



ALBERTA COALITION FOR HEALTHY SCHOOL COMMUNITIES (ACHSC)

ACHSC Telephone Survey Results ✦ December 2004

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EXECUTIVE SUMMARY

- ✦ Nineteen (19) people were interviewed from education, health, non-profit and academic sectors.
- ✦ The telephone interviews were designed to enhance network development, to provide a baseline regarding awareness of the ACHSC and comprehensive school health (CSH), verify key goals and objectives in the draft 3 Year Strategic Plan, and inform priority setting.
- ✦ Awareness of the ACHCS network varied among those interviewed: Approximately 1/3 ranked awareness as low, 1/3 medium and 1/3 high.
- ✦ Awareness of CSH was generally high: Over 2/3 of the interviewees ranked their familiarity as high or very high.
- ✦ Interviewees related that they understand CSH to be a) based upon community development principles, b) a multi-faceted approach, and c) a collaboration between home, school, and community.
- ✦ The main barriers to implementing CSH are a) resources, b) leadership and shared vision, c) knowledge and skill, and d) participation by parents.
- ✦ The top issues with respect to the health of school-aged children and youth are: physical activity and obesity, nutrition, mental well-being, social health, family and community supports, poverty, and student engagement.
- ✦ Five priority areas that people would like information from the ACHSC are: best/promising practices, implementation of the CSH approach, what's happening in Alberta schools, resources, and partnership opportunities.
- ✦ Priorities with respect to evidence-based practice in CSH are: implementation, interventions, and student learning.
- ✦ Recommended knowledge exchange strategies are: web-based list serves, conferences and newsletters.

- **T**wo main opportunities described for increasing meaningful involvement in the ACHSC were facilitating involvement in strategies in the ACHSC 3 Year Strategic Plan and attending an annual conference.
- **R**ecommended provincial projects in CSH are: knowledge exchange strategies, healthy school policies/guidelines, clearinghouse of resources, and research and evaluation initiatives.
- **S**uccess of the ACHSC is characterized in terms of its' viability, credibility, and achievements.
- *"What will it take? Funding, leadership, dissemination"*

1. INTRODUCTION

A telephone survey was conducted during the first three weeks of November 2004. It was anticipated that the survey would

- Enhance network development
- Provide some baseline as to current levels of awareness of the Alberta Coalition for Healthy School Communities (ACHSC) and comprehensive school health (CSH)
- Verify key goals and objectives in the draft 3 Year Strategic Plan (2004-07)
- Inform priority setting as to strategies for strengthening the ACHSC network and increasing knowledge exchange about the CSH approach.

ACHSC network members, partners, and stakeholders were targeted and a broad representation was sought from school-based professionals; health and education decision/policy makers; individuals from northern, central, and southern Alberta; academics; and ACHSC members at large. The sample was drawn from existing lists of ACHSC members, past members, current partners, and potential stakeholders.

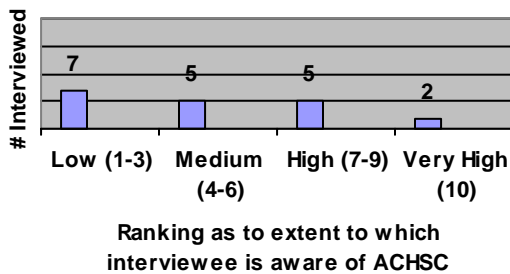
2. DESCRIPTION OF PEOPLE INTERVIEWED

Sector	# Interviewed	# Provincial focus	# North Alberta	# Central Alberta	# South Alberta	Positions
Education (School-based or government)	5		3	1	1	Executive Director, Principal, Resource Manager, Teacher, Superintendent
Health (Regional Health Authority or government)	9		4	1	4	Rural School Health Coordinator, Health Promotion Facilitator, Public Health Nutritionist, School Health Facilitator, Medical Officer of Health, Regional Manager Health Promotion, Health Promotion Coordinator, Executive Director
Nonprofit	2	2				Executive Director, Nutrition Educator
Academics	3		2		1	Professors
TOTAL	19	2	8	3	6	

3. AWARENESS OF THE ACHSC NETWORK

The awareness of the ACHSC network was varied among those interviewed and this was expected. It was hoped that by interviewing a wide variety of people, emergent themes would be that much more pertinent to the needs of the network.

