teaching and learning strategies. The following quote is representative of this sentiment.

ES2: Well, pretty much giving me free run to design that segment how I wanted it. Like, they might give me a topic. Say, like, Schoolies[1]*, they'd say, "Can you do some stuff on, you know, drug and alcohol stuff," or something like that. So it was cool for me to tailor that to, you know, adding not just drug and alcohol things, but more harm minimisation and things and however I wanted to present it. If I wanted to do a play, that would have been fine by them. If I wanted to just stand up there and talk with a chalkboard, I could have done that. If I wanted to do a Powerpoint, I could have done that and they were happy. Whatever I needed, they were happy for me to do it. So they were supportive in that way.*

This subtheme includes the idea of trust and respect. Participants suggest they are invited to participate in health education in the classroom because there is a sense of trust and respect between themselves and teachers. This trust relationship makes participating in health education in the classroom easy and ongoing. One participant identifies s/he works in a rural and a city school. This participant speaks about the relationship s/he had in the city school.

ES3: In the city school, easy. You know, really good relationship because they wanted me there, you know, or they wanted the role there. That they certainly trusted me. They certainly respected what I did. So, yeah, working with them was really easy. But on the subject of health education, and fitting into their sort of curriculum, not a problem. It was really easy.

Another participant elaborates on the idea of trust and respect. Teachers who identify a health concern amongst students approach the participant to participate in the health education in the classroom as a strategy to address the problem. The participant suggests this partnership is based on trust and respect.

ES7: They were very helpful, the ones, and they could see the relevance of what I was doing and the benefit because they were able to identify issues and problems that the young people might be experiencing. Areas that needed to be addressed. So more

[1] *Schoolies* is the term given to a holiday taken by Year 12 students at the completion of their secondary schooling.

often than not, I was working with teachers that I had some rapport with. So therefore we were on the same page, so to speak, in terms of identifying a problem and how it could be addressed. And more often than not, they were very accepting and appreciative of my input and ideas and willing to support me in that.

Another concept in this subtheme is the level of engagement which takes place during health education in the classroom. Participants suggest teachers who have a genuine interest or concern in a specific health issue are more likely to invite them to participate in health education in the classroom. They are more likely to actively engage in the planning and delivery of health education in the classroom. These teachers are more likely to relate the information to the local community or environment. This is represented in the quote below.

ES11: I guess, when teachers were very interested in a topic and they could be quite supportive and generate a lot more discussion and a lot more learnings than what would have been covered if it was just straight curriculum and the topics that I had covered because I think conversations and people's personal experiences or how they might apply that and how they can bring in from a youth perspective or a local something that had occurred locally or how they can relate it, I think, was really valuable.

4.1.2. *I can go and do my reports or whatever.*

This subtheme represents participants' perceptions of teachers actions and is underpinned by participants sense that teachers do not wish to partner for health education and team teaching. This subtheme includes concepts about behaviour management or control of students in the classroom, teachers misunderstanding that health education was free time to 'do reports or whatever' and some teachers are unprofessional and rude when participants are conducting health education in the classroom.

Many participants illuminate the concept of the responsibility of controlling and managing the students in the classroom. Participants identify it is the teachers responsibility for behaviour management and not the SBYHN responsibility. This understanding reflects the principles of the SBYHNP to ensure SBYHN are seen as approachable rather than

authorative or disciplinary. Many teachers did not actively reinforce good behaviour or manage bad behaviour. Participants feel students are out of control and this influenced the experience of participating in curriculum. This idea is represented in the following quote.

> *ES2: When it didn't work was when the teachers had no control over the kids and that was really hard and it was hard on the nurses to try and keep control of the kids because that's not our job.*

One participant spoke about her/his frustration in relation to poor behaviour management by teachers and how this impacted on the experience of participating in health education in the classroom.

> *ES6: In fact, I can remember one situation where I did speak up to a teacher about that. It was one of those all day affairs where you have every sort of topic pertaining to health and I think at this particular time, I for some reason got the job of talking to the kids. It was about domestic violence, I think. And, you know, put together a few programs, but the kids were so ratty. They were terrible. You know, when you look at the whole day's activities and they I couldn't get their attention. The teacher was not doing anything about their behaviour and so it became unmanageable. In the end, I just stopped giving any information. I just went to the teacher and said, "Listen, you're the teacher. You need to control your kids."*

Many participants articulate ideas about teachers' perceptions of health education by SBYHN as an opportunity to do other things. Participants tell stories about teachers who, for example, sit up the back and mark assignments, call students to the back of the classroom and conduct a conversation or slip out the back of the classroom. Some participants provide a reason for the teachers behaviour, for example, they are over worked, burnt out or just need time out.

