

TOWARD THE CREATION OF HEALTHY SCHOOLS:
CONSTRUCTING A SCHOOL HEALTH PARTNERSHIP MODEL FOR STUDENT WELL-BEING TO
INSPIRE AND GUIDE PUBLIC HEALTH AND EDUCATION PROFESSIONALS, AT ALL LEVELS,
AND MENTAL HEALTH LEADS

A thesis submitted in partial fulfillment of the requirements for the
Doctorate in Philosophy degree in Population Health

Interdisciplinary School of Health Sciences
Faculty of Health Sciences
University of Ottawa

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ABSTRACT

Over twenty years ago, the World Health Organization launched a health promoting school movement as part of its settings approach to creating healthy environments. Partnerships across the public health and education sectors are vitally important in efforts to improve the health of children and youth in a school setting. In support of this principle, major advancements have been made within Ontario's education sector, such as mandating local school systems to incorporate the goal of student well-being into their improvement plans and promoting the use of their Foundations for a Healthy School framework. Furthermore, the provincial ministries of education and health are actively encouraging the strengthening of local school health partnerships. However, there is a lack of knowledge within the health promoting school literature as to how to go about establishing well-functioning partnerships within local school systems.

To address this problem, the thesis project aimed to generate knowledge about partnerships between public health professionals and local school system actors, and to shed light on the potential for collaboration toward the creation of healthy schools. Before embarking on this thesis project, however, a conceptual framework was developed to gain a firm understanding of cross-sector collaboration for social change, since collaboration represents a partnership at the highest level of engagement. Two other literature reviews were carried out to understand further the partnership component of health promoting school models, and to show the extent of the knowledge gap existing in this area. The literature review on health promoting schools identifies, to a limited extent, the fundamental elements that specifically constitute school health partnerships at both the school and school board levels. Likewise, the scoping review that examines the knowledge-base on the different types of partnership for health promotion within school systems revealed an absence of in-depth knowledge on this topic.

When setting out to fill this knowledge gap, an exploratory research methodology that was primarily qualitative in design was chosen. It included a participatory orientation, whereby a research steering committee of 10 public health managers provided guidance with the formulation of the research question,

and with the data collection and interpretation stages of the research project's public health sector phase. An online survey of school health partnership actors from all 36 Ontario public health units was carried out, along with semi-structured interviews with key school health informants from 32 of these public health units and from six school boards in the province. Although the contribution from the education sector was not as pronounced, school board participants corroborated the findings from participating public health professionals and provided additional insights to gain a clearer understanding of partnership challenges and how to strengthen school health partnerships. Thematic analysis of the collected data was performed based on both deductive and inductive reasoning.

From the public health perspective, a school health partnership model for student well-being was constructed. This model was enhanced to some extent by the views of school board representatives. It is composed of two dimensions: the Partnership Generator, and the Collaboration Continuum. The Partnership Generator comprises four inter-related components, namely cross-sector engagement, connection, capacity, and continuity, with relationship building at its core. The cross-sector engagement component encompasses various elements that enrich engagement across the public health and education sectors, while the other three components consist of those elements that enable this engagement. The connection elements motivate school health partners to engage, whereas the capacity elements determine the extent to which engagement can take place. Finally, the elements that make up the continuity component maintain the momentum that motivated cross-sector engagement created based on the capacity that was made available through this engagement. Each of these elements contribute to a school health partnership's strength. The Collaboration Continuum dimension refers to school health partners' movement from one partnership arrangement to the next, with increasingly more extensive levels of cross-sector engagement. It includes three sets of supporting conditions to promote movement along the continuum, going from networking to cooperation and then to collaboration.

The resulting model provides the knowledge base for assessing the strengths of a given school health partnership and for shedding light on which partnership areas would need to be further developed. Overall, this model offers any professional, from the field of public health, education, or mental health, a closer look at what would be required for a school health partnership to become truly collaborative and reach its maximum potential. It promises to inspire and guide school health partners in their pursuit of more meaningful engagement with one another toward greater improvements in the well-being of school-age children, in recognition of their shared responsibility.

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My doctoral thesis is about working in partnership, supporting one another by sharing information, resources, and the decision-making process. It is only fitting, then, that my own doctoral experience be one of collaboration. And I am very grateful for the many people who have joined me on this partnership experience, which has been quite exhilarating and productive, and has made all the difficulties along the way that much more bearable.

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Chapter 1: Introduction

1.1 The need for knowledge about cross-sector partnerships

The research direction I have chosen for my doctoral thesis reflects my aspiration to co-create knowledge about cross-sector partnerships with diverse actors—decision makers, management personnel, and front-line workers—spanning the public, not-for-profit, and business sectors, and crossing a variety of policy sectors. In-depth knowledge on how to strengthen cross-sector partnerships would greatly support efforts to effectively tackle pressing population-health issues in today's complex and ever-changing society that is still grappling with an ongoing epidemic of preventable chronic diseases. My research journey began with a keen interest to discover the world of collaborative governance, where representatives from different sectors would come together to act in a concerted manner for greater impact toward a common goal in order to make a substantial improvement in people's lives.

The multifaceted problems of modern society, and especially poor health outcomes within the population, do not lend themselves to straightforward solutions. They can only be resolved through a systems approach involving diverse actors from various policy domains. Rittel and Webber (1973) coined the term “wicked” to characterize these intractable and complex societal problems. Wicked problems are by their very nature difficult to define, and options for their resolution are strongly dependent on the value judgements and specific interests of a broad array of social and political actors (Rittel & Webber, 1973). Enduring governance processes and structures are needed in society to find common ground and promote collaboration across sector boundaries in a sustainable manner.

Taken together, inter-related factors pertaining to the physical and social environments of daily living determine the health of the population to a greater extent than does universal access to health care services (Heymann, Hertzman, Barer, & Evans, 2006). These health-influencing factors are referred to as upstream determinants of health, or the physical and social determinants of health—for example, people's low socioeconomic positions within society's hierarchy, with their corresponding levels of material deprivation, psychosocial stressors, and exposures to toxic products, both at home and at work, which are known to underlie the disease process (Commission on the Social Determinants of Health, 2008; Evans, Barer, & Marmor, 1994; Lynch, Davey Smith, Kaplan, & House, 2000; McIntosh, 2010; Wilkinson 1996).

The health care sector deals mainly with medical conditions and symptoms once they have manifested further down a disease pathway. Tacking action on the physical and social determinants of health would help prevent the onset of disease, thereby improving the health of the population while at the same time relieving the pressures hampering the health care system. These health determinants may be improved through society's ability to pursue intersectoral action, given that the causes of disease lie outside the health care sector (McQueen, Wismar, Lin, & Jones, 2012). The challenge lies in knowing how to establish partnerships that are effective in directing sustainable collaborative efforts at the systems level. For this to happen, it will take a paradigm shift regarding the way society is governed; that is to say, it will require a much-needed move away from traditional top-down, silo-based decision-making toward cross-sector collaboration (Greaves & Bialystok, 2011; Shankardass, Solar, Murphy, Greaves, & O'Campo, 2012). Through such a shift, we stand a greater chance of resolving the complex and interwoven problems plaguing society today.

Society's problems cannot be resolved by any single organization acting alone. Collaborative arrangements among multiple stakeholder sectors (e.g., public, civil, academic, business), crossing various policy sectors, hold much promise for addressing wicked problems affecting the health of populations. My quest to gain a clear understanding of cross-sector partnerships led me to focus on the younger generation within the school system, since this represents the age group where desired population-health improvements can more readily take place through a systems approach.

1.2 Chronic disease in Canada: A growing epidemic

The Public Health Agency of Canada (PHAC, 2008) reports that approximately 80% of all Canadian adults need to address one or more modifiable risk factors (i.e., smoking, alcohol consumption, physical inactivity, and low fruit and vegetable intake) known to be associated with preventable health-related conditions. Doing so would reduce the likelihood of developing a chronic disease, such as cardiovascular disease, cancer, diabetes, chronic obstructive pulmonary disease, arthritis, and mental illness.

The rise in overweight and obesity, along with diet-related chronic diseases, has reached epidemic proportions around the world, including Canada (Pouliou & Elliott, 2010; Reilly & Kelly, 2011; Wang & Lobstein, 2006). These conditions may start to set in during childhood and adolescence. Based on the

Canadian Health Measures Survey, a staggering proportion of Canadian children and youth were overweight (19.8%) or obese (11.7%) during the covered period of 2009–2011 (Roberts, Shields, de Groh, Aziz, & Gilbert, 2012). Furthermore, nearly one in three Canadians aged 12 years or older currently live with one or more chronic health conditions, and this figure is expected to keep increasing over time (Touchie, 2013). In addition, it is estimated that one in five Canadians experience a mental disorder or addiction problem in any given year (Smetanin et al., 2011), with the majority of cases beginning in adolescence or young adulthood (Government of Canada, 2006). Of the estimated 15% of Canadian youth suffering from a mental disorder, only about one fifth receive mental health care (Kutcher, 2011). The need for health promotion initiatives to curtail and reverse the growing rates of chronic health conditions has become an urgent matter that can no longer be contained within the longstanding realm of public health advocacy but must now be propelled into the world of collective action.

1.3 Research focus and setting: Health promotion within the school system in Ontario

The younger generation constitutes a substantial proportion of the Canadian population. Almost one quarter of the Canadian population in 2012 (22.4%) fell within the age range of children and youth under 19 (Touchie, 2013). The school system represents an ideal setting to reach these young people in order to promote their health (Stewart-Brown, 2006; Veugelers & Fitzgerald, 2005), which may then lead to greater academic success. Education status is closely related to income and occupation, and together, these social indicators constitute a person's socioeconomic position in society, a major social determinant of health (Commission on the Social Determinants of Health, 2008; Mittlemark, 2007). A recent systematic review of the school health literature found that healthy nutrition and participation in team sports have a positive effect on academic performance, while the opposite effect was observed for unhealthy behavior, such as alcohol use, smoking, early sexual activity, bullying, and screen time use (Busch et al., 2014). Promoting healthy behavior over unhealthy behavioral patterns leads to greater success in school, and in turn, achieving well in school has major health implications. People who have attained greater educational success tend to enjoy better health than their less educated counterparts (Freudenberg & Ruglis, 2007). Evidently, there is a high level of interdependence between the health and education sectors.

For decades, public health professionals have led the way in strongly advocating for a positive definition of health and facilitating “intersectoral actions and citizen participation to improve local living conditions”

(Potvin & Jones, 2011, p. 246). In view of the apparent interdependence between the sectors of health and education, public health nurses have long been active within the school system to ensure that students receive proper health care services in order to reduce school absenteeism. After the major turning point in the field of public health marked by the Ottawa Charter in 1986, they have included health promotion in school settings to their formal duties (Schoessler, 2011; Whitehead, 2006). Indeed, school-based health promotion initiatives are meant to engage multiple stakeholders. Stakeholders range from the school community itself (e.g., school administrators, teachers, other school staff, students, and parents) to community partners (e.g., public health nurses, dietitians, other professional groups, service agencies, community-based organizations, municipal departments, and local businesses). Clearly, these initiatives signify a major strategy to tackle the current chronic disease epidemic and improve population health.

The World Health Organization (WHO) had already added in the preamble to its constitution a broad definition of health that went far beyond the simple lack of ill health: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (WHO, 1946, p. 100). The 1986 Ottawa Charter for Health Promotion builds on this core definition and introduces an expanded role for public health professionals. They are being called to “enable, mediate, and advocate” the promotion of health by undertaking five key actions: “build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, and reorient health services” (WHO, 1986, p. 425). The health promoting school approach makes use of these principles and the five action strategies by applying them to the school setting (WHO, 2000).

Over twenty years ago, the WHO launched its global school health initiative, which has come to be known as the health promoting school movement, as part of its settings approach to creating healthy environments. Indeed, the movement for the creation of health promoting schools (HPS) has proliferated throughout the world through the emergence of regional networks, driven by WHO’s leadership. This movement began to take hold in the mid-1990s as WHO’s European Regional Office, the Council of Europe and the Commission of the European Communities joined forces to pave the way for every young person to have the right and the opportunity to attend a health promoting school (WHO, 2000). The European network appeared first in 1995 and then other networks spread across Asia-Pacific, Latin America (including Mexico), and Africa (Barnekow et al., 2006; Doria, 2007; Nederveen, 2010; Vince Whitman & Aldinger, 2009; WHO, 1998). Additional countries such as the United States, Australia, and New Zealand

had been pursuing similar HPS-related initiatives around that same period. In Canada, each province has their own adaptation of the HPS approach, and all provinces except Quebec have links to their respective HPS strategies available on the website of the Pan-Canadian Joint Consortium for School Health (Veugelers & Schwartz, 2010; see <<http://www.jcsh-cces.ca>>).

WHO's Health Promoting School framework is an internationally recognized best practice for the development and delivery of comprehensive health promotion programs within a school setting. This "whole-school" approach goes by various names. Whereas the term "health promoting school framework" is mainly used in European countries and Australia, this approach is known as "the coordinated school health model" in the United States and "the comprehensive school health model" in Canada (Allensworth, 1997; Booth & Samdal, 1997; Parsons, Stears, & Thomas, 1996; Veugelers & Schwartz, 2010). It may also be referred to as the "healthy school approach" (Flaschberger, Nitsch, & Waldherr, 2012; Pucher, Candel, Krumeich, Boot, & De Vries, 2015). Canada's Comprehensive School Health model was conceived in 2005 by the Joint Consortium for School Health, a partnership of provincial and territorial ministries of health and education across the country, and the Public Health Agency of Canada. One distinguishing feature of this multi-prong approach is the emphasis on addressing a broad array of health concerns based on school needs, to the extent possible. Health topics range from healthy eating and physical activity, to mental health promotion and sexual health, to the prevention of substance misuse and injury.

Cross-cutting these health topics are the building blocks for creating health promoting schools. Although variations exist in the way governmental jurisdictions organize the components of their own framework, the underlying dimensions for action remain the same: curriculum integration, enhancement of the school's social and physical environment (including policy development), and the involvement of the family and community, as it pertains to local partnerships. Within the domain of health promoting schools, partnerships are considered one of the most critical factors for the successful implementation of health promotion initiatives within a school setting (McKay et al., 2015; Thomas, Rowe, & Harris, 2010; Veugelers & Schwartz, 2010).

In Ontario, Canada, major advancements have been made within the provincial school system. For the last decade, the Government of Ontario has steadfastly made explicit the importance of attending to the well-being of students beyond legislated health protection services. In 2006, one year following the establishment of the Joint Consortium for School Health, the Ontario Ministry of Health and the Ontario

Ministry of Education came together to produce the Foundations for a Healthy School framework, based on the tenets of comprehensive school health (Ontario Ministry of Health Promotion, 2010). Afterward, the Ontario Ministry of Education amended the *Education Act* in 2010¹ to mandate the goal of student well-being within local school systems, and they launched a revised version of its Foundations framework in 2014 (Ontario Ministry of Education, 2014a), as shown in Appendix 1A. This forward-thinking direction culminated in their renewed vision for academic achievement that incorporated student well-being as one of its primary goals (Ontario Ministry of Education, 2014b). Following these groundbreaking developments, a joint Committee of the Council of Ontario Directors of Education and the Council of Ontario Medical Officers of Health was formed to strengthen partnerships across their respective sectors.

The new Ontario Public Health Standards that came out in 2008, and were revised in 2018, support an expanded role for public health professionals within the school system (Ontario Ministry of Health and Long-term Care, 2018). Through these standards, they have been mandated to work in partnership with school boards and schools and engage in the promotion of comprehensive school health. Although no similar partnership expectation has been formally specified within the school system, decision-makers within both the education and public health sectors in Ontario have come together to recognize their shared mandate of health promotion. In 2013, the Executive Director of the Council of Ontario Directors of Education (CODE) and the Chair of the Council of Ontario Medical Officers of Health (COMOH) agreed to embark on a joint initiative to “explore opportunities to build upon and enhance current agreements and practices between public health units and school boards (...) [and] identify opportunities to better support the delivery of services for students and families” (Healthy Schools 2020, 2014, p. 1). They established a committee, composed of seven members from each council along with representatives from the Ontario ministries of health and education and a project coordinator (CODE-COMOH Committee, 2015).

Referred to as the CODE-COMOH Committee, the members have committed to meet at least three times per year. In their November 2014 letter to their peers, the committee co-chairs explicitly stated their agreement on a shared mandate:

¹ Government of Ontario. (2010). *Education Act*, R.S.O. 1990, c. E.2. December 15, 2009—January 31, 2010. Retrieved from <https://www.ontario.ca/laws/statute/90e02/v36>

[The promotion of child and student well-being] is an important mandate in which school boards and boards of health have a shared responsibility. Strong partnerships that focus efforts on strategic priorities can improve health outcomes for children and students, positively affect their achievement, and reduce preventable illness and injuries. This, in turn, will contribute to healthier and better-educated citizens. (CODE-COMOH Committee, 2014, p. 1)

Partnerships across public health units and school boards in Ontario are of vital importance in efforts to promote the well-being of children and youth within a school setting. However, more research is needed on how health and education institutions can work closer together (St. Leger, Kolbe, Lee, McCall, & Young, 2007). Therefore, the purpose of this doctoral thesis project is to inform and complement the CODE-COMOH Committee's initiative to help foster strong partnerships between school boards and public health units.

1.4 Thesis goal, objectives and rationale

The goal of my doctoral thesis project is to generate knowledge about partnership development across the public health and education sectors and to shed light on the potential for collaboration toward the creation of healthy schools in Ontario. Research objectives are as follows:

- (1) to determine the different types of school health partnerships and possible ways of engagement across public health units and school boards throughout Ontario, specifically in relation to health promotion and prevention initiatives beyond legislated health services;
- (2) to identify the enriching, enabling and hindering factors experienced in these cross-sector partnerships as well as possibilities for improvement and for moving along the collaboration continuum; and
- (3) to examine the extent to which these cross-sector partnerships are utilizing the Foundations for a Healthy School document for guidance.

In this doctoral thesis, all references to health promotion implies the aspects of both promotion and prevention (e.g., prevention of substance misuse and injury) other than the prevention of dental caries and infectious diseases through dental health care and immunization, respectively. The latter are legislated health services that involve a different partnership dynamic between public health units and school boards, and therefore, they are considered to be beyond the scope of the thesis project.

The seed for a settings approach can be found in the Ottawa Charter's statement that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO, 1986, p. 427). It has blossomed into "a plethora of international and national programmes and networks, (...) covering settings as diverse as regions, districts, cities, islands, schools, hospitals, workplaces, prisons, universities and marketplaces" (Dooris, 2006, p. 4). A settings approach points out that people's health status cannot be characterized solely by their behavioral patterns or medical conditions. Rather, the environments in which they find themselves may profoundly affect their health status by influencing what health-related behavior they choose to adopt and the type of living conditions they are facing on a daily basis (Green, Poland, & Rootman, 2000). According to Mullen et al. (1995), settings may be defined as "major social structures that provide channels and mechanisms of influence for reaching defined populations" (p. 330). A settings approach provides the impetus for public health professionals to take action, as Green et al. (2000) posited:

We suspect that the settings approach also has powerful appeal for practitioners as a concrete, practical focus insofar as settings represent a pragmatic and manageable scale at which to direct change efforts. Settings come equipped with readily definable structures, routines, pathways of entrée and of change, are relatively stable over time, are less amorphous than community or 'society,' and are more easily operationalized than a focus on specific risk groups (p. 12).

School-age children, regardless of their socioeconomic status, can be conveniently reached in schools, where they spend a large proportion of their waking time (Anderssen, 2013). For this reason, public health initiatives aimed at children and youth are now often delivered within this key setting (Inman, van Bakergem, Larosa, & Garr, 2011). For long-term health and well-being, it is important to begin fairly early in peoples' lives to establish healthy behavioral patterns (McIsaac, Kirk, & Kuhle, 2015). Adolescence, in particular, is a critical period when the youth begin to form their ideas about health (Michaelson, McKerron, & Davison, 2015). The advantage of promoting health within a school setting is that school life has the potential of positively shaping their knowledge, attitudes, and behavior with respect to their health and well-being for lifelong health benefits (James, 2010).

Parcel, Kelder, and Basen-Engquist (2000) give a number of reasons why schools are an appealing setting for health promotion:

The amount of time children spend in school, both in a single day and on a weekly basis, provides a large window of access to this population. The breadth of activities that students

engage in during this time, including learning, playing, eating, and socializing, provides a diverse array of controlled environments in which children can learn, practice, and be reinforced in making healthful decisions. (...) Thus, changes in either the physical environment of the school (e.g., decreasing the fat content of food served in the cafeteria, display of health-related messages through wall posters or bulletin boards) or the social environment (e.g., forming student organizations to work on health issues, encouraging students to make a public commitment to health behavior) can have an impact on student health (p. 88-89).

However, health is not the only consideration when endeavoring to create healthy schools. Expanding on a crucial point made earlier, promoting health early in life not only instills values of healthy living and improves educational outcomes throughout the school year, but it may also have lifelong advantages (Berlot & James, 2011; Florence, Asbridge, & Veugelers, 2008; Murray, Low, Hollis, Cross, & Davis, 2007; Nyaradi, Li, Hickling, Foster, & Oddy, 2013; Nyaradi et al., 2014; Rosas, Case, & Tholstrup, 2009; Shi, Tubb, Fingers, Chen, & Caffrey, 2013; Suhrcke & de Paz Nieves, 2011; Vassiloudis, Yiannakouris, Panagiotakos, Apostolopoulos, & Costarelli, 2014; Vinciullo & Bradley, 2009). Succeeding in school contributes to enhanced life management skills and a favorable socioeconomic status in adulthood, both of which are associated with better health outcomes (Commission on the Social Determinants of Health, 2008; Cutler & Lleras-Muney, 2006; Furnée, Groot, & Maassen van den Brink, 2008). Strengthening partnerships across the public health and education sectors would offer children and youth greater opportunities to acquire the necessary skills and knowledge to take better care of their health so that they may do well in their academic studies and go on to leading a healthy and successful life throughout their adulthood.

1.5 Thesis overview

Before embarking on an exploration of school health partnerships for student well-being, I chose to first identify the fundamental elements of cross-sector collaboration, since collaboration represents a partnership at the highest level of engagement. To this end, Chapter 2 introduces my conceptual framework of cross-sector collaboration for social change to promote population health. This conceptual framework provides a basic understanding of what would constitute a well-functioning collaborative partnership that crosses sector boundaries. It served as a practical tool for reviewing the literature related to school health partnerships; developing data collection instruments; and applying deductive reasoning when analyzing the collected data. Two other literature reviews are then presented to understand further the partnership component of health promoting school models, and to show the extent of the knowledge

gap existing in this area. In Chapter 3, the literature review on health promoting schools identifies, to a limited extent, the fundamental elements that specifically constitute school health partnerships at both the school and school board levels. In Chapter 4, the scoping review examines the knowledge-base on the different types of partnerships for health promotion within school systems and reveals an absence of in-depth knowledge on this topic.

A description of the methodology used for my doctoral thesis project is found in Chapter 5. The chosen methodology is primarily qualitative in design and includes a participatory orientation. The participatory component, which called for the establishment of a research steering committee of public health managers, proved to be indispensable for ensuring a productive line of questioning and for eliciting a high rate of study participation from their peers. Being unfamiliar with the complexity and nuances that characterize school health partnership experiences, this research project would not have yielded relevant and valuable results without the committee's guidance with fine-tuning the research question and developing the data collection instruments. All public health units across Ontario participated in the School Health Partnership Survey, and professionals from a large majority of these public health units underwent follow-up interviews. A much smaller number of school board representatives were interviewed, but partnership insights were gained from this group, nevertheless.

The next series of chapters provide the answers to my specific research questions. Chapters 6 and 7 explore the partnership elements that enrich and enable cross-sector engagement, respectively. Chapter 8 deals with the level of partnership satisfaction experienced by public health professionals, and it examines the challenges and aspirations of those whose partnerships are not as advanced. This chapter also identifies the conditions that support movement along the collaboration continuum. In Chapter 9, findings on the enriching, enabling, and hindering elements of school health partnerships are presented from the perspective of school board representatives, in addition to their other insights on progressing toward a truly collaborative school health partnership. Finally, Chapter 10 discusses key research findings in relation to my conceptual framework of cross-sector collaboration, and in relation to the management literature that studies important conditions for supporting collaborative partnerships.

Chapter 2: The Fundamentals of Cross-Sector Collaboration for Social Change to Promote Population Health

2.1 Introduction

Cross-sector collaboration is increasingly relied upon to tackle society's pressing and intractable problems (Andrews & Entwistle, 2010; Chen, 2008; Head & Alford, 2015). Societal problems with their social, economic and environmental consequences diminish the quality of life that in turn affects the health of populations (Heymann et al., 2006). Indeed, the ongoing chronic-disease epidemic stems from the effects of unfavorable structural and social determinants of health. These health determinants shape the conditions in which people lead their lives, marked by material disadvantage, exposures to psychosocial stressors and/or environmental toxins both at home and in the workplace, and influence their health-related behaviors, such as dietary habits, level of physical activity, and substance use (Commission on Social Determinants of Health, 2008). As Marmot (2005) asserts, the poor health status of a population is "an indicator that the set of social arrangements needs to change (p. 1099)." Positive social change would necessarily contribute to the prevention of chronic disease by providing a social environment more conducive to healthy living for improved population health.

No one organization or sector can resolve these problems alone. The ability to positively change these upstream determinants of health rests on the collaborative processes and structures of governance across diverse sectors in society (McQueen et al., 2012). However, working across diverse sectors is often challenging. Knowledge on cross-sector collaboration is needed to effectively direct and sustain partnerships across sectors to make lasting change.

The purpose of this chapter is to present a conceptual framework that sheds light on the basic requirements of cross-sector collaboration for social change in order to promote the health of populations. It begins by identifying leading sources of scholarly and practice-based knowledge in this area. It then examines the evolution of theoretical understanding and the current emergence of practitioners' insights. Finally, it elaborates on fundamental elements considered critical for effective cross-sector collaboration. Focusing on capacity building for social change to promote population health is not

enough, equal attention must be paid to the engagement process, the motivation to engage, and collective learning at the core of effective collaboration across sectors.

2.2 Method

A search for theoretical articles on cross-sector collaboration in the fields of public administration and public health was conducted within the journal databases ABI/INFORM Complete and MEDLINE. Collaboration among various organizations can be regarded either as being itself a multi-stakeholder arrangement, such as in cross-sector collaboration, or as a feature or a goal of simple partnerships and networks of partner organizations (Provan & Kenis, 2008; Xu & Morgan, 2012). Additionally, multisector partnerships and goal-directed networks may be considered as examples of collaborative governance, or network governance (Johnston, Hicks, Nan, & Auer, 2011; Provan & Kenis, 2008; Saz-Carranza & Ospina, 2011). Given these interchangeable terms, the search strategy was based on the following key words referring to interorganizational collaboration across sectors: “cross-sector collaboration”, “collaborative governance”, “network governance”, “multisectoral partnership”, and “multi-sector partnership.” The search strategy was further refined by using the key words “theory”, “framework”, and “model”. The search was limited to scholarly articles published in the English language from January 2005 to December 2015. To be retained, the theoretical articles had to present a broad perspective of fundamental elements of a collaborative arrangement, as a whole, that could be applied to any policy area and involve more than one stakeholder sector. Furthermore, the articles had to draw their evidence from a thorough examination of the existing literature covering a wide range of disciplines, rather than a small number of case studies.

The search strategy was supplemented by an internet search of the grey literature on cross-sector collaboration initiatives to identify high-profile models currently being put into practice in Canada and the United States. Practice-based models that are being promoted by influential actors have been selected to confirm, and bring further clarity to, existing scholarly frameworks. The term ‘influential actors’ is defined as individuals who have demonstrated high visibility as knowledge brokers in the area of cross-sector initiatives or who are in a position to champion a particular cross-sector collaboration model, such as funding organizations.

2.3 Theoretical frameworks and practice-based models

Scholarly conceptualization of collaboration across sectors has tended to center on one or a few case studies from a single policy area, such as natural resource management. However, some studies have developed theoretical frameworks of a general nature, irrespective of any policy domain, and have described concepts that cover collaboration, as a whole. Other models, found in the grey literature, have been widely promoted within North America. These models emphasize essential conditions for effective cross-sector collaboration for social change. In this section, we explore the way in which theoretical understanding has evolved up to now, and how current insights from the practice field are contributing to this understanding.

2.3.1 Evolution of theoretical understanding

From the wealth of knowledge that exists on cross-sector collaboration, three theoretical frameworks stand out for their broadness and wide-ranging applicability. First, the earlier work of Bryson, Crosby, and Stone (2006) categorized the extensive knowledge base that had been accumulating on cross-sector collaboration since the mid-1980. Then two years later, Ansell and Gash (2008) presented their own framework by undertaking a meta-analysis of 137 case studies from a wide range of policy areas and settings. Later on, Emerson, Nabatchi, and Balogh (2012) developed an integrative framework that resulted from a series of expert consultations and an extensive review of the literature.

All three theoretical frameworks align closely with each other with respect to the elements they contain. Nevertheless, the relationship between these elements has been reinterpreted from one framework to the next. Bryson et al.'s (2006) framework was kept simple with no consideration for the interactions within and between the two main categories of “process” and “structure and governance”. Maintaining similar key elements of collaboration, Ansell and Gash (2008) brought out the nonlinear character of the collaborative process, describing it as a virtuous cycle of collaboration—albeit still in a simplistic manner. This cycle begins with engagement through face-to-face dialogue. As engagement proceeds, trust and commitment are increasingly cultivated. This, in turn, facilitates the adoption of a shared understanding that results in intermediary outcomes, such as a strategic plan and small wins, which further enrich the dialogue; and so continues the collaboration cycle. Leadership has been removed from the “process”

category, appearing as an element that supports the collaborative process and not as an integral part of it. Emerson et al. (2012) have further teased apart “process” elements in their integrative framework, and brought out the dynamic interplay among three major collaborative-governance components, namely engagement, motivation, and capacity. The interconnected cycles of engagement and motivation are thought to reinforce, and be reinforced by, the capacity for joint action.

With their framework encompassing the two previously mentioned ones, Emerson et al.’s (2012) broadly define collaborative governance as “the processes and structures of public policy decision making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished” (p. 2). All forms of boundary crossing are thus considered relevant, including the horizontal and vertical boundaries within the public sector itself. However, this conceptual framework focuses on collaboration that spans diverse sectors.

2.3.2 Insights from the field of practice

An internet search for articles on prominent models of cross-sector collaboration revealed the work of two leading organizations in North America: Foundation Strategy Group (FSG), in the United States; and the Tamarack Institute of Community Engagement, in Canada. They are both nonprofit consulting firms offering their expertise in cross-sector collaboration (Weaver, 2014). These organizations stand out in particular due to the major charities and heavily endowed private foundations that support their cross-sector collaboration approach (Gemmell, 2014).

These leaders and champions have adopted a particular approach of cross-sector collaboration referred to as the collective impact model. FSG coined the term “collective impact” as a contrast to the isolated impact made by various public agencies and community organizations working on similar goals but in isolation from each other. FSG developed their model following in-depth interviews with participants in highly successful cross-sector collaborations to address such issues as unemployment, academic underperformance, homelessness, nutritional deficiencies in developing countries, and environmental degradation—all complex societal problems with implications for population health. The collective impact model offers a consistent language for the rigorous pursuit of cross-sector collaboration by focusing on

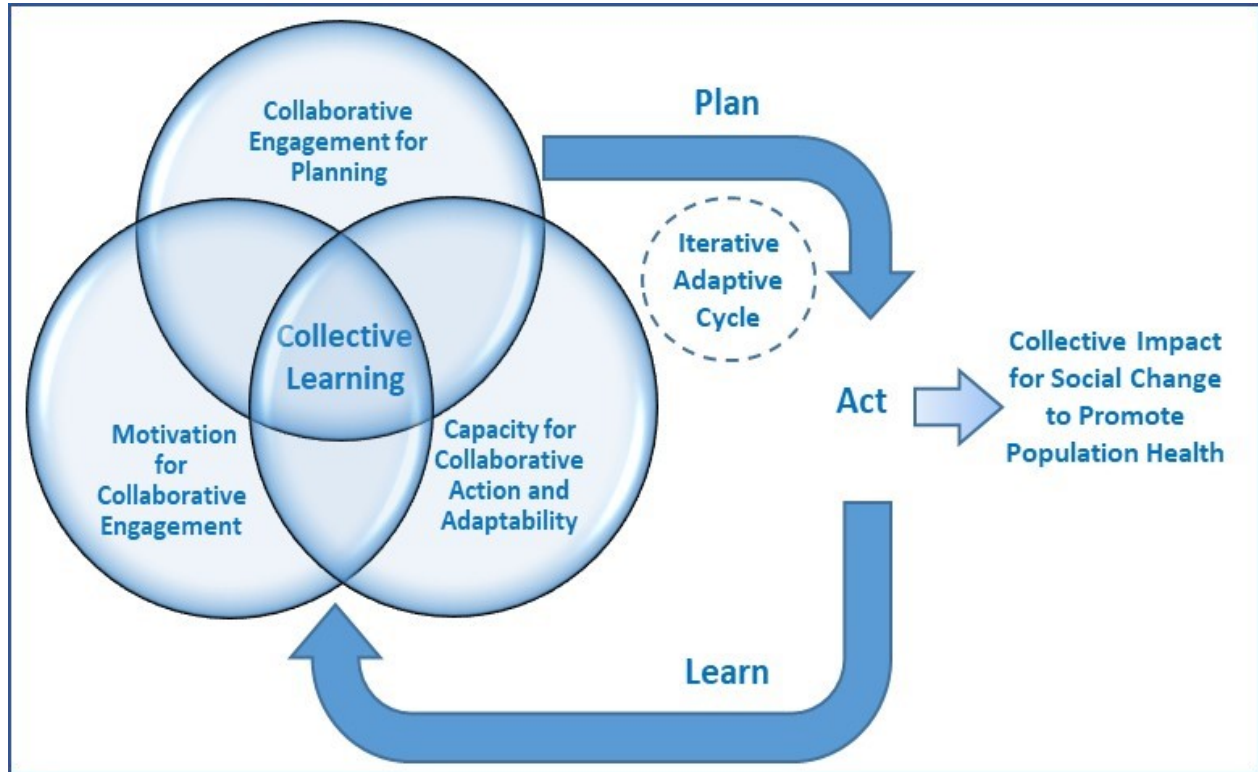
conditions identified as critical for success: a common agenda, mutually reinforcing activities, continuous communication, a shared measurement system, and a backbone support organization (Kania & Kramer, 2011). These conditions are deemed essential but not sufficient. Additional consideration have been given to the use of a comprehensive, yet simple and flexible, strategic framework for engagement purposes; collective vigilance to detect emerging opportunities; cascading levels of governance for better coordination of local action; and collective learning (Hanleybrown, Kania, & Kramer, 2012; Kania & Kramer, 2013).

Echoing these success factors is the constellation model of collaborative social change, conceptualized by Surman and Surman (2008), experts in the area of multi-stakeholder partnerships. The constellation model is based on years of experience with working on cross-sector initiatives. Many achievements were made possible through a fluid governance structure that was based on “light-weight” agreements by a voluntary but long-standing executive-level stewardship group (Surman & Surman, 2008). A fluid structure ensures greater responsiveness to the natural fluctuations in participation on action teams. This model also emphasizes the need for coordination support by a separate “third party” agent (e.g., a consultant or consulting firm). The collective impact and constellation models are consistent with the theoretical frameworks presented earlier, and provide additional knowledge for implementing social-change initiatives.

2.4 Integrating scholarly and practice-based knowledge

The field of cross-sector collaboration has flourished over the years due to the persistent need to know how diverse stakeholder groups could work together more effectively. This section introduces a conceptual framework that builds on the integrative work of Emerson et al. (2012) by placing emphasis on the collaboration dynamics (i.e., engagement, motivation, and capacity) in relation to the collective impact approach, and on the pivotal role of collective learning at the core of cross-sector collaboration. This conceptual framework brings to light the complementarities of theoretical understanding and current practice-based insights about effective collaborative arrangements for social change. As shown in Figure 1, it consists of four main dimensions: drivers of collaboration; the collaborative engagement process; motivation for collaborative engagement, itself; and the capacity for collaborative action and adaptability (see Appendix 1B for a more detailed representation). Overlapping all three dimensions is the central element of collective learning that makes adapting to a complex and unpredictable environment possible.

Figure 1. Conceptual Framework of Cross-Sector Collaboration for Social Change to Promote Population Health



2.4.1 Drivers of collaboration

Before a cross-sector collaboration gets established, there usually exist certain conditions to stir organizations' willingness to combine their efforts. These preconditions, or drivers, include the recognition of organizational interdependence; a compelling incentive; an influential leader; and adequate resources.

Organizational interdependence is a frequently mentioned driving force for collaborative action. Engagement across sectors tends to occur when organizations come to realize that the problem they aim to address cannot be solved by acting on their own but require a collective undertaking (Chen, 2008; Crosby & Bryson, 2010; Koschmann, Kuhn, & Pfarrer, 2012; Velotti, Botti, & Vesci, 2012;). Furthermore, organizations may be inclined to work together if they thought it could produce some economic, social, political and/or organizational advantage, such as the possibility of overcoming failure, leveraging resources, carrying more influence, and streamlining operations (Emerson et al., 2012; O'Leary & Vij, 2012).

A second driver is a compelling incentive that generates the impetus to collaborate. It refers to a crisis, need or opportunity that would have negative consequences, or would compromise or hold back organizational performance, if not acted upon in an immediate and concerted manner (Emerson et al., 2012; Hanleybrown et al., 2012; Surman & Surman, 2008). Such an incentive, in terms of either “a sense of urgency for change” or a “magnetic attractor,” is instrumental in persuading actors who are working on the same issues, separately, to stop competing for scarce resources and instead come together to create a greater impact (Hanleybrown et al., 2012; Surman & Surman, 2008).

An influential leader, or a group of champions, represents another critical precondition by serving as a catalyst to convene the right people for the long term (Crosby & Bryson, 2010; Emerson et al., 2012; Hanleybrown et al., 2012). Two key leadership roles appear to be of particular importance early on: (1) a champion, whose focused intention can inspire stakeholders from various sectors to collaborate; and (2) a sponsor who commands prestige and authority and who can secure resources (Bryson et al., 2006). Lastly, these initial resources must be sufficient to cover the first two to three years of the collaboration, such as multi-year funding, so that momentum can be maintained long enough to ensure a strong and lasting foothold (Hanleybrown et al., 2012).

2.4.2 Collaborative engagement process

Once a cross-sector collaboration is underway, engaging the many partnering stakeholders is a process that must skillfully strike a balance between reaching a common understanding and encouraging a diversity of perspectives for effective planning. A common understanding provides the foundation on which to unite collaborating partners. Scholars speak of collaborative engagement as a “dynamic social learning process,” which begins by discovering shared interests, concerns, and values, and then endeavors to generate, on an ongoing basis, a shared meaning of what the collaboration is all about (Emerson et al., 2012, p. 11). Shared values are important to foster collaborative behavior, especially when there are significant differences regarding organizational mission and culture among collaborators (Bardach, 2001). Erakovich and Anderson (2013) describe organizational values as “an integral part of the organizational culture (...) that influence what is perceived as acceptable” (p. 165). Through shared values, reaching agreements become more feasible. Engaging multiple actors calls for the establishment of shared meaning through the use of a common language and through ongoing deliberation on the purpose of the

collaborative arrangement, the goal to be achieved together, roles and responsibilities, the general nature of the current problem, and its potential solutions, all along the life of the collaboration (Ansell & Gash, 2008; Emerson et al., 2012). When pointing out this requirement, the collective impact model makes reference to the creation of a common agenda, the first essential condition for producing the desired social change (Kania & Kramer, 2011). A collaboration's cohesiveness depends on a common understanding centered on a shared goal, but its problem-solving capabilities would be deficient if all participants were to think exactly in the same way about how to achieve this goal.

Encouraging a diversity of perspectives is another collaboration attribute (Chen, 2008). As Kania, Hanleybrown, and Splansky Juster (2014) point out, a major weakness of many collaborations is that they "still omit critical partners in government and the nonprofit, corporate, and philanthropic sectors, as well as people with lived experience of the issue" (p. 2). Participating actors typically perceive a common problem from their own vantage point. Voicing different perspectives in order to learn from each other may provide an expanded and more realistic picture of the problem and allow the detection of emerging solutions that a narrower outlook would have missed (Hanleybrown et al., 2012). Diverse perspectives can also enhance the collective undertaking of fact-finding tasks and other analytical work (Emerson et al., 2012). When each participating organization shares their unique strengths and expertise, the collaboration is likely to be more successful (Bryson et al., 2006; Magee, 2003). That being said, encouraging the exchange of diverse perspectives may pose a challenge to group cohesion. This challenge manifests as a unity-diversity tension that is so often characteristic of cross-sector groups (Saz-Carranza & Ospina, 2011). Skillful conflict-management approaches are usually employed to mitigate this tension during deliberation and planning. Conflict-management practices include negotiating decision-making rules and putting in place fair and constructive processes for safely exchanging ideas, ensuring equal voice, and resolving impasses (Bryson et al., 2006; Chrislip, 2002; O'Leary & Bingham, 2007).

With respect to collaborative planning, emphasis on flexibility has become paramount in today's society marked by complexity and uncertainty. Traditionally, mandated collaborations have been expected to engage in deliberate, formal planning with a pre-defined logic model, and undergo performance evaluation following full implementation of the strategic action plan that was prepared before undertaking any action (Bryson et al., 2006; Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010). However, rigid planning is counterproductive for social innovation (Surman & Surman, 2008). The common agenda that is characteristic of collective impact initiatives involves a simple, flexible strategic

framework (Hanleybrown et al., 2012). Flexibility leaves space in strategic planning for accommodating the ongoing input of a cross-sector leadership table, or stewardship group, as they remain constantly vigilant to detect emerging opportunities and creative ideas that cannot be known, or discovered, until some set of actions has been initiated first (Kania & Kramer, 2013). This approach facilitates a more responsive iterative process of learning, planning, and taking action in order to adapt better to the surroundings and make greater progress (Hanleybrown et al., 2012).

Functioning in a collaboration relies as much on learning through taking action than on expertise from external sources, especially when needing to know “how to work with diverse people, analyze situations in real time, or seize the moment” (Bingham, Sandfort, & O’Leary, 2008, p. 271). A focus on learning enhances alertness to new opportunities that may lead to more productive ways of working together or to additional resources that had gone unnoticed (Kania & Kramer, 2013).

Flexible strategic planning is particularly useful for adapting activities to reflect the natural energy flow of working groups, or action teams (Surman & Surman, 2008). This means that activities are adjusted, upwards or downwards, to better fit with existing levels of interest and resources. Planning is thus directed toward areas where efforts show more promise of being productive. However, it is the alignment of strategic plans that makes all the difference. Aware that isolated planning by multiple groups results in limited impact, actors of collective impact initiatives ensure that their action plans are well coordinated by first identifying mutually reinforcing activities for each of their respective organizations—the second collective impact condition (Kania & Kramer, 2011). Integrating efforts in this way can leverage the skills and resources of multiple actors to produce substantial results on a large social scale (Weaver, 2014).

2.4.3 Motivation for collaborative engagement

Participants’ motivation to maintain their engagement rests on a number of interacting elements: the frequency and nature of communication, the extent of trust-building behavior, the appraisal of mutual benefits, and the level of commitment. Continuous communication for the purpose of building trusting relationships is the third essential condition of collaboration promoted by the collective impact model (Hanleybrown et al., 2012). Meeting regularly and exchanging information in-between meetings keeps participants engaged, as they gain a better appreciation of working toward the same high-level goal even

though their organizations are pursuing different sets of activities (Kania & Kramer, 2011). However, group meetings and the use of communication technologies are unlikely to be enough to sustain common motivation. Regular one-on-one contact with participants in leadership roles, often undertaken by process facilitators, can further ensure continued contributions to the collaboration's vision (Surman & Surman, 2008).

Although continuous communication helps generate mutual trust, the extent to which trust is cultivated depends on participants' personal behaviors. Behaviors that build trust include the act of being mutually supportive and transparent as well as the demonstration of "competency, good intentions, and follow-through" (O'Leary & Vij, 2012, p. 514). Trust is the most commonly cited determinant of collaboration effectiveness. It is the "glue" that binds a collaboration together, and it can facilitate the safe expression of diverse views (Silvia, 2011).

In particular, trust promotes candid discussions about needs and how they could be met. Candid discussions can help identify mutual benefits that make continued engagement worthwhile (Ansell & Gash, 2008). For instance, sharing difficult experiences in order to learn from others about ways to overcome obstacles has been found to be a rewarding practice in collective impact efforts, especially when engaging with those who share the same deep concern about an issue (Kania & Kramer, 2011). If participants do not view their collaboration as a legitimate means to gain some benefit and advance their organizations' objectives for the greater good, they will disengage (Bryson et al., 2006; Provan & Kenis, 2008). Taken together, trust building and sustained mutual benefits contribute to participants' commitment. Commitment to the engagement process involves the collective belief that improved organizational performance and desired outcomes are best achieved through the existing collaborative arrangement (Ansell & Gash, 2008; Chrislip, 2002). It is strengthened by a sense of shared responsibility whereby all collaborating actors take "ownership" of their collective endeavor (Ansell & Gash, 2008). This shared commitment creates the bonds that seal participants' motivation to work across organizational, sectoral and jurisdictional boundaries and embark on a common path (Emerson et al., 2012).

2.4.4 Capacity for collaborative action and adaptability

Engaged and motivated participants build capacity for collaborative action by securing or providing knowledge, resources, leadership, and institutional structure. These elements of capacity, in turn, support

the collaborative engagement process and the motivation to engage (Emerson et al., 2012). For example, knowledge is fundamental for learning, which has been presented above as both an integral aspect of the engagement process and a benefit arising from cultivating mutual trust. Knowledge derived from rapid feedback loops fuels learning in collective impact initiatives. Rapid feedback loops entail regularly scheduled site visits and frequent interviews with key actors for ongoing assessments and reflection. Rapid feedback loops can generate improved learning of unexpected opportunities and previously overlooked resources to produce quick wins and keep momentum going (Kania & Kramer, 2013). When these feedback loops uncover what is not working well, they can lead to the creation of new strategies to move progress further along. Knowledge also takes on the form of content and process expertise. Whereas content expertise shapes the views of participating actors, process expertise bolsters the performance of interconnected organizations (Chrislip, 2002).

Resources that can be pooled and leveraged through collaboration represent another collaborative advantage. Generally required resources include time, funding, logistical and administrative assistance, and specialized professional skills (Emerson et al., 2012). However, no matter how well resourced an initiative may be, its effectiveness would be lessened without investing in monitoring and evaluation that takes the whole cross-sector collaboration into account. A critical resource, and collective impact condition, is a shared measurement system. The measurement of a core set of indicators that are used consistently across collaborating organizations is indispensable for tracking progress over time and aligning mutually reinforcing activities (Kania & Kramer, 2011). Besides performance measurements, human resources are needed to conduct different evaluation approaches (i.e., developmental, formative, and summative) along the different stages of a cross-sector initiative (Preskill, Parkhurst, & Splansky Juster, 2013). This provides the necessary capacity with which to ensure that efforts are well directed. It is through such resources that knowledge can be generated to promote the continuous learning that is so vital to the success of collective impact initiatives. Agreements on goals and strategies would be meaningless without the means to measure the extent of progress made toward these goals and evaluate how and why progress is being made, or not (Kania & Kramer, 2013; Parkhurst & Preskill, 2014). Performance measurement and evaluation are vital to make sound judgments about adapting and improving cross-sector collaboration.

In addition, collaboration initiatives that span across sectors necessitate both formal and informal styles of leadership. Collaborative leaders in formal positions, such as chairing a cross-sector committee, behave

differently than the authoritative type of leadership generally seen in organizations. Formal leaders in a collaborative arrangement are more likely to remain neutral by letting participants come up with their own solutions while not favoring one point of view over another (Emerson et al., 2012; Hanleybrown, 2012). Furthermore, collaborative leadership is multifaceted, and includes a variety of functions such as convener, enforcer of group norms and rules, conflict manager, mobilizer of key stakeholders and resources, motivator, relationship broker, facilitator, negotiator, and knowledge synthesizer (Ansell & Gash, 2008; Chrislip, 2002; Silvia, 2011; Salamon & McGregor, 2004). Distributing these functions across participating actors in the role of informal leaders avoids both burnout and control by a single individual (Nowell & Harrison, 2011). Leadership may also be shared in the sense that participants can equally influence decision making and can serve as thought leaders around issues falling within their respective area of expertise (Nowell & Harrison, 2011). Whether formal or informal, collaborative leaders play a particularly important role in collective learning. Collaborative leadership facilitates collective learning by encouraging frequent interactions among collaborators and cultivating trust (Gerlak & Heikkila, 2011).

The last element of capacity is institutional structure, which refers to governance procedures and structural arrangement. Consensus-oriented decision-making procedures, although ideal, tend to lead to either a stalemate or a broad agreement that lacks specific expectations (Ansell & Gash, 2008). Therefore, consensus building may not be the best approach, especially when the collaboration is meant to encourage a diversity of perspectives. In this situation, other decision rules would need to be followed. What matters most is that participants perceive the decision-making procedures as transparent, fair and inclusive (Chrislip, 2002). Such procedures legitimize decision making and increase commitment to the engagement process by allowing equal voice and by reassuring participants that the views of all those concerned and affected by the problem have been heard and are seriously taken into consideration (Ansell & Gash, 2008; Chrislip, 2002). Open and inclusive procedures for deliberations and the creation of interconnected groups for knowledge-sharing are additional factors that promote collective learning (Gerlak & Heikkila, 2011).

With respect to structural arrangement, experts in cross-sector collaboration for social change propose a fluid structure, run by a stable executive body. A cross-sector executive committee, also referred to as a stewardship group, sets the broad strategic framework and guides the progress of interconnected working groups (Hanleybrown et al., 2012; Surman & Surman, 2008). These working groups, or action teams, develop their own action plan with the adaptive flexibility to incorporate opportunities as they arise from

an ever-changing environment. Their membership may be ever changing as well, due to fluctuating levels of interest and resources (Bryson et al., 2006; Surman & Surman, 2008). For greater stability, the cross-sector collaboration needs to be supported by “backbone” functions, which constitute the fifth collective impact condition. Attempting to pursue a shared goal without establishing a backbone infrastructure is one of the main reasons for failure (Hanleybrown et al., 2012). In collective impact initiatives, a backbone infrastructure ensures that dedicated staff provide the ongoing support, coordination, and progress reports that are essential for sustaining collaborative efforts (Kania & Kramer, 2011). This infrastructure may involve third-party coordination or other suitable types of administrative arrangement. It is meant to support governance-related operations, and create essential linkages across and within multiple governance levels, from executive and steering committees to working groups and the community at large (Hanleybrown et al., 2012; Surman & Surman, 2008).

2.4.5 Collective learning

There cannot be effective collaboration without addressing the need for ongoing learning at the basis of planning and taking action. It is required to constantly adapt to changes in complex socio-ecological systems. According to collective impact proponents for social change, collective learning is at the core of effective cross-sector initiatives, specifically because of its critical role in constantly adapting strategies to changing circumstances and unanticipated situations within complex socio-ecological systems (Kania & Kramer, 2013). Likewise, many scholars place learning at the center of collaboration (Pennington, 2008). Ongoing collective learning enriches the collaborative engagement process to plan wisely; enhances motivation to continue to engage; and is enabled by the collaboration’s capacity, especially in terms of continued investments in performance measurement systems and the evaluation of actions taken. Collective learning may also take place less formally through appreciative inquiry exercises, reflection time at the beginning of meetings, and retreats/forums to explore questions and exchange information and ideas for continuous improvement (Preskill, Parkhurst, & Splansky Juster, 2013). The iterative cycle of ‘learn-plan-act’ allows a cross-sector collaboration to continuously adapt, making course corrections as necessary, seizing opportunities as they arise, and adjusting the alignment of activities accordingly.

The importance of social learning and adaptability is increasingly receiving attention in the environmental and natural resource policy literature, yet the literature on cross-sector collaboration has been focusing

primarily on the capacity for action, lagging behind in its consideration of adaptive capacity (Emerson & Gerlak, 2014). Emerson and Gerlak (2014) define adaptive capacity as “the ability of individuals and groups to respond to and shape change through learning and flexibility” (p. 770). They use the term flexibility in the sense of being open to experimenting and trying out innovative approaches. Learning through trial and error is a prominent feature in collective impact initiatives, where unpredictability may give way to emergent solutions for producing the desired outcomes (Hanleybrown et al., 2012; Kania & Kramer, 2013). Much insights about adaptability within the social domain are currently being captured through practice-based knowledge from these social-change efforts.

2.5 Conclusion

The conceptual framework of cross-sector collaboration for social change brings together theoretical knowledge and current practice-based insights for greater understanding of the fundamental elements of cross-sector collaboration. Scholars’ wide-ranging body of work provides a sound evidence-base for identifying the basic requirements for effective cross-sector collaboration. As broad-based as the previous theoretical frameworks may be, they are nevertheless lacking in emphasizing the most essential conditions for making substantial social change happen. From collective impact initiatives, these conditions include a common agenda, mutually reinforcing activities, continuous communication, a shared measurement system, and a backbone infrastructure. Furthermore, these initiatives are shedding light on the need for flexible planning, multi-level and interconnected governance structures, and ongoing collective learning for greater adaptability to a complex and unpredictable social environment.

Much effort is required to undertake a collaborative engagement, cultivate the motivation to engage, and build the capacity for collaborative action and adaptability, while fostering a culture of collective learning. However, no other approach will be able to make substantial progress on today’s most pressing societal problems due to their sheer complexity and persistence. Through the five essential conditions for collective impact and the iterative adaptive cycle of learning, planning, and taking action, a cross-sector collaboration may enhance its ability to seize opportunities and solutions as they emerge for greater impact toward positive social change, which may in turn lead to improved population health.

The conceptual framework of cross-sector collaboration, as presented above, has been published in the peer-reviewed journal, *Global Health Promotion* (de Montigny, Desjardins, & Bouchard, 2017). It was modified to align with the journal's aims and scope. Any references to North America was removed, and instead, a global perspective was added in response to the peer reviewers' request to broaden the article's appeal to better suit an international readership. Having established a basic understanding of what constitutes cross-sector collaboration as the highest form of partnership, the thesis now turns to a review of the health promoting school literature to find out what specifically are the fundamental elements that compose school health partnerships at both the school and school board levels.

Chapter 3: The Fundamentals of Cross-sector Partnerships for Health Promoting Schools

3.1 Creating partnerships with the broader community

Schools provide an ideal setting to anchor the valuable contributions by various external stakeholders in school health (Davidson, Schwartz, & Noam, 2008; Thomas et al., 2010). Through relationship building, these external stakeholders can play a vital role in the development and implementation of initiatives to encourage healthy living and instill well-being in the student population. When many hands come together to act comprehensively, the work load may be considerably reduced.

Comprehensive school health is rewarding work, but it does have its challenges. Nevertheless, much support exists all around the school. This support is especially helpful in overcoming resistance. Not all school administrators are prepared to prioritize the link between students' health and well-being and their academic performance (DeWitt, Lohrmann, O'Neill, & Clark, 2011; Maras, Weston, Blacksmith, & Brophy, 2015). This reluctance may relate to competing demands due to limited capacity (Flaschberger et al., 2012; Staten et al., 2005), and in certain cases, to crisis situations that overshadow opportunities for health promotion across the whole school (Firth et al., 2008). Even so, amid the educational pressures and community issues, some school administrators and fellow teachers remain willing to engage in health promoting initiatives. Buy-in comes about when school personnel believe that such efforts could possibly meet a perceived school need or enhance their students' school experiences.

Although schools' buy-in is necessary to adopt the comprehensive school health approach to create health promoting schools, it is not sufficient. Additional challenges usually arise during implementation. By joining forces with community partners, schools can receive help in meeting these challenges. Indeed, students' well-being is more likely to be improved by engaging and motivating each other and building capacity together with the aim of sustaining health promoting initiatives. Table 1 presents the fundamentals of school health partnerships. The first three partnership components—engagement, motivation, and capacity—were derived from the conceptual framework of cross-sector collaboration for social change, whose foundation draws heavily on Emerson et al.'s (2012) work on the collaborative dynamics. However, the elements that make up each component refer specifically to partnerships for the

promotion of comprehensive school health. The added dimension of sustainability is an ongoing concern within health promoting schools (HPS).

Table 1. Overcoming comprehensive school health challenges with community partners: main partnership components and their elements

Partnership Components	Partnership Elements			
Engagement	Diverse partners	School buy-in	Common understanding	Stepwise approach
Motivation	Ongoing communication for cultivating trust	Mutual support	Commitment and school ownership	Passion
Capacity	Inter-organizational structures	Adequate resources	Operational knowledge	Leadership at all levels
Sustainability	Cost-effective initiatives, including progress monitoring and professional development	Notions of a healthy way of life embedded in the school culture	Alignment of organizational priorities among partners	Whole-school participation with strong focus on student engagement

3.1.1 Engaging with external stakeholders in school health partnerships

HPS-related engagement succeeds through a diversity of partners, strong buy-in for health promotion, a common understanding, and a stepwise approach to implementing health promoting initiatives. More can be done to engage with external stakeholders from various sectors to promote health in a school setting (Ahmed, 2005; Stewart, 2008). Working directly with a variety of community partners can ensure that initiatives complement one another and provide benefits to students (Christian et al., 2015). Diverse partners may be found in the broader community, such as the local public health unit, community health centres, police department, social service agencies, not-for-profit organizations, clubs for children and youths, recreation and sports groups, local businesses, the media, and most importantly, parents. Public health units, for example, offer their specialized skill set in relationship building across the broader community and in facilitating team work. Furthermore, public health personnel can help secure buy-in for health promotion at the school level.

Strategies to secure buy-in include raising awareness of research showing that student well-being benefits both academic performance and classroom behavior; seeking and valuing students' input on ways for them to take action on their own behalf; and supporting opportunities in schools, school boards, and parent councils to discuss students' well-being and develop a sense of shared responsibility (Stolp, Wilkins, & Raine, 2014).

Partnerships with the school community flourish when open dialogue is used to foster a common understanding of what the school personnel and community partners wish to achieve together and how to do so. Engaging openly with one another creates opportunities to share information, as well as examine concerns and explore possible ways to address them (Aston, Shi, Bullot, Galway, & Crisp, 2005; Butterfoss, Goodman, & Wandersman, 1993; Coulter & Coulter, 2003; Thomas et al., 2010). Meaningful engagement occurs naturally when the conversation centers around a shared vision and goal, and partners begin to speak the same language, and clarify roles and procedures for a common understanding (Corbin & Mittelmark, 2008; Davidson et al., 2008; Firth et al., 2008; Viig & Wold, 2005).

As the school engages with partners, feasibility becomes a key consideration to maintain buy-in. Implementation of comprehensive health promoting initiatives in schools may need to proceed in a stepwise manner while continuously engaging with partners (Firth et al., 2008). When aiming for a comprehensive approach, it may be more advantageous to build gradually on what is already happening in the school to avoid overwhelming the participants.

3.1.2 Motivating partners by cultivating relationships

Fundamental to motivating schools and their external stakeholders to engage in the HPS approach is the cultivation of positive and reciprocal relationships. This is done through ongoing communication that fosters trust; mutual support that reinforces ties between partners; commitment and school ownership that generate a sense of shared responsibility; and passion that keeps momentum going. In turn, the development and strength of these relationships depend on the role played by school health champions (Rothwell et al., 2010). Relationships are usually strengthened through ongoing communication, especially face-to-face gatherings in which participants engage openly with each other (Thomas et al., 2010). Regular communication maintains the connection between partners and brings them to appreciate what each

partner has to offer. This appreciation enables partners to develop the mutual trust necessary to encourage interdisciplinary relationships (Aston et al., 2005; Butterfoss et al., 1993; Coulter & Coulter, 2003; Thomas et al., 2010). Motivation also emerges through helping each other, or providing mutual support. Teachers value their community partners when these partners readily respond to their requests for assistance; similarly, community partners appreciate teachers who take care of organizational tasks in support of the partnership (Thomas et al., 2010).

Mutual support between the school and the broader community goes hand in hand with committed engagement, which is a critical aspect of school health partnerships. Commitment and school ownership develop when partners demonstrate their responsiveness by first engaging with the school community to identify their perceived needs and priorities, and adapt their relevant offerings, such as healthy eating programs or self-esteem programs, to meet the school's existing capacity level (Christian et al., 2015; Firth et al., 2008; Senior, 2012; Viig & Wold, 2005). It often used to be that community partners would have already set in their minds what health promoting initiatives they wanted to implement in schools. However, their proposed initiatives were not always accepted by the schools, and when they were, their implementation was not always successful. The tide has changed, and community partners realize that the partnership is more likely to succeed when the school community, meaning school administrators, staff, students and their parents, have a say about how to get started in efforts to promote students' well-being in their own schools, and how to build on what has been done so far. This voice gives them more control, and thus greater appreciation, of the direction they are taking for positive change (Firth et al., 2008). When teachers, other school staff, and students are invited to work on goals that directly cater to their own interests and level of readiness, they are more apt to fully commit. Engagement is also motivated by the passion shared among like-minded partners who are acting as change agents for the health and well-being of students. The passion shared by teachers and community partners fortifies their relationships and increases the effectiveness of their shared work (Jack, 2005; Thomas et al., 2010).

3.1.3 Building capacity to support engagement among school health partners

Building the capacity to engage in a partnership means putting in place the interorganizational structures, resources, knowledge, and leadership that are required in order to achieve a shared goal (Emerson et al., 2012). Many forms of interorganizational structures may be encountered in school health partnerships—

for instance, a steering committee managing a local network of various community organizations at a district level; a consortium coordinating services for a specific group of students with similar needs; and a school-based group composed of the principal (when available), the school health champion, fellow teachers, other school staff, students, a health professional and other community representatives who all work together to plan and implement whole-school initiatives (Davidson et al., 2008; Flaschberger et al., 2012; Rothwell et al., 2010; Thomas et al., 2010). The latter type—the school-based group—is often referred to as a health action team, school health committee, or more generically, a school council. Such a group is charged with preparing action plans based on needs assessments, and it is a key element of the HPS approach. In cases where all team members come from the school community, the group can still seek input from community partners on school action plans as needed (Ahmed, 2005).

School resources may be in short supply. Regarding financial resources, schools often lack district-level mechanisms to seek grant funding, and additional school resources for promoting students' well-being may not be readily available. (DeWitt et al., 2011; Firth et al., 2008; Flaschberger et al., 2012). As a result, teachers often volunteer their services to make up for lack of teacher release time and workforce shortages. Resource limitations may also force schools to choose only those activities that have minimal associated costs. Therefore, the main benefit of working in partnership is that it allows participants to pool valuable community resources in order to expand the realm of possibilities for greater impact (Butterfoss et al., 1993; Christian et al., 2015; Stewart, 2008).

Barriers to the use of human resources include personnel changes, whether in the school community or in partnering organizations. When people move to other positions, relationships must be rebuilt, which can result in loss of momentum and even changes in direction. To maximize stability, then, it is important to seek at least a three-year commitment from members of school health committees (Firth et al., 2008). Still, turnover is often inevitable. Fortunately, the effects can be lessened by sharing action plans with teachers, school board representatives, and parents, thus helping to ensure that health promoting initiatives remain at the forefront of school administrators' thinking and retain their ongoing support (Staten et al., 2005).

Time is an equally valuable partnership asset. It takes much time to cultivate relationships, set up health action teams or committees, conduct needs assessments, and prepare collaborative action plans. Feeling that there is not enough time to get everything done is a frequently cited challenge that can leave

participants feeling overburdened (DeWitt et al., 2011; Firth et al., 2008). For this reason, mutual support among partners, commitment, and passion, as mentioned earlier, are crucial for moving forward with school health initiatives.

In order to implement health promotion initiatives comprehensively, participants must acquire knowledge in the form of CSH expertise and professional skills on an ongoing basis. Government departments and other community partners may help meet knowledge requirements by providing training opportunities (Ahmed, 2005; Thomas et al., 2010). Since teacher release time is likely limited for professional development, some of the knowledge gap can be filled through external organizations as well. Local public health units can provide information about best and promising practices, thus minimizing the time required for school staff to find out about creative ideas for engaging the school community. Engagement in knowledge-exchange networks, or other partnership meetings, offers another practical way of learning what has worked well in schools and how to overcome obstacles along the way.

Even with sufficient knowledge, along with resources and interorganizational structures, comprehensive health promoting initiatives depend heavily on effective leadership. Leaders, who can be found at various levels in school boards and schools, drive initiatives forward. In fact, the departure of a leader has been shown to delay progress until the replacement can fully assume her or his new responsibilities (Rothwell et al., 2010). Leadership by school administrators may take on various forms—for instance, serving as the formal point of contact with external partners; seeking available resources; and supporting teacher release time for planning activities (Firth et al., 2008; Viig & Word, 2005). Another type of leader is the internal school coordinator, or school health champion, who may fulfill a number of roles, such as steering a school team or committee, who are engaged in action planning, and encouraging participation in school health promotion activities. The school champion's vision and passion for creating a healthy school can inspire and attract engagement and support from both within and beyond the school (Stolp et al., 2014; Thomas et al., 2010).

3.1.4 Aiming for sustainable comprehensive health promotion in schools

One major challenge with the HPS approach is that of sustaining the initial enthusiasm by means of continued support and resources. Sustainability is more likely to be achieved by selecting cost-effective

initiatives, embedding notions of a healthy way of life in the school culture, aligning organizational priorities among partners, and encouraging whole-school participation with a strong focus on student engagement. Health promoting initiatives with start-up funding must be cost effective in the long run, if the school is to cover ongoing expenses, above and beyond what can be expected from community partners. These initiatives also need to establish ways to monitor progress in order to keep interest high, make course corrections as required, provide appropriate professional development opportunities, and maintain activities after the intervention period concludes (Christian et al., 2015).

Sustainability can also be ensured by taking steps to embed notions of a healthy way of life in the school culture. These steps, which are integral aspects of the comprehensive school health approach, include making the school's ethos, or social environment, more conducive to healthy living; pursuing goals identified by the school for a sense of ownership in health promoting initiatives; and integrating health promotion concepts into the curriculum and into daily school practices (Firth et al., 2008; Flaschberger et al., 2012; Senior, 2012; Stewart, 2008). Historically, teachers and school staff have viewed health promotion as an add-on—that is, something to be done on a voluntary basis outside of routine tasks at school. But times are changing, and new ways of thinking are emerging. Now, school personnel are beginning to view health promotion activities as an “add-in” —in other words, as part of their day-to-day jobs (Flaschberger et al., 2012; Viig & Wold, 2005).

In order to achieve lasting change, health promotion efforts require school health partnerships in which all partners align their organizational priorities. Such partners help ensure sustainability through shared goals, complementary resources, and contributions to school staff development (Gillies, 1998; Inchley, Muldoon, & Currie, 2006; Laurence, Peterken, & Burns, 2007; Thomas et al., 2010; Warwick et al., 2005). Sharing goals not only means ‘being on the same page,’ but also signifies that community partners are meeting their respective organizational priorities, and are therefore well positioned to continue their engagement.

Special attention must also be given to engaging the whole school community as much as possible. When only a few teachers contribute to health promotion efforts, they may feel overloaded with additional responsibilities (Barnes, Lohrmann, Shipley, & O’Neill, 2013). This outcome can be avoided by distributing the work more evenly among teachers and staff members, as well as reaching out to community partners for support. Furthermore, responding to ideas and preferences expressed by students—who are key

internal partners—can produce remarkable health outcomes because students generally listen attentively to what their peers have to say. Thus, school champions and fellow teachers serve not only as essential role models of healthy behavior but also as significant way-showers to bring out the leadership potential in schoolchildren and sustain their engagement (Stolp et al., 2014).

The first part of this literature review, as presented above, has been published in its entirety, albeit with some minor adjustments, in book chapter, titled ‘Comprehensive school health in teacher education and schools: Becoming a champion of health’ (Lloyd, de Montigny, & Whitley, 2018). This chapter appears in the teacher textbook that goes by the title of *Physical and Health Education in Canada: Strategies for Elementary Teachers*, edited by Barrett and Scaini.

3.2 Engagement of district school boards in school health partnerships

What is the role of district school boards related to the comprehensive school health approach? District school boards are known to set strategic direction and policies in this regard. They can make significant contributions by incorporating health in their vision, mission statement, and strategic framework; developing healthy school policies and procedures; and requiring schools to include health in their plans, complete with health-specific goals, performance indicators, strategies, and timelines (Gleddie, 2011).

Research about district school boards and health promotion in schools has been conducted mainly in North America, especially in the United States. Fueling this line of research is the enactment of a US federal mandate that conferred greater responsibility to certain district school boards for broader engagement in student wellness. As of 2004, all school districts receiving federal funding for school meal programs were mandated to develop and implement local wellness policies in collaboration with a variety of stakeholders (Barnes et al., 2011). Key stakeholders included district-level personnel, such as food service directors and physical education staff, along with school principals, teachers, parents, and community partners. One Canadian study explored a similar path, one that focused on a collaborative approach to health promotion involving policy development and coordination at the school-district level. The Albertan Battle River Project serves as an exemplary case model within the Canadian context. Years ago, the Battle River School Division entered into a collaborative partnership with the local health authority and Ever Active Schools (EAS), a non-government organization (Gleddie & Hobin, 2011). This school division established a

committee composed of trustees, division staff, school administrators, teachers, EAS staff, and health professionals, to collaborate on a comprehensive wellness policy. Their policy statement aimed to “solidify the connections between health and learning,” give more weight to school champions’ efforts, and integrate the comprehensive school health approach in schools’ three-year plan (Gleddie, 2010, p. 33).

Policies for the promotion of health in schools serve as gateways to support change within the school environment. In the United States, district wellness policies were meant to generate improvements in several areas: increased availability of more nutritious food; reduced access to non-healthy food; professional development for teachers; designation of school health champions for each school; distribution of evidence-based health education curricula; reduced tobacco, drug and alcohol use; and the hiring of a school health coordinator at the district level (DeWitt et al., 2011). Although school districts are complying with the federal mandate, their local wellness policies have generally lacked rigor and comprehensiveness, and they have only been partially implemented (Barnes et al., 2011; Hoxie-Setterstrom & Hoglund, 2011).

On the other hand, much progress took place between the Battle River School Division and the Ever Active Schools organization in Alberta, Canada (Gleddie & Hobin, 2011). This non-profit organization provided the district’s participating schools with health assessment and performance measurement tools for planning purposes; training and engagement opportunities for teachers within and across schools; and access to expert advice and events; and other resources, including partial funding for a coordinator. In turn, the school district contributed funding for district-wide professional development, staff release time for planning, implementing and assessing health promotion activities, as well as a coordinator position and office space. The district health coordinator encouraged school champions (e.g., lead teacher) to form school action teams and engage staff, parents and the broader community in planning for change. This coordinator also facilitated teams’ engagement process to ensure that survey and assessment data were purposely used to direct action toward actual student needs and that evaluation results were applied to refine plans further. Heavy reliance on evidence for action has galvanized school staff, parents, community members, and the school district, alike. Apparently, the coordinator position has been instrumental in mobilizing the school community and their partners. However, this position would not have been created were it not for the added funding received by the provincial non-government partner (Gleddie & Hobin, 2011). The strong emphasis on coordination in the American approach to comprehensive health promotion might be creating more opportunities in that country for the hiring of district health coordinators, a major implementation enabler. In successful cases where highly skilled coordinators have been hired, many

advantages were reported. An excellent example is the work of district health coordinators in the San Francisco Bay Area. School personnel from four participating school districts have experienced more efficient use of resources, much less duplication of efforts, greater knowledge of best practices, and stronger collaborative relationships with local community partners for expanding programs and securing new resources (Westrich, Sanchez, & Strobel, 2015).

Much may be expected of those individuals filling a school health coordinating position at a district school board level, when in actuality, they may be lacking in required competencies. The state of New York presents a remarkable situation where all school districts are required to identify a district health coordinator among their staff. Based on a survey to all New York school districts (with a response rate of 72%), there exists a considerable implementation gap between required skills and coordinators' ability to perform these skills (English, Bonaguro, & Madison, 2005). The authors concluded that the training of district health coordinators needs to be multifaceted and frequent if these coordinators are to promote school health in a truly comprehensive and coordinated manner.

Although advancements are being made in some jurisdictions, challenges with health promotion initiatives are still encountered in many school systems, regardless of whether or not there exists a district health coordinator. Other challenges include the absence of grant-seeking structures, health leadership teams, and other organizational support at the school district level; the general lack of attention paid to the effect of health and well-being on academic performance; and the unmet need for more opportunities to collaborate with all stakeholders (DeWitt et al., 2011; English, Bonaguro, & Madison, 2005; Westrich et al., 2015). Indeed, the competencies of coordinators, should district school boards have the means to fund such a position, may be enhanced and complemented through collaboration with local health organizations and professional groups (English et al., 2005). Engaging in such collaborative efforts would contribute to greater success with the implementation of coordinated school health.

