An evaluation of the effect of a health promoting school approach, *The Healthy Schools Programme*, on the psychological health and well-being of primary school-aged children

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GLOSSARY OF TERMS

AHPSA	Australian Health Promoting School Association
ANCOVA	Analysis of Covariance
ANOVA	Analysis of Variance
BMI	Body Mass Index
CDI	Childhood Development Initiative
CDI-S	Children's Depression Inventory-Short version
CFIR	Consolidated Framework for Implementation Research
CSHE	Comprehensive School Health Education
DEIS	Delivering Equality of Opportunity in Schools
DH & DfES	Irish Department of Health & Department for Education & Skills
ENHPS	European Network of Health Promotion Schools
GUI	Growing Up in Ireland
HP	Health Promotion
HPS	Health Promoting School
HRBQ	Health Related Behaviour Questionnaire
HRQoL	Health Related Quality of Life
HS	Healthy Schools
HBSC	Health Behaviour in School-aged Children
HSC	Healthy Schools Coordinator
HSCLC	Home School Community Liaison Coordinator
HSE	Health Service Executive (Ireland)
HSP	Healthy Schools Programme
ICP	Irish College of Psychiatrists
INHPS	Irish Network of Health Promoting Schools
IS	Implementation Science
IUHPE	International Union for Health Promotion and Education
M	Mean
MOU	Memorandum of Understanding
NHSP	National Healthy Schools Programme (UK)
Ofsted	Office for Standards in Education, Children's Services & Skills (UK)

ONSMHCYP	Office for National Statistics Mental Health in Children and Young People (UK)
PATHS	Providing Alternative Thinking Strategies curriculum
PHN	Public Health Nurse
RATS	Relevancy, Appropriateness of qualitative method, Transparency of procedures, Soundness
RCT	Randomised Control Trial
SATS	Standard Assessment Tests
SC	Steering Committee
SD	Standard Deviation
SES	Socio-Economic Status
SHEN	Schools for Health Europe Network (formally ENHPS)
SNA	Special Needs Assistant
SPHE	Social, Personal and Health Education curriculum
WHO	World Health Organisation

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ABSTRACT

An evaluation of the effect of a health promoting schools approach, *The Healthy Schools Programme*, on the psychological health and well-being of primary school children

Background: A 'health promoting school' approach has become an increasingly popular framework internationally within which to address the health needs of school communities. A growing evidence base indicates that, if applied successfully, a health promoting school approach can lead to improvements in both health and educational outcomes (including children's psychological health and well-being). The *Healthy Schools Programme* (HSP) is an initiative developed through partnership between a Dublin-based voluntary sector organisation and a number of local urban DEIS band 1 schools, the aim of which is to promote positive health outcomes for children in their primary school years and including the psychological health and well-being of children (in line with health promoting principles). To date, few studies have comprehensively examined how such initiatives address the psychological health needs of children.

Objectives: The overarching aim of this study was to examine how, and to what extent, the *Healthy Schools Programme* addressed the psychological health and well-being needs of a sample of primary school-aged children. The study assessed the impact of the initiative on children's health outcomes including a focus on how the programme helped the schools to address psychological health. A secondary aim of the study was to explore the impact the implementation strategy on the overall effectiveness of the HSP.

Method: A concurrent mixed methods design was used to address the study objectives. The study comprised two parallel phases: (1) a comparative impact evaluation of the HSP on children's psychological health (aged 7-12 years) and; (2) a process evaluation of programme planning and implementation. Data were collected over a 24-month period using a number of methods including: (a) follow-up self-report health questionnaires with children ($n = 434$); and (b) one-to-one interviews and focus groups with key stakeholders (n=48) (i.e. HSP funders, Healthy Schools coordinators, school principals and staff, parents as well as health and educational professionals); and (c) non-

participatory participant observation at steering committee meetings (n=9). The quantitative data were subjected to a series of descriptive and inferential statistical analyses including t-test, chi square, and ANOVA. Qualitative data were analysed thematically using Framework Analysis.

Results: At baseline, children maintained average levels of psychological well-being as well as other aspects of health-related quality of life (e.g. physical well-being, peers and social support, autonomy and parental relations, school environment) relative to national and international studies. At follow-up, comparisons of self-report health measures between children in Intervention (n=5) and Comparison schools (n=2) found some health improvements for the entire sample over time. However, the lack of any substantial differences between Comparison and Intervention school samples suggest that any changes in health cannot be attributed to the HSP. The qualitative findings suggest some positive changes in how schools addressed health as a result of the HSP, although these were not demonstrated in the children's health outcome data at the year 2 follow-up.

The results of the process evaluation highlighted the slow, evolving and often challenging aspects of programme implementation. In particular, psychological health was not addressed by the HSP until the second half of the implementation period, and when prioritised, was identified by most participants as more challenging and complex than other aspects of health (i.e. nutrition and physical activity). A number of fundamental implementation factors were identified as not being sufficiently well developed to facilitate the effective implementation of the HSP in the local context. These included: a lack of a shared understanding of the HSP amongst all key stakeholders (including the planning group); an absence of appropriately experienced Healthy Schools Coordinators; poorly developed forms of collaboration and joined-up working; and the lack of a properly functioning national health promoting school framework/governmental support. It was evident that more coherent planning and a retrospective process of review (relating in particular to the quality of the HS manual and issues around implementation fidelity) were needed for more effective programme implementation.

Conclusions: This study provided a comprehensive assessment of how a local health promoting school initiative attempted to address the psychological health and well-being of children in an Irish primary school setting. Importantly, the study also examined the *process* of programme implementation as well as the impact of the programme on children's psychological health. The study findings clearly demonstrate the complexity and many challenges involved in developing and implementing a HSP initiative in an Irish context and also in using this approach to tackle the psychological/mental health needs of school children. The identification, in this study, of key enablers of, and barriers to, the implementation of the local health promoting school initiative is important in informing the design, planning and implementation of these kinds of initiatives both in Ireland and elsewhere.

CHAPTER ONE

INTRODUCTION

1.1 Background

According to the World Health Organisation (WHO, 2001), health is not simply the absence of disease but *"a state of complete physical, mental, and social well-being"* (p1). This definition encompasses a holistic conceptualisation of health whereby psychological health is intertwined with, and inter-dependent on, all other aspects of an individual's well-being. More specifically, the WHO defines psychological health as "*a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"* (WHO, 2001, p.1).

Most children report a generally good level of both physical and psychological health. For example, the 2010 follow-up of the Health Behaviour in School-aged Children study – one of the largest child-based studies undertaken in Ireland to date (n=16,060) - found that 70% of children in Ireland aged 8-9 years indicated that they were 'very happy' with their lives whilst approximately half (49%) reported that their health was 'excellent' (Kelly, Gavin, Molcho, & NicGabhainn, 2010). Likewise, according to another large-scale longitudinal study, the Growing Up in Ireland study (GUI, Williams *et al.*, 2009, n=8,570), 85%-90% of children obtained scores within the normal range of behavioural, emotional, and relationship functioning.

However, a number of international studies have shown that an estimated 10%-20% of young people have an identifiable psychological health disorder (EU Pact for Mental Health and Well-being, 2008; Psychiatric morbidity in England, 2007; The Office for National Statistics Mental Health in Children and Young People in Great Britain, 2005). In an Irish context, approximately one quarter of the general population will develop one or more psychological health problems during their lifetime (e.g. Brooks, Hanafin, Cahill, Nic Gabhainn, & Molcho, 2010; HSE, 2007; Irish Royal College of Psychiatrists, 2005). The Irish Health Research Board also reports that 406 children were admitted to Irish psychiatric hospitals in 2008 - an increase from 333 children in 2005 (Health Research Board, 2008). Approximately one third were admitted for

neuroses (34%) whilst around one quarter (26%) were admitted for depressive disorders. These figures are a considerable source of concern to public health policy makers as psychological disorders amongst primary school-aged children have been associated with a number of negative health and social outcomes (e.g. WHO, 2001; 2003).

There is also evidence of an association between academic potential and psychological ill-health (e.g. Currie *et al.*, 2004; Warwick, 2009). For instance, Healy (2004) found in an interview-based study that poor overall health status is associated with reduced learning potential. Similarly, Ravens-Sieberer and colleagues (2004) found a positive association between academic performance and higher levels of self-reported health and life satisfaction whilst a study by Quiroga and colleagues (2013) demonstrated that depressive symptoms negatively correlated with self-reported academic competence. The UK Office for National Statistics Mental Health in Children and Young People in Great Britain (ONSMHCYP, 2005, n=6,236) report also identified that approximately 44% of children aged 5-16 years with emotional difficulties lag behind in terms of their intellectual development compared with approximately one quarter (24%) of children without such disorders (ONSMHCYP, 2005). Interestingly, this study also indicated that school absenteeism was much higher amongst children with anxiety and depression. For instance, one quarter of children with generalised anxiety disorder and 17% with an emotional disorder missed more than 15 days a term compared with 4% of children without a diagnosable disorder (ONSMHCYP, 2005). Whilst the ONSMHCYP report provides valuable information on psychological health from a large sample of children, unfortunately self-reported data were only collected from children aged 11 and older. Nonetheless, the wide-ranging consequences of psychological health difficulties are clear. Indeed, these can also lead in the longer term to an increased risk of poor mental health in adulthood (Geller, 2001; WHO, 2001). Perhaps more worryingly, a 2008 Eurostat report highlighted that up to 90% of suicide cases display some form of prior psychological health difficulty.

1.2 Risk factors: An overview

A number of studies have attempted to identify the factors that contribute to psychological ill health in children (e.g. WHO, 2004; ONSMHCYP, 2005; Rueden *et al*, 2006). Not surprisingly, the WHO (2004) reports that children who have experienced

a major life event, such as a death of a family member or an illness, tend to display lower levels of psychological health. Furthermore, factors related to the social environment, such as social exclusion, complex family structure, inequalities in education and welfare structure, can negatively affect psychological health (UK Child Poverty Action Group, 2009; Health Service Executive, 2011). These factors can impinge on health directly or can create barriers to appropriate prevention and care, thereby increasing the risk of stressors in an individual's life.

The European Kidscreen study (2006) further identified a number of associations between lower socio-economic status (SES) and poor psychological health (e.g. Von Rueden, Gosch, Rajmil, Bissegger, & RavensSieberer, 2006). These findings are supported by other international comparative studies which have found that the prevalence of mental health disorders amongst lower SES populations is two to three times greater than high SES groups (e.g. Patel, Araya, de Lima, Ludermir, & Todd, 1999; Kohn, Dohrenwend, & Mirotznik, 1998). The UK study for the ONSMHCYP (2005) again identified more specific SES-related risk factors to be associated with a higher prevalence of psychological ill health including, in particular, living in a one parent or step-parents, and having parents who are unemployed and/or who have lower levels of educational attainment. In addition, children from ethnic minorities have been found to have higher levels of psychological health difficulties (WHO, 2004). This variation has been explained by such factors as availability of services, financial resources, educational status, and minority group membership, all of which tend to reduce access to appropriate treatment/intervention (WHO, 2001).

In an Irish context, the Health Behaviour in School-age Children study (e.g. Currie *et al.*, 2012) compared the health of children attending DEIS band 1[1] schools and non-DEIS schools. The results showed that girls attending the former were less likely to report being "very happy with their lives at present" (55% vs. 49% of matched non-DEIS schools). In addition, fewer boys in DEIS band 1 schools indicated that their

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[1] DEIS band 1 schools: Delivering Equality of Opportunity in Schools (DEIS) is a standardised system for identifying levels of disadvantage at a school level. DEIS band 1 schools are categorised as schools in need of most resources, both human and financial, based on the degree of disadvantage experienced (Department of Education and Science, 2005).

health was "excellent" (33% vs. 41% of matched DEIS schools). Similarly, children from lower social class groups obtained lower life satisfaction scores (Currie *et al.*, 2004; Currie *et al.,* 2012). Likewise, according to the Growing Up in Ireland study (GUI, Williams *et al*., 2009), children whose mothers fell into the lowest educational group, were nearly three times more likely (20%) to be classified in the 'abnormal' category of emotional symptoms when compared to children whose parents attained a third level qualification (7%). Similar patterns emerged when children were compared by family income; in this instance, 18% of children in the lowest income group displayed 'abnormal' levels of emotional symptoms compared to only 10% of the highest income group (Williams *et al.*, 2009). Another Irish study commissioned by the Department of Health and Children reported that individuals who are entitled to government-funded medical cards (i.e. of a lower SES background) and those who have only completed primary school level education are twice as likely to be diagnosed with generalised anxiety disorder when compared to individuals in the highest income group and who have completed third level education (SLÁN Report; Barry *et al.,* 2007). Collectively, these findings are a source of some concern in view of the dramatic changes in the economic climate in Ireland in recent years (e.g. increased unemployment and emigration) which may further impact children's lives and their psychological health and well-being (Williams *et al.*, 2009).

Clearly therefore, there are many factors both in the wider community and at home that may affect a child's well-being. Links between school environment and psychological health have also been identified. For example, using the HBSC data, Ravens-Sieber, Kokonyei, and Thomas (2004) found an association between being bullied and lower life satisfaction scores, increased health complaints and lower levels of self-reported health. However, as with all studies based solely on quantitative data, there was little exploration of potentially important contextual issues. A recent Parliament and Senate Report on early school leaving in Ireland also noted the impact of trauma on children's educational experience and, in particular, how this can be influenced by the way a school responds to such events (House of the Oireachtas Joint Committee on Education and Skills, 2010). Importantly, this report showed that school responses to trauma were limited by insufficient professional training, a lack of resources, and poor inter-agency collaboration. A school environment that promotes trust, respect and inclusive practice was also considered crucial in supporting young people effectively. A number of papers

also emphasise the importance of individual resiliency in terms of positive health outcomes (e.g. Luthar, Cicchetti, & Becker, 2000; Masten, 2000). For example, Masten (1994) defines resiliency as the relationship between a child's individual characteristics and the environment the child inhabits. Indeed, Wong and colleagues (2009) note, not surprisingly perhaps, that environments which are not emotionally supportive are linked to higher levels of psychological ill-health.

All of these studies illustrate that, whilst causal mechanisms cannot be easily identified, the dynamic environmental circumstances of children's lives clearly influence (positively or negatively) their psychological health. Moreover, the most socially vulnerable in our society seem to be most at risk of psychological ill health. The Irish College of Psychiatrists (ICP, 2005) caution that, even throughout the significant economic growth period in Ireland during the first decade of the 21st century, poverty has always been prevalent and health services have always struggled to meet demand. Furthermore, since the publication of the ICP report in 2005, this has become an even greater challenge as government resources have been depleted and levels of poverty and unemployment have increased. Indeed, a recent UNICEF report (2013) observed a 10 per cent increase in child poverty between 2008 and 2012 and ranked Ireland as 37 out of 41 countries in terms of relative negative changes in child poverty. Similarly, an Irish Central Statistics Office report (2015) estimated that one in eight children in Ireland are experiencing material deprivation on a daily basis - a statistic of some concern considering the well-established relationship between poverty and psychological well-being (e.g. Yoshikawa, Aber, & Beardslee, 2012). Notably, even though mental health disorders account for more than 10% of all diseases, the WHO (2001) maintain that less than 1% of government health budgets, in most countries, is spent on mental health service provision. This is a source of some concern in view of the succession of austerity budgets passed by the EU and Irish governments in recent years. It also underlines the importance of adopting appropriate intervention models that are consistent with evidence-based best practice as well as good value for money. The next section describes one of these models, a health promoting school approach to children's health.

1.3 A Health Promotion Approach

A large body of research literature highlights the benefits of adopting a preventative child-centered approach to addressing health issues that impact positively on both the child and wider society (e.g. Leibson, 2001; Stewart-Brown, 2006). This approach is in line with the guiding principles of the Ottawa Charter for Health Promotion (WHO, 1986) which specifies five main areas of action for the promotion of health including: (1) the building of healthy public policy; (2) the creation of supportive environments; (3) the strengthening of community action; (4) the development of personal skills and; (5) the reorientation of health services (WHO, 1986). This charter recommends a model of social change that encourages the promotion of health of entire populations in their everyday environment rather than exclusively targeting groups of people with health problems. This model, known as the 'settings approach', is characterised by *"an ecological model of health, a systems perspective and a whole system organisation development and change focus"* (Dooris, 2006, p2).

The school environment, in particular, is an ideal setting within which to address the health needs of children. Indeed, the concept of a 'health promoting school' has developed out of this settings approach and has become an increasingly popular framework internationally within which to address the health needs of school communities (e.g. Weare, 2000, Stewart-Browne, 2006). The European Network of Health Promoting Schools - now known as Schools for Health in Europe - emphasises the need for adaptation within the school setting that will lead towards a more health promoting environment. According to the WHO (1993), the health-promoting school aims to achieve *"health lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment" (p3).* Thus, the primary objectives of a health promoting school are to: (1) improve collaboration both across the school community and between the school community and external agencies; (2) adapt the physical and social environment of the school through policy development and management structures; and (3) improve curriculum and school activities to address the health needs of the individual (Denman *et al.*, 2002).

A review of reviews (n=3) undertaken by Weare (2000) and based on hundreds of pro-social programmes that were implemented within this *"eco-holistic"* framework (i.e. Durlak, 1995; Durlak & Wells, 1997; and US Government General Accounting Office, 1995; cited in Weare, 2000, p34), found that holistic approaches to children's health are more effective than curriculum-only based programmes. A second WHO-funded systematic review by Stewart-Browne (2006) found (like Weare) that health promoting school initiatives that support a more holistic approach, led to more positive health outcomes. In particular, the most successful programmes addressed health issues by promoting a bottom-up approach which was inclusive of the entire school community in the planning and implementation stages of the intervention. Holistic programmes which continued over a longer period of time also proved more successful than more time-limited, targeted interventions.

Since the late 1990s, a growing number of studies have shown that, if applied successfully, a health promoting whole school approach to health may lead to *both* improved health and educational outcomes (including children's psychological health and well-being) (e.g. Cushman, 2008; Lee, Cheng, Fung, & St Leger, 2006; Lister-Sharp, Chapman, Stewart–Brown, & Sowden, 1999; Moon *et al.*, 1999; St Leger, 1999; Schagen *et al.,* 2005). Wong and colleagues (2009) also observed that HPS implementation can be effective in improving self-reported resilience by students and teachers. Overall, these studies demonstrate the potential for health improvements by adopting a HPS framework. However, few studies comprehensively examine the impact of HPS on psychological well-being both in terms of health impact as well as implementation. Thus, it is difficult to determine whether any improvements to children's health directly as well as broader school-level improvements are a result of HPS implementation.

1.4 The Current Study

The current study sought to address this gap in our knowledge by investigating to what extent a new health promoting school initiative in Ireland - entitled the *Healthy Schools Programme* (HSP) - was successful in addressing the psychological health and well-being needs of a sample of primary school-aged children attending designated DEIS schools. A secondary aim of the study was to assess, by means of a process evaluation, broader issues around the implementation of the HSP within the local context and how

this had impacted on its perceived effectiveness, especially with respect to its ability to address psychological health.

1.4.1 Specific Objectives

The specific objectives of the study were as follows:

1. To profile, at the baseline stage of HSP implementation, the state of psychological health and well-being in a sample of primary school-aged children (7-12 years) attending DEIS band 1 schools (n=7).

2. To interrogate the extent to which the *Healthy Schools Programme* impacted on the psychological health outcomes of children in participating schools during the course of programme implementation.

3. To delineate and discuss the *perceived* effects of this health promoting school-based initiative on children's psychological health and well-being

4. To identify what were the primary facilitative or inhibitive factors of the implementation process that influenced the HSP and especially with regard to how it addressed children's psychological health.

The study represents an important addition to the international literature, whilst it is also innovative in an Irish context in that it focused on the first comprehensive health promoting school initiative to be implemented in Irish schools. An additional innovation was the location of the study which took place in an urban area of high poverty and social exclusion. In the literature these challenges are more frequently examined in isolation to health promotion school initiatives

1.5 Outline of the thesis

A brief outline of the thesis is provided below.

Chapter Two will consider current health promotion approaches for children. A detailed overview of the theoretical underpinnings of health promotion will be presented, followed by a discussion of the evolution of the health promoting school concept and

the use of implementation science in the assessment of innovative innovations like health promoting school initiatives. An overview of the Healthy School Programme will also be presented, including an outline of its theoretical underpinnings, as well as how this initiative fits within the current literature on health promoting schools.

In *Chapter Three,* a review of the evidence of the current national and international literature for the effectiveness of health promoting school approaches in addressing children's psychological health will be presented. This will examine the results from studies undertaken over the last twenty years including individual studies, systematic reviews and meta-analyses. This chapter will also explore the Irish research context relating to children's psychological health and health promoting schools. In addition, the potential benefits and limitations (as well as primary facilitators and barriers) of health promoting school initiatives (and their evaluations) will be highlighted.

Chapters Four and *Five* presents the methodological framework of this study. The first of these chapters provides an overview of the key epistemological and methodological considerations including the theoretical and conceptual underpinnings of the study. An overview of the ethical considerations of the study is also presented. The second of these chapters introduces the study design and details the specific methodological approach undertaken to complete phase one (the quantitative component) and phase two (the qualitative component) of this study.

The results from this study are presented in two sections. *Chapter Six* presents the findings from phase 1 of the study relating to children's self-reported psychological health outcomes. The findings across several time points are collated for purposes of a comparative analysis to identify patterns within the data, as well as examining the factors which correlate with psychological well-being.

Chapter Seven, Eight, and Nine present the findings of a process evaluation relating to both broader contextual issues as well as psychological health more specifically. The findings are based on a range of data sources including meeting observation notes, one-to-one interviews (n=27) with HS stakeholders and professionals, and focus groups (n=4) with parents and teachers.

Chapter Ten provides a critique of the findings emanating from the two phases of the study under four key areas and summarises the key issues identified and discussed in relation to each. Firstly, the impact of the HSP on children's health outcomes in terms of health-related quality of life, depressive symptoms, and health behaviour is described. Secondly, this chapter reflects on the impact of the programme on broader school-level outcomes including: school physical and social environment, policy, curriculum, and service and community collaboration. Thirdly, the findings of the HSP implementation process are considered. Finally, the implications of the findings from the current study are reviewed in the context of practice and policy. The strengths and limitations of the study are also presented, as well as recommendations for future research. The thesis concludes with some key recommendations for the future development of school-based health promotion initiatives aimed at addressing children's psychological well-being.

CHAPTER TWO

CONCEPTUALISING AND DEVELOPING HEALTH PROMOTION IN SCHOOLS

2.1 Introduction

Traditionally, the medical model of disease prevention and treatment has been the dominant approach to health and is still widely used today within the medical sciences (Antonovsky, 1996; Shah & Mountain, 2007). However, there has been a growing recognition of the importance of broader health-related issues, such as environmental factors and healthy living choices, and this has led to a shift towards more health-promoting models of health (Oliver & Peersman, 2001). In line with this perspective, a growing number of healthcare reports acknowledge the inter-relationship and mutual dependency of physical and psychological health (e.g. Fox, 1999; Goldberg, 2010; UK Royal College of Psychiatrists, 2010). In considering the regular co-occurrence of psychological and physical symptoms across the population it is clear that a more multi-level approach to the consideration of health and well-being is appropriate (e.g. Bronfenbrenner's bio-ecological theory of human development (Bronfrenbrenner & Morris, 1998). Indeed, Currie and colleagues (2012) suggest that a more holistic view of health should be incorporated into 'best practice' health care planning and the promotion of health and well-being.

The health promotion model - in contrast to the disease focused model - aims to empower people and communities to take control of, and improve, their own health and well-being (WHO, 1986). This focus on the promotion of health rather than illness permits a broader population health perspective. For instance, Currie and colleagues (2012) point out that, instead of focusing on intervention-led policy, health policies and programmes aimed at improving quality of life in children and young people should focus specifically on building skills in coping with all aspects of life (and not just psychological health). In this way, an emphasis on structures (or settings) rather than individuals, has been suggested as the most effective means of comprehensively addressing population health (Oliver & Peersman, 2001). According to Dooris (2009), *"this [ecological] perspective acknowledges the significance of mapping the*

*interconnectedness and synergy between different components, and recognizes that settings are both complex systems (unpredictable) and open systems (interacting with the other settings and the wider environment)" (*p30*)*.

Most notably, the WHO has embraced this ecological system or "settings-based" model of human behaviour as a means of addressing the health needs of people in their social contexts and developing appropriate and effective health promotion policies (WHO, 1986, 2005). The WHO Ottawa Charter for Health Promotion (1986), in particular, endorsed this approach, thereby reflecting a shift away from the treatment of disease to health promotion. This endorsement in turn has led to policy makers on the ground focusing more on settings-based health promotion initiatives. The settings approach to health promotion is also based on concepts of community empowerment and competence enhancement and aims to support people or communities in becoming more involved in and responsible for their own health (Naidoo & Wills, 2009). Thus, the settings approach endeavours to improve specific aspects of the environment and improve its capacity to support the health needs of those who interact within it (Poland, Krupa, & McCall, 2009). This approach also enables a more multidisciplinary approach to public health as, at its core, it aims to take a holistic view of health and well-being. Indeed, this model is concerned with all aspects of health, from policy design to environmental changes, from collaboration with different groups to individual health, all with a view to developing a more health-promoting environment (Whitelaw *et al*., 2001). Whitelaw and colleagues (2001) note that the conceptual and theoretical underpinnings of the settings approach require further development and that a vision regarding the practical aims of this approach needs to be more clearly demonstrated. Nevertheless, despite these limitations this approach has an important function in the promotion of health. In particular, the holistic ecological nature of an effective settings-based initiative means greater ability to integrate the entire system to improve community health (Dooris, 2005).

A settings approach to health promotion has had many applications including prisons (Caraher, Dixon, Carr-Hill, Hayton, McGough, & Bird, 2002), universities (Dooris, 2001), and even cities (Plumer, Kennedy, & Trojan, 2010). It has been acknowledged, however, that this flexibility of application can also create challenges. For example, settings such as homes, which are less formal, or other social settings like communities,

which can be more complex and less tangible, can make it difficult to assess system change; these are also seen by some as a limitation of the approach (Dooris, 2005). In the current context however, the school forms a more discrete setting and the debate can mainly focus on how extensive beyond the physical school this setting should reach. The next section will now explore the different health promotion models which can be incorporated in this way.

2.2 Theoretical underpinnings of health promotion

The application of health promotion practices to specific settings is, understandably, a complex endeavour. As a result, a number of different conceptual models of health promotion strategies have been proposed based on underlying values or assumptions that describe and categorise health promotion practices. These fall broadly into two categories: (1) descriptive or iconic taxonomies; and (2) analytical or analogic models. The first, as their name suggests, provide descriptive accounts of health promotion practices (e.g. Ewles & Simnett, 1985; Tannahill, 1985). However, whilst these are useful, they have been criticised due to a lack of detail in relation to their appropriateness across different contexts and inadequate information on the values underpinning them (Earle, 2007). Analytical (or Analogic) models of health promotion attempt to address this weakness by presenting a theoretical framework which attempts to account for and provide an understanding of health promotion practice (Rawson, 1992). Beattie (1991), Caplan and Holland (1990) and French (1990) are examples of some of the most well established theoretically driven models of health promotion. The most useful of these, in terms of an appropriate conceptual model within which to locate the present study, is Beattie's (1991) four-paradigm model. This model provides a helpful account of the philosophy underpinning key approaches to health promotion strategies as well as the methods of engagement in applied settings (Earle, 2007).

Mode of Intervention

Authoritarian

Advice
Education
Behaviour Change
Mass Media Campaigns

Legislation
Policy Making & Implementation
Health Surveillance

Individual ← → Collective

Counselling
Education
Group Work

Lobbying
Action Research
Skills Sharing & Training
Group Work / Community Development
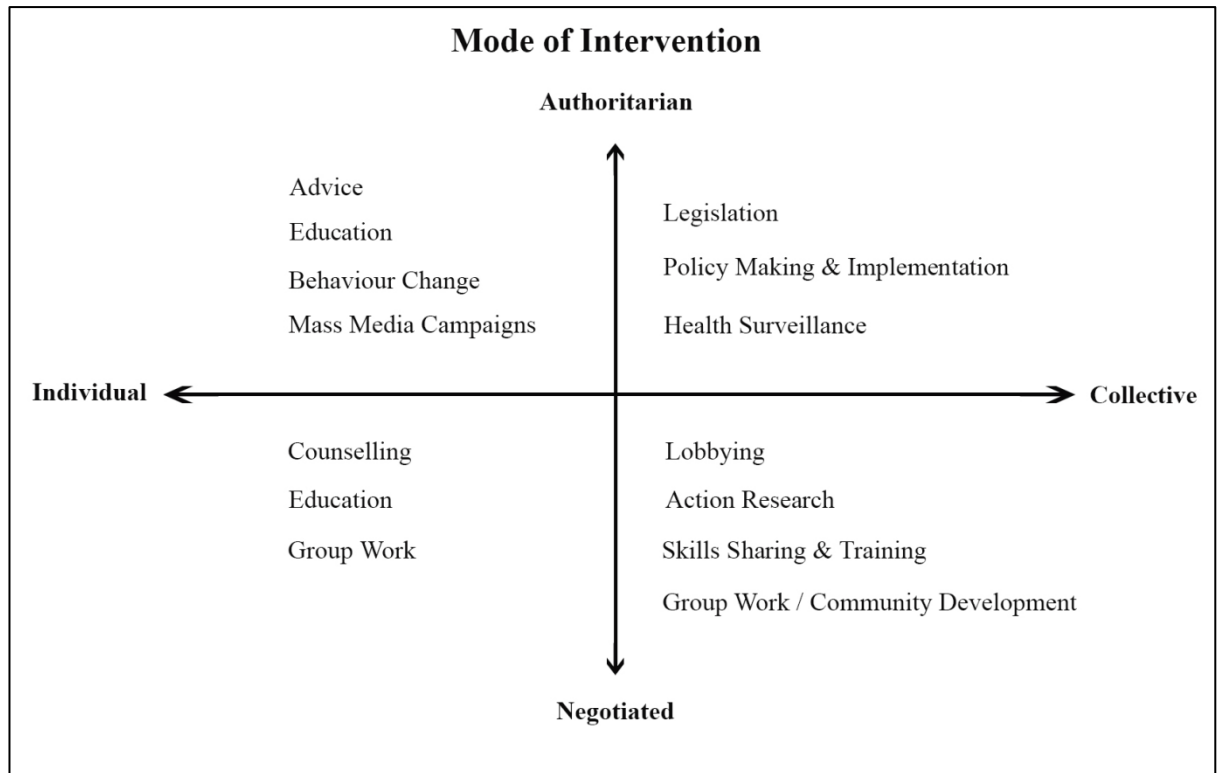
Negotiated

Figure 2.1 Beattie's (1991) model of health promotion strategies

Beattie's model comprises four paradigms that are based on several modes of intervention, ranging from 'negotiated' at one end of the spectrum to 'authoritative' at the other (see Figure 2.1 above. Beattie's model also acknowledges that health promotion is comprised of many different factors ranging from societal to individual and sets out how different promotion practices can be engaged, depending on the level of engagement of an initiative (Beattie, 1991; Wills & Earle, 2007). This design, therefore, provides a useful account for the practical application of health promotion activities in different settings. In comparison to Beattie's model, Caplan and Holland's (1990) model is more complex and theory driven and focuses on what determines health. This model is primarily concerned with how both the construction of society (i.e. the nature of society, social regulation, societal change) and the theory of knowledge (i.e. subjective or objective) impact health. French's (1990) model on the other hand, whilst more straightforward, is somewhat disease-focused in design (Piper, 2009).

The model of health promotion strategies set out by Beattie above provides a useful tool to explain how health promotion practices operate. However, such models do not explore in what way such strategies interact at, or incorporate, an individual level. A

number of well-established theories and models within health psychology aim to explain such changes and these are often incorporated into health promotion models and used in an eclectic way by health promotion practitioners (Oliver & Peersman, 2001). The Theory of planned behaviour (Ajzen, 1991), the Health belief model (Becker, 1974) and the Transtheoretical model of stages of change (Prochaska & DiClemente, 1982) are all well-established psychological models of health behaviour. Arguably, these models fail to adequately consider the influence of environmental factors on behaviour change. This is particularly important when considering the complexities inherent in many health promotion initiatives as well as the broad setting within which they function. More specifically, given the broad dimensions of a health promoting school approach, explanations of the relationship between the environment and behaviour are important to understanding how to effectively achieve health improvements in children's lives. In this context, it is important to identify an alternative model that provides a useful framework that explicitly explores how complex multi-level health promoting settings initiatives might best address a child's health and well-being (Bartholomew Parcel, Kok, & Gottlieb, 2001).

Bandura's Social Cognitive theory (e.g. 1977) provides a model which identifies the importance of the wider context within which an individual behaves. This theory purports that an individual learns from models in their environment and that what they learn is dependent on their emotional and cognitive interpretation of the situation (Bee & Boyd, 2004, p22). However, this theory, whilst useful, still does not account clearly for the processes which occur between the wider environments and the individual that are particularly relevant to the concept of a health promoting school. Similarly, Green and Kreuter's (1999) 'precede-proceed' model also examines the influence of environmental conditions on human behaviour, although this model does not provide a sufficient explanation of the levels of environmental influence on child and adolescent health and health behaviour.

Bronfenbrenner's (1998) bio-ecological theory of human development provides a more detailed model of how an individual's environment comprises multiple interacting systems which influence and impact upon each other to shape all aspects of a person's development including their health (Earle, 2007). This ecological and holistic perspective recognises health as a state which arises based on the interactive roles of the

environment and the individual. This environment ranges from the immediate social setting such as family and friends to the broader societal level such as the governmental structures and policies which frame the individual's environment (Kok *et al.,* 2004).
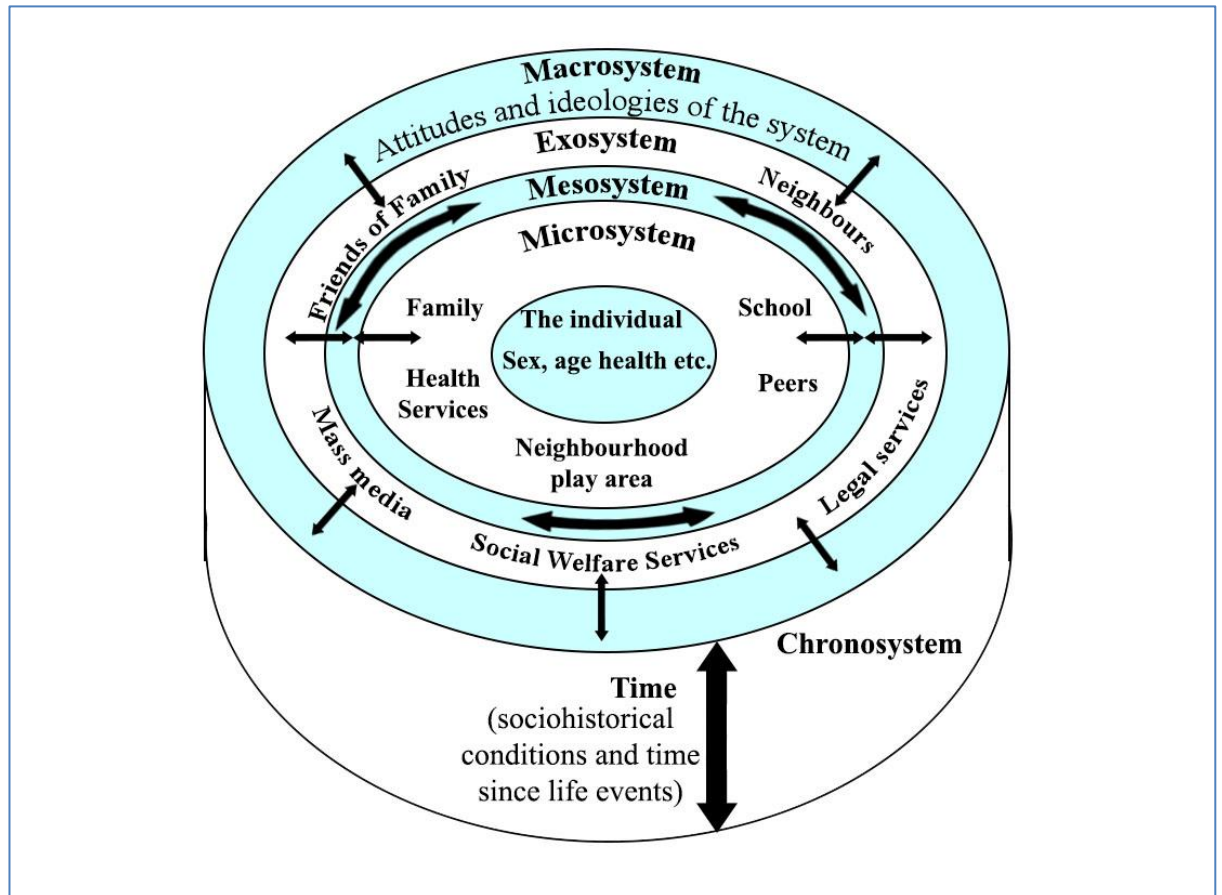
Figure 2.2 Bronfenbrenner's Bioecological model of human development (extracted from Santrock, 2007)

An advantage of this model, the most recent version of which was set out by Bronfenbrenner and Morris (2006), lies in the extent to which it goes beyond person-environment relations to emphasise five dynamic systems (microsystem, mesosystem, exosystem, macrosystem and chronosystem) that encompass the immediate and wider environmental contexts which interact with each other as an individual develops (Bronfenbrenner & Morris, 1998, 2006; Tudge, Mokrova, Hatfield & Karnik, 2009). According to this framework, an individual's development is complex and changeable. It is also apparent that health-based programmes/initiatives which do not address these components may not lead to sustainable improvements in overall health and well-being (Tudge *et al.,* 2009). In line with a settings approach to health promotion, the ecological model examines the complex systems with which an individual interacts on a

daily basis and, based on this model, it is clear that health cannot be addressed in isolation from other aspects of everyday life. Whilst the individual is not neglected, the importance of the systems within which the individual exists and interacts is also perceived as crucial to human health development.

However, this model is not without its limitations. For example, it does not explicitly address the importance of resilience (e.g. Luthar *et al.,* 2000) - a major framework in developmental psychology and one which has become increasingly popular in recent years (though not the focus of the current study). Nor does Bronfrenbenner's model explore this issue of system blockage and its impact on system (and therefore initiative) efficacy (Downes, 2014). However, in terms of a health promotion intervention, this kind of ecological model is useful in that it reflects a more salutogenic and holistic view of health (and health promotion) involving a complex interplay of environmental, organisational and personal factors, whilst it also focuses on addressing the health needs of communities within a system (or setting) rather than solely on an individual basis (Whitelaw, *et al.*, 2001).

Lohrmann (2010) builds on Bronfrenbrenner's model to provide, more specifically, an ecological model of *health-promoting schools* programmes (or in Lohrmanns' case, 'Coordinated School Health Programmes'). Lohrmann's conceptualisation, which incorporates all components of Bronfrenbrenner's model, presents a clear structure outlining how a health promoting school aims to influence the child's environment (see Figure 2.3 below), as well as identifying the many influential factors in a child's school environment. The model also indicates how different stakeholders can influence the extent to which a school can effectively address the health and well-being of its pupils (Lohrmann, 2010). The next section of this chapter explores further how the school as a setting can effectively address children's health.
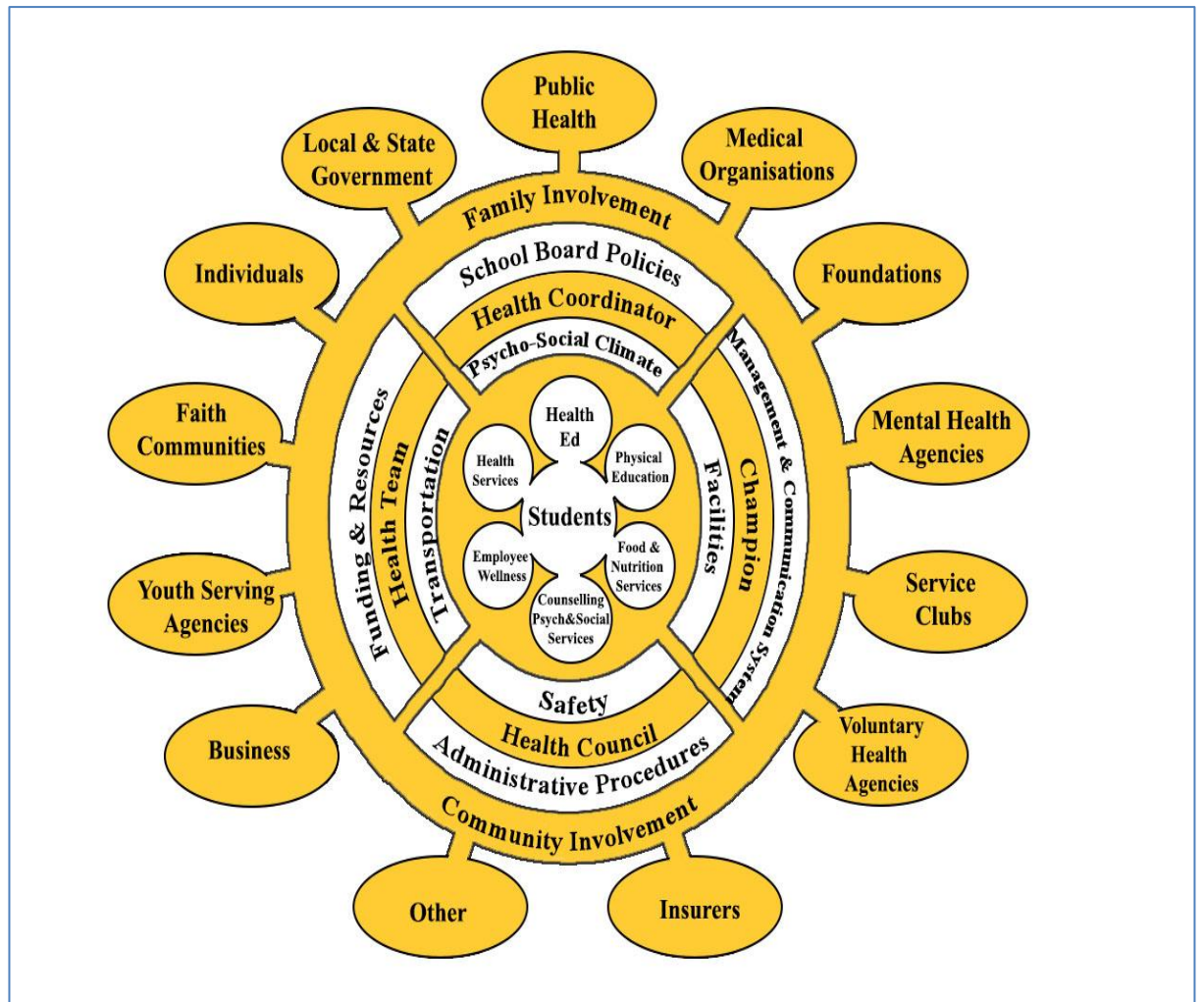
Figure 2.3: Coordinated School Health Programme ecological model, (extracted from Lohrmann, 2010)

2.3 The school as a health promotion setting

Lee (2009) argues that a lifespan approach to health promotion (i.e. which begins at a young age) such as the health promoting school approach may be most effective in improving the long term health and well-being of individuals, especially amongst the most vulnerable. A more holistic view of children's health that incorporates the family, school and community, as outlined in Bronfrenbrenner's model, has broadly been accepted. These environments have been identified as social settings that are central to the promotion of children's health and well-being (Moon, *et al*, 1999; Stewart, Sun, Patterson, Lemerle, & Hardie, 2004; Tones & Tilford, 1994). However, the potentially individualistic and private nature of the home environment may lead many challenges in incorporating a settings approach to health promotion at this level. Not surprisingly

perhaps, the school has become a primary setting for engaging in health promotion practices with child populations. Indeed, as pointed out by Stewart and colleagues (2004), schools may influence children's development (from 5-12 years) as much, if not more than, the family.

Similarly, the Australian Health Promoting School Association (AHPSA, 2001) argues that the school environment is one of the best environments to support children and develop resilience, regardless of the child's social environment outside of school. Sormunen, Saaranen, Tossavainen, and Turunen (2012) highlight that the broad reach of schools means that the school environment provides a unique opportunity to address children's health needs. This is further supported in numerous other studies (Hornby, & Atkinson, 2003; St Leger & Nutbeam, 1999; Wells, Barlow, Stewart-Brown, *et al.,* 2003; Stewart *et al*, 2004; Lee, 2009). In line with both Bronfrenbrenner's and Lohrmann's models, Deschesnes, Martin, & Jomphe-Hill (2003) emphasise that as the school is often the centre of a school-based health promotion programme, the school setting should go beyond the physical environment of the school buildings to include the local community and any environment which is part of the young people's lives. In this way, a school-based initiative provides an opportunity to address all aspects of a child's life. Clearly, incorporating a more holistic approach to health promotion in the wider school setting is more far reaching than a health education model as it involves the examination of all aspects of the entire school environment (i.e. both physical and social environment, curriculum, policies, as well as health services and community links) (St Leger, Young, Blanchard, & Perry, 2010; Stewart, Sun, Patterson, Lemerle, & Hardie,, 2004).

More specifically, the school setting can play an important role in the effective promotion of children's psychological health. For example, Weare (2007) argues that the school is a major access point from which to improve the accessibility of mental health services for families. For instance, the teacher is often perceived to be the first point of contact for parents who may be concerned about their child's psychological health and many aspects of a school environment can determine the extent to which school staff can effectively identify and manage the psychological health needs of the pupils under their care (Weare, 2007). However, dealing with such issues may not, understandably, be viewed as a teacher's primary role. Nevertheless, the impact of health on academic success has necessitated that school staff try to address such

concerns (Barnekow *et al.*, 2006). Thus, the development of the health resources of a school setting can be important in supporting staff in the management of issues related to the psychological health of children which, in the longer term, may also impact on educational outcomes (Lee, St. Leger, & Moon, 2005). This unique position of the teacher demonstrates the importance of equipping staff with the skills to develop relationships with students that are based on respect and trust. For example, a number of US-based studies reported that, where teachers perceive a supportive teacher-student relationship, improvements in students' behaviour and academic development were noted (Hamre & Pianta, 2001; Hughes, Cavell, & Jackson, 1999; Ladd, Birch, & Buhs, 1999; Meehan, Hughes, & Cavell, 2003; O'Connor & McCartney, 2007). Conversely, Bernstein (2013) argued that teachers, who develop an authoritarian approach to teaching, by definition, create environments based on control and discipline. Such environments are likely to minimise opportunities for students to seek support and help. Thus, if implemented effectively, a Health Promoting School approach can provide a useful framework to support schools in addressing the wider needs of children through health promoting practices.

2.4 Health Promoting Schools – current conceptualisation

A Health Promoting School may be broadly characterised as "*a school that is constantly strengthening its capacity as a healthy setting for living, learning and working*" (WHO, 1998; p11). The health promoting school concept developed out of policy work by the World Health Organisation in the 1950s and 60s (e.g. WHO, 1966). This framework was further developed through the Declaration of Alma Ata (WHO, 1978) where national governments were encouraged by the WHO to address health through policy and action plans which sought to promote multidisciplinary collaboration. The Ottawa Charter (WHO, 1986) further identified health behaviour change as being much broader than individual health behaviours; changes in health behaviour at a systems level are emphasised. In the school, for example, improvements to the core school setting, such as health-related policies as well as the school's social and physical environment and ethos, are key. In this way, the health of the entire school community is addressed in a more sustainable manner instead of using a targeted individual level approach. This conceptualisation of school level health promotion was further enhanced and developed through the WHO school health initiative in 1994 (St. Leger, 1999). This initiative drove the development of the framework for health promoting schools as it is currently

conceptualised by the WHO. A WHO health promoting school ethos may be achieved in a number of different ways and these are set out in table 2.1 below.

Table 2.1: Important factors in establishing a health promoting school ethos (International Union for Health Promotion and Education; IUHPE, 2009)

- Using available resources to develop health and learning
- Establishing and developing links with members of the school and local communities as well as with multidisciplinary services to expand school relationships and address the school's needs.
- Working towards a more health promoting and inclusive physical and social school environment with increased health-promoting opportunities for its entire community
- Adopting and implementing health promoting policies
- Delivering age-appropriate health education and life skills training
- Supporting improvements in health service accessibility
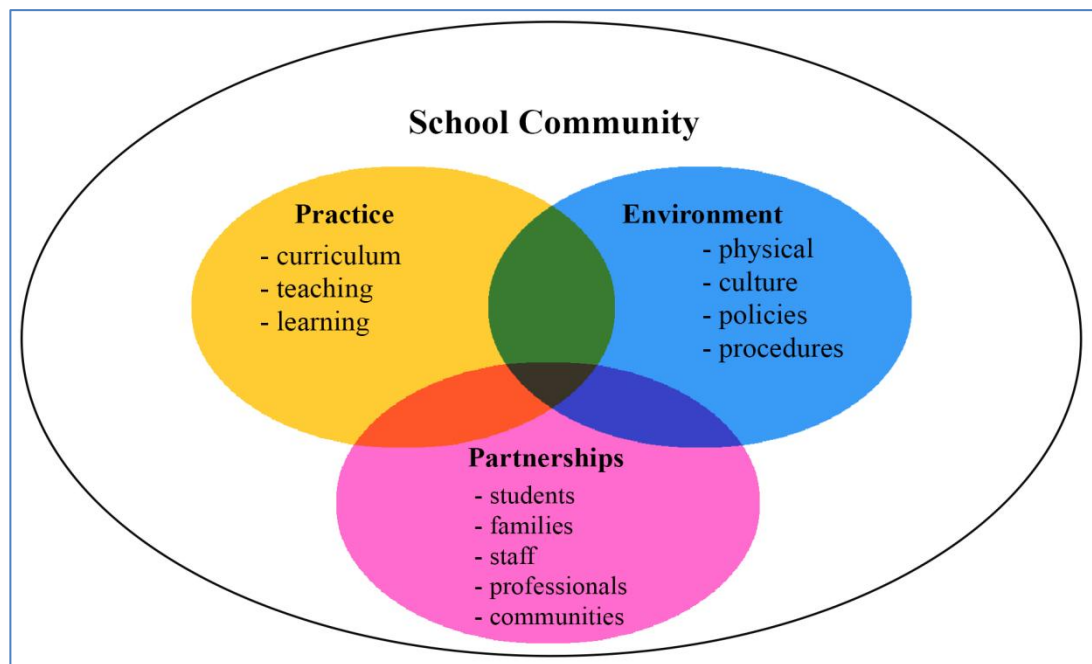
Figure 2.4: A model of a Health Promoting School (extracted from Australian Centre for Health Promotion, 2012)

The process of becoming a Health Promoting School is dynamic and ongoing whereby the school assesses, plans and implements ideas which are in line with the principles of

a health promoting school, as outlined above. According to the International Union of Health Promotion and Education guidelines, all health promoting school work should be achieved by following five core principles: democracy; partnership and equity; ownership and action by the school community; endorsing health capacity building; and using sustainable means (IUHPE, 2009). The school community (i.e. school staff, families and students) itself decides, on the basis of a self-audit, which priority areas are relevant for its school and this in turn provides a focus for the work of the health promoting school. In this way, the details of the health promoting school programme of work can be tailored to the individual school, thereby ensuring a more empowering experience for all stakeholders. Whilst the nature of this work may change and evolve over time in line with the needs of the school, the overarching aim remains one of improving the overall health of the entire school community.

2.5 Health Promoting Schools: the international context

Individual countries have developed their own interpretation of the WHO's policy documents and adapted the health promoting school concept to their own needs and resources (e.g. The Australian Health Promoting Schools Association, 1996; Allensworth & Kolbe, 1987; Moon *et al*, 1999; European Network of Health Promotion Schools, 2002). For example, in Canada and the USA, the health promoting school is known as the 'Comprehensive School Health Program (CSHP)' model. Both CSHP models are closely aligned with each other and have been increasingly endorsed by policy makers since the 1980s (Allensworth & Kolbe, 1987; Leurs *et al*., 2005; McCall, 2003; Walcott *et al.,* 2008). The key components of CSHP include: addressing all aspects of children's health using school-based planning; supporting and involving families and the entire school community; collaboration with communities and external disciplines; and ensuring all aspects of CSHP work is to be directed in its approach through a bottom-up democratic process (Allensworth*,* 1995). The US Centre for Disease Control and the Canadian government Department for Public Health subsequently endorsed this model, leading to its development across the country (McCall, 2003). In Australia, a health promoting school was developed more recently in the mid-1990s with the aim of addressing the health needs of the entire school community (Rowling, 1996). In 1997, the Australian Health Promoting Schools Association (AHPSA) was set up to guide the process of planning and implementation

using almost identical objectives to those of the IUHPE (2009) criteria indicated above (see Table 2.1 and Figure 2.4).

In Europe, the Schools for Health Europe Network (SHEN, previously known as European Network for Health Promoting Schools, ENHPS), has been the main driver of policy change. Established in 1991, the ENHPS identified a framework from which to develop health promoting schools. Six key areas were highlighted including: school physical environment; social environment; community involvement; policies; health skills; and access to services (WHO, 1996). At present, 43 countries including the Republic of Ireland and the UK, are members of the network which is working towards shared SHEN core values (i.e. equity, sustainability, inclusion, empowerment and action competence, and democracy) (Buijs, 2009). Many countries have engaged with SHEN through the implementation of pilot health promoting school schemes involving a group of participating schools (see Bruun Jensen, & Simovska, 2002). Initial findings from studies based on these pilot schemes (e.g. in countries such as Finland, Norway and the Netherlands) point towards the overall utility of this approach (e.g. Leurs *et al*., 2007; Tossavainen *et al*., 2002; Tjomsland, Iversen, & Wold, 2009). However, the implementation of health promoting schools has been variable between countries and very few have incorporated a health promoting school approach nationwide (Aldinger & Whitman, 2009).

As a long-standing member of the ENHPS/SHEN, the UK has notably embraced the ethos of a health promoting school at a national level since the 1990s. Across the UK, regional governments have endorsed the health promoting school concept (e.g Department of Health and Department for Education and Skills (DH & DfES), 2005; NI Department of Health, Social Services & Public Safety & the Department of Education; Public Health Agency, 2002; Scottish Health Promoting Schools Unit, 2004; Welsh HM Inspectorate of Education, 2004). Government level support and guidance on the promotion of a holistic healthy school environment has facilitated substantial changes in the way schools can address health (Moon *et al*, 1999; Scottish Health Promoting Schools Unit, 2004). For example, regional Healthy Schools Coordinators are funded by the government and provide guidance and support for schools. At a school level, staff members are also supported in the role by a school-based coordinator who organises the health promoting work of the school.

Support at a national level ensures that health promoting school development plans are devised more consistently across schools and in a sustainable way. The allocation of funding for publications such as health promoting school implementation guidelines (e.g. NHSP, 2008; Public Health Agency, 2002; UK Department for Education and Employment, 1999) also provides clarity for schools in how to attain health promoting school standards in a structured way. These guidelines clearly set out the responsibilities and targets of participating schools and aim to clarify for schools how initiatives work and what can be expected for schools engaging in the health promoting school process. This National Healthy Schools strategy aims to have all schools working towards a healthy school status in a broadly standardised way that is consistent with that recommended by the WHO (NHSP, 2008).

The British model differs from the Australian and US/Canadian models which advocate a less structured approach. Whilst it is based primarily on the WHO health promoting school model, the British adaptation is somewhat prescriptive in that it sets out four pre-established themes for development by the schools to gain HS status. These include: personal social and health education, emotional health and well-being, healthy eating, and physical activity (Arthur *et al*., 2011). Whilst schools still maintain the autonomy to focus on areas of most importance to them, there is less flexibility for the individual school and local area to develop their own plan as envisaged in the original health promoting school initiative. On the other hand, Simovska (2012) suggests that the flexibility inherent in health promoting schools often leads to differing interpretations and implementation structures which, in turn, create challenges for assessing overall effectiveness. Whilst a more flexible bottom-up approach is theoretically in line with the health promoting school concept, there is also a risk that quality control will be difficult to determine and, as a consequence, some schemes, such as the Australian model, have begun to move more toward the UK auditing approach (Marshall *et al.,* 2000). This may enable a more focused approach whilst also simplifying the evaluation process.

2.6 Health Promoting Schools: The Irish context

In the Republic of Ireland, the transition from a health education model to a health promotion model by the Health Service Executive (HSE, known previously as the National Health Board) began during the 1970s. However, it was not until the mid-

1990s that national health and education policy began to shift specifically towards a more health promotion school model (Kelleher, 1999). In 1992, Ireland joined the ENHPS and an Irish Network of health promoting schools (INHPS) was established through a joint effort by the Department of Health and Children and Department of Education and Science, in line with the WHO guidelines (HSE, 2012). Initially, this network focused on managing a pilot project involving a number of schools that were interested in building an Irish health promoting school network. The aims of the network were based broadly on the WHO concept, and evaluation findings of the first phase of this pilot indicated that the health promoting school approach was a useful framework for addressing health even if schools found it challenging to understand how the overall mandate of health promoting school approach applied to their school (Lahiff, 2000). The subsequent recommendations arising from this research – in line with other international studies - highlighted a need for greater clarity by stakeholders regarding the concept and application of a health promoting school approach. School management and staff were also found to need more support to implement the health promoting school ethos whilst greater involvement of parents was deemed essential (Lahiff, 2000). However, despite promising beginnings in the implementation of a health promoting school framework in schools, until recently there has been little development of HPS (and INHPS) during the last decade especially at a national level. Localised networks have been set up between some schools around the country (e.g. HSE, 2009), although this has been achieved without any governmental support and are dependent on the work of dedicated local health and educational professionals rather than a national policy-led initiative.

In the early 2000s the Health Promotion Policy Unit (National Health Promotion Strategy, 2000-2005) also began supporting the Department of Education and Skills (DES) in implementing health promotion in schools through the development of the Social, Personal and Health Education (SPHE) curriculum. There are a number of parallels between SPHE implementation in schools and some components of a WHO health promoting school approach. According to the Department of Education (1999), the aims of the SPHE curriculum are: to promote all aspects of health and well-being of the child; to support children in developing respect for themselves and others in society; and to enable children to become effective decision makers. National level SPHE support services are available to assist schools in implementing the curriculum, train

staff and develop health-related school policies (Geary & Mannix-McNemara, 2003). According to SPHE policy, collaboration between all those involved in children's education and health (i.e. staff, parents, board of management, health and educational professionals as well as members of the wider community), are key to the effectiveness of SPHE in addressing children's health and well-being (Department of Education and Science, 1999). In this way it is clear that the SPHE initiative endorses a whole school approach to the improvement of children's well-being.

There have been no independent evaluations to date of the SPHE implementation in primary schools. One study by the National Education Inspectorate (Department of Education and Science, 2009) identified the value of the SPHE curriculum and role of SPHE in the development of a positive school and classroom environment. Similarly a small number of evaluations at secondary school level indicate a number of benefits in terms of how schools address health (Geary & McNemara, 2003; NicGabhainn, O'Higgins, & Barry, 2010; O'Higgins *et al.,* 2007). For example, school-based respondents indicated that staff training on health issues as well as the provision of the national SPHE support service[2] have all positively influenced the teaching of the SPHE curriculum (NicGabhainn et al., 2010; Geary & Mannix-McNemara, 2003). In this way, the introduction, in 2000, of SPHE as a compulsory subject across schools, has been instrumental in supporting the health education component of the health promoting school approach (NicGabhainn, O'Higgins, & Barry, 2010). A similar evaluation by Miller (2003) compared schools incorporating the SPHE curriculum with schools in which the SPHE curriculum was not being taught between 2000-2001[3]. This study indicated that, whilst all schools maintained policies on general issues affecting school life (e.g. bullying), schools which had incorporated the SPHE curriculum effectively were also more likely to have developed policies on a number of additional health-related issues specific to the SPHE curriculum (i.e. substance use, child protection, sexuality and relationships) when compared to non-SPHE schools (Miller, 2003).

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[2] The SPHE support service is a national service established through a partnership between the Department of Education and Skills, the Department of Health and Children and the HSE. This service provides consultation, in-school training and health-related literature to assist schools in the implementation of SPHE

[3] SPHE became a mandatory part of the curriculum in all primary and junior cycle post-primary schools in 2003.

These, albeit limited, findings suggest promising outcomes of the SPHE model with regard to its impact on the some areas of health and well-being of school children. Overall however, there is little evidence to indicate that the SPHE can embrace *all* components of the health promoting school ethos as articulated by the IUHPE (Geary & McNemara, 2003; NicGabhainn, O'Higgins, & Barry, 2010; O'Higgins, Galvin, Kennedy, Nic Gabhainn & Barry, 2007). Supporting this point, Burtenshaw (2003) argues that a health promoting school is much broader than the SPHE curriculum in the extent to which it aims to establish a health promoting school ethos. Indeed, it is clear from the evaluation studies discussed above that, besides some health policy developments, much of the SPHE work by schools has clearly focused on curriculum-based activities with the children instead of systems-level capacity-building health promotion work (i.e. addressing the whole school health ethos via the school physical and social environment, health policy work, links with the wider community, school-health service collaboration work). This indicates a preference towards a more health education model of addressing children's health needs instead of the health promoting school approach as envisaged by the WHO. In Burtenshaw's (2003) evaluation, there were still diverging views as to how SPHE and a health promoting school ethos were related even amongst respondents involved in the planning and coordination of SPHE. According to Burtenshaw, this lack of a shared understanding created difficulties in how SPHE has been implemented and to what extent it incorporates a health promoting school ethos.