This quote is representative of this sentiment.

> *ES6: I know that in giving a health education session, the teachers are supposed to remain in the classroom, but I tell you what, the teachers probably thought oh, this is good. I can go and do my reports or whatever. So generally it was look, yeah,*

anything for a break. Just do it. Some teachers did become involved in the content of what I was teaching and contributed also, but more often than not, they saw it as an opportunity for them to do something else.

One participant tells a story about a teacher to demonstrate how extreme the situation was in relation to teachers acting inappropriately while the SBYHN is conducting health education in the classroom.

ES9: I actually had one teacher like, an example of devaluing you. What did he do? I was in the middle of my talk or whatever and he just, it only happened once. It was one teacher, but he just sort of, like, spoke out in the middle of something and asked like, very disruptive. Asked the students to come up and he was marking something and he got them, like, in the middle of my lesson, I guess, and he was sitting, like, just to the side of me at the front of the class, but he was running his own sort of lesson with me, like, doing his own thing and I thought how do you keep your line of thought when someone's there obviously not listening to any of it...

4.2. Partnerships and services

The context of this theme is the relationship between participants and the partnerships and services component of the HPS framework. Participants' suggest the foundation of this theme is relationships with teachers for health education in the classroom. Participants feel rapport and an element of personalisation with teachers is fundamental and translates into engagement and reciprocity. Participants perceive relationships are affected when teachers do not value the role of the school nurse and feel they are vulnerable in a teacher's world.

Participants' experience of partnerships and services emerged in two distinct and opposing subthemes. The first subtheme is *I had a beautiful science teacher who just was delightful and really just wanted to do things in a partnership.* The second subtheme is *It's all airy fairy arty farty stuff that's not important.*

4.2.1. *I had a beautiful science teacher who just was delightful and really just wanted to do things in a partnership.*

This subtheme represents participants' experience of relationships with teachers. Participants express the notion that relationships are critical in forming good partnerships for health education and team teaching in the classroom. Participants feel rapport is fundamental to establishing and developing a partnership with certain teachers. Rapport makes the difference to health education in partnership because the existing relationship is based on support and value. This makes partnerships easy. This concept is demonstrated in the following quote.

> *ES7: They were very helpful, the ones, and they could see the relevance of what I was doing and the benefit because they were able to identify issues and problems that the young people might be experiencing. Areas that needed to be addressed. So more often than not, I was working with teachers that I had some rapport with. So therefore we were on the same page, so to speak, in terms of identifying a problem and how it could be addressed. And more often than not, they were very accepting and appreciative of my input and ideas and willing to support me in that.*

Participants suggest these relationships transcend a professional relationship because there is an element of personalisation. Participants intonate warmth and regard for those teachers with whom they build personal relationships. Participants speak with a level of affection and congeniality about those teachers with whom they had personal relationships.

> *ES12: I'll start with the most positive one. I had a beautiful science teacher who just was delightful and really just wanted to do things in a partnership. So it was very much about the two of us teaching and about sharing information. So she would always contribute during the session. She would actually manage her class extremely well and be there as a support person. Would always ring and give me an outline of what was happening with the class and what was expected and what, even the time frames. She would negotiate time frames with me. So it wasn't about this is my class. This is the day. It was about when are you free and maybe I'll be able to manipulate my program to help you and it was always a term in advance. So very, very organised and very it was a nice partnership, I guess.*

This participant also spoke about ‘groups of teachers’ with whom s/he had relationships for health education in the classroom. The tone does not reflect the same level of familiarity however the outcomes in terms of a successful partnerships is the same.

> *ES12: There were some standard teachers, the home ec teachers as well who were really, really supportive. Used to give me quite a bit of notice, but they were the ones who had the strict classes. So but would always give me the outline for the class et cetera and I taught the same subjects every year and some of them were great fun and some of them were boring and so that relationship with them and that built from there because then they actually became part of my committees as well. So I think that, you know, we've built a lovely relationship through those health education sessions....*

Other participants spoke about how rapport and familiarity translated into engagement and reciprocity for health education in the classroom. This participant feels there are no barriers to communication and there is a level of engagement throughout health education in the classroom which reflects this connection. For example;