With or without the presence of a district school health coordinator, contributions from the health sector offer complementary opportunities for enabling district school boards to move forward with creating school environments that are more conducive to health and well-being. For example, Hoxie-Setterstrom and Høglund (2011) argue that school health nurses, as prominent stakeholders, have a strong role to play in the development and implementation of wellness policies through their engagement with district-wide committees, school health programs, and parent-teacher organizations.

The relationship between schools and school health nurses varies greatly across North America. Based on an American study commissioned by the National Association of School Nurses (NASN, 2007), a majority of school health nurses are hired directly by the school system through various employment arrangements, and the remainder comes from partnering health organizations' personnel. Depending on schools' available capacity, schools may either have access to a full-time school health nurse or share a part-time school health nurse with other schools. These nurses may either be a staff member on the school district's payroll, a contractor, or an employee of the local health department. Only in the latter case would there be the need to put in place a partnership arrangement. However, regardless of who the employer is, school health nurses can increase their ability to improve the health of their school community by collaborating with other nurses at their health department (NASN, 2016). In Canada, public health professionals fulfilling the health promotion role of a school health nurse are more likely to maintain their employment within the health sector and work in partnership with school teams or school councils (Chabot, Gagnon, & Godin, 2012; MacDougall, 2004).

As a member of the school's health action team, the school health nurse or other public health staff play a vital role as health promoter within a school setting. However, engagement between external school health professionals and personnel from district school boards may be of equal, if not greater importance, to ensure that students' health and well-being are being promoted in a comprehensive and coordinated manner. Although the literature on health promoting schools does reveal fundamental elements for well-functioning partnerships at the school level, in varying degrees of detail, the research in the critical area of partnerships is largely underdeveloped at the higher school board level as it pertains to how school board personnel actually engage with public health professionals. For this reason, I have chosen as my thesis project the exploration of school health partnerships that brings together local public health units and school boards for the creation of healthy schools in Ontario. Having briefly familiarized myself with this topic through members of my research steering committee, I came to realize that school health partnerships could take on distinct arrangements of a networking, cooperative, or collaborative nature. Before delving deeply into my doctoral thesis project, I mapped out the literature to examine the current knowledge base regarding the different types of partnership arrangements that exist for the creation of health promoting schools. The resulting scoping review is presented in the next chapter.

Chapter 4: Mapping the Literature on the Different Types of Partnership for Health Promoting Schools

4.1 Background

Increasingly, educators are viewing comprehensive health promotion approaches as a promising path to school innovation and enhanced learning abilities, in addition to better health for the student population (Basch, 2011; Jourdan, Simar, Deasy, Carvalho, & McNamara, 2016; McKay et al., 2015). Studies on health promoting schools (HPS) are beginning to yield evidence of improved academic achievement resulting from school health interventions delivered in a comprehensive manner (Berlot & James, 2011; Florence et al., 2008; Murray et al., 2007; Pucher, Boot, & Vries, 2013; Rasberry, Slade, Lohrmann, & Valois, 2015; St. Leger, 2006; Suhrcke & De Paz Nieves, 2011; Trudeau & Shephard, 2008), although no firm conclusions can be drawn at this time since too few studies in this area have investigated both health and education outcomes (Langford et al., 2014). Furthermore, implementation challenges have undermined the sustainability of many school health interventions, thus keeping them from reaching their potential to bring change within the school system (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Osganian, Parcel, & Stone, 2003; Roberts-Gray, Gingiss & Boerm, 2007; Rohrbach, Grana, Sussman, & Valente, 2006). Nevertheless, urban and rural communities in countries on every continent of the world have been actively engaged in HPS initiatives, responding innovatively to obstacles encountered during implementation through their commitment to creating healthy school environments for the younger generation (Vince Whitman & Aldinger, 2009).

The global health promoting school movement continues to gain prominence especially in Europe and North America. Although Europe, Canada and the United States have developed their own framework for a comprehensive approach to health promotion in schools, their overall philosophies and intentions remain very similar and they all include the critical aspect of partnerships between schools and the broader community. The Schools for Health in Europe, formerly known as the European Network of Health Promoting Schools, encourages a whole-school approach to school health promotion. They have adopted the World Health Organization's HPS framework, which comprises the following six components: individual health skills and action competencies, physical environment, social environment, healthy school policies, health services, and community links (International Union for Health Promotion and Education, 2009). With respect to 'community links,' the school community consults and participates with students'

families and key community groups on HPS initiatives to gain support for their efforts to promote health in their schools. Other countries, such as Australia, follow the same framework (Senior, 2012).

In Canada, the provincial, territorial, and federal governments in 2005 established the Pan-Canadian Joint Consortium for School Health (JCSH, 2017) as a means of building bridges across the health and education systems throughout the country for improved wellness and academic achievement among the student population. Their Comprehensive School Health model is founded on four interconnected components for their synergistic effects: teaching and learning; social and physical environment; policy; and partnership and services. The latter component is described as:

Community- and school-based partnerships and services [that] are essential links for student achievement and the health and well-being of everyone in the school community. They enhance the range of supports and opportunities for students, parents, educators, and others (JCSH, 2017).

Among community partners are community organizations that support school activities, student safety, risk interventions, or the development of the academic curriculum.

Recently, the Coordinated School Health model of the Centers for Disease Control and Prevention (CDC, 2015) in the United States was expanded into a whole school, whole community, whole child model. The American approach consists of ten interactive components: health education; nutrition environment and services; physical education and physical activity; physical environment; social and emotional school climate; counseling, psychological, and social services; health services; employee wellness; family engagement; and community involvement. They define the community involvement component as follows:

Community groups, organizations, and local businesses create partnerships with schools, share resources, and volunteer to support student learning, development, and health-related activities. The school, its students, and their families benefit when leaders and staff at the district or school solicits and coordinates information, resources, and services available from community-based organizations, businesses, cultural and civic organizations, social service agencies, faith-based organizations, health clinics, colleges and universities, and other community groups. Schools, students, and their families can contribute to the community through service-learning opportunities and by sharing school facilities with community members (e.g., school-based community health centers and fitness facilities) (CDC, 2015).

The Coordinated School Health model is the product of a cross-sector initiative between the CDC and the Association for Supervision and Curriculum Development (ASCD), in collaboration with other key leaders

from American health and education systems (ASCD, 2014). In addition to expanding the focus of schools' psychosocial and physical environments, their revised model now emphasizes the broader roles that families and community agencies must fill to create healthier environments for the schoolchildren.

Although these three models have been constructed with varying degrees of detail, they essentially cover the same basic domains of curriculum integration, the school environment, and family/community involvement. Cultivating partnership ties between the local school system and the broader community are expected to ensure both the effectiveness and sustainability of comprehensive school health initiatives, as espoused by these models. Despite ongoing efforts, building partnerships that span the boundaries of public agencies and community-based organizations has been a persistent challenge (Tang et al., 2009). Unfortunately, the developers of health promoting school models offer little explanation of the dynamics of partnership arrangements, even though engagement with community partners is a prominent feature in their models (Hunt, Barrios, Telljohann & Mazyck, 2015). Although community partners and their critical role within the school system have been notably featured in comprehensive school health approaches, how and to what extent partners actually engage with the school community and district school boards requires further elucidation.

To assess the extent to which the scientific community has addressed this gap in understanding, I conducted a scoping review that identifies and describes scholarly literature on HPS approaches initiated by government or non-governmental organizations across the world. A scoping review provides “a rigorous and transparent method for mapping areas of research” on a broad topic being investigated through various study designs in order to assess the comprehensiveness of the available evidence” (Arksey & O'Malley, 2005, p. 30). The purpose of this scoping review is to determine the breadth and depth of evidence shedding light on cross-sector partnerships within the context of health promoting schools.

4.2 Method

4.2.1 Conceptual framework

Broadly speaking, partnerships exist along a continuum of increasing levels of engagement, commitment and asset sharing. Various continuum models that appear in the scholarly and grey literature basically

cover the same components. One collaboration continuum model featured prominently within the education sector consists of four equally important types of partnership arrangements: networking, cooperating, collaborating and integrating (Government of Alberta, 2013; Linkages Committee, 2011). The collaboration continuum model accepted within Alberta's education sector resembles closely the one developed by Himmelman (1994, 1996, 2001), which has been used within Australia's health sector to describe the various partnerships among a broad range of agencies, organizations and practitioners for the delivery of integrated health promotion programs (State Government of Victoria, 2003; VicHealth, 2011). It is analogous to the integration continuum model developed by Ryan and Robinson (2005) and adopted by Browne et al. (2004) for public health service delivery in North America.

As one of the early contributors to collaboration continuum models, Himmelman (1994, 1996, and 2001) described the components of his model, namely networking, coordination, cooperation, and collaboration, as relationship management strategies for engaging among partners under particular circumstances. The appropriate strategy would depend on the extent to which there is agreement on a common vision and plan of action, and the extent to which the availability of time, trust, and low turf protectionism, is enabling the engagement process. Building on this earlier work, Crosby and Bryson (2005) introduced a continuum of similar components, characterized by a cumulative sharing of organizational assets: information, resources, and decision-making influence. From their viewpoint, the transition from networking to coordination/cooperation to collaboration can be understood as progressing from the sharing of information to the sharing of resources as well, and then, adding the sharing of the decision-making process, as shown in Table 2.

Networking in and of itself may be sufficient to gain immediate benefits, but it also marks the first stage of a partnership, before significant engagement between partners can take hold in terms of cooperation and collaboration (Himmelman, 2001). Significant engagement actually begins with the sharing of resources that characterize cooperative partnership arrangements. When engaged in a cooperative partnership, resources are shared for a common purpose while each partner maintains their autonomy in pursuit of advancements for their own organization. Schermerhorn (1975, p. 847) defines interorganizational cooperation as "the presence of deliberate relations between otherwise autonomous organizations for the joint accomplishment of individual operating goals". Resource sharing is also a feature of a collaborative partnership arrangement, but it is based on closer engagement than that experienced through cooperation. When sharing resources to collaborate, each partner willingly

relinquishes some of their autonomy to make decisions together, and thereby, move away from a “you and me” attitude toward a “we” mentality for the good of all parties concerned (Durlak & DuPre, 2008). Durlak and DuPre (2008) equate the shared decision making that is observed within collaborative partnership arrangements with community involvement, local input, and local ownership.

Table 2. Collaboration continuum model

<i>Item (Source)</i>	<i>Types of Cross-Sector Partnerships</i>		
	<i>Networking</i>	<i>Cooperative</i>	<i>Collaborative</i>
<i>Definitions</i> (Himmelman, 2001)	“exchanging information for mutual benefit; it does not require much time or trust nor the sharing of turf” (p. 277).	“exchanging information, altering activities and sharing resources for mutual benefits and a common purpose; it requires significant amounts of time, high levels of trust and a significant sharing of turf” (p. 277-278).	“exchanging information, altering activities, sharing resources, and a willingness to enhance the capacity of another for mutual benefit and a common purpose; it requires the highest levels of trust, considerable amounts of time and an extensive sharing of turf” (p. 278).
<i>Trust as motivating factor</i> (Government of Alberta, 2013; Himmelman, 2001)	A low level of trust is sufficient since no resources are being shared.	A higher level of trust needs to be cultivated to set in motion the sharing of resources and some joint decision making.	A high level of trust must be established to engage in shared decision making, enabled by shared goals and structures while maintaining most of their organizational autonomy.
<i>Organizational assets being shared</i> (Crosby & Bryson, 2005; Himmelman, 1996, 2001)	Sharing information about missions, goals, programs and services.	As in the previous category, as well as sharing resources such as human, financial, and technical contributions.	As in the two previous categories, as well as sharing the decision-making process, including responsibilities, risks and rewards.
<i>Examples from the school system</i> (Government of Alberta, 2013)	Representatives from a school board, or school, and community partners attend meetings where they talk about their respective practices, projects and programs.	Representatives from a school board, or school, accepts the expertise of community partners for professional development purposes or gains access to their partners’ programs.	A school board, or school, and community partners work very closely together to make decisions about pooling resources to deliver programs and services.

The key feature distinguishing cooperation from collaboration is the degree to which partners participate jointly in the decision-making process. But what about coordination? After all, it is highlighted in the very name of CDC's Coordinated School Health Model. When coordination is taken into consideration, there does not seem to be a consensus as to where it belongs on the collaboration continuum. Some authors place coordination between networking and cooperation because, in their view, it does not require the 'sharing of turf' but is rather limited to sharing information and linking existing activities (e.g., Butterworth & Palermo, 2008; Himmelman, 2001; National Association of City and County Health Officials, 2013; Wilson, Mohr, Beatty, & Ciecior, 2014). By contrast, other authors see coordination as belonging between cooperation and collaboration along the continuum (e.g., Goldman & Intriligator, 1988; McDougall, Rajabifard, & Williamson, 2005; Peterson, 1991; Waibel, 2010). Mulford and Rogers (1982) consider interorganizational coordination as "the process whereby two or more organizations create and/or use existing decision rules that have been established to deal collectively with their shared task environment" (p. 12). This definition deals with the control and allocation of resources through joint decision making. More explicitly, Pucher et al. (2015) understand coordination within the intersectoral field of health promotion as being "an interactive, integrative process of collecting information, interpreting it, determining knowledge requirements, outlining the next steps and elaborating ways in which results could best be presented to the parties involved (...), followed by formalization of final decisions (e.g., multi-year plans)" (p.11).

Coordination is a very broad concept, ranging from simply linking activities, without having to share turf, to participating in an extensive process of integrating decisions being made collectively. Viewed differently, coordination may well be aspects of cooperation and collaboration. For instance, Ryan and Robinson (2005) describes cooperation among agencies not only as a means to avoid duplication of services by altering each other's delivery plans but also as a way to improve links between their respective services. For the sake of clarity and simplicity, this conceptual framework considers 'coordination' to run parallel to both cooperation and collaboration, extending across most of the collaboration continuum. The level and extent of joint decision making related to coordination activities would thus determine whether these activities would correspond more to a cooperative arrangement or to a collaborative arrangement. When considering the context in which health promoting schools operate, including the complexity of managing the delivery of a myriad of health promotion initiatives by a multitude of actors extending their work across the local school system, coordination would more likely entail a great deal of

joint decision making, and would therefore be a form of engagement falling under the category of a collaborative partnership arrangement.

The highest level of integration along the collaboration continuum has been called ‘the fusion domain’ by Ryan and Robinson (2005) when referring to a merging of service agencies to create a new organizational entity. Likewise, Crosby and Bryson (2005) included, at the end of their collaboration continuum model, the aspect of ‘shared authority’ within a ‘merger’ arrangement of integrated organizations. This uppermost level of integration has been omitted here since educational and health institutions would not typically evolve to the point where all partners would be blending their funding together to form a single incorporated governance group, although the possibility of a merger involving an educational institution and their community partners has been reported at an extra-organizational level (Government of Alberta, 2013).

4.2.2 Scoping process

The scoping review followed Arksey and O’Malley’s (2005) scoping framework. This framework comprises six stages: (1) formulation of a broad research question to retrieve and select relevant articles; (2) retrieval of potentially eligible articles in a comprehensive manner; (3) screening for eligibility by applying inclusion and exclusion criteria to the set of retrieved articles; (4) charting of the data from selected eligible studies, including the sifting and sorting of the information based on categories of issues or themes; (5) reporting of the results; and (6) consultation with key stakeholders to confirm study findings. All but the last stage has been undertaken for this scoping review.

The research question that guided the selection of relevant published articles was as follows: What does the scholarly literature on health promoting schools say about the partnerships being established for the promotion of student well-being, in terms of their functioning, structure and purpose? The electronic databases Medline, EMBASE, Social Policy & Practice, ERIC, Scopus and the Campbell Library were used to retrieve relevant studies based on the search strategy shown in Table 3 (see details in Appendix 1C). The search strategy retrieved scholarly articles from journal databases pertaining to the disciplines of health, education, and social sciences. Search limits were applied based on language, publication date and publication type due to time and resource limitations. However, this focused search is deemed acceptable

given the distinct research area to cover, and the exponential growth of publications seen only in recent years.

Table 3. Details of search strategy

<i>Search Strategy Key Words</i>	• Concept 1: health promoting school OR coordinated school health OR comprehensive school health OR whole school OR healthy school - AND • Concept 2: Implementation OR process OR capacity OR partner/partnership OR community OR network/networking OR cooperation/cooperating/cooperative OR collaboration/ collaborating/collaborative
<i>Databases</i>	• MEDLINE: bibliographic database with broad coverage in biomedicine and health for health professionals in such areas as public health and health policy development (see <http://www.nlm.nih.gov/pubs/factsheets/medline.html>) • EMBASE: bibliographic database with substantial coverage in medicine and biomedical science as well as Allied Health subjects. (see <http://www.elsevier.com/_data/assets/pdf_file/0016/92104/Embase-indexing-guide-2015.pdf>, p. 3) • Social Policy and Practice: bibliographic database with access to research in a variety of multi-disciplinary subjects, including social and public policy, children and young people, physical and mental health, community and public health, education and special educational needs (see <http://www.spandp.net/about-spp/coverage/>) • Education Resources Information Center (ERIC): bibliographic database providing access to educational literature and resources (see <https://www.ebscohost.com/us-high-schools/eric>) • SCOPUS: largest bibliographic database of literature in the fields of science, technology, medicine, social sciences, and arts and humanities, with special focus on interdisciplinary research (see <http://www.elsevier.com/solutions/scopus>) • Campbell Library: systematic reviews of research evidence on the effectiveness of social interventions for social and behavioral scientists and social practitioners (see <http://www.campbellcollaboration.org/background/index.php>)
<i>Limits</i>	English peer-reviewed journal articles, published since January 1, 2005 (as of August 31, 2015)

After conducting the search strategy, eligibility criteria were applied to the 1,191 retrieved articles. During the screening stage, journal articles were retained if they (1) presented findings of a primary study on a health promoting school initiative, or its equivalent, initiated by the public and/or nonprofit sector; (2) described some implementation aspect related to health promoting schools; and (3) presented data on partnerships related to health promotion within the school system. Excluded articles were those that (1) dealt with topics other than health promotion (such as immunization, communicable diseases, school reforms, etc.); (2) investigated the school environment or student behaviors, only; and (3) focused solely on outcomes of health promotion initiatives.

Once eligible studies were selected for inclusion in the scoping review, they were examined for data extraction and charting. Data were deemed relevant if they provided information on the partnership-related context, organizational management practices to support cross-sector partnerships, and one or more of the three types of partnership arrangement. Significant contextual factors included (1) the geographical setting where health promoting initiatives were being implemented, and (2) the extent of coordination support to facilitate engagement with community partners. Organizational management practices involved the possible establishment of informal coordination within the school community as well as management structures that could enable engagement across sectors at various jurisdictional levels. Each category of extracted data is further described in Table 4.

Data extraction was carried out by using the software NVivo 11, a computer-assisted qualitative analysis program to organize and manage text data. Themes were identified both deductively and inductively. Deductive analysis was based on preselected codes for external and internal coordination (i.e., presence or absence of an external coordination position/committee; presence or absence of an informal internal coordinator); organizational structures (i.e., presence or absence of a team/committee at various jurisdictional levels; presence or absence of community partner(s) on this team/committee); and partnership type (i.e., networking, cooperation, collaboration). Before undertaking this kind of analysis, all included studies were first read to generate ideas about recurrent patterns for inductive analysis. During the inductive analysis stage, somewhat consistent data could be retrieved on the employment status, duties and titles of external coordinators; the duties, official positions and informal designation of school-based internal coordinators; and names, membership composition and purpose of teams/committees. An inductive approach was also undertaken to uncover the key characteristics of the three types of partnerships. Coding and the development of themes entailed an iterative process of

rereading the included studies, extracting data, and refining themes to better match the additional data that was being extracted. The final coding scheme, which was deductively and inductively derived, was systematically applied to all relevant text within the corpus of included studies.

Table 4. Data extraction template for scoping the literature on community-school partnerships

<i>Scoping Categories</i>	<i>Description</i>
<i>Context</i>	The countries where HPS initiatives were being investigated as well as the presence or absence of formal coordinating functions, whether undertaken through an external coordinator or a coordinating committee at a jurisdictional level above that of schools
<i>Informal coordination</i>	In-school coordinating functions, whereby a school representative volunteers to provide HPS-related coordination support in addition to their officially recognized responsibilities of their regular position
<i>Management structures</i>	Committee/team structures through which school system representatives would engage with external stakeholders in partnership arrangements at either the school, school district, local, regional (state) or national level
<i>Partnership Types</i>	The three distinct purposes for which actors within the school system may choose to engage with their broader community: networking, cooperative, and collaborative (as described in Table 1)

4.3 Results

The search strategy yielded 31 studies to be included in the scoping review. The included studies were then sorted into one of three mutually exclusive categories based on the absence and/or presence of formal coordination, external to the school community (see flowchart in Appendix 1D, as well as a table of included studies with background information and scoping results in Appendix 1E). Within the collection of 31 studies that were reviewed, three studies investigated the same initiative during the same time period so that, in actuality, there are 29 unique investigations explored in this scoping review.

Based on the data extraction template presented above, the findings from the included studies are organized into three main areas. These areas are as follows: source of formal coordination (when present); organizational management; and types of partnership arrangement.

4.3.1 Source of formal coordination

Formal coordination from outside the school community was either not explicitly mentioned as being part of any of the investigated schools (8 studies); occurred in some investigated schools but not in others (3 studies); or occurred in all the investigated schools (20 studies). Of the 23 studies that did mention external coordination, partially or fully, six studies described this type of coordination as having been established through a public or nonpublic health-related agency at the national, regional or local level; four studies, through a health and education partnership; three studies, through a multi-agency group, and 10 studies, through a school district. The countries corresponding to each of these sources of formal coordination appear in Table 5.

The duties related to formal coordination were largely fulfilled by a single individual, but in certain studies, coordination responsibilities were distributed across members of coordinated school health teams within school boards when no funding was available to hire a coordinator (Barnes et al., 2013). In general, formal coordination from outside the school community consisted of four distinct functions: (1) facilitating the planning and implementation of the HPS approach; (2) conducting needs assessments regarding health-related issues, or organizational requirements, and/or progress monitoring/evaluations; (3) liaising with a variety of community partners to make use of their resources; and (4) providing access to, or offering, training opportunities/technical support to school personnel.

In regard to those studies that mentioned formal coordination to a greater or lesser extent, about less than half of the studies (43%) mentioned all four functions through three coordination sources (i.e., health-related agency [4 studies], a health and education partnership [2 studies] and school district [4 studies]). In another study that examined the implementation of a school health education program in Greek schools, Soulatou and Duncan (2009) reported on the very limited and ineffective contribution of the school health education officer. This person's efforts to link schools to the broader community were met with low interest within the school system. It is not clear whether the other studies that identified

less than four coordination functions did so due to a limited coordinator's role, or to the under-investigation of such a role despite indication of its importance in promoting health within the school setting (e.g., Flaschberger, Gugglberger, & Dietscher, 2013; Senior, 2012; Stolp et al., 2014).

Table 5: Country of origin where health promotion initiatives were being implemented, according to the absence and/or presence of formal coordination, external to the school community

I. Without Formal Coordination N = 8	II. With and Without Formal Coordination N = 3	III. With Formal Coordination N = 20			
(n)	(n)	A. From public or nonprofit health-related agency 25% (n)	B. From health and education partnerships 20% (n)	C. From multi-agency group 15% (n)	D. From school district(s) 40% (n)
Austria (3)	Australia (1) ^e	Australia (4)	Greece (1) ^b	Australia (1)	Canada (3) ^d
China (2)	Canada (1) ^f	Netherlands (1) ^a	Scotland (1) ^c	USA (2)	USA (5)
Ireland (1)	USA & Canada (1) ^g		Taiwan (1) ^c		
USA (1)			Wales (1) ^c		
Wales (1)					

- a. Study focuses on regional coordination via regional public health agencies and does not explicitly refer to the Dutch health promoting school network
- b. Specific to the national school health education curriculum
- c. Specific to the country's health promoting school network
- d. All of these studies are related to the same HPS initiative during the same time period
- e. 19 out of 45 participating schools received formal coordination from a local health agency
- f. This study covers 13 projects on comprehensive school health, one of which was carried out at the school district level
- g. Of the 11 pilot sites, only 2 were at the school district level; at least one of these sites had a wellness coordinator

Coordinators who are employed by agencies or organizations outside the school community receive specialized training in the implementation of comprehensive health promotion, and therefore, they may play a critical role in the success of health promoting schools. Yet implementation research has covered this topic with a variable degree of depth. Of the relevant 23 articles, about half (48%, 11 studies) merely listed the functions of the coordinator or coordinating committee without providing further details. In

other studies that involved coordinating committees at the district level, the delineation of coordination responsibilities was considerably ambiguous (e.g., Cornwell, Hawley, & Romain, 2007; Miller & Bice, 2014).

Over a third of the studies (35%, 8 studies) included more details with respect to the coordinator's responsibilities. However, only three studies described the position of the coordinator in a significant manner. One of these studies, conducted in the Netherlands, extensively examined the managerial styles of regional coordinators, as they guided collaborative groups in their efforts to streamline health promotion initiatives to support schools through local advisors who would conduct regular school visits (Pucher et al., 2015). Among their other duties, these regional coordinators have been trained to create the space within which all stakeholders at the collaborative planning table could arrive at a common understanding about the group's vision and role distribution, and openly discuss their views during the decision-making process. The other study revealed the critical role that external coordinators played in the implementation of the coordinated school health program. Employed through a local community coalition in the state of Arizona, USA, these coordinators served as health advocates and went beyond merely facilitating planning and implementation meetings (Staten et al., 2005). They helped remove implementation barriers, and kept the momentum going for health promotion initiatives within the schools, in addition to securing resources from other community partners and contributing to needs assessments and planning. The third study was entirely dedicated to the role of coordinators. District-level wellness coordinators undertook wide-ranging tasks related to the planning and implementation of the HPS approach: conducting school needs assessments; soliciting input from school personnel; providing resources to school staff and students; cultivating school site wellness champions; leading district wellness advisory committees; raising awareness of health and wellness among staff and teachers; supporting the integration of health and wellness into the school culture and curriculum; and leveraging limited resources (Westrich et al., 2015).

External coordinators go by several titles. The literature speaks of them using specialized terms such as 'critical friends' and 'buddies,' or more generalized ones such as 'healthy schools coordinators,' 'health and wellness coordinators,' 'regional coordinators,' and 'project coordinators.' At other times, these coordinators are referred to by their position or role: health education officer, health promotion officer, project officer, program manager, facilitator, expert, and consultant. Only in one instance was the position of coordinator filled at the Director's level (i.e., Director of the Office of the Coordinated School Health Program) although a position of program coordinator was also created at the programmatic level within the same school

district (Hoyle, Samek, & Valois, 2008). External coordinators' role may vary significantly across local context but one main task that they tend to undertake is providing assistance with planning at the school level.

4.3.2 Organizational management practices

As shown in Table 6, the included studies on the implementation of the HPS approach have been further examined along the theme of organizational management, and more specifically the three sub-themes of (1) informal coordination support through an in-school coordinator; (2) creation of healthy school environments through school health teams or committees; and (3) community mobilization through teams or committees above the school level. Within the latter two categories, studies were subdivided according to whether or not the identified management structures included community partners.

a. Informal coordination support

Slightly over half of the studies reporting formal coordination to a greater or lesser extent (i.e., 13 out of 23 studies) also revealed the involvement of an informal in-school coordinator. By contrast, three-quarters of studies on schools without formal coordination (i.e., 6 out of the 8 studies) did so—but this is not to say that informal coordination is less important when coordination from outside the school is available. As with the topic of external coordinators, the literature presents an uneven coverage of informal coordinators in a school setting. Only nine of the included studies specified the official positions held by these coordinators, and another four studies just stated that the in-school coordinator was not the school administrator. In the Scottish study, head teachers or a member of the senior management typically fulfilled the role of in-school coordinator, whereas authors of one of the Austrian studies pointed out that authority figures took on this duty in only some of the schools (Flaschberger et al., 2013; Inchley et al., 2006). Teachers, or more generally speaking school staff, are also cited as assuming this informal coordination role (Flaschberger et al., 2012; Gledlie, 2011; Westrich et al., 2015). Designating a member of the school's welfare team (i.e., psychologist, counsellor, pastoral care) or senior management (i.e., school principal, assistant/deputy principal) as coordinator of the MindMatters program led to greater results (Khan, Bedford, & Williams, 2011).

Table 6: Organizational management practices to engage in the HPS approach with and without formal coordination

	I. Without Formal Coordination (N = 8) n (%)	II. With and Without Formal Coordination (N = 3) n (%)	III. With Formal Coordination (N = 20) n (%)
A. In-school coordination			
1. No coordinator mentioned	6 (75)	3 (100)	10 (50)
2. With assigned coordinator	2 (25)	0 (0)	10 (50)
B. School health teams/committees:			
1. No teams/committees mentioned	1 (13)		6 (30)
2. Internal stakeholders only	2 (25) ^a		2 (10)
3. With community partners in some participating schools	2 (25) ^a	2 (67) ^{a,b}	2 (10)
4. With community partners in all participating schools	3 (38) ^c		6 (30) ^b
5. Inclusion of community partners unclear		1 (33)	4 (20)
C. Team/Committee structures above the school level:			
1. No committee mentioned	7 (88)	2 (67)	5 (25)
2. School district committees with community partners	n/a	1 (33) ^d	8 (45) ^e
3. Regional/local groups with community partners	n/a		4 (15) ^f
4. Network structure (cross-sector) (national/regional levels)	1 (13)		3 (15)

a. In one study, not all participating schools had a school health team

b. In all but one of these studies, organizations providing an external coordinator were the only community partner represented on the schools' committees

c. In one study, all school councils in participating schools received input from community partners but not necessarily as council members

d. This study only mentions that partnerships can include contributions to district-wellness steering committees

e. In one study, some school district councils may not have included all core members, such as community partners, as expected

f. One of these studies focused heavily on cross-sector partnership at the state level, but also reported on district-level school health advisory councils

Other authors concluded that the implementation of HPS initiatives and partnership building was more effective when the role of coordinator, as team leader, went to a member of the senior management, even if they were not fully engaged. This was attributed to the fact that their participation, however limited, brought about project visibility, integration opportunities, and/or increased access to community resources (Inchley et al., 2006; Valois, Lewallen, Slade, & Tasco, 2015). Still some authors contended that informal coordinators need not be the school administrator, as long as senior management continue to work very closely with the designated in-school coordinator, or the school team, to ensure team effectiveness (Flaschberger et al., 2013; Khan, Bedford, & Williams, 2012; Rothwell et al., 2010).

A variety of terms have been used to refer to coordinators who promote the health and well-being of students in addition to carrying out their regular school-related duties. The title 'coordinator' may be accompanied by one of the following prefixes: in-school, health promotion, school health, healthy schools, internal, program, project, or council. They have also been called 'project champions,' 'school health champions,' 'wellness champions,' and even 'cofacilitators.'

Although a key implementation factor, the subject of internal coordination support has not been well explored in the literature. Overall, 12 studies (39%) made no reference to in-school coordinators, or champions. This omission may be due to the topic falling outside the scope of the research project; an incomplete investigation; or the absence of such an individual in the school. An equal number of included studies (12 studies) did offer some form of explanation of what this role entailed, whereas the remaining studies (7 studies) only briefly touched on this topic. For instance, two studies merely referenced an in-school coordinator as part of an interviewee's verbatim quote (Christian et al., 2015; Firth et al., 2008).

When an explanation was given, the role of in-school coordinator was presented in two distinct ways. Some authors described an in-school coordinator, or champion, in terms of a connector who engages with internal and/or external stakeholders in order to support the HPS planning and implementation process through the establishment of a school health team. Other authors saw the role of school health champions in a much broader capacity that went beyond implementation considerations (e.g., Rowe, Stewart, & Somerset, 2010; Westrich et al., 2015). These champions were very active in encouraging the whole school community, including parents, to participate in health promotion activities, as advocates or catalysts for change.

b. School health teams or committees

HPS initiatives for the creation of healthy school environments are usually implemented through school-level committees. Again, the terminology varies greatly in the literature, with the use of such terms as 'school health committee,' 'coordinated school health council,' 'coordinating team,' 'core team,' 'HPS committee,' 'HPS steering committee,' 'school action team,' 'school council,' and 'school wellness team.' Of the 24 studies that mentioned school-level committees, five did not include any additional information, while most of the other studies briefly commented on the purpose of school health committees. Despite differences in the way they are called, these management structures basically carry out similar HPS-related operations. School-based committees usually conduct needs assessments, prepare action plans to respond to identified needs, and implement these plans.

A school-level committee is primarily composed of teachers, and ideally, led by a senior management representative from the school. Other school staff may also join this committee. In some schools, parents and/or students were invited to become members as well (e.g., Gugglberger & Dür, 2011; Stolp et al., 2014). Of the 15 studies that indicated the presence of community partners on a school committee in some or all of the investigated schools, nine studies provided generic information about who these partners were, such as health experts, local organizers, and service providers. The remaining six studies involved external coordinators as the only community partners on the school committee (e.g., Firth et al., 2008; Khan et al., 2011). In these studies, more details were included on the partnering organizations.

c. Community mobilization through teams or committees above the school level

Not all studies contained information about committees above the level of individual schools, but when they did, these committees invariably included stakeholders from the broader community. Management structures outside the school community to support HPS implementation exist either at the school district level or beyond the education sector, within local community, regional, or national boundaries. According to ten studies, four types of support structures appear to characterize district-level management: wellness committees, steering committees, coordinating school health teams, and health advisory councils, in addition to various sub-committees. However, the first three types of committees are similar in their functioning. They engage in needs assessments based on local demographic data; develop district-wide

strategies; prioritize and coordinate programs/activities; identify community resources; and/or formulate comprehensive school health policies and procedures.

Health promotion planning may begin at the district level to provide district-wide strategic direction so that schools could then prepare their own action plans under the same guidance. However, district-level committees may also engage in operational planning on behalf of a small number of schools by having school representatives participate in committee meetings (e.g., Miller & Bice, 2014). In some districts, advisory councils that include community partners exert a direct influence on the planning process (e.g., Barnes et al., 2013; Gollub, Kennedy, Bourgeois, Broyles, & Katzmarzyk, 2014). By contrast, in other districts, these councils either serve as health advocates and enhance connections to community resources or provide a source of expertise to the main district committee, but they do not have shared decision-making authority (e.g., Hoyle et al., 2008; Westrich et al., 2015). District committee members may be composed of district-level personnel, trustees, school administrators, teachers and other staff (e.g., school counselors, school nurses, food service managers) and to a lesser extent parents. Parents were mainly engaged through health advisory councils. All school districts that were reported to have established committees included community partners.

Besides partnerships through school district committees, other external management structures provide the means through which ongoing support can be offered to schools. These structures may take on the form of either community coalitions (1 study), multi-agency steering committees (2 studies), or networks operating at various jurisdictional levels (4 studies). The purpose of the Boarder Health coalition in the United States was to advocate for health promotion and policy change within the local school system, in addition to employing external coordinators to assist schools in their internal HPS implementation efforts (Staten et al., 2005). On the other hand, the intention behind multi-agency steering committees was to render more efficient the delivery of community resources to schools. For example, the Logan Healthy Schools Project in South-East Queensland, Australia, established a steering committee to bring together key personnel from five schools, along with state and local government representatives, community-based partners, and a project officer, to adopt a common vision and strengthen partnerships through the resources that each partner had to offer (Thomas, Rowe, & Harris, 2010).

Health promoting school networks are usually found in Eurasia, but they differ greatly among each other in the way that they are structured. Four studies were identified that introduced the workings of such

networks. Taiwan's Health promoting School Supporting Network operates through an administrative body and consultant team that link support from the national government to local governments and schools (Liao et al., 2015). The Network of Healthy School Schemes in Wales employs healthy schools coordinators to run local schemes of health promoting schools by establishing steering groups that unite representatives from schools and various other organizations (Rothwell et al., 2010). In Scotland, their health promoting school network appears to be supporting schools mainly through education officers/advisers from the national department of education, who are acting as facilitators with further assistance from health promotion specialists (Inchley et al., 2006). Lastly, Austria has at least one regional health promoting school network that organizes knowledge exchange events, such as workshops, lectures, and seminars (Flaschberger et al., 2013). This regional network does not seem to provide formal coordination to schools but rather offers organizational learning opportunities to member schools, along with on-site coaching for additional learning (as opposed to facilitated planning) to those schools who are highly committed to HPS integration.

Each of these network structures brought on various levels of success and their unique set of challenges. The study from the Netherlands that was mentioned earlier may also be exploring the Dutch version of an HPS network, but such a network was not explicitly stated. In that study, the regional coordinators were employed by public health agencies to establish regional steering groups composed of representatives from the education, health and public service sectors (including HPS advisors) to streamline their school health promotion efforts (Pucher et al., 2015).

4.3.3 Types of partnership engagement

Schools and/or school districts and their external stakeholders, whether they be health-related agencies, social service providers, other community-based organizations or even network organizers, engage in three types of partnership arrangements: networking, cooperative and collaborative. Table 7, shown below, indicates the number of included studies that provide evidence for the different types of partnerships, according to identified partnership characteristics.

Table 7: Types of partnership with community partners, according to engagement characteristics

Partnership Types	n
A. Networking (N = 21)	
1. Informal knowledge exchange on successes and lessons learned across schools	13
2. Familiarity with potential partners to receive additional resources	7
3. Knowledge of available community-based programs and services for potential referrals [both in school and in the community]	5
4. Advocacy communications for students' health and well-being	7
5. Unspecified networking	1
B. Cooperative (N = 21)	
1. Off-site training to schools/school districts, with funding (without ongoing external facilitation)	7
2. On-site technical assistance	11
3. Community programs/professional services delivered in the school or accessed in the community	7
4. Material and equipment	7
5. Resources in general (not specified)	8
C. Collaborative (N = 29)	
1. Joint training through inter-organizations at the national, state or regional levels	8
2. Higher-order joint planning within school districts	9
3. Higher-order joint planning at state, regional or local levels	7
4. School planning with community partners	12
5. School planning with external coordinator	6

a. Networking partnerships

Twenty-one of the included studies brought up the topic of networking, although one study used the term without explanation. Based on these studies, networking within the school system can be understood as the sharing of information to (1) informally exchange knowledge across schools regarding lessons learned and success stories (13 studies); (2) connect with potential community partners for opportunities to enhance school capacity through additional resources (7 studies); (3) find out about health and social

services available for students and their families at the school or in the broader community for potential referrals (5 studies); and (4) advocate for the promotion of students' health and well-being (7 studies).

Networking partnerships are especially valuable for collective learning. In Austria, networking for inter-school learning tended to take place when organized by an outside agency (Gugglberger & Dur, 2011). At such networking events, school personnel can build skills by exchanging perspectives about health promotion issues and learn from each other's experiences in order to acquire knowledge that they could then put into practice in their own schools (e.g., Gugglberger & Dur, 2011; Stolp et al., 2014). A recent Healthy School Communities (HSC) initiative undertaken by the American Association for Supervision and Curriculum Development (ASCD) ensured beneficial knowledge exchanges by having pilot schools enter into a formal written agreement to "share with other HSC sites best practices, strategies, policies [and] procedures," as one of the conditions for participation (Valois et al., 2015, p. 272). Professional development workshops present another avenue through which personnel from different schools could network with one another to learn about good practices (Rowe et al., 2010).

Networking is beneficial for more than just learning purposes. Another benefit of networking is the prospect of building capacity to promote student health by connecting with stakeholders who have yet to express an interest in engaging directly with schools to develop and/or implement HPS initiatives on school premises. For instance, Dutch regional coordinators would get in touch with 'potential stakeholders' to increase familiarity with their healthy school approach, particularly at conferences, and to make motivating presentations at meetings in efforts to garner their interest and engagement (Pucher et al., 2015). A third advantage of networking is the expansion of schools' referral systems. Health and social service providers are known to engage with schools to inform them about professional services and community programs to which school staff could refer students and their parents, should they be interested (e.g., Clarke, O'Sullivan, & Barry, 2010; Khan et al., 2012; Westrich et al., 2015). A fourth purpose of networking relates to advocacy to gain support from the local community or to encourage the uptake of the HPS approach in schools. For example, in a rural, low-income community in the United States, the coordinated school health team shared information with local businesses (e.g., banks, grocery stores) and community institutions (e.g., churches) so that they may learn how they could contribute to the development of students' self-esteem (Cornwell et al., 2007). As part of their missions, the American community coalition called Boarder Health and the local health promotion schemes in Wales would advocate for schools to engage in the HPS approach through their offer of training and guidance (Rothwell

et al., 2010; Staten et al., 2005). Continued advocacy has helped position school health as a priority among community leaders and school administrators, alike.

b. Cooperative partnership

A second set of 21 studies mentioned various kinds of resource sharing within a cooperative partnership arrangement to support the implementation of HPS initiatives, or activities. These resources can be grouped into four categories: (1) off-site training workshops/conferences on the implementation of the HPS approach, with initial funding as an incentive (7 studies); (2) on-site technical assistance/guidance (11 studies); (3) community programs and professional services (7 studies); (4) material and equipment (7 studies); and (5) resources in general (8 studies). Schools and school boards cooperate with a variety of community partners, including health-related agencies, community groups, research institutions, nongovernment organizations, local and state/provincial governments, as well as local businesses, by accepting to take on their programs and services, as part of the sharing of financial, physical, human and data-related resources.

Off-site training through a cooperative partnership arrangement involves stakeholders from within and outside the education sector, who are not part of any collaboration initiative, but rather are engaged for the sole purpose of developing knowledge and skills in school personnel. Schools and school districts have volunteered to undergo training from partners in the government, nonprofit and/or academic sectors (e.g., Aldinger, Zhang, Liu, Guo et al., 2008; Valois et al., 2015). In certain cases, participating schools and school districts signed binding cooperative agreements whereby they agreed to adopt the lead organization's vision and strategic direction and follow through with the expectations placed on them in exchange for the opportunity to receive training and funding so that they may implement their own action plans (e.g., Flaschberger et al., 2013; Valois et al., 2015). However, obtaining resources from an external source does not necessarily constitute a cooperative partnership. For those schools that receive grants to operate HPS initiatives, their interaction with the funding agency would be related to a funding arrangement, rather than a partnership arrangement.

The availability of external human resources through cooperative partnerships is one of the most important factors for successful HPS implementation. Stolp et al. (2014) define HPS-related human

resources as “those individuals who could provide services and contribute their time, knowledge and/or skills to the development of a healthy school community” (p. 306). This contribution of knowledge and skills may be referred to as technical assistance, expert advice, or guidance. To a certain extent, it can be transferred to school personnel to build their own knowledge and skills for sustainability once the source of external expertise is no longer available (Christian et al., 2015; Gugglberger & Dur; 2011). With few exceptions, the literature offers little description of what is the nature of the technical assistance, or individualized guidance, given by external experts who are contributing their time free of charge. One specific type of assistance that authors point out as having great value is the provision of writing skills, especially for grant proposals (Ahmed, 2005; Stolp et al., 2014). Another key source of advice comes from nutritionists, or dietitians, who teach kitchen staff how to prepare nutritious meals that students could enjoy eating (Aldinger, Zhang, Liu, Pan et al., 2008; Miller & Bice, 2014). On a collective note, professionals may come together to work as volunteers on school health advisory committees/councils to provide their expert advice in a consultation capacity, in addition to enhancing connections with other internal and external stakeholders (Hoyle et al., 2008; Westrich et al., 2015). Health promotion experts are a diverse group of professionals, some volunteering their time on occasion, while others are receiving payment for their services (Gugglberger & Dur; 2011; Stolp et al., 2014). Another distinction must therefore be made between the former, as an actual partnership arrangement, and the latter, as a contractual arrangement that can be likened to an employer-employee relationship.

The guidance, or ‘consultation opportunities’ (Rowe et al., 2010), given within cooperative partnership arrangements can go in both direction. Not only can external stakeholders be a source of expert advice, but school personnel may provide guidance, as well, on their community partners’ initiatives. For example, *beyondblue*, an Australian initiative to prevent the development of depression in young people, was met with a number of challenges during the first year of its implementation within a school setting (Firth et al., 2008). Implementation obstacles were alleviated when the program developers consulted with teachers and made programmatic changes to address their concerns.

Programs and services from the broader community offer additional resources at no charge through cooperative partnership arrangements. Health promotion programs and professional services are offered by community-based organizations and health professionals on or outside school premises through schools’ referral systems. For instance, one of the *beyondblue* modules supports school personnel’s efforts to link the youth experiencing mental health problems to professional services both at school and

in the broader community (Firth et al., 2008). Local community centers, municipalities and local business can support student health in various ways (e.g., sports coaching, personal and social support, training in parenting and health matters, internship opportunities for youth development) (Clarke et al., 2010; Stolp et al., 2014). Hindered by restricted financial and resource allocations, cooperative partnership arrangements have proven to be an indispensable means to bolster schools' capacity to undertake their comprehensive school health approach (Cornwell et al., 2007; Miller & Bice, 2014).

HPS-related physical resources include material and equipment required to promote school health. Health-oriented lesson plans, healthy recipes, and booklets on physical activity are some of the material contributed by partners to support schools' health promotion activities (Stolp et al., 2014). In addition, the sharing of project management tools, such as needs assessments/survey instruments, are very useful for the identification of issues and areas for improvement, as are forms to assist with the preparation of action plans (Ahmed, 2005; Flaschberger et al., 2012; Valois et al., 2014). Implementing these plans may call for the use of equipment that tend not to be covered by schools' limited budgets. Equipment to support health promotion initiatives is a capital asset that would likely be difficult for schools to acquire, were it not for their cooperative partnerships that can help fill this need (Christian et al., 2015). For example, a school district located in a rural, low-income community in the United States, obtained the means to purchase essential equipment through a local community group, simultaneously meeting one of their schools' resource needs and helping to fulfill their partner's charitable mission (Cornwell et al., 2007). This success arose through the school district's endeavor to initiate community-school partnerships for all of their schools' health promotion projects.

The last category is a generic one that groups together the remaining studies where authors have not been explicit when discussing the provision of 'resources' or 'support.' Community partners are often times health professionals, such as experts in health promotion, who provide assistance with program implementation and with 'every-day' health promotion activities. Unfortunately, in this set of studies, one cannot discern whether the resources that authors speak of in general terms are being brought into the schools or being accessed by students out in the community. Nor can one know whether the support being received is financial, material, data-related, or simply for encouragement purposes. It is likely that authors choose the generic terms of 'resources' and 'support' to mean a number of possible resources being shared. Depending on the nature and scope of the research, resource-related details may not be deemed necessary. However, gaining an understanding as to the type of resources involved and the

factors that has led to this exchange would shed light on the types of engagement underlying the HPS implementation being studied.

c. Collaborative partnership

As with cooperative partnership arrangements, partners within collaborative partnership arrangements share a variety of resources: training opportunities, expert advice, equipment, tools and other material for HPS implementation, and links to outside agencies for additional support. The distinguishing feature between cooperation and collaboration is whether or not the partners are extensively contributing to the decision-making process when putting forth HPS-related initiatives. Three kinds of collaboration appear in the HPS literature: joint training on the HPS approach (8 studies); high-level joint planning to direct the implementation of the HPS approach in schools (9 studies at the school district level, and 7 studies beyond the school system), and school-level planning to implement HPS initiatives based on school needs (12 studies with community partners, and 6 studies with externally facilitated planning).

Within the same initiative, different types of partnership may exist among partners at different jurisdictional levels, as has been found to be the case with the delivery of joint training opportunities. Overall, eight studies dealt with the aspect of joint training to a greater or lesser degree. Half of these studies involved off-site training (2 American studies and 2 Austrian studies), which were mentioned earlier as being limited to a cooperative partnership arrangement with the training organizers. However, the organization of the training itself pertained to a collaboration between the departments of health and education either at state, regional, or national levels—with the involvement of other external stakeholders in some of these training initiatives. In the other four studies, joint training was embedded within a collaboration initiative that was spearheaded by a council of multiple agencies at the state level (1 American study), or by a national health promoting school network (3 Eurasian studies). Training on HPS implementation may cover such topics as leadership, the creation of school teams/councils, team building, needs assessments, and/or action planning (e.g., Ahmed, 2005; Flaschberger et al., 2013).

Other forms of high-level planning occurred at, or above, the school district level. However, for the most part, not much information has been provided in this area, as most of these studies included only some brief description about committee membership that implied joint decision making. At the district level,

collaboration usually takes place through Coordinated School Health Program teams, District Wellness Committees, or similar structures, whose membership includes school-level personnel. Interestingly, community partners were part of the membership composition of school districts' committees or advisory councils in all North American studies that mentioned them. These committees either engaged in high-level strategic planning to develop comprehensive school health policies and steer implementation efforts across schools in their jurisdictions (Gleddie, 2010; Gleddie, 2011; Gollub et al., 2014), or engaged directly in operational planning on behalf of their schools (Cornwell et al., 2007; Miller & Bice, 2014).

Two initiatives in the United States specifically encouraged the establishment of a district-level school health advisory council with a diverse membership (Barnes et al., 2013; Gollup et al., 2014). Contrary to their 'advisory' designation, these councils were very influential in school district's high-level decision-making process such that they functioned more as steering committees in a collaborative rather than cooperative capacity. For instance, as part of the Michiana Institute Leadership Training, each participating school districts' core team and advisory council members would work closely together to conduct needs assessments, identify priorities, plan activities, and evaluate how much progress had been made (Barnes et al., 2013). The role played by the advisory council members in these studies lie in contrast to the limited engagement of advisory council members in the decision-making process of district committees in other studies (Hoyle et al., 2008; Westrich et al., 2015). This variability likely depends on factors related to the people who are engaged on either side of the partnership (i.e., the giving or receiving end of advice), but the current research has not explored this area to any depth to ascertain what these factors could be.

Other researchers explained how a school district may collaborate directly with community partners on program development. District wellness coordinators within the San Francisco Bay Area would connect with their local community partners to jointly enhance, expand or introduce new wellness programs and co-organize health-related events across their jurisdiction (Westrich et al., 2015). District-level planning can therefore encompass both strategic thinking (i.e., needs-based prioritization) and action-oriented thinking (i.e., developing initiatives).

Higher-order planning for schools is not restricted to school districts, particularly in countries where this organizational structure is less prominent. Steering committees composed of community partners, educators, and other professionals have been established at regional or local levels for planning and coordination purposes in such countries. With respect to nation-wide collaboration, regional or local

steering committees spanning across entire European countries have been the chosen management structure through which to unite a diverse group of collaborators from the education, health and other sectors (Pucher et al., 2015; Rothwell et al., 2010). Through such collaboration, agreements were reached on how best to work together to maximize the effects of each organization's contributions to HPS implementation efforts. As another example of higher-order planning, the previously mentioned Logan Healthy Schools Project benefited from the strategic capabilities of a community-based steering committee and their hiring of a project officer who initiated additional collaborative partnerships. These collaborative partnerships involved local organizations and service providers to carry out nutrition and physical activities with the students before, during and after school hours (Thomas et al., 2010). The five schools participating in this project were directly engaged in the planning process with their local community partners through this partnership arrangement. Collaborative planning can also be undertaken for the development of initiatives at the local community level. Similarly, implementers of the MindMatters program from a local health department in Australia recognized the importance of capturing the views of a number of schools on how to improve program delivery (Khan et al., 2011). To this end, a planning forum was organized to undertake a collaborative process that resulted in the creation of the buddy scheme project, which was shown to enhance program implementation.

With respect to school planning with outside agencies, the HPS literature indicates two possibilities: schools that collaborate with community partners, especially through school teams or committees (12 studies); and school committees that are composed predominantly of internal stakeholders and only one community partner, as external coordinator to facilitate planning meetings (6 studies). A large majority of the first group of studies gave only minimal information about collaborative partnership arrangements, either indicating the presence of community partners on school committees without specifying who these partners were, or simply mentioning that collaboration was taking place with external stakeholders. One study did include that 'health experts' were among the members of school health teams (Stolp et al., 2014), but no further details on engagement was provided. On the other hand, Scottish researchers elaborated on deliberations among members of schools' multi-agency steering groups. Through their collaborative engagement, these schools and their external stakeholders succeeded in broadening their perspective on nutrition-related issues and reached a common understanding about principles and values, as well as goals and expectations—all of which resulted in greater clarity as to what each stakeholder could contribute to the partnership and how each could benefit from their participation in this partnership (Inchley et al., 2006). The immediate outcome was stronger alliances.

The HPS approach is meant to encourage schools to collaborate with community partners as a major implementation enabler (Inchley et al., 2006). American researchers involved with the ASCD-led initiative described community-school collaboration as “active engagement in problem solving, two-way resource identification and sharing, and inclusive planning” (Valois et al., 2014, p. 276). The contribution of an external agency can be instrumental in building community-school partnerships. The strong involvement of consultants within Taiwan’s HPS Network was associated with a greater likelihood of establishing community-school relationships, which was in turn associated with HPS implementation, although the exact collaborative nature of these relationships was not discussed in the study (Liao et al., 2015).

The elementary-school initiative, known as *Kids Café*, in Southeast Queensland, Australia presents a particularly interesting account of community-school engagement. Prior to this initiative, the school organized a one-day event to engage the school community and their community partners in a conversation about the HPS approach (Rowe et al., 2010). Through the leadership of a teacher champion and the school’s HPS committee, senior students at this elementary school surveyed the views of students, school staff, parents and external stakeholders at this event as part of their curriculum requirements. Based on survey results, the school’s committee formulated a common vision of an ‘ideal school’, identified priority areas and policy focus (e.g., healthy eating), and planned accordingly. Through the support and community connections of a program manager from the state health department, as well as project funding, this committee proceeded to build collaborative partnerships with community agencies to further plan and secure additional resources for the development of the physical infrastructure needed to create a school-based café where nutritious meals could be purchased by students at an affordable price. It is remarkable that students as young as 11 and 12 years old were directly engaged in planning this HPS initiative, which engaged the whole school and the broader community.

The second group of studies related to schools’ facilitated planning process. It comprised six studies—two of which dealt with the same buddy scheme project of the MindMatters program. All of these studies covered the topic of collaboration by describing the role that external coordinators filled on school health committees. These committees were composed of school personnel, and in certain cases, students and/or parents would also be counted among committee members. The external coordinators, serving as process facilitators, were the only members from the broader community. These coordinators were heavily engaged in the decision-making process regarding the development and implementation of action plans, and as such, took part in a collaborative partnership arrangement with the schools.

One Australian study on a collaborative partnership between a community health agency and a school described a two-tiered planning process (Senior, 2012). After an extensive negotiation period, personnel from the community health agency and the school's senior leadership team jointly decided on what health promotion initiatives were to be carried out in the school. Then they proceeded to establish a planning committee with school staff, through which a health promotion officer would be guiding the implementation of these initiatives. Since the authors commented that the multifaceted, HPS-based initiatives included a partnership component, it is highly likely that partnership arrangements were made with other community partners; however, the study did not further explore this possibility. A second study, pertaining to the MindMatters program with the buddy scheme, also alluded to establishing other partnerships with external agencies at the school level without adding any partnership description (Khan et al., 2011). This category of studies focused more on the delivery of specific interventions, highlighting the pivotal role of external coordinators for implementation success.

4.4 Discussion

The adoption of the health promoting school framework throughout the world follows the same general principles of a whole-school approach, however coordination structures vary across countries, and most notably, across continents. Regional networks of health promoting schools tend to be established in Eurasian countries to provide direction, training and technical assistance to help schools with their implementation efforts. By contrast, school districts, or school divisions, take on this function in North America when sufficient capacity is available to enable them to do so.

Whatever the source of coordination may be—whether an HPS network, a school district, a public health agency, a nongovernment organization, or a multiagency group—external coordinators are critical for the successful implementation of the HPS approach in schools (Senior, 2012; Winnail, Dorman, & Stevenson, 2004). Researchers contend that training provided to internal program implementers working in service agencies, including schools, is usually insufficient to achieve desired outcomes. Evidenced-based programs have been poorly implemented due in part to training being provided without adequate follow-up measures, such as ongoing coaching, technical assistance and other external support (Bumbarger & Perkins, 2008; Fixsen et al., 2005). Surprisingly, there is a significant gap in the literature on external coordinators as an important implementation factor, as pointed out by Westrich et al. (2015). These

authors sought to address this gap by thoroughly examining the role of district-level wellness coordinators in improving wellness programs through ‘purposeful coordination’ that included the cultivation of community-school partnerships to reap synergistic benefits. Having formal coordination in place has significance since it may determine the level of engagement with other external community partners.

Similarly, the subject of internal coordination has not been well covered in the literature. Yet the prominent HPS approach known as the Coordinated School Health Model in the United States has, since its inception, emphasized the need for school board districts to create a coordinator position and for schools to appoint an internal coordinator who would be responsible for overseeing the school health program when establishing a school health team (Allensworth, Lawson, Nicholson, & Wyche, 1997). Although led or supported by the internal coordinator, this school health team would be charged with developing policies, designing and implementing programs with the involvement of students and parents, as well as coordinating activities and resources. As efforts to promote health within the school setting has evolved over the years, school health teams, or school health councils, are being encouraged to also involve service providers from the broader community in schools’ planning activities (e.g., Ahmed, 2005; Aldinger, Zhang, Liu, Pan et al., 2008; Liao et al., 2015; Valois et al., 2015). This practice of building community-school partnerships, especially during the initial funded phase of an initiative, can help sustain the initiative after the funds have been depleted (Paine-Andrews, Fisher, Campuzano, Fawcett, & Berkley-Patton, 2000). However, exploration of the partnership-building process between the school system and community partners has not been extensive. Indeed, the collaborative nature of community-school partnerships at times could only be inferred through indications of community partners’ participation on a planning committee.

Notwithstanding the dearth of knowledge about partnership development within the school setting, information can be gleaned from the literature on health promoting schools to gain some understanding of the three main types of partnership between the school system and the broader community: networking, cooperation and collaboration.

Networking for the purposes of inter-school learning or community-wide health promotion advocacy can produce immediate returns and need not progress to higher levels of engagement. Once information is shared, school personnel can begin to put it into practice in their own schools. Likewise with advocacy by school health teams and other health promoting groups, local community partners can initiate, from their

side, their own process of figuring out how they can contribute to schoolchildren's health and well-being. However, networking in the traditional sense is a pre-engagement strategy (Himmelman, 2001). Networking is, above all, about seeking to build up an organization's referral system and familiarizing oneself with the programs, services and other resources of 'potential' partners. The transition from networking to cooperation, in these instances, happens at the moment the decision is made to accept a partner's offering of resources.

Cooperation appears to be the partnership strategy of choice, where training, or technical support is being sought from an outside group of experts to implement schools' own initiatives. A cooperative partnership arrangement is also more appropriate where engagement of school personnel is minimally required. This is usually the case when schools only need to provide access to school premises and/or students and their families so that their community partners can deliver the programs and services which they, themselves, have developed based on their expertise, without requiring the direct participation of school personnel. Such an arrangement places no significant time demands on teachers and other school staff and would therefore accommodate their need to attend to educational pressures.

However, implementation difficulties may arise when community partners must depend on school system actors to deliver their programs during the school day. Expecting school staff to cooperate by delivering a program that originates from an outside agency may not be the best approach. It does not give the staff the opportunity to provide input in program development, for a smoother implementation process. Implementation difficulties could lead to negative first impressions of a community partner's program among school staff, and possibly result in the unrecoverable loss of interest and commitment (Firth et al., 2008). Opting for a collaborative partnership arrangement may yield greater success.

Collaboration, as it pertains to health promoting schools, manifests for two distinct reasons: to deliver joint training opportunities by health and education departments, and to engage in the joint planning of health promotion initiatives. The key underlying principle of health promoting schools is a systems approach to promoting health among the student population. Therefore, the application of the HPS approach *per se* rests heavily on the engagement of all relevant stakeholders, within and beyond school communities, not only in the coordination of available programs and services but also in the joint planning for the cognitive, physical, social, and emotional development of the whole child (Allensworth & Kolbe,

1987; Cornwell et al., 2007; Gleddie & Hobin, 2011; Lewallen, Hunt, Potts-Datema, Zaza, & Giles, 2015; Murray, Hurley, & Ahmed, 2015; Rothwell et al., 2010; Valois et al., 2015).

Health agencies, and multi-agency groups, tend to provide external coordinators whose role includes a facilitative style of leadership during the planning and implementation of whole-school initiatives. Contrary to traditional leadership that consists of top-down command and control, facilitative leadership is about promoting “respect and positive relationships between team members, productive conflict resolution, and open expression of ideas and opinions” (Hirst, Mann, Bain, Pirola-Merlo, & Richter, 2004, p. 312). The role of a facilitative leader is to tap into the insights and creative thinking that each team member can bring to the collaborative partnership (Jones, Forlin, & Gillies, 2013; Kayser, 2011). Although the facilitative leader of a partnering organization may not directly contribute to the decision-making process of a school health committee, their participation would still constitute a collaborative arrangement between their organization and representatives of the school system since he or she would be playing an instrumental role in making collaboration possible within the school community. According to Jones et al. (2013), a facilitator guides collaborative planning by involving the implementers of the plan in all phases of the decision-making process in such a way as to enable them to contribute meaningfully to the change process as a collective. Therefore, it becomes imperative to ensure that external coordinators have the training and skills to fulfil such a role within the context of health promoting schools for maximizing implementation effectiveness.

Collaborative partnerships are meant to act as catalysts for comprehensive school health promotion. The required HPS infrastructure, understood as “the basic framework of policies, resources, organizational structures, and communication channels,” has often been affected by fragmentation and lack of coordination (Allensworth et al., 1997, p. 261). This fragmented and uncoordinated infrastructure calls for collaboration that extends beyond the school community, aligning and integrating programs and services offered by health and social service providers and community-based organizations, with the input of school personnel. In this way, a seamless and continuous system of care can be offered to students and their families. Such a comprehensive and coordinated approach would maximize impact and sustainability (Alvord & Grados, 2005; Bond, Gover, Godfrey, Butler, & Patton, 2001; Brooks, 2006; Greenberg et al., 2003; Weist, Ambrose, & Lewis, 2006). Schools may use various collaborative organizational structures to pool and coordinate resources in efforts to solve complex problems affecting students and their families, although with similar functions (Blank, Jacobson, Melaville, & Pearson, 2010). Along with these efforts,

joint development of school policies, processes, and practices across the education and health sectors ensures that the health promoting school framework gets translated into action as intended for systems change (Lewallen et al., 2015). When it comes to the development of system-wide strategies, the active participation of school districts in North America and HPS Networks in Eurasia in collaborative partnerships is indispensable (Blank et al., 2010; Buijs, 2009). Nothing less than multi-level collaborative partnership arrangements for promoting the health and well-being of schoolchildren will suffice to create the conditions needed for the unfoldment of their full potential.

Schools are part of a dynamic and complex multi-level system (Barry, Domitrovich, & Ma Asunción Lara, 2005; Colquhoun, 2005; Hoagwood & Johnson, 2003), with overlapping partnership arrangements. For any given HPS initiative, schools, school boards or HPS networks may connect with one or many outside health-related agencies and community-based organizations to network, cooperate and/or collaborate. Although effective HPS implementation rests on community-school collaborative partnership arrangements involving diverse stakeholders for comprehensive planning and coordination, the school system may still benefit from other types of partnership arrangements as additional sources of support. Complementary networking and cooperative arrangements could still be advantageous within a broader system of collaboration, for example, where schools accept the delivery of healthcare services on school premises and the one-time training of kitchen staff by nutritionists from a local university. As Himmelman (2001) points out the choice of partnership strategies would depend on intent, as well as the strengths of existing relationships.

4.5 Conclusion

The successful creation of health promoting schools is rooted in partnerships, engaging a variety of stakeholders from the education, health and social services sectors, as well as the business sector at times. Networking in and of itself is fundamental for interorganizational learning and advocacy, but it also represents the initial stage of community-school partnerships. Through cooperative arrangements, schools and higher-level jurisdictions may acquire or access additional health promotion resources, programs, and services from community partners. By contrast, collaborative arrangements offer a way for representatives of the school system to work closely with their community partners to ensure the

feasibility and practicality of health promotion strategies and initiatives as well as the proper coordination of service and program delivery.

Each of these partnership strategies has merit. However, the collaborative efforts of all relevant stakeholders, both within and beyond the school system promises to break down silos and improve the fragmented delivery of programs and services. Building the capacity for a systems approach calls for pooling resources and eliciting the wisdom inherent within cross-sector partnerships for comprehensive school health. Given the complex nature of school systems, many actors from diverse sectors need to come together to learn about what works, develop resources to support desired change, and jointly contribute to the decision-making process in order to enable this change to unfold in a systematic and sustainable manner.

Childhood and adolescence are critical periods for embracing healthy living. A healthier way of life during these life stages can lead to greater success in school, and academic success is a major social determinant of health. Equally important, what students learn in school about how they can promote their own health could remain with them for the rest of their lives. Indeed, schools are a convenient setting through which to reach children and youth and make a significant impact on the persistent epidemic of chronic disease plaguing modern society. But schools cannot accomplish this aim on their own. As the various health promoting school models advocate, schools need to work in partnerships that cut across sector boundaries for greater results in promoting the health of students. Unfortunately, the preceding literature review and scoping review indicate a dearth of knowledge in the scientific literature about how professionals from different sectors can build strong partnership ties within the local school system and maximize their partnership's potential, especially at the school board level. So then, the problem to be addressed is the lack of knowledge about how to maximize the functioning of cross-sector partnerships, especially between local public health units and school boards, to promote healthy living among the student population. My thesis project, as presented in the following chapters, endeavors to fill this knowledge gap.

Chapter 5: Methodology

5.1 Research questions

For my doctoral thesis project, I sought to gain a full understanding of partnerships between public health units and school boards, and to uncover the potential for collaboration across the public health and education sectors. My overall research question was, 'how and to what extent are public health units and school boards engaging with each other to promote the well-being of schoolchildren and how are they progressing toward cross-sector collaboration for the creation of healthy schools?'

Specifically, my research addresses the following questions:

1. What types of partnerships exist specifically across public health units and school boards for the promotion of student well-being?
2. To what extent do representatives from public health units and school boards engage with each other for the promotion of student well-being?
3. To what extent is the Foundations for a Healthy School framework utilized to work in partnership across the health and education sectors?
4. How do public health units and school boards engage with each other in an enriching manner?
5. How are public health units and school boards able to engage with each other for the promotion of student well-being?
6. How are public health units and school boards hindered in their ability to work together for the promotion of student well-being, and how can partnership challenges be overcome? and
7. How can public health units and school boards move along the collaboration continuum?

The boundaries of this doctoral thesis project have been set around partnerships between public health units and school boards for the purpose of health promotion (including prevention) to the exclusion of health protection services, because the partnership dynamics involved in delivering each of these types of services are very different. Partnership dynamics related to health protection are more standardized and enforceable, given that school boards are legally obligated to work with their local public health units in this area.

5.2 Research design

The Ontario Ministry of Education's renewed vision extends beyond student achievement to encompass student well-being as well. This makes Ontario an ideal province in which to explore school health partnerships. To this end, an exploratory research methodology that is primarily qualitative in design and includes an aspect of participatory research was chosen. An exploratory qualitative design seemed most appropriate because the full range of opportunities, challenges, and breakthroughs related to partnerships between public health units and school boards are still unknown. Indeed, qualitative research possesses a number of relevant attributes: acquisition of in-depth understanding of a social phenomenon through study participants' experiences and perspectives, along with the gathering of contextual information; appropriateness of small sample sizes; the interactive feature of the data collection process that enables the further exploration of emergent issues; the availability of information-rich and extensive data; data analysis that may lead to the discovery of new concepts and ideas; and the possibilities of generating a detailed description of the phenomenon being investigated, identifying patterns of association, and/or developing a typology (Snape & Spencer, 2003). As such, the use of qualitative methods offered a practical means for gaining a deep understanding of the complex nature of partnerships across the public health and education sectors.

Importantly, my qualitative thesis project design included a participatory orientation. It called for the direct engagement of a subset of study participants, as the knowledge users, in the research project through the establishment of a research steering committee. The intent was to ensure project relevance to committee members and their peers in order to recruit a high number of participants for meaningful results. This inclusive approach to my qualitative inquiry required that I, as principal researcher, be sensitive to the views and preferences of my study participants, and that I interact closely with them during the preparation of the research design (Patton, 2015).

The driving principle underlying my thesis project was the generation of knowledge that study participants could find of practical value to inform their practice and strengthen their school health partnerships. My research stance was therefore one of pragmatism. Patton (2015) asserts that pragmatism is about "inquiring into practical questions in search of useful and actionable answers" and "making methods decisions based on the situation and opportunities that emerge rather than adherence to a pure paradigm, theoretical inquiry tradition, or fixed design" (p. 153). As described below, the data collection

process was heavily influenced by input from the research steering committee members, who represented the local public health units across Ontario.

The focus of this research is primarily on public health professionals in Ontario, given that their mandate is to initiate partnerships with school boards and schools. However, efforts were made to also obtain the perspective of school board personnel as much as possible.

5.3 Research phase 1: Ontario public health units

The first phase of the doctoral thesis project pertained to local public health units across Ontario. Following a presentation of my initial research proposal at their November 24, 2014 teleconference, the Ontario School Health Management in Public Health Network expressed interest in taking part in this project. In keeping with this project's participatory approach, a research steering committee was established to formulate the research goal, objectives, and relevant research questions in order to meet their knowledge needs and interests. Additionally, committee members were requested to engage in (1) the co-development of data-collection tools for phase 1, (2) data interpretation, and (3) the preparation of recommendations. Eleven Network members volunteered to be part of the research steering committee. They were all welcomed to join the committee for the sake of inclusivity. Shortly after establishing this committee, one member dropped out due to other work commitments, bringing the final number of committee members to 10. The committee work began in January 2015.

Engaging with the research steering committee led to major changes to my research proposal after learning more about the realities of their work. Initially, I had planned to focus the research questions on collaborative partnerships. However, the research steering committee members commented that different public health units were at different levels of cross-sector engagement, and they expressed a strong interest in exploring engagement variations. They also wanted to find out about the difficulties that some of their peers were experiencing with their school health partnerships, and how others were succeeding in developing strong, collaborative partnerships. They provided me with reference articles on an integration model along a continuum of care that was co-authored by a researcher with whom they were already familiar (Browne, Kingston, Grdisa, & Markle-Reid, 2007; Browne et al., 2004). Some public health managers had been using this model to help define their existing cross-sector partnerships with

other community partners. It served as a starting point to search for other works on the concept of ‘collaboration continuum’ from the scholarly and grey literature.

Additional references were identified, namely *Leveraging Collaboration: Building Strategic Coalitions Among Boards* (Linkages Committee, 2011) and *Working Together: Collaborative Practices and Partnership Toolkit—Supporting Alberta Students* (Government of Alberta, 2013). The latter was a joint effort among the Alberta Ministry of Education, a provincial school board association and other professional associations within Alberta’s education sector. They emphasized the collaboration continuum model taken from the *Leveraging Collaboration* document, prepared through a committee that was co-chaired by representatives from the education and family service sectors in Edmonton, Alberta. This model was closely aligned with Himmelman’s (1994, 1996, 2001) conceptualization of the collaboration continuum. Himmelman’s collaboration continuum model was featured in the report entitled *Integrated Health Promotion: A Practice Guide for Service Providers*, published by the State Government of Victoria (2003) in Australia. This rapid literature review provided reference material to support the research steering committee during the co-construction of a data-collection instrument. Interestingly, Kania and Kramer’s (2011) work on the collective impact approach was referenced in the *Leveraging Collaboration* document, bridging the collaboration continuum concept to the grey literature about collective impact that is extensively featured in my conceptual framework.

Another key consideration that required a substantial adjustment to the initial research question was the need to distinguish between the delivery of one-off health promotion initiatives within schools and the comprehensive implementation of the healthy school approach. The research steering committee explained that public health units often frame the delivery of their health promotion initiatives along the Foundations for a Healthy School framework, a useful resource guide. However, the extent to which they are able to undertake such a comprehensive approach in a collaborative manner when delivering their school health programming is highly variable and may be subject to many constraining factors. For this reason, they guided me to keep inquiries into partnership experiences to promote student well-being separate from inquiries into their efforts to work closely with school boards on the healthy school approach. This direction was made explicit in the overall research question. Furthermore, placing too much emphasis on the Foundations for a Healthy School framework was problematic as it appeared that a sizeable number of school boards were not receptive, or at least not fully knowledgeable, about this

approach at this time. It was therefore left out of the research question. As I have come to realize, the collaborative creation of healthy schools is a journey to be undertaken at a slow, gradual pace.

5.3.1 Study population and recruitment process

The study population comprised professionals from all 36 Ontario public health units, who interact directly with school board representatives (see Appendix 2A). In preparation for the recruitment process, the research steering committee encouraged me to seek an endorsement from the joint Committee of the Council of Ontario Directors of Education and the Council of Ontario Medical Officers of Health (the CODE-COMOH Committee). Auspiciously, this committee had recently launched a joint initiative to help strengthen partnerships between their two sectors. A briefing package was forwarded to the committee co-chairs in time for their upcoming face-to-face meeting in May 2015 (see Appendix 2B). The following week, I was notified of the committee's agreement to lend their support to our research project, based on a favorable review conducted beforehand by the research ethics board of the committee co-chair's public health unit.