Similarly, NicGabhainn and colleagues (2010) found that amongst secondary level teaching staff, SPHE was very much perceived as merely another component of the school curriculum. Likewise, O'Breachain and O'Toole (2013) noted a recent national shift in strategy toward a narrower curriculum that emphasises numeracy and literacy to the exclusion of other topics. This highlights the vulnerability of SPHE as a curriculum-focused approach. Additional challenges have been identified in the implementation of SPHE. For example, Mannix-McNemara (2012) highlighted that (in-career) training support for SPHE teachers is confined to 40 hours of in-service training modules and from this, staff are expected to "*employ more interactive and experiential pedagogies in their teaching.*" The SPHE pedagogy is broad and far reaching, but according to Mannix-McNemara, the training resources allocated, in themselves, indicate a lack of priority given to the SPHE curriculum (Mannix-McNemara, 2012

Burtenshaw's evaluation of SPHE (2003) showed, further, that school staff also identified the lack of training when compared to other subjects as a key issue in the development of SPHE, especially given the potentially sensitive nature of the subject matter covered in the curriculum. Aside from the challenges for school staff, two evaluation studies highlight a lack of involvement by parents and children in the planning and development of SPHE (Department of Education & Skills, 2009; NicGabhainn, O'Higgins & Barry, 2010). Indeed, it was identified across a number of studies, that many parents were not informed adequately about the SPHE programme to comment on its implementation (Geary &McNemara, 2003; NicGabhainn, *et al.,* 2010). It has also been argued that partnerships across the entire school community are essential in creating a broader SPHE school ethos (NicGabhainn *et al.,* 2010). However, there is little evidence, to date, to indicate how democratic collaboration will occur going forward. The curriculum-focused approach, as well as the lack of collaboration with all members of the school community, highlights the differences between SPHE and a WHO health promoting school approach. However, whilst some efforts have been made to incorporate SPHE into the formal school planning structure, only limited progress has so far occurred. The perception by staff of SPHE as merely another (less important subject) further emphasises the difference between developing a health promoting school ethos and establishing an SPHE curriculum (NicGabhainn *et al.,* 2010). The lack of reference within SPHE documents to the WHO health promoting school concept further creates difficulties in determining to what extent the implementation of the SPHE programme can facilitate the development of a health promoting school approach in Ireland. Thus, overall, it is evident that the SPHE curriculum has supported schools in addressing health issues in the classroom, but it is less clear how this work has led to schools becoming more health promoting environments. Indeed a recent guidelines document produced collaboratively between the Irish Department of Education, Health Services Executive and Department of Health (2015) states that a coordinated whole-school approach to mental health that involves the SPHE curriculum is needed. However, this document notes that such an approach should go further to also include a system of school self-audit as well as the development of effective inter-agency partnerships at both a service (i.e. National Educational Psychology Service, Health Service Executive) and governmental level (i.e. Department of Health and Department of Education & Skills) using a HPS model.

Whilst Ireland is a member of *Schools for Health in Europe*, health promotion policy in primary schools outside of the SPHE curriculum still lacks a cross-national approach in practice. Importantly, such an approach is further impeded by the nature of the Irish educational system. Whilst the Department of Education supports and resources schools, each school is led and managed by a separate Board of Management which decides the ethos of the school at an individual level. In this way, school settings can differ considerably in how the health needs of the school community are addressed. Without a national mandate, therefore, it is very challenging to implement an approach based on ethos change across schools.

Encouragingly, the Health Service Executive (HSE) in Ireland has recently established a national health promoting school strategy. A recent report on this strategic framework indicates that, going forward, national policy will endeavour to establish a health promoting school approach across Ireland as envisioned by the WHO in order to fulfil their duty of care to children (HSE, 2013). However, this framework is still in its infancy and any HPS initiatives using this framework, to date, have only been implemented in a small number of schools in, for example, the South of Ireland in County Cork. These have involved school collaboration with HSE health promotion officers to develop school capacity to address health using a health promoting schools framework. However, it is important to note that the effectiveness of this approach has yet to be established in an Irish context through a process of rigorous research and evaluation. In summary, the original aim of the INHPS to integrate the health promoting school concept with SPHE has not occurred in line with its original mandate. Unlike the UK health promoting school model, it is also evident that the health promoting school approach as conceptualised by the WHO, has only recently been embraced as a key element of Irish government policy (see HSE, 2013).

2.7 The *Healthy Schools Programme*

A principal aim of the *Healthy Schools Programme* (HSP) that is the subject of the current study is to improve the psychological health and well-being of the children of participating schools through the establishment of a health promoting school environment. This programme is based on a project developed through a partnership between a voluntary Dublin-based organisation (the Childhood Development Initiative)

and a number of local urban DEIS[4] band 1 schools, with a view to promoting positive health outcomes for children in their primary school years.

School-based health promotion initiatives can address the psychological health needs of children by means of a universal, indicated or targeted approach. The Healthy Schools programme is a universal model within which indicated or targeted initiatives using specialised services (e.g. trained specialists in mental health) can be incorporated once a need has been identified. The aim of the HSP is to develop a school environment where health promoting practices and activities are encouraged and implemented with a view to minimising the need for such specialist services. However, when specific issues for children arise, this model also helps to ensure that such needs are also identified and addressed in a timely and effective manner. The HSP model is guided by the overarching principles of a health promoting school as defined by the European Network of Health Promoting Schools. The components specific to this initiative were developed by a working group comprised of several stakeholders with expertise in the area of children's well-being. This Healthy Schools working group set out their vision through a HS manual to guide programme implementation (Lahiff, 2009). The manual was designed to provide both background to the programme by setting out the theoretical research which underpins the HS programme (i.e. the national and international health promoting schools literature), as well as practical guidelines for key implementers (Comiskey, *et al*., 2012). The model of a Healthy School as set out in the manual also indicated that, in order to effectively address the health needs of the school on a 'whole–school basis, the entire school system and not just health outcomes should be addressed (Lahiff, 2009, p38). The health promoting school model mirrors the WHO school systems which include: (1) school policies; (2) the school's physical and social environment; (3) the curriculum; (4) school staff development and inclusion of families; and (5) building partnerships and services which include the community and health services (Wyn, Cahill, Holdsworth, Rowling, & Carson, 2000). To achieve its objectives, the manual presents its own HS logic model to provide a framework for the programme and outline desirable outcomes and indicators of success from the HS initiative (see Figure 2.5 below).

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[4] Delivering Equality Of Opportunity In Schools (DEIS). DEIS band 1 schools are schools designated as being in areas of significant social and economic disadvantage
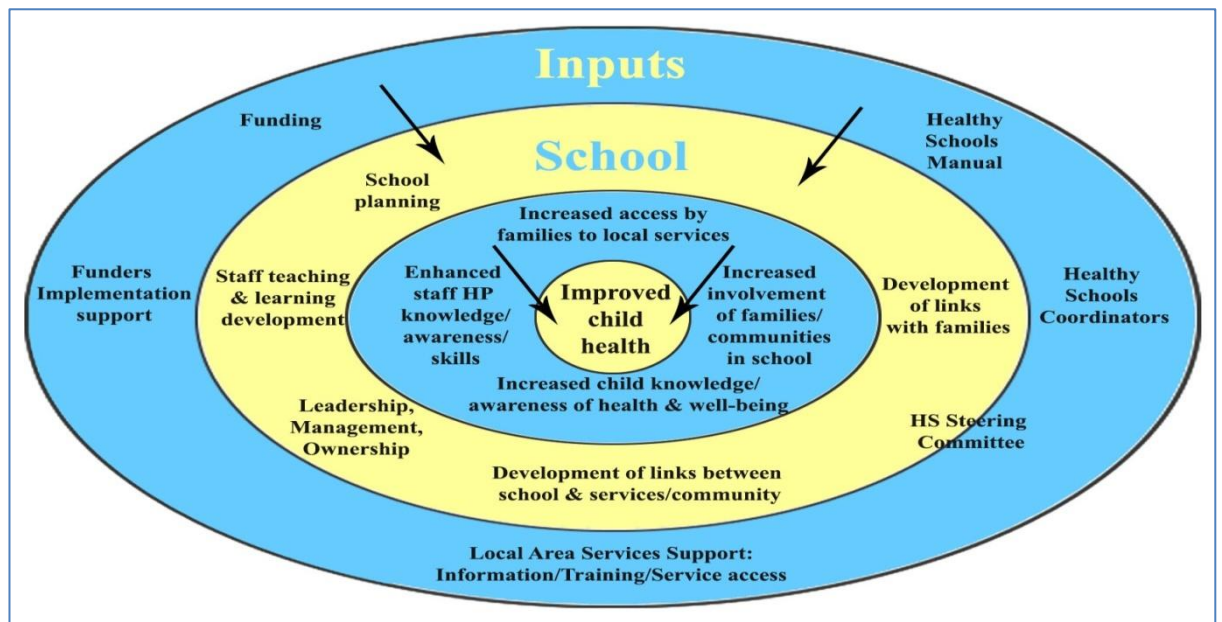
Figure 2.5: The *Healthy Schools Programme* logic model (extracted from Comiskey *et al*., 2012)

Similar to other health promoting school schemes, a checklist for schools is provided in the manual so that each school can decide which component of health should be prioritised. In addition, specific pre-determined outcomes are set out in the manual as a guide for schools because they were considered by the HS working group to be important indices of overall physical, psychological and social well-being (HS manual, Lahiff, 2009, p38). These include the need for children to: (1) demonstrate age-appropriate physical development; (2) have access to basic health care; (3) show an awareness of basic safety, fitness and health care needs; (4) be physically fit; (5) eat healthily; (6) feel good about themselves and; (7) have at least one guardian who is involved in their child's health (Healthy Schools Manual, Lahiff, 2009, p50-57).

The manual also provides a set of role descriptions to direct the work of the programme outlining the roles and responsibilities of key stakeholders alongside a memorandum of understanding to be agreed upon by the schools and funders (Lahiff, 2009). The school itself is expected to lead and manage the direction of the HSP work whilst the objectives, as outlined in the manual, are achieved with the support of a Healthy Schools Coordinator (HSC), whose role is to facilitate the development of a health promoting school environment. The manual also states that a HS steering committee (comprising all key stakeholders) should be set up to lead the programme development and implementation across the intervention schools (Lahiff, 2009). According to the

manual, the HSP will address the psychological health needs of children in a number of ways such as: improving the school environment to becoming more health promoting, increasing accessibility to relevant health services, and improving the knowledge and awareness of children in terms of their psychological health as well as other aspects of health and well-being. This is in line with the EU Support-Project (2008) definition of mental health promotion which *"aims to protect and support emotional and social well-being and create the conditions that enable optimal functioning of individuals, families, communities, and societies."* (p6).

2.8 Conclusion

This chapter described, firstly, the theoretical underpinnings of a health promoting school. The health promoting school approach incorporates a multi-level ecological approach to health promotion in the school setting which is being embraced at an international level through the coordination of a number of national and international networks. However, whilst many countries are experimenting with the health promoting school approach, only a few have integrated this approach with national level support. In Ireland more specifically, pilot programmes were completed in the late 1990s, but since then, only limited progress has been made in the development of a National Health Promoting Schools Network. Efforts to incorporate this approach into existing structures such as the SPHE curriculum have also experienced limited success. Despite these challenges, more recent policies from the Irish Department of Health endorse the Health Promoting School as the best approach to addressing health using the school setting. Thus, further advances in our knowledge regarding how health promoting school approaches can be effectively implemented is essential to ensure best practice both in terms of overall utility and cost-effectiveness. Finally, this chapter also provided an introduction to the health promoting school initiative – the *Healthy Schools Programme* - that is the subject of this study. This has been developed from the foundations of a health promoting school approach as defined by WHO and SHEN policy documents and has further been adapted to suit implementation in the local context. The following chapter will present a review of the research literature examining the ways in which a health promoting school initiative, such as the *Healthy Schools Programme,* can address children's health and, more specifically, their psychological well-being.

CHAPTER THREE

HEALTH PROMOTING SCHOOLS: THE RESEARCH CONTEXT

3.1 Introduction

As indicated in the previous chapter, the health promoting school represents a *"holistic whole school approach to personal and community health promotion within a school setting"* (Moon *et al*, 1999). The multi-component nature of a health promoting school provides a way of addressing many aspects of a child's life which are known to affect both physical and mental health as well as educational outcomes (Senior, 2012). A review of school-based interventions aimed at promoting mental health concluded that health promoting school programmes which are longer-term, comprehensive and inclusive, produced more positive changes in children's psychological well-being (Adi., 2007). These findings are supported by a number of other reviews (e.g. Browne *et al.,* 2004; Tennant, Goens, Barlow, Day, & Stewart-Brown, 2007; Wells, Barlow, & Stewart-Brown, 2003) which indicate that an ecological model of health promotion which addresses the psychological health of all children through the school setting is most effective.

Many school-based health promotion programmes which address psychological health have pre-determined objectives rather than embracing a school-led approach. These initiatives aim to provide schools with a framework within which to address children's mental health and well-being specifically (e.g. the Providing Alternative Thinking Strategies curriculum (PATHS), Greenberg *et al*., 1995; Al's Pals, Lynch & McCracken, 2001; Zippy's friends, Mishara & Ystgaard, 2006; Mindmatters, Wyn, *et al*., 2000). Marshall and colleagues (2000) argue, however, that instead of being implemented in isolation, such topic-specific projects should be established within the wider health promoting school framework and based on the self-identified priorities of the school. Thus, by embedding topic-specific initiatives in the ethos and culture of the school in this way, more sustainable school-led health-related changes can occur (Lister-Sharp *et al*., 1999; Laurence, Peterken & Burns, 2007). Importantly, few studies acknowledge the differences between health promoting school initiatives which address psychological health and health promoting mental health initiatives in schools (e.g. Lister-Sharp *et al*., 1999; Stewart-Brown, 2006). Whilst both approaches aim to

implement a health promoting approach to psychological health, they differ in terms of their theoretical framework and therefore the mode of implementation. Cushman (2008) points out that many schools which view themselves as a health promoting school may, in reality, only adhere to some of the principles of a health promoting school as articulated by the WHO. Similarly, Simovska (2012) argues that whilst several reviews of the literature indicate that effective health promoting school approaches should be holistic in terms of health and implemented on many levels, many studies which purport to be health promoting school-based are still topic-focused from the outset and tend to prioritise individual-level health (e.g. see Stewart-Brown, 2006). For this reason, there is a need to differentiate between both health outcome results and process evaluation findings.

3.2 Literature review search strategy

A list of key terms identified as relevant to the evaluation of health promoting school programmes are provided in Appendix 3.1. An extensive search of several academic databases was conducted, including: Psychinfo; Education Index; EBSCO; ProQuest; ERIC; Scopus; Taylor & Francis Online; Cochrane database of systematic reviews; as well as the search engines Google and Google Scholar. An additional reference list was compiled through relevant articles, reviews and book chapters. An online search of individual journals was also completed; these are also listed in Appendix 3.1.

A number of search inclusion criteria were established to guide and frame the review. This criteria includes studies published after 1991 which evaluated a health promoting school approach - the European Network of Health Promoting Schools was formally established in 1991 by three partners: the European Commission, the Council of Europe, and the World Health Organisation Regional Office for Europe (Barnekow *et al.,* 2006). The search inclusion criteria is also comprised of studies of initiatives that included primary-school aged children (i.e. aged 4-13); literature reviews, systematic reviews and meta-analysis of health promoting school initiatives and studies written in the English language. Considering the broad and complex nature of a health promoting school, the review was not limited to studies which addressed psychological health and well-being. Process and impact evaluation findings relating to the broader structure of a health promoting school were also included as these provide valuable information concerning how a health promoting school approach can be effective in addressing

children's health. The literature pertaining to how a health promoting school approach can tackle health in schools is considered first, followed by an examination of some of the key challenges to the successful implementation of a health promoting school.

3.3 Addressing health (including mental health) through a Health Promoting School approach

3.3.1 Effecting change in children's health outcomes

A number of traditional literature reviews and systematic reviews have been published in the last two decades which purport to examine the effectiveness of health promoting schools. One of the first and best known is that conducted by Lister-Sharp and colleagues (1999), although only two of the twelve health promoting school studies that were included in their review measured psychological health. These two studies included in the review (Arora, 1994 Bullying initiative; and Jamison *et al.,* 1998, the ENHPS evaluation project in England) provided some interesting evidence of the positive impact of a health promoting school initiative on social and mental well-being (including self-esteem) when compared to comparison schools that did not have the intervention. For example, one of the studies that examined bullying behaviour reported lower levels of experienced bullying and aggression in the intervention schools. There were mixed findings, however, regarding increased awareness by the school community of health promotion, especially amongst the pupils.

Lister-Sharp and colleagues (1999) found that most of the health promoting school initiatives in their review led to improvements in health-related knowledge, although improvements in mental health-specific knowledge were not analysed separately. General improvements were also observed in terms of staff development, health promoting school activities, as well as the social and physical environment of the school. Whilst these findings suggest some positive improvements in health, the variability of change does not provide a clear indication of the effectiveness of the health promoting school approach. The authors further acknowledge that due to the complexity of health promoting school approaches, each initiative was unique in its design and implementation. Consequently, it is difficult to attribute specific components of the health promoting school to improvements in children's health. The review also reported that no intervention implemented *all* components of a health promoting school

approach, whilst limited sample size and a lack of explicitly stated theory in seven of the twelve studies further precluded any definitive conclusions.

More recently, Mukoma and Flisher (2004) completed a traditional literature review of nine health promoting school initiatives across the world. Similar to the review above, the interventions varied considerably with regard to the aspects of health which they addressed and the extent to which all of the components of a health promoting school were established. This review focused explicitly on initiatives which adhered to the WHO health promoting school ethos and only included programmes which: (a) were not based around a single topic from the outset; (b) encouraged schools to identify priorities; and (c) where the activities of the initiative were based on at least one of the components of a health promoting school (i.e. health education curriculum; involvement of wider community; school ethos and environment).

Overall, the changes in health outcomes amongst intervention schools were again mixed when compared to comparison schools and few significant differences were identified. The authors acknowledged that such mixed findings made it difficult to assess whether there had been any direct improvements on children's health as a result of the health promoting school initiative. Whilst none of the initiatives measured psychological health specifically, some interesting findings were reported regarding the broader structures of a health promoting school, such as improvements to the school ethos and environment as well as an improved awareness of health promotion. Two of the studies also identified an increase in health promotion-related activities with one study indicating that participating schools increased the availability of resources (i.e. time, personnel and funding) allocated to health promoting activities as a result of health promoting school implementation. Teachers' health-related knowledge was also found to have improved over the course of one of the included studies. There was also some evidence to indicate that these initiatives had a positive impact on health-related policy development in the schools concerned. For instance, one study reported positive developments although another indicated that little change had occurred (Mukoma & Flisher, 2004). Whilst the studies included in the review had to meet certain criteria (e.g. health promotion practices are addressed through ethos and/or environment of the school, the curriculum and family and/or community; information on programme implementation and content is provided; study incorporated a comparison group and/or

pre-post design; study reported on health-related outcomes), in many cases the evaluations did not report comprehensively on all elements of programme implementation. Thus, many of the studies focused on child health behaviours rather than broader school changes (i.e. policy, environment, interactions with the wider community) and few details concerning how the programmes were implemented on the ground were presented (Mukoma & Flisher 2004).

Importantly, a systematic review of reviews in this field was conducted by Stewart-Brown (2006) who examined the evidence for both school-based health promotion initiatives and 'health promoting school' initiatives. One of the reviews which specifically examined health promoting school initiatives was based on the Lister-Sharp paper discussed above. The author indicated that many of the other reviews included shorter-term, class-based programmes aimed primarily at improving knowledge and skills. Stewart-Brown (2006) concluded that these types of initiatives led to less effective outcomes than programmes which were multi-dimensional, and which addressed more than one domain of the school environment (i.e. curriculum, school environment and community). Interestingly, the author also suggested that all aspects of a child's life should be considered in health promoting school initiatives in order to effectively impact psychological health. He also called for a greater emphasis on process evaluations in future health promoting school evaluation studies as well as further investigation of what constitutes the different components of an effective health promoting school.

Mixed health outcome findings were also noted in a cross-national Cochrane review of 67 cluster randomised control trial studies on the effectiveness of health promoting school initiatives (Langford *et al.,* 2014). Whilst improvements in Body Mass Index (BMI), increased physical activity, nutrition and experiences of bullying were observed, there was limited evidence to indicate health promoting school effectiveness in terms of substance use, mental health and bullying behaviour. Langford and colleagues noted that the half of studies included focused on measures of physical activities and only three studies reported on emotional health outcomes specifically (Bond 2004; Fekkes, Pijpers, & Verloove-Vanhorick,., 2006; Sawyer 2010) and only one of these studies examined a primary-school-aged population (Fekkes, *et al.,* 2006). This again reflects a lack of evaluations of health promoting school initiatives that examine emotional health

and well-being and highlights the need for further research in this area. Cochrane reviews provide a high quality assessment of effectiveness, however the complete focus on child health outcomes without consideration of the processes experienced during the implementation stages of each study further limits conclusions drawn from this study.

Clearly, the evaluation of a health promoting school is a complex endeavour. In an effort to address some of the complexities inherent in implementing (and evaluating) WHO conceptualised health promoting school initiatives, some countries have developed *Healthy School* (HS) award schemes or standards whereby participating schools may aim towards a determined criteria of progress (e.g. Lee 2009; Lee, St. Leger, & Moon, 2005; Moon, *et al*, 1999). In this way health promoting school progress is monitored against a standardised set of criteria. These schemes set out the health promoting school framework upon which the initiative is based, thereby providing a clearer structure for both implementation and evaluation. Both the UK and Hong Kong in particular have well established HS award systems currently in place in primary schools. Whilst the idiosyncratic nature of the health promoting school ethos is maintained, a clearer model of the overarching initiative is established.

In the UK, Moon and colleagues (1999) observed that such schemes can have many positive results for participating schools (e.g. improved healthy food choices, increased involvement of wider community, more stimulating clean safe, tidy environment, more equal opportunities and access to health education). During the early stages of implementation of the UK National Healthy Schools Programme (NHSP), Moon and colleagues completed a three-year mixed method quasi-experimental evaluation of the Wessex Healthy School Award scheme (n=887). However, pupil health related behaviour outcomes for children aged 11-12 years (as well as 15-16 years) were found to change little between baseline and the 15-month follow-up. The authors suggest that the period of evaluation may have been too short to observe any significant changes in behaviour, but did note that school audit scores for most areas of health promotion had improved whilst staff and parents indicated that the HSP had a positive effect on how the schools addressed health. These findings suggest that systemic improvements in how schools address health, had occurred during the evaluation period, but that these had not translated into discernible change on the assessment measures. This discrepancy

between the quantitative and qualitative data led to illustrate the importance of including different data types when evaluating such initiatives.

More recent findings from a number of published studies evaluating the Hong Kong Healthy Schools (HS) Award scheme indicate some psychological health improvements in children attending the schools. For example, Lee, St. Leger, and Moon (2005) noted significant reductions in depressive symptoms, feelings of hopelessness and mild self-harm. Whilst these findings appear promising, the lack of a comparison school in this study makes it difficult to determine if these changes occurred directly as a result of health promoting school implementation. In a later study, Lee and colleagues (2006) further found that amongst schools who had achieved HS Award status, health status scores (including life satisfaction scores) had increased significantly. Reported self-harm as well as feelings of low mood also decreased significantly amongst children in participating schools when compared to control schools who had not achieved HS Award status. Children from HS awardee schools were also less likely to experience violent or anti-social behaviours when assessed against comparison schools (Lee, Cheng, Fung, & St Leger, 2006). In a third related evaluation, Lee and colleagues (2008) reported that students from schools who had attained HS Award status, also displayed improved personal hygiene practice, better knowledge on health and hygiene, and had a greater awareness on how to access health information.

Further research investigating the effects of the NHSP in England has provided mixed findings. For example, in a study by Schagen and colleagues (2005), comparisons between intervention and comparison schools on measures of health behaviour revealed very little differences between school types. Healthy School Level Three Awardee[5] schools did, however, display higher Ofsted[6] school inspection scores at a school level on most rating scales. School level Ofsted scales (which include measures of positive behaviour and school environment) revealed significantly higher scores on ten of the eleven scales, for HS Level Three schools when compared to non-Level Three schools

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[5] A Level Three Award is the highest standard a school can be awarded in their progress to incorporating a health promoting school approach. These awards are determined by the UK National Healthy School Standard led jointly by the UK Department of Health and Department of Education and Skills in partnership with the Health Development Agency (Warwick *et al.,* 2004).
[66] Ofsted is the UK Office for Standards in Education, Children's Services and Skills. Purpose of office is to independently regulate and inspect children's services and report on findings directly to the UK parliament. See www.ofsted.gov.uk

(Schagen *et al.*, 2005). However, this study employed a cross-sectional design and the authors acknowledge that as no pre-post measures of schools were undertaken, it is difficult to ascertain how each school improved over the course of achieving Level Three HS status. Furthermore, an assumption inherent in this study was that all schools, prior to health promoting school development work, would have had an equal baseline on measures of health which may not have been the case (Schagen *et al.*, 2005). Similar to previous studies, a significant minority of participating schools (40%) again did not provide clear information on the nature of the health promoting school initiative under investigation. This lack of specific detail limits the extent to which conclusions can be drawn about the impact of the initiatives on psychological health (Schagen *et al.,* 2005).

One notable study by Levin and colleagues (2012), albeit based on a cross-sectional design, was carried out to assess the impact of a health promoting school approach on the mental health of children aged 13 (n=1510) (as well as children aged 15 years) in Scottish HS scheme schools (n=1510). The study was based on data from a 2006 Health Behaviour in School-aged Children (HBSC) study in which mental health scores were compared between HS Award schools and non-award schools. The findings showed that larger proportions of children reported better subjective health and psychological well-being outcomes in health promoting schools when compared to non- health promoting schools. More specifically, an increased perceived level of inclusion in schools and improved awareness of health issues (by female students only) were observed amongst children in HS status awarded schools, although no differences on measures of life satisfaction, confidence or happiness were identified. Again, the study design and the lack of a process evaluation limit the extent to which any conclusions can be reached concerning how successfully the schools implemented the health promoting school ethos. The authors called for further investigation of mental well-being in schools using measures of well-being that went beyond those used in the HBSC study (Levin, Inchley, Currie & Currie, 2012).

As outlined above, measurements of children's health and well-being may not always improve as a result of health promoting school implementation but equally, these may not provide a complete picture of programme success. Exploring the broader organisational changes which occur as a consequence of a health promoting school initiative is essential to understanding how these kinds of initiatives can support the

school's capacity to address children's health (Arthur *et al.,* 2011; Inchley, Muldoon, & Currie, 2006; Levin *et al.,* 2012; Simovska, 2012). For example, children's awareness and understanding of psychological health may be achieved through policy changes in how the school community addresses mental health issues. Similarly, how children's psychological health needs are addressed may be impacted through the improvement of mental health service collaboration with schools. If objective pre-post psychological health outcome measures are solely used as the indicator of success, these important, albeit indirect indicators of change may be overlooked (Judd, Frankish, & Moulton, 2001; Rowling & Jefferys, 2000), thereby jeopardising the entire process of building a broader health promoting school ethos. Thus, a number of studies (i.e. Arthur *et al.,* 2011, Inchley *et al.,* 2000; Inchley, *et al.,* 2006; Moon *et al.,* 1999) argue that care is also needed when concentrating on short-term health outcomes both in implementation and evaluation of his model. If unrealistic goals are set and not met (i.e. expectations of significant short-term improvements in children's health outcomes), a school's progress in implementing the health promoting school model can be undervalued which, in turn, may lead to reduced motivation towards implementing the model. As a consequence long term health improvements are also less likely to be realised.

Arthur and colleagues (2011) completed a two-year mixed methods evaluation of the National Healthy Schools Programme (NHSP) in England, the findings of which indicated little improvement on measures of emotional well-being amongst the sample of children (n=4182) across 102 primary schools. Whilst the authors acknowledged the methodological limitations of this work (e.g. low response rates, sample size and time restrictions) the organisational level evaluation component of the study indicated a number of school changes over the course of programme implementation. Such changes included: more collaboration with external services, activities addressing psychological health promotion in schools (i.e. anti-bullying week), and school ethos development work, including additional support for staff mental health and peer relationship work. In this study, several improvements were clearly observed over the course of implementation in terms of how the schools addressed health even though health outcomes did not improve significantly. This further reinforces the argument that evaluations of a health promoting school approach need to go beyond health outcomes to sufficiently assess the efficacy of such initiatives.

Evidently, there are many factors to consider in the evaluation for health promoting school initiatives. Indeed, there is continued debate as to what may be considered appropriate indicators of success (e.g. Barnekow, *et al*., 2006; Marshall *et al.,* 2000). Mukoma and Flisher (2004) further suggest that these will differ depending on the priorities set out by each school and the chosen mode of implementation. In this way, blanket approaches to health promoting school evaluations are often not useful due to the distinctive nature of each initiative under investigation. However, St Leger, Young, Blanchard, and Perry (2010) maintain that school-based initiatives which address the psychological health needs of children effectively have a number of basic shared characteristics which need to be assessed including: linking the entire school community (Bond *et al.*, 2004; Lister-Sharp, Chapman, Stewart-Brown. & Sowden, 1999); addressing both individual and community needs (Weare, & Markham, 2005); seeking to be evidence based (Green, Howes, Waters, Maher, & Oberklaid, 2005; Wells, Barlow, & Stewart- Brown, 2003) and addressing the ethos and policy of the school (Wells *et al.*, 2003). Many of these components have been discussed in this chapter. The last of these components forms the focus of the next section.

3.3.2 Implementing health promoting policies

Arguably, it is difficult to properly address children's psychological health in the absence of appropriate policy guidelines and supports. As outlined above, school policy development is a key pillar of health promoting schools. Health promoting policies (from government to local level) are also central to increasing the capacity of schools to effectively address the health issues of the school community in a sustainable way (IUHPE, 2009; Leurs *et al*., 2005; Moyses, Watt & Sheiham, 2003). For example, Mukoma and Flisher (2004) identified a positive association between health promoting policy improvements and the perceived amount of interaction between schools and the wider community, thereby creating a more inclusive school environment. Gleddie (2011) also found that greater resources were allocated to health-related work in schools as a result of these shifts in policy and particularly with regard to psychological well-being, physical activity, nutrition and healthy eating. Policy changes also led to improvements in school health procedures, such as more efficient health databases for pupils. These kinds of changes can all potentially lead to a more sustainable and organised school-led approach to meeting the health needs of the school community (Gleddie, 2011).

Effective health promoting policies and practices which address both the school academic and social environment can improve children's emotional well-being as well as their academic outcomes (Lister-Sharp, Chapman, Stewart-Brown & Sowden, 1999; Young, & Currie, 2009). Similarly, the prioritisation of social inclusion in school policies has led to improvements in academic and health outcomes (e.g. Greenberg, *et al.*, 2003). The effects on teachers are also important; for instance Adamson, McAleavy, Donegan, and Shevlin (2006) found that where schools maintained clear health education policies, teachers' perceptions of health education practices were significantly more positive when compared to schools with no formal policies in place.

Available evidence also points toward positive changes in school health-related policy following the implementation of a health promoting school approach. Whilst the majority of this work focuses primarily on nutrition rather than psychological health, it still provides useful evidence around the importance of integrating policy with health promoting school work on the ground. Evaluations of the NHSP in England indicate that this initiative has supported schools in addressing health related issues through the development of relevant policies aimed at achieving a more health promoting approach in schools (e.g. Warwick, *et al.,* 2009; Arthur *et al.,* 2011). Similarly, Lee, St. Leger, and Moon (2005) found that the proportion of participating schools (in the Hong Kong HS awards scheme) that had established healthy eating policies had almost doubled between baseline and follow-up. A process evaluation of the Hong Kong HS scheme further identified improvements across schools in terms of up-to-date health policies (Lee, *et al.*, 2005; Lee *et al.*, 2008). In addition, Lee, and colleagues (2007) found that if schools work to develop health-related policies and put them into practice, they were more likely to attain better health promoting school standards, thereby improving their capacity to address the health needs of their pupils.

Despite these positive developments, there are many barriers to implementing health promoting school policy. This is illustrated well by an RCT-based evaluation in Australia which showed that, whilst an awareness of the importance of health promotion by staff did increase in health promoting schools (n=20 schools) when compared to control schools (n=18), structural changes proved more challenging. Indeed, there was little evidence of participating schools adapting at a systems level to support a more

health promoting ethos (e.g. health-related policy changes, changes to the physical and social environment) (Mitchell *et al.*, 2000). These findings support those from elsewhere which suggest that the successful implementation of school policies requires the understanding, support and collaboration of the entire school community (e.g. St. Leger, 1998; Gleddie, 2011). Overall therefore, whilst few studies have focused specifically on mental health policy, the available findings indicate that improved health policies in general help to increase the capacity of a school to address all of the health needs of the school community.

3.3.3 Developing effective collaboration between schools and the health service

The effective co-ordination of education and health services can help to develop clearer and more efficient pathways of care for children and their families. In Ireland, a number of efforts, (e.g. improved communication and information-sharing pathways, inclusive and collaborative school-health policies) have aimed to improve these links (Department of Health and Children, 2007). For example, a report by Eurochild (2011) describes an innovative approach in Germany where family multidisciplinary services are all based in one centre that maintains direct links to schools and where early support and intervention for children and families is the primary objective. In Ireland, a review of cross-sectoral approaches for early school leaving prevention, further endorsed this model of care which aims to minimise a fragmentation across services (The Alliances for Inclusion report; Edwards & Downes 2013). Similarly, several studies have also highlighted the importance of cross-sector collaboration in ensuring that a health promoting school approach can effectively address the health needs of the school community (Allenworth, 1995; Barnekow *et al.,* 2006; Cushman, 2008; Kolbe, 1993; Lee *et al.,* 2007; Marshall *et al.,* 2000). This example of targeted supports within a universal approach to health promotion and prevention illustrates the potential of the HPS model. More specifically, work conducted by a number of authors has shown, perhaps unsurprisingly, that access to health services should be a key component of any school health initiative and can enhance their HS status (e.g. Arthur *et al*., 2011; Lee *et al.* 2007; Warwick *et al.,* 2004).

Whilst there is evidence to suggest that the implementation of a health promoting school ethos can support improved school-services collaboration, there may also be challenges. For instance, participants in the study by Warwick and colleagues (2004), indicated that

considerable time and resources were required to establish links with agencies whilst the difficulty in sustaining such links was also highlighted. Participants further reported that whilst such partnerships were useful for supporting schools in delivering specific services or activities, they were perceived as less useful at a strategic planning level. Differing perspectives of health across the health and education sectors and, in particular, the predominant 'medical model' view amongst health services personnel, had limited the engagement of health services with the more holistic health promoting school ethos.

Broader national issues have further hindered sustained cross-sector collaboration. Thus, in the above study, Warwick and colleagues (2004) also noted that structural and staff changes within the health services had a negative impact on the level of engagement between schools and the health services. Similarly, an EU Commission report on early school leaving (2013) notes that "*successful and sustainable cooperation takes time to develop; local and regional cross-sectoral cooperation needs sustained support from higher political levels*" (p15). Likewise, in an Australian review of health promoting school practices, Marshall and colleagues (2000) observed that links between the wider school community and the health service, did not properly materialise except in emergency situations. These studies indicate the challenges inherent in trying to create meaningful links between the, often very different and ideologically separate, education and health sectors, as well as the need for appropriate time and resources to facilitate the communication process. In response to such challenges, the EU Commission report (2013) outlined a number of enabling factors necessary for effective cross-sectoral collaboration. These include: formalised inter-agency or inter-institutional arrangements; ensuring that schools play a central role; involving and engaging with both pupils and parents; and creating opportunities for stakeholders to learn about effective cooperation. However, despite the importance of cross-sector partnership, few studies have examined specifically how the implementation of a health promoting school approach has changed how schools and health services (including mental health services) collaborate to address the needs of children. Nevertheless, it is apparent from the work completed, to date, that the establishment of strong health service-school collaborative links, in general, are important in supporting schools to effectively address the health needs of their pupils.

3.3.4 Promoting family involvement and collaboration

A systematic review by Weare and Nind (2011) of school-based mental health programmes reported that increased family involvement in school psychological health initiatives can lead to greater health benefits for children. This may take the form of increased reinforcement of health messages as well as improved communication between children, their families and the schools. Denman (1998) highlights that in general parents are interested in their children's health education and want to be consulted on school health related activities. In practice however, school policies in this regard are often not consistent and contact between schools and families can vary considerably across schools. In addition to developing links with multi-disciplinary professional services, the health promoting school approach aims to develop better links with the wider school community and especially families of children attending health promoting schools. The International Union for Health Promotion and Education (IUHPE, 2009) suggest that increased family involvement and collaboration with schools is central to the establishment of positive relationships between the school and community. These improved relationships have also been found to increase health related activities in schools as well as reduce the communication barriers between the home and school environments for the child (IUHPE, 2009).

Some evaluations have indicated improvements in school-family involvement as a result of health promoting school activities. For example, the findings of two process evaluations of the Hong Kong HSP illustrated improved links with the wider community as well as increased involvement of parents amongst participating schools (Lee, *et al*., 2005; Lee *et al*., 2007). Similarly, more recent case studies of the effects of the NHSP in England suggests that health promoting school schemes have supported schools in establishing improved partnerships with the wider school community, including families (Warwick *et al.,* 2009). The implementation of the HSP was also found to increase the perception by the wider school community that the school advocates an ethos of social inclusion (Warwick *et al.,* 2009). Interestingly, Stewart-Brown (2006) also reported that where family involvement was targeted by health promoting school initiatives, health knowledge was found to improve amongst families, thereby indicating further benefits as a result of increased family involvement.

Conversely, a number of studies have shown that attempts to increase the involvement of families and the community is one of the most challenging aspects of implementing an health promoting school ethos within schools (Deschenes *et al.*, 2003; Inchley, Muldoon & Currie, 2006; Mitchell *et al.,* 2000; Senior, 2012). For example, Senior (2012) found in their evaluation of health promoting school planning in Australia that, whilst schools made efforts to involve parents in different ways (e.g. school audits, programme steering committees), parent involvement in the planning and implementation of a health promoting school initiative proved challenging. Specific reasons for this lack of engagement were not identified although feedback from staff indicated that, going forward, schools hoped to create more opportunities for parental involvement to increase parental support for the implementation of health promotion initiatives. Clelland, Cushman, and Hawkins (2013) note that a lack of guidance for staff on how to engage with parents around health issues may be a primary impediment to parental involvement in school health promotion planning and implementation. In their case study of six New Zealand schools, they observed that a lack of understanding by staff of how to involve parents as well as a lack of understanding of collaboration in health promotion led to reluctance to engage with parents in this way. Despite these difficulties, Clelland and colleagues (2013) acknowledge there would appear to be a general consensus on the importance of community partnership with schools and its centrality to establishing an effective health promoting school ethos in schools (e.g. see Young, St Leger, Buijs, 2013). It is likely that the creation of appropriate and timely opportunities to involve families in a democratic and collaborative way might help to address some of the challenges of engaging them in the successful implementation of a health promoting school ethos and culture.

3.3.5 Promoting a positive school ethos

The importance of promoting a positive school ethos when implementing health promoting school initiatives has already been mentioned in the context of some of the studies discussed above and, indeed, this was highlighted specifically in a traditional review of the literature by Greenberg and colleagues (2001). Arguably, the multilevel nature of the health promoting school approach is an important factor in helping to improve the overall school ethos and environment (IUHPE, 2009; Sun & Stewart, 2007). Rowe and Stewart (2009) maintain that the development of a health promoting

school ethos can positively impact on how the entire school community interact with each other as well as how school staff engage with and involve the wider community in a constructive and supportive way. Thus, improving access to health services, increasing the supportiveness of staff and students, building school relationships with the local community, enhancing family involvement and promoting supportive and non-judgemental policies are all key components of a health promoting school approach which contribute to a positive social and physical school environment/ethos. This in turn is important in promoting, amongst other things, children's psychological well-being (Barnekow *et al.,* 2006; Cushman, 2008).

There are a number of ways in which a positive health promoting school ethos can be nurtured and developed. These might include promoting a sense of ownership whereby all staff are consulted about, and involved in, programme planning and implementation process, and/or using resources to make improvements to the physical environment (e.g. equipment, facilities) (Moon *et al*., 1999; Lee *et al*., 2005, Warwick, 2009). Clearly, however, some components of the school environment were more challenging to address than others. For example, Marshall, and colleagues (2000) in their study of Australian health promoting school schools reported that the schools were *"most comfortable and confident with welfare, pastoral care, and social aspects of the health promoting school framework, and least confident in developing and using wider community and health resources"* (p252). Thus, the development of a positive school ethos is inextricably linked with other issues discussed earlier in this chapter, such as developing links with health services and engaging meaningfully with families within the wider community. For this reason, it has been suggested that further clarification is required on all components of a health promoting school in order to help schools better understand how all aspects of a school environment can help to improve the health of the school community (St. Leger, 1998).

3.4 The process of implementing Health Promoting School Initiatives

When evaluating health promoting school initiatives and how these programmes impact schools (both at an individual and organisation level), it is an important to identify *why* and *how* any changes (or lack thereof) have occurred. To this end, process evaluations may also be conducted to assess the developments that occur during programme planning and implementation and ascertain how these processes influenced the overall

effectiveness of the initiative. *"Process evaluation is used to monitor and document program implementation and can aid in understanding the relationship between specific program elements and program outcomes"* (Saunders, Evans & Joshi, 2005, p134). Thus, findings are also useful in identifying the strengths and weaknesses programmes which in turn can help to develop and improve ongoing programmes (Durlak & DuPre, 2008).

Despite the potential utility of such findings, few studies have explored the implementation context. In a review by Domitrovich and Greenberg (2000), approximately one-third of 32 evaluations of evidence-based mental health programmes examined implementation. Nonetheless, the complexity of health promoting school initiatives and the broad scope of various conceptualisations therein highlight the importance of assessing the process of implementation (Nutbeam, 1998). Indeed, as already indicated earlier in this thesis, there would appear to be some variation around the conceptualisation of health promoting schools 'on the ground' versus in the research literature. Thus, whilst there has been an increasing acceptance of the theoretical principles of a health promoting school, the practical implementation of these principles still varies widely both within and across initiatives. Some initiatives and the evaluations of those initiatives work in line with the WHO definition and aim, therefore, to address aspects of health in a holistic way but many others define topic specific evaluations where a health promoting school approach was used (e.g. Lister-Sharp, 1999; Stewart-Brown, 2006).

The lack of a universal agreement on what constitutes a health promoting school is an important barrier to the successful implementation of health promoting school initiatives internationally as well as their subsequent evaluations. Several authors (e.g. Guggleberger & Inchley, 2014; Nic Gabhainn, *et al.,* 2010; St. Leger, 1998; Stewart-Brown, 2006) have highlighted the importance of programme design in addressing such challenges as well as calling for greater clarity in the literature on how health promoting schools are defined and in what way initiatives are implemented. Over 10 years ago, Mukoma and Flisher (2004) argued that the health promoting school concept was still developing and that core characteristics ought to be identified and measurement indicators operationalised from the outset. Unfortunately, since then only a few studies

have described in detail their programme design as well as details around their implementation. This has been an important factor in restricting progress in the development and evaluation of health promoting school initiatives. However, the small pool of studies which do examine the process of planning and implementation of health promoting school initiatives have provided many interesting and useful findings and especially concerning the main challenges and facilitators of health promoting school practice. These are discussed in the following section.

3.4.1 Developing a shared understanding of what constitutes a health promoting school

A shared language of a health promoting school between all stakeholders is critical for initiative objectives to be defined, understood and realised (IUHPE, 2009). For example, the way in which psychological health can be addressed through a health promoting school initiative depends, at least in part, on the way in which such objectives are defined and understood. This may involve simply the provision of appropriate and timely information/literature and guidelines on mental health to participating schools (Bruce, Klein, & Keleher, 2012). However, it has also been suggested that the continued use of 'medical model' terminology when describing health promotion initiatives can inhibit the development of a successful health promotion model in schools as defined by WHO, whilst the same is true of persistent differences in the kind of language used across the health and education sectors (Inchley, Muldoon, & Currie, 2006; Leurs *et al*., 2005; Terre, 2008). These differences in language and ideologies can create many challenges in designing and implementing a health promoting school initiative.

Differences in language may also be evident within the education sector itself. Marshall (2000), for example, found that the term 'health promoting school' was understood in different ways across different schools. In some schools, this term was perceived as a philosophy, an ethos to be developed and modelled by the school itself to address the communities' health needs in line with the WHO conceptualisation of a health promoting school. In other schools, however, a health promoting school approach was perceived as an activity separate from the main running of the school whilst others saw engaging with HSP initiatives as simply being part of a network of schools who are stating their commitment towards addressing health (Marshall, 2000). Clearly, such

different conceptualisations may impact on how school staff will attempt to incorporate the health promoting school ethos in a standard and sustainable way. This lack of understanding and agreement amongst the school community, as well as a lack of consultation with parents and support staff and inadequate training has all been identified as key challenges to the successful implementation of a health promoting school ethos (Leurs *et al.*, 2007; Moon *et al*., 1999; St Leger, 1998).

3.4.2 Supporting the implementation process

In an effort to address these fundamental planning and implementation issues, some initiatives have developed (or recommended) specific strategies to support the health promoting school process. For instance, Inchley and colleagues (2006) have argued that a clear structure of management and roles along with the structured involvement of the wider community in all stages of design, planning and implementation are key to the sustainability of health promoting school -related school improvements. More specifically, a number of authors have found that the setting up of school-based health promoting school steering groups/committees provides a useful framework for schools in planning and designing health promoting policies, procedures and activities (Lee, St. Leger, & Moon, 2005; Leurs *et al.*, 2005; Senior, 2012). These committees aim to engage with various stakeholders and work towards developing all components of a health promoting school ethos. Perhaps unsurprisingly, this kind of shared responsibility amongst school staff and indeed amongst all stakeholders (e.g. the creation of health committees) has been identified as crucial to the success of this type of initiative (Mitchell, *et al*., 2000).

3.4.2.1 Importance of HSP support staff

At the same time, these kinds of groups/committees/teams can be difficult and time-consuming to develop, especially when time and resources are limited. It is also often the case that one or two champions are required to drive the initiative forward (e.g. Gleddie, 2011; Weare & Nind, 2011). For this reason, the appointment of a health promotion coordinator to support schools in taking responsibility for the planning and implementation of health promoting school work has been recommended (e.g. Cushman, 2008). Almost 15 years ago, a British author called Weare (2000) was among the first to identify the need for such a role to ensure primarily that any initiatives put into practice are based, not only on the needs of any school, but on the priorities

identified by the entire school community, thereby ensuring a bottom-up approach. In this way, where appointed, HSCs can have the capacity to guide and encourage democracy, participation and collaboration amongst the entire school community with the aim of incorporating a health promoting school ethos into the daily school environment (Cushman, 2008).

Indeed, one evaluation of a HSC-led coordinated school health programme in the US suggested that the provision of a HSC as an additional staff member (coordinating less than three schools) was linked to an improved health education curriculum as well as greater improvements in the development, implementation, and sustainability of health related policies (O'Brien *et al.,* 2010). Likewise, Inchley and colleagues (2006) reported that the appointment of a senior member of staff as a school-based coordinator of a health promoting school initiative was important in gaining enthusiasm and support by the school community for the work. This suggests that the role of the HSC may still be effective in leading and supporting the implementation of a health promoting school ethos even if it is assumed by an existing member of the school community.

However, according to Leurs and colleagues (2005), a regional coordinator should also be involved as an external support to schools, thereby reflecting the importance of fostering broader support at a national level for health promoting school plans. For example, HSCs are provided at a regional area as part of the UK National Healthy School Standards and are involved in supporting schools in developing and implementing health promoting school initiatives as well as collaborating with schools to evaluate progress (UK National Healthy Schools Standard, 2000). The findings of a recent evaluation of this service suggest that this 'link person' played an important role in helping schools to progress the implementation of health promoting school procedures and practices (Arthur *et al.,* 2011). The kind of support provided varied from one-to-one support for staff on issues such as implementing an audit as well as delivering group level training and guidance. This work highlights the intrinsic value of a national level health promoting school structure.

3.4.2.2 School ownership and staff buy-in
Whilst external guidance is clearly important, school ownership and 'buy-in' from all staff is also essential for a successful and sustainable initiative and, again, this appears

to be inextricably linked to the development of an effective health promoting school ethos/culture. Turenen Tossavainen, Jakonen, and Vertio (2006) also point out that a bottom-up approach involving all members of the school community is essential. Leurs and colleagues (2007) identified, for instance, that teachers' enthusiasm for health promotion initiatives was associated with positive pupil feedback on the initiatives. This suggests the wider influence on school-level buy-in in terms of the acceptance of health promoting school practices by the school community. Gleddie (2011) argued in favour of *both* top-down and bottom-up processes are necessary for successful implementation of a health promoting school approach. Thus, the way in which the programme is coordinated and managed at senior level is important, as is the buy-in from everyone 'on the ground'. Interestingly, Gleddie's (2011) case study evaluation of a Canadian health promoting school initiative noted the importance of the involvement of different staff members from the beginning of the programme who participated in developing goals and organising health related activities. A further related aspect was the 'readiness' of the school community for change and their willingness to address and improve how health is addressed in their school. Furthermore, the significance of principal buy-in cannot be underestimated. The principal's role as both a leader and a key influence on other school staff in terms of their enthusiasm for driving innovative projects like a health promoting school approach has been highlighted by a number of studies (Aggleton *et al.*, 2000; Deschesnes, Trudeau, & Ke´be, 2010; Lindahl, 2010; St. Leger, 1998). For example, Valois and Hoyle (2000) reported, perhaps unsurprisingly, that when a principal shows an interest in the values and objectives of a health promoting school approach, more positive changes are likely to occur. This highlights the importance of programme administrators/funders engaging with key staff members and ensuring buy-in prior to the implementation of these kind of initiatives.

3.4.2.3 Additional key components facilitating the establishment of a health promoting school approach

In addition to the involvement of staff and the establishment of an in-school steering committee, the IUHPE (2009) highlight a number of additional key factors that facilitate the capacity of the school to effectively address health in an health promoting school way. These include: the development of agreed objectives between different stakeholders and how to achieve them; the establishment of a health promoting school philosophy statement and charter approved by all stakeholders; and the development of

self-audit processes to identify areas of health to be prioritised at a school level. Senior (2012) provides an example of this in a previously mentioned evaluation of a health promotion initiative in Australia. In an agreement of terms between schools and a local service, the health services agreed to provide school support via a health promotion officer whilst the schools agreed to set up a committee of school members to complete an audit of health practices and also to engage with a health promoting school evaluation. In this way, a close partnership between health and education was established from the outset and stakeholders' responsibilities were clearly defined (Senior, 2012). Pre-implementation training by the health services as well as ongoing opportunities for discussion and relationship building also helped to establish a meaningful partnership between key education and health stakeholders. These findings suggest that some kind of pre-implementation work is important in providing a strong foundation for any health promoting school initiative.

Senior (2012) also emphasises the value of conducting a school-led audit in establishing a health promoting school ethos. Indeed, the completion of a needs audit by schools at the outset of any initiative is highlighted across the health promoting school literature (e.g. Arthur *et al.,* 2011; Leurs *et al*., 2005; Leurs *et al.,* 2007; St. Leger & Nutbeam, 2000). These are important in identifying the needs of a school in order to focus planning and design as one of the first steps in the implementation of a health promoting school (Leurs *et al*., 2007). If conducted effectively, schools themselves identify which areas of health should be prioritised and in this way, the nature of health promotion work is relevant to the needs of each individual school. As a result, the school community is more likely to get involved, thereby increasing the possibility of sustainable and manageable improvements in how schools address health in an inclusive way. This flexibility to adapt a programme to the needs of any individual school is a central component of the health promoting school model, although it is important to note that this should be followed up by a structured plan of action (Mitchell, Palmer, Booth, & Powell-Davies, 2000). It is this aspect, perhaps, which is more challenging in terms of practical implementation and maintenance.

On a related point, several studies in the literature have identified workload concerns amongst some school staff involved in health promoting school programmes. Understandably, endeavouring to implement a health initiative in an environment where staff are already under pressure to maintain and often improve upon academic

standards, may raise some concerns and a perception amongst teachers of an additional burden (Aggleton, *et al*., 2000; Rowe & Stewart, 2009). According to St. Leger (1999),*"it may be unrealistic to expect teachers to adopt the agenda of the health sector and involve themselves in more direct interventions outside the classroom which seek to improve the health of their students"* (p66). Therefore, it is important to establish the link between learning and health from the outset and ensure that the education sector is aware of how a health promoting school approach can support *both* educational and health outcomes (Rissel & Rowling, 2000; IUHPE, 2009). This might also involve developing the perception that this approach is a 'way of being' for schools rather than a discrete add-on whilst also building a momentum amongst the school community (Inchley *et al.,* 2006).

3.4.2.4 The role of cross-discipline collaboration

Another key challenge, in this respect, is convincing the health sector that it should embrace the concerns of educationalists and address health promoting school in a way that facilitates academic achievement whilst also addressing the health needs of children. This kind of inter-agency thinking and working is notoriously difficult and not least when the goals of each sector may be perceived as ideologically different and very distinct from each other (Weare, 2007). Arguably, however, improvements in one area will support improvements in the other (Barnekow *et al.*, 2006), whilst an effective school is one in which children's overall development is supported (Guldbrandsson & Bremberg, 2005). The findings of the systematic review conducted by Murray Low, Hollis, Cross, and Davis (2007) on the impact of a health promoting school approach on academic achievement, helps to clarify, at least to some extent, how such initiatives can address the educational outcomes of children and how health and education are intertwined. For example, whilst the evidence is somewhat mixed, the authors suggest that additional health and nutrition services, as well as psychological health initiatives, in the school setting may contribute to positive educational outcomes (Murray *et al.,* 2007).

Inchley, Muldoon, and Currie (2006) identified in their evaluation of the national framework for HPS in Scotland, that the involvement of the Education Department had benefitted participating schools in a number of ways including, in particular, the provision of professional guidance in the areas of policy change, staff training and

curriculum, all of which are considered important positive supports for schools in implementing a health promoting school ethos. Increased governmental support and involvement are also needed to facilitate greater efforts towards joined-up thinking on how both the health and education sectors can support schools effectively, thereby increasing the likelihood of a shared understanding of a health promoting school ethos and its objectives (Bruce, *et al.,* 2012; Stokes & Mukherjee, 2000). However, several studies have also noted that staffing, time and other resource constraints are important factors in predicting the extent to which schools do/do not adopt a health promoting school approach and thus whether the health promoting activities can be sustained over time (e.g. Bruce*, et al.,* 2012; Deschesnes, Trudeau, & Ke´be, 2010; Leurs *et al*., 2007; Senior *et al.,* 2012). Not surprisingly, Deschesnes, Trudeau, and Ke´be (2010) highlights for example that constraints faced by schools mean that some schools may resist such initiatives unless adequate support and commitments are provided at a national government level.

Warwick and colleagues (2004) further highlight the importance of allowing adequate time for the establishment of a successful health promoting school initiative and, in a more recent study undertaken in Britain, Senior (2012) reported that it took nearly a year for the initial planning of the initiative to be completed. Thus, the comprehensive implementation of these kind of initiatives may take years to fully bed down and lead to meaningful changes in children's health. As mentioned earlier in this chapter essential elements at the outset might include agreeing the terms between education and health stakeholders, completing a school audit and establishing key health promoting school structures (such as the steering committee), and all of these may require considerable resources. The way in which funding is provided is an also important contributory factor in the sustainability of these types of initiatives. Not surprisingly perhaps, Mukoma and Flisher's (2004) review identified that the provision of funding had a significant positive impact on the implementation of health promotion activities. Interestingly however, where schools progressed the health promoting school initiative by focusing on initiatives already established in schools - instead of developing new health promotion initiatives and activities - external funding was not perceived as essential to the success of the initiative. Other schools reported providing *new activities* as a result of funding, in which case funding was deemed to be essential to the successful roll-out of the health promoting school programme of work (Mukoma &

Flisher, 2004). In the same way, Inchley, Muldoon & Currie (2006) found in their evaluation, that whilst financial support was important in initiating changes, it was not, in itself, an essential component for successful implementation. Importantly, respondents in this study indicated that where schools were provided with their own small budget, this led to a sense of responsibility and empowerment around the implementation of the health promoting school work. This suggests that, although important, health promoting school -related funding should be incorporated into the existing plans of individual schools rather than provided as an 'add-on' resource.

3.5 Conclusion

The available evidence suggests that health promoting initiatives which involve longer term, multilevel integrated approaches, provide more evidence of effectiveness than short curricula-based topic specific approaches (Senior, 2012; Stewart-Brown, 2006; St Leger, 1999; St Leger & Nutbeam, 1999; Wells *et al*., 2003). The World Health Organisation (1997) further maintains that the health promoting school approach, if implemented effectively, is potentially the most efficient method to comprehensively address the health needs of children in an educational setting. The literature reviewed in this chapter indicates that, whilst improvements in health outcomes are mixed, health promoting school initiatives can indeed improve, albeit to varying degrees, how schools address health in various ways. It is apparent, though, that both the implementation and evaluation of health promoting school initiatives is still very much evolving and that a number of challenges still exist in implementation including in particular: developing a shared understanding of the principles and application of health promoting school practices; implementing a school-led approach; building effective collaboration; and tackling broader issues such as adequate support and resources.

All these factors may both support and inhibit the progress of health promoting school initiatives. However, an examination of these through rigorous evaluation should help to inform the planning and implementation processes underpinning health promoting school programmes and to identify and tackle barriers going forward. To date, however, there are very few mixed method studies which comprehensively evaluate health promoting school initiatives as defined by WHO (Deschesnes, Martin, & Jomphe-Hill,

2003; Dooris, 2005; Lister-Sharp, 1999) whilst several authors over the years have also called for further studies of the facilitative and inhibitive factors which influence effective implementation (e.g. Deschesnes, Trudeau & Ke´be, 2010; Inchley, Muldoon & Currie, 2006; Lister-Sharp, 1999; Mukoma & Flisher, 2004; Stewart-Brown, 2006; Clarke *et al.,* 2010).

In terms of psychological health more specifically, and as indicated earlier, there are numerous studies examining universal and targeted school-based mental health promotion initiatives, but only a small number have evaluated how psychological health is addressed by health promoting school programmes as conceptualised by the WHO (e.g. Levin, *et al.,* 2012). Some of these studies have provided evidence on psychological well-being and emotional health, but the results thus far have been mixed. Furthermore, it would appear that exploring the effects of a health promoting school approach on psychological health using only health outcome measures, may not be sufficient to comprehensively determine the value of these types of programmes. As with all aspects of health, a more in-depth analysis of health promoting school initiatives and the extent to which they address psychological health is needed in order to explore the broader process of implementation. Again, less concrete and tangible factors such as the school ethos, health policies and collaboration with external agencies (and parents), as well as the numerous facilitators and inhibiting factors within initiatives, all need to be considered when evaluating any health promoting school initiative in terms of how such initiatives can address children's health needs and in particular (in the context of the current study), their psychological health. In addition, broader implementation issues such as programme design and implementation fidelity and quality all need to be explored in the context of process evaluations. Whilst a small number of more recent evaluations have used mixed method approaches, more are needed, whilst few of these have focused on psychological health specifically.

There are a number of reasons for the lack of comprehensive evaluations. In addition to various resource limitations, there are differing perceptions in the research literature surrounding even fundamental elements of a health promoting school. This has led to variation regarding what constitutes such programmes (e.g. examples of different kinds of studies which have different focus) and consequently how each should be evaluated (St. Leger, 1999). Evaluations of the processes inherent in health promoting school

initiatives in general are also difficult and complex as, in contrast to pre-designed topic specific interventions, the outcomes are often less tangible (Moon, 2000). The ecological model addressing all aspects of the school community is a complex shifting one which creates difficulties for many traditionally framed evaluation methods (e.g. Nutbeam *et al.,* 1993; Weiler, Pigg, & McDermott, 2003). The idiosyncratic school-led nature of the health promoting school also creates obvious difficulties in the replication of initiatives and evaluation studies. This may explain why the many earlier evaluation studies examining their efficacy are often exclusively outcome motivated and tend to concentrate on a subset of the primary pillars of a health promoting school. Indeed the practical difficulties in achieving adherence to such a holistic and multifaceted model have been highlighted as a factor in many health promoting school initiatives of reverting to the traditional topic-specific individual-based intervention model (e.g. Dooris, 2004; Dooris, 2005).

CHAPTER FOUR

METHOD I: OVERVIEW OF DESIGN AND RELATED ISSUES

The current chapter sets out the overall design of this study. Details of the theoretical rationale underpinning the study design are presented followed by a discussion of pertinent ethical considerations.

4.1 Study design: An overview

This study formed part of a larger project undertaken to evaluate the impact of a health promotion (HP) programme on the overall health of primary school-aged children attending DEIS band 1[7] schools. The study was conducted in two phases. Phase one focused specifically on the impact of the HS programme on the psychological health and well-being *outcomes* of children. Phase two of the study was concerned with understanding how the HS programme was working in general and in what ways psychological health was being addressed (if at all). Chapter Five provides more detailed information on each phase.

