COMPREHENSIVE SCHOOL HEALTH:

THE STRUGGLE FOR COLLABORATION

by

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ABSTRACT

This study examined the importance of curriculum development and dissemination practices and subsequent implications for the implementation of a complex innovation. In particular, it investigated the role of multidisciplinary collaboration, necessary in a complex innovation.

Specifically, the **Learning for Living** Program in British Columbia was reviewed. This program is a complex innovation based on the framework of comprehensive school health. This framework requires the integration of three components: health instruction, services for students and a healthy school environment. The complexity of this program adds a layer of difficulty to implementation as it requires an integration of services among different sectors and the collaboration of various agencies or participants. This process may represent a shift in some of the established structural relationships and routines within school districts and communities.

An analysis was made of how multidisciplinary collaboration was addressed at the Ministry, school district and school-based levels during the development and dissemination of the innovation. A school-based team was studied as an example of multidisciplinary collaboration at work in a large school system in Canada.

Results support research that shows that obstacles to achieving implementation of a complex innovation, e.g.

comprehensiveness, are due to significant failures of policy and practice during development and dissemination. These obstacles can be mediated by the influence of external agencies, social support, and policy changes over time. A general recommendation for complex innovations would be to seek a variety of strategies that might facilitate the multidisciplinary, collaborative approach throughout the development - implementation continuum.

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The writer also wishes to acknowledge DASH The Directorate of Agencies for School Health and CASH The Canadian Association for School Health for their commitment to the promotion of comprehensive school health. Working with these organizations facilitated access to information that was helpful in the preparation of this thesis.

It should be noted that, at the time of writing, the Ministry of Education further planned to change the name of the **Learning for Living** curriculum to **Personal Development,** and is apparently striving to develop a framework resembling comprehensive school health.

Chapter 1. INTRODUCTION

Lest we forget the souls that we nurture
Beyond our professional and political doors
It was all for the children
This 'Learning for Living'
In a world eventually theirs.

Identification of the Problem.

This study examines the importance of curriculum development and dissemination practices and subsequent implications for the implementation of a complex innovation. Specifically, the role of multidisciplinary collaboration, necessary in a complex innovation, will be reviewed from policy injunction to what actually seems to happen in schools. A critical issue is how multidisciplinary collaboration is developed and how the notion and practice is disseminated over time through provincial, local and school levels. Further, an analysis of a multidisciplinary school-based team approach will provide one example of the collaborative process at work in a large school system in Canada.

An analysis of the **Learning for Living** Program in British Columbia will be conducted to illustrate how development and dissemination practices affect multidisciplinary collaboration. The **Learning for Living** Program is a complex innovation based on the framework of comprehensive school health. This particular comprehensive framework requires the incorporation of a multidisciplinary approach in its planning and execution on an on-going basis. The necessity for multidisciplinary

collaboration adds a layer of difficulty during the implementation of a comprehensive program, unlike strictly in-class curriculum to be delivered by teachers. A comprehensive program requires, at the very least, an integration of services among different sectors and the collaboration of various agencies or participants.

The complexity of **Learning for Living**, and the need for multidisciplinary collaboration, may represent a shift in some of the established structural relationships and routines within school districts and communities. Collaboration among participants from various sectors, both at the provincial and local levels, may not routinely occur causing initial difficulties in establishing multidisciplinary collaboration. This issue has been cited by Richardson et al (1989) who note that "improving coordination among agencies is hardly a simple process" (p. 31). Complex innovations requiring multi-disciplinary collaboration are likely to undergo a transitional process that may cause obstacles to the implementation of the innovation. Basch et al (1986) have cited some obstacles as being the "attendant reallocation of power and resources, change in social relationships and structures, and loss of the familiar that occurs as part of all innovations" (p. 16-17). The transition process may occur over many years, and recently advocates for comprehensive school health have been concerned that implementation efforts have not been as successful as hoped

(Learning for Living Coordinator, Correspondence, 1992, November 27).

Groups from different sectors that would be required to work together to implement a comprehensive school health approach may not have been able to address how their collaboration would be achieved. Aspects of interorganizational dynamics become apparent when different sectors need to work together. The organization of multidisciplinary collaboration would also be more difficult in the absence of a consistent comprehensive school health framework upon which to base planning for implementation. Lovato et al (1989) recommend the utilization of "a multidisciplinary team of service providers including nurses, psychologists, counselors, and food service personnel, as well as the instructional expertise of educators" for school health programs (p. 8). The use of such a team approach may mean changes in the current policies, structures and/or routines that would represent possible barriers to comprehensive school health implementation.

While there is a growing body of research on the use of multidisciplinary teams within the health services field it has been noted that

> a broadly applicable conceptual model of team function remains obscure... Factors such as leadership may vary from team to team. There may be confusion as to whether there should be a team leader, who the leader should be, and who, in the final analysis, is responsible when things go wrong (Battista and Lawrence, 1988, p. 131).

More information is needed about the dynamics of a multi-

disciplinary approach that should be a foundation element in a comprehensive program and possibly other complex innovations. It is essential, therefore, to get a better understanding of the desired interactions among individuals working in different sectors of the school community. A multidisciplinary school-based team was observed in order to examine these interactions. The team example illustrates how policies, structures, and responsibilities affect subsequent coordinated action.

The Innovation.

Learning for Living is a required program for the schools of British Columbia. Prior to the adoption of **Learning for Living,** the Province of British Columbia had an elementary health, and a secondary guidance curriculum, however, these were "in very poor use... they were something that you did either when there were too many classes booked into the gym or it was raining so badly that you couldn't do P.E. outside" (former Learning for Living Coordinator, 1992). A former Learning for Living Coordinator (1992), who had been teaching guidance for over ten years, stated that prior to the mandating of **Learning for Living**, many interest groups were approaching the Ministry with requests to incorporate health instruction into programs and services that would better serve the changing needs of youth.

Learning for Living advocates a comprehensive school health approach (see British Columbia Learning for Living Primary - Graduation Curriculum Guide, 1990, p. 14-15). This comprehensive

approach rests on the delivery of three components: health curriculum, healthy school environments, and support services for students. On the surface, this can be diagrammatically represented, as in Figure 1, to look like a simple process when in fact, the dynamics of the social actions involved within the 'intersections' are quite complex.

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Insert Figure 1
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This model of comprehensive school health, as adopted by the British Columbia Ministry of Education (1990), has been considered by many to be the best method of ensuring outcomes in health knowledge, attitudes and behaviours among school children. This three-component model was being promoted federally through Health and Welfare Canada at the time of curriculum development, provincially through DASH The Directorate of Agencies for School Health, and by the Ministry of Education's Health/Guidance Advisory Committee. A former Learning for Living Coordinator (1992) notes that,

> it was well recognized that health behaviours had to be reinforced and they had to be wider than an hour in the classroom at a time. They had to happen on a bigger scale in a child's life... Ontario had [health education] for years and they weren't seeing a lot of change in behaviour.

Belzer (1987) has reinforced the concept of cooperation among the various sectors involved in the 'traditional three-component model' noting that measures of effectiveness can be achieved which would satisfy the goals of different sectors (i.e. health,

education).

> Indicators of program effectiveness could be derived from behavioural impacts and health outcomes that are of interest to community health promotion workers, as well as from effects on scholastic performance and achievement, which are of primary interest to school officials in the face of 'back-to-the-basics pressures' (Belzer, 1987, p. 9).

The degree of cooperation between these sectors represents a socio-political dynamic that exists within the intersection of the three-component model. It is important to remember that effectiveness for the students will be determined by the degree to which comprehensiveness is achieved. An interesting analogy was illustrated by Krawetz (1993) in the Canadian School Boards Association Newsletter.

> Imagine that a child is drowning in a pool of water... Several adults stand surrounding the pool, each with a piece of rope. Each one throws his life line to the child, but individual pieces are not long enough to reach the endangered youngster. Now imagine all of these adults tying their pieces of rope together and using their collective strength to pull the child from the water. When they work together, they can save the child. When they work alone, the child is lost (p. 10).

The necessity for a comprehensive and multidisciplinary approach becomes clear when viewed through this lens; however, the details and dynamics of how this multidisciplinary team approach is to be achieved have not yet been clearly articulated or tested. For example, it is not yet clear how governance structures among different sectors, such as Ministries, health departments/units, school districts, parent organizations, and agencies are challenged by the prospect of multidisciplinary collaboration and how they have responded?

In an initial attempt to map out the dynamics and practice of Learning for Living District Liaison Persons (DLPs) in each school district were charged with overseeing implementation. **Learning for Living** was scheduled for optional implementation in the new Primary Program in 1991-92. A few districts, having previously initiated their own K-12 health curriculum, were well equipped to address the scope of the **Learning for Living** curriculum and have begun to use a comprehensive approach. However, many district staff were only vaguely aware of its content and less so of its potential as a comprehensive program. Districts throughout the province are currently at various stages of adoption and implementation. The Director of the School Programs Branch (1994) has stated that implementation "is spotty out there".

Through Ministry support DLPs could have been involved in negotiating and coordinating individual/group responsibilities within a collaborative, multidisciplinary framework in order to facilitate a comprehensive approach. Many other factors commonly associated with curriculum innovations (Fullan, 1991) arising from the social and political contexts of school/community cultures would, in some cases, preclude this kind of collaboration. It should be remembered, as Fullan (1991, p. 67) points out, that it is a "system of variables [that] interact to determine the success or failure" of an innovation.

Purpose.

This study is intended to examine the need for multidisciplinary collaboration within the development and dissemination practices of a complex innovation and the subsequent effect upon implementation. Specifically, the study focuses on the complexities of multidisciplinary collaboration and the team approach, and critical issues related to these in the context of the **Learning for Living** Program (i.e. coordination of the three components of comprehensive school health: curriculum, services for students, healthy school environment). An examination of the policies and practices from the development through to the implementation of this program will provide information on some of the difficulties associated with achieving comprehensiveness through complex innovations.

If, as the experts advise us, comprehensive school health works best with a multidisciplinary approach, then a framework needs to be provided to address how different groups and individuals can best work together. This study examines how the need for a multidisciplinary approach was addressed in the case of the development and dissemination of **Learning for Living**, and how collaboration and coordination have developed over time. In particular, the purpose of examining the continuum of this innovation, from development to implementation, is intended to illustrate how obstacles to implementation are partly due to curriculum development and dissemination policies and practices.

Definition of Terms.

The terms used in this study are based on the following:

1. Comprehensive school health, as defined by the B.C. Ministry of Education (Learning for Living Primary-Graduation Curriculum Guide, 1990, p. 14) - represents an interdependence among three components: health curriculum, healthy school environments, and services for students.
2. Coordination - situation(s) in which two or more individuals, units, divisions, or agencies work together to accomplish a specific task (cited in Richardson et al, 1989, p. 32)
3. Linkage mechanisms - the transaction process whereby exchange/interaction occurs between organizations (Lindsay et al, 1981, p.12)
4. Multidisciplinary team - a team in which different professionals meet for planning purposes but each discipline remains independent (Battista and Lawrence, 1988, p. 131)

Chapter 2. REVIEW OF THE LITERATURE

Multidisciplinary Approach.

Over the past two decades comprehensive school health has been advocated as the most effective means of promoting the health of children within the context of schools. The comprehensive model, as previously noted, integrates three components. This integration was explained in a draft **Learning for Living** Teacher's Guide (Lower Mainland School District, undated) which states that

> this means our schools must go beyond merely instructing children about health. To be effective, health education instruction must be... comprehensive. Educators must be prepared to create and maintain a healthy school environment and to coordinate their own efforts with those of parents, the community and various systems and agencies that are delivering student health and social services (p. 1).

In a review of the literature it has been found that there are frameworks for comprehensive school health programs that describe actions to be taken within each of the component parts and people to involve (Canadian Association for School Health, 1993; Killip et al, 1987; Massachusetts Department of Education, 1990; Nelson, 1986; US Department of Health and Human Services, 1986). However, studies suggest there has rarely been an inter-relationship and coordination among the components, but that they have operated along parallel tracks (McLeod & McLeod 1989 in Saskatchewan School Trustees Association, 1992; Porter, 1987). In this approach, it has been noted by Sossong and Hornyak (1988) that "previously, each discipline had treated the students on the

basis of its own separate plan [but] it was realized that the traditional approach to health care was not meeting the needs of all students" (p. 135). It would appear that the mode of functioning, in the past, has not been prescriptive of a multidisciplinary team approach; and this has been shown to lead to overlap, duplication or the delivery of unnecessary services in schools (Porter, 1987). Models of collaboration are beginning to be used within the health services field.

When a team is pulled together to work cooperatively it is more likely that roles and responsibilities can be identified and issues of concern addressed in a coordinated manner. As Campton and Salaway (1984) point out, "cooperative work requires that we disclose our relationship with the client to other helping authorities who are valuable because they bring different knowledge, roles, and functions to the helping process" (p. 519). However, this process may also reveal both cooperative and competitive elements (Basch et al, 1986; Campton and Salaway, 1984; Richarson et al, 1989; Walker and Gorman, 1992). Some of the obstacles to cooperative work cited are:

- complicated interagency communication due to differing and changing regulations (Richardson et al, 1989, p. 31);
- different budgets, planning horizons, decision-making structures, disciplinary territorialism (Walker and Gorman, 1992, p. 32); and
- lack of clarity in information dissemination, support and

involvement by local and government departments of education and health (Basch et al, 1986, p. 18 and Health & Welfare Canada, 1990, p. 36).

Deciding to cooperate will obviously not automatically lead to a smoothly coordinated effort among individuals from different disciplines, agencies and departments. In a survey conducted by the Committee on School Health Services for the Alberta Teachers' Association (1988) it was found that "although all partners in the provision of service agree that coordination of service is essential, such coordination often does not exist" (p. 9). Once people have agreed to cooperate a process of collaboration may take place in which participants can address common goals and values and begin to work toward more effective communication and power sharing (Rootman in Health & Welfare Canada, 1990, p. 17). However, whether any concrete actions result from this process may be questionable. Barriers to change may still need to be broken down; new policies may be required which will enable a true coordination of services to take place. As an illustration to this point, a document Prevention through Partnership: Collaborating for Change, produced through a collaborative effort among health professions, is prefaced with this statement:

> The views expressed in this report emerged from a collaborative, developmental workshop process and do not necessarily reflect the positions of the sponsoring organizations or other organizations with which participants are associated (Health & Welfare Canada, 1990).

As previously mentioned, the research seems to be lacking in

specific examples of how coordinated efforts are generated, how they function, how they are sustained, and what their resultant outcomes might be (Health & Welfare Canada, 1990, p. 17).

There are some diagrammatic models and lists of the elements and agencies to be considered in a comprehensive school health program (Killip et al, 1987, Canadian Association for School Health, undated); however, there is very little discussion on how these elements and agencies are to interact with one another. A further concern is cited by Richardson et al (1989), who state that while "interagency agreements are important vehicles for facilitating coordination, neither child welfare nor developmental disabilities agencies entered into such agreements more than one-third of the time" (p. 34). Provided that agreements are reached for the establishment of comprehensive school health programs another stage is still essential in ensuring that interaction occurs. Lindsay et al (1981) identify linkage mechanisms as critical to the process of interaction.

> The agreement phase... only provides a setting... The transaction process whereby exchange occurs represents a distinct phase of interorganizational relations... [where] interaction such as cooperation, coordination, and collaboration [involve] transactions or linkages (p. 12).

Linkages may be characterized somewhere between structured and loose. As Lindsay et al (1981) note,

> when the transaction can be highly formalized the potential for conflict is reduced since agreement has been reached on a number of issues and authority exists in the form of fixed rules. However, when the linkage mechanism or transaction is more collegial, the potential for conflict remains high and no clear cut authority exists to resolve conflict and keep

the transaction process moving (p. 13).

The nature of the agreements and linkages established for a comprehensive school health program will determine its resultant characteristics or comprehensiveness. Linkage mechanisms will undoubtedly vary from district to district and even among schools because of the myriad of people involved, different needs, and differing ways of doing things. The use of formal linkage mechanisms, particularly for multidisciplinary collaboration, will also be dependent upon the policies and practices in the development and dissemination of programs.

As collaborative efforts emerge, particularly within the health services field, there is still a lack of understanding about the way in which multidisciplinary teams work together. Continued fragmentation of services, not to mention curriculum information and environmental factors, should not only focus our concern on the costliness of duplication, overlap and redundancy but on the problems this might create for families and children

> left alone to resolve professional conflicts, to reconcile these incongruities, and to deal with often contradictory advice, multiple talents and inputs, [which] no matter how skilful... becomes burdensome rather than helpful (Campton and Salaway, 1984, p. 516-7).

This becomes more of a concern as one reviews the literature on the culture of schools and teaching. Significant barriers to a multidisciplinary approach are apparent when one considers the pervasiveness of privatism and isolation (cited by Cuban, 1982; Goodlad, 1983; Hargreaves, 1989; House, 1974; Lortie 1975 in

Fullan, 1991; and Tye and Tye, 1984).

District Climate.

The essence or meaning of a curriculum or program innovation should be communicated to district staff through the Ministry of Education. However, strategies for implementation will be, initially, partly dependent on district climate. The prehistory of innovations in the district will be a factor in how **Learning for Living** is received. Teachers already feeling overloaded may be resentful of further innovations, particularly complex ones. In fact, there may be contracts which have been negotiated on the basis of putting any further innovations on hold (Personal Communication, DLP, 1991). It has been noted by Taylor and Werner (1989, p. 16) that the "level of motivation to engage in the change" is a factor in implementation. The best approach for the dissemination of an innovation should therefore consider the social and political contexts within school districts. House (1974) emphasizes that "the ultimate meaning of an innovation comes from the context and social system in which it appears" (p. 102). This knowledge should lead to extensive involvement and communication with districts by curriculum developers.