In June 2015, a personalized invitation letter from the University of Ottawa was sent electronically to every medical officer of health in Ontario to approve the participation of their public health unit in this research project—the electronic message was copied to their staff who were member(s) of the Ontario School Health Management in Public Health Network. This letter was accompanied by the letter of support from the CODE-COMOH Committee (see Appendix 2C), along with the same information sheet that had been part of the committee's briefing package as well as the University of Ottawa's certificate of ethics approval. Within a period of six weeks (from June 12 to July 28, 2015), 19 medical officers of health accepted our research invitation after the first email invitation round, and 15 notified me of their acceptance following the second email invitation round. The two remaining public health units agreed to participate in October 2015—one of these public health units conducted their own ethics review before accepting our invitation.

Primary contact status in each public health unit was assigned to the member(s) of the Ontario School Health Management in Public Health Network, typically school health manager/program managers (referred to, in this thesis, as public health managers), with the expectation that they would facilitate the

participation of other school health personnel (i.e., director, liaison staff, program staff) in the research project for a whole health-unit perspective on the development of their partnerships with school boards. As of late spring 2015, the primary contact(s) began to receive, via email, a secure online survey link and instructions, one at a time, as they obtained the approval of their medical officer of health and communicated to me their interest in participating in the research project (see Appendix 2D).

All primary contact people, except for two, initially indicated their willingness to take part in follow-up interviews at the end of the online survey. In May 2016, public health managers were invited to a telephone interview and they could bring along any other public health professional at the interview session (see email invitations in Appendix 2E). From June 1 to September 1, 2016, 32 health units participated. Only three of the 32 interviews were conducted with public health unit personnel who were not public health managers. Nearly half of the interviews (15 out of 32) involved a single representative of the public health unit. Group interviews were held with the other public health units: ten interviews were conducted with two public health unit representatives; five interviews, with three representatives; one interview, with four representatives; and one interview, with five representatives. Among the interviewees were 30 school health managers/chronic disease and injury prevention managers, eight other managers, two directors, ten liaison staff, four public health nurses/health promoters, and five other team members. The interviews ranged in duration from 50 minutes to 3 hours, with an average of 1 hour and 37 minutes spent per interview. After asking permission at the start of the interview sessions, the interviews were audio-recorded so that they could be transcribed at a later date. Each participant was given the opportunity to review their confidential interview transcripts to ensure accuracy and completeness and make any other revisions as they wish.

Not all public health units participated in the follow-up interviews. The primary contacts from two public health units had already indicated at the end of the survey that they would not be available for an interview, but since then, one of them left their position and their replacement agreed to be interviewed. Among the primary contacts of the remaining three non-participating public health units, one provided no explanation for declining the interview invitation while the other two cited work pressures. An offer was made to extend the interview period to accommodate their workload, and one of them expressed interest. Unfortunately, the window of availability was not wide enough to fit that interview.

5.3.2 Data collection

The research steering committee felt that a survey was the most suitable data collection method, given that public health units often participated in this type of practice as part of their work. To support the research steering committee in the co-construction of the survey questionnaire, I prepared a summary report of my findings on collaboration continuum models from the published literature. The report included a preliminary attempt to describe the various types of partnerships across the public health and education sectors based on a rapid literature review as well as core practice documents from the Ontario ministries of health and education.

Through a series of teleconferences and electronic exchanges during a period of about four months, the research steering committee gave indispensable direction for the development of the survey instrument, making valuable comments as to the type of data to be collected, the suitability of the survey questions and the appropriate wording to be used. After three iterations and additional refinements, the survey questionnaire was ready to be shared with the CODE-COMOH Committee for their endorsement. This online survey was created to capture public health units' partnership experiences and the possibilities that lie ahead for partnership development. The steering committee felt it was important to clearly state upfront that the purpose of this survey was to inform and complement the CODE-COMOH Committee's initiative to help foster strong partnerships between school boards and boards of health. This statement was included in the consent form preceding the survey questions, along with the specific objectives of this survey. These objectives were to: (1) determine the types of partnership that public health units are experiencing with school boards; (2) identify public health units' level of satisfaction with opportunities to partner with school boards; (3) collect feedback on the sharing of information, resources/activities, and decision-making influence; and (4) collect feedback on the use of the Foundations for a Healthy School document. The survey questionnaire was administered online via the database *Fluid Survey*.

The survey questionnaire can be found in Appendix 2F. It was accompanied by a survey appendix that contained definitions of concepts and terms. The survey appendix included the list of health topics that are of interest to both public health and education sectors; an abbreviated description of the adapted collaboration continuum model (mentioned above), with corresponding partnership scenarios to help focus survey responses; and a summary of the Foundations for a Healthy School framework (see Appendix 2G). This information was sent along with the survey questionnaire to assist public health respondents in

answering questions related to the development of partnerships with school boards. The survey questionnaire and appendix had received final approval by the research steering committee before seeking the endorsement from the CODE-COMOH Committee and launching the online survey.

In the survey appendix, a clear distinction had to be made between topics related to health promotion/disease prevention and those related to health protection services (i.e., oral health care and immunization) since each topic category corresponds to a completely different partnership dynamic. Because of the Dental Health Act and the Immunization of School Pupils Act in Ontario, school boards are mandated by law to partner with their local public health unit to deliver these services. Local public health units exert a high level of authority over mandated health protection services, while having to respect school boards' policies on student access. With regards to health protection services, school boards are obligated to partner with their local public health units, paralleling a contractual agreement, with serious implications if they do not comply. As a school health coordinator pointed out:

It's that we are mandated to (...) immunize in the schools. So, they're willing to work on that because it's something that they have to do, whereas health promotion isn't something that they necessarily have to do [with us]. They know that their students will be suspended if they don't have these immunizations, so they're willing to work with us because they don't want all their students to be suspended. It's that they have something at stake. There's nothing at stake for them to work with us over health promotion. (...) The health protection piece, it's something that schools see as legislated. From the perspective of the Immunization of School Pupils Act, that's very prescribed, I would say, and so I would think they're more parallel processes.

By contrast, partnering with public health units for health promotion/prevention is left to the discretion of school boards and schools. It is a voluntary choice on the part of the education sector. Consequently, partnership development within the context of health promotion (hereafter including disease-prevention practices, other than dental care and immunization) would necessitate greater attention on pursuing cross-sector engagement, cultivating motivation and building capacity. For this reason, the research was limited to health promotion-related topics.

The survey questionnaire was subdivided into eight parts. The first part, *Entering your Health Unit's Profile*, sought to obtain information on the public health units' context in terms of geographical setting and location, organizational arrangements (i.e., existence of school health teams from within the public health unit itself), and a preliminary description of the means whereby the public health units interacted with school boards. In part 2, *Determining the Types of Partnership between your Health Unit and School*

Boards, I attempted to gain a snapshot of the current partnership landscape pertaining to health promotion beyond legislated services by asking survey respondents to assign, to each of their partnering school boards, one of the four main types of partnership—awareness-raising, networking, cooperative, or collaborative—based on the highest level of integration they experienced together, regardless of the personnel with whom they interfaced within the school board or the health promotion topic of concern. The ‘awareness-raising’ category was added to identify those instances where no significant engagement was taking place. This line of inquiry was meant to group public health units into categories based on the degree to which they had made advancements in establishing close ties with their school board partners.

The next three parts dealt with the exploration of partnership experiences as they related to the sharing of organizational assets: information, resources, and the decision-making process. The intention behind this series of questioning was to collect data on what was working well, in what ways obstacles were being encountered, and how could progress be made to further strengthen partnerships between public health units and school boards. At the start of each of these three parts, study participants were asked to rate their level of satisfaction about their partnership experiences as they pertained to the sharing of a particular organizational asset. The purpose of focusing on satisfaction levels was to acquire a general sense of how strong their partnerships currently were in a given area, and to help them frame their responses on the subject matter at hand. The questions that followed were meant to elicit responses that could then be used to construct a cross-sector partnership model with insights on critical elements for enriching and enabling partnership experiences. Close-ended questions were added to part 4 to identify the level of resource support from partnering school boards for professional development, partnership engagement, and inter-school learning. Part 5 included questions about the sharing of staff and committee structures.

Part 6 of the online survey covered specifically the Foundations for a Healthy School. In keeping with a prior request from the research steering committee, questions regarding this framework were kept separate from questions related to school health partnerships for student well-being, which could apply to any health promotion initiative, whether comprehensive or not. The committee’s rationale was that efforts are being made by public health units to carve a path for health promotion in schools, and that the concept of comprehensiveness is adding a whole other level of complexity to this undertaking. Therefore, it was felt that focusing on partnership development without necessarily viewing the healthy school approach as an obligatory requirement in such partnerships, but rather a separate consideration, would yield a greater range of survey data. This survey component was then followed by two more survey parts,

one to learn about formal agreements and additional matters of relevance (Part 7), and the other to request permission to connect with the primary contact for a follow-up interview (Part 8). Throughout the survey questionnaire, most questions were broadly stated to allow respondents the flexibility to answer openly based on their own experiences and understanding.

Since the survey questionnaire was designed to obtain a team perspective, a period of four weeks was given for survey completion to permit sufficient time for both personal and group reflection. The research steering committee approved this approach since public health units are accustomed to filling out surveys in this collective manner. The survey completion process also allowed multiple members of the public health unit to add, one at a time, responses to the same survey questionnaire so that collating responses would not be necessary. Survey completion time was expected to vary across public health units depending on how much input school health personnel would have available for answering each survey question. Since the survey launch coincided with the beginning of the vacation period, the deadline for survey completion was extended to accommodate all 36 public health units. Thirty-four public health units submitted their completed survey questionnaire by the end of August 2015. The remaining public health units did so by the end of November 2015. All but two public health units gave their consent to be further contacted for a follow-up interview to clarify and go deeper into their survey responses.

Preliminary data analysis of survey responses revealed a higher level of complexity than expected. To make sense of public health units' varied partnership experiences and to make the best use of limited time for the follow-up interviews, a quasi-structured interview guide was developed to tease out different levels of engagement for different types of interaction. Through synchronicity, as I was contemplating how to analyze the complex survey data, a member of the research steering committee shared with me a public participation framework that their public health unit relied upon to sort out the different types of partnership engagement they were experiencing. This framework, called *IAP2's Public Participation Spectrum*, is derived from the work of the International Association for Public Participation (2007). It describes the various purposes of public participation in the decision-making process: inform, consult, involve, collaborate, and empower. This framework served as reference material to develop the interview guide for the first part of the interviews with public health respondents. The objective was to shed light on different types of interaction found between public health units and school boards in terms of policy development, strategic planning, operational planning, development of initiatives, and the implementation of the Foundations for a Healthy School approach (see Interview Guide in Appendix 2H).

Keeping my analysis of survey responses in mind, I prepared an interview guide that presented a list of possible engagement scenarios along IAP's spectrum of participation in decision-making, for each type of interaction that public health units may have been having with their school boards. Study participants were asked to examine the interview guide in advance of their follow-up interview and circle the number beside the statements that applied to their partnership experiences with school boards, or place a check mark to indicate their aspiration. At the interview, the study participants would simply state which numbers they circled, or check marked, and then they were invited to elaborate on their answers through a series of prompts, providing a rich description of their engagement experiences in a standardized manner. Representatives of four public health units tested the interview guide on separate occasions, and refinements to the wording were made for greater accuracy in representing realistic scenarios. It proved to be a very useful data collection tool as it enabled very focused answers in a short amount of time. Interspersed in the line of questioning, at opportune moments, were additional questions to further elucidate survey responses that had been flagged prior to the interview as needing clarification or elaboration.

During this research phase, direct observation of teleconferences organized for the Ontario School Health Management in Public Health Network was carried out in order to gain a greater familiarity with public health managers' practices (see information sheet provided to the Network co-chairs for this purpose, in Appendix 2I).

5.4 Research phase 2: Ontario school boards

Phase 2 relates to Ontario's education sector. In late fall 2015, during one of my research updates to the Ontario School Health Management in Public Health Network's teleconferences, Network members encouraged me to connect with superintendents, as key actors within their field of practice, to gain a better understanding of school boards' perspectives on their school health partnerships. A similar participatory research process as the one followed in the first research phase was proposed to the Ontario Public Supervisory Officers' Association (OPSOA) and the Ontario Catholic Supervisory Officers' Association (OCSOA), but this approach did not garner interest from their respective boards of directors. Instead, I was recommended to connect with the executive director of the Council of Ontario Directors of Education (CODE). CODE is an advisory and consultative organization composed of the chief executive

officer of each of the 74 district school boards in Ontario (see Appendix 3A). By going through this organization, the directors of education from all four school systems (i.e., public and Catholic school systems working in either English or French) could be reached through the same recruitment process.

5.4.1 Study population and recruitment process

The study population was intended to be a fairly representative sample of school board personnel (i.e., directors of education or their designates) across Ontario. A letter of invitation, along with an information sheet, in both official languages was prepared to recruit the participation of CODE members in this research phase in order to capture school boards' perspectives on their partnership experiences with local public health units to promote student well-being, as shown in Appendix 3B. Since the initial research plan called for a group of study participants who proportionally represented their school system, the letter stipulated that recruitment would be limited in the following manner: 7 members from the 33 English-speaking public school boards, 7 members from the 29 English-speaking Catholic school boards, 2 members from the 8 French-speaking Catholic school boards, and 1 member from the 4 French-speaking public school boards. The research invitation was sent by the Executive Director of CODE on June 29, 2015. This was followed by a second invitation on August 15, 2015, given that many Directors may have been away on vacation at the time of the initial invitation.

Of the 74 Directors of Education who received the invitation, six accepted to participate in this research project, either directly or through their designate. The study population representing the education sector consisted of two directors of education, two superintendents, one mental health lead, and one communications manager, collectively from four English school boards and two French school boards, with two representing the public school system and four representing the Catholic school system.

5.4.2 Data collection

My main contact with superintendents was OPSOA's executive director who had arranged for the recruitment process to go through CODE. He recommended interviews as a more appropriate data-collection method for school board personnel at that time. Given a reduced access to this study

population, I created a semi-structured interview guide that would contain a rather limited range of questions but would mirror the more prominent lines of questioning taken from the online survey and interview guide of phase 1, and in this way, complement public health units' responses (see Appendix 3C). The first section of the interview guide for school board personnel—Parts A and B—aimed at uncovering interviewees' level of buy-in for health promotion within the school system. The middle section, or Part C, explored school boards' partnership experiences working with their local public health units on the promotion of student well-being regarding enriching, enabling and hindering factors. This part placed emphasis on two critical areas of partnerships between the public health and education sectors: mental health promotion, identified as a major partnership driver by public health units in their survey responses; and inter-organizational structures, considered a key enabler of engagement. Part D expanded the interview with an inquiry into the potential that currently existed for collaboration between their school boards and local public health units to jointly plan at the strategic and operational levels, co-develop health-related policies, and coordinate the implementation of the healthy school approach. The interview guide was tested with a director of education, who rephrased some of the questions for greater clarity and applicability.

Semi-structured interviews were carried out by telephone between August 11 and September 6, 2015. Interviews lasted from 54 minutes to 1 hour and 50 minutes, averaging 1 hour and 23 minutes in duration. Again, permission was requested from all interviewees to audio-record the interviews so that responses could be transcribed verbatim. Each participant was given the opportunity to review their confidential interview transcripts to ensure accuracy and completeness and make any other revisions as they wish.

5.4.3 Other considerations

Given the very large volume of data available to work with, in terms of completed surveys and interview transcripts, focus groups sessions and interviews with government representatives that had been originally proposed were not conducted due to time and resource constraints.

5.5 Data analysis

5.5.1 Data analysis approach

Although data from study participants were collected primarily through open-ended questions, some survey questions were close-ended for an overall description of the current partnership situation between public health units and school boards. Descriptive statistics and frequency charts have been produced for the purpose of gaining an overall sense of the partnership landscape and experiences at this present time.

Guiding the analysis stage of the collected qualitative data is the conceptual framework of cross-sector collaboration for social change that was derived from a broader literature review on collaboration. My conceptual framework adopts similar core components as those constituting Emerson et al.'s (2012) "collaboration dynamics," and it brings together additional insights found in theory and practice. It describes three interconnected dimensions of collaboration: the cross-sector engagement process itself, the motivation to engage, and the capacity to engage and adapt through collective learning. Elements corresponding to each of these dimensions provided codes to analyze survey responses and interview transcripts. However, data coding combined both deductive and inductive approaches. Whereas deductive reasoning makes use of *a priori* codes for organizing and classifying the collected data, inductive inquiry searches for unanticipated themes (Bradley, Curry, & Devers, 2007). The qualitative data were managed, coded, and analyzed using the NVivo 11 (QSR International, Cambridge, MA, USA) qualitative analysis computer software.

Research quality depends largely on the selection of appropriate analytical strategies to yield convincing results. Regarding the current research, the framework analysis method by Ritchie, Spencer, and O'Connor (2003) was followed, given that it integrates deductive and inductive techniques. The authors' framework-analysis method consists of a 5-step process: familiarization; identification of a thematic framework; indexing (i.e., coding); charting; and mapping and interpretation. A brief description of each step is given below:

- *Familiarization*: Gaining awareness of key ideas and recurring patterns, either through the use of pre-established concepts or by allowing the data to dictate concepts that have not been anticipated.

- *Identification of a Thematic Framework:* Using emerging themes to form the basis of a thematic framework in order to filter and sort the data.
- *Indexing:* Selecting textual data that correspond to each emerging theme for coding purposes, and applying a numerical system for indexing these coded passages.
- *Charting:* Lifting the data from its original source and placing them in charts that consist of the headings and subheadings derived from the previously drawn thematic framework.
- *Mapping and Interpretation:* Analyzing the key characteristics of the charts in order to produce a schematic representation of the phenomenon being studied, and “defining concepts, mapping range and nature of phenomenon, creating typologies, finding associations, providing explanations, and developing strategies” (Ritchie & Spencer, 1994, p. 186).

The framework-analysis method involves the development of a matrix whereby the iterative process of going through these five different levels of abstraction can be undertaken in a systematic manner while keeping the raw data in mind (Ritchie et al., 2003). Since the framework approach starts deductively and then progresses inductively, “the data collection tends to be more structured than would be the norm for other qualitative research, and the analytical process tends to be more explicit and more strongly informed by a priori reasoning (...) [such] that it can be viewed and assessed by people other than the primary analyst” (Pope, Ziebland, & Mays, 2000, p. 116). For this reason, this approach is widely used in applied research.

As an additional step in the data analysis stage, relevant documents have been analyzed to complement information gathered from study participants. In contrast to other sources of data, documents are multi-purpose. They can provide contextual data, historical facts, and other background information, and they can supply information to contextualize survey responses, focus observation activities, track change and development over time, as well as corroborate findings from other sources (Bowen, 2009).

5.5.2 Explanation of data analysis

Data analysis was conducted in three phases, according to the data collected: school health partnership survey responses; key public health informant interview responses; and key school board informant interview responses. Thirty-six completed survey questionnaires were returned for a 100% response rate.

Thirty-two public health follow-up interviews and six school board semi-structured interviews were recorded and transcribed. Each one of the transcripts was emailed to the respective study participant to ensure accuracy and to request minor clarifications from brief questions inserted within the verbatim text. Overall, a deductive and inductive approach to thematic analysis was used to create higher-order themes and sub-themes.

a. Survey data analysis

The first coding exercise with the survey data was done in a very detailed manner. I first listed the 12 elements taken from my conceptual framework (see Appendix 1B) for use as preliminary codes. I went through all completed survey questionnaires to code them deductively using this list of pre-set codes. At the same time, I would pick out unanticipated codes by applying inductive reasoning. Hundreds of detailed codes were registered to help me gain a deep familiarity with the survey data in their entirety. I then tentatively sorted the codes according to my conceptual framework with its three main components of engagement, motivation and capacity. Some of the codes did not fit in any of these categories, and so they were grouped in a provisional category. All along the coding process, illustrative text corresponding to each category was coded and numerically indexed, using the software application NVivo 11.

With this new list of codes, I re-analyzed all the survey data to capture the thematic patterns that were emerging. The indexing was refined as some codes were identified as sub-elements of higher-order codes, and this resulted in a much-reduced number of relevant codes. At this point, the higher-order codes were sorted under four main categories: cross-sector engagement, connection, capacity, and continuity. The preset motivation codes were now split into the two different but related categories, called connection and continuity, and unanticipated codes were added to each of these categories. The other categories also contained additional codes, compared to my initial conceptual framework.

I applied this new list of codes when analyzing the interview transcripts of public health participants, while remaining open to any additional unanticipated codes. These codes were sorted according to the four main categories identified earlier. Since this process uncovered more codes, the revised coding list was used to analyze the interview transcripts of school board participants. Here again, additional codes

surfaced, but not to the same extent since the number of participants was much fewer. These codes still fit within the previously identified categories.

With the data giving rise to themes and subthemes, I developed an initial understanding of how school health partnerships were generated and supported, and what was hindering their progress. Through an iterative process of defining the concepts underlying each of these themes and going back to take a closer look at the raw data to further refine my understanding and capture relevant text that had been missed earlier, I prepared a first written draft of my research findings. These findings were then schematically represented in a tentative diagram of our school health partnership model for student well-being.

Once I had a preliminary diagram of our partnership model, I tested to see if the partnership elements, as the captured themes (including sub-themes), were well identified, and if they were under the most appropriate component, or category. To this end, I took a closer look at the list of themes taken from my preliminary partnership model, regardless of how they had been sorted under the four main partnership components, and I asked myself the following questions:

- Does this theme indicate an actual partnership element? Or,
- Could this theme represent rather a sub-element, in terms of a characteristic of another partnership element that is on my list? Or,
- Does this theme represent more than one distinct partnership element?

By following this line of questioning for all the themes that were initially identified, I was able to reduce the number of main themes, or elements, to a minimum, while still providing a complete list of distinct elements. I was seeking to find out if some of the identified elements could be subsumed under other elements on the list or separated out. For example, 'Know whom to contact' was an important consideration for public health professionals, especially when trying to reach key contacts within large school boards, with complex, hierarchical structures. It was identified as an element under the component 'Connection'. After working extensively with the data, I realized that it made more sense to see it as an aspect of 'Communication protocol', which was categorized as a feature of 'Interorganizational structures', a main partnership element within the component of 'Capacity'. As another example, the elements of 'Passion' and 'Excitement' had been grouped under the major theme of 'Optimistic disposition', along with the element 'Determination'. I then reconsidered this grouping and listed

‘Determination’ as a separate theme, or partnership element, still under the component of ‘Connection’. The theme ‘Optimistic disposition’ then became ‘Generating enthusiasm’.

With my final list of 24 distinct partnership elements, I then proceeded to ensure that they were sorted within the right categories that became our partnership model’s components. I did so by asking the following series of questions, which reflected my growing understanding of what each partnership component represented:

- Does this theme, as a distinct partnership element,
 - enrich the cross-sector engagement experience itself? Or,
 - motivate the partners to engage with one another? Or,
 - determine the extent to which they can engage with one another? Or
 - ensure that the partners can continue the momentum after cross-sector engagement has been initiated?

For each of the 24 partnership elements, only one of these four statements constituted a best fit. This series of questions did lead me to move elements from one component to another within the model. For example, ‘Flexible and adaptable planning’ was moved from ‘Cross-sector engagement’ to ‘Continuity’ and became ‘Flexibility and Adaptability’. The data analysis process was extensively iterative; there was a great deal of back and forth in my reasoning, and when this analytical exercise was completed, I felt better assured that the four components were put together in a sound manner.

There were other elements that did not fit in any of the four main categories, which I came to label the Partnership Generator dimension. These elements had been set aside for the time being, until my understanding became clearer about what they actually represented. I eventually could see that they reflected conditions that supported school health partners’ movement along the collaboration continuum, whereby organizational assets were being cumulatively shared—first information, then information and resources, and finally these assets, plus the decision-making process. There were a few instances where the distinctions between elements constituting the partnership generator dimension and supporting conditions for partnership advancement were blurry. To distinguish these categories from one another, I asked myself the following questions:

- Does this theme enrich or enable cross-sector engagement itself? Or,
- Does it help ‘open the door’ for a particular type of partnership arrangement to take hold, in terms of fostering a willingness, or buy-in, to engage more extensively?

This resulted in further adjustments to the model. For example, ‘Access to data’ was no longer considered a supporting condition for progressing to a cooperative partnership arrangement, but rather an enabling sub-element that fit better under ‘Resources’ as part of the ‘Capacity’ component. Regarding ‘Shared language’, this theme was initially sorted as a sub-element of ‘Common understanding’ but it was later on identified as a supporting condition to gain buy-in for cooperation, based on a deeper understanding of the data. The only theme that came close to being duplicated in the model is relationship building. However, after further reflection, it was not exactly the same theme in both categories. The partnership generator points to relationship building as an ongoing process with the aim of establishing and maintaining strong ties between school health partners. The establishment of a strong relationship, once accomplished, then becomes one of the supporting condition for seeking to advance toward cross-sector collaboration, especially as it pertains to strategic planning.

Lastly, to sort out the themes falling under the category of ‘supporting conditions’, I asked myself:

- Of these remaining themes, which ones indicate conditions that would increase the likelihood for:
 - networking, to start sharing information and explore partnership opportunities?’
 - cooperation, to start sharing resources, such as school health program, projects, advice and guidance, based on the recognition of shared interests? and
 - collaboration, to start sharing the full decision-making process?

The themes that could answer these questions were not necessarily outside the cross-sector engagement process, but they were clearly determining factors in moving school health partners along the collaboration continuum, according to participants’ partnership experiences.

Each partnership element contributes to a stronger school health partnership, but not all of the supporting conditions need to be prominent for a particular type of partnership arrangement to take place—this is the reason they have not been called ‘essential conditions’. For example, certain public health units and school boards have already been interacting in the area of health promotion long before the ministries of

education and health began to encourage cross-sector engagement at the local level. As another example, cooperation may still happen even though the school health partners are not speaking the same language. Simply the recognition that health promotion within the school system is an expectation from the Ministry of Education could be sufficient for cooperation to occur at any given time. However, speaking the same language can increase the likelihood that cooperation will be more satisfying and productive. Likewise, a deep sense of shared purpose may not be required to collaborate during action planning to develop a small project, but it would certainly be a key condition for joint strategic planning.

5.6 Ethics consideration

The University of Ottawa's Office of Research Ethics and Integrity approved this research project in accordance with the Tri-Council Policy Statement—a joint policy of Canada's three federal research agencies (i.e., the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research Council of Canada, and the Social Sciences and Humanities Research Council of Canada)—and other applicable laws and regulations in the province of Ontario. The ethical review submission included (a) the purpose of the research project, as well as research questions; (b) the context—literature background and study rationale; (c) a description of the methodology—methods and procedures for collecting data; (d) the data analysis plan; (e) the anticipated scholarly contribution of the research; (f) the participant recruitment plan; (g) the nature of participation in the research project; (h) an assessment of risks; (j) a description of research benefits to the participants and society as a whole; (k) privacy considerations—confidentiality and data storage safeguards, and (l) the consent process. Ethics certification was renewed annually.

Ethics approval was sought and granted after the Ontario School Health Management in Public Health Network agreed to join me in this research project. However, the ensuing research steering committee significantly refined the research proposal to better fit their knowledge needs and interests. All final changes to the research design were then communicated to the University of Ottawa's ethics review board in accordance with ethics certification requirements.

5.6.1 Collection and use of personal information

Public health professionals who volunteered to participate in the online survey were asked to include the name of their organization and that of their school board partners for the purpose of visually representing on maps the complexity of linkages between public health units and school boards across Ontario. At the end of the survey, they were also asked for contact information should they be interested in a follow-up telephone interview to clarify and explore in greater depth their survey responses. However, their anonymity and the confidentiality of their responses were guaranteed in the thesis report as indicated in the consent form at the beginning of the online survey questionnaire. Since the interviews were an extension of the online survey, the consent form that was signed on behalf of the public health unit remained in effect for the interview process. A pdf version of the online consent form was included with the email message containing the survey link for public health units' records.

In regard to the research phase involving school boards, the study participants were requested to submit a scan of the consent form, containing their signature, prior to their telephone interview (see Appendix 3D). No identifying data were collected with this group of study participants.

5.6.2 Research benefits

The research project was designed specifically with practical benefits to study participants and their peers in mind. An abbreviated report with key research findings will be disseminated to all public health units and school boards in Ontario as reference material to help inspire and guide their efforts in establishing strong school health partnerships for student well-being. This report is expected to illustrate in what ways cross-sector partnerships are taking place, and what are the factors to consider for further progress across the collaboration continuum. From this knowledge, a set of recommendations will be formulated in collaboration with the research steering committee to inform the way forward for decision makers, thereby assisting public health units and school boards in fulfilling their aspirations of creating supportive school environments for improving the lives of the student population.

It is expected that the resulting report will serve as reference material to provide direction not only to public health managers and school board representatives, but also to the joint committee of the Council

of Directors of Education and the Council of Medical Officers of Health. This information may guide their decision making toward the formulation of strategies to maximize partnership opportunities and to mediate barriers in cross-sector collaboration across the school system in Ontario. By strengthening school health partnerships, the student population will be able to reap greater benefits in terms of the creation of a more supportive school environment that can improve their well-being and academic performance, and set them on a lifelong course of healthy, productive living.

The research findings are presented in the next series of chapters. As it turned out, the first specific research question was not answerable since it was possible for the same school health partnership to take on all possible types of partnership, be it networking, cooperative or collaborative, across time and at the same time, depending on a variety of factors. Therefore, we can only speak of networking, cooperative or collaborative arrangements within school health partnerships, as explored in Chapter 6 under the engagement spectrum (research question 2). This chapter takes an in-depth look at all the elements that enrich the cross-sector engagement process (research question 4), in addition to the various ways school health partners' engage with one another. It also covers public health professionals' experiences with the Foundations for a Healthy School (research question 3). Chapter 7 goes into the enabling partnership elements (research question 5), while chapter 8 deals with the hindering partnership elements (research question 6) and the move along the collaboration continuum (research question 7). Chapter 9 answers research questions 2 to 7 from the school board perspectives. Key research findings are then discussed in Chapter 10, which includes concluding remarks.

Chapter 6: Enriching the Cross-Sector Engagement Process from the Perspective of Public Health Units

In this chapter, as well as the next two chapters, the results from the online survey and the follow-up interviews with public health professionals are presented. The School Health Partnership Survey was instrumental in identifying the key elements that characterize partnership experiences from a public health perspective, in broad strokes. More refined knowledge of these elements was gained during the interview period with the majority of survey respondents. This chapter focuses on those partnership elements that enrich engagement across the public health and education sectors toward the creation of healthy schools. First, it provides background information on the Foundations for a Healthy School framework and its use by public health units when interacting with their school board and school partners. Then, it explores in depth those elements that constitute satisfying cross-sector engagement, as well as the full engagement spectrum of school health partnerships.

6.1 Foundations for a Healthy School

6.1.1 Background information

The Ontario Ministry of Education's Foundations for a Healthy School framework is a strategic tool to guide the development of school health initiatives for the improvement of student well-being (Ontario Ministry of Education, 2014a). From this point forward, the term 'initiative' is used as a collective term representing policies, programs, project activities, professional development events/educational sessions, and/or other resources. Some school health initiatives are targeting the whole school; some are targeting certain grades; and some are for those school system actors expressing an interest in taking part in a specific health promotion activity. These initiatives may or may not be designed in a comprehensive manner. Although partnership efforts may center around one-off health promotion initiatives, public health professionals stated that they continuously sought ways of moving partnership activities closer to a comprehensive healthy school approach. In line with the revised health and physical education curriculum, the Foundations framework places emphasis on the importance of comprehensively addressing a wide range of curriculum-linked, health-related topics.

When considering the health topics of major concern within the education sector, a broad overlap is found between the new, expanded version of the Foundations for a Healthy School and public health units' school health programming, as shown in Table 8 (Ontario Ministry of Education, 2014a; Thomson and Montagnese, 2012). In this thesis, relevant health topics are those falling under the general category of health promotion and prevention.

Table 8: Comparing health-related topics of concern

<i>Category</i>	<i>Foundations for a Healthy School (Ontario Ministry of Education, 2014a)</i>	<i>Public Health Units' School Health Programming (Thomson and Montagnese, 2012)</i>
Health promotion and prevention	- Healthy eating - Physical activity - Substance use, addictions and related behaviors (i.e., tobacco control; substance misuse) - Personal safety and injury prevention - Mental health (i.e., Mental health promotion; mental health problems) - Growth and development (i.e., body image; sexual health and human development; health services, other than legislated services)	- Healthy eating - Physical activity - Smoking/chewing tobacco - Substance misuse (e.g., alcohol use; marijuana use; drug use, such as oxy/painkillers) - School ground safety and injury prevention - Positive mental health promotion (e.g., bullying; stress/anxiety; discrimination; loneliness/sadness; peer pressure) - Healthy weights (i.e., body image) - Sexual health (i.e., non-legislated services but some related to reportable conditions: birth control; teen pregnancy; reproductive health; STI/HIV/AIDS screening) - Human development (i.e., poverty; environmental health protection; rabies prevention and control)
Legislated health protection services	Growth & Development: - Oral health care - Immunization	- Dental health (Dental Health Act) - Vaccine-preventable diseases (Immunization of School Pupils Act)

Recently, the Ministry of Education released its revised Health and Physical Education Curriculum for Grades 1-8 and for Grades 9-12. According to these curriculum guidance documents, one of the priorities for educators across the province is:

promoting the healthy development of all students, as well as enabling all students to reach their full potential, (...) [since] [s]tudents' health and well-being contribute to their ability to learn in all disciplines, including health and physical education, and that learning in turn contributes to their overall well-being. (Ontario Ministry of Education, 2015a, 2015b, p. 3 in each document)

The newly revised curriculum emphasizes a holistic approach to educating students on how to promote their health. It does so by addressing a variety of inter-related health topics, namely healthy eating, physical activity, mental health, substance use, safety and injury prevention, human development, and sexual health, such that children and youth can better care for themselves in every aspect of their lives. Through this approach, it is expected that students will gain the knowledge and skills necessary for leading a healthy, productive and socially responsible way of life.

The health and physical education curriculum is a practical resource to support school board and school personnel in implementing government policies and strategies related to schoolchildren.¹ The abovementioned curriculum guidance documents for elementary and secondary schools describe the contributions of community partners as vital to the success of a school's health and physical education curriculum, drawing particular attention to the Ontario Public Health Standards mandating public health units to work in partnership with school boards and schools on comprehensive health promotion. In partnership with school boards and schools, a public health unit's messaging can be integrated not only in health-based courses but also in other disciplines, where appropriate, for greater relevance to the students' learning experiences (Ontario Ministry of Education, 2015a, 2015b). Furthermore, the health and physical education curriculum is meant to be delivered using the Foundations for a Healthy School document. In this way, what students are learning in the classroom can be reinforced through initiatives that promote healthy, active living within other areas of the school environment, the home, and the broader community.

¹ Information taken from the Ontario Physical and Health Education Association (OPHEA)'s website at <https://www.ophea.net/sites/default/files/file_attach/RESP_FactSheet_02OC12.pdf>

The Foundations for a Healthy School framework consists of a multi-pronged approach to promoting well-being within a school setting (Ontario Ministry of Education, 2014a). Ideally, school health initiatives are designed in such a way as to encompass five interconnected areas within the school context for comprehensiveness. Its key strategic areas are summarized as follows:

- 1) *Curriculum, Teaching and Learning*: Formal curriculum programs and informal learning opportunities for students to lead healthy, active lives, supported by teaching/learning strategies, resources, and assessment/evaluation practices, and by professional learning opportunities for teachers and staff.
- 2) *School and Classroom Leadership*: Creation of a positive classroom and school environment by integrating healthy school policies and programs into school improvement planning processes, including policy monitoring and data collection to identify priority areas and related programming that is responsive to student needs.
- 3) *Student Engagement*: Opportunities for students to be empowered as active contributors not only to their own learning and well-being, but also to the development and implementation of policies, programs and initiatives at school and in the broader community.
- 4) *Social and Physical Environments*: Support for the development and maintenance of positive relationships and for access to appropriate equipment, material, and supplies on school premises, including healthy food, in order to promote the positive cognitive, emotional, social and physical development of students.
- 5) *Home, School and Community Partnerships*: Engagement of parents, school staff, school/student councils, school boards, family support programs, public health units, and other community groups, and coordination of available services, expertise and resources that are available within and outside the school community.

From a strategic perspective, the Foundations for a Healthy School document is intended as a companion resource to the K-12 School Effectiveness Framework, which is itself based on the strategic areas mentioned above. The Framework was produced by the Ministry of Education to inform instructional

practice, programming and professional learning, in order to support reflection for school improvement planning (Ontario Ministry of Education, 2013).

As advocated by the Ontario Physical and Health Education Association (OPHEA), the healthy school process is meant to engage the school community in planning and implementing a comprehensive set of activities related to the health priority that the school will have chosen to address for the current school year. OPHEA is a provincial, not-for-profit organization working in partnership with school boards, public health agencies, government, non-government organizations, and private sector organizations. It describes the healthy school process as a series of six distinct steps that consist of: (1) establishing a school health action team, which may be composed of school staff, students, parents, a public health representative, and additional community partners; (2) conducting an assessment of needs and assets (i.e., organizational strengths); (3) identifying a health topic to prioritize based on the school's needs and assets, with the possibility of integrating other health topics; (4) creating an action plan; (5) taking action as well as monitoring and evaluating results to keep track of the successes and challenges met along the way; and (6) celebrating what the school has accomplished together.² Based on public health professionals' partnership experiences, planning for healthy school initiatives may be taken up by schools on their own, or it may be facilitated by a public health frontline staff, with varying degrees of comprehensiveness. It may also receive ongoing coordination and guidance support from school boards.

6.1.2 Public health units' use of the Foundations for a Healthy School framework

According to the results of the first phase of this doctoral thesis project, regarding the School Health Partnership Survey, all public health units, except one, had adopted the revised Foundations for a Healthy School framework as their overall strategic approach to guiding the development of their school health initiatives. It closely resembles the public health sector's Comprehensive School Health model, as endorsed by provincial ministries of education and health forming the pan-Canadian Joint Consortium for School Health (Veugelers & Schwartz, 2010), but it is couched in the language of Ontario's education sector. As of the time of survey completion, public health units will be supporting their school boards and

² Information taken from the Ontario Physical and Health Education Association (OPHEA)'s website at <<https://www.ophea.net/healthy-schools-certification/6-step-healthy-schools-process>>

schools by working on most, if not all, of the Foundations components, when developing their school health programming, as shown in Table 9.

Table 9. Use of the Foundations for a Healthy School in school health programming

<i>Foundations for a Healthy School (FHS) Components</i>	<i>Number of Health Units Integrating FHS Components in their School Health Programming</i> (N = 36)			
	Too Soon to Tell	Not Likely	Likely	Very Likely
Curriculum, Teaching and Learning	1	4	7	24
School and Classroom Leadership	4	4	5	23
Student Engagement	2	2	5	27
Social and Physical Environments	1	1	6	28
Home, School and Community Partnerships	2	0	4	30

Of the 36 public health units in Ontario, 27 will likely or very likely incorporate all five components in their school health initiatives, and three will likely or very likely incorporate four of the five components. Those components that are more likely to be receiving attention are student engagement, the school environment and partnerships. School health programming includes both stand-alone, one-off health promotion initiatives as well as healthy school initiatives.

In the School Health Partnership Survey, public health units were asked how they were using the Ministry of Education's new Foundations for a Healthy School resource. Seven different uses were reported: guiding internal operational and action planning; raising awareness of the comprehensive nature of the healthy school approach; educating interested school system actors on how to apply the healthy school approach; encouraging school health partnership opportunities; guiding the planning process of school boards and/or schools; assessing schools' progress in undertaking a comprehensive approach to health promotion; and preparing grant applications.

a. Guiding internal operational and action planning

Public health units were using the Ministry of Education's Foundations for a Healthy School framework as

the basis for their operational and action planning to ensure that their initiatives aligned with the healthy school approach. They considered this document instrumental in preparing logic models and work plans. It was used for formulating strategies and developing initiatives, such as classroom resources and specific activities for youth.

b. Raising awareness of the comprehensive nature of the healthy school approach

The Foundations for a Healthy School framework was found useful for raising awareness of the importance of promoting health in a comprehensive manner. It also enabled public health professionals to emphasize the need for school health policies. Notably, it opened doors to contact schools that had not yet embraced a comprehensive approach to health promotion. Public health units relied on the Foundations document when making presentations to school communities to encourage comprehensive thinking when planning health promotion activities, as supported by evidence of effectiveness. These presentations also offered an opportunity to hold discussions on the public health unit's role related to the healthy school approach. Public health units were bringing awareness of this approach to parents and community partners as well, through information-sharing events.

c. Educating interested school system actors on how to apply the healthy school approach

When school boards or schools expressed an interest in adopting a comprehensive approach to health promotion, public health units would offer education sessions on the Foundations for a Healthy School framework. They delivered in-person presentations, or webinars, to school board personnel, school principals, teachers, students and/or parents. One public health survey respondent explained how they went about educating different stakeholders on the Foundations for a Healthy School framework:

We use it at the board level as well as at the school level. [We] change the message depending on who the audience is. If talking to school administrators, we will focus on the strategic component of it and how it will assist them in meeting their school improvement plans and board plans. If talking to teachers we will focus on how it supports curriculum and impacts classroom activities and children. If talking to students/parents, we focus on how they can make an impact, difference, within their school, school board. Health promoters, public health dietitian and public health manager use the document with varied audiences.

d. Encouraging school health partnership opportunities

The Foundations for a Healthy School framework was also being used to justify and promote working in partnership on policy-related and program-related school health initiatives. This framework's component on community partnerships was reinforcing the role of public health professionals within a school setting, and encouraging joint planning with school boards and schools. Furthermore, it provided the rationale for creating health action teams through public health facilitation support, and sharing data, such as improvement plans and survey results, so that public health frontline staff (e.g., public health nurses, health promoters) could be of greater assistance within the local school systems. Following the newly released Foundations document, public health professionals took this opportunity to increase receptive schools' engagement with other community partners, as well.

e. Guiding the planning process of school boards and/or schools

Public health professionals drew from the five components of the Foundations for a Healthy School framework when helping to guide school boards' planning processes for developing district-wide policy-related and program-related school health initiatives. In addition, public health units used this framework when contributing to schools' own planning processes. Some public health units prioritized the delivery of their services to those schools that aimed to integrate all five Foundations into their action plans, as stipulated in service delivery agreements with their school boards.

Public health units developed Foundations-related resources, such as healthy schools checklists and planning tools to further support schools' school health planning. Planning tools included healthy school action plan templates and sample action plans that gave ideas on how to put in place each foundation. These resources helped assess needs, facilitated discussions, and engaged school communities in the development and implementation of initiatives as part of their operational and action planning for student well-being. Some of these resources had been developed in partnership with representatives from school boards and/or schools.

Planning-related resources were considered essential for creating healthy schools but not all schools were found to be ready to adopt this comprehensive approach to health promotion. One public health survey

respondent mentioned using the Foundations document to determine their schools' receptivity and readiness to take on this approach.

As captured by the following public health survey response, there were various ways that the Foundations for a Healthy School could be used by public health units:

Our Healthy Schools team will use the new foundations as the basis for our operational planning. We will use this tool to initiate contact with schools that have not yet embraced the healthy schools approach. We will also educate the schools who have embraced the healthy schools approach, on the new Foundations for Healthy Schools resource. We will work with school board staff and school staff, to educate them about the new foundations, and to determine how to implement the healthy school approach in the schools. For example, we will use it to encourage data sharing (i.e., the school operational plans, and the school climate surveys), and the development of a healthy school committee or incorporation of the healthy school approach into an existing school committee.

f. Assessing schools' progress in undertaking a comprehensive approach to health promotion

Another use of the Foundations for a Healthy School framework consisted of assessing the progress being made by schools in their efforts to improve student well-being. Through school profiles, or school assessments, public health units assisted schools in determining their strengths and limitations in relation to all five Foundations so that they could then seek those additional resources required to build on what already existed:

We use [the Foundations for a Healthy School] document to help us map out what is happening in a school within each of the document's components, identify what is working well, what might be missing, who could we invite to collaborate, to guide where we may want to focus and to ensure that we work as comprehensive as we can. (...) People involved would vary but could include: school staff, parents, students, community partners, public health, school board leaders.

g. Preparing grant applications

Lastly, the Foundations for a Healthy School framework had been used as key reference material when preparing grant applications to support healthy school initiatives. Public health units had applied for funding, at times in partnership with their school board partners and other community partners, to

increase schools' capacity to engage in health promotion. Referencing the healthy school approach emphasized an evidence-based focus.

6.1.3 The healthy school approach in the broader context of student well-being

More recently, the Ministry of Education has sought to bring together all aspects of student well-being within their broader Well-Being Strategy for Education.³ It consists of four main components: Equity and Inclusive Education; Safe and Accepting Schools; Positive Mental Health; and Healthy Schools. All of these components work together synergistically to promote student well-being. Although this strategy is still under development, it indicates a move on the part of local school systems to integrate all activities for the promotion of student well-being under a single, umbrella strategy for greater coherence and effectiveness.

Public health units are increasingly engaging with school board partners to improve the well-being of the student population. However, even though public health units deliver initiatives to promote student well-being to the best of their abilities, these school health initiatives do not always reflect the five Foundations for a Healthy School for various reasons. According to public health professionals, the two main reasons for implementing a school health initiative in a non-comprehensive manner are the lack of public health capacity, and low receptivity or readiness within schools due to competing priorities and capacity limitations of their own. When possible, school health initiatives are planned and implemented in an incremental manner to gradually take on a comprehensive approach to health promotion. The next section covers the key elements related to satisfying cross-sector engagement, as school health partners progress toward the creation of healthy schools together.

6.2 Cross-sector engagement

Within the context of school health partnerships, cross-sector engagement is the coming together of representatives from public health units and school boards, and/or their schools, to share information

³ Information taken from <<http://www.edu.gov.on.ca/eng/about/WBDiscussionDocument.pdf>>

about each other's field of work, and when the conditions are suitable for further engagement, to then actively embark on partnership opportunities. Moving beyond information sharing, school health partners engaged with one another by sharing professional input and/or implementation resources, as they contributed to each other's school health plans (i.e., decision-making process) to a lesser or greater extent along an engagement spectrum.

Elaborating on their cross-sector engagement, public health professionals spoke of process elements that either enriched or could enrich their interactions. They saw their cross-sector engagement being enriched by engaging at all interorganizational levels for efficient information sharing and planning; pursuing open dialogue for clarity about partnership possibilities; establishing a common understanding for a solid foundation to plan together; exchanging complementary perspectives for enhanced decision-making abilities and collective learning; and planning comprehensively and incrementally for greater effectiveness and feasibility. In addition to process elements favorable to cross-sector engagement, itself, partnership experiences revealed a wide variability in engagement patterns. The many ways school health partners engaged with each other constituted an engagement spectrum of possible interactions increasing in levels of extensiveness across the collaboration continuum in relation to distinct planning phases.

6.2.1 Engaging at all interorganizational levels for efficient information sharing and planning

Within advanced school health partnerships, cross-sector engagement proceeded through multiple actors, interacting across the public health and education sectors at various interorganizational levels: executive, district, programming, and school-based. Engagement at all interorganizational levels was considered important to initially facilitate the sharing of information in order to bring about widespread understanding of what could be accomplished together, and then, to produce efficiencies in school health planning. A school health partnership was believed to further advance not only through horizontal engagement between counterparts across partnering organizations but also through bi-lateral top-down and bottom-up engagement.

Public health professionals in advanced school health partnerships reported various ways in which their cross-sector engagement was taking place. They were engaging with their school system partners at all interorganizational levels through different meeting arrangements undertaken at varying frequencies, as

follows: executive-level meetings between the medical officers of health (MOH) and the directors of education, in-person and/or by teleconference (perhaps with other personnel present), from once to a few times per year; district-level principals' meetings, with public health presentations by invitation; program-level meetings between public health units' directors and/or managers, possibly along with program specialists, and school boards' superintendents and/or central staff, such as mental health leads, curriculum consultants, and communications specialists, ranging from quarterly to monthly, and even weekly, depending on the partnership task being carried out; and meetings between public health frontline staff (and possibly program specialists) and school communities, as needed, to put school health initiatives in place. A public health director could also serve as the MOH designate when engaging with a director of education, or superintendent as their designate at the executive level.

a. Executive level of cross-sector engagement of utmost importance

As stated by public health professionals, relationships across the public health and education sectors were more readily built at the school level, where interactions occurred more frequently. To the extent that cross-sector engagement took place at the programming level, partnership ties could also be cultivated between with school boards' central staff. However, public health professionals asserted that relationships were equally, if not more, important among executives to clear the way for partnership work at the other interorganizational levels. As one of the public health professionals expressed:

The purpose [of that executive meeting] was to talk about public health and the programs and services that we have to offer, to start building relationships between the decision-makers within each respective health unit and school board and to start talking about mutual interests, mutual needs, what we have to offer, how the connections can be made between the education and the health sectors. This is just the very beginning step for them toward developing a very successful relationship and working collaboratively with [each] other. (...) From our perspective, it's our frontline staff and middle management that are building these individual relationships and we're trying to build the groundwork now for the upper level to have that same kind of relationship to make it easier for us to be able to actually work together.

With further cross-sector engagement at the executive level, school health partners gained greater familiarity with each other's work; provided direction at the other interorganizational levels; and contributed much needed support in a meaningful and timely manner. As a public health director commented regarding their experiences at executive-level meetings:

We have regular [executive] meetings throughout the year, like three, it could be more, (...) [the public health leaders and managers] and then the liaison from each school board, [which] is a superintendent—we require that it be someone in a decision-making capacity. (...) So, we will discuss priorities, strategic direction; we will discuss potential policies there, and it's an opportunity for the school board as well where they will bring things up for our attention, or concerns they have or issues they have for us to either help them with or just talk out.

The main purpose of engaging at the executive level was said to be about building relationships in order to share high-level information, and provide input into each partner's strategic plans. Where joint strategic planning had not yet been established, high-level discussions had helped public health units make sure that their work aligned with what their local school boards considered to be important to them. Such determination could also occur at the district level of cross-sector engagement.

b. District-level engagement with school personnel

Regular district-level management meetings were being organized by school boards for all of their principals. From time to time, when the occasion presented itself, a public health unit's director or manager would make a presentation at some of these group meetings to discuss appropriate courses of action or simply share information about partnership opportunities. Public health professionals felt that securing principals' buy-in for school health initiatives was paramount because they were the ones determining the extent to which the local public health units could engage with their schools, and whether a health action team, or well-being committee, could be established. As a public health professional stated, even the most enthusiastic school staff champion would not have much success in creating a healthy school without their principal's full support.

According to public health professionals, principals' meetings offered a convenient forum through which to exchange information about needs, priorities, and available support, as well as make a lasting impression to help spur cross-sector engagement at the school level. Although this engagement opportunity was considered very important regardless of a partnership's level of advancement, it was especially deemed critical by public health managers who were stretched across multiple portfolios, or by public health units whose frontline staff had limited access to schools. As a public health professional stated:

[Attending a principals' meeting] would give us an opportunity to start the ball rolling: Talk to the principals about what we can do and how we can support their school—who we are and where to find us and start the relationship. It's really hard to do anything until you develop the relationship, but it's really hard to develop a relationship if you can't get into the school.

When engagement at the district level did happen, it did not necessarily result in invitations to schools' planning meetings. Nevertheless, this type of engagement was still thought to be one among many worthwhile occasions to further build partnership ties.

c. School-based level of cross-sector engagement

Very satisfying school-based engagement occurred when public health frontline staff not only had the chance to interact directly with principals, but were also surrounded by school health champions and eager students. Public health nurses or health promoters were expected, as part of their duties, to engage with various actors at the school level, such as principals, teachers, and other school community members, in order to prepare their school health plans and put initiatives in place for the promotion of student well-being. In certain school health partnerships, public health frontline staff were encouraged to meet directly with the principals, around the beginning of each school year, to explore opportunities to work together.

In advanced school health partnerships, public health professionals attributed much of their successes to the school health champions at both the school administration and school staff levels. Of equal importance was the active engagement of students who had been eager to participate in school health initiatives. As one public health manager experienced:

What we found (...) [is that] in every school, you need administrative support, whether it's the principal or one of the VPs. (...) To be successful, you absolutely need at least one of your administrative [members] to be a strong champion for health, plus the teacher support, plus engaged students. (...) So, it's a combination of factors. We have a few schools that are absolutely amazing, who have that perfect recipe of administration that are supportive, multiple teacher and staff champions that are supportive, and some of these health action teams have up to 50 or 60 students on them. It's pretty amazing.

An integral part of the healthy school approach is student engagement, which includes building leadership skills in youth and cultivating their planning abilities for participation in health action teams. One public

health manager asserted that student engagement was especially critical for shaping peer-to-peer role models and creating greater receptivity toward school health messaging within the student population:

You need [student engagement] because the youth are listening to the youth, they're not listening to the adults. (...) They want to engage in these initiatives with their friends and hear the messaging from their peers. They don't want to hear it from the staff. So, though the staff and the admin might be there to champion it and facilitate things moving forward, you need the students engaged as well.

d. Bi-lateral top-down and bottom-up engagement

Cross-sector engagement was thought to be enriched in part by bi-lateral top-down and bottom-up engagement. Top-down engagement that was jointly driven by public health and school board executives was considered by public health professionals to be pivotal in delivering consistent partnership-related messaging to all other school health partnership actors. According to these professionals, when relationships were cultivated among leaders at the top partnership level, it sent the message that cross-sector engagement was a worthwhile undertaking for the other interorganizational levels. For example, at one school health partnership, public health frontline staff engaged more actively with schools in a resilience-building strategic approach when their own school board leadership was directly promoting it, in partnership with public health executives.

Aside from top-down engagement, bottom-up engagement may offer distinct advantages. Those public health professionals who were working in programming areas and interacting with school communities were seen as having valuable input to stimulate executive-level partnership discussions. As a public health director commented, insights gained through mid-level and ground-level interactions held much potential in enhancing partnership leaders' planning efficiencies:

We have staff that is assigned to each school. So, with our staff as part of their environment, it would be good to have them be involved in some of that [school board planning], what's working, what's not working. (...) And by representing the staff at that higher level, (...) there could be some really good discussions. (...) We all interface at different levels: the staff from various programs, our public health nurses and our dietitians who go out to the schools to promote the healthy schools model. There could be a really good draw from a number of people in our organization, staff as well as management and directors.

In less advanced partnerships, the intention to engage along interorganizational levels was not about producing planning efficiencies but rather about systematically sharing information to increasingly bring attention to partnership possibilities. Public health professionals, whose partnerships were often running at the networking stage, were seen as needing to engage vertically, as well as horizontally across the various interorganizational levels, on a regular basis, in order to gain the attention of busy school system actors and explore any partnership interests with them. As a school health coordinator experienced:

We have to do this (...) from a top-down approach and a bottom-up approach (...) and it has to be repetitive, for any awareness [about our public health role] to happen because we all lead very busy professional lives. We're inundated with information and it's making it really difficult to have that one-on-one discussion.

Constant information sharing through different channels flowing from both the top and bottom levels of school health partnerships was perceived to be necessary for clarifying the public health role in promoting student well-being, given that people's attention was often spread in many directions.

e. Additional key partnership actors

(i) Parents:

Although public health professionals would gear some of their school health initiatives toward parents as one of their target populations, parents were other possible partnership actors with whom public health professionals sought to engage. In actuality, parents represented a valuable source of information for school assessments on which public health units' operational plans were based. As a public health manager pointed out:

Then [the public health nurses will] go in and start to build the relationship with the principals and the teachers, as well as potentially, with the parent councils, depending on the level of engagement that's available. And they'll get a better understanding of what's going on and they'll complete that [school profile].

In addition to forming parent councils at the school level, parents participated on school boards' parent involvement committees, with possible encouragement and support from public health professionals to take on school health initiatives. On occasion, parents were invited to sit on schools' and school boards' other committees and working groups that engaged in health promotion.

(ii) Other community partners:

A school health partnership is understood in this thesis to be primarily about engagement between local public health units and school boards, but at any partnership meeting, a variety of other community partners may be present. Indeed, public health professionals spoke of cross-sector engagement with their school boards and other community partners through their many existing committees. Especially for school boards in rural/urban areas with small capacity levels, their main planning sessions tended to include other community partners, in addition to representatives from their local public health units. As a school health coordinator stated:

I think they acknowledge there's a lot of kids in crisis that their supports scratch the surface of, but there's all the other students that would benefit from positive mental health and well-being, coping strategies, and just positive psychology. There's a lot of work to be done, and [our school boards] don't have the human resources. Maybe it's a difference between large urban centers that do have more staff, more money, versus smaller. When we are in small urban/rural settings like we are, we have the same community partners for everything, so you have to really work together.

There were a number of community partners that worked with the school boards and contributed to student well-being. In fact, one public health manager pointed out that their local school boards partnered at times with a variety of other public agencies and non-profit organizations that had a broader health promotion mandate.

Nevertheless, public health units could be instrumental in helping their partnering school boards get in touch with other potential community partners through networking activities, as part of their school health partnerships. By recruiting other community partners to participate in the planning process, they have helped secure more resources from outside school boundaries. As a public health manager commented:

[Our school board] tried to reach out to [mental health] partners and they weren't able to engage [them]. (...) I guess that reinforced the interdependence where they said, 'Maybe we should have invited public health to assist us with the engagement part and get the partners at the table.' We were able to reach out (...) It turned out really well.

Public health professionals were aware that school boards were facing increasing demands to improve students' social, emotional, mental and physical well-being, and that resources needed to be gathered

from multiple sources. Thus, they would facilitate school boards' engagement with various service agencies and community-based organizations as part of their role in supporting their school health partnerships.

Besides school health partnerships with other community partners, public health units and school boards would be part of community-based partnerships where the focus was on children and youth within both school and community settings. Public health professionals and school board representatives would find themselves sitting at the same community-based partnership table or participating on the same community coalition. These types of gathering not only represented a source of additional support for children and youth but they also provided more opportunities to build relationships for further engagement in school health partnerships.

Prominent community-based partnerships included the children's planning tables, funded by the Ministry of Children and Youth Services. As explained by a school health coordinator, every region in the province was expected to have established a children's planning table, where community partners were brought together to look at the betterment of children and youth. From this table, sub-groups would be formed to plan for school-specific health promotion initiatives, in addition to initiatives that were to be implemented in the broader community.

6.2.2 Pursuing open dialogue for clarity about partnership possibilities

Cross-sector engagement flourished with the creation of a safe space for open dialogue, where partners could freely and candidly express themselves. Free and candid communication meant asking questions, voicing concerns in a non-offensive manner, and fully articulating what was important to each other and what could possibly be done through partnership activities. By engaging openly, school health partners could discuss, with greater clarity, ways of improving their efforts to promote student well-being, together. Through the building of trusting relationships for open dialogue, conversations became more meaningful such that partnership opportunities were seized, and partnership-related issues were addressed, more readily.

When engaged in open dialogue with their school system partners, public health professionals reported that greater partnership opportunities were uncovered and adopted; implementation hurdles were more

easily overcome, and/or school health plans could be prepared more realistically. Engaging in open dialogue meant freely asking questions and candidly expressing views to gain clarity about how to move the partnership further ahead. As a public health professional pointed out:

We have regular meetings [at different levels]. The director of education and the medical officer of health meet one on one. There's an agenda. On that agenda, sometimes it's just for sharing information [such as] concerns or questions and they come from both ways. (...) [At any level,] there's very open and free dialogue around things that are working well, some new projects that we want to explore, concerns that have come up on either end around something that has happened. (...) We speak very openly and freely about our plans, things that we'd like for them to be interested in, or engaged in. And sometimes it's about concerns because of the way something is not working well.

Engaging in open dialogue at various interorganizational level increased partnership satisfaction. However, public health professionals also emphasized that care had to be exercised when expressing certain types of concerns so as not to inadvertently offend their school system partners.

The ability to engage in open dialogue was attributed to the strength of the relationship. As one public health manager explained, the relationship with their local school board representatives strengthened as they gained more familiarity with one another, such that ideas for working together could then come to mind more spontaneously and be freely exchanged:

The stronger your personal relationships get with people, the more familiar you are with them. (...) [And so, the conversation] just naturally happens more openly. You might stick a little more on script with someone you're just not familiar with; where in another scenario, you might go off on a tangent talking about all the potential ideas that might not happen in a more underdeveloped relationship. (...) [Greater familiarity] creates that space for open dialogue that's not necessarily related to the reason you're meeting, (...) and that comes from a deeper understanding of the other organization's goals, objectives, and priorities, (...) [where they'd say] 'Oh, I didn't know your public health unit did that!'

According to public health professionals, open dialogue through impromptu meetings, and telephone calls on the spur of the moment became a regular occurrence with closer partnership ties, thereby furthering cross-sector engagement.

6.2.3 Establishing a common understanding for a solid foundation to plan together

Facilitated by open dialogue, the establishment of a common understanding consisted of a series of agreements and clarifications that laid the foundation for planning together. For public health professionals, reaching a common understanding, or common ground, in its fullest expression meant sharing the same values, developing a common vision, and having the same specific goals in mind when engaging with each other. It included agreeing on an overall strategic approach toward comprehensive planning, as well as on the same or compatible operational strategies for pursuing their shared specific goal. It also required the clarification of roles to fully understand what public health professionals could contribute in efforts to improve student well-being.

a. Shared values

To reach a common understanding, considerable time had to be spent engaging in conversation, building relationships, and recognizing shared values, if values were not readily shared at the onset of cross-sector engagement. Public health professionals felt that school boards themselves needed to value health, as much as they valued student achievement, for health promotion efforts to have a significant impact on students' health-related behavior and state of wellness, at the basis of their academic performance. Within advanced school health partnerships, the link between health and learning had been explicitly embraced by public health professionals and educators alike. One public health manager associated shared values with an unwavering commitment to the partnership, and to the creation of healthy schools, despite roadblocks encountered along the way:

It's sitting around the table; it's finding common ground. Our partners at the school board are completely committed and on board and believe that addressing health helps to improve learning. So, they're on board, and we work very closely together to find ways to be supportive and using a comprehensive approach. (...) Is that going to translate at every single school into a full health committee with a comprehensive plan? Probably not. But there's definitely that long-standing idea of working together towards health, and health and education are inter-related.

Shared values revolved around the social determinants of health. Public health professionals were not only concerned about students' health status and its influence on learning, but also about students' academic achievement and its influence on health, given that educational attainment was recognized as

one of the major social determinants of health in adulthood. As a public health professional pointed out, the recognition that educational success in and of itself was as important to the field of public health as it was to the education profession provided a common platform on which to build their school health partnership:

There's a lot of common ground between school boards and public health. And so, we both believe that we have to address the social determinants of health, one of which being education. (...) We came together, and these are our common shared values. (...) We didn't have to convince them.

Since education was considered a social determinant of health within the public health profession, the promotion of academic success by improving student well-being was strongly justified as a partnership focus. As a public health manager expounded:

Education is a major determinant of health, of getting a job, of having income, of being able to have a roof over your head. So, for us, from a 'determinants of health' point of view, supporting schools in having good success in educating the young people is a huge priority for us. We want to do everything we can to make sure that every child stays in school and graduates successfully. (...) We say '[Education] is our priority,' because it's a determinant of health (...) but I'm just saying that for clarity of vision, there needs to be lots of in-depth discussions at the high level to say, 'Ok, what needs to happen in order to make that a reality'.

b. Common vision and shared goals

In addition to shared values, public health professionals emphasized the importance of a common vision and specific shared goals in shaping the common understanding underlying the ability to plan together. In less advanced school health partnerships, public health professionals found that failure to communicate a long-term vision and a shared sense of direction across all levels of their school health partnerships had led to ambiguity within their local school systems as to what could possibly be accomplished by working with public health units beyond mandated health protection services. One public health manager stated that a common understanding, in terms of a shared vision and goal, was a pre-requisite for joint planning:

It's the relationship, the trust, [and] the understanding of what each one of us can bring too—that's the big difference. If we can't find mutual ground, it's very hard to plan together. (...) [Mutual ground is about] a shared vision, a shared goal, (...) and then you build on that: (...)

what's your strategic priorities are, what would you like to see as an outcome, what's important to you.

c. Common strategic approaches

When public health professionals spoke of a common understanding, it was in the context of a collaborative partnership arrangement, where an agreed-upon shared goal was being pursued through a shared decision-making process. Agreeing on the same underlying strategic approach, such as the Foundations for a Healthy School, along with the Ontario Ministry of Education's Well-Being Strategy, contributed to planning discussions by providing a common platform on which to build partnership ties. However, such an agreement applied equally to a cooperative partnership arrangement, where school health partners' well-being goals were not shared but undertaken through separate planning processes that at times would intersect to receive some partner input. Nevertheless, the shared use of an underlying strategic approach helped pave the way for more extensive cross-sector engagement. Other features of a common understanding included agreements on joint operational strategies and on respective partner-led strategies from which to create synergistic linkages.

Whether part of a cooperative or collaborative partnership arrangement, the adoption of the Foundations for a Healthy School framework did not only validate the promotion of student well-being in a comprehensive manner within a school setting, but it also provided a common, primary strategic approach that validated partnership work across the public health and education sectors. As a public health manager commented:

From a chronic disease and injury prevention perspective, we are mandated to work with schools and promote health topics based on the Foundations for a Healthy School document, and likewise the schools (...) work with us within the direction of that document. (...) And so, in that sense we have a common strategy because we are tied together through that document by the Ministry [of Education]. (...) That document provides the common strategy, the common ground, that we work from.

At times, certain public health professionals stated that school boards and schools were not held to the same standards as were public health units in terms of a professional requirement to work in partnership with other sectors. With its partnership-related component, the Foundations for a Healthy School framework was considered by some public health professionals, as in the quote above, to be a good

substitute for a common partnership-based mandate. Furthermore, other public health professionals noted that educators at the school level had been paying closer attention to the Foundations framework, now that it was linked to their schools' new reporting process through the Ministry of Education's School Effectiveness framework. Linking the two frameworks together had brought accountability to the creation of healthy schools, thereby providing a firm basis for partnership work. As a public health liaison pointed out:

[Work on Healthy Schools] is shifting pretty fast, and in part, that's because (...) [the Ministry of Education has] attached it to the School Effectiveness Framework, which is a planning and reporting system that schools have. Before, it was more of a voluntary process. Now they have to reflect those five domains of the Foundations framework in what they're doing. (...) [So, this] was the first time that I've gone to a school, (...) and have anybody say 'Oh, that's our Ministry of Education's diagram, that's awesome that you're using our diagram.' (...) [And I would say,] 'You are absolutely right, [and] we're here to support you in the work you're doing in your school. How can we work on this together?' [...] They were familiar with it because they had been working with it around their School Effectiveness plan.

The Well-being Strategy formed a broader basis for establishing a common understanding. Since this high-level Strategy was not tied to any specific goal, reaching a common understanding still necessitated agreements on joint or compatible operational strategies through which to pursue specific well-being goals. For example, one public health unit and their main school board partners had set, as their partnership-specific well-being goal, the improvement of student resilience. To move toward this goal, they agreed to co-develop a resilience-building strategy that focused on healthy relationships and personal growth, as part of their joint operational planning process.

Not all joint operational planning processes undertaken within school health partnerships were centered around a joint strategy. Public health professionals in advanced school health partnerships reported times when they would set shared goals, and together, looked for ways to tailor their respective strategies to ensure that they were compatible and could build off of each other for a synergistic effect. For example, as part of their school health partnerships with a specific long-term focus, the public health unit would meet with their main school boards, separately on an annual basis, to come up with operational strategies that could produce synergistic effects in order to increase the impact of their respective efforts. As the public health manager explained:

We participate when it's time for their multi-year [strategic] planning, and we participate yearly [on] the priorities for that year. (...) Now, with certain [school] boards, we meet

regularly, at the end of the year to plan for the next year. (...) Programming for the year: 'Where do we want to go? What difference do we want to make? What are some of the outcomes we would like to co-create together? What's important to them? Are there any policies that they would like to work on?' (...)— it's looking at all of that and finding synergy, and then, [action] planning from there.

d. Clarification of the public health role in the healthy school approach

Role clarification was another critical feature of a common understanding. A combination of various engagement pathways may be necessary before a common understanding can be thoroughly established. Cognizant of this situation, public health professionals had tried different means of engagement with their local school boards to help achieve greater familiarity with their health promotion role and the healthy school approach: (1) presentations at different school board gatherings; (2) an agenda item for discussion at a district-level principals' meeting; (3) reliance on a healthy school champion at the school board level to speak to the senior management on their behalf; and (4) the distribution of a briefing document that outlined all the relevant topic areas and services that the public health unit supported. Although a briefing document would be highly informative, direct face-to-face engagement had led to greater results in stirring school boards' interests for engaging in partnership activities, in certain instances.

On the other hand, certain approaches may be sufficient to garner partnership interest. Public health professionals in less advanced school health partnerships felt that school boards still mainly saw them in their traditional role of providing health protection services, not yet fully recognizing that their role had evolved considerably in the realm of student well-being. Some public health professionals mentioned that they had an informative document be circulated within their local school systems to raise awareness of the resources and services that they could provide. Other public health professionals took a more direct approach to clarifying their role, either making presentations at school board meetings or showcasing their school health initiatives at partnership meetings. This single approach resulted at times in increased partnership interest. For example, one public health manager experienced increased interest in their organization's health promotion services when one of their partnering school boards began to invite them to present on their expanded role during annual leadership meetings for board improvement planning:

In the last few years, it's generally taken place at [their] leadership training event. At that point they have all their superintendents as well as principals and vice-principals and that's generally where the discussion on new policies for the upcoming year takes place. (...) We have been coming in to talk about policy support, to talk about how we can support them in implementing the new [health and physical education] curriculum, whatever the hot topic of the day is. It's not strictly policy. We just try to use [the board improvement planning] opportunity to encourage more healthy policy and healthy school strategies (...) [and] to present and provide information on how we can support them. (...) [As a result], I usually see an increase in interest in the months following.

In this school health partnership, more opportunities for cross-sector engagement emerged with greater understanding of the role that the local public health partner could play in supporting school boards' student well-being goals.

Some public health professionals mentioned that they would have an informative document be circulated within their local school systems to raise awareness of the resources and services that they could provide, while other public health professionals had opportunities to clarify their role and available support during partnership meetings, resulting at times in an immediate response of interest. For example, at an annual extended partnership meeting to provide school health programming updates, a public health manager had the opportunity to showcase their current programs being delivered at one partnering school board, which immediately captured the attention of personnel from another partnering school board:

Right now, with one school board, we were able to strategically look at the year and what fits to support their initiative, which is really nice. (...) [But our other school boards] don't always think of the health unit as a support that could be there for them. I guess we still have to do a lot of education. We're trying to find that support for the directors because we feel that they have such competing priorities. (...) When we had our communication meeting this year [and we mentioned our available programs], the communication staff were there. It was an A-ha moment. They said, 'Oh my goodness, we need to be connected with you.'

6.2.4 Exchanging complementary perspectives for enhanced decision-making abilities and collective learning

By bringing different, but complementary, perspectives to their cross-sector engagement process, school health partners expanded each other's viewpoint for more relevant, encompassing, realistic and sound decisions, and for learning opportunities. They added to each other's perspective in various ways. Firstly, they shed light on school-based needs through their respective data sources, when available and accessible, for prioritization purposes. Secondly, they offered evidence-based ideas to strategically

improve student well-being, which broadened the field of possibilities for school health planning and collective learning. Thirdly, they combined evidence-based and practice-based knowledge for putting in place evidence-informed initiatives. Finally, their respective skills in distinct planning approaches could be used to help guide each other's planning process. School health planning and learning was enhanced through these exchanges of information, ideas, and know-how.

a. Shedding light on school needs through school health partners' respective data sources

Through their respective data sources, such as surveillance systems and school assessments, to shed light on students' needs, school health partners may assist one another with priority setting for the preparation of school health plans. For example, well-resourced public health units could gather population health surveillance data to uncover community issues and trends that negatively affected school-age children's health and ability to learn, including high rates of poverty and elevated prevalence of anxiety among pre-teens. Seeing themselves as the voice of the surrounding community, public health professionals reported having reached out to their local school boards so that together they could address the younger generation's pressing needs through the school system.

Public health frontline staff's casual observations made during regularly scheduled school visits, as well as their school assessments, or school profiles, were additional ways through which needs could be identified to support the decision-making process. One public health manager mentioned the perceived value of exchanging data for assistance with planning:

The public health nurses, when they engage with their principals, they go through that front-end process of developing their school profiles for each school. (...) [So,] we keep feeding into their school improvement planning. What we're looking at is, 'Can we work with [the schools] to look at their data, but also (...) share other data that we have access to?' And that really becomes something of great interest for them.