In order to address the study objectives, a quantitatively driven concurrent mixed methods design (i.e. quantitative and qualitative methods) was used. Findings from the different methods were integrated in the discussion stage of the study. The methodological framework is illustrated in Figure 4.1 below.

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[7] Delivering Equality Of Opportunity In Schools (DEIS). DEIS band 1 schools are schools designated as being in areas of significant social and economic disadvantage
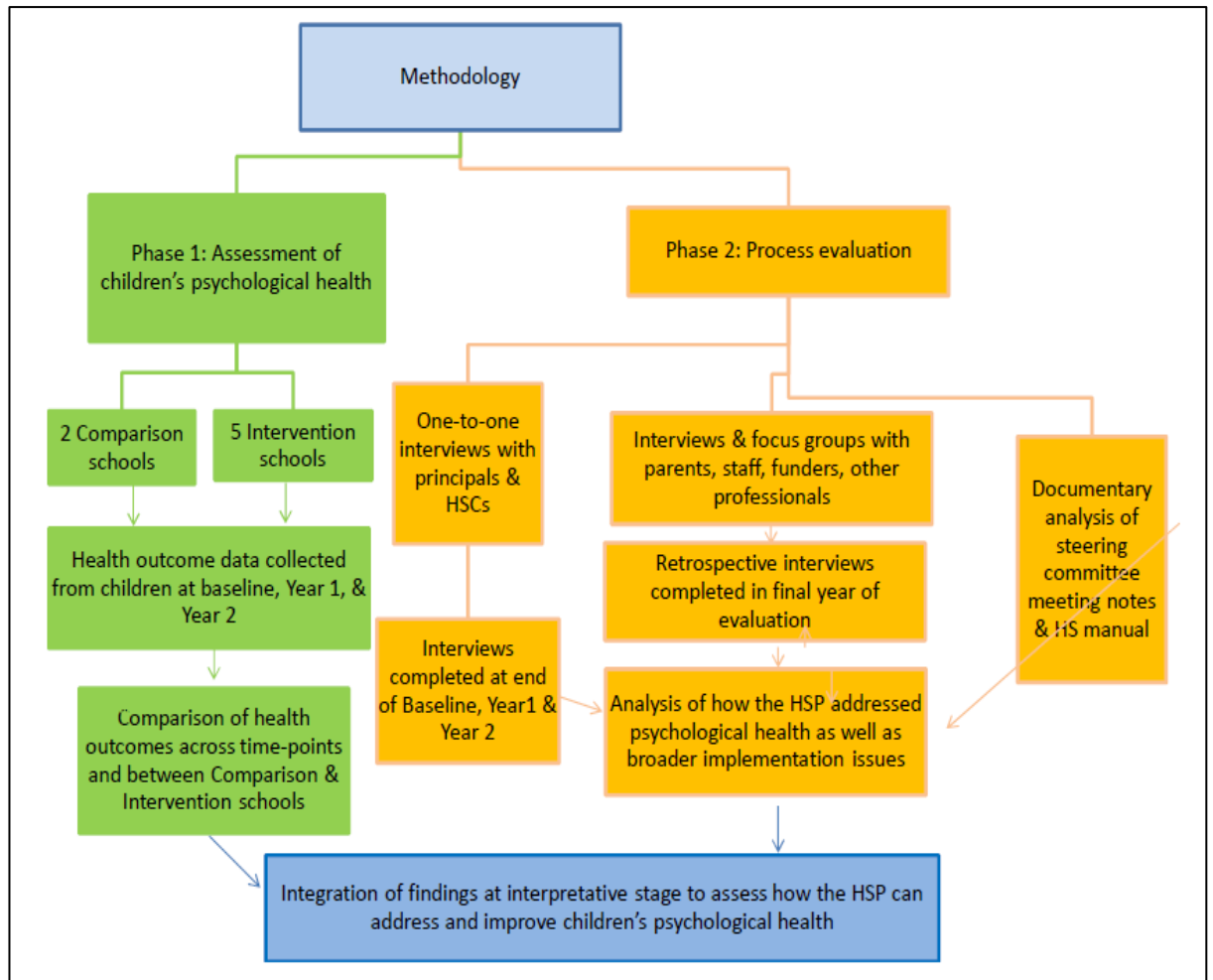
Figure 4.1: Overview of the research methodology

4.2 Epistemological framework

The current study is interested in both the causal effects (what happened), and causal mechanisms (why it happened) of the HSP and, therefore, methodological pragmatism was considered the most appropriate approach (Tashakkori & Teddlie, 2010). Pragmatism is *"a philosophical doctrine … that evaluates theories or beliefs in terms of the success of their practical application"* (Reber & Reber, 2001, p554). The pragmatist position argues that knowledge is only meaningful when accompanied by action and maintains that nothing is true or false, it only does (or does not) work (Johnson & Onwuegbuzie, 2004). Thus, pragmatism is concerned with the reality of life and more specifically with the direct experience of the individual who inhabits that world (Maxcy, 2003).

Morgan (2007) argues that, due to the limitations of epistemological-based paradigms as a rationale for research designs, the adoption of a pragmatic approach would provide a more coherent and flexible model for determining research designs. Based on Dewey's assertions that ontological and epistemological explanations are not adequate in explaining beliefs, Morgan (2007) suggests instead, that the focus should follow the agreement amongst researchers as to which research questions are most useful and what is the most useful method of obtaining answers to these questions. Pragmatism rejects a predisposed approach to methodology and instead suggests a continuum for researchers within which to situate themselves depending on the requirements of the research study (Teddlie & Johnson, 2009). According to this position, methodological tools should emerge based on agreed shared meanings between researchers as to how to most logically answer a research question (Morgan, 2007). The pragmatist position, therefore, permits the inclusion of methodologies which may be traditionally seen as incongruent thereby bridging the gap between the traditional paradigms (Onwuegbuzie & Leech, 2005).

4.2.1 A mixed methods approach to the current study

Methodological pluralism, as espoused by Johnson and Onwuegbuzie (2004), promotes the use of various methodologies to best address research questions thereby improving the quality of research outputs. Accordingly, the current study took aspects of methodologies traditionally associated with different paradigms based on their usefulness and appropriateness in order to obtain rich and useful data to address the research questions (Pawson & Tilley, 1997). In this way, the use of various methods of qualitative data collection coupled with quasi experimental data collection was considered to provide a more comprehensive examination of the research questions. In the current study, data collection and analysis of different methods were completed separately, and the findings merged during the interpretative stage (i.e. the discussion chapter). It is envisaged that qualitative and quantitative findings may produce conflicting findings as well as complementary and convergent results, thereby providing a more comprehensive picture of the initiative under investigation.

4.2.2 Advantages of a mixed methods approach

According to Creswell, Fetters and Ivankova (2004) *"mixed methods investigations involve integrating quantitative and qualitative data collection and analysis in a single*

study or programme of inquiry" (p7). Both quantitative and qualitative methods provide a useful means of addressing research questions depending on the needs of a research study. Quantitative methods are useful in examining and testing relationships among variables as well as comparing groups within studies. However, the inclusion of qualitative methods in a research study enables the researcher to explore phenomena in more depth. When used in a mixed methods design, qualitative findings provide an opportunity to assess the quantitative findings in the wider context using more contextually rich data often not attainable in quantitative designs (Song, Sandelowski, & Happ, 2010, O'Cathain, Murphy & Nicholl, 2007). Even experimentalists acknowledge the importance of context in the interpretation of findings (Yardley & Bishop, 2008). As highlighted by House (1994 as cited in Yardley & Bishop, 2008, p356), an understanding of how an experiment occurred and the potential for error, or lack thereof, is crucial to ascertain whether findings can be trusted. Furthermore, the interpretation of findings is inherently connected to the researcher's own experience and perspectives regardless of their ambitions to be objective (Yardley & Bishop, 2008). Mertens (2003) suggests that mixed methods studies also provide a more equitable approach to data collection by increasing opportunities for wider participation in a study.

According to Sandelowski (2000), the use of different types of data may also increase the quality of both and where one method becomes challenging or provides a lack of useable data, the other method may still provide useful findings. The effective implementation of such a design can simultaneously allow the researcher to address both confirmatory (quantitative theory verification) and exploratory (qualitative theory generation) questions to develop and confirm theory in a study (Creswell & Plano Clark, 2007). By applying different techniques, the limitations of a single technique can be complemented by the strengths of another method and vice versa. This approach enables the researcher to make stronger inferences from the findings of the study. Indeed methodological triangulation has become increasingly viewed by many applied researchers as a superior method of answering research questions by combining the strengths of different methodological paradigms (Creswell & Plano Clark, 2007). O'Cathain, Murphy, and Nicholl, (2010) define triangulation as *the process of studying a problem using different methods to gain a more complete picture"* (p1147).

4.2.3 Incorporating an Implementation Science framework

There are many complexities involved in designing, planning, implementing and evaluating a health promoting school initiative. As Fixsen, Blase, Naoom, and Wallace (2009) note, *"ineffective programs can be implemented well and effective programs can be implemented poorly…desirable outcomes are achieved only when effective programs are implemented well"* (p533). Over the last decade, there has been increased emphasis on how the process of implementation impacts on initiative outputs in general. In the area of health promoting schools specifically, recent studies have also increasingly examined the implementation process itself and not just outcomes (e.g. Guggleberger & Inchley, 2012; Lee, *et al.,* 2007; Mitchell, Palmer, Booth, & Powell-Davies, 2000; Senior, 2012). In order to provide a comprehensive assessment of the HSP, the current study will consider the key enabling and inhibiting factors of implementing the *Healthy Schools Programme* within an implementation science framework.

A number of useful implementation frameworks have been put forward that outline the stages of implementation (Burke Morris & McGarrigle, 2012; Damshroder *et al.,* 2009; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Whilst variations exist across the literature, Burke Morris and McGarrigle (2012) provide a simple model of the stages of implementation which incorporates the key components of many of these other models. An outline of this framework is illustrated in Figure 4.2 below.
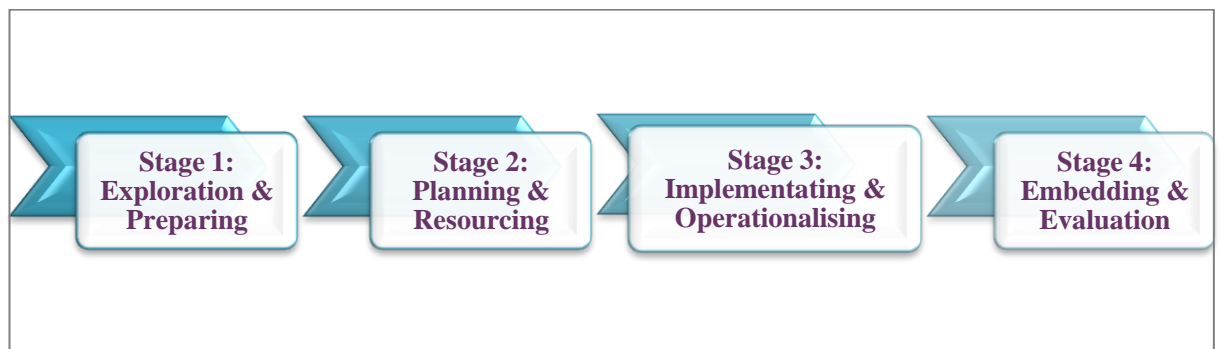
Figure 4.2: Burke and colleagues' (2012) Stages of implementation

Whilst each stage forms a chronological phase of the programme, the authors note that these stages are not discrete or static and initiatives are likely to move back and forth between stages depending on how the initiative rolls out. There would seem to be general consensus across studies that most initiatives take two to four years to

effectively incorporate all stages of the implementation process (Burke *et al.,* 2012). However, it is likely that only successfully implemented initiatives, that are relatively straightforward in design, will be operational in this way. Indeed, Shiell, Hawe and Gold, (2008) acknowledge the increased complexity inherent in health promoting school implementation, considering the involvement of the complex settings required to introduce such an initiative (i.e. educational agencies, health agencies and political agencies)- each with their own perspectives and interests. Supporting this position, Guggleberger and Inchley (2012) provide an example of the implementation process of a successful Scottish health promoting school initiative and noted that the stages of implementation have been evolving and developing since the 1980s. This suggests that, depending on the implementation experience, a longer term approach to implementation may be necessary to fully realise targets and objectives in a sustainable way.

Damschroder and colleagues (2009) recommend a pre-implementation phase of self-assessment both in terms of setting capacity and needs to help identify potential enabling and inhibiting factors so they may be developed or addressed in a pre-emptive way. Indeed most models also identify both facilitators and barriers in the development of a successful implementation process and again Burke and colleagues (2012) provide a useful overview of these main enabling and inhibiting factors (see Figure 4.3 and Table 4.1 below). Whilst all enabling factors are important, it is clear from Figure 4.3 below that three elements are crucial across all stages including: Consultation and buy-in; Leadership; and Resources (Guggleberger & Inchley, 2012). However, most challenges, as set out in Table 4.1 below, may arise at any stage of the implementation process.

Implementation Enablers	Stages of Implementation			
	1. Exploring & Preparing	2. Planning & Resourcing	3. Implementing & Operationalising	4. Business as Usual
Stakeholder consultation & buy-in				
Leadership				
Resources				
Implementation teams				
Implementation plan				
Staff capacity				
Organisational support				
Supportive organisational culture				
Communication				
Monitoring & evaluation				
Learning from experience				

Figure 4.3: Key enablers through the stages of implementation (extracted from Burke, *et al.*, 2012)

Table 4.1: Overview of potential challenges to implementation (extracted from Burke, *et al.,* 2012)

Potential Challenge	Considerations
External environment	• Are environmental structures and processes in line with the implementation of the project? • In what way can existing policies, research, theories and practices also influence implementation?
Resistance to change	• How enthusiastic/supportive are leaders involved in delivering the initiative? • To what extent do stakeholders feel consulted in the decision-making process? • Are stakeholder concerns acknowledged and validated?
Vested interests	• Are the vested interests of stakeholders incongruent with the innovation?
Skipping stages of the implementation process	• Has each stage been addressed? • Were necessary have earlier stages been revisited to adapt and develop the initiative effectively?
Unrealistic timeframes	• Do all stakeholders maintain appropriate expectations?

Additional health promoting school specific issues such as inter-agency collaboration and partnership working as well as programme fidelity can all become either enabling or inhibiting components of implementation progress. Effective interagency communication and partnership working, in particular, is considered a key facilitating factor to more efficient and co-ordinated services that also protect and support children effectively (Brown & White, 2006; Department of Children and Youth Affairs, 2011; Dowling, Powell, Glendinning, 2004; Sloper, 2004). On the other hand, Brown and White (2006) conclude that different terminology evident between services limits effective integration and notes the likelihood that current language differences pose a barrier to inter-agency collaboration. Implementation fidelity is also likely to influence the effectiveness of initiatives. In this way, Carroll and colleagues (2007) note the

importance of considering implementation fidelity to appropriately evaluate programme outcomes and identify if success (or lack of) is due to initiative quality or implementation quality (assessing for a type III error).

4.3 Ethical considerations

This study was carried out in accordance with the Codes of Conduct of the British Psychological Society and the Psychological Society of Ireland (British Psychological Society, 2009; Psychological Society of Ireland, 2003). The study received ethical approval from the ethics committees of both Trinity College Dublin and Maynooth University.   The sample for this study comprised a number of different participant groups, all of whom were informed of their rights as participants in the research process, both in writing and verbally, before and after participation. Figure 4.4 below sets out all stakeholders involved in the research study.

Figure 4.4: Key participants of the research study

In particular, information was provided to participants outlining the purpose of the study, the level of involvement being requested by participants and their right to informed consent. Participants were also informed they had the right to withdraw their participation and/or data from the study at any stage without penalty. Issues of confidentiality and anonymity were also explained and participants were provided with an opportunity to discuss concerns and ask questions at any stage of data collection.

Additional ethical guidelines were adhered to for each sample group. For example, parents' were reassured that their views or involvement in the study would in no way affect their children's involvement in the HSP and that school staff would not have access to the transcripts. School staff were also informed that their identifiable responses would not be available to anyone outside the research group. As both the school staff and parents worked closely with the HSCs in all schools, consideration was required regarding how this might affect their responses to interview questions. Participants were informed that the evaluation was of the entire programme and how it rolled out rather than a specific evaluation of the quality of the individual HSC. In addition, assurances by the researcher were provided to ensure school based participants did not feel it was their school which was being evaluated rather than the HS programme. Templates of information leaflets and consent forms for all participants are provided in Appendix 4.1.

As highlighted by Burgess (1989), in social science, participants are more likely to be harmed by the process of social enquiry itself than by the application of the knowledge gained. Thus, given the sensitive nature of conducting research with children, a number of supplementary considerations in addition to the standard ethical procedures are addressed below.

4.3.1 School staff as gatekeepers

Parental consent to collect questionnaire data from the children was obtained via the school setting. A gatekeeper (i.e. the class teacher) was involved during the recruitment stage of the sample in order to uphold the rights of all potential participants. They facilitated the collection of consent forms and were available to direct any questions concerning the research process to the researcher. This practice was decided in consultation with the school principals. As the evaluation was examining a health promotion programme in the schools, there was a risk that a guardian may feel it necessary to take part in case their child might miss out on a school based activity. The use of a gatekeeper helps to ensure voluntary participation whilst minimising any potential pressure placed upon families as a consequence of being directly asked to participate by the research team.

However, as with the guardians, the role of school staff in this study as gatekeeper for the children had to be considered with due care. As gatekeeper, numerous concerns arise for school staff in their position of trust with both families and students. For example, whilst informed consent is not actually sought from the teacher for the child to take part, it may be perceived by families and children that if the research is being authorised by their school, then it has also been approved by the staff. Thus, it is important to communicate fully with teachers and provide them, in advance, with details about data collection so they are conscious of what the research entails from the beginning. As gatekeepers, teachers are also invaluable in terms of identifying those children who may need additional support to participate in the study. On the other hand, however, it is important that the teacher is removed from the process of consent and data collection to minimise undue pressure on the child and family, as a refusal to participate may be perceived as breaking the school rules. Furthermore, relationships between staff and students (and their families) may vary due to, for example, interpersonal, cultural and other factors so it is also important not to assume that a relationship of trust exists. Indeed, individual relationships between teachers and parents/guardians are likely to influence family enthusiasm for such health promoting activities. In this way, the role of the teacher as gatekeeper in the current study was limited to the distribution of information leaflets and consent forms and, if any questions arose, families were directed to the research team. Similarly, when administering questionnaires, it is important that teachers are removed from the process to manage potential problems of social desirability. Indeed, David and colleagues (2001) go so far as to argue that other settings should be considered to increase the voluntary nature of the study and the true nature of informed consent. At the same time, however, schools may be the best place to deal with any sensitive issues should they arise as a result of any research and have resources to address many potential issues.

As with the families, research burden is a significant issue for school staff and it is to be expected that the research process *does* create a level of disruption to the normal school day. With longitudinal studies, this is an even greater concern and may impact most negatively on relationships between researchers and participant schools/ settings. Thus, the degree of commitment expected from a research team should be presented at the beginning of any study. As a result, the teachers' role in this research study was limited so that as little burden as possible was placed on them. Their role was to facilitate the

study by handing out the sealed envelopes, with the information sheets and consent forms, to the children for placement in their school bags. A box was placed in each classroom wherein children returned the consent forms over a period of approximately three weeks. Data collection for the study was completed in collaboration with the wider evaluation team to ensure minimum disruption for the schools.

4.3.2 HS funding team and Healthy School Coordinators

Due to the nature of the funding team's role in the HSP, the limited ability of the researcher to anonymise their data was discussed and agreed prior to the interview. The researcher was also aware that, due to the role and involvement of the funding team and HSCs, there was an expectation by their organisation that all members would take part in the research. Thus, there were concerns regarding to what extent participants understood that their participation was voluntary. To address this concern, it was emphasised to these participants that, should they wish to withdraw any data or not answer any questions, this would be completed confidentially.

4.3.3 Additional ethical considerations with child participants

There is a requirement to balance the right of a child to have their own voice in a research study with the right to be protected from the negative impacts of research. As Morrows (2009) highlights, the four primary ethical considerations when doing research with children include: the level of competence; consent; confidentiality/referrals and; reciprocity.

4.3.3.1 Levels of competence

Competence levels of children need to be matched to the assessment used in any study (Morrows, 2009). Consideration of appropriate assessment tools is also required to minimise the possibility of distress for children who may be unable to complete the questionnaire. Specific considerations outlining how the researcher ensured the questionnaire was appropriate for the sample are outlined earlier in this chapter. Furthermore, colour and cartoon pictures were included throughout the survey in order to promote the attractiveness of the questionnaire and minimise boredom, (see Appendix 4.2). At the end of the questionnaires age appropriate puzzles were attached so that children who finished early were occupied and this also allowed more time for all children to complete the survey without feeling pressurised.

4.3.3.2 Informed consent/assent

As outlined previously parents and school staff acted as gatekeepers for children during the research process. Written consent was also obtained from the child's legal guardian prior to the commencement of data collection. On the day of data collection however, additional steps were required to obtain assent from the children which is defined as follows: *"A decision by a minor to participate in research is considered to constitute assent, defined as 'a child's affirmative agreement to participate in research'* (US Department of Health & Human Sciences, 2005, p1). A great deal of care was required to ensure that the children fully understood their involvement in the research study and also of their right to withdraw at any stage without consequence.

The researcher took part in training provided by the Irish Society of the Prevention of Cruelty to Children; this focused on child centred approaches and on how to ensure that children's concerns and questions are addressed. The children were informed as a group, of their rights as a participant in the research process and the researcher also spoke with each child individually to check in with them and explore how they felt about the research process. In line with the BPS ethical code, the child's assent always precedes the parental consent. If any child decided not to partake, this decision was respected and the child either returned to class or stayed and completed a puzzle whilst the other children completed their questionnaires. This option was added to minimise any potential negative feelings the child may have had about leaving the room early.

4.3.3.3 Confidentiality/Referrals

The researcher also completed child protection training by the HSE (based on the national child protection policy document, Children's First, Department of Children and Youth Affairs, 2009) and Garda clearance was gained for the entire research team. A referral template (see Appendix 4.3) was developed by the researcher so if any concerns arose about any child, the principal could be consulted formally. After discussions with the school, it was agreed that all concerns would be conveyed directly by the researcher to the principal and that these would be followed up by the researcher to ensure adequate action was taken where appropriate. This structure was utilised for a small number of students at each data collection point. Most concerns were resolved at a school level and student Social Welfare services were engaged through the school to address the concerns regarding one particular student.

The children themselves were informed in child friendly terms on the day that their teachers and classmates would not see their answers. However, they were also informed that there were limits to that confidentiality and if anything arose which concerned them or the researcher, this would have to be discussed with the school principal. The children were given opportunities to speak about what these issues mean and discussion was encouraged.

4.3.3.4 Reciprocity

A number of steps were taken to emphasise an appreciation of children's involvement. Participation certificates were provided to all the children as a token of appreciation. In addition, the children received individual feedback on their data in follow up years by the wider HS evaluation team (e.g. last year's BMI). This occurred as it was possible to provide children with last year's height data from their BMI measurements. Upon completion of the assessment, time was allocated for discussion where the children were informed on how their information would be used and questions were encouraged.

4.3.4 Additional considerations for the researcher

4.3.4.1 Support for the researcher

As mentioned earlier, the researcher completed training in a range of relevant child related procedures and issues relating to the research process. Questionnaires were completed by the children in groups and the researcher was assisted by a trained fieldworker at all times. At no stage were individual children and researcher left alone. All interviews were completed in the school setting, or where appropriate, in the participants' place of work. The researcher followed the procedures outlined in the Maynooth University Psychology Department departmental Guidance for Safe Working Practice in Psychological Research[8]. The researcher also received regular supervision from senior members of the research team as well as Children's Health Lecturers in the School of Nursing and Midwifery, Trinity College Dublin. This practice was put in place to address potential difficulties arising as a result of completing the health questionnaires with the children. The researcher also met, on an ongoing basis, with her research supervisor to discuss and resolve any issues of concern.

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[8]https://www.maynoothuniversity.ie/sites/default/files/assets/document/Guidance%20for%20Safe%20Working%20Practice.pdf

4.4 Chapter summary

This chapter presented the methodological framework underpinning the current study by setting out the philosophical foundations underpinning this research. The rationale for a mixed methods approach to the design was discussed along with the application of elements of an implementation science framework to guide the evaluation. A dissemination of important ethical considerations was also provided, highlighting many factors which were considered when conducting research with the current cohort. The chapter that follows will discuss how this methodological framework was applied in practice by describing the qualitative and quantitative data collection and analysis process undertaken.

CHAPTER FIVE

METHOD II: PHASES OF THE RESEARCH STUDY

This study is comprised of two concurrent phases: (1) a comparative impact evaluation of the *Healthy Schools Programme* on children's psychological health; and (2) a process evaluation of programme implementation. This chapter will describe the methods used in each.

5.1 Phase One: A comparative evaluation of the impact of the HSP on children's psychological health

Phase one of the research involved a quasi-experimental, prospective, comparison follow-up design to assess the effects of the HS programme on the psychological well-being of the children. Data were collected at three time-points - baseline, year 1, and year 2. The baseline provided an outline of the children's psychological health prior to the implementation of the programme. The year 1 follow-up provides an early stage outline of the children's psychological health. The year 2 follow-up provides information on the effects of the programme on the children's psychological health after two years of programme implementation. A quasi-experimental design was chosen in preference to a randomised controlled trial (RCT) design as the health promoting school initiative was an innovative initiative that was still in its development stage. In addition, the random allocation of the schools to comparison and intervention school types was not possible due to the nature of the programme design which is described in further detail below. For these reasons (amongst others including resources and other constraints), an RCT methodology was not considered appropriate or suitable for the present study.

5.1.1 Participants and settings

The funders of the *Healthy Schools Programme* invited all DEIS band 1[9] primary schools in the local catchment area (n=9) to participate and participation in the HS programme itself was then agreed at a school level. Intervention schools were selected from those who indicated their interest. The selection of intervention schools was

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[9] Delivering Equality Of Opportunity In Schools (DEIS). DEIS band 1 schools are schools designated as being in areas of significant social and economic disadvantage

decided by the funder prior to the involvement of the researchers. A letter of invitation was sent by the researcher to three matched comparison schools in the greater Dublin area. It was decided that these schools would not be chosen from the same catchment area as the intervention schools to minimise contamination. Two comparison schools indicated their interest and were invited to take part. Matching variables included socio-economic factors (e.g. DEIS Band 1 status, area, structure of the school), the type of school (mixed sex) and the school ethos (ie. Christian or not Christian-based). All children and their parents attending participating schools were invited to participate in the research.

The larger evaluation study examined all aspects of children's self-reported/proxy health as well as measures of Body Mass Index (BMI) (n=604). However, the current study examined a subsample of this group (n=434) who had answered self-report questions related specifically to psychological health and well-being. The sample was recruited with the help of the schools and consent was sought from parents in addition to assent from the children on the day of data collection. Ethical considerations concerning this sample are discussed in Chapter Four and further details pertaining to the ethical and data collection procedures are presented later in this chapter. Psychological health outcomes of the children were measured in the school setting. Questionnaires were completed in small groups in an adapted classroom in the presence of the researcher.

5.1.2 Inclusion and exclusion criteria

The sample for the current study was extracted from the wider HS evaluation study based on certain exclusion/inclusion criteria. In all schools, children from first class to fifth class in the school year 2008/2009 were invited to take part and complete the psychological health component of the questionnaire. Children in 6th class were not included as no follow-up data would be available for those children. Any children below the age of 7 years were excluded from analysis in accordance with best practice research for investigating self-report studies with children. In general, children aged 7-8 years or more are more likely to have the ability to complete survey type assessments (Borgers, de Leeuw & Hox, 2000). Whilst individual differences require some flexibility in this respect, the development of language and temporal relations, adequate reading skills, the ability to distinguish different points of view and classify objects, all

develop considerably at this stage and are necessary skills for the valid completion of self-report questionnaires. It is acknowledged that using an age-based criterion for participation may be a somewhat arbitrary method and consideration was maintained throughout data collection, therefore, as to the individual needs of the children. The ability of a child to complete the questionnaire was assessed on a case-by-case basis by the researcher in consultation with the school. Consent was only obtained at the baseline stage of data collection and only these children were included in the follow-up stages.

5.1.3 Measures

The HS Child Survey is comprised of a number of different psychometric tools which measure health behaviour as well as specific feelings of psychological well-being/negative affect and Health Related Quality of Life. Each of these is described below. The battery of questionnaires was adapted to suit children from the age of 7 years upwards and where possible an abbreviated version of each questionnaire was used. The identification of appropriate measures to suit children's needs was a fundamental consideration of the current study.

5.1.3.1 Profile Questionnaire

A brief background questionnaire was administered to the children which elicited information on key demographics. The questionnaire comprised of one page of descriptive questions including age and gender, who the child lived with, the nationality of parents, and whether they had any medical conditions. This questionnaire was designed by the researcher and was based on the needs of the both the wider HS evaluation and the current study. Details of this questionnaire are included in Appendix 4.2.

5.1.3.2 Children Depression Inventory-Short version

The Children's Depression Inventory-Short version (CDI-S) is a measure of negative affect in children ages 7 to 17 years (Kovacs, 2009). This provides a brief 10-item single scale screening tool which was extracted from the full length CDI assessment tool (see appendix 4.2). The full version examines a range of emotional well-being including: negative mood, interpersonal problems, ineffectiveness, anhedonia or inability to experience pleasure, and negative self-esteem; the CDI-S has been designed to reflect these areas and provides comparable results (Kovacs, 2009).

The CDI-S was chosen for the study in preference to the original version as it was considered to be sufficiently detailed for the requirements of the study without overburdening the participants. The full version was considered too time consuming considering that different measures of health behaviour and HRQoL were also obtained from the sample during the data collection period. As detailed below, reliability tests on the CDI-S indicate internal consistency with the full length version of the CDI (which is appropriate for both non-clinical and clinical settings), whilst validity tests also indicate the CDI-S is highly correlated with the full CDI (Kovacs, 1992). The summative score from the ten items of the CDI-S can be transformed into standardised T-scores for further statistical analyses (see Table 5.1 below).

Table 5.1 Interpretive guidelines for CDI T-scores (extracted from Kovacs, 2009, p 31)

T-score	*Overall Symptoms/Complaints*
Above 70	*Very much above average depressive symptoms*
66-70	*Much above average depressive symptoms*
61-65	*Above average depressive symptoms*
56-60	*Slightly above average depressive symptoms*
45-55	*Average depressive symptoms*
40-44	*Slightly below average depressive symptoms*

The psychometric validation of CDI-S has produced supportive evidence for its use. The *CDI-S* demonstrates good internal consistency with a Coefficient of 0.796 (Kovacs, 2009). This version of the CDI was also found to correlate sufficiently with the full version (r=.89) As the CDI measures a state rather than trait, the test-retest reliability time period was examined using a relatively short time lapse (2-4 weeks). Finch and colleagues (1987) found varying levels of reliability with a normative sample of youths ranging from r=.82 using a 2 week time interval to r=.67 using a 6 week time period between administrations. The CDI-S was chosen in preference to other measures of emotional well-being, such as the Connor's scale (which is ADHD focused) or the Strengths and Difficulties Questionnaire (a non-clinical screening tool)), as it is a well-known measure of negative affect. The CDI-S is based on the CDI-long version which is considered an appropriate clinical assessment tool. Thus, this tool was deemed appropriate to provide a good indication of emotional health when used along with the other instruments of the HS survey, although it is important to note that it is not a

measure of clinical depression. In addition, the CDI-S was identified as being brief and appropriate for the age profile of the sample (i.e. 7-13 years).

5.1.3.3 Kidscreen-27

The Kidscreen-27 (Kidscreen Group, 2004) is designed to provide a "*generic health related quality of life measure for children and adolescents*" for children aged 8 years and older (Kidscreen Group, 2006, p11). This version has been developed from the broader Kidscreen-52 tool and the current version measures five HRQoL dimensions: Physical well-being (5 items); Psychological well-being (7 items); Autonomy and Parent Relations (7 items); Social support and peers (4 items); School Environment (4 items) (Kidscreen Group, 2006, p12). The Kidscreen-27 provides ordinal raw data but, similar to the CDI-S, also supports the transformation of data into standardised T-scores.

Reliability tests conducted on the Kidscreen-27 indicate internal consistency with full Kidscreen-52 whilst convergent and discriminant validity also displayed satisfactory correlations (Kidscreen Group, 2004). In particular, Cronbach's Alpha (Internal consistency values) ranges from 0.79 (Physical well-being) to 0.84 (Psychological well-being). Using a two-week interval, test-retest reliability analysis ranged between 0.61 and 0.74 (Kidscreen Group, 2006, p12). Comparisons with appropriate measures by the Kidscreen research group (2006, p13) indicated satisfactory convergent and discriminant validity. The Kidscreen-27 was chosen over other measures (such as the Child Health Questionnaire, HealthActCHQ, 2008; Paediatric Quality of Life inventory; Varni, Burwinkle, Seid, & Skarr, 2003) as it has been effectively validated in the literature, is cost-effective, does not focus on medical illness, and provides a short, appropriate and child-friendly measure of HRQoL for the sample under investigation. In addition an Irish national study of children's HRQoL has been previously completed using the Kidscreen-52 (full version) which could provide useful comparable data. A copy of the Kidscreen-27 is presented in Appendix 4.2.

5.1.3.4 Health Related Behaviour Questionnaire

The Health related Behaviour Questionnaire (HRBQ) provides a descriptive assessment of health behaviour, knowledge and attitudes (Balding, 1992, 2002). This questionnaire has been used in evaluations of UK Healthy Schools programmes and other health

behaviour studies (Balding, 2002). The authors of the HRBQ (Balding, 2002) highlight that reliability is maintained by the survey administrators adhering to strict research protocol – and such protocol were implemented in the current study. This tool was chosen over the more established Health Behaviour in School-aged Children questionnaire (e.g. Currie *et al.,* 2004) for a number of reasons. In particular versions of the HRBQ questionnaire can be used with children aged 7-18 years rather than from 11 years as indicated for the HBSC. In addition the HRBQ has been used in previous evaluations of health promoting school initiatives in the UK (e.g. Warwick *et al.,* 2009). An adapted version of the HRBQ was used in the current study. In particular, questions pertaining to bullying, self-esteem and social supports were extracted from the HRBQ to obtain a broader picture of children's psychological well-being. These questions are purely descriptive in nature providing primarily nominal data (see Appendix 4.2 for details of the HRBQ).

Permission to use the questionnaire tools detailed above was obtained from each relevant body (see Appendix 5.2).

In order to minimise systematic errors (bias) and random errors (chance), the HS survey was administered at a similar of the year on each follow-up time point; it was carried out using optimal ratios of researchers to children; and used a number of measurements tested for high levels of reliability and validity. Questionnaires were chosen with consideration to the appropriateness of language used and were tested during the pilot stage and adapted where necessary. A common problem when using questionnaires is the issue of social desirability. A number of steps were undertaken to address this issue including informing the children that there are no right or wrong answers only what is true for them and that no one will see their responses unless there is something of concern around their safety.

5.1.4 Pilot study

A pilot study was completed with a sample of children (n=32) in one of the intervention schools. A sub-sample of 5th class children were chosen from those who had agreed to take part in the HS evaluation and whose guardians had already provided consent. This age group were selected as it was believed that the older sample would be best able to discuss their views on the questionnaires with the researcher and recommend any necessary changes. This process informed a number of adaptations to the study. It was

decided, for example, that class teachers would not be present during data collection at any follow-up data collection stages. This was deemed appropriate in order to alleviate any performance pressure on the participating children which was observed during the pilot study. The research team wanted children to feel that completing the questionnaire was different to normal class work and if they did not want to take part, they could freely indicate their concerns to the researchers.

This pilot study also highlighted some individual differences between children in their ability to complete the questionnaires. The researcher consulted with a school-based Special Needs Assistant (SNA) to prepare for the main study and ensure adequate support would be provided to all children. Support researchers were also involved in the data collection to provide language assistance to children where necessary. Overall, the time taken for the majority of children to complete the assessment in the pilot study was deemed to be too long and, therefore, the Kidscreen-52 was substituted for the Kidscreen-27 and a number of questions on the HRBQ were removed or adapted. The pilot study also highlighted a number of additional language issues with some of the items on the survey. Minor changes to simplify some words in both the Kidscreen-27 and HRBQ were completed with the authors' approval. Any minor revisions were completed prior to the administration of the questionnaire with the wider study sample.

5.1.5 Data collection procedure

Parents of children completing the questionnaires were furnished with information leaflets and given a period of at least seven days to consider their interest in the evaluation (Appendix 4.1). After this period of reflection, a detailed Information sheet and consent form were provided to families via their children (Appendix 4.1). Parents were also given contact details for the research team in case anyone wished to discuss the research further. Parents were informed of their right to withdraw their child from the study at any stage and without penalty. A copy of the questionnaire was left with the principal of each school and parents were informed that they may view this document should they so wish. Only children whose parents had returned completed consent forms were invited to take part.

A room was set aside in the school and the children completed the assessments in small groups (<10). Special needs assistants were available to the researcher throughout the data collection process to ensure that children had sufficient support. Children with

additional learning support needs were also highlighted to the researcher by members of the school team prior to the data collection process.

Children were seated in age-appropriate chairs and spaced far enough apart so that no responses could be read by another participant. Each participant was provided with a pencil, eraser and pencil sharpener. As children were settled, the questionnaire was explained in appropriate language. Issues of confidentiality were also explored and participants were informed that if anything arose which concerned the researcher; they were obliged to pass that information on to the school. The children were also informed that this was not a test and that they could withdraw at any time. A number of open-ended questions were asked by the researcher to encourage discussion and questions from the children about the questionnaire. Participants were also reminded that researchers were available at any time throughout the questionnaire administration should they have any further questions or concerns. If a child decided to withdraw from the study, their data were removed and their parental consent was overwritten so they were not requested to take part at the follow-up stage. Children were requested not to speak to each other during the data collection process so that participants could think about their answers.

The questionnaire took approximately 30 minutes to complete with time for breaks when required. The researcher went through the first two questions with the children to explain how they should fill it in. From that point on, the researcher routinely checked in with each child to ensure they had an opportunity to ask for assistance. Where children did require further support, additional support fieldworkers were available to sit with the child to help them complete the questionnaire. All fieldworkers were trained to give the participant as much privacy as possible to answer each question. A toy puzzle was provided to any child who had finished early so that all children had time to complete the questionnaire without feeling pressurised. Upon completion of the questionnaires, the children's completed forms were placed in a large envelope and the participant was asked at an individual level how they found the questionnaire and whether they had any questions. When all the children returned their forms, the class was debriefed as a group and participants were asked what they thought about the questionnaire and an informal discussion took place. Participants were also encouraged to discuss the questionnaire with their teacher or family if they so wished. Finally the

participants were escorted back to their classroom where both the children and the teaching staff were thanked for their time. School staff were also provided with the researchers contact details should they have any further questions.

Prior to the follow-up data collection periods in year one and year two, information was sent to families reminding them of the study and again of their right to withdraw. The same procedure as outlined above was followed.

5.1.6 Data analysis

The children's self-reported data were entered onto an SPSS file[10] (version 20) and the data were cleaned and audited (further details on this audit are provided in Appendix 5.1). Fieldwork notes were taken throughout data collection, and if any child displayed behaviour which may question the validity of their responses, their data were excluded from the analysis process. In such an event, the participant was still invited to take part in any follow-up data collection. In accordance with best practice guidelines, any CDI-S questionnaires for which more than 10% of responses were missing (i.e. one missing response) were excluded from analysis in order to maintain validity (Kovacs, 2009). Similarly, if more than one item from any subscale of the Kidscreen-27 was missing, then data pertaining to this subscale were removed (Kidscreen group, 2004). However, it is important to note that these strict exclusion criteria may have led to a bias against those with literacy difficulties and/or special needs. In an effort to minimise such bias, research support staff were available during the data collection process to assist the children. Children under the age of seven were also excluded from data analysis even if they were in First Class or Second Class. As outlined earlier in this chapter, seven years was considered the appropriate age cut-off for self-report completion.

Descriptive data pertaining to demographics of the child sample were analysed including age, gender, and family background. Descriptive data in the form of means and proportions were analysed from the HRBQ relating to children's psychological well-being. These questions included bullying, worries, satisfaction with self, peer relations and school. T-scores from both the psychological subscale of the Kidscreen-27 and CDI-S were calculated from the raw data scores and mean T-scores for the

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[10] Software package used for statistical analysis

comparison and intervention schools were compared using T-tests at each time-points. Subscale scores and total scores on each of the measures were calculated for each participant. Overall scores on the measures of psychological well-being were identified for the group as a whole and these were analysed to establish any correlation with other measures.

Comparisons were also made across the three time points for each school type using analysis of variance. Post-hoc tests were used to identify where differences (if any) occurred. Within group analysis also examined each group separately (i.e. intervention and comparison) across the three time-points. Inferential analysis were also undertaken to establish any differences between the two groups both cross-sectionally and longitudinally.

5.1.7 Data management

In phase one, after children were finished, all questionnaires were placed in a sealed envelope upon completion of the survey. Each questionnaire was given a unique code based on school, year, and class. Questionnaires were therefore only identifiable to the research team. Class lists for follow-up years were maintained on encrypted excel files only accessible to the research team. Completed questionnaires were subsequently filed in a locked cabinet in a secured room to which only the research team had access. Questionnaire data were subsequently entered onto an encrypted SPSS file.

5.2 Phase Two: Process evaluation of HSP planning and implementation

5.2.1 Overview of research design

Phase two gathered the views and experiences of various stakeholders involved in the *Healthy Schools Programme*. This included analysis of interview and focus group data collected over the course of the HSP implementation as well as documentary review and analysis of material relating to the HS programme. Semi-structured one-to-one interviews and focus groups were considered most suited to the research given the focus on eliciting perceptions and experiences of key HS stakeholders. These individual interviews provided a useful forum to discuss with relevant participants experiences of the HSP planning and implementation process in detail. Focus groups with parents and staff were also completed as it was a convenient method of engaging with a larger

number of individuals without overburdening the schools. An additional textual analysis of the HS manual was also deemed appropriate as the HSP was based on this document and programme design was a key consideration.

5.2.2 Participants and settings

Participants were identified using theoretical sampling with the aim of gaining a diverse range of views of the HSP. Individuals were invited to take part by the researcher and were fully informed of the research study (details of the ethical procedure are detailed in Chapter Four).

(a) HSCs (n=3) and Principals (n=7) were interviewed at the end of each year of implementation to explore how the programme was rolled out in the schools. A number of staff changes occurred throughout the course of the evaluation period in which case, replacement members of staff were invited to participate. All invited participants agreed to take part in the interview process.

(b) At the end of the baseline year, HSC and principal interviews indicated that the HS funders were actively involved in programme implementation. A decision was subsequently made to interview key members of the funding team (n=2) at the end of year 1 and year 2 to ensure that a range of relevant views and experiences were explored by the study. As with the school-based interviewees, all invitees participated in the study.

(c) Health and education professionals involved in the HS programme (in some aspects of design, planning and/or implementation) were interviewed at the end of year 2 of programme implementation by the researcher to examine their retrospective views on the efficacy of the programme to address psychological well-being. This included a Department of Education professional (n=1) and a HSE health professional (n=1)[11].

(d) A number of focus groups (n=4) also took place at the end of year 2 to explore teaching staff and parents' retrospective views and experiences of the programme. In total, 16 parents participated in two parent focus groups and 18 school staff participated in two teaching staff focus groups. Family members can prove difficult

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[11] Two additional health professionals were invited to take part in the interviews. One potential participant had taken maternity leave during the evaluation period and was not available for interview. The second potential participant had retired in the final year of programme implementation and chose not to respond to the researcher's request.

to engage with the research process and the researcher was also aware of time constraints experienced by many school staff. Thus, focus groups were considered a more appropriate, convenient, and efficient method of data collection. It is acknowledged that selection bias was a possible issue as individuals who agreed to take part are more likely to be parents and school staff who were most engaged with the HSP. Nevertheless, an important component of the study was to explore the experiences of individuals who were aware of the HSP and thus, it was considered appropriate that these individuals were identified for participation in the study.

Table 5.2: Overview of participants involved in the process evaluation

	Baseline 2008/2009 (n)	*Year 1 2009/2010 (n)*	*Year 2 2010/2011 (n)*	*Total participants (n)*
Semi-structured one-to-one Interviews				
Healthy School's Co-ordinators Interviews*	2	3	2	**3***
Principal Interviews*	4	5	5	**7***
HSP funder Interviews	0	2	2	**2**
Health and Educational Professional Interviews	0	1	1	**2**
Total	**6**	**11**	**10**	**14**
Focus groups				
Parent focus groups	n/a	n/a	2	**16**
Teaching staff focus groups	n/a	n/a	2	**18**
Total[12]	n/a	n/a	**4**	**48**
Meeting minute notes				
Steering Committee Meeting observation notes (i.e. number of meetings observed)	1	4	4	**n/a**
Documents analysed				
Funder Annual Reports & audits x4				
Healthy School Programme manual				
*Where members of staff left, replacement staff completed follow-up interviews				

5.2.3 Eligibility

Participants were identified by the researcher and invited to take part if:

1. The participant was involved in the design, planning or implementation of the Healthy Schools;

2. The *Healthy Schools programme* was rolled out in a school in which the participant worked; and

3. The participant was a parent/guardian of a child attending a HSP participating school.

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[12] A total of four retrospective focus groups were completed at the end of year two. In total, 48 participants took part in these groups. Participants who completed an individual interview were not part of the focus groups.

5.2.4 Measures

5.2.4.1 One-to-one semi-structured interviews with key stakeholders
Follow-up interviews were completed with participants who were directly involved in the planning and implementation of the HS programme (i.e. healthy school coordinators, principals). These interviews were completed at the end of each school year (i.e. at the end of the baseline year, end of year one, and end of year two). As previously mentioned, initial baseline interviews with HSCs and principals identified the direct involvement of the HS funders in the planning and implementation of the HSP. Consequently, the researcher decided to interview members of the funding team in subsequent follow-up years (i.e. at the end of year one and year two).

Baseline interviews with HSCs and principals also highlighted that, as the programme was only beginning to be implemented at the end of the baseline year, many of these participants were only able to provide limited responses to questions. As a result, a decision was made not to interview all other stakeholders (i.e. teachers and parents, professional stakeholders) at this stage, as many were not yet even aware that the HSP was being implemented in their school. Consequently, these stakeholders were only interviewed in the final year of the evaluation period. Retrospective interview schedules were designed to explore the views and experiences of the key stakeholders in relation to how the HSP had addressed the health and psychological well-being of primary school-aged children. All semi-structured interview schedules for this cohort included specific questions relating to how the HSP addressed psychological health as well as broader questions concerning the efficacy of the HSP in general (see Appendix 5.3).

5.2.4.2 Parents and teaching staff focus groups
Four focus groups were conducted in collaboration with the wider Healthy Schools evaluation and questions relating to psychological well-being specifically were included along with questions relating to the roll out of the HSP in general.

5.2.4.3 Documentary analysis
A documentary analysis of the HS manual was completed to assess the design, planning and implementation of the programme. The theoretical underpinnings of the manual were examined and compared to the health promoting school literature. In addition, a review of the HSP funders' policy documents and end of year reports were examined

(i.e. CDI, 2004; CDI, 2005; Keogh, 2007; Report of the CDI Stakeholder Consultation Process, 2005). The notes of Healthy School steering committee meetings were also collated by the researcher as they occurred over the course of programme implementation. These consisted of the main discussion points which arose during meetings as well as views and opinions indicated by individuals in attendance. These notes were used to supplement the views of HS stakeholders.

The final data collection period occurred at the end of the third year of implementation (i.e. year 2). This cut-off for data collection was chosen as, when asked at the beginning of year 2, the funding team were unable to confirm to the research team whether the HSP funding (and thus the HSP) would continue beyond this period.

5.2.5 Procedure: One-to-one interviews and focus group

All relevant participants (i.e. HSCs, Principals, HS funders, Health and Educational Professionals) were invited to take part in a one-to-one semi-structured interview at the end of the baseline year. Participants were contacted through the HS evaluation team as part of the wider evaluation and, due to time constraints, interviews were completed concurrently by the research team. Participants were interviewed in their place of work or at the school depending on the individual's involvement in the programme. Interviews were conducted in a private room to ensure privacy and participants were informed of the purpose of the interviews.

Questions relating to the psychological well-being of school children were added to the larger evaluation schedule which examined how participants felt the programme was designed and implemented. The researcher explained that, in addition to the wider evaluation, their data may be used for the current study to explore how the HSP addressed the psychological well-being of children. Prior to the interview, each individual was provided with an information sheet and consent form and participants were asked to provide their written informed consent (see Appendix 4.1). Participants were also informed of their right to withdraw at any stage of the data collection. Interview topics were not deemed particularly sensitive by the researcher although it was acknowledged that discussing individual's views about programme implementation may cause anxiety on the part of the participant. To address this issue, all participants

were informed of the nature of the questions at the beginning of the interviews and also that they could withdraw at any time.

The researcher also requested for each interview to be recorded for ease of transcription. Where a participant did not agree to a recorded one-to-one interview (n=1), the researcher took notes manually. Interviews took approximately 45-60 minutes to complete. At the end of each interview, participants were debriefed and any questions were answered. All participants were thanked for their time and provided with contact details of the researcher. Participants were informed they would be provided with a summary of the research findings upon its completion.

5.2.5.1 Additional procedural considerations for each participant group
   Healthy School Coordinators and Principals
Healthy school coordinators and principals from each of the intervention schools were invited to take part in a one-to-one semi-structured interview at the end of each academic year. As these participants were directly involved in the planning and implementation of the HSP, it was deemed necessary to identify how the programme developed over the evaluation period. Where a HSC (n=1) or principal (n=3) left their position for a period of one academic year or more, their replacement was invited to be interviewed on their behalf instead.

   Members of the HS funding team
At the end of the baseline year, HSC and principal interviews indicated that the HS funders were actively involved in programme implementation. To ensure a range of relevant views and experiences were explored, a decision was subsequently made to interview funders (n=2) who were directly involved with HSP planning and implementation at the end of year 1 and year 2.

   HS health and education professionals
Health and educational professionals who were directly involved in the planning and roll out of the programme (n=2) were also interviewed at the end of year 2 to ascertain their retrospective views on the efficacy of the programme to address psychological well-being.

Parent and teaching staff focus groups

At the end of year 2, parents (n=16) and teaching staff (n=18) of the intervention schools were also invited to take part in focus groups which examined their retrospective views and experiences of the HS programme. Parents were chosen based on their involvement with the HSP and were recruited via the HSC. All staff were invited to partake by the research team via the principal and HSCs. As previously mentioned participants were requested to respect the confidentiality of other participants and a code of conduct was discussed and agreed prior to the focus group taking place.

Steering Committee: non-participatory observational analysis

The researcher was permitted by the HS funding team to attend HS steering committee meetings in a bystander capacity and take notes. All members were informed of the researcher's observation role and permission was requested at each meeting for the researcher to continue this work. The researcher did not participate in these meetings. Observation notes were compared to steering committee meeting minutes to confirm data accuracy and ensure data collection was not selective or influenced by researchers' views or biases.

5.2.6 Data analysis

Interviews were audio recorded for the purpose of transcription and analysis. The interviews were recorded using an Olympus DS-2300 DSS Version 6 Dictaphone and was transcribed verbatim using Microsoft MaxQDA software[13] and Microsoft Excel in preparation for analysis. In one case, a participant chose not to be recorded and interview notes were instead generated during the interview by the researcher manually; these notes were also transferred to MaxQDA for inclusion in the analysis.

The data were examined in detail, collated and explored for themes relating to the HSP and psychological health using a framework approach (Pope, Zieblan, & Mays, 2000). A framework approach supports a more systematic way of completing a thematic analysis. This approach was taken as it is *"recommended for deductive data categories when interview questions and categories of interest are considered before the interviews"* (Evans & de Souza, 2008, p492). The Framework Approach was originally developed by the Social and Community Planning Research institute in the UK to

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[13] MaxQDA is a software package designed to assisted in qualitative data analysis

address the specific needs of applied policy research studies (Ritchie & Spencer, 1994). Thematic analysis and indeed qualitative analysis, in general, are sometimes criticised because the process by which themes emerge from the data is often difficult to assess (Braun & Clarke, 2006). Framework Analysis, however, provides a structured and transparent method to effectively manage and analyse qualitative data thematically (Smith & Firth, 2011). Whilst deductive qualitative analysis is less popular (Pope, Ziebland, & Mays, 2000), it was deemed most appropriate in the current context because:

(a) In many applied research studies, as in the current study, objectives are based on pre-decided information requirements as well as the background literature. As a consequence, many themes are often identified a priori and the data are then fitted into the categories or themes for interpretation (Ritchie & Spencer, 1994). Framework analysis provides an appropriate methodology for this type of research as it adopts a deductive approach to the identification of categories or themes. In the current context for example, the HSP was designed to establish components of a health promoting school (e.g. IUHPE, 2009) and the current study aims to explore how these components were addressed in terms of mental health.

(b) Framework analysis provides a more structured approach to the organisation and analysis of the data which was important given the large volumes of data involved.

(c) However, this approach still allows for considerable flexibility. Similar to other qualitative approaches, additional themes which emerge from the respondent's responses can still be included alongside pre-established themes (Ritchie & Spencer, 1994).

(d) Interpretative phenomenological analysis and grounded theory approaches were deemed not to be appropriate in the current context as they are theoretically bound to a particular epistemology (Braun & Clarke, 2006). In contrast, thematic analysis using a Framework approach is not fixed to a certain

theoretical framework and is in line with the pragmatic perspective of the current study.

Pope, Ziebland and Mays (2000) recommend a number of specific phases of data analysis required for an effective framework approach and structured method of synthesising the available data. These include five key stages: familiarisation; identifying a thematic framework; indexing; charting; and mapping and interpretation. According to Matt (2004), a number of strategies can also be employed by the researcher to increase the validity of analysis. In particular, the presentation of the analysis procedure as well as the process of interpretation improves the transparency of the analysis. The inclusion of useful quotes as well as a justification of the "*appropriateness of constructions*" is also of importance (Matt, 2004, p329). In adhering to this recommendation, an account of the stages of analysis is described below. Further information on enhancing the reliability of qualitative analysis more generally, is provided in section 5.2.8 below.

5.2.7 Stages of analysis

Stage 1: Researcher familiarisation with the raw data is an essential first step in order to list key ideas and recurrent themes. All transcripts were read by the researcher a number of times to ensure adequate immersion in the data and relevant notes were made along each transcript.

Stage 2: Upon achieving satisfactory familiarisation with the data, the next stage in the analysis process is the identification of a thematic framework. The purpose of this stage is to identify the main issues and themes within the data that warrant exploration. The initial framework was based upon a priori themes as well as new emergent issues highlighted by participants as identified by the researcher. Data that emerged from the interviews and documentary analysis, as well as literature material, were examined during this stage. In this way the predetermined aims of the study were incorporated along with the emerging themes from the data. As each interview was examined, codes identified were adapted and new emerging themes were established and re-organised into an initial framework using a new table created in Microsoft Excel. Upon completion of this first thematic framework, the researcher reviewed notes and identified key issues, concepts and themes. The various theme headings were again

checked with participants' verbatim responses to ensure data representation was maintained.

Table 5.3: Initial thematic framework for: "HSP planning and early implementation" (Stage 2)

Overarching theme: HSP planning and early implementation	
1. HSP understanding	2. HSP governance
3. Roles and responsibilities of key stakeholders	4. Inclusive collaboration in HSP planning
5. The national context	6. Leadership and management of the HSP

<u>**Stage 3:**</u> In stage three the data was indexed (i.e. the thematic framework was applied to the data) and numeric codes were applied to the transcript data. Sub-theme heading/s identified in stage 2 were revisited and explicit and implicit codes were applied to the data. The theoretical framework established in stage two was applied to the transcripts. As each transcript was assessed, the framework was adapted where appropriate. Codes were included along with these summaries so the researcher could refer to the raw data source with ease and ensure that each summary accurately reflected the data. Summarised themes and sub-themes were continually refined, based on re-examination of the transcripts and code. This process was repeated until a concise and comprehensive index of themes and sub-themes was achieved.

Table 5.4: Example of data indexing

Theme 2 sub-theme: "Roles and responsibilities of key stakeholders"	
Example of data indexing	**Supporting quote**
The central role of the Health School Coordinator	*"Now for people that mightn't be as quick to speak up as I would,* [the HSC is] *the link between the teachers and the parents. And I think we need that"*. [Parent, focus group, year 2, S236]
	'The presence of the healthy schools coordinator has helped maintain those linkages [between the school and health services]*, better than the school could have done without the healthy schools coordinator."* [School Principal, year 2, J008]

Stage 4:. In stage four data was organised or 'charted' according to its relevant thematic framework. Related charts were grouped under headings which permitted comparisons across respondents. A chart was created for each theme/sub-theme to include data from different respondents. Each summary point (within each case) maintained its own reference code for ease of access to the transcript quote. A number of categories were found to overlap both across and within themes and where this occurred, relevant sections were reviewed and edited. A descriptive analysis of each sub-category including the data-point codes was completed. This process was repeated for each theme.

Table: 5.5 'Charted' participant data

Case (Participant)	Case A	Case B	Case D	(Continues on from case 'E-W')
Theme content: Hands-on role of HSC; Duplication of role with existing posts, sustainability of the role; Centrality of role in progressing HSP work	Focus on physical activities A119; A104 (Active-flag HSC work); Active flag work-model for HSP A122	HSC sees own skills as important to delivery activities, e.g. B115; B138; Persistent view by HSC as having sole responsibility for HSP B138; HSC views quality of activities delivery as dependant on own abilities e.g. B115; B125;B138;	HSC as do'er helps create relationship with school D122; Challenge of HSC as do'er and role of HSC D109;D111; D120; Sustainability of HSC role D126; Role of HSC going forward D125;	

Stage 5: In the final stage of analysis, each chart was examined separately and a process of mapping and interpretation was undertaken (i.e. established charts were used to explore the range and nature of phenomena and any emerging associations between sub-themes were identified in order to explain the findings). In addition to emerging themes, this analysis was completed with the research questions in mind to ensure the data reflected the overarching aims of the study. Each chart was also re-examined for data accuracy and each data point was double checked to confirm if it supported the point being discussed. The most pertinent quotes were selected for inclusion in the chapter

from the data base and the chapter was drafted to provide an interpretive as well as descriptive account of the data.
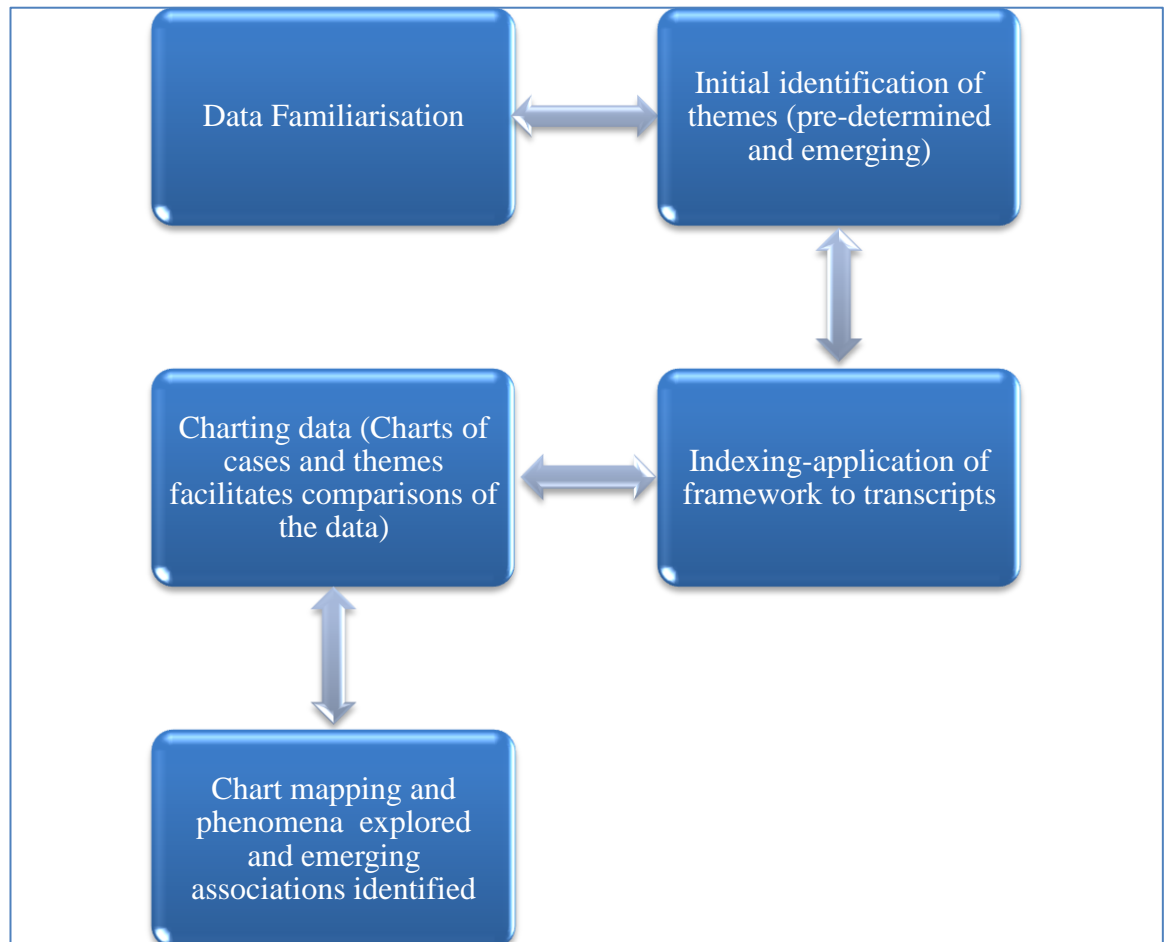
Figure 5.1: Stages of the framework analysis process

5.2.8 Ensuring reliability and validity of the qualitative research

A number of steps were taken in the current study to ensure a good standard of reliability and validity of the qualitative data. These steps were based on the RATS qualitative research review guidelines (i.e. Relevancy, Appropriateness of qualitative method, Transparency of procedures, Soundness; Clark, 2003) and further informed by the consolidated criteria for reporting qualitative research (COREC; Tong, Sainsbury & Craig, 2007).