"On a scale from 1 (low) to 10 (very high) to what extent are you aware of the ACHSC network?"

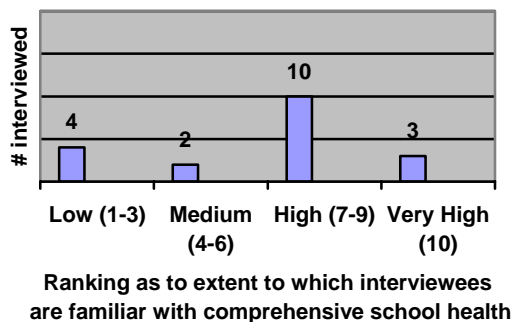


ACHSC activities that people were most aware of included forums/conferences, newsletters, and the website. Other activities that people identified were: the application to Health Canada, Population Health Fund; the position paper to Alberta Learning Commission; Stakeholder meetings; the linkage to Alberta Healthy Living Network (AHLN); and finally the work around creating a Strategic Plan.

4. AWARENESS OF COMPREHENSIVE SCHOOL HEALTH

The extent to which people were familiar with the comprehensive school health (CSH) approach was generally high. Over 2/3 of those interviewed ranked their familiarity as high or very high.

"On a scale from 1 (low) to 10 (very high) to what extent are you familiar with comprehensive school health?"



People were asked to state what they believe makes CSH different from other approaches. The following three themes emerged:

- ✦ **CSH is based upon community development principles**

"Lead by key stakeholders that identify priorities and foster collaboration."

“Uses a broad definition of health, for example, healthy schools can address issues over and above traditional issues like transportation.”

“An approach not one intervention.”

➤ **CSH is a multi-faceted approach**

“Range of activities to promote healthy school communities.”

“Curriculum, health services, and connection with communities.”

“Integration of curriculum and environment.”

“Includes atmosphere and social and physical environments.”

➤ **CSH is collaboration between home, school, and community**

“What impacts health - not only what happens at school but what happens in home, school, and communities.”

“It’s not just the health sector; it’s multi-sectoral and targets community participation.”

“All encompassing as it’s not just the programs but it’s people working together in a strategic direction in a coordinated effort.”

5. BARRIERS TO IMPLEMENTING COMPREHENSIVE SCHOOL HEALTH

5.1 Resources

The most frequently mentioned barrier to implementing CSH (or school health promotion for those interviewees with low awareness) was **resources**. One interviewee summed this up by stating that it all about “energy and money.” Many comments were targeted specifically to “teachers are too busy” and that CSH is just one more thing. Furthermore, by introducing this “add on”, tension will be created as it will be difficult for anyone to commit to anything extra. Several pointed out the new demands facing schools, for example, daily physical activity and mandatory second languages. It was not just teachers’ **time** that was lacking to implement CSH. Public Health Nursing time was mentioned several times, as “they are just not available anymore.” Parents’ time was characterized as being “spread very thin.”

Closely linked to the above discussion was the lack of **funding** in all sectors to implement CSH. Some stated that funding was needed for skilled human resources “to do community development” and this means facilitating and coordinating the intensive planning and maintaining ever changing community partnerships.

Among interviewees in the health sector it was acknowledged that it is a “tough health promotion climate right now as health promotion in this province has taken a back seat – where are the health promotion resources – where are the people?” Another stated, “What is happening in other countries and provinces [with respect to CSH] makes us look like we’re standing still.”