Public health professionals mentioned instances where their partnering school boards and schools provided them with data, such as student survey results. Access to school-level data, either through public health-led school assessments or through schools' own data gathering methods, was considered indispensable to ensure the relevance of operational plans.

b. Offering evidence-based ideas to one another, critical to collective learning

Professionals from the education and public health sectors brought to each other's attention evidence-based practices and theoretical concepts in the area of well-being, derived from their respective professions. Through the formal and informal sharing of such complementary perspectives, learning opportunities became embedded in the engagement process. In certain instances, collective learning considerably broadened the field of possibilities for improving student well-being, and it even shifted mindsets for transformational change.

Within the education sector, the Ministry of Education employed a team of mental health experts, called the School Mental Health ASSIST team, to inform and coach the mental health leads from all of the school boards across the province. Public health professionals viewed these mental health experts as a highly reputable source of advice for evidence-based strategies and initiatives on mental health promotion in schools. In complementing this source of expertise, public health partners had additional strategic ideas to suggest in line with available evidence. As a public health manager pointed out:

[The mental health leads] get provincial support from psychologists and people who tell them what programs are evidence-based, what are the best programs to offer. (...) [And then,] they'll ask if we could support them with that, (...) and they'll help to roll it out in schools. (...) They know I trust their judgment because they're being advised by the best people possible at the province, [School Mental Health ASSIST]. (...) Sometimes public health picks something ourselves that we want to try in the schools, and so we ask them if it's okay for us to do this.

The suggestions that public health professionals made to their partnering school boards' mental health leads aimed to promote mental health either directly, or indirectly through improvements to other aspects of student well-being. By taking into consideration how various health topics were inter-related, public health units offered their varied expertise to support a school board's broadly designed overall mental health strategy. As another public health manager expressed:

I will say [the mental health leads] have been a good connector and they are our glimmer of hope. (...) When they are looking at mental health and well-being, they're really looking at overall health, so many of our health promotion programs as far as healthy eating, physical activity, tobacco use, substance use, sexual health [are concerned], (...) they have pieces of [all of] that in their mental health and well-being strategies.

When exploring new partnership opportunities, public health professionals in advanced partnership arrangements mentioned holding in-depth discussions with their partnering school boards to share their health promotion knowledge and further establish a common understanding about their proposed strategic approaches, initiatives, and their rationale. As one public health manager commented, they *“would always bring [their] evidence, (...) [and discuss] a combination of theory, approaches and programming,”* when deliberating about possible new partnership activities.

By sharing their professional perspectives at partnership meetings, school health partners from both sectors brought about collective learning opportunities, which took on two equally useful forms: first-order learning as it related to prevailing ways of thinking; and second-order learning pertaining to a transformational shift in mindset. First-order learning was about sharing new but conventional information required to develop school health strategies and initiatives that conformed to prevailing underlying assumptions. One example of first-order learning was the sharing of practical ideas from the health promotion and mental health fields to shape the content of a well-being workshop, as experienced by a public health manager:

If we're developing something new and it has a mental health component, then we work with the board's mental health lead on the program, or the workshop, and fine tune it [together]. (...) We are presently developing a workshop for students (...) [and one of our school board contacts] provided input (...) to consider: feedback and suggestions for material to include or remove.

As valuable as this type of exchange was for refining current efforts to promote student well-being, it differed from second-order learning, where transformational change ensued on account of a shift in mindset. For example, within an extended school health partnership, a paradigm shift occurred following the introduction of ground-breaking research by one of the partners. Together, the school health partners examined new ways of thinking about disciplinary practices and student resilience, prompted by newly introduced research findings that challenged long-standing assumptions. Lengthy conversations contributed to the adoption of a new mindset concerning practices to improve student behavior, which in turn brought remarkable school innovation success. As the public health manager recounted:

At the foundation of [our whole-school, resilience-promoting initiative] is to adopt a strength-based approach. (...) We're inviting school boards (...) to have meaningful relationships with the students, because the research shows that when you have that, it reduces a whole bunch of risk factors and increases a whole bunch of protective factors. (...) [Our early data analysis] is exactly following the trends that other researchers have found. (...) [Our initiative] has had

an impact around (...) all kinds of things that we're measuring. We're already seeing a significant improvement. (...) It's really out there; it's not always easy because it requires some key fundamental paradigm shifts, and that takes time. It's about seeing strengths versus problems. And it's about seeing people at potential versus at risk. So, there's a lot of key paradigm shifts that are required.

Sharing complementary perspectives about evidence-based ways to improve student well-being has led school health partners to consider well-being strategies that would not have come to mind otherwise, thereby enhancing their ability to make more encompassing decisions for operational planning purposes.

c. Combining evidence-based and practice-based knowledge

Public health professionals emphasized the importance of combining their knowledge about evidence-based practices with educators' practice-based knowledge. They looked to their school board and school partners to provide various kinds of practical guidance on how to deliver their public health messaging, reach out to schools, and plan and implement more elaborate school health initiatives. For example, they sought input from curriculum consultants to ensure that their curriculum resources were being developed in a useable format for teachers. Additionally, school boards offered valuable knowledge for increasing the likelihood of partnership success at the school level. This knowledge included how best to disseminate a school health resource across schools; which schools would likely be receptive to public health support; and how to gain principals' interests in evidence-based initiatives requiring substantial school engagement.

Regarding more elaborate initiatives, public health professionals relied heavily on evidence-informed decision-making, since they acknowledged that their school health plans had to be suitable for the local school context, in addition to being evidence-based. They recognized that what was working effectively in one context may not necessarily work as well in another context. Given school system partners' familiarity with the conditions under which their own schools functioned, they were seen to play an invaluable role in assessing how worthwhile and feasible public health ideas for promoting student well-being actually were. As a public health manager pointed out:

As a public health unit, we really do value evidence-informed decision-making and evidence-informed practice. We really want to ensure that whatever strategies or programs we're delivering, they are rooted in evidence and hopefully will have the greatest positive impact on

our school communities. (...) Where the schools [and school boards] are really great at, is helping us in identifying what the needs are and what is really practical and feasible, and really trying to work together to marry what are the realities in these school environments, what is best practice saying, and how can we come up with an approach that will really meet the school's needs in a realistic way.

Public health professionals with close partnership ties reported receiving practical guidance from partnering school boards and schools so that their decisions surrounding the identification and implementation of evidence-based initiatives could be more realistic. In contrast, one public health manager commented that, in one instance, difficulties with the implementation of a well-being initiative could have been lessened had their decision-making process included the perspective of their local school boards' mental health leads. In their view, successful implementation of more elaborate public health-led initiatives did require school board input during the operational planning phase.

d. Familiarizing each other with distinct planning processes

In addition to engaging in evidence-informed planning, school health partners may familiarize each other with their distinct planning process for sound decision-making around student well-being. From the public health sector, public health professionals spoke of the training sessions and facilitation services that they provided to educators to guide them on how to apply the healthy school approach when preparing their school health plans at both school board and school levels. From the education sector, educators brought to public health professionals' attention, in certain instances, the collaborative inquiry process that has been adopted within local school systems for improvement planning.

Public health professionals drew on their familiarity with the Foundations framework to assist school boards with their districtwide planning, and to encourage schools to follow the six-step healthy school process for their own school health planning. For example, one public health professional reported that a school board partner relied on their public health unit to become better skilled at applying this comprehensive approach in their planning process:

[One of the school boards has] been doing work with [the Foundations for a Healthy School framework] to reference it in all kinds of different ways, in conversations, in meetings, tying it to different pieces of work that is going on, bringing public health in whenever we can to talk about the Foundations (...) at the board level, to try and build that understanding and

awareness of what that Foundations framework with those five domains actually means. (...) So, providing the information and having senior administration work with what that document says.

At the school level, another public health professional observed that the extent to which their public health unit was providing planning facilitation services appeared to have had an effect on the comprehensiveness of a number of schools' health action plans:

Sometimes the schools just need a little bit of support, and so, we build that relationship and provide the support that they need and then we work toward moving them along that continuum to more of a healthy school approach. In that, I mean how they're addressing it, so involving the stakeholders, doing a needs assessment, coming up with a plan (...) and then evaluating that. I would say that we're always evolving our process a little bit and so in moving to a more generic supporting role for the healthy school approach, we seem to have decreased the number of schools that are doing a more comprehensive approach.

While public health professionals were helping to familiarize school system actors with the Foundations framework for planning purposes, educators were in certain instances familiarizing in turn public health frontline staff with their planning process, called collaborative inquiry. Having public health professionals take part in this type of planning process, alongside teachers, has now become a possibility in the area of student well-being. So far, at least one public health unit's planning process has been integrated with that of their partnering schools through the collaborative inquiry approach. As a public health manager reported:

Also, [our school health coordinator] is working with the board on some HQ stuff that's advanced. There's a collaborative inquiry group that she's been with—a group of teachers. That's their new pedagogy that's required for planning. We use some of that in our work. (...) My nurses, when they're doing work in healthy eating and some of those areas, do co-planning with teachers [in this way].

6.2.5 Planning comprehensively and incrementally for greater effectiveness and feasibility

Although school health planning calls for comprehensiveness, an incremental approach to planning comprehensively may be required, at times, to ensure implementation success. The Ministry of Education has developed the Foundations for a Healthy School framework for school system actors and their community partners to promote student well-being through a comprehensive approach to health promotion. Public health professionals fully supported this approach for its greater effectiveness in

improving student well-being, relative to isolated, one-off school health initiatives. However, they were also aware that comprehensive planning may have seemed a daunting task to educators in certain instances. Consequently, they felt that the promotion of student well-being could be carried out in a more feasible manner by starting with what already existed within the school system, and then slowly progressing from there, planning and implementing increasingly more comprehensive initiatives one step at a time.

a. Comprehensive planning for greater effectiveness

The importance of undertaking a comprehensive approach to health promotion rested in the understanding that the isolated, fragmented practice of implementing one-off school health initiatives was much less effective in producing desired outcomes. As a school health coordinator pointed out:

Some of our schools are doing different [health promotion activities] that are part of comprehensive school health but they're doing it in a one-off manner. (...) [Comprehensive health promotion is] about getting things happening in a more strategic way. Because we know that when things happen in a strategic way, you're going to see better results.

Public health professionals made use of the Ministry of Education's Foundations for a Healthy School in many ways. They supported its use in the planning process since it was meant to empower teachers, mobilize the school community and its community partners, and create positive change in the school environment in a strategic manner. The Foundations' five components, including the curriculum, school leadership, student engagement, the social and physical environments, and partnerships, were implicitly understood as mutually reinforcing activity areas that built off of one another to then produce a greater impact due to their synergistic effects. School boards and schools were being encouraged to prepare school health plans that incorporated relevant activities under each of these components, to the best of their ability.

In addition to providing guidance with schools' comprehensive school health planning, public health professionals offered their support directly to individual school teachers. They would start with a teacher's request for curriculum-based resources, and then suggest additional activities to reinforce the health messaging, while aiming for comprehensiveness. As a school health coordinator indicated:

Often times, requests from schools come around curriculum. That we know. If we can go in with, 'Okay, your request is around the curriculum. Within your curriculum document, it talks about the importance of addressing all of these other components to be more effective.' That's usually how the request comes in, and then we try and spin it and make it more comprehensive when we approach them, and use their Ministry's documents to show them that, the connection and how it can be done. (...) [So,] it's more about how a teacher can make the topic more comprehensive within their classroom and not always for the entire school. For example, if the teacher is teaching about nutrition, [it's about] supporting the teacher with creating a healthy eating environment such as non-food rewards, non-judgment of student lunches, providing a positive eating environment, involvement of students.

Comprehensiveness was also meant in terms of the inter-relationships between the various aspects of a person's health. In seeking to encourage a comprehensive approach to health promotion, public health professionals would point out that the different aspects of student well-being—physical, emotional, cognitive, social, and spiritual—were actually inter-related. One public health manager commented that the Foundations framework itself served as an excellent resource through which to nurture the role of healthy school champion within a key school board representative:

We worked with [this mental health lead], two years ago, to really try and build her understanding of what the [Foundations for a Healthy School] framework was and how public health units could support. It has really paid off, because now there's that internal champion in that board who can see the connections. So even though she's the mental health lead, she gets how healthy eating supports mental well-being and how physical activity supports mental well-being. And how school connectedness is a critical part of mental well-being in school, and how the framework pulls all of those pieces together. So, at every opportunity that she has, she's bringing it back to that framework because we've agreed that it's the underlying piece that pulls everything together.

Through their comprehensive viewpoint, this champion succeeded in bringing home the message that improving students' well-being in areas such as physical health and social health can have positive effects on their mental well-being as well, for a variety of school system actors.

b. Incremental planning for greater feasibility

Much importance was placed on a comprehensive approach to health promotion, but it was difficult to undertake at times. Those public health professionals who sought to implement a healthy school initiative all at once tended to encounter resistance by an already overwhelmed school personnel. To increase the feasibility of their proposed initiatives, they turned to incremental planning, by starting off in one of two

ways. They offered to work initially on a small, easily achievable school health project in line with the school board's priorities, using the resulting early wins as a springboard to gradually add more activities as further milestones were being reached. Alternatively, if a school was already showing success in a particular health promotion area, they focused their school health plan on that area in order to take advantage of the momentum which had already been created.

Indeed, public health units' plans for schools were purposefully cut back. They chose instead to propose that they either start on a small initiative or build on existing activities that had already garnered much interest. This approach appealed to school boards that had been concerned about the perception of extra work by their school staff. For example, one public health unit increased their local school boards' receptivity to partnership work by proposing to build incrementally on schools' successes with their existing school health initiatives. As the professional at this public health unit recounted:

We originally thought we would start with 'Every school needs to have that comprehensive [approach] right from the beginning,' but we weren't getting anywhere that way. So, we backtracked a bit and said, 'Okay, school by school, we'll see where they're at and how we can further them.' So that's when we spoke about what's already happening in the schools (...) [at our partnership's executive-level meeting]. (...) Some of our schools have some really great things happening, so we sort of highlighted those things [to build from there.] (...) That was how we marketed it, 'We noticed many things happening in your schools that fit the healthy schools model, let's look at those and then build on them and make it more of a comprehensive thing. (...) [The school board executives at that meeting] seemed keen. They like to be a partner with us, so overall, they were supportive, with the tag as long as it wasn't going to create a lot of extra work for their school staff.

Likewise, public health professionals found that certain school administrators became more receptive to engage in partnership activities toward the creation of healthy schools after being reassured, during an in-person exploratory meeting, that planning would be done incrementally. Notably, satisfying cross-sector engagement was experienced in one particular school health partnership by first gaining familiarity with schools' aspirations and strengths, as a starting point for planning school health initiatives together. As a public health manager pointed out:

We meet on a regular basis, we don't come in with a program to offer but we co-create our approach together. We recognize that each school has a unique culture, so we really spend time hearing their story, what is important to them, what are their strengths and start from what is working well.

Over time, public health professionals have been moving away from explicitly offering to support their local schools in implementing comprehensive, whole-school health promotion initiatives right from the beginning. One public health manager explained that, when eager to produce a substantial impact, public health professionals may be running the risk of complicating the planning process by focusing too much on how a school could possibly put all the various pieces of a comprehensive health promotion approach in place before getting started:

The comprehensive approach is something that, as practitioners, we used to make sure that we are thorough in our practice. (...) [But, some] are making it too complicated. (...) We don't [say any more], 'You need to have this, and you have to make sure [you have that].' (...) We don't ask that all the ducks be in order, before we start. Those things come along the way. We don't need to have [it all] at the beginning.

From this public health professional's partnership experiences, opportunities to plan for the other key pieces of a school health initiative emerged at a later stage, when the time was ripe.

Public health professionals underscored the necessity of moving slowly, even if eager to make change happen. They realized that by gradually building from what school boards and schools were currently doing well, the task of applying the healthy school approach became more manageable and more likely to eventually lead to a comprehensive school health initiative. As a public health manager asserted, this journey was not for those seeking big changes within a short span of time, but rather, it was for those who could be satisfied with making slow but steady progress:

A challenge at times is having the patience to take small steps versus leaping. Sometimes, we would like to see change [happen] faster than it is humanly possible. When that is understood, the partnership strengthens. (...) [We] continue to keep informed about each board's strategic direction and [seek] ways to contribute to that, inviting them in conversations and finding small steps to take, [while] acknowledging and respecting where they are at.

Intending to plan in an incremental manner called for presenting only those parts of a healthy school initiative that were most appropriate for the situation at hand. As another public health manager stated:

[Being] aware of the theory of change, it's [about] (...) where are they at. And so sometimes if we meet them where they're at, then you can move them to the next level and then start to pitch more evidence-based ideas or concepts, (...) [related to] comprehensive school health, [and] move them along in terms of how they address their issues.

6.2.6 Full engagement spectrum for maximizing the partnership's potential

Being very protective of their cross-sector relationships, public health professionals generally paid a great deal of attention to nurturing their school health partnerships. This being the case, their level of partnership satisfaction did not rest on the quality of the interactions but was rather based on the level of extensiveness of their cross-sector engagement. They felt that less extensive interactions were suitable in certain situations, while in other situations, they wished for more extensive engagement with their school board and school partners. For any given partnership task at any given interorganizational level within the same school health partnership, school health partners sought to engage at a particular level of extensiveness found at some point across a broad spectrum of engagement possibilities along the collaboration continuum. In-depth analysis of cross-sector engagement patterns revealed a spectrum of engagement pertaining to interactions of increasing levels of extensiveness along the collaboration continuum, going from networking to cooperation to collaboration.

Each school health partnership has the potential to make use of the full engagement spectrum, consisting of the following cross-sector engagement levels: information-sharing, verification, consultation, involvement, coordination, and collaboration. This nomenclature was based, in part, on the Public Participation Spectrum, developed by the International Association for Public Participation.⁴ It has been modified to better fit the School Health Partnership Study data and reflect the school health partnership context. As the least extensive engagement level, the sharing of information, alone, related to networking among school health partners. Verification and consultation indicated cooperative engagement, while involvement, coordination, and collaboration signified collaborative engagement. Adding another layer of complexity, the engagement spectrum concerned each of the three distinct planning phases constituting a partnering organization's decision-making process: organizational, multi-year strategic planning; annual (strategic) operational planning; and action planning. The following description of the full engagement spectrum derives from an exhaustive analysis of the vastly varied partnership experiences that public health professionals described during their interview sessions (further details can be found in Appendices 4A and 4B).

⁴ International Association for Public Participation. (2007). *IAP2's Public Participation Spectrum*. Retrieved from https://www.iap2.org/resource/resmgr/files/iap-006_brochure_a3_internat.pdf.

The engagement spectrum runs along the collaboration continuum. In a networking partnership arrangement at the school board level, school health partners *informed* each other of their respective fields of work. The purpose of this type of interaction was to acquaint one another with existing plans, priorities, as well as available resources, and/or talk about emerging concerns and discover mutual interests to explore partnership opportunities. This level of engagement laid outside the decision-making process. When an agreement was made to move forward with a partnership opportunity, then the partnership arrangement took on either a cooperative or collaborative nature.

In a cooperative partnership arrangement, implementation resources and/or professional planning resources (i.e., advice or guidance) were shared, in addition to information. Planning input was being requested either to *verify* a plan that had already been prepared for possible modification, or to *consult* on a plan that was in the process of being prepared. A public health unit would seek to have their completed operational or action plan be verified by their school system partner during the review process, in order to ensure its compatibility, feasibility, and/or suitability relative to the needs, priorities, and context of the local school system. In contrast, a school board, or a school, would be asking their public health partner to verify their plan for student well-being, mainly to ensure soundness, accuracy and completeness in relation to their local public health unit's own data and evidence-based perspective. Similar expertise from mental health leads was sought by public health professionals for the mental health initiatives that they were leading. Cross-sector engagement at the verification level was viewed as expedient. On the other hand, consultations were preferred when embarking on more elaborate planning so as to reduce the likelihood of having to make changes far into the planning process.

What distinguishes a collaborative partnership arrangement from a cooperative one is the extent to which the decision-making process is shared. School health partners collaborated when engaging with one another all along the decision-making process, as they exchanged information and resources to achieve a shared goal. A collaborative partnership arrangement was experienced at two different levels: involvement and collaboration. Regarding the former, the lead organization continuously *involved* the other partner in the planning deliberations, giving full consideration to their planning input before making their final decisions. Alternatively, both partners *collaborated* in contributing input into a joint plan that they co-led. *Coordination* is also a form of joint decision-making since it refers to joint implementation

planning for the delivery of an existing or newly developed school health initiative by public health professionals within educators' workplace.

Besides coordination, which relates to implementation planning only, any of the other five engagement levels mentioned above can be chosen regarding the three planning phases that each partnering organization undertakes as part of their health promotion efforts. At the organizational level, these planning phases, along with their distinctive tasks, are as follows: (1) high-level, multi-year strategic planning, pertaining to the setting of strategic directions and broad goals (or corporate priorities), either for each partnering organization, or specifically for the school health partnership; (2) annual operational planning, pertaining to the determination of priorities/emerging needs, and the formulation of specific goals, objectives, and operational strategies/ideas; and (3) action planning, pertaining to the selection and development of school health initiatives, and the identification of implementation steps. Policy development is a particular form of operational and action planning. The engagement spectrum also applies to schools regarding information sharing and school-level planning, a collective term that denotes school-based operational and action planning for policy-related and program-related school health initiatives.

It is during the action planning phase that agreements on the sharing of implementation resources take place. The term '*implementation resources*' is defined in this thesis as fully developed school health initiatives (e.g., programs, project activities, professional development events/educational sessions, curriculum material, and other resources) to be delivered during the implementation phase.

The move from networking to cooperation and collaboration may happen in relation to any of the abovementioned planning tasks. For each of these tasks, public health professionals experienced different engagement levels across the different school boards and schools within their catchment areas, and even with the same school board, or school, at different times and for different areas of work. Differences in engagement levels along the collaboration continuum depended on the specific health topic, or need, being addressed as well as the situations and circumstances that shaped the supporting conditions for organizational asset sharing, especially the strength of the relationship, which was affected by various factors (e.g., competing priorities, personnel turnover).

Although the collaboration continuum has been described in a linear fashion, movement from one partnership arrangement to the next could fluctuate back and forth over time within the same school

health partnership. Furthermore, networking to discover new partnership directions could progress directly to collaboration without having to first go through a cooperative arrangement. The following sheds more light on the collaboration continuum as well as the different cross-sector engagement levels for each of the three planning phases related to school boards and schools, as perceived by public health professionals.

a. The Collaboration Continuum in the context of school health partnerships

Moving along the collaboration continuum means choosing increasingly more extensive levels of cross-sector engagement, corresponding to the three distinct types of partnership arrangement: networking, cooperation, and collaboration. Although increasingly more extensive engagement levels represented greater partner input into a particular decision-making process, one type of partnership arrangement was not necessarily viewed as better than another. Furthermore, in certain instances, all three partnership arrangements were experienced within the same school health partnership at the same time for different work areas. From a public health perspective, each type of partnership arrangement may be the most suitable option depending on the task at hand, the degree of expertise or guidance required for planning purposes, and the prevailing situation and circumstances.

Networking was undertaken between public health units and school boards, or their schools, to discover mutual interests before proceeding to engage in a resource-sharing arrangement, especially when intending to partner in a new health promotion area or with new school health actors following personnel turnover. As a public health manager stated:

It's not a linear process. Sometimes it's good to be networking around. I'm networking a lot right now to have a [particular activity] implemented in all the schools, lots of networking. But there'll come a time when it will be about collaborating, because it's going to be getting closer to the implementation stage. (...) But right now, it's dropping those seeds, (...) planting seeds of information to see if there is any appetite to develop [that activity] more and bring [it] to a collaboration level.

However, another type of networking activity was carried out within the broader community, as part of school health partnership activities. Public health professionals reported that, as an additional support, they would seek more specialized skills, additional expertise, or implementation resources from other

potential community partners to increase their local school systems' capacity to promote student well-being. As a public health manager pointed out:

We were able to reach out to (...) [a large number of] community partners that could provide support in regard to mental health in schools. (...) [We asked ourselves,] 'What does it mean in regard to community work to support the [school] environment; what partners can assist to really improve the school environment; what resources can be shared; and what can we do together to push the agenda?' (...) That was a great opportunity for us to make those connections with the school boards and really show that we can work with them.

As part of their school health partnerships, this public health manager and their team facilitated the networking process for their partnering school boards' mental health leads by making further connections with various service agencies and community-based organizations to help secure health-promoting resources from outside school boundaries.

When moving beyond networking to start engaging in direct partnership work, not all school health plans required an extensive level of partner input. At times, it was more appropriate to partially share the decision-making process, with the cooperating school health partner providing strategic advice or practical guidance at key moments. At other times, suitable planning input would be most basic, as when commenting about the acceptability of an existing school health initiative. As one public health manager stated:

You can't sit and plan together for everything, (...) there wouldn't be enough time to do that. Sometimes you have an initiative that you know is evidence based, you know that it works, but you want to take it to that group and see what they think about it. (...) There are [school health] activities we might do because we have been doing them for a long time, or maybe we're taking it to them to ask, 'Do you think this will work in the schools?'

Another public health manager echoed the same viewpoint, regarding being strategic about what the partnership is to be focused on:

We have a close relationship with the mental health lead and the social workers. So, sometimes they will come to us and say 'We want to do this, what do you think? And at other times, they just deliver it. So [for instance] they've decided that they want to deliver the program [X], they didn't come to us to check that. And it wouldn't have necessarily been needed. [...] We don't have to be aligned on everything (...) and plus we would never get anything done. We're not the only service provider in the school board.

In other instances, a collaborative partnership arrangement at the strategic planning level was chosen to pursue a shared goal. Potentially, school health partnerships could take on any type of partnership arrangement at one time or another, and even simultaneously, for different planning phases and different work areas. For instance, certain school health partners collaborated on shared health promotion goals for joint strategic planning, while they cooperated on other health promotion work requiring less extensive cross-sector engagement.

Certain partnership activities have been purposefully designed for a lower level of cross-sector engagement to focus more attention on higher-priority efforts. As a public health manager asserted, what truly mattered in their school health partnerships was being conscious of the intention behind each occasion for cross-sector engagement and choosing the most suitable engagement level (i.e., level of extensiveness) that corresponded to that intention:

You just can't have it all, all the time. You have to choose. We are very clear here that when it comes to our program [on resilience], that's where we want to collaborate. But if we want to provide information on tobacco, for example, we're okay to [do just that] (...) Whatever works for whatever you're doing. But it's the consciousness around it, and being aware of whether you're picking the right modality.

While public health units were proposing partnership opportunities to promote student well-being, school boards may have been engaging in school health initiatives on their own, or with other community partners. Public health professionals stated that they were not seeking to partner on all of their school boards' school health initiatives. However, in advanced collaborative partnerships, public health and education professionals made high-level agreements as to what would be their partnership-specific goal to achieve together, and they would then plan their strategies and initiatives accordingly, at times collaboratively and at other times cooperatively.

b. Multi-year strategic planning

Multi-year strategic planning is meant to direct the entire organization's annual operational planning processes for the following three to five years. As part of community needs assessments, school boards and public health units may be invited to provide input into each other's organizational multi-year strategic plan, to a lesser or greater extent, so that their interests and concerns could be taken into

consideration when determining focus areas for the years to come. However, multi-year strategic planning can also be undertaken to specifically give direction to the school health partnership.

The choice of verifying an already completed multi-year strategic plan elicited at least two types of response. Some public health professionals responded minimally, feeling reluctant to suggest any changes to already made decisions by their school board partners, curtailing the exploration of greater partnership opportunities. Other public health professionals responded with a sense of resignation, fully accepting the exchange of limited feedback on each other's plan given their complex situation of working with multiple school boards and lacking capacity. In the latter case, verification of existing plans to identify compatible areas in which to focus partnership activities was deemed more practical. For example, at one extended school health partnership, the multiple school boards and their common public health partner did find agreement on a partnership focus in the area of mental health, which was a pressing concern to them all. By contrast, in less complex partnership situations, public health professionals experienced increasingly more latitude in making suggestions that could broaden the field of possibilities for partnership activities with their local school boards. Either they were consulted by their school board partners through group sessions and individual interviews, or they were involved in a steering committee during the planning process.

Alternatively, in advanced partnership arrangements, public health professionals collaborated with their partnering school boards on a joint multi-year strategic plan, whose strategic direction and broad goal were specifically meant for the partnership. A partnership-specific strategic plan set the school health partnership on a strong footing to provide clear and long-term guidance for greater engagement at all interorganizational levels. As a public health manager indicated:

Planning together is key, (...) [including] developing a shared vision. (...) It makes a huge difference when you get to do the health promotion initiatives, because if we get buy-in from the school board, then we can engage the principals, [and say] 'This is a shared strategic direction.' And they receive that message, and then that makes our working relationships so much easier on the ground.

Within a collaborative engagement process of strategic planning, enlisting the participation of public health frontline staff and mid-management, along with the directors, was believed to hold much promise for productive partnership-focused deliberations with their school board counterparts. As a public health

director pointed out, regarding the sharing of first-hand observations and insights from public health professionals closer to the implementation level:

I think for me that partnership would be really rich if strategic planning would be part of our relationship. We did do strategic planning a few years ago in our organization, and at that point we did do a call out to all of our partners, to give us feedback on where we're going. So, the school boards were a part of that, but it wasn't unique to the relationship that we had. (...) We have staff that is assigned to each school. So, with our staff as part of their environment, it would be good to have them be involved in (...) [discussions about] what's working, what's not working, for some visioning. And representing the staff at that higher level, it would be great to be part of that because we have common populations that we deal with. (...) So, I think there could be some really good discussions, (...) with the staff from various programs, our public health nurses and our dietitians who go out to the schools to promote the healthy schools model. There could be a really good draw from a number of people in our organization, staff as well as management and directors.

The high-level partnership-specific strategic plans that had been prepared within certain school health partnerships either fed into, or stemmed from, each partnering organization's own multi-year strategic plan. For example, at one extended school health partnership between a public health unit and their coterminous school boards, a cross-sector advisory group had been established to come up with partnership focus areas each time a new multi-year planning cycle was to begin. The group's membership included public health professionals at the programming level, who were knowledgeable about partnership activities in schools, as well as school board decision-makers, and/or those who directly reported to the decision-makers. Agreements on proposed focus areas were being brought back to the senior management of their respective organizations so that these focus areas could be fed into existing multi-year strategic plans at the organizational level. This advisory group then oversaw the operationalization of their joint strategic plan by the partnership's operational group.

A high-level partnership-specific strategic plan was found to be advantageous to give clear and long-term direction toward a shared goal. As another example, in another school health partnership, a partnership strategic framework for healthy schools had been co-developed through the partnering school board's internal steering committee with a cross-sector membership. This framework stemmed from that portion of the school board's multi-year strategic plan that intersected with the public health partner's health promotion mandate, as it related to the Ministry of Education's student well-being goal. It specified the vision and strategic directions that would focus school health partners' mutually reinforcing strategies for the improvement of student well-being:

[Our school board] had already set a steering committee. (...) We looked at what, currently, is [our school board's multi-year] strategic plan, (...) and looking at what the Ministry of Education has outlined, and what are our mandates. (...) [Based on these,] we've developed a partnership strategic framework together. We have that in [our steering committee's] terms of reference as to what we want to do, and we plan (...) and evaluate it all together. (...) The Ministry of Education added the goal of student well-being, and then they released the Foundations for a Healthy School. So, the discussion came [about as], (...) 'How is the board then going to implement this [well-being] goal?' And then from there, we started talking about (...) strategic planning, and marketing: what are the things that they want to focus on, and what we want to focus on. It's developing the vision, and the areas of focus. (...) It was [all] put into a framework. (...) Then once we came to that, it was, 'Okay, now we know what we can provide support with.'

c. Operational planning at the school board level

Operational planning, or work planning, means strategic planning in the short term, to be carried out on an annual basis with possible adjustments made over the course of the year. It may result in a formally written plan. It may also take place through verbal agreements to address emerging needs. School health partners have been invited to provide input into each other's operational plans to one extent or another, according to which level of engagement was being sought—whether it was for a verification, consultation, involvement, or collaboration.

Operational planning required school assessments to uncover actual school needs. With assessment results, public health professionals were better able to pinpoint the best strategies to effectively bring about the needed improvements. For example, in one school health partnership, the broad goal of student well-being was specified in terms of reduced anxiety and self-regulation within the student population. Public health nurses would conduct needs assessments in schools to identify which target population was in greatest need of an intervention in order to come up with the strategic approach that could have the greatest impact. As the public health manager clarified, different strategies may be formulated according to the school grade in question and the context:

So, we're working with [the mental health lead] to say, 'Why don't we identify the groupings, and the ages, stages, and what the issues are, and identify the potential interventions that could support a school [in the area of anxiety and self-regulation], and then look at the assessment at the school level of what the issue is?' [and] from a population perspective, 'Is the issue something that needs to be first dealt with by the principal, (...) by the teachers, (...) by the parents, or is it an issue at the student level itself?' (...) [Operational plans will have]

different approaches depending on the population that you're working with. (...) [So then, the mental health lead] can say 'We're working on anxiety and self-regulation, and here are the multiple interventions being used depending on the needs of the school.'

Public health units may choose to verify the appropriateness of their priorities and operational strategies to ensure their school board partners' approval before proceeding with the selection or development of school health initiatives. When more extensive engagement was preferred, or warranted, public health units and school boards either consulted on each other's operational plan as it was being prepared, or embarked on joint operational planning. In the latter case, school health partners chose one of two options, or a combination of both: (1) they involved each other to discuss the mutual alignment of their respective strategies, and how these strategies could build on one another to create synergy; or, (2) they collaborated on the formulation of a joint operational strategy, which could span multiple years. For both of these collaborative engagement levels, public health professionals found that the in-depth conversations that went into jointly preparing operational plans allowed them to gain a clear understanding of what their school boards were aiming to accomplish, and where they could focus their collective efforts.

Partnership priorities were set in various ways. For their own operational plan for student well-being, a public health unit may be granted school access to conduct school assessments in order to prioritize needs that fall under their multi-year strategic plan, or their Ontario Public Health Standards. They may then seek to verify their priorities' compatibility with those of their local school boards. Or, they may decide to go along with those priorities found in their school board partners' board improvement plans for student achievement (BIPSA).

When public health units were not able to conduct school assessments, or to consult any existing BIPSA, they tried to find out about school board priorities through casual conversations within their local school systems. At times, public health professionals devised planning strategies to accommodate both public health and school board priorities. In the education sector, a school board's well-being priorities that informed their BIPSA may have been reflecting school-based data that they had gathered themselves. Nevertheless, their priorities could be determined, or adjusted, by accessing their public health partners' own data from their surveillance system and/or school assessments, when available, and these priorities could then form the basis for further cross-sector engagement.

Key to partnership advancement was the establishment of a collaborative arrangement, where school health partners agreed on a multi-year partnership-specific direction, and then determined shared priorities, and selected specific goals on which to jointly strategize for the coming school year. For example, as part of their school health partnerships with a specific long-term focus, the public health unit would meet with their main school boards, separately on an annual basis, to come up with shared or compatible strategies that could produce synergistic effects, in order to increase the impact of their respective efforts. As the public health manager explained:

[With our school board partners,] we participate at different levels. We participate when it's time for their multi-year [strategic] planning, and we participate yearly [on] the priorities for that year. (...) Now, with certain [school] boards, we meet regularly, at the end of the year to plan for the next year. (...) Programming for the year: 'Where do we want to go? What difference do we want to make? What are some of the outcomes we would like to co-create together? What's important to them? Are there any policies that they would like to work on?' (...)— it's looking at all of that and finding synergy, and then, [action] planning from there. (...) Sometimes it's more of strategic planning (...) [for] understanding where they want to go, so that when we do things within their school board, we can link it to that and it all makes sense to them. (...) So, it's that kind of conversation that happens.

The strategies that public health professionals prepared jointly with their local school boards, at times, covered multiple years, with a partnership-specific strategic direction being either explicitly articulated as such or expressed as a partnership declaration. When working with a multi-year overall strategy, the included annual priorities and operational strategies were refined in the year they were to be put into action. A partnership-specific multi-year strategy could even be designed to fit with a school board partner's multi-year mental health strategy. For example, a public health unit was collaborating with their main school board partners on a shared goal geared toward resilience building within the student population to enhance each school board's overarching mental health strategy. Together, they designed a long-term evidence-based strategic approach to guide the development of resilience-promoting initiatives across schools. As the public health manager indicated:

We meet with [our] school boards to come up with key priorities – every year we confirm our [partnership's strategic] direction. For us, right now, it's all about (...) resiliency. (...) It's what we will do every year that gets revisited– the overall strategic direction is multi-year. (...) Our resiliency model fits within [each of our school boards'] mental health and well-being strategy and it is one of the links we make. (...) At the school board level, we prioritize what it is that we're going to be doing [together].

By agreeing on a long-term resilience-building strategy, this public health unit discovered that high-level partnership planning could directly impact schools' receptivity to engaging across sectors. This partnership outcome highlighted the importance of cross-sector engagement at all interorganizational levels.

When school health partners came together to collaboratively prepare operational plans, it was to focus on a prioritized partnership-specific goal. However, cooperative cross-sector engagement levels were still experienced for health topics that were of a lower priority. Being complex in nature, a school health partnership can cover a number of health promotion areas, not all of which would call for extensive joint strategic planning.

d. Action planning at the school board level

As with operational planning for student well-being, action planning may proceed through increasingly more extensive cross-sector engagement. School health partners may seek to verify their action plans for appropriateness or arrange to consult, involve or collaborate with the other partner on the selection or development of school health initiatives. Where relationships were well established to be conducive to any level of cross-sector engagement, one engagement level would be more suitable than another depending mainly on how much time would be available to perform the partnership-related task, and how much planning input was actually required from the other partner.

Even though school health partners may be collaborating on the preparation of operational plans to come up with feasible strategies together, it may not be necessary for them to then jointly develop the initiatives that these strategies call for. For example, a public health manager reported that their partnership activities included participation on a collaborative committee that would regularly meet to strategize together about how to address needs as they emerged within the local school system. Although the strategies were jointly formulated, the initiatives (e.g., resources for training workshops, curriculum material) would in large part be developed by public health professionals in consultation with this group.

(i) Verification:

Verification of action plans occurred across the public health and education sectors for many purposes. Basically, public health professionals verified the appropriateness of their planned school health initiatives in order to obtain school board approval for delivery in schools, when required. They relied on educators' curriculum expertise and practical knowledge of their local school system contexts to gain insights as to how feasible and suitable their initiatives were for their schools. They would also ensure that their mental health initiatives corresponded with their partnering mental health leads' expertise. Similarly, public health professionals mentioned times when their partnering school boards tapped their evidence-based knowledge to check the soundness of their board-led school health initiatives. Another reason given for a verification by a school board pertained to their search for implementation resources. School boards were reported to have reached out to confirm that a partnership-relevant initiative they wished to implement met their local public health unit's mandate and interests, in order to make arrangements for its co-delivery.

As part of partnership activities, public health professionals and their partnering school boards' mental health leads and curriculum specialists would also review each other's well-being programs and curriculum material to see if there were any "*glaring concerns*" to be addressed and to suggest certain adjustments for clarity, accuracy, and completeness. This engagement level also ensured that partners' health messaging was consistent across the local school system.

Verification may not always be sought, but its usefulness may be discovered in hindsight. For example, a school health coordinator recounted the time they participated in a school board's information session about one of their school health initiatives. The open dialogue brought up unanticipated issues that turned the cross-sector engagement into an unexpected verification, with positive consequences:

A meeting [was organized] (...) where we learned more about the [school board's health promotion] program. We had some concerns (...), [and] so, we assisted in [suggesting adjustments]. (...) I think, if we didn't have this opportunity, it wouldn't have opened the door to talk about [our approach to mitigate the identified issue]. (...) So initially we thought, 'Oh, that wasn't a great outcome. They already purchased the program,' but if you look at some of the secondary outcomes that have come about, I think it opened the door for conversation on other things. You don't know what you don't know. (...) I think it was really eye-opening.

(ii) Consultation:

Public health professionals and school board representatives consulted each other at key time points during the process of selecting and developing their school health initiatives, which included making revisions to existing curriculum resources. Public health professionals felt that consultations were particularly advantageous for avoiding the risk of having to rework plans following partner input much later into the development process. A consultative engagement was found suitable for accessing relevant support to ease the planning process and to ensure that initiatives, such as lesson plans, could be put to practical use.

When developing their school health initiatives, school boards' interests may be better served by consulting their local public health units, especially early on into the action planning process. One public health manager commented that their readily available professional knowledge may cut down on the amount of work that would otherwise be required by school board staff in their search for pertinent information, thereby enhancing their ability to develop initiatives:

I think it would save them some effort, in some cases, if they came first and ask for [our input]. (...) Because sometimes when we've come across some things they have developed, and then provided some input, they're like, 'Oh, we didn't think of that.' (...) Sometimes, it takes a lot of their capacity to go and find information, because they're not necessarily familiar with it. If they'd ask an external partner like the health unit, we might have that at our finger tips and that would save them time and effort in doing it, and we could sort through some more valid information [for them].

In turn, public health partners' familiarity with curriculum requirements and the usability of their curriculum resources may be significantly increased through regular consultations with curriculum leads within their local school boards. Input from curriculum specialists was seen as particularly worthwhile when aiming to prepare relevant curriculum material in a customary format that teachers could find acceptable and practical to use. As a public health manager asserted:

To have a good working relationship with the curriculum specialists within the boards, [is important] (...) because they can be very helpful to us when we're looking at the curriculum. (...) [They can] make sure that our lesson plans reflect not only the structure and even the lay-out of what the curriculum typically looks like for teachers, but that we make sure that we're doing a good job of embedding the health messages in a way that is 'teachable,'—something that the teachers are used to looking at, and that is familiar to them when they look at it to plan their lessons or activities for their kids.

(iii) Involvement:

There were reported instances where one school health partner who was leading an action planning process (i.e., the selection or development of an initiative) involved the other partner by inviting them to join their working group or their series of planning meetings. This engagement level was chosen when the lead partner was seeking to receive extensive content expertise and/or additional planning and implementation support from the other partner within a pre-defined scope of partnership activities. It was particularly suitable for the development of public health-led training workshops, or well-being programs, that required significant contributions from mental health leads, and for school board-led initiatives to be co-delivered.

Involvement was about providing input early on and at various times during the planning process, including at the very end when all decisions were to be finalized. For example, at one public health unit, the partnering mental health lead was involved throughout the process of developing a workshop. As the public health manager reported:

If we're developing something new, for example, and it has a mental health component, then we work with the boards' mental health leads on the program, or the workshop, and fine tune it [together]. (...) [We developed] a workshop for students (...) [and] one of our school board mental health leads was involved in the development of that workshop, (...) [providing input on] existing programs or research to consider, feedback and suggestions for material to include or remove in the beginning of the program planning process, and off and on during the whole development process, including a review at the end. There were [a few] working group meetings and communication via email.

(iv) Collaboration:

As with involvement, collaboration on action planning united school health efforts to improve student well-being. However, these two engagement levels differed in that the planning process was co-led when school health partners fully collaborated with each other, such that decisions were made together. For example, professionals from the public health, education, and service sectors would come together to co-plan mental health activities to present a united front. As the public health manager stated:

The steering committee met twice after the initial meeting and they left it to the two working groups which (...) [included] the health promotion part. (...) [Our health promotion and prevention] group is still very active. (...) When we plan for the mental health awareness week, we bring those partners back on because we want to make a collaborative effort and we want to have one voice.

As the example above showed, collaboration on a joint initiative may be preceded by joint operational planning.

(v) Coordination:

Cross-sector engagement at the implementation planning stage, understood as *coordination*, was by necessity collaborative. It required joint decision-making as to how initiatives could be delivered in schools by community partners through the assistance of school system actors. Public health professionals counted on the ability to coordinate the delivery of their school health initiatives through school or school board representatives so that all main partnership actors could know who was to do what. Well-orchestrated coordination was viewed as essential for a smoother and more effective implementation of a school health initiative in the school. Districtwide coordination was found to be necessary to avoid the duplication of efforts. It was also considered advantageous for enhancing delivery efficiencies, especially when engaging through a school board committee that included key community partners. As a public health manager commented:

I think it's just good to be in on the things that are brought forward by the community as concerns, as part of that [school board's] committee, and being able to bring forward things (...) at that board level that then trickles down to the schools. (...) [That] is really important. It's very efficient as well. (...) [And] the purpose of establishing [this committee] was to bring together community stakeholders and pulling in all of the services that students need and working together to provide those services in a coordinated way.

This public health manager went on to say that the ongoing coordination of a wide array of programs and services provided the added advantage of gaining clarity as to what was being carried out across the school board's district and how they could better support that work:

[And this coordinating committee offers] a direct line into the board, and what the priorities are, and knowing more about how they operate (...) [by knowing] all of the partners that they've pulled in, [who now] are at the table. (...) [This way,] we can better work with them.

e. Policy development and implementation planning

The full engagement spectrum, except for the collaboration level, could be undertaken during the development of school health policies. Since these policies were always the sole domain of school boards,

there were no joint policies to be prepared collaboratively. However, school boards could still choose to involve their local public health partners in their policy work.

Verification and consultation were considered the most suitable levels of cross-sector engagement when the public health partner's policy advice was not required to a great extent because such advice could be found elsewhere. Other available sources of expertise included neighboring public health units with larger capacity, other community partners with more specialized professional knowledge, and ministry-provided reference material. However, public health professionals with less extensive input to provide did appreciate being asked for their feedback regardless of what had been obtained through other means, even if it was at the final stage of policy development, so that they could contribute their unique perspective to ensure completeness.

When public health professionals were in a position to offer more extensive policy input, they were not necessarily contributing to the full extent of their capabilities. For instance, online surveys did not afford the possibility of discussing policy options nor were their opportunities to present more suitable policy alternatives after gaining a better understanding of school boards' views. According to a public health manager, being thoroughly involved in a school health policy development process would provide the chance to listen to any reservations that the school board partner may have toward public health recommendations. In this way, the rationale behind the policy advice could be clarified to reach an agreement, or more appropriate alternatives could be suggested to satisfy all concerned. This public health manager felt that discussing each other's perspective through a partner involvement process could provide reassurance of having been heard and understood. This could in turn help clear the way to find middle ground, where public health recommendations could be adjusted to better suit their school board partners' viewpoint.

Policy involvement had other advantages over policy consultation in certain situations. During in-person policy consultations, public health professionals' technical assistance, or content expertise, would be provided as requested through a combination of meetings with school board representatives and back-and-forth electronic communication to supplement group discussions. By contrast, policy involvement provided an additional value for implementation purposes. By being present during all deliberations on a school health policy that was to be implemented with their support, the public health representative could better understand what was required of them and for what reason. As a school health coordinator stated:

I would be an advocate of being involved right from the beginning, just to have a greater understanding of how they got to that certain place. When you come in afterwards, you kind of miss out a little bit on how they got there and what the rationale was for a certain thing. My preference would be, to be a part of it right from the beginning. (...) [In the past] I kind of felt like I was playing a little bit of catch up with the board, just to find out where they were at and what stage, and what was left to do, and that sort of thing.

f. School-level school health planning

Cross-sector engagement for school-level planning varied along the engagement spectrum in a similar manner as that presented earlier for planning at the school board level. Furthermore, a school's planning process to promote student well-being could proceed along one of two possible paths, distinguished mainly by which partner had initiated it. The first path was driven by the school. Each year, all publicly-funded schools in Ontario were expected to prepare a school improvement plan for student achievement (SIPSA). This planning process consisted of an operational planning phase, related to the prioritization of needs based on school surveys and other assessment methods, as well as an action planning phase. Although the focus was on educational outcomes, SIPSA could include a student well-being section. Public health frontline staff have interacted with schools in a variety of ways, with regard to their SIPSA process: by being involved as a standing member of their planning committee; by being consulted during some of their planning discussions around well-being; or by being asked to verify their completed plan to ensure completeness and soundness.

The other path was initiated and facilitated by public health frontline staff, when directly promoting the healthy school process. While their engagement in school improvement planning may not have been substantial in some schools, their facilitation of the healthy school process in other schools have allowed them, in certain situations, to be extensively involved in the preparation of the well-being component of school-led improvement plans. When faced with staffing shortages, it permitted them to provide at least consultative support. The healthy school process consists of six steps: (1) the establishment of a health action team, or healthy school committee; (2) a school needs assessment; (3) need prioritization; (4) the preparation of an action plan for school-led initiatives; (5) an evaluation of the effectiveness of actions taken; and (6) the celebration of early wins. Similar to school-driven planning, this process also encompassed operational planning (i.e., the second and third steps), and action planning. When sufficient frontline support was available, public health units could offer to facilitate the healthy school process in

all receptive schools within a particular school board district, and when this was not possible, they would direct their staff to those schools that had been designated as high-needs schools and that had demonstrated adequate readiness to take on this process.

School-level planning, whether driven by the school or facilitated by their public health partner, was a process that belonged to schools for the planning and delivery of their own school health initiatives. Different schools would be focusing their efforts on different initiatives, depending on their needs, capacity levels, aspirations, and local contexts. In parallel to either of these school planning processes, public health units would be preparing their own internal operational and action plans to complement school-level plans with public health-led initiatives designed to meet the needs of the local schools. As a public health manager explained:

The [public health nurse] is one of the leading members of the [schools' health action teams]. It is [our public health unit's] initiative within each school that addresses comprehensive school health – (...) [doing a school needs assessment,] helping form the [team], engage students and staff, work together to come up with an action plan, etc. (...) [This] action plan is one piece of the public health nurse's action plan for the whole school. She may (...) [also] have different workshops and presentations for varying classes, implement a triple P parenting seminar out of the school, etc. (...) Some [partnership activities] might be larger projects. (...) Other things might just involve teachers in classrooms. (...) [So,] her action plan for the school typically includes many things – one of which being to implement and support a [health action team]. [This team] will have their own action plan. Things that the kids will implement within the school. (...) The kids and adults come up with the action plan together and the adults support the initiatives that the kids want to do.

Public health units' school health planning may be carried out at the school level, more or less in partnership with school administrators, along with other members of the school community to deliver initiatives that range from simple health promotion activities to whole-school programs. For their planning purpose, public health frontline staff may also engage directly with individual teachers, to a lesser or greater extent, to plan school health initiatives (e.g., curriculum material, lesson plans) for their class.

Regarding the establishment of health action teams, or healthy school committees, public health professionals may provide intensive facilitation support to individual schools, or they may provide initial guidance and then step back and have school community members take over the planning process. Ultimately, the intention was to empower school communities by building their competencies to prepare health action plans by themselves. Although public health professionals aimed to have schools plan

healthy school activities on their own, they would still be offering consultative support to help maintain the momentum:

We do the facilitation. We'll have the principal's support and we'll have a teacher champion or staff champion within the school that are part of all of that. But a lot of the facilitation in the beginning is us, the school health nurses, with the goal of working with the schools so that they can eventually try and sustain that on their own. (...) The staff are here to support and help to maintain those [health action committees], and they can also focus on schools that maybe don't have [committees] and then to establish them in those schools.

Staffing shortages in certain public health units limited the amount of support that could be made available to schools. Empowering schools to plan school health initiatives was seen as advantageous to allow some public health support to be redirected to other schools that had attained an adequate level of readiness. However, in moving away from extensive engagement in school planning, and providing consultative support instead, public health professionals observed a decline in the number of schools that were following a comprehensive approach to their school planning for student well-being.

School-level planning may be rendered more efficient by engaging with local public health units in a district-level group meeting structure. Public health professionals have participated in joint strategic planning with groups of school personnel (e.g., principals or teachers), where a large number of school could access their planning input. For example, as an indication of a cultural shift, one school board arranged for their public health partner to be consulted during their principals' group planning meeting early into their strategic planning process to receive useful input, such as local surveillance data for needs prioritization and suggestions for operationalizing well-being goals.

As another example, one partnering school board organized a one-day workshop, referred to as a community-of-practice day, where teachers from selected schools were brought together, along with public health professionals, to work on the action planning aspect of their respective school improvement plans regarding student well-being. Although the teachers came with certain priorities and strategies in mind, their plans were not fixed. As they were looking for assistance with the preparation of action plans and securing the necessary implementation resources, they were nevertheless open to making operational planning adjustments by consulting with representatives from their local public health partner unit. As the public health manager recounted:

That community-of-practice day that we had, it was school board initiated. They were trying to do some of their school planning and they invited health unit staff from various programs and we brought all kinds of resources that we have. We brought programs that we run, we brought data that we've collected, and they sifted through all of that to develop their school initiatives. (...) Some of them came thinking they're doing one thing, but when we displayed the data, which drive what we do, they realized they needed to focus somewhere else. So, some of them changed their plans, or it broadened their plans.

This partnership experience represented a consultation midway into schools' operational planning phase. It provided the basis for their public health partner's participation in action planning that was to be carried out on school premises. During that planning day, the public health frontline staff made arrangements to be involved in their assigned schools' action planning process. They also offered to bring to the teachers' planning table, back at their schools, other community partners who could provide resources to put their chosen operational strategies into action.

Chapter 7: Enabling the Cross-Sector Engagement Process from the Perspective of Public Health Units

In the previous chapter, the elements that enrich cross-sector engagement within the school health context were fully examined from a public health perspective. The present chapter explores how cross-sector engagement is made possible, based on public health professionals' experiences as well. It further elucidates the dynamics of a strong school health partnership by first covering the importance of relationship building, at its core. Then it identifies and expounds on the key elements that enable cross-sector engagement, which have been categorized within one of three inter-locking domains, referred to as connection, capacity and continuity. The strength of any given school health partnership would depend on the extent to which it expresses each element that either enriches or enables the cross-sector engagement process.

7.1 Relationship building at the core of school health partnerships

Consistently, participating public health professionals emphasized the fundamental importance of cultivating relationships when coming together to work on the promotion of student well-being. Through relationship building, cross-sector engagement became more meaningful. As well, relationship building was found to create avenues through which to share resources, including advice and guidance, and plan together more extensively. For these reasons, relationship building is at the core of school health partnerships for promoting student well-being.

Public health professionals relied on relationship building to fulfill their mandate of working in partnership across various sectors to promote the health of the populations they were meant to serve. As a public health manager stated:

We can't do any of our work alone. One of the four pillars of public health is partnership and collaboration. So, we're mandated to collaborate and to partner. (...) There's nothing we can do, if we didn't have that mandate, and you can't partner and collaborate without a relationship at the foundation.

Mental health was a high priority across local school systems. This was another health topic where relationship building matters a great deal to public health professionals. It was even more crucial in situations where school boards employ social service professionals, since concerns over the division of responsibilities within the area of mental health may arise. One public health manager went on to suggest that a stronger relationship with their local school boards' mental health leads may bring resolution to issues of service duplication and untapped public health support:

From our relationships' standpoint, we don't meet routinely with the mental health leads from [our] boards, but we should. We should better align our services (...) with what they're doing, or if they're doing certain aspects of it, then maybe we don't need to do that, and we can re-focus on other activities. It's just that [we] have to build the relationship, first, before we would have the opportunity to have that discussion, (...) to smooth it out, to have potentially better alignment with what services they're providing, (...) [and ask] 'Can we help? Can we assist them?'

Through their relationships, school health partners may chart a clear course for further cross-sector engagement, increasing the level and relevance of public health support while minimizing role ambiguity and overlap.

Relationships are built as engagement proceeds across sector boundaries over time. The four partnership components, called cross-sector engagement, connection, capacity, and continuity, necessarily gravitate around relationship building. What follows is an examination of those elements that enrich the cross-sector engagement process related to school health partnerships.

7.2 Connection

Establishing and nurturing a connection between school health actors motivates cross-sector engagement. As school health partners engaged with each other to a lesser or greater extent, the connection that was created between them spurred further engagement. Public health professionals connected with their local school boards and schools by exhibiting determination to initiate engagement despite system barriers; by displaying enthusiasm to promote interest in partnership opportunities; and by garnering respect to provide planning input. Moreover, the connection was enhanced by mutually cultivating trust to further advance cross-sector engagement. Additionally, public health units increased the connection by demonstrating partnership-derived benefits to highlight the merit of working together,

while school boards did so by formally acknowledging partnership achievements to raise the partnership's visibility. These were the connecting elements that motivated cross-sector engagement.

7.2.1 Exhibiting determination to initiate engagement despite system barriers

With limited capacity and the many demands vying for the attention of public health and education professionals alike, much determination was required to initiate engagement at times. Determined public health professionals persisted in finding openings to connect with their local school boards despite system barriers, such as competing priorities, dynamically changing environments, funding constraints, and other impeding circumstances. Public health professionals spoke of their efforts to offset these system barriers by steadily sending out reminders to set aside time to meet, and by repeatedly delivering the same message of available support at various interorganizational levels. Furthermore, connections had to be rekindled whenever a personnel turnover occurred, or educators' interest in school health became overshadowed by more pressing issues.

Much determination was required in finding time to meet despite competing priorities. As another system barrier, the existence of a dynamically changing environment called for public health professionals to repeatedly reach out to school system actors at all levels and deliver the same message of support. As a public health manager stated, the cross-sector connection had to be restored not only after a personnel change, but also following a change in educators' focus, where their initial interest in school health became overshadowed by emerging issues deemed more pressing:

It just depends on who we have as a partner on the other side as things change. Sometimes you have great leaders that have health as a priority. [But] you have to (...) keep promoting the message [because], at different times, different people embrace it and you work with those—you have to be determined, there's no doubt about it. That's why you keep promoting the message and hoping it falls on the right ears, somebody that has an interest or sees this as a priority, both at the school board and the school level, (...) [because] it really depends on whose ears that message falls on—whether it gets embraced and something actually gets done.

To move forward with cross-sector engagement, public health professionals did not allow setbacks to discourage them. By remaining “*tenacious*” in front of system barriers, they held on to their common

purpose of improving student well-being, secured in the knowledge that sooner or later a way would be found to work alongside their school board counterparts. As a public health manager asserted:

You really have to value the fact that [you] don't give up, that you continue to strive, (...) [and] you have to work within the context of what's happening in the environments. (...) [It's] keeping [our school board partners] informed of opportunities (...) of working together. (...) [And] it's working together to find ways to get things done. It's about determination and always trying to continue the connection. (...) And really, the big thing we do is we keep the students at the center of it, because we all care about the students' well-being.

7.2.2 Displaying enthusiasm to promote interest in partnership opportunities

Enthusiasm also increased the likelihood of making a connection between school health actors. Displaying enthusiasm, such as passion and enjoyment, was an essential feature of public health professionals' promotional efforts to increase interest in partnership opportunities. Enthusiasm to forge a school health partnership stemmed from a deep conviction that a healthy school environment would more likely be created by joining forces.

Public health professionals found that, whether in a top leadership position, in mid-management, or on the frontlines, an enthusiastic disposition could evoke in themselves and in the other partner a genuine drive to promote student well-being through partnership arrangements. As one public health manager expressed, exuding passion for healthier school environments contributed significantly to having this topic appear on school boards' meeting agendas:

I'm very passionate about working with schools and school boards and I have a team that is passionate as well. (...) [Because of this] passion, I'm always engaged. I'm on a number of committees and I make it a point to look for opportunities to increase the understanding and to engage others in the process. And I think it translates to my nurses. (...) We go with an intentional purpose to make (...) [the schools] healthier and build a supportive environment, [and] it's really about always keeping it on the agenda. (...) The school boards, they know me well, I guess I can say, and I think they appreciate the work that we do to support them.

Public health units succeeded in stirring enthusiasm in their local school boards in many ways. Means to increase interest in cross-sector engagement included making a compelling presentation to the school board leadership, vividly demonstrating their value proposition; organizing highly engaging conversations with a program expert from academia to encourage program implementation through a partnership

arrangement; and reporting research findings of positive outcomes that their proposed initiative achieved elsewhere.

At the school level, promotional efforts to engender enthusiasm needed to be directed primarily at principals, since they were the ones who decided which partnership activities could be undertaken in their schools. However, principals, as with other personnel within local school systems, had heavy workloads. A school health manager commented that their public health frontline staff would necessarily require well-developed marketing skills to garner a principal's interest in the short amount of time that would be made available to introduce their partnership proposal:

[School health nurses] have to have very highly developed skills in marketing, in creating a vision and being able to stir excitement. You basically have five minutes with the principal. (...) [They] have the (...) task to go out there and convince this principal that together they can have a huge impact on the school community. You want that principal to say, 'I have to work with this person.'

This public health manager felt that introducing an enticing partnership proposal through the dynamics of a face-to-face meeting, no matter how brief, could produce a lasting first impression to inspire principals to take a closer look at partnership opportunities that they may not have considered, otherwise. Being well aware of this reality, public health professionals emphasized the importance of having in-person meetings with principals so that they could make better-informed decisions about whether or not to enter into an active partnership arrangement.

7.2.3 Garnering respect to provide planning input

Garnering respect was a partnership element that enabled public health professionals to be invited to partially, or fully, share the decision-making process and provide planning input at school board and school levels. Public health professionals felt respected when their school system partners recognized them as a credible source of guidance for health promotion in a school setting. This respect was seen as contributing to opportunities to plan school health initiatives alongside school board and school personnel.

Respect for public health units' health promotion role within local school systems characterized close partnership ties. Public health frontline staff, in particular, were reported to have felt respected for the

specialized knowledge that they were sharing during planning discussions with school community members. One public health professional commented that the professional respect that was mutually experienced, over many years, contributed to fruitful planning opportunities with school boards and schools concerning program-based initiatives:

At the school level, (...) [we're] working together. But also within boards' program areas, we work together on some initiatives, whether it be (...) [about] mental health or health and phys-ed (...)—so, at many different levels. (...) I think we've had a history of meeting and communicating, (...) and of mutual respect for each of our roles in ensuring that students are able to learn and be healthy. (...) I think that our long-standing positive relationship has contributed to us continuing to work well over the years.

Over time, public health units saw their presence at school boards' policy table increase. Another public health professional asserted that their organization's well-established professional status contributed to their participation in school board policy work:

[Our school boards'] respect of public health expertise in regard to health promotion and policies, (...) [helped us get] invitations to the table for policy development and policy support.

7.2.4 Cultivating trust to further advance cross-sector engagement

Trust was related to school health partners' level of comfort in engaging with one another. The cultivation of trust was considered essential for fostering close partnership ties in order to pursue open dialogue and further advance cross-sector engagement. Public health professionals in less advanced school health partnerships gave much attention to trust building so that conversations with their school board partners could eventually turn to exploring more extensive levels of cross-sector engagement, particularly joint strategic planning.

Public health professionals waited to cultivate sufficient trust with their school board partners before proposing a more extensive level of cross-sector engagement. As a public health manager reported, care was taken to first increase the levels of comfort so that they could more fully discuss possibilities for accessing their school boards' data and sharing strategic planning processes:

We've expanded a bit this year to include looking at opportunities to share data and looking at opportunities to be part of their strategic plan. We're going forward slowly so that we can

build that trust and that relationship. (...) We're always striving to make it better and hopefully everyone will be able to benefit from it.

Trust was cultivated through supportive behavior that was experienced in various situations: when jointly solving implementation problems in a climate of non-judgment and respect; when showing empathy toward the other partner during difficult times; and when serving as a reliable source of support to respond to needs, all year round.

a. Jointly solving implementation problems in a climate of non-judgment and respect

A climate of non-judgment and respect was seen as a prerequisite for cultivating the necessary initial level of comfort, or trust, to jointly solve implementation problems. Public health professionals found that a certain level of comfort among school health partners was necessary to express a diversity of views in attempts to solve problems encountered when implementing more elaborate school health initiatives, and applying the healthy school approach. In turn, the very act of jointly solving problems seemed to fortify bonds of trust in this virtuous cycle of trust building.

To do well in joint problem-solving efforts, school health partners required the creation of a safe space where they could openly express their views, or ideas, when trying to work out implementation issues. That safe space emerged through the fostering of a nonjudgmental climate for cross-sector engagement, in which it was understood that all opinions were to be offered and received in a respectful manner. As a public health manager explained:

For us, the foundation [for respectful interactions] was laid out a long time ago, (...) [to] have an open conversation. (...) [Our school board partners] are open to having discussion and even [to us] asking the hard questions that we sometimes face, because they face the same things on their end about (...) initiatives that are coming through and that we're trying to figure out how to make it work. (...) At that open table, we can have those discussions. (...) [People] can come to that table and they can bring their ideas, (...) [knowing] they're not going to be judged.

A climate of non-judgment and respect, based on an initially adequate level of trust, facilitated a meaningful exchange of views for increasing implementation success. Relying on each other's views to solve implementation issues may in turn result in bonding experiences that would further raise the comfort level between school health partners. For example, a public health manager commented that

mutual feelings of trust appeared to have increased following problem-solving exchanges with their partnering schools and school boards:

The [health unit] staff [are] working with the schools to help them through the whole [healthy school] process. (...) They would attend meetings, give presentations, and they would help problem solve. (...) If we had some issues implementing a particular initiative, or working with a particular school, [school boards] might have insights on how to better do it. I think this (...) [helped] build relationships and build trust.

Joint problem-solving was but one way of increasing trust levels to motivate further cross-sector engagement. Other means centered around the offer of support that went beyond refining implementation plans.

b. Showing empathy during difficult times

Demonstrating empathy during difficult times was another means through which school health partners raised trust levels. Trust increased when sector boundaries faded away and all that remained were people going through relatable challenges, with a sincere desire to help each other out, to the best of their abilities. For example, a public health manager reported that trust grew when they and their school board partners accompanied each other through difficult situations, and steps were taken to alleviate concerns by working through challenges together, or at the very least, by making sure not to complicate matters:

[Trust is built by] really taking the time to get to know each other, get to know the players, get to know what are each organization's strengths, and then what are our challenges and pressures, and being mindful of that and trying to work together. (...) [We] really wanted to support the schools and the school boards and not make any matters worse or more stressful [during a major challenging period]. We were very mindful about our communications and collaborations with them at that time, and vice versa, if there's challenges going on from [the health unit] side of things. (...) [So, it's] really [about] sharing what we're going through (...) [and] listening to what our concerns are. If there are challenges, say at the school level, what are they, and how can we work through them together and find a solution that is supportive and meets everybody's needs, and doing that together.

c. Serving as a reliable source of support to respond to needs, all year round

Trust was also built when school health partners took care of each other's requests and needs as they arose throughout the school year. In these instances, the feeling of trust, or comfort, came from an assurance that support would consistently be made available to the extent possible. Public health professionals stated that trust grew when the school boards and schools knew they could rely on their local public health units to provide assistance in a timely manner and to follow through on their commitments. One school health coordinator mentioned that responsiveness to educators' calls for assistance was intrinsically featured in their job description:

It takes time to build trust between the organizations. I think that's an individual skill of someone in my role. That's my job, it's to reach out and build those relationships. (...) [Trust is built by] responding to [our partners'] requests and supporting them when they need something, (...) [and] after a period of time, [it's] them knowing (...) 'If we call the health unit, they're going to be able to help us with this.' (...) We do our very best to help them.

7.2.5 Demonstrating partnership-derived benefits to highlight the merit of working together

Cross-sector engagement became a worthwhile investment of time and effort in the eyes of school system actors when benefits were shown to have arisen directly from a school health partnership arrangement. Public health professionals stated that school boards and schools, in certain instances, were more receptive to working in partnership when demonstrating the benefits that had been reaped by other schools within their board districts. This was particularly the case with efforts to create healthy schools.

Partnership-derived benefits spurred interest in further cross-sector engagement, when they were effectively communicated at both school board and school levels. For example, one public health unit enhanced their school board connection by presenting early school successes with the healthy school approach through the use of compelling storytelling visual tools to highlight partnership successes. As the public health manager recounted:

Part of [school boards' receptivity] is just us being good partners in showcasing the work that we're able to do within the schools. (...) One thing that we did this year was we did infographics (...) that outline (...) all the successes that we've had within the schools in terms of our comprehensive school health programming, (...) and they love it. It's like a nice visual that they can see that shows them, 'Oh wow, there's so much being done in the schools, this is great stuff.'

Although school board executives were openly supportive of partnership opportunities with this public health unit, not all of their schools shared that same receptivity. A variety of possible factors may have overshadowed the benefits achieved in other schools within the same district. As the public health manager quoted above added:

The superintendents at the board level are very supportive. It's once you get down to the school level that it's a little bit of a mixed bag. So, you have some principals who are hugely supportive. (...) [With others] it's not that they're not supportive, it's just not a priority. It may be something that they just personally haven't thought too much about. They may be a newer principal. They might be overwhelmed with other things within the school. Those sorts of things. The same would go for the teachers. In some schools, we have teachers that are real champions. In other schools, we may not have really found those teacher champions yet. It's just a constant work in progress.

In other school health partnerships, school boards were instrumental in directly disseminating information about partnership benefits to all of their schools through district-wide events, such as their regularly scheduled professional development days (i.e., in-service training). Signs of increased partnership interest were experienced when emphasizing what the schools themselves could achieve through partnership work. At one school health partnership, the public health partner chose to take on a low-key role when school health successes were being presented. Despite having provided crucial guidance, the public health frontline staff made sure that all the credit went to the school staff and students. As another public health manager described:

There's been a lot of amazing work done, but more recently it's really been highlighted. (...) A lot of our initiatives that our public health nurses have supported, [the schools] have presented at various school-board in-service days. Other schools are saying, 'Oh, they're doing all that great work, we want to do that too!' Everyone's jumping on the band wagon, which is great. (...) Usually our nurses (...) have the staff and students who were involved in the initiatives be the ones that get up there to present (...) and have their moment in the spotlight. (...) The work that is going on at the school level is really catching on.

Within this type of partnership arrangement, presentations of partnership-related benefits as part of in-service training appeared to carry much weight for the school staff in attendance, who happened to all be mental health champions. As the public health manager further explained:

We have developed pretty good working relationships with the mental health leads at both of the school boards. (...) So, each school board has identified a mental health [champion] from each school; a staff member (...) has been assigned [this] task. (...) The school boards then would get all of those mental health [champions] together for in-servicing and professional

development a few times during the school year. (...) So at these sessions, they have put public health as a standing agenda item, allowing us the opportunity to come in and either do (...) success stories, [or] whatever is most fitting and meets the needs at the time.

7.2.6 Formally acknowledging partnership achievements to raise the partnership's visibility

The sixth and last connection element is the formal acknowledgment of partnership achievements. The act of acknowledging achievements nurtured the connection between school health partners by officially showing appreciation for the work that had been done together. This has had the effect of raising a partnership's visibility for further cross-sector engagement. Acknowledgements were made through various means, including celebrations organized by school health teams themselves; schools' recognition assemblies or award ceremonies; and districtwide announcements, where partnership-related successes appeared as feature stories in school boards' newsletters and on their websites. Acknowledgements contributed significantly to a more satisfying partnership experience.

The formal recognition of partnership achievements, mentioned by public health professionals, usually happened within schools. However, one public health manager reported that such recognition occurred at both school and school board levels within their extended school health partnership. This widespread recognition, and the resulting media coverage, captured the attention of school board leaders, and helped energize cross-sector engagement:

Our health action teams always have some type of year-end celebration to congratulate themselves on their work. (...) [Also,] our health action team students, or students involved in the various health initiatives, will often be recognized at [their schools'] assemblies. (...) They're often recognized and celebrated through feature stories on the [school board's] website. They oftentimes make it into our local newspaper, which is really cool. (...) In our last directors' meeting, (...) [seeing all of this,] one superintendent has verbalized appreciation to public health and how much [they] value our partnership, (...) [and wants to] continue these discussions and explore what that can look like.

The many ways that school staff and students were acknowledged in their efforts to create a healthier school environment increased the school health partnership's visibility such that the superintendent in charge expressed greater interest in further exploring partnership opportunities.

7.3 Capacity

The capacity that each partnering organization brings to their school health partnership determines the extent to which cross-sector engagement can be pursued. To build partnership capacity, school health partners established interorganizational structures to help ensure regular and well-performing cross-sector engagement; provided leadership to drive and facilitate this engagement; allocated time to engage in meaningful conversation; assigned human resources to supply the necessary professional skills and expertise to carry out partnership activities; made material, financial and data-related resources available to plan and implement school health initiatives; and undertook knowledge acquisition practices to enhance understanding and decision-making abilities. Each of these capacity elements were contributing factors to school health partnership's strength.

7.3.1 Interorganizational structures to help ensure regular and well-performing cross-sector engagement

Interorganizational structures helped ensure regular and well-performing cross-sector engagement. They consisted of structured meeting arrangements and formally written agreements, secondary to relationship building. School health partnerships varied according to which possible combination of meeting structures was chosen for any given interorganizational level, at any given time. Additionally, a formally written agreement could have been prepared for the partnership as a whole, or in the absence of a partnership agreement, a data-sharing agreement and/or a communication protocol could have been drawn up. All of these interorganizational structures contributed to the stability of cross-sector engagement.

a. Structured meeting arrangements

There was no single customary set of structured meeting arrangements through which school health partners engaged with one another. School health partnerships had their unique combination of interorganizational meeting structures. As another point of consideration, meeting structures took on one of two distinct forms of membership: dyadic and extended. In a dyadic partnership arrangement, meetings took place between one school board and one public health unit. An extended partnership

arrangement occurred when at least three partnering organizations had meetings together. That is, one or more local school boards with overlapping jurisdictions (i.e., coterminous school boards) met with one or more public health units that were servicing their schools. One or both of these forms of membership could be established for any school health partnership, since all public health units had the potential of partnering with at least two coterminous school boards from the English public and Catholic school systems.