Relevancy of the research question is fundamental to the quality of any study. As set out in Chapter 2, Health Promoting School approaches have been endorsed by the World Health Organisation as an effective, comprehensive approach to address the health

needs of children in the school setting. In addition, the Health Service Executive (HSE, the Irish National Health Service Authority) has recently published a policy document indicating that the health promoting school approach should be implemented across schools in Ireland (HSE, 2010). The literature review also highlights however that this approach is still evolving and only few comprehensive evaluations have been completed to date. Even fewer studies have comprehensively examined how such initiatives address mental health specifically. As national policy is endorsing a health promoting school approach, it is important that sufficient empirical research is available to guide their implementation in schools. An essential consideration for schools and policy makers to understand is how such initiatives can best address the health needs (and especially the mental health needs) of the school community and what facilitating and prohibiting factors may affect future implementation. The identification of these issues may improve the effectiveness of future health promoting school initiatives. In this way, the research question in the current study is very relevant to public health and policy.

Appropriateness refers to the suitability of the qualitative methods used to address the study objectives. The justification for the use of interviews, focus groups and textual analysis are clearly addressed earlier in this chapter.

Transparency of procedures refers to the rationale for the sample, recruitment, ethics, and role of researcher. Justification of the approach used for each of these important components is also set out in detail earlier this chapter. An additional important consideration in the research process concerns the involvement of the researcher. In phase two of the study, researcher reflexivity was inherent throughout the development of the study design. For example, when designing the interview questions, a critical reflection of the questions asked and the way in which this has been achieved, was examined and alternatives explored (Gergen, 2008). Clear representation of the steps involved in the collection, analysis and dissemination of the qualitative data by the researcher was also necessary to ensure that the findings will be as representative of the participants as possible. In doing this, the researcher underwent a continuous process of self-reflection to explore to what extent personal biases or experiences may have interfered with the interpretation of the data and how this can be minimised. Further considerations of potential ethical issues relating to the researcher as well as other general ethical considerations are presented earlier in Chapter Four.

Finally, to ensure *Soundness of interpretative approach,* the framework analysis approach is described in detail earlier in this chapter, as is the justification for its use. A number of interpretation checks were also discussed to ensure reliability of the data (e.g. continuous reviewing of raw material to compare with analysis process). The quantification of the data was not deemed appropriate for most of the qualitative findings. The diversity of participants as well as their different levels of involvement would mean that quantification of opinions may not usefully represent participants' experience of the HSP and the way in which implementation was perceived to be effective or ineffective. In later chapters which present the qualitative findings, quotes were chosen carefully based on their insight and relevance to the study. Furthermore, the findings are discussed in detail in Chapter 10 in relation to existing theoretical and evaluation research literature.

5.2.9 Data management

In phase two, a number of data management measures were considered. All hard copy interviews were anonymised, coded and maintained in a locked cabinet. Softcopy data were retained in an encrypted file to which only the research team had access. Meeting observation notes were also recorded on an encrypted Word document and saved on the same PC as the other data material.

5.3 Chapter summary

This chapter detailed how the range of methods used in this study was applied in practice. The findings from both the quantitative and qualitative stages are presented in Chapters Six to Nine. The next chapter examines the findings obtained from the quantitative data collection process. The qualitative findings are detailed in Chapters Seven, Eight, and Nine.

CHAPTER SIX

CHILD HEALTH OUTCOME FINDINGS

6.1 Introduction

The aims of this chapter are two-fold: (1) to present an overall picture of the psychological health status of the sample of children attending DEIS primary schools (including an investigation of the variables which are potentially correlated with psychological health and well-being); and (2) to describe the findings pertaining to the investigation of the effects of the local *Healthy Schools Programme*, on the children's psychological health. Details pertaining to the sample at baseline are presented in Section One. Comparisons between the Intervention and Comparison school children across each time point are reported in Section Two to determine the nature and extent of any differences if any, between the groups during the course of programme implementation.

6.2 Section One: Baseline findings

6.2.1 Demographic profile

Questionnaire data were collected from children in seven DEIS band 1 schools in total; five Intervention schools (where the HS programme was implemented) and two Comparison schools. The overall response rate was 47% (44% in Comparison schools and 49% in Intervention schools). Data for all participants from first to fifth class who took part in the data collection process at the baseline stage were included in the data analysis (n=434). The children ranged in age from 7-12 years (M=9.17 years, SD=1.42) and comprised almost equal numbers of males (51%; (n=222) and females (49%, (n=212). Most of the children who responded to profile related questions indicated that their mother lived with them in their family home (95%, 353/370) whilst approximately two-thirds of fathers also lived in the family home (67%, 247/370). The median number of brothers and sisters reported by the sample was 2, ranging from 0 to 15 siblings. The mean proportional absenteeism for the group during the baseline year was 7.2 days compared with a national average proportional rate of 6 days and the DEIS band 1 schools national average of 9.4.

6.2.2 Baseline depressive symptoms

As indicated in the previous chapter, the CDI-S was used to assess depressive symptoms amongst the sample of children. In total, 364 children fully completed the CDI-S at baseline. The mean raw score of this sample was 2.34 (SD=2.8) which is comparable to the Irish normative mean (M=2.07, SD=2.69, n=1100; Meehan, Houghton, Cowley, Houghton & Kelleher, 2008; $[t(363^{14}) = 1.834, p=0.067]$ but lower than the US normative score (M=3.05, SD=3.19; n=867; Finch, Saylor, & Edwards, 1985; $[t(363) = -4.74, p=0.000]$. The mean *T* score was 47.8 (SD=8.9; range= 40-90) found to be within the *average* range (i.e. 45-55) (based on American norms-see Appendix 6.1 for details on norm ranges). However, as shown in Figure 6.1, 82% (300/364) were categorised as s*lightly below average* or *average* on this normative scale, thereby indicating that most of the children reported no difficulties with depression.
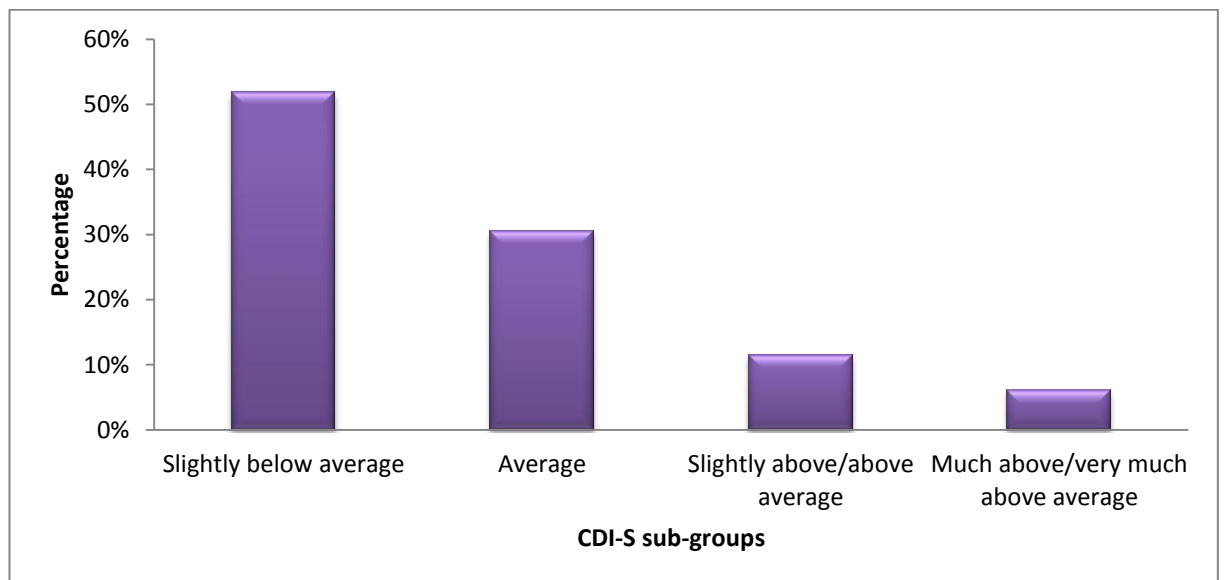
Figure 6.1: Proportion of sample who fell within each CDI-S subgroup at baseline stage

The relationship between CDI-S scores and a range of key background variables was also investigated. A Pearson's product-moment correlation indicated a small negative correlation between age and CDI-S scores (r=-0.138, p<0.01). This suggests that at baseline, older children reported slightly lower CDI-S scores than younger children. However, the coefficient of determination (r^2) indicated that the age and CDI-S shared only 2% of their variance. There were no differences between males (M=47.4,

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[14] Figure in bracket refers to degrees of freedom

SD=9.14) and females (M=48.13, S=8.7) [t(362) =-0.782, p=0.434] nor was there any correlation between levels of absenteeism and CDI-S scores.

6.2.3   Health related quality of life

At baseline, a total of 407 children completed the Kidscreen-27 Psychological well-being subscale. The mean T-score for these children was 53.1 (SD=11.1) ranging from 21-74. This mean score fell within the *average* range (48.07-58.01) when compared to European norms for children of similar age (8-11 years). Figure 6.2 below illustrates the distribution of scores obtained by the sample when compared to European normative data. It can be seen that the distribution of scores is evenly spread with a little under one third (31%; 127/407) scoring within the *below average* range, thereby indicating that a substantial minority of children were presenting with poor psychological health and well-being.
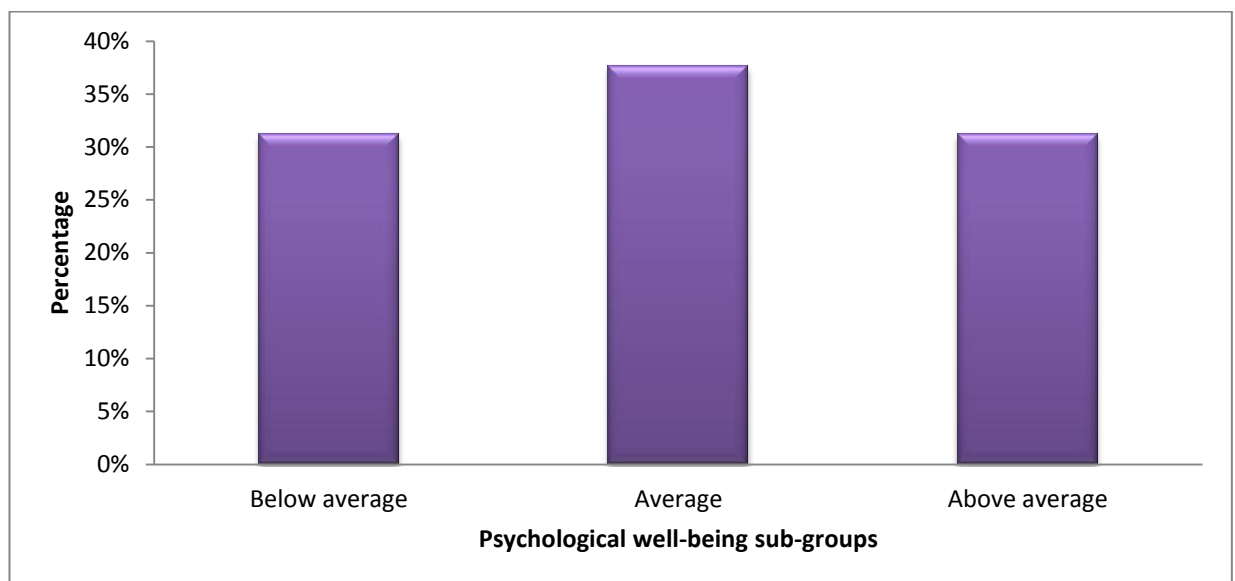
Figure 6.2 Distribution of psychological well-being scores at baseline when compared to European norms

A series of chi-square goodness-of fit tests were conducted to examine any differences between the current sample and a 2005 national HRQoL study (Keenaghan & Kilroe, 2008, n=355). Keenaghan and Kilroe (2008) also used the Kidscreen questionnaire and explored the proportional distribution of responses by children on individual sub-scale items (see Table 6.1). Overall, in response to positively phrased questions, the current sample were more likely to respond *always* whilst the national sample were more conservative and more likely to respond *very often*. For example, the current sample

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(43%) was more likely to indicate *always* being in a good mood than the national study (17%). Conversely, on the negatively phrased questions, children in the national study were more likely to indicate *never* experiencing negative feelings whilst children in the current sample were more likely to be conservative and instead choose *seldom*.

Table 6.1: Comparisons between the current and national samples on Kidscreen psychological well-being items

Psychological well-being item	Sample (n)	Never %	Seldom %	Quite often %	Very often %	Always %	p
Has your life been enjoyable?*	Irish Kidscreen study (355)	1	7	20	42	30	p<0.001**
	Study cohort (411)	3	8	8	24	57	
Have you been in a good mood?	Irish Kidscreen study (355)	0	9	27	46	17	p<0.001**
	Study cohort (408)	2	14	11	30	43	
Have you had fun?	Irish Kidscreen study (355)	1	6	19	43	31	p<0.001**
	Study cohort (402)	1	5	7	16	71	
Have you felt sad?	Irish Kidscreen study (355)	34	38	18	7	2	p<0.001**
	Study cohort (406)	27	53	8	6	5	
Have you felt so bad you didn't want to do anything?	Irish Kidscreen study (355)	61	19	10	6	2	p<0.001**
	Study cohort (403)	55	26	10	4	5	
Have you felt lonely?	Irish Kidscreen study (355)	60	19	10	5	3	p<0.001**
	Study cohort (405)	58	28	6	4	4	
Have you been happy with the way you are?	Irish Kidscreen study (355)	3	4	13	29	51	p<0.001**
	Study cohort (409)	3	9	6	12	71	

*Responses for this question are: not at all, slightly, moderately/sometimes, very, extremely/always*Irish Kidscreen study 7-12yr cohort comparisons

**Significant. Bonferroni adjusted p level set at 0.01

The relationship between psychological well-being and a number of other descriptive variables at baseline were also examined. A Pearson's product-moment correlation indicated a negligible negative correlation with age whilst an independent t-test showed no significant differences in scores for males (M=52.46, SD=11.4) versus females (M=53.51, SD=10.71); [t(405) =-0.963, p=0.336]. Again, as with the CDI-S, no significant relationship was found between absenteeism and reported psychological well-being.

The findings in relation to other aspects of HRQoL as measured by the remaining four subscales of the Kidscreen-27, showed a similar pattern to those presented above with the mean scores for each falling within the *average* normative range (see Table 6.2). Similar to the *Psychological well-being* subscale findings, *Physical well-being* scores were evenly spread with approximately one third (32%, 131/407) reporting lower than average scores. However, the largest proportion of children (39%, 158/404) reported *below average* scores with respect to *Autonomy and parent relations* indicating that this was perhaps the most problematic aspect of HRQoL for most of the sample. Conversely, the smallest proportion (26%, 106/408) were categorised as *below average* on the *Social support and peers* subscale whilst the great majority of children (72%) were also functioning at an *average* or *above average* level with respect to *School environment.* Again no significant relations were observed between absenteeism and measures of HRQoL. This suggests that other factors besides health and well-being may influence child absenteeism.

Table 6.2: Mean T scores (SD) on each Kidscreen-27 subscale at baseline and number (%) of participants in each category

Categories	Below average		Average	Above average	Total
	M	%	%	%	
	±SD	F	F	F	F
Physical well-being	54.1	32	32	35	
	10.9	131	132	144	407
Autonomy & parent relations	50.4	39	40	21	
	12.1	158	160	86	404
Social support & peers	53.2	26	28	46	
	12.1	106	113	189	408
School environment	54.4	29	40	32	
	12.1	115	160	129	404

6.2.4 Health related behaviour

A number of questions relevant to psychological health were also extracted from the Health Related Behaviour Questionnaire for analysis.

6.2.4.1 Life worries

First, children were asked how frequently they worried about a range of life issues such as school work and health Table 6.3 below illustrates out the proportion of children at baseline who reported worrying: *never, sometimes* or, *a lot* about different aspects of their life.

Table 6.3: Proportion of children at baseline expressing worries on a range of life issues

Worry type (n)	Never % F	Sometimes % F	A lot % F
School work (355)	41 / 145	41 / 145	18 / 65
School tests (355)	34 / 120	39 / 139	27 / 96
Friend worries (352)	37 / 130	39 / 137	24 / 85
Family worries (351)	37 / 131	28 / 97	35 / 123
How I look (351)	55 / 193	27 / 95	18 / 63
Money (348)	59 / 204	26 / 92	14 / 52

These findings indicate that school tests were the most commonly reported source of concern for (66%) in terms of the proportion who stated that they worried *sometimes* or *a lot* about this subject. However, children indicated that they were most likely to worry *a lot* about *family problems* (35%) with *school tests* (27%) second most likely issue to cause a lot of concern. Much smaller proportions worried *a lot* about how they looked (18%), school work in general (18%) or money-related issues (14%).

6.2.4.2 Bullying

At baseline, approximately one third of the sample indicated that they had been bullied in the last year. Worryingly, more than one in ten (13%) of the sample also stated that they believed their school does not try to stop bullying whilst another 29% did not know. This suggests that improvements concerning this issue are needed by schools so children feel adequately supported.

A one-way between-groups multivariate analysis of variance (ANOVA) was performed to investigate differences on a range of variables, between those children who had been bullied in the last year when compared to those who had not. Six dependent variables were

included: CDI-S scores; and the five sub-scales of the Kidscreen as these were the validated measures of emotional well-being and HRQoL included in the study. There was a moderate statistically significant difference between both groups on the combined dependent variables [F (6, 285) =6.49, p<0.001; Wilks' lambda=0.88, partial eta squared=0.12[15]]. When the results for the dependent variables were considered separately (using a Bonferroni adjusted alpha level of 0.008), two variables emerged as statistically significant: the *CDI-S* [F (1, 290) =35.9, p<0.001, partial eta squared=0.11] and *Social supports and Peers* [F(1, 290)=11.0, p=0.001, partial eta squared=0.04]. An inspection of the means indicated that children who reported being bullied displayed significantly higher levels of depression (M=51.3, SD=11.0) than those who reported not being bullied (M=45.2, SD=6.3). Similarly, the 'bullied' group fared significantly worse with respect to *Social supports and Peers* (M=51.2, SD=14.4 versus M=56.0, SD=10.2).

Additional questions relating to bullying were also administered by the older children (3rd-5th class; ages 8 to 12). The purpose of these more detailed questions were to investigate what type of bullying behaviours were most frequently experienced by the sample. Interestingly, in some instances, a greater proportion of children indicated having experienced some form of bullying behaviour than those who had actually indicated being bullied (36%), thereby suggesting that perhaps children did not fully understand the term[16]. For example, respondents reported that the most common form of bullying behaviour that they encountered *sometimes or always* was either *being called nasty names* (52.2%, 145/278) or *being teased* (47.1%, 131/278). Experience of bullying behaviour (*sometimes or always)* through social networking mediums such as email (11.9%, 29/244) or by mobile phone (7.1%, 17/241) were the least commonly reported forms of bullying behaviour amongst the cohort. Nevertheless, in a similar way to the findings concerning how the school addresses bullying, these differences suggest that more work around bullying is needed in the school setting.

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[15] Group comparison effect size statistic (i.e. partial eta squared) was interpreted using guidelines set out by Cohen (1988)

[16] Bullying was defined to participants using the Irish Society of Prevention of Cruelty to Children definition: *"Bullying is when a person or group keeps saying or doing things to hurt or control another person in a harmful way"*. https://www.childline.ie/index.php/support/bullying/1395

Table 6.4 Type and frequency of bullying in the last year (for the entire sample at baseline

Bullying behaviour (n)	Never % F	Sometimes % F	Always % F
Teased (278)	53 147	38 105	9 26
Called nasty names (278)	48 133	40 111	12 34
Bullied through mobile phone (244)	88 215	10 24	2 5
Bullied through email (241)	93 223	5 12	2 5
Pushed/hit for no reason (273)	58 159	31 85	11 29
Belongings taken or broken (243)	69 167	26 63	5 13
Been threatened for no reason (244)	73 177	21 52	6 15
Asked for money (242)	78 189	17 41	5 12
Ganged up on (247)	76 188	17 43	7 16

6.2.4.3 Satisfaction with weight-an indicator of satisfaction with body image

Children were also asked to indicate their satisfaction with their weight as an indicator of perceived body image. Overall, 58% (214/366) of the sample at baseline reported *being happy with their weight* although more than one third indicated they *would like to lose weight* (35%, 128/366) whilst fewer than 10% reported wanting to *put on weight* (7%, 24/366).

The responses were categorised for purposes of comparative analysis into those children who indicated *being happy with their weight as it is* and those who wanted to *lose or gain*

weight. A number of t-tests were completed on the CDI-S scores as well as each of the subscales of the Kidscreen-27. Not surprisingly perhaps, on all measures besides the subscale *Social support and peers*, children who indicated being happy with their weight reported significantly better HRQoL and significantly lower levels of depression than their counterparts who reported wanting to lose/gain weight (see Table 6.4). This suggests a relationship between perceived body image and feelings of health and well-being.

Table 6.5: Comparisons between children who are happy versus not happy with their weight on measures of well-being and depressive symptoms

	Happy with weight	Would like to lose/gain weight	p
	M (±SD) N	M (±SD) N	
CDI-S*	46.1 (7.5) 212	50.2 (10.2) 150	<0.001
Psychological well-being*	55.1 (10.9) 211	50.1(11.1) 151	<0.001
Physical well-being*	56.1(10.9) 211	51.7 (10.7) 151	<0.001
Autonomy and parent relations*	51.6 (12.3) 210	48.7 (12.2) 149	p<0.033
Social support and peers	54.0 (12.1) 212	52.0 (12.6) 152	ns
School environment*	56.5 (11.9) 211	53.7 (11.5) 149	p<0.03
***Significant at p<0.05**			

6.3 Section Two: Comparisons between Intervention and Comparison schools over the course of the HSP

6.3.1   Demographic profile

The mean ages of the Intervention and Comparison group children were comparable at 9.18 years (SD=1.4) and 9.12 years (SD=1.5) respectively. However, there were proportionately more boys in the Intervention school sample (52%, 175/335) when compared to the Comparison group (47%; 47/99). The mean number of absent days in both schools was almost identical (7.2 days in Intervention schools and 7.1 days in Comparison schools). This indicates a higher rate of absenteeism than the national average (6 days) but lower when compared to DEIS band 1 schools nationally (9.4 days). A participation attrition rate of 2% and 20% was observed for year 1 and year 2 respectively. The higher proportion of attrition at year 2 was mainly due to 6th class children moving to a secondary school in the final year of data collection.

6.3.2   Depressive symptoms

A number of comparisons between the Intervention and Comparison school samples were undertaken at baseline, year 1, and year 2 time points of the HS programme in order to assess whether or not the programme had led to any changes in overall levels of depression in the Intervention schools. Overall, a larger proportion of Intervention school children reported *above average* levels of depressive symptoms (18%, 50/274) when compared to the Comparison sample (15%, 14/90) at baseline. T-test analysis on mean T scores indicated no statistically significant differences between Intervention school children (M=47.8, SD=9.2) and Comparison school children (M=47.8, SD=7.9; t (362) =-0.007, p=0.95) at the baseline stage.

The proportion of children who fell within the *much above/very much above average range* decreased slightly at year 2 for both Intervention school children (16%. 35/217) and Comparison school children (11%, 8/75). This suggests that while children in the Intervention schools displayed higher levels of depressive symptoms at the outset, similar improvements were found across school type over time. A one-way between-groups analysis of covariance was also conducted changes in children's reported symptoms of depression over the course of programme implementation. Participants' CDI-S scores at baseline were used as the covariate in this analysis. Preliminary checks were conducted to

ensure that there was no violation of the assumptions of normality[17]. The overall mean T scores for both groups had decreased at year 2 when compared to baseline showing an improvement over time. However, after adjusting for baseline scores, no significant difference was found between Intervention and Comparison schools at year 2 [F (1,271) =2.54, p=0.112, partial eta squared=0.01]. There was a large relationship between the baseline and year 2 scores on CDI-S as indicated by a partial eta squared value=0 .121.

Table 6.6: Comparisons of CDI-S mean *T*-scores between Intervention and Comparison schools across three time points

	Baseline		Year 1		Year 2	
	M (±SD)	M (±SD)	M (±SD)	M (±SD)	M (±SD)	M (±SD)
School type	I	C	I	C	I	C
CDI mean T scores	47.7 (9.2)	47.8 (7.9)	47.0 (10.1)	47.3 (7.4)	46.5 (9.4)	45.1 (6.3)
N	274	90	313	93	217	75

Notes: T test analysis indicated no significant differences between Intervention and Comparison schools at year 1 (t (404) =-0.182, p=0.855) or year 2 (t (290) =1.21, p=0.227)

A 2 x 2 between groups analysis of covariance was also conducted to assess if there were any differences by gender in levels of depression in both groups over time. After adjusting for CDI-S scores at baseline, no significant interaction effect (school type x gender) was observed: [F(1, 269) = 0.641 , p= 0.43] and neither were there any statistically significant main effects: [school type: F (1, 269) = 2.67, p = 0.104; gender: F (1, 269) = 0.203, p = 0.65]. These results indicate that were no gender differences on CDI-S scores in either the Intervention or Comparison groups over time.

The *above average* sub-group within Intervention and Comparison schools was also examined separately using paired sample t-tests to assess if scores changed in any way at year 2 for children who reported higher levels of depressive symptoms at baseline. Whilst this sample group was relatively small, some interesting findings were observed. For the Intervention group, a significant decrease in CDI-S scores was observed between baseline (M=63.2, SD=8.1) and year 2 (M=54.1, SD=12.9) (t(42)=3.9, p<0.001; eta squared=0.3).

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[17] Linearity, homogeneity of variances, homogeneity of regression slopes, and reliable measurement of the covariate were assessed using guidelines set out by both Pallant (2010) and Tabachnick and Fidell (2014)

A similar result was observed for the Comparison school group between baseline (M=60.9, SD=6.8) and year 2 (M=47.9, SD=5.8), t(8)=3.44, p<0.01; eta squared=0.6). This indicates that the greatest improvement in depressive scores was observed amongst the most vulnerable group. No significant differences were observed between school types at year 2 for this sub-group.

6.3.3   Health-related quality of life

6.3.3.1 Psychological well-being

Further comparisons between Intervention and Comparison school children were conducted to explore any differences with respect to overall *Psychological well-being*. At baseline, a larger proportion of Intervention school children (34%) when compared with the Comparison group (23%) fell *below average* on this subscale. This proportion fell to 31% at year 2 although, conversely, the proportion of Comparison group children in the *below average* range at baseline (whilst still lower than the Intervention sample) increased by 3% at year 2 (26%) (Table 6.7).

Table 6.7: Comparisons between Intervention and Comparison schools across three time points on psychological well-being

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
School type	I	C	I	C	I	C
Below average	34	23	29	33	31	26
	106	21	90	30	69	20
Average	35	48	40	42	34	41
	109	44	126	38	76	31
Above average	32	29	31.	25	35	33
	101	26	97	23	79	25
Total	316	91	313	91	224	76

Kidscreen mean T scores were also generated for each group at each follow-up time point and tests conducted to assess any differences (see Table 6.8 below). Firstly, at baseline, no statistically significant differences emerged between both groups (t (165.8) =-0.63, p=0.53). A one-way between-groups analysis of covariance was then conducted to

compare both groups on self-reported psychological well-being over the course of programme implementation. Participants' scores at baseline were used as the covariate in this analysis and preliminary checks were again complete to ensure no violation of test assumptions. After adjusting for baseline scores, there were no significant differences between Intervention and Comparison schools at year 2 (F $(1,281)$ =0.07, p=0.77, partial eta squared=0.000). Again, there was only a small relationship between the pre-intervention and year 2 scores with a partial eta squared value of 0.099.

Table 6.8: Comparison between Intervention and Comparison groups of mean T scores on the Kidscreen-27 subscale psychological well-being across three time points

	Baseline		Year 1		Year 2	
	M	**M**	**M**	**M**	**M**	**M**
	(SD)	**(SD)**	**(SD)**	**(SD)**	**(SD)**	**(SD)**
	I	**C**	**I**	**C**	**I**	**C**
Psychological	52.8	53.6	53.2	52.2	53.9	53.3
well-being	(11.4)	(9.7)	(11.5)	(9.4)	(12.8)	(9.0)
n	316	91	313	91	224	76

Note: t test analysis revealed no significant differences between Intervention and Comparison schools on Kidscreen Psychological well-being scores at year 1 (t (402) =0.76, p=0.45) or year 2 (t (185.42) =0.39, p=0.70)

A 2 x 2 between groups analysis of covariance was again conducted to assess any differences in psychological well-being by gender. After adjusting for baseline psychological well-being scores, no significant interaction effect (school type x gender) was observed: [F(1, 279) = 0.007, p= 0.934]. No main effects were observed either, indicating no gender differences in the intervention and control groups over time F (1, 279) = 0.066, p = 0.797].

6.3.3.2 Other aspects of HRQoL

The remaining four subscales of the Kidscreen-27 were also examined separately and the proportion of children on each dimension compared by type of school over the three time-points. On all but one of the subscales, mean T scores increased slightly across time for both Intervention and Comparison schools. Whilst changes were not significant this indicates that most children fare somewhat better over time. However, mean T scores on the subscale *Physical well-being* decreased marginally between the baseline (M=51.6) and year 2 (M=50.2) time points

An analysis of co-variance was conducted on each of the Kidscreen-27 subscale scores to test for any statistically significant differences between the Intervention and Comparison school children across the three time-points. These results are presented below.

Physical well-being

With respect to *Physical well-being,* substantial proportions of Intervention and Comparison school children obtained *below average* scores at baseline (30% and 40% respectively). Interestingly, at year 2, the proportion of Intervention school children in this category had declined by 1% compared to a slight increase of 3% amongst the Comparison school group (43%).

Table 6.9 Comparisons between Intervention and Comparison schools across three time-points for physical well-being

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
School type	I	C	I	C	I	C
Below average	30	40	28	45	29	43
	95	36	89	42	66	33
Average	33	31	33	32	28	32
	104	28	105	30	64	24
Above average	37	30	38	23	42	25
	117	27	120	21	95	19
Total (n)	316	91	314	93	225	76

The differences in mean scores between Intervention and Comparison schools at year 2, when adjusted for baseline *Physical well-being* scores, were also examined using ANCOVA analysis. After determining no violation of the assumptions of normality, the results showed statistically significantly higher scores in the Intervention group when compare to their comparison school counterparts at year 2 [$F_{(1,280)} = 8.27$, p=0.004, partial eta squared=0.03]. However, very little improvement in mean scores were observed between baseline and year 2 for the intervention school sample and Comparison school

children's mean scores decreased. No gender differences were observed between the intervention and comparison groups on the measure of physical well-being F (1, 278) = 1.283, p = 0.258].

Table 6.10 Mean (SD) scores on physical well-being at baseline and year 2

	Intervention school (n=215)	Comparison school (n=68)
Time period	M (SD)	M (SD)
Baseline	55.0 (±11.1)	51.2 (±10.6)
Year 2	55.8 (±11.5)	50.1 (±10.6)
Adjusted Year 2	55.4	51.1

Autonomy and parent relations

On the *Autonomy and parent relations* subscale, approximately one third of children in the Intervention schools and half (51%) in the Comparison school sample fell below the average. However, these proportions decreased over time in both cases, especially in the Comparison group, thereby indicating an increase in reported levels of autonomy and parental relations over time. In year 2, just over 27% of comparison school children were within the *below average* range. This change may have occurred because as children got older, their feelings of autonomy increased, or perhaps some environmental factors/changes had led to children feeling more independent (e.g. Boykin, McElhaney, & Allen, 2001). However, it should be noted that autonomy can increase due to positive or negative changes in a child's life and so without further qualitative exploration of this issue with the children; it is difficult to draw any conclusions.

Table 6.11 Comparisons between Intervention and Comparison schools across three time points on the Kidscreen-27 autonomy and parent relations subscale

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
	I	C	I	C	I	C
Below average	36	51	29	43	26	27
	113	45	91	40	57	20
Average	41	35	36	34	37	37
	129	31	111	32	82	27
Above average	23	15	35	23	37	37
	73	13	110	22	83	27
Total (n)	315	89	312	94	222	74

Intervention and Comparison school mean T scores were also compared. At baseline, the mean T score for Intervention school children (M=51.2, SD=12.3) was significantly higher than the Comparison school sample (M=47.8, SD=11.1; t (402) =-2.32, p=0.021). A one-way between-groups analysis of covariance was then conducted to compare Intervention and Comparison schools scores on this subscale as the HSP was implemented. Preliminary checks were conducted to ensure that there was no violation of the assumptions. After adjusting for baseline scores, no significant difference between Intervention and Comparison schools was found at year 2 [F (1,275) =0.003, p=0.958, partial eta squared=0.000]. Again, a large relationship between the baseline and year 2 overall scores on *Autonomy and parent relations* was indicated by a partial eta squared value of 0.222. No gender differences were observed between the intervention and comparison group sample at pre- and post-intervention [F (1, 273) = 0.171, p = 0.679].

Social support and peers

At baseline, a much lower proportion of children from the Intervention schools (23%) fell within the *below average* category on the *Social support and peers* subscale when compared with their comparison group counterparts (36%). Similar to the other subscales, the proportion in the *below average* range decreased at year 2 for both schools (see Table 6.12).

Table 6.12 Comparisons between Intervention and Comparison schools across three time points on the Kidscreen-27 social support and peers subscale

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
	I	C	I	C	I	C
Below average	23	36	22	30	21	25
	74	32	68	28	47	19
Average	28	26	19	21	19	20
	90	23	58	20	42	15
Above average	48	39	60	49	60	55
	154	35	186	46	131	41
Total (n)	318	90	312	94	220	75

There was no statistically significant difference at baseline in the mean T score for the Intervention versus comparison group sample. A one-way between-groups analysis of covariance was also completed (there was no violation of the assumptions). The differences in mean scores between Intervention and Comparison schools at year 2 when adjusted for baseline *Social support and peers* scores, again indicated no significant difference between school types [$F_{(1, 275)} = 0.809$, $p = 0.369$, partial eta squared=0.003]. There was a large relationship between the baseline and year 2 overall scores on *Social support and peers* (partial eta squared value = 0.138). No gender differences were observed between the intervention and comparison group sample at pre- and post-intervention [$F_{(1, 273)} = 2.5$, $p = 0.115$].

School environment

On the final Kidscreen-27 subscale, *School environment*, almost identical proportions of children in Intervention schools (28%) and the Comparison schools (29%) fell within the *below average* range at baseline and as above, these proportions showed decreases, albeit only marginally so in this case, at year 2 for both groups.

Table 6.13 Comparisons between Intervention and Comparison schools across three time points on the Kidscreen-27 school environment subscale

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
	I	C	I	C	I	C
Below average	28	29	21	28	23	20
	89	26	66	26	51	15
Average	39	42	39	45	38	39
	123	37	120	42	83	29
Above average	33	29	40	28	39	41
	103	26	124	26	84	31
Total (n)	315	89	310	94	218	75

A t-test analysis revealed no significant differences at baseline in these mean scores between the Intervention sample (M=54.4; SD=12.4) and Comparison group children (M=54.2; SD=11.0). As before, a one-way between-groups analysis of covariance was conducted to compare children's self-reported responses to items on the *School environment* sub-scale over the period of HSP implementation. But after adjusting for baseline scores, no significant difference between Intervention and Comparison schools was found at year 2 [F (1,270) =0.118, p=0.732, partial eta squared=0.000]. There was however a moderate relationship between the baseline and year 2 scores on *School environment* (partial eta squared value= 0.093). As above, no differences by gender were observed between the intervention and comparison group sample at pre- and post-intervention [F (1, 268) = 0.776, p = 0.432].

6.3.4 Health related behaviour

In addition to assessments of health related quality of life and depressive symptoms, children's scores were also compared on a number of questions from the Health Related Behaviour Questionnaire (HRBQ) to identify any changes on children's perceived health-related behaviour as these issues relate to the objectives of the HSP. These included level of worrying, satisfaction with weight and experiences of bullying.

6.3.4.1 Life worries

At baseline, similar levels of worrying were reported by school type. In particular, more than one third of both Intervention (35%, 94/266) and Comparison school (34%, 29/85) children indicated they worried *a lot* about *Family problems. School tests* were the second most commonly reported concern with approximately one quarter (26%, 71/270) of Intervention school children and almost 30% (25/85) of Comparison school children reported worrying *a lot* about this issue.

Between baseline and year 2, there was an overall reduction in the proportion of children from both school types who indicated worrying *a lot* about the majority of life issues. However, despite this overall trend, there was an increase in the proportion of Intervention school children who reported worrying *a lot* about *School tests* between baseline (26%, 71/270) and year 2 (32%, 72/224). It is important to note that at baseline questionnaires were completed prior to the Easter break whereas in year 1 and 2 questionnaires were completed after the Easter holidays. Whilst the holiday may have influenced well-being scores, the final school term includes summer exams and this may also have influenced scores concerning school exams. Interestingly, at year 2, a higher proportion of Intervention school children than Comparison school children also indicated worrying *a lot* about each of the life issues. For example, whilst almost one in five (18%, 39/223) of Intervention school children reported worrying *a lot* about *the way they look* at year 2, only 7% (5/74) of Comparison school children responded likewise. Chi-square analysis revealed a statistically significant association between school type and worrying *a lot* versus *never/sometimes* about *the way I look* [χ^2 (1, 297) =4.26, p=0.04, chi=0.13] suggesting that a significantly higher proportion of intervention school children worried a lot about this issue. This suggests that perhaps children in the intervention schools were more aware of these issues compared to the comparison school children. However, it may also be the case that differences between schools and samples were present and the HSP was not effective in addressing this aspect of child well-being. Chi-square analysis performed on all categories to exam associations between school type, gender, and level of worrying found no other significant associations.

McNemar tests were completed on responses to each life worry between baseline and year 2. The only significant difference found was with regard to *school tests* where

proportionately more Intervention school children reported worrying *a lot* at year 2 (33%) than at baseline (22%). No other significant differences were observed.

6.3.4.2 Satisfaction with weight

Table 6.14 below highlights the similarities and differences between school type concerning perceived satisfaction with weight. Chi-square analyses were also completed at each time point to exam associations between school type and children who indicated *being happy with their weight as it is* versus children who *would like to lose/gain weight*. No significant differences between groups emerged at baseline indicating similar proportions of children being satisfied and dissatisfied with their weight [χ^2(1, 366) =0.145, p=0.704, phi=-0.26. Similarly, no significant association between school type and satisfaction with weight was found at either year 1 [χ^2(1, 405) =0.312, p=0.577, phi=-0.034] or year 2 [χ^2(1, 298) =0.403, p=0.525, phi=0.045]. McNemar tests were completed separately on the Intervention school sample as well as the Comparison school sample to explore change in scores across the three time points. Again there was no significant change in the proportion of participants in either the Intervention schools or the Comparison schools across the 3 time-points who indicated *being happy with their weight*. There was also no significant association between gender and satisfaction with weight across schools at each time point.

Table 6.14: Comparison across three time points of the proportion of Intervention and Comparison school children who indicated being satisfied or dissatisfied with their weight

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
School type	I	C	I	C	I	C
I would like to put on weight	8	3	7	6	4	3
	21/277	3/89	21/311	6/94	9/222	2/76**
I would like to lose weight	33	40	35	39	35	32
	92/277	36/89	109/312	37/94	78/222	24/76
I am happy with my weight as it is	59	56	58	54	61	66
	164/277	50/89	181/311	51/94	135/222	50/76

*Chi-square tests performed for each year using dichotomous variable coded: *would like to lose/gain weight* or *happy with weight as it is*: none were significant

6.3.4.3 Bullying

Table 6.15 below compares the proportion of reported bullying across Intervention and Comparison schools over the three time points. However, there was no significant association between school type and bullying (χ^2 (2, 359) =4.78, p=0.091, phi=0.12). Likewise, no significant associations between school type and reported bullying were found at later time-points [χ^2(2, n=378) =1.951, p=0.377, phi=0.07] or year 2 [χ^2(2, n=288) =0.499, p=0.779, phi=0.042].

Table 6.15 Comparison across three time points of the proportion of Intervention and Comparison school children who indicated being bullied at or near their school in last 12 months

	Baseline		Year 1		Year 2	
	%	%	%	%	%	%
	F	F	F	F	F	F
School type	I	C	I	C	I	C
Yes	33	44	33	36	27	31
	91/273	38/86	97/290	32/88	58/214	23/74
No	55	42	55	57	60	55
	151/273	36/86	158/290	50/88	128/214	41/74
Don't know	11	14	12	7	13	14
	31/273	12/86	35/290	6/88	28/214	10/74

There was no significant change (p>0.05), according to McNemar tests, in the proportion of participants in either the Intervention schools or the Comparison schools across the three time-points who indicated being bullied at or near their school. Neither were there any statistically significant associations between the type of bullying.

McNemar tests were also completed on each type of bullying behaviour to explore any changes between baseline, year 1, and year 2 for Intervention school and Comparison school children. Again, no significant findings were observed amongst the Comparison school sample over time although a number of changes were found amongst the Intervention school children over the three time-points. For example, the proportion of Intervention school children who indicated *sometimes or always being teased* increased significantly between baseline and year 1 (p=0.044) but significantly decreased between year 1 and year 2 (p=0.005). Whilst no changes were noted between baseline and year 2

with regard to *being called nasty names*, a significant decrease was found between year 1 and year 2 (p=0.01). Across the three time points, a significant reduction was also found in the proportion of children who indicated *having belongings taken or broken* amongst the Intervention school children between baseline and year 2 (p=0.001). Similarly the proportion of children who reported *sometimes or always* being *asked for money* decreased significantly between baseline and year 2 (p=0.014). Finally, on the question *how often have you been ganged up on*, a significant decrease was found in the proportion of Intervention school children who indicated this happening sometimes or always between year 1 and year 2 (p=0.04). No other significant changes were observed for this question.

6.4 Chapter summary

The findings from this chapter highlight that, overall, the children in this study fell within normative ranges of psychological health and well-being. However, substantial minorities across schools indicated higher than average levels of depressive symptoms and lower overall psychological well-being at baseline. Nearly half of the sample also indicated being dissatisfied with their body weight. This suggests that an important proportion of children in these schools may be struggling with their feelings and self-confidence. In addition, a large proportion of children in the study reported experiences of bullying within the last year and many children also indicated worrying a lot about various life issues, especially family life. Thus, it is likely that many of these children perceive aspects of their social environment as challenging and require improved supports than they are currently receiving.

Comparisons of self-report health measures between Intervention and Comparison school children over the evaluation period indicate that, whilst some health improvements were observed for the entire sample over time, the lack of any substantial differences between Comparison and Intervention school samples suggest that any changes in health are unlikely to have been due to the HSP. These improvements may indicate that the health assessment itself may have influenced how children reported on their health over time. Interestingly however, Intervention school children scored significantly higher than their Comparison school counterparts both at baseline and at year 2 on measures of physical well-being- a key focus of the HSP.

The next chapter will explore in more depth the perceived impact of the programme on children's health through interviews and focus-groups with key stakeholders. This chapter that follows will also examine the process of implementation to explore the importance of contextual factors on implementation quality. In this way, the reasons for why the apparent lack of any changes in children's health outcomes as a result of HSP implementation will be investigated further.

CHAPTER SEVEN

PHASE II: QUALITATIVE RESULTS

7.1 Introduction and overview of qualitative data analysis

This first component of Phase Two of the study contained two elements: (a) an exploration of the experiences of all key stakeholders regarding the HSP; and (b) a review and critical analysis of materials documenting the implementation process of the HSP.

Several categories of data were collected during the course of programme implementation including 27 one-to-one follow-up interviews (14 participants), 4 retrospective focus groups (n=34 participants), observation notes, and relevant published and unpublished documents by the HSP funding team. Understandably, some stakeholders who were involved in all stages of the HSP design and planning (e.g. the manual author and the HS funders) were more aware of the HSP content than those stakeholders who participated in the HSP at the later planning and implementation phases. Thus, in some instances and where appropriate, relatively more weight was given to these individual views. For this reason, it was considered inappropriate to report on participant numbers throughout this chapter. Instead, both majority and minority views of participant groups (e.g. parents, staff, and principals) are reported.

It was beyond the scope and aims of the current study to undertake an exhaustive analysis of all of the rich data collected. Therefore, the analysis was initially guided by the research objectives as set out in Chapter One and a number of *a priori* themes based on the implementation science literature. Framework analysis revealed three overarching key themes to encapsulate the views of the stakeholders. Within each primary theme, 18 sub-themes were also identified. All of the themes and sub-themes are detailed below in Figure 7.1. However, for purposes of simplicity and clarity, only the first overarching theme is presented here; the remainder are presented in the two chapters that follow and each are discussed, where relevant, in the context of the literature.
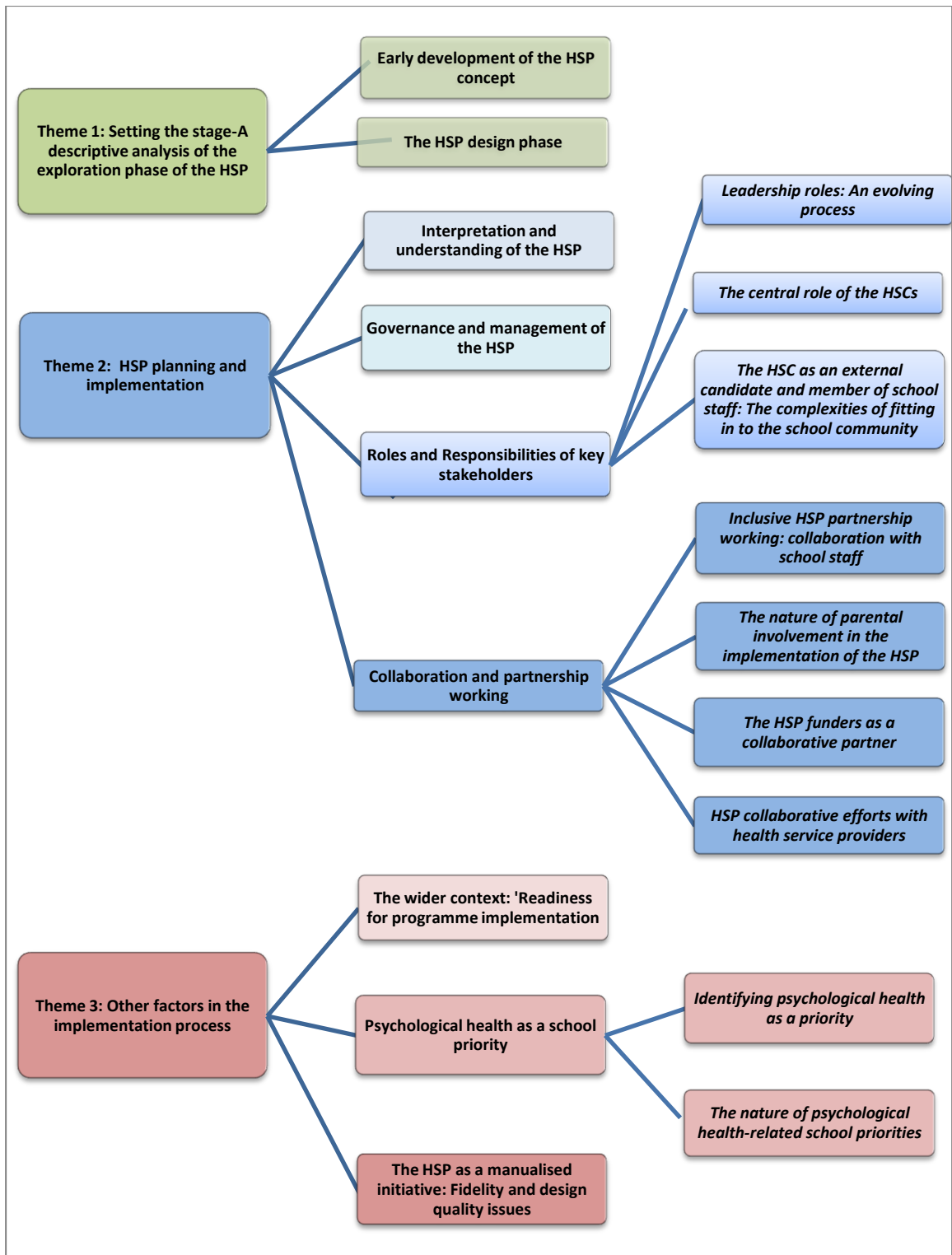
Figure 7.1 Diagrammatic overview of thematic framework

7.2 QUALITATIVE FINDINGS I: SETTING THE SCENE - A DESCRIPTIVE ANALYSIS OF THE EXPLORATION PHASE OF THE HSP

The initial 'exploration' stage of the HSP occurred prior to this study (and the larger evaluation). This section provides a descriptive overview of this phase drawing on HSP funder documentation, observation notes and the findings from the interviews.

7.2.1 Early development of the HSP concept

A review of relevant funder reports and the meeting observation notes indicate that, from the outset, CDI placed much emphasis on developing initiatives that addressed the needs of the local community in an effective and appropriate way. For instance, in line with best practice recommendations of the implementation literature (e.g. Burke, Morris, & McGarrigle, 2012), CDI's work was informed by a number of consultation processes completed with representatives of local community including: a needs analysis completed in 2003 (How Are Our Kids? CDI, 2004); an audit of services in Tallaght West (CDI, 2005); consultations with children from the local area (Experiencing Childhood Citizenship, 2005); and consultation with local community members (Report of the Stakeholder Consultation Process, 2005). The CDI team also engaged and consulted with a range of professionals from the health, educational and welfare sectors to define the parameters of the programme as a manualised initiative. According to one CDI report, in 2007 a number of innovative initiatives evolved from these consultations that aimed to address various identified community needs. One of these initiatives was the HSP. Thus, the development of the HSP *"centred on understanding the current health-related provision of services in schools, gaps in that provision, the promotion of healthy lifestyles within both the school and the community, how to engage parents and the role and responsibilities of the programme facilitator in the delivery of this service"* (Keogh, 2008, p15).

To further develop this work, CDI established a Healthy Schools working group whose remit included the development of a HS manual in collaboration with CDI and a manual author (contracted in March 2008). Importantly, the manual author had extensive experience of health promoting schools and was a central figure in leading the direction of the manual until the manual approval stage. Other members of the working group included Health Service Executive (HSE) and Department of Education representatives as well as

members of South Dublin County Council (HS manual, Lahiff, 2009, p 3). It was clear from the manual as well as from interviews with key informants, who were members of the working group, that some members had previous experience of health promotion as well as health-related educational practices. In addition to this working group, the CDI Board also established an expert advisory committee to support and oversee the work of the HS working group and the development and approval of the HS manual and programme content. This committee comprised experienced academics with backgrounds in the implementation and/or evaluation of health-related evidence-based initiatives. These collaborative efforts again highlight the commitment of CDI to produce a health promotion initiative based on best practice and local experience.

7.2.2 The HSP design phase

According to the HS manual (Lahiff, 2009), Dartington Social Research unit were contracted to carry out a literature review of best practice to complement the HS working group and expertise of the manual author. Overall, this phase of manual design and development occurred over a period of approximately nine months. It was clear from the observation notes, along with the views of the manual author, that much consultation and negotiation between members of the working group was necessary before the manual was approved by the expert review panel and distributed to schools in January 2009. It was also evident from interviews with the author and a key member of the funding team that CDI had considerable input into the content of the manual. According to the manual author, the funders adapted components of the manual to ensure the programme reflected the overarching objectives of CDI as an organisation. The author incorporated these changes alongside outcomes based on health promotion literature. In this way, according to Keogh (2008), the purpose of this manual became twofold. Firstly, the HS manual aimed to provide a guide to the implementation of a settings-based health promotion approach that was based on international best practice. Secondly, the manual was adapted to meet the specific objectives of CDI as a PEIP organisation[18]. As a result of this negotiated process, two sets of objectives were included in the manual: (1) objectives identified at an individual school level through a self-audit of health priorities (included in the manual) in line with health promoting school best practise (e.g. IUHPE, 2009) and; (2) a set of pre-determined health outcomes to be aimed for by all participating schools based

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[18] Prevention and Early Intervention Programme

on a local area needs analysis carried out by the funders. An overview of manual content is present in Table 7.1 below. It is evident that the two sets of objectives conflicted with each other.

Table 7.1 Manual overview

Material informing the HSP	• **Health promotion literature**
	• **HS funders local research and needs analysis**
	• **Logic model[19]**
	• **Information on school as a setting for HP**
Objectives/Focus of programme implementation	• Self-audit of health priorities to be completed at the school level[20]
	• Cross-school pre-determined health outcomes to be addressed[21]
Guidelines for implementation	• HSC role and remit
	• HS governance and management structure
Planning procedures to support implementation	• Memorandum of agreements of roles and responsibilities between all key stakeholders
	• Induction training
	• School-led audit of needs

While aspects of the manual reflected the international literature in the health promoting school field, it appeared that the subsequent adaptations that were completed to address pre-identified objectives by CDI at a local level added a layer of complexity to the manual in terms of using it as a guide for implementing a health promoting school approach. For instance, the manual set out an audit of needs to be completed at an individual school level at the outset of programme implementation to ensure that the programme would focus on health issues identified by individual schools. Other components included in the manual (i.e. memorandum of agreement, roles and responsibilities, aims and objectives) have been identified in literature as essential steps in the *process of implementing* a health promoting school approach in schools (Leurs, Bessems, Schaalma, & de Vries, 2007; Senior, 2012) rather than being set in stone from the outset as was the case here.

In addition, the working group and CDI included a set of seven pre-determined areas of health to be addressed by all involved schools[22]. The inclusion of these objectives was to address the health issues identified at a local community level by CDI in their consultation papers (e.g. 'How Are Our Kids?' CDI, 2004). Whilst intended to address the needs of the local area community, clearly this approach was not school-led at an individual school

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[20] See Appendix 7.2
[21] See Appendix 7.3
[22] See Appendix 7.3

level. It is notable that the manual author indicated that these objectives were not in line with health promoting school international literature. Nevertheless, through a process of consultation between the author and HS working group, they were included in the final manual. Table 7.xx below provides an over view of these two sets of objectives. The impact of the inclusion of two diverging sets of objectives on HSP implementation (as set out in Appendix 7.2 and 7.3) is examined further in Chapter Nine.

Table 7.2 Comparison of two sets of HSP objectives included in the HS manual

Pre-determined outcomes of the HSP as set out in the HS manual	HSP Self-audit of health priorities
- Children demonstrate age-appropriate physical development - Children have access to basic healthcare - Children are aware of basic safety, fitness and healthcare needs - Children are physically fit - Children eat healthily - Children feel good about themselves - Parents are involved in their child's health	- Management Structures and Policies - Physical Environment - Ethos and Social Environment - Clarity of the Healthy School Coordinator Post/ Job Description - Partnerships/ links with Services and Community Groups / External Supports - Curriculum and teaching/ Learning Styles - Parent and Family Links/ Supports - Supports for Transitions

During the period of manual and programme design phase, all DEIS Band 1 primary schools in the local area (n=9) were invited to take part in the HSP by the funding team. Out of these schools, five expressed an interest in participating (CDI, 2008). According to the principals, they were informed by the HSP funders at this stage that the programme would be led by a nurse who would support them in addressing specific health issues in schools. However, the principals were not involved in the manual design and pre-implementation stage and along with the two newly recruited HSCs were only invited to join the HSP implementation Steering Committee just prior to the implementation of the HSP in September 2008. The finalised manual was provided to the HSCs and principals in January 2009. Figure 7.2 below provides an overview of the design, planning and implementation phases of the HSP. The following chapters explore the experiences of all key stakeholders (i.e. members of the funding team, HSCs, education and health professionals involved in the steering committee and/or HS manual development), as well as principals, other staff and parents involved from this stage onwards.
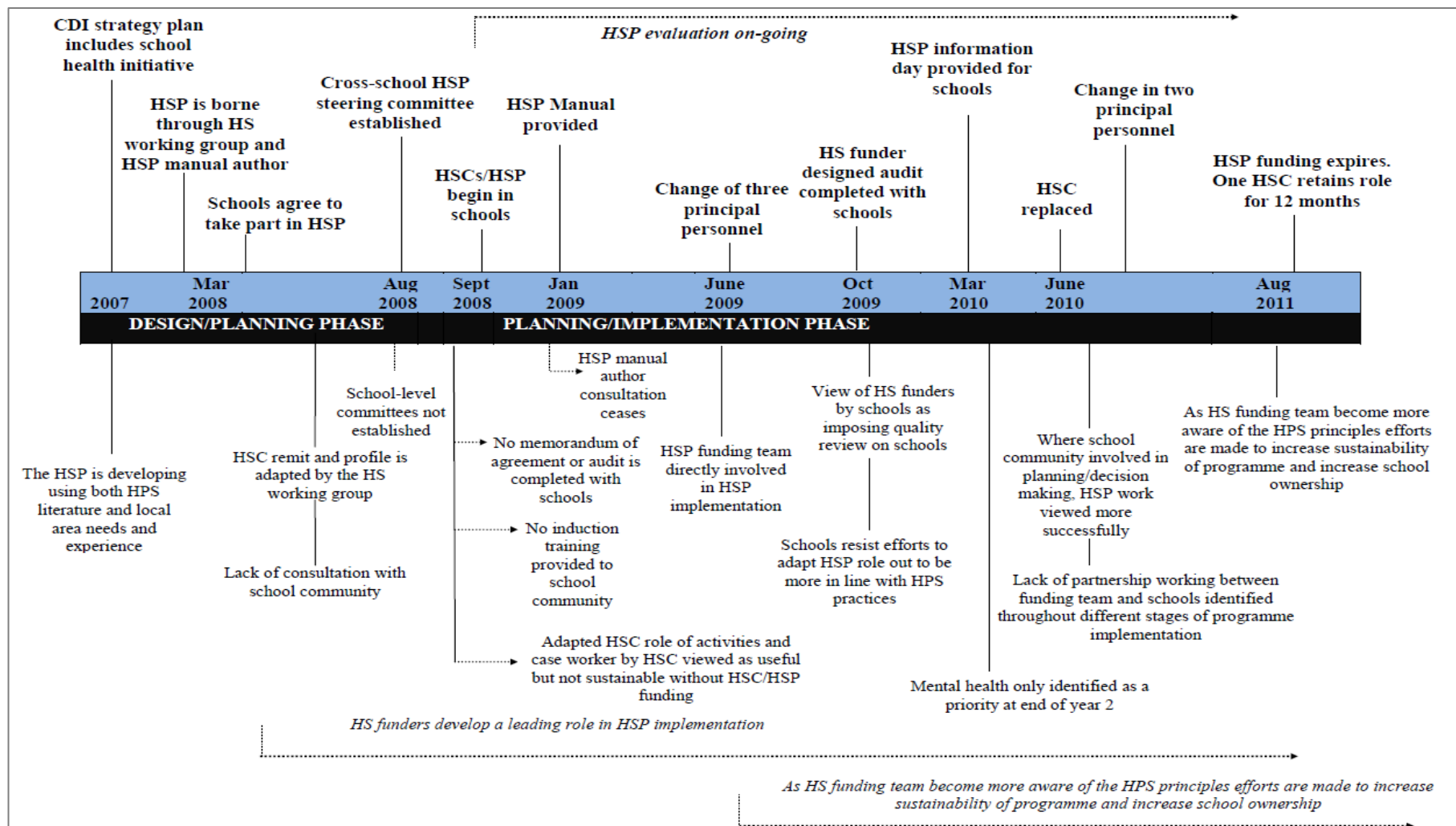
Figure 7.2: HSP planning and early implementation timeline

7.3 Chapter summary

This chapter described the first set of qualitative findings to emerge from the study. A brief overview of all key themes was also outlined. The focus of this chapter is the 'exploration' or planning phase of the implementation of the HSP that occurred prior to the evaluation period. A range of individuals with experience and expertise in health, education and community development were involved in this process and it was clear that the HSP team endeavoured to develop a programme based on evidence-based practice in conjunction with their knowledge and experience of the implementation context. However, it is also clear from the findings that a number of adaptations were made to the manual before its distribution to the schools and HSCs - some of which deviated from an evidence-based health promoting school approach as outlined in the international literature. Most importantly perhaps, members of the manual working group amended the manual to include an additional set of pre-set health outcomes of the HSP. The purpose of this adaptation was to address health issues raised in the funding team's exploration research with the local area community. However, these pre-established outcomes conflict directly with the individualised school-led approach espoused by the health promoting school literature (as well as the school-led audit of health priorities included in the manual by the manual author). The impact of these important early stage decisions in the initial exploratory stage of programme implementation is considered in the two chapters that follow.