> *ES10: Being a relationship, just being flexible in the classroom. Just really quite open conversation. Looking at the teacher, your partner there, engaging in things. But also, you know, if we are needing to, we are clarifying things. Just peer to peer and no sort of barriers in regards to that communication. So a lot of trust and an underlying awareness of and I suppose that's with a little bit of experience, where the person was likely to go and knowing their teaching style because having been in there before. So I suppose where it works really well is obviously where there's some level of similarities in that teaching style so that you just because there's some sort of connection there. You relate well. So then it comes across very easy to the students as well. So I think that's the stuff where the team teaching works really, really well and you are not sort of you are really engaged.*

4.2.2. *It's all airy fairy arty farty stuff that's not important.*

This subtheme represents participants' experience of the perceptions of teachers' attitudes about the role of the SBYHN for health education in the classroom. Participants express the idea that partnerships between school nurses and teachers are poor because teachers do not know about the role of SBYHN. Participants feel teachers think school nurses do not do anything and if they do, it is not very important. This idea can be seen in the following quote.

> *ES1: Some teachers thought that you weren't really doing a job that you know, like you were you know, "What were you doing, sitting there? It's all airy fairy arty farty stuff that's not important."*

Another participant explained the same idea from a different perspective. This participant feels teachers do not understand what SBYHN do and are resistant to change. In some way, teachers were desensitised to this new initiative because it was just another initiative.

> *ES4: They didn't understand the concept of what the school based youth health nurse role was all about... it was another initiative. It got funding. It was promoted and then it died, which is what Queensland Health seems to be don't know whether I should be naming Queensland Health, but it's what Queensland Health seems to be very good at doing. And so, yeah, it was promoted as, like, this fantastic, like, new concept that had never really, you know, been realised before and this was going to sort of, like, yeah, take this on in the high schools and we can change a whole heap of things, but teachers didn't have an understanding of what was involved in implementing or introducing change and that it took a long period of time.*

Other participants feel the barriers relate more to the 'teachers world'. Participants feel schools are a teachers world, teachers live in this insular world and teachers are cliquey. Participants suggest they are somehow at the mercy of teachers, teachers have control and power and this affects their ability to form partnerships for health education and team teaching in the classroom. The following two quotes reflect this concept.

ES4: It was very cliquey. I mean, PE teachers would invite you in if there was a space. It was always ad hoc lessons. It was never, they never, I don't think they saw the school based youth health nurse role as a valuable role or a valuable resource in actually scheduling or you working with you to come into, you know. So it was never once again, it was always unscheduled.

ES14: I think the teachers are just so caught up in being teachers. I think that's such an insular world. You know, I think they're decades behind the rest of the world to start with. They're very set in their ways. I just don't think they realised. I just don't think they've ever had to interact with nurses before. It's just not something that they've had in their face before.

4.3. School organisation, ethos and environment

The context of this theme is the relationship between participants and the school organisation, ethos and environment component of the HPS framework. Participants' suggest the principle of this theme is the poor communication between the top, that is, school administration and the bottom, teachers, of the school structure.

Participants' experience of school organisation, ethos and environment surfaced as one unambiguous theme; *I just don't know how well the top of those organisations communicate with the bottom of those organisation.*

4.3.1. *I just don't know how well the top of those organisations communicate with the bottom of those organisations.*

This theme represents participants experience of school organisation, ethos and environment in the school in which they are working. Participants suggest the success of partnerships for health education and team teaching in the classroom can be linked to how the school administration, that is, the principal and others, embrace and promote the value of the SBYHN. Participants feel this has an impact on their ability to form and maintain partnerships in the school environment. This concept is represented in the following quote.

ES3: So it has, so the role of the school based youth health nurse really centres around whose in administration as to how well that that person is received, you know. If that person goes all out and says, "This is a really good person to have in the school. You know, you really need to give referrals to this person. They're really going to do really well for the kids and it's going to be an excellent position," and what have you, then your reputation is built, you know, from day one. But if you're on the back foot to start with, which I was, you know, coming into that school, it made it very, very difficult. And lots of changes in staff and people want to own anything.

This participant reflects this sentiment more specifically.

ES3: Out at the rural school, I had more altercations with the principal. So I had difficulties there getting into the curriculum in the first place. They wanted me, but it was the principal that was putting up the barriers. Conservative, you know. As I said before, you know, doing a condom demonstration. What's the harm in that? I mean, as I said to him, you'd be very surprised. You know, probably half of your Year 9's are out there having sex and I would prefer them to be out there doing it safely.