5.2 Leadership and shared vision

The second most frequently discussed barrier to implementing CSH was the lack of leadership and shared vision. The key themes are as follows:

➤ There is no strong direction from a **provincial** perspective. People called for a systematic provincial focus backed by the ministries of health and education. “We need a big and credible picture.” For example, one person discussed the issue of vending machines in schools as not being a

top issue and schools were reluctant to address this issue without the support of government policy.

➤ “Whose agenda is it anyway?” There is a natural resistance to change in schools (and in health systems) therefore “everyone has to buy in and be on the same page.” Parents, teachers, health, and government often have different **agendas**.

➤ There are an increasing number of competing priorities in education and “what’s valued is what’s tested.” There is a lack of **priority** for health education (e.g., measurement in education is aligned with math, language, social studies, and science) and therefore there is “no accountability for how healthy your school is.”

➤ Further to this, several people talked not just about teachers’ time but their **attitude** toward CSH as “just one more thing” and that it is “not a teacher’s job.” Health continued to be perceived as health services.

5.3 Knowledge and skill

The third most frequent barrier described was the lack of awareness and understanding of the CSH approach. One person stated that “we need a common understanding of what CSH is about” and this will require education strategies for staff and administration in both health and education. Others spoke about the lack of suitable **frameworks** that can be tailored to a local community or school district. And finally, another interviewee discussed what they considered to be the “extreme disconnect between what is going on in health promotion in schools and what we know in **evidence-based** decision making.”

It is worth noting that there were several comments regarding the need for special attention to be paid to learning how to **integrate** CSH into “what we are currently doing.” It was the sense that there is no starting from scratch and that practitioners must look closely and find “areas of overlap in the many competing agendas.”

5.4 Participation of parents

A final theme area regarding barriers was the lack of ability to reach and engage parents. “It’s a big one for me - parents are talking about immediate issues in their **busy lives** and this translates into no attention to things like healthy eating in the long term.” Many comments were directed to parental involvement and discussion often ventured to the attitudes of society in general that contributes to this barrier.

6. TOP ISSUES WITH RESPECT TO THE HEALTH OF SCHOOL-AGED CHILDREN AND YOUTH OR THE SCHOOL COMMUNITY

The following list is in order of frequency that people identified top concerns as to the health of school-aged children and youth or school communities.

- 1 **Physical activity and obesity**
- 2 **Nutrition**
 - “Junk food in vending machines and the lack of accessible good food”*
 - “Cheaper to buy junk food (time, money, ability to serve needs of kids) – the decision has already been made for a low income single mom”*
 - “Perceptions that it is only the low SES kids that need support – high SES gets lots of junk food too”*
- 3 **Mental well-being**
 - “Self-esteem”*
 - “Relationship/psychological issues*
 - “Dealing with diversity”*
 - Substance abuse, alcohol and tobacco use*
- 4 **Social health**
 - “Schools should model healthy choices – healthy choices should permeate all decisions”*
 - “Support from teachers in role modeling health”*
 - “There are stresses all over the system – we’re at a melting point – ready to burst”*
 - “Schools are workplaces too”*
- 5 **Family and community supports**
 - “Families are not involved with kids and kids are not connected to the community”*
 - “ [need more] opportunities [in the community] to become involved in healthy living activities”*
- 6 **Poverty issues**
- 7 **Student engagement**
 - “Lack of student involvement in decision-making”*

7. PRIORITY AREAS FOR INFORMATION FROM THE ACHSC

7.1 Best/promising practices in school health promotion

Interviewees overwhelmingly stated that information on the latest **research as to what is effective** in school health promotion should be the top priority for ACHSC.

“Dissemination of research and connect to student learning”
“Evidence that specific school policies can be effective e.g., mandatory physical activity, banning smoking, doing away with vending machines, etc.”

One person noted that putting money into ineffective practices is doing harm because of lost opportunity costs. Another stated that “one best practice can’t serve all schools - schools are so different” and therefore best/promising practices needs to be approached cautiously and are necessarily context specific.