CHAPTER EIGHT

QUALITATIVE FINDINGS II: HSP PLANNING AND IMPLEMENTATION

This second qualitative findings chapter reports on the experiences and views of those who were involved in HSP in some way during the implementation phase.

8.1 Interpretation and understanding of the HSP

The research literature suggests that a shared understanding of key concepts of an initiative paired with a clear vision of aims and objectives are fundamental indicators of success (Brown & White, 2006; Dowling, Powell, & Glendinning, 2004). In the context of the current study, most members of the steering committee acknowledged the importance of a shared understanding of the programme by all stakeholders as a prerequisite for successful implementation of the programme. Nevertheless, the findings suggested that there were mixed views and understanding of the *Healthy Schools Programme* (HSP) as a health promoting school approach. In particular, during interviews undertaken in the first year, none of the respondents alluded to the theoretical underpinnings of the Health Promoting School.

The literature indicates that the central aim of the health promoting school approach is to support each community to empower themselves by increasing their capacity to improve how health is addressed. Here, the term 'community' is used to refer to each individual school setting (e.g. IUHPE, 2009; Mitchell, Palmer, Booth, & Powell-Davies, 2000; Senior, 2012) and indeed, this notion of 'separateness' is essential for encouraging ownership of the initiative by each participating school (Turunen, Tossavainen, Jakonen, & Vertio 2006). Thus, in the current context, each school should be considered separately in terms of programme planning. However, according to a CDI consultation report (Keogh, 2008), the term 'community' was defined by the funding team as '*those living and working in the Tallaght West area*' (p6). In a similar way, steering committee observation data indicated that members of the HSP steering committee and funders understood the term 'community' to refer to the local area community and not the specific school community. This appears to have had important implications for the planning and implementation of the HSP in the sense that the steering committee focused its efforts on rolling out the HSP at a broader cross-school

level rather than in an individual school-led way and this, in turn, created a number of challenges in the planning and implementation of the HSP. These are discussed throughout the findings.

"At the start…I don't think they had been briefed enough on it [the HSP] *... really and truly we should have all known* [what the programme entailed] *from the very start but that's hindsight, that's a great thing."* [Teacher, Focus Group, Year 2]

"It was envisioned [in the manual] *that* [each] *school would set up a Health Promoting Schools committee…through which the school would develop the HSP… I do think* [without the committee] *eventually the co-ordinators…took on more of a hands-on role than might have been envisaged because there was a vacuum left by the absence of a strong* [school] *committee"* [Health Educational Professional, Year 2]

The HS manual outlines that training in the HSP should be provided to key stakeholders in the early stages of the implementation process. Despite this guideline, no HSP training was provided for any members at the planning stage (or any other stage) of the programme. This is likely to have contributed to the divergence in understanding by stakeholders. Several of the interviewees also noted that the HS manual was not ready in the early stages of programme planning and was only printed and provided to the schools, HSCs (and evaluation team) four months after programme implementation officially commenced. The delay in the manual was due to the process of consultation and adaptation of the manual between the manual author and the HS manual working group. However, members of the funding team noted that funding restrictions necessitated the commencement of the programme despite the manual delay. Whilst members of the working group were involved in manual development and were aware of its content, other key stakeholders such as principals and the HSCs were not. Understandably, this delay led to different interpretations of the HSP as well as some key components of the programme not being applied. Importantly, a number of teaching staff participants commented that, although induction training and the establishment of a memorandum of understanding (MOU) between stakeholders was recommended by the HSP manual, these measures were not implemented. Without an understanding of a health promoting school approach, other key components underpinning this framework, such as a school-led needs audit, were also not completed. The literature indicates that the use of such a school-led audit of needs is an important first step in ensuring that the

priorities of a health promoting school initiative are relevant to the schools involved (Arthur *et al.,* 2011; IUHPE, 2009; Kok, Schaalma, Ruiter & van Empelen, 2000; Leurs *et al*., 2005; Leurs *et al.,* 2007; Senior, 2012; St. Leger & Nutbeam, 2000). Without a completed audit, identifying school-led health priorities and addressing these priorities using a health-promoting school ethos proved challenging for the HSCs, HSP funders, and school community. This limitation highlights the importance of promoting an awareness of, and appropriate training for, members of the steering committee and school staff in health promoting school practices before or in the early stages of programme implementation. Training in these practices was also essential for the members of the steering committee members to enable such initiatives to be planned and implemented in an evidenced-based way and necessary for school staff so the school community were empowered to incorporate the components of a health promoting school into their school effectively. It is likely that this lack of understanding impacted on how aims and objectives of the HSP were identified and addressed.

"My sense of it is that they [the HSC funders and HSC] *probably struggled a bit to find their feet ...there were things in the manual, like the schools were to set up a committee, a healthy schools committee, and I think* [those components were] *slow getting off the ground ... in each of the schools."* [Health/Educational Professional, year 2]

"In terms of re-design, I'd have schools...involved from the outset – clearer planning and agreeing aims and objectives... [the schools] *obviously don't have a sense of that ...an induction* [was] *needed...and greater awareness and understanding of what* [the HSP] *is all about."* [HS Funding Team Member, year 2]

In contrast, both health and educational professional interviewees were clearly conscious of the conceptual aspects of the programme and the objectives of a health promoting school as defined by the WHO. These interviewees also acknowledged the divergent views of other stakeholders and, not surprisingly perhaps, along with the majority of the funding team and HSCs, commented on how this had negatively impacted on the programme implementation (and ethos) in supporting schools.

In the second year of implementation, the steering committee observation notes describe a number of remedial actions that were made to increase the understanding and awareness of the programme. These efforts included encouraging the school community

to engage more with the HSP as an initiative that could address issues such as mental health at a systems level as well as introducing additional physical health-related activities in schools. A staff workshop was delivered in the second year to members of the steering committee and teaching staff in all participating schools by Ms. Anne Quirke, well-known health-promoting schools professional from Wales, where a similar Healthy Schools initiative is well-established in most primary schools. There was evidence to suggest that as a result, some stakeholders (especially principals and teaching staff) indicated an increased awareness of how the programme could be used to address all aspects of health including psychological health.

In follow-up interviews, some principals and most members of the funding team described how the local HSP was modelled on the ethos of a health promoting school as outlined in international guidance and principles. In follow up interviews, most interviewees also demonstrated awareness that the programme was designed to improve the capacity of the schools to address the health needs of the school community. Based on these findings, it would seem that in cases where effective health promoting school-related information had been provided to the school community, their awareness of the HSP as an initiative which can address all areas of health (including psychological health) in a holistic way was more evident. However, several of these participants still emphasised the primary importance of activity work and other discrete events in follow-up interviews and it was unclear how the development of a health promoting school ethos had been addressed. Thus, despite increased awareness by some stakeholders, it was clear from the majority of responses that there was a lack of understanding around the fundamental conceptualisation and attendant guiding principles of the HSP throughout the period of implementation.

"We thought [the HSP] *was physical activity and diet and nutrition and tying in with parents around that.* [The HSC] *was doing skipathons and taekwondo and all those type of things and* [we believed that the HSP] *was just to improve you know the general physical health of the children and make parents more aware."* [School Principal, year 1]

"It was very much [clear] *to me that they* [some teachers] *didn't really get the concept of the Healthy Schools Programme, and saw the co-ordinator more as, "It's great, they*

can free us up for half an hour in the yard while I go in and do some bits and pieces." [HS Funding team member, year 1]

"*I don't think* [many of the schools understand the HSP]…*I think* [one principal] *gets it. I think he knows exactly what the Healthy Schools should be about….and I think that's making the difference there…he's saying to his staff "It's about the whole school being a healthy school. It's not about* [the HSC] *coming in and doing it for us. It's how do we change the whole school?"* [Healthy School Coordinator, year 2]

The challenges discussed above suggest that whilst a shared understanding of key health promoting school components is essential for stakeholder buy-in, it is important that this also accurately reflects the correct conceptual underpinnings of any new initiative as outlined in the international literature.

8.2 Governance and management of the HSP

An effective governance and management structure is considered a key contributory factor in the successful engagement of, and collaboration with, stakeholders in any new initiative (Brown & White, 2006; Dowling *et al* 2004). In the current context, sustainable HS governance and management structures were particularly important to supporting schools in taking more responsibility for the HSP. For example, the HS manual makes a number of recommendations aimed at providing a coherent and sustainable infrastructure for programme implementation. Thus, at an individual school level, each school was expected to establish its own HS committee comprising representatives from the entire school community. The objective of this committee was to drive the HSP and ensure the programme was rolled out in an effective and relevant way. In this way, it was thought that schools would be more likely to take ownership of the programme thereby promoting programme relevancy and sustainability (Senior, 2012). At a broader level, an overarching HSP steering group unique to the HSP was also recommended to guide and direct the work of the HSP across all participating schools. This committee, according to members of the HS funding team, was envisaged to be principal-led with representation from all schools as well as key stakeholders of the HSP.

These governance structures were developed, albeit with varying degrees of success, and were encouraged by the funding team to promote a school-led management model

in an effort to embed/establish/achieve school buy-in to the HSP. However, the school-based HSP committees, as set out in both the manual and the HS literature (IUHPE, 2009), were never established due to resistance from school management from the outset. Most of the school principals expressed concerns that assuming responsibility for HSP governance and management would create additional workload pressures for staff. These concerns were perfectly legitimate in view of the public sector pay cuts and national level budgetary constraints that were introduced in Ireland[23] at the time of HSP implementation (2009-2011). Indeed, these kinds of workload concerns relating to programme implementation and governance have commonly been reported elsewhere (e.g. Inchley *et al*., 2007; St. Leger, 1998)**.** Conversely the aim of the school-level committee in the local study was to reduce the responsibilities of principals and instead create a more inclusive and sustainable style of governance and management. Results from the interviews with principals indicate that this approach was generally not accepted. This reluctance to embrace the establishment of a HSP support infrastructure further reflects the lack of clarity around the understanding of the programme and the absence of shared agreement on roles and responsibilities. Furthermore, the programme tended to be seen by members of the school community as an add-on to school services rather than a proper framework and ethos embedded within existing school structures. Some of these challenges are illustrated well in the comments below from one health/educational professional stakeholder:

"It was envisioned that the school would set up a Health Promoting Schools committee…through which a school would [direct the HSP]… [but because these were never established] *eventually the co-ordinators possibly took on more of a hands on role than might have been envisaged because there was a vacuum left by the absence of a strong committee or a… nucleus of people who would drive the agenda."* [Health/Educational Professional, year 2]

 Responses from both school-based participants and members of the HS steering group suggest that, in some ways, the higher level cross-school HS steering committee structure was more successful in how it was rolled out. According to the participant observation data, this HS steering committee was set up prior to programme

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[23] Financial Emergency Measures in the Public Interest Act 2009 http://www.per.gov.ie/public-service-pay-policy/

implementation and was maintained throughout the period of evaluation. It was evident from these data that the funders encouraged involvement by the HSCs and principals of all participating schools as well as by the external professional interviewees. This reflects the efforts made by the funding team to engage and collaborate with a wide range of professional stakeholders which is an essential component of successful programme implementation (IUHPE, 2009).

These efforts notwithstanding, the lack of school level committees led to the overarching steering group making decisions on issues related to the direction of HSP implementation in each school. Thus, the HS steering group became (inadvertently) a key mechanism for programme implementation. Whilst this governance and management structure was useful in the absence of a school-level structure, it was clear from participant responses that the structure also presented some obstacles to successful HSP implementation. An analysis of the minutes from the steering group meetings over the course of programme implementation indicate that many HSP health priorities were established by the steering committee at a cross-school level. The results of the interviews with individual members of the funding team suggest that these priorities were often based on the seven pre-determined outcomes which had been included in the manual. The focus of work, as determined by the group, was therefore applied to *all* participating schools rather than a tailored focus being determined at a local level by each individual school.

According to some of the participants, this process had led to a disconnect between the overarching health priorities as designed by the HS manual working group (who were involved in the exploration and planning stage of the HSP) and the priorities identified at a school level in line with best practice health promoting school literature as outlined in the previous chapter. Perhaps unsurprisingly, according to a number of principals and the HSCs, these seven HSP priorities sometimes did not relate the individual school context and thus were not viewed as priority issues by all schools. This led to frustration amongst school staff which, in turn, gave rise to reluctance by some schools to engage fully with the programme. As the programme progressed, resistance to the programme became increasingly obvious. As a result the HSP funding team subsequently made efforts to address these challenges in the latter half of the programme implementation period by working towards a more school-led approach to HSP planning that involved

principals and HSCs developing HSP activity plans at a school level. However, as discussed later in the findings, the seven pre-determined priorities were retained and the challenges identified with this core component of the manual was not revisited by the funding team

"There were some [pre-determined] *objectives* [in the manual] *and to this day I kind of argue as to why are they there – you know kids will be taller and that kind of stuff.. I find that very difficult to maintain as an objective for a health promotion agenda"* [Health/Educational Professional, year 2]

The importance of schools developing their own HSP-health related ideas and priorities (as opposed to at a cross-school level) was reiterated by many of the school staff in the focus groups. This suggests that a more school-led approach to the management of HSP from the outset may have helped to improve school buy-in, thereby increasing support for the HSP as a whole. This is consistent with reports in the literature concerning the importance of a school-led approach to implementing health promoting school initiatives (e.g. Barnekow *et al*., 2006). Similarly, most teaching staff in the focus groups agreed that any school-led ideas were viewed more positively by schools, whilst the HSCs also reported that school-led components of the programme tended to be more effective.

*"I suppose we [*the funding team*] would have seen that you could have applied the seven outcomes to all schools and just come up with a plan and implemented it. But, definitely we learned it wasn't even campus-led… it was individually school-led. So, you had to come up with an action plan for each school as opposed to having a generic plan. … One size doesn't fit all."* [HS Funding Team Member, year 2]

"It has to be in conjunction with the school not something that's imposed on the school. Teachers and everybody have to be a part of it and developed in the school… but if somebody comes in and imposes a program on a school it won't be so successful. But if it's developed within the school". [Teacher, Focus Group, year 2]

8.3 Roles and responsibilities of key stakeholders

8.3.1 Leadership roles: An evolving process

Principals were perceived by the majority of stakeholders and especially by the funding team, as essential to the roll-out of the HSP. Indeed, many examples of principal leadership were reported by a broad range of participants and they were central in filling the gap left by the absence of school-level committees. Such examples included consulting with the HS steering committee, directing and guiding the work of the HSP in their individual school and advising the HS funding team. However, there were also quite a few examples which showed a lack of enthusiasm on the part of some principals in leading on this kind of work. As indicated earlier in this chapter, the importance of completing a memorandum of agreement with all involved with the planning and implementation of the HSP is integral to its acceptance/adoption/success. For instance, it was mainly the principals who opposed the development of school-level HSP committees. According to members of the funding team as well as some principals themselves, most principals reported their reluctance to become what they perceived to be line managers to a HSC working in different participating schools. These interviewees stated that while some principals engaged to some degree with this responsibility, the system of management was not successful due to the cross-school nature of the HSC work. There was also a clear suggestion from the responses of most principals that they were uncomfortable with this leadership role. Understandably, principals did not wish to be involved in the workings of another principal's school, particularly given the independent nature of each school setting.

Rushmer and Pallis (2002) argue that leadership and vision in implementing an initiative alongside a sustainable governance and management infrastructure are essential components of any successful multi-agency initiative. It was evident that the lack of school-directed committees created a HSP leadership vacuum at a school level. In cases where principals were reluctant to direct the HSP at a cross-school level, many decisions were made either by the HSC in a non-democratic way or at the cross-school committee level. This model differs substantially from a school-led model of leadership as espoused in the health promoting school literature (Gleddie, 2011; Leurs *et al*., 2005; Senior, 2012). The reluctance of principals to lead and manage HSC work also resulted in a lack of clear support structures for the HSCs, as evidenced by the narratives of the

majority of participants along with the observation notes. There were, in turn, important 'ripple effects' for the HSCs:

"When I [the HSC] *said to* [the principal]*, "Oh, you're going to be my boss" she went, "Oh, no! I'm not your boss. I'm not telling you about the three schools. I'm only about my school"…It's hard to know who to approach, like even just about practical things."* [Healthy School Coordinator, year 1]

"I think there is a real lack of clarity as to who is responsible… [One principal] *was close to retiring…and then* [the principal of another school on campus] *was just starting here …So … she did not have the time really either and then* [the principal of the third school on campus]*, never came to any of the steering committees the whole year."* [Healthy School Coordinator, baseline year]

The HSCs and most of the Principal interviewees reported that they had not been fully briefed as to how the HSP should be managed and led. This again suggests a marked lack of pre-implementation planning and little or no shared agreement of roles and responsibilities by the schools as recommended in the manual. It was clear that this lack of communication led to poor relationship building and collaboration between key stakeholders and that this in turn led to a lack of buy-in and an impaired understanding of the HSP amongst school staff. By contrast, a number of international studies highlight a need for clearly defined roles and responsibilities (as well as a shared understanding of objectives as indicated earlier), which is key to successful partnership working and collaboration (Brown & White, 2006; Dowling *et al*, 2004; Sloper, 2004; Stewart *et al.,* 2003). By these measures, it is perhaps unsurprising that there was a lack of confidence and trust in how the programme should be led and implemented thereby impeding progress:

"I suppose the [HS management] *structure is complicated enough … I never felt that they* [the principals] *really took on board their line management responsibilities or that they actually got that bit either….I don't know whether we* [the funders*] should have done things slightly differently as well that in terms of the contracting with the school, should we have had more kind of regular progress meetings with them maybe."* [HS Funding Team Member, year 2]

Most of the funding team members who were interviewed acknowledged that their encouragement of principals to lead the implementation of the HSP was met with mixed success and that this was a significant source of disappointment for them. As a result, the funding team members themselves assumed responsibility for managing the steering group. However, efforts continued over the course of the implementation period to transfer responsibility to the principals (the role of the funding team in this respect is examined in more detail later in this chapter). Consequently, many parents, staff and even the HSC interviewees reported experiencing difficulties in clarifying who was responsible for directing the HSP. This can be explained by the fundamental lack of shared understanding that underpinned many of the challenges faced by those involved in implementing the HSP during its lifetime. The lack of pre-implementation planning, consultation and agreement limited the success of a school-led model which in turn impacted negatively on programme implementation in a number of important ways which are discussed in the sections that follow.

8.3.2 The central role of the HSC

One particularly important adaptation to the programme was how the role of the HSC developed over time. In the pre-planning stage, principals and members of the funder team reported that it was agreed between funders and school communities that the appointed HSC should have a health background. However, according to members of the funding team, concerns over resources and possible duplication with the work of the HSE Public Health Nurses (PHNs) led instead to recruitment of HSCs from a community development background instead. Importantly, this change was completed without consultation with school representatives and there was no evidence to suggest the adaptation followed evidence-based practice. Interviews with the principals suggested that this adaptation to the HSC role was a particular source of frustration for them:

"*At the start when we heard of all this money and you know that maybe we might have like a speech therapist on-site or a psychologist on-site and the programme just seems to have evolved into 'we have a healthy schools person', which is great like you know, but… it's a bit of a disappointment really.*" [School Principal, baseline year]

Clearly, the lack of training and understanding amongst those leading the HSP implementation led to the HSC role being developed without specific adherence to a

health promoting school approach. This lack of information for school staff and parents about the HSC role, especially in the early stages of the HSP, was also likely to impact on school community buy-in to the role. The findings from several sources including the interviews with principals, as well as feedback from parent and staff focus groups, suggest that the level of ambiguity amongst the school community persisted throughout the evaluation period as to how the newly established HSC, as a non-health worker without experience in a health promoting school approach, would be in a position to appropriately develop this central role.

Yet again, this emphasises the importance of initiating and sustaining close and inclusive collaboration with the school community at each stage of the development of the HSP - an issue explored in more depth later in this chapter. It was also apparent that the HSCs themselves were unclear as to the precise remit of their role. Without training in health promoting school practices or a manual to guide their work in the early stages of the HSP roll out, the HSCs' understanding of the role was based on interpretations of the HSP through meetings with the funding team and principals who themselves had little understanding of this approach. As one professional stakeholder noted below, consultation and planning with principals prior to the introduction of the HSC in schools may have increased clarity around the parameters of the HSC role and HSP initiative itself:

"Maybe it would have been better if a lot of background work had have been done with the principals first and then the co-ordinators were brought on-board." [Health/Educational Professional, year 1]

"I think initially it was quite confusing [group agrees here] *I mean [*the HSC*] didn't really know what her position was, she wasn't given very specific [*guidelines*], and I know that it was quite difficult for her because she was told quite a lot of the time that what she was doing wasn't good enough but she* [also] *wasn't told what you* [are supposed to be] *doing. And I know that that was a conflict."* [Teacher, focus group, year 2]

"I think we [the schools] *learned what it* [the HSP] *was about through taking chances and literally I think the* [HSCs] *took chances and I know this isn't about* [the individual HSCs] *…but … maybe for six, seven months, that girl … was trying to figure out you*

know "what am I here for… well I'm not very sure because my people [the funders] *haven't told me what I can do and anything I tell them I'm doing they're saying well that's not really what you are there for", … it was very confusing."* [Teacher, focus group, year 2]

In response to the concerns raised by the school communities, the HSP steering committee and funders allocated additional resources to the implementation of health-related activity work (led by the HSC) in schools. As a result, the role of HSC as a school support worker (i.e. activities coordinator and referral case-worker) was increasingly encouraged by the funding team and principals instead of higher level HSP coordinator work more comparable to health promoting school initiatives elsewhere in the world (Arthur *et al.*, 2011; Inchley *et al.,* 2006; Leurs *et al.,* 2005). According to members of the HSP funding team, this was encouraged in order to build up trust with schools and to demonstrate the potentially useful role of the HSC. Members of the funding team anticipated that, as schools developed a relationship with the HSC, school involvement in the programme would increase and the schools themselves would eventually lead HSP work. Indeed, according to implementation literature, efforts to establish trust and confidence between stakeholders are key for the success of initiatives that require effective integrative working (e.g. Brown & White, 2006). However, it is clear that in the case of the local initiative, efforts by the funding team to establish such partnerships led to both benefits and challenges for HSP implementation:

"Over the recent months… there were concerns around child welfare and even child protection…Those issues wouldn't be coming up if the Co-ordinators hadn't done the Skipathons and the Healthy Eating stuff. …so, in some ways, ... that [activity] *stuff actually was necessary because it built up trust and it built up confidence in them* [the HSCs] *and it kind of gave it time for the Principals to suss out and think about it."* [Health/Educational Professional, year 1]

Interviews with the HSCs and members of the funding team as well as the observational data indicated that work completed by the HSC was very broad and hands-on. For example, as an activities support worker, the HSCs organised and implemented a range of health-related activities, workshops and once-off events with children and their families (see Appendix 8.1 for further details on HSC activities work). Any health-related activity work which was completed in collaboration with the school community

was generally described positively by participants and was encouraged. School staff suggested that this work led to an increased awareness and broader understanding of various health issues including psychological health amongst the school community. Thus, whilst this activity-focused approach to the *Healthy Schools Programme* differs substantially to the school level ethos approach espoused in the health promoting school literature (i.e. a primary focus on health promotion policy development, school environment, service development, and community relations, with activity curriculum work being only one component), the hands-on involvement of the HSC did improve the extent to which health was addressed in schools during the evaluation period.

"The most important thing in my view, looking back on the year is that I feel there is a much greater awareness in the children's minds and in their parent's minds about the importance of good health." [School Principal, baseline year]

"All constituents of the school community… are certainly far more aware of the issues that are out there in relation to health…I think a very good example of that would be the schools effort to gain the active school award, where you have children involved in that, parents, teachers, and the Healthy School Coordinator all working together with a common goal, which is of benefit to everybody. So there is no doubt about that, yes - although it is difficult to measure". [School Principal, year 2]

In addition to the health-related activities curriculum work with children and staff, the HSC worked to engage families and parents. The objectives of HSC family engagement work were to address parental health and establish better relationships between parents and school staff to achieve a more inclusive school environment (see Appendix 8.1 for further details of this work). In a similar way to the children-focused activity work, the HSCs organised numerous health related events (e.g. classes and workshops involving parents) throughout the three years of programme implementation. Most parents reported that, as a result of collaborating with the HSCs, they had more opportunities to engage with a variety of health related school-based activities in which they had an interest. School staff in both the focus groups, including the principals, reported that they valued and encouraged the HSCs' activity work with parents and had noted an increased involvement by families in the school as well as perceived improvements in family awareness of various health issues:

"I think…the Healthy Schools Open Day … it was very successful…I think because the parents were …able to plan that activity and implement that activity, that made it really successful, …I think parents felt that they're valued, their opinions were valued, their input was very important." [Healthy Schools Coordinator, year 2]

These findings suggest that the presence of the HSCs in the schools helped to develop a certain level of confidence by families in the programme as it was implemented. This, in turn, may have provided a positive experience for some families with regard to how they engaged with their school generally. Whilst much HSP family work was activities-focused (e.g. yoga classes, cooking classes, self-care workshops), the perceived success of additional family engagement work like the HS Open Day[24] led some school members to recognise that the HSP could provide more support than just the roll-out of activities for children. For example, one principal highlighted how such efforts with families had broadened his view of the HSP to include mental health and all aspects of the school environment:

"Initially we would have had the idea that [the HSP] *was more to do with … physical activity and diet and nutrition…but I suppose I have a fuller idea of it now in that it's not just based on physical health, that it would incorporate mental health as well as reaching out to parents and helping them, you know it's not just for the children in the school…But it's kind of for the greater community as well and that it will encompass mental health."* [School Principal, year 1]

Based on the HS steering committee observation notes and the interviews with the funders, it is apparent that the HSC was also expected to support schools in forging relationships with external agencies and other disciplinary services, such as local area Health Service Executive mental health services, dieticians, public health nurses and speech and language therapists. The primary purpose of this work was to support families in engaging with services and to improve communication pathways for school staff. It was clear from the responses of most of the interviewees that the HSC had worked continuously to improve relationships between a number of local services (e.g. local mental health agencies, speech and language services, HSE public health nurses

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[24] The HS Open day was a one day health awareness and education event in each school whereby local health-related agencies and services were invited to maintain an information stand in the school hall. Families, staff, children and the local community were invited to attend and meet with these services to learn more about what services are available to them and how each can be accessed.

and health promotion officers) and participating schools. Thus, the HSC was perceived by most teaching staff and families to provide a valuable resource to the schools. Indeed, as the programme rolled out, the HSC noted that they had increasingly engaged with services to support individual children on a case-by-case basis. This "hands-on" work included supporting families with health appointments and acting as the school contact person for families with health-related issues including psychological health. The HSCs themselves indicated that this family referral case work was important and created opportunities to engage with families.

According to a number of staff and the HSCs, there are many reasons why parents do not follow up with health-related referral appointments for their children. These included families' general lack of confidence as well as limited understanding of the system due to the current complicated referral processes compounded by long waiting lists. Several school-based respondents maintained that these issues were particularly relevant for families dealing with mental health services. The HSC, in their role as caseworker, attempted to focus on addressing these challenges by engaging with services on behalf of both staff and families and supporting families with the paperwork required for referral appointments. At an individual level, this support was beneficial to some families while some interviewees also observed increased awareness amongst families of health services and appropriate referral pathways. In general, parents also viewed this new support role in schools positively and indicated that they felt 'listened to' by both the HSC and the Home School Community Liaison Coordinator (HSCLC). It is likely that the provision of the HSC in this capacity was a valuable resource for families needing additional support.

 "There are a significant number of families here that would be hard to reach, and hard to get through to. And I think one of the major successes of the healthy schools programme has been - now it has taken time - but it has been a growing capacity to break through those invisible barriers that do exist out there." [School Principal, year 2]

"Now for people that mightn't be as quick to speak up as I would, [the HSC is] *the link between the teachers and the parents. And I think we need that"*. [Parent, focus group, year 2]

Many teaching staff also believed that the casework aspect of the HSC role helped to reduce their own workload and the HSCs were perceived by many to be well placed to take on the responsibilities of the school in relation to health referrals. Thus, it is likely that, where the HSC was involved in referral casework, this had led to reduced involvement by existing staff in child referrals. Indeed, as the comments below suggest, several school-based participants felt that the HSC took on responsibility for case-work work that had previously been completed by other members of staff such as the HSCLC and school management.

"[The HSC] *... has done loads of referrals for me... Either principals or one of the teachers in school would generally have done that. So to have someone to do that and follow up on it....it was just great having her just to ring the parent* [of a child who did not attend a clinical psychology appointment] *...and annoy the parent and nag the parent, you know so she has helped with a lot of, she has referred a lot of children on to different agencies."* [School Principal, baseline year]

"Now, if we didn't have a healthy schools coordinator, the home school liaison officer would be trying to do that. ...the presence of the healthy schools coordinator has helped maintain those linkages, better than the school could have done without the healthy schools coordinator." [School Principal, year 2]

This referral work was initially viewed by some HSCs as more useful than their broader work remit which further suggests they viewed themselves as case workers rather than as health promotion coordinators. Clearly, this perception impacted on how the work of the HSP progressed, as the HSCs became more focused on the health of individual children instead of the whole school community as demonstrated by the following comment:

"It's trusting my own instinct that I know what's right for the kids... I see the small individual kids, that picture. Whereas, I think [the funders] *and the steering committee see this big picture that you can change, you know we've got like five hundred and something families in this school that you can make big changes in all of them, because you can't."* [Healthy Schools Coordinator, year 1]

This view illustrates the importance of developing and promoting a clear understanding of the HSP from the outset amongst all key stakeholders. Whilst perhaps useful to staff

in the short term, this HSC referral case work was not consistent with health promoting school principals as it focused on children with health difficulties at an individual level rather than addressing overall school well-being in a sustainable health promoting way. It is evident from the findings that the HSC spent much time and effort in engaging in this role and that this further impacted on how the HSC work incorporated a more broadly focused health promoting school approach. Indeed over time, the HSCs became aware of the limitations of this caseworker role. It was highlighted by both HSCs that as referral support work occurred on a case by case basis, only the health needs of a few families could be addressed. Importantly, in the latter half of the evaluation period, one HSC explicitly acknowledged that the role of caseworker had limited their progress in developing a health promoting school ethos and embracing the role as a facilitator of school change. Whilst useful to staff, the HSCs reported that increased administrative duties such as writing to services regarding individual referrals were very time consuming and not in line with the original remit. Furthermore, while most teaching staff noted the involvement of a referral support worker as useful, this HSC case-worker role was not accepted universally by the schools. In particular, a minority of principals explicitly stated their reluctance for HSCs to be involved with referrals due to their non-health background. As illustrated below, two principals also perceived HSC involvement as a barrier to routine procedures in terms of overlapping with existing roles in the school (e.g. HSCLC). Indeed, in the first half of programme implementation, concerns were raised by some staff at the HS steering committee meetings that the HSC was encroaching on the HSCLC role.

"I was very frustrated with it, because we don't need a home school person. We have a very successful model in home school, and to me it was very much just replicating that"…. So there is a kind of an overlap. I'm trying to clearly define what the healthy schools role is. It is actually quite difficult…" [School Principal, baseline year]

Many interviewees also noted that the majority of service link work completed by the HSCs related to discrete activities (i.e. linking with a local service to provide an information evening for parents, referral of individual children) rather than system change (e.g. setting up sustainable referral systems between schools and services). At the same time, many staff and parent interviewees acknowledged the importance of the individual HSC in contacting service providers on the school's behalf. This indicates

that the HSC continued to engage with services informally - similar to the approach taken by staff prior to the introduction of the HSP. Thus, whilst a number of positive improvements between local services and the schools were attributed to the HSC, there was little evidence to indicate how such developments would be sustained in the longer term or independently of HSP funding and resources. As the quote below suggests, the HSC was viewed as a referral link person and not a coordinator. This suggests, again, a lack of longer-term HSP planning with regard to increasing the capacity of schools to establish more effective service-school links.

"It's just knowledge of the services and who to go to… whereas if [the HSC] *is there and we know that we can go to her and then she sources … services you are needing or who you need to talk to or whatever information that you are looking for. It's easier if there is one person to go to and they do all of that.*" [Teacher, Focus Group, year 2]

Importantly, outside of this casework, there was a perception by both principals and HS funders that the HSC would be unable to complete higher level work such as negotiating with services due to their non-health background. It is likely that these views further impeded the type of service-school engagement work completed by the HSC. In addition, according to some interviewees, a number of local services were also unclear as to the remit of the HSC role, which created additional difficulties for the HSCs in developing school-services links (as external services were reluctant to engage). This further limited the support that HSCs could provide to the schools and families. One health professional noted that the HSE health promotion (HP) services demonstrated a reluctance to get involved with the HSP due to concerns over the services' inability to commit in the long term. As discussed earlier in this chapter, broader issues such as constraints on information-sharing between children's services also clearly limited the HSC service engagement work. The participant response below describes how mental health referrals proved particularly challenging:

"[Schools need support with mental health] *service access and knowing exactly who to go to and when …that takes somebody with that particular knowledge and who would be listened to when they picked up the phone and I don't think a co-ordinator will be. I think…it* [the HSP] *needed a HSE person who would have the clout. …a HSE person*

would have that knowledge base [to engage with mental health services].*"* [School Principal]

"It's a pity that there wasn't the partnership between HSE Health Promotion and [the HSP]*... so that if* [the funders] *pulled out* [the HSC] *was still there with the HSE Health Promotion, working in schools, still working in* [the local area]*... if the two Co-ordinators had been employed by HSE as Health Promotion Schools Officers, it just would have allowed it to be more sustainable."* [Health/Educational Professional*, year 1]

These challenges further reinforce the fact that the implementation of the programme would have benefitted from further work at both the planning and early implementation stage to establish a frame of reference for individuals and agencies who engage with the schools through the HSP/HSC. Without a clear remit and no experience in health promotion, it is understandable that the HSC struggled with engaging with health services in this way. According to the observation notes of the steering committee meetings, as well as responses from members of the funding team, attempts were made by the HS funders to address these difficulties through organised meetings with health services and inviting health representatives onto the HS steering group, but little progress was reported. This demonstrates the wider challenges present in addressing school-service links as previously identified in the literature (e.g. Barnekow *et al*., 2006; Marshall *et al*., 2000; Warwick *et al*., 2004)**.** It is likely that, while a representative from the HSE was involved in the HS steering group (a HSE Health Promotion Officer), increased representation by influential HSE professionals may have improved the success of the HSP team to develop Health-Education partnerships.

It is apparent that the HSCs struggled to balance their dual role as activities coordinator/ support worker with higher level HSP work (e.g. promoting a wider HSP ethos within schools). For example, in the first year some principals reported dissatisfaction with the lack of direct work undertaken by the HSC in terms of the delivery of activities. Attempts by the HSCs in the second half of the implementation period to undertake a coordination role and to encourage staff to roll out activities themselves were also met with some resistance. Many school staff were reluctant to address higher-level structural health related issues such as school policy work via the HSP as this work did not fit

with their conceptualisation of the HSP. Concerns were also raised by the majority of school staff in both the individual interviews and focus groups about the programme creating additional work for them if the HSP moved more towards the whole school health promoting school model. As a result, there appeared to be a consensus that the HSC should be involved solely in rolling out health-related activities for the school.

"It is a very difficult line to hold between facilitating the work in the schools and actually doing the work in the schools and I think they became a little bit trapped ... to deliver things ...my feeling with health promoting schools would be that unless it becomes part of the fabric of the schools it doesn't work...but I think the schools ... would have preferred to have people doing things for them – than taking all of the responsibility for doing it themselves". [Health/Education professional, year 2]

For this reason, the HSCs were increasingly viewed by the school community as providing an 'extra pair of hands' instead of as a facilitator of higher level system change more typical of a health promoting school approach as outlined internationally (Arthur *et al.,* 2011). Based on these views, it again seemed that many school members remained unclear as to how the HSP fits with this health promoting school framework. Significantly, some school staff even indicated that they believed the schools already do what the HSP offered. Unfortunately, this limited the extent to which the HSP was able to focus on improving the capacity of the schools to address the health needs of their pupils. Despite an initial expectation by the funding team that the schools would eventually take over this hands-on role of the coordinator, the work of the HSCs had instead had the opposite effect to that which was intended by reducing the capacity of staff to address child referrals and health curriculum in a school-led way.

The inclination to shift from a health promoting school model to a more directive and activities-focused programme has been reported as a common challenge for these type of initiatives (Weare, 2000). A number of studies have also highlighted the importance of a coordinator to champion the work of a health promoting school initiative (e.g. Arthur *et al*, 2011; UK National Healthy Schools Standard, 2000; Weare, 2000) but the provision of an externally appointed (but school-based) HSC from a community development background is unique to the local HSP. Indeed, this role differed substantially from the role of a HSC in health promoting school initiatives elsewhere in

the world (Arthur *et al.*, 2011; Inchley *et al.,* 2006; Leurs *et al.*, 2005). In the UK model for example, an existing member of school staff is expected to take responsibility for leading school efforts to embrace a health promoting school ethos with externally appointed regionally-based HSCs providing advice and expertise to school communities (e.g. Arthur *et al.*, 2011; Weare, 2000). Therefore, in developing the HSP as a HSC-led initiative instead of a school-led approach (as endorsed by health promoting school literature), this health promotion work was less sustainable. These findings, once again underline a need for a greater understanding of the HSP by schools and all key stakeholders from the outset as well as the importance of a clearly defined memorandum of agreement by all stakeholders. Had sufficient collaboration and consultation with the school community occurred throughout the planning and early implementation stages, it is likely a stronger communicative partnership could have been established, thereby precluding the need for any adaptations to the local HSP model. The quote below highlights how the lack of understanding by both the schools and the funding team limited the development of the programme:

"The schools didn't really understand what this was about. It didn't really help, [that] *you were kind of giving* [the schools] *somebody to organise all these things, then saying, "well, no, this is more about the school taking responsibility. It's more about …the health promoting ethos"* [Health/Educational Professional, year 1]

"The danger is that [schools]*… go for the easy option – 'if we can implement the curriculum then we are there'. But I think the evidence is far from that… that unless the curriculum is not supported by an environment that is conducive to the principles of* [a health promoting school]*, it becomes just an academic exercise"* [Health/Education Professional, year 2]

8.3.2.1 The HSC as an external candidate and a member of school staff: The complexities of fitting in to the school community

In view of wider contextual issues, it is unsurprising that the HSCs reported considerable resistance to their work from school staff during the early stages of implementation. It was evident from the interviewee data that the strategy of introducing the HSC to the school community as a new member of staff was met with uncertainty and suspicion by most school members. This illustrates the complex nature

of the HSC role as an external 'actor' attempting to work within the schools and the challenge for schools to be flexible in their engagement with new initiatives and types of working. The HSCs were each provided with their own office in the schools, but despite this they remained relatively isolated from the school community, particularly in the first two years. The HSCs noted for example that they often felt excluded from school meetings and that this limited their engagement with staff. They also reported they were frequently not informed of key events in schools and were generally left out of school life.

It was evident from the funding team and HSC interviews that significant resources were invested in developing relationships between the HSCs and school community in order to address this challenge. As previously discussed in this chapter, the HSC took on an increasingly hands-on role in schools with the purpose of creating 'a presence' and increasing relations with the school community. As a result, according to the HSCs, in the final half of the programme implementation phase they were eventually accepted, at least to some extent, by most schools as an additional member of staff. This again alludes to the longer-term approach required to appropriately assess initiative progress. However, both funder and HSC interviewees acknowledged that despite the HSCs becoming more integrated in the schools, they still faced challenges fitting in with school structures because they were not full-time members of staff. Based on the feedback from school staff, it would seem that if the HSC role had been taken up by either an existing member of staff with protected time or an external candidate with appropriate training, the role may have been more readily accepted by the school community. Unfortunately, it seems that a lack of understanding of a health promoting school approach by members of the HS steering group combined with a lack of clear direction from the HS manual led to the employment of HSCs without the necessary experience. Such an approach in the current context may also have helped to more effectively engage other staff in the programme. For example, in the UK model a regional coordinator is available in a consultancy capacity to a catchment area of schools (Arthur *et al.*, 2011). These regional coordinators provide guidance and support to the school-based coordinators who are existing members of staff.

" *I think there was always a bit of ambivalence about wanting them to be part of the school but not wanting them to be part of the school so you're included and you're not*

included … it's quite a difficult environment to work in" [HS Funding Team Member, year 2]

"How do you get on their [the school's] *agenda, when you are in the schools, and you don't go to the staff meetings unless you are invited? … unless you have some kind of structure… how do you make that happen, so it becomes much more part of the school, than an add-on to the school?"* [HS Funding Team Member, year 2]

8.4 Collaboration and partnership working

8.4.1 Inclusive HSP partnership working: Collaboration with school staff

According to the HS manual and the broader health promoting school literature, collaboration which is inclusive, democratic and equitable is a key component of an effective health promoting school initiatives (Bamehow-Ramussen, 2005; Irish Health Service Executive, 2013; Lahiff, 2009) and indeed, this was also acknowledged by most interviewees. At a strategic level, most respondents viewed certain aspects of the HSP more positively when the school community was involved in the planning and implementation of the programme. For example, despite mixed enthusiasm of principals to lead and manage the HSP, school principal involvement in decision making was viewed by all stakeholders as central to the implementation of the HSP. The HSCs and funding team interviewees commonly reported that when principals were consulted and when they approved the work of the HSC, much more progress was observed. Thus, it is likely that the involvement of principals helped to ensure that the work of the HSP was relevant to the needs of each school. The findings indicate that, whilst not taking a leadership role, principals' engagement in collaborative decision making with the HS funders and HSCs both at the steering committee level and the school level was integral to programme development. For example, according to both HSCs and the HS funders, most of the school principals did work with the HSC to some extent to decide on the how the HSP would roll out in their particular school. This was an important factor in determining the nature and extent of any collaboration between the HSCs and school staff.

"If you don't have a good relationship with the principal then nothing else works because the principal is … the main person in the school who decides what we're going to do or what happens and what is not happening. So having that relationship and

forming a relationship takes a long time - you can't just develop this relationship overnight." [Healthy Schools Coordinator, year 2]

"I think [the HSC work at the beginning was] *not necessarily in line with what the schools needed…at the beginning … [the HSP work] was very… all over the place, but … in time it kind of worked out very well because* [the HSC] *sat down with the principals and we decided ok… let's see what the needs are and what…would best meet those needs, so I think that's what made it work and I think that improved over time."* [Healthy Schools Coordinator, year 2]

"[If] the Principal is on board, they will make sure that the teachers do what they're supposed to do…Everything runs smoothly…If Principals not on board and doesn't kind of, give that message to their staff, it doesn't happen. So, like that, I see that working differently in different schools."* [Healthy Schools Coordinator, year 1]

The involvement of school staff in HSP decision making varied from school to school. As discussed earlier in this chapter, the level of enthusiasm amongst principals was key to the involvement of the wider school community. Many planning issues such as the lack of a memorandum of agreement and training had clearly impacted on levels of staff involvement and these are examined further in Chapter Nine where school buy-in is examined in further detail. However, in terms of collaboration, it was apparent that when school staff were consulted and involved in decision making, the resulting HSP activities were viewed more favourably by interviewees. For instance, the involvement of the HSC in coordinating the *Active Flag award*[25] application in some schools shows how positive collaboration occurred with school staff. This idea was very much driven by the school community and, in this way, school members took responsibility for progress themselves with the HSC providing support:

"We [school staff] *were all asked if there was anything we thought maybe for the second year… anything that* [the HSC] *could do, or anything that we might like …* [There was] *the opportunity to give your ideas if you had them…"* [Teacher, focus group, year 2]

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[25] The Active Flag award is a national recognition award established and driven by the Department of Education and Skills (DES). This initiative designed to recognise schools that strive to achieve a physically educated and physically active school community using a Whole School health promotion ethos. http://www.activeschoolflag.ie/faqs.html#A1

8.4.2 The nature of parental involvement in the implementation of the HSP

HSP efforts to involve parents deciding what health-related parent workshops would be rolled out (such as yoga and cookery classes and self-care workshops) were also considered beneficial by many school-based respondents. For example, most school staff respondents as well as parents themselves indicated that the HSCs had made multiple efforts to engage with parents throughout programme implementation and to involve them in the generation of ideas for health-related activities that would be rolled out for parents. This kind of improvement in school-parent involvement is consistent with the health promoting school literature (e.g. Lee *et al.*, 2008; Warwick, 2009). Not surprisingly, most respondents who discussed parent involvement also held the view that this work was more successful than when families were not involved. As the programme rolled out, some interviewees suggested that parent turnout also increased as the activities were based on needs identified through parent-HSC consultation. This would indicate that when collaboration with parents occurred, HSP work was more likely to meet the needs of parents and families.

"Well [the HSC] *does always ask, if you* [as a parent] *have any ideas to put them forward, what would we like to be brought in, or any particular area that we'd like, and she'll go and get whoever it is to come in and give a talk or to do whatever."* [Parent, focus group, year 2]

"So we came up with this idea ok, let's, what if we get, we have somebody who works with school on-and-off ...so we invited her to demonstrate the soup-making ... And that received more than 90% attendance from the parents... I know that from the feedback from the school principal ... that was a very successful activity." [Healthy Schools Coordinator, year 2]

"We found that parents that did come were really interested... I suppose the eating thing, to come up over and over again...Parents came back then for a few talks after that, so that went really well as well.... the mental health side of things too ...I did a sensory play session with all of them just to try ease of transition of school...and make it a positive kind of experience for them." [Healthy Schools Coordinator, year 1]

However, while parents were involved in generating ideas for the HSP activity events for parents, they were not formally consulted or involved in the design, planning and

implementation of the HSP at a strategic level, suggesting a lack of collaboration with this important stakeholder group. It is likely that this exclusion may have limited, at least to some extent, parental understanding of the HSP as a health promoting school initiative and may have curbed the enthusiasm of families for the higher level strategic work of the HSP (e.g. school-health service collaboration development, the development of more health promotion-based school policies etc.). This approach contrasts starkly with studies that emphasise the importance of collaborating with families at all stages of school-based health initiatives (Browne, *Gafni,* Roberts, Byrne, & Majumdar, 2004; Diekstra, 2008; Greenberg *et al.,* 2001; Weare & Nind, 2011). According to steering committee observation notes, no parents were represented on the HS steering committee either, even though it is explicitly recommended in the HS manual that all key stakeholders should be represented. It is likely that this lack of involvement of parents in the planning and design of the programme had influenced the extent to which certain components of the HSP were considered useful and relevant to the wider school community. This in turn may have negatively affected enthusiasm for the HSP by the school community.

"I think it was envisaged that there might be a monthly meeting... [and] that there would be that kind of representation [from the entire school community including parents].. .Well that's how I would have envisaged it… I also know that schools are busy places and in some schools [might say] "not another bloody committee"... so you do have those kinds of issues." [Health/Educational Professional, year 2]

"I think ideally if there was a committee that involved parents as well and children and staff it just might be a bit more open into maybe discussing issues or just an overall sort of an overall strategy ...everybody could have a say in it more." [Healthy Schools Coordinator, year 2]

8.4.3 The HSP funders as a collaborative partner

The involvement of the funding team in HSP implementation (and more importantly in the hands-on role) was not set out in the manual, suggesting that the funding team were not supposed to be directly involved in programme implementation beyond the development and planning stage. As indicated earlier, a lack of understanding of the school-led nature of the HSP as well as the challenges experienced by the HSCs had

limited the progress of the HSP and necessitated some level of intervention and additional support from the funders. Indeed, this was highlighted by all involved including the principals and the HSCs. Responses by both the HSCs and the funders indicate that this increased funder involvement over the course of programme implementation had led to the HSP funders and the HSCs working at different levels on HSP. Thus, whilst the HSC took on a staff support role, the involvement of the HS funders was more in line with the HSC remit as described in other HS models in the wider literature (e.g. the UK health promoting school model, Arthur *et al*., 2011). For example, it was clear from HSP steering committee observational notes as well as interviews with the majority of individuals involved in the HS steering committee that the funding team had led on a number of fronts including: leading the Steering Committee work; supervising HSC work plans; directing the HSP agenda; leading on the improvement of children's health referral pathways from schools to the relevant health services; and promoting collaboration between schools and health services (e.g. HSE Health Promotion and mental health services). According to some members of the funding team, the negotiations with health services proved very useful and a number of health related projects were established/initiated as a direct consequence (e.g. referral pathway development work; information sessions for schools). Despite developing a role in the HSP that was not set out in the manual, the funding team themselves believed they helped to improve school awareness of services:

"I suppose they [the funders] *co-ordinate…they seem to be quite involved at that level. And…they manage the Co-ordinators…. It's kind of been* [a member of the funders team] *that I've dealt directly with… I would go through* [a member of the funding team] *then and follow the link then with the Co-ordinators*." [Health/Educational Professional, year 1]

"I think a lot of that [service link work] *is happening through* [the funding team]…*In terms of the bigger picture stuff…I suppose that part of it we* [the funding team] *need to be looking at it more… strengthening all those relationships."* [HS Funding Team Member, year 2]

However, whilst useful to some extent, it is possible that the funders remained too involved/hands-on for too long in trying to alleviate the difficulties that had arisen. In addition, there was little evidence to indicate that the school community was actively

involved in negotiations with local services as part of the HSP. Furthermore, a few interviewees questioned how this HSP funder-led service engagement work could be sustained without the direct involvement of the schools. Despite clear efforts by the funding team to improve school-service links, some principals argued that the involvement of the funding team merely created an additional 'layer' in addressing the objectives of the schools. Indeed, some staff interviewees maintained that service links should instead be developed at a government department level to ensure the sustainability of such plans and links. This again highlights the misunderstanding amongst some participants that the HSP is an additional activity provided by HSP funders and HSCs rather than the school community. If the programme had been implemented and understood from the outset as a *school-led* initiative based on health promoting school principles, it is more likely the schools themselves would have had a leading role in establishing links with health services with the support of the HSP team. The HSP may also have provided a more useful means of supporting members of the school community in an effective and sustainable way.

"But I wonder why a group like [the HSP funding team] *need to intervene there when* [services are] *there already. Why don't the Department* [of Health] *do what the Department is supposed to do? Sometimes we give them a way out by doing it for them."* [School Principal, year 2]

It is important to note also that the direct involvement of the funders in the HSP work was not supported by many stakeholders. The HSP funder interviewees maintained that they were working towards a school-led model, but notably many school-based respondents disagreed with this perspective. This further supported the lack of shared views of the HSP as discussed earlier in this chapter. It was noted by some teaching staff as well as the HSCs that sometimes the HSC was unable to address the needs identified by the school as the HSP funders had given specific directions to the HSC to focus on other projects. This suggests that in some ways, the HSCs' efforts to develop a school-led implementation strategy may have been limited by the funders' involvement at a cross-school level. Consequently, the HSCs often struggled in balancing school-led ideas and funder-led plans. It was also clear from the interviews with school-based respondents that this represented a source of frustration for them (as well as the HSCs) and was another barrier to effective implementation:

"We [the school] *felt* [the HSC] *had her a job to do that was coming from* [the funding team] *and that it wasn't our remit to go and say 'well, this is what you have to do for us, this is what we need'….she's not employed by us, she's employed by* [the funding team] *so therefore she's not on our staff so …*[her work was directed by the funding team]*"* [School Principal, year 2]

Other efforts by the HS funding team to guide HSP implementation also created difficulties for schools. In particular, efforts to address health-related school policies using a HS funder-developed needs audit was viewed negatively by the majority of school-based respondents. Understandably, similar to other areas of school management, such efforts to review policies by the HS team were met with strong resistance by school members. This top-down approach by the funding team again appeared to have negative consequences for the programme particularly in terms of the schools enthusiasm to address health-related school policies through the HSP**.** For example, many school and management staff indicated their reluctance to engage with other school policy work via HSP (especially mental health), thereby limiting the potential of this area of the HSP. This again highlights the challenge in adapting school protocols and ethos without full consultation and approval from the school community**.**

"I think the [HS audit] *didn't go down very well because the teachers kind of reported back that they felt very intimidated and threatened by it... [the audit] talked about policy and so…if they mentioned a certain policy the teachers would say 'well, we've no policy on this, we've no policy on that".* [But] *just because we've no policy on this doesn't mean we don't do it."* [Healthy School Coordinator, year 1]

"[The audit] *got peoples back up" a little bit, about us* [the HSP funders] *touching the policies. So, we have left that kind of idle for the moment…"* [HS Funding Team Member, year 1]

Certainly, in some instances the HSP funders were perceived by a range of interviewees (such as HSCs, Health and Educational professionals as well as school staff) to have completed HSP planning and development independently of the school communities (e.g. discussions with health services regarding the development of sustainable links). Despite some positive examples of collaboration and partnership working, it appeared to be the case that some members of the school community felt excluded from the planning and design phase of the HSP, even though it is likely that this was not the

intention of the funding team. In particular, the funder-led audit mentioned earlier in this section was rolled out in an attempt to establish a set of individual school priorities. However, this process was not school-led or planned collaboratively with the school community. It is somewhat predictable therefore that most school staff reported a sense that they were being 'quality assessed' by external reviewers. Understandably, this lack of communication between key stakeholders also created challenges in terms of promoting a sense of confidence and trust by schools of the HSP. According to the HSCs, the negative view by school staff towards this funder-led audit and lack of democratic collaboration further complicated efforts to engage the schools with the programme as originally envisaged within the manual. It is probable that this experience by school community members also impacted on levels of buy-in to the programme as a health promoting school initiative. Indeed, responses from the HSCs and members of the funding team suggests that as a result of this funder and the HSCs' involvement, members of the school communities took a more passive role in the roll out of the HSP. Indeed, it was apparent that many of these participants did not seem aware of the importance of the programme becoming school-led to ensure that health-related improvements are sustainable. This again underscores the negative impact that a lack of effective collaboration, which is not sufficiently inclusive or democratic, may have on health promoting school initiatives (Sloper, 2004).

"I think the [HSP funder-designed] *Audit… was taken defensively by some schools. That it was kind of, questioning of their policy and of their procedures. And who are we* [the HS funders] *to do that, type of thing."* [HS Funding Team Member, year 1]

The challenges faced by the funding team in engaging and collaborating with the school communities – as discussed throughout the findings reported here – explain why the funding team gravitated towards a top-down planning approach to the HSP. Indeed, an enthusiasm and commitment from management and staff towards integrative working and respect between partners is considered a primary facilitating factor for effective collaboration (Brown & White, 2006; Dowling, Powell, & Glendinning, 2004). Nevertheless, this exclusively top-down approach contrasts clearly with the health promoting school literature which emphasises the importance of taking a collaborative, school-led approach to programme planning and implementation (e.g. Barnekow *et al*., 2006; Gleddie, 2011; IUPHE, 2009). Importantly, a number of studies suggest that any

ambiguity surrounding leadership and management can negatively affect collaborative working (Brown & White, 2006; Sloper, 2004). Considering the leadership and management issues discussed earlier in this chapter, it is likely that these challenges will have impacted adversely on collaborative efforts.

Despite these limitations, several interviewees (including the HSCs, principals and teaching staff) reported that as the programme rolled out, there was increasing evidence of collaboration at a school level between the school community and the HSCs in terms of generating ideas for HSP activities. The funders also responded to these concerns and challenges during the final year of programme implementation by shifting the responsibility for HSP work plans and HSP priority areas from the inter-school steering committee to the principals and the HSCs, thereby trying to ensure a more school-led approach. Whilst the HSP work was still directed primarily by the funders and HSCs, these changes did indicate some degree of improvement in terms of promoting greater collaboration and inclusivity. Unfortunately, this occurred too late in the implementation process to demonstrate a more evidenced-based HSP model. Encouragingly however, one principal acknowledged:

"I think, [the funding team] *were instrumental in identifying the need for such a programme and providing the initial support for the programme to actually get up and running, and for coordinating the management of it. I think myself, as the programme has gone on, the role of* [of the funding team] *has become less important, and that's how it should be".* [School Principal, year 2]

"The more closely the integration works, the more successful the programme will be... Not [an objective] *that's imposed on the school from somebody else's agenda, but an agenda and a set of objectives that are mutually agreed by the stakeholders in the school... and that they would be very much in line with the vision of the school and the perspective of the HSC... So everybody is going in the same direction."* [School Principal, year 1]

"I think everybody needs to be informed at some level and involved... There has to be a consultation process, it is important that everyone gets to give their opinion. I've just found from things they've rolled out in our school the last few years, stuff that

everybody is consulted on, people buy into more than something that's been put on you."[Teacher, focus group, year 2]

8.4.4 HSP collaborative efforts with health service providers

As discussed earlier in this chapter, the creation of structures such as the cross-school steering committee were established by the funding team in an effort to work towards a more collaborative model of implementation as recommended in the implementation science literature (Higgins, Wiener, & Young, 2012). There were many examples in the meeting observation data which also suggest that the funding team utilised this steering committee forum to facilitate the involvement of various stakeholders and relevant health and educational representatives in the planning and implementation of the HSP. For instance, external professionals from health and education agencies (e.g. representatives from local psychological health services, public health care team, as well as health promotion officers) were invited by the funding team to support, advise and collaborate with the HSP steering committee. These efforts were viewed positively by the majority of interviewees involved in the HS steering committee as these members provided useful additional perspectives on how best to address the health needs of the school community. Such work by the funding team emphasises their commitment to developing the HSP in a collaborative way, albeit not as successfully as may originally have been anticipated. Unfortunately, despite these efforts it is likely that the lack of professionals with specific health promoting school experience and expertise on the HS steering group limited how these collaborative efforts developed the HSP in an evidenced-based way.

In response to suggestions by HS stakeholders, the HS funders organised various seminars providing information on local health services delivered by different health agencies (including mental health services). These events were arranged for members of the steering committee and school staff. However, as observed in the previous section, members of the funding team acknowledged that most of this work was again led and directed by funders rather than the school community or HSCs. Nonetheless, some interviewees who were involved in the HSP steering committee pointed out that they were regularly consulted and in this sense, many organised events were based on the needs of the school community. Indeed, according to some principals, the committee

often indicated to the funders which service providers should be invited to present at seminars. For instance, seminars were delivered by a local psychological health service and a community public health team. In general, these events were viewed positively by members of the steering committee and had enabled school principals to liaise with health services including psychological health in a more informed way. This provides a good example of an instance where the funders listened to the schools and focused on identified needs, thereby ensuring that this work was embraced more readily by the school community and seen as a positive outcome of the HSP.

"Through the ...steering committee we've had speakers from the primary care team and we had speakers from [mental health services]. *That was quite good, 'cause we* [the schools] *never had contact with those, it was very hard for us to contact them, so we know a bit more about them ...I suppose the thing would be for me to try and follow-up ... to try and keep those channels open...those people have spoken to us, and given us their position, you know it's a brighter situation than it was before."* [School Principal, year 2]

8.5 Summary of findings

- There was little shared or accurate understanding of the HSP initiative amongst the majority of stakeholders particularly in the first year of implementation. While awareness of the programme slowly improved, the overall lack of understanding had some significant implications for the implementation of the programme. Inadequate training provision and a lack of clarity and agreement around central components of the HSP clearly limited progress. Increased involvement of all stakeholders in the planning and design stages as the initiative progressed is likely to have improved the quality of HSP implementation. However, considering the importance of each stage of the implementation process, these improvements may have occurred too late in the overall schedule of implementation to progress the initiative in an effective, evidenced-based way.

- The HSP manual sets out some key components for a successful governance and management structure. Whilst some components of this structure, such as the cross-school steering committee, were successful to some degree, others, such as

the school-level steering committees and HSC support structures, were perceived as less so. It is likely that the HSP management structure ought to have taken account of the essentially independent nature of schools in an Irish educational context. These challenges limited the progress of the HSP in schools and led to the development of a programme that was led by the funding team instead of the school itself. Thus, many aspects of the programme were perceived as not being relevant to the needs of each school while the ultimate sustainability of the HSP as an 'add-on' initiative implemented by external parties was also uncertain.

- School principals were fundamental in leading and directing the HSP, especially without the establishment of school level steering committees. However, principal engagement with this leadership role varied across schools and this had an important bearing on how the HSP progressed in each school. The funding team and HSCs took responsibility for the HSP in cases where principals did not engage with this role. This approach to leadership and management appeared to create some confusion amongst the school community and few interviewees were clear on who was responsible for leading the HSP.

- The early change in the recruitment criteria for the HSCs (i.e. from a health professional to a community development worker) was a source of considerable frustration and disappointment for members of the school community. School staff believed a healthcare professional such as a nurse was essential in the role. However, the funding team viewed that the provision of a nurse would merely replicate the role of the public health nurse and would not be cost-effective. Importantly however, the funding team completed recruitment of the HSCs independently of the school principals. The lack of consultation and agreement on this issue between the funding team and principals clearly created a barrier to programme progress, especially in the first year. In many ways, this adaptation to the role, coupled with a lack of understanding of the principles of a health promoting school approach, appeared to have limited school enthusiasm and in turn, the impact of the programme. In response, the HSCs adopted a more 'hands-on' approach to their work in an effort to increase school enthusiasm for the HSP. Indeed, there was lots of evidence to show that the HSCs had invested

considerable efforts in rolling out a broad range of health-related activities in schools as well as providing referral case-work support to individual families. This work was generally viewed as useful in terms of reducing staff workload. However, this external HSC-led approach does not fit with a WHO conceptualisation of a health promoting school approach and lacks sustainability. In addition, in an effort to increase school enthusiasm for the HSP, the view of the programme as an 'add-on' which was the responsibility of the HSC and HSP funders, was compounded by this adapted HSC role.