An underlying theme of the **Learning for Living** Program is the use of a 'team approach' which is school and community based. The curriculum guide (1990) states that, "parent and community involvement in health matters can provide support and reinforcement for the objectives of the school-based curriculum"

(p. 16). **Learning for Living** cannot be considered as just curriculum, as a comprehensive school health program, encompassing services for students and a healthy school environment. The focus for involvement and communication strategies must go beyond school personnel to members of the community. One dissemination strategy might be to assess the feasibility of setting up multidisciplinary advisory committees within districts with representatives from the various local stakeholder groups (eg. teachers, principals, health professionals, service groups, parents and students). Such an advisory committee will not only provide advice but can be used to model the team approach and facilitate communication strategies within schools. Ways to address the concerns of groups affected by the innovation should be discussed. Familiarization events or the distribution of easily read promotional literature, such as a pamphlet, will assist with clarification of the meaning of the new program. The effectiveness of school-community communication channels or networks should be determined; perhaps a more comprehensive system needs to be established. While teachers should be involved at all levels of the communication process, the importance of the administrator's role should not be overlooked. The program might be initially disseminated through pilot projects, thereby generating examples of the framework in action. Successful groups could be asked to present this information

through a newsletter or special event. The curriculum developers should seek ways to build clarity, defining operating rules, and possibly presenting research on the benefits of the program prior to the policy injunction of mandate. Generating involvement and communication in this way can keep motivation up and create a climate of credibility and support for the innovation, particularly in districts with a tenuous climate.

Sustaining Commitment.

Sustained involvement with the project, rather than just handing down a directive, will encourage the trust of school personnel to become involved with the program. Commitment to the success of **Learning for Living**, and support for those who will actually implement, will be judged by "the amount of time, professional development, and other allotted resources" (Taylor and Werner, 1989, p. 18) given to the project. Support for, not only teachers, but the administrative efforts of superintendents and school trustees should be provided, as well as support for parents and other interest groups. A recognition that such things as district funding priorities and staff may require sustained support during the dissemination process over a number of years is necessary.

The facilitation of an innovation within each school will be unique based on the internal social and political dynamics. The micro-politics within represent "meaningful differences between 'climates' of different schools" (Halpin and Croft 1983 in

Lortie, 1975, p. 197). As the leader of the school, the principal's stand toward the facilitation of **Learning for Living** will play a dominant role. This will depend on his/her relationship with district staff and the perception of how serious the program is being treated in the educational community and well as in their general community (eg. Parent Advisory Council). The extent of the principal's commitment will be an important factor in ensuring successful implementation as the "principal gives subtle but nonetheless strong messages concerning the 'legitimacy' of continuing project operations in the schools" (McLaughlin and Marsh, 1978, p. 82). While principals may not be directly involved in the day-to-day concerns of implementation, their understanding and support of school-based initiatives will need to be felt by staff.

Whether a teacher or school nurse coordinates the facilitation of the **Learning for Living** Program at the school level, requests for resources and possible changes to the way the school is run must be brought to the principal's attention. If faced with an array of concerns about the health of the school environment this may be troublesome for some administrators as "in the course of time, sacred qualities are attached to the conditions and procedures of the school" (Peterson 1964 in Ball, 1987, p. 65). The relative influence between administrators and teachers comes into play when status or resources are 'up for grabs'. The notion of teachers competing for influence over

school policies has been termed 'baronial power' by Ball (1987, p. 221) who describes schools as sites of conflict processes, divergent values and fragmentation of social systems into interest groups. The competitiveness of teachers may be more prevalent in high schools where the departmental structure is clearly defined. Although a program like **Learning for Living** may be integrated, there is a potential for conflicting responses from Home Economics, Physical Education or other departments that have traditionally taught health and guidance. The personal ties of the principal to these 'barons' represents "the social network, both its formal and cross-cutting elements, [which] embody and carry the working arrangements, the negotiated order of [the] organizational life" of the school (Ball, 1987, p. 214). Schubert (1986) also emphasizes that while "rarely is there a conscious conspiracy; at the same time, rules have a way of accumulating to favour those who make them" (p. 329). A social network which is based on a consequence of personal affiliations rather than a just and equitable system, will inevitably shape the dynamics of the formation and functioning of any multidisciplinary school team. It has been noted by Ball (1987) that these dynamics can actually operate to inhibit change. This is confirmed by Hall (1975 in Fullan, 1991) who concludes that successful change "seems to be related to how well the principal and these other change facilitators work together as a change facilitating team" (p. 156).

Treatment of Knowledge.

Ministry policies and curriculum guides for the implementation of the **Learning for Living** Program will not necessarily be translated into the desired learning outcomes. McNeil (1988) explains that curricular content may be fragmented into lists, mystified, or omitted and that "matters of controversy [are] rarely dealt with as issues, as matters having more than one interpretation that should be explored" (p. 73). Non-traditional teaching strategies are advocated in health education (Pollock, 1984) which can be compared to a new inquiry-based social studies curriculum studied by McNeil. In McNeil's (1988) ethnographic research it was expected that

> the information would be treated differently... that noting all talk during the classes would be extremely difficult... because many students would be working in groups or out of the room... In fact, all course content emanated from teacher lectures or teacher-supplied films (p. 70).

McNeil calls this 'defensive' teaching and considers it due to a desire to control student behaviour through the control of knowledge. Even where teacher ideologies differ defensive teaching was predominant. McNeil states that the kinds of knowledge made accessible to students and the treatment it receives are factors of the way schools are organized. In other words, policy decisions made at the administrative level of the school can have direct effects on the learning environment generated in the classroom. McNeil also notes that these policies affect responses by both students and teachers. Giroux

(1988) also maintains that "control, not learning, appears to have a high priority in the traditional curriculum model" (p. 14).

The micro-politics of a school provides a possible tension between educating and controlling, which is particularly felt by the teachers who are charged with classroom control. This may lead to a closed-door policy for the classroom which will not serve the interests of a critical inquiry into health care issues nor the comprehensive approach based on multidisciplinary collaboration. McNeil (1988) points out this dilemma, noting that "the cultural content, regardless of whose interests it may have served before, comes to serve only the interests of institutional efficiencies" (p. 13). Where school routines and bureaucracies function with such regularity that there is 'loose coupling', between teachers and administrators, teachers have the flexibility to create alternative approaches but they may also do "little that is critical and merely reproduce their own biases" (Werner, Personal Communication, 1992).

Clarifying Assumptions.

The introduction of a new curriculum or program obviously indicates something is new. The community affected by it will make some assumptions about what changes are actually required. It has been shown that it is important to clarify just what the innovation means in order for the appropriate changes to be made. Werner (1987) cites the process of clarifying assumptions as

important because it

> assumes that implementation does not occur necessarily because someone prescribes change, nor does it always happen in ways that external curriculum experts or change technologists may wish; rather, classroom practice is shaped through the decisions and actions taken by teachers and district personnel (p. 46).

The **Learning for Living** Program poses a particular challenge in developing clarity because what is new is not just content, or teaching strategies, or school organization but all of these. If the meaning of the program is not clearly articulated there may be a tendency for the curriculum to be "modulated by the user, almost to the point of its becoming unrecognizable" (Roberts 1978 in Munby, 1979, p. 246). Fullan (1991) cites several authors' concern that curriculum guides in Canada suffer from vagueness, especially of means of implementation, where there will be "false clarity if the teachers' perception is based only on the more superficial goal and content aspects of the guidelines to the neglect of beliefs and teaching strategies" (p. 70). Much of the curriculum component's success depends on the teachers' own values and commitment to the learning outcomes. The teachers' skill in promoting affective outcomes will, further, depend on the rapport which must be built with the students. As Greenberg (1978) puts it,

> without teacher-student rapport, attitudes and values pertaining to such controversial topics as premarital sexual intercourse, marijuana use, abortion, and mental health will seldom be expressed (preface).

Through clarifying assumptions conflicts in values are sure

to arise, and there will likely be some 'turf protection' or resistance to any changes in professional autonomy. Therefore, several and ongoing orientation sessions or forums may be required prior to and during implementation. Goodlad (1983) recommends:

> extensive dialog at the district and building levels regarding the meaning of these goals... this dialog should create an awareness of the need for an attention to teaching procedures and learning activities frequently neglected in classrooms (p. 556).

The problem is that, traditionally, very little of this type of collaboration goes on in schools. It has been noted by Lortie (1975 in Hargreaves, 1989) that teachers seem to be "present-oriented, conservative and individualistic. They tend to avoid long-term planning and collaboration with their colleagues, and to resist whole school decision-making" (p. 27). Curriculum developers should consider whether school cultures are going to be an impediment to gaining clarity about an innovation, due to a lack of congruence with traditional practices. Werner (1991) states that "as one starts to work, and deals with questions as they arise, new insights are gained and the innovation attains progressive clarity" (p. 7). One of the questions inherent in this research is whether or not developing clarity should be a function of the dissemination process as opposed to relying on local efforts after mandating the implementation of an innovation. Through such a process the obstacles to implementation will emerge and issues such as multidisciplinary

collaboration can be addressed.

To summarize, the collaborative, multidisciplinary team approach should be considered as a means for addressing the multitude of factors which in the end affect the implementation of an innovation like a comprehensive program. If the purpose of curriculum development is successful implementation, then attention should be given to all these factors throughout its evolution (i.e. development, dissemination, adoption, implementation). As stated in a policy guide by the British Columbia School Trustees' Association (McClaren, 1989),

> curriculum implementation will be more likely to succeed if the people who are expected to use curricula have some clear, effective, active input into its development, and thus have a sense of ownership of it (p. 16).

This means the work of curriculum 'development' really should not stop once a curriculum guide has been produced. As the program evolves efforts must continue in:

a) assessing district climate and response to the program,

b) finding and supporting advocates of the program,

c) developing clarity around what the innovation means,

d) providing ongoing support activities to facilitate effective implementation, and

e) ensuring that the philosophy or foundation of the innovation (eg. comprehensive, multidisciplinary approach) becomes a standard feature through the establishment of related policy.

Chapter 3. METHODOLOGY

Design.

This study was undertaken in two phases. Phase 1 reviewed the emergence of comprehensive school health in British Columbia, the curriculum development process and a number of related dissemination activities. Phase 2 examined how one school district reacted to this innovation and examined dissemination and implementation activities in this district. It also examined a school-based team for the purposes of reinforcing the concepts of multidisciplinary collaboration and coordination. Phase 1 provides an analysis of the social and political dynamics operating within the B.C. Ministry of Education and provides a context for the analysis of the information in Phase 2. Document analysis, interviewing and observation were the primary sources for data collection.

Generalizability vs. Construct Validity.

Since multi-site studies were not practical for the purpose of this research, external validity and generalizability may be weak. No claims are made for generalizability in terms of the implementation of the particular program studied. The intention is to provide a narrative evaluation of a process and, through glimpses from within one school district, extract an insight into some of the factors which were relevant along the continuum of the program's evolution.

Information from multiple sources has increased internal

reliability and respondent validation has been sought. This latter process not only acknowledges the reflexivity of the researcher but provides greater construct validity. As Geertz (1973, p. 15) points out, initially "we begin with our own interpretations of what our informants are up to, or think they are up to, and then systematize those". Participants have had the opportunity to review and respond to a draft document. This research should lead to an understanding of the relationships and actions among groups operating within the education system during the evolutionary process of this particular innovation.

Procedure and Data Collection.

1. Procedural Format

A procedural format for the conduct of the study is outlined below.

Phase I: A review of the emergence of comprehensive school health in British Columbia, curriculum development and early dissemination was undertaken, using:

a) documentary analysis and

b) interviewing.

Phase II: This phase includes: 1) a review of one School District's (i.e. study district) response to the innovation, adoption, and support activities; and 2) a look at a school-based team (i.e. study school) with a focus on team coordination. This phase used:

a) observations and

b) interviewing.

2. Document Analysis.

Document analysis consisted of a review of the Ministry of Education's **Health/Guidance** and **Learning for Living** files for the period 1986-1990. Other documents cited include Minutes from DASH The Directorate of Agencies for School Health and the Learning for Living Implementation Advisory Committee. Through this analysis questions were constructed, primarily, for the interviews of Phase I.

3. Selection of Subjects/Sampling.

Phase I participants were selected on the basis of involvement with the development and/or inservice of **Learning for Living**. Six people were interviewed between October and November, 1992:

- two former Learning for Living Coordinators, Ministry of Education (1986-89 and 1989-90);
- two former Learning for Living Working Committee Members (Elementary teachers, one also a Learning for Living Associate); and
- two Learning for Living Associates (one had also been a Working Committee Member and was on the Curriculum Framework Committee during Phase I.)

The participants in Phase II consisted of:

- the Director of the School Programs Branch, Ministry of Education;

- a Learning for Living Contact for the study district; and
- a school-based team where the coordinator had indicated they were trying to implement Learning for Living in the study school.

The school-based team consisted of: the Learning Assistance Resource Teacher (Team Coordinator), Principal, Vice-Principal, ESL Teacher, French Immersion Learning Assistance Teacher, Area Counsellor, Area Educational Psychologist, and Area Public Health Nurse.

The primary site of Phase II was the study school. As previously noted, this data was provided to reinforce concepts of multidisciplinary collaboration and coordination. While document analysis and interviews are expected to define some categories, such as structures, policies, roles and responsibilities, this data alone could not provide in detail how a multidisciplinary team might best function. The best way to explain the dynamics among the participants in such a process is to actually view them in action. Geertz (1973) endorses the fact that

> behaviour must be attended to, and with some exactness, because it is through the flow of behaviour - or, more precisely, social action - that cultural forms find articulation... [and] we gain empirical access to [symbol systems] by inspecting events, not by arranging abstracted entities into unified patterns (p. 17).

The events and the dynamics between the individuals and groups involved represent a social process which is represented in Figure 2. This figure indicates that it is the social support which allows for the integration and coordination of a

comprehensive approach.

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Insert Figure 2
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The observational study of the school-based team provided an understanding of the social processes at work in a much more holistic and particular manner (Geertz, 1973), illuminating the obstacles, solutions and benefits of a coordinated team approach. Hammersley and Atkinson (1983, p.177-8) point out that this procedure "allows us to feed the process of theory generation with new material rather than relying on our previous knowledge of cases relevant to the theoretical ideas we wish to pursue". As indicated in the review of literature, there is very little documentation on the functioning of multidisciplinary teams.

Interviews were conducted with some of the individuals attending the school-based team meetings, i.e. Principal, Psychologist, and a teacher who was also the school's Teachers' Association representative. Observations were dependent on the meeting schedule of the school-based team. Regularly scheduled meetings took place weekly from approximately 10:30 - 12:00 in the Learning Assistance Resource Centre. Observations were permitted at all meetings, except those where a parent might be present to discuss a child in 'crisis'. This was agreed to as such instances were not deemed necessary in order to examine the general functioning of the team. Field Notes were written during the observations. Interviews were tape-recorded and ranged from

one half hour to one hour in duration. For the purpose of simplicity interview citations within the text will show the year only. The interviews of the school-based team members were conducted as a follow-up to information obtained through the observations or other sources.

Content Analysis.

Analytic note-taking, appended to both the field notes and interview transcripts, provide an account of the unfolding and conduct of the research and the emergence of categories of analysis. Atkinson (1981b in Hammersley and Atkinson, 1983) notes that categories can be thought of as "'sensitizing' concepts - indicating some broad dimensions or assumptions for comparison between projects, and for the development of general frameworks to tie together disparate projects and evaluations" (p. 37). Categories of analysis were used to form the basis of the analysis of the innovation's evolution. Such an analysis, while it may not be generalizable, can be used to 'look' at other complex innovations. A sort of quasi-triangulation has emerged through the various forms of data collection, which contributes to and reinforces the categories of analysis.

The Researcher.

It seemed to me important that the researcher who looked at this question should be familiar with the concept of comprehensive school health as well as the field to be studied. As pointed out by Ayers (1989), the researcher "is someone who is

both aware of the current literature in the field and capable of interacting productively with the literature as well as with the field of study" (p. 12). I have worked in the field of comprehensive school health/health education promotion for the past eight years. Primarily, access to information and contacts have been facilitated through Executive involvement in DASH The Directorate of Agencies for School Health. One of the focuses for DASH over the years has been the fact that Learning for Living was intended to be a comprehensive school health program.

Chapter 4. RESULTS OF PHASE I: THE DEVELOPMENT OF THE CURRICULUM

This chapter will address the social and political factors acting on the emergence, development and early dissemination of the **Learning for Living** curriculum in British Columbia. It will examine how different interest groups and events, in both the education and health sectors, have shaped the outcome of this innovation.

Invention.

Goodson (1988) categorizes the emergence of an area of study as 'invention'. He explains that teachers and students will begin trying out new ideas and approaches in "response to new 'climates of opinion'" (p. 189). This period of invention spanned over a decade within the area of **Learning for Living.** In the early 70s a program had been developed in a school district, called **Steps to Maturity,** in order to address a number of health issues for children, from self-esteem to grieving and sexuality education. A former coordinator of this program, explained that it was supported by the School Board and parents, and had achieved much success and acclaim throughout the district. As a locally developed program the School Board made a request in about 1976, through the local MLA, to the Ministry of Education for funding. The Minister of Education at that time, refused this request. A similar curriculum **The Guide for Life,** developed in another school district in the 70s was never implemented. One of the writing committee members for this guide explains that

"most of the developers were consultants at the time and went back to classrooms, administrative or counselling jobs" (former Learning for Living Working Committee Member, 1992). Both the refusal to fund and discontinuation of a project represent the lack of importance given to this type of curriculum.

After a tour of the Province in 1982-83, when about fifty briefs were presented on the need for sexuality education, a group of people were finally brought together to develop a sexuality resource. A "**Family Life** 'how to' manual;... was camera-ready and then [the new] Minister of Education... would not permit it" (former Learning for Living Associate, 1992). It appears that while there has been a continuous drive towards the emergence of this type of education both the political will and administrative support have been lacking. Although there was a recognized need for family life or sexuality education it was also an area of such controversy that many administrators are unwilling to tackle it. For example, a study by Marini and Jones (1982), based on the returns of 616 policy makers in Indiana schools, it was found that:

> seventy-five percent of policy makers in Indiana schools believe that the school has a responsibility to teach about human sexuality [and] eighty-two percent approve of sex instruction in their schools... [however] the primary reason for not offering sex education in schools appears to be: a. concern over parental reaction; b. lack of qualified teachers; c. concern over community reaction; d. concern over church reaction (p. 40-41).

Political Will.