7.2 Implementation of the comprehensive school health approach

A second area that was mentioned frequently by interviewees was the need for information as to how to **implement effective interventions**. There were many ways that people articulated this priority:

“Support for” and a “model for implementation of CSH”
“Effective ways to address issues”
“How to work with schools ... working multi-sectorally”
“Motivating school communities”
“Integrate into the work that schools do”
“How to get parents involved”

7.3 What’s happening in Alberta

There was considerable interest in obtaining information about “**success stories** in schools” in the province. People want to know **what schools are doing**, how they can adapt successful practice and whom they can get in touch with. Many suggested that regular updates on what is happening in local initiatives are needed. One person suggested that they wanted “surveillance reports on the health of [Alberta] school aged children and youth”

7.4 Resources

Many people spoke about the need for “resources that **schools can use**.” Examples that were given included lists of speakers or groups that come into the school, parenting workshops, resource kits for immediate use in the classroom, one page health topics that can be included in school newsletters, and finally lists of potential funders.

7.5 Partnership opportunities

A final theme with respect to information people would like to obtain from the ACHSC was partnership opportunities. Some talked about using the strategic plan to engage people in partnership discussions. Others indicated that ACHSC could facilitate the development of school health research questions and the placement of university students.

8. PRIORITIES REGARDING EVIDENCE-BASED PRACTICE IN COMPREHENSIVE SCHOOL HEALTH

8.1 Implementation

As indicated above, a chorus of people identified questions with respect to **effective models or ways to do CSH**. The following are examples of this:

“Is there one piece in the CSH puzzle that is particularly important or is the whole greater than the sum of the parts? For example, some people talk about curriculum and others talk more about environmental influences.”

“Have to have the full meal deal to be impactful, effective?”

“How are pieces fitting together that all contribute to CSH?”

“Current implementation of CSH and how effective it is?”

“What do we want to know – what are the benchmarks in physical education and health for a good program?”

8.2 Interventions

Some people wanted fundamental information as to “how do you change behaviors.” There was a call among interviewees for clear information as to “what has been done that has been shown to work” and “what is the best bang for resources.” The following statements expand on this plea:

“What works, for example, programs like DARE and PARTY - which work and which don't.”

“Tell me what works with respect to obesity prevention and I'll run with it.”

“What is effective practice in bullying.”

“Is there a difference in educational outcomes at the school level between implementing something like reducing class size vs. implementing a multi-strategy health promotion program?”

“Does having a school health policy impact student health? For example, does it make a difference in daily physical activity?”

8.3 Student learning

Several interviewees put forward questions about student learning. For example:

“What influence does health education, information have on kids when it comes to changing behavior?”

“What are effective models for self assessment of performance for teachers in health education?”

“What evidence are we going to use re: enhanced child health? student learning?”

“What are kids learning about health in the broad definition of terms? On paper they have committees, etc but ... when the rubber hits the road [what are they learning].”

9. RECOMMENDED KNOWLEDGE EXCHANGE STRATEGIES

Web-based strategies for the dissemination of evidence-based practice in CSH was most frequently recommended and the vehicle suggested most often was through a list serve. This was followed closely by conferences and workshops for professional development. A newsletter was also mentioned however not to the degree the above were discussed.

One thing that came across loud and clear was that “people are overwhelmed with the amount of printed word” and **to use existing channels and networks** as “I cannot look at another thing.” This flows well into another recommendation that any dissemination strategies would very much depend upon the target audience. People suggested existing channels or networks to target strategies and they are as follows

- Alberta Healthy Living Network (AHLN) newsletter and list serve
- ATA monthly magazine (“write the articles”)
- ATA Administrators group
- Teachers Conventions
- Provincial Nutritionists network
- Regional Consortia
- Identify key contacts in the organizations and ask them to provide a brokering function.
“Engage people who are interested in the issues in the outset of implementation – people who are dying to know.”