- The adaptations to the HSC role reduced their capacity to develop a profile more in line with other international models of a health promoting school approach. Instead, the HSP funding team were viewed as central to supporting schools at a strategic level. Indeed, in the first half of the implementation period, the HSP funding team became increasingly involved in leading and managing the implementation of the HSP. Where core school-led components of the HSP were not established, the HSP funding team filled these implementation gaps. Whilst useful in the short-term development of the HSP, their increasing involvement is likely to have limited the involvement of school communities thereby impacting on levels of school ownership of, and buy-in to, the HSP. In addition, there was also some resistance to the role of the HSP funding team in the schools and many were reluctant to engage with the programme in this way. However, it was clear that the funding team became increasingly aware of the limitations of this role and in the latter half of the evaluation period they responded to this challenge by attempting to transfer responsibility of the HSP to schools, albeit with only mixed success.

- The HSCs were external staff based in schools with responsibility for HSP roll-out. However, they were viewed by many as a member of school staff who provided hands-on support to the school community. This role duality appeared to lead to some confusion amongst school staff as to how to engage with the HSC. Furthermore, whilst the HSCs were based in schools, they were often excluded from important school staff meetings and events and reported feeling isolated in some schools. While integration with the school community

improved over time, the lack of sustainability of this externally funded position limited the extent to which he HSC could fully integrate into each school community. The model of the HSC roll-out and profile in the current context differs substantially from international models of health promoting school initiatives and the role of HSCs therein. It is likely, therefore, that HSP implementation may have been more successful and sustainable if based on established HSP frameworks.

- The findings demonstrate the importance of collaboration and partnership working when implementing any new initiative. It was evident that where inclusive collaboration occurred with members of the school community, the HSP was more successful. However, it was also apparent that many planning and implementation decisions were made without consultation with members of the school community; this had contributed to a lack of school enthusiasm and engagement whilst aspects of the initiative were viewed as not relevant to the needs of individual schools. Increased involvement of parents as well as staff is likely to have benefitted programme implementation quality and school community engagement. The findings outlined above are discussed further in the final chapter.

CHAPTER NINE

QUALITATIVE FINDINGS III: OTHER FACTORS IN THE IMPLEMENTATION PROCESS

This final results chapter will examine participants' views on how the wider national context, in which the HSP was implemented, influenced the programme in practice. In addition, this chapter will examine how the HSP addressed psychological health specifically as well as how the manual, both in terms of design quality and fidelity, supported and restricted HSP progress.

9.1 The wider context: 'Readiness' for programme implementation

A key consideration in the exploration and planning stage of implementation is an assessment of the 'readiness' of the setting (Weiner, 2009). Not surprisingly perhaps, and as indicated in the previous two chapters, it was evident from a range of interviewee responses that many broader factors had posed an obstacle to successful HSP implementation. For example, most principals noted that the economic climate and budgetary restrictions had led to pay cuts as well as a reduction in staff numbers and these challenges had in turn impacted on the ability and openness of schools to support new initiatives. On the other hand, some teaching staff pointed out that reform under the Croke Park and Haddington Road public sector work agreements[26] meant that staff were expected to complete additional school hours; thus any engagement with the HSP could be encouraged in this way. These differing perspectives suggest that whilst national budgetary constraints are important, adapting initiatives in a way that incorporates the needs of staff can help to increase their involvement and in turn provide greater support for an initiative such as the HSP.

"I'd say there would definitely be more uptake on [HSP staff training workshops] *with these* [new] *Croke Park hours.* [Teaching staff] *are supposed to do this continued professional development so schools are dying to get things like that now…"* [Teacher, Focus Group, year 2]

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[26] The Croke Park (2010-2014) and Haddington Road (2013-2016) public sector work agreements are agreements between the Irish Government and various public sector union concerning work practice efficiencies, reform as well as pay and employment protection.

Importantly, some stakeholders perceived that a current lack of Departmental support at a national level for a health promoting school approach in Ireland would limit the extent to which staff might engage with such initiatives. Examples of independent localised HP initiatives (e.g. the North Cork Network of Health Promoting Schools[27]) were mentioned by a few interviewees, but a lack of link-up between these established initiatives was believed to have impeded their expansion. As one health professional interviewee identified, without national level management, the impact of these types of initiatives on systems level improvements, such as health related policy, is limited. This finding reflects conclusions from previous studies that emphasise the importance of both Department of Health and Department of Education support to achieving sustainable health promoting school progress (e.g. Bruce, Klein, & Kelleher, 2012; Deschesnes, Trudeau, & Ke´be, 2003).

"If the Department [of Education] *said to them* [the schools], *this is really important, and yes you need to be able to go to the meetings and you need…well of course it would take on a completely different… it has to be* [driven centrally]." [HS Funding Team Member, year 1]

"There's no official Department of Education buy-in to Health Promotion in Schools [in Ireland]…*until that happens... I think it was very obvious* [in the Welsh HSP model] *that there was very strong commitment from the Welsh Assembly to drive this down through schools. And that's why it worked actually ... I just think if the Department of Education were to sanction it, if the principals had bought into it and if Health Promotion could link more closely with the schools and deliver training and all that sort of thing ...then ... it would ... make* [the HSP] *more effective."* [Health/Educational Professional, year 1]

"I think that's one of the difficulties [for the HSP is that]... *if there was a national endorsement of the basic principles behind it then it would gather momentum I think a*

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[27] North Cork Health Promoting Schools Network is a network of 30 schools who have worked together with the Health Service Executive to develop a health promoting school ethos in their schools http://www.hse.ie/eng/services/news/2008_Archive/Mar_2008/Health_Promotion_celebrated_by_30_Nor th_Cork_schools.html

lot quicker than basically being on its own or being a front runner in the way so…"
[Health/Educational Professional, year 2]

However, health and educational professional interviewees as well as members of the funding team observed that the organic and holistic nature of the HSP created challenges in gaining support at a governmental level. In particular, these participants commented on the short-term nature of public policy and how this impacts on the potential of health promoting school strategies. As one external professional stakeholder noted, a general lack of enthusiasm by policy-makers for longer-term initiatives, in addition to the lack of measurable outcomes inherent in health promoting school initiatives, makes it difficult for policy makers to endorse them. It is likely that more clearly defined short-term targeted initiatives are more attractive to fund and support than the HSP model. Thus, developing a health promoting school model like Healthy Schools is challenging. Nevertheless, according to some participants, efforts have been made by the Department of Education to address this challenge of incorporating health promotion in schools. For instance, in recent years efforts have been made to address health promotion in a more definable way via the Social Personal and Health Education (SPHE) curriculum[28]. Indeed, some studies suggest that the SPHE model is a practical way forward for integrating health and education using a health promotion approach (e.g. Lahiff, 2000; NicGabhainn, Barry, & O'Higgins, 2010). However, as one educational professional noted, the SPHE initiative, as it is currently being implemented, is more limited in scope than the health promoting school model. Indeed, based on interview feedback, this programme is viewed primarily as part of the school curriculum and does not fully incorporate a 'whole school' approach to health promotion:

"There is no point in telling the government that in 10 years' time you will see [health] *gains…they will say well, four years will be the next election. The HSE in particular…everything is built around their planning in terms of their funding…the long term gets lost in all of that then…"* [Health/Educational Professional, year 2]

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[28]According to the Department of Education (1999) the aims of the SPHE curriculum are to: promote all aspects of health and well-being of the child, support children in developing respect for themselves and others in society, as well as enable children in effective decision making. The curriculum is comprised of 3 primary themes: 1. Myself; 2. Myself and Others; 3. Myself and the Wider World.

"The whole vision for SPHE was that it would pull those things together…[However,] *one of the things ...* [that] *annoyed me with the department, having set up SPHE, they then set up separately an anti-bullying program...that dichotomy has always been there."* [Health/Educational Professional, year 2]

In addition to governmental support, effective collaboration between the education and health services is also central to the sustainable development of a national health promoting school strategy. For example, one external professional stakeholder with extensive professional experience in health promotion practices suggested that focusing on the development of partnership working with established structures could provide a more sustainable approach to the implementation of the HSP. However, in Ireland there is little history of health professionals (i.e. a school nurse or therapist) maintaining a presence in educational settings and as a result the Irish school setting is not designed to accommodate health workers. For instance, it was acknowledged at the steering committee meetings that efforts by the HSE to develop links with schools were limited due to the complex and individualised structures of the Irish education system. According to some members of the funding team and external professional stakeholders, the lack of flexibility in schools in general limits the potential of the school as a health promoting setting. Indeed, one HSC indicated that practical issues such as the two month closure of schools during the summer period created difficulties in terms of consistency for some of the HSC work. Similarly, the structured nature of the school day and fixed school working hours were found by many school-based participants and HSCs to limit the extent to which staff are available to support and engage with the HSP. On the other hand, a number of participants working on the HSP also believed that structural complexities within the health services further impeded the availability of adequate provision of children's health services for schools. One external professional stakeholder, for example, pointed out that whilst the HSE HP would normally have approached schools with ideas for health promotion, ongoing changes in HSE HP structures had led to a shift in emphasis away from settings-based health promotion. Clearly, these broad structural challenges had been a factor in limiting school-service collaboration and establishing an effective and sustainable health promoting school model.

"I think that communication needs to happen, the schools need to talk to the service and say, "ok, how we can best work?", rather than defend. I think both sides are defending themselves... and then the health services need to take some ownership of that. So I think it's not just the schools in this area, it's nationally...nationally, it's a strategy that's the health and education, the heads come and sit down together and, you know, find out a strategy." [Healthy School Coordinator, year 2]

Several participants noted that a lack of collaboration between health and education services at a national level also negatively affects collaboration at a local level between services and schools. In particular, according to most of the interviewees involved at a professional level, current restrictions on information sharing between health services and education services are an ongoing major limiting factor. For instance the HSCs as well as members of the funding team observed that attempts by the HSP and HSCs to address the accessibility of children's mental health services were hindered because of reluctance by health services to share information. As a result of a lack of overall governmental strategy on collaboration between health and education services, many participants described a dependency on individuals building links in an informal way. In some instances these links have proved effective for schools. However, it is difficult to assess the consistency or sustainability of this approach as such links are based on both the enthusiasm of individual services as well as school staff.

The responses of principals as well as the HSCs and funders, suggest that the area of health referrals is predominantly dependent on this approach. Again, according to a range of professional interviewees, both the Department of Health and the Department of Education need to take greater ownership in creating stronger links. As Brown and White (2006) note, a lack of effective integrated partnerships can lead to such services being viewed by schools as an add-on service and not a sustainable "overarching framework" for the delivery of child services. Importantly, this study also highlights the negative impact on child protection services, particularly if integrative collaboration between health and education agencies is not effectively managed (Brown & White, 2006). One member of the funding team in the current study pointed out that there were ongoing efforts to develop health and education links, but it was difficult to assess from the respondents' feedback, to what extent these early-stage negotiations could support the HSP directly; this finding is not unique to the current study. For example, according

to Johnston and colleagues (2003), partnership studies often cite improvements in the number of collaborative meetings but with few measurable outcomes observed.

"[The mental health services] will only talk to you if the parent has given permission for them to do it….and they [parents] don't necessarily want to come back to school and tell people that their child is going. Sometimes you mightn't even know… originally when this whole role started it was based on [the HS funders] having an agreement with the HSE around sharing of information and that's never came through." [Healthy Schools Coordinator, year 1]

9.2 Psychological health as a school priority: Identifying and understanding psychological health issues in participating schools

In addition to the broader factors outlined earlier, the way in which psychological health and well-being was identified and understood by participants as a HSP priority was an important contributory factor in terms of how this issue was addressed. This section explores issues which both enabled and limited the prioritisation of psychological health by the programme.

9.2.1 Identifying psychological health as a priority

Importantly, at the end of the first year of implementation, few interviewees identified psychological health as a HSP priority. By contrast, in follow-up interviews (at the end of year 2 and 3), the majority of interviewees indicated that psychological health (and psychological health resources) was a priority in all schools. However, it is unlikely that psychological health only became an issue for schools at this stage of implementation, considering the general consensus from the group of the need to address psychological health in the follow-up interviews. It is more probable that the lack of understanding of the HSP by the school community (as outlined in Chapter Eight) influenced stakeholder views on how the HSP could address psychological health. For example, many school staff and members of the funding team perceived psychological health to be too complex and sensitive a topic for the HSP. This view tended to limit the remit of the programme to nutrition and physical health activities, especially in the first half of programme implementation. Indeed, interviews with the majority of members of the funding team also indicated that the HSP focused initially on nutrition and physical activities as these issues were seen as a 'safer' way to build up trust with the schools. In

so doing, these participants believed that as the programme progressed and confidence in the HSP grew, the schools would become more responsive to engaging with more sensitive issues through the HSP, particularly with regard to psychological health. There was some evidence to suggest that this belief had led to schools working with the HS funders and HSC on more complex issues as the programme progressed. This explains why psychological health was not a primary focus of the HSP in the first half of the implementation period. This approach also highlights the longer term nature of these initiatives, especially in terms of developing trusting and collaborative partnerships.

"One of the things that have become clearer in [the second year that] *we didn't really give it a lot of attention in* [the first year]*, was the dimension of Healthy Minds as well as Healthy Bodies… I think that is probably something we will pay more attention to in* [the third year]*... an awful lot of children who have mental health issues."* [School Principal, year 1]

Nevertheless, one HSC noted that this longer term approach to sensitive issues such as psychological health also led to a shift in focus away from other important needs of the schools. This approach led the HSCs to concentrate efforts on areas of health that were not necessarily primary concerns of the school communities, which clearly contrasts with the needs-led health promoting school ethos outlined in the literature. It is likely that this approach may also have impacted on how the participants identified the ways in which the HSP might address the psychological health needs of the children. Again, this reflects the importance of a school-led approach to the identification of needs, as highlighted elsewhere (e.g. Lister-Sharp, Chapman, Stewart–Brown, & Sowden, 1999; Mukoma & Flisher, 2004; Weare, 2000). It would seem that despite the logic underlying this strategy of relationship building, the emphasis on nutrition and physical health activities throughout the programme created a perception by the school community that the programme was topic-focused, thereby limiting the possibilities for addressing more complex issues including psychological health.

"I don't know if it should be the primary focus because mental health issues are far more difficult to pin down than an issue like… speech and language therapy or head lice, or swine flu, or hearing or visual problems…. They're kind of easy to define. Mental health is far vaguer and it's far more difficult for a school to be able to do anything …But there's no doubt that since the beginning of the programme that issues

relating to mental health have stormed more and more into the picture". [School Principal, year 2]

9.2.2 The nature of psychological health-related school priorities

Interviewees who did highlight psychological health as a priority issue, provided a number of examples which could have been addressed through the HSP. For example, a broad range of participants, (including members of the funding team, HSCs, professional stakeholders and school staff) maintained that many of the issues affecting children's well-being are not related to education. Most of the school staff acknowledged that broader social difficulties impact children's psychological well-being and that these occur most commonly outside the school and often in the family home. This view supports the evidence from elsewhere which emphasises the importance of addressing health using an ecological, multi-level approach (Lohrmann, 2010). In this way, the importance of addressing parental health and well-being as well as family school involvement, were considered key priorities. As outlined earlier in Chapter Eight, the HSCs addressed family involvement and parental health in many ways in an effort to support schools in supporting children within their various contexts.

Importantly, some staff in the focus groups indicated a lack of confidence in addressing psychological health issues in the classroom and these participants considered that better supports for school staff in dealing with children's psychological health were needed. Thus, most efforts by the HSCs to develop class based activities to address sensitive issues (e.g. body image and hygiene, anger management) were viewed positively. Interestingly however, a number of interviewees highlighted that more evidence-based psychological health programmes in the schools were needed to address the broad range of psychological health issues in a more structured way. For example, two principals mentioned the possibility of using the HSP resources to introduce the Roots of Empathy[29] initiative. Established initiatives such as Mindmatters[30] (Wyn *et al.*, 2000), Zippy's friends[31] (Mishara & Ystgaard, 2006), or Incredible Years[32]

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[29] Roots of Empathy is a preventative programme for young children that aims to reduce aggressive behaviours whilst improving prosocial behaviours and emotional awareness (Gordon, 2005)
[30] Mindmatters is a needs-based school mental health promotion programme (Wyn *et al.,* 2000)
[31] Zippy's friends is a programme which aims to promote the emotional well-being of young children by developing their coping and social skills (Bale & Mishara, 2004; Mishara & Ystgaard, 2006).

(Webster-Stratton, Reid, & Stoolmiller, 2008) are other examples of whole school approaches to psychological health that could be incorporated into schools through the HSP. As explored earlier in this chapter, it was clear that a more structured approach to psychological health than the HSP offered (i.e. akin to the Active Flag award) was considered important by school staff. This suggests that the HSP, as it was implemented, was not considered to have the capacity to support schools in addressing psychological health in a structured way. However, if adapted, a HSP framework which incorporates topic-focused evidenced-based initiatives for schools that identify specific health priorities could be used to provide a range of options to schools, as one principal noted:

"I feel myself that a programme like [Roots of Empathy[33]] *which has been almost globally accepted as being successful and has been scientifically measured, can help greatly towards the mental and interpersonal issues...I would like to see that tying in with the HS project."* [School Principal, year 1]

9.3 The HSP as a manualised initiative: Fidelity and design quality issues

As indicated earlier, the HSP was a manualised initiative and therefore, it is important that fidelity is supported and maintained (Hill, Maucione, & Hood, 2007). Implementation fidelity refers to *"the degree to which an intervention or programme is delivered as intended"* by the programme developers (Carroll *et al*, 2007; p1). This highlights the centrality of the manual in the current context. However, as discussed in Chapter Eight, delays in finalising the manual created a number of challenges, including the issue of implementation fidelity. According to responses from members of the funding team, HSCs, and principals themselves, without the manual to direct the programme for the first four months of implementation principals tended to implement their own version of the HSP in each school. Thus, the programme was initially based on individual views of how the programme would be delivered rather than the evidence-based health promoting school practice which underpinned it. Indeed, most of the

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[32] Incredible Years is *"a series of inter-locking, evidenced-based programmes for parents, children, and teachers. It aims to prevent and treat behavioural problems and promote positive social, emotional and academic well-being"* See www.incredibleyears.com

principals still reported at the end of the implementation period that they had either not read the manual fully, or found it difficult to understand. Likewise, while the majority of teaching staff were aware of the manual, most of them were not familiar with its content. Similarly, parents in the focus groups reported that they were not even aware that the programme was a manualised initiative. As the programme was intended to be a school-led initiative, a lack of awareness of programme content by the majority of the school community is a source of some concern. This lack of awareness indicates that insufficient time was allocated to informing all stakeholders fully of the HSP model throughout the early (and later) stages of implementation - with negative consequences:

"The manual would point out that in order for the schools to become engaged, it requires them to make a very definite commitment ... I think initially [the funders] *found it difficult to engage schools and so I think the initial engagement might have been watered down a bit, ...rather than* [the funders saying] *saying 'if you are not going to sign on the bottom line here you are not going to be part of this project'."* [Health/Educational Professional, year 2]

As set out in Chapter Seven, the manual was developed in a collaborative way between the manual author (who had extensive experience of health promoting school planning) and the HS working group. According to participants who were involved in its development, the original manual was based primarily on health promoting school literature and subsequently adapted by the working group to meet the perceived needs of the local community area. Interviewees from the funding team considered that this eclectic approach led to a health promoting school initiative which was tailored in a more relevant way to the local community. As discussed earlier in this chapter, the delays with the manual and a lack of knowledge surrounding its content led to a number of important components (e.g. the school-led audit and memorandum of agreement) being omitted. Without the implementation of these central components, it is difficult to comprehensively assess manual effectiveness. Some principals as well as members of the funding team indicated that when utilised, the manual did provide structure to HSP implementation. For example, the concept of addressing health in a whole school way using the health promoting school model was viewed positively by most of the interviewees. This indicates the potential of the HSP manual if incorporated fully and with fidelity by the school community.

However, some principals felt that the HSP framework of implementation was not as clearly structured or defined when compared to many more structured, definable manualised initiatives such as 'Green Schools'[34] or the Active School Flag Award [35]. A small proportion of principals as well as one of the HSCs suggested a need for more focused, clearer HSP objectives. The vagueness of the HSP manual was perceived as an obstacle to successful implementation. For example, many key outcomes of the HSP manual were broad statements (e.g. Outcome 6: *Children feel good about themselves*; Lahiff, 2009; p56) and there was a lack of specific instruction regarding how to address health concerns. This perceived limitation of the manual indicates that a periodic manual review may have proved beneficial for successful programme implementation. Indeed, most models of implementation emphasise the importance of review and adaptation in the implementation of any innovative initiative (e.g. Burke, Morris, & McGarrigle, 2012). Significantly, this lack of structure made it particularly difficult for the programme to address more complex issues such as psychological health which is the focus of the current study. Indeed, as some principals acknowledged, given a choice they would have preferred a more structured topic-focused model (such as Roots of Empathy [36] for psychological health and well-being). Despite efforts by stakeholders to implement the HSP, this perception of a weak programme design by a small number of principals appeared to adversely impact programme implementation. Perhaps unsurprisingly, these views also led to further resistance amongst school communities to certain aspects of the programme manual:

"No [in comparison to other initiatives the HSP] *is a wee bit bitty. I think the healthy schools…* [attempts] *lots of different things…*[but] *it could probably do with being a little more focused."* [School Principal, year 2]

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[34]Green Schools is an awards scheme operated by the Foundation for Environmental Education which aims to encourage schools to adopt environmentally friendly practises (www.greenschoolsireland.org).

[35] The Active School Flag Award is an Irish initiative driven by the Department of Education and Skills. Awards are given to schools which demonstrate actions towards improving physical health in their school community (www.activeschoolflag.ie).

Many interviewees who were also members of the steering committee recognised that the fundamental nature of the HSP as a health promoting school created challenges in adhering to manual guidelines. Measuring success and improvements in the schools was viewed as particularly challenging as many objectives are longer term and implicit (such as policy focused system changes). Indeed, the complexity of setting appropriate indicators of change, considering the holistic and organic nature of health promoting school objectives, has previously been acknowledged in the literature (e.g. Nic Gabhainn, Sixsmith, Delaney, & Moore, 2007). Whilst many interviewees reported that children were generally healthier as a result of the programme (e.g. a better awareness and understanding of healthy living behaviours, were happier at school, had more opportunities to engage in health related activities), identifying where and how that had occurred proved difficult (see below). This challenge in assessing measurable change also appeared to impact on the enthusiasm of, and support provided by, the school community. School staff tended to shift their emphasis back towards a more targeted, outcome-focused approach to the HSP. This is not unique to the current initiative and has been observed in the implementation of similar programmes (see Weare, 2000).

"...specific objectives are much easier to meet. Now if you can say our lunch boxes are twice as good now as they were a year ago, then you can say you have reached a target, but if you can say, our school is a better place now for kids than it was a year ago, then how do you measure that?" [Health/Educational Professional, year 2]

"I have no doubt that…the children attending this school are healthier … as a direct consequence of the HSP. …It is a little bit of a Catch 22 situation. If the HSP is going to be successful, it has to be very closely linked in, and knitted in with the work of the school, so therefore, it's impossible to measure the effectiveness of the [HSP] *on its own, because it's not on its own."* [School Principal, year 2]

The majority of principals as well as the HSCs found that the two different set of manual objectives relating to HSP implementation had led to some confusion as to how the programme should actually function. More specifically, the seven pre-set health outcomes outlined at the beginning of the manual directly conflicted with the school-led school health audit (also in the manual) which schools were supposed to use to identify their own priority HSP health outcomes. Whilst the use of a school-led health audit is in line with best practice in the literature, as implementation progressed it became apparent

that the funders became increasingly focused on the pre-established seven outcomes of the manual rather than the establishment of a health promoting school ethos. As noted in Chapter Seven, these changes to the programme design were made by the HS manual working group to address the identified needs of the entire local community (and thus this component of the programme was not tailored to meet the specific needs of each individual school). Whilst these adaptations were made with good intentions, it highlights the importance of adhering to an evidence-based model in the development of a manualised initiative. Indeed, one external professional stakeholder involved with the development of the HS manual observed that it was understandable that those involved would focus on the more tangible goals. However, the emphasis on the seven pre-set objectives instead of identifying the individual needs of the schools clearly had important implications for how the HSP was rolled out and managed. The comment below provides an indication of how the funding team had tried to progress the HSP in this way:

"We [the funders] *were very clear that the seven outcomes had to be achieved, so the action plan and the yearly plan that the coordinators would have used, would have had those seven outcomes as a standard set and then we would have to come up with activities to work with them."* [HS Funding team Member, year 2]

Crucially, one member of the funding team as well as one of the health/educational professional stakeholders noted that there were no arrangements for a follow-up consultation between the HSP manual author and the HSP implementation team. Responses from these participants indicate that little consideration was given to subsequent adaptations to the manual and the involvement of the author beyond the manual development stage was not considered necessary. This limited the possibility for the author to support and advise the implementation group as to how the manual should be interpreted and applied in the schools. In contrast Meyers, Durlak, and Wandersman (2012) maintain that all stages of implementation should be reviewed and revised based on the experience of those involved. However, without the retention of the HSP author, as pointed out by one health/educational professional, there were few opportunities available for teasing out any potential negative impact that such changes may produce in terms of how the HSP successfully implemented a health promoting school approach. In particular, the lack of consultation with the author led to a number of adaptations of

the programme to suit the needs of the funders without any consideration of the literature on health promoting school initiatives. Follow-up consultation and collaboration by the HS steering committee and funding team with key members of the HS manual working group (especially with the manual author) may have provided valuable support and advice and led to the implementation of the HSP in a way that was more consistent with international health promoting school principles. Furthermore, it is likely that, the application of implementation science framework to the development of the HSP would have helped to address many of the challenges as they arose by incorporating a reflection and adaptation component to the implementation process.

"*Yes* [there should have been a role for the author to consult on programme implementation]… *But* [the author] *would have needed a mandate for that role and…There wasn't one.*" [Health/Educational Professional, year 1]

9.4 Summary of findings

It was evident that many national level issues (such as budget restrictions, school structures and flexibility) had influenced the development of the HSP in the school settings. A lack of national level support from the Department of Education and Health was perceived to limit the degree to which school communities can be incentivised to engage with this innovative approach to health. Furthermore, a lack of collaboration between health and education services, in general, limited the scope of the HSP to address important priorities such as school-health service referral pathways, children's psychological health and well-being as well as access to health resources in general for both staff and families

- Psychological health was not identified as a key priority by school communities or the HSP funding team in the first year of implementation. Understandably, this influenced how the HSP addressed this issue of health during this period. In follow up interviews, participants indicated that psychological health was a key priority of most schools. However, the perceived capacity of the HSP to address this issue varied. Indeed, members of the funding team acknowledged their preference to focus on nutrition and physical health given the relative simplicity of these aspects of health and the sensitivity and complexity inherent in

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addressing issues of psychological health. Likewise, in many cases, members of school staff were unclear as to how the HSP could address psychological health given that the programme operated a primarily activities-focused model. Importantly however, focusing on relatively 'simpler' health issues in the early stages of implementation helped establish trust between the school communities and the HSP team. This was particularly important, considering the challenges faced by the funding team in developing trusting and collaborative partnerships with school principals following the challenges raised by the HSC recruitment. In addressing nutrition and physical health initially, it is likely that schools would have become more comfortable in addressing issues relating to psychological health through the HSP in the longer term. This suggests that a longer term view to evaluating HSP initiatives is appropriate.

- As the programme progressed, psychological health increasingly came into focus. Issues such as health referral pathways, parental and children classes, as well as awareness training for staff, were all identified as key school priorities and where possible, were addressed by the HSC. Importantly however, many school staff noted that the lack of structure had limited the extent to which the HSP initiative was able to address psychological health. There was a clear preference for a more structured approach to mental health which could be incorporated under the HSP model. Indeed, a more coherent national award framework, similar to initiatives for other aspects of health (i.e. the Active Flag Award), was viewed as a more useful support tool for schools. In this way, it is clear that the HSP, as it was implemented, was perceived not to provide adequate guidance and support for schools in addressing the psychological health needs of children.

- A lack of understanding as well as limited collaboration with the school community restricted the extent to which the school community could take ownership of the HSP. As the programme progressed there were increasing instances of the school community taking a more active role in programme delivery. This indicates the long term nature of programme implementation. However, the direct involvement of the HSCs and funding team is likely to have

constrained how the school perceived the HSP as a school-led initiative. Critically, efforts by the funding team and HSCs to shift responsibility for the HSP on to the schools were met with resistance. Concerns regarding staff workload further minimised support for such school involvement. The resistance experienced by the HSP team highlights the complexities inherent in adapting a model in the early stages despite the laudable intention of encouraging stakeholder buy-in.

- Overall, it was clear that for a number of reasons, there was poor adherence to the manual. Delays in finalising the manual were an important constraint as participating school communities as well as the HSCs began implementing the programme without manual guidance. However, it was also apparent that when the manual was provided, not all stakeholders read it or engaged with its content. It is likely that a lack of training in manual use, as well as the HSP in general, contributed to this general lack of implementation fidelity.

- For this reason, it is difficult to assess manual quality as many essential components of the manual were not implemented (e.g. school audit, memorandum of agreement). Furthermore, the inclusion of two specific sets of objectives (i.e. the pre-established health outcomes included by members of the manual working group in addition to the school-led audit of health priorities included by the author and based on health promoting school literature) clearly created many difficulties for implementation. In particular, without the implementation of the audit as recommended by the manual, a school-led approach to implementation was problematic. It was clear that the funding team focused primarily on the pre-determined seven objectives included in the manual and as a result, programme implementation was not based on the principles of a health promoting school approach. This, in turn, had implications for the relevance of aspects of the programme as implemented in schools while also impacting on levels of overall enthusiasm for, and school engagement with, the HSP.

CHAPTER 10

DISCUSSION

The principal aim of this study was to explore how, and to what extent, a health promoting schools initiative, the *Healthy Schools Programme (HSP),* could address the psychological health and well-being of a sample of primary school-aged children attending designated DEIS schools. The study comprised two key components: (1) a quantitative assessment of children's psychological health outcomes over the period of HSP implementation; and (2) a qualitative analysis of the experiences and views of key stakeholders of the HS programme. In this chapter, the results from the above two study elements are integrated, synthesised and critiqued with reference to existing literature in the field of health promoting schools. Overall, this study found that whilst a number of perceived benefits of the programme were observed, few changes in measurable psychological health outcomes were identified. A number of challenges were also identified in terms of the implementation process and it is likely that improved programme planning in the pre and early implementation stages of the HSP could address these challenges in any future work.

10.1 The impact of the HSP on children's health outcomes

Overall, the sample of children included in the study maintained average levels of psychological well-being as well as other aspects of HRQoL, when compared with European normative data (Kidscreen Group, 2006). These findings also reflect the results of the national Kidscreen study (Keenaghan & Kilroe, 2008). This indicates that this sample of children who attended designated DEIS schools maintain similar levels of health and well-being as the wider Irish population which is, in itself, reassuring. In a similar way, the majority of children also demonstrated normal ranges of depressive symptoms when compared to international samples (Kovacs, 2009). Collectively, these findings are very encouraging, especially in view of the wealth of literature highlighting the health inequalities amongst groups of children based on their socio-economic status (SES; e.g. Kohn, Dohrenwend, & Mirotznik, 1998; ONSMHCYP, 2005; Patel, Araya, de Lima, Ludermir, & Todd, 1999). Indeed, many school staff noted the challenges faced by children in their daily lives, such as difficult family situations and community issues and how this affects well-being. Notwithstanding, the outcome findings suggest

that, despite these challenges, the majority of children are resilient in terms of their perceived levels of HRQoL and emotional well-being.

However, it is important to note that a substantial minority of children (18%) reported above average levels of depressive symptoms. This suggests that whilst most children are coping well, some are struggling with their health and especially their psychological health and well-being. The reasons for such poor levels of health and well-being are likely to be complex and multi-faceted (ONSMHCYP, 2005) and the findings also highlight the importance of appropriate health service provision, training and resources for schools to effectively address the emotional health needs of all children. Indeed, a systematic review conducted by Wells, Barlow and Stewart-Brown (2003) concludes that whilst universal approaches to psychological health are likely to be the most effective approach in the school setting, a more targeted approach could also be employed to help support children with additional health needs. The findings reported here tend to support the argument for a more flexible approach to children's psychological health.

The level of children's reported experiences of bullying were also a source of some concern. Worryingly, the findings from the current study indicate that more than one-third of respondents had experiencing bullying behaviour in the last year. This compares with figures of 40% from the Growing Up in Ireland national study of 9-yr-olds (2009) and a much lower 13% in a cross-national HBSC study examining data from 40 countries (Craig et al., 2009). Furthermore, the questionnaire used in the current study did not include 'exclusion bullying' as a form of bullying behaviour and so, if included, it is likely that the proportion of children who had experienced bullying behaviour may have been larger. Importantly, a little less than two-thirds of the children also expressed a view that schools were not dealing effectively with the issue of bullying. In contrast however, the feedback from parents indicated overall satisfaction in this respect thereby indicating a 'disconnect' between parents and children and a suggestion perhaps that the issue is discussed less between parents and children than it might otherwise be. These divergent views also emphasise the importance of engaging all stakeholders in identifying and addressing all health issues in the school setting including bullying, which is likely to affect overall mental health (Shakoor *et al.,* 2010). These differing views further suggest that more child-focused collaborative and inclusive efforts are

also needed by schools to ensure that children feel adequately listened to and supported, regardless of adult views.

The outcome findings related to satisfaction with perceived body weight were also worrying in that almost half of the sample indicated dissatisfaction in this regard. However, the wider HSP evaluation study demonstrated that nearly 28% of intervention school children and 34% of comparison school children were overweight/obese whilst only 1% of intervention school children and none of the comparison school children were underweight (Comiskey *et al.*, 2012). These findings suggest that many children may have an unrealistic view of their body weight even at a very young age. There are many reasons for these distorted views, with media and parental influences found to be most influential amongst younger children (Field *et al.*, 2001).

The follow-up findings of children's health outcomes suggest that the *Healthy Schools Programme* did not have a clear or significant impact on children's psychological health outcomes. For example, whilst the proportion of children who reported worrying 'a lot' about most life issues decreased over time, few differences were observed between the intervention and comparison schools in this respect. No differences emerged either between the scores of the two school's other psychological-related measures of health behaviour such as satisfaction with weight and experience of bullying. Despite this lack of change in health outcomes, a number of teaching staff indicated that HSP activities such as children's workshops rolled out by the HSC had had a beneficial effect on children's health. However, these workshops only occurred in a minority of classes - and only in some schools and therefore, any positive effects were most likely diluted as a result in the analysis of the sample as a whole. It is also possible that any smaller impacts may not be detected by the questionnaire data alone.

Small improvements in reported levels of depression were also observed across all schools over time. Interestingly, a significant improvement was identified for children who reported above average levels of depressive symptoms at baseline. Again however, these improvements were observed for the entire sample, regardless of whether they were attending Intervention or Comparison schools and so this change cannot be attributed to the HSP. It is possible that this improvement was due to other intervening

variables experienced by all schools (e.g. shared support services, additional budget allocation) which were not accounted for in the current study. However, there was no indication of these from the interviews with principals or in the Steering Committee meetings.

Some improvements were also observed on most of the measures of health and well-being (including psychological health), although these were again observed for all schools. The only exception was found on children's physical well-being in which case, the intervention school children reported significantly better physical health at both baseline and year two. Interestingly, it was evident from stakeholder feedback that most of the HS work had focused on physical health (including nutrition) and this may explain this outcome. There was much less evidence of instances where psychological health had been addressed. Indeed, it was identified in the qualitative findings that psychological health and emotional well-being was not identified as a priority of the HSP until after the first year of programme implementation and very few activities focusing on issues relating to children's psychological health were implemented in the first half of the evaluation period. Nevertheless, considering the inter-dependant nature of different aspects of health and well-being, it is likely outcomes that improvements in physical well-being may lead to improved psychological health outcomes.

Collectively, the quantitative and qualitative findings suggest that where the programme focused on specific areas of health, more notable improvements were more likely to be observed. As mentioned previously however, this finding regarding physical health was unique and should therefore be treated with caution. In particular, overall improvements (albeit mostly non-significant) between the two types of schools on most of the measures may indicate that engaging with the research process itself had an effect on children's health outcomes (i.e. the Hawthorne effect). Thus, it is likely that completing the questionnaires alone may have led to some positive changes in outcomes by simply enhancing participants' awareness of and behaviours around various issues; the possible 'therapeutic' effects following researcher-participant interactions are also commonly reported in applied research of this kind and may help to explain, at least in part, why these (small) improvements had materialised. For example, the impact of observation effects has been previously acknowledged in health promotion evaluation studies (e.g. Audrey, Holliday, Parry-Langdon & Campbel, 2006; Kohli *et al.,* 2009) and whilst

efforts to address this effect were undertaken[37] it is difficult to determine how this influenced the data. Interestingly, for example, two principals noted the value of the health questionnaires with one suggesting that these assessments were one of the most useful components of the HSP experience. Similarly, the majority of parents in one focus group also pointed to the value of the children's follow-up health assessments as opposed to components of the HSP itself.

Importantly, it was clear that psychological health was only prioritised by the HSP in the second half of the evaluation period. For example, referral system work, school-services links and policy work all only began to roll out in the latter half of programme implementation. There was also evidence that the HSCs began responding to feedback from school staff as the initiative progressed in terms of how to address mental health in a needs-based way (e.g. provision of training workshops by health promoting school experts, information evenings by health workers, increased family support). These changes indicate a shift in the HSP in line with the kind of health promoting school ethos reported in the literature (e.g. IUPHE, 2009). However, the evolving focus of the HSP strongly suggests that an evaluation period longer than two years may be required to capture potential outcomes. Indeed, the challenge in capturing change within a specified time-frame is not unique to the current study (e.g. Arthur *et al.,* 2011; Inchley, 2006; Murray, Low, Hollis, Cross, & Davis, 2007). Accordingly, Fixsen, Blase, Naoom and Wallace (2009) suggest that most innovations generally take two-to-four years to become fully operational. It is likely, therefore, that any observed changes in children's mental health may necessitate a more conservative evaluation timeframe considering the specific challenges experienced in addressing this sensitive issue.

The divergent findings between the positive qualitative feedback and the inconclusive outcome findings of this study are also consistent with the HSP literature (e.g. Moon *et al.,* 1999; Arthur *et al.,* 2011). For example, Arthur and colleagues (2011) reported the challenge for initiatives in linking any improvements in children's health to HSP participation. Thus, it is likely that whilst the broad and developing nature of a health

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- [37] The confidential nature of the data collection was emphasised to participants.
- Data was collected in participant's own environment (i.e. the school setting)
- The researcher maintained, as much as possible, an unobtrusive role in the school setting.
- The Hawthorne effect is thought to be short-term in nature. The longitudinal design of the current study minimises the threat of this effect.

promoting school approach is considered a key strength of the model, the individualised and holistic nature of these types of initiatives also creates evaluation challenges (Lister-Sharp, Chapman, Stewart–Brown, & Sowden, 1999; Moon, 2000; Stewart-Brown, 2006). Not surprisingly perhaps, Mukoma and Flisher (2004) acknowledge that such variability can make it difficult to draw definitive conclusions regarding the efficacy of health promoting schools in terms of direct improvements on children's health.

In an effort to capture the holistic nature of health promoting school and capture a broad range of health outcomes, many studies (including the current study) tend to be characterised by methodological weaknesses that tend to limit the extent to which changes might be seen to occur. A number of challenges have been identified including: insufficient power; control group differences including pre-test non-equivalence; unintended changes in control schools; small sample sizes; poor implementation fidelity; and insufficient follow-up times. All of these can also impact on evaluation efficacy (e.g. Moon, 2000; Murray, *et al*., 2007). For instance, Moon (2000) notes that whilst the risk of type I errors are often addressed in these type of evaluation studies, type II errors are a particular concern. He further highlights the potential for a type III error where a lack of change is attributed to the HP programme not working without determining if that is as a result of the quality of implementation or the quality of the intervention itself. These findings support the rationale for the use of a mixed methods approach, as self-report measures of health and well-being alone, whilst important, may provide insufficient evidence to demonstrate the full impact of HSP and health promoting school initiatives. The next section explores the HSP implementation at a school level to identify the potential of the initiative to address health in line with health promoting school practices.

10.2 The pillars of a Health Promoting School: Perceived change at a school-level
10.2.1 The curriculum-health activities work with children
Health activities work with children was clearly the main focus of the HSP and many resources were invested in developing this component of the programme (this included the HSCs themselves rolling out activity programmes for children as well as the HSCs supporting school staff in delivering health-related activities and workshops). Most schools are currently facing budget restrictions (e.g. Darmody & Smyth, 2013) and therefore, positive feedback from stakeholders regarding the continued development of

this component of the HSP is perhaps unsurprising. Importantly however, whilst health related curriculum and activity work can benefit schools in the short-term, this work alone is not sufficient in terms of implementing a sustainable and effective health promoting school approach that will yield longer-term health benefits for children (Arthur *et al.,* 2011, Inchley *et al.,* 2000; Inchley, 2006; Moon *et al.,* 1999; Lee, *et al.,* 2007; Stewart-Brown, 2006). Indeed, it has been found that an emphasis on the health curriculum increases the likelihood of neglecting the wider aims of a health promoting school framework (Simovska, 2012). Furthermore, given the broadness of HSP approaches, attempting to address all aspects of health using the curriculum is an ambitious goal and if not realised, is likely to undermine confidence and support for the longer-term efforts of a HSP approach (Inchley, 2006).

Consequently, efforts to address a broad range of health outcomes in the current context (i.e. the predetermined seven outcomes set out in the manual-see Appendix 7.3) appeared to limit the extent to which specific priority health issues identified at the individual school level could be effectively addressed. It might be expected, therefore, that few changes in children's health outcomes would result. For example, some school staff noted that some of the HS work was not needed in their school (e.g. HSC health activities roll-out). Nevertheless, this work continued across all schools for the duration of the evaluation period. The resources needed to continue this work is likely to impact on the availability of the HSC to address other school-led priority issues. The tendency to shift towards a health education-focused approach rather than maintaining a health promoting school approach is also not unique to the current study. For example Deschesnes, Martin and Jomphe-Hill (2003) observed that schools tended to shift towards curriculum-type work instead of developing a health promoting school approach as this was a more familiar concept to them. It is likely therefore, that improvements in the planning and implementation of the HSP (including a greater shared understanding of a health promoting school framework) may have supported efforts to address all key components of a health promoting school instead of solely the health curriculum. The key findings related to implementation are discussed later in this chapter.

10.2.2 Policy development work

Despite this focus on the health curriculum, there were efforts by the HSCs to develop other components of a health promoting school ethos (i.e. policies, family/community links, health service collaboration and environment). For example, in relation to policy work, the HSCs supported staff in developing policies around nutrition and physical health. By contrast however, there was a lack of evidence surrounding the development of policies relating to psychological health. Interestingly, a number of health promoting school initiatives have also been shown to support the improvement of school policies in the area of physical health and nutrition (e.g. Arthur *et al*., 2011; Lee, St. Leger, & Moon, 2005; Lee *et al.*, 2008; Warwick, 2009), whilst few evaluations have identified how health promoting school initiative policies address psychological health policy in schools (e.g. Arthur *et al.,* 2011). This suggests that the issue of psychological health may require additional planning, support and resources. Importantly, in the current context it was evident that in school staff were not enthusiastic about HSC policy work especially with regards to more sensitive issues such as SPHE and psychological health. Therefore, it is not surprising that little change in terms of psychological health policies were attributed to the HSP.

More broadly, Mitchell, Palmer, Booth, and Powell-Davies (2000) observed that changes in the school ethos (e.g. policy change) were much more difficult to achieve in health promoting school initiatives than changes to other areas such as the health curriculum. As alluded to by some principals, health-related policy development work in general is an ongoing evolving process in schools and in this way, attributing policy development work to the HSP can also be difficult to demonstrate (Arthur *et al.,* 2011). However, the development and improvement of health-related policies is an important facet in terms of sustainable change in how schools address health. Gleddie and colleagues (2011) found that improvements in school health policies often led to improvements in the health-related curriculum. Similarly, Mukoma and Flisher (2004) observed that improvements in policies encouraged greater family involvement in schools. Policy improvements can also lead to clearer targets set by schools which in turn lead to more coherent approaches to addressing school health (Gleddie, 2011). In light of these observations, the perceived lack of any change in policies in the *Healthy Schools Programme* is a source of some concern. The findings suggest that a lack of important implementation components such as training on the central components of a

health promoting school approach by key stakeholders (such as the HSC, principals and other members of the steering committee) as well as the recruitment of HSCs with a HP background were key limiting factors in the limited success of health-related policy work. These important implementation considerations are emphasised in the literature as key to implementation success (e.g. Burke *et al.,* 2012) and are discussed in more detail later in this chapter. Going forward therefore, it might be more useful (and less resource intensive) for these type of initiatives to begin with the broader components of a health promoting school ethos and allow these to lead and inform curriculum changes rather than vice versa.

10.2.3 HSP family engagement work: The development of a more inclusive school environment

Throughout the evaluation, many staff highlighted the challenge of effectively engaging with parents. Encouragingly however, many examples of improved parent involvement and increased awareness of health issues were attributed by respondents to the work of the HSCs (e.g. HSC-led health-related activities and workshops). Indeed, the literature has also identified the role of HSP initiatives in enhancing parent-school relations and parental involvement as well as enhancing perceptions of inclusiveness and improving parental knowledge of health issues (Lee, *et al*., 2005; Lee *et al*., 2008; Stewart-Brown, 2006; Warwick, 2009). Importantly, the health benefits for children of involving parents in children's' schooling is also acknowledged in a number of studies (Browne, Gafni, Roberts, Byrne, & Majumdar, 2004; Diekstra, 2008; Greenberg *et al.,* 2001; Weare & Nind, 2011; Shucksmith *et al.*, 2007). The association between parental mental health and children's health and educational outcomes has also been well documented (e.g. Mustillo, Dorsey, Conover, & Burns, 2011; Jaser *et al*., 2005; Stallard, *et al*., 2007).

However, there was little evidence to indicate the sustainability of this HSP-led family engagement work. Thus, it is probable that, engaging with and supporting the health of parents through the HSP requires sustained efforts over a longer time frame than this study would allow in order to impact on child outcomes. For instance, as noted above, most of the HSC work focused on the provision of workshops and activities for families rather than involving family representatives in the planning and implementation of the HSP. In addition, feedback from the interviewees indicated that parents were not consistently involved in developing, planning or improving health promoting practices

in schools. Indeed, much of the HSC-led work involved engaging with the parents on a one-to-one rather than on a whole school basis. Thus, whilst this relationship building was perhaps beneficial in the short-term, there was a lack of evidence to indicate how such relationships could be maintained without the direct involvement of an externally funded HSC.

Furthermore, some respondents noted that the most isolated families continued to prove difficult to engage and there was little evidence to indicate how the HSP had improved the involvement of this vulnerable population. Not surprisingly however, many school-based health initiatives acknowledge the challenge in engaging with the most isolated and vulnerable families (Deschesnes, Martin, & Jomphe-Hill, 2003; Mitchell *et al.,* 2000; Senior, 2012; Steckler *et al*., 2003; Story *et al*., 2000). Nevertheless, it is evident from these studies that creating opportunities for families to be involved in school planning in an inclusive and collaborative way may in the longer term can help to improve family attitudes towards school and increase family participation. A greater emphasis on collaborative parental involvement in the local initiative throughout each stage of the implementation process could have led to a more empowering positive experience for parents and helped to develop and deliver the initiative in a more relevant and effective way.

10.2.4 Collaborative partnerships between schools and health services

The importance of effective collaboration between health and education services in addressing the health needs of children is well established in the literature (e.g. Allenworth, 1995; Barnekow *et al*., 2006; Cushman, 2008; Kolbe, 1993; Lee *et al.,* 2007; Marshall *et al.,* 2000). It is not surprising, therefore, that the development of collaborative health service-school links was identified as a priority issue by most participating schools. It was also clear the HSCs and funding team attempted to respond to this priority in a number of ways (e.g. improved child referral pathways, case-worker support for families, and information evenings on services for school staff). This work by the HSP implementation team suggests that efforts were made locally to incorporate a needs-led approach to HSP work in line with HSP principles (IUPHE, 2009). However, despite these efforts, the extent to school-health services' collaborative working improved as a result of the HSP was less clear. Paradoxically, HSC and HSP funder involvement in referrals and partnership development work had reduced the

involvement of school staff in this type of work. The lack of involvement of the school community in this way also seemed to generate some resistance to change amongst staff. Thus, there was little evidence of positive sustainable change in how schools managed referrals. Importantly, that fact there was no school representation at health service meetings with the HSP funding team to develop this work further demonstrates a lack of inclusive collaboration. The funding team themselves indicated, in their interviews with the researcher, that such work may be more effective without the involvement of schools. Nonetheless, without this key partner at such important meetings it is difficult to understand how such efforts could address the needs of both the health and education sectors. By contrast, Gleddie, (2011) emphasises that a school-led approach to school capacity building is key to the successful development of an effective HSP ethos such that schools and services are more likely to establish effective and sustainable working partnerships based on inclusivity (Senior, 2012; IUPHE, 2009). Similarly, a number of recent European level reports emphasise that the school should be central to the development of effective and collaborative cross-sectoral children's services (Edwards & Downes, 2013; Eurochild, 2011. This position is echoed by the European Network of Education Councils (EUNEC, 2013) conference statement which emphasises the importance of the school environment in supporting positive child well-being and development. This perspective sits in stark contrast to the the approach of the HSCs and funding team in the current study, where some HSP planning and activities were completed independently of theschools and were very much HSP-funder/HSC led. These issues are examined in more detail later in the chapter.

Importantly, as Brown and White (2006) highlight, this lack of formalised collaboration can have negative consequences for children's health and in particular child protection. Despite efforts to address this school priority in the local context, the HSP work in many ways merely duplicated service collaboration work by existing school staff. For instance it was clear that the HSCs continued to rely on informal 'once-off' links with health services to process child referrals. Indeed, some principals indicated that the involvement of the HSP funding team and HSCs only further complicated school-service collaboration. In addition, many health services were reluctant to develop partnerships via the HSP and HSC which further limited this work. It is likely that had the HSC been a permanent member of the existing school staff with a remit to develop collaborative partnerships with health services, there may have been more engagement

on the health service's part and the HSP funding team may not have had to be involved in such a direct way. Furthermore, the hands-on approach taken by the HSP funders indicates a shift away from the health promoting school model and it was unclear how this role was driven by best practice or the HS manual. These finding suggest that incorporating a model more in line with previously established health promoting school initiatives could prove more effective (i.e. Inchley *et al.*, 2006; Leurs *et al.*, 2005); for example, this could involve a staff member taking on a lead role with regard to HSP progress alongside a regional HSC, endorsed and supported by both the Department of Health and Department of Education. It is likely that some adaptations to the HSP in its current form to incorporate a more collaborative model based on the principles of a health promoting school approach may lead to more sustainable improvements.

The challenge in establishing sustainable links between schools and health services is well documented (e.g. Barnekow *et al.,* 2006; Marshall *et al.,* 2000; Warwick *et al.,* 2004). Nevertheless, health-education partnership improvements through health promoting school implementation are achievable (Arthur *et al.*, 2011). Importantly however, effective and sustainable collaborative developments between health and education services necessitate support at a national level (Aggleton *et al.,* 2000). For example, in the UK, HS model regional coordinators retain a mandate (jointly supported by both Department of Education and Department of Health) to support schools in developing such work. However, no such framework exists in an Irish context. The development of such collaborative departmental policies could provide a first step in the promotion and maintenance of effective health-education service partnerships. According to Health Service Executive documents (i.e. HSE, 2011), efforts are ongoing to develop such strategies but these efforts have not yet demonstrated improvements at a school level. Without this policy framework, it is likely that health promoting school efforts to develop school-service links at a local level will continue to be based on individual contacts and non-formal engagements.

As discussed earlier, the broad nature of the HSP approach also creates challenges in identifying measurable improvements that can be attributed to the initiative. In particular, Barnekow and colleagues (2006) acknowledge that service-development work is a long-term outcome of a successful health promoting school approach and therefore may not be observable in shorter-term assessments of change (e.g. two years).

Nevertheless, whilst the development of partnerships between health services and schools is an ambitious goal, these findings suggests that if the HSP were: (1) implemented more in line with health promoting school principles; (2) supported at a national level and; (3) evaluated over a longer period of time, it may support schools in developing more sustainable partnerships with health services. These important implementation issues are discussed further in the section that follows.

10.3 The implementation process: Key enablers and barriers

10.3.1 Early stage issues

As Fixsen and colleagues (2005) note, successful implementation depends on how implementation teams address the key enablers and barriers that arise throughout the implementation process. Therefore, each stage of the implementation process (i.e. exploration and preparing; planning and resourcing; implementation and operationalising and; implantation (innovation embedded) and evaluation) needs to be considered carefully (Meyers, Durlak, & Wandersman, 2012). In the current context, the findings indicate that much effort went into aspects of the exploration stage in terms of identifying the health needs of the community and how these could best be addressed. The funding team, in collaboration with the manual author and a working group of education and health professionals, subsequently developed the HSP framework by using these findings together with the international literature, as a basis for developing the HSP manual (Lahiff, 2009). Thus, programme design was evidence-based and needs-focused. However, only the manual author and one other health professional had previous experience of health promoting schools specifically and a number of subsequent adaptations to the manual by the working group reflected a lack of awareness of a HSP ethos. Whilst it seems that these changes were well-intentioned and made in an effort to address the identified needs of the local community, the inclusion, in particular, of a set of pre-determined health outcomes of the HSP by the working group contradicts both health promoting school best practice as well as other sections of the manual (i.e. the school-led audit of health priorities) (IUPHE, 2009; Lahiff, 2009). This underlines the need for individuals with appropriate experience to lead and direct programme implementation as has been reported in implementation studies conducted elsewhere (Burke, Morris & McGarrigle, 2012).

Importantly, it was also evident that not all key stakeholders (e.g. children, parents and school principals) were represented on the planning (and in some instances implementation) committees despite this being outlined within the HS manual. For example, parents were not included at any stage of the planning and implementation process and school principals from participating schools only joined the HSP steering committee prior to HSP implementation. In some instances, this was due to a lack of enthusiasm for the programme by school staff, but it appeared to be due mainly to a limited awareness of, and opportunities for, their inclusion in the planning process. Clearly, this demonstrates an absence of the kind of effective planning by the HSP leaders and planning committee that is essential for the success of any new and innovative initiative (Fixen *et al.,* 2005). As a result, a number of HSP planning and design decisions (e.g. the background and remit of the HSCs) were made by the committee without adequate consultation with schools and members of the funding team and the HSCs became increasingly responsible for HSP decision making. This shift toward a top-down management structure further impacted the level of inclusion and collaboration with the school communities.

This implementation approach is somewhat at odds with the core values of a health promoting school (e.g. Grey, Young & Barnekow, 2006). Indeed, organisational support and 'readiness' are fundamental components in an effective implementation process (Weiner, 2009). In addition, Burke and colleagues (2012) highlight that collaboration and effective communication between stakeholders is another important contributory factor to implementation success. Dowling, Powell and Glendinning (2004) further underline the importance of developing and maintaining effective and collaborative partnerships in the development of any new initiative, especially when it involves different agencies establishing a new relationship. It was clear from the findings reported here that participating school communities were not adequately prepared to develop the HSP in their schools. Clearly, more effective early stage planning in terms of organisational support and developing a sense of readiness for HSP implementation was required. This again highlights the importance of adopting a structured approach to implementation and of addressing key enabling and limiting issues as soon as possible in the implementation process (Burke *et al.,* 2012; Meyers, Durlak, & Wandersman, 2012; Weiner, 2009).

This fundamental lack of collaboration impacted on programme development in other ways. For example, some of the schools tended to perceive aspects of the programme as not relevant to the needs of their school and this further compounded their lack of ownership and buy-in to the HSP. In contrast, where there was evidence of collaboration between the school community and members of the funding team/HSCs, the HSP work was viewed more positively. Similar findings emerged regarding the involvement of other members of staff as well as parents. Unsurprisingly, many studies highlight the importance of engaging and communicating with the school at every level in the development and implementation of health promoting school initiatives (Gleddie, 2011; Lee *et al.,* 2007; MacNab, 2012). Clearly, more emphasis on the core values of a health promoting school approach was needed in the local context in order to develop a collaborative, inclusive approach to school health planning. Without a school-led approach, the effectiveness of any health promoting schools model is likely to be limited.

10.3.2 Additional planning and implementation considerations

In terms of planning and implementation, Fixsen and colleagues (2005) describe many core implementation planning components such as adequate training, clarification of roles and responsibilities, establishment of a clear delivery model and identification of inputs, outputs and outcomes. Whilst these components are all important influencing factors on programme success, many were not in evidence within the local HS initiative. According to Fixsen and colleagues (2009), these 'implementation drivers' interact to: (1) compensate for limitations of each component of the implementation process and; (2) support the development of a progressive implementation setting ethos. For example, a lack of stakeholder agreement on roles and programme outputs clearly created considerable difficulties in terms of developing the HSP in an evidence-based way. Importantly, in addition to delays with the manual, the lack of training, support and consultation with all key stakeholders led many involved to develop their own conceptualisation of the HSP. Thus, without these essential components, it was not surprising that the HSP was not effectively implemented. Accordingly, the theoretical framework underpinning health promoting school practices was not fully understood and therefore not adhered to by the majority of stakeholders.

By contrast, a shared understanding of a health promoting school framework has been identified as a core factor in the successful implementation of such an approach (Bruce 2012, IUPHE, 2009; Lee, *et al*., 2007). However, similar to the findings of the current study, many evaluations have identified the difficulties experienced in this respect which are likely to impede programme implementation (Inchley, Muldoon, & Currie, 2006; Leurs *et al.,* 2005; Marshall, 2000; Terre, 2008). On a more positive note, as the programme progressed, it was clear that the funding team as well as some principals became more aware of the health promoting school framework and efforts were made to adapt the programme and create a more sustainable approach. Therefore, it is possible that, over a longer time frame, the programme may have developed into a more evidence-based and successful model of implementation in participating schools.

10.3.2.1 HSP organisational governance and leadership

The cross-school multi-disciplinary HSP steering committee established just prior to programme implementation was central to leading and governing programme development. This structure was effective to the extent that it helped to progress the HSP at a strategic level. Importantly however, it was envisaged from the outset that this committee would provide strategic support to localised committees established in each school to direct and manage the day-to-day running of the HSP, thereby reflecting the school-led approach endorsed in many studies with the aim of nurturing a supportive organisational culture and developing an effective health promoting school ethos (e.g. Arthur *et al.,* 2011; Gleddie, 2011; Kok *et al*., 2000; Leurs *et al*., 2005; Leurs *et al.,* 2007; Senior, 2012; St. Leger & Nutbeam, 2000). However, without a memorandum of agreement, school staff dis-engaged from the development of individual school-level committees and as a result, these committees were never established. Consequently, many health priorities were also set out at a cross-school level, but school buy-in and support for the programme were constrained when these priorities were not deemed relevant to individual schools. Furthermore, the subsequent roll-out of the HSP via the HSC and cross-school committee strengthened the perception by the school communities that the HSP was an 'add-on' initiative for schools. Consequently, the HSP did not become embedded in the school as intended and an important component of successful implementation was absent (Laurence, Peterken & Burns, 2007; Lister-Sharp *et al.,* 1999).

The leadership and involvement of school principals were key influencing factors in the planning and implementation of the HSP and this is consistent with the findings of a number of previous studies (Aggleton *et al*., 2000; Cullen *et al*., 1999; Deschesnes, Trudeau, & Ke´be, 2010; St. Leger, 1998; Valois & Hoyle, 2000; Wyllie *et al*., 2000). In particular, where principal leadership and support for the HSP was in evidence, the wider school community were more likely to engage with the HSP work. By contrast, in schools where principals displayed only limited support for the programme, this also clearly impacted on programme implementation in terms of cooperation and involvement of staff. Importantly, whilst some principals were open to directing the HSP, principals expressed concern about the expectations placed upon them by the HSP funders to lead on an initiative that was being implemented in another principal's school. It is likely that these concerns limited principal enthusiasm for the HSP as well as inhibiting the development of the kind of strong and effective leadership that has been identified as important in establishing such new initiatives (Burke *et al.,* 2012). Such concerns again highlight a lack of sufficient consultation during the planning stages as well as a limited understanding of educational 'structures' by the HSP funders. As noted earlier in this chapter, it is likely that if principals were involved more collaboratively in the pre-implementation phase of HSP, such organisational challenges may have been identified and addressed at an earlier stage.