Although a Ministry of Education needs assessment survey was

underway in 1986 there appeared to be no real concern to proceed with a revision of the former **Health/Guidance** curriculum that, as previously noted, was in very poor use. There were no set time frames, it was just a "data collection phase" (former Learning for Living Coordinator, 1992). However, two things happened in the 1986-87 school year that gave impetus to the revision process, and it was officially under revision "as of September 2, 1986" (Correspondence, former Learning for Living Coordinator, 1986, Fall). The **Health/Guidance** curriculum was long overdue for the standard revision process established by the Ministry of Education, the last time being in 1967. However, this particular revision seems to have been initiated, not as standard procedure, but because of the increasing number of requests and queries from the public to the Minister of Education about the inclusion of topics related to health and social issues, in short, political pressure. A former Learning for Living Coordinator (1992) describes the changing environment in which the Ministry of Education was having to respond in the early 80s:

> Children were coming to school in great numbers, for the first time, emotionally incapable of engaging in the day... They were hungry, they had witnessed a fight that might include a battery between the parents, they may have been battered themselves, they were beginning to act out.

While these issues were not necessarily new they certainly were drawing more public attention and provided a politically ripe climate in which to promote health education. Many educators will concur with the statement of one inner-city school teacher

who found that he "was dealing with children's health before [he] got to teaching them the subject" (former Learning for Living Associate, 1992).

However, prior to the hiring of the Health/Guidance Coordinator there seems to have been a wait-and-see attitude with regard to any concrete development in health education, stemming from a view that perhaps these concerns were the responsibility of other ministries such as the Ministry of the Attorney General, Health or Social Services. As Dunkel (1962 in Goodlad, 1964) has stated,

> a pluralistic society wished for an obvious and open decision never to occur. A struggle of this sort would be divisive, indicating quite clearly to a number of subgroups that their views were not being adopted by the society as a whole. Thus a pluralistic society may prefer to ignore this question as long as possible in the hope that it will not become too troublesome (p. 55).

As discussed, the commitment to provide support for this type of education had been lacking for some time. However, both the government and the Ministry of Education were faced with such political pressure in the 1986-87 school year that it was impossible not to proceed with an official revision of **Health/Guidance**. The first pressure came in October 1986 when there was a case of child abuse which directly affected the school system (R. v. Noyes, 1991) prompting people to demand that the Ministry of Education do something about this issue. Although there was public pressure to respond, the Health/Guidance Coordinator's stand at that time was typical of

the government's reluctance to proceed. The following response to a request illustrates this point, "It is expected that a review paper will be presented in March 1987... if there was to be a curriculum revision it is likely that the subject of sexual abuse would be included" (Correspondence, former Learning for Living Coordinator, 1986, December 15).

The second factor that supported the development of a new **Health/Guidance** program was fear about the impending epidemic of AIDS. The concerns about this disease put a Family Life Education curriculum on a fast-track for implementation because of its perceived threat to "thousands of lives and the financial integrity of our health care system" (Family Life Education Curriculum Guide, 1987, p. 6). The media heartily supported this position because of the rising costs of health care, with a budget that swallowed about one third of the provincial coffer. The seriousness of this epidemic was presented to Cabinet in March 1987 by the Head of the Department on Sexually Transmitted Diseases, Ministry of Health, in economic terms which could not be ignored, particularly in a time of recession. The major focus was to reduce the costs which would be associated with caring for the ill through preventive education. This belief was fostered by a Newsweek poll (in Hartog-Rapp, 1987) which found that,

> 70% [of respondents] believe that education in grade school is an important way to combat AIDS. Thus, Surgeon General Everett Koop in his plea for education estimated that 12,000-14,000 people could be saved from death by AIDS by 1991 if people avoid sexual and drug related activities that transmit AIDS. Education is then our best cure (p. 30).

The Ministry of Health suggested that the Ministry of Education develop a curriculum which would address this issue. Direction came from Cabinet to provide the Ministry of Education with funding for this purpose. A former Learning for Living Coordinator became a part-time coordinator for the development of Family Life Education, grades 8 - 10. She states (1992) that "the decision was to have a **Family Life** curriculum in September [1987]".

Family Life Education.

This study does not intend to look at the development of **Family Life Education** in any detail as

> the intent was not to provide a comprehensive Family Life program... Presently the development of a comprehensive Health Education program is occurring (Correspondence, former Learning for Living Coordinator, 1988, February 9).

In an observational study, the Family Life Assessment Report, Friesen (1988) explains that "more than in most other subjects, the personal characteristics and life experience of the teacher become important as these are interrelated with the subject matter" (p. 11) and teacher preparation was of great concern. It was reported to the Curriculum Branch that

> the main reason for conducting the Observational Study was to provide information for the Advisory Committee and Working Committees for the new **Health/Guidance** Curriculum... and [the] recommendations have already influenced the preparation of the response draft for **Learning for Living** (Correspondence, Assessment Branch, 1989, July 26).

A former Working Committee member (1992), who was involved in the review of the evaluations after the first two years of

implementation, describes the **Family Life** course as a "crisis-centred, quick shot program... it was a disaster... you got the information, very little discussion, the discussion was in the video, the students observed a discussion".

The **Family Life Education** curriculum had a markedly 'cookbook' approach to dealing with AIDS, and perhaps this was the only way to handle this crisis in such a short time-line. However, what became apparent to the curriculum developers was that a more comprehensive approach was needed in order to affect behaviour change and provide a foundation for other health crises as they arise. In a review of AIDS education necessary for 1989-93, Walters (1989) cites the need for 'targeted, sustained and coordinated program development' through: improving consultation, the development of model programs, initiating projects in health behaviour research, improving communication and resource sharing, and providing program management at the community level (p. S5-6). Walters (1989) also warns us to consider the consequences of inappropriate or non-action.

> The entire response to HIV and other STDs will approximate the services and resources demanded by cancer and heart disease which have become massive chronic disease epidemics demanding huge allocations of public funds. The magnitude of these epidemics grew from a failure to implement sufficiently massive prevention, education and research programs early in their development (Ibid, p. S8).

While the development and implementation of **Family Life Education** went ahead the Learning for Living Coordinator was continuously involved in processing correspondence on issues such

as child abuse and substance abuse. One example is represented in correspondence to an analyst with the Liquor Licensing Review Working Group in which it is noted that districts are responsible for putting alcohol abuse prevention programs into place but many do not "due to a lack of funding and time allotments" (former Learning for Living Coordinator, early 1987). Similarly, many other groups were promoting health education publicly, including a coalition of health and education organizations established in 1983, DASH The Directorate of Agencies for School Health. The Ministry's **Health/Guidance** Correspondence files (1986-89) show a continuous stream of support for a revised curriculum and the need for health and social issues education for children. Educators were also concerned about offering only a 'bandaid' solution to the health needs of students. The proposal for a revised **Health/Guidance** curriculum is noted once again with an estimated completion in 1989. However, there was no official direction at this time for the completion of a revised **Health/Guidance** curriculum.

Political Approval.

While the specific content issues such as child abuse, substance abuse, and sexuality may have been offensive to some, another aspect of health education was emerging which had to do with making decisions about health. In mid 1987 the Premier received correspondence from a business man identifying himself as a past President of a constituency of the Social Credit Party.

He had attracted media attention to a public meeting at which he cited the need for a "drastic revision of the material to be used" (Correspondence, 1987, May 4) in a **Health/guidance** program. He was promoting a video resource on personal growth and development, entitled "I Can". In a memo to the Deputy Minister of Education (1987, June 9) it is noted that "the Premier has also requested that the Minister [of Education] meet with [this person]". Perhaps the notion of personal growth skills is a more palatable way to proceed with Health/Guidance for on July 8, 1987 the former Learning for Living Coordinator notes that there has been direction from the Minister of Education to establish an Advisory Committee "to assist in the creation of a comprehensive school health and guidance program" (Correspondence).

The Advisory Committee.

Health and Welfare Canada (1986) was advocating that health promotion should be a "multifaceted exercise which included education, training, research, legislation, policy coordination, and community development (p. 6). On the surface, the Ministry of Education's process of selecting an Advisory Committee to act as an external advisor on curriculum revisions sounds like it applies to the health promotion framework. Correspondence was sent to various organizations in order to seek representatives for the Advisory Committee, many of whom had been vocal in support of a **Health/Guidance** revision. They were advised that this committee would "provide input and advice on program details

and teaching materials" (Correspondence, former Learning for Living Coordinator, 1987, July 8). The following organizations were represented on the Advisory Committee, although they were not all initially approached:

Alcohol-Drug Education Service
B.C. Council for the Family
B.C. School Counsellors Association
B.C. Home and School Federation
B.C. Medical Association
B.C. Nutrition Council
B.C. School Trustees Association
B.C. Teachers' Federation
Canadian Mental Health Association
Career Education Society of B.C.
DASH Directorate of Agencies for School Health
Federation of Independent Schools' Association
Health and Welfare Canada
Insurance Corporation of B.C.
Kaiser Substance Abuse Foundation
Ministry of Education
Ministry of Labour
Ministry of Health
Physical Education Provincial Specialist Association
Teachers of Home Economics Specialist Association.

It has been noted that the government "ran into some significant problems in the appointment of the Advisory Committee... there was a significant amount of political interference before the Advisory Committee ever met" (former Learning for Living Coordinator, 1992). While these external groups are representative of Goodson's (1988) notion of 'subjects as coalitions', he cautions that groups with a common theme of endeavour "should not be viewed as a homogenous group whose members share similar values and definition of role, common interests and identities" (p. 190). This political struggle around the establishment of an Advisory Committee not only

signified the pressure these groups may have been exerting externally but that a considerable degree of appeasement was necessary in order to work with such a committee. While there was an understanding that their purpose was to provide advice toward the curriculum development process there actually was a lack of clarification on this role (former Learning for Living Coordinator, 1992). Their actual involvement and collaboration with educators was minimized (see Educational Decisions). This was perhaps a way of avoiding dealing with the politics of the interest groups. The potential for further development and clarification around multidisciplinary collaboration, a critical issue of this complex innovation, rested in this early stage of the curriculum development process. However, this opportunity was missed. The lack of dissemination and promotion around this issue may be partly responsible for obstacles to multi-disciplinary collaboration at the district level. This, further, leaves the responsibility of sorting through the larger social struggle of the politics of health to individual districts.

The Politics of Health.

The development of a health education curriculum should take into account the political nature of the health care system itself. It should be understood that within the health care system several health professions compete for resources, their share of which is, in part, determined by the sociopolitical legitimacy they have attained. This is important as this

competition represents the basis of a form of cultural and ideological hegemony which is perpetuated by the medical profession, the largest controlling group involved in the health care system. It has been noted by Coburn et al (1987) that,

> because of the social origins of physicians, their association with elite educational institutions and their favourable connections with socially and politically dominant groups, physicians with the aid of the state achieved dominance over the healing enterprise (p. 7).

Medical authority over the definition of health has become so powerful that there has been what Illich (1977) refers to as a 'medicalization' of life. Illich (1977) and Fisher (1986) contend that patients have lost the ability to actively participate in the decision-making of the medical process.

The health care system is an example of a reproduction of medical hegemony. Health insurance, in Canada, was originally opposed by the medical profession which "sought to stop or at least to slow changes that threatened its autonomy [thus retaining control] over the way health care was organized" (Coburn et al, 1987). Fisher (1986) hypothesizes that the social structure of medicine forms a 'contextual web' for individual action, and ultimately social action. With this in mind, the question that must be raised concerning the development of any health education program is, 'Whose knowledge is being transmitted?'

Further, resistance to preventive measures and broader policy changes are cited by Fisher (1986) and Wilk et al v. AMA et al

(1987). The notion of health promotion and prevention cannot be considered as a serious mandate of government when they do not ascribe fees for these services. The link between medical hegemony and government policy-making must be viewed in the context of the sociopolitical reality of the health care system where medical personnel have traditionally advised government on how the health care budget should be spent. Illich (1977 in Navarro, 1976) refers to how

> over-medicalization changes adaptive ability into passive consumer discipline. The cause for that [dependency] is the manipulative behavior of the medical bureaucracy that perpetuates and encourages that passive addictive consumer behavior... [through their] exclusive and monopolistic power over the definition of what is health and what method of care may be publicly funded (p. 6).

It is important to note that the Ministry of Education is able to "control what texts are used through adoption and evaluation procedures... [including] funding formulae for their purchase" (Werner, 1991, p. 109). This may result in district policies which make these resources the only ones teachers have access to. In this case it will be virtually impossible for teachers to identify the 'omissions and distortions' (Werner, 1991, p. 107). Bush (1986) also reminds us that "the decision-making process is likely to be determined ultimately according to the relative power of the participating individuals and groups" (p. 71). Without a critical pedagogy to uncover these unseen elements the curriculum resources will merely serve as tools for the reproduction of the status quo, which may ultimately mean a

perpetuation of the medical model of health. This should be of concern to critical educators as the British Columbia Medical Association has recently been given a ten million dollar contract (albeit through the Ministry of Health) to develop a resource on 'how to utilize the health system' (Personal Communication, 1993, December 15).

Passive Curriculum.

While teachers' interpretation of the goals of **Learning for Living** will be based on their own attitudes and beliefs these will also be coupled with the sociopolitical constraints operating within the school district/community. There is a chance that fidelity to the goals will be diminished as teachers try to find content-based resources to fill the allotted classroom time. Unless a major shift occurs in pedagogical practices, moving away from the traditional teacher-centred transmission of information to a student-centred, critical inquiry-based approach (see Fullan 1991; Goodlad 1983; and Reynolds 1989) it will be difficult to find students who have been truly empowered.

Although interpretation of goals leaves room for 'constructive possibilities' (McNeil, 1988) there is a chance of perpetuation of the status quo. This becomes apparent as one examines the expected learning outcomes which become "social and ideological configurations... part of the taken for granted reality of curriculum workers and other educators" (Apple, 1990,

p. 121). One goal is addressed here as an example of how the learning outcomes may not necessarily represent the goal to be achieved. Goal #15 can be used to illustrate how a person's ideologies can determine the treatment given to the subject. Goal #15 states that "students should grow in the ability to access information" (Learning for Living Primary - Graduation Curriculum Guide, p. 89). However, learning outcome 2.15 promotes "using experience and critical thinking to determine the validity and relevancy of information sources encountered in work experiences and job shadowing situations". In a critical pedagogy the concerns must be: what experience situations will be provided for students, whose knowledge do these situations represent, and what values or biases are being transmitted? While the possibilities are many there is also a danger of providing only a 'selective tradition' (Giroux, 1988) of options.

The strength and potential for greater possibilities in **Learning for Living** rests on its comprehensive approach, which would involve the participation of people from many different sectors of society. A multidisciplinary approach would be one way to help ensure a more balanced and open approach to addressing health issues. In the words of one high school student:

> schools should teach you to realize yourself, but they don't. They teach you to be a book. It's easy to become a book, but to become yourself you've got to be given various choices and be helped to look at the choices. You've got to learn that, otherwise you're not prepared for the outside world (Giroux, 1988, p. 88).

The intention to keep political or ideological conflicts out of the schools has led to a very passive curriculum in terms of any meaningful inquiry into notions about health and illness, and subsequently, any relationship to the sociopolitical realities of health care issues.

Conflicting Roles.

Potential for political conflicts also exist in the interactions among the Deputy Ministers, Assistant Deputy Ministers and senior management/coordinating staff within each branch of a Ministry. These are the key people who are in touch with the 'political barometer' and yet have the responsibility to carry out the on-going commitments within their branch. Their level of collaboration both within the Ministry of Education and between ministries are significant to the development of the comprehensive school health model.

A Manager of the **Health/Guidance** revision (also responsible for Language Arts and Social Studies) had some decision-making authority over the curriculum development process. However, much of the work was taken to the Executive Director as well as the Assistant Deputy Minister "who would get the political approval" (former Learning for Living Coordinator, 1992). It has been noted by one Working Committee member and two Learning for Living Coordinators that they had to do a lot of 'selling' to senior management. For example, while no one ever questioned the need for a comprehensive approach, there were discussions about

whether it should be contained within the main body of the curriculum guide or placed in an Appendix. The reluctance to highlight comprehensive school health was explained by a former Learning for Living Coordinator (1992).

> People could see that once we started paying attention to this area we'd have to do something about it. [For example] when you start putting child abuse prevention programs into schools... you've got disclosure... and all of a sudden there's all this energy and resource has to go into dealing with those issues (Ibid).

Some members of both the Advisory and Working Committees, who felt it was an essential concept, had to make an extra effort to ensure that it stayed in (former Working Committee member, 1992). They felt the curriculum could not survive without the support of the other components. The Working Committee came to a point of giving the Ministry the option to proceed in a comprehensive manner or not at all (former Learning for Living Coordinator, 1992).

Priorities within one Ministry branch may at times be in conflict with the political will of the government as a whole. There may be competition for funding between Ministries or differing priorities which can create obstacles to collaboration with regard to a comprehensive school health program. Something as simple as personnel changes can also be an obstacle. This has the potential to interrupt information dissemination and the development of a broad base of support. Through the early dissemination of **Learning for Living**, between 1990 and 1992, there were several staff changes. The necessity for a

comprehensive program, the need for multidisciplinary collaboration between different sectors, and further development on these issues was not clearly supported.

Educational Decisions.

While the decision to proceed with a curriculum revision may be a political one, there is indeed a technical part of the curriculum development process (see Appendix A). This arena is, however, kept primarily under the control of the Working Committee and Project Coordinator who are all seconded educators. Although many of the people on the Advisory Committee were specialists in a particular content area they were not generally included in the actual writing process.

A Working Committee member states (1992) that they "did not use the expertise of the Advisory Committee in the way that many of us thought we could have". The Learning for Living Coordinator at that time concurs (1992) that his "preference would have been to have those people on Working Committees... doing the grinding, the pondering". However, the Working Committee is traditionally made up of teachers; they are the ones given the task of producing an 'educationally sound' document (former Learning for Living Coordinator, 1992). Even though it was judged that this curriculum might require the expertise of other professionals in the writing process the response from senior management was that "we haven't done that before" (former Learning for Living Coordinator, 1992).

Essentially, what evolved was that "there was great confusion within the Ministry on how to use the two groups... there was a lot of struggle" (Ibid). They were not brought together with educators to work collaboratively as a multidisciplinary team. This is an indication that the Ministry of Education was not prepared to develop and utilize the concept of a multi-disciplinary approach at this time.