Other participants articulate this theme in terms of communication. Participants feel schools are fragmented and there is disconnection between the top and the bottom. The participants see this from the perspective that the SBYHNP was hailed as a great new support service yet there was little downwards trickle to the operational level in the school environment.

ES16: I just don't know how well the top of those organisations communicate with the bottom of those organisations. For example, the way that that Smart Choices came down and the way that the child safety legislation came down and affected school nurses. They're two really prime examples of knee jerk political strategies that were implemented with great haste much to the concern and distress of the people that had to actually influence them and I just think that that's what I mean by great organisations that don't have their feet on the ground and the way that the panic that happened for Smart Choices coming down, you know.

5. Discussion

The findings of this research raise a number of significant issues for partnerships for health education and team teaching between school nurses and teachers in the school environment. Firstly, there is the issue of health promotion in schools. The premise of the HPS philosophy is a whole-school approach and health promotion strategies should address all three areas of the HPS framework. Carlsson (2005) found SBYHN have the capacity to support the implementation of the HPS framework in the school setting. The participants in this research work across the three areas of the HPS approach however their work is not evenly distributed across all three areas. The contribution of participants to HPS is based on the stories told, not the number of coded and themed responses. Participants contribute most significantly to the *curriculum, teaching and learning* area of the HPS approach, somewhat significantly to *partnerships and services* and least significantly to *school organisation, ethos and environment*. Participants refer to partnerships for health education and team teaching as two professionals conducting health education in the classroom. This understanding of team teaching is identified by other authors such as Minnett, 2003 and Piechura-Couture, Tichenor, Touchton, Macisaac and Heins, 2006. This suggests participants conduct health education as the foremost health promotion strategy in the school environment. Consequently, participants spend more time conducting 'midstream' strategies in health promotion, for example health education and less time in 'upstream' strategies, for example, policy influence.

There is also the issue of collaboration in planning and preparation of health education. Collaboration extends from the design and evaluation of the curriculum delivery to the delivery of health education in the class room. Planning and preparation of health education is a critical aspect of team teaching and collaborative teachers plan, present, and evaluate classroom activities with the participants in this inquiry. Planning and preparation time allows participants and teachers to plan ahead as significant factors for success. Similar findings by Carlsson (2005) suggest SBYHN feel there is limited support for health issues in the curriculum. However, Shibley (2006) suggests the collaborative approach to planning and delivery of health education contributes to teachers (and school nurses) professional development and improves teaching and learning approaches. According to Stivers (2008) and Gayton (2010), collaboration includes evaluation however participants in this research do not acknowledge evaluation as part of collaboration. Thus, preplanning allows participants to

feel valued and respected by teachers and contributes to better collaboration and engagement in the classroom.

Trust and respect for reciprocal relationships is another issue. Concepts of trust and respect are critical to team teaching for health education in the classroom. Relationships between participants in this research and teachers are established and maintained through rapport and familiarity and lead to reciprocity and confidence. These relationships are symbiotic, based on open and honest conversations and are a key success factor in team teaching. This open communication and positive relationship leads to a sense of reciprocity in the classroom. Participants feel supported and valued by teachers who actively engage in the discussion in the classroom and manage student behaviour. Findings by Carlsson (2005) suggest SBYHN feel enabled by staff who believe school personal have a role in school health. Carpenter, Crawford and Walden (2007) suggest trust amongst team teachers produces innovative teaching outcomes. This idea is also supported by Jacob, Honey and Jordan (2002) who highlight a balanced distribution of decision making power in classroom activities and the learning objectives. Fundamentally, relationships based on these values lead to better outcomes for team teaching across a range of health education activities from planning to delivery.

Another issue is the lack of engagement for partnerships. The absence of trust and respect between participants in this inquiry and teachers leads to a breakdown in team teaching. Teachers lack of support in the classroom by not engaging in discussion, failing to manage student behaviour, interrupting, doing something else or leaving the classroom may be the result of the absence of trust and respect between participants and teachers. Again, Carlsson (2005) found SBYHN indicate a number of barriers including time constraints by school staff and management. Piechura-Couture, Tichenor, Touchton, Macisaac and Heins (2006) suggest there are implications for team teaching, for example, division of labour, willingness to try a new approach, fear of change and the unknown, and control issues which may impact on engagement for team teaching. Shapiro and Dempsey (2008) acknowledge team teaching is ineffective if school nurses and teachers have opposing personality types and inflexible teaching styles. This breakdown leads to resentment by participants for teachers who take advantage of the situation and do not meet their responsibilities in the classroom.