Where there was evidence of limited principal leadership, members of the funding team became centrally involved in directly leading HSP work as well as governing and managing the programme (e.g. leading the cross-school steering committee, managing and supervising the HSCs). As discussed earlier in this chapter, whilst providing an essential role, the direct involvement of the HSP funding team in the management and implementation of the programme created additional challenges. In some instances, members of the school community indicated that they felt they were being externally audited which had in turn led to a reluctance to engage with the programme. In addition, the involvement of the funding team further reduced involvement by the schools as it became understood that the funding team would take responsibility for certain elements of the HSP. The inadvertent disempowerment of schools in this way contrasts sharply with the ethos of a health promoting school approach (e.g. WHO, 1998) and may have further impacted on how the programme was embedded in the schools and how it impacted on the health of the children. In contrast, Valois and Hoyle (2000) emphasise

the importance of involving schools in leading and coordinating a health promoting school initiative roll-out to ensure that the programme becomes integrated meaningfully within existing school structures. In this way, by supporting school policies, ethos, environment and curriculum, the initiative can build on existing school resources and increase the capacity of the school to address the health needs of children in a more sustainable way (Gleddie, 2011; Valois & Hoyle, 2000).

Other important organisational issues, such as staff changes, also emerged throughout the planning and implementation period and these were also likely to have impacted on the nature and extent of organisational support for the HSP. Unsurprisingly, staff turnover has been demonstrated to impact on implementation quality (Rollins, Salyers, Tsai, & Lydick, 2010). However, this is not peculiar to the current study and other evaluations (e.g. Kelder *et al.,* 2004) highlight ways in which this challenge can be effectively addressed (e.g. follow-up training workshops, ongoing consultation). By contrast however, three out of the five schools in the current study experienced school principal changes during the period of the study but despite this, no health promoting school training was provided to new school staff. Again the incorporation of an implementation science framework (e.g. Burke *et al.,* 2012) could have helped to guide the funding team to review and address such issues as the programme progressed. This is likely to have further impacted on stakeholders' understanding, involvement and overall levels of ownership of and buy-in to the programme.

10.3.2.2 The contribution and sustainability of HSP resources
The HSP initiative clearly brought a number of additional resource-related benefits to participating schools. In particular, the provision of additional staff (i.e. the HSCs), funding and increased training opportunities for staff and parents were all highlighted by interviewees. Many of these resources were based on the external funding provided by the HSP funding team and it was acknowledged by the team that these resources were provided to schools in an effort to increase buy-in to the HSP. However, the sustainability and longer-term impact of these resources is not clear. Critically, the resource intensive nature of some of the HSP-led activities and perceived need for HSC involvement meant that much HSC work would most likely not be sustained beyond the lifetime of the HSP pilot programme. Indeed, some staff expressed concerns regarding the sustainability of funding for the HSC position; the funders had costed the HSC

position at €12,650 per school per annum[38]. Some staff suggested that, instead of a funded school-based HSC, school communities could be provided with a much smaller annual stipend as well as departmental support which may allow them to address health priorities using a HPS model in a more sustainable cost-effective way. Whilst such an approach would require clear guidelines to ensure that spending is in line with HPS practice, it is possible that, as demonstrated in the literature, a less expensive model may be more attainable and sustainable.

These findings again suggest that the approaches taken by the HSP funding team and steering committee were not always in line with HSP best practice. By contrast, Inchley, Muldoon and Currie (2006) suggest that the provision of financial resources, such as a funded school-based HSC position or annual stipend, is not necessary to increase buy-in from schools. From their experience of evaluating the UK HSP initiative, they argue that the development of structural supports using minimal funds that focus on sustainable and achievable targets can have a greater longer-term impact. Guidance,support and consultation at a national, regional and local level are also viewed as critical to enable schools to take responsibility for HSP roll-out in a sustainable way rather than simply providing them with additional financial resources (Becker, Edmundo, Bonatto, Ferreira do Nascimento & Silva, 2005; Bruce, 2012, Deschesnes *et al.*, 2003; Stokes & Mukherjee, 2000).

It was clear from the interviewees' comments that the lack of support at a national level with regard to implementing HSP was a key challenge in developing the programme sustainably. For example, whilst the funding team invited members of the Department of Health and Department of Education to take part in HSP steering committee, no formal commitment from these Departments was established. Without official endorsement by the Department of Education in particular, there was little incentive for school staff to engage with the programme. Similarly, members of the Department of Health were clearly reluctant to engage with the HSCs without support from health services due to concerns regarding sustainability of the HSP model. The impact of this

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[38]

http://www.effectiveservices.org/images/uploads/file/Policy%20Brief%20on%20Healthy%20Schools%20Programme%20CDI.pdf

lack of partnership working was evident in many aspects of HSP implementation (e.g. including service development work, school-buy-in, HSC remit).

10.3.2.3 The role of the HSC

Another important resource provided by the HSP was the HSC which was intended to drive the initiative. However, the recruitment of HSCs from a community development background instead of a health promotion/nursing background (as originally envisaged) was an important change in the early stages of programme planning. Whilst school staff believed a healthcare professional (e.g. a nurse) was necessary, the funding team felt that the provision of a nurse would merely replicate the role of the public health nurse and would not be cost-effective. Despite these differing views, the funding team completed recruitment of the HSCs without consultation and agreement from school principals. This contrasts clearly with the values of a health promoting school ethos as set out in the HSP manual (Lahiff, 2009). Furthermore, it was evident that this had created an early barrier to programme progress especially in the first year. Further adaptations to the role (by the steering committee and principals) from the outset were made to address a lack of school enthusiasm but these meant that the HSC provided much more of a support role to staff than was originally intended by the manual author. Understandably, many school staff noted the value of having this additional staff member to take responsibility for the health curriculum in their school and in this respect, the HSCs provided a very positive resource for schools in terms of short-term gains in the health curriculum. However, this direct hands-on HSC role also created challenges. As mentioned earlier in this chapter, the importance of appropriate staff recruitment is an essential component in the implementation of any innovative initiative (Burke *et al.*, 2012). In line with this, it was clear that without health promoting school experience, the HSCs were limited in the extent to which they could make progress in an evidence-based way and be perceived as being in a position to address higher level issues such as the development school-service collaboration networks. The resource intensive nature of the HSC work also led school communities to further view the HSP as an add-on resource instead of a whole-school approach that could be incorporated into existing school structures - a perception not unique to the current programme (Brown & White, 2006). Not surprisingly, without staff engagement the HSCs also struggled with the workload. Consequently their capacity to support schools in developing the key components of a health promoting school (i.e. policy work, school

environment, school-health service development) was further limited, as much of their time was focused on the roll-out of specific health-related curriculum/activities for children.

Similar to the current study, O'Brien and colleagues (2010) observed improvements in the school health curriculum in a US school context as a result of the contribution of a HSC as an additional member of staff. However, in contrast, many studies emphasise the importance of schools themselves engaging with, and taking ownership of, the health promoting school process and work to increase the sustainability of the programme (Gleddie, 2011; St. Leger, 1999; Turenen *et al*., 2006). Indeed, a bottom-up approach to health promotion is one of the key principles of the WHO conceptualisation of a health promoting school (Turenen *et al*., 2006). Thus, whilst the work of HSCs was viewed within the current study as a source of considerable support to staff in the short-term, there was no strategic plan or direction with regard to how the model could be sustained in the longer term. Interestingly, whilst many efforts to encourage schools to take more responsibility for HSP work were met with resistance, school staff were more likely to engage with the programme in those isolated cases where school members did lead on generating and implementing HSP ideas. This again highlights the importance of a number of factors designed to promote health promoting school best practice (e.g. Moon *et al*., 2000) including school-led HSP development, the use of a school-led audit and the establishment of a memorandum of agreement from the outset.

The hands-on role of the HSC, as it was realised in the current study, is unique when compared with other health promoting school studies that describe the involvement of HSCs. For example, many studies describe the school-based HSC as an existing member of staff whilst external non-school staff HSCs are more likely to provide regional guidance and consultation to these in-school coordinators (Inchley, *et al*., 2006; Leurs *et al*., 2005; O'Brien *et al*., 2010). Thus, schools are supported but importantly each school assumes responsibility for the initiative. It is likely that this type of HSC model could have supported local schools to engage with the HSP process in a more sustainable way.

10.3.3 Implementation fidelity and manual design: The importance of reflection and programme review

The production of a manual, as was the case for the current programme, provides evaluators and policy makers with a valuable tool to develop and improve upon health promoting school approaches. Evidently, the HS manual provided a useful framework in a number of ways for the local initiative in terms of, for example, setting out objectives and providing a useful reference point for school staff and the HSCs. However, it was also clear that a number of factors, such as delays in manual provision and lack of training as discussed earlier in this chapter, led to differing interpretations and perceptions of the HSP which in turn meant that the manual was not implemented with fidelity. The funding team also adapted the programme in many ways in an effort to generate greater enthusiasm in the schools. Whilst the reasoning behind such adaptations was understandable, such changes to a manualised programme demonstrate a lack of implementation fidelity (Keith, Hopp, Subramanian, Wiitala, & Lowery, 2010). However, as Carroll and colleagues observe, fidelity is essential to the determination of programme impact on outcomes and point to numerous studies which demonstrate that programmes with high implementation fidelity are more likely to prove effective (e.g. Dusenbury, Brannigan, Falco, & Hansen, 2003; Schneider, 1998; Elliot & Mihalic, 2004; Mihalic, 2004; cited in Carroll *et al.,* 2007). Thus, programme adaptations are likely to impact on programme efficacy.

In practice, these changes (e.g. the hands-on role of the HSC, the direct management role of the funding team, no memorandum of agreement, the non-use of the manual audit) created many challenges with regard to the extent to which the programme adhered to a health promoting school ethos. For example, without the incorporation of a memorandum of agreement between all stakeholders, agreed roles and responsibilities changed throughout the course of implementation. The school self-completion audits, as set out in the HS manual, are another key component of health promoting school planning and implementation (Arthur *et al*., 2011; Kok *et al.,* 2000; Leurs *et al.,* 2005; Leurs *et al.,* 2007; Senior, 2012; St. Leger & Nutbeam, 2000). These audit reports maintain the focus and vision of the initiative for each school and as such, the manual for the local initiative was designed in an evidence-based way. However, this school-led audit was never completed due to a lack of formal Memorandum of Understanding (MOU) between schools and the funding team and a subsequent lack of enthusiasm by

principals. Not surprisingly, the HSP lacked a school-led approach to programme implementation. Instead, the cross-school steering committee (led by the funding team) decided which health issues should be addressed across participating schools. This had many implications concerning the relevance of a number of HSP activities in some participating schools, which is likely to have a negative impact on school interest and buy-in to the overall programme as well as potentially affecting the health outcomes for the children.

The design of the manual was another important factor in implementation fidelity. The school-led needs audit in the manual was designed to establish individualised HSP objectives and is in line with health promoting school best practice (Senior, 2012). However, as this audit was not used by schools, the individual priorities of each school were never formally established. Critically, the inclusion in the manual of an additional seven pre-determined outcomes was at odds with the school-led audit approach recommended in the literature and instead encouraged a cross-school approach to programme planning and implementation. Indeed, it was clear that the HS steering committee based much of its work around addressing these seven pre-established outcomes which is not consistent with the health promoting school literature (Arthur *et al*., 2011; Leurs *et al.,* 2005;Leurs *et al.,* 2007; Senior, 2012; St. Leger & Nutbeam, 2000). In addition, as indicated by some principals, a number of these outcomes were not realistic and more importantly perhaps, meaningful to the participating school. Thus, the design of the manual itself created difficulties and in some ways limited the extent to which the schools were able to implement an evidence-based approach.

It was also clear that many stakeholders struggled with the broad scope of the HSP manual. According to members of the funding team, the semi-structured approach to manual content was designed to allow schools to develop a more school-led approach to HSP implementation in their school. Understandably however, the lack of structure and clear guidelines in the manual proved challenging in terms of how to roll out the programme with fidelity and in a structured way. The lack of adequate training in the health promoting school approach coupled with the perceived vagueness of the manual led many involved to revert to a more curriculum topic-focused approach to health promotion. Indeed, this has also been reported in a number of studies conducted elsewhere (Dooris, 2004; Dooris, 2005; Moon, 1999; Weare, 2000). It is not surprising

that after a defined period of implementation fidelity, a structured manual review and adaptation process may be necessary considering the innovative nature of this initiative. Indeed, many implementation studies consider the process of review and adaptation as a key stage in the implementation process so practices may be updated (and thus improved) based on feedback and outcomes (e.g. Burke, Morris & McGarrigle, 2012; Fixsen, Blase, Duda, Naoom, & Wallace, 2009; Meyers, Durlak & Wandersman, 2012). However, despite this important component of the implementation process, there was no evidence of a formalised process of programme review and adaptation in the current study. Critically, the manual author, the only individual with previous experience of implementing health promoting school initiatives, was not involved in the programme beyond the manual design stage (i.e. during the planning or implementation stages) and no manual-focused consultations or reviews occurred over the evaluation period. The lack of consideration of this key stage of implementation clearly restricted the potential for HSP development and improvement (Fixsen *et al.,* 2005). As noted previously, the implementation team did become more aware of the health promoting school framework as the programme progressed and sought to adapt programme implementation in a way that would ensure closer adherence to this approach. However, no efforts were made to review manual quality or consider its impact on programme effectiveness. These challenges are certainly not unique to the current context (e.g. Cushman, 2008; Marshall, 2000; Rissel & Rowling, 2000). However, these findings again highlight the importance of a clear and transparent process of programme review and, more broadly, the importance of following a convincing and coherent implementation strategy.

Key lessons learned

- It is recommended that the HSP implementation team are experienced or adequately trained in the theory of a health promoting schools approach prior to the implementation of the programme in schools

- The importance of agreement by all stakeholders on the core components of any initiative cannot be underestimated. In particular, clarification on roles and responsibilites as well as programme aims and measurable objectives is an essential first step in the development of a successful HS initiative

- A more structured approach to the stages of design, planning and implementation may facilitate a more effective initiative especially considering the complex nature of a health promoting school approach

- Inclusive consultation and collaboration between all stakeholders (especially school staff and the 'drivers' of the HSP) thoughout the stages of implementation is essential to the success of a health promoting school initiative like the *Healthy Schools Programme*

- School-led planning and implementation as well as school ownership of the HSP is essential if the HSP is to become part of the ethos of the school setting and not just an 'add-on' initiative that simply promotes health activities in the school

- Manualised initiatives need to be evidence based and a continuous self-assessment of fidelity should be maintained throughout programme planning and implementation

- Innovative initiatives like the *Healthy Schools Programme* also necessitate a retrospective review period to identify and address any initiative design and quality issues going forward

- A more simplified and clearly defined in-school Healthy School Coordinator role that is in line with HPS best-practice is needed to improve school acceptance and engagement with the programme.

- The HSC role should be established in parallel to the formation of an in-school HS committee. The purpose of this committee is to drive HS implementation in a school-led way. All local stakeholders (including parents, and students) will be represented on this committee.

- National level support and involvement from both the Department of Health (DH) and Department of Education (DE) is essential to the sustainable development of a health promoting school stategy in schools

- A more active Irish Network of Health Promoting Schools (INHPS) could lead to an improved support resource for schools developing a health promoting school ethos

- The establishment of a national level HSP award system (supported at a national level) may encourage and motivate schools to develop a HPS culture

- A national level multi-disciplinary consultation panel with experience in HPS implementation and/or practices should replaces the current system of cross-school committees. The purpose of such a panel would be to support schools in developing an evidenced-based HPS model. Such a panel should be developed through the INHPS, DH and DE as well as in consultation with existing resources (such as School completion programme coordinators and Home School Liaison Coordinators)

- Psychological health is a particularly sensitive and complex issue. Additional support, guidance, and training is needed for school staff to address this topic through a health promoting school approach with confidence

Figure 10.1: Key lessons learned in the implementation of the *Healthy Schools Programme* as an innovative health promoting school approach

10.4 Strengths and Limitations of the study

This study was unique in that it provided a comprehensive assessment of how an innovative Health Promoting Schools initiative addressed the psychological well-being of children in an Irish primary school setting. Importantly, the mixed methods design

utilised by this study permitted the examination of the process of programme implementation as well as programme impact on children's psychological health. The quantitative findings of this study provide inconclusive evidence for the effectiveness of the HSP in terms of psychological outcomes. Consequently, the qualitative findings provided an important support to the quantitative findings by contextualising the outcome findings. The Framework Analysis approach to qualitative analysis also delivers a clear and structured approach to the large volume of data collated in this study.

Importantly, the qualitative component of this study identified the significant influence of the implementation process. Issues such as design, planning and the experience of the implementation team were all identified as important contributing factors to successful programme implementation regardless of the local context. The discipline of implementation science is still relatively new and to date, few studies have examined health promoting school initiatives specifically (Guggleberger & Inchley, 2012). Thus, the current study, incorporating an implementation science framework, provides a useful research approach in view of the complex task of identifying appropriate indicators of success and measuring school change over time.

As mentioned earlier in this thesis, an RCT design was not possible in the current context considering the impossibility of establishing a random sample as well as other financial and resource constraints. However, the comparison, follow-up design of this study provides a high quality, cost-efficient alternative approach to the assessment of children's health outcomes. As noted above, the outcome findings do not provide conclusive evidence for the effectiveness – or lack of – of the HSP on psychological health. Nevertheless, these findings do provide an important baseline of the health status of children in these schools. Considerable attention was given to the selection of appropriate self-report assessment tools and the data collection process was completed using an evidenced-based approach. Whilst the qualitative findings indicate that delays in the implementation phase limits the conclusions drawn from the questionnaire data, the results drawn from this data provides an important indicator of children's psychological well-being for longer-term follow-up HSP studies.

Whilst manual limitations are clearly demonstrated throughout this chapter, the availability (and consideration) of a manual does provide important details concerning the specifics of the HSP. Indeed, the HSP literature often lacks detail concerning programme specifics and process evaluations are often not incorporated into evaluations (Stewart-Brown, 2006). These limitations add to the challenge of successfully evaluating the efficacy of health promoting school initiatives and of making valid comparisons across studies. The examination of programme details which occurred in the current study provides a useful in-depth evaluation relevant to all health promoting school evaluation studies.

This study also had a number of limitations. For example, participating schools were identified by the implementation team prior to the involvement of the researcher and therefore randomisation was not possible. As discussed earlier in Chapter 4, comparison groups were chosen by the researcher based on similarities with participating schools. The small number of local schools participating in the programme also limits to some extent the generalisability of the findings to other school contexts. All of the schools involved in this study were urban and designated as DEIS band 1[39] schools and therefore, the many challenges faced by school staff in engaging with children and their families may be more marked in these schools (Department of Education and Science, 2005). Conversely however, these schools also have resources available that are not provided to other schools (e.g. lower staff-student ratios, additional funding) due to their DEIS band 1 status (Department of Education and Science, 2005). Nevertheless, despite these differences, comparisons of the outcome data in the current study to other national studies revealed little differences between children in terms of psychological health. In addition, it is likely that many of the broader issues highlighted in this study are relevant across all school settings.

At a school level, principals also highlighted their concerns regarding the selective sampling and recruitment of participants within each school. In response to this concern, cluster random sampling of children in each school was not employed and instead, all pupils were invited to participate in the study. Justifiably, participation in the

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[39] Delivering Equality Of Opportunity In Schools (DEIS). DEIS band 1 schools are schools designated as being in areas of significant social and economic disadvantage

study was dependent on parental (and child) consent. However, given the response rate (46%), a sizeable proportion of children were not involved in the study. It was identified by staff that some children did not receive consent forms as they were absent during those days. Importantly, children with high rates of absenteeism are often the most vulnerable (e.g. HSE, 2011). Whilst additional efforts to include these children were made (e.g. extended return times, additional information provided by the research team, reminders to staff), it is likely that children from the most excluded families were not fully represented. An assessment of children's views on health promotion in general and how they felt the HSP had made a difference in their school may also have proved useful. However, it should be noted that this was considered by the research team but it was decided that as the programme was still in the pilot stage, this may not have added much value to the findings in the short term.

The challenge of incorporating appropriate indicators of success in health promoting school evaluations has been well documented (Inchley, Muldoon, & Currie, 2006; WHO, 1998; NicGabhainn, Barnekow, *et al.*, 2006). A before-and-after assessment of school health is considered a useful way to assess changes in how the school community addresses children's health over time. As the local HS manual already included indicators of school change (the manual audit) based on best-practice, the inclusion of a separate audit in this study was considered an unnecessary burden on participants. Unfortunately, as discussed earlier in this chapter, this audit was never implemented during the implementation period. As noted earlier, this demonstrates again the potentially useful role of collaboration and consultation between researchers and the implementation team at the planning stage. The funding team and HS research team met on a regular basis to discuss evaluation progress. However, whilst the issue of programme fidelity was raised, the funders did not wish to consult with the research team in this way due to concerns regarding evaluation independence.

Not surprisingly perhaps, the manual, in terms of design as well as implementation, was identified as an important influence on how the programme was implemented. However, data on the quality of implementation was limited to the views of stakeholders and steering committee meeting observation notes. Therefore, an objective assessment of manual quality and implementation fidelity was not possible. As many important fidelity and manual quality issues were identified by stakeholders, it is likely

that a more structured approach to these issues would have provided more insight into why these issues arose.

As noted earlier in this chapter, programme implementation progressed at a much slower pace than originally envisaged by the HSP funding team. Unfortunately, there was no flexibility to extend the time-frame due to limited resources. This had implications for the evaluation whereby the relatively short two-year timescale limited the extent to which any multi-level changes could materialise and be measured mainly due to a lack of 'readiness' of both the implementation team and the schools. It is also likely that the period of evaluation was not sufficient to identify other longer term outcomes of health promoting school implementation and, therefore, any possible sleeper effects (Barlow *et al.*, 2007). Fixsen, Blase, Naoom and Wallace (2009) note a general implementation time-frame guideline of two to four years to properly establish an operational innovation. More collaborative engagements between the evaluation and implementation teams during the planning stage may have helped to clarify the 'readiness' of the HSP.

The variability in the number of children who responded to each question was also a limitation of the study, albeit one that is not uncommon in these kinds of evaluations. These non-responses may indicate that some children found aspects of the survey challenging. As discussed in Chapter 4, individual competency is also an important consideration. Whilst a number of measures were put in place to enhance data quality, variability in ability may have contributed to this limitation. Nevertheless, a comparison of demographic characteristics between 'completers' and 'non-completers' revealed no differences. Thus, it seems likely that the conclusions drawn from the analysis were not likely to have been influenced by this issue.

10.5 Implications for policy and practice

Collectively, the findings of this study emphasise both the potential benefits and challenges of developing and implementing a health promoting school initiative in an Irish context as well as internationally. As Bronfrenbrenner (1998) maintains, one component of child health cannot be addressed in isolation and the more holistic approach underpinning the health promoting school model/ethos clearly offers an opportunity to address the health needs of children more effectively and

comprehensively. The school setting provides a particularly unique opportunity to address the physical and mental health needs of most young children (Fazel, 2014). The HPS model is useful in that it takes a universal approach to health promotion whilst permitting the development of targeted/indicated interventions and prevention initiatives where appropriate. In this way, this model takes a positive approach to well-being as opposed to developing solely a model of therapeutic education aimed at, for example, tackling social and emotional learning (see Ecclestone & Hayes, 2009).

Many components of the HSP model reflect current governmental policy regarding children's well-being (i.e. "Better Outcomes Brighter Futures"; Department of Children and Youth Affairs, 2014; "Well-being in Primary schools"; Department of Education, Health Services Executive & Department of Health, 2015). Thus, the HSP, if implemented in an effective way, provides a potential framework for addressing key targets of this policy document. In particular, the HSP health promotion ethos supports a universal, early prevention approach and other key objectives of governmental strategy, such as the expansion of cross-discipline collaboration, improved child services, enhanced staff training and support, and increased parental involvement. A health promoting schools approach also endeavours to be child-centred by involving children in health-related decision making and planning so, whilst not clearly evidenced in the current context, the HSP model could be revised to ensure the development of such inclusive health planning in schools.

Prior to these recent governmental policy documents supporting a HPS framework (i.e. Department of Children and Youth Affairs, 2014; "Well-being in Primary schools"; Department of Education, Health Services Executive & Department of Health, 2015), the health promoting school approach has already been endorsed at both a national (e.g. HSE, 2011) and international policy level (e.g. WHO, 1997; 2007). However in an Irish context, health and education services have traditionally not worked collaboratively together. Thus, it is not surprising that the school staff in the current study had reservations about engaging with an innovative approach such as the HSP. However, whilst educationalists are concerned with the potential burden that this approach may place upon staff, many studies acknowledge the two-way relationship between health and education which emphasises the importance of health for achieving academic potential as well as the importance of education in addressing health inequalities

(Symons *et al* 1997; UK Department of Health 2002; Office of National Statistics 2002).

The lack of enthusiasm for, and engagement with, the HSP amongst school staff suggests a need to provide greater incentives to schools to encourage them to begin considering and implementing a HSP approach. Efforts have been ongoing since the 1990s to develop an Irish Network of Health Promoting Schools to support schools in this way (Nic Gabhainn & Kelleher, 1998). The HSP manual author was central in evaluating the first phase of this network (i.e. Lahiff, 1999). However, progress has since slowed down and only recently has a new national HPS strategy been established (HSE, 2013). Up until recently there were only a few isolated examples of initiatives which aim to incorporate a health promoting school approach (e.g. Cork Network of Health Promoting Schools). Without national level support, these appear to have been based more on the enthusiasm and interest of selected individuals/champions rather than an established and sustainable model.

By contrast, in the UK HSP model, the regional HSCs are available to guide and support schools in their endeavour to incorporate a HSP ethos in their schools (Arthur *et al.,* 2011). However, the involvement of the UK Department of Education and Skills as well as the Department of Health is central to the success of this approach. In Ireland, without similar levels of support and endorsement, health promoting school initiatives such as the HSP, which aim to address broader health issues (e.g. school ethos, school-service links, policy etc.), will remain limited in scope. Encouragingly however, the launch of this new HPS strategy through both the Department of Health and Department of Education, aims to deliver a framework for HPS roll-out nationally[40]. The future establishment of a national HS award system by means of such a network as in other countries (e.g. Lee 2009; Schagen *et al.*, 2005) could further provide a useful incentive and support structure for schools. For example, in the current context, positive feedback regarding the national Active Flag award[41] demonstrates the potential of a similar award system for developing health promoting schools throughout Ireland.

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[40] See https://www.healthpromotion.ie/health/schools
[41] http://www.activeschoolflag.ie/index.html

If, as suggested in policy documents, Irish governmental policy aims to incorporate a health promoting school ethos into Irish schools (e.g. HSE, 2011; HSE, 2013), then a clear message from relevant Departments to schools is needed. The Social Personal and Health Education (SPHE) curriculum has, in many ways, attempted to address health promotion in schools (Geary & McNemara, 2003; NicGabhainn, O'Higgins, & Barry, 2010; O'Higgins *et al.,* 2007). However, whilst elements of a health promoting school ethos such as health-related policy developments (Millar, 2003) and school-service partnership development (Burtenshaw, 2003) have been incorporated into SPHE, it appears to have developed into a curriculum-focused model rather than incorporating all elements of a health promoting school ethos (NicGabhainn, O'Higgins & Barry, 2010). The development of an effective HPS strategy will be determined by the enthusiasm of leaders for an evidenced-based model. The development of links between HPS and existing organisations could further support the establishment of an effective model of HPS. For example, in the current study, a lack of training and understanding, amongst principals, of HPS and its implementation, was identified as a key barrier to its success. This could be addressed by providing training opportunities to HSP implementation teams through support and training organisations such as Meitheal[42]. [Meitheal is a training and support agency tailored specifically to the needs of community development organisations].

In a similar way, a lack of effective partnership working between health and education services at a national level has clear implications for service quality. Indeed, school-health service collaboration was identified by most staff as a health priority. In particular, many respondents believed that the way in which schools addressed children's health was negatively impacted by a lack of communication between services. The HSP attempted to address this issue but again, without clear national-level policies and practice-based protocols and policies concerning communication between health and education services, any progress was limited and beyond the capacity of the HSP implementation team. These findings again point to the importance of ensuring that existing health education policies are implemented in practice (i.e. Department of Children and Youth Affairs, 2014; HSE, 2011). According to members of the funding team this lack of progress seems to be primarily a result of services re-organisation,

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[42] http://www.meitheal.ie/services.php

staff changes and reductions as well as budgetary restrictions. Clearly departmental enthusiasm and buy-in is essential for the realisation of demonstrable improvements. Indeed, the development of functioning cross-sectoral collaboration will depend on the ability of policy-makers to address the issue of system blockage (Downes, 2014).

The HSCs clearly invested considerable effort in developing health promoting practices and activities in the schools. However, many respondents acknowledged that the issue of psychological health required a more structured and evidence-based approach than was provided through the HSP. Indeed, a number of authors (e.g. Lee *et al.,* 2007; Marshall, Sheehan, Northfield, Maher, Carlisle & St. Leger, 2000) suggest that effective topic-specific projects should be established in a coherent way within the wider health promoting school framework to address mental health (amongst others). This approach has already been incorporated in other similar initiatives with regards to some aspects of health, such as healthy eating (Laurence, Peterken, & Burns, 2007; Shi-Chang *et al.,* 2004).

In an Irish context, as mentioned earlier in this section, the national Active Flag award has developed in this way. Interestingly, interviewee feedback in the current study suggests that this initiative was incorporated successfully in participating schools that wished to address physical health through the HSP. Unfortunately however, no equivalent award currently exists in Ireland to support schools in addressing psychological health. In the absence of this kind of support or the provision of an evidence-based mental health-specific initiative, it proved challenging for the HSP to address psychological health in a coherent, consistent and effective way. Furthermore, whilst a universal school-level approach to health is useful, a child-centred approach to psychological health is also important. In this way, where appropriate, evidenced-based targeted/indicated interventions should continue to be delivered in schools within the guiding framework of a HPS model. Going forward, this approach to the HSP may provide the necessary structure that was clearly absent in the current context. However, there is little literature that explicitly examines similar approaches to mental health within the wider health promoting school framework. However, a number of evidence-based mental health specific initiatives that fit within such an ethos have been evaluated and found to be effective in addressing the psychological needs of children (e.g. Zippy's friends, Bale & Mishara, 2004; Clarke & Barry, 2010; Social Emotional Aspects of

Learning; DfES, 2005, Hallam, Rhamie & Shaw, 2006 PATHS, Greenberg *et al.*, 1995; Al's Pals, Greenberg *et al.*, 1995; Lynch & McCracken, 2001; Lynch *et al.*, 2004). Whilst none of these studies espouse a school-led prioritisation of need (given their pre-determined topic-focused nature), many implement similar values and components of a health promoting school approach and can be adapted to address the needs of specific groups of children. It could be beneficial if, in the future, some of these evidence-based initiatives were recommended and implemented by the local HSP. Programmes such as these, if implemented as part of the HSP, are likely to provide schools with a more coherent and structured approach to mental health promotion than the current HSP manual/process allows. A summary of additional challenges experienced in the HSP and possible remedial actions are presented in table 10.1 below.

Table 10.1 Summary of system blockages experienced and preventative actions

	System blockages to avoid in future	Action	Review and evaluation
School Level Factors	Divergent views of programme and manual implementation	• HPS Training provided to all stakeholders prior to and during implementation • Agreement by all stakeholders of core components HSP ,aims and objectives and, roles and responsibilities • Manual based on HPS evidence-based principles and practices that also includes a clear implementation framework	Clear and accountable self-review process of all stages of implementation (i.e. exploration, planning, implementation and embedding) in terms of HPS best practice. Transparent account of process of adaption and improvement throughout implementation
	HSC role	• HSC to be recruited from, or trained in, HPS principles and implementation • Clearly defined and simplified HSC role • School-based role managed/supported by HSE Health Promotion service	
	Lack of buy-in and ownership by school community	• Memorandum of agreement approved by all stakeholders • Training in HPS practices provided to stakeholders • Establishment of school-level committee and completion of school self-audit first steps in programme implementation	
	Parents not sufficiently involved in planning (only activities)	• Inclusive steering committees • Training to stakeholders on inclusive and democratic planning and implementation practices (e.g. through organisations such as Meitheal)	
	Tendency to implement health education not school-level change (e.g. policies)	• Structured and continuous process of review and revision of implementation to reflect HPS best-practice • Ongoing training in HPS practices for stakeholders • Establishment of support and consultation service by HSE health promotion agency	
	Staff turnover	• Training in the Healthy Schools Programme and HPS implementation to be provided on a regular basis • Establishment of school-level committee at outset to ensure implementation planning is not dependent on individuals	
	Workload concerns for teachers	• Roles and responsibilities agreed at outset of implementation	
	Cross-school committee over-involvement	• Roles and responsibilities to be agreed at outset of implementation • School-level committee established as a first step	
	Disempowering role of staff	• School-based steering committee to include staff representation • Role of cross-school support service limited to consultation role via school-level committee	
	Funder-led not school owned	• Establishment of inclusive and democratic school-level committees • Annual school self-audit of health priorities to guide implementation	
	Most vulnerable families not engaged	• Family representation on planning committees • Cross-service consultation and support structure established with in-school HSP committees (i.e. home-school liaison service, school completion service)	
Governmental Factors	No official endorsement by Department of Education and Skills	• The HSP incorporated as part of the national strategy for HPS and developed in collaboration with both the Department of Health and Department of Education	
	Lack of quality label for psychological health promotion practices	• Establishment of psychological health-focused initiative similar to the 'Active Flag' award	
	Mental health perceived as particularly challenging, complex, and sensitive by	• Additional training and supports to be provided to schools on mental health promotion via HSE Health Promotion Service • Development of HPS national website to include information detailing in what ways the HPS	

10.6 Directions for future HSP implementation and research

This study drew upon existing models of implementation to highlight the facilitating and inhibiting factors that arose during the evaluation period (Burke *et al.,* 2012). The process evaluation findings from this study also clearly highlight the value of introducing a new innovative programme through an evidence-based implementation protocol. This is particularly important in the current context considering the complexities inherent in the implementation of health promoting school initiatives more generally. The use of an evidenced implementation science framework by implementation teams as a tool for self-assessment and quality control may provide a way of addressing key challenges and limitations of newly established initiatives (Damschroder *et al.,* 2009). It is likely that many challenges experienced by the HSP funding team and HSCs in the current study could have been addressed if such an approach to implementation was adopted by the HSP funding team and Steering Committee. For example, it was evident in the current context that insufficient programme planning had occurred which had negatively impacted on programme implementation in a number of significant ways including a lack of appropriately experienced staff, a poorly developed shared understanding of HSP, an absence of clear roles and responsibilities and no memorandum of agreement. Similarly, it was apparent that the longer term benefits and sustainability of some components of the HSP (e.g. the role of HSC, HSP funding for activities) were perhaps not considered sufficiently. The implementation of practices that were highly unlikely to be sustainable beyond a limited funding period raises issues about their ultimate value.

The findings suggest that programme planning and implementation itself would have been more effective if stakeholders applied such a structured approach to the implementation process (Burke *et al.,* 2012). For example, Damschroder and colleagues (2009) constructed an implementation typology, the Consolidated Framework for Implementation Research (CFIR), from their review of the literature which identifies the primary factors influencing implementation success. These factors include: the broader context; the individual setting; the nature of the implementation team and; the nature of the project itself (Chaudoir *et al.,* 2013). The incorporation and consideration of such factors by implementation teams is likely to more effectively support the effective progression of innovative initiatives like health promoting school. The complexity of health promoting school initiative implementation has been demonstrated throughout

this study and the application of this framework could help structure implementation and consider potential barriers and facilitators in a systematic way.

As indicated earlier, an effective working partnership between stakeholders is an important influencing factor in the successful development of a setting-based multi-discipline initiative (Brown & White, 2006; Dowling, Powell, & Glendinning, 2004). For example, in the current study the relationship between the external implementation team and the school community was clearly important in the development of school 'buy in' and in generating overall enthusiasm for the programme. Thus, an analysis of such relationships prior to, and during, the introduction of an innovative initiative like the HSP may help to identify and tackle barriers to implementation on an ongoing basis. Indeed, the school culture itself is another important yet often neglected consideration in the implementation of health promoting school initiatives. For instance, the support for staff by school management as well as staff attitudes have been found to impact on staff confidence as well as staff development efforts (Bommer *et al*, 2005; Kurt *et al.,* 2011). Similarly, the role of the family in school life and how family members can contribute to health initiatives in an empowered way is also an issue that requires further exploration. Exploration of the role of children in the development of a health promoting school ethos in schools could also provide some interesting insights into how these kindf of initiatives can truly achieve an inclusive and democratic school-led approach to health (Simovska, 2012).

The findings of the current study demonstrate that across schools, psychological health was clearly a priority issue but one which was particularly challenging for schools to address. Thus, it is likely that school communities require more support and guidance to address psychological health than might be necessary for other aspects of health, such as nutrition and diet. Despite this, very few studies have examined how and to what extent health promoting school initiatives address psychological health. Many studies purport to examine psychological health interventions which espouse similar values but few demonstrate how such initiatives adhere to the core principles of a WHO conceptualisation of a health promoting school (Stewart-Brown, 2006). More mixed method longitudinal comparative studies may demonstrate how health promoting school initiatives can best support schools' capacity to address psychological health. Importantly, as discussed earlier, process evaluation studies are key to identifying

facilitative and inhibiting factors that school communities need to consider in their attempts to address psychological health through a health promoting school approach. In addition, more detail on programme content in evaluation studies is essential to allow more meaningful comparisons and evaluations of programme quality. Similarly, few studies have examined the cost-effectiveness of the health promoting school in primary schools (Stewart-Brown, 2006) so this is a clear gap in our knowledge. Such information is essential to accurately inform policy and decision makers on how to best address children's health.

10.7 Conclusion

This mixed method study provides important insights into the impact, and process of implementing, the *Healthy Schools Programme* with a particular focus on the psychological health and well-being of primary school-aged children living in urban disadvantaged areas in Ireland. By so doing, the findings represent an important addition to the national and international literature.

The findings of the impact evaluation showed that, whilst some improvements in children's outcomes were identified, most occurred in *both* the Intervention and Comparison schools, thereby suggesting that the HSP did not impact on children's health in any significant way, or at least not within the two-year study time-frame. Additional findings showed that, over time, children who reported the highest level of depressive symptoms also demonstrated the most improvements. The study also indicated that a substantial proportion of children had been victims of bullying.

The qualitative findings from the process evaluation component of the study, suggest that whilst there had been some positive changes in how schools addressed health in the short-term, these were not demonstrated by any measurable changes in health outcomes over time. Importantly, these findings also highlighted the slow and evolving nature of programme implementation. Psychological health, in particular, had not been addressed by the HSP until the second half of the implementation period. However, psychological health, once prioritised, was identified as one of the most challenging and complex health issues to address (e.g. compared to nutrition and physical activity). Thus, there appeared to be a reluctance by both the funding team and school principals to address

this issue through the programme. This suggests that psychological/emotional well-being is likely to require more careful consideration when implementing health promotion initiatives such as the HSP. Not surprisingly, therefore, it was not possible to demonstrate any changes in children's psychological health outcomes that could be directly attributed to the HSP within the time-frame of the study. It is also likely that such changes may take longer to materialise and may only be apparent within the framework of a longer term follow-up study.

The results of this study further illustrate that a number of fundamental implementation 'enablers' are central to the development of the kind of HSP model that is relevant to, and can effectively support, the needs of schools. These include: a shared understanding of the initiative, a school-led approach, and inclusive collaboration with all stakeholders. The sustainability of the work was also identified as a key challenge, as was the importance of a fully functioning national health promoting school framework with appropriate governmental support. In addition, the more specific issue of school-health service collaboration was highlighted as something which needs to be addressed effectively at a national level before initiatives such as the HSP can be successfully integrated within schools.

Most importantly of all perhaps, the findings reported here underline the need to assemble a HSP implementation team whose members have an accurate and shared understanding of the fundamentals of health promoting school theory and implementation from the outset. Indeed, the application of a more structured approach to implementation was also illustrated here. In particular, the importance of coherent planning as well as an effective implementation review process, were identified as essential to programme success. The implementation challenges identified here highlight the limitations of the Bronfrenbrenner model as a theoretical framework underpinning HPS initiatives. Whilst the model aptly illustrates the complexity of factors that influence children's lives, it is limited in terms of how it explains the dynamic interplay between these and how they can affect a child's well-being. For example, system blockages, such as the lack of collaboration between health and education services and existing power-relations (e.g. children/parents and school staff), all play an important role in successful implementation and, therefore, need to be considered and developed, in more depth than in Bronfrennbrenner's model.

On a more practical level, the findings reported here highlight a number of implications for policy and practice as well as some key recommendations for future research. It must also be noted that the wider literature described and critiqued in this thesis, highlights the potential utility of health promoting school initiatives, when implemented effectively, as an approach that can support schools in addressing children's psychological health (and other aspects of health) in a comprehensive and sustainable way.

This study brings further 'added value' by bringing together issues of mental health with social inclusion in education. Whilst some of these may be peculiar to an Irish context, the qualitative findings provide important additional insights into the implementation of health promoting school initiatives more generally. In particular, the current study clearly demonstrates the complexity and challenges involved in - and key enablers and barriers to - planning, developing, implementing and sustaining a HSP initiative. In so doing, the findings suggest a number of key lessons for schools and policy makers both in Ireland and elsewhere, that should be helpful in terms of identifying how best to plan, design and implement these kinds of initiatives (across a range of settings) in an appropriate and effective way.

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APPENDICES

APPENDIX 3.1

Key search terms, journal titles and health promotion websites identified as relevant to the evaluation of health promoting school programmes

Table A3.1A: Key search terms of the literature review

Key term	Sub key-term	Key term were combined with search terms		
		Sample	Setting	Intervention key word
Health promotion	Emotional health	Children	School	Promotion
Mental health	Emotional well-being	Young people	Primary school	Intervention
promotion	Psychological health	Youth	Elementary	Program
Health Promoting	Psychological well-		School	Implementation
School	being		School-based	Evaluation
Coordinated School	Mental health		Settings	Initiative
Health	Mental well-being		approach	Whole school
Program	Mental health			approach
	Promotion mental			Manualised
	health			Manualized
	Positive mental			
	health			

Table A3.1B: Individual journals for which an individual search was undertaken

Journal title
Health Promotion International
Health Education
Health Education Research
Health Education Journal
Health Development and Health Promotion Practice
International Journal of Mental Health Promotion and Global Health Promotion (formally titled Promotion and Education)
Journal of School Health

Table A3.1C Health promotion websites searched

Health promotion website
World Health Organisation Global Health School Initiative
The Irish Department for Health and children
The Irish Department of Education and Science
Health Behaviour in School-Aged children
The Kidscreen group
UK Office for Standards in Education
Children's Services and Skills (Ofsted)
Schools for Health in Europe (SHE)
American School Health Association
International Union for Health Promotion and Education (IUHPE)

Parent/Guardian Letter of Invitation
The Evaluation of the *Healthy Schools Programme*

13[th]June

2009

Dear Parent/Guardian,

Your child's school has been selected to take part in an evaluation of a new type of partnership between the Health Services Executive (HSE) and schools called the *Healthy Schools Programme*. This programme aims to prevent significant health problems in primary school children and is currently being piloted in five schools in the Dublin area. To see how well this programme works we need to compare these schools to others in which the programme has not yet begun and your school has been selected to join this evaluation project. By taking part in this evaluation your child will be given a comprehensive physical and psychological assessment. This evaluation will involve assessing the health of your child over a three year period. If any health concerns are highlighted by these assessments, you will be informed and given information on how best to access services for your child.

Participation is entirely voluntary, however this is a very important study on the health and well-being of school-aged children and the results of this study will be much stronger if we have a large number of participants. Therefore, we would be most grateful if you would consider allowing your child to take part in the health questionnaires and measurements. If possible, we would also appreciate your participation in answering some questions relating to your child's health too. Please find attached a detailed information sheet on the study and what it involves.

All of your information will be treated in strict confidence. You or your child may decide to withdraw from the study or withdraw your information at any time. Should you agree to your child participating in the study, please sign the attached consent form and return it to the collection box in your child's classroom. If you have any questions, please do not hesitate to contact me, or another member of the research team at 087 xxxxxxx.

Many thanks.
Yours faithfully,

APPENDIX 4.1.B

What is the study about?

The Healthy Schools Programme aims to demonstrate a new type of partnership between the Health Services Executive and schools with a view to preventing significant health problems amongst primary school children.

The aim of our research project is to carry out an evaluation of this Healthy Schools Programme and its implementation in a number of schools in Dublin.

To see how well this programme works we need to compare schools operating the Healthy Schools Programme to schools in which the programme has not yet begun. Recently, your school has been selected to join this study as a comparison school.

Children who take part in this evaluation will be given a free health assessment by trained researchers and nurses. If any health issues are highlighted by this assessment, you, as the child's guardian will be fully informed via your school principal

Do children have to participate in this study?

No. Participation is completely voluntary. However this is a very important study. With your involvement, we can establish how useful the Healthy Schools Programme will be in

all schools. We can identify those parts of the programme which are helping to improve the health of children and also establish which parts of the programme might need more work. You or your child may decide to withdraw from the study or withdraw your information at any time without consequence

What if my child I do not participate?

Whether or not you or your child participates in, or withdraws from the study will not affect your child in any way as involvement is completely voluntary.

What does the study involve?

If your child takes part in the study they will be asked to fill in a questionnaire (first class and above) about their health, wellbeing, food preferences, and social activities. The questionnaires will be completed by your child during school time in the presence of a researcher with experience of working with children. Parent/guardian of younger children (junior and senior infants) will be contacted at a time suitable to them to fill in the questionnaire on their child's behalf. This can be done over the phone or at the school.

These questionnaires will be completed once a year over three years to find out if the Healthy Schools programme

affects the overall health of primary school-aged children.

If your child has any additional needs they will have the assistance of a school staff member or researcher in completing the questions. If you agree for your child to participate you will have an opportunity to highlight any particular concerns or requests on the agreement form.

Also, during P.E. class your child will be asked for some physical measurements. These will include height, weight and waist measures. This will be carried out in privacy with only a nurse and researcher present. You are very welcome to attend this short P.E. break if you wish. All children will receive a Healthy Schools 'participation certificate' for being part of a Healthy School

Finally, with your consent, dental and immunisation records will also be accessed through the public health nurse.

From these results, we can find out much more about the health of school-aged children than would be possible with questions on nutrition and lifestyles only.

Are there any risks involved?

There are no known risks involved in this study. Every effort will be made to explain each stage of the study to your child. At all times, the well-being of your child will be the priority. If your child verbally or non-verbally expresses a wish not to participate, or decides to withdraw, their decision will be fully respected.

Is the study confidential?

Yes. All the information from the study will be treated as strictly confidential and the name of your child will not be disclosed to anyone outside the research team. The survey has been approved by the Faculty of Health Sciences Research Ethics Committee, of Trinity College Dublin, which checks that proper safeguards are in place. If however as a result of these assessments it is believed that your child needs medical or further attention, you will be informed of this immediately via the school principal.

This study is being carried out by scientific researchers who have extensive experience in working with children and in healthcare research. The study team comprises:

- Researchers
- Doctors
- Psychologists
- Service Providers
- Family Members
- Teachers
- Children's Nurses

What if I have any other questions?

If you have any questions or would like more information about the study, please do not hesitate to call or email the Research team below.

Contact name: xxxxxxx

Mobile: 087 xxxxxxx
E-mail: xxxxxxxxxxxxxxxxxxx

Trinity College Dublin

An evaluation of the *Healthy Schools Programme* for the Tallaght West Childhood Development Initiative

Parent Information Leaflet

CDI

Childhood Development Initiative

NUI MAYNOOTH
Ollscoil na hÉireann Má Nuad

Who is involved in the study?

What is the study about?

The Healthy Schools intervention aims to demonstrate a new type of partnership between the Health Services Executive and schools with a view to preventing significant health problems amongst primary school children. The aim of our research project is to carry out an evaluation of this Healthy Schools intervention and its implementation in a number of schools in Dublin.

To see how well this intervention works we need to compare schools operating the Healthy Schools programme to schools in which the programme has not yet begun. Recently, your school has been selected to join this study as a comparison school.

Children who take part in this evaluation will be given a free physical and psychological assessment by trained researchers. If any health issues are highlighted by this assessment, the child's guardian will be contacted and will be given support on how to access the relevant services if needed.

Do children have to participate in this research study?

No. Participation is completely voluntary. However this is a very important study. With the child's involvement, we can establish how the Healthy Schools intervention is progressing. From this, we can identify

Are there any risks involved?

There are no known risks involved in this study. Every effort will be made to explain each stage of the study to the child. At all times, the well-being of the child will be the priority. If the child verbally or non-verbally expresses a wish not to participate, or decides to withdraw, their decision will be fully respected.

Is the study confidential?

Yes. All the information from the study will be treated as strictly confidential and the name of the child will not be disclosed to anyone outside the research team. The survey has been approved by the Faculty of Health Sciences Research Ethics Committee, of Trinity College Dublin, which checks that proper safeguards are in place. If however as a result of these assessments it is believed that the child needs medical or further attention, the parent will be informed of this immediately via the Healthy Schools coordinator, or the school principal.

/ho is involved in the study?

those parts of the intervention which are helping to improve the health of children and also establish which parts of the intervention that might need more work. The child may decide to withdraw from the study or withdraw their information at any time without penalty.

For children to participate in the study parental consent will first be obtained. In accordance with Trinity Ethical policy, information leaflets will first be given out to children to bring home. Soon after this consent packs will be distributed to children.

Parents/guardians, if willing to partake in the study, will be asked to return their consent form via their children to a consent return box available in each classroom.

What if the child does not participate?

Whether or not the child participates in, or withdraws from the study, will not affect the child in any way.

What does the study involve?

This is a longitudinal evaluation and data pertaining to the children's health will be collected once a year over three years. Children in 1st class and above will be asked to fill in a questionnaire about their health, wellbeing, food preferences, and social activities. This will be completed in the school at a time convenient for you. In-class assessments will take 45 minutes.

This study is being carried out by scientific researchers who have extensive experience in working with children and in healthcare research. The study team comprises:

- Researchers
- Doctors
- Psychologists
- Service Providers
- Family Members
- Teachers
- Children's Nurses

What if I have any other questions?

If you have any questions or would like more information about the study, please do not hesitate to call or email the Healthy Schools research team.

Contact name: xxxx

Tel: 087 xxxxxxxx
E-mail: xxxxxxxxxxxx

Trinity College Dublin

The parents/guardians of children in junior and senior infants will be contacted by phone (or at the school if more convenient) and asked questions by the interviewer on similar topics as the older children. This will be done in a sensitive and confidential manner.

If a child has any additional needs they will have the assistance of a researcher (or if feasible a school staff member) in completing the questions. Parents/guardians will also have an opportunity to highlight any particular concerns or requests on the consent form.

In addition, with the guardian's consent, dental and immunization records will also be accessed through the public health nurse.

Also, at a suitable time during P.E. class, physical health measurements will be taken by our paediatric nurses. These will include height, weight and waist circumference and will be completed in a private manner. The parent/guardian will be invited to attend if they wish. All children will receive a 'participation certificate' for being part of the assessment.

From these results, we can find out much more about the health of school-aged children than would be possible with questions on nutrition and lifestyles only.

healthy schools

An evaluation of the *Healthy Schools Programme* for the Tallaght West Childhood Development Initiative

Teacher Information Leaflet

CDI
Childhood Development Initiative

NUI MAYNOOTH
Ollscoil na hÉireann Má Nuad

Healthy Schools Evaluation
Parent/Guardian Consent Form (Comparison School)

This research aims to evaluate the implementation of the *Healthy Schools programme* and its impact on the well-being of children, their families, and their communities. Evaluating the *Healthy Schools programme* will involve assessments of the children's social, emotional, physical and nutritional health. Your school has been invited as a comparison school to participate in this study and so the children of your school can also avail of these assessments.

By participating in this study, you are agreeing for you and your child to be asked questions about your child's psychological and physical health, and their diet. Children in 1st class and above will answer these questions in school during class time. If your child has any additional needs (such as literacy difficulties) we invite you to highlight your concerns below so that we may provide extra support during assessment time.

All children will also have their weight, height, and waist measurements taken, privately, in the presence of a children's nurse. As their parent/guardian, you may also be contacted by phone or at the school and asked questions relating to your child's health. This information will be collected once a year beginning in June 09 and will continue for most children over the next 2 years.

All information and your child's identity will remain confidential. Your name and your child's name will not be published or disclosed to anyone outside the research team. Access to any information relating to your child will be fully accessible to you upon request. This information will only be held for purposes of the research study. If as a result of the assessments or measurements it is believed that your child needs medical or further attention you will be informed of this via the principal.

Parent/Guardian Declaration:
I have read, or have had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to support my child to be part of this research study. I understand that my child or I may withdraw from the study or withdraw our information from the study at any time without penalty.

Please sign below to indicate that you are willing to support this study by agreeing that you and your child can participate in the questionnaires and measurements.

I voluntarily give my agreement for (   ) to participate in this study without prejudice to their legal and ethical rights. I (   ) also agree to be contacted by a researcher at a time that is convenient for me.

Your Signature: _____Date: _____

Phone number (s): _____

Best day and time to call: _____

Any requests or concerns regarding your child's needs (i.e. literacy difficulties):

APPENDIX 4.1E

Parent/Guardian Letter of Invitation
The Evaluation of the *Healthy Schools Programme*

09th   June 2009

Dear Parent/Guardian,

Your child's school has been selected to take part in a brand new type of partnership between the Health Services Executive (HSE) and the school with a view to establishing a strong link between education, health and social care. The school is implementing a Healthy Schools early intervention programme through a 'healthy school co-ordinator' working with the principal, the teachers and families to improve children's health and increase their access to primary care services.

We would like to invite your child to take part in an evaluation of this *Healthy Schools programme*. This evaluation will involve assessing the health of your child over a three year period. The evaluation will also review how the programme is being run and what possible changes can be made to the programme to improve its impact on the health of primary school children.

Participation is entirely voluntary, however this is a very important study on the health and well-being of school-aged children and the results of this study will be much stronger if we have a large number of participants. Therefore, we would be most grateful if you would consider allowing your child to take part in the health questionnaires and measurements. We would also appreciate your participation in answering questions relating to your child's health and your views on how the programme is being run. By providing your views on the programme, we can identify the parts of the programme which are successful in improving the health of children and also areas that need further development. Please find attached a detailed information sheet on the study and what it involves.

All of your information will be treated in strict confidence. You or your child may decide to withdraw from the study or withdraw your information at any time without prejudice. Should you agree to your child participating in the study, please sign the attached consent form and return it to the collection box in your child's classroom. If you have any questions, please do not hesitate to contact me, or another member of the research team at 087 6193106.

Many thanks.
Yours faithfully,

What is the study about?

The aim of this research is to carry out an evaluation of the Healthy Schools Programme and its implementation in a number of primary schools in Tallaght West.

The Healthy Schools Programme aims to demonstrate a new type of partnership between the Health Services Executive and schools with a view to preventing significant health problems amongst primary school children.

Five schools will set up a health promotion and early intervention programme through a 'healthy school coordinator' who works with the children, school principal, teachers and families to improve children's physical and emotional health and increase their access to primary care services.

Do children in schools with the Healthy Schools Programme have to participate?

No. Participation is completely voluntary. However this is a very important study. With your involvement, we can establish how the Healthy Schools Programme is progressing. In doing so, we can identify those parts of the programme which are helping to improve the health of children and also establish which parts of the programme might need more work. You or your child may decide to withdraw from the study or withdraw your information at any time without consequence.

What if my child or I do not participate?

Whether or not you or your child participates in, or withdraws from the study, will not affect your child in any way, or the service they receive from the Healthy Schools Programme.

What does the study involve?

If your child takes part in the study they will be asked to fill in a questionnaire (first class and above) about their health, wellbeing, food preferences, and social activities. The questionnaires will be completed by your child during school time in the presence of a researcher with experience of working with children. Parent/guardian of younger children (junior and senior infants) will be contacted at a time suitable to them to fill in the questionnaire on their child's behalf. This can be done over the phone or at the school.

These questionnaires will be completed once a year over three years to find out if the Healthy Schools programme improves the overall health of primary school-aged children.

If your child has any additional needs they will have the assistance of a school staff member or researcher in completing the questions. If you agree for your child to participate you will have an opportunity to highlight any particular concerns or requests on the agreement form. This will be sent to you in the near future.

Also, during P.E. class your child will be asked for some physical measurements. These will include height, weight and waist measures. This will be carried out in privacy with only a nurse and researcher present. You are very welcome to attend this short P.E. break if you wish. All children will receive a Healthy Schools 'participation certificate' for being part of a Healthy School.

From these results, we can find out much more about the health of school-aged children than would be possible with questions on nutrition and lifestyles only.

Parents are also invited to participate in the evaluation of the effectiveness of the healthy schools programme. With your help we can identify the parts of the programme which are successful in improving the health of children and also establish which parts need further development. This will involve an interview with a small group of parents/guardians to hear your views.

Are there any risks involved?

There are no known risks involved in this study. Every effort will be made to explain each stage of the study to your child. At all times, the well-being of your child will be the priority. If your child verbally or non-verbally expresses a wish not to participate, or decides to withdraw, their decision will be fully respected.

Is the study confidential?

Yes. All the information from the study will be treated as strictly confidential and the name of your child will not be disclosed to anyone outside the research team. The survey has been approved by the Faculty of Health Sciences Research Ethics Committee, of Trinity College Dublin, which checks that proper safeguards are in place. If however as a result of these assessments it is believed that your child needs medical or further attention, you will be informed of this immediately via the Healthy Schools coordinator, or the school principal.

This study is being carried out by scientific researchers who have extensive experience in working with children and in healthcare research. The study team comprises:

- Researchers
- Doctors
- Psychologists
- Service Providers
- Family Members
- Teachers
- Children's Nurses

What if I have any other questions?

If you have any questions or would like more information about the study, please do not hesitate to call or email.

Contact name: xxxxx

Tel: 087 xxxxxxx
E-mail: xxxxxxxxxx

healthy schools

An evaluation of the *Healthy Schools Programme* for the Tallaght West Childhood Development Initiative

Parent Information Leaflet

CDI

Childhood Development Initiative

NUI MAYNOOTH
Ollscoil na hÉireann Má Nuad

Trinity College Dublin

Who is involved in the study?

What is the study about?
The aim of this research is to carry out an evaluation of the Healthy Schools Programme and its implementation in a number of primary schools in Tallaght West. The Healthy Schools Programme aims to demonstrate a new type of partnership between the Health Services Executive and schools with a view to preventing significant health problems amongst primary school children.

Five schools will set up a health promotion and early intervention programme through a 'healthy school coordinator' who works with the children, school principal, teachers and families to improve children's physical and mental health and increase their access to primary care services.

Do children in schools with the Healthy Schools Programme have to participate?
No. Participation is completely voluntary. However this is a very important study. With the child's involvement, we can establish how the programme is progressing. In doing so, we can identify those parts of the programme which are helping to improve the health of children and also establish which parts of the programme might need more work. The child may decide to withdraw from the study or withdraw their information at any time without consequence.

Teachers may also be invited to participate in a focus group to hear your views concerning the effectiveness of the healthy schools programme. With your help we can identify the parts of the programme which are successful in improving the health of children and also establish which parts need further development.

Are there any risks involved?
There are no known risks involved in this study. Every effort will be made to explain each stage of the study to the child. At all times, the well-being of the child will be the priority. If the child verbally or non-verbally expresses a wish not to participate, or decides to withdraw, their decision will be fully respected.

Is the study confidential?
Yes. All the information from the study will be treated as strictly confidential and the name of the child will not be disclosed to anyone outside the research team. The survey has been approved by the Faculty of Health Sciences Research Ethics Committee, of Trinity College Dublin, which checks that proper safeguards are in place. If however as a result of these assessments it is believed that the child needs medical or further attention, the parent will be informed of this immediately via the Healthy Schools coordinator, or the school principal.

For children to participate in the study parental consent will first be obtained. In accordance with Trinity Ethical policy, information leaflets will first be given out to children to bring home. One week later consent packs will be distributed to children.

Parents/guardians, if willing to partake in the study, will be asked to return their consent form via their children to a consent return box available in each classroom. To improve child participation, a member of the research team will visit each class during this period to remind children to ask their parents to return the consent forms.

What if the child does not participate?
Whether or not the child participates in, or withdraws from the study, will not affect the child in any way, or the service they receive from the Healthy Schools Programme.

What does the study involve?
This is a longitudinal evaluation and data pertaining to the children's health will be collected once a year over three years. Children in 1st class and above will be asked to fill in a questionnaire about their health, wellbeing, food preferences, and social activities.
This will be completed in the school at a time convenient for you. In-class

Who is involved in the study?
This study is being carried out by scientific researchers who have extensive experience in working with children and in healthcare research. The study team comprises:

- Researchers
- Doctors
- Psychologists
- Service Providers
- Family Members
- Teachers
- Children's Nurses

What if I have any other questions?
If you have any questions or would like more information about the study, please do not hesitate to call or email.

Contact name: xxxxx

Tel: 087 xxxxxxx
E-mail: xxxxxxxxxxx

assessments will take approximately 40 minutes.

The parents/guardians of children in junior and senior infants will be contacted by phone (or at the school if more convenient) and asked questions by the interviewer on similar topics as the older children. This will be done in a sensitive and confidential manner.

If a child has any additional needs they will have the assistance of a researcher (or if feasible a school staff member) in completing the questions. Parents/guardians will also have an opportunity to highlight any particular concerns or requests on the consent form.

Also, at a suitable time during P.E. class, physical health measurements will be taken by our paediatric nurses. These will include height, weight and waist circumference and will be completed in a private manner. The parent/guardian will be invited to attend if they wish.

From these results, we can find out much more about the health of school-aged children than would be possible with questions on nutrition and lifestyles only.