Public health professionals viewed structured meeting arrangements as essential means of communicating on a regular basis in order to build relationships and gain easier access to key partnership actors, especially when the school health partners had complex organizational hierarchies. Meeting structures with cross-sector participation were found at all partnership-relevant levels: top (executive), district, liaison, middle (programming), and ground (school). In certain instances, school health partnerships were enhanced by shared workspaces, inter-unit meeting arrangements, and community-based structures.

(i) Top-level interorganizational meeting structures:

Based on public health professionals' partnership experiences, top-level interorganizational meeting structures were required to enable executives to give clear direction to the other partnership levels. At one extended school health partnership, top-level meetings were found to be especially advantageous for exchanging views and insights regarding common concerns and interests, and to think strategically together for overall guidance on how to improve student well-being. As a public health director stated:

We have regular meetings throughout the year, like three, it could be more, that's our school-board/health unit liaison meetings that are usually held here at the health unit. We have terms of reference. (...) [The public health leadership] attend, the managers of school health attend, (...) and then the liaison from each school board, [which] is a superintendent—we require that it be someone in a decision-making capacity. (...) So, we will discuss priorities, strategic direction; we will discuss potential policies there, and it's an opportunity for the school board as well where they will bring things up for our attention, or concerns they have or issues they have for us to either help them with or just talk out. If something comes up, we have ad hoc meetings, we email regularly, or they'll feel very comfortable picking up the phone and calling, either myself or the other director or either of the managers of school health.

On the other hand, board-specific planning called for separate meetings. At another extended school health partnership, where coterminous school boards had the same specific goal, the public health unit

experienced the need to hold separate meetings at more concrete planning levels because progress was not proceeding at the same pace due to different capacity levels.

When partnership-specific top-level meetings occurred, they tended to be hosted by public health units. One major partnership advancement involved regular meetings at the top executive level to specifically shape the course of partnership efforts, with corresponding mid-level cross-sector engagement being integrated within the school boards' own internal structures. For example, at one extended school health partnership, executive-level meetings were to continue to guide partnership direction, while school board committees opened their memberships to public health professionals, at the mid, or programming, level. In this way, these public health professionals could participate in internal school health discussions of relevance to their partnerships. As another public health director stated:

We historically met with the directors of education two times a year, (...) and those meetings were called by us. (...) We've started seeing a shift that the directors of education want us to join them at their table, so that we could be part of the discussions when they're talking about health and well-being, (...) [and] maybe put more emphasis on our staff being part of their meeting structure. (...) [But] we still need to meet as directors (...) [and so] we would maybe meet (...) to review the Memorandum of Understanding, or any high-level thing that really drives our relationship.

In one reported instance, a public health director was invited to participate in a school board' internal executive committees. As the public health manager pointed out, such integration provided an opportunity to bring greater visibility to partnership accomplishments:

We used to have senior admin meetings with the school boards twice a year, (...) but they fell by the wayside a number of years ago because it was difficult to bring those people all together for it. But then, the school board had this [well-being steering] committee that was already meeting. (...) The opportunity [has now come] for our director to sit there and hear what's going on related to topic areas that we're working in and also to be able to give them information on what we actually do for healthy schools. (...) So, it's given us the opportunity to say 'This is what we're actually doing. Here's the relationship we have with your curriculum consultants and we do these networking meetings and we go into the schools and provide these supports. (...) So, it gives a voice to healthy schools and they can see the amount of work that is being done that they didn't' necessarily know.

In certain instances, the integration of public health leaders also took place within school boards' internal executive committees. Whether at the executive or programming levels, public health professionals who became standing members of school board committees, and sub-committees, saw their school health

partnerships make advancements to a lesser or greater extent depending on the degree to which meeting agendas were able to accommodate partnership-relevant discussions. There were instances where the public health representative was present as a reference source to provide updates or information upon request, rather than engage in any partnership-specific planning at the school board level, as in other school health partnerships.

Multi-year strategic plans were usually finalized through executive-level meeting structures. Across the province, school health partners' multi-year strategic planning cycles were unlikely to coincide. Establishing a committee structure at the top partnership level to engage in joint strategic planning afforded a means of circumventing this misalignment. As an advanced partnership-specific structure, an advisory group for multi-year strategic planning was established within one extended school health partnership to inform leaders' decision-making process, guide annual operational planning by another interorganizational group of professionals, and ensure the evaluation of implemented plans. As the public health manager explained regarding their participation in this advisory group:

I just had my advisory group meeting, (...) [where] we have agreed that we're going to develop our three-year strategic plan [together]. (...) That's a new structure for us, since our healthy schools declaration. The advisory group is the strategic group, (...) [overseeing] the operational group. (...) The advisory group is our new layer [for our school health partnership] (...) mutually decided upon by the directors of education and the medical officer of health (...) [for] being able to advance our objectives. (...) What we ask [our school boards] is to provide the best person that they feel has the decision-making ability, or at least the ear of the decision-maker, whether that be a superintendent or DOE [director of education]. And they sit on that group, the advisory group, to be able to jointly make decisions in order to plan, implement and evaluate our outcomes.

The abovementioned arrangement was the result of establishing the value of a public health perspective during strategic deliberations to meet ministerial expectations of improved student well-being. Another possible driving force behind integrated meeting structures for school health partnerships was a decline in capacity levels over the years. A public health manager reported that their organization no longer had the resources to provide support to all of the schools within their catchment area, and therefore, the consolidation of strategic planning efforts at their partnering school board's leadership table was seen as a way to alleviate this capacity gap:

Because of the way we were structured—the nurses were in the schools—things would happen because of that relationship at the school level. But it didn't start at the top and come down; it was more grass roots. (...) It's probably going to be a mixture of both. We don't have the

resources any more to be in all of the schools and so we're going to have to look at it through working with the boards and think how we can implement [the healthy school approach]. (...) We're going to be (...) supporting it more at a leadership level.

(ii) Liaison meeting structures:

Another key interorganizational meeting structure was the liaison arrangement, in which a point person from each partnering organization was assigned the duty of liaison. These liaisons established a stable line of communication amid a variety of partnership activities that were being undertaken across the school board's district. Liaison meeting structures could be established for either an extended or dyadic school health partnership. The liaison meeting structure provided a consistent means through which to establish fluid interorganizational communication that brought together the right people at the right time and enabled relevant and meaningful cross-sector engagement.

An advanced liaison meeting structure involved frequent engagement between the public health liaison and a school board decision-maker, taking on a liaison role for their school health partnership. For example, one public health unit arranged for their liaisons to engage with a senior member of each of their main school boards' administration, as the liaisons from the education sector. Interacting through various means (i.e., in-person monthly meetings, phone calls, emails), these liaisons would be fulfilling the role of conveners, orchestrating cross-sector engagement among various other partnership actors to work either on school board priorities or compatible public health priorities. As one of the professionals at this public health unit indicated:

Some of the things that we're in discussion about would be priorities of the school boards and them wanting to involve us and collaborate with us or get our health expertise on a particular issue. And sometimes it goes the other way, where the health unit has identified priorities and would like to run a particular initiative in the school setting or would like to address a particular topic of public health importance. (...) [Our core structure] is a liaison nurse working with an assigned person at the board they are partnered with. (...) So that's an ongoing partnership that exists, and then where there are opportunities to bring in other representatives from the school board or from the health unit to collaborate, we are able to facilitate that through that ongoing partnership.

In addition, these liaisons were serving in two other capacities. As internal connectors, they provided assistance with navigating their respective organizations, and as primary contacts, they would be framing partnership opportunities in relevant terms to increase other school board decision-makers' receptivity. As another professional at this public health unit further explained:

There's work done behind the scenes and then there's work done at the level of the liaison. (...) It's a dialogue between [the liaison person at each agency] around anything really, but if we took it from an initiative perspective, then they might be discussing, 'Okay well the health unit has this particular item or issue that they want to move forward', and (...) [so] they might [say], 'You may want to connect with this person.' (...) [Or] they have this open dialogue, 'It's relevant for health because of this, but how do we make it relevant for education?' (...) [It would be] about making sure that it's framed in a way that it's relevant to the education sector, that it fits in with the Foundations for a Healthy School, or the School Effectiveness Framework, or a number of different items. (...) That kind of conversation can happen at that liaison level so that you can provide that information back to the program team. (...) [And so,] when it goes out to the board, broader than just the contact [school board] person, it's meaningful.

The one-on-one liaison structure provided the means to hold open dialogue about preliminary ideas that public health professionals had for possible partnership work, in order to bring further refinements to their partnership proposals and make them more appealing. At another school health partnership, one-on-one liaison meetings were equally valued but occurred less frequently since the public health liaison had been integrated into the school board's internal well-being committee as a standing member.

In this extended school health partnership, the liaison structure provided the means to hold open dialogue about preliminary ideas that public health professionals had for possible partnership work, in order to bring further refinements to their partnership proposals and make them more appealing. At another school health partnership, liaison interactions were equally valued but occurred less frequently since the public health liaison had been integrated into the school board's internal well-being committee as a standing member.

Holding a senior position at the school board, with decision-making authority, was thought by some public health professionals to be a major advantage in a designated liaison. With their school board liaison occupying a position of authority, they felt that action items could be moved forward more quickly. Other public health professionals were able to have good partnership experiences, even when the school board liaison was not a decision-maker. They found that curriculum consultants or mental health leads were helpful as primary contacts for addressing their concerns, or questions, and as internal connectors, especially when allowing greater access to school board executives. As a public health manager reported, their partnering mental health lead could fulfill all three roles of a liaison, including that of a convener to help seize opportunities for cross-sector engagement with other school board representatives:

[Mental health leads] know the people that you need to contact. If [these mental health leads] are not the people you need to be talking to about a specific issue, they can direct you to [that person] or they take your issue where it needs to go. And then hopefully it gets dealt with or your question gets answered or they help you navigate each of their [school boards'] respective systems. (...) And this could possibly lead to other initiatives. (...) [These mental health leads] could assist in contacting the right people who have that particular program in their portfolio to see if there are opportunities to work together.

A person in a liaison position would be assuming all three possible roles that a point person could undertake: internal connector, primary contact, and convener. An additional liaison function, for a public health unit, was that of progress reporting to nurture the connection through reminders of partnership benefits. Fulfilling this complementary function, the public health point person may be teaming up with one or more other public health professionals to carry out the data collection and analyses. As a public health manager recounted:

When we give [our school boards] a report at the end of the year, 'Here's how we've helped make your schools safe. Here's how we've helped your leadership strategy grow'—(...) the things that are important to them, they love that. (...) So as not to forget all the accomplishments that happened throughout the year, we package it all nicely at the end of the year. Right now, there's common themes around mental health, safety, (...) [and physical] health because of the Auditor [General]'s report around nutrition and physical activity. So, if we know that's important, then we focus our energies on that.

A school health partnership's liaison structure, with its engagement-promoting and reporting functions, provided the means through which partnership activities could be initiated and valued. Although this liaison structure initiated cross-sector engagement, it was not the main way through which school health partners worked together. The actual partnership work was carried out through a variety of committees and working groups, as presented below.

(iii) Mid-level interorganizational meeting structures:

Within the same school health partnership, different mid-level interorganizational meeting structures may be established to carry out networking, cooperative and collaborative arrangements for various health-related topics. These meetings would not necessarily be initiated through a liaison structure. For example, as part of certain school health partnerships, a group of public health mid-management and program staff and a group of school board representatives would meet through networking-type structures where the purpose was to come together and share information only, while any required partnership planning activities would be conducted through other meeting structures.

Generally speaking, annual operational planning and action planning with partner input were being done through committees and working groups, respectively, if not undertaken less formally through scheduled meetings. Formal committees were either jointly established, with a co-chair from each sector, or they were set up as internal meeting structures hosted by either the public health unit or school board. Partners were presented either as standing members or invited participants. Whereas some partnership-relevant committees were permanent structures, other committees and working groups were assembled and dissolved as partnership work was initiated and then completed. Such interorganizational structures tended to have a fluid membership, whereby the right people would be convened to perform whatever partnership task was required at the time. In committees with a broad membership that included various community partners, the coordination of services was a particularly critical task for achieving more efficient service delivery across the school board's district.

Besides this advanced partnership-specific structure, other structures that were rather internal to the school boards provided means through which to focus partnership activities. With a growing emphasis on student well-being, school boards had started to establish permanent well-being committees. In some instances, public health representatives attended committee meetings as invited participants, and in other instances, they were asked to serve as standing members. As one public health director explained, regarding their public health staff's integration within school board committees:

We used to have a joint working group/committee and that went on for quite a few years where we had reps from the [school board], we had reps from the health unit, we had a couple of other reference people. (...) [And] we would all come together and start talking about how we would do things together and we would bring that agenda up to the directors [of education] to say, 'What do you think?' The tide has changed because I think the school boards are now looking at their health and well-being committees with a bit more robust perspective and they wanted us to join their committees instead of having us have a separate joint one.

With a growing emphasis on student well-being, school boards had started to establish internal well-being committees. Of note, public health professionals spoke about recent reorganizations of school boards' meeting structures to integrate the operational planning of various well-being efforts that school board personnel were themselves carrying out in order to produce greater coherence under one umbrella strategy. This structural reorganization was reflected in the Ministry of Education's strategic initiative called the Well-Being Strategy, and its four main strategic areas: Equity and Inclusive Education; Safe and Accepting Schools; Positive Mental Health; and Healthy Schools.

In certain instances, partnership work related to this Strategy was being carried out through an overarching committee, for efficient planning, and through subcommittees, for more focused planning deliberations. This overarching committee was established as either an internal or external structure relative to the school board, but with similar functions. At one school health partnership, the school board partner was in the process of forming an interorganizational committee whose membership would include representation from key community partners who could oversee all activities falling under student well-being for greater efficiencies. As the public health manager reported:

[Our Healthy Schools steering committee,] that's where [we] get to strategic planning. That's where the discussions happen, (...) [about] goals. (...) Now well-being has already been defined by the Ministry of Education as [these] four strategic components (...) that look at student well-being. [The school board] had then thought about integrating all these committees that we sit on into a big one, and then subgroups—like integrating [safety], [equity and] inclusion, mental wellness, healthy schools, all into one. (...) [This is] because they're doing similar work that's all leading to student well-being. (...) [There may be] some good indicators that we can look at as a collective, and then prioritize our work, (...) to see what are some common things that we want to work on together, because they're all leading to student well-being.

This school board's healthy school steering committee included public health representatives as well as the mental health lead, whereas their mental wellness steering committee's membership encompassed multiple external stakeholders in addition to public health representation. These interorganizational committees were to be transformed into sub-committees to be guided by a higher-level internal well-being committee, also with a cross-sector membership.

(iv) District-level meeting structures:

Public health professionals commented that school boards tended to organize meetings with all of their principals on a regular basis, even monthly. They felt that principals' meetings could serve, or have served, a very important function of providing a convenient forum through which to convey the availability of local public health assistance with all aspects concerning healthy schools. However, not all principals' meetings that included public health presentations resulted in cross-sector engagement at the school level. One public health manager pointed out that a series of meeting occasions, across the many interorganizational levels, would be necessary for messages of public health support to eventually take hold, especially when school system actors were being inundated with information and their attention was being spread in many directions.

Besides networking, public health units could contribute planning input to many schools within the same time period by attending district-level planning meetings. Certain public health professionals reported that arrangements had been made for them to be consulted during district-level school improvement planning sessions, with groups of school personnel. While participating in this type of meeting, groups of either principals or teachers made use of public health professionals' data and expertise when determining whether any adjustments or additions to their school health priorities would be worthwhile. Discussions also centered around appropriate strategies and initiatives to tackle these priorities with public health resources. This school board-organized school improvement planning process led to opportunities for further engagement at the school level, where more focused planning meetings could take place. As a public health manager stated:

Some of [the schools] came thinking they're doing one thing, but when we displayed the data, which drive what we do, they realized they needed to focus somewhere else. So, some of them changed their plans, or it broadened their plans. (...) Most of the goals of their school improvement plans do fit within our health promotion mandate. We offer [school-level] assistance in areas where they do overlap, and link them with community partners who can also help.

In one particular extended school health partnership, school improvement planning meetings, with public health participation, was being co-organized at the district level twice a year. The coterminous school board executives and their common public health partner regularly hosted breakfast events to gather all principals in one place, and together, explored possible future directions for the student well-being portion of their improvement plans. They would also take this occasion to problem-solve implementation issues and celebrate school successes. Further meetings could be held at individual schools to refine their improvement plans with the assistance of their assigned public health frontline staff.

(v) Ground-level interorganizational meeting structures:

As with school boards, local public health units engaged with their school partners through scheduled meetings, committees, and working groups. In certain school health partnerships, public health frontline staff, whether nurses or health promoters, were being assigned to specific schools to meet with the principals and determine what health promotion areas they could work on together. Depending on what needs had been detected, these public health professionals would arrange additional planning meetings with available school-level actors, if they were not already standing members of school committees. In keeping with the six-step healthy school process, meetings to develop school health plans were preferably

structured through school committees, with public health facilitation support. As a public health manager explained:

Using the healthy school approach, one of the steps our school health nurses (...) [undertake] is ensuring there is a health committee (...) to work on the identified health topic. This is the same as a health action team. At the school level, these committees can be called numerous different things. Every committee at every school acts differently. (...) The school health nurse advises the committee on the steps of the healthy schools approach and facilitates the process.

School committees went by various names, including health action teams, healthy school committees, and healthy school clubs. For committees with a broader scope, they may simply be referred to as school councils. Across a school board's district, individual schools may or may not have established specialized committees to work on the student well-being component of their annual school improvement plans. However, public health professionals felt that a healthy school committee would be beneficial, especially as a means to fulfill the student engagement requirement promoted by the healthy school approach.

Regarding the healthy school process, public health professionals stated that school committee membership would ideally be composed of an administrative champion (e.g., principal or vice-principal), teacher champions, other school staff (e.g., guidance counsellor, social worker staff, etc.), a public health nurse/health promoter, students, and possibly parents and other community partners. Although this type of meeting structure would be fostering cross-sector discussions, schools made the final decisions concerning their school-led plans to promote students' well-being. However, these plans could be supplemented by public health-led school health plans.

An additional structure for possible cross-sector engagement was the parent council, also called parent advisory committee, at the school level. In certain instances, public health frontline staff and dietitians had been invited to attend these meetings on a regular basis, as standing committee members. When schools did not have a school committee, or their committee did not include external stakeholders, public health professionals' attendance at parent committee meetings was particularly appealing to them. This type of meeting afforded them opportunities to find out what health-related activities were being planned in the school so that they could know what assistance to offer. Furthermore, parent councils constituted a convenient forum through which to communicate to parents useful and reliable health-related information for influencing children's behavior.

(vi) Shared workspace structure:

In a few school health partnership dyads, innovative interorganizational meeting arrangements had been put in place to ensure regular cross-sector engagement through which to cultivate closer partnership ties. School boards had agreed to allocate part-time workspace within their central offices to their public health liaisons. These liaisons would perform their regular duties at their partnering school boards' central offices, a few days per week. According to public health professionals whose partnerships had such an arrangement, shared workspace enabled casual impromptu conversations that helped build steady relationships with school board representatives. It also fostered a greater understanding of their partnering school boards' organizational cultures, thereby allowing them to respond to needs and priorities in a more culturally acceptable manner.

(vii) Inter-unit meeting structures:

Public health units in extended school health partnerships recognized the importance of creating regular opportunities to engage with one another through a formal inter-unit meeting arrangement. Some public health units had more success in formally meeting with each other than others did, for more satisfying partnership experiences. For example, one public health manager spoke of a shared interest among partnering public health units to present a united front when meeting with their common school board partner, although finding the time to do so proved to be difficult. It was thought that greater progress could be made by establishing a regular inter-unit meeting structure through which to regularly explore points of commonality and then discuss these points with their partnering school board either through the lead public health unit or with all public health units represented at the partnership meeting. In spite of working with different levels of capacity and different service delivery models, they planned to find ways of advancing their partnership with the school board that they shared.

At another extended school health partnership, the partnering public health units would routinely meet with their common school board partner to discuss partnership opportunities, and then hold additional inter-unit meetings to better align and coordinate the delivery of similar services, whenever possible, with ongoing communication. As the public health professional mentioned:

When we meet with the school board, the other health unit is present as well and there's an ongoing partnership between the three agencies. (...) [Our relationship with the other health unit], that's been ongoing, and it happens in opportunities that the school board presents. When we have health meetings both health units are present. So that helps to establish that relationship. And then there's a coordination that happens just between our two health units.

Whenever we're planning initiatives that we'd like to undertake with the support of the school board, we do that connecting back and forth or even just keeping each other in the loop, so sending communications and making sure that the other health unit is copied—[so] if our health unit is planning something specifically for the schools in our area, informing the other health unit of that and vice versa.

(viii) Community-based meeting structures:

Public health and school board representatives occasionally crossed paths in the broader community, when finding themselves at the same community table, as part of a multi-stakeholder network, a community coalition, or a community-based project committee. Participation in these community-based meeting structures led to additional school health partnership opportunities in three different ways: (1) by raising public health professionals' awareness of school boards' issues and needs, when brought up during group discussions; (2) by having side conversations to be followed up through their own partnership meeting structures; and (3) by working together on one or more components of community-based initiatives to be implemented within schools.

For example, the Healthy Kids Community Challenge provided community partners with a funding pool, through which health promotion initiatives could be delivered in schools, as well as within the broader community. As a public health director pointed out, regarding school health partnership opportunities:

[Our school boards] right now are all implementing [the Healthy Kids Community Challenge project] and they sit at the steering committee level with us. So physical activity and healthy eating are our priority and [all of our main school boards] have been very good about jumping in. And in most cases, it's been them working with [our public health managers and their] team in school health. So, we provide the expertise, the messaging, some of the resources, and then their facilitating that (...) out to their schools. So that is what is happening with Healthy Kids, that would be probably the biggest health priority.

b. Formal written agreements

School health partners sought to document their agreements to give more substance to their cross-sector engagement process. In certain school health partnerships, a formally written partnership agreement was supplemented by a data-sharing agreement and a communication protocol. In other school health partnerships, data-sharing and communication arrangements were formalized as stand-alone documents in the absence of a written partnership agreement.

(i) Partnership agreements:

A formally written partnership agreement, known as a partnership declaration or a memorandum of understanding, recorded the school health partners' intentions in pursuing cross-sector engagement and provided certain assurances in moving forward with their school health partnerships. A partnership declaration was a brief statement of intent that made explicit each school health partner's commitment to taking on certain partnership structures and processes. In the form of a memorandum of understanding, a partnership agreement could be more elaborately stated, putting in writing what the school health partners were committing to do together, as well as other pertinent partnership-related information. In its most advanced form, the partnership agreement documented the arrangements that had been made for a collaborative partnership, including provisions to engage in joint strategic planning.

Public health professionals expressed mixed views about the necessity of formalizing their school health partnerships. The matter of whether or not to prepare a formally written partnership agreement, and what would be the content of such an agreement, was closely tied to relationship considerations. In less advanced school health partnerships, public health professionals who aspired to enter into a formal partnership agreement that went beyond service provision, felt that the relationship with their local school boards was not developed enough to proceed with formalizing their partnership with a broader scope of engagement—one that included strategic planning tasks. In contrast, there was no impetus to proceed with the formalization process in other partnerships precisely because the relationship between school health partners was deemed to be very strong and there were already collaborative arrangements firmly in place, without the need to rely on a written agreement. For example, one public health unit felt that relying on the strong relationship they had with their school system partners was what really mattered, because regardless of any formal document, they still had to come together and share their perspectives so as to continuously reaffirm their common understanding about what their cross-sector engagement meant to them. The concern that relationship building efforts would be diminished within a formalized partnership arrangement was also expressed.

Viewed from yet another angle, one public health unit found that the process of formalizing their school health partnership afforded a greater opportunity to clarify intentions. It spurred deeper conversations around what could be done together to support each other's health promotion efforts, thereby developing the relationship further. As the public health manager stated:

[Our directors of education] are interested in formalizing it and it's going to be much better for us. I think it's going to be easier for us to get on the agenda of principals' meetings, [and] their senior admin team meetings. Our memorandums are that specific. (...) They also include specifically how and when we will plan together and what we'll talk about and that sort of thing. (...) So far, [it's been] in the creation of the agreement that the relationships are further developing. (...) I think there's more awareness about how we can support the schools on their own objectives. We do have overlapping goals around student wellness. (...) [And so, it's about] letting them know that we're willing to work in a way that helps them meet their needs rather than just pushing our agenda.

Where there was a fair degree of collaboration already underway, some public health professionals saw the process of formalizing their school health partnership as a means to explore ways of collaborating even more. On the other hand, other public health professionals felt that, even though agreements on collaboration may have been on paper, other types of interactions would be required to translate these agreements into a partnership reality, such as establishing the actual structures and processes that would be necessary for engaging in joint strategic planning.

School health partnerships were at different stages of advancement, and each partnership dyad was progressing at its own pace. Overall, public health professionals gave a number of reasons why they felt a written partnership agreement with their school board partners could be advantageous. According to them, the process of jointly preparing a well-crafted agreement could:

- Create a valuable opportunity to jump start meaningful conversations about working together more collaboratively;
- Clarify roles and responsibilities for a better understanding as to what supports the public health unit had to offer and what supports they could count on receiving from their school board partner;
- Instill greater confidence in public health frontline staff when approaching school administrators with their offer of support, in the absence of a shared partnership mandate;
- Preserve corporate memory around prior partnership arrangements, especially during times of leadership turnover;
- Articulate formal procedures to effectively identify school champions;
- Specify arrangements for integrating services and avoiding duplication of efforts to ensure a more efficient use of resources; and
- Authenticate commitments to enhance resource-sharing and joint strategic planning opportunities.

(ii) Data-sharing agreements:

Public health professionals considered data-sharing practices to be indispensable for well-performing cross-sector engagement. These practices were undertaken either through verbal or written agreements. Data-sharing agreements could be formalized in various ways: as an integral part of the partnership agreement; as a stand-alone memorandum of understanding; or as part of a school board's ethics review process, giving approval for public health units to collect school-based data on a case-by-case basis.

School health partners prepared written data-sharing agreements to receive data from their respective sectors. While public health units committed to providing all relevant surveillance data and program evaluation data, school boards in some instances formally granted access to their student survey data, including data from the Climate survey, with the potential sharing of school improvement plans as well. In certain school health partnerships, written data-sharing agreements included official school board support of school-level data collection by their partnering public health units, to conduct school assessments or student surveys. Public health professionals relied on formal agreements to obtain the data necessary for program development and evaluation. A formalized data-sharing agreement was particularly required when the public health unit and school board, or an individual school, decided to engage in the evaluation of a joint school health program or jointly implemented health promotion activities.

Public health professionals relied on these agreements to obtain the data necessary for program development and evaluation. One public health manager stated that their formally prepared data-sharing agreement allowed their organization and their school board partners to use one another's data for their respective strategic planning, with the potential for planning strategically together. A formalized data-sharing agreement was particularly required when the public health unit and school board, or an individual school, decided to engage in the evaluation of a joint school health program or jointly implemented health promotion activities.

(iii) Communication protocols:

A communication protocol was found to be useful as a written agreement between school health partners regarding the establishment of clear, efficient, and consistent communication channels. Communication protocols could be prepared in various forms: a comprehensive contact information list to be routinely updated and circulated; a stand-alone memorandum of understanding for communication; and an

integral part of the partnership agreement. In its more detailed form, it provided school board instructions as to what processes had to be followed for making requests; distributing information; obtaining approval for school health initiatives; and delivering these initiatives in schools.

Mainly, communication protocols enabled each partner to know whom to contact for a variety of cross-sector engagement purposes. The number of main contacts from the public health unit and the school board listed in these protocols ranged from one point person, representing each partnering organization, to several contact people. Based on public health professionals' partnership experiences, an individual who had been assigned the duty of a point person within their organization took on one to three distinct roles, namely internal connector, primary contact, and convener. As internal connector, the point person connected their partner with the most suitable person within their own organization for direct interactions. Assuming the role of primary contact, he or she communicated with their co-workers to address their partner's questions or issues on their behalf. Serving in the capacity of convener, the point person not only directed the communication to the right partnership actors within their organization but also ensured that a meeting took place for a greater likelihood of further cross-sector engagement. Acting as a liaison, the point person assumed all three roles.

7.3.2 Leadership to drive and facilitate cross-sector engagement

From the public health perspective, active engagement by executives at the top-partnership level, as well as school health champions at the school level, provided the primary leadership for making major partnership advancements. Public health professionals felt that the medical officer of health, along with the public health director responsible for health promotion (where applicable), and the school board's director of education and the superintendent responsible for healthy schools, all had a pivotal leadership role in driving and facilitating engagement at the other interorganizational levels. In advancing their school health partnerships, top leaders prepared a path for joint strategic planning, and encouraged exploratory meetings between the principals and their local public health representatives. School health champions played an especially vital role in making strides toward creating healthy schools.

The top leadership was seen as instrumental for taking action on partnership opportunities. As a school health coordinator emphasized, the level of authority held by the school board contact represented the degree to which opportunities to work together could be seized with ease:

It is the level of decision-making capability of the school board representative that has a direct impact—the higher the decision-making authority, the easier the identification of mutual interests and capability to mutually move forward on those interests.

Public health professionals spoke of three distinct partnership areas that had received, or that required, focused attention from top-partnership leaders. The first area concerned the establishment of a joint strategic planning system to drive the school health partnership. This important leadership function entailed creating structures and processes for the preparation of partnership-specific long-term plans and for integrated school health planning at the school level. High-level partnership plans, such as the adoption of a resiliency-building strategic approach, served to direct the development of districtwide school health initiatives for tailored delivery in receptive schools. As a parallel planning process, the integration of public health units' and schools' operational planning for improved student well-being as part of school improvement efforts had started to take place in certain school health partnerships. The leadership of school board executives had begun to open the door for greater engagement between public health professionals and school personnel through their routine district-level group planning sessions. Where such an event occurred for the first time, it was viewed as a culture shift. Follow-up partnership activities in school improvement planning for student well-being naturally took place, once the personnel returned to their individual schools.

The second area dealt with the inherent difficulties of working in extended school health partnerships, in which multiple public health units that shared a school board would be operating through different service delivery models and at different capacity levels. Top leadership engagement was felt to be advantageous for strategizing ways of working more effectively together. One public health manager commented on the practical value that would be generated by holding leadership discussions around partnership requirements that were common to all partnering public health units. Common requirements included the development of data-sharing agreements and the setting up of a mutually agreed-upon approach for engaging directly with schools on the healthy school process.

The third area pertained to the general need for top-level facilitation of cross-sector meeting arrangements with school administrators. Public health professionals commented that their health promotion efforts could be considerably eased by encouraging principals to meet with their local public health representatives and explore partnership possibilities. However, it was also understood that principals had the final say about partnership arrangements in their schools. As a public health director stated, *“As much as it comes from the top, and the director [of education] is saying ‘We endorse this framework of healthy schools,’ how it is supported within schools really depends on the individual principal.”*

Even though it was left to the principals to accept or decline partnership invitations, the active engagement of top-partnership leaders was still considered helpful when attempting to cultivate partnership ties. For example, one public health manager highlighted the importance of the school board leadership’s active engagement in organizing meeting events to foster conversations about creating healthy schools between public health professionals and school system leaders:

It does start at the top. You have to have the directors [of education] knowing the MOHs [medical officers of health], [and] you have to have the superintendents knowing at least one manager or director at the health unit, (...) if you really want systems change and system development. (...) The school initiatives, (...) [like the] healthy school certification program, can help move the school forward but really what has to happen is (...) the school board engaging the schools rather than individual public health nurses going around and trying to get the schools engaged. (...) [For that,] health units need to be engaging with the directors [of education], superintendents and principals at the school board level (...), directly. Each school board does it separately. (...) [For one smaller] school board, they have all the principals come together regularly. The health unit has certainly been involved in those meetings at some different intervals.

In certain instances, school board leaders facilitated cross-sector engagement in school improvement planning, at the district level. At least within a few school health partnerships, school boards had arranged to have public health professionals be present during school improvement planning sessions with groups of school personnel to help guide planning around student well-being. Where such an event had not taken place before, both public health and education professionals called it a cultural shift.

Public health professionals saw value in engaging with school personnel at both the district and school levels. Those in less advanced school health partnerships mentioned that they would highly welcome their local school boards’ facilitative leadership role in initiating opportunities to meet directly with principals

at their schools, thinking that these principals may have been so inundated with information that their meeting invitations could have simply gone unnoticed. Cross-sector engagement seemed to flourish in instances where school board executives directly sent the meeting invitations, as this may have increased the likelihood of attracting principals' attention. As the public health manager reported:

I sent an email letter (...) to each board superintendent and asked that they share with their principals to encourage them to meet with their designated PHN [public health nurse]. (...) The superintendents (...) are supportive of it all, and they said that they will send out [our] communication to their principals, which is great because (...) [I knew] for sure the principals will read it. (...) [And so,] they did this and we have had a greater uptake of principal-PHN meetings this fall.

As another point of consideration regarding the exploration of partnership opportunities, public health frontline staff were reported to have gained a sense of validation from school board executives' encouragement to seek permission to carry out school assessments for tailored public health support. As a manager at another public health unit commented:

[The healthy school process,] it's in the partnership agreement. It's part of the discussion around the [school board] table. (...) [The superintendent] is a very key element, because then when we are talking with the principals, we can definitely say that we have the support of the school board (...) [by referencing] our meetings with the superintendent. (...) In terms of those public health nurses talking with the principals, it would be more about the superintendent (...) [than] about this partnership agreement. (...) [So,] when [our frontline staff] talk to the principal, they would say to them, 'It's our understanding when our managers met with the superintendent that this is supported by the school board' (...)—doing a school assessment [as part of the healthy school process].

Although school boards' leadership role was seen to be important for partnership advancements, public health professionals pointed to another system requirement at the school level. Making headway with the healthy school process called for the cultivation of school administration champions and teacher champions to drive the promotion of student well-being within their schools and create partnership opportunities. As a public health professional noted:

It's a struggle to get [the healthy school process] implemented systematically throughout our region. I would say we have certain schools that are doing bits and pieces of it and doing it well, but we don't have it systematically throughout. (...) I think that's happening at those schools because they have a champion teacher or principal, more than that it is necessarily coming down from the school board level.

7.3.3 Time to engage in meaningful conversation

Time was one of the most critical factors determining the extent to which partners could engage with one another. School health partnerships basically ran on how much time was available to get to know one another and engage in meaningful conversations. Indeed, building a strong relationship was seen as a skill that required the investment of much time to accomplish. As a public health manager pointed out:

It's all about developing relationships first. If you don't know the people and can't pick up the phone and have conversations, I just don't see how you'd get started. I think, that's the art of partnership. We have the science now that backs up the need for partnership, but it's an art. And so, everybody has to recognize that it takes time. (...) And people need to put that as a priority, to continue to build those relationships and to get to know each other, and to get to trust, and all of that.

Time was an essential element that served many engagement purposes, in addition to relationship building through trust-enhancing interactions. As public health professionals stated, the more time that was allocated to cross-sector engagement, the more extensive the planning process between school health partners could be, thereby creating opportunities for collaborative partnership arrangements at either the school board or school level. On the subject of creating healthy school environments, they emphasized the need for school personnel to be granted sufficient time to apply the healthy school approach since it required direct engagement on their part.

7.3.4 Human resources to supply the necessary professional skills and expertise to carry out partnership activities

Within the context of school health partnerships, human resources consisted of the availability of staff from each partnering organization to carry out partnership work, along with the professional skills and expertise that they possessed to carry out that work. Public health units varied according to the size and composition of their workforce, owing to differences in funding and budgetary allocation decisions. The same applied to school boards. School health partnerships' strengths depended in part on the extent to which partnership actors could dedicate their time and pool their professional skills and expertise toward common or shared goals.

a. Staff dedicated to partnership work

All public health units employed a workforce that included staff whose positions were either fully or partially dedicated to school health partnership work, although the number and type of these positions varied widely across the province. Staff who were mainly active at the mid-partnership level included public health managers, program specialists/planners, epidemiologists, and/or school health coordinators/liaisons, who may also have been active on the ground with school personnel. In addition, all public health units had frontline nurses and/or health promoters who worked directly with schools. Assigning a public health frontline staff to a school enabled the delivery of a much wider array of programs and services. Some public health units had sufficient frontline staff to service every school in their catchment areas, while other public health units that could not do so had to look for strategic ways to enhance their cross-sector engagement in schools. As a public health manager mentioned:

It is a real gap that there are [a large number of] elementary schools in our board that don't get any PHN service. So that's something we're always looking at, how can we better support those schools. We can largely do that now by co-developing resources and supports with the mental health leads at the boards, [and] that's where the in-servicing comes in, at these [professional development] days.

Public health frontline staff directly worked in a variety of programming areas, such as healthy eating, physical activity, safe schools, mental health, healthy relationships, and the prevention of substance use, across a set of schools at varying levels of intensity. Especially in situations of limited public health staffing, the amount of time spent in each school would depend on their level of need and readiness for public health support, and how engaged these schools chose to be. According to public health professionals, the practice of assigning a public health frontline staff to specific schools was one of the best ways of raising awareness of the support they had to offer. They also commented that as schools got to know their assigned public health representative, they tended to reach out more for health promotion resources and for guidance with school health planning.

School boards had also hired professionals to work in areas entirely dedicated to students' well-being. Based on public health professionals' partnership experiences, the presence of mental health leads, and at times, health and physical education curriculum consultants, had significantly increased cross-sector engagement at the school board level, in certain instances. For example, with direct access to health and physical education curriculum coordinators, public health professionals reported that they were able to

participate in policy development; receive guidance with the preparation of curriculum resources; and be referred to other curriculum consultants to engage in inter-curricular health messaging activities. Additionally, the recently created position of mental health lead in all school boards had enhanced certain public health professionals' ability to contribute input into school boards' school health plans.

b. Expertise and skill set for specialized partnership activities

Public health professionals' skill set had evolved considerably beyond the traditional role of health protection services. Well-resourced public health units offered a widely diversified set of professional skills and expertise to supplement their school boards' capacity to promote student well-being. Their offer of support was not limited to fulfilling teachers' requests for health promotion material to meet curriculum requirements. It included a variety of specialized skills. As a public health professional mentioned:

[Our school boards] will search us out when they know exactly the type of areas where we can support. So, when they need our support with the PPM [Policy/Program Memorandum]—that's a very obvious one, with public health and nutrition—they'll seek us out. I think where we haven't yet got it down to a fine art is there potentially are areas that they've never considered that we could actually provide support to them because they either don't know that that's in our wheelhouse of areas that we could support or they're not sure that—even if we're not a content expert—we could bring certain skills to the table for them, [such as] facilitation, strategic planning, research and evaluation. I can tell you because we have smaller school boards in this area and maybe [for school boards in] Toronto it's quite different, but I'm not convinced, unless I'm just not overly familiar with them, that they have people at a board level that would specialize in data collection, research, evaluation of their program, continuous quality improvement.

As importantly, public health professionals used their relationship-building skills to link school boards with a variety of other content experts and community-based organizations from the broader community. Public health professionals placed much emphasis on their interpersonal skill set to cultivate community linkages in order to access additional resources to support school boards' improvement efforts.

Public health professionals' own content expertise could be particularly useful in the area of school health policy development to help ensure that all relevant viewpoints were being considered. As one public

health professional commented, policy input coming through a public health lens could increase school health policies' accuracy, completeness, and ease of implementation:

[Providing policy advice] is our job. We have the information and the best practice, and we have the knowledge about the health-related policies and have the knowledge of the needs of our community. (...) [Joint policy making] helps prevent some of the implementation problems that occur, and that also helps correct some misinformation that could go in the policy.

However, in the area of policy development as in other areas relevant to school health partnerships, some public health professionals openly expressed that they felt their skill set was being underutilized by their school board partners. When school boards did not have the capacity to conduct research on students' issues, undertake performance measurements, and evaluate school health initiatives, public health professionals stated that they could fill in this capacity gap. Conversely, when the school boards had a team of researchers on their payroll, public health professionals welcomed the opportunity to access these researchers' skill set and collaborate with them on evaluation tasks. As another public health professional stated:

[We] would like to do some measurement and evaluation on some of our strategies, and our larger board has access to a lot of resources that could support this measurement and evaluation. They have a whole evaluation team that could support this process in collaboration with us. (...) Whereas the other board is a lot smaller, and doesn't have such a team in place. They would be a lot more reliant on our resources (...) to support this process.

The larger school boards employed researchers to meet their data requirements, especially the collection and analysis of student survey data, which could be made available to public health units as well. Access to school board researchers offered an additional advantage to public health units. Having these researchers conduct the evaluation of school health initiatives on their behalf would ensure a more accurate appraisal of their services. As one public health manager pointed out:

[Our larger school board] employs researchers. They do a lot of evaluation work for the school board. In our area, they coordinate many of the data collection surveys that go out across the board. So, they do (...) [for example,] the Tell Them for Me Surveys, and then those research staff coordinate the analysis and integration of that data back into practice. (...) They are board employees, though they are not educators. They have a research background and they proposed doing the administration of the [evaluation] questions, as well as the recording of the responses versus us doing that just so (...) we would make sure that that wouldn't be diluted by our recording or presence in that. (...) [And then,] they will be sharing that data with us.

Whether or not school boards employed researchers, other key personnel such as their mental health leads and curriculum consultants provided a source of valuable expertise in their respective professional fields for partnership work. Public health professionals commented that they relied on these school board representatives' own content expertise and know-how when developing their school health resources for schools.

7.3.5 Material, financial, and data-related resources available to plan and implement initiatives

In addition to human resources in the form of professional skills and expertise (e.g., planning advice or guidance), cross-sector engagement relied on the sharing of basic material, financial, and data-related resources to plan and implement school health initiatives—referred to in this thesis as implementation resources. Within the context of school health partnerships, material resources included the basic educational material and other tangible supports that were necessary to put in place school health initiatives. Financial resources came from the provision of funds by either school health partner, or by both in instances of cost-sharing arrangements. Third-party funding may also have been made available through government sources or nongovernmental organizations. Data-related resources served to identify actual school needs as well as monitor and evaluate school health initiatives for the informed use of limited resources.

a. Material resources

Material resources used in school health partnerships consisted of all the basic physical types of resources that went into the development and implementation of school health policies, programs, projects, and other health promotion activities. These resources were being made available for various purposes, such as undertaking awareness-raising campaigns; delivering school personnel's training sessions (e.g., professional development days); organizing youth workshops; supporting health promotion messaging through classroom curricula; and creating a school environment conducive to student well-being.

The material resources that public health units typically provided to school boards and schools to support health promotion efforts included the following: electronic documents, such as web-posted reports and

e-newsletters, post cards, fact sheets, and all printed informational material for dissemination; lesson plans, and other curriculum resources; classroom discussion guides; presentations and handouts for workshops; and educational videos. Additionally, healthy school planning toolkits were key resources developed to empower schools. As a public health manager stated:

[Our health unit is] developing toolkits related to healthy eating, physical activity, mental health and growth and development. The toolkit is a comprehensive set of evidence-informed activities developed by the health unit that can be integrated into the school improvement plan for implementation.

Regarding policy work, public health units offered health-related material for policy development, such as literature reviews, reports on community issues, reference documents from other community partners, and documentation on what had already been done in a given policy area by other school boards. Material resources that had been offered specifically for policy implementation included online modules, DVDs, and other training material.

Partnership-related material resources may have been developed by the public health unit on their own or in partnership with their school system partners. Basic material resources went into developing elaborate school health programs. Some of these finished resources were delivered to schools through public health nurses, or health promoters. Other finished resources could be used across all schools regardless of whether or not they had a public health frontline staff assigned to them, by building teachers' capacity to directly make use of these resources.

b. Financial resources

Besides human and material resources, additional funding to enable school health initiatives mainly came from the school boards. However, it had occasionally come from public health units and third-party grant competitions, as well. Furthermore, funding could be made available through cost-share arrangements.

Public health professionals reported that partnership decisions had at times centered around the sharing of certain costs for the delivery of school health initiatives, such as promotional material, French-language translation, and training, in addition to staff time. For example, a school board would purchase a third-party well-being program and their public health partner would have their frontline staff deliver it. In one school health partnership that was dealing with nursing shortages, school health partners pooled some of

their financial resources to establish a cost-share program of school-based public health nurses so that schools could have greater access to public health support.

Teachers' release time was another financial resource that enabled schools to participate in partnership activities through the hiring of substitute teachers. With release time, teachers could then attend partnership meetings, co-develop health-based lesson plans, or participate in skills-building workshops for school health initiatives. The necessary funding for the release time came either from the school board, the school itself, or at times, the public health unit.

Notably, partnership funding had served as a catalyst for undertaking the healthy school approach at the school board level. Even a small amount of funds had been sufficient to bring school health actors together to engage in the joint planning of healthy school projects. As a public health professional recounted, working on small-scale inexpensive projects afforded first-hand experience in applying the healthy school approach through a collaborative partnership arrangement:

What also helped a little bit [with collaborative engagement] at the board level [is that] there had been some funding. It wasn't a lot of funding. But it was projects that were funded that allowed us to actually come together and do some of that joint planning. And that's when we utilized the healthy school approach to plan the initiatives that we could then roll out in the schools. So, I think that has helped (...) [to have] some joint funding that we could work on.

Catalyst funding cleared the way for gaining experience with the healthy school approach. Although the investment was a modest one, it enabled school health partners to seize opportunities to jointly plan projects that would not have been possible otherwise.

c. Data-related resources

Data-sharing practices contributed to building the necessary capacity to establish well-performing school health partnerships. Data constituted a highly sought-after resource since the accessed data could ensure that school health partners' health promotion effort was being directed where it was mostly needed and was producing intended results. Under favorable circumstances, school health partners could avail themselves of two main types of data: a public health unit's population health surveillance data, and data from the local school system. The most advanced data-sharing practice was the establishment of a shared

measurement system by school health partners for effective joint planning. These data were used for school-based situational assessments and performance measurements.

(i) Population health surveillance data:

Well-resourced public health units had population health surveillance systems, including various datasets, that could provide valuable data to support not only their school needs assessments to guide partnership activities but also their partnering school boards' and school's needs assessments for their own planning purposes. Their local surveillance systems at times uncovered school-age children's well-being issues, as well as community-based issues related to the social determinants of health such as poverty, which could be addressed to a certain extent within local school systems. As a public health professional reported, adverse social determinants of health could negatively affect students' well-being and academic performance:

We have done a huge piece around child health status. So, looking at a lot of different datasets and types of information that contribute to a really detailed picture of the health and well-being of children in our community, taking that information and sharing it with the school boards in terms of how children are coming to school and what does that mean in terms of children being hungry when they come to school, children who live in poverty and its implication. Because there's some huge ramifications in terms of the learning environment with children who live in poverty.

Local surveillance data could be obtained either from the public health unit with sufficient capacity, or through school health partnership networks that had secured the necessary funding for data collection and analysis.

(ii) Local school system data:

Local school system data were being collected by school boards, schools, and public health units, either separately or jointly for knowledge production, in terms of situational assessments (i.e., school profiles), and the monitoring and evaluation of school health initiatives. When school boards did not have sufficient capacity to collect school-based data, their local public health unit could do it for them or in partnership with them—although joint data collection could still be undertaken regardless of capacity levels. Any available population health surveillance data would be combined with school boards' own data, when expressing an interest.

Partnership-relevant data from the local school system were being shared through various practices. One data-sharing practice by school system leaders consisted of granting public health professionals access to

schools and allowing them to collect data for their school assessments. Another data-sharing practice, considered as important, was educators' willingness to give their public health partners copies of available school-based data, including survey results on students' well-being needs, findings of school capacity gaps in this area, as well as board and school improvement plans. Sharing survey data tended to be at the principals' discretion. In one school health partnership, public health nurses would have access to these survey data through their work with school committees if it happened to be in a related area. The release of public health units' school health evaluation reports constituted a third data-sharing practice. Lastly, a fourth data-sharing practice concerned the joint collection of data for assessing needs and/or evaluating joint initiatives.

Public health professionals depended on data-sharing practices to adequately prepare their operational plans. School-based data were seen as essential for public health units' planning purposes to ensure that their efforts were well directed. However, data-sharing practices were not a routine occurrence within school health partnerships across the province, especially regarding the results of student health behavior surveys. Public health professionals' partnership experiences taught them that school boards, or individual schools, were increasingly more willing to share their data as relationships strengthened, and more trust was built.

As a very practical resource, a shared measurement system would be indispensable for enhancing school health partners' ability to work in a collaborative manner and make decisions together, based on evaluation results. As a public health manager pointed out:

I think education now understands and sees the value of health and so the timing is right just like any policy window to come into a joint partnership. (...) If we're going to jointly plan and implement, we have to be able to jointly evaluate (...) and report on our outcomes.

Anchored in the local school system, a shared measurement system would call for the joint collection of data for conducting needs assessments and prioritizing school needs. In one school health partnership, the periodic administration of student surveys was performed jointly. As the public health professional stated:

As part of our health unit's operational planning for school health, we'll develop indicators to help us monitor our progress on some of our school health objectives. We've got some data collection that we do in partnership with schools through the SHAPES and the Compass surveys. And then any additional independent activity that we do—because we really do quite

a number of health promotion activities in schools each year, probably over 100 with different schools each year—each of those have an evaluation component to it that then we can roll out. There is that expectation from the schools that we will do some evaluation of our activities.

Even with a shared measurement system in place for joint strategies or initiatives, supplemental data could still be collected by the public health partner for a direct evaluation of the school health initiatives that they would be leading, as the example above demonstrated.

(iii) Shared measurement system within the context of the broader community:

A second layer of performance measurement existed at the local community level to guide the planning processes of community-based partnerships and the evaluation of their health promotion initiatives for children and youth. As an extension of school health partnership activities, these tasks called for the establishment of a shared measurement system based on common indicators for directing efforts toward the same goal of improving the well-being of school-age children living in the surrounding community, including the schools where they learned and played. Partners from a few school health partnerships had been participating in larger community-driven partnerships, where agreements were in the process of being reached about building a performance measurement system that would be accessible to all key partnering organizations.

The catalyst for such an important undertaking was the adoption of the collective-impact approach to strategically guide large-scale community collaboration initiatives. Through such initiatives, local community-based organizations were partnering with public health units and school boards to have a greater effect on the well-being of children and youth in the surrounding areas. These community partners had come together to develop a shared measurement system through which to articulate clearly defined and measurable objectives in order to plan mutually reinforcing initiatives that could then be evaluated using common core indicators. This would give them the ability to align their strategies for more substantial results. As one public health professional commented,

I always think that we need to have opportunities for various ministries to collaborate on system development. For me that's what population health is about, how do you support system development across sectors. And I'm really interested in the collective impact [approach], how do we ensure that we actually have a variety of organizations working together to support the end outcome for really complex issues. (...) We already do a lot of collaborative work together. What I think collective impact allows you to do is to move toward that shared measurement system. We're not there yet, for sure, but what we're really trying

to come toward is looking at how you can have the various organizations share their data, that they are already collecting. (...) [With respect to privacy issues] right now, we're looking at data that is already analyzed. So, it's not that we are getting raw data, we're just getting data that is already available. (...) For me, collective impact is moving collaborative work to a more strategic direction to support outcome-driven results.

According to public health professionals, school boards participated in community-based initiatives on and off, depending on how much time they could spare amid their numerous educational pressures. Nevertheless, it was reported that school boards that had signed on to collective-impact efforts would still have access to the measurement system once built, and this in turn could further advance their school health partnerships for those strategies that would be actionized in a school setting.

d. French resources

When there was a broad overlap between the public health unit's catchment area and a French-speaking school board's jurisdiction, material resources had to be made available in the French language, given the large number of French-speaking schools being serviced by them. Other public health units with a relatively fewer number of French-speaking schools resorted to using French-language resources when possible from public health units that had the capacity to serve their local school systems in both official languages.

7.3.6 Knowledge acquisition practices to enhance understanding and decision-making abilities

Knowledge acquisition enhanced partnership action for the promotion of student well-being. Within the context of school health partnerships, knowledge about health promotion and the healthy school approach was imparted to increase partners' basic understanding, and develop their planning and implementation skills. Other specialized knowledge that was either produced or exchanged served to further sharpen partner's decision-making abilities for preparing school health plans and refining implementation steps.

a. Knowledge-imparting practices

Knowledge-imparting practices were referred to as training opportunities. These training opportunities were meant for gaining a better understanding of health promotion concepts and the public health role in school health efforts, including the healthy school approach, and for developing competencies in planning and implementing school health initiatives. Training was organized by either public health units, or school boards. Both educators and public health frontline staff benefitted from partnership-derived training to specifically put school health initiatives into practice. The youth received similar training as part of student engagement.

Training to engage in partnership activities was offered in many ways. Public health units delivered training sessions during school boards' leadership meetings, and during meetings with their central staff. In addition, they reached teachers through their professional development days for in-service training, and through more topic-specific workshops, with the support of their partnering school boards. According to public health professionals, not all school health initiatives required the direct engagement of public health frontline staff for delivery. Teachers were seen as the best implementers of those initiatives that could be integrated within classroom practices.

Through their school health partnerships, certain public health units were, themselves, requested by their local school boards to undergo training. At times, it was to deliver third-party school health initiatives in their schools. At other times, school boards' initiatives needed to be co-delivered, and therefore training invitations would be extended to public health professionals so that they could adopt the same language, or the same approach, as the education professionals within their local school system. By undergoing the same training, public health frontline staff could become a greater source of support in providing relevant guidance and additional resources during the implementation phase. In doing so, these newly trained public health frontline staff helped further build the comfort level of teachers so that they could feel more confident in putting into practice their budding school health skills in the classroom.

According to public health professionals, training was also being offered to student representatives as part of the youth engagement component of the healthy school approach. At youth-training workshops, the youth learned about health promotion concepts. Furthermore, they were taught how to plan school health initiatives that included activities related to the components of the Foundations for a Healthy

School framework for greater results. For example, a working group of public health professionals and mental health leads collaborated on a project to train youth leaders on the topic of positive mental health. Once trained, these leaders could then return to their schools and form mental health champion teams to plan and implement their very own healthy school initiatives for promoting their mental well-being and that of their classmates.

b. Knowledge-producing practices

Knowledge was not only imparted from one school health partner to the other, it was also produced. Public health professionals worked with school boards and/or schools to produce knowledge that could inform their respective or joint planning processes. Knowledge-producing practices included school assessments, monitoring and evaluation, and partnership-related opportunities to ‘learn by doing’ (i.e., process-related observations and reflections). These practices made relevant and sound planning possible for moving ahead with partnership activities.

(i) School assessments:

Public health professionals mentioned that their local school boards’ priorities tended to be broadly stated such that they could be addressed in a number of ways. Whenever possible, public health units conducted school assessments to tailor their school health plans to schools’ local context, culture, and actual well-being needs within their school board’s corresponding priority areas. School assessments were carried out by public health units to inform their own operational plans for initiatives that they would be leading in schools. However, assessment results could be used to support schools’ improvement planning process as well.

School assessments, also referred to as school profiles or situational assessments, uncovered both needs and strengths. Needs assessments aimed to reveal students’ specific well-being needs and related capacity gaps existing at all levels of the school system, usually around the beginning of the new school year. Student needs were identified for individual schools or for clusters of schools as part of trend analyses to look for patterns of need. Trend analyses were conducted across the broader community to detect prevailing health-related issues faced by segments of the school-age population. Trend reports offered a practical means to determine which areas of health promotion would be most worthwhile as a

school health partnership focus. In addition to conducting school assessments by the start of the new school year, public health professionals with open access to schools also assessed teachers' professional development needs and other capacity gaps at any other time throughout the year, either on their own or in partnership with the school boards or schools. These capacity gaps would then be filled as best as possible by developing appropriate initiatives and/or securing additional resources.

Whereas the results of needs assessments were used to set priorities within operational plans, the assessment of a school's strengths indicated their state of readiness to engage in partnership work, and the extent to which additional capacity was actually required from the public health partner. Strengths assessments centered on a school's current school health policies; the levels of interest, capacity and project momentum that could support partnership work; and supportive factors that already existed in the surrounding community. When public health frontline staff were in short supply, school assessments served to determine if a school was a high-need school that could gain from public health support. Numerous factors were taken into account when proposing to work together in partnership at the school level. As a public health professional pointed out:

The school health nurses, when they engage with their principals, they go through that front-end process of developing their school profiles for each school. So, it's part of their documentation process, but also their pre-engagement process. They do their research in the community, surrounding the school, the school itself, their policies, whatever they can find, both through their contacts but also online. (...) When looking at strategic planning for health promotion in schools, (...) that's where for me, it's our school health profile. (...) It's very much based on our nursing process where we do a needs assessment, we identify any issues, any gaps, any trends. (...) It's an opportunity for us to develop that relationship, that dyad with the principal, (...) [and] really identify what are their concerns.

The practice of conducting school assessments was seen as a vital aspect of public health units' operational planning. This practice included gathering data already collected by the schools to increase their ability to identify actual school needs. This knowledge formed the basis of their action plan. As a public health manager explained:

[The nurse] goes through the needs of the school and gets input from the principal in terms of programming and support needed from the PHU [public health unit]. (...) [The school assessment] also asks that they share any school data with their PHN that might be helpful. All of this information helps the PHN come up with an action plan, in consultation with [the healthy school team] for the school.

In certain cases, the public health unit or the school board carried out another type of knowledge-producing practice, referred to as a community needs assessment, which likely covered the other school health partner's input as member of the broader community. This type of assessment took into consideration the views of external stakeholders related to their respective mandates, with possible implications for school health planning. This practice was usually required for multi-year strategic planning at the organizational level.

(ii) Monitoring and evaluation of school health initiative:

The monitoring and evaluation of school health outcomes was a knowledge-producing practice that particularly served both adaptive planning and scaling-up purposes. School health initiatives were monitored and evaluated, either by public health professionals or by school boards that had the capacity to staff their own researchers. This practice was useful for finding out in a timely manner if initiatives needed to be modified or abandoned all together. Public health professionals relied on outcome measurement reports to make course corrections along the way in order to continuously improve their service delivery.

The practice of monitoring and evaluating school health initiatives ensured a more appropriate use of limited resources. It also supported decisions to widely implement a successful school health pilot project across a school board's district, and beyond. For example, one public health unit was granted permission by some of their coterminous school boards to pilot test a newly developed program to be delivered in classrooms. A positive evaluation report led to the widespread implementation of this program not only within the participating school boards but also within the other coterminous school boards that had not yet adopted it.

(iii) Learning by doing:

In addition to school assessments and formal monitoring and evaluation practices, valuable knowledge could be produced when immersed in action. Learning by doing was seen as especially appropriate for school health partners who had not quite grasped what the application of the Foundations for a Healthy School framework was all about. One public health professional suggested that full understanding of the healthy school approach may only come after spending a considerable amount of time actually applying it in their school setting:

[Principals] are likely starting to recognize [the Foundations for a Healthy School document] at the administrative level. (...) They might not really understand what it means quite yet, I think that's going to take a year or two of actually working with it to have the realization of what those domains actually mean.

The practice of learning-by-doing was brought to a higher level through experimentation with an innovative initiative. Indeed, one public health unit worked closely with their main school boards to stretch the range of partnership possibilities by stepping outside of the ordinary, and venturing into uncharted territory, where mistakes that occurred as a result of trial and error with a novel student well-being approach had been turned into learning experiences to further advance their partnership. As the public health manager recounted:

We create opportunities to work together, to strategize together and celebrate together any time we can. We share our successes a lot internally and externally and we learn from the mistakes we make, (...) [while] thinking outside the box. (...) [We're] not afraid to try new things and learn from it.

Within their supportive partnership environment, these school health partners dared to risk having the innovative initiative they were implementing not work out as expected, since they considered any seeming failure to be rather learning opportunities.

c. Knowledge-exchange practices

Formal collective learning opportunities within the same school health partnership, or across different school health partnerships, represented knowledge-exchange practices through which school health partners could sharpen their planning skills, and potentially improve their partnership arrangements through hearing about other partnerships' progress. Two key knowledge-exchange practices were experienced for enhanced decision-making abilities: joint problem-solving at the implementation stage; and participation in healthy school networking activities. These practices enhanced decision-making abilities by enabling school health partners to share success stories and lessons learned concerning the

planning and implementation of their school health initiatives. In this way, participants at these events could benefit from each other's 'learning-by-doing' experiences, and professional insights.

Joint problem-solving was undertaken as a type of collective learning to refine implementation plans. School health partners depended on each other's experiences and insights to learn about ways of overcoming implementation hurdles when delivering more elaborate school health initiatives. The possibility of jointly solving implementation problems was especially critical when taking on a healthy school initiative without much prior experience with the comprehensive approach to health promotion, or when implementing an innovative initiative that required a change in mindset. For example, in one school health partnership, school board executives and the principals who were ready to engage in a paradigm-shifting, resilience-building program would meet on a regular basis with their public health partner to learn from each other's implementation experiences how to make the program work as expected, while immersed in program activity. As the public health manager reported:

Sometimes there's way more involvement, it's problem-solving together. Like, right now we're having intense conversations with a whole bunch of principals who are saying 'I love this approach, I'm living it, but here are the glitches,' (...) [or asking] 'How do you get somebody to buy-in when they have a fixed mindset, or they're really not wanting to shift?' So, we problem-solve those things, with what they're encountering in the implementation of the program. (...) The outcomes and the successes are way higher when the school board is involved. (...) [And this] is more around trust and respect and believing it what we all bring. (...) The school board has to be there [to problem-solve] because we need to talk things through together.

As well, collective learning through knowledge-exchange networks was organized to enhance school actors' operational and action planning abilities. In certain school health partnerships, public health units joined their local school boards, and possibly other community partners, in establishing networks of principals and/or other school community representatives who expressed an interest in increasing their ability to apply the healthy school approach. Through this type of network, school representatives came together to share their experiential learning in support of each other's efforts to create healthy schools. As a public health manager indicated:

We also engage with [one school board's] schools through joint networking meetings. (...) [Through our joint planning committee,] we work with one board and community partners in the planning and implementation of Healthy Schools Network meetings. (...) We have [these network meetings] two times a year where we bring teachers, students and parents to learn about Healthy Schools, and to learn from each other on what has worked well.

Some school boards' jurisdictions were so vast that much variation existed across school clusters. According to public health professionals, these school boards would group representatives of schools with similar local contexts within the same "*family of schools*" to enhance the productivity of group discussions. This meant that a knowledge-exchange event would be organized for each family of schools. These knowledge exchange practices helped guide healthy school planning within each participating school, with the possible support of public health frontline staff. As a public health manager pointed out, the appeal of knowledge-exchange networks was the ability to explore possibilities for improving student well-being by learning directly from the experiences of other similar schools:

The steering committee, they've chosen a family-of-schools approach, so the superintendent that's part of that family, we discuss what are some key things we can do to motivate and initiate Healthy Schools amongst that family. We do some family of school-level activities, so the healthy school champions and [school] administrators get to network and have more opportunities to learn from each other. I think what was mentioned is, '[Coming together is] (...) more about learning what others are doing,' and from there, where they want to take it.

Beyond providing a means to build planning skills for implementation purposes, knowledge-exchange opportunities were considered beneficial for finding ways of improving current school health partnership arrangements. Greater competencies in strengthening school health partnerships may be gained by acquiring knowledge from those experiencing much success in this area. One public health unit expressed a desire to be mentored by successful school health partners across the province to fill a knowledge gap about how to generate productive partnerships through which to plan together. As the public health manager commented:

A lot of the conferences or knowledge exchanges are about particular programs or initiatives but less about the process, or the relationship building, or what are the key elements to successful breakthroughs. We do hear in other parts of the province where school boards seem to be talking about a healthy school approach and involving their health units more in the planning process, either at the school level or the school board level, so what were some of those processes, or best practices for that? And what were some of the key elements, did it require the MOH and the directors to have stronger relationships for that top down approach, or at the manager level? Or if there are examples where it's not working well, what else can be done? Different strategies? How can their ministry help?

Discovering how advanced school health partnerships came to be so strong was considered a worthwhile knowledge exchange outcome to inspire and encourage school board executives whose partnerships were not faring as well. As a public health professional commented:

If you look at some of the other school boards in Ontario or even across Canada, they are doing wonderful things and it's working. For [less advanced partnerships] to be able to see that and understand it, I think would be a selling feature. (...) Maybe it's about connecting different school boards' directors with each other. I'm sure they have some sort of network, (...) [but] it's probably just a discussion that doesn't happen at that table. So, if they already have an existing network let's get that on their agenda, 'Let's talk about what healthy schools looks like in your district.'

7.4 Continuity

Continuity elements embedded within school health partnerships maintain the momentum that motivated cross-sector engagement created based on the capacity that was made available through this engagement. Engagement continuity across the public health and education sectors was promoted through many ways: an emphasis on flexibility and adaptability to remain relevant and productive; ongoing communication to keep cross-sector engagement active and refine implementation plans; clear and bidirectional information flow to avoid engagement interruptions; consistency of partnership contacts to maintain close partnership ties and current partnership work; turnover management to reduce the effects of personnel changes on partnership progress; and commitment to perpetuate engagement between school health partners. It is by maintaining continuity of engagement that advancements within school health partnerships can be upheld.

7.4.1 Emphasis on flexibility and adaptability to remain relevant and productive

A flexible and adaptive approach to operational planning allowed school health partners to adjust their plans for a better fit with local school system realities. Through this approach, they took into account the local context, including capacity limitations; seized emerging partnership opportunities; and pursued continuous improvement efforts. By doing so, their cross-sector engagement could remain relevant and productive to the extent possible, based on available capacity levels.

a. Local school system realities

Public health professionals recognized that school boards set long-term strategic directions that were unlikely to change but their short-term priorities could be modified if warranted by newly accessed data. Likewise, they would keep their operational planning process flexible to be able to respond to school boards' needs or any unanticipated issue that could arise over the course of the school year, provided that it fell within their mandate and sufficient capacity existed. As a public health manager stated, it was much easier for them to adapt to the complex realities of local school systems than to expect school boards to alter their plans to meet their public health partner's health promotion interests:

I am far more comfortable saying that I'm less worried about us identifying our (...) [needs] because I think that in our negotiations about meeting [our school boards'] needs, it will be embedded. The reality is that the school boards' system is far bigger and more complex than anything we have. We can adapt to the schools; the schools don't need to adapt to us. (...) We'll find a way to meet our mandate within the work we do with [our school boards]. I think that's the reality.

By adjusting their school health plans in response to local school boards' intended course of action and emerging needs, this public health manager felt assured that, one way or another, their cross-sector engagement would be continuing.

Based on public health professionals' observations, not only did each of their school board partners function differently, but each school within the board's district had its own culture and operational preferences. This meant that local contexts had to be taken into consideration if public health support was to remain relevant. For example, the public health frontline staff at one public health unit modified their operational strategies and initiatives to fit each unique school culture in different but equally meaningful ways. As the manager representing that public health unit pointed out:

[Our public health frontline staff] take the time required to really understand the culture of the school and what is important to them. They then adapt their services accordingly. Together as a school community, they have been able to advance projects, outcomes and health, in a meaningful way. (...) We are also very aware that what works for one board may not work for another. Because we have deep knowledge of the [school] communities we work with, we have developed flexibility in adapting our work (...) to reach our goals and effect change—(...) flexibility in adapting based on current needs, not a one-size-fits-all strategy.

By trying out different strategies with different school boards and schools, public health partners maintained engagement productivity as they adapted to current situations and seized partnership opportunities as they emerged. They varied their strategies according to available resources, the degree of ease with which certain stakeholder groups (e.g., teachers, parents, students) could be mobilized into action, and other circumstances influencing their ability to engage with their partnering school boards and schools.

b. Continuous improvement

Emphasizing adaptability, public health units geared their health promotion efforts toward making continuous improvements so as to maintain school boards' interest in the school health partnership. For example, at one public health unit, service delivery strategies were adapted by relying on annual feedback loops as part of routine evaluation practices through which to capture partnering school boards' views about their concerns and preferences. As the public health manager reported:

We course correct throughout our involvement, whenever it's needed. It's important to be responsive to what shows up [in our evaluation results] and have the agility to adapt accordingly. (...) So, we definitely get their feedback, and we review those every year.

Through regular cycles of evaluation and adaptation, school boards received public health support that best suited them. Improving services based on school board partners' regular feedback kept partnership activities relevant.

7.4.2 Ongoing communication to keep cross-sector engagement active and refine implementation plans

Ongoing communication was carried out through the establishment of steady lines of communication to keep cross-sector engagement active for continued school health discussions and planning. It was also considered necessary during the implementation of more elaborate school health initiatives to improve coordination, address any hurdles encountered along the way, and facilitate the learning curve when implementation planning skills were still in development. When communicating on an ongoing basis, school health partners maintained the relationship at the basis of their cross-sector engagement; stayed

highly engaged in partnership activities; and refined implementation plans as school health initiatives were being delivered.

a. Maintaining relationships at the basis of cross-sector engagement

Ongoing communication was vital to school health partnerships for various reasons. However, public health professionals' main purpose for being in continuous contact with their school system partners was to nurture the relationships. As a public health manager asserted, it was by keeping the communication flowing that relationships could flourish and bring forward additional possibilities for working together in partnership:

When we say continuous contact, it's about constantly building and maintaining the relationship with (...) our schools and school boards. (...) If we don't have relationships with them, they're not going to think about us and pick up the phone and have a conversation about health or any other topic. It pays dividend when you've got good relationships, (...) because it's the relationship that provides the opportunities. (...) [So,] we need to keep in frequent contact with our schools and school boards.

One assured way of building and maintaining partnership ties with school board partners was through more frequent and personal communication, especially during operational planning. As another public health manager reported, close ties were cultivated as their partnering school boards' input was sought much earlier into their operational planning process:

We're trying to get a little more [personal]. (...) We just keep calling them, and they pick up the phone and they return calls and they return emails. Things are going pretty well right now. (...) [It's] to continue (...) building those personal relationships and also giving them more of a chance to input into the plan that we'd like to put forward—not necessarily coming to them with a final activity but talking about the idea and how that fits.

Rather than engaging mainly through back-and-forth email communications, this public health professional took on a more direct, personal approach of cross-sector engagement in order to enliven their partnership. When in-person meetings were not possible, frequent telephone conversations were considered a suitable alternative to creating a lasting personal connection.

b. Staying highly engaged in partnership activities

Ongoing communication enabled school health partners to remain highly engaged in partnership activities. However, the ability to communicate on an ongoing basis varied according to contextual factors. Urban public health units tended to be large and hierarchically structured, complicating the ability to know whom to contact and stay connected. On the other hand, rural public health units tended to have smaller workforce, but their personnel would be assigned multiple portfolios. Despite these constraints, some public health units located in rural settings communicated with their local school boards easily and frequently due to informal networks existing within their close-knit communities, where practically everyone knew each other. For other rural public health units, however, the situation was the opposite. Their ability to maintain very active levels of partnership participation was hampered because their attention would often be spread across many directions.

Steady channels of communication were not necessarily established in the same manner for school health partnerships that operated mainly in urban centers versus those that were largely run in rural areas. Nevertheless, designating a point person within each partnering organization, especially for urban or mixed urban-rural settings, had served as a productive cross-sector bridge to provide a direct and constant line of communication. To provide an efficient communication link, liaisons regularly communicated across their respective sectors through one means or another, keeping each other informed about health-related matters, and engaging in conversation on how to keep the partnership moving forward. At one public health unit, liaisons interacted through various methods every month to discuss a variety of topics relevant to the continued functioning of their school health partnership:

It's a dialogue between [the liaison person at each agency] around anything really, but if we took it from an initiative perspective, (...) it's about how to work together. (...) Those ongoing partnership meetings (...) are an opportunity to discuss a range of things that are happening related to health, on a month to month basis. (...) It depends on the board in terms of the structure of those meetings and how often they happen, but there's regular contact whether it's in-person meetings, by phone, by email, with those partners.

Point people provided a constant line of communication between partnering organizations. In their role as liaisons, they identified suitable partnership opportunities and brought together the right people at the right time to further develop these opportunities.

c. Refining implementation plans as school health initiatives were being delivered.

In addition to nurturing relationships and maintaining high levels of engagement, ongoing communication helped ensure that school health initiatives were smoothly implemented. Communicating regularly was seen as an integral part of monitoring the implementation process to detect and overcome hurdles. Possible refinements to the implementation steps could be discussed as they were being undertaken. Public health professionals commented that the implementation phase reached completion with greater ease through joint process monitoring and improved coordination, made possible through constant communication to uncover what was working well and not so well. For example, a public health manager mentioned that information gathered during the implementation of one of their partnership's school health initiatives signaled a need to secure additional resources to keep that initiative from stalling.

Regular implementation updates were particularly viewed as important when uncertainties clouded the practical application of the healthy school framework. Having just begun to work with the healthy school approach, one public health professional stated that their unit relied heavily on ongoing communication to facilitate their learning curve about how best to put into practice this approach, which was still unfamiliar to them:

This new [Foundations for a Healthy School] framework, in our work with individual schools, (...) is a shift for some health unit staff as to how we deliver our services. From the school board perspective, it is also relatively new. So, understanding the role of public health in implementing the framework will take some time. (...) Regular communication, and updates, to the school boards will help facilitate this process. (...) Communicating roles and expectations will help mitigate potential challenges.

