

Teaching Prevention by Infusing Health Education into Advisory Programs

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An eighth grader strolls into math class just after the bell has sounded, late for her midterm examination. Seemingly unconcerned, she is in fact high, having smoked marijuana with friends minutes earlier. The drug calms her, helping her to mask the anxiety she feels because she has neither understood the material, nor felt comfortable seeking help from her teacher.

Her behavior illustrates how education and health are intrinsically intertwined. Students who are fully engaged in the learning process tend to behave healthily, while those in poor health do not learn easily (Carnegie Council on Adolescent Development, 1995). Dryfoos (1994) contended that more than 10 million American children are currently at risk of school failure because of physical, emotional, or social problems. Students who do not feel as though they belong in school, or who fail to perform well academically, are also at greater risk for substance abuse, unprotected sex, and violence (Tanaka, Warren, & Tritsch, 1993; Dryfoos, 1990). Since the transition from elementary to intermediate school provokes negative academic, social, and psychological consequences for many students (Kann, Collins, Pateman, Small, Ross, & Kolbe, 1995; Eccles & Midgley, 1989), educators of young adolescents need to address both educational and health issues.

Health educators realize that students' psychosocial concerns can be successfully addressed in the classroom. Indeed, at the middle school level, health education curricula emphasize the reinforcement of several "life skills" considered to be essential in modifying behaviors: decision making, stress management, setting and achieving goals, problem solving, critical thinking, resistance skills, and communication (Miller, Telljohan, & Symons, 1996).

Many middle school students, however, also benefit from another intervention—the advisory group—an initiative proposed by advocates of middle school reform who have sought to create within schools smaller, caring communities in which every student can be better known by teacher-advisors. The advisory is a student support group which ideally helps young adolescents enhance the very same problem solving, decision making, and interpersonal skills emphasized in comprehensive school health programs, with the assistance of a staff member who functions as the "designated caring adult."

Thus, the advisory group is potentially an excellent adjunct to formal health education. This article explores the possibility of infusing health education into a school-wide advisory program by either developing or redesigning existing advisories to emphasize life skills training and possibly parallel health education content. Further, health educators can contribute to the staff development process necessary to prepare teacher-advisors to facilitate these groups.



THE ADVISORY'S CONTRIBUTION TO MIDDLE SCHOOL STUDENTS

Advisories are considered by some experts to be potent interventions in preventing absenteeism, dropping out, and behaviors like smoking and alcohol use (Mac Iver & Epstein, 1993; Putbrese, 1989; Simpson & Boriack, 1994) because they provide students with the peer feedback they seek and adult guidance they need. They also permit teachers the opportunity to develop close-knit relationships with students which help to engage them in learning (Cushman, 1990; Ziegler & Mulhall, 1994; MacLauiy, 1995). A teacher-advisor role allows educators to become mentors for their advisees, to know them holistically, and to become their advocates. Knowing their students more intimately also increases teachers' abilities to become effective liaisons between school and home.

The number of grade 6-8 schools nationwide which have advisory programs has increased substantially since 1980, and 47% of all American middle and junior high schools now offer them (McEwin, Dickinson, & Jenkins, 1996). This trend is significant because, while early adolescence is a stage rich with opportunities for educators to guide youngsters, it is also one of minimal contact between adolescents and adults (Hamburg, 1993).

Typically, teenagers spend less than 5% of their time with parents and 2% of their non-school hours with other adults (Nightingale & Wolverton, 1993). Although 25% of this population experience symptoms of emotional distress, only about 11% of students talk to a school counselor in any given academic year, possibly in part because there is only one guidance counselor for every 600 students nationally (Dryfoos, 1994). Advisories provide another opportunity for youngsters to receive attention from a caring adult.

Limitations to Prevention of Existing Health Education Approaches

While adolescents are concerned about their health, their likelihood of acting out increases significantly from middle school to high school, suggesting that they may not always be sufficiently motivated to act in their own best interests (Millstein, 1993). As a group, young adolescents indicate that they want schools to teach them more about psychosocial issues like stress management, dealing with major life events that affect families, and self-esteem. Indeed, more than two thirds of students in one study believed that health education was as important as their academic subjects (Hill, Piper, & King, 1993).

The affective nature of these topics suggests that students need to feel particularly comfortable with their teacher and class before they can discuss them or begin to make personal decisions about them. Regrettably, one survey has indicated that fewer than half the students polled believe their teachers either understand or care about them, making it unlikely that students will disclose their concerns or discuss their actions freely (Takanishi, 1993). Students will seek information from their peers, however, if they feel safe doing so. Indeed, their perceptions of their class's emotional climate have the most impact on students' willingness to participate. Therefore, teachers need to be able to facilitate activities which increase students' confidence (Fassinger, 1997). Classroom teaching on health can have a positive effect on how students behave when it includes opportunities to learn and practice healthful behaviors (Tyson, 1999). Tanaka (1996) cautioned that teachers must be conversant with group process for formal classes to achieve their full potential, since many students have indicated their greater ease in discussing affective topics in small groups rather than before their full class.