People provided specifics about how ACHSC could communicate effectively with them personally:

“Educators like a hard copy, for example, 3 pages of highlights at a time”

“Mail me a hard copy and then email me to say you did and have a link to a website where I can get it the original electronically”

“Email me summaries of evidence-based practice”

10. OPPORTUNITIES FOR MEANINGFUL INVOLVEMENT IN THE ACHSC

➤ *“Membership should bring with it meaningful connection to people in the province.”*

10.1 Strategic plan

Several people recommended that the ACHSC widely disseminate the strategic plan document and include “**actionable items**” where “people could see themselves.” The plan should clearly indicate how the ACHSC is moving toward the vision of CSH in every school in Alberta. It should demonstrate **how people could become involved**. It was noted that people “have to get something back that’s worthwhile – the benefits that you think you’ll get is the criteria for getting involved.”

One very pragmatic suggestion for the ACHSC to increase involvement was as follows: “To become a truly province wide coalition – develop specific projects – form task groups -- involve people in the tasks – provide facilitation from the coalition.” Several people suggested that the coalition “join forces with other initiatives”, for example, “partner with Lions Quest and Safe & Caring Schools and make the links explicit.”

10.2 Annual conference

An annual conference was seen as an important opportunity for people to become involved in the coalition. A conference has the ability to increase energy, renew enthusiasm and interest in order to move CSH forward in the province. When people were asked what the most important ‘take away’ would be from conference attendance, four themes emerged.

➤ **Increase knowledge about CSH**

The first and foremost conference ‘take away’ that interviewees reported was increased knowledge about CSH. People want some theory and philosophy, however, the real interest is in **learning “better ways of doing things and incorporate what we’re doing already” in a CSH approach**. Further to this, people thought a conference might be able to gain consensus about “common purpose”, “common elements”, and “common language” around CSH.

“Presentations from schools that have actually been using this approach for a number of years and what is their evidence for success.”

“Demonstration schools ... finding schools that are outstanding in CSH and making the connections with schools doing it effectively.”

➤ **Foster network development**

The second area that emerged was the development of key contacts, networks, and potential research partnerships. Developing a strong network of people involved in school health promotion and establishing linkages among initiatives was a common ‘take away’ that people would deem critical to conference attendance.

“The people I meet at the conference – who do I meet and want to work with.”

“New network of people engaged in evidence-based practice – action research, engaged in inquiry”

➤ **Specific answers to tough questions**

There were many specific questions posed that people would like answered at the conference. The following are examples:

“What does it take to enable kids to make healthy choices? How to remove barriers?”

“How to link Daily Physical Activity and CSH?”

“How people effectively address issues facing small rural/remote communities?”

“How to get parental involvement?”

“How to ensure students voices are heard?”

“What is the research on large-scale change interventions in school systems?”

➤ **Next steps**

A frequent ‘take away’ discussed by interviewees was how they could immediately support CSH and get involved – “OK now what can I do, who to do it to, regardless of where I am working (rural/urban setting).” If the conference could provide “action plans” and set out examples of “how to do” it would be deemed a successful conference.

11. RECOMMENDED PROVINCIAL PROJECTS IN COMPREHENSIVE SCHOOL HEALTH

11.1 Knowledge exchange

The most frequently mentioned province-wide project was a mechanism for knowledge exchange. This is undoubtedly a familiar theme and suggestions ranged from an annual conference to a clearinghouse to “share great projects -- what’s working.” This was seen as enabling people to move

toward CSH approaches and help integrate the “many people entering the school wanting to do good work.” One suggestion that is worth consideration is to build upon programs, such as a Shell-sponsored summer institute for junior high science teachers, and plan a summer school for school health promotion.