Public health professionals found that steady channels of communication improved the coordination of health promotion efforts, helped resolve implementation problems as well as facilitated learning about what needed to be done and by whom for a smoother implementation of school health initiatives, especially those based on the healthy school approach.

7.4.3 Clear and bidirectional information flow to avoid engagement interruptions

Clear and bidirectional flow of information helped avoid engagement interruptions. In advanced school health partnerships, information flowed well from the public health unit to the school board, and through the school board down to the schools, with follow-up communications going back up the system. It consisted of well-established information dissemination channels, purposeful electronic messages, and prompt replies, as time permitted, so that cross-sector engagement could proceed as intended. At times, it included confirmation that any action request had been carried out. With this efficient flow of information, public health units reported that they were able to implement their initiatives in a well-organized manner; discover where additional partnership interests laid; and increase the uptake of public health support. An unbroken flow of information, which was being passed on to schools through school board representatives, meant that the public health unit's message of support could be fully received without much delay, and the delivery of school health initiatives could be more easily integrated into the schools.

In less advanced school health partnerships, public health professionals experienced situations where school personnel were not aware of attempts to contact them to explore partnership opportunities. One public health professional recounted the time when their public health unit found out by chance that certain partnership-inactive schools were indeed interested in their resources. They felt that the school personnel must have been so inundated with information that their invitation for a meeting either got *"buried or [didn't] get to the right person in a timely manner,"* such that no response had been sent back.

In other school health partnerships, arrangements were made to ensure uninterrupted information flow among all key actors. This type of arrangement aimed to prevent situations where public health communications were not being received by principals or teachers as intended. It served to notify schools of available resources and to avoid confusion as to who was to do what, and how the delivered resource was to be used and for what reason. For example, in one school health partnership, a process was put in place for the clear and purposeful communication of instructions to schools by school board representatives who had been specifically assigned to carry out this type of task, and who could provide reassurance that any action item had been taken care of. As the public health manager indicated:

When it came to [our major] initiative, the nurses noted that most principals, save for a couple, seemed to know and expect when these resources and activities were being delivered and

implemented in their schools. (...) We do a fair amount of communication through email and we try to do that strategically. (...) It'll usually be myself reaching out to the group, clearly stating what the purpose of the [email] communication is, and if there's an action required, I'm asking for them to confirm that that's been done. (...) This particular group of school board reps, (...) if we make requests for them to send information throughout their schools, they're accustomed to do that. So, we'll provide an opportunity for them to review, and then we ask that they disseminate. (...) That usually happens smoothly. (...) Sometimes, for example, it'll just be communicating that a certain resource, or service, is ready to be launched, 'Could you please, send this information to your principals?' And a lot of times we'll attach a letter [to their principals] that says (...) the who, where, what, when, how and why of something, and then provide a link to the information.

7.4.4 Consistency of partnership contacts to maintain close partnership ties and current partnership work

One of the most important partnership elements to keep school health partners' work moving along was the consistency of partnership contacts. Public health professionals with consistent partnership contacts stated that they enjoyed high levels of familiarity and comfort, as well as productivity, with their school board partners, owing to a long history of rewarding partnership experiences. Consistency in leadership roles was found to be especially critical in ensuring the continuation of partnership work regarding the gradual implementation of comprehensive school health initiatives. A second key consideration was the mobility of school personnel. Creating large school health teams was considered an effective way of ensuring consistency of school-level partnership activities through the identification of multiple school health champions.

According to public health professionals, consistent contacts were advantageous not only for furthering cross-sector engagement through strong partnership ties, but also for implementing a comprehensive school health initiative that was to be implemented incrementally. They commented that, when an influential contact from either sector changed mid-way into the implementation phase, the initiative was more likely to either stall, or be abandoned all together, thus diminishing the partnership's productivity.

As well, the departure or resignation of school health champions among the school staff had at times limited partnership-based health promotion efforts. Public health professionals stated that greater attention needed to be placed on recruiting champions who were permanent school staff rather than temporary replacements. One public health manager asserted that the recruitment of more than one

school health champion from the permanent workforce was an excellent practice for ensuring contact stability:

In the schools where we've had a lot of success, there's been more than one champion identified and these champions are permanent staff at the school. (...) When we've formed health action teams that have at least two permanent teacher champions, or often times the school's social worker is involved at a secondary level as a champion as well, they have been able to gain a lot more traction and have a lot more success than those schools that have health action teams with a more limited number of teachers or staff, and when the staff are temporary staff. (...) We've found it helpful to identify more than one.

7.4.5 Turnover management to reduce the effects of personnel changes on partnership progress

Personnel turnover was viewed as a major partnership impediment. With unavoidable changes to partnership contacts, turnover management practices were adopted to restore interorganizational relationships as soon as possible. Management practices that had been used to lessen turnover effects included regular networking events organized by the school board; early introductory meetings, with the direct transfer of work files, when possible; and routine invitations to take part in an exploratory partnership meeting at the school level. Underlying successful turnover management efforts was the cultivation of an organizational culture that valued the nurturing of partnership ties.

a. Regular networking events organized by the school board

According to public health professionals, personnel turnover could happen quite frequently in their respective sectors. Regardless of how long a school health partnership had been running, public health professionals spoke of having to engage often in networking activities to mitigate turnover effects at various interorganizational levels. One turnover management practice was the promotion of networking activities at the school board executive level. For example, a school board's annual executive planning meeting offered a convenient way of reducing the effects of personnel turnover by doubling as a networking event for public health partners. This type of meeting was held around the beginning of the new school year to plan strategically for the year ahead. As a public health manager reported, invitations to present at their partnering school board's all-day annual leadership meeting enabled them to re-establish partnership ties with new school board contacts during break times:

It's really their big [leadership] meeting of the year prior to school starting. (...) It's a full day and we would be [given] an hour of their meeting day (...) to present and then network with some of their staff, usually over lunch. (...) It's a good opportunity, (...) [for] new superintendents in these [health and safety] roles to reintroduce and confirm (...) our expanded role in their eyes. [Comprehensive health promotion] has always been our role but I don't know if they really realized to what level we were there to support them.

b. Early introductory meetings, with the direct transfer of work files when possible

Another turnover management practice aimed to produce a smoother transition from one partnership tie to the next. Public health professionals mentioned the practice of holding introductory meetings early into a personnel change to help preserve partnership momentum. Likewise, public health professionals emphasized the importance of minimizing turnover effects through early introductory meetings, and especially before the change in personnel to allow the direct transfer of work files, whenever possible. Within a school health partnership dyad, interorganizational relationships were retained to a considerable degree where the outgoing school board representative was able to brief their replacement on their current partnership activities, making the necessary introductions and passing along their files so that the work could proceed as close to the initial plan as possible. As the public health professional experienced:

If each organization recognizes the importance of the partnership, then there's a built-in methodology of making sure that there's connection happening right away and there's not a lag. I think if the lag is too long, then you're starting at a lower level. (...) For example, one superintendent [who is retiring soon] is handing over all of [their] files to the [incoming] superintendent. [This outgoing superintendent] has made all of the introductions between the two of us, and we've already started conversations this week, so it's keeping things moving forward. (...) The person is changing but the work is continuing.

7.4.6 Commitment to perpetuate cross-sector engagement

Commitment is the last of the six continuity elements, but equally important for bringing school health partners together for the long term. Making a commitment to perpetuate cross-sector engagement meant putting aside time to engage with each other, especially early into the planning process; encouraging partnership work at all interorganizational levels; and to the extent possible, contributing resources to carry out partnership activities.

Public health professionals were mandated to work in partnership with other sectors. In contrast, school system actors' level of commitment to working in partnership with their local public health units was reported to vary considerably across the province. From a public health perspective, establishing school health partnerships was "a marathon," and "not a sprint," in that much time was required to build trusting relationships and instill commitment for continuous cross-sector engagement. At one school health partnership, the top school board executive demonstrated strong commitment by allocating suitable time for partnership meetings and keeping their local public health unit in mind whenever they started making plans that centered around the promotion of student well-being. As the public health manager expressed:

[The director of education] is very committed. (...) He takes the time to meet and he always responds to our communication. (...) He has made it his mission to partner with us, [and] (...) he always tried to include us in their activities. I know that they wanted to initiate [a health promotion] program. Right from the get go, when they wanted to initiate that, they asked for assistance.

When school boards made a commitment to engage with their local public health units, partnership meetings were prioritized, partnership work was encouraged at all interorganizational levels, and school system resources such as student survey data and release time for teachers were provided, to the extent possible, for continued cross-sector engagement. In one advanced school health partnership, commitment ran much deeper. Deep-seated commitment went well beyond the allocation of time and resources for partnership activities. It brought about the actual integration of public health professionals within the very culture of the local school system. As the public health manager experienced:

At the school board level, (...) we want to partner [on a specific strategic approach]. We agree on that, (...) [and so,] it's a prioritizing and a commitment. (...) The school board's role is to encourage their schools to work on [our shared strategic approach]. They support their staff, and if there were resources needed, they would consider it. (...) Everybody's committed. Monthly meetings (...) are already happening, but now the health unit is part of the school culture through the school board's adoption of [this approach], which is being implemented together.

Chapter 8: Partnership Satisfaction Levels and Related Factors

This chapter covers the extent to which public health professionals have had satisfying experiences with their school health partnerships, and it examines factors surrounding partnership satisfaction levels. First, it presents the results of the quantitative portion of the School Health Partnership Survey, asking how satisfied public health respondents were with respect to the main types of partnership arrangements, categorized according to the key organizational asset being shared: information (networking); resources (cooperative); and the decision-making process (collaborative). Second, it explores additional material from the follow-up interviews to shed light on partnership challenges, mitigating elements, and public health professionals' aspirations. Lastly, it delves into the supporting conditions for moving along the collaboration continuum to increase satisfaction levels.

8.1 Analysis of the quantitative survey responses

In Ontario, there were 36 local public health units and 75 publicly-funded school boards (i.e., 37 public school boards and 37 Catholic school boards from either the English-speaking or French-speaking local school system, along with one English-speaking separate school board). Due to misalignments of jurisdictional boundaries, there were actually 142 unique school health partnership dyads—not counting other partnerships with aboriginal education councils. Because jurisdictional boundaries between public health units and school boards did not often overlap completely, the number of existing partnership dyads, with a unique set of partnership experiences to study, was far greater than what would otherwise have been the case.

School health partnerships were experienced, in some instances, as a public health-school board partnership dyad, and in other instances, as an extended partnership configuration. As shown in Table 10, all public health units had at least two coterminous school boards with schools located within their catchment areas. Nearly one fifth of public health units (19%) partnered with two school boards, representing either the English-speaking public or Catholic school system, while 14% also partnered with a third school board that may be either English-speaking or French-speaking. Coterminous English-speaking school boards tended to cover the same geographical area. Almost half of public health units (44%) had

one school board partner from each of the four local school systems. The catchment areas of another fifth of public health units (22%) included schools from more than four school boards. Cross-sector engagement may become more complicated to manage with greater numbers of partnering school boards.

Table 10: Proportion of public health units per partnership category

Quantity of school board partners within public health units' catchment areas	Percentage of public health units (n)
2, English-speaking	19% (7)
3, English- or French-speaking	14% (5)
4, English- or French-speaking*	44% (16)
5 to 9, English- or French-speaking	22% (8)

*(1 from each of the four school systems, represented)

Viewed from the education sector, the vast majority of school boards (80%) only had one or two public health partners, as indicated in Table 11. This was because public health units' catchment areas did not overlap with one another, as school boards' jurisdictions do. However, 13.3% of school boards were partnering with three or four different public health units, and 6.7% had more than four public health partners. The latter category affected exclusively French-speaking school boards, whether they be part of the public or Catholic school system, given that their jurisdictions covered a greater geographical area. Planning together became increasingly more challenging as the number of partners rose and the distances separating school health partners increased.

Table 11: Proportion of school boards per partnership category

Quantity of public health partners within school boards' jurisdictions	Percentage of school boards (n)
1	60.0% (45)
2	20.0% (15)
3	12.0% (9)
4	1.3% (1)
5 to 12	6.7% (5)*

* All are French-speaking school boards

Partnership configurations may be far more complex than what has been presented above. In certain extended school health partnerships, one public health unit may have had one or more school board partners, all or some of which may have been, in turn, partnering with one or more other public health units. This situation is graphically represented in Appendix Section 5. However, some of the partnership

dyads within extended partnership configurations may have been peripheral. Certain partnering school boards only had one or a few schools located in a public health unit's catchment area, and therefore engagement between these school health partners would be quite low, compared to a partnership pertaining to a large number of schools. In such cases, public health units engaged more at the school level.

The complexity of partnership configurations may have had an effect on partnership satisfaction. The School Health Partnership Survey comprised both qualitative and quantitative questions. The majority of the quantitative survey questions sought to examine the level of satisfaction experienced by public health professionals in three main partnership activity areas at the school board level: (1) sharing information to discover mutual interests; (2) sharing resources and engaging proactively; and (3) sharing the decision-making process and planning supports. For the latter two partnership activity areas, survey respondents were asked to enter the number of school health partnership dyads that corresponded with a given satisfaction level.

Responses of 'not satisfied' or 'slightly satisfied' for each of the three partnership activity areas can be attributed in large part to low engagement across the public health units and school boards. Based on follow-up interview responses, dissatisfaction was mainly due to the inability to engage to the extent desired, as opposed to conflictual partnerships. Both types of responses are indications of very limited engagement with school boards, and they have been combined under the category of low satisfaction in the final analysis. Conversely, responses of 'mostly satisfied' and 'completely' satisfied,' indicative of very active engagement, have been brought together under the category of high satisfaction.

Regarding public health professionals' perception of the types of school health partnership they had with their local school boards, 24.6% of partnership dyads were categorized under 'Awareness', indicating that there was practically no cross-sector engagement at the school board level. According to data from the follow-up interview sessions, this set of responses appears to be due to minimal jurisdictional overlap, where only a few of a school board's schools would be located in the public health unit's catchment area; in certain cases, the overlap covered only one school. This was affecting mostly French-speaking school boards, with vast geographical jurisdictions, but some English-speaking school boards were facing the same situation. Where no cross-sector engagement would be taking place at the school board level, public health frontline staff may have been engaging solely with the few schools in their catchment area. However, this may not be the case for French-speaking schools, since there would be a much lower

probability of having public health staff who spoke French, considering the small volume of schools to service in French. The presence of only a few schools in a public health unit's catchment area, especially those within the French school systems, could account for responses of 'Not Applicable' related to subsequent survey questions.

Since all 36 public health units participated in the survey, the total number of dyads was expected to be 142 for each quantitative survey question. However, some values were missing for certain quantitative parts of the questionnaire (i.e., 4% missing values related to 10 questions, and 7% missing values related to one question). The denominators used to calculate proportions were adjusted accordingly.

The themes corresponding to high partnership satisfaction have already been explored in the previous chapters. What follows is a presentation of the quantitative responses from the School Health Partnership Survey, regarding levels of satisfaction with key partnership activity areas. Next, public health professionals' perspectives on partnership challenges and mitigating elements, as well as their aspirations are further explored. The public health perspective that has been captured through follow-up interviews brings to light the reasons why satisfaction levels would be low, and how to mitigate this situation. Finally, the conditions supporting the movement from low to high cross-sector engagement along the collaboration continuum are elucidated.

8.1.1 Sharing information with school boards to discover mutual interests

Satisfaction with sharing information across sectors to discover mutual interests was noticeably mixed. As shown in Figure 2, only slightly more than half of survey respondents in each of the higher-ranking positions had highly satisfying partnership experiences in this area. Of the participating directors, managers, and liaisons, 58.8%, 54.1%, and 62.5% respectively reported this level of satisfaction.

The proportion of highly satisfied program staff was considerably reduced. Only one third (33.3%) of the participating program staff were very pleased with the extent to which they could share information at the school board level. It may be that this professional group did not have nearly as many opportunities to interface with school board representatives as they did with school personnel.

Figure 2. Satisfaction levels with information sharing



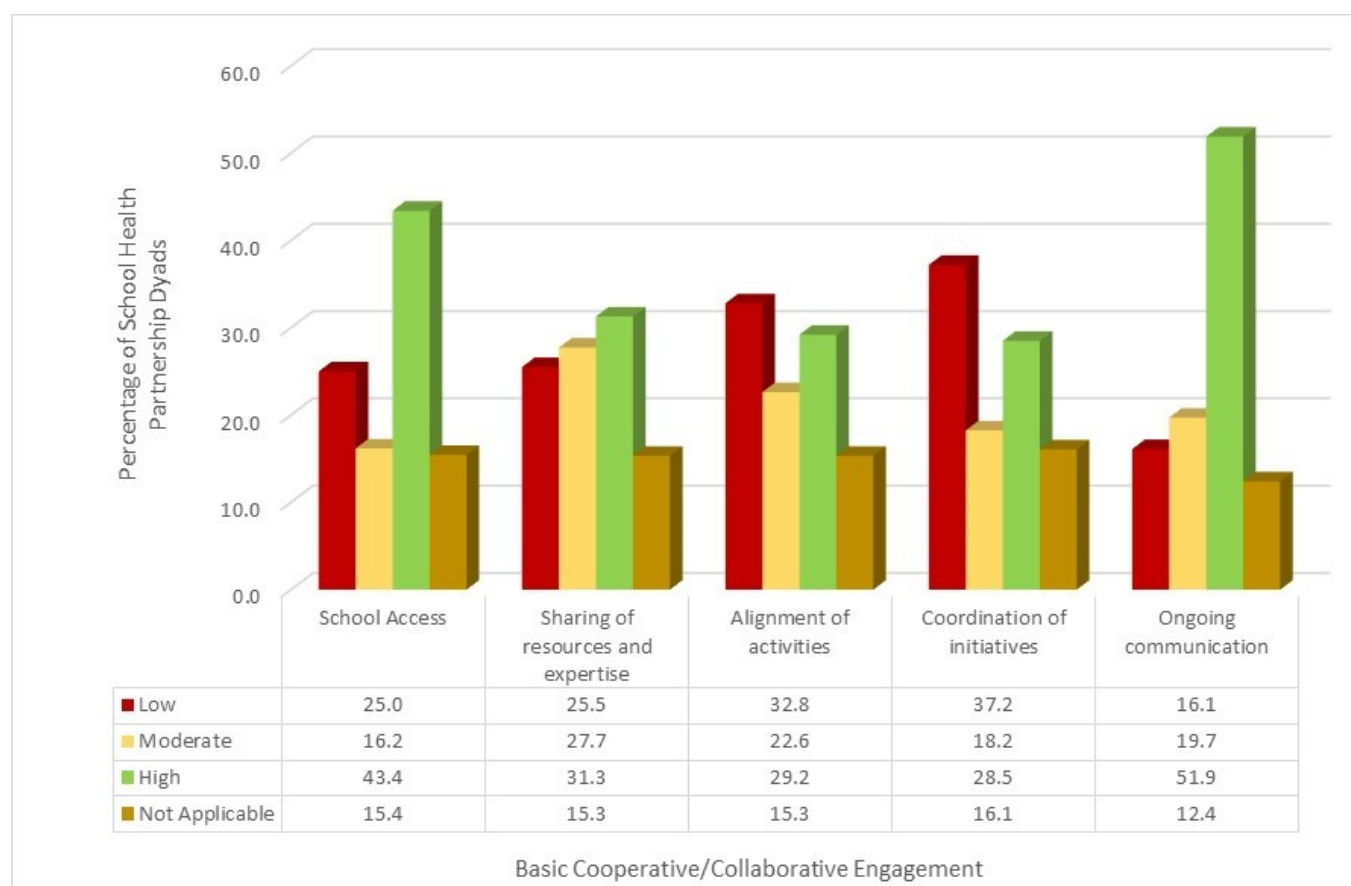
8.1.2 Sharing resources and engaging proactively with school boards

Quantitative survey responses pertaining to basic cooperative and collaborative partnership activities indicated high variability in satisfaction levels, as well (see Figure 3). Although slightly more than half of the partnership dyads (51.9%) yielded highly satisfying experiences in terms of the extent to which there was good communication between the public health unit and the school board, the level of satisfaction with cross-sector communication did not seem to have fully translated into satisfying experiences in other partnership activity areas. Less than one third of partnership dyads were highly satisfying when it came to opportunities for sharing resources and expertise (31.3%), aligning activities (29.2%), and coordinating initiatives (28.5%). Apart from ongoing communication, satisfying experiences were mostly related to a public health unit's access to schools. However, public health units were highly satisfied with their ability to access schools in less than half of the partnership dyads (43.4%) across the province.

Evidently, school boards were underutilizing the support that was being made available to them by their local public health units, with the exception of those public health units that were unable to service French-speaking schools. Even though French-language resources may have been secured from larger public health units for distribution to the few French-speaking schools in another public health unit's catchment area, this practice did not seem to be happening consistently, given the proportion of 'Not Applicable' responses, especially for resource sharing.

Sharing implementation resources, granting school access, and ensuring cross-sector alignment would signify a cooperative partnership arrangement with school boards, in relation to activities being carried out in the schools. However, the coordination of initiatives was a partnership activity that corresponded to a collaborative partnership arrangement, although it entailed jointly determining delivery steps at the most basic stage of action planning.

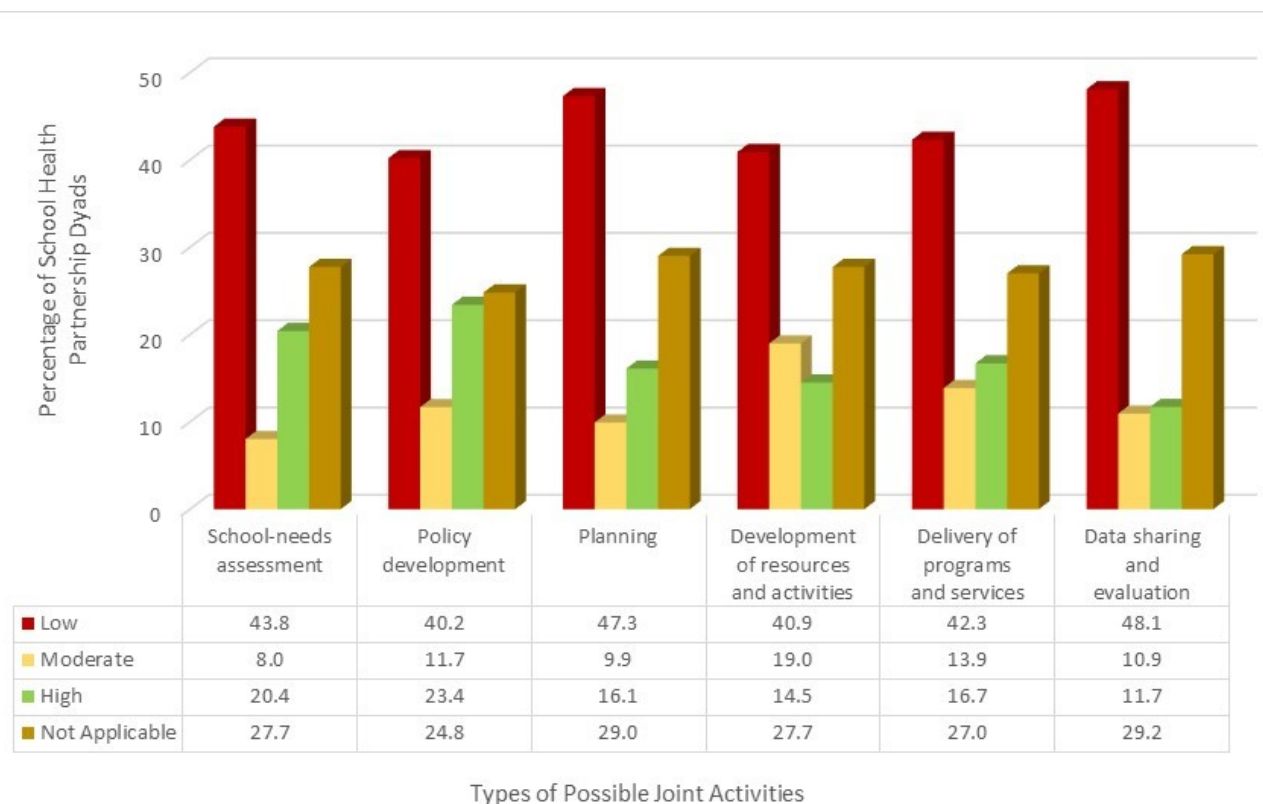
Figure 3. Satisfaction levels with basic cooperative and collaborative engagement



8.1.3 Sharing the decision-making process and planning supports with school boards

With respect to sharing the decision-making process and planning supports, such as data and evaluation practices, survey responses were in stark contrast to the previous chart, especially for the category of 'Low Satisfaction'. As presented in Figure 4, only a small proportion of partnership dyads were highly satisfying in regard to school needs assessments (20.4%), planning (16.1%), the development of policy-related (23.4%) and program-related (14.5%) initiatives, and the co-delivery of these initiatives (16.7%). A much less favorable situation was found regarding data sharing and the joint evaluation of initiatives (11.7%) to support the partnership's decision-making requirements. These figures indicated that greater attention would need to be directed at improving how the decision-making process is being shared and supported in order to strengthen school health partnerships. Furthermore, low satisfaction with the ability to conduct school needs assessments has major implications for the relevance and effectiveness of public health support being offered to school system partners.

Figure 4. Satisfaction levels with the sharing of the decision-making process and planning supports



'Not Applicable' responses pertaining to these planning-related processes were of the same order of magnitude as the proportion of school boards that had been categorized as being at the 'Awareness' stage of partnership development, due to minimal jurisdictional overlap. However, for five of the six planning-related processes, the proportion of partnership dyads in the "Not Applicable" grouping was somewhat higher than expected. Therefore, it cannot be determined for certain that 'Not Applicable' meant that there was practically no engagement in the area of student well-being because of minimal overlap across geographical jurisdictions, in all instances. Survey respondents may have given this response due to missed opportunities to engage in the specified partnership activity areas.

In addition, situations of minimal jurisdictional overlap may still have given rise to some cross-sector engagement, albeit very limited. As a public health professional reported:

One school board only has two elementary schools within our catchment area. So, the partnership level is lower there just because we do not have a large amount of their schools. We work together when it pertains to those two schools.

Future surveys would need to distinguish school board partnerships of minimal jurisdictional overlap from the rest of the existing partnership dyads when investigating partnership dynamics.

8.1.4 Reasons for low levels of satisfaction

Overall, survey questions on public health professionals' satisfaction levels with school health partnerships yielded mixed results. However, their partnership satisfaction, by and large, was not related to the quality of their relationships with school board personnel, but rather to the extensiveness of their cross-sector engagement. Relationships across the public health and education sectors were primarily kept professional and cordial. Where partnerships were less than satisfying, public health professionals felt that they could have been contributing much more to the improvement of student well-being than what they were currently doing.

Low cross-sector engagement occurred due to either large distances separating school health partners' respective headquarters; official language-related issues; or other challenging situations. Public health professionals found it difficult to engage with school boards whose central offices were situated far away

since there was much less opportunity for face-to-face contact in order to build relationships and engage in more meaningful ways, despite a fair number of schools being served through their school health partnerships. This was often the case in the northern region for all four local school systems, and across the province, for French-speaking school boards, whose geographical jurisdictions covered vast territories. In the latter case, the offer of public health support would likely be limited to material printed in English and the small amount of French material they may have had on hand, usually secured from another public health unit servicing a considerably larger number of French-speaking schools. Their poor ability to provide support left them dissatisfied, although French-speaking school boards were able to overcome such limitations by relying on their internal translation services:

We offer information in English only; (...) it is very difficult. [Although] we borrow resources from [other health units who] have to have French services—curriculum resources or things like that—our role with them is quite limited. (...) [However,] we have offered some programs that they have then taken and translated themselves.

Besides geographical and linguistic considerations, public health professionals mentioned other factors that might account for lower cross-sector engagement opportunities. School boards might not have viewed public health contributions as necessary, especially when they considered that their personnel held sufficient competencies to develop school health initiatives by themselves, and when other community partners were available to provide suitable resources.

Conversely, school boards might not have thought of engaging with their local public health units because they were unaware of what public health support was available for them to access. This lack of awareness may have been due to each other's hierarchically complex organization that made it difficult to know whom to contact. As a public health professional pointed out:

There're a lot of reasons why this might happen: [the school board] may have the expertise already, [so] that they feel as though they can develop [school health initiative] without needing to consult us, (...) and a lot of that has to do with the physical activity type initiatives. They have experts in their phys ed department who can develop all sorts of great initiatives without checking-in with us. (...) And sometimes, they can connect with other partners other than public health to develop health initiatives. (...) We're not the be all and end all, nor do we claim to be. There are lots of partners that work with schools to contribute to health. (...) And we can't consult on everything that they plan to do. (...) The school boards create partnerships with many, many different agencies and some are health-related. (...) [And so,] it's impossible to be kept in the loop about everything that they do related to health. (...) They can approach a variety of different organizations that have a broader mandate to do things, like perform to their students, so there's a whole variety of other approaches that we can't do. (...) Or, in some

of the other areas, too, they may not know, because there're so many areas, like the board is huge and we're big, so they might not even know who to connect with. So, it might be part of that too, with some of the initiatives that are developed in one area of the board that is not as connected to us.

Although this public health professional gave possible reasons why a school board might have chosen not to engage with their local public health unit, these situations arose only occasionally within their school health partnerships. For other school health partnerships, low engagement might have been rather a pervasive occurrence, perhaps due to these same reasons and other challenging situations, as further explored below.

8.2 Partnership challenges and possible mitigating elements

School health partnerships were at different levels of functioning, with some experiencing more challenges than others. Challenges with cross-sector engagement centered on a lack of familiarity, or incomplete understanding, of partnership opportunities; communication barriers; turf protection; high rates of personnel turnover and complex organizational structures; multiple overlapping jurisdictions; competing priorities and diverse portfolios due to insufficient capacity; and the absence of a well-established system for joint strategic planning. However, a number of mitigating steps may be taken to help alleviate these challenges.

8.2.1 Lack of familiarity, or incomplete understanding, of partnership opportunities

Not having a common understanding of how to improve student well-being together hindered the cross-sector engagement process. In certain local school systems, public health professionals were still encountering a lack of familiarity, or misunderstanding, about their health promotion role in schools and the importance of a comprehensive health promotion approach to achieve a greater impact. They felt that the hesitancy by certain school boards to encourage cross-sector engagement at the school level was due to a perception of extra work. School board executives may not have been aware of the substantial amount of public health support that could be provided to help school staff improve student well-being, without having it be an onerous undertaking for them. As one public health professional commented:

The decision-makers back at the board, I think I would be more satisfied if we could get to those high-up tables [with] superintendents and principals. We don't get a lot of opportunities to speak to those levels, so [the curriculum consultants] champion it, we champion it, but I feel like there is still a lot of principals that don't understand what healthy schools [approach] is. I think there're superintendents that don't understand. And we're always trying to get the opportunity to speak at those levels but it's very challenging to try and get into any of those meetings [such as] the monthly principals' meetings, the superintendents' meetings. (...) And so, it's just so busy. We're not seen as a priority, but I think it's because they don't really realize (...) the benefit it could have in their schools.

In less advanced school health partnerships, public health professionals were not able to engage with decision-makers, such as school board executives and school administrators, to the extent that would be necessary to achieve a common understanding of their health promotion role and the comprehensive nature of the healthy school approach as a shared strategy. Even when invited to present at school board leadership meetings, or school staff meetings with principals in attendance, they reported that they typically had to cut their talk short due to a packed meeting agenda.

Not fully understanding the public health role in the creation of healthy schools was thought to be one major contributing reason why not all school boards were fully engaged in school health partnerships. Public health professionals spoke about their role evolving over the years and moving away from delivering limited one-off school health programs and teaching health-related classes in schools. They were directing their efforts increasingly more toward making positive changes to the school environment, building teachers' capacity, strategizing with school board executives, and helping to shape school board policies for a greater impact in the well-being of the student population. However, certain school boards were reported to still be turning to their local public health units for resources to implement programs that were topic-specific and that addressed their health-related curriculum needs. Missed from these partnerships was the possibility of working together on a common vision and shared goal for collaboratively improving school environments.

For those school health partnerships that were not as advanced as they could have been, misunderstandings may first need to be dispelled about what it truly means to create a Healthy School, and how the public health unit fits in this process. As a public health manager noted, certain school board personnel did not appear to be ascribing the same meaning to the term 'healthy school' as those in the public health profession have been:

At [our school board], they call it healthy school, but I think [their] definition of healthy schools might be different than other people's definition of healthy schools. For example, we've been using the term 'healthy schools' at the public health unit to refer to those schools that actually signed on to the Healthy Schools Process, where they get a committee together, they do an assessment, they identify a priority, they put in an action plan [based on the Foundations for a healthy school framework]. (...) But I'm not sure at a board level, when they use the term 'healthy schools,' if that just means schools being healthy. I don't know. There's a bit of confusion.

From a public health perspective, a main feature of the healthy school approach is the six-step healthy school process to be taken up by each individual school. However, this process did not seem to have been adopted by all school boards that aimed to create a healthy school.

Within the field of public health in Ontario, the creation of a healthy school calls for engagement in the healthy school process. The Foundations for a Healthy School framework is intended to be an integral part of schools' action planning, which is one of the six steps in this process. Confusion may set in when the meanings given to key terms and concepts are not fully discussed and embraced during cross-sector engagement to reach a common understanding. Indeed, public health professionals have stated that one-off health promotion initiatives were still being implemented, without any intention of further expansion, in those schools where the comprehensive healthy school approach had not yet fully caught on.

Public health professionals observed that certain school communities considered themselves to be healthy schools simply because they were undertaking health promotion activities as part of their school operations. They were engaging in school health initiatives, on their own, while not realizing that other criteria needed to be met as well to become a 'healthy school'. For one public health unit, many schools in their catchment area appeared to be unaware that more could be done to rise to the standards of a healthy school, and that public health professionals were actually mandated to work in this area:

We're mandated to support them. (...) A lot of [schools] believe that any initiative that they are doing for health is part of their Healthy School plan. (...) They're doing it on their own. They don't understand our role to assist them with (...) the Foundations for a Healthy School. [The principals] just don't get the connection. They feel that health is part of their school board's work with their school. (...) It's been ongoing for years, and at the beginning, we approached a large number of principals to introduce all of this, and very few schools took us up on becoming healthy schools. The schools that have, have done a great job.

Public health professionals in less advanced school health partnerships felt that more needed to be done across the province to create greater understanding of what the term ‘healthy school’ truly meant, and how students’ performance in school could be enhanced by promoting their well-being through partnership work.

In addition to possible misunderstandings about their role and the actual meaning of the healthy school approach, public health professionals pointed out a lack of shared values about the reciprocal effects of health promotion and student achievement, as another factor for low cross-sector engagement. Where cross-sector engagement was not very active at the school level, public health professionals perceived that the principals may not have fully grasped the link between health and learning, such that health promotion was not a high priority for them. As a public health manager indicated:

Some schools work with us more comprehensively than others, currently. A lot has to do with the principals and their views on health promotion, and whether or not they find it valuable for their school. Some principals, they haven't quite come to the understanding that what we can do in public health can actually help make their jobs easier because they haven't bought into the whole health promotion approach in school.

Reaching a common understanding may be a matter of time and persistence. For instance, one public health unit had experienced favorable responses among principals when explaining their public health role in a group setting, for the first time, but without much uptake. This poor outcome had made them realize that much time would be required to repeatedly communicate the same message about available support before they could start seeing an increase in cross-sector engagement:

They listen to us. We have a very positive relationship with both of our school boards. I still don't think they understand exactly the role of public health. (...) It was a principals' meeting (...) to give them an overview, a better understanding of public health, our role and what we could do for them. (...) [The response] I would say positive, but nobody's been calling and our phone's not ringing off the hook, that's for sure. (...) This is a process. This is a marathon, this isn't a sprint.

In terms of mitigating factors, public health units’ offer of support for the promotion of student well-being may need to be repeatedly explained through a series of networking opportunities until a shared language could be established, along with other conditions for cooperation. Public health professionals have also suggested that more active engagement by the top leadership partners would help mitigate incomplete understanding across their two sectors.

Not all school health partners are promoting a common understanding across their respective sectors. Based on public health professionals' partnership experiences, certain executives were not actively providing direction for partnership work at the other interorganizational levels, or when they did, it was only for districtwide, topic-specific initiatives to increase the uptake by schools, for example a tobacco-control program. In advanced school health partnerships, common understanding was established by communicating a partnership-specific vision and developing suitable strategic approaches for improving students' well-being together based on prioritized shared goals. This type of engagement was seen as critical at the top-partnership level. As a public health professional stated:

That's how you make system changes, it's that buy-in at the top level. (...) We often run into trouble at that mid-level where those gatekeepers are, and there isn't as much support or engagement there. And then as far as school level engagement, it really depends on the administration at that school and really the staff at that school whether they are engaging or not. We have some that are really gung-ho and want to do things, and then we have others that really aren't interested at all. I often think it's just [that] they don't understand healthy schools and they do feel like it's going to be more work and more rules and that sort of thing. But I think a major struggle for us is that midpoint, so the directors seem very supportive when we talk to them about it but to implement things it becomes rather difficult just because of that hesitancy at that mid-level, at the gatekeeper level. (...) We have more engagement with the mental health leads but [regarding] their plan, I don't know if that trumps the gatekeepers. (...) I think that the engagement with the mental health leads is really great and I think it will help us move forward with things, because many of the things we are looking to do in schools, the mental health leads are also looking to [do]. But I also think that the mental health leads, although they're part of the school board, they're often not people who come from the education world. So, they are part of the school board, but they are almost a little bit like outsiders too, because their background is not education. I think it affects the dynamic a little bit. At the top level, they always seem supportive, but I think if they are truly supportive they will make sure it's happening and trickling down. I think it is important to even get more buy in at that top level so that the levels underneath them understand that this is the priority, and this is the way we are going. Because it's okay for them to say, 'Yes, we think that's a great idea, yes go ahead and do it,' it's another thing for them to encourage their [central] staff to participate.

To help increase the level of engagement between the top partnership leaders, the public health professional quoted above, further commented:

If you look at some of the other school boards in Ontario or even across Canada, they are doing wonderful things and it's working. For [our school boards] to be able to see that and understand it, I think would be a selling feature, (...)—to even be able to talk to other school boards [where] it's working well. (...) CODE-COMOH is probably a good place to engage them. If it's coming from that group that says, 'Hey, we need to get on board with this,' that's probably a good thing. Maybe it's about connecting different school boards' directors with

each other. I'm sure they have some sort of network. It's probably just a discussion that doesn't happen at that table, so if they already have an existing network, (...) [to say,] 'Let's talk about what healthy schools look like in your district.'

8.2.2 Communication barriers

Communication barriers contributed to missed partnership opportunities. Public health professionals spoke of difficulties with accessing the right people within the local school system in a timely manner to talk about the support they had to offer. Certain school boards had designated a primary contact person to act as a gatekeeper and make decisions about which partnership requests would merit further consideration. Although this arrangement may have been useful to help manage heavy workloads for the personnel at the school board and in the schools, public health professionals viewed this practice as limiting their ability to effectively communicate the kind of work they could do for them. One public health manager stated that they aimed to find a way to engage directly with the key individuals within the local school system who could directly benefit from their work. They intended to fully grasp these individuals' perspectives in order to convey their offer of support in relevant terms, for example in the area of policy development:

[Those working on a school health policy] don't always think of the health unit as a support that could be there for them. (...) We want to involve the director but if there were other people involved maybe there would be more buy-in because they're the ones doing [the policies]. (...) We want to get that delegated somebody getting the message, too. (...) They have the list of the people to connect with at the health unit, (...) but we're not sure it goes to the person doing the policy work.

The public health professional quoted above felt that policy support may remain untapped if no process is in place for the key actor working on a school health policy to be made directly aware of this potential partnership resource.

When a public health unit's offer of support had been passed on directly to the right person within the local school system for a response, it may nevertheless have been through a passive communication channel. Public health professionals found that the mere distribution of contact information and written offers of support, may be ineffective in reaching certain school system partners who would otherwise have been interested in working with them. Clogs in the flow of information may hamper cross-sector

engagement within the local school system. For example, at one public health unit, they knew of instances where their communications were not actually reaching intended school representatives, resulting in missed opportunities for resource sharing:

We go through a communications person at the school board and they then relay that information to each school. Sometimes it's emailed, sometimes it's a hard copy. Because schools themselves and principals receive so much information, it sometimes gets buried or doesn't get to the right person in a timely manner. (...) Then we find out later in talking to somebody from a school, for example, they're like 'Oh, I wish you guys did this,' and we're like 'Yeah, we do do that.' They don't know, because it's a (...) [communication] barrier. (...) We are able to connect with principals and teachers who reach out to us, but (...) [we're] not able to go and contact each school and say, (...) 'Do you want us to have a meeting to talk about [our services]?' (...) We know that we are going to have schools who aren't interested in this right now, they're not there at that level [of readiness]. (...) [But] we've talked to other schools who want this, and they didn't know it existed.

Communication barriers were compounded by heavy workloads, leadership changes, and a barrage of information vying for principals' attention. Based on public health units' partnership experiences, communication barriers could be mitigated through various approaches. One mitigating approach was the designation of a point person from each partnering organization, acting as liaison, to jointly identify partnership opportunities and bring the right people at the table to move forward with cross-sector engagement. Such a liaison structure was also advantageous for tailoring public health professionals' offer of support in a language that resonated with influential school system actors. Other approaches included the establishment of a clear and bidirectional flow of information, with follow-up mechanisms, and top leadership endorsement of school-level exploratory partnership meetings around the beginning of the new school year.

8.2.3 Turf protection

Tensions arising from turf protection was a major challenge in some school health partnerships. One of the most critical areas of health promotion within a school setting was positive mental health, since public health professionals were aware of the significant prevalence of students who were experiencing stress in their daily lives. Students' mental health was a grave concern to educators and public health professionals alike, and efforts were being made to help students gain stress management skills and enhance their resilience. However, for certain school boards, public health units' engagement in mental

health was a contested prospect, giving rise to union issues regarding the delineation of roles and responsibilities between public health frontline staff and board-employed social service professionals.

According to public health professionals, social service providers employed by certain school boards had expressed worry that their advocacy for more social workers in schools would carry less weight and be less justified if their school boards were to partner with public health units to provide additional mental health support in schools. This issue was believed to have arisen from a misperception of public health professionals' real intent. As a public health manager explained:

In some cases, even though altruistically it's the best possible thing to be working with public health in the area of mental health, we have seen resistance at a local school level and a local board level because of labor relations issues. (...) They're a union, so I'm just trying to bring that facet of it too. I'm not saying that all health units are locked in that way, but it is a factor around why sometimes a school board might not include [public health]. (...) [And so] that's what we work with 365 days a year: (...) to build those relationships and (...) [reassure] that in public health, we're not looking to take on what they fear we're wanting to take on. It's actually the polar opposite. (...) We are not in something to stay in it and to own it. We want to work together with sectors in this area to build capacity to help them with implementing by providing support and expertise, (...) [rather than] wanting to wrestle away work. That's where we need to reassure the boards.

Partnership impediments ensued where union issues had not been fully addressed to avoid turf protectionism. In such a situation, the mitigation of turf protection was being attempted through more open and candid conversations. For example, one public health manager was taking steps to explain that their upstream well-being programs were not meant to cross professional boundaries, and that they were willing to cease the delivery of any programs that were duplicating efforts so that they could focus on other well-being areas of interest to their school board partner:

There's been questions about some of the programs that we're offering, [like] when we talk about resiliency and well-being; it's that sometimes, the social workers thought this was infringing on their work. (...) [But] the programs that they thought we were infringing on in social work, we don't do. (...) It's not really up to us to do that [kind of work]. (...) We're going to be meeting [with our school board representatives] (...) to discuss how we can better align [our] programs to their needs. We've never had that before, so I think that's been a positive development. So [now] we can work on this perception that some of the services that we provide are duplicating services they want [to provide].

Professionals at this public health unit intended to contribute as much as possible to their school board partners' health promotion initiatives. They were respectful of the fact that their activities were being

carried out in school board territory, and they were looking for ways to resolve tensions regarding the division of labor between public health frontline staff and school boards' social workers through relationship building for candid conversations. As the public health manager quoted above further stated:

[Once] having (...) [built] some level of a relationship, [they're] more apt to hear our view and then maybe it's really more about us trying to align more our services that fits into the model that they want us to. Because, ultimately, it's their house and we have to play by their rules. (...) From our relationships' standpoint, we don't meet routinely with the mental health leads from [our] boards, but we should. We should better align our services (...) with what they're doing, or if they're doing certain aspects of it, then maybe we don't need to do that, and we can re-focus on other activities. It's just that [we] have to build the relationship, first, before we would have the opportunity to have that discussion, (...) to smooth it out, to have potentially better alignment with what services they're providing, (...) [and ask] 'Can we help? Can we assist them?

Mental health was a topic area where relationship building across the public health and education sectors mattered a great deal. Well-cultivated relationships between public health managers and mental health leads was thought to be critically needed in order to work out instances of service duplication and untapped public health support.

Where professional tensions had been noticed, public health professionals sought to bridge the current divide that existed with social service professionals in the area of mental health, so that they could build on each other's work and make better progress in improving students' lives. As another public health manager expressed:

The [school] board operates in a highly complex environment, and (...) [so,] public health's role is really to help translate those complexities and help solve those complex wicked problems alongside the board because we are both publicly funded to do that work. There is no competition. It is side-by-side support. It works best when we are part of that voice; (...) [it] allows them to understand better those challenges because we may have a different insight and experience related to that pillar of well-being (...) [in terms of] how complex it is to address those [mental health] issues (...) [and] how best it can be addressed.

Sharing diverse backgrounds was seen as valuable for making progress with improving students' lives, and more so, than what would otherwise have been possible by planning in isolation.

8.2.4 High rates of personnel turnover and complex organizational structures

Another major partnership challenge related to high rates of personnel turnover within public health units, school boards, and schools. Positions had been vacated either temporarily, in such cases as maternity leaves, or permanently, due to a relocation, a promotion, a retirement, or another employment opportunity elsewhere. Public health professionals witnessed much personnel change within the education sector, where teachers were often on career trajectories toward becoming superintendents, or even directors of education. On their way from being a teacher to attaining a school board executive position, they would possibly be filling a series of occupation, such as curriculum consultant, vice-principal and principal. One public health professional commented that, once a teacher reached the position of director of education, they were usually a few years away from retirement.

According to public health professionals, personnel turnover was one of the main reasons why school health partnerships did not progress at a satisfactory pace. When personnel turnover occurred interorganizational relationships needed to be re-established, and school health plans either proceeded more slowly, changed course, or were abandoned altogether. In public health professionals' view, partnerships were more about ties between individuals than between organizations, and consequently, when there was a change in personnel, or in their portfolio, the school health partnership itself may have undergone a drastic change.

Maintaining a high level of partnership productivity may be challenging amid changes in personnel, where interest in cross-sector engagement has not been matched. For example, one public health manager had faced a great deal of personnel turnover, including portfolio changes, within their partnering school boards. They expressed concern that one of their strong collaborative partnership arrangements may be affected, should the incoming school board employee not be as partnership-oriented as their predecessor:

Everyone's been so busy, so I think I want to revisit those conversations maybe in early fall and, who knows, the superintendents may change again and, therefore, [we'd be] starting that again. I think that goes on both ends in that we have a lot of turnover, as public health often does, with mat leaves and people leaving and management changes and the board often every year, sometimes, their portfolios change. So, you're constantly trying to rebuild that relationship, which I think hinders some of the work moving forward, sometimes, because I find often it's not about whether the agency buys in, and this is speaking for any partner, it's about whether the individual in that position at the agency buys in. (...) I'll give another example. The curriculum lead for physical education and health seems like a great guy, really

gets it, really understands community capacity building and collaboration, but now he's moving on to be the vice principal, so if his replacement comes in and doesn't get that, or doesn't see the value in that, then we'll have a totally different relationship.

Dealing with changes in personnel was even more difficult when the organization in question was structured in a complex manner. A high rate of personnel turnover in a hierarchically complex organization increased the challenge of knowing whom to contact in order to maintain interorganizational relationships. The highly dynamic workforce in both the public health and education sectors, coupled with variations in partners' organizational structures, could be quite disruptive to cross-sector engagement efforts. As a public health manager stated:

I think the biggest systematic problem is [that] school boards are very complex organizations. They are like health units. They set themselves up differently. You have different levels and different people covering different things and you have to learn that. Each school board is different. Then you have health units that organize themselves very differently as well. Some by topics, some by strategies. Each school board we work with, we have to learn what their organizational setup is and who do we need to contact for what kind of projects and then you've got turnover—people change and things change. Conversely for every school board, they have to learn about the organizational structure of the health units that they're working with and again there's turnover there and change plays a big role too. (...) [So] the relationship building is the key component, and every time somebody leaves, you've got new relationships to build up and (...) [new paths of] communication.

Regarding leadership turnover, not only are individual relationships severed and in need of rebuilding with the incoming leader, but there may be a risk that the time and effort put into partnership activities will be wasted. This would be especially the case with comprehensive school health initiatives that are being implemented incrementally. For example, public health units faced the possibility that their multi-year, multi-component health promotion initiatives could be abandoned midstream into their implementation phase when new principals were hired, as they could decide to go in another school health direction. As another public health manager noted:

That's how it's meant [to be], and this is part of the issue, that it's a program that is meant to be implemented over a couple of years, but what can be really challenging about that is one principal may come on and agree to the plan, because they've identified this as a need, but then that principal gets relocated, somebody new comes in and changes it. As much as somebody may have, with very good intentions, really detailed this comprehensive plan and timelines for implementing it incrementally, if leadership changes, priorities tend to change. It's tough.

However, personnel turnover was not in and of itself a negative occurrence. The consequences may still be favorable. For example, a public health director pointed out that a change of leadership may spur school health partners to re-examine current partnership practices, and this type of conversation could then lead to an enhanced way of functioning:

When you have relationships with organizations, when there are changes in the leadership, it really impacts relationships. And we had changes in our own organizations and there were changes at the school boards. And it's primarily our biggest school board that tends to lead the charge on a lot of school-based initiatives. So, when [change in leadership] happens and we're all at the table, you can understand that the conversations sometimes change from what they've been for (...) years. (...) [But] there are sometimes when change in leadership is good. (...) It was a good time to step back and say 'Maybe we need to do things a little differently. Is there another way we could work together?' I think we're at that turning point now where we want to look at how our relationships could be beneficial for both and fit with the changing times.

A new leader on the scene could present an opportunity to re-think old patterns of cross-sector engagement in order to explore more integrative ways of working together.

Given that a change in personnel could at any time disrupt the partnership, school health partners had taken up a number of ways to mitigate the effects of personnel turnover, especially within complex, hierarchical organizations. Firstly, the establishment of regular meeting structures to engage across the two sectors provided a convenient forum through which to start being acquainted with the new people coming into the partnership and their role. Secondly, the assignment of point people who could assume all three key liaison functions, namely internal connector, primary contact, and convener, was instrumental in knowing whom to contact within a dynamically changing workplace, and in rebuilding relationships. Lastly, transition accommodations, as presented earlier, could help with the continuity of the partnership as well.

8.2.5 Multiple overlapping jurisdictions

a. Multiple public health partners with different capacity levels

Some extended school health partnerships were more challenging to run than others. When a school board's geographical jurisdiction encompassed the catchment areas of multiple public health units, the

act of building relationships was considered difficult. This was certainly the case when two or more public health units that shared the same school board differed considerably in the services that they could provide. As a public health manager pointed out:

[With only one public health unit,] you can build that relationship with the board as their [sole] provider. When there's multiple [public health] providers, with multiple relationships, multiple service models, multiple programs, it's hard.

Challenges with overlapping jurisdictions were further exacerbated when the public health unit had an extended school health partnership with more than one school board, which in turn had more than one public health partner. As one public health manager reported:

We also share some of the school boards with other health units which makes it even more challenging. (...) The geopolitical lines are not all in sync, so most of our boards we share with other health units.

According to public health professionals, school boards preferred to have all of their schools receive the same level of service, even though they were located within the catchment areas of different public health units. However, public health units serving the same school board were not always able to provide the same school health initiatives to their schools for various reasons. Distinct geographical factors were thought to have given rise to different local needs. Additionally, the different partnering public health units may have had their own set of organizational structures and practices; different capacities in terms of the size of their public health team and other available resources; and a different volume of schools to service. As was the case with this public health unit:

[Our nearby health unit] and us, [we] are doing the same kind of process and in between we are trying to tweak so that we are providing the same kind of programs throughout all [of our common] school boards. (...) But it's not always possible to do so, because you've got different health units with different MOHs [Medical Officers of Health], different priorities and ways of doing things. Trying to get consensus on different types of programs and stuff is not always possible. We also have very different capacities. So [the larger health unit further away] has a very large school health team whereas [our health unit and nearby health unit] have very small school teams. (...) There's a whole bunch of factors that determine our priority areas including our local needs. So [this larger health unit] has a very different geographical basis, so they have slightly different [needs.] (...) Although we've come a long way, it is a challenge because [our common school boards] have, for many years, felt that whatever [the larger health unit] is offering, (...) we should be offering the same. (...) But we don't have near the capacity they do, so it's not possible. (...) And that's across the province where each [school board] has a certain number of schools that cross different health units. (...) [Similar programming is] more so with mental health. (...) It seems to be a definite priority across all of our schools. (...) And

it's also a major component with all other topics. It's a bridge. Physical activity and mental health promotion go hand in hand, sexual health and healthy eating, there's a mental health component to all of those topics.

For those public health professionals in extended partnerships, whose organizations had relatively greater capacity issues, it was challenging to offer the same school health programming as that of their partnering public health units with more capacity. Nevertheless, interest was still expressed in getting together to align and coordinate their health promotion efforts as much as possible. As well, they mentioned the importance of having all partnering public health units come together and meet with their common school board, on a regular basis, in order to significantly enhance the communication.

In large part, differences in capacity levels usually led to the inequitable provision of services spanning across geographical boundaries. Whereas southern public health units tended to have greater capacity than public health units in the North, those located in highly populated areas (i.e., urban centers) tended to be more resourced than those in less densely populated areas. A public health unit serving a larger population with more resources, including more staff, was able to provide a broader array of services. Conversely, a public health unit with a less populated catchment area had to be more selective about the services they could offer. Furthermore, different workforce sizes brought public health units to structure their teams differently, making it more difficult to “match” each other’s school health programming, even if they share the same school board.

When there were two or more partnering public health units in an extended school health partnership, school boards tended to either engage more with the largest public health unit because they usually served a greater number of district schools, or interacted with the public health unit that was located nearest to them because it was more convenient for direct cross-sector engagement. Consequently, the partnering public health units that were smaller or further away may have been overlooked. The situation had even arisen where two public health units of similar size shared a school board that was located at a far distance, but approximately mid-way between these two agencies, creating another set of challenges with the alignment and coordination of partnership activities.

In working within extended school health partnerships, managers from smaller, more rural public health units found themselves left out of the loop when their partnering school boards engaged with the public health partner that was located in the same city. Not knowing what was going on with their school board’s

other school health partnership, one public health manager reported that they constantly had to be checking for openings to contribute their critical rural perspective. However, opportunities to do so may have been lost at times due to breaks in communication:

Sometimes I think that the problem we find, is [we] could be an afterthought, that they've got their input from the [larger] health unit and maybe they're feeling that's sufficient. Then the communication isn't really there, between our health unit and the other health unit, 'Is that happening?', 'Could we provide feedback for this?' So, these are, I think, some of the challenges that come with how we are structurally laid out, in relation to the school board.

In Ontario, five school boards within the French-speaking school systems had five or more public health partners, which may have been separated by large geographical distances. Extended school health partnerships were especially challenging when public health units were partnering with French-speaking school boards with vast geographical jurisdictions. One public health manager in such a situation stated that it became logistically cumbersome for their partnering coterminous school boards to interact directly with the many public health units that were servicing their schools:

Each of these school boards have very different realities in [our] city. We have our catchment area, and if you look at our school boards, the biggest school board from a population of schools perspective, is [our English public school board], the majority of their schools are here [in our city]. And then you have the English Catholic board, which is also in [our city], but it's a smaller board, also very engaged. Then you go to the French boards. Now the French boards, just by the nature of the population of Ontario, they cross over beyond our boundaries. So, for the French Catholic [board], we're still a large catchment area for them, whereas for the French public [board], we're a very small blip compared to their larger reach that they have in terms of their catchment area. So, I would say that's what accounts for the differences [in levels of engagement]. Because if you were the French school board, you're engaged with many, many more public health units. So, they only have so much time and availability to connect with us, when we only cover [a small proportion] of their schools.

For matters concerning French-speaking school boards, whose geographical jurisdictions usually covered a large expanse of territory, inter-unit engagement was hindered substantially owing to the considerable distances separating the many public health units within this type of extended partnership.

Specifically regarding the development of school health policies, greater engagement opportunities among all partnering public health units and their common school board were seen as worthwhile, particularly when it came to taking into account more of the variation existing across local school contexts. Despite having fewer schools within their catchment area, public health professionals in this situation felt

they had a unique perspective to share with their school board to help them make better-informed strategic decisions. They considered their own perspective to be worthy of being brought to their school board's attention, even though there was a larger public health unit as part of the extended partnership. However, as a public health professional pointed out, such engagement would not necessarily have to be through direct means:

I think it's important that there's engagement of some sort across health units. (...) There does need to be engagement [at the policy level], (...) [while] not necessarily being physically at a table. I think it depends on the policy and what they're looking at. There needs to be the opportunity to be aware that it's happening and the opportunity to provide input depending on what policy they are addressing and whether there's unique issues that we would feel we would want to have additional input on. It's not a one size fits all.

At times, an in-person meeting with all partners within an extended school health partnership at the table was deemed more productive. In certain extended school health partnerships, inter-unit relationships were being cultivated by organizing joint meetings between partnering public health units and their common school board partner for improved communication. Additionally, public health professionals, whose inter-unit partnership arrangements needed improvement, were starting to formalize meetings among themselves as time permitted in order to gain greater familiarity with how each other functioned. They sought to create more partnership opportunities with their common school board. They also intended to share operational strategies and harmonize their strategic approaches as much as possible; ensure that all were invited at meetings with their common school board partner when discussing relevant matters; and establish consistent processes. At one school health partnership, an important shift began, where they had experienced more participatory cross-sector engagement across their extended partnership. As a public health professional recounted:

We invite ourselves (...) and sometimes, with our counterparts at [the other] health unit, which is slowly starting to work. (...) Or, [the school boards] invite us. (...) It's more regularly now, because we know that together we cover [a large majority] of both [school boards] in our area. We also know that school boards like a lot of similarities and the more that they see health units cooperating and offering similar programs, services, resources, that seems to open up a few more doors. (...) We also have a pretty good relationship with [our nearby] health unit.

Through the cultivation of relationships, the public health units were taking the liberty of inviting themselves to each other's meetings with their common school board, when they felt it was important for them to be present.

b. Multiple school board partners

While two out of five school boards (42%) across the province had more than one public health partner, each local public health unit was partnering with at least two school boards, one from the English-speaking public school system and the other from the English-speaking Catholic school system. Having more than one school board partner became a challenge when they took on different priorities, and operated with different levels of funding and organizational structures, similar to the situation with public health units.

With school boards that were focusing on different health-related priorities, it may have become unmanageable for their common public health partner to address their varied needs when preparing their operational plan. However, school health partners had been successful on occasion to focus on a common priority, especially in the area of mental health. One public health manager reported their inability to completely respond to all of their local school boards' partnership-relevant needs due to capacity shortages, but mental health promotion was one area where they could direct their cross-sector efforts in a productive manner across their extended school health partnership:

We try to work with a lot of [school board] partners which makes it even more challenging. (...) It's hard enough to work with one, but I think with [much more than one school board,] it's more of a juggling act to communicate with everybody. (...) I'm not sure if I sat with each individually and said, 'What do you need?', (...) [that] I would have the capacity to respond to all the needs of the different school boards. I think we were lucky with mental health because it was something common and we could put our resources there.

Although not an easy task, bringing many school board partners together to attend the same meeting could nevertheless have its advantages. For example, one public health unit had been told by their many partnering school boards that they looked forward to having all of them come together and engage in high-level discussions about areas of mutual concern. As school board partners were becoming aware of what was happening in each district, a broader range of school health possibilities could be discovered. As a public health manager expressed:

It's very challenging to get all [of our] school boards together. We asked to see if it would be better if we met individually but they enjoy coming to the table together because they say they share common issues. (...) We share what we do in the different schools and it also informs them of what can be done. (...) I know that they really like to hear about our new programs. I know that they're very excited about them.

Extended partnership meetings were especially advantageous for bringing up ideas about how to address common issues. However, to move forward with any one of these ideas through a partnership arrangement, public health professionals were finding that additional meetings would need to take place at the partnership dyad level for more concrete conversations about the specific priorities and needs of each school board. Meetings with multiple partnering school boards appeared to be more conducive for information sharing, while more extensive engagement seemed to be more realizable at the school health partnership dyad level.

Even when coterminous school boards were focusing on the same school health goal, public health units may still have faced challenges with operational planning. One public health unit found that, even with a common strategic focus of mental health promotion—a broad topic in and of itself—their partnering school boards’ priorities and operational strategies still diverged considerably:

We're finding, for instance with the mental health piece now, that both school boards are in different places. Where we may have perhaps preferred to continue the process together so that it's not two different processes, we're finding we maybe need to have a different approach and provide different support to each of the school boards, just because their strategies and priorities (...) are quite different.

Because both school boards were at different stages with their own mental health strategies, consideration was being given to pursuing separate planning processes for more targeted discussions on partnership activities.

c. Low engagement at the top partnership level

Efforts to strengthen partnerships may be hindered by complications related to extended partnerships, especially when it concerns multiple public health units of different capacity levels. Where public health units with different structures and capacities partner with the same school board, more guidance from the CODE-COMOH would be welcomed to bring clarity as to how to resolve the issues inherent within these extended partnership configurations and make them more collaborative. As a public health manager expressed:

We've been hoping that this would happen through the CODE-COMOH [committee], that there would be this joint work between the MOHs and the directors of education, (...) [so that] this

is something that they want to do and that they're prioritizing. (...) It might have happened in the past, that [we and our partnering] health units have come together to try and work with the school boards [that we share] on formalizing relationships, but [the school board executives] have to welcome it. (...) I've been waiting for something to come out of those [CODE-COMOH] discussions about (...) how do we [handle our] different organizations, different service models, what's going to be the way for us to move forward (...)—to set the framework, to set the model, or to at least provide direction.

Specifically, working within extended school health partnerships complicated the potential for joint strategic planning at the school board level, in the long-term and short-term, even when the public health units sharing the same school board were not that distant from each other. Lack of top leadership engagement was seen as compounding this challenge. Nine Ontario school boards, each, had three public health partners, which may or may not have been located close enough to organize in-person partnership meetings. In this situation, the larger public health unit was likely to be urban-based and located nearest to the common school board, while the other partnering public health units were likely to be rural-based, with smaller capacities and less opportunities to cultivate partnership ties. The crux of the challenge was that the smaller public health units may have been struggling with their efforts to increase the extensiveness of their cross-sector engagement, and this difficulty may have been heightened when interactions between the top leadership from each sector was not very active.

For one extended school health partnership with multiple public health partners servicing the same school board, three public health managers met regularly with their common school board liaison mainly to verify their respective public health action plans. From the public health perspective, the work being carried out through this partnership would not be as effective as it could be without the ability to engage in joint operational planning across the two sectors. However, one of the public health professionals pointed out that at least three issues stood in the way of pursuing more extensive planning: each partnering public health unit had a different service delivery model and was therefore offering different services to schools within the same board district; inter-unit engagement for better service alignment was not well structured; and cross-sector engagement at the top-partnership level that could encourage joint strategic planning was low. As this public health professional from one of these public health units explained:

So, we meet quarterly as a group [through this liaison committee] and then each health unit has different relationships with different members within the board, depending on the work that they do. (...) I don't know if there's a table where those conversations are happening around healthy schools and how they're doing that. (...) I'm not 100% clear how they're implementing their healthy schools approach. (...) We do actively seek out their comments on

programs and services (...) [but] not specifically from the [strategic] planning aspects of our program. (...) There are three health units, (...) and we have different models on how we provide [our] services. So, there might not be any ability for the board to set that tone [for joint planning] (...) [Furthermore,] we have [inter-unit] meetings, but we don't have a good structure of when and how often we're going to meet, it's more ad hoc. (...) It's kind of tricky and muddy: 'Should all three health units be providing the same services?' I think, in an ideal world, that would be what we want. Are we capable of doing that? Probably not. (...) [But] what we could do more of, is (...) [getting] input from the board level on some of our strategic planning. (...) I would definitely like [our school board leadership] to be more engaged. (...) I would like it to be more of a two-way street, because we have assessed the need [for more engagement at the top level]. (...) [Joint strategic planning] hasn't been prioritized. (...) It's just that it's not on [our senior management's] radar as something that we need to work on, and so I work on other things that are priorities.

Although partnering public health units were delivering different services due to different capacities, they had nevertheless adopted the same strategic healthy school approach to promoting student well-being. To overcome the complication of partnering with different public health units that had different service delivery models, one public health professional suggested placing greater attention on what all partnering public health units had in common: a need for a data sharing agreement with the school board for identifying school priorities together; and a need to figure out how to closely work with the common school board on applying the healthy school approach across their schools.

According to this public health professional, the challenge with their extended partnership may be mitigated if the three public health units were to join forces at the inter-unit level, with a more formal meeting structure, and firmly establish a commonality of purpose to validate the importance of joint operational planning with their common school board. The intention would be to demonstrate the need to devise a common process for the creation of health schools that each public health unit could follow within their shared local school system, regardless of the specific services that would be offered to the schools. In their view, this joint demonstration of need may help catch the attention of public health leaders so that they could see the value of having more in-depth conversations about joint operational planning with school board executives. As the public health professional explained:

I think that our mission now is to work more collaboratively, to get these things sorted out. (...) Trying to get everyone on the same page (...) to figure out what might be some things that we want to work on together, like a data sharing agreement, (...) because we'd all three benefit from more collaboration. (...) I think we try and do our best to stay on message: 'What we are'; 'How we can provide support'. The levels of support might be different, but we're there to provide certain activities in the schools. All three health units are working with the healthy school approach. That is the basis of our action planning. (...) We've been trying to

establish more of a formal local network between the three of us to figure out, 'Okay, how do we, as three health units, work with one board more collaboratively'. (...) It would be helpful to invest the time and energy to work more collaboratively with our partnering health units and to have a more formalized process to do that. (...) I think we could do the first step, that would be that the three health units get together and say, 'Look, we want to expend some resources into (...) [building] a better partnership with our board—(...) before you could really approach the board to do that. (...) We all have to get on the same page to offer that, and I can guarantee that [the other health units] are interested. (...) Okay, great, we have that discussion and all three health units are on board [for joint planning], but we have to have a willing partner across the aisle. (...) I think we probably should meet as health units, with that board, to do some planning about how we can all three health units assist them in applying the healthy schools approach, (...) [but] then it would be up to [the top leadership] to set that tone. (...) [So, we could] bring it up that way [to our Medical Officers of Health] to show that there is a need and bring [attention to joint strategic planning] from the ground up.

8.2.6 Competing priorities and diverse portfolios due to insufficient capacity

Inadequate resources, as well as a shortage of time, were additional factors hindering engagement across the public health and education sectors. Some school health partnerships were not faring as well as others. This was, in part, due to the issues mentioned above related to multiple overlapping jurisdictions, which were complicating efforts to build relationships and provide equitable services, and in other part, due to a lack of capacity, resulting in the emergence of competing priorities. As one public health manager indicated:

I would like for us to be at the forefront, (...) [where] we can work with them [and there's] more back and forth. Right now, we always send the invite out. We reach out, but we don't always get responses. Again, it's that communication part. We feel that our boards are really overwhelmed with the region and all the different priorities. (...) We're trying to find that support for the directors because we feel that they have such competing priorities.

Public health professionals spoke of competing priorities within their own organizations, as well. Another stark consequence of inequities in resource distribution dealt with the portfolios of managers from public health units located in large urban centers versus those in more rural or northern areas, whose populations were smaller and/or more dispersed. Public health units in large urban cities could finance managerial positions where the sole focus was health promotion in schools. In less urban areas, public health managers with a health promotion portfolio were covering both school and community settings, such that they were not able to engage with key actors in their local school systems to the same extent as their counterparts in larger urban areas. As one public health manager commented, they would find

themselves be pulled in many directions due to having a diverse portfolio that encompassed different public health domains, not just school health:

I have three portfolios that I manage, versus at the large health unit, they have a manager for elementary schools and a manager for youth [in secondary schools]. (...) Their capacity there is quite a lot higher. I'm in different meetings all the time, so for me to expend the energy or the time commitment on something that's specific, it's difficult to prioritize. (...) So these are some of the things that can happen, because of location and capacity. When you're managing just schools, you have the ability to concentrate more on that topic area, so you can build more relationships and have more time to do that work than, potentially, (...) [someone] who has multiple portfolios.

Not all public health managers working in school health could dedicate their time exclusively to working with school boards and schools. Those who could not were engaged in many community collaboratives as well as school health initiatives, and therefore, they found it “*challenging to make space to meet.*”

Competing priorities arose from a lack of capacity, such as a shortage of dedicated personnel to work on school health, combined with too many unmet needs. This was directly related to time constraints for cross-sector engagement, especially in regard to extended partnerships. For example, at one partnership with multiple school health partners, issues with capacity, including the availability of time for planning discussions, were encountered across all partnering organizations. As the public health professional stated:

The strategic planning process at each organization is very difficult to pull together. (...) We don't necessarily have the time to be sitting on everybody else's strategic planning table to help identify [operational] priorities, and it goes for all organizations, both ways. It's a time and capacity factor as well. Ideally, it would make sense, but logistically and realistically, it's very challenging. Just trying to get your own health unit, [that is your] management and board of health teams together to be able to do the strategic planning is challenging enough, never mind dealing with [other] health units and different school boards. They have their own processes that they have to deal with. (...) I would say that there is this time restraint. It's very hard for decision-makers in these organizations to get together, so it's very fortunate when we can get them together once a year.

With widespread capacity insufficiencies, meetings may not be easily set up between public health units and school boards, as each may have their own respective sets of organization-based needs that require their immediate attention. However, the unmet needs giving rise to competing priorities within local school systems may be more complex and more demanding than those faced by public health units. According to public health professionals, educators encountered two sets of priorities that could

overshadow cooperative or collaborative partnership opportunities for health promotion in schools, by exacerbating resource limitations. These priorities revolved around major student-related problems and heavy education pressures.

Those school boards and schools that were located in low socioeconomic communities tended to spend much of their time and resources countering issues pertaining to crisis situations and student misbehavior in the classroom. As a public health manager explained:

If there is a school that is struggling with crisis after crisis, after crisis, we may not be that involved with comprehensive school health because they're just trying to meet the daily needs and don't have a lot of resources to put toward comprehensive school health. So, they may have a large number of students who potentially are hurting themselves like suicide risks, cutting, drug use, who are not getting enough to eat. Behavioral issues are a huge problem. Kids come from families that don't often have a lot of rules and regulations, or don't have a lot of resources, so they come to school and there's a lot of acting out, there's a lot of challenging behaviors that the school has to deal with. And a lot of these schools have many students that are like that. So, they're just trying to keep a sense of calm, and control, in the schools by dealing with those kinds of behavior.

In schools where a significant proportion of students lived in low socioeconomic conditions, a pattern of reacting to constant crises was consuming a great deal of educators' time and keeping them from taking on more of a health promotion focus. More concerted efforts would be required to bring these schools to a state of readiness where the healthy school approach could be embraced.

The second set of priorities centered on the traditional education pressures to get students to excel in literacy and numeracy through academically oriented efforts. Public health units engaged more or less extensively with different school boards, depending on the degree to which they were prioritizing health promotion within their district, along with education priorities as such. At one public health unit, cross-sector engagement with one of their main school boards was being undertaken at their highest level of capacity because participation in the school health partnership was highly prioritized. By contrast, health promotion was not given as much attention by their other school board such that less time was being allocated for partnership activities. As the public health manager explained:

It's also a sense of where [the school boards] put their priorities. It's very clear to us from [our main] school board that health and student well-being is a priority, working with the health unit, that's a priority. We'll do it as best as we can, based on our capacity and our resources and our organizational structure. With the other school board, (...) they have a student well-

being department, and they have a mental health lead, and it's all very important, but (...) high decision-makers say the priority is education. (...) [So,] it's a bit more challenging to get in the door, (...) because they make it very clear that their priority is education first. Literacy and numeracy come first. (...) Student mental health, student well-being, physical activity, healthy eating, those things have really been amplified now in education, but we still have a long way to go, because they're still seen as the add-ons for teachers and school boards. They still see their core priority, and I'm speaking very broadly, generalizing, as education, literacy and numeracy. (...) It's like you have to find out, what's the priority, what's coming from the Ministry of Education that actually has dollars tagged to it, because that's where the work gets done, unfortunately. It's a sign of the times: nobody has staff or money.