Years of research into what makes prevention approaches successful have also revealed that students benefit from activities which require them to participate in groups and reflect upon and practice decision-making and problem-solving skills within a social environment which promotes health (Botvin, Dusenbury, Baker, James-Ortiz, & Kerner, 1989; Weissberg, 1990; Compas, 1993).

Health educators need to communicate to people the process of making health-related decisions rather than telling them what their decisions ought to be. ... To determine what is really healthy for someone requires that person to judge the worth of the behavior using his or her value system and comparing the benefits and disadvantages of the behavior relative to all five components of health: social; mental; emotional; spiritual; and physical health (Greenberg, 1995).

Despite educators' understanding that students learn most when actively involved in their instruction, a recent study indicated that the most commonly used health education teaching methods are lecture, large group discussions, and seat work. Fewer than one third of the teachers surveyed indicated that they relied heavily on small group discussion (Collins, Small, Kann, Pateman, Gold, & Kolbe, 1995).

The topics typically included in middle school health education curricula include sexuality, AIDS, violence prevention, nutrition, emotional wellness, and substance use. These are all exceptionally complex, multifaceted topics with strong affective and behavioral components. Beyond providing factual information, teachers must allow students ample opportunity to reflect on their personal views and how these views impact subsequent behaviors.

Even in those classes where health educators create a safe environment for students to learn actively, there is rarely sufficient classroom time to positively affect behaviors (Haignere, Culhane, Baisley, & Legos, 1996; Tappe, Galer-Unti, & Bailey, 1995). It is estimated that at least 50 hours of classroom instruction are needed to promote significant changes in health attitudes and behaviors, but fewer than half of all school districts require that health education be taught as a separate course at the intermediate school level (Connell, Turner, & Mason, 1985).

While nearly all middle schools require that health education be taught in one or more classes, nearly two thirds of these are, at most, a year long, and half are only a semester. In schools where health education is infused into other disciplines, the situation is even worse. Only about half the teachers in one survey said that their course focused "primarily on health education," while the remainder indicated that theirs contained some health education but dealt mostly with other subjects (Collins et al., 1995).

Indeed, asking teachers of other disciplines to infuse health education into their curricula can itself be threatening to these teachers and cause resistance. Many teachers undoubtedly feel pressured to cover considerable material within their own courses and may be unwilling or unable to adequately integrate health constructs into their classes.



THE RATIONALE FOR INFUSING HEALTH EDUCATION INTO ADVISORY PROGRAMS

Since young adolescents learning to think abstractly require considerable repetition of learning experiences, health education needs to be taught actively around the development of life skills, with sufficient time allowed for students to practice those skills. Structuring health curricula in this way also ensures relevance to students' lives. They will likely be socially motivated to learn what may be expected of them in real-life situations (Hicks, 1997).

Given that health education and advisories share the mission of creating a safe environment in which students may reflect on their attitudes and how these attitudes shape health behaviors, health educators might partner with advisors to ensure that health related life skills are infused into the advisory program. To do so, the advisory group would be planned by the health educator and core teachers to select advisory topics which parallel, or complement, those being taught in health education. For example, if a seventh grade class is discussing nutrition in health class, a fun and non-threatening advisory group topic might be students talking about (a) their favorite and least favorite foods, (b) how they feel when they are really hungry and how they act as a result, or (c) what they realize about how they act in class when they have not eaten. These are all health-related discussion topics designed to encourage students to assess their feelings and behaviors comfortably within a time frame which may not be possible within the health class.

An important goal of education is to build critical thinking skills in students. While teachers of other subject areas may shy away from infusing health topics into their courses, teacher-advisors are often compelled to promote wellness by helping students reflect on their beliefs and behaviors and consider personal and social decisions. Consequently, advisories would appear to be logical venues for infusing life skills and health information.

Assisting teacher-advisors to infuse health topics is also very helpful to staff willing to facilitate advisories but uncertain about how to do so. Teachers are trained to be content specialists rather than process observers. Many become disillusioned by the difficulties inherent in running their advisories and instead structure them to become more like formalized classes, a format more familiar to them.

Indeed, of all the initiatives proposed by middle school advocates, none has proven harder to sustain than the advisory. While staff are often initially enthusiastic about the groups' potential to allow them to know the "whole student," many advisory programs fail due to inadequate teacher preparation, lack of necessary skills, and confusion about the purpose of the groups (Ayres, 1994; Galassi, Gullede, & Cox, 1997).