The findings of this research reveal some significant issues which contradict the literature. These issues are the concepts of leadership, modelling and competiveness. According to Hanusch, Obijiofor and Volcic (2009) team teaching involves a range of leadership roles in the classroom. Participants in this research do not discuss leadership as important to successful team teaching. The literature also suggests school nurses and teachers model collaboration techniques in the classroom (Carpenter, Crawford and Walden, 2007). Again, participants do not consider modelling collaboration as an important component of team teaching. Furthermore, the literature suggests there is conflict between school nurses and competitive teachers who are reluctant to take a *backseat*. However, participants in this research do not have a sense of competiveness with teachers. Rather, they are frustrated by teachers because they take a *backseat* role in the classroom. According to Dieker and Murawski (2003) and Hang and Rabren (2009) school nurses should negotiate a level of collaboration and 'meet in the middle'. Participants do not consider leadership, modelling and competiveness an issue in team teaching for health education.

Another issue is the perception of effectiveness. Participants view effectiveness of team teaching for health education as strong relationships and productive partnerships. These partnerships are related to personal or supportive professional relationships which affect partnerships for health education and team teaching. These individual relationships are an important precursor to successful team teaching. This idea is iterated by Dryud (2010) who proposes team teaching is supported by synergistic relationships between teachers and school nurses. Conversely, Hanusch, Obijiofor and Volcic (2009) note team teaching exposes students to specialised, evidence-based knowledge from experts and suggest students benefit from expert knowledge from a health professional. However, participants do not see effectiveness of team teaching as students' health or learning outcomes.

There is another issue related to school nurses in a teacher's world. Participants in this research feel vulnerable in a 'teachers world' compounded by organisational culture and values. Participants consider teachers do not value their position or what they can offer in the school environment because teachers do not recognise them as peer professionals and understand their position. Participants feel their role is not clearly defined and teachers consider their role is soft and not important. Carlsson (2005) found SBYHN consider there is limited support from management for the role of the SBYHN. The literature suggests school

nurses and teachers should clearly understand relationships, roles and responsibilities in the classroom (Shibley, 2006) while Hang and Rabren (2009) suggest teachers in interdisciplinary teaching teams feel more supported. Participants consider about their role is strongly influenced by school organisation, culture and values and schools do not communicate well. There is an obvious disconnection between those at the top and bottom and administrative support is essential for successful team teaching. Administrative support needs to be in the context of organisational culture change. Carlsson (2005) found SBYHN are enabled by strong support for health promotion from school management and are constrained by limited support from management for health promotion. Minnett (2003) suggests school administration does not think team teaching engages and transforms classroom dialogue. This attitude has a direct impact on the success of school nurses role in partnerships for health education and team teaching.

5.1. Implications for school nurses

The most important implication for school nurses relates to strategies to build trust relationships from the top. School nurses should advocate at the highest level, the Principal. Principals and other members of the Administration team have the ability to influence middle management and classroom teachers. School nurses should advocate a new way of thinking about health education through effecting organisational change, for example, presenting new ideas at staff meetings, become a member of relevant committees and maintaining a visible presence in the school environment.

The other implication relates to developing partnerships with classroom teachers. These relationships should be based on rapport. Rapport can be established through a series of mechanisms, for example, having breaks in the staffroom, attending school camps, or taking part in school events such as the swimming carnival or school play. This rapport leads to better engagement in the development, planning and delivery of health education.

5.2. Implications for teachers

The first implication for teachers is engaging school nurses in the planning and development stages of health education. Teachers should approach school nurses with sufficient lead time

to negotiate and develop collaborative opportunities and maintain this collaboration from curriculum planning through to and including classroom delivery.

The second implication for teachers relates to supporting school nurses in the classroom. Teachers should also actively participate in the classroom during the health education by joining the discussion, relating the topic to the local community and managing student behaviour.

The third implication relates to teacher training and professional development as a conduit to team teaching. This will address resistance to, help build an interdisciplinary focus and complementary relationships and enhance the experience of team teaching

6. Conclusion

The findings of this research suggest there are successful partnerships for health education and team teaching between school nurses and teachers in the school environment. These partnerships are based on trust and reciprocity and a personal relationship based on rapport. There are still barriers to strong and fruitful partnerships. Teachers do not understand and value the role of the school nurse and do not engage with school nurses in the classroom. Administrative support from the top down is fundamental to the success of team teaching.

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