How priorities were determined may have had much to do with the availability of capacity, such as earmarked funding for health promotion, in addition to the extent of pressing needs.

Although there may have been cross-sector planning happening at the school board level, school health partnership activities were usually concentrated at the school level. Despite limited capacity, a principal's mindset in and of itself could be a major determining factor in the extent to which the school health partnership was to be prioritized in their school. As one public health manager noted, cross-sector engagement varied in extensiveness from school to school, within the same school board district, depending on principals' convictions, and feeling of proficiency with school health planning:

It depends on who and what the priority of each principal is. Some would want to focus on literacy. Some would want to focus on numeracy and you won't receive a call from them or perhaps they have a lot of experience in school health and they're okay. But then you'll have others that reach out constantly for help. I think that's a very common issue. The priorities of the school depend on the strengths and priorities of that principal.

Public health professionals commented that school boards and schools were not mandated to partner with their local public health units for health promotion as they were for health protection services. Their approach to circumventing competing priorities within local school systems was to bring home the message that health promotion was a major contributor to academic success:

Oral health, dentistry, when kids are in pain because of multiple caries, they can't learn, that's pretty black and white. (...) How to teach kids how to make healthy snacks, 'How does that help me?' in terms of education looking at the value, because they have such competing priorities. The health protection stuff, it's going to happen, (...) because it's mandated, it's legislated. Then with all the other stuff, it just perhaps has never been articulated as having value. But when you tie student health and well-being, especially mental health promotion and the protective factors of healthy eating and physical activity to mental wellness and to

thinking clearly, then it has value because that affects those kids in school and that affects their learning outcome.

8.2.7 Absence of a well-established system for joint strategic planning

Besides the challenges covered above, another factor that was hindering less advanced school health partnerships was the absence of an established system for high-level joint planning that was partnership specific. To maximize the collaborative potential of cross-sector engagement, joint planning that articulated a vision for the partnership itself and that dealt explicitly with partnership activities was considered to be of utmost importance by public health professionals. In advanced school health partnerships, high-level partnership-specific strategic planning consisted of setting a common vision, strategic direction and broad shared goals for the long term. Joint strategic planning for the short term occurred at the operational level, when deciding together on common priorities, specific shared goals, and operational strategies to guide their school health partnership for the coming school year.

The general planning practice of public health units and school boards was to design a multi-year strategic plan (or set corporate strategic priorities) for their respective organizations, every three to five years. This planning process was meant to cover the full range of strategic activity areas within their entire organization. Each school health partner could still seek input from the other partner during their multi-year strategic planning process when it pertained to student well-being. However, as a public health director pointed out, a more critical planning practice was engaging in strategic thinking that was rather specific to the school health partnership, in order to drive it forward more purposefully:

I think for me that partnership would be really enriched if strategic planning would be part of our relationship. We did do strategic planning a few years ago in our organization, and at that point we did do a call out to all of our partners, to give us feedback on where we're going. So, the school boards were a part of that, but it wasn't unique to the relationship that we had. It was more of a broad call out to community partners for input on our strategic planning. We have staff that is assigned to each school. So, with our staff as part of their environment, it would be good to (...) [look together at]—what's working, what's not working—for some visioning. And representing the staff at that higher level, it would be great to be part of [joint planning] because we have common populations that we deal with, we have very common goals when it comes to health and well-being.

Following a joint visioning exercise and the setting of a clear multi-year partnership direction, joint operational planning—which is still part of strategic thinking—would then be prepared to articulate the

main partnership priorities and corresponding operational strategies on an annual basis. Public health professionals in less advanced school health partnerships felt that their partnerships were far from reaching their potential when their professional knowledge, insights, and data were not being fully tapped during school boards' planning processes. As one public health manager expressed:

I feel we should have in-depth discussions with our school board partners about how we can work together [and] what are the areas that are the most challenging that need the most resources. (...) There's communication back and forth about concussion, or about nutrition in schools, or about mental health programming in the schools, topic-specific stuff. It really should start even higher up than that. It should be at the high level where we gather input from the lower levels and bring that up and say 'OK, let's look at the big picture here. What are the most important areas where we can focus our efforts just for the next three years, let's say, to make some improvement.' (...) And that's assuming we have gathered input from students, parents, school staff, public health staff, etc. (...) We are out in the schools, with the teachers, with the students. So, we hear a lot, we see a lot, we know a lot of the struggles that the teachers are having and that the students are having, and the families, the parents we have connections with. The boards do surveys of parents and surveys of students; we rarely see their data – the results of their surveys. So, we're both working in the dark, in our own little world. And I love my boards. In the things that we work together on, the work is fantastic. I just see that we could make it better, we could make it more effective.

Indeed, not all school boards had been putting their local public health unit's available data to full use. Public health professionals articulated the value that their local school boards could draw from them, were they to be invited to provide the necessary data that would ensure a better fit between their strategic directions and actual local needs:

Now that [school boards] have a direct pillar in their strategic plan around health and well-being, by [...] allowing public health to come in and listen to our thoughts and [look at] our data, they [would be] (...) really ensuring that their plans reflect the local level. (...) The health unit can bring that local data forward to really help (...) [know] what are the real issues. In actual fact, our role is really to ensure that we work around data and that we can do something about that. Involving public health in the development of their strategic plan, (...) it's about [the health unit] providing the data and the information they need to build a better plan.

Another major challenge regarding joint strategic planning was the lack of a formal process to collect and share data for evaluation purposes. At one school health partnership, the partnering organizations had begun to closely examine what were the system barriers preventing them from planning together, especially in regard to the ethical considerations of producing student-based data necessary to evaluate progress. As the public health manager indicated:

I think education now understands and sees the value of health and so the timing is right just like any policy window to come into joint partnership where we can jointly plan, jointly implement, jointly evaluate. (...) We identified that we have to work through some existing barriers related to research and data sharing. We've agreed to forming a subcommittee to deal with just that because if we're going to jointly plan and implement we have to be able to jointly evaluate (...) and report on our outcomes. (...) We're in this together, (...) [so] we're right now each identifying who those people will be that will sit on a subcommittee to address research and ethics and data sharing [requirements].

According to public health professionals, there was much potential in exploring collaboration possibilities at a strategic level, for the purpose of making more significant improvements in students' lives. Yet, in many school health partnerships, the tendency was to plan strategically in isolation for the most part. One public health manager explained why they considered joint operational planning to be important for school health partnerships:

We haven't been able to establish a strong working plan with the school boards. We'd like to be able to be part of the planning part so that we could get all the programs in line with what they need, basically. We haven't been able to formalize that strategic planning together. I think once we get to that stage where we can plan together, what we will be offering in the coming year, I think that will really assist both the school boards and ourselves in regard to working toward the healthy school approach. Right now, I think that that's the issue. We're planning on our side. They're planning on their side. We haven't made that connection in regard to how do we plan together. (...) That's what was nice with mental health, because it was easy. [Our school boards] have all identified that, and that was where we concentrated our efforts, but we can't just do mental health. We need to do all the rest of the public health work. If we look at the model in regard to the Foundations for a Healthy School, we have to address physical activity, healthy nutrition, healthy relationships. Everything. It's all intertwined. (...) [Joint planning is important] so that we can look at policy, we can look at the school environment, look at the community partners that need to be brought in to better support the schools in regard to the safety and the health of the students.

As a major system barrier, parallel planning structures that maintained a silo mentality perpetuated sector isolation. To remove such barriers, as well as produce efficiencies in time management and increase their partnership's impact, public health professionals were seeking opportunities to integrate planning processes across the public health and education sectors. School boards were already expecting their schools to engage in improvement planning along school board priority areas. As one public health manager reasoned, making arrangements to have public health representatives be present during those parts of their planning processes related to student well-being would necessarily lead to a more efficient use of time as well as the alignment of specific goals and objectives for better results:

We're mandated to collaborate and to partner. (...) [Teachers] are not provided with time and opportunity to spend with a community partner to plan something specific. And so, it's in addition for them to partner. For us, it's part of our core work. We're given time, we're given that as priority. (...) If we had more alignment for the strategic planning, [between] school boards and public health, (...) if we had mutual goals and objectives—I don't mean everything has to be the same, but if there was some alignment—I think it would take care of some of these [time-related] issues because it would be part of the school board improvement plan, it would be part of the individual school improvement plan, and it would happen more readily than it is now.

Public health units and their school board and school partners had their own operational planning processes for improving student well-being that had yet to be brought together in many school health partnerships. In certain instances, public health professionals conducted school assessments and involved their local school boards and their schools in the preparation of their public health units' operational plans, but this practice was not well linked to schools' improvement planning processes. As a public health manager indicated:

When looking at strategic planning for health promotion in schools, looking at whether the health unit and the school boards can come together for joint strategic planning, that's our school health profile. We have regular meetings that we set up with our school boards as a review of our programs and services that are being provided to schools, but also as an opportunity to identify any new strategies that we're promoting [and] to hear their concerns of anything that's coming up on their end. (...) In the past, it's been hit or miss. The schools have their school improvement planning that they have to do. We have our school profile that our nurses do. So far, we haven't linked the two formerly.

To mitigate this situation, the public health manager quoted above had started a conversation with their school board partners about the possibility of formally integrating their respective operational planning processes, especially at the school level:

But now we're trying to formalize that, (...) because we know at a ministerial level, there isn't an interministerial agreement saying, [or] Public Health Standards, (...) [telling us,] 'Work with education to ensure school improvement plans are aligned with your health priorities.' That doesn't happen. But we know that at our level we can look city-wide, and say to our board counterparts 'If we can sign an MOU to define our role to support your principals as a dyad to be your health professional guidance, providing surveillance data, providing some expert advice, and also aligning to give you evidence-based approaches to fulfill that, we can move you forward with your [well-being] strategy and we can fulfill our mandate as public health. (...) And [having it in writing] would probably be year to year because those priorities adjust every year.

In advanced school health partnerships that were already geared toward cross-sector strategic thinking, formally written documents had been prepared to articulate how the school health partners were to engage with each other at a high strategic level. By contrast, public health professionals who were experiencing difficulties in their ability to plan strategically alongside school boards and schools commented that a joint planning system would need to be established through the direct engagement of the top leadership from each sector. However, the additional challenge was that these decision-makers did not necessarily meet for this purpose, if they did meet at all. As another public health manager explained:

Some schools are more engaged than others and work with us at more of a comprehensive level than others do. But it's a school-health unit relationship, not a health unit-school board relationship. (...) [School board engagement] would still be really important. I think it would make it much easier if the school board was the one to say 'Yes, this is how we work on joint initiatives together.' That's the piece that's missing. We've gone as far as we can at the school level. We need the top level to be setting a framework for how we're going to function together. I don't think there's a lot of formal communication that goes on about the relationship between the school board and the board of health. I don't think that this is something that is discussed at the board of health at all. (...) [School boards'] priority is around the academic and success of the student. So, anything related to health promotion is like an extra add-on for them. So, it falls low on their list of priorities, to work on programming in that area with anybody.

When insufficient resources were available to provide adequate health promotion support to all of the schools within their catchment areas, public health professionals felt that planning efforts would need to be integrated at the school board level, as well, so as to enable greater success in producing a significant impact. More partnership-focused conversations between senior management from both partnering organizations, and even ministerial partners, were seen as imperative to give clear directives for establishing system-wide structures and processes to engage in joint strategic planning. As one public health manager indicated:

The key actors in that would need to be the directors of education, the medical officers of health, and management staff in public health to facilitate that. (...) We can't be expecting teachers to sit down and think strategically and all of that at the systems level. (...) [So,] we need to put the building blocks in place to make a structure for teachers, everyone to be successful. Without doing that at an executive or higher level, it doesn't get done at the frontline level because there's no time, and it's not supposed to get done at that level.

Many public health professionals echoed the need to put a joint planning system in place to maximize their partnership's collaboration potential. For instance, another public health professional contended

that the tendency for their organization and their partners to work in silos could best be countered through the concerted efforts of the ministries of education, health, and children's services to provide the necessary system supports that would enable cross-sector collaboration:

This goes further than just school boards and health units. (...) The Ministry of Education and the Ministry of Health and Long-term Care need to work more closely together along with the Ministry of Child and Youth Services (...) to set the systems in place for us to work together. (...) [In] a society where we're having to do more and more with less and less resources, you find people silo-ed more and more.

8.3 Public health professionals' aspirations

Public health professionals in less advanced school health partnerships spoke often of feeling hopeful about eventually being able to engage at a more extensive level with their school board and school partners. They aspired to cultivate closer partnership ties, where they could have more thorough discussions about how they could work together to make better use of available public health resources. In those situations where public health units had not yet established a collaborative partnership arrangement, they were hopeful about coming across partnership opportunities where they could be invited to attend their school boards' strategic planning meetings. Beyond having input into each other's strategic plan, public health professionals expressed their aspiration to jointly create, with their partnering school boards, a multi-year strategic plan that was specific to their school health partnerships to set a clear and strong direction for moving forward together on the same path to improving student well-being.

Although public health professionals had historically been working in schools to provide health protection services, not all had close working relationships with the personnel at their local school boards and schools in the area of health promotion. For those whose school health partnerships extended to school boards, engagement was limited, in certain instances, to obtaining approval for delivering school health initiatives in their schools. Furthermore, several public health units reported that their school boards were likely developing school health initiatives without knowing about relevant public health information and resources that could be shared (e.g., connections with other potential partners, evidence of best practices). An aspiration often expressed by public health professionals in less advanced school health partnerships was the opportunity to engage in joint strategic planning with their school board and school partners. As a public health professional commented:

We're trying to link to the strategic planning processes in the school boards. Right now, we are having those discussions in regard to how to plan together because we really want to support our schools as best we can and really understand what their issues are, (...) [and] how do we move forward and put a holistic approach to the strategic plan of the schools. (...) We're looking at opportunities to sit with them (...) [for the strategic] planning part. (...) Hopefully, this will go well, and the school boards will see the value of working directly with us.

By sitting at the main planning table together, public health professionals stated that they would have a clearer idea of how they could support their school board partners, as they look for opportunities to fulfill their public health mandate to a greater extent. For example, one school health coordinator expressed their hope of one day being able to have strategic discussions with their school board partner about the direction that could be undertaken together regarding their school health partnership:

What I would like to see happening is – they're still going to write their own school board strategic plan that is broader than health and student well-being. They're going to look to meet the goals of their Ministry of Education in the vision document. So, they're looking at graduation rates, and they're looking at public confidence, and all those pieces are in their strategic plan—but what I see us doing, hopefully, is joint planning related to health and physical [curriculum], and student well-being. (...) That's what I was hoping to accomplish through the partnership and service agreements, that it would be that first high-level commitment to go down that path together.

With a hopeful disposition, public health professionals were seeking more meaningful engagement with their school board partners so that they could provide greater support.

For less advanced school health partnerships, a major joint task at the top of public health professionals' list of aspirations was the co-creation of a strategic plan, or strategy, that was specific to their school health partnerships, as the next planning phase to flow from the intersection point between their respective multi-year strategic plans, or mandates. As one public health manager stated, this would give both school health partners the ability to jointly focus on areas of mutual interests and measure how well their partnership was succeeding in making desired improvements:

That's where I would say the community comes together for joint strategic planning, but that very focused 'health unit and school board coming together' is really where we would like to see [us go]. So absolutely [there's] connection and partnership within the community, but [not] that focused health unit and school board only, in that area. We have definitely identified that as an area of growth for us for the next strategic year. We would [like to] secure a more formalized conversation with the boards to identify the areas of mutual interest, and then (...) see that become strengthened through more formalized reflection around mutual plans—then measuring success around that working relationship.

A truly collaborative school health partnership was considered to have begun when the public health unit was able to make arrangements to engage in specific shared goals that figured among their school system partners' top priorities. Such an arrangement ensured that both partnering organizations were maximizing the impact of their efforts by joining forces and focusing their limited resources on the same prioritized well-being issues for a sustained period of time. The following school health coordinator's aspiration was one that was shared among many other public health professionals:

That is what I am hoping to accomplish. I'm hoping that through that joint planning, then we as public health can bring that back and say, 'Okay, staff, these are the joint priorities. We're going to put our limited human resources and money behind these priorities for the next two years. This is our goal. These are our objectives that we've set together. Now we develop the programs, or we pull the provincial programs, and we start implementing them. We know that it's meeting our mandate. We know that it's meeting the school board's mandate. We've decided jointly that based on the data, this is an important thing for our school communities. That's my pipe dream. (...) Right now, we plan separately, and we connect where we see obvious connections, but we're like two kids playing in a sandbox beside each other, and we might share our toys every now and then, but we're not actually working together to build a sand castle. I want to build the sand castle [together].

Public health units and school boards may be working diligently from their respective sides to fulfill their common mandate of improving student well-being, with mutual support being provided along the way. However, joint strategic planning for that deep sense of working on the same goal together was missing.

On that note, public health professionals gave a number of reasons why they were aspiring to engage in joint strategic planning with school board executives. Strategizing together in the area of student well-being would (1) allow public health units to know how their support could better fit in their school board partners' high-level strategic plans and annual operational plans; (2) standardize the development of initiatives across the district to ensure equity in service, as best as possible; (3) create efficiencies in their service delivery to help overcome resource shortages; and (4) most importantly, increase their ability to improve student well-being through the synergistic effects of their collective efforts. Working alongside each other promised to create synergies through which to achieve much greater results than what would have been possible when planning the work in isolation. Public health professionals pointed out, though, that the top leadership from both public health and education sectors would need to be more actively engaged with partnership activities if joint strategic planning was to become a possibility.

Public health professionals felt that they had valuable knowledge to share about health-related issues concerning the younger generation, and that they could bring forward school health policy ideas, backed up by evidenced-based strategies and best practices, to assist school boards in their efforts to tackle these issues. They aspired to collaborate on policy work with their local school boards, if they were not already doing so. The main reasons for wanting to engage in joint policy development were to accomplish better cross-sector alignment and ensure more effective policy implementation. Public health professionals reported that their work at the school level could proceed more productively by engaging in policy discussion with school board executives so that together they could figure out how best to align school board policies and health promotion efforts. Furthermore, their presence at the policy planning table was seen as beneficial for ensuring well-informed school health policy decisions and smoother policy implementation. As a public health professional indicated:

We have the knowledge about the [school health] policies and have the knowledge of the needs of our community. I think it makes perfect sense that we would work with them on their policies. (...) That helps prevent some of the implementation problems that occur, and that also helps correct some misinformation that could go in the policy. (...) It is to make sure that the policy covers what it should cover, to make sure it covers that minimal requirement.

Contributing their views on school boards' policies was very important to public health professionals, as it could well lead to greater partnership advancements in creating healthy school environments. Although they were mandated to partner with school boards on the healthy school approach, public health professionals were not necessarily being contacted by school boards. Another public health professional felt that school boards could make greater progress in creating healthy school environments if they were more aware of how partnering with their local public health unit could support them:

We have many resources that we would be able to give [our school boards] and support them in their decision-making. Sometimes it makes it hard for us to meet our standards because we're not engaged with them, [and] so the policies don't necessarily always have the health lens that we are looking for. (...) For example, in my world—I do school health—so comprehensive school health is hard to do without their engagement because sometimes they create internal policies that don't reflect what we are looking for. Or, I think they always do what they think is best but sometimes if they had more information from us, or one of us at the table, it might be a better overall policy. (...) We do provide information if they want to take it, but that isn't necessarily always the case. I don't know that they don't want it, they just don't think of us.

Joint planning at the school level was yet another public health aspiration. Since schools were proceeding with their own planning process to put in place school health initiatives, those public health professionals

who had the capacity for working collaboratively on operational planning with their local schools were wishing for the integration of planning approaches. They felt that partnership efficiencies could be reaped by merging their public health unit's school needs assessments and strategic ideas on how to address identified needs with each school's own improvement planning process. As a public health professional commented:

The hope would be that the school boards would encourage their schools to work closely with their assigned nurses on their planning process, especially their well-being strategy, to ensure integration and coordination.

Joint operational planning would ensure a seamless flow of partnership-related activities at the implementation stage. Equally of value to public health professionals was the opportunity of co-delivering school boards' school health initiatives. Public health professionals commented that when school boards planned school health initiatives by themselves, they may not have realized that they could access implementation resource support from their local public health units. For example, one public health unit stated that they would have appreciated receiving school board training in areas that were compatible with their public health mandate so that they could serve as an additional pool of human resources. By being trained to deliver initiatives on their school board partners' behalf, it was thought that the public health frontline staff could then strengthen partnership ties at the school level to further advance cross-sector engagement:

We are always interested in partnership and collaboration and would benefit from [the mental health leads'] expertise. We would like to be involved especially if there are opportunities for our school health staff to support and contribute to their initiatives and if they also complement our programming. Being involved in their initiatives could impact skill and knowledge growth among our staff and increase our presence in the school setting which impacts relationship building with school staff and students.

In those situations where joint strategic planning was not yet possible, public health professionals aspired to, at best, be consulted on school boards' multi-year strategic and operational plans so that their partnerships could be more at the forefront of health promotion activities within their local school systems. As well, they wished to be able to consult their school system partners in turn for their input on public health-led initiatives they were considering offering schools in order to ensure their relevance and feasibility.

8.4 Supporting conditions for moving along the collaboration continuum

As relationships become stronger, school health partnership arrangements move along the collaboration continuum. This movement toward a fully developed partnership depended on a wide variety of factors. So far, in the previous chapters, the generation of a vibrant partnership has been explored through the perspective of the public health sector. The enabling and enriching elements generating school health partnerships granted partners the *ability* to engage with one another in *enriching* ways, through the relationships that were being built during cross-sector engagement. Additional elements have been uncovered that are related to cross-sector engagement, but distinctively represent those sets of conditions that support the initiation and progression of this engagement, going from networking to cooperation to collaboration.

8.4.1 Networking conditions for exploring partnership opportunities in health promotion

In Ontario, the Ministry of Education has incorporated the ideals of a healthy and thriving child within the education profession. To address the needs of the whole child, they have given health promotion responsibilities to educators and have participated in inter-ministerial strategic initiatives that encourage local cross-sector partnerships for the promotion of student well-being. These provincial actions represented the conditions that supported networking activities across the public health and education sectors, where cross-sector engagement had not been very active at the school board level for health promotion. With these networking conditions in place, cross-sector engagement that was mainly centered around health protection services began to include, in certain instances, the sharing of information about health promotion and possible ways of engaging more extensively in this area.

a. Ministry-assigned health promotion responsibilities

The Ontario Ministry of Education has shaped a health-oriented education sector by adding health promotion to educators' realm of responsibilities through the mechanism of legislation. In 2010, the

Education Act was amended to mandate the goal of student well-being within local school systems.* The Ministry's expanded vision for student achievement with its added student well-being goal emphasizes health for greater academic success and introduces the aspect of accountability in health promotion efforts, thus increasing the relevance of engaging with local public health units. As a public health manager pointed out:

There's value to [school boards] in working in partnership with us because student well-being is now one of their four identified goals in their [Ministry of Education's] vision document. It's now going to be measured and therefore it gets traction.

As a result of this ministerial action, public health units that did not yet have close partnership ties with their local school boards around health promotion found an opening to begin exploring the potential of working together on matters of mutual interests in this area. As another public health manager reported:

[School boards] are very much focused on academia. (...) Now, while it's been long understood that both are interrelated, education and health, it's finally been adopted at the highest level, from a Ministry level. So, it was huge (...)—this new way of thinking. (...) The Ministry of Education added the goal of student well-being, and (...) [this] actually initiated the conversation [with our school boards].

It is to be noted that certain school boards have been promoting student well-being in partnership with their local public health units long before the Ministry of Education made it one of its mandated goals.

b. Inter-ministerial strategic initiatives that encourage local partnerships

As an added measure to innovate local school systems, inter-ministerial strategic initiatives served in part to encourage cross-sector engagement within the education profession. Public health professionals found that these provincial-level initiatives helped foster networking activities to explore partnership opportunities for student well-being. These initiatives included joint regional training events, and school health policy directives.

* Government of Ontario. (2010). *Education Act*, R.S.O. 1990, c. E.2. Retrieved from <<https://www.ontario.ca/laws/statute/90e02/v36>>

Regional training sessions were found suitable to foster networking activities for health promotion in schools. The Ministry of Education enhanced networking opportunities by having public health professionals attend their regional training sessions about the revised Health and Physical Education Curriculum, which had been linked to the healthy school approach. Such joint training allowed public health units to make their potential school health contributions known to local school boards in efforts to raise partnership interest. As a public health manager pointed out:

The Ministry of Education, they did [regional training] sessions (...) related to the new [health and physical education] curriculum's implementation—and the Foundations for a Healthy School also is a component of that—to show how the two should work together: you just can't teach what's in the curriculum without impacting the environment of the school or your community partnerships. (...) When you're sitting around the same table as education staff, (...) some of the relationships (...) were built through that and [through] them recognizing that we can support them in their work.

As well, the inter-ministerial launching of school health policy directives promoted cross-sector engagement at the local level. Regarding policy work, a trend began at the inter-ministerial level to communicate school health policy requirements through both the education and public health sectors. The Ministry of Education disseminated, in conjunction with the Ministry of Health and Long-term Care, school health policy directives that ranged from the promotion of healthy living to the management of medical conditions in schools. Situations arose where public health units were prompted by their ministry to reach out to local school boards with their offer of policy advice. Likewise, school boards were receiving their own ministerial requests to actively seek the policy support of their local public health units as a valuable partner. One public health manager indicated that their networking activities increased as a result of the coordinated communication activities of the ministries of education and health:

We would get an email through our Ministry that would be from the Ministry of Education. We are often included now in communications; we are considered a key stakeholder, which is really nice. (...) The Ministry of Health and the Ministry of Education, in the last couple of years, have been working together a lot closer. So, what we have found is that, as they roll out policies, like PPM 150—the School Food and Beverage one—or the concussion protocol, Rowan's Law, Sabrina's Law, those are legislations, when those things are rolled out, the Ministry of Education is encouraging their school boards to connect with public health to create a policy that would work for the schools, (...) or we have been made aware of these policies coming down [by our Ministry of Health]. (...) So, we would definitely connect with [our local school boards] and do that.

Inter-ministerial actions played an important part in bringing public health units together with some, but not all, school boards for which school health partnerships had been slow to initiate. However, networking to explore partnership opportunities could still be taking place, to a lesser or greater extent, after experiencing a cooperative or collaborative partnership arrangement. Regardless of prior engagement levels, public health professionals stated that without a stable interorganizational structure to enable partnership activities for the long term, major networking efforts were required on a yearly basis, or whenever a new school health idea came to mind, the personnel changed, or some other change in the work environment occurred. In such situations, they needed to market their offer of support repeatedly until a cooperative or collaborative arrangement could be established once again. Moving from networking to at least cooperation called for other conditions, as presented below.

8.4.2 Conditions to garner buy-in for cooperation in sharing school health resources

A cooperative partnership represents a mutual willingness to enter into a resource-sharing arrangement following a networking stage where cooperation conditions have either arisen or been created. Public health professionals realized that school boards and schools were likely to cooperate when a state of readiness was reached; a shared language was adopted; and partnership proposals were focused on what mattered within the context of school boards' strategic directions or emerging needs, so as to alleviate concerns about extra work.

a. State of readiness reached

First, school boards and schools had to be ready to engage in the upstream promotion of student well-being for cooperation to even be possible. At times, noncooperative school boards or their schools (i.e., low buy-in) were found to be unwilling to go along with their local public health units' proposed school health idea or initiative because the timing was not right. Those schools that were willing to enter into a partnership arrangement but were not yet ready to take on the healthy school process either received public health support to reach an adequate state of readiness to adopt this approach or engaged with their public health partners at whatever level of capacity they had.

When lack of buy-in was due to poor timing, school boards or their schools were either occupied with organizational restructuring or dealing with more pressing issues. Public health professionals were respectful of their school system partners' lack of readiness. They were careful not to push their own health promotion agenda, or priorities, since they were well aware that to do so would be unproductive. As a public health manager commented, regarding the need to wait for the right timing:

We want to try to sell the role of health promotion and what we can do in schools, but we also know that [school boards] have got a lot of other priorities coming down the pipe. (...) We have to meet them where they're at. So, when they say, 'We're now ready to do X,' we'll say, 'Great, let's jump on that.' That's our philosophy now. (...) We cannot force them to do anything that they're not ready to do. (...) We'll definitely share what we would like to be able to support them with, but if they're not interested, then we can't make it happen.

Persisting with their networking activities, this public health unit stayed in touch, as they waited to be notified by their local school boards that they were ready to cooperate on a common goal.

Readiness and capacity were closely related. Not all schools that were willing to partner were ready to engage in the healthy school process. These schools were seen as lacking either the capacity or interest in establishing a healthy school committee. In the former situation, public health frontline staff would provide facilitative support to build the schools' capacity to run a committee so that they could reach the necessary state of readiness to adopt the healthy school process and participate in more partnership activities. In the latter case, the school health partnership would proceed without a committee, engaging across sectors at whatever capacity the schools had. In certain school health partnerships, more support was provided to receptive high-needs schools, relative to high-functioning schools, due to a shortage of public health frontline staff. As a public health manager commented:

Basically, there has to be buy in; there has to be that readiness in the school to enact the changes and to do the [partnership] work. (...) Usually, it's through a healthy schools committee, to go through that [healthy school] process. (...) I have to prioritize my staff [for] the schools that have no healthy schools committee, who don't have much capacity or readiness to do these things [on their own]. (...) We provide more services to those schools. We're trying to bring the schools that are low functioning up to at least some level, (...) [either helping to set up] the healthy school committee or doing some health promotion activities, if there's not the buy-in to actually get a healthy school committee up and running.

Having attained a suitable level of readiness, other supporting conditions may have been required to reach resource-sharing agreements for the promotion of student well-being. With the availability of an

adequate level of initial capacity as a key partnership enabler, there were instances where the move to a cooperative partnership arrangement was supported by the use of a shared language for discussing partnership possibilities.

b. Adoption of a shared language

Clear communication during the networking stage supported the move to a cooperative partnership arrangement through a greater understanding about the work that could be carried out together. Public health professionals realized that the clarity of communication depended on whether or not they and their school system partners were speaking the same language—that is, using the same terminology, concepts, and expressions, and applying the same meaning to key terms. For greater ease of communication during their networking activities, public health professionals sought to gain familiarity with the language of the education sector, including their local school boards' culture, and to make use of that language in their conversations and in partnership documents. Then, once at the cooperative stage, ongoing attention to the use of a shared language helped ensure that cooperation remained a viable partnership option.

In their efforts to foster cooperative partnership arrangements, public health professionals remained current with the new developments coming from the Ministry of Education and adjusted their own language accordingly. For example, instead of talking about their Comprehensive School Health model, they spoke of the Foundations for a Healthy School framework to reference the same concepts and terminology as what was being used within the education sector. They also included the Ministry of Education's Well-being Strategy in their conversations with school system actors. Although this overarching strategy was still under development, its draft version was nevertheless deemed valuable for adopting the same language. As one public health manager pointed out:

We've got a Well-being Strategy that just got released by the Ministry of Education. (...) People are providing feedback to the Ministry, so it's not fully in place yet. (...) [But,] we stay in touch with what is going on. We adjust our language, (...) [so,] it makes a lot more sense. (...) We'll adopt the language [of that strategy], and when we look at the language, it aligns well with what we're doing.

Another public health professional from the same public health unit added:

Healthy schools is part of that [Well-being] approach; it's already embedded in there. (...) It's explicitly stated, but also for us it creates a great segue into how we fit in with them as well, because we also practice that model, the comprehensive school health [model]. So, it definitely aligns very well with their Well-being Strategy.

By adopting the same language, this public health unit's offer of support was being presented in terms that were most relevant to their local school boards and schools. It allowed all of them to make sense of opportunities to work together.

Public health professionals considered a shared language essential if culturally different organizations were to come together and intend on working on a common purpose for the long term. In one school health partnership, steps to create a shared language included the development of a glossary. In this glossary, key concepts and expressions from the public health and education sectors were defined so that each partner would be clear about the meaning behind the words being spoken during their conversations.

However, to fully establish a shared language, it may not be sufficient to employ the same terms and concepts found in official Ministry of Education documents, and clarify the meaning of key terms. Becoming familiar with educators' way of thinking was identified as equally necessary. For example, one public health unit took the initiative to get to know their local school board in the way they viewed student well-being and how they chose to function within this area. In doing so, they came to understand how their school board counterparts saw themselves improving the lives of students and what types of support would actually bring about a genuine and lasting interest in resource sharing. As the public health manager at this public health unit explained:

[At first,] it wasn't moving. It was just having conversations about [the school health partnership] to begin with, (...) [and about wanting to get] to work rather than to know what does 'well-being' mean to [the school board], and what is it that [the schools] are doing (...) [to know] what are the supports needed. (...) So, we did some briefings on mental well-being, what does it mean [in terms of] cognitive, spiritual, emotional, and physical well-being. I gave them a list of different definitions for them to discuss and to see what does well-being mean [to them]. (...) [Our school board is] a different organization which speaks a different language, so we needed to understand it. My previous experiences taught me that [when] we just go there with something that they may be interested in, we get buy-in but then we lose it. (...) It's not about, 'I'm going to come and do this,' or 'I can offer you this.' It's about actually

understanding how they work, so you can gain their buy-in in a meaningful way, because you speak their language. (...) Those kinds of things, you need to take into consideration before working with them. (...) [If we] don't understand how they function, and what is their organizational culture, (...) we come and we ask, 'Can we do this?' [but] then it's not what they need.

c. Partnership proposals focused on what matters to school boards

Even when speaking the same language, another condition had to be present for cooperation to be possible. Public health professionals were well aware that their proposed partnership focus had to matter within the context of school boards' strategic directions or emerging needs, so as not to be perceived as extra work. They commented that historically, they used to propose school health initiatives that they themselves wanted to implement in schools. They eventually realized that the resistance they were encountering was due to mounting education pressures within the local school systems. Consequently, more attention was given to school boards' own priorities and teachers' curriculum requirements. As a school health coordinator explained:

When I talk about resource development, support, and capacity building with the teachers, it's also to ensure that it aligns with their curriculum so that what we're doing is actually benefiting and supporting them and not pushing our priorities. It's actually working with them, (...) and allowing them to be able to do their job, and also to be able to pass along health promotion messages that are a part of their curriculum.

There have been situations where a given public health unit's own priorities were wholly matched with those of their local school board from the very start. With common priorities already identified at the school board level, public health frontline staff would then seek to gain buy-in from schools that were ready to receive their resources. When priorities were not that well aligned, a more tailored partnership approach had to be followed to increase the likelihood of cooperation.

Eager to do more for their local school systems, public health professionals employed various strategies to meet their priorities, while responding to those set by school board executives and school administrators. They did so in various ways: by gradually justifying partnership work in other public health areas; by framing public health proposals in a way that served their school system partners' own interests; by proposing initiatives that responded to both public health and education priorities, simultaneously; and by minimizing the perception that the healthy school approach would be extra work.

(i) Gradually justifying partnership work in other public health areas:

To engage in a cooperative partnership, public health professionals geared their support toward what school boards were prioritizing, while keeping in mind their own health-related topics of interest, if not the same. By first demonstrating their good fit within the local school system, public health professionals were in a better position to gradually bring their partnering school boards to understand how addressing other aspects of student well-being could serve them well. As a public health manager pointed out:

We used to go to the school boards and say, 'This is what we can offer you, and pick and choose.' We don't do that anymore. We say, 'What's important to you?' and we start there. And we always, always get to where we want to go. (...) We kept hearing that schools are overwhelmed. (...) So, how can we become one of them, and help them move their successes forward? And no matter what's important to them, (...) we always end up talking about our mandated stuff. (...) I totally trust that it always leads to what we are responsible for, in schools, around key topics like physical activity, nutrition, drugs, tobacco, alcohol.

(ii) Framing public health proposals to serve school system partners' own interests:

In other instances, public health professionals secured cooperation by first familiarizing themselves with what truly mattered to their local school boards. Then they would frame their initiatives, which were based on a public health priority, in a way that would primarily cater to these school boards' own interests. In doing so, resources that addressed a public health issue were offered to support a priority of greater importance to school board executives. Keeping their school boards' interests in mind, public health units did not present their proposed school health initiatives as a resource for a particular public health aim, but rather as a means to achieve a more appealing school board end. As another public health manager explained:

We may say, 'We want to promote physical activity.' (...) We're looking at it from an outcome perspective—that's what you're going to get. (...) [But then,] they're thinking, 'I want people to belong to the school,' 'I want to have a school culture, or a board culture, that's inviting and inclusive.' (...) I need to shift my thinking, because they are looking at [physical activity] as an objective, not as an outcome. (...) It's framing it as, 'You can create [school] belonging by promoting activities that bring people together.' (...) [Physical activity] becomes then the means to getting what they want.

(iii) Proposing initiatives that respond to both public health and education priorities simultaneously:

In search of strategies for moving from networking to cooperation, public health professionals found creative ways of designing school health initiatives that aimed to promote public health messaging, while at the same time, enhance competencies in the primary building blocks of education, namely literacy and

numeracy. Greater interest in public health support was experienced when resources, such as health-related lesson plans and teaching kits, met other curriculum-related requirements as well. For instance, one public health manager spoke of integrating mathematics exercises within nutrition-based lesson plans to assist teachers in developing their students' numeracy skills:

Whenever we can provide health-related programming, or services, that align really well and intersect with the other parts of the curriculum that they have to prioritize, (...) it makes it seem not so much as an add-on to what the teachers already are struggling to get in. (...) When it comes to teaching some things around nutrition, we can incorporate some numeracy around, say, calculating the [number of] teaspoons of sugar in a sugar-sweetened beverage so that there's overlap there, and the teachers are able to say 'Okay, by taking on that health-related lesson plan, I can also make sure that I'm reinforcing certain things in numeracy for my math curriculum.'

By integrating traditional curriculum requirements into school health initiatives, public health units garnered greater interest in their resources since this practice further supported teachers in fulfilling overall ministerial expectations.

(iv) Minimizing the perception that the healthy school approach will be extra work:

Public health professionals knew that what also mattered to school boards was minimizing the perception of extra work when proposing to partner on the healthy school approach. They succeeded in obtaining school boards' cooperation through assurances that their offer of support would be tailored to meet actual school needs and would strategically build on what already existed in their schools, so as not to overwhelm school staff. As a public health manager stated:

[Our school health programming] was built using the pillars that were in the healthy school foundations [document]. (...) At the directors' level, it was something that [the school boards] were open to and that they bought into. (...) We did share some of the great things that they are already doing in the schools to have the conversation that it's not meant to be extra work. (...) [That's] the intention of this model, to try and meet with principals to assess their needs for their school for that year under the comprehensive school health model, (...) [and say,] 'These are the areas that we can support.'

In situations where school boards were supportive of partnership work toward the creation of healthy schools, cooperation at the school level did not necessarily follow due to a lack of networking opportunities between public health frontline staff and principals. Public health professionals felt that the chance to directly meet with principals could potentially increase school-level cooperation by enabling

them to make a lasting first impression and alleviate any concerns over extra work in the same manner as what was done with their school boards.

During a cooperative partnership arrangement, the planning process is partially shared. While some public health professionals commented on their aspirations to enter into a collaborative arrangement with their school board partners, others in more advanced partnerships shared insights regarding the conditions for making collaboration possible, as presented below.

8.4.3 Conditions to garner buy-in for collaboration in fully sharing the decision-making process

Entering into a collaborative partnership arrangement means holding cross-sector planning discussions throughout the main decision-making process, rather than at the end of this process, or during side meetings. Even though resources were being shared for the delivery of school health initiatives, public health units and school boards may still have been preparing their multi-year and annual strategic plans, for the most part, through separate processes. For collaboration to take place, especially in terms of partnership-specific strategic planning, further conditions would have to be met in addition to the cooperation conditions already mentioned.

When school health partners collaborate to the fullest extent, they not only share information and resources, but they also fully share their main decision-making process for joint strategic planning. Public health professionals reported two distinct ways through which joint strategic planning occurred at the school board level: (1) one partner would be involved in contributing considerable input into the lead partner's annual strategic (operational) plan (or overall multi-year strategy); or (2) both school health partners would be collaborating on the co-development of a partnership-specific multi-year and/or annual strategic plan (or overall multi-year strategy). At the school level, in some instances, schools provided extensive input into public health units' operational plans to specifically address school needs, and in other instances, public health frontline staff offered extensive input into school improvement plans. When possible, public health units used their available capacity to co-plan strategically with receptive schools. Alternatively, they provided consultative planning services. In either situation, public health professionals aspired to engage in joint strategic planning with their local school boards when feasible, if not already doing so.

Public health professionals spoke of conditions that supported the progression from a cooperative to a collaborative partnership arrangement. These conditions included the existence of strong, trusting relationships; the pursuit of a prioritized shared goal, characterized by a deep sense of shared purpose, or shared responsibility; the perceived added value of an external public health perspective at the main planning table; and an internal culture of cohesiveness, openness, and learning for continuous improvement.

a. The existence of strong, trusting relationships

Repeatedly, public health professionals emphasized the importance of having strong, trusting relationships with their local school boards and schools so that they could eventually work collaboratively together. They often mentioned their mandate to work in partnership across sector boundaries, which encouraged them to seek collaborative arrangements to the extent that their capacity would allow. They made reference to the fact that school boards and schools were not mandated to partner with their local public health units on health promotion. Partnerships in the area of health promotion was at the discretion of school board executives and school administrators, unlike the legal partnership requirements they were expected to fulfill regarding health protection services. On the one hand, some public health professionals felt that the lack of a partnership mandate for health promotion within the education sector was a major stumbling block for collaboration. On the other hand, other public health professionals recognized that full collaboration to promote student well-being entailed much more than the coordination of service delivery, as was the case with legislated health protection services. Rather, it necessitated joint strategic planning, and they believed that this could not be mandated.

For joint strategic planning to be possible within local school systems, public health professionals generally understood that emphasis must be placed first and foremost on the cultivation of trusting relationships.

As a public health manager explained:

We've known for years that if we wanted to impact the population (...) with what we're doing, (...) it can't be about us coming in and saying, 'These are our priorities, you do them.' The only place we'll do that is when it comes to something that is legislated, otherwise that doesn't work with partnership development. (...) [And so,] we usually come at it from what their needs are. (...) We've demonstrated by building the relationships with them that we're not there to push our mandate. We're there to fulfill their mandate with them. And that's the shift. If we

tell them that they have to do this because it's our mandate and it doesn't fit their requirements, they're not going to want us at the [planning] table. (...) [But] if you can build that trust with them that we're not here to push our agenda, (...) they will be welcoming (...) [our] health expertise.

By shifting to a more responsive partnership approach and producing positive partnership experiences, public health professionals created strong, trusting relationships, as well as possibilities for collaboration with their school system partners. Through their well-established relationships, one public health manager stated that their public health unit no longer felt like an outsider, as they worked on school health plans “*with*” school boards rather than “*for*” them.

In addition, public health professionals spoke of going slowly with their cross-sector engagement to make sure that trust could grow with further interactions. They were taking their time to proceed at a comfortable pace so as not to overwhelm their school board and school partners. As relationships between school health partners became stronger, collaboration at the strategic level ensued in certain, but not all, instances. There were situations where close ties did not lead to a collaborative partnership arrangement for joint strategic planning. Since a strong, trusting relationship did not automatically bring about full collaboration, other conditions would need to be met for partnership advancement. These conditions are explored next.

b. The pursuit of a prioritized shared goal, along with a deep sense of shared purpose

When cross-sector collaboration occurred during strategic planning, the partnership’s focus was directed toward a goal that had been assigned a high priority by the school board or school. Additionally, public health professionals in collaborative partnerships mentioned experiencing a deep sense of shared responsibility, or shared purpose, that permeated their relationships while in pursuit of a prioritized *shared* goal, where the strategic planning process was fully shared. In contrast, in cooperative partnership arrangements, school health partners were directing their efforts toward *common goals* related to student well-being, while engaging in separate strategic planning processes with possible partner input at some point along the way.

In certain instances where strong, trusting relationships had been established, cross-sector engagement was still primarily about sharing school health resources in areas deemed worthwhile by school system partners, without going into extensive strategic discussions to maximize the impact. This cooperative arrangement was found to be the best option in those situations where the extended partnership configurations were complex. Cooperation was deemed to be more suitable in extended school health partnerships with multiple school boards and/or multiple public health units because of inherent difficulties with setting shared goals. However, one public health manager working in an extended partnership arrangement with more than one public health unit talked about plans to further strengthen inter-unit ties. They intended to increase their intra-sector engagement in order to present a united front to their common school board partner for joint strategic planning on matters they all had in common, such as data-sharing needs and other system requirements for promoting the healthy school approach in individual schools.

Public health professionals recognized that the numerous needs encountered within local school systems required prioritization due to limited capacity to tackle all of them completely. Those health-related needs that were assigned a lower priority tended to be addressed through cooperative partnership arrangements. When a health-related need was placed high on both school health partners' priority lists, collaboration was more likely since more time would be allocated to addressing that particular need. As a public health manager commented in relation to school boards:

It depends on the topic. In some cases, if it's something that [the school boards] are allocating staff time toward and it's a priority for them, then it would very much make sense to do joint [planning]. (...) And if it's something that is not necessarily a priority for them but it's a priority for public health, then realistically, it would be great to have their feedback and their input, but we would be leading most of it.

The same condition was found at the school level. As a public health manager pointed out, a principle's decision to cooperate or collaborate on a school health partnership focus depended on whether or not the identified health-related need was prioritized:

[The planning process] will depend on the level of engagement between the nurse and the school. [In] some schools, (...) health is not a priority. So, the nurse may develop an action plan based on the survey and interview and receive feedback in the fall from the principal. Others engage in a more meaningful dialogue with principals and make mutually agreeable goals from the outset. It really depends on the specific schools and their priorities.

Collaboration at the strategic planning level was not only about engaging in joint strategies. It was also about finding ways of building off of each other's respective strategies for a synergistic effect toward a shared goal. Public health professionals sought to create synergy to produce a greater impact than what was achievable by each partner acting alone. As a public health manager stated regarding the development of joint and compatible strategies:

I want to make sure that our conversation is about finding common direction, so we can focus on it. (...) We develop together the shared goals and (...) [then we] work jointly. (...) [For example,] we have a close relationship with the mental health leads in [our main] school boards and the social workers. (...) [We] talk about what we are each doing and what we can do together. (...) When we connect, it is about sharing our priorities and finding the synergies that bring us together.

From a public health perspective, a deep sense of shared purpose in moving toward a prioritized shared goal supported the move to a collaborative partnership arrangement. Emphasizing a shared purpose in pursuit of a shared goal, rather than the Foundations for a Healthy School framework, was perceived by a public health manager to be fueling more extensive cross-sector engagement:

[Public health professionals] should focus on what they want to improve and keep in mind that if they do something around that issue in all of those five foundations, you have greater chance of achieving success. (...) [But the comprehensive approach] shouldn't be the focus. Focus on what needs to get done: 'We need people to thrive and be healthy.' That's what I'm focusing on, and (...) we'll co-create it together.

Although the Foundations framework was considered important guidance on how to plan for a given student well-being goal, a collaborative partnership arrangement was fostered by focusing primarily on a mutually meaningful purpose through which to bond with school system partners at a deeper level.

c. The perceived added value of an external public health perspective at the main planning table

For there to be collaboration on strategic planning, the conditions of a strong, trusting relationship and a prioritized shared goal, supported by a deep sense of shared purpose, were identified as pre-requisites, whether the planning process was led by one of the school health partners, or co-led, provided that sufficient capacity existed. When school board executives and/or school personnel were leading the planning process, however, an additional condition had to be present for joint strategic planning.

Partnerships based on strong, trusting relationships did not immediately result in an invitation to join a school board's main planning table, even if their goals did align. According to public health professionals, another supporting condition for a collaborative partnership arrangement was school boards' and schools' perception that an external public health perspective could add value during their strategic planning discussions.

Since the Ontario Public Health Standards had explicitly placed value on cross-sector collaboration, public health professionals were already aiming to strategically plan with their community partners, in situations where their own capacity would allow such arrangements. Joining school boards' main strategic planning process was also seen as a way to greatly ease the integration and coordination of their health promotion efforts within the schools. For this to be possible though, they realized that their school system partners would have to perceive the added value that an external public health perspective could bring to their high-level planning deliberations. This condition emerged through various cross-sector engagement opportunities: an enticing presentation of the public health unit's value proposition; participation in community-based collaborative planning; and positive partnership experiences with strategic planning at some point during the planning process.

(i) Value proposition:

Aware of the myriad of pressing educational demands being faced by educators, one public health unit reasoned that school board executives might be more willing to collaborate with them were they to be viewed as a means to boost internal planning discussions about how to meet ministerial expectations of improved student well-being. To this end, a compelling marketing statement was delivered at a cross-sector leadership meeting, showcasing available public health knowledge that had been repeatedly demonstrated to be useful during previous interactions. This statement presented a value proposition that marketed them as a key source of advice and guidance for their school board partners' consideration. As the public health manager recounted:

We articulated our value proposition (...) [stating that] we can help them meet their goal of student well-being. (...) [And then] they agreed to enter into a formal [collaborative] partnership with us (...) [because] we sold our value to them. (...) Part of understanding their language, understanding their key documents, understanding what's important to them, is to use that to weave in the health piece and to demonstrate our value over and over again. Public health has credibility; (...) [it's] an authentic source, a source where school boards who aren't in the business of health per se, or health experts, can come to us for sound health information. (...) With so many competing demands, (...) [school boards are likely saying,] 'I

have to invest time and resource, so what do I get out of it?' (...) We have to be able to articulate that, so that they walk away from that meeting saying, 'We have to work together.' That's part of marketing, being able to do that, have that skill to profile your value.

This public health unit's value proposition highlighted how a collaborative partnership arrangement could better support their school boards' strategic planning processes for student well-being, while focusing on what was important to them.

(ii) Community-based collaborative planning:

Participation in a community-based collaboration was another means through which a school board could come to appreciate their local public health unit's planning contributions toward student well-being. For example, one public health unit reported that their local school boards became aware of the added value that a public health perspective could bring to strategic planning discussions, while engaged in a joint community initiative. As the public health director stated:

[Our Healthy Kids Community Challenge] is probably the first really large-scale joint planning of an activity that occurred all over many schools. (...) We already had a good relationship. I think it enhanced the relationship, it showed [our school boards] how much we could do. So, it was an opportunity for us to see some of their challenges and be able to be more aware of how things needed to occur in order to work with the school boards at that level. But then, for them, they were impressed by what we could do if we were engaged from the beginning. (...) They saw what a successful partnership could look like and what it could yield.

This community-led health promotion initiative not only offered the public health unit the opportunity to understand how best to partner with their local school boards, but it also allowed them to demonstrate to these school boards what could possibly be gained by engaging in joint strategic planning as part of their school health partnerships.

(iii) Positive partnership experiences with strategic planning at some point during the planning process:

There were instances where local public health units were consulted at some point during schools' improvement planning processes related to student well-being. These cooperative arrangements provided opportunities for public health professionals to demonstrate their value as they shared an external perspective to supplement school community members' strategic thinking. At one school health partnership, positive responses to such public health contributions led to an opportunity at the district level to engage in strategic planning much earlier into schools' planning processes. As the public health manager recounted:

Whenever we bring them the new data, [the schools] take it and they say, 'What could we do with this?', 'Okay, we've got to change our priorities to focus on some of these new areas,' or 'Does it validate our plan?' (...) [When the school board] brought [their schools] together, they invited us to (...) be part of [their group planning sessions] this year, because we've been talking to them, trying to get them to understand the role that we can play. And they saw the value and they said, 'Let's try it out.' (...) [They invited us] because they see the value [for their schools].

During this group planning session with school personnel from across the school board's district, valuable contributions were made once again. The public health professionals helped ensure that school health plans were heading in the right direction by sharing additional pertinent data, all the while making suggestions on how to act on the data that were deemed most relevant to the schools. With continued positive partnership experiences at the planning table, the public health manager commented that they intended to further explore ongoing opportunities for joint strategic planning with their partnering school board.

d. An internal culture of cohesiveness, openness and learning for continuous improvement

There appeared to be yet another, more fundamental, condition that would support a school board's willingness to engage in high-level collaboration. This condition centered around a school board's internal organizational culture. From a public health perspective, a school board appeared to be more willing to collaborate across sector boundaries when their internal culture was characterized by a state of cohesiveness, underlying a shared drive for continuous improvement; such a culture seemed to promote an openness to diverse views, even those of external stakeholders.

Public health professionals in less advanced partnership arrangements felt that their local school boards' internal cultures were not yet conducive to planning strategically together. Specifically, they indicated that their partnering school boards either appeared “*baffled*” and unable to make sense of their request to directly participate in their schools' improvement planning processes, or did not provide any response when such an offer was made. In addition, one public health manager commented that simply establishing formal meeting structures may run the risk of being token efforts to work in a collaborative partnership, if the underlying culture within the partnering organization did not actually value spending time to share the decision-making process:

[For] collaboration, (...) it has to do with the values, and what is the culture of the organization. (...) You can put in some structures, but unless that person at the other end has the value and the culture to support that continuing path, it's really hard to just have a structure, because it's the buy in [that really matters].

Could it be then that a cultural change is at the basis of a school health partnership's move from a cooperative to a collaborative arrangement? In one school health partnership dyad, a cultural transformation was underway as local public health representatives were participating in a school board-organized school improvement planning session. As the public health manager pointed out:

[Joint strategic planning] is a real shift for them. (...) It's a cultural shift as well for the nurses to participate in [school improvement planning]. (...) [The principals] were a little surprised by our presence there because the planning has always been just with the schools. So, it's been the first time ever that we, an external partner, were invited into their planning process. (...) So, it will become, hopefully, a much more common thing for us to be working together as they plan for their next school cycle.

There were only a few public health nurses at the principals' group planning session, since this was not a customary practice within their local school system, and the public health partner preferred to proceed slowly so that all participants could have sufficient time to get accustomed to this new partnership activity.

But what could account for an organizational culture that would welcome an external perspective during strategic planning to consider any added value? Contrasting partnership experiences with coterminous school boards may shed some light on this matter. In comparing their partnership arrangements with two different school boards, a public health manager perceived clear distinctions between these school boards' internal cultures. This manager suggested that cross-sector collaboration was likely to occur when the school board's culture was based on a highly cohesive group of school board personnel who were keen to keep on making improvements to their school communities. Such a culture of cohesiveness, deeply focused on continuous improvement, appeared to promote an openness to consider an external perspective at the strategic planning table:

We generally find that the culture at each school board is very different. That may be a contributing factor [to planning collaboratively] (...). I would say that what we find in our smaller board is they really do have a unified vision and mission, and ultimately everybody is on the same page as far as really just wanting to create caring and supportive school communities. (...) You can feel that in the board environment. (...) Whereas, in the larger board, I don't know if it's because there has been so much turnover, but you don't find that there is that consistent and unified purpose to being there. (...) [Also] I'm finding in our smaller

board, they are very appreciative of any and all support that they can get. They are very open and flexible to working together and working collaboratively. (...) [They are] not necessarily going along with [our ideas], but certainly open to suggestions and collaboration.

As this example demonstrates, consensus building was not the actual aim of sharing the decision-making process. What made the partnership experience satisfying for the public health manager and their team was the chance to discuss their viewpoint before their school board partners made their decisions. What mattered to them was not to have their school board partners go along with their ideas, but rather to be given the assurance of being heard. They were aware that final decisions were to be made by the school board.

The example mentioned above makes reference to differences in organizational culture and size. The smaller partnering school board had a seemingly more cohesive and open organizational culture, which appeared to have made cross-sector collaboration possible. However, other public health professionals enjoyed a high-level collaborative partnership arrangement with their school boards, regardless of their size. A cohesive and open organizational culture geared toward continuous improvement, irrespective of school board size, may be associated with the progression to a collaborative partnership arrangement.

Chapter 9: Insights on School Health Partnerships from School Board Representatives

This chapter presents school boards' views about their own experiences with school health partnerships. It begins with key information about the study participants: their vision for their respective local school systems as it pertains to student well-being, their use of the Foundations for a Healthy School framework, and the importance they place on relationship building. Next, it delves into the four main partnership components, namely cross-sector engagement, connection, capacity and continuity, as seen through the perspective of school board representatives. Then, it explores school boards' insights on the conditions supporting school health partners' move along the collaboration continuum. Finally, the main challenges mentioned by the school board representatives are elucidated and corresponding mitigating factors are underscored. These factors have been featured among the elements that strengthen partnerships across the public health and education sectors.

9.1 Background

The second phase of this doctoral thesis project included semi-structured interviews with six representatives from the education sector: two directors of education, two superintendents, one mental health lead, and one communications manager. Collectively, they represented the Catholic school system (4 interviewees) and the public school system (2 interviewees), with two representatives coming from French-speaking school boards. They held similar visions for their student populations, and all but one study participant were familiar with the Ministry of Education's Foundations for a Healthy School framework.

9.1.1 Vision of healthy schools

The six school board representatives held a vision of education that placed emphasis on creating a healthy environment in which students could thrive and express more of their potential. The following vision articulated by a superintendent captured well the sentiment expressed by all study participants from the education sector:

[My vision] spans several levels. The first is to have children who are happy to come to school, in that they are able to grow in an environment that is healthy. When I say "healthy", I mean an environment that brings them security and well-being, and so, they can come to school and feel that they have a say, that they have a place and that they are able to flourish. And of course, once that space is set up and the students have that feeling of well-being, then we can talk about everything that is called pedagogy, that is called learning, that is called reasoning—so the ability for them to develop competencies related to a certain curriculum and go far in developing these competencies to eventually be able to develop a life plan and realize it fully. (...) If there is no well-being, (...) [and] no sense of belonging, of security, it's in my opinion very difficult to be able to embark on a journey of reflection and learning.

The school board representatives fully acknowledged that well-being was fundamental to the learning process and to achieving success in life. Within the provincial school system, well-being was a generic term that encompassed many areas, such as equity and inclusive education, safe and accepting schools, mental health, and healthy schools. The mental health lead explained that mental health itself had different aspects, with one of these aspects dealing with the upstream promotion of mental well-being, also referred to as positive mental health.

9.1.2 School boards' use of the Foundations for a Healthy School framework

The school board executives (i.e., director and superintendent levels) and the mental health lead were very knowledgeable about their Ministry of Education's Foundations for a Healthy School framework and have used it for their planning purposes. Notably, one director of education reported that they, along with the directors of education from their coterminous school boards, were "constantly pointing to this document or making reference to it." Coterminous school boards, which belong to either the English-speaking public school system, the English-speaking Catholic school system, the French-speaking Catholic school system, or the French-speaking public school system, have all or a substantial number of their schools located within the same geographical area.

All participating school board executives played a role in the promotion of student well-being, in one way or another, and most had first-hand experience applying the Foundations for a Healthy School framework. One superintendent pointed out that making use of this framework was a worthwhile practice because its purpose to integrate all aspects of student well-being within schools' day-to-day practices was well suited for creating a school culture than embodied the values of well-being as part of school life:

[The purpose of the healthy school approach] is to try to incorporate everything, I would say, in such a way that it all fits within the school's context [in an integrated manner]. (...) Students should not feel as though we're having them go through 50 different initiatives. Instead, everything must be integrated into educational activities in schools so that the schools can develop a culture where students' health, their well-being, is at the core of how they function.

According to this superintendent, the Foundations for a Healthy School framework was indispensable to a school culture that valued well-being for greater student achievement. Likewise, the mental health lead, considered this framework to be highly useful for guiding the teaching faculty in promoting positive mental health, which included social-emotional learning—an area of school life that was gaining prominence within the education sector:

That really has been a new focus for mental health leads: (...) helping educators see the role that they play in promoting student mental health. There are things that they can do every single day that can promote mental health and well-being, enhance resiliency, enhance the possibility for self-regulation—all of those really important things—and not to just make a referral to the community agency to offer mental health supports. That's the role that I play in the implementation of [the] Achieving Excellence [vision from the Ministry of Education]. It's a shift in focus to everyday mental health and wellness for students. (...) When I talk about that tiered model, (...) [at its basis], in the tier 1 level, you see the Foundations for a Healthy School is really reflected in that, in terms of activities around school climate and positive mental health initiatives, and social-emotional learning programs within each school, or each classroom, focusing very much on foundational pieces as opposed to more reactive pieces.

With emphasis being placed on a broader definition of student well-being, the education sector was now embarking on a new path, one that gave as much attention to positive mental health as it gave to mental-health issues for improving students' academic performance. Positive mental health—the health promotion aspect of mental well-being, including students' social-emotional development—was a major upstream feature in the creation of healthy school environments that lend itself well to the application of the Foundations for a Healthy School framework.

9.1.3 Importance of relationships at the core of school health partnerships

Besides mandatory health protection services, school boards may partner with their local public health units on a variety of health promotion initiatives. Based on public health professionals' partnership experiences, school health partnerships varied greatly in the strength of the relationship between partners, with implications for the extent to which public health support could be provided for health

promotion. With well-established relationships, partnership activities could span far beyond the delivery of health protection services and the issuance of health-risk advisories. As a director of education pointed out:

If you called a particular board, they may have no contact, other than getting some of the heat warnings and the recalls. If that's their only current link to their health unit, there's lots of areas that they're missing out on. I think because we have a really good relationship with public health, (...), for our board, it's very positive that most of those [health promotion] areas have already been established and are being implemented. We can always improve. We'll continue to look for those areas [for improvement]. I think we're fortunate with the relationship that's been built.

All school board participants underscored the critical importance of building relationships, thus affirming public health professionals' similar perspective. They found that it was easier to get the required work done and move closer toward their well-being goals by cultivating and maintaining strong relationships with their local public health partners, in addition to other community partners. This shared view validates placing relationship building at the core of school health partnership for student well-being.

9.1.4 School health partnerships for student well-being

The school board representatives' interview responses not only corroborated the responses obtained from the public health sector, they also provided further insights into those elements generating and supporting school health partnerships for student well-being. Findings from the education sector have been categorized within the same four main partnership components as in the previous chapters: cross-sector engagement, connection, capacity and continuity. School board representatives' perspective of each of these components are explored below.

9.2 Cross-sector engagement

Emerging from the school board interviews, the elements that fell under the category of cross-sector engagement were similar to those that were brought up by the interviewed public health professionals. As with the public health participants, participating school board representatives mentioned their engagement with multiple actors at different interorganizational levels. Furthermore, their partnership

experiences were likewise enriched by the creation of a safe space for open dialogue, especially to tackle sensitive partnership issues; a common understanding of what the partnership was all about; complementary perspectives; and the practice of planning comprehensively and incrementally from what already existed. Additionally, they validated a broad engagement spectrum that characterizes school health partnerships, where cross-sector interactions of varying levels of extensiveness are being undertaken for various partnership tasks.

9.2.1 Engagement of multiple actors at different interorganizational levels

Across the public health and education sectors, many actors may be engaged in school health partnerships for student well-being to one extent or another. As described by school board representatives, the senior management of each school board, composed of the director of education and superintendents, and perhaps, an associate director, were responsible for creating a multi-year strategic plan, from which was prepared the annual board improvement plan (BIPSA) that directed their efforts aimed at promoting student achievement, including well-being, for the coming school year. Goal-specific operational plans stemmed from the BIPSA, and these plans were developed, with or without input from their community partners, including their local public health units. As part of their duties, senior management accompanied their schools, or oversaw their work, as they embarked on their own school improvement planning process.

Superintendents had central staff who reported to them, and who supported various initiatives. According to the school board representatives, the central staff who would mainly be engaged in school health partnerships at the programming level were the curriculum consultants/coordinators, mental health leads, and communications personnel. These mid-level staff would be engaged in operational planning, which could require the direct participation of superintendents, especially when corporate decisions were to be made. As they planned school board-led initiatives in support of school health, they sought the assistance of their local public health units to various extents.

At the school level, principals functioned as the key decision-makers, granting permission as to which initiatives could be carried out in their schools. However, school health champions, or mental health

champions, were key facilitators in putting together school committees for action planning and for the delivery of school health initiatives. As the mental health lead asserted:

We also have in each school a mental health champion, a teacher who is championing the mental health strategy, so those staff members are also a resource to the development of the [healthy school] committee and the ongoing work of the committee.

For additional support and resources, school boards and schools engaged with their local public health units, as well as a variety of other community partners, to a lesser or greater extent. Any of the abovementioned representatives from the local school system could interact, one way or another, with one or more public health units within the school boards' district.

The school board representatives viewed their local public health units as an important partner. Most considered them to be their primary partner for the promotion of student well-being, for various reasons. Many factors contributed to a school board viewing their public health partner as their main source of support in the area of health promotion. These factors included being a valuable participant on an internal school board committee; having a long history of working together on health promotion initiatives; ensuring a broad presence of public health nurses in the schools throughout the district; directing their public health efforts toward what the school board considered to be important to them; and fulfilling a key role as connector by bringing other relevant community organizations and agencies to the school board's awareness.

In the area of mental health, public health units may be thought of as bringing unique contributions to the promotion of students' mental health, compared with other local community partners whose expertise would be focused mainly on downstream mental health issues. As the mental health lead explained:

Of all of our community partners, the public health units, their primary mandate: health promotion, mental health promotion. Other service providers in the community do lots of great work in supporting our system around mental health and well-being but their focus is more at that tier 2 or tier 3 level: early intervention around mental health needs, and more intensive kinds of interventions for kids who are really struggling and families who are really struggling. (...) So, our public health unit are the primary source of support at that tier 1, [for] mental health promotion.

This school board engaged primarily with public health professionals in positive mental health promotion. However, this was not necessarily the case with the other represented school boards.

The local public health unit may not be considered a primary partner for mental health promotion, where the school board was in search of a more specialized source of support. One school board executive acknowledged that their public health partners did provide a very useful health promotion service. However, this school board tended to engage with agencies that had more specialized expertise in the area of mental well-being, which were of particular interest to them, such as aggression prevention. Furthermore, engagement with their public health partners was happening much more at the school level rather than the school board level. Their jurisdiction covered a vast geographical area, and a large proportion of their schools, and consequently some of their partnering public health units, were located far away from their headquarters. Nevertheless, the public health partner was viewed as having an important role to play in helping the school board assess local mental health needs through the use of their population health surveillance system.

Engagement between key actors from the education and public health sectors varied according to school boards' geographical location and size, among other factors. In the larger school boards, engagement with public health partners was reported to be taking place more readily at all interorganizational levels of their school health partnerships, provided that they were not separated by long distances. Whereas in small school boards, there may be hardly any engagement between the top leadership and public health professionals because of heavy workloads. As the communications manager pointed out:

We're very small and (...) we only have [a few superintendents]. They're stretched thin (...) and initiatives that fall under, let's say, healthy schools or healthy nutrition, (...) the superintendents themselves don't do very much directly with public health. Rather, they oversee [principals or] staff who are working on projects with public health. (...) They're incredibly busy. (...) The principals take on some central office responsibilities. (...) [But if] some of the work is facilitated by [other staff], the responsibility still is that of the superintendents.

Owing to differences in capacity levels, there was much variability in terms of which key actors within local school systems were engaging with public health professionals.

9.2.2 Open dialogue

During formal meetings, openly engaging across sectors could enhance the quality of the work to be done for improved student well-being. As one school board superintendent stated, thorough cross-sector communication of ideas at the beginning of their planning process brought “*coherence in [their] initiatives and strategies*” to address students’ well-being needs.

Open dialogue may create coherence not only in school health plans, but also in the work environment. Specifically, communication that exposed sensitive partnership-related issues helped bridge initial differences of opinion to produce a more coherent work environment for all concerned. Indeed, one school board experienced a successful streamlining of services when their community partners persevered in candid deliberations to resolve issues related to the apparently overlapping roles and responsibilities that they had first carved out for themselves. As the mental health lead explained:

At the community level, we're having those discussions about 'You do this, and I do that, how similar is it?' It hasn't always been easy, (...) but I think we've worked through that. (...) That's not to say that there wasn't some conflict or some tension or some confusion or frustration, but we've managed our way through it. (...) I think when you make room for the conversation, (...) [you get] to air some stuff. It's time consuming and it's messy. (...) I think we got through it because we gave it some time rather than pushing through it and pretending it wasn't an issue. People want to do the right thing, nobody's necessarily holding on to their turf and not wanting to budge. (...) They put stuff on the table, which was important, (...) sorting out roles—who does what, how do we support the schools—(...) [and this helped] build relationships. (...) The other thing that helped too was just the experience of working together (...) [and having] the client help us figure it out. (...) I think we're in a better place. (...) It feels less personal because it's really about what the client needs. It's not about us anymore.

Feeling supported in honestly expressing their views on sensitive turf considerations, public health professionals and other community partners worked out their differences of opinion and avoided having to suppress tensions and frustrations. In this example, candid deliberations flowed more readily to create a coherent work environment when the partners put their attention on what was in the best interest of those they were serving. Open dialogue was also said to have contributed to relationship building, while the reverse was mentioned by the public health professional previously quoted, indicating a reciprocal effect between these two partnership elements.

9.2.3 Common understanding

School board representatives spoke about the importance of establishing a common understanding as the foundation for their cross-sector engagement process in terms similar to those used by public health professionals. They made reference to a common vision, shared specific goals, the adoption of the same overall strategic approach for the promotion of student well-being, as well as the need to clarify roles and responsibilities.

A partnership vision, by virtue of its general nature, was considered particularly instrumental in guiding high-level discussions within extended school health partnerships that included coterminous school boards and their common public health partner, especially for public health-led school health initiatives. For example, the superintendent holding this view felt that a broadly stated vision and goal was useful in uniting the coterminous school boards in conversation, but not so for specific goals. When it came to setting specific shared goals, this planning task was thought to require more focused discussions at each single school health partnership dyad, given the distinct realities and needs that each school board was experiencing through their schools' local contexts:

The common vision that was created between the [coterminous] school boards and then the health unit was to ensure that the health unit's initiatives are applicable to [all these] boards (...) [but] this shared vision (...) is very broad. (...) We were always cognizant of this common vision, and of the differences in our strategic plans. (...) [We] have a common vision, [but] then we must agree on the goals and objectives. (...) [These must] be much more focused, much more specific to the board. (...) [And this comes] from examining the data to determine actual needs.

According to participating school board representatives, various efforts related to student well-being were being consolidated under one umbrella strategy, whose components included equity and inclusivity, safety and acceptance, mental health, and the healthy school approach. This practice was being formalized by the Ministry of Education's integrative strategic initiative, called the Well-being Strategy, still under development. One superintendent explicitly stated that purposeful cross-sector engagement would necessitate the mutual adoption of this strategy, to produce greater coherence when planning together for improved student well-being.

Establishing a common understanding essentially meant agreeing on a vision, shared specific goals, and the strategic approach to direct the school health partnership dyad forward. However, proceeding with

cross-sector engagement would also require a good familiarity with the contributions that the local public health unit could make, for them to even be considered as part of the school board's well-being efforts. As another superintendent pointed out, their school board partnered mainly with other health-based organizations at the district level, because these organizations provided services targeting specific mental health issues faced by students, and there was incomplete awareness of the more general health promotion role that public health units could fulfill:

I have to say that there are services for students experiencing problems where (...) specific needs [are being targeted]. But for broader needs that are relevant across the entire board, we don't have those kinds of initiatives. (...) If you just consider the health units, there may be some initiatives that we could try out, but it's not something that's done on a regular basis. I think it's perhaps not being aware of what services they can offer us, what is available. (...) We may not know all of that, and so we would not necessarily be knocking at their door.

Much role clarification was required on account of the wide variety of service agencies that had been engaging at the school board level. As explained by the mental health lead, the field of mental health is very broad, with mental health services ranging from health promotion programs for all students, including primary prevention (tier 1), to early preventative interventions for at-risk students (tier 2), and then to individualized treatments for those students with mental health problems (tier 3). With mental health services being provided along a broad continuum of care from promotion to treatment, the mental health lead reported that much time had to be spent clarifying roles not only among service providers but also within the local school system:

In our board, (...) we've kept it pretty clear that public health is tier 1, (...) [so] more of that promotion/prevention tier 1 work, (...) [and we're] helping schools sort out that stuff too, (...) 'Here's your tier 2 and tier 3 service possibilities, who you might go to.' (...) [All the agencies] want to get this right. (...) I think that that helped: just more time sitting in the room together chatting encourages some knowledge exchange and helps to understand what the other agency actually does and how it's similar or different to ourselves. (...) I think we're clearer about the tier one, tier two, tier three, who does what.

The school board represented in the example above engaged in lengthy conversations with all of their key community partners who were actively providing mental health services for school-age children. Together, they clearly defined roles and responsibilities, and thereby, settled turf-related concerns and avoided further confusion. Furthermore, clarifying their local public health units' role led to greater receptivity for cross-sector engagement at the school level. The mental health lead went on to say:

[Our local public health partners] who are aligned with our [mental health] strategy would be sitting at tier 1. (...) The [strategy's] tier 1 focuses very much on that whole student: so, the physical well-being, mental health well-being, [and] social, emotional, spiritual, cognitive [well-being]. It's that whole picture, and public health supports each of those. (...) [Our] mental health strategy encourages the role of public health, so then the staff are just more open at each school.