11.2 Healthy school policies

It was unanimous that the ACHSC should be a central knowledge broker for best practice in healthy school policies as there is duplication of effort in the province. However, one interviewee stated, “education is highly regulated – not supportive of policies however guidelines would be welcome.” It was acknowledged that school communities like to develop and tailor policy to fit their unique circumstances however there are few channels for sharing what’s working and what is not.

“How did you get that change to happen in your school?”

“How individual schools develop, implement and evaluate policies and anticipate potential negative fall out, e.g., respond to parents response re: limiting food choices in schools?”

Further to this, people wanted clarity as to “ACHSC roles vs. Alberta Health and Education roles with respect to who should be providing supports in policy development.” Effective/best practices in policies in a number of areas were identified, e.g., daily physical activity, bullying, and school uniforms.

11.3 Resources

Mechanisms to share resources were voiced by many interviewees as an important provincial project. Suggestions were as follows:

- A provincial clearinghouse of resources
- A traveling medical van to go to schools in rural Alberta and assess individual health (e.g., BMI, BP, cholesterol, nutrition, etc).
- Traveling resources to implement school-based Health Fairs

11.4 Research and evaluation

Several people saw that the ACHSC could play a role in school health promotion research and evaluation. There is no single organization tracking what’s happening in school health promotion projects and particularly research projects. Several specific examples were given with respect to research and evaluation: a) the need for demonstration schools, that is, “put any money into a few schools, target interventions, evaluate them and then disseminate”, b) the need for longitudinal studies of 8-9 years and happen at the level of instruction, for example, “how teaching practice influences students positively in terms of fully agreed upon health goals.”

12. WHAT SUCCESS LOOKS LIKE

➤ **The ACHSC is Viable**

The ACHSC is fully funded, with guaranteed funding from province sponsors. There is at least one staff person and a functioning office. There is a Librarian or network developer who keeps track of all the initiatives, projects, and resources and puts it on the website for all to access. The ACHSC has the resources to carry out the strategies articulated in the 3 Year Strategic Plan.

➤ **The ACHSC is Credible**

There are high-level decision makers on the Executive Committee of ACHSC from government departments such as Alberta Learning and Health. Key stakeholders work on coalition initiatives and this leads to credibility – to the necessary backing. There is broad-based membership and includes school-based professionals, students, parents, and health professionals. There is a provincial network of school health liaisons or coordinators that meet regularly and discuss and share what’s working and what’s not. The ACHSC is invited to participate annually at every Teacher’s Convention.

ACHSC is a household name in schools because it offers value and people are clear on what they offer. The ACHSC is successful because the strong school partnerships facilitate conversations about CSH with front line teachers. Key people in the ACHSC are involved in 30-40 demonstration schools where we can see with absolute certainty we are successful. All stakeholders are aware of ACHSC, for example, Regional Health Authority health promotion staff, school administrators, School Councils, and Health and Physical Education teachers go to the ACHSC when they are looking for ways to improve their school.

➤ **The ACHSC is known for its’ Achievements**

The ACHSC paints the big picture and advocates for health in schools. The coalition has a compelling message and a catchy slogan that just can’t lose. Everyone buys in as evidenced that CSH is happening in every school -- CSH is the norm in every school in Alberta. There is a common understanding of what good school health promotion looks like.

Strategies are concrete, actionable, and immediately useful for schools. For example, there is a hot line that people could call and get immediate answers. The hot line would further the goal of being the *go to* agency for anything related to CSH. The coalition advocates for provincial policies and ensures that policy frameworks are readily available. The ACHSC operates a clearinghouse of clearly endorsed programs and resources that are accessible to support people implementing CSH. People depend on the ACHSC for information and support. The ACHSC hosts a high quality annual conference on school health promotion and maintains a highly useful website. Through these strategies the ACHSC harnesses the power of research and documents changes in health and education overtime in Alberta.

“Oh yes, I use your resources, attend the conferences, and generally look to you for solutions in this field.”