Asking faculty to assume an advisory role without adequate preparation is akin to asking them to ride bicycles blindfolded. They may have a memorable trip, but it is bound to end prematurely. To be a confident and competent teacher-advisor, one must know basic facilitation skills, be at least somewhat knowledgeable about the topics students will want to discuss, understand the stages of development through which a group moves, understand the nature of resistant behaviors and be comfortable helping students work through them, and be able to identify and refer at-risk students for more intensive help (Cole, 1992; James, 1986).



Furthermore, one staff member must be designated as advisory program coordinator to assess staff needs, plan appropriate training, and oversee the provision of ongoing support and supervision to the teacher-advisors. Once faculty and staff have been trained to run them and begin doing so, they quickly realize their need for assistance in handling the types of questions and group dynamics that invariably emerge from working with small groups. At minimum, they require monthly meetings with their colleagues and a coordinator/supervisor who is able to answer their questions and help them to increase their group skills. Without this structure, many advisory programs fail.

HOW HEALTH EDUCATORS CAN PARTICIPATE IN ADVISORY PROGRAMS

Several years ago a visitor sat in on an eighth grade advisory group facilitated by a health education teacher. The advisor seemed very much at ease with his student advisees, and the group atmosphere was warm and open. The students were talking about whether or not to have sex. The teacher-advisor skillfully led the discussion, eliciting students' points of view, listening actively to their responses, reflecting back what he perceived to be deeper-level concerns, and then encouraging students to consider the possible consequences of various courses of action. When the visitor complimented him on how well the group had gone, the teacher said, "I just did what I would normally do in class, but in my advisory group I'm working with half as many students."

This teacher, by virtue of his personality, training, and experience, was an excellent teacher-advisor. His state certification in health had undoubtedly also prepared him in some of the group facilitation techniques he used so effectively in that session.

Currently, the preservice training of health educators is varied at best. Fewer than half of American health educators are state certified (Collins et al., 1995). In some states it is possible to teach health without ever taking a single health methods teaching course. Other educators go on to do graduate work in health and may become state or even nationally certified health education specialists. Depending on their interest, training, and availability, there are a number of different levels at which health educators can contribute to the development of advisory programs.

1. Educators with some health education preparation

Teachers who have had some health education training but lack state certification can, at minimum, contribute to a school's advisory initiative by making presentations to their colleagues on staff development days or during faculty meetings. They can inform their peers about what they are teaching in health, in what sequence, and might make recommendations about what topics teacher-advisors could address in their advisories over that semester. They could share ideas for some appropriate handouts on exercises and activities.

2. State Certified Health Educators

In addition to faculty presentations, health educators with state certification could, and should, be part of any committees designated to plan advisory programs or to retool existing efforts. They might meet at least once each semester with other staff to provide more specific information about the health education curriculum. They could make recommendations about how teacher-advisors could amplify the psychosocial dimension of health education topics in their groups and supply written resources as requested.



3. Certified Health Education Specialists (CHES)

Health educators who meet the qualifications for national certification might not only contribute to advisory programs in the aforementioned ways, but also assist with the initial staff development of teacher-advisors, participate in their ongoing supervision, or actually assume the role of advisory program coordinator. Research indicates that such ongoing support, rather than one-shot workshops, may be vital to truly prepare teacher-advisors for their new roles (Corcoran, 1995).

An ideal staff development scenario might be one in which a CHES and a co-worker design and deliver a minimum of 30 hours of instruction which encompasses both prevention and group work strategies to potential teacher-advisors. What is often missing in comprehensive school health programs, and virtually all middle schools offering advisories, is the presence of such a coordinator to ensure the initiative's smooth functioning by supporting the staffs efforts to reach its goals. The CHES could best fill this role.

CONCLUSION

Health is a critical factor in early adolescent development. Prevention specialists understand that youngsters often act out behaviors if they are unwilling or unable to discuss the feelings which precipitate them. Those whose self-esteem is fragile—and what young adolescent's is not—are likely to be at even greater risk.

Advisories have proven to be a potentially valuable approach to helping students navigate areas of physical, emotional, and social concern. With the attention and caring of teacher-advisors, students can be encouraged to value themselves and to help one another to act healthily. While a middle school health educator typically also teaches physical education, works with school medical staff, or participates in school-based counseling services, it is just as feasible that he or she might instead devote time to the advisory initiative, emphasizing the need for educators to attend to the psychosocial aspects of their students' health. Staff who assume the roles of teacher-advisors become important prevention resources and, in turn, enable health educators to more fully realize their classroom goals. Just as importantly, advisors develop group skills which help them to become more effective teachers in their respective classes.

From the perspective of the [health education] profession, it is imperative that organizations such as the American School Health Association recognize the emergence of character education and begin exploring its relevance to school health education.... Health educators need to step in from the 'sidelines,' recognize the important role which they have to play in developing the character of children, and contribute to emerging programs (Governali, 1995).

Realizing the potential of the health educator as a staff member who not only can formally educate students, but can also assist colleagues to provide additional psychosocial support in advisories, is an important step in genuinely promoting wellness in schools.



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