All children will also receive a Healthy Schools 'participation certificate' for being part of a Healthy Schools.

healthy schools

An evaluation of the _Healthy Schools Programme_ for the Tallaght West Childhood Development Initiative

Teacher Information Leaflet

CDI
Childhood Development Initiative

NUI MAYNOOTH

Trinity College Dublin

Healthy Schools Evaluation Parent/Guardian Consent Form

This research aims to examine the *Healthy Schools programme* and its impact on the well-being of children, their families, and their communities.

By participating in this study, you are agreeing for your child to be asked questions on their physical and psychological health, diet and social behaviour. Children in 1st class and above will answer these questions in school during class time. If your child has any additional needs (such as literacy difficulties) we invite you to highlight your concerns below so that we may provide extra support during assessment time.

All children will also have their weight, height, and waist measurements taken, privately, in the presence of a children's nurse. As their parent/guardian, you may also be contacted by phone or at the school and asked questions relating to your child's health as well as your views on the *Healthy Schools programme*. This information will be collected once a year beginning in April 09 and will continue over the next 3 years.

All information and your child's identity will remain confidential. The name of you or your child will not be published or disclosed to anyone outside the research team. Access to any information relating to your child will be fully accessible to you upon request. This information will only be held for purposes of the research study. If as a result of the assessments or measurements it is believed that your child needs medical or further attention you will be informed of this via the Healthy Schools Coordinator or Principal at your school and efforts will be made to help you to access the relevant services.

Parent/Guardian Declaration:
I have read, or have had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to support my child to be part of this research study. I understand that participation or non-participation will in no way affect the receipt of services for my child from the *Healthy Schools programme*. I understand that my child or I may withdraw from the study or withdraw our information from the study at any time without prejudice and have received a copy of this agreement.

Please sign Part One to indicate that you are willing to support this study by agreeing to allow your child to participate in the questionnaires and measurements.

Part One

I voluntarily give my agreement for (insert child's name here) to participate in this study without prejudice to their legal and ethical rights. I also agree to be contacted by a researcher at a time that is convenient for me.

Your Name: _____

Your Signature: _____Date: _____

Any requests or concerns regarding your child's needs (i.e. literacy difficulties):

_____

Please sign Part Two to indicate that you are willing to support the part of the study that evaluates the progress of the *Healthy Schools programme*, which gives you the opportunity to say your views.

Part Two

I (insert guardian's name here) voluntarily give my consent to be invited for an interview to give my views on the progress of the *Healthy Schools programme* at a time that is convenient for me.

Your Signature: _____
Phone number (s) _____Best day and time to call: _____

APPENDIX 4.1I

Information sheet for participants invited to take part in one-to-one interviews

<u>**Participant Information Sheet**</u>

We would like to invite you to take part in an important research study. Before you decide whether or not you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take a few minutes to read carefully through the following information and discuss it with others if you wish. Also, please ask us if there is anything that is not clear, or if you would like more information.

What is the purpose of this study?
The aim of this study is to assess the *perceived* effects of a school-based health promotion programme on the psychological well-being of primary school children.

Why have I been asked to take part?
We are inviting a small number of health and educational professionals who are currently, or who have been previously, involved in school-based health promotion programmes, to take part in a one-to-one interview. The purpose of these interviews is to elicit the attitudes and views of individuals who have experience in this area to establish the prohibitive and facilitative factors that might influence the effects of such initiatives with respect to children's psychological well-being.

Who is carrying out the research?
This research is being carried out by researchers at the Department of Psychology, NUI Maynooth.

Who has approved this study?
The Social Research Ethics Sub-Committee of NUI Maynooth have approved this research design. (**contingent upon outcome of this application**)

Do I have to take part?
No, you are under no obligation whatsoever to take part in the research. However, we hope that you will agree to take part and give us some time to describe your experiences of retirement. It is entirely up to you to decide whether or not you would like to take part. If you decide to take part, you are still free to withdraw at any time (and withdraw your information) without giving a reason.

What will happen to me if I take part?
Should you agree to participate in the study the researcher will contact you to arrange a convenient time to complete the interview at a mutually convenient time and place of your choice. Prior to the commencement of the interview you will be asked to sign a consent form indicating your approval to participate.

How long will the whole process take?
The interview should take approximately 60 minutes to complete.

Will my taking part in this research be kept confidential?
All information which is collected about you during the course of the research will be kept <u>**strictly confidential**</u>. All information will be held under lock and key and will be accessed only by the Researcher and will not be distributed to any other unauthorised individual.

What will happen to the results of the research?
The research will be written up in report format to help develop policies and procedures and may be published in journals and presented at conferences.

Who do I contact if I have a question?
Please feel free to address any questions to **Mary Quirke** who is also available on the telephone to discuss the study with you (Tel: 01 708 6768).

Alternatively, you can email or write to:

Dr Sinéad McGilloway, (sinead.mcgilloway@nuim.ie) Department of Psychology, John Hume Building, NUI Maynooth, Maynooth, Co. Kildare, Ireland.

Thank you for taking the time to read this information sheet
If during your participation in this study you feel the information and guidelines that you were given have been neglected or disregarded in any way, or if you are unhappy about the process, please contact the Secretary of the National University of Ireland Maynooth Ethics Committee at research.ethics@nuim.ie or +353 (0)1 708 6019. e

Consent Form
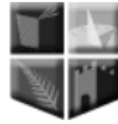
NUI MAYNOOTH

Ollscoil na hÉireann Má Nuad

Participant Consent Form

No. _____

Please initial box

1. I confirm that I have read and understand the Information Sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw from the research at any time (and withdraw my data), without giving any reason

3. I understand that all information will be treated in the **strictest confidence** and my anonymity is guaranteed. All information will be held in a locked cabinet at NUIM which will be accessed solely by the researcher, and will not be distributed to any other unauthorised individual. These data may be accessed by me at my discretion and at any time.

4. I agree to take part in the above study.

5. I agree to allow the use of my anonymised data in any future research if so required.

_____   _____

Name of participant   Signature   Date:

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APPENDIX 4.2

Some tips to begin!

- Here are some questions for you to answer on your own.

- If any questions is unclear, ask the Healthy Schools team for help ☻

Your class teachers and friends will NOT find out what your answers are. Don't look at anyone else's answers and keep your answers private.

- We are interested in your honest answers. If any problems come up for you about your health we will talk to you and your family about this at another time.

- When you have answered all of the questions watch us put this booklet in the large envelope. We will then take it away from the school.

Healthy Schools Questionnaire

Part A: Profile Questionnaire

♥ **(1)** I am a. . .

	Boy	Girl
	○	○

(2a) Age ………………years

(2b) If you know, write down your date of birth:

Date_____ (e.g.24th)   **Month**_____ (e.g. June) **Year**_____ (e.g. 2001)

✈ **(3)** Who do you live with? *tick all the people who are in your home*

Mother • Brother(s) • Grandmother •

Father • Stepbrother(s) • Grandfather •

Stepmother • Sister(s) • Other adult relative_____ •

Stepfather • Stepsister(s) •

Foster parent •

☻ **(4a)** How many brothers do you have? (include your stepbrothers)

Place the number in the box (0,1,2....)   ☐

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(4b) How many sisters do you have? (include your stepsisters)

Place the number in the box (0,1,2….) ☐

(5) If you have brothers and sisters, how many are older than you?

Place the number in the box (0,1,2….) ☐

◄ **(7)** Do you have a medical condition (like diabetes, asthma, eczema etc.) that has been treated by a doctor?

Tick one box

Yes	No	Don't know
○	○	○

If Yes, what is it?…………………….

Kidscreen-27

1. Physical Activities and Health

Tick one box

✿1.

In general, how would you say your health is?

○ excellent

○ very good

- ○ good
- ○ fair
- ○ poor

For all the questions please tick one box on every line

Thinking about the last week...

		not at all	a little	a fair amount	very	All the time
		not at all	a little	a fair amount	very	All the time
♥ 2	Have you felt fit and well?	○	○	○	○	○
☼3.	Have you been physically active (e.g. running, climbing, cycling)?	○	○	○	○	○
♦ 4	Have you been able to run well?	○	○	○	○	○

Thinking about the last week...

		never	sometimes	quite often	very often	always
		never	sometimes	quite often	Very often	Always
5.	Have you felt full of energy?	○	○	○	○	○

. General Mood and Feelings about Yourself

Thinking about the last week...

		not at all	a little	a fair amount	very	All the time
		not at all	a little	a fair amount	very	All the time
1.	Has your life been enjoyable?	○	○	○	○	○

Thinking about the last week...

		never	sometimes	quite often	very often	always
2.	Have you been in a good mood?	never ○	sometimes ○	quite often ○	very often ○	always ○
3.	Have you had fun?	never ○	sometimes ○	quite often ○	very often ○	always ○

Thinking about the last week...

		never	sometimes	quite often	very often	always
4.	Have you felt sad?	never ○	sometimes ○	quite often ○	very often ○	always ○
5.	Have you felt so bad that you didn't want to do anything?	never ○	sometimes ○	quite often ○	very often ○	always ○
6.	Have you felt lonely?	never ○	sometimes ○	quite often ○	very often ○	always ○
7.	Have you been happy with the way you are?	never ○	sometimes ○	quite often ○	very often ○	always ○

3. Family and Free Time

Thinking about the last week...

		never	sometimes	quite often	very often	always
1.	Have you had enough time for yourself?	never ○	sometimes ○	quite often ○	very often ○	always ○
2.	Have you been able to do the things that you want to do in your free time?	never ○	sometimes ○	quite often ○	very often ○	always ○
3.	Have your parent(s) had enough time for you?	never	sometimes	quite often	very often	always

		O	O	O	O	O
4.	Have your parent(s) treated you fairly?	never O	sometimes O	quite often O	very often O	always O
5.	Have you been able talk to your parent(s) when you wanted to?	never O	sometimes O	quite often O	very often O	always O
6.	Have you had enough money to do the same things as your friends?	never O	sometimes O	quite often O	very often O	always O
7.	Have you had enough money for things you need to buy?	never O	sometimes O	quite often O	very often O	always O

4. Friends

Thinking about the last week...

		never	sometimes	quite often	very often	always
1.	Have you spent time with your friends?	never ◯	sometimes ◯	quite often ◯	very often ◯	always ◯
2.	Have you had fun with your friends?	never ◯	sometimes ◯	quite often ◯	very often ◯	Always ◯
3.	Have you and your friends helped each other?	never ◯	sometimes ◯	quite often ◯	very often ◯	always ◯
4.	Have you been able to rely on your friends? (rely = have your friends been there for you when you needed them?)	never ◯	sometimes ◯	quite often ◯	very often ◯	always ◯

5. School and Learning

Thinking about the last week...

		not at all	a little	a fair amount	very	All the time
1.	Have you been happy at school?	not at all ◯	a little ◯	a fair amount ◯	very ◯	All the time ◯
2.	Have you got on well at school?	not at all ◯	a little ◯	a fair amount ◯	very ◯	All the time ◯

Thinking about the last week...

	never	sometimes	quite often	very often	always

			never	sometimes	quite often	very often	always
3.	Have you been able to pay attention?		○	○	○	○	○
4.	Have you got along well with your teachers?		○	○	○	○	○

Children's Depression Inventory – short form (CDI-S) (Kovacs 2009)

Pick out the sentences that describe you best in the PAST TWO WEEKS.

1

I am sad once in a while.	0	☐
I am sad many times.	1	☐
I am sad all the time.	2	☐

2

Nothing will ever work out for me.	2	☐
I am not sure if things will work out for me.	1	☐
Things will work out for me O.K.	0	☐

3

I do most things O.K.	☐ 0	
I do many things wrong.	1	☐
I do everything wrong.	2	☐

4

I hate myself.	☐ 2	
I do not like myself.	1	☐
I like myself.	☐ 0	

5

I feel like crying every day.	2	☐
I feel like crying many day.	1	☐
I feel like crying once in a while.	0	☐

6

Things bother me all the time. 2		☐
Things bother me many times.1		☐
Things bother me once in a while.	0	☐

7

I look O.K.		☐ 0
There are some bad things about my looks.	1	☐
I look ugly.		☐ 2

8

I do not feel alone.	0	☐
I feel alone many times.	1	☐
I feel alone all the time.	2	☐

9

I have plenty of friends.	0	☐
I have some friends but I wish I had more.	1	☐
I do not have any friends.		☐

10

Nobody really loves me.	2	☐
I am not sure if anybody loves me.	1	☐
I am sure that somebody loves me.	0	☐

Health Related Behaviour Questionnaire

These questions are about Food

1 How important do you think it is to eat healthy food?

Not at all important	A little important	Fairly important	Very important
○	○	○	○

2 **Which sentence describes you best?**

I would like to put on weight . . . . •

I would like to lose weight . . . . •

I am happy with my weight as it is . . . . •

3 How many pieces of fruit or vegetables do you eat on

  a normal day? (e.g. an apple or some carrots)

Put number in box(e.g., 1,2,3…)   [ ]

Tip: One portion = 1 piece of fruit or some veg or salad with dinner.

 Potatoes don't count when thinking about fruit and vegetables

4a Did you eat or drink anything before school this morning?

Tick more than one box if you need to✔

No.. [ ]

```
Yes, something at home  ........................................ ☐

Yes, something on the way to school............................ ☐

Yes, something at school  ...................................... ☐
```

Skip this question if you answered NO above

4b If you did eat breakfast, ***What*** did you eat or drink this morning?(e.g. cereal, toast, juice, tea, sweets)

(*Please write*

in the box)↘

5 How often do you eat or drink any of the following?

	never	sometimes	most days
Meat	○	○	○
Fish	○	○	○
Any of **Milk/Yogurt/Cheese**	○	○	○
Brown bread	○	○	○
Any of **Potatoes/Rice/Pasta**	○	○	○

	never	sometimes	quite often
Cereal	○	○	○
Fruit or Vegetables	○	○	○

	never	sometimes	most days
Fizzy drinks	○	○	○
Water	○	○	○
Crisps	○	○	○

	never	sometimes	most days
Sweets/Chocolate	○	○	○

6 How much do you enjoy exercise? (like running and jumping)

Not at all	A little	A lot
○	○	○

7 How important do you think it is to be fit?

(i.e. able to do exercise without going out of breath)

Not at all important	A little important	Fairly important	Very important
○	○	○	○

8 How often do you play or do any of these things <u>outside school</u>?

(in your own time or in a club)

	never	1-2 days a week	3 or more days a week
Riding your bike	○	○	○
Running (races or games)	○	○	○
Dancing/gymnastics	○	○	○
Going on walks with someone	○	○	○
Swimming	○	○	○
Playing computer fitness games (like Wii fit)	○	○	○
Playing other computer games	○	○	○
Watching TV/DVDs	○	○	○
Playing with your friends	○	○	○
Playing a sport	never	1-2 days a week	3 or more days a week

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	never	1-2 days a week	3 or more days a week
Reading a story book	○	○	○
Doing Homework	○	○	○
Extra lessons you go to Write here what the lessons are _____	○ never	○ 1-2 days a week	○ 3 or more days a week
Go to a minder afer school write below who your minder is _____	○ never	○ 1-2 days a week	○ 3 or more days a week
Doing something else outside school Write here _____	○ never	○ 1-2 days a week	○ 3 or more days a week

9a This question is about alcohol, tick the box that is true for you

(WHOLE DRINKS like beer and wine, NOT JUST A SIP)

	Never	One or two times *ever*	Sometimes (e.g special occasions)	Once or twice a week	I don't know
I have drank alcohol	○	○	○	○	○

If you have never drunk alcohol, go to Question 10a

9b If you have ever drunk alcohol, please write the names(s) of the drink(s) in the box below.

_____

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10a Have you ever smoked a cigarette(s)?

If you have never smoked a cigarette, go to Question 10c. Otherwise, please go to Question 10b below.

10b How many cigarettes did you smoke <u>in the last 7 days</u>

Write number here⇨

10c Do you think that you will smoke when you are older?

	No	Maybe	Yes
	○	○	○

11 Have any of the people below told you what illegal drugs are?

(illegal means drugs that are not used as medicines)

	Yes	No	Don't know
Parents	○	○	○
Teachers in school lessons	○	○	○
School nurse (if there is one)	○	○	○

Yes
○

12 Do you know anyone (not as medicines?) ... who uses drugs

	Yes	No	Don't know
Visitors in school lessons	○	○	○
Friends	○	○	○
Brothers or sisters	○	○	○
Other close family member (e.g. cousin)	○	○	○

Write who _____

13. Have you ever been ... offered illegal drugs?

Yes ○	No ○	Don't know ○

How harmful do you ... think these are?

	Not at all harmful	A little harmful	Fairly harmful	Very harmful	Don't know
Alcohol	○	○	○	○	○
Smoking cigarettes	○	○	○	○	○
Illegal drugs	○	○	○	○	○

These questions are about Travel

15 How do you usually get to school?

Car	School bus	Walking	Bicycle	Ordinary bus	Taxi	Other_____
○	○	○	○	○	○	○

16 Have you got a bike?

Yes	No
○	○

17 If you do have a bike, do you wear a seftey helmet when cycling?

Never	Sometimes	Always	I don't have a bike
○	○	○	○

18 Do you wear a seatbelt when in t

292

he car?

Never	Sometimes	Always
○	○	○

Thinking about the last   **2 questions........**

19. How important do you think it is to stay safe? (e.g. when crossing the road and not talking to strangers etc..)

Not at all important	A little important	Fairly important	Very important
○	○	○	○

20. Do you wash your hands after going to the toilet?

Never	Sometimes	Always
○	○	○

21 How many times a   **day do you clean your teeth?**

0 times a day	1 time a day	2 times a day	3 times a day	More than 3 times a day
○	○	○	○	○

22aIn the last year, did you have an accident and had to go to a doctor or a hospital? (e.g. a broken bone, burn …)

Yes	No	Don't know
○	○	○

22b. If yes, what happened_____

23 Do you feel safe in the area where you live?

Always	Sometimes	Never	Don't know
○	○	○	○

24 Do you think where you live is a good place to live?

Yes, it's really good	It's OK	No. it's not good	Don't know

			never	Sometimes	A lot
Schoolwork			○	○	○
	○	○	○	○	
Tests			never ○	Sometimes ○	A lot ○
Health problems			never ○	Sometimes ○	A lot ○
Friend problems			never ○	Sometimes ○	A lot ○
Family problems			never ○	Sometimes ○	A lot ○
The way I look			never ○	Sometimes ○	A lot ○
Not having enough money			never ○	Sometimes ○	A lot ○
Crime			never ○	Sometimes ○	A lot ○
Anything else you want to add? _____			never ○	Sometimes ○	A lot ○

26 **If you were feeling worried or sad about the things below, who is the first person you would talk to about it?**

	Mum/Dad	Sister/Brother	Friend	Teacher	Keep it to myself	Other adult , who_____
School Problem	○	○	○	○	○	○
Family Problem	○	○	○	○	○	○
Health Problem	○	○	○	○	○	○
Problem with friends	○	○	○	○	○	○
Bullying problem _in_ school	○	○	○	○	○	○
Bullying problem **_outside_** school	○	○	○	○	○	○

27a Have you been bullied at or near school in <u>the last year?</u>

	Yes	No	Don't know
	○	○	○

27b Have any of the following happened to you <u>in this school year?</u>

	never	Sometimes	Always
Been teased or made fun of	○	○	○
Called nasty names	○	○	○
Bullied through my mobile phone	○	○	○
Bullied through email/internet	○	○	○
Pushed/hit for no reason	○	○	○
Had belongings taken/broken	○	○	○
Been threatened (scared by someone) for no reason	○	○	○
Been asked for money	○	○	○
Been ganged-up on	○	○	○
Any other reason? (write below) _____	○	○	○

→ *If you ticked 'never' to all, go to Question 29. Otherwise, please go to Question 28 below.*

→ **28 Do you think you are being 'picked on' or bullied for any of the following reasons?**

	Yes	No
Your size or weight	○	○
The way you look	Yes	No

The clothes you wear	Yes ○	No ○
Your family background/skin colour/religion	Yes ○	No ○
A illness or disability	Yes ○	No ○

29 Do you think your school tries to stop bullying?

Yes	No	Don't know
○	○	○

These Questions are about
ENJOYING and ACHIEVING

30 During school break times, do you spend time doing the following?

	never	Sometimes	Often
Chatting/talking with friends	○	○	○
Playing running skipping games (e.g. football)	○	○	○
Doing something else? *Write here_____*	○	○	○

31 Please think about each of these sentences and say if you agree with them or not?

	Yes	No	Not sure
The rules in this school are fair	◯	◯	◯
Our school is a nice place to be	◯	◯	◯
I feel I belong at this school	◯	◯	◯
Teachers listen to me	◯	◯	◯
When I need extra help, I get it	◯	◯	◯
Our teachers treat us all the same	◯	◯	◯
My school work is corrected so I can see how to do better	◯	◯	◯
I get praised (told I've done well) for working hard in school	◯	◯	◯

THE END!

Thank you for completing this questionnaire!

Eating with Color Word Search Puzzle!
Find the Red Foods


```
D Q S M V T L Z F M G K K O I
X R F L Y R R E B P S A R J R
R E I F I F N R G I C Z E T S
O P P I T X K U F R S T O S E
B P A A P P L E A H A M L Z I
Y E J Q O E N N O N A P N G R
R P H Q E T B G A T E G O X R
R L J G E U R O X Y E L X E H
E L I D R A G D L W J J E T H
B E M R V E V Z R T A E M I C
W B Y A M Q L E P Q X F R J C
A D O O U C B E F S O J E A V
R E P W D Q L U U C Q L T Z Q
T R D D K F V O R Z P Y A M X
S G V W P A V T M H N F W G D
```

TOMATO	STRAWBERRY
RED BELL PEPPER	CRANBERRY
APPLE	POMEGRANATE
CHERRIES	GUAVA
RASPBERRY	WATERMELON

Appendix 4.3

Referral Template

HEALTHY SCHOOLS EVALUATION REFERRAL FORM AND INITIAL INFORMATION RECORD - WRITTEN CONFIRMATION OF A CHILD PROTECTION REFERRAL TO SCHOOL PRINCIPAL
This form should be used by Healthy Schools Evaluation researchers to detail a referral to the School Principal where there is concern that a child is at risk of significant physical or mental harm. This form must be presented to the Principal immediately for him/her to proceed with the case.

DETAILS OF REFERRAL

Name of referrer (please print):	**Role:**

Office address:

Telephone:	**Fax:**

Date and time of assessment:

Name of School:	**Name of Principal:**

DETAILS OF CHILD

Surname	Forename	Gender	Age	Class	Class Teacher

Is the child aware of the referral?   Yes   No

NATURE OF THE PROBLEM

APPENDIX 5.1 DATA AUDIT

SPSS Database audit

All data was cross-checked during data entry with the hard-copy questionnaire data at least once for accuracy. An additional comprehensive audit of the completed SPSS database was conducted for each year of data collection to check for data entry accuracy and quality. At baseline, a random sample of 12 cases from the spss database were printed out and compared to the original paper questionnaires. The database had 26 errors in total and, of these, five were real errors. The true error rate was 0.18%. In year 1, a random sample of 22 cases was checked and a total of 22 errors were identified. Eight of these were coding errors and 14 real errors. The true error rate was 0.53%. In year 2 a random sample of 16 cases from the database were compared against the paper questionnaires. The audit revealed 4 true errors and the true error rate was 0.10%. All errors were cleaned on the SPSS database. Where coding errors were identified these errors were amended for the entire database.

APPENDIX 5.2

Permission to use questionnaire tools

Kidscreen-27 permission

Dear ██████████

Thank you for your interest in the Kidscreen instruments. I am a co-worker of Prof. Dr. Ravens-Sieberer, working in the co-ordination of the European Kidscreen project in Hamburg , Germany . We have received your signed collaboration form and are very happy to collaborate with you.

You are registered for the use of the Kidscreen Quality of Life questionnaires for children/adolescents and parents. For the following countries linguistic adapted language versions are available: Austria , Brazil , Czech Republic , France , Germany , Greece , Hungary , Ireland , Korea , Netherlands , Poland , Portugal , Spain , Sweden , Switzerland , United Kingdom.

The non-commercial use of the Kidscreen questionnaires is free. In case of commercial use, the licence fee is 500 Euro for each language version of the Kidscreen questionnaire in each study. If that is applying to your study you will find the corresponding invoice attached to this email.

We are looking forward to collaborating with you and whish you all the best for your studies.

With best wishes,

Anne Jäger

Kidscreen Group Europe

Collaboration Center

Children's Depression Inventory permission

Access to tool was only possible upon payment-Invoices available

Health Related Behaviour Questionnaire permission

Hi ███████
Agreement for [HRBQ] arrived this morning, thanks.
We are obliged to charge VAT - as a charity, I guess you don't get to claim this back.
Have you come across this before?
1000 Euros will be fine although if we could add the VAT on top of this it would be better from our point of view.
Year 2 questionnaire attached

Best wishes
Angela Balding

Survey Manager at the Schools Health Education Unit (SHEU)

angela.balding@sheu.org.uk

APPENDIX 5.3

Semi-structured interview schedule

1. What is your current professional role?

2. Tell me about what has been your experience of School-based health promotion programmes

3. What does a health promoting school mean to you?

4. What has been your experience of the Health promoting school network (HPSN) (either the European or Irish). How do you see the HPSN developing in the future?

5. In general, how do you feel psychological well-being can be best addressed by schools using HP programmes? (probe for organisational and community changes rather than specific one-off events).

6. What factors do you think could limit the effects of school-based health promotion initiatives on children's psychological health outcomes? How do you feel these barriers could be overcome?

7. If you were to advise a school or organisation considering developing a health promoting school initiative to address psychological well-being, what advice would you give them?

8. How would you advise them in terms of:
    a. -the main benefits that they can expect from implementing the programme?
    b. -the main challenges they can expect while implementing the programme?

Sample additional questions for *Healthy Schools Stakeholders* to be included in above schedule
Looking back over the last three years, what is your overall perception of the *Healthy Schools Programme* (HSP)?

1. In general, how do you feel the HS programme addressed *psychological well-being* in your school?

2. Do you think that the HSP has impacted upon the schools *knowledge* and *awareness* of psychological health and well-being? If yes, in what ways-can you provide any examples of this in practice?

3. Has the HSP impacted upon psychological health and well-being related *practices* and *behaviours* in the schools (i.e. among and between school staff, parents, children). If yes, in what ways?

4. What do you think may have limited the effects of the HSP in improving psychological health and how this was addressed in the schools?
5. Has the way schools and services work together in relation to referrals concerning psychological well-being changed as a result of the HSP? Can you provide any examples of what occurs, and personnel responsible for this occurring?

APPENDIX 6.1

Table A.6.1a: Normative T score range based upon Kovacs, 2009 CDI-S American norms

CDI subgroups	Standardised mean *T* score range
Slightly below average	40-44
Average	45-55
Slightly above/above average	56-65
Much above/very much above average	>65
Total	

Table A6.1b: Reference T Scores from European Normal Data for the five Kidscreen Dimensions of the Child Self Reports*

Dimensions of Kidscreen-27	T Scores (T) ranges		
	Below average	Average	Above average
Psychological well-being	<48.07	48.07 – 58.01	>58.01
Physical well-being	<48.74	48.74 - 58.7	>58.7
Autonomy and parent relations	<46.41	46.41 – 56.73	>56.73
Social support and peers	<45.98	45.98 – 56.02	>56.02
School environment	<45.85	45.85 – 59.21	>59.21

*(Children aged 8-11 years; extracted from the Kidscreen Questionnaires Handbook, 2006, p 152 – 179)

APPENDIX 7.2

Management Structures and Policies

That there is ownership and management structure that implements effective, realistic and achievable policies, practices and procedures congruent with the charter and guiding principles for a 'healthy school'.

Indicators	0	1	2	3	4	5
Does the articulated 'characteristic spirit of the school' reflect a commitment to promoting the health and well-being of pupils and staff?						
Does the school plan reflect a commitment to promoting the health and well-being of pupils?						
Are the decision-making processes of the Board of Management characterised by openness, accountability, clarity of communication, and sharing of responsibility?						
Is there a shared understanding that 'school community' includes school, pupils, parents, teachers, and all out-of school services and activities that impact on the lives of pupils?						
Do the policies, procedures and practices of the Health Services Executive reflect a commitment to promoting the health and well-being of pupils?						
Do the policies, procedures and practices of South Dublin County Council reflect a commitment to promoting the health and well-being of pupils?						
Do the policies, procedures and practices of other local services (e.g. Lucena) reflect a commitment to promoting the health and well-being of pupils?						
Are relationships within the school and throughout the school community characterised by mutual respect, openness, and concern?						
Is communication within the school and throughout the school community effective and does it reflect the values and principles outlined in the charter and guiding principles for a 'healthy school'?						
Are health promoting policies – code of behaviour, anti-bullying, child protection, substance misuse, healthy eating, equality – articulated in the school plan and shared with the school community?						
Is the school community sensitive to the needs of pupils with special educational needs and those from disadvantaged and minority backgrounds?						
Does the school community have opportunities and structures to promote student participation and student leadership?						
Does the 'post-of-responsibility' structure in the school show commitment to supporting the health and well-being of pupils?						
Are the charter and guiding principles for a healthy school (as outlined in this manual) integral to the school plan?						
Are the policies, procedures and practices of the Healthy School Steering Committee supportive of the work of the Healthy School Coordinator in promoting the health and well-being of pupils as characterised by the CDI Strategy?						

Physical Environment

The physical environment is conducive to providing a safe, hygienic and eco-friendly setting.

Indicators	0	1	2	3	4	5
To what extent:						
Is the school welcoming, warm and friendly?						
Is the school clearly signposted?						
Is the school an attractive place to be?						

Are the school and its environs clean and tidy?						
Does the state of the school buildings encourage respect in pupils and others?						
Does the school environment promote health:						
By being smoke free?						
By having an adequate and safe play ground?						
By having indoor/ outdoor sedentary areas?						
By having regularly maintained toilet facilities?						
By having indoor sitting down eating area(s)?						
By having adequate and safe PE facilities?						
Are there safe and clean out-of-school areas where children can play?						
Does the school community pay attention to the responsible, efficient and economic use of materials and resources in order to minimise waste, conserve non-renewable energy, and reduce negative impact on the environment?						
Are provisions made to enhance the environment (e.g. plants, hanging baskets, litter bins, displays of student work)?						
Is health and safety a major issue (e.g. coat hooks, hand washing facilities, storage and contents of school bags, clear corridors, walk ways, play areas, foot-paths and cycle-ways)?						
Are there provisions for first aid, storage of medicines, catering for feeling unwell?						
Is there accommodation space for the HSC?						

Ethos and Social Environment

The characteristic spirit is maintained as one that promotes the self esteem of all members of the school community; and where the social values outlined in the charter and guiding principles are evident.

Indicators	0	1	2	3	4	5
Does the school have a welcoming, comfortable and inclusive environment?						
Do out-of-school services frequented by pupils and their parents have a welcoming, comfortable and inclusive environment?						
Has the school made its characteristic spirit or ethos explicit?						
Are school staff aware of the characteristic spirit of the school?						
Are parents aware of the characteristic spirit of the school?						
Are pupils aware of the characteristic spirit of the school?						
Are out-of-school services aware and supportive of the characteristic spirit of the school?						
Are health promoting policies – code of behaviour, anti-bullying, child protection, substance misuse, healthy eating, equality – evident in the day to day running of the school?						
Are health promoting policies – code of behaviour, anti-bullying, child protection, substance misuse, healthy eating, equality – evident in the day to day running of out-of-school services?						
Are school policies developed through an inclusive process involving management, staff, parents and pupils as appropriate?						
Are the contributions of students valued and their achievements positively praised?						
Are the contributions of staff valued and their achievements acknowledged?						
Do pupils report feeling safe and liking school?						
Are the charter and guiding principles for a healthy school (as outlined in this manual) integral to the day-to-day running of the school?						

	0	1	2	3	4	5
Is the role of the HSC valued and supported by the whole school community?						

Clarity of the Healthy School Coordinator Post/ Job Description

There is a shared understanding of the role of the HSC by CDI, the school, community groups and service providers. This is clearly articulated in the job description made available to the post holder.

Indicators	0	1	2	3	4	5
Has the CDI and the school developed a shared understanding of the contribution that the post can make to the school, the families and community that the school serves?						
Does the Healthy School Steering Committee have clarity re the role, functions and activities of the Healthy School Coordinator?						
Has this understanding of the post (as identified in this manual) been clarified through a collaborative process of engagement with statutory and voluntary agencies?						
Is there a written job description for the post?						
Has a skills analysis for the requirements of the post been conducted?						
Is the governance, day-to-day management, lines of reporting and supports for the post holder clearly articulated for and understood by the whole school community?						
Has the school committed to supporting the post holder by providing suitable accommodation, access to resources, and links with staff and relevant post holders?						
Have statutory and voluntary agencies (Department of Education and Science, HSE, Gardai, Local Authority, Local Drugs Task Force, Youth Services, sports organisations, community groups) agreed to work in partnership with CDI, the school and the Healthy School Coordinator?						
Has an induction process that assists the introduction and integration of the post holder with school staff, parents and relevant agencies and voluntary groups been planned and implemented?						
Has the Board of Management of the school committed to supporting the post of HSC?						

Partnerships/ links with Services and Community Groups / External Supports

Statutory and voluntary agencies and their representatives contribute appropriately to planning and maximising learning supports available to children in the school and in the community.
As a means of providing an integrated service for children and their families, there is a shared belief in, awareness of, and commitment to a partnership approach between the school, the home, and statutory and voluntary agencies.

Indicators	0	1	2	3	4	5
Does the existing partnership relationship between the school and statutory and voluntary agencies support the work of the Healthy School Coordinator?						
Have the relevant agencies and the CDI agreed a working arrangement that facilitates an interagency approach to the HS project?						
Does the school engage in a regular review, on a partnership basis, of its relationships with statutory and voluntary agencies?						
Does the school organise out of school learning activities?						
Has the contribution which the HSC might make to out of school learning activities been considered and acted on?						
Is the school an active participant in the 'local committee' (a forum of local services providers that is convened by HSCL Coordinators and meets quarterly)?						
Is the school a welcoming place for personnel from external agencies?						
Does the school link with national and regional calendar events and initiatives?						
Does the school have a positive and supportive relationship with the Department of Education and Science, its Regional Office and its agents (National Education Psychological Service (NEPS), Home School Community Liaison (HSCL), School Completion, Primary Curriculum Support Programme						

	0	1	2	3	4	5
(PCSP), Walk Tall, Primary School Development Planning Support (SDPS), and Visiting Teachers)?						
Does the school have a positive and supportive relationship with the Health Service Executive (HSE), Primary Care Team and its agents?						
Does the school have a positive and supportive relationship with the Local Authority and its agents?						
Has the school developed a directory of services that support personal well-being?						
Does the work of the HSC support and enhance partnership arrangements with statutory and voluntary agencies?						
Is maximum use made of local resources (e.g. youth clubs, games pitches, swimming pool) for the benefit of pupils?						
Has the HSC identified barriers to the uptake of health and social services and proposed action to address these?						
Has the HSC agreed effective protocols with relevant service providers for sharing of information and promoting access to services?						

Curriculum and teaching/ Learning Styles

Pupils experience an integrated and holistic curriculum that conforms to national guidelines, and promotes a sense of achievement, ownership and well-being. Co-curricular and out-of-school activities extend the learning opportunities available.

Indicators	0	1	2	3	4	5
Is there synergy between the Primary School Curriculum, the curriculum policy and objectives set out in the school plan and the curriculum as implemented?						
Is the curriculum offered by the school holistic and does it reflect breath and balance?						
Does the school provide a timetabled slot for SPHE and PE in accordance with Department of Education guidelines?						
Is health education complimented within the planned cross curricular framework?						
Is the curriculum adapted to the needs and abilities of students, and the level of success involved?						
How effective is the school's response to educational disadvantage among its pupils?						
Does the educational experience meet the learning needs of all pupils?						
Are pupils actively involved and challenged in their own learning through a variety of methodologies?						
Are pupils more engaged than previously in learning outside school, as a result of the work of the HSC?						
Are pupils helped to develop strategies and skills for coping with set tasks?						
Is the range of co-curricular activities provided sufficiently broad to ensure it meets interests of all pupils and so encourages them to participate?						
Is the range of extra-curricular activities and/ pupil engagement enhanced by the work of the HSC?						
Does the health education component of the curriculum foster attitudes and values that promote healthy living?						

Parent and Family Links/ Supports

Communications between parents, their child and the school and community are promoted. Family supports are identified, maximised and developed as appropriate.

Indicators	0	1	2	3	4	5
Does the school facilitate contact between parents and teachers and foster partnership with parents?						
Are parents and pupils involved in determining the needs and interests of pupils?						
Are parent's views on key issues sought, welcomed and listened to?						

	0	1	2	3	4	5
Are parents regularly informed and consulted about key decisions?						
Is such consultation appropriate and meaningful?						
Is the school a welcoming place for parents?						
Are parents and pupils involved in policy development?						
Is the flow of information between the school and the parents of each child of a high quality?						
Are the support needs of families that are troubled or having difficulty identified and adequately responded to?						
Is the range of family supports available through statutory and/or voluntary agencies adequate?						
Does the school offer a parent education programme?						
To what extent have the education needs of parents been identified and responded to in parent education programmes?						
Have barriers to participation in parent education been identified?						
To what extent have these barriers been addressed?						
Do statutory or voluntary agencies or community groups facilitate/ contribute to parent education programmes?						
Are support programmes appropriate to the needs of parents and families available?						
Are these support programmes being accessed by those who need them?						
Do parents positively contribute to the local community?						
Do pupils positively contribute to the local community?						
Are community resources now being better utilised by pupils and their families?						
Is the role of the HSC in supporting families understood by parents?						
Has the work of the post-holder contributed to further developing parent-child relationships?						
Does the post holder work with parents/families to enhance the learning experience of pupils in relation to health education?						

Supports for Transitions

'Transitions' are seen as a time of challenge and an opportunity for development. Children and their parents are supported at times of transition.

Indicators	0	1	2	3	4	5
Is an induction programme provided for parents and pupils and to what extent are pupils prepared for entry to Primary School?						
To what extent are pupils and their parents prepared for movement from one class/teacher to another?						
To what extent are pupils and their parents supported on return to school after absence (through illness, bereavement or family difficulty)?						
Does the school have an effective transitions programme from Primary to Post Primary school?						
Do Primary and Post Primary Principals communicate about transition?						
Do teachers exchange views at times of transition?						
Are newcomers to existing classes/ groups, and their parents, welcomed and supported on entry (due, for example, to family relocation etc.)?						
Are newcomers from minority groups welcomed and supported?						
Does the school have a school completion programme resourced by the Department of Education and Science?						

Pre-determined outcomes of the HSP as set out in the HS manual	
1	Children demonstrate age-appropriate physical development
2	Children have access to basic healthcare
3	Children are aware of basic safety, fitness and healthcare needs
4	Children are physically fit
5	Children eat healthily
6	Children feel good about themselves
7	Parents are involved in their child's health

Overview of HSP activity work (extracted from HSP evaluation report; Comiskey *et al.*, 2012)

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
1. Children develop age-appropriate physical development and 4. Children are physically fit	Skip Hop	Skipping Programme over a 3 day period	All children participated. Six trained teachers facilitated skipping programme. The Healthy Schools Coordinator (HSC) designed, distributed and collected child friendly questionnaires for feedback at end of programme.	3/5		
	Skipping during break times	Skipping during break times was encouraged, once a week a skipping session was facilitated by the trained HSC and skipping clubs were formed	Children from 1st, 3rd and 4th Class participated from 2 schools and out of all the children that were targeted in the 3 other schools a random group of 105 participated. HSC collaborated with teachers and principals regarding who to target. Teachers brought class to the PE hall. HSC facilitated one skipping session per week during break.		5/5	2/5
	Skipping After-school Club	4-week skipping club to target overweight/inactive children who prefer less competitive activities	1st and 2nd Class children targeted and participated in one school. A group of 20 children from different classes were targeted and participated in another school. HSC collaborated with teachers and principals regarding who to target. Training delivered by HSC.		2/5	
	Monthly skipping competition	A monthly skipping competition to target overweight/inactive children who prefer less competitive activities	All children were involved. HSC collaborated with teachers and principals. Competition coordinated by HSC.		2/5	
	Skipathon	One day Skipathon event	All children were involved. HSC collaborated with teachers, distributed skipathon sponsor cards, planned timetables, prepared rhymes/games, shopped for prizes, invited parents and informed children and facilitated the one day event.			1/5
	Yoga	8 week yoga sessions	Junior Infants were involved. HSC delivered the programme and designed, distributed and collected child friendly questionnaires for feedback at end of programme.			1/5

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Walk on Wednesday (W.O.W.) campaign and Walk to School Programme	Children and parents were encouraged to walk to school every Wednesday as part of a healthy lifestyle. Talks were given to children on the importance of walking to school. Prizes were given at the end of the term for children who walked the most and class who walked the most. The Walk to School Programme that ran in a couple of schools, however, was a short term intervention.	All children were involved. HSCs did posters and 'walking charts' for all classes and distributed them to all teachers. Teachers filled out the charts every Wednesday.	3/5	1/5	4/5
	Basketball After-school Club	After-school Basketball Club ran once a week	One class per month was selected (e.g. 1st Classes) Teachers distributed and collected letters. Training delivered by professional basketball coach and assisted by HSC		1/5	1/5
	Basketball Tournament	A half day Easter Basketball Tournament was organised where the winning team won trophy and certificate.	All 2nd Classes were involved. HSC organised the event (teams, timetable, matches, trophy, certificate and Easter eggs) in collaboration with teachers and Basketball coach on the last day of term.			1/5
	Football Training After-school Club	After-school Football Training Club ran once a week	One class per month was selected (e.g. 1st Classes) and participated once a week Teachers distributed and collected letters. Training delivered by Local Football Club and assisted by HSC		1/5	
	After-school Martial Arts introductory sessions	Introduction to Martial Arts after-school sessions.	40 children from 5th and 6th Classes were involved. Teachers distributed and collected forms. Sessions delivered by the Local Martial Arts Club facilitator assisted by the HSC.		1/5	
	Cardio Kids After-school Club	Physical activities, interactive games, PandA information, importance of food pyramid	Care Team identified children from two classes in one school. In other schools, classes identified by principals. Teachers distributed and collected letters. Training delivered by expert in the Local Leisure Centre and assisted by HSC in collaboration with the principal.	2/5	3/5	3/5

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
2. Children have access to basic healthcare	Referrals and follow-up	Following up on children who have been referred to external services (e.g. SLT, Psychological Services, Dental). Looking at whether referrals are appropriate, developing a contact list of service providers working with children and families in the locality, supporting children and their families to attend appointments, and identifying families who need support accessing health services.	Collaboration between principal, vice-principal, Primary Care Team, HSC, SNA coordinator, HSCL, Regional SLT, Occupational Therapy team, parents and children re referrals and appointments, Non Governmental Organisations (NGO), the National Educational Psychological Service (NEPS), Child and Adolescent Mental Health Service and school counsellors. HSC investigated children's health needs and the process of referrals and fed back on case developments to the Care Team and principal. The Care team identifies children who need support but the HSC assisted in further referrals. For example, the HSC linked children to speech and Language supports available while on the waiting lists for the Speech and Language Therapist (SLT) and referred children and parents to relevant local supports (Counsellors, Therapists etc.). The HSC linked in with a couple of parents twice a month to put advice of speech and Language into practice, and the HSC supported parents with information on head lice, epilepsy, health-promoting activities and services in the area, dyspraxia and separation rights. HSC provided support in advocating for appointments, making scheduled appointments, with phone calls, reminders and accompanied parent and child to appointments where necessary. At the beginning of Year 2 in one of the 5 schools a decision was made at the STC level that referrals would not be covered by HSC.	5/5	5/5	4/5

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
3. Children are aware of basic safety and health needs	Healthy Schools Open Day	'Our Health is Our Wealth' – Open Day with health-promoting stations in the school hall to create awareness on healthy habits for families and the importance of being and staying healthy.	All children attended. Collaboration between the HSC, Initiative Funders, parents, HSCL, SCP, Health Promotion Department, Public Health Nurse, Dental Nurse Educator, Primary Care Health Centre, SLT, Expert on Nutrition and Balanced Diet from Local Food Producing Company, social worker, and different local services who donated prizes (e.g. Local County Council, Health Promotion Department, FAI). Parents were involved in collecting prizes from local shops, advertising the event to other parents, organising the details for the event. HSC designed and distributed posters and notes to all parents. HSC informed all teachers and their classes about the event and encouraged children to attend. They advertised event locally, organised facilitators, resources and prizes.		2/5	3/5
	Healthy Schools Week (Easter)	Week of promoting the Walk to School Programme, Skipathon, yoga, art competitions, Skipping Rhyme, cardiokids, Healthy Lunch Competition, sensory play talk, after school activities and golf lessons	HSC consulted all classes about the event, distributed sponsor cards, planned timetables for schools and shopped for prizes. All children kept informed of timetable and motivated by teachers to be involved in activities. HSC liaised with parents, children, teachers, local sports facilitators to organise their involvement. One teacher helped by organising a rounders game for parents and children		3/5	
	Easter Camp	4 days multi activity Easter Camp	In collaboration with 2nd and 3rd class teachers, children who are isolated and not good at sports were identified HSC collaborated with 4 other local schools, distributed/collected letters from all classes, reminded parents about the camp, resources, trainers and prizes.		5/5	
	Sun Safety Activities	Sun Safety Activities ran during school and on the Sports Day	HSC distributed packs to classes re; Sun Safety to do in class. HSC liaised with school staff. HSC had a Sun Safety Stand on sports day and provided Sun creams, info, workbooks etc to children and provided information to parents who attended. Children got involved and encouraged other children to apply sun cream.		3/5	
	Active School Week	Multi activity week in school	HSC planned and organised activities, organised sports trainers in collaboration with Active School Committee Members		2/5	

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Summer Camp	1 week multi activity Summer Camp (interactive games and sports, healthy smoothie making, certificates and prizes, Little Chefs Healthy Cookery Summer Camp and linked children to local activities/events over the summer)	HSC identified children in 1st Class and above who could benefit the most from this camp in collaboration with each teacher. Two HSCs co facilitated planning, organising and roll out of camp. They collaborated with school staff in 5 schools, teachers (distributed/collected letters from all classes and verbally reminded parents), Home School Community Liaison (HSCL) officer and School Completion Programme (SCP) Officer and local sports facilities/services.	5/5	5/5	2/5
	Golf After-school	Golf training for children delivered by Golf Pro trainer.	principal, Care Team and teachers identified children (5th and 6th Class) who were overweight, lacking in confidence and self-esteem. Training delivered by Golf Pro trainer in collaboration with the local County Council, schools in the area and the HSC who distributed and collected letters, and accompanied children to golf course.		3/5	1/5
	After-school Dance training for children	After-school dance training for children	All children targeted (40 children participated). HSC coordinated with the teachers in collecting and distributing letters and reminding children about activities. Training delivered by dancing trainer and assisted by HSC.	1/5	1/5	1/5
	Yard Games	Planned and coordinated School Yard Games	All children and teachers participated. Children went out in the yard with their teachers where they were taught new yard games. Games organised in collaboration with Active School Committee. HSC photocopied and distributed yard games for teachers. Talked to all teachers to arrange times suitable for all of them. Did timetable and distributed it to all teachers.		1/5	

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
5. Children eat healthily	Adapting SPHE lesson plans to include Nutrition sessions for all 3rd Classes	Nutritional resources received from Health Promotion were used in SPHE classes.	HSC collaborated with SPHE Post Holders/support teachers to review Nutrition lesson plans. HSC provided health-promoting resources. 3rd class teachers used charts, posters, session plans in their sessions.		1/5	1/5
	Healthy Eating Community Forum	Established links with the local Healthy Eating Community Forum and attended meetings in order to promote healthy eating as a community and to facilitate a large healthy eating community event in the area. This did not go any further.	Collaboration between the HSC and the local Healthy Eating Community Forum	3/5		
	FOOD DUDES Programme	FOOD DUDES healthy eating programme ran over 15 days. Children received fruits and vegetables every day and encouraged to increase their fruit and vegetables intake at school and also at home.	All children participated HSC and two teachers went to training delivered by Bord Bia in order to implement this project into their school. They organised timetables, delivery system for each class and parents to support with delivery.			1/5
	HSC Organic Gardening training and Gardening Project	HSC attended 8 week Organic Gardening course for use with parents/children in Year 2 which involved facilitated sessions on gardening.	All children were involved. Coordinated by HSC and facilitated by expert in wildlife.	3/5		3/5
	Nutrition sessions for children and parents	Nutrition sessions during SPHE lessons with children and parents to see and encourage children's healthy eating (e.g. Healthy Bites, shopping for the right foods, Soup Tasting and Brown Bread Snacks sessions)	Children in Junior and Senior Infants and their parents. Children designed invitations for their parents to invite them to attend the sessions. HSC collaborated with the principal, HSCL and teachers to plan the sessions. Teachers distributed notes to parents. Sessions facilitated by teacher and assisted by the HSC during SPHE lessons. Handouts, presentations, posters, notes for parents, resources and evaluation sheet for children prepared by HSC.		1/5	1/5
	Incredible Edibles Growing Competition	Children grew fruit and vegetables with their teachers.	40 children participated (3rd class and 5th class). HSC collaborated with teachers throughout the process		1/5	

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
6. Children feel good about themselves	Plan for transition from school to school	Began developing plans to support children transitioning to new schools. In the end it was decided that this was already being covered by the School Completion Liaison (SCL) Officer	Initially the HSC consulted with parents, teachers and SCL officer in developing plans to supports to children transitioning to new schools.	3/5		
	Bug busting campaign	A campaign promoting good hygiene	HSC, pupils, parents, teachers, other schools in the area and the PHN were involved	5/5		
	Sensory Room Committee	Committee set up to develop new Sensory Room	Made up of teachers, HSC and Deputy Head	3/5		
	Sensory Room	Use Sensory Room to facilitate Sensory Play with children in order to promote positive mental health.	Initially was used for 150 children. Now different groups of children in the school use it. HSC collaborated with Sensory Room Committee to organise use of the room.	3/5	3/5	3/5
	Review S.P.H.E. Policy	Review S.P.H.E. Policy and identify strengths, weaknesses and gaps in SPHE policy.	Collaboration between HSC, Deputy head and teachers. HSC designed and distributed questionnaires for staff with aim of identifying strengths, weaknesses and gaps in SPHE policy. The HSC compiled a report based on the findings, met with staff to discuss how to address issues, formed an SPHE Policy Review committee and devised new SPHE policy.	1/5		
	SPHE Curriculum and Policy Change incorporating Sensory Room	Incorporated use of Sensory Room into SPHE Programme and policy.	HSC lead this process In collaboration with the Deputy Head of the school	1/5		
	Health and Hygiene incorporated into SPHE curriculum	Carried out as part of SPHE Curriculum and included: games discussion activities, DVD and discussion and practical sessions around hygiene	All 4th and 6th class children participated in one school. Issues were raised by teachers. HSC co-facilitated sessions with teachers to support existing SPHE Curriculum in a fun informal way. Teachers supported with collection and distribution of letters.		1/5	1/5

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
7. School community/ parents' involvement and capacity-building/training	SLT-related Health Education Session with Parents	Provided updates on SLT in the Health Centre and updates on SLT appointments and current waiting list	Targeted all parents. HSCL coordinator contacted parents, HSC organised posters, notes home, talked to parents and arranged healthy snacks. Information was provided by the SLT.		2/5	
	Monthly Health Education sessions for parents	One Healthy Breakfast session/talk for parents per month to increase their awareness of local health services that can promote their children's physical and mental health, nutrition and access to HSE referrals	Principal, teachers, HSCL coordinator, parents, HSC and guest speakers from the Health Promotion Department, the local Primary Care Team and the local Basketball Association. HSC organised speakers, venue, healthy bites, handouts with useful tips on how to encourage a healthy diet and handouts on reading food labels. Teachers reminded parents about these sessions. HSCL coordinator informed parents about these on their visits.	2/5	2/5	2/5
	Healthy Breakfast Events for Parents	Healthy breakfast events with aim of forming a parents support and healthy activities group went ahead as part of the Parental Quit Smoking Programme	Small group of parents attended. Coordinated by HSC and facilitated by the Regional Health Promotion Officer			3/5
	Quit Smoking Programme for parents	Parental Quit Smoking Programme	Small group of parents attended. Coordinated by HSC and facilitated by the Regional Health Promotion Officer			3/5
	Breakfast Club with parents	2 Breakfast Club sessions organised for parents whose children are coming to Breakfast Club.	HSC organised these in collaboration with HSCL coordinator and Learning Support Teacher		1/5	1/5
	Dyspraxia training for parents	Based on training received by the HSC, information material was provided to parents on Dyspraxia to identify problems and support children at home (e.g. exercise ball to strengthen hand and a fatter pen for child to try out, swimming pool vouchers) For 2/3 schools, the HSC collaborates with the Care Team on these issues.	HSC, care team, SLT and parents.	3/5	3/5	3/5

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Health and Hygiene Programme	A 5 week, a 7 week and a 6 week health and hygiene programme was ran each year which incorporated Therapeutic Play, educational and practical sessions	All of 5th and 6th class children participated from 2 schools in the final year and 5th class girls participated from one school participated the previous two years. Need identified by teachers and the Principal due to hygiene concerns. HSC co-facilitated the programme with the teachers, the SCP, guest speakers Dental Educator, Nutritionist, and conducted an ongoing evaluation of it.	1/5	1/5	2/5
	FARE (Football Against Racism in Europe) Art Competition	Racism art competition to mark 2010 Social Inclusion Week. Children were invited to design a poster to highlight social inclusion – themed 'Football against Racism in Europe). Posters were displayed in the Local Football Stadium on the night of the match. Prizes provided.	4th, 5th and 6th Class children participated. Initiated by HSC in school in collaboration with Local Football Club and a local newspaper.		1/5	
	Active School Committee	Active School Committee set up to obtain Active School Flag.	Monthly meeting with the Active School Committee which consists of principal, PE post holder, Home School Community Liaison (HSCL)coordinator, teachers, SNAs, parents from Local Committee) HSC to support with organising training for teachers in Term 2.		2/5	2/5
	Low Energy Day	HSC and Green School Committee organised a Low Energy Day.	All children were involved. HSC collaborated with Green School Committee, teachers and children. HSC facilitated low energy benefits talks through classes and also reminded all children and teachers to keep energy levels down.			1/5
	Breakfast Club	A daily Breakfast Club which also focused on hygiene, healthy diet, linking with disadvantaged parents and their children.	Deputy principal and HSC identified children in need.		1/5	1/5

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Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Last Day Dance Training Ceremony	Parents were invited on the last day ceremony to watch their children's dance performance.	HSCs, principal, HSCL coordinator, dance trainer and parents (15 attended)and the local Sports Complex Co-ordinator HSC organised a few prizes and co-ordinated the day.	1/5	1/5	1/5
	Last Day of Cardiokids Ceremony	Parents were invited on the last day ceremony to play a game of volleyball with their children. All children received certificates and family swim vouchers to Tallaght Leisure Centre.	HSCs, principal, HSCL coordinator, dance trainer and parents (15 attended)			1/5
	Parent Visit to Local Foods Company	One day guided tour of Local Foods Company for parents to look at the importance of a balanced diet.	HSC, HSCL coordinator, parents, Local Foods Company		2/5	
	Parent Bug busting workshop	Bug Busting workshop for parents supplying and educating families about the bug busting kit.	HSCs collaborated with other schools in the area, PHN, all parents and children.	5/5		
	Parent pamper day	Ran Relaxation and Healthy Lunch for parents on Local Committee.	HSCs collaborated with other schools in the area, HSCL coordinator, parents from Local Committee. HSC organised and co-facilitated the day.	5/5		
	Parents support and healthy activities group	A parent health forum	HSC drafted questionnaire up to be given to parents initially to identify interests and needs. HSC planned regular meetings and events using this information to suit interests and needs of parents and facilitated meetings weekly initially with aim of group becoming self managed.	3/5		
	Supporting parents with child referrals and follow-ups	Supporting parents with child referrals and follow-ups	The HSC provided information to parents regarding referral pathways, explanation of service. They provided support in advocating for and making scheduled appointments; with phone calls, reminders, encouraged attendance and accompanied parent and child to appointments where necessary. They also linked parents to monthly drop in advice clinic while awaiting assessment for speech and language therapy.	3/5		
	Parent and Child Yoga	A 4 week after school parent and child yoga sessions	Junior infants and some of their parents were involved. HSC designed, distributed and collected child and adult questionnaires for feedback at end of programme An outside facilitator ran the sessions	1/5	1/5	

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Information on Local Healthy Activities	Link parents to local sports facilities/groups.	Some parents were informed. HSC collaborated with the County Sports Partnership	3/5		
	Healthy Cookery Programme	4 weeks Healthy Cookery Programme for parents	All parents targeted (8 participated). Dietician from the Health Promotion Department used a Resource pack to run the session. HSC co facilitated Healthy Cookery Programme and collected and documented feedback at the end of the programme.	3/5		
	Health Promotion Education Sessions for parents	Organised 4 health talks for parents as part of group/ forum based on interests and needs of group. 3 Nutrition sessions held after follow-up to concerns about eating habits, sugar content in foods and comparing labels for fat, sugar, salt content.	All parents targeted (25 participated). Visiting nutritionist facilitated the sessions. HSC collected and recorded feedback from parents	3/5		
	Capacity building nutrition training for parents	8 wks Capacity building training programme (food and nutrition) for parents	A small group of parents participated. HSCL coordinator informed parents about these on their visits and HSC identified parents interested from the Breakfast Club. HSC and Health Promotion representatives facilitated the training.		2/5	
	Personal evelopment training for parents	Personal Development training for parents called 'Time Out 4 Me' (7 weeks covered goal setting, a session on cookery and another 6 weeks covered mental health awareness). The theme of the training was identified by parents in the previous school year. HSC organised admin details and other facilitators.	A small group of parents were identified in collaboration with HSCL coordinators and teachers. HSC collaborated with the Regional Health Promotion Officer, local County Council, Demonstration Chef, HSCL coordinators, teachers, parents and the Personal Development Trainer facilitated sessions.			5/5
	Play Therapy talk for parents	The session was focussed on using play to support children's emotional development and gave handouts to parents with suggested activities.	All children in Senior Infants and most parents participated. Talk was facilitated by the HSC.		2/5	

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Health Info Stand for parents	Health information and support provided for parents in the HSC office/main hall once a week (e.g. health promotion leaflets, fliers, linking with parents advert in school newsletter about future events and activities for children and parents).	HSC targeted all parents and children and many availed of this service.	5/5	5/5	5/5
	Healthy Schools Committee	A Healthy Schools Committee was set up to organise the Healthy Schools Day	Healthy Schools Committee is made up of 10 parents, HSC and the HSCL coordinator.		2/5	
8. School Staff capacity-building/training	Anti bullying	Anti-Bullying session for teachers as part of their staff meeting	HSC and teachers were involved in this session	2/5		
	School Speech and Language Therapist (SLT)	SLT employed to provide speech and language therapy to school children and provide training to teachers in identifying children with difficulties and in applying techniques in class to improve the children's speech and language.	Junior and Senior Infants and all teachers in the schools were involved in accessing SLT supports.		3/5	3/5
	Teacher Stress management training	Stress management training for teachers	HSC and all the teachers were involved in this training.	2/5		
	FOOD DUDES Programme training for teachers	FOOD DUDES healthy eating programme ran over 15 days. Children received fruits and vegetables every day and encouraged to increase their fruit and vegetables intake at school and also at home.	HSC accompanied by 2 other teachers went to training (delivered by Bord Bia) to implement this project into their school.			1/5
	Skip Hop facilitation training	Teachers were trained in facilitating the children's skipping programme	6 teachers, HSC and the skipping facilitator were involved.	3/5		
	Dyspraxia training for teachers	Based on training received by the HSC, information material was provided to teachers on Dyspraxia.	HSC in collaboration with the Care Team provided teachers with Dyspraxia training in relations to tools for teachers to identify children with difficulties and support children in the classroom and during PE and games (e.g. using an exercise ball to strengthen hand and a fatter pen for child to try out).		3/5	
	HSC was trained up on ccupational Therapy issues and techniques.	HSC received Dyspraxia training in relations to tools for teachers to identify children with difficulties and support children in the classroom and during PE and games	HSC attended workshop.		3/5	

Outcomes	Activities Services Training	Description of Activities, Services or Training	Who will be/was involved	How many schools were involved in each year		
				2009	2010	2011
	Buntus:	Had information table at Healthy Schools Open Day regarding getting access to sports equipment for the school. Buntas programme is not currently in operation in the schools.	All staff received information about it. HSC collaborated with the Regional County Sports Partnership.			3/5
	Steering Committee Expert Panel	Experts were invited to attend the Steering Committee meetings to exchange information with school staff.	Steering Committee members and expert advisers from, for example, psychological services, primary care teams and regional health promotion offices attended.	5/5	5/5	5/5
	Healthy Schools Initiative Information Exchange Seminar	Experts were invited to attend Information Exchange Seminar about Health-promoting Schools.	Initiative Funders, an International Health-promoting Schools Coordinator, HSCs, teachers, principals, health promotion officer, Healthy Schools manual developer, service providers, community members and HS evaluators attended.		5/5	
	Postgraduate course in Health Promotion	A part funded postgraduate course in health promotion for members of the school community was provided.	2 teachers and a small number of community members registered.		5/5	5/5