The Working Committee.

Initial selection of the Working Committee members was based on four content areas: careers, child abuse prevention, family life, and substance abuse prevention. This was later expanded to include healthy living, mental well being and safety and accident prevention, on the advice of the Advisory Committee. A memo from the Learning for Living Coordinator (1988, January 29) to senior management states that "A number of organizations and individuals have written to us recommending that the scope of the project be expanded, including the Ministry of Health". While there may have been some political motivation in the expansion of the content areas, their importance was never really questioned by the Working Committee. As a Learning for Living Associate (1992) recalls, in working with these at the district level, "we never really saw a gap".

Some Working Committee members, who understood they were selected on the basis of their experience in a specific content area, found their initial meeting was not what they expected.

They were being asked to start from the beginning and create a rationale for health education. As one member (1992) puts it, "we expected to roll up our sleeves and create lesson plans... As far as we were concerned the rationale had been created years before". The Working Committee drafted the initial Program Goals and Statement of Intent (Philosophy, Rationale). These statements were then reviewed by the Manager who presented them to the Advisory Committee "for further consideration" (Minutes, Health/Guidance Working Committee, 1988, January). While the draft Statement of Intent was, in fact, revised by the Advisory Committee (former Working Committee member, 1992) the bulk of the curriculum writing process remained within the realm of educators (see Appendix A).

Influence of Educational Reform.

A Royal Commission on Education (1988) occurred at the time of the **Health/Guidance** curriculum development process. There were concerns about the influence of an educational reform movement on the integrity and even the survival of the **Health/Guidance** curriculum. The status of **Health/Guidance** was essentially, on hold. This can be inferred from correspondence by the Deputy Minister, Educational Programs to the Chairman of the Alcohol and Drug Abuse Prevention Task Force, in which he states that "the Ministry of Education is reviewing the [Royal Commission's] recommendations and by December 1988 the status of health education will be determined" (1988, September 30).

At the senior management level there were indications that the Royal Commission was going to advise that intellectual development was the primary responsibility of education. Working Committee members were concerned that Health/Guidance 'didn't have a life in the new program'. While Health/Guidance Working Committee members were finalizing the Curriculum Response Draft Royal Commission writers were working "just down the hall" (former Working Committee member, 1992). As the Learning for Living Coordinator (1992) at that time notes, when the recommendation of the Royal Commission for **Lifespan Education** came along "there just wasn't [any way for the Ministry] to turn out of this thing". The importance of **Health/Guidance** was now supported by a Royal Commission and gave renewed impetus and respectability to the project. Approval was given on September 19, 1988 to continue with the **Health/Guidance** curriculum development (Month End Report, Learning for Living Coordinator), and it was at this time that it was renamed **Learning for Living.**

It is interesting that during the final writing stage of the Royal Commission report the manager who oversaw **Health/Guidance** was seconded to help with this. A major shift in emphasis of the new Programs (Primary, Intermediate and Graduation, which emerged out of the Royal Commission recommendations) was a focus on the learner. In position papers following the Royal Commission intellectual development was indeed cited as the prime responsibility of schools. What was new was that other areas

were now publicly recognized as being a shared responsibility with parents and the community: vocational development, social development and human development. These goals, of course, presented an excellent match with the goals of **Learning for Living** and, further, could have been used as a foundation for generating discussions and activities around the multi-disciplinary approach. However, within the final curriculum document the focus on the new shared responsibility philosophy is brief. In a section on implementation at the back of the guide there is a paragraph each on parent and community involvement (p. 106). The implication seems to be now that the development of the curriculum guide is complete it is up to districts and communities to figure out how to tackle this shared responsibility process on their own. There was no coordinated provincial effort to clarify and solidify this concept at the administrative level of school districts. Many other factors would become priorities for the education community prior to tackling this one.

Integration.

While there was relief about the inclusion of **Learning for Living**, there was also some confusion about the issue of integration. **Lifespan Education** had been recommended under the Practical Arts but was placed under the Humanities; so, along with integration there was also to be a shift away from the traditional Physical Education/Guidance approach. As Werner

(1991) points out, "many possibilities now exist because 'integration' proved to be an elastic notion. Inherent within it were no criteria for organizing curriculum" (p. 233).

This is of particular concern to the development of a comprehensive school health program, where other components come into play beside the curriculum. **Learning for Living** presented great difficulties for implementation because it did not have an 'Instructional Design'; "it wasn't something you could develop lessons from easily and know where you were going" (former Working Committee member, 1992). The problem of having no criteria for organizing the **Learning for Living** curriculum was evident in the Primary Program Resource Document, 1990. Under Curriculum Related Materials, the sections on Language Arts, Social Studies, Physical Education and Science receive attention on research, themes, planning and resources; however, the **Learning for Living** section supplies only a Glossary of Terms and Bibliography, with a reference to only one resource book.

Some members of the Working Committee formed a sub-group to produce an Instructional Design document. It is interesting to note that this recommended "resources and plans for community involvement... [and] the facilitation of community partnerships" (Draft Instructional Design, undated, p. 1). The design could have provided an organizing tool for getting the curriculum into the classroom. The design was not published and there were no Ministry of Education initiatives toward multidisciplinary

collaboration in **Learning for Living** at this time.

Working in Isolation.

One of the difficulties associated with this development project was working in isolation. This may seem odd in a climate where integration is the philosophy but not when you consider the traditional departmentalization of a large bureaucratic system. So it was that the Primary Program Writing Team didn't know about **Learning for Living.** When **Learning for Living** was in its last draft one of the Working Committee members was asked to meet with the Primary Team and "put it into the document" (former Working Committee member, 1992). This had consequences for **Learning for Living** during the dissemination of the Primary Program. Two former Working Committee members noted difficulties (1992): "teachers leave out **Learning for Living** because they don't know what it is" and people were "just ignoring those pages... [because] the people who have the expertise in one field are not necessarily those who have the expertise in the other". While the Ministry provided funding to the districts for the implementation of the new programs there wasn't any specifically tied to the inclusion of **Learning for Living.** It was intended that **Learning for Living** be recognized as an integrated part of the new programs; however, it desperately needed some targeted assistance in order to ensure that relationship between them.

Effect of Delays.

There was about a six month delay in finalizing a response

draft to go to the field because of the need to ensure a match with the recommendations of the Royal Commission and highlight these in the document. Such a delay was of concern because of district time-lines for setting priorities for the following year. A Response Draft allows the field to respond with a critique of the proposed curriculum so that minor revisions can be made, and also allows districts to prioritize diffusion activities such as budgeting for release time to inservice teachers. The Principal of the Study School (1994) noted that "the Ministry, more so recently, has recognized the importance of the opinions of the people who are working with [an innovation]". Delaying a response would also hold up resource development and make it difficult for Working Committee members and DLPs to plan for their future commitments on the project (Memo, former Learning for Living Coordinator, 1988, November 23).

The response to the Learning for Living P-10 Curriculum Guide Response Draft (1989, May) recommended the extension of the curriculum to include grades 11 and 12, which was carried into the revision. As well, several other areas of concern emerged: resources, in-service, and funding (Summary of Field Responses to the Learning for Living Response Draft, 1989). It should be noted that such concerns represent significant factors in implementation and that the dissemination of an innovation may be resisted without the appropriate support in place. In any event, district resources were now being channelled into the new Primary

Program.

Shifting Focus with the New Programs.

Inservice concern continued to mount as the new Primary Program Foundation Document (1990) was scheduled for release at the same time as the Learning for Living Primary - Graduation Curriculum Guide (1990). **Learning for Living** would be embedded in this document along with Language Arts and Social Studies within the Humanities area. The curriculum developers looked for reassurance that **Learning for Living** would be highlighted when the Primary document was presented (Minutes, Advisory Committee, 1989, December 11/12). The Primary Program introduced a shift in focus from content to process. The Advisory Committee expressed concern that there be a balance between knowledge, attitudes and skills "across the seven content areas, especially where teachers are not health advocates" (Minutes, Advisory Committee, 1989, December 11/12). The Primary Program, however, seemed to emphasize the thematic approach almost to the exclusion of core content. There was a concern that teachers might teach, for example, individual awareness and responsibility without linking it to substance or child abuse prevention, leaving a possible gap in the information base applicable to those situations. Ungerleider (1992) also expresses this concern about process skills and integration;

> it is clearly advantageous to possess procedural knowledge that transcends disciplinary boundaries, such as the abilities associated with thinking critically. One must also have something to think critically about (p. 8).

The Advisory Committee expressed this concern in their letter to the Minister (Correspondence, 1989, August 28), stating that **"Learning for Living** learning outcomes and content will be so integrated into Humanities that they will disappear, or will be too diluted to be effective". The Director (1994) of the School Programs Branch (created to support the new Programs) says of this period, from 1989-91, that "a lot of the rules governing programs were not really clear... and the issue of integration was thrown on the table".

It appears that the release of the Primary Program created so much anxiety for school districts that **Learning for Living** did not fare well in receiving attention or commitment. It was perceived as an additional subject area to contend with along with everything else. As previously noted, this led to **Learning for Living** being completely ignored by some districts.

Dissemination.

The work of training educators in **Learning for Living** began in the summer of 1989 when an orientation was held prior to the release of the curriculum document. This was attended by 100 delegates who came expecting another 'cookbook' like **Family Life Education.** This orientation really became a selling job for **Learning for Living** (former Working Committee member, 1992) rather than training. DASH meetings also had an aura of promoting the new vision of **Learning for Living,** which now seemed to focus more on the structural themes than the content areas.

Concern was expressed at DASH and Advisory Committee meetings that students might not receive all the content information.

A former Learning for Living Coordinator (1992) explains that groups

> wanted their individual concern to be prominent in the program and this shift from content area caused the Advisory Committee to go through a phase whereby they also had to look at who the curriculum was for instead of what was the curriculum about.

However, there was considerable concern around other issues with regard to the dissemination of this curriculum. In the summer of 1989 a new Learning for Living Coordinator reports that the Advisory Committee was concerned about "targeted funding and support for **Learning for Living**, integration, and teacher training (Memo, 1989, September 8). The Advisory Committee, in fact, wrote a letter directly to the Minister on these matters (Correspondence, 1989, August 28).

Trying out Partnerships.

Apparently, there was a considerable amount of external lobbying to the government on substance abuse prevention education at this time as well. The Ministry of Labour and Consumer Services responded by giving a percentage of liquor sales toward **Learning for Living** (former Working Committee member; former Learning for Living Coordinator, 1992). The TRY funds represent one of the first projects in Interministerial coordination. This process was described as "philosophical as well as financial" (Memo, former Learning for Living Coordinator,

1990, May 10). Through the increased budget the project was able to retain the Working Committee, the Advisory Committee, hire two more coordinators and conduct further orientations. The job of the two new Learning for Living Coordinators would be to:

> develop a curriculum in-service model for use by district staff to 'enhance teacher confidence and comfort in the teaching of the **Learning for Living** curriculum'; assist with implementation plans and integration and liaison with other branches of the Ministry to ensure a coordinated approach to implementation and assessment (Notice of Secondment Opportunity, 1989, October).

Regional orientation workshops (then called Zonals) were able to be continued through the 1989-90 school year.

As well, the Ministry undertook another type of inservice project at this time, because of a partnership opportunity with the B.C. Children's Hospital. The idea of a health education conference was born; it was called "Partners in Prevention". This conference would bring two delegates from each school district for the **Learning for Living** inservice. The intention was to bring specialists, through Children's Hospital, as speakers to address some of the content areas. The Advisory Committee expressed concern that the child's perspective be maintained (Minutes, 1990, February 8). This is further reflected in the words of a Working Committee member (1992) that while they were "wonderful speakers... there was some worry there about bringing teachers in and having doctors do a medical presentation, teachers can't relate to that style". In fact, the result of the conference was an example of the difficulties with

and perpetuation of the medical model.

Working Committee members representing their content areas were to act as facilitators for small group sessions, however, there was no agenda or guidelines on how these should proceed. There seems to have been some uncertainty on the part of either the coordinator, who took on the task of the conference, or senior administration within the Curriculum Branch as to how to proceed. There seemed to be a wait-and-see attitude. Facilitators were asked to conduct sessions in a way that would determine what the delegates thought **Learning for Living** should look like in a classroom. Some of the Working Committee members were extremely opposed to this style, saying teachers "don't want anyone in the Ministry to bring them a new program and say 'how do you think we should do it?'... If we bring teachers in we'd better give them the goods" (former Working Committee member, 1992).

The majority of the delegates, as it turned out, were **Family Life** educators and they had expected the cookbook approach. One former Working Committee member (1992) remembers this experience as proof of the hunch that **Learning for Living** would suffer because of **Family Life**. The **Learning for Living** situation was more difficult because there were no models for organizing teaching **Learning for Living** at that time. In particular, it was difficult for teachers to conceptualize how the scientific specialists' knowledge was intended to be translated into

classroom practice.

Summary.

The development of **Learning for Living** reveals a lack of clarity and promotion of the concepts of comprehensive school health. This foundation philosophy was not promoted as a framework or model for incorporating **Learning for Living** into school programs. Further development of this framework could have served as a vehicle for encouraging a multidisciplinary approach to dealing with health issues and the needs of students. Any work which attempted to bring professionals from different sectors together (e.g. Advisory Committee, Partners in Prevention) did not reflect a truly collaborative approach. Multidisciplinary teams were not encouraged to work together in order to plan a coordinated approach to the implementation of a comprehensive school health/**Learning for Living** program.

Chapter 5. RESULTS OF PHASE II: THE GAP IN THE CONTINUUM.

This chapter will review some of the dissemination activities related to **Learning for Living** and how one district responded to this program. Initially, prescriptive information concerning the implementation of a new program is disseminated to district staff, for example: time allotments, phase-in periods and other policies. At this point the act of adoption rests within school districts. The degree of adoption and diffusion activities, within a district, are based upon many 'interactive factors' (Fullan, 1991) which can be summed up as priority motivated decisions. Fullan has discussed the importance of the multifactor view in terms of the "extent that they causally influence implementation" (1991, p. 67). The following sections examine how the priorities given to various factors have affected this particular innovation. This analysis identifies gaps in the curriculum development - implementation continuum, where it can be seen that a multidisciplinary approach was not promoted as essential for this complex innovation.

District Climate and Commitment.

The implementation of **Learning for Living**, initially scheduled for September 1989, was rescheduled to 1990-91 for the 'Orientation Year'. Districts were being informed of the curriculum development project as early as January 1988 and districts were asked to identify staff to be a District Liaison Person (DLP) (Correspondence, former Learning for Living

Coordinator). It is noted that the "intent is to develop a program... that when implemented would have administrative and pedagogic support for teacher training" (Correspondence, 1988, January 12). DLPs would be kept informed of progress on the development of the curriculum and have input into the process. The DLPs are important as change agents in the diffusion of the new curriculum from a coordinating perspective. As Pine (1985) has noted,

> someone should be in charge of health education, even if he or she has other responsibilities... [but] that person should have a genuine interest in health education. Program evaluators have pointed out that whether a teacher is interested in the subject makes a difference in how much students learn (p. 57).

The same may be applied to in-district dissemination activities depending on the attitudes of the DLPs and/or their senior management. In many cases, as at the Ministry, this task must be added to someone's portfolio. There appears to have been some resistance at the district level to appoint DLPs. Some districts were opposed, for example, because it was felt that the Minister had not provided funding for this. The Learning for Living Coordinator's reply, at that time, was

> the Ministry's stance [is] that Districts have the responsibility of curriculum implementation and the funding is provided within budget allocations to Districts. The Ministry regards the appointment of a District Liaison Person to be part of implementation (Correspondence, 1988, July 29).

It is clear that the degree of adoption and diffusion throughout a district will not simply be based on a Ministry mandate. If one accepts that a mandated curriculum will eventually be

adopted, the process can be seen in terms of the priority given to other issues before curriculum implementation activities. There has to be the will to make it a priority before policies will be made, from which planning and action can proceed. Here the clarity around the innovation and its judged value will contribute to the effectiveness of dissemination.

District priorities most often have to do with funding for competing needs and interests within the district infrastructure. Presentations to the School Board, combined with securing the support of parents and other interest groups, will be necessary in order to procure further and/or sustained funding for the continuation of the implementation process. An understanding of these formalities is even more important when the competing curriculum is one of traditionally low importance. As Governali (1983 in Lohrmann and Zimmerli, 1987) observed,

> health education is poorly understood and unappreciated, and is viewed as a recent, nonessential interloper on curricular time and resources. Consequently, health education fares poorly in educational turf battles (p. 68).

Pine (1985, p. 25) states that "a modern school health promotion program starts with modernized written school board policies" and, further, cites the superintendent's role as a key one.

> The superintendent's leadership is a prime necessity, and a first action for the superintendent is to take a fresh look at the work of the district-wide health coordinator... Coordinators must be able to convey the importance of health by word and deed, to the staff, parents, and community groups... The single most important thing that superintendents and principals can do for health promotion is to stand behind the program (Pine, 1985, p. 26-30).

Although a DLP was chosen in the study district, the School Board initially made no policy concerning **Learning for Living** and did not establish a specific school health coordinator position. In this district teachers generally felt they "were bombarded with all this stuff and... there was a lot of confusion about what [the resource binders] were and there really wasn't a lot of explanation given to them" (Learning for Living Contact, Study District, 1994). This is echoed by a teacher at the study school (1994, also a representative to the District's Teachers' Association), who suggests that "it was kind of just dumped... and certainly there was not a lot of background... and there's certainly not a lot of support as far as training or implementation".

While two Primary Helping Teachers and two Counsellors had attended the first orientation there was not much of a chance to proceed with further dissemination activities due to job action in the district. In fact, the climate around **Learning for Living** was such that, during the district's dispute the union decided to collect all the curriculum guides and send them back to the Ministry as a way of saying 'enough's enough'. The Teachers' Association Representative (1994) who collected them at the study school said that "some people didn't even really know that they had it, it was just sitting there".

Although information is 'traditionally' passed to School Boards by Superintendents there was a concern that Boards "be

apprised of the fact that this program [was] coming" (Correspondence, former Learning for Living Coordinator to DLPs, 1988, November 1). This indicates that there had been resistance on the part of some Superintendents to act as an advocate for the program. The Minister of Education, in fact, responded to someone on this matter, stating "it is within your role as a school administrator to ensure that a mandated curriculum is offered in your school" (Correspondence, 1988, November). It should be noted, however, that when district administrators choose not to proceed with dissemination activities which would facilitate the implementation of an innovation it does not necessarily mean that it's seen as unimportant. They may not see how it

> can be mandated and in place and implemented in the time frame that it's been asked for... the budget isn't there, the consultants aren't there, the vehicle isn't there yet to get it into the classrooms in one broad sweep (Learning for Living Associate, 1992).

This represents the difficulty with **Learning for Living** perceived as a new curriculum area which had to be added onto or into everything else. The implications for it as a comprehensive school health program were certainly far from being realized or addressed within the field. Although this position is also emphasized by the Principal (1994) of the study school, he offers an important message about getting started:

> our job is to ensure that it's properly introduced, that materials are there, resources are there. If you want to kill a new curriculum... introduce it without resources... [but] don't say I can't do it because I don't have the

resources, [say] what is it that I can do?

When regional DLP meetings began in the Fall of 1988, a primary concern had to do with district awareness of the curriculum. **Learning for Living**, although recommended for integration into the Humanities, was still perceived as an extra curriculum area, just as **Family Life Education** had been, implying extra time allotments. In the study district the climate was certainly an obstacle to successful dissemination, "the people in the district at that time felt there were more issues that needed to be looked at that took priority such as implementation of the Primary Program" (Learning for Living Contact, 1994). So with the advent of the new Language Arts curriculum and the Primary Program document at the same time as **Learning for Living** it appears that they received the majority of the emphasis and support. The Teachers' Association Representative (Study School, 1994) explains that when the Intermediate Program was introduced a lot of frustration was expressed among Intermediate teachers at union meetings and workshops;

> it was just kind of like 'well here it is and we're going to start doing this now' and it wasn't so much people saying 'it's up to you to implement' but that's really what it amounted to... [and teachers thought] how am I going to do this, how am I going to find the time to figure out what the heck I'm supposed to do?

Curriculum Resources.

As already mentioned, one of the challenges for a program innovation is to produce or procure the necessary resources. The Ministry of Education traditionally establishes a 'Recommended

Resources List' of materials appropriate for the program. In the case of **Learning for Living** this was by no means complete at the time of curriculum dissemination. There was a concern that districts understand what the program could do for students and families. The Learning for Living Coordinator, at that time, noted that "there is some difficulty in impressing upon Boards what this program will do... as the learning resources package has yet to be developed" (Correspondence, 1988, November 1). There were not considered to be any concrete resources which could demonstrate how the goals and themes of the program would be achieved.

The selection of resources is touted as "a really interesting phase... the stuff which makes the course" (Memo, former Learning for Living Coordinator, 1988, November 4). Although the writing of the Rationale and Objectives are important as 'educationally sound' it is well known that teachers, traditionally, develop lessons from content-based resources. As Zahorik's (1975) study of classroom planning models showed, "objectives are not a particulary important planning decision... in terms of quantity of use" (p. 137).

The issue of resource development was, in fact, a contentious one since many of the initial groups requesting inclusion of health related information in schools now had a formal means to do it through the new curriculum. Weber (cited by Collins 1977 in Whitty, 1985) points out that

> cultural resources... can create and channel additional interest groups and conflicts... [with] education as part of a multi-sided struggle among status communities for domination, for economic advantage, and for prestige (p. 34).

These political pressures can be seen to affect the Resources Branch even though it has a systematic educational review process for the determination of resources which will make up the Recommended List. Just as there were questions raised about the addition of content areas, there were also concerns about whose and what information was to be presented within an area. As already noted, some of the decisions made around these issues may be partly attributed to values embedded within a medical hegemony, but also other ideological configurations may play a role. On this basis, it must be stressed that one should not "take for granted that curricular knowledge is neutral" (Apple, 1990, p. 17). The 'Call for Resources' is, in fact, sent to only a pre-established target group of publishers and organizations, which may not necessarily represent the full spectrum of current day health concerns, attitudes and professions.

In November of 1988 the Working Committee began the process of resource selection for Primary. This stage was one of the few times when the Advisory and Working Committees actually met "to review [the] scope and sequence outline from a content area perspective" (Memo, Manager, 1988, November 15), although much of the resource selection had already taken place. It was obvious at this time, as one Working Committee member (1992) recalls, that there needed to be an 'Instructional Design' to accompany

the curriculum guide. The concern over resources and inservice was expressed by the Working Committee and DLPs. One school district had been developing an Implementation Guide but due to staff changes it was put on hold. DLPs were concerned not just for teachers; they also suggested "an administrator's guide describing the course and suggesting ideas for implementation [with] an administrator's in-service [to] accompany this guide" (Memo, former Learning for Living Coordinator, 1988, December 14). As previously noted, the support of superintendents and principals is considered a key element in the implementation of a school health program. No such guide was produced.

Resource development, of course, began to be focused on the Primary Program and how **Learning for Living** fit into this. A video package, Introducing Learning for Living - Primary - A Presenter's Resource Package (1990), was produced that would assist the coordinators and DLPs in giving orientations. A classroom resource, Personal Growth: Humanities Resource Book (Primary and Intermediate) (1990), was also being field tested and receiving positive feedback. The development of this resource represents an instance of integration between the Learning for Living team and the Primary Language Arts team. Three people were taken from each team to develop this resource. This was probably one of the last resources produced by the Ministry.

At this time the Provincial Educational Media Centre was

scaled down through being partially privatized and partially amalgamated with the Learning Resources Branch in Victoria. There was a push to recognize outside publishers. A former Learning for Living Coordinator (1992) states that this was possibly a "political push to look at publishers and the publishing business in B.C. that was coming from Cabinet level, especially if we look at our Premier at the time and entrepreneurship was a big issue". A recommended resource list had been established by the Ministry's Resources Branch, but this work may have slowed with the downscaling. A Learning for Living Associate (1992) notes that people would be coming in with other resources, saying "these are good resources but some of the ones recommended aren't very good, and some of the ones left out should have been put in". There are still gaps in the resources available for the seven content areas.

The lack of classroom resources, an administrator's guide, and lack of dissemination about the vision of comprehensive school health may all have contributed to the negative impact of **Learning for Living**. The difficulties around resources can be found at the district level as well. School districts generally have a Curriculum Resource Centre or a Resource Coordinator whose task is to procure appropriate resources for programs. In the case of **Learning for Living** this should be an ongoing process as new health issues arise. However, the Teachers' Association Representative (Study School, 1994) illustrates some of the

logistical difficulties around gaining access to resources,

> there are [probably] a lot of resources somewhere but you have to find them, you have to go and look for them and you have to know who to talk to... but I don't think that it's particularly well coordinated, but I could be wrong... [maybe] I haven't taken the time to be aware of it.

Time and coordination seem to be a constant echo. As previously mentioned, the School Psychologist (Study School, 1994) also states that information about the program and inservices did not seem to come through their department.

BCTF Inservice Project.

In June 1990 the Learning for Living Coordinator met with an 'ad hoc' committee of the B.C. School Counsellors' Association, a Health/Guidance Committee, and reported that they were "interested in a proposal for 'BCTF Associates' to help train teachers in appropriate professional development to support **Learning for Living** curriculum in the Primary, Intermediate and Graduation Programs" (Memo, former Learning for Living Coordinator, 1990, June 29). This initiative led to a BCTF Learning for Living Inservice contract. The position of BCTF Learning for Living Coordinator was established to be responsible for developing inservice workshops for teachers. Due to a provincial election in the Fall of 1990 this contract was delayed. The new government administration approved funding for it and the position was posted one year later in June 1991. A coordinator was hired and the 1992-93 school year was spent developing workshops with Learning for Living Associates, also

newly established positions.

This contract is extremely important because the BCTF represent a powerful interest group of teachers in this province. Their support of the program, not only ideologically but materially in terms of professional development, could alleviate a lot of the uncertainty and ambiguity around **Learning for Living**, at least amongst teachers. Eggleson (1975 in Whitty, 1985) claimed that,

> teachers retain considerable power to resist curricular initiatives at the point of implementation. This is especially significant where professional power becomes articulated with that of a powerful interest group outside the school (p. 147).

However, the support of the BCTF Inservice Project could not overcome all the obstacles to implementing the curriculum within school districts and, in particular, to achieving a comprehensive school health program.

Recognizing the Need.

After a turbulent few years in the study district, there has been a focus on **Learning for Living** in the 1993-94 school year. This district has been dealing with an increase in issues like violence and the importance of wellness. The Learning for Living Contact (1994) stated that people were "starting to see now that we've really got to help the kids in our schools and how we can't reach them with curriculum; we have to first deal with their social and emotional". This year the district put a focus on Learning for Living through holding two Professional Development

days for district staff "because a lot of people were at a very, very minimal awareness level and they didn't really understand the program" (Ibid). Although this is an essential step for the district it is somewhat overdue. As the School Psychologist (Study School, 1994) explains "going to a bunch of different schools [I'm] supposed to be able to tell people what's coming from the district... I heard that term **Learning for Living** for the first time this year".

District Collaboration.

The School Psychologist (Study School, 1994) was appointed to a district committee which initiated five Focus Days for the district; these could be used as Professional Development by school staffs, and one of these was on **Learning for Living.** The intention of the appointment to this committee was to facilitate communication between the Curriculum Department and the Student Services and Special Education Departments. However, the School Psychologist has not been able to continue to attend committee meetings due to lack of time and, as before, further information or notices on ongoing events doesn't seem to be forthcoming.

The initiation of a collaborative, cross-departmental communication process is an excellent beginning for modelling what needs to happen within schools. It needs to be followed-up with action initiatives based upon concrete resources which support them. Too often time is a limiting factor because of lack of funding for release time or extra support staff to reduce

case load limits. Workshops themselves suffer from time constraints in which there is only so much time to present the necessary background information and either little or no time for an action-oriented planning activity. This process must be incorporated to enable participants to go back to their schools with a concrete initiative and some initial action steps. Some of this may be resolved in a three day Learning for Living Inservice, hosted by the study district, which it is able to provide through a grant from the Ministry of Education's Developmental Site Funds. The money will be used, primarily, to release teachers to attend. Using the DASH "Living School Health" conference model (see under Promotion of Comprehensive School Health), they are "trying to put together teams from schools so it's not just the teachers but hopefully a counsellor and a parent and an administrator" (Learning for Living Contact, Study District, 1994).

Funding.

Funding is an extremely important factor in the priority an innovation receives. Some funding will be made available through the district office, for example, through the Curriculum Services Department. The Ministry of Education's funding formulas to districts may determine the actual use of the funds towards the innovation, as previously discussed, depending on whether the funds are targeted or not. Such economic concerns will be partially dependent on political influences and will inevitably

play a part in the allocation of resources, particularly time and personnel. As Bush (1986) indicates, this is "likely to be among the most significant aspects of the policy process in schools" (p. 73). The policy commitments by school districts as well as local health units are essential to the successful implementation of a comprehensive school health program.

In the past two years grant funding has been available to school districts for the initiation of projects a) associated with **Learning for Living** through the Ministry of Education, and b) for "Healthy Schools Projects" through the Office of Health Promotion, Ministry of Health. There have been some excellent results through these funding programs. However, some concerns have emerged. In the case of the Healthy Schools Projects there has not necessarily been a connection made with **Learning for Living**, to the extent that in the study district the Learning for Living Contact did not even know that there was a Healthy Schools initiative in the district until she happened to meet the coordinator at a DASH conference. This is not only a cross-departmental concern but an issue for Interministerial consideration as well.

The promotion of the comprehensive school health model and collaboration between Ministries and their counterparts at the local level could have generated a more broad based, coordinated approach. Rather than stretching taxpayers funds in two directions to accomplish similar objectives through different

projects, incorporating them together could have the effects of: a) reaching a wider audience, b) reducing overlap, c) providing a coordinated approach, and d) presumably reducing costs. Without such coordination and sustained support, initially through joint funding, it is difficult to imagine the existence of a truly comprehensive program in the years to come.

Professional and Staff Development.

The scope and complexity of **Learning for Living** may be too much to address all at once. A major organizational task in assessing the need for professional and staff development will be to fully identify the total changes addressed by the innovation and prioritize which areas to cover first, however, this should not mean losing sight of the big picture, i.e. the comprehensive framework. As Fullan (1991) notes,

> change is the result of system initiatives that live or die based on the strategies and supports offered by the larger organization. This is especially true of multilevel, complex system-oriented innovations where what is being changed is the organizational culture itself (p. 73).

It will be necessary to prioritize the organization of resources: release time for teachers to attend inservice, resource procurement/development, and the involvement of community partners in projects and the coordination of services. The DLP or Learning for Living Contact plays a key role in identifying, negotiating for, and coordinating these resources. As noted, in the study district, this process had been delayed due to the climate, and dissemination became a gradual process where the DLP

felt "the better way for it was through the infusion model" (Learning for Living Contact, Study District, 1994).

Werner (1987, p. 42) states that the "essence of educational change consists in learning new ways of thinking and doing", therefore, appropriate professional and staff development are critical to accomplishing the changes in practice which are inherent in **Learning for Living**. However, the question should be asked, 'Would there be greater diffusion today if the resources for more broadly based staff development had been available, regardless of the difficult climate in the study district?' Certainly, teachers need to know how the innovation is going to affect their classroom practice. While the BCTF Inservice had begun to meet this need, much of the vision for the comprehensive model, multidisciplinary collaboration and coordination might have been clarified and developed through district and/or staff support activities. At this point, the district is faced with doing it all. The recent Professional Development/Focus Day on **Learning for Living** (Study District, 1993, November 19) attempted to highlight the components of a comprehensive program. There was a speaker on the curriculum and one on healthy school environments; however, there was no discussion on Services for Students. This is a big issue in the district where, in fact, school-based teams are now written into contracts (see Services for Students section). Again, the opportunity for presenting a coordinated vision of comprehensive school health has been

missed.

Support Activities.

The multidisciplinary nature of comprehensive school health requires the recruitment of a strong support network of school and district based advocates to provide a coordinated approach. The team approach is similar to Fullan (1991) and Werner's (1987) concepts of 'collegiality', where

> everyone is viewed as having different kinds of expertise... involved at different times in the development of innovations... come to understand an innovation better than if a finished 'product' were handed to them; they are able to build in their relevances and interests into the innovation, and consequently, they become committed as it represents their own work (Werner, 1987, p. 45).

Teams can be guided toward collective 'vision-building' (Fullan, 1991) in order to clarify what the innovation will look like in their schools. They should be encouraged to meet on a regular basis so that communication through sharing, problem-solving and planning will reinforce the collegiality of the team and increase the innovation's clarity. However, like time for professional development, the time and resources must be made available for these people to meet, to share and to plan for coordinated action.

Staff support activities, not just training, can be facilitated by Ministries, School Districts, Public Health Departments or coalitions such as DASH. McLaughlin and Marsh (1978) found that well-conducted support activities had "strong positive and direct effects on the longer-term project outcomes -

teacher change and continuation of project methods and materials" (p. 77). In the study district the DASH Living School Health conference served as an excellent support activity for the facilitation of the multidisciplinary team concept. At this conference, the Learning for Living Contact (Study District, 1994) met people from the district that she had not previously worked with and they have now developed an ad hoc committee. They acknowledge that there's a real lack of communication between the different areas, like the health [unit] and what's happening in the schools (Learning for Living Contact, Study District, 1994; Personal Communication, Public Health Staff, 1994). In such cases it is essential that the participants have the flexibility in their schedules for the time associated with the collaborative activity. In the case of many teachers this will mean release time, for counsellors reduced case loads.

Principals.

Ideally, principals will take an active role in the promotion and support of comprehensive school health, realizing that as an integral part of school life it is intended to be of benefit to learning. Cox (1983) cites the principal as important in innovations because they can give encouragement and positive reinforcement (p. 10). The extent of principals' commitment to an innovation should be assessed, as their support will be essential to successful implementation within schools. McLaughlin and Marsh (1978, p. 82) have noted that the "principal

gives subtle but nonetheless strong messages concerning the 'legitimacy' of continuing project operations in the school".

Initially, the B.C. Principals and Vice-Principals' Association was not represented on the Learning for Living Advisory Committee. A representative was appointed in 1992-93. This group has only recently become involved in a collaborative project with the B.C. Confederation of Parent Advisory Councils to provide such things as: articles, a pamphlet and an implementation strategy kit to support Learning for Living (Correspondence, Learning for Living Coordinator, 1993, May 20).

Each district's efforts to bring principals on board are still essential. As Hall (1988 in Fullan, 1991) concludes, successful change "seems to be related to how well the principal and these other change facilitators work together as a change facilitating team" (p. 156). The principal must help to build in collaboration at the school level so that teacher isolation does not act as a 'foil' to change efforts (Tye and Tye, 1984). He/she will be required to facilitate an atmosphere which is conducive to the goals of the innovation. As Goodlad (1983) also points out,

> this does not occur when teachers are drawn out of schools as individuals to engage willy-nilly in workshops and courses and are then returned to the isolation of their classrooms and a school culture where how and what one teaches are not matters for peer-group analysis, discussion, and improvement (p. 557).

Although the exact nature of principals' roles will differ from school to school they should be encouraged to develop school

policies associated with the innovation. This will be symbolic of their ongoing participation in the form of support for school-based initiatives. The Principal (1994), of the study school, suggests that while it is important to establish what the teachers want to do, "if you want the staff to do something and I as a principal believe in it, then my responsibility is to convince staff and bring them on board".

There can be resistance to innovations if principals or other district administrators feel their authority is threatened. For example, when teachers and others talk of restructuring a school environment administrators may require district support. Professional development and/or support activities for the administrators themselves is also essential. Fullan (1991) has observed that "principals do not have or create much opportunity to interact professionally with other principals" (p. 165; see also Blumberg & Greenfield 1980 and Sarason 1971 in Fullan, 1991). As previously noted, while there may have been a great deal of support for the new Programs the message of **Learning for Living's** supportive role does not seem to have come across in all districts.

Prior to 1993 there had not been any Ministry of Education support activities on **Learning for Living** specifically for school administrators. While the registration policy of the DASH conferences encouraged their participation their attendance was noticeably minimal. Werner (1991) notes that "teachers complain

about the organization of time which does not encourage the kind of collaborative planning necessary to implement curriculum integration" (p. 13), let alone the development of a comprehensive approach which requires administrative support. It would probably have been helpful to have dealt with the meaning of this innovation at an administrative level prior to the mass distribution of the curriculum. It has been noted that the quality of implementation increased when "pre-implementation training [was combined with] assistance during implementation" (Huberman & Miles 1984 and Louis & Rosenblum (1981) in Fullan, 1991, p. 84). As the Ministry of Education and School Districts look to providing professional development and support activities for **Learning for Living** they should not forget to include administrators. Districts which are now beginning to promote a team approach, such as in the study district, may see greater fidelity to and institutionalization of the innovation in years to come.

A Broader Community Context.

The **Learning for Living** Program's potential is much broader than the curriculum components use in classrooms. As a comprehensive school health program its intention is to engage the whole school, including district support staff, and encourages community interaction with it. Therefore, the degree to which this comprehensive program can be achieved is directly related to the school culture and the sociopolitical climate of

the district and its community. Unruh (1983, p. 100) remarks that "each community is different; there is no exact model for explaining the power and decision-making phenomena that fits all". Implementation plans will be affected by this climate.

The **Learning for Living** Program advocates a 'team' approach that is school and community based. As stated in the curriculum guide, "parent and community involvement in health matters can provide support and reinforcement for the objectives of the school-based curriculum" (1990, p. 16). The task of setting up a team may be a relatively simple or complex task depending on the sociopolitical context of the district. There are, of course, stakeholders to be considered; will the team consist of a school nurse, counsellor, psychologist, a parent, Learning Assistance Teacher, students, an RCMP or a corporate sponsor? The answer will vary depending on the relative influence or interest of various individuals and on a spirit of democracy from the gate-keepers. The Principal (Study School, 1994) states that he believes in "participatory democracy, and if you have an involved [group] that are making decisions then they are going to be committed to it". This is clearly evident in the structure and function of the school-based team, to which much of its success is attributed (see under One School: From Structure to Function).

Still the support of the teachers is essential to getting an initiative off the ground in a school. The Principal (Study

School, 1994) recommends that implementation be "grass roots... the teachers have to have the ownership of it... [and] there's a lot of funding out there to tap, but first of all... you need to be sure that you've got the staff with you". A necessary pre-condition to staff commitment, however, is again the degree of clarity about the innovation or project proposals. Defining what is really new, what resources are available, and what action is currently possible, as well as defining a collective vision for the program will require considerable discussion and negotiation at all levels.

Clarity.

One of the problems with the complexity of this program is ensuring clarity. A variety of strategies around school health may be attempted resulting in lack of cohesion or gaps within the organization, as already cited. There will likely be some 'turf protection' or resistance to any changes in professional autonomy. This will not only be the case at the district/ community level but within schools themselves. The clarity around the model of comprehensive school health has obviously been developing over time. There were only minor references to healthy school environments and services for students in the curriculum guide, after which the Ministry of Education seemed to abrogate any responsibility for these areas. It would be more efficient to talk about all the components of the comprehensive model in order to reach out to a wider audience and facilitate

participation in a collaborative process.

It is encouraging to see that the current grant application from the Ministry of Education for Learning for Living Developmental Sites (1993-94) does make mention in its criteria that projects "should demonstrate inclusion of school based health promotion concepts, for example comprehensive health education models". However, as previously noted, there is not a consistent pattern in terms of what is happening in school districts. A closer look at the Services for Students component, in the next section, illustrates the importance of a concept (i.e. the school-based team) being built into the structure of a system. This also gives rise to the question of whether or not that system itself is modelling the goals which they claim to support.

Services for Students.

This component of comprehensive school health has yet to be clearly modelled for school districts. In 1990 the beginning of a more formal effort toward addressing the issue of services for students in schools was the establishment of an Interministerial Committee (Correspondence, Minister of Education, 1990, February 20). This committee would look into matters such as the alteration of fiscal frameworks in order to provide services to schools and the Inter-ministerial Protocols for the Provision of Support Services To Schools (1990) was produced. At a September 25, 1991 meeting of DASH a Ministry of Health representative

discussed the protocols, stating that "depending on funding... the next protocol to be developed may deal with the level of public health nurses' involvement in schools" (Minutes, DASH). She went on to say that a study on trends in nurses' time shows that in the 1980s nurses spent about 30 percent of their time in schools and it is now only about 8 percent. In a review of the protocols it is clear that a great deal of cooperation must take place between the various Ministries and respective local departments involved.

The protocol for 'Generalized School Health Services' states that the public health nurse will "develop and maintain communication concerning the referral of pupils to the nurse or other qualified health personnel and the reporting of pertinent results to the appropriate school personnel" (p. 5). However, in the study school, the school-based team coordinator has indicated that "lots of times we wouldn't get information on home visits, you'd have to bug them" (Field Notes, 1994, January 12). Nurses assigned to this school had typically not been very visible for the past few years and there was much staff turn-around. The time allotted to the current nurse is one morning a week until recess and is used primarily for home visits. Although she is considered a member of the school-based team, attendance at a meeting would be rare. This can pose some logistical drawbacks. For example, on an occasion when the team proposed a strategy for a student which included the nurse, an additional linkage needed

to be made with the nurse prior to everyone else's role in the strategy being finalized (Field Notes, 1993, October 6).

The development of the services for students component was again another development that took place in isolation from developments in other departments of the Ministry of Education. A former Learning for Living Coordinator (1992) explains that this meant

> charting new territory... government expense in times of recession... [and] ethically it's not hard to get anybody to agree that it has to be done, but when you sit people down and say, 'do you have the [ability] to take on this tremendous challenge' you get varying degrees of wavering.

Services for students, although identified in **Learning for Living**, became the responsibility of the Special Education Branch. It is somewhat disconcerting to note that in the Primary Program Foundation Document (1990) under the **Learning for Living** section there is no specific mention of this component, (although added in a revision) while there is a section on Healthy School Environments. Further, in the Primary Program Resource Document (1990), under the section 'Children with Special Needs' (p. 148) there is an explanation of the use of support services through the school-based team; however, there is no mention of the comprehensive school health model advocated in Learning for Living. In a comprehensive school health program, it should be remembered, the intention is to provide an integration of all three components: curriculum, healthy school environments and services for students. It is unfortunate that the opportunity

was missed to show the integration and inter-relationships of a comprehensive program, tying the developments within other branches together. It is obvious that while this curriculum development project could lead the way to something much broader than a curriculum guide the structures for multidisciplinary/ departmental coordination were yet to be developed.

While the Inter-ministerial Protocols are certainly an important initiative, they were scheduled for implementation over a ten year period. School Districts at least have a policy framework which can assist them in adapting their organizational structures over time to allow them to coordinate services for students more efficiently. Still, districts may approach this new framework in a similar fashion as the new curriculum and, consequently, the development of policies and service delivery structures will depend on the sociopolitical climate of the community in which interaction must take place.

One School: From Structure to Function.

In the study school an established and well coordinated multidisciplinary, school-based team was observed. The team consisted of the Learning Assistance Resource Teacher (who was the Team Coordinator), Principal, Vice-Principal, ESL Teacher, School Psychologist, School Counsellor and School Nurse. This team was initiated within the school and has functioned for about 5 - 6 years. The belief in the necessity of the team as a resource for the whole school has given it a lasting priority

status and a clearly established structure.

While the team recognizes the essential role of having someone designated as a coordinator all members are considered equal, including the Principal. Everyone feels free to throw in their ideas. The team always meets at a regular time, weekly for about one to one and a half hours. There is always an agenda, generally 3 - 5 cases are reviewed, there is brainstorming, discussion of who will do what, and recommendations are recorded (see Referral Form, Appendix B). As well, when recommendations are made if someone feels too pressed for time, for example, to complete a referral form another member can be asked to do this; or someone may feel another member would be more appropriate to approach the parent(s) on a matter (Field Notes, 1993: September 22, October 6, 13, December 7). In this way tasks are not only shared but coordinated, so the action is more likely to take place. The Team Coordinator facilitates the meeting, keeps and distributes Minutes, and provides follow-up.

The team also acts as an advocate for the teacher by providing a broader base of support when approaching parents or administration, and by helping to ensure that the environment within their classroom is as healthy and productive as possible. Teachers presenting concerns about students are given appointment times during the team meeting and one preparation period is used for a teacher to supervise classes as their teachers attend the meeting. This method was considered essential in order to

structure meetings and appointments for teachers within school time. In this way it is more convenient for teachers to use the service and provides a consistency which can be relied upon. At times a teacher may find themselves with an overabundance of difficult children, not all 'identified' and qualifying for assistance. The team may be instrumental in gaining a new referral or bringing this problem to the attention of the Principal and/or the Teachers' Association (Field Notes, 1994, January 12). However, in the end when there are no more resources (students don't classify as identified, too many cases, no more time) the team is able to look at the whole school and prioritize cases. Rarely, but occasionally, a student may not be able to receive help that year (Field Notes, 1993, December 15).

Participants were asked to describe their experiences with the team. The Teachers' Association Representative (1994) states that as a teacher:

> it's really hard to find the time to take a problem... and be able to contact all the people that might have some kind of an input or some kind of background or some resources or whatever can help that [student] and to have a group that meets regularly where you get, generally, most of the people that could be involved... as individual classroom teachers we don't have to worry about making sure that this or that person gets contacted... and when you can pull all those people together it seems ludicrous not to.

This comment really sums up the essence of multidisciplinary collaboration and coordination. It is more than cooperation between different departments saying 'here's your job, you can do it in this school or with this population'. In the team meetings

information about students is shared, there is more input and a consensus can be reached on the best approach. Actions to be taken can often be shared as well and individuals can often negotiate within the group as to who will do what. This may be dependent on time, who has the best access to a family, or whose authority will be accepted.

Through keeping a record of the proposed transactions, and distributing it to members of the team, follow-through becomes more efficient. The School Psychologist (Study School, 1994) remarks that an efficiently functioning school-based team makes

> a big difference in the ability to organize... and nobody comes in with a personal agenda... [and] without the coordination I think we end up with more children that aren't individually serviced.

One problem-solving situation which arose in a team meeting (School Psychologist, 1994) identified a number of students in ESL and LA whom it was decided could be more efficiently served by having them work together, and this also freed up time to service someone else. This type of scenario is not as likely to happen without the school-based team approach. Those different professionals, without the 'formal' linkage mechanism (Lindsay et al, 1981) of the school-based team, would not necessarily have made that connection on site to share information about the needs of those students and discover a mutual solution. In a study by the Alberta Teachers' Association (1988) data suggest that "practices may be in operation, but not supported by policies which are known to other groups who are working in the same area

of concern" (p. 9).

Through the team patterns within the school can also be recognized, and as the Principal (Study School, 1994) notes, "if a pattern comes up... it'll cause you to change strategies... [or] examine [your] delivery service in that particular area". A pattern such as violence may be more readily identified through the team and they may then be able to act as an advocate for a program on violence prevention. It happens that the Team Coordinator in the study school also chairs the Professional Development Committee and a violence prevention program, **Second Step**, was chosen as a focus for one of the school's Community Interaction Days (Field Notes, 1993, October 25). **Second Step** is a resource which is advocated for **Learning for Living**. This illustrates how services for students, curriculum and healthy school environments become interwoven and interdependent. The Teachers' Association Representative (1994) states that being proactive in terms of racism issues and violence prevention are the approaches he uses which would fall into Learning for Living. **Second Step** was a readily accessible resource, well promoted in a time of growing media attention on the need for violence prevention in schools. In the study school it was financially supported by the parents' group. Other needs may not be as visible, creating public outcry and media awareness, but the needs are still there and require attention and resources to enable students to come to school ready to learn. A

comprehensive approach seems to be a reasonable method to ensure that this happens. It has been stated about **Learning for Living** that "you can't deal with it as a curriculum, you must deal with it as a philosophy of how to treat the whole child, and the environment that the child works in, and the adults that work with the child" (Learning for Living Associate, 1992).

Is funding the issue or does the lack of collaboration have more to do with how people choose to work together? Certainly, cutbacks have affected the number of students and types of problems which can be served. In the study school the Team Coordinator, the Principal and the School Psychologist (1994) feel that more children are 'falling through the cracks'. The Inter-ministerial Protocols do have a specified maximum number of students for each service provider's population. However, in the study district there is a provision within staff contracts that states "if [the school board] can prove that they're not capable of paying for some of these things then they can take out certain parts of the contract, and one that they use that against is the population numbers" (School Psychologist, Study School, 1994). It was also noted that counsellors now share more schools and the number of counsellors was also cut (Field Notes, 1993, September 22). Issues such as these can become areas of contention between the union and the school board. In the study district the Special Needs issue was cause for a strike (Teachers' Association Representative, Study School, 1994). Two things which have

developed out of this debate were: 1) that school-based teams are now written into contracts (identifying criteria for membership), and 2) a lump sum of money has been allocated to each school to support teachers with special needs students. The use of the funds was to be decided by school-based teams which "would set priorities and determine the best use of its school fund for integration purposes" (School Board Memorandum, 1993, October 13). This process will obviously be more efficiently facilitated in schools which have functional school-based teams.

As previously cited, coordinated approaches can be more readily addressed within the team meeting. Not all schools within the study district have school-based teams at this time (Principal; School Psychologist, Study School, 1994). Again, it appears that mandates and policies alone are not always followed automatically by results. The Ministry of Education is criticized in a BCTF newsletter article which states that "the government's integration policy was not accompanied by the guidelines, models, training, supports and resources required to achieve complete success" (Kuehn, 1994). The Principal (Study School, 1994) concurs, and while he has demonstrated that he is a strong believer in providing services for children in schools, he also cautions that if schools are

> going to have that responsibility then you have to have the resources; it's not a fair expectation for us to be able to deal with all these children, counselling time gets cut back, aid time gets cut back... we are being asked to do more with less.

In a system that promotes the essential components of comprehensive school health (although in a somewhat disconnected manner) which can neither fully support all these elements or be expected to on its own other sources must be tapped. This system needs to say 'What can we do, where can we get more support?'. Multidisciplinary teams, both school-based and at the district level, can brainstorm ideas and begin to seek further assistance, and develop networks and partnerships not only to support current needs but to be better prepared for future demands. The Canadian Association of School Administrators (1993) has recommended that

> as we reinvent schools, we must also reinvent communities. It is the relationship between the school and the community that will give meaning to the learning in which we ask students to engage. It is that relevance that we must continue to seek as we first understand the current realities, examine our alternatives through broadly-based discussions and then undertake mutually supportive actions (p. 13).

Seeking Broad Based Support.

Collaboration and a jointly coordinated sharing of resources with other community groups/agencies and government departments would become the norm in an education system with a comprehensive school health program. Middleton (in Pine, 1985), of the National Center for Health Education points out that,

> administrators are sometimes surprised at the many potential health-minded allies they have in the community. Community groups can provide political support, materials, and guest speakers for programs... They need to be involved (p. 26).

Organizations like DASH The Directorate of Agencies for School Health can provide a wealth of contacts, information and

advocacy. Associations for School Health exist in every province and territory in Canada and are represented and supported federally by a national organization, the Canadian Association for School Health (CASH). All of these groups promote comprehensive school health.

Parents.

Parents should also be considered in providing a supportive role to students. The Ministry of Education's position on working with parents in the dissemination of **Learning for Living** was that "the Ministry does not have as its mandate the education of parents, but works with parents as partners in the education of their children" (Correspondence, Minister of Education, 1990, Spring). However, there does not appear to have been any provincially directed effort to organize school districts to work with parents as partners in **Learning for Living**. Even though parents were represented on the Learning for Living Advisory Committee there had been no provincially supported initiative until 1993 (as previously noted).

Parents can be a tremendous resource for schools not only as fundraisers but as advocates, sources of information, and service providers. One of the issues addressed in the school-based team was whether parents could be brought in to provide one-on-one attention for some of those students who needed but did not qualify for services at the current time. The School Psychologist (Study School, 1994) felt this could be effective in

a school such as this one where the support and coordination of the school-based team was strong. She offered to provide the initial training for parents but the day-to-day coordination and trouble-shooting would have to be looked after by someone within the school. While the team thought the idea worthwhile, at the time of writing they had not developed the plan further.

Partnerships.

All in all, what the larger picture looks like is more people involved in schools. While this may pose quite a change for the culture of certain schools the question that should be asked is, 'Is it going to be of benefit'? The DASH "Living School Health" conference in 1992 was the first provincial effort to model the comprehensive approach encouraging parents, administrators, public health professionals and other groups to become involved in Learning for Living. A Past President (1994) of DASH remarks that if the Ministry of Education

> had really promoted partnerships Learning for Living could've taken off... If they had modelled it right the way through, that this is a curriculum that needs to be owned by everybody, then there would have been more collaboration and communication with the other Ministries that are directly involved.

If parents, health professionals, and other groups are to be considered as partners in education perhaps a more serious look at the efficacy of communication and collaboration efforts between Ministries, School Districts, Health Units/Departments and other groups is warranted. The objective of communication should not only be ensuring that people are on the same

'wavelength', but also sharing of responsibility for the coordination of programs and services. We should not have to wait for tragedy and crises to bring us together, as reported in the Education Leader (1992),

> none of these tragedies had anything to do with getting school curriculum into kids' heads, scheduling classes, or offering extra-curricular activities, but they all completely took over the schools they touched... [principals] stressed it would have been nice to talk to another principal who had gone through a similar tragedy (p. 1, 8).

Comprehensive school health committees or teams are one way to ensure that health and social issues are dealt with in a coordinated manner. The model of the school-based team can also serve as a model for a larger school health or Learning for Living committee. The school-based team could be extended, perhaps through a subcommittee structure, including interested teachers, parents and students. A school health committee should be comprised of individuals who can address all the components of comprehensive school health. A Superintendent in Pine's study (1985) suggests that "no school district should be without a school health committee... because no school health program can be effective without one" (p. 27).

Healthy School Environments.

The definition of a healthy school environment was extended in **Learning for Living** from the traditional view concerned only with the physical environment. The Learning for Living Primary - Graduation Curriculum Guide (1990) defined the environment as that which "includes the psychological and social climate as well

as the physical surroundings" (p. 15). A recent trend toward educator wellness can be regarded as an aspect of this concept. Districts and schools are quite likely to be faced with such initiatives if Learning for Living is implemented in a comprehensive manner. Such programs will of course be dependent on district priorities because, once again, funding for staff inservice will be necessary. School Boards and administrative staff should not be reluctant to consider this; as Pine (1985), citing one administrator's report, explains:

> his district's staff wellness plan has saved money because his schools have had to hire fewer substitutes. 'I can say from 20 years' experience that I've had fewer teachers absent due to illness than in the past, and much of this record is due to their inservice on stress management, diet, alcohol and tobacco, and general staff fitness' (p. 58).

The Healthy School Environment component of **Learning for Living** has been addressed by the Ministry of Health through a multidisciplinary team approach. A collaborative **Healthy Schools** initiative was introduced to the Ministry of Education by the Office of Health Promotion, Ministry of Health in April 1990. This project-based initiative could be used to facilitate a process in schools that would promote the component of healthy school environments. This initiative represents one of many strategies within the health promotion movement. Stevenson and Burke (1992) have some cautionary comments about the origins of this movement being from within the state.

> This restricted social base results in limits to health promotion... generat[ing] contradictory pressures to ground new policy initiatives in ready-to-use health promotion

> indicators, on the one hand, and in community-based definitions of need on the other (Ibid, p. S47).

The Office of Health Promotion's resource Healthy Schools is one such ready-to-use health promotion tool, and has been included in the Recommended Resources List for **Learning for Living**. Grant funding was provided by the Office of Health Promotion for schools to initiate projects from 1990-94. Healthy Schools Coordinators were hired, primarily through provincial health units, Union Boards of Health and through DASH for the facilitation of projects within schools. Their responsibility would be to approach school districts with the concept, explain the process to be followed, provide assistance and administer the grant.

The primary focus of the process for project development was that it be based on the participants', including students', views of what makes a healthy school environment. The importance of including student peers in health related matters has been noted in a national survey conducted by Steinhausen (in Perry, 1986) who concluded that "peer education can no longer be regarded as a fad in education, in fact, peers are seen as performing a unique role in promoting proper health behavior" (p. 62). This non-traditional approach is an example of Giroux's (1988) call for "diffusion of authority along horizontal lines" and can help both teachers and students learn to "share and appreciate the importance of learning collectively" (p. 39). This has been expressed by a student involved in a British Columbia **Healthy**

School project who stated that "through more interaction between students and teachers relationships were built and it became easier to work together" (British Columbia Ministry of Health [Video], 1992).

Although the **Healthy School's** process uses a ready-to-use tool it also strives to incorporate community-based definitions of need. However, Stevenson and Burke (1992) would argue that while this may represent a better conceptualization of 'community empowerment' it is still

> vaguely specified... and the political road to empowerment, as well as the obstacles likely to be encountered along the way, are left unmapped... Gaining power, in any meaningful sense of the term power, will involve the 'community' in economic, political and ideological struggle with the state, capital, the medical profession, and alternatively defined communities (p. S49).

Obstacles to empowerment are likely to become apparent if schools wish to apply directly to their district or community health unit for support of a **Healthy School** project rather than through the incentive funding of the Office of Health Promotion. At the time of writing, the Office of Health Promotion has been disbanded making this a most relevant concern. This change is part of the Ministry of Health's 'New Directions' restructuring (British Columbia Ministry of Health, 1993). At this time there does seem to be an interest in continuing the **Healthy Schools** Project promotion. However, health promotion and health education are considered to be 'Core Services' which may be locally managed (British Columbia Ministry of Health, 1993) by the emerging

Regional Health Boards and Community Health Councils, that would have some authority to decide whether such projects would be undertaken locally. There is as much a potential for dissipation as there is for further spread of the **Healthy Schools** initiative, particularly in those districts where **Learning for Living** is not seen as a priority making linkages with schools more difficult.

It has been clear that while the Ministry of Health may reach out to the education system the education system has made less "effort to reach out and embrace health at the provincial level for shared initiatives... It's kind of unfortunate it's not at the policy level" (DASH Conference Coordinator, 1994). It is not surprising that the policies are often vague, that what is a program philosophy remains abstract, leaving communities to determine their own course yet without the models and structures and, therefore, empowerment to be able to do that without reliance on the private sector. This appears to be a pattern of activity undertaken by governments in the past. Ungerleider (1991) remarks on this parallel noting a Throne Speech in 1983:

> government's mandate requires restraint on the public sector 'by eliminating some programs that may be desirable but are not essential and by transferring other activities to the private sector' (p. 16).

This strategy may, again, represent an inability or unwillingness to address political conflicts. If an initiative like Healthy Schools is taken out of provincially directed policy this will only set the stage for that struggle of power identified by Stevenson and Burke.

Regardless of the future of the **Healthy Schools** Projects, at the community level School Boards are finding that they are increasingly having to deal with problems associated with schools' physical environments. In a study conducted by the Ontario Association of School Business Officials (Hansen, 1993) it was found that

> eight out of ten administrators in Canada think the condition of a school facility is a 'key factor' (65%) or 'absolutely critical' (18%) to student achievement... [and] half of the school systems in the country... cite building deterioration and/or deferred maintenance as their biggest facility concerns (p. 3,4).

In many of the **Healthy Schools'** projects multidisciplinary groups, including parents and students, formed to establish a vision of what their school needed to become a healthier place in which to be and to learn. The importance of Parent Advisory Councils taking a proactive role in this area should not be underestimated, particularly since concerns about the school environment have been associated with academic achievement. Berner's (1993) study found that the school building's condition was

> shown to be statistically related to the student's academic achievement. An improvement in the school's condition by one category... is associated with a 5.5 point improvement in average academic achievement scores (p. 6).

Establishment.

Will the value of the comprehensive school health framework be recognized as a framework for schools, communities, Ministries and departments to function together in a more collaborative,

multidisciplinary and coordinated manner? The BCTF Learning for Living Coordinator (Personal Communication, 1994, April 28) expresses concern for the lack of vision, communication, consultation and coordination; and, further, states that after six years people involved with **Learning for Living** are "still fighting for [their] lives".

The Learning for Living Primary - Graduation Curriculum Guide (1990) was 'signed-off' in April 1990. Still, there was much concern at that time that without support the curriculum could 'die'. In 1992 there was concern that the **Learning for Living** Program 'in use' would not reach its full potential. In fact, Assistant Deputy Ministers were wondering why implementation had "not been more successful" (Correspondence, Learning for Living Implementation Advisory Committee, 1992, December 9). The framework of comprehensive school health had not been supported and this was, in fact, cited as one of the factors causing poor implementation (Ibid). As reported here, much of the difficulty seemed to rest on the lack of communication and clarity around the model as well as obstacles related to district priorities and lack of coordination between different sectors. Projects such as the BCTF Inservice, Healthy Schools and the Inter-ministerial Protocols now provide some substance for the framework of comprehensive school health which had been lacking at the time of dissemination. These provide ways of viewing, interpreting and proceeding within the three components of a comprehensive school

health program as identified in Figure 1. However, these activities are individually tied to distinct and often separate funding formulas. They are often based on narrowly defined fiscal frameworks and policy structures within, rather than across, various government Ministries, departments and local boards.

Social Support.

In order to provide a fully comprehensive school health program some discussions need to take place, for example, about the restructuring of budgets and policy criteria for project definition. If these were based on the comprehensive approach there would have to be consideration for a sharing of costs at all levels. Rather than a linear direction, funding policies and projects would take on a more collective or joint approach. The Canadian Association for School Health (1994) states that "an integrated, comprehensive approach is more cost-effective than fragmented programs" (p. 3).

Some might take the view that as long as each of the components are in place then we have comprehensive school health. In such a model each sector in turn defines the content for that component rather than jointly establishing the contents through collaboration that can then lead to coordinated efforts. When cross-over occurs, as it does, this will be an area for further conflict unless there is a common framework in which to establish linkage mechanisms. Various sectors need to work together to

develop a consensus about what the contents of the components will look like and, thereby, becoming a basic 'innovation profile' (Taylor and Werner, 1989) for comprehensive school health in that school district/community. The involvement of many sectors such as: the education sector, health, social services, community agencies, parent groups and students represents the broad based, multidisciplinary social support advocated by DASH and CASH (as represented in Figure 2). Collaborative and coordinated social support is the necessary ingredient that ties the rest of the components together in a truly comprehensive manner. Baldwin et al, 1990; Kirby, 1984; Vincent et al, 1987 (in Oickle, 1993) remind us of the importance of a coordinated innovation profile, stating that when

> instruction about health is combined with accessible health and social services, with organized social support from parents, media, public policy makers and the community and with a healthy physical environment in the school the effect on the health and learning capacity of students is even greater (p. 36).

Preservice.

It will be interesting to see how preservice programs on **Learning for Living** incorporate and provide examples of the multidisciplinary approach to comprehensive school health. As public school program policies change revisions to traditional preservice pedagogy must be anticipated. As recommended by Goodlad (1964),

> broad-scale implementation of current curriculum projects depends upon both the usefulness of materials produced and the in-service education of the teachers who use them...

> Continuing self-renewal of the current curriculum reform movement, however, depends upon the pre-service preparation of teachers in the new content (and accompanying pedagogy) (p. 85).

There was a lot of discussion around this issue, at the November 23, 1988 meeting of DASH, when the Curriculum Response Draft was presented (Minutes, DASH). At this meeting a recommendation was made to request a meeting with the Ministry of Advanced Education and the Ministry of Education to consult on this matter. The concern at that time was that 50% of this new curriculum addressed the affective domain and that many teachers were not trained in this area. This was cited in the Summary of Field Responses to the Learning for Living Response Draft (Correspondence, 1989), "teachers were deeply concerned that their present skills did not adequately prepare them to teach **Learning for Living**". Another concern relating to the framework of comprehensive school health should have been whether their training prepares them to work within a multidisciplinary context. Further clarity is needed on this issue if **Learning for Living** is to be seen as an important area of educational inquiry, not simply as the 5% of curriculum time allotment which 'we may get to on a rainy day' or when a crisis presents.

A former Humanities Manager (Minutes, Advisory Committee, 1990, April 20) indicated that a 'marker' for the successful completion of the program would be preservice. One of the Learning for Living Coordinators at that time looked into approaching universities on preservice training in **Learning for**

Living (Correspondence, 1990, April 27). There were no preservice programs specifically addressing **Learning for Living** at that time. The Minister of Education also recommended teacher training citing many factors to the success of a curriculum, "not the least of which is effective training of, and support for, our teachers" Correspondence, 1989, August 3). In early 1992 DASH was asked for support in promoting the necessity of preservice health education and health/physical education to Simon Fraser University and the University of British Columbia respectively (Minutes, DASH, 1992, January 29). The Minister of Education found himself reassuring people on this subject, however, he only cited the BCTF Inservice (Correspondence, 1990, January). Not all teachers will have the benefit of the BCTF Inservice. Perhaps the National Centre for Health Education's concerns (1986 in Hayden, 1990) on the credentialing of health educators should be considered with respect to the question of who will teach it:

> there are specific skills and knowledge needed by individuals to plan, implement and evaluate health education programs, and that a credentialing system will distinguish between individuals and programs of study that meet or do not meet specific standards (p. 41).

If **Learning for Living** is to be implemented as a comprehensive program, incorporating all the components and utilizing a multidisciplinary approach, then a certain standard should be expected for the province. As Ungerleider (1992) warns,

> teachers, by virtue of their preparation and responsibilities, should play a central, collective role in curriculum interpretation [however, it is] inappropriate for each individual teacher to freely interpret the 'curriculum

> intentions'; in so doing, we will lose curricular coherence and end up with significantly greater inequalities in the outcomes students achieve than those we now have (p. 8).

From **Learning for Living's** origin, through its struggle for emergence, and promotion by its coalitions it may now have come to a level where it can "attract support and legitimation" (Reid 1984 in Goodson, 1987, p. 192). It is encouraging to note that there is currently a Steering Committee at the University of British Columbia overseeing the development of a Diploma Program in Health Education (Correspondence, BCTF Learning for Living Coordinator, 1994, June 20). This may signify Goodson's (1988) culminating phase in the establishment of a subject. Both the Universities of Victoria and British Columbia have updated their undergraduate Health courses to reflect **Learning for Living**. The University of Victoria's Department of Psychological Foundations requests that it be integrated in such courses as Child Psychology, Learning Difficulties, and Adolescent Psychology, which uses the Learning for Living Primary - Graduation Curriculum Guide as a required text (Personal Communication, Director, 1993, January 21).

Policy Guidelines.

As noted, when the **Learning for Living** Program (1990) was released other reforms were taking place within the Ministry of Education related to the new Primary, Intermediate and Graduation Programs. The development of 'Curriculum/Assessment Framework' documents began as "an attempt to standardize the curriculum

documents... to make [them] manageable... [and] to take it to larger ideas" (former Framework Committee Member, 1992). These Frameworks represented process models rather than prescriptive documents like the Learning for Living Primary-Graduation Curriculum Guide (1990) with its approximately 1130 student learning outcomes from K-12. The Primary through Graduation Curriculum/Assessment Framework Humanities Strand Learning for Living (1992) cites the four structural themes of **Learning for Living** under Curriculum Intentions, with 'Implications for Planning' and 'Implications for Observing'. This begs the earlier question, 'Will some of the content area knowledge and associated learning outcomes be lost?'. The comprehensiveness of scope and sequence may be jeopardized. Individual teachers may feel they are left to interpret the Framework freely, without using to their advantage the comprehensive scope and sequence supplied in the original guide. In reflecting on classroom practices a former Working Committee member (1992) warns,

> the risk is that we're going to do bursts of things... If [children] haven't had a lot of practice as they grow up... you can't approach them at 15 and say, 'now we're going to learn how to communicate, because they've already got communication skills and attitudes about them.

However, it was hoped that the new Framework would allow a more 'generic' way in for the more cautious teachers, "their comfort level growing so they take on more controversial levels" (former Framework Committee Member, 1992), and then they will have the **Learning for Living** Program to refer to.

This Ministry of Education can't seem to win, either they're told they're too prescriptive or too vague. Responses to the draft Framework focused on the need for a "model with examples of format and organization" (Personal Communication, Assistant Director Cross Curricular Research, 1992, November 13) which lend themselves to implications for planning and assessment. As with the original guide, it appears that there was still a need for greater clarity and understanding about how **Learning for Living** could be fit into everyday practice.

It is obvious that a clear and consistent message about a standard innovation profile for a **Learning for Living** Program has not yet been established. The rules, in fact, continue to change as rapidly as our politicians. This does not seem to be an 'educationally sound' basis for conducting business. The Ministry of Education has currently released two documents that are intended to provide greater clarity around the expectations of the new Programs: The Intermediate Program Policy (December 1993) and The Graduation Program Policy (December 1993). However, in the case of **Learning for Living** the 'operating rules' still appear to be unclear. To reference the Intermediate document, in particular, the chart of 'Curriculum Requirements with Recommended Time Allotments' (p. 6) recommends 5% for **Learning for Living.** (Also note: this now comes under a new area called Personal Planning.) However, this time allotment appears to be contradicted in the text under Personal Planning (p. 8):

> This component consists of two key elements: advising students and developing Student Learning Plans. It also incorporates the Learning for Living curriculum and career exploration.

The focus appears to be moving away from **Learning for Living.** In particular, there seems to be a pulling back from the content areas or health issues, but also from the themes of social responsibility and relationships even though these are embedded in the goals of the new Programs. This document was, again, a missed opportunity to point out how a comprehensive approach in **Learning for Living** would facilitate the role that the education system must play, "a supportive role in terms of the rest of the community and the home" (Director, School Programs Branch, 1994).

The Alberta Teachers' Association Committee on School Health Services (1988) points out that "to promote a school health curriculum without the support of adequate school health programs seems incongruous" (p. 9). Thus, while the School Programs Branch endeavours to make the operating rules around **Learning for Living** clearer, neglecting to mention the comprehensive school health framework in a policy document does not entirely lend itself to playing that supportive role with other partners. This can only contribute to the continued resistance and obstacles faced within districts.

Meanwhile, it should be noted that staff within various departments of the Ministry of Education and across Ministries are undertaking joint meetings to "communicate and make sure everyone's on the same wave length, [and] at the senior level

what has been on the table for six or seven months now is the comprehensive sort of community health concept" (Director, School Programs Branch, 1994). In the final analysis, the role of the school within that larger picture may or may not be addressed for some time to come.

Those school districts which are experiencing success with a comprehensive approach can boast that "more networks existed between the different service agencies and community [and] there is a growing positive relationship between those agencies and the School Board and Parent Advisory Councils" (Director, School Programs Branch, 1994). In the 1993-94 school year the Ministry of Education hired three Regional Coordinators who were able to facilitate further networking activities related to **Learning for Living**. In particular, funding enables the coordinator to bring people together and the positive work that is happening can be partially attributed to the fact that the Ministry of Education has "been able to network these people" (Director, School Programs Branch, 1994).

In a complex system, such as a school district, the degree of communication and collaboration which can be generated around the innovation appears to be directly related to the degree of clarity obtained and subsequent fidelity to the innovation. As the process of networking builds in those schools and districts where grant funding has been provided, there is a greater chance that more staff will become trained and provide ongoing support

for the innovation. However, it must be stressed again that one of the factors in the "institutionalization of innovations [is] whether or not the change gets embedded or built into the structure (through policy, budget, timetable, etc.)" (Huberman & Miles 1984 in Fullan, 1991, p. 89). More work needs to be done to foster the institutionalization of this comprehensive innovation. There is a growing body of research on comprehensive school health, multidisciplinary approaches, and there are now models in practice. Perhaps it is time this information was passed along. This will surely come when the political will is there to make a commitment to supporting and promoting comprehensive school health.

Promotion of Comprehensive School Health.

The framework of comprehensive school health carries with it an implicit expectation of multidisciplinary collaboration, as presented here, a concept which was in need of further development and dissemination. There may be many ways to approach this, different locations will develop and apply their own unique frameworks. In the final analysis, however, the characteristic multidisciplinary approach should be one of the constants in the implementation of a comprehensive school health program. The school-based team, presented in this study, provides an example of how collaboration can be generated and coordinated among educators, health professionals and others.

The concept of using a multidisciplinary team approach toward

the implementation of comprehensive school health has been one that DASH has advocated since the initial **Learning for Living** document was produced. No other organization has reached out to the entire province with this mandate. In three consecutive years DASH held an annual conference on comprehensive school health called "Living School Health". This has been the only provincial initiative to present to a wider audience all the components of the **Learning for Living** Program: curriculum, services for students and healthy school environments.

The DASH conference brought together teams of people from school districts representing the education (teaching, counselling, administrative), health, parent and student communities. The registration policy was based on the concept of a multidisciplinary approach. The coordination among these various groups was considered essential in order to plan for the implementation of a comprehensive school health program. The actual response to team registration further illustrates the lack of direction on the comprehensive approach. "In some districts it's been a bit of a struggle actually to have them include a health professional... sometimes there is that resistance to involving agencies outside the education realm" (DASH Conference Coordinator, 1994).

Action Planning Guides were developed for the teams in order to facilitate planning for the implementation of a comprehensive program, incorporating all three components. Another important

function of the conferences was that it provided regional networking sessions in which participants could hear about implementation efforts or concerns from other people within their regions. The DASH conferences not only provided a forum for district-based, multidisciplinary collaboration but, as an association, it models this process through a multidisciplinary internal structure.

Summary.

In order to alleviate some of the concerns about the coordination of a comprehensive school health program a multidisciplinary approach using a school-based team/committee structure should be considered. This model for planning has been slow to develop and has been primarily supported by sectors external to the education system. Broad based social support, comprehensive policy guidelines, and further development of inter-sectoral structures are needed in order to promote the institutionalization of a comprehensive school health/**Learning for Living** Program.

Chapter 6. SUMMARY AND CONCLUSIONS

Summary.

This study underlines the importance of development and dissemination policies and practices of complex innovations to subsequent implementation. Specifically, in a comprehensive program obstacles to multidisciplinary collaboration may be a result of significant failures in policy and practice during the development and dissemination stages. In the case of **Learning for Living**, one of the primary failures was the very low observability of a comprehensive approach. The vision of comprehensive school health was left at an abstract level, what it meant in practice was unarticulated. If this approach was considered the best means of promoting and reinforcing the health behaviours of youth (as cited under The Innovation) then the policy makers had an obligation to see that this was carried out. The lack of observability was compounded by a lack of direction and sustained political and administrative support. Further, there was too little effort expended on developing a shared understanding among different sectors, and correspondingly, too little time to consider and try out ideas before acting on them.

Goodlad (in Basch and Sliepcevich, 1983) remarks that "often innovations which are thought to have failed really have not; they really were never implemented" (p. 20). Part of the problem for **Learning for Living** was the lack of observability of how the comprehensive program could be implemented. There were no

practical examples provided of what the coordination of the three components might look like in a school or district and the resulting benefits that could be expected. There were no guidelines or models provided on multidisciplinary collaboration. As the example of the school-based team points out, concerns for students, staff and the general environment of the school were more readily identified and addressed through a coordinated, multidisciplinary approach. Rogers and Shoemaker (1971 in Basch and Sliepcevich, 1983) also identified observability as an important factor in the success of an innovation, noting that if participants "can observe an innovation being used they will be more aware of what is actually involved in the implementation process" (p. 21). However, the results of this study point to the importance of creating and sustaining policies and practices that support the intentions of the innovation and, thereby, provide a better climate in which shared understandings can be nurtured over time.

The lack of political and administrative support through policy and practice can be seen to have been detrimental to the implementation of this complex innovation. Policy makers were remiss in failing to articulate a more concrete model of how school districts could apply the comprehensive approach. Other sectors were working towards this through the initiation of projects which could be used in schools, for instance the Healthy Schools initiative through the Ministry of Health. While

guidelines and models were necessary for multidisciplinary collaboration, the roots for changes to district structures, routines and relationships rest in changes at the Ministry level. Through working with other sectors, trying out and modelling multidisciplinary collaboration, the Ministries might have facilitated the development of a structure that would support their constituents to operate in a similar fashion. There didn't seem to be any promotion on the part of the policy makers of what a coordinated, multidisciplinary approach was to ensure the delivery of a comprehensive program. Messages were inconsistent, what it meant in practice was undefined, and the operating rules were never spelled out. Whether responsibilities and policies should be changed or how were not clearly articulated at the Ministry, district and/or school levels. It was the responsibility of the policy makers to ensure that these issues were properly addressed and to present a common vision. While Ministry staff at the lower levels did attempt to support the concept (as noted under Conflicting Roles) these people had to do a lot of selling. Lack of observability was directly related to a lack of clarity around the innovation during development because of the lack of political and administrative support in the articulation of a clear vision. Subsequently, dissemination efforts would suffer from both the lack of observability and support.

This study points out that insufficient attention was given

to the needs of training and assisting district staff. Time for school personnel to respond to the draft program was short, the innovation was unclear, and there was a lack of support. Groups could not even begin to get together to discuss what it meant in practice. This is of concern in complex innovations when a process of changing structures and relationships are required. This takes time and the development of a shared understanding. There was too little consultation with persons and agencies outside of the educational system, such as health professionals and parents, not incorporating them into development and dissemination practices in effective and practical ways. For instance, during the days of the Learning for Living Implementation Advisory Committee groups were willing to offer service as opposed to just advice. There could have been a direct link established in collaboration with school districts that might have needed those services. Such a process might have better facilitated learning together, a sharing of important information from other sectors, and allowed for a more reflective and constructive process to emerge. As a consequence of the lack of policy and planning around this multidisciplinary collaboration, later implementation efforts were also lacking in this regard. We either do not see different sectors collaborating at the district level or there were difficulties in trying to do so. As previously cited (under District Collaboration), some of the professionals within a district did

not even know of each other and yet combining their efforts could have generated that coordinated, comprehensive approach.

While **Learning for Living** has received much local and institutional support over the past few years, it will require a combination of broad based political and social support through intersectoral and multidisciplinary collaboration to ensure the establishment of comprehensive school health. Through this approach the principles of the new Programs (as discussed under Policy Guidelines) might in part be achieved. For instance, the Graduation Program Policy Document (1993, December) recognizes that "people learn on their own as individuals, but they also learn and develop knowledge as members of a group or team" (p. 13). Many of the activities within the comprehensive school health model are dependent on a group or team approach based on multidisciplinary collaboration. The policy makers missed an opportunity to provide a concrete example of how this principle could operate.

Building Bridges.

A Ministry of Education may not be able to mandate other sectors to become involved in a comprehensive process. However, in this case other sectors did attempt to participate with the educational system in a collaborative manner, as in the **Healthy Schools** Projects. Bridges can be built that will close the gaps, reduce overlap and duplication, and provide a coherent and coordinated approach for all participants, and ultimately reduce

costs. The Director of the School Programs Branch (1994) has stated that it would not be acceptable "if a school had a healthy school type of project but they were not dealing with... the mandated components of the curriculum". Perhaps joint initiatives and pooled funding can provide a more comprehensive approach which achieves various sectors' objectives, as previously noted (Belzer, 1987). The Council of Chief State School Officers (1991) explains that a comprehensive school health program may mean expanding programs or services that already exist but it also means "integrating separate pieces into a coordinated whole" (p. 11).

This study has shown that it takes more time and more discussion for a complex innovation to be understood at all levels and also for the structures to be built that can support it. As Martin (1960 in Goodlad, 1964) reminds us,

> no dramatic crash program will feed the illusion that violent threshing-about means improvement. At best, whatever comes... will be a slow and steady ordering... It is too early to talk of ceilings, for the present we shall be satisfied to put a solid floor under the feet of those ready, with a little encouragement, to stand against fashion and special pleading (p. 49).

In order to effectively apply the multidisciplinary team theory in practice, the interests of external and often competing groups will need to be viewed with less guardedness and suspicion. Each group or sector that has a legitimate interest in the health and/or education of children should ideally have an opportunity to participate in a comprehensive program. Certainly, each

school district/community should have the right to approach comprehensive school health/**Learning for Living** depending on the needs of that community. However, encouragement through policy and governance structures can foster and support the multidisciplinary approach necessary for the implementation of a complex innovation such as a comprehensive program. When the political will from various sectors is harnessed in a collaborative effort, in order to proceed with joint initiatives, districts and communities will be in a better position to develop local policies that will support collaborative planning and coordinated action.

This study has cited the importance of collaborative planning throughout the development - implementation continuum of a complex innovation. McLaughlin and Marsh (1978) cite this as the only strategy that can "generate the broad-based institutional support necessary to [achieve] effective implementation and the continuation of successful practices" (p. 74). As this study has indicated, dissemination activities supported by the Ministry of Education did not promote multidisciplinary collaboration or a team approach. Such a process has been slow to develop. A shift was needed in the usual dynamics of the culture of schools and the educational system in general. The challenge for various Ministries and their respective community Boards will be to overcome this obstacle and build partnerships for promoting and supporting the necessary changes. As Fullan (1991) states,

"alliances provide greater power, both of ideas and of the ability to act on them... some of the most powerful strategies involve inter-institutional partnerships" (p. 349).

Recommendations.

This study has brought a number of issues to light on how curriculum development and dissemination practices contribute to the subsequent implementation of a complex innovation. The following suggestions are offered for consideration as just some of the strategies that would help to facilitate the implementation of complex innovations.

1. **Use collaborative planning in complex innovations:** Program developers could provide a more practical way to develop and disseminate complex innovations. There needs to be more time to discuss the implications for practice with a wider audience than educators alone, i.e. a multidisciplinary approach. The developer could facilitate and support forums for this purpose. There is a need to put more focus on the philosophical changes implied, discussing the feasibility and challenges for districts, staff and other community representatives.
2. **Build consensus on what the innovation means in practice:** Through discussion with districts during dissemination and early implementation efforts attempt to develop further clarity. Be clear and consistent about the operating rules. Provide guidelines and models that identify structural

changes, roles and responsibilities.

3. **Provide administrative support:** People responsible could survey districts throughout initial dissemination and early implementation in order to provide information to other districts, e.g. multidisciplinary collaboration strategies. Provide concrete, practical information and contacts rather than an abstract model.
4. **Establish partnerships:** Policy makers could define a broad range of potential partners. Actively seek out and develop partnerships that can help to facilitate and support meaningful activities that will be helpful to school districts and communities. Continue to seek more partnership opportunities for greater exposure of the innovation over time.
5. **Model the philosophy being promoted:** Policy makers at the Ministry level could establish intersectoral committees that collaboratively discuss and work together jointly on initiatives in a coordinated manner, possibly using a pooled funding system. Maintain support to facilitate this process at the local level. Accountability can be a shared responsibility.

These recommendations answer a central question in curriculum development and dissemination, 'How should we work together and treat one another in the case of complex innovations?' Any program based on the rationale of a comprehensive approach needs

to be based on working together in a collaborative, multidisciplinary and coordinated manner. Without this process gaps will inevitably appear in the continuum from policy injunction to what schools actually do. This leaves complex innovations in jeopardy of never really being tried and tested. Perhaps some of these steps can contribute to more rapid and widespread success in the implementation of complex innovations.

Conclusions.

In spite of the rhetoric devoted to the need for multidisciplinary collaboration in the implementation of **Learning for Living,** this study has shown that neither policies nor practices supportive of multidisciplinary collaboration were in evidence during the program's development and dissemination. This study should provide an understanding of the obstacles to the development of such policies and practices in order to reduce the likelihood of their preventing the multidisciplinary collaboration that other complex innovations require.

When the collaborative process is successful much of the affective objectives of **Learning for Living,** such as social awareness and responsibility, will have been modelled by the participants during implementation. This modelling, in itself, may go a long way toward promoting student achievement toward these objectives. The implementation of a comprehensive school health program may be an effective way to pass on this value in schools.

Comprehensive school health is still in need of being seen as a "framework for cooperative action by [health and social service] agencies, schools, parents, governments, community leaders and young people" (Nicholson, 1993). Not many will argue the merits of health education or that accessibility to information, services and a healthy school environment should not be a universal right. However, to echo Hislop (1986) "we must act if we truly believe that the priority given to health in schools is a critical factor in the development of a healthy society" (p. 6). More important, however, is the recognition that we rarely act alone. The job of implementing a complex innovation, such as comprehensive school health, is just too big. It requires leadership, teamwork, collaboration and coordination at all levels. Only in so doing will the professional and political doors be opened and the human and social development of children will, perhaps, be addressed in schools.

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APPENDIX A

Technical Steps in Curriculum Development

The Working Committee.

The Working Committee's task was to produce an 'educationally sound' **Health/Guidance** curriculum document. The technical steps involve: the adoption of a Statement of Intent, based on the philosophy and goals of education, a Rationale for the program, Program Structure (including principles, themes, and content), Program Goals, and a detailed Scope and Sequence identifying Objectives and Specific Learning Outcomes for each objective. A call for Working Committee members was sent through superintendents for the secondment of educators to work on the Health/Guidance curriculum revision. Although people were chosen for their knowledge in a content area, consideration was also given to provincial representation, gender equity (in the case of social issues trying to get more men involved), and a balance was sought between abstract and sequential thinkers (former Learning for Living Coordinator, 1992).

Rationale.

At the first meeting of the Working Committee the concept and philosophy of comprehensive school health was presented by the Coordinator. There are two elements in the concept of comprehensiveness, one being that it is taught consistently from Kindergarten through high school, using an age appropriate scope

and sequence. This is reported by Pine (1985) who cites two studies verifying the effectiveness of a continuous scope and sequence. In one study conducted by the University of Washington, Seattle (under the auspices of the American Lung Association), in which researchers followed students in two New York schools from 1977, it was found that

> students who had the full health education program - kindergarten through sixth grade - have more positive attitudes toward good health practices (and more negative attitudes toward smoking) than control group students (Pine, 1985, p. 31).

Another study conducted by Abt Associates in Cambridge, Massachusetts, which followed 30,000 students in grades 4 - 7 from 1981 - 1985, found that health education

> works better when there is more of it, and that it works best when it is implemented with broad-scale administrative and pedagogic support... when there is attention to the building of foundations of basic health knowledge, rather than starting with categorical health problems later in the academic career (Pine, 1985, p. 64).

At this time the **Health/Guidance** revision was considering a scope and sequence for Kindergarten through grade 10.

The second concept of comprehensiveness is the broader definition of school health, previously indicated, which identifies the interrelationship of the three components: health curriculum, services for students and healthy school environment. This model of comprehensive school health was being promoted federally through Health and Welfare Canada, provincially through DASH, and the Advisory Committee agreed with this as a basis for the new program. As previously noted, there had been some

reluctance to use this as a foundation element in the document.

Goals and Objectives.

After the foundation stages of the document were established the Working Committee broke into small groups representing the different content areas. They were directed by the Learning for Living Coordinator to brainstorm what the knowledge and skills would be of a graduate of this program. The combined results from the groups revealed some generic skills running through all of the content areas. Five 'themes' emerged from this process: decision-making, individual awareness and responsibility, social awareness and responsibility, relationships and lifelong development. The Coordinator's (1992) remarks about this process highlight, perhaps, a significant difference between the approach of educators and health professionals/agencies, that being process vs. content oriented.

> Initially... we envisioned **Learning for Living** [as] seven content areas... [but we] realized that the content areas were the issues on the surface - symptoms, that what we wanted to get at was the cause... and that brought us to looking at kids, to looking at how do we want to deal with kids in schools [who] are going to learn all of this stuff... then that drove us into themes very quickly (Ibid).

Decision-making was later dropped as a theme when, in future work, it kept coming up as a generic skill under the other four. The learning outcomes place an emphasis on knowledge, skills and attitudes, where content areas and themes are viewed as information and process, respectively.

APPENDIX B

SCHOOL BASED TEAM REFERRAL
_____ ELEMENTARY SCHOOL

Student's Name _____ Grade ____ Div. ____ Age ___

Classroom Teacher _____ Date _____

Does this student receive ESL, LA, SLD, other support? _____

Has the support teacher been consulted re this referral? _____

Please give a brief description of the problem: _____

_____

_____

_____

_____

_____

_____

_____

What would you like to see happen? _____

_____

_____

_____

_____

_____

Referring Teacher: _____ Signature of Referring Tchr. _____

Have the parents been notified of the problem? Yes No

THIS PORTION TO BE FILLED OUT BY SCHOOL BASED TEAM MEMBERS ONLY

Classroom Teacher: _____ L.A. Teacher: _____

Principal: _____ E.S.L. Teacher: _____

Counsellor: _____ S.L.D. Teacher: _____

Vice-Principal: _____ Psychometrician: _____

Speech Therapist: _____ Referring Teacher: _____

Meeting Date: _____ Time: _____ Place: _____

Minutes of School Based Team: _____

Recommendations: _____

Case Co-ordinator: _____

Review Date: _____

FIGURE CAPTIONS

Figure 1. **Comprehensive School Health.**

This figure represents an interrelationship among the three components of a comprehensive school health program.

Figure 2. **Coordination of Comprehensive School Health.**

This figure identifies that one of the implications of a comprehensive school health program is that it requires coordination through social support, i.e. multidisciplinary approach based on sociopolitical climate, policies and structures organized to support the comprehensive program.

Figure 1.

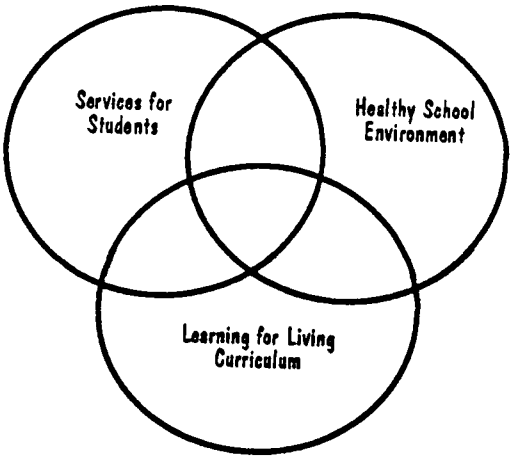

Figure 2.