Public health professionals were seen as being able to promote student well-being in many areas. As a result of demonstrating their expanded role through the school board's mental health strategy, school personnel were more likely to consider partnering with their local public health unit on their schools' own plans and priorities.

9.2.4 Complementary perspectives

Basically, cross-sector engagement was about bringing different but complementary perspectives together to enhance each partner's thought process for greater decision-making abilities, in addition to sharing implementation resources. Similar themes as those brought out by the participating public health professionals were captured from the perspective of school board representatives. The latter spoke about two of the four sub-themes identified in the first research phase: offering ideas on possible evidence-based practices for planning and collective learning purposes; and familiarizing each other with their respective use of distinct planning processes.

a. Offering ideas on possible evidence-based practices for planning and collective learning purposes

Through their cross-sector engagement with local public health units, school boards received additional health promotion ideas to supplement their own well-being strategies for a greater impact. As one of the school board executives pointed out, the expertise coming from public health professionals in the area of physical health promotion served them well in complementing their mental health strategy:

We must avoid [perspectives that] divide the student. The challenge is to take on a holistic perspective that considers the whole student, because of course, good physical health is linked to good mental health. (...) [And so] we have made certain links that connect our health units to our Mental Health Strategy.

Even though some school health partnerships focused mainly on physical health, all participating school board executives said that their public health partners could play, or have played, a significant role in their mental health strategy to address the whole child holistically. A school board executive commented that local public health units ranked highly among their community partners, when seeking support with their overall mental health strategy:

I would say [our local health unit] is our key partner [for promoting student well-being]. (...) There is for sure a role for public health in mental health. It's an area that we want to continue to expand. We identified that last year as a key area from our student feedback and staff feedback, and we're exploring areas that they can provide more assistance, (...) [such as] the area of mental health [promotion]. Obviously with the mental health lead, in each board, one of their roles is linking with partnerships. (...) They would be our link in the area of mental health with public health.

Complementary perspectives were found to be a critical aspect of cross-sector engagement within the area of student well-being, given the broad continuum of mental health care that spanned from promotion to treatment, and the guidance being provided to school boards from both provincial and local levels. According to the mental health lead, their perspective on how to address students' mental health needs was being supplemented in two distinct ways: (1) through the recommendations of experts at the provincial level, and (2) through their public health partners' knowledge of additional evidence-based practices, with direct or indirect implications for mental health promotion.

As school health partners come together and exchange viewpoints from different professional backgrounds and theoretical foundations, cross-sector engagement may turn into gainful collective learning opportunities. For example, the participating mental health lead received much up-to-date scientific knowledge from the mental health experts at the provincial level. This expertise, along with their own professional understandings, was then passed on to their public health partners. In turn, these public health professionals shared their practical and theoretical perspective on the various aspects of student well-being influencing mental health. Work on mental health promotion became more satisfying when merging the knowledge from both the mental health and public health fields. As the mental health lead indicated:

[Public health representatives] really do come at it from a promotion/prevention perspective which is new for those of us who are clinical social workers. (...) Their job as a community partner is (...) [to sit] at the table with me. (...) That's the difference: School Mental Health ASSIST is more that higher level implementation support, whereas Public Health is right at the

table with me. (...) It's a different kind of learning just because it's local, and it's timely, and it's in response to some planning that we're doing, maybe related to a school request or an emerging need that we didn't really forecast. (...) Students with more complex, mental health needs, that's my background, so that's the information that I bring to a meeting with Public Health. Then in the conversation, I learn from them about (...) safe and healthy schools, that bigger picture context, the environment, the school climate that supports student learning. (...) [So] it's their access to research, my access to research, and then where those two areas just overlap. That's where we just do our best work. (...) [By working] together, we learn so much from each other too.

From this mental health lead's partnership experience, the myriad of possible ways that partnership work could be carried out became even more evident as they engaged with their public health partners to gain greater familiarity with the scientific understanding at the basis of their respective professions.

Within the broader sphere of health promotion, one superintendent stated that cross-sector engagement within their extended school health partnership yielded far richer conversations about possible ways to improve student well-being than similar types of discussions held strictly within their school board:

We don't always have the required expertise within our organization, (...) [and so, our local health unit] can bring us insights that we do not have. Then, of course, by engaging with our health unit and attending meetings where other (coterminous) school boards are often present, we increase our ability to take action. This means that we are no longer limited to what we're doing in our own little ways locally, but it's a much larger field of possibilities that can open up with greater opportunities. It's that the expertise becomes greater now that there are more people at the table.

For this school board executive, exploring effective strategies with their public health partner and all of their coterminous school boards was deemed to be worthwhile because it allowed them to learn about a much broader realm of possibilities for taking action on student well-being.

b. Familiarizing each other with their respective use of distinct planning processes

As covered in the interviews with public health professionals, the school board representatives also commented on the distinct planning processes that were being promoted by either the public health or education sector. Public health professionals' planning guidance was seen as an asset during a school

board's deliberations centered on how to apply the Foundations for a Healthy School framework while engaged in operational planning. As a superintendent indicated:

Now, in my opinion, the question to ask is, 'How can a health unit support the [planning] needs of a board?'. (...) Perhaps the role of health units should be more about the five pillars of the Ministry's [Foundations for a Healthy Schools] to show in a broad sense how this could be applied within school boards.

On the one hand, public health units' familiarity with school needs assessments and planning health promotion strategies using the healthy school approach was considered useful to inform school system partners' own planning processes. On the other hand, educators were assessing school needs through their own process. According to a participating director of education, problem areas within their teaching practices were being identified through a mechanism called Professional Learning Cycle, as part of their collaborative inquiry process for improvement planning. A problem area to be improved within the local school system was known as a *"challenge of practice"*. The director of education defined the term challenge of practice as *"an area that [educators] had identified as needing further research/learning"*. Once a challenge of practice had been identified, the director went on to say that an iterative cycle of Plan-Act-Observe-Reflect would then be put in motion to resolve this challenge either in a particular school or in the broader system. This four-phase collaborative inquiry process provided a useful feedback mechanism. From a school board perspective, this collaborative inquiry mechanism was viewed as a distinct process that was primarily focused on students' academic learning needs for improvement planning purposes, but it could also be used to tackle well-being issues.

As another school board executive explained, educators were widely using the collaborative inquiry process for identifying schools' needs, in all aspects of education:

Collaborative inquiry—we work a lot with this in education. (...) [It's] about making decisions based on evidence. Of course, we take a lot of time to analyze the data (...) so that our strategies target the actual needs found in schools.

According to this school board executive, the collaborative inquiry process was mainly a practice for use by the teaching profession to fulfill their teaching requirements. However, an expanded use of this process was seen as advantageous within the area of mental health promotion, where it could be further integrated into teachers' routine planning efforts. If local school systems were to be receptive to using the collaborative inquiry process for the promotion of mental health, the participating mental health lead

saw much potential for greater cross-sector engagement at the school level. As the participating mental health lead explained:

Collaborative inquiry is a process of planning. (...) A teacher, a whole school, or small group of staff members might engage in a collaborative inquiry. (...) It's more around instructional strategies than mental health strategies. (...) [But if] the focus is on mental health and well-being, you are going to invariably enhance instructional strategies just by the very nature of paying attention to the mental health and well-being and emotional well-being of the kids in the class. It's a shift in thinking for educators. (...) They may not be thinking (...) 'What are some really basic things I need to do every morning to connect and engage with these kids?' Some people, I think, do it intuitively, and they're just so good at it. (...) Other folks, I think, need some support and time to reflect on practices that support well-being in the classroom.

This mental health lead further stated that public health units could find opportunities for joint strategic planning at the school level, by gaining familiarity with the collaborative inquiry approach, especially in relation to the promotion aspect of a school board's mental health strategy:

[Collaborative inquiry would] have an impact on instructional practices but it would also be an opportunity for public health to (...) be invited. Either use that approach themselves, which is an interesting concept—so health units inviting educators to their collaborative inquiry—or for educators to invite public health to their collaborative inquiry. (...) If we did a collaborative inquiry around well-being, [this] might be actually a great way to support the implementation of [our mental well-being] strategy in the school board. If we were to do that, then my first move would be to suggest that we invite somebody from public health.

According to this mental health lead's point of view, public health professionals may use the collaborative inquiry process for better integration of their own planning process with that of schools, since it was particularly used for school improvement planning, which also related to the promotion of student well-being. This cross-sector practice was actually reported by one of the public health professionals participating in the first round of interviews. Although promising, such an integrated practice did not seem to have been widely taken up across school health partnerships at that time.

9.2.5 Planning comprehensively and incrementally from what already exists

The Ministry of Education's Well-being Strategy captured a holistic vision of student well-being that encompassed all facets of a child's life—from physical to spiritual—for well-rounded efforts in promoting health and raising academic performance. One director of education, who fully embraced this vision,

eloquently illustrated the link between student well-being and student achievement, perceiving them not as competing priorities, but rather as equal priorities that need to be addressed simultaneously as much as possible:

A lot of our efforts and energy in the last several years were going into literacy, trying to help kids read and write better and having a good number of our kids be successful in that, whether it was on EQAO tests or just on their report cards. Lately the data are showing that we're slipping in math, so a lot of the work of our staff has been focused on trying to build capacity and teaching better so the learning can be better, not only in literacy, but in numeracy. But that won't happen if kids don't have physical well-being, if they don't have emotional well-being, and if they don't have spiritual well-being. (...) Sometimes [these priorities] can be in competition, but we try to reframe them so they're all seen to be linked – they are all part of the whole child. (...) I know that there's research to show that physical activity can cause the brain to be more open to learning. Good nutrition, you know that if kids are coming in hungry in the morning, they can't learn properly. (...) Mental health, if kids aren't well mentally, they can't learn. So, we're trying to cover all the bases, or as many bases as we can.

According to public health professionals, planning a comprehensive health promotion initiative in incremental steps helped minimize the feeling of being overwhelmed. However, this theme was only briefly mentioned by one of the school board representatives, who stated that a strong partnership is “*a matter of incrementally building on successes*”. By planning initiatives one step at a time, school health partners were taking advantage of the momentum being generated by early wins.

9.2.6 Full engagement spectrum

As public health professionals commented, school boards' engagement with local public health units was experienced as interactions of varying levels of extensiveness relative to the main partnership-relevant planning phases: multi-year strategic planning at the organizational level; annual operational planning; and action planning. The latter two planning phases related to schools as well. Information sharing for discussion purposes only, as another possible cross-sector engagement level, took place outside the planning process (that is, during the non-planning phase). Policy development was also mentioned as a partnership-relevant task. Additional details can be found in Appendix 4B.

a. Overview of school boards' planning phases

Participating school board representatives described their planning phases in a similar manner as public health participants. A school board's multi-year strategic planning process set strategic directions and broad goals that were meant to remain unchanged for the next three to five years. Although school boards' senior management was ultimately responsible for preparing a multi-year strategic plan, all levels within their organization could participate in its development, with possible contributions from the broader community. Although the strategic directions remained the same throughout the period covered by the multi-year strategic plan, strategic goals were usually fine-tuned during the operational planning phase to provide more specific guidance for the development of initiatives pertaining to the action planning phase. As a school board executive explained:

It's that the [multi-year] strategic plan will give us the broad directions. (...) And from there, we come up with very specific goals. (...) There is then an operational plan that flows from this strategic plan. (...) It's the plan that will allow us to actually move forward and get a little further ahead—(...) [so] to move the multi-year plan forward, 'Here is how we will do it.' (...) [This operational planning then] allows us to develop (...) initiatives at the board and local [school] levels.

According to school board representatives, the planning process started with the preparation of a multi-year strategic plan that was converted into a board improvement plan for student achievement (BIPSA) each year by school board executives. This plan led to more detailed planning processes at the school board level as well as the school level. BIPSA set the priorities for the school improvement plan for student achievement (SIPSA) that each school within the district had to prepare yearly. But exceptions applied. Schools whose needs fell outside districtwide trends set their own priorities accordingly.

The board improvement plan was considered the one-year version of the multi-year strategic plan. It contained the same strategic directions as what was found in the multi-year strategic plan, but refinements were brought to the goals from year to year in order to make them more specific for operational planning. Traditionally, this plan was meant to deal with education practices to increase students' academic performance, but its scope could be broadened to include all of the strategic directions that composed a school board's multi-year strategic plan. School boards were starting to include student well-being in their board improvement plans as well. As a director of education indicated:

Sometimes that term, [board improvement plan], applies mostly to student achievement. (...) Our multi-year strategic plan really is our board improvement plan and it covers (...) well-being, (...) [as well as] student achievement, and (...) [the other strategic directions] that I mentioned earlier. (...) There are goals under [each of these] strategic directions. (...) We do tweak individual goals. (...) [And so] we get into detailed goals that we're working on each year.

In addition, a school board's operational planning phase would periodically include the development of a multi-year overall mental health strategy that covered the same period as their multi-year strategic plan. Across the province, each school board was expected to produce a multi-year overall mental health strategy, which may have consisted of a series of annual operational plans covering the strategy's full timeline. Each year the priorities and operational strategies would be articulated in more concrete terms. As the mental health lead pointed out:

What I have to do every year is an actual work plan to go along with [our multi-year mental health] strategy. That's the place where we have to spell out some of the [strategic] activities that we're going to do or the priorities for the upcoming school year.

This mental health lead's overall strategy documented need-driven priorities and strategic activity areas (operational strategies) to be carried out in each of the years covered by this strategy. The priorities had been derived from a districtwide assessment that revealed students' mental health needs and gaps in teachers' capacity, including deficiencies in awareness, knowledge and skills related to mental health promotion and management.

Still at the strategic thinking level, but with a shorter timeframe, operational planning called for decisions to be made about annual priorities and specific operational strategies in order to operationalize each broad goal within the multi-year strategic plan. Priorities were described as problem areas where improvement efforts needed to be focused, while operational strategies were understood as the types of action that were to be undertaken for achieving the desired improvements. Strategies were aimed either at building capacity within the school system, or at students' direct well-being needs. Once having fully defined their key problem area for well-being, referred to as their "*challenge of practice*" in the area of well-being, the school board committee (or team) functioning under their assigned well-being goal would then proceed to formulate suitable strategies for improving specific practices. According to a director of education, the resulting operational plan was then used to guide the action planning process of a sub-committee, pertaining to the development of board-led initiatives:

[There's a] committee that's looking at the board improvement plan in terms of well-being. (...) [They] may decide that we need to improve in a specific area (...)—a challenge of practice. (...) When they're looking at implementing the components of the [committee's] plan, they're coming up with the specific strategies. (...) They would have already established their challenge of practice—so what are the key areas that they feel we need to look at or focus on. There would have been some initial data analysis to come up with that determination. (...) Then they'll break off in terms of a work group [to do] more of the [action] planning of initiatives.

A school board's board improvement plan may include a well-being component, specifying the priorities that are to be operationalized by each school through their own school improvement plan. One superintendent distinguished these two types of plans in the following way:

We have a [multi-year] strategic plan for the board, and then we have a board improvement plan, and this is reflected in the school improvement plans. (...) For example, here, (...) the multi-year strategic plan (...) has a dimension that relates to well-being. So, we ensure that this piece is covered [in the board's improvement plan] and that it is more concretely reflected in the school improvement plans, (...) because if, in the strategic plan we say that we want to improve well-being in the schools—for example, (...) let's say we want to reduce the incidence of bullying in the schools—(...) the school has to take action to address it.

Schools' priority setting was meant to be driven by the board improvement plan, as well as their own individual school-based assessment of needs. As a director of education explained, school boards determined board-level annual priorities, called challenges of practice, in order to guide their schools' efforts in making concerted improvements during the upcoming school year. These priorities were determined according to trend analyses across their schools. This director of education further pointed out that schools whose well-being needs rested outside districtwide trends were allowed to focus on a different priority area:

One of the challenges of practice [for all of our schools] is around well-being. For a particular school, it could have to do with substance abuse, for example. For many of our schools, because of our board focus, it would have to do with social emotional learning.

However, when priorities were school specific, they still had to be aligned with their school board's strategic directions.

b. Information sharing outside cross-sector planning processes

School health partners from time to time *informed* one another about their work and built linkages with other community partners for potential cross-sector engagement. Networking was being undertaken at the top partnership level to gain familiarity with each other's field of work and explore partnership opportunities to promote student well-being. In certain school health partnerships, the main purpose of engaging at the executive level was to build relationships in order to share high-level information, and provide input into each other's strategic plan. For example, the executive meetings held within an extended school health partnership, composed of coterminous school boards and their common public health partner, allowed them to expand each other's perspective on possibilities for making improvements that would not have come to mind otherwise. As the superintendent from one of these school boards asserted, such executive meetings "*are excellent because it allows the exchange of ideas, it allows a richer way of thinking [strategically].*" By sharing views about what improvements could be possible, they experienced a greater ability to infuse strategic thinking into their school board's internal planning discussions.

At the program, or mid-partnership, level, school boards may arrange to have community partners, such as their local public health units, share information about what resources they have to offer, simply as a reminder and as a way of exploring partnership possibilities. These presentations could take place either at internal school board committee meetings or at group sessions with school representatives from across a board's district. For example, the mental health lead regularly organized districtwide information-sharing gatherings between community partners and mental health champions, who would then bring information about available resources back to their respective schools to see what partnership activities could possibly be undertaken:

We introduced the concept [of mental health champions], and principals asked folks in their schools who might be interested. Then people volunteered, and they come together with me two or three times a year to just talk about mental health and wellness and look at resources. (...) Then [the public health staff] can share information (...) around mental health promotion and wellness promotion, (...) [and be] a link back to me. (...) Last school year, I invited all of our [key] community partners actually to meet with the [mental health] champions, (...) [and] public health came and presented and helped to facilitate some of the presentations, so Tier 1. (...) Everybody did a presentation just to let champions know what was available [so that] they could offer that information to their school.

Networking was happening at the school level as well. In addition to organizing information-sharing sessions, the mental health lead created direct linkages between public health professionals and individual schools to raise awareness about their role in promoting mental health:

I think we [the mental health leads] are little connectors in a way. We connect back out to the community but then we bring those community partners into the school and help our school see the role that [public health nurses and health promoters] can play and the importance around mental health in terms of wellness, not mental health in terms of mental illness.

According to school board representatives, both mental health leads and public health professionals were relied upon to serve as networking agents. Public health professionals' networking abilities further supported their local school boards by finding additional community partners that could potentially assist with health promotion efforts. As a director of education indicated:

[Our local health unit] really acts as an umbrella for many other groups. While we may work with [another] organization, (...) often that organization has come to our attention or we've been connected to them through [our public health partner]. They're the key liaison for all health-related areas in the board.

In the role of external connectors, public health partners could be active in all aspects of health promotion, even in areas beyond their realm of expertise. Regarding matters outside of their professional competencies, they were still seen as instrumental in bringing to their partnering school boards' attention other community partners with the right set of specialized skills and implementation resources to best deal with the issues at hand.

c. Multi-year strategic planning at the school board level

When the time comes to prepare their organizations' multi-year strategic plans, school board executives may choose to receive less or more extensive input from their public health partners, relative to input from other sources. Based on public health professionals' interview responses, the full spectrum of cross-sector engagement as it pertains to this strategic planning phase had been experienced within school

health partnerships across the province. Owing to a much smaller sample size from the education sector, of partnership experiences was brought up by school board representatives.

Two levels of cross-sector engagement were mentioned regarding this high-level strategic decision-making process: indirect general consultation through a broad community engagement process to shape school board-led initiatives; and collaboration among executives of extended school health partnerships, composed of coterminous school boards and their common public health partner, to shape public health-led initiatives. Where the extended partnership was based on one school board and multiple public health units, there was no cross-sector engagement during this planning phase, although arrangement could be made if warranted.

Broad community engagement may be carried out at the beginning of a multi-year strategic planning cycle. As a consultative process, it engaged a vast number of stakeholder groups that extended to the general public. The participating communications manager reported that their school board conducted a community needs assessment via an online survey to see what concerns and aspirations the broader community had regarding the education and well-being of the children and youth in their local area. This on-line survey was considered a practical method for consulting thousands of internal and external stakeholders. In actuality, several thousands of people, mainly parents, students and staff, but community-based organizations and public agencies as well, contributed their views about the path they would like to see their local school board take in the coming years. A similar community needs assessment was conducted at another school board. As the superintendent at that school board explained, regarding their broad stakeholder consultation that gave direction to their improvement initiatives:

It's not done every year, but we engage with our community to see where they want to go, what their needs are, what their visions are. (...) It's this collection of data that we will be looking at, (...) [since it's] from our clientele. (...) [So] from these results, an analysis is done and a [multi-year strategic plan] is then drawn up. (...) Usually strategic planning is done by senior management teams, where we look at the data that we received at that time and set the [strategic] directions.

School board executives from two separate extended school health partnerships both experienced a collaborative level of cross-sector engagement as part of high-level partnership-specific strategic planning, where they similarly embraced with their respective partners a common vision and a shared goal to direct the joint operational planning of public health-led initiatives. Both extended partnerships

were composed of coterminous school boards and their common public health partner. According to one director of education, joint strategic planning in the long and short term became attainable since the schools within their combined jurisdictions were largely facing the same student well-being issues, namely obesity and poverty:

We have a directors' committee for our coterminous boards, working with (...) the [public health unit's] executive. (...) We jointly look at what the needs are. (...) We've got a lot of childhood obesity in our community, (...) [and] poverty. (...) [The public health unit's executive] decided with us, the directors, based on [our health index] statistics for the region.

Collaboratively, they assessed regionally-based data and set a partnership-specific strategic direction to address a major health-promotion issue that they had all prioritized. They jointly decided that the public health unit would be focusing their efforts on the physical aspect of well-being for the time being, based on regional data pointing to poor living conditions and physical health risks among the student population. The director of education further stated that the collaboration included operationalizing their shared goal together.

The type of partnership dynamics seemed to underlie which level of engagement was preferred during the multi-year strategic planning phase. When the extended partnership arrangement included only one public health partner, the partnership focus was concentrated within the catchment area of that one public health unit. School clusters within this area, although belonging to different school boards, would more likely be facing similar sets of issues. This extended partnership arrangement made joint strategic planning a suitable engagement option. By contrast, no joint strategic planning was reported by the superintendent whose main extended school health partnership arrangement included multiple public health partners. The sheer complexity of the different geographical characteristics of these public health units' catchment areas produced considerable variability across local school contexts. Finding a consultative process more suitable, this school board executive commented that they preferred to seek a unified public health perspective through consultation, and then bring this perspective forward during separate planning deliberations. Given their school board's large geographical jurisdiction and varied school needs, they felt that high-level strategic planning was best to be carried out mainly as an internal process for greater ease in preparing a plan that coherently integrated health promotion and education practices:

One, we work with different agencies depending on the location [within our board's jurisdiction], and two, the challenges that schools face can vary from one location to another. The challenges [in an urban setting] are quite different from the challenges that we find in a rural school (...). That's why our [well-being] team looks at the various situations across the different schools, in their entirety, and tries to plan accordingly. (...) Everything must be integrated within the school board's strategic plan, so that we may have more coherence across our planning stages. (...) If I were to become aware of any upcoming changes (...) about health and well-being that we would have to [address], (...) perhaps I would have discussions with our public health partners before we finalize our [strategic] plan at our executive table (...) [to ensure] coherence in our strategies. (...) It still comes down to having good working relationships with our public health partners, such that I could bring their perspective to the group discussion during our strategic planning.

For the superintendent quoted above, high-level joint strategic planning was not a viable option due to the logistical complications of partnering with multiple public health units and the high variability in local school contexts. However, even though public health partners would not be sitting at the executive table to participate in strategic thinking, consideration was still given to the possibility of capturing their perspective and keeping their views in mind when making strategic decisions through a separate internal process.

d. Annual operational (strategic) planning at the school board level

Cross-sector engagement in operational planning could be initiated by either school health partner. As with high-level strategic planning, a limited range of partnership experiences with operational planning was reported due to a small sample size. School board executives spoke of cooperative planning sessions organized by their local public health units. Cooperatively, when preparing or updating their own operational plans, public health partners would conduct consultations a few times a year to find out about school board needs and discuss ideas about how to address these needs through public health-led initiatives. Regarding school boards' operational planning, cross-sector engagement was mentioned to have been initiated by them at various levels of extensiveness: verification, consultation, involvement, and collaboration.

With the release of the Ministry of Education's Well-being Strategy, the ability to link together the various aspects of student well-being within one coherent strategic plan had been a major focal point for participating school board executives. They were endeavoring to avoid disjointed operational plans and

find initiatives that could be implemented in their local school systems in a logical and integrated manner. One director of education commented that their school board was “*working hard at trying to get great coherence in all the work that [they’re] doing [on student well-being] so that [their strategic directions] map to one strategy, (...) so it all overlaps*”. To work on operational plans for their Well-being Strategy, another director of education specified that their school board had adopted a cross-departmental approach:

[In our school board,] each of the superintendents has different portfolios. (...) Well-being really is something that comes into many areas, (...) [such as] equity and inclusive education, (...) [and] safe schools. (...) [Also,] many [well-being] aspects of the policy documents come under our Student Services Special Education Department. (...) It really is a generic term that covers all areas of the board. (...) [Our well-being committee] is multi-layered. The lead would be a superintendent but then there would be a coordinator and consultants. There’s always going to be someone, in our board, from student services, so that could be your chief social worker, or it could be your chief psychologist. We have an integrated approach that’s cross-departmental for each of our goals. We don’t assign well-being just to the Student Services Department. The head of Student Services might be the lead superintendent, but they bring together a cross-departmental sector and they plan the activities for the year for the board improvement plan. (...) [Our] central staff [are the] coordinators, consultants, psychologists, social workers, or staff that report to superintendents. (...) All of those groups together, they do the strategic part and then there’s work groups that will go out and implement it. When the work groups go out to implement it, that’s when they would [engage] public health. [SB1]

According to the school board executive quoted above, their public health partner tended to be engaged at the end of their operational planning process at the verification level. Although the initial purpose would be to have an information-sharing session about their plan and seek implementation resources, changes could still be brought to their operational plan, owing to a flexible planning approach. As the director of education further explained:

Once [the well-being committee has] determined what the challenges of practice are—when they look at how do we now actually address that challenge of practice—(...) at that point, they may choose to consult public health to get additional assistance on what [that committee’s operational plan] looks like or those initiatives or action items look like at the school level [through the committee’s work group]. (...) [Since] it’s a fluid plan, there are different iterations. (...) [So, the public health’s] input could result in the plan being changed.

Since their planning process was iterative, public health professionals could still verify the plan’s completeness and suggest additional strategies during their side meetings, thereby expanding partnership opportunities.

There was no set manner in which school boards requested external planning input. Although annual needs assessments at the school board level tended to be conducted outside of cross-sector engagement, school board representatives mentioned that engagement with their public health partners could occur at the end of their operational planning process for a verification, or even during this planning phase for a consultation. As the superintendent pointed out:

This [operational] planning is done by our well-being and safety team. (...) I know that [they] speak with public health people when there are needs at that level. They have side meetings to see what [ideas] the health units have to offer to support our goals. (...) [They meet] sometimes, when the [operational] plan is completed; sometimes, it may be during the development of the plan. Some team members will contact the health units to get their expertise.

While some school boards were engaging with their local public health units at cooperative engagement levels, other school boards undertook the Well-being Strategy through a collaborative partnership arrangement or a mix of these two types of arrangement. For example, the participating mental health lead reported collaborative and cooperative engagement levels being initiated when developing and operationalizing their school board's multi-year overall mental health strategy, an integral component of the Well-being Strategy, as further explored below.

First, the mental health lead collaboratively developed their overall multi-year mental health strategy through their extended school health partnership with a coterminous school board and two public health units, along with other community partners. Together, they had already been engaging in in-depth conversations about what a suitable mental health strategy could look like, long before it became a ministerial requirement. Now the conversation was being expanded to include the other well-being aspects that composed the Well-being Strategy. As the mental health recounted:

The school board created [a mental health and wellness strategy] at that time, in collaboration (...) with some of our community partners. (...) So, the board creates its own strategy, but I work pretty closely with the community partners. (...) In the past, there was lots of good discussions about mental health in schools, about the development of a strategy, actually having to look at it and talk about it and make sure that what we were hoping [for], could happen in my school board. (...) [So that external] structure was already there, but it shifted a bit and became a bit more focused when we had [Mental Health] Leads because then there was a real focal point to the work around that tiered model [from the Ministry of Education]. (...) I was largely responsible [for drafting the strategy]—myself and my superintendent, and my mental health [advisory] committee, internal to the board—(...) but the community partners were instrumental in informing the [overall] strategy. (...) [There was] lots of

discussion about it, [although] they didn't sit with me and write it [with me] (...) [Also,] I shared information about the Well-being Strategy with them, as the strategy was being released, and our partners in public health were aware of it, as well, because they get the information, too. We just started talking about what that might look like and what the focus could be for education and how public health could support the strategy and components of the strategy.

Engaging outside of the school board's meeting structures, public health unit representatives and the other community partners had been nevertheless *involved* in the main planning process for the creation of this school board's mental health strategy that spanned a multi-year timeline. Although this overall strategy was being led by the school board, the community partners contributed significantly to the decisions being made, in that much time had been spent listening to their views and understanding their perspectives through continuous engagement before decisions were finalized. For this reason, the engagement process that had taken place was still collaborative in nature, as pointed out by the mental health lead. This example showed that a school board's decisions could be made in a collaborative manner even when deliberations with community partners were taking place through an external engagement process.

Second, these same community partners were engaged in a cooperative planning process with executives at that school board. Once the multi-year mental health strategy was completed, superintendents prepared their own annual operational plans by *consulting* with their community partners for ideas about school board-led well-being activities. The community partners cooperated by sharing additional strategic ideas that school board executives could consider implementing themselves. As the mental health lead further explained:

Operational planning, when I hear that, I think some of that's about how we're rolling stuff out within the school board, so those are internal conversations. (...) Some of the operationalization of [the Mental Health and Wellness Strategy], some of that happens in conversation with my two superintendents. (...) [So,] there's consultation that happens with community partners, but they're not sitting at that (...) table within the board. (...) Those are decisions that are made at the executive council level and superintendent level. That's outside of the scope of me and a community partner table.

This cooperative operational planning process pertained to specific board-level operational strategies that were peripheral to the external advisory committee's sphere of activity.

Third, cross-sector engagement was more extensive when community partners' advice was sought during the preparation of the mental health lead's own annual operational plan, or work plan. Public health professionals, especially, were *involved* throughout this distinct operational planning process because they had been relied upon for their insights, acquired through their direct engagement with school personnel. Each year, thorough discussions with public health professionals brought further refinements and rationale to the annual work plan. As the mental health lead pointed out:

'What do you hear from the system?' [This] is often the conversation I have with public health because they're going in and having conversations with principals and teachers, and sometimes they're hearing and seeing stuff that I may not hear or see. So, they help, and they inform me, which then informs the priority for the upcoming school year related to [our overall mental health] strategy. They're quite instrumental in supporting [my work plan] but also helping to develop it because they're really close to the action, and they hear lots of stuff first hand. (...) [Public health and the other community partners are] collaborating with us as we are looking at that work plan and thinking what's reasonable, what can we accomplish this year, what are we going to do together—they're very much a part of that. That's very much the spirit of those conversations.

This series of conversations informed not only the mental health lead's work plan but also the public health partners' operational (work) plans. The school health partnership for student well-being would be operating within the front end of the continuum of mental health care (i.e., Tier 1). The scope of the collaborative school health partnership arrangement centered on the intersection between the mental health lead's work plan covering all aspects of well-being and their public health partners' operational plans dealing with comprehensive school health—that intersection point dealing with the primary prevention and promotion aspects of positive mental health and wellness. It was from here that began action planning for students' mental well-being. Having extensive input into each other's operational plan guided the decisions as to which initiatives, whether school board-led or public health-led, were to be selected or developed, and then proposed to school principals. It was left to each principle to decide which initiatives would best fit within their own school improvement plan.

The school board mentioned above conducted their joint operational planning by involving their community partners through an external advisory committee structure. Alternatively, school boards may establish an internal well-being committee, with their main community partners attending as standing members for preparing a joint operational plan. For example, a director of education stated that they had created an internal steering committee to operationalize goals that aligned with the Ministry of Education's Well-being Strategy, with its four components of equity and inclusive education, safe and

accepting schools, mental health, and healthy schools. As a committee, they collaborated by coming together to identify and prioritize students' needs; refine strategic goals related to the various aspects of well-being; and formulate operational strategies. As the director of education further commented:

Our well-being committee aligns [the Ministry of Education's] Safe Schools, Equity and Inclusion, and Mental Health. (...) So, we'll be shaping some of the goals of that committee based on the [Ministry's overall Well-being Strategy] document. (...) It's a board committee, but we invite external partners [as standing members]. (...) One of [the public health nurses] is on the committee. (...) [Our health unit] are partners at the table and all of the members are part of the decision making, (...) We're trying to bring action to the goals that are part of that strategic direction. (...) [Our local health unit has] been good partners with us, (...) helping with the delivery of programs at the schools. (...) Certainly, wherever there's a need that's identified, they try to fill a gap [in programming]. (...) They will help us wherever there's a gap area.

In this example, a public health representative was participating in joint operational planning in whatever way that was considered relevant to their school health partnership. This public health partner was contributing by filling any gaps in programs and services related to their mandate. More specific collaboration took place between the local public health unit and other community agencies to work toward other operational strategies and initiatives, as required to support their common school board partner.

The same school board participated in another form of collaboration through their extended school health partnership arrangement. The director of education reported that the executives who were active within their extended partnership met regularly to co-lead ongoing operational planning toward specific partnership goals surrounding poverty and obesity issues. This operational planning engaged other key personnel and occasionally included update reports:

It's through dialogue and collaboration that we come up with workable goals. (...) The directors of our coterminous school boards meet a couple of times a year with the executive of our health unit and some of their team. (...) Sometimes the superintendents join us at these meetings with some of our curriculum staff because they're the ones that tend to be closer to the implementation in the schools.

Not all school boards may be preparing their operational plans for student well-being with input from their partnering public health units. One possible reason for low engagement in this area is having to deal with the complexity of extended school health partnerships with multiple public health partners covering an expansive geographical area. This was the case with one of the participating school board executives,

where their geographical jurisdiction was so large that it covered in whole or in part the catchment areas of several public health units. Historically, they had their community liaisons be invited to join their partnering public health unit's internal operational planning meetings to help guide the identification of public health-led initiatives. Despite their complex partnership configuration, joint operational planning was still seen as a possible partnership activity in the future. As the superintendent commented:

It would be difficult, I think, and I'm not saying it's impossible, but it could get difficult at some point if there are a lot of outside people coming in to guide boards' [multi-year] strategic plans. So, I think it's an exercise that needs to be done in-house. (...) [Then with operational planning, it's] to make sure that we're getting into the practical. (...) Certainly, the superintendent is part of it, but it's up to our service departments that are responsible for those [student well-being] projects to (...) start planning to ensure that action is taken. (...) So, it's really about planning at a much more operational level with people who can ensure implementation—(...) so not necessarily doing it at a very general [strategic] level (...), but much more at the operational level based on the board's [strategic] goals. (...) The idea of sitting down [with a public health partner], taking a look at our board's [multi-year strategic] plan, looking at the health and well-being component, and then saying, (...) 'Here's what we would like to work on together, and here are some of our data,' that's something that could be done. (...) [Discussions during operational planning] could bring about actions that would lead us to meet the goals from our strategic plan. (...) Well, at the operational level, this is where it could get interesting to sit down and discuss with our partners. This way, we could get ideas and perhaps find things to do together.

The superintendent noted that collaborating with their public health partners on operational planning could be advantageous in areas of mutual interests. It could broaden their thinking about how to operationalize more effectively their broad strategic goals related to student well-being.

e. Action planning at the school board level

Action planning consists of two main tasks: selecting and/or developing school health initiatives; and specifying implementation steps for delivering these initiatives within the local school system, and for promoting their uptake.

The least extensive level of cross-sector engagement during this planning phase is the verification of already developed public-health initiatives. This engagement level occurred whenever approval was required from school board decision-makers, before these initiatives could be offered to their schools. As

a director of education stated, this engagement level did not call for much planning input, but was rather limited to providing comments about what was acceptable and what needed to be modified:

[At the meeting with our health unit point of contact], we will look at any changes or programs or resources. (...) [They] will clear with [us] anything that's to be distributed to the schools before a public health nurse, for example, would send resources to the principals. (...) [These resources] are cleared at the board level. (...) [We] will review the resources, [and] let them know, 'Yes, they're great to go out' or 'Here's the change we would need' and then they distribute them directly to the schools through their public health nurses.

Verifying the appropriateness of available initiatives required minimal cross-sector engagement. By contrast, *involving* a partner in jointly identifying the right initiatives to put an operational plan into action could entail lengthy conversations. As the mental health lead reported, much collaborative discussions went into figuring out what existing initiatives public health partners could offer to their school board and schools:

It's a pretty informal conversation about programs and resources and research and what they want to try out this year and how that fits the needs of our system. (...) They're clear about what their mandate is in terms of health promotion and mental health promotion, their mandate within the school board, and (...) looking at where it overlaps. Tier 1 is their mandate, so what does that mean in terms of Tier 1 of a mental health strategy, where might they fit in, what parts can they actually support. That's really the spirit of the planning.

Since the public health partners had also been involved in the mental health lead's operational planning process, they had already contributed input into the articulation of those strategies that determined the kinds of initiatives they could propose.

The coordination of implementation steps ranged from being simple to multi-faceted, although not all implementation steps would be calling for coordination. One key implementation step requiring a coordinating level of engagement was the use of a school board's districtwide communication channel for promotional purposes, encouraging schools to take on an initiative spearheaded by their local public health unit. As a superintendent pointed out:

Of course, we work with them to promote some of their activities. For example, 'Activity of the Week' when students are riding their bikes, [or] walking to go to school. So, health units also have certain activities like that and then we, through our school system, we promote it.

f. Policy development at the school board level

Policy work is a combination of operational and action planning where broad policy ideas are articulated in concrete terms with clearly stated implementation activities. School boards engaged with their public health partners in policy work, either as a ministerial requirement or a school-board policy initiative.

Participating school board representatives had few policy-related experiences with their local public health partners to share. However, where there had been cross-sector engagement, it was extensive. Both directors of education commented that they involved public health professionals in the development of their school health policies, usually referred to as procedures or protocols. One advantage in doing so was the possibility of tapping into other school boards' policy work. As a director of education indicated, regarding accessing school board policy examples from their public health partner:

Probably the most recent [example] would be developing a protocol, so there's no policy, but a protocol for supporting students with diabetes. The public health shared with us documents from other boards that they were aware of, or that they had worked with and helped. Our student services department (...) will work closer with public health to create the actual documents that's specific to our board and then implement it.

According to school board representatives, additional public health contributions to policy work included the sharing of reference material to prepare a school health procedure or protocol; advice on what the procedure should contain in terms of health-related requirements; assistance with raising awareness about school health procedures in the schools; and implementation support, especially when the school board did not have sufficient capacity for training. Another school board executive mentioned that their public health partner provided networking support by connecting them with other school boards so that they could work on developing together their respective policies in similar areas.

g. School-level planning

School-level planning entails preparing a school improvement plan that is meant to align with the board improvement plan. The priorities and operational strategies that compose the school improvement plan guide the selection or development of initiatives during this plan's action planning phase. The purpose of action planning was to make appropriate implementation resources available to address the prioritized

needs. According to participating school board representatives, school boards provide assistance to their schools' improvement planning process. Additional support may be received by local public health units through a direct school request or through the facilitation efforts of school boards.

The school board executives reported different patterns of cross-sector engagement at the school level. In one school board district, schools would conduct needs assessments on their own, with possible guidance from school board personnel, and then seek implementation resources from their local public health unit in a cooperative partnership arrangement. Another school board had invited public health representatives to join their group of principals' early engagement in school improvement planning. During this group planning session, consultation support was provided to assist in identifying operational strategies for future action planning. Yet at another school board, each of their schools' well-being committees had public health representation for partner involvement in the school health planning process, consisting of both operational and action planning processes.

Within certain school boards, schools' preferences may be to inform their local public health unit of their operational plans and consult with them about available implementation resources to actionize the well-being strategies that have already been determined. For example, one superintendent indicated that their schools used their own needs assessment tools to carry out their operational planning in an incremental manner, such that engagement with their local public health unit occurred mainly during their action planning phase:

Often, it's that we're working on some sort of continuum that allows the principals to take a snapshot of their schools, to find out what stage they're at with implementing the five different components [of the healthy school approach] so that they can see where they need to put more effort. So, at the board level, we're using tools that allow [the schools] to do needs assessments well, and then from that, choose appropriate strategies to improve [the situation]. (...) If the school identifies needs related to challenges in the area of students' health and well-being, they will work with the health unit, or with the board's resources, to actually implement actions to improve the situation.

This school board's geographical jurisdiction encompassed both urban and rural settings, producing wide variability in local school contexts. The superintendent stated that internal planning was preferred overall to ensure the preparation of more integrated, and coherent action plans—similar to their position on planning at the school board level. They felt that having their various community partners at the table for the operational (short term strategic) phase of the school improvement planning would accentuate the

difficulty of preparing coherent, seamless plans. They sought to provide a seamless array of initiatives that could be smoothly embedded into the schools' daily practices by preparing school health plans themselves in a manner that would make sense to the schools. For this reason, cross-sector engagement was occurring rather during action planning. As the superintendent explained:

[Planning with internal personnel] is done so that our school administrators do not feel that they're really making 42 [action] plans per year out of 42 different strategies, and basically, seeing no coherence when bringing it all together. (...) So, if we were to be working [with our community partners] on all sorts of things separately, this would then have a big impact on the staff, leaving them exhausted (...) It's just that sometimes we think we're working on some aspects of health, but it's going to be linked to other aspects as well. (...) We could be working on goals that are related to health and well-being, and at the same time, be working on other aspects that are also part of our strategic plan, related to mental health, related to perhaps the delivery of some curriculum and other things. So, we prefer to put it all together so that it doesn't look as though the school is implementing 42 different initiatives, but rather implementing one plan to support the students that deals with different aspects, but under one umbrella [strategy].

Other school boards with less geographical variation may find it suitable to consult with their public health partners much sooner into the school planning process. One director of education spoke about a culture shift that occurred within their school board when they permitted public health representatives to be present during school improvement planning sessions with groups of principals:

At the school level, we have what's called a school improvement plan—(...) we added the [component] well-being. (...) In one of our meetings with public health, they asked if they could attend some of those planning sessions to offer some support to our principals. We had never thought of that, and we welcomed it. (...) We had them attend (...) [and] they sent different representatives.

Various factors may have contributed to their incorporating a cross-sector function into their traditional group planning practice. First, they considered their local public health unit as their primary partner for health promotion in their schools and they relied on their support to make additional links with other partners within the broader community to enhance their plans. Second, conditions for joint strategic planning were present with respect to their organizational culture and the value they placed on an external perspective at the planning table.

Even though individual school health plans would usually be created around the beginning of each school year, unanticipated needs may emerge later on, over the course of the upcoming year. These needs would

be calling for additional operational planning at the school level, where the local public health unit could possibly be consulted to see if they have any available implementation resources that could address an emerging need. At times, this request may come through the school board, itself. As a superintendent pointed out:

[During the school year,] if I have a particular need in a school, I can communicate with people at public health to ask them to do something at that level and then they will say, 'Yes.' I put the principal in contact with them and they organize everything. (...) [For example,] if I need training or a workshop on a particular topic for an issue in a school, we can do something [together] sometimes. We work with them or they will suggest resources. So, we always manage to meet the needs.

Other school boards may incorporate cross-sector collaboration within their schools' own planning structures. This planning practice may be suited for school systems where needs assessments for school improvement planning is conducted at the school board level. For example, at one school board, needs were determined collectively with their main community partners, including their local public health unit, acting as standing members on their internal steering committee. This committee helped to direct school committees, which also included public health representation, in their efforts to strategize ways of addressing their prioritized needs. As the director of education explained:

The superintendent that works most closely with [our] health unit (...) is also part of the team (...) [leading] our well-being committee. (...) So, there are needs that emerge from [our Student] Climate surveys. (...) Poverty is another issue. (...) [Our well-being committee] tries to take the high-level [goals] and then helps, through the network of principals and public health nurses, to operationalize them. (...) [These are our] school well-being subcommittees and the (...) public health school nurses are part of those. (...) Those sub-committees will develop strategies to try to deal with [issues identified by the well-being committee].

In the example above, the participating director of education had facilitated the *involvement* of public health professionals in school health planning by encouraging their participation on schools' well-being committees. These committees' school health planning was guided by the school board's own well-being committee. When parts of the school plans were a good fit with their local public health unit's expertise and mandate, then further engagement would be taking place with additional public health staff to identify and deliver suitable initiatives.

9.3 Connection

Making a connection, in the sense of establishing a close tie with one's school health partner, motivates engagement across the public health and education sectors. School board representatives identified two connecting elements, which had also been mentioned by public health professionals during the first research phase. These similar connecting elements are determination, in terms of a proactive attitude; and trust, in terms of its advantage and cultivation. Although there was no mention of the other connecting elements, they may still have been integral to the school health partnerships. It may be that the participating school board representatives simply did not think of bringing these topics up during their interview sessions.

9.3.1 Determination

From a school board perspective, a determined public health professional was seen as one who was “proactive” in making sure that discussions about matters of mutual concern would be held at some point. A director of education revealed that they regarded a public health professional's determination to initiate partnership meetings as a positive trait, since this served to counterbalance the various education pressures that demanded much of their attention:

I would say the fact that public health takes the initiative to reach out to us has been really important. (...) They're not waiting for the school board, as a partner, to contact them when we need their supportive services. They're being proactive in contacting us. That has really helped. They set up the meetings. (...) They will come with the agenda; they will be open to our agenda, but they'll have their list. (...) I think from a school board's point of view, there's so many responsibilities and partnerships and activities and initiatives that are a priority that sometimes public health might be seen as 'When we need them, we'll call them.' If the mentality is 'Our primary focus is academics' as opposed to the growing mentality of 'It is academics and well-being,' they may not be seen as the first person that we need to meet with. (...) The fact that [our public health partners] are taking the initiative, brings them higher on the agenda to make sure that things get taken care of.

By actively pursuing a connection, public health professionals were providing a valuable service in helping to keep matters related to student well-being close to this school board executive's attention so that partnership activities could be undertaken.

9.3.2 Trust

School board representatives linked the cultivation of trust with the building of relationships underlying their cross-sector engagement. In line with the public health professionals' responses, trust was viewed as essential for engaging in open dialogue and for further advancing cross-sector engagement. With trust, the conversation was found to deepen and to move the partnership further along. As a director of education pointed out, the trust that permeated their school health partnership enabled their public health partner to suggest ideas about possible strategies that could advance their cross-sector engagement:

Where [public health professionals] have ideas for new ways to expand the partnership, there's a culture of trust that has been built such that they can suggest them. I think that's been the key, that the individuals involved are contacting us with information and ideas and it's not always us just calling them when we need their support or their service.

School boards could also function as a reliable source of support, which contributed to the building of trust at the basis of open dialogue. For example, a superintendent reported that trusting relationships set in and conversations opened up with a growing sense of mutual support:

When we have questions, we call them; when they have questions, they call us. (...) [And we're] reaching out to the other when we have needs, on a mutual basis. So, we're there for them and they're there for us. (...) So really the key thing is to have good contacts [to build] good relationships with our partners, (...) [and then there's] free exchange of information coming from both sides.

Supportive behavior was wide-ranging. School board representatives stated that their public health units acted supportively by providing a steady presence in schools; by contributing to school board presentations or making presentations to schools on their behalf; and by sharing professional advice and implementation resources whenever the need arose, as best as possible. School board representatives cited times when they in turn offered support to their public health partners. In support of their local public health units, they promoted their school health initiatives; granted them access to facilities to run programs and have meeting space; and fulfilled their request for information in a timely manner. All of these supportive interactions created trust to further advance cross-sector engagement.

From a school board perspective, open dialogue was essential to resolve problems and reach agreements related to data sharing. Engaging in open dialogue was facilitated by the trust that school health partners cultivate when they gave each other mutual respect and support. As a director of education expressed:

We've got a very open relationship with [our main public health unit]—a very close relationship, very collaborative. It's based on open communication. (...) As long as I've been director, which is going into my [x]th year, and I think I speak for my counterparts at the other boards, we've always had a collaborative way of working out things [about data sharing]; there's a trust that's been achieved here, (...) [through] mutual respect and understanding our roles and how we can complement—(...) the ability to be open with each other, willingness to support each other. (...) [And for problem-solving], we really try to maintain respectful dialogue.

9.4 Capacity

Having sufficient capacity is pivotal to pursuing cross-sector engagement. The capacity elements that were brought up by the school board representatives centered on interorganizational structures, time, human resources, material and data-related resources, and knowledge acquisition—elements that were also prominently featured through a public health perspective. Notably, the element of leadership was not brought up by any of the school board representatives as a critical factor within their school health partnerships—although this is not to say that they considered this element unimportant, only that it was not mentioned.

9.4.1 Interorganizational structure

Interorganizational structures may enable regular interactions across partnering organizations and ensure well-performing partnerships. The structures that school board representatives spoke about included interorganizational meeting arrangements at various partnership levels, partnership agreements, and communication protocols.

a. Interorganizational meeting arrangements at various partnership levels

Based on participating school health representatives' accounts, school health partners got together through various combinations of possible meeting structures, including executive meetings, mid-level committees (including advisory groups), working groups, and community liaison structured interactions as well as meeting structures at other levels: district, school, and the broader community. The means through which they engaged with their public health partners gave some indication of the different types of interorganizational meeting arrangements that existed within school health partnerships, but this was certainly not a complete picture of all possible structures, due to the small sample size from the education sector.

(i) *Executive-level meeting structures:*

Participating school board executives engaged with their public health partners through top-level meeting structures that accommodated either extended partnerships or partnership dyads. Extended partnership meetings brought together executives from all coterminous school boards and their common public health unit to set a common vision and explore partnership-related strategic directions that could be universally applied. However, one superintendent pointed out the added advantage of also meeting separately, as a partnership dyad, for more focused operational planning:

With the health unit, [the team of superintendents] sat down, and we developed a common vision in the area of health and well-being in our schools. So, 'Here is where we want to go,' and from there, initiatives that are much more specific should come out in the next few years. (...) These big visions, they are broad enough to serve [the coterminous] school boards. (...) A health unit could come to support us, but this support would not be the same from one board to another. (...) I think we would find differences [at the board level] that would need to be considered [through separate meetings].

Having separate meetings for their partnership dyads was considered more suitable for planning specific strategies and initiatives since school boards tended to function differently and have their own set of priorities, and local contexts.

(ii) *Committees and working groups at the mid-partnership level:*

In addition to agenda-based meetings, cross-sector engagement was carried out through a variety of committees and working groups at the mid-partnership level, with school board representatives, public health professionals and possibly other community partners. The person representing the school board

at these types of meetings depended on whether decisions needed to be made or not. For example, when large distances separated the school health partners' headquarters, community liaison agents located within the public health units' catchment areas attended partnership meetings, but for information or discussion purposes only. School board executives would join the conversation, either remotely or in person, whenever a decision needed to be made. As a superintendent explained:

For us, it's about making sure to have a voice at these tables. (...) Most of the time, [our public health partner] would be inviting us. (...) So, there are certain [meetings] where, for example, if they were to ask for the participation of someone with decision-making authority, in that case, it would be the superintendent who would attend the meetings. But since these are often information meetings or discussion meetings, in that case, it's the community liaison who can do the work. (...) The community liaisons are on the ground to see what's going on. They have a very specific mandate, which is to have others get to know our board, but it also gives us visibility and a voice at that local table with respect to health.

The position of community liaison in this example pertained to French-speaking school boards with large geographical jurisdictions; they were mainly active at the local school level, representing the voice of the school board that was located much further away. It was a different arrangement than what was found in other school boards, where the liaison was working at their headquarters, and could more easily orchestrate interactions between the public health professionals and school board representatives.

Whether part of the French-speaking or English-speaking school system, school boards' geographical jurisdictions overlap with public health units' own jurisdictions, or catchment areas, to a greater or lesser extent. In situations where only one or a few schools fell within a public health unit's catchment area, either the principal or the superintendent, as authority figure, would be attending meetings, in person or by telephone. As a director of education explained:

We have more peripheral partnerships with [other health units]. They are peripheral, but (...) they invite us to teleconferences. We only have one school with [one health unit], in that district, so a lot of times our principal up there will be involved in teleconferences or meetings that they have. Sometimes my superintendent will participate; (...) they keep me in communication. (...) I would say it's very similar to [another] health unit [servicing only a few of our schools].

School boards' internal structures may be somewhat more elaborate than those found in public health units. School board executives stated that their organizations would establish a team or committee for each of their broad goals, identified in their multi-year strategic plans. Together, the members would

prepare an operational plan for their assigned goal. Then, either the team, or a working group formed by members of the larger committee, would be working on putting that plan into action, possibly with input from their community partners, as deemed appropriate. For example, one director of education mentioned that their school board tended to engage with public health representatives only during action planning through a working group set-up. This working group would have their priorities and strategies already determined, and would then be seeking their public health partner's input as to what resources they could offer to translate their strategies into action. However, they did not rule out the possibility of cross-sector engagement during strategic planning in the future:

We have four different committees (...) right now that are each run by a superintendent. Each one is in charge of one of [our strategic] goals. (...) Often, they don't bring [public health] in to sit on the committee [for student well-being], but they use them as a resource. (...) It's the actual working documents or creation of programs or implementation of programs that tends to be when we're contacting public health to ask for representation [on our work groups] or support [of resources]. (...) It's more at the initiative or work group level as opposed to the strategic level, at this stage. It doesn't mean we won't do it.

Another type of interorganizational structure at the mid-partnership level was an internal school board mental health advisory committee, where public health professionals and other community partners would regularly join as invited participants. This committee structure increased community partners' ability to share information and resources at the school board level. The mental health lead felt that the presence of their community partners at these meetings was a recognition of the valuable contributions that they were making within the local school system:

I have a mental health committee that's an advisory committee to me. (...) I invite [public health and other community partners] to come a couple of times a year to sit in or to present, share some information or resources with our mental health committee. (...) I think it underlines the role that public health plays in supporting mental health and wellness in school boards. I think that they have been playing that role for a really long time, but it's not been well understood, not been properly highlighted.

This mental health lead was also a participant in a cross-sector mental health advisory committee, whose focus spread beyond their school health partnerships with local public health units, while still targeting schools. This advisory type of committee was mainly composed of community partners who were collectively active across the full mental health continuum of service delivery. Their concerted work to establish and maintain an efficient service delivery system had progressed to where they could now focus on expanding their community support to better align with the Ministry of Education's broader Well-being

Strategy. Given the wide-ranging conversations that this Strategy involved, separate meetings with the public health partners were set up to engage in more partnership-specific discussions. As the mental health lead recounted:

We've created [an external] advisory structure (...) where organizations that offer school-based services or supports to schools come together. (...) I shared information about the [Ministry of Education's] Well-being Strategy. (...) We just started talking about what that might look like and what the focus could be. (...) That's been our main mechanism for engaging with our community partners. (...) That structure (...) is a place where we come together regularly to share information, update one another, plan together, just make sure that we're not missing anything, we're not duplicating anything. (...) [My] work plan is developed, shared with the people at that [advisory committee] and then separately in another meeting with both health units to really specify activities that would support the implementation of the strategies, so there's very specific conversations that happen with public health.

The committee's membership included representatives from two coterminous school boards and the two public health units that they both shared, as well as representatives from other service agencies. All were coming together to contribute their perspectives to the conversation and provide input into each other's planning process, when required, to ensure that any service gaps could be filled, and any redundancies could be eliminated. Conversations were wide-ranging, with partners sharing their expertise related to mental health, whether in the area of promotion, risk prevention, or treatment, and/or expertise about the other well-being aspects covered by the overarching ministerial strategy. Separate meetings were held between the mental health leads and public health professionals for more specific conversations about what initiatives would be suitable to propose to principals in the area of mental health promotion.

In other school boards, public health professionals may already be integrated, along with various other key community partners, as standing members in school boards' internal committees. One notable interorganizational structure was an internal school board committee whose cross-sector membership was tasked with the upstream promotion of student well-being and how the broader community could best support the school board in this area. Since student well-being was such a broad activity area, consideration was being given to establishing sub-committees through which the larger well-being steering committee could provide clear guidance to individual schools with their own planning process. As the director of education explained:

Our own board's [joint well-being] committee includes members from [our main public health unit] and other agencies and community organizations. (...) It's a larger working committee. (...) They're invited every month; they're standing members of our committee. (...) The work of

the committee has been more of a large global group, but I think we'll probably see smaller sub-groups tasked with different action items. (...) We have a direct role in supervising our schools, but it's this joint committee that we've got, this well-being committee that helps steer the work of the school-based well-being committees.

(iii) District-level meeting structures:

Meeting structures at the district level enabled school board-organized gatherings of personnel from all district schools or a subset of school for group discussions, with public health professionals attending at times as invited participants. These school personnel consisted of principals, teachers, or champions of school health (including school social workers). Although similar interactions between school health partners may have been occurring at individual schools, district-level meeting structures granted additional opportunities for engagement with public health units, and in certain instances, they represented a means to gain greater access to school personnel.

District-level meeting structures suitable for cross-sector engagement took on various forms: professional development days (in-service days); regularly scheduled principals' meetings; and school improvement planning sessions. Advantageous for networking purposes, professional-development days offered public health professionals a practical meeting structure through which to highlight partnership benefits and share information with school staff about available implementation resources and support. Likewise, networking could be carried out during principals' meetings in order to bring greater clarity about the healthy school process and the public health role in this process. As the mental health lead indicated:

We met with principals last week, in our system and talked with them about the healthy school committee, the role of the committee, the purpose of the committee, those six steps, and we introduced the certification process which schools can take on if they wish. (...) There's a public health nurse attached to each school in our system, so they know that that person could support them in setting up the healthy school committee and [in] coming up with some priority areas and facilitating access to resources. (...) As the principal, they are responsible overall, at the end of the day, for the creation of that committee, but they know that there's support there from myself, and from public health.

(iv) School-level meeting structures:

According to school board representatives, each individual school may establish a specialized committee of their own to plan for the promotion of student well-being, as part of their annual school improvement planning process. Healthy school committees were considered a key structure through which to apply the

healthy school approach, with possible public health facilitation. As the mental health lead explained, the extent to which such a structure was active within each school depended on the level of interest of the school community and the extent of parental engagement, but their public health partner could provide direct assistance to help ensure its good functioning:

Healthy school committees are in different kinds of conditions, depending on staffing interest and parent availability. (...) [So,] we've shared the information [at the principals' meeting] and then are hoping to do a follow-up with the schools to just inquire about how that [healthy school] structure is going and what they might need to support their work. Public Health will be a big part of that.

When it comes to school-level planning, public health professionals may be consulted for their guidance, as an invited participant, or they may be involved as a standing member of their school well-being committee.

(v) Community-based structures in support of school health planning:

School boards may also be engaged in cross-sector planning through community-based structures, along with their local public health units. These committees' scope would be much broader, covering initiatives for delivery in schools as well as in the surrounding community. This type of external committee structure brought together school board representatives and a multitude of community partners, including public health representatives, to jointly plan strategies and coordinate the delivery of initiatives that served the well-being needs of school-age children within the broader community. For example, a director of education spoke about their participation on a community-based well-being committee structure that engaged a large group of community partners by operating at two levels:

We've got tightly interwoven connections. Besides the direct connections we have with our directors' table, (...) we've got a larger community leadership table. (...) I'm a member of the executive, (...) [and it steers] a broader table that includes (...) public health leaders (...) [as well as] the other agencies that support kids in our communities and their well-being. (...) It's a fairly large table.

There existed additional community-based committees, whose interests did not lie solely within the school system but expanded across the local community. As another school board executive reported, coterminous school boards and their local public health units had been participating in municipality-led committees of community partners for engagement in whole-of-community initiatives, such as the

Healthy Kids Community Challenge, an initiative of the provincial ministry of health, also mentioned by public health participants.

b. Written partnership agreement

(i) Formal partnership agreements:

While some public health professionals raised a concern that a formal agreement would diminish efforts to cultivate the relationship, other public health professionals experienced the contrary. Adding to the latter perspective, the mental health lead asserted that the act of formally capturing, in writing, the original intent of the partnership did not only clarify its purpose for them and their partners, but could also preserve that sense of shared purpose to keep the partnership on track for the years ahead:

When I think about structures, it could be a written document. (...) We worked on [our partnership agreement] this past year. (...) That's been, I think, a really important process. (...) [And] the relationship piece, (...) I think we need both. (...) We've just been extremely fortunate in this community to have those relationships and connections, (...) [and] then, [to have these relationships] supported by a partnership agreement that says, 'Here's why we're in the room. Here's what we believe in. This is what we want to work together toward,' I think that in my mind that is absolutely essential. I think sometimes people don't spend a whole lot of time on that because they think it's not necessary and it takes a lot of time and a whole lot of work. (...) [But] if you don't do that at the very beginning, then you end up five years down the road wondering--sort of like mission drift--'Why am I doing this and why am I not doing that?' Well, because we never really formalized it to begin with.

Their formally prepared partnership agreement served as a constant reminder of the reason why each organization chose to embark on their school health partnership so as not to deviate from that sense of shared purpose, which was ignited in the very beginning. It also served as a valuable instrument to clarify the local public health unit's role and underscore their contributions within the education sector. As the mental health lead further stated:

I think we still have (...) [to] really underline the important role that public health plays in supporting education. (...) So, I see the value of a partnership agreement is to really underline, formalize and spell out what it is that public health units can do to support what's happening in a classroom, or in a school, and that is really essential.

(ii) Communication protocols:

Communication protocols were agreements between school health partners as to how communication was to be channeled across each other's organization. The designation of a point person was deemed instrumental for easily knowing who within the other partnering organization was the right person to contact, and for establishing clear channels of communication. As a director of education stated:

I meet with the public health outreach, and information is then disseminated by me to the appropriate individuals at our organization. (...). [This person is] our contact through to public health for the nurses. (...) During the year, if there're questions, I have a primary point of contact. That's key, that we're not trying to figure out who to call at public health. I can always call [the school health manager] and (...) [I'll be put] in touch with the right person. (...) They will do that work for us.

Another major consideration for efficient communication centered around the standardization of administrative and information-sharing procedures for consistency across public health units that engaged with the same school board partner. This was thought to be a worthwhile practice, especially given that principals tended to move across schools located within the same school board's geographical jurisdiction, but serviced by a different public health unit. According to the communications manager, establishing common communication procedures significantly helped enhance cross-sector engagement within their extended school health partnership:

Our staff really moves around, our principals especially. Our principals will be with one public health unit one year, and they'll be with another one the next. (...) In order for them to work well with public health and ensure procedures are adhered to, it is important that the units have similar procedures. (...) [Also] we work with our coterminous board, (...) [and so, we] have moved toward standardized procedures for everyone involved. This makes our work easier and helps ensure that we don't 'drop the ball' on our public health friends.

9.4.2 Time

Most participating school board representatives mentioned that they were often faced with time constraints. At center stage within school health partnerships was the support that public health units had to give to local school systems in their efforts to create healthy schools. However, school boards and schools may not have found the time required to fully engage in health promotion work. As a director of education indicated:

We need to keep our eye on [literacy, numeracy, and well-being]. Sometimes they can become competing. We only have limited capacity and limited time to build that capacity. (...) [Also,] we only have so much time to meet with our principals and teachers. [The teachers] need to be in the classrooms with the kids, so it's trying to do many things and affect change and [take on the] implementation [of the healthy school process]. There are competing pressures. (...) We're continually working it through or trying to find ways [to overcome this]. (...) It's just that it's very complex. Each school has got a different context and each principal has a different skill set and we're a small system. It's challenging sometimes to get things aligned.

When time was in short supply, it was considered even more critical to put in place as many time-saving measures as possible. The communications manager noted that their school board could have more time to engage with their public health partners on school health initiatives if they did not have to be “reinventing the wheel at a local level” so often. They commented that it would be worthwhile to have school health initiative templates be produced, or promoted, from a provincial body for use in school health partnerships, such that only adjustments would need to be made to reflect variations in the local context. In this way, working together to figure out how to develop and implement a school health initiative would be less time-consuming:

It's not that we don't involve public health or think it's not important. It's just that we're stretched thin with other initiatives. (...) Again, our public health partners are amazing people, (...) [but] with the pressure of increasing our EQAO results, our teachers are so stretched also, and the requirements are so heavy on them. That happens even more so at the top with our tiny management team. (...) If somebody comes to me and says, 'What do you need? I'll create a customized program for you,' that kind of a thing, we just don't have the time to be, 'Oh, let's sit down and we'll talk about this.' (...) [Time issues need to be dealt with] top down. I'm all about standardizing procedures. Of course, it's going to work differently in the city. Let's say, you've got these great projects planned: the start, middle and end, [and] the way to measure them. (...) [For example] it's about Grade 4 healthy eating. It might look differently in a classroom in Toronto, where the demographics are different from ours. In Toronto, you might find a school with a high population of Muslim students, [whereas] we might be a school with a high percentage of Aboriginal students. Of course, we would serve different foods to those groups. They would have different menus—but the project and the direction and the measuring and the procedures, and the things that you're going to do, are still the same—(...) [and then it's being] able to localize the initiative.

With capacity limitations being experienced within the local school system, school health partnerships may fare better if more of the groundwork, such as project templates, could be prepared for their direct use.

9.4.3 Human resources

Within the context of school health partnerships, human resources included the staff from public health units, school boards, and schools who were available to take on partnership work as well as the skills and level of expertise that they brought to the cross-sector engagement process for carrying out that work. Through their partnership arrangements, the school board representatives reported that they received advice and guidance from public health professionals in such areas as healthy eating, physical and health education, positive mental health, and the creation of healthy and safe school environments. However, cross-sector engagement at the school level varied depending on a school board's internal capacity to support their schools in promoting student well-being.

Cross-sector engagement may have been more active in those local school systems that were not well resourced. According to a director of education, the larger school boards had specialized teams of researchers and curriculum consultants who provided much planning support to their schools such that there was less of a requirement to seek external assistance with their school improvement planning for student well-being. However, with growing emphasis on the upstream promotion of student well-being, this director of education reported having successfully pursued further engagement with their local public health unit in a school board-organized school improvement planning session.

Even with highly qualified personnel, school boards could still make use of their local public health units' wide-ranging expertise. As one superintendent asserted, no matter how competent their personnel were, school boards could always take into consideration their public health partner's views about promoting student well-being, an area that was seen as vast and still relatively new to them:

We do have qualified staff. (...) For example, we have support teams that are trained to work on safe and accepting schools. But very often, we need external expertise to add to what we have. So, in those instances, we can go knock on agencies' doors, like at a health unit. (...) Ten years ago, we spoke very little about health in our schools and we did not have that mandate then. That mandate was added, and to think that a school board alone can develop all this expertise, I think that's asking a lot. So, with the health units, we can develop these partnerships and provide better services according to ministerial requirements.

Human resources also needed to meet both official language requirements. According to the school board representatives from French-speaking school boards, much effort was being made by their public health partners to ensure that their services were delivered in the schools by French-speaking frontline staff.

Generally speaking, they felt that the professional services they were receiving in French were adequate, but in certain geographical areas, this requirement was difficult to meet, due to lower proportions of Francophones in the local communities who could be hired as public health frontline staff. The likelihood of engaging with a Francophone from a public health unit at levels higher than frontline staff was much lower, even in urban settings. However, French-speaking school board representatives were comfortable attending meetings where the conversations were held in English, as they were usually fluently bilingual. There were instances where meetings could be conducted in French, but this only happened upon the school board's request.

9.4.4 Material, financial and data-related resources

In addition to human resources, school health partnerships were enabled by material, financial and data-related resources. Of these partnership resources, participating school board representatives mentioned the specific use of tangible resources, such as printed educational material, to be distributed to teachers, students, and/or parents for educational purposes and as part of other more elaborate partnership-related initiatives. French-language resources were provided by local public health units to French-speaking school boards, when available. Alternatively, French-speaking school boards had internal teams of translators to ensure resources were also prepared in French.

In terms of financial resources, one school board executive commented on cost-sharing arrangements that they had made with their public health partner. Their school board provided funding for public health frontline staff to receive training in the implementation of a program they had purchased for delivery in their schools. The local public health unit in turn covered their salaries when providing this service. This type of arrangement also built the partnership's human resource capacity through the further development of public health staff's professional skills.

According to school board representatives, school-based data were one of the most critical resources for engaging in the promotion of student well-being because these data helped ensure that actual school needs were being targeted. Partnership-relevant data for prioritizing needs came from public health units' local population health surveillance systems and school assessments, as well as student surveys conducted by either sector. A superintendent commented that their local public health partner's

surveillance data on the well-being status of school-age children were particularly useful in supplementing their own data sources, and in allowing them to plan more strategically:

What's great about public health units is that they very often have a good knowledge of the area. We do have a good knowledge of the environment we serve, but public health can have access to data that we do not have access to, and then we can paint a better picture of what we need. So, from their analyses, they can bring an interesting piece to support us in our initiatives, [like those to] support mental health.

Data could also be used through a collective data-sharing practice. For example, one of the participating school board executives mentioned having established an internal well-being committee whose standing members would discuss the data being regularly collected within the local school system for joint planning purposes:

[Public health professionals] are standing members of our [internal well-being] committee. (...) One of the key data collection pieces from this committee is our student Climate surveys, so there are needs that emerge from those Climate surveys. (...) Some of the work will be taking that data and working with the well-being committee to address some of the issues that are surfacing. (...) Those sub-committees [in the schools] will develop strategies to try to deal with these.

Data-sharing was not, however, a routine practice within the education sector. As one school board executive stated, their school board was well resourced with an internal team of researchers to collect and analyze data for their own planning purposes, and the practice of sharing this data was not given much consideration, although this could change as they further explored the value of joint planning at the strategic level:

[Data-sharing is] something I hadn't considered. We receive the results of surveys that public health conducts. We receive an annual or biannual survey report. (...) When we do our school Climate surveys, we tend to deal with the individual schools. So, we haven't gone to public health to say, 'Here's an area in one particular school that's a concern.' It's not something we've done in the past. I think again that's an area that we'd be open to seeing the value of sharing the data. Normally what would happen is we would unpack the data here. We have a research department. We have researchers, they would identify the trends, (...) [and] once that trend is identified, then we sit down with the principals and with the student services department to look at what can we do about it. That would be the level at which we would contact public health to say we're looking for some help in running workshops. But the actual analyzing the data, we have our own staff to do that. Many boards don't have researchers, but we do.

School board executives spoke about being protective of their student data due to privacy concerns. Being cautious about sharing these data, they identified critical requirements that, once met, could make them more amenable to sharing the results of their student surveys with their public health partners. Specifically, one school board executive stated that a high level of trust had to be present so that educators would feel confident that the shared data would not be used by their public health partner to cast a dim light on the school board or any of their schools when interacting with other external stakeholders, or the media. Additional data-sharing prerequisites included a well-established communication protocol between partners; assurance that public health partners had a clear understanding of information privacy rules and the type of data that could be shared; and a common vision and goal to ensure that the work to be carried out aligned with the school board's strategic plan. As a superintendent indicated, regarding using their school board's data toward a shared goal:

The Ministry requires that School Climate surveys be conducted every two years. We use that data to work on [our strategic plan's] health and well-being component with our schools. (...) If the board were to undertake a planning process together with their local health unit, then surely, we would have to sit down and look at the data and share it. But I think they would be shared only if there is a shared goal, (...) [since] we'd have to always be tying it back to our board's multi-year plan. (...) [Our school board] goals must be based on specific needs that are identified through the available data.

From this school board executive's perspective, the prospect of joint strategic planning would be calling for data sharing so that partnership efforts could be targeting actual school needs.

9.4.5 Knowledge acquisition

Public health professionals spoke of various knowledge-acquisition practices for enhancing planning abilities within partnership arrangements. From the series of school board interviews, the usefulness of knowledge-exchange events as collective learning opportunities was pointed out. As a director of education stated, knowledge exchanges about school health collaboration successes could be worthwhile for partnerships that were still in development as well as partnerships that were already collaborative, but could perhaps strengthen their cross-sector engagement even further:

Particularly if the relationships aren't strong to begin with, I see merit in learning how the interactions and the partnerships work in other jurisdictions. (...) There might [even] be shortcomings on what we're doing here that would only be highlighted by seeing some other

examples of collaborative efforts, and joint initiatives. (...) I think for the school boards and the public health agencies, it's good to see lots of collaboration [possibilities].

9.5 Continuity

The fourth and last component characterizing school health partnership experiences is 'continuity'. It deals with those elements that maintain the momentum created by motivated cross-sector engagement. Participating school board representatives mentioned four out of the six continuity elements identified by their public health counterparts, namely flexibility for adaptive planning, ongoing communication, turnover management, and commitment. Missing from this list of elements, as compared with public health responses, are the importance of clear and bidirectional flow of information and constant partnership contacts.

9.5.1 Flexibility in planning for adaptability

Although their multi-year strategic directions were unlikely to change, school boards incorporated flexibility within their operational planning processes, to better adapt to the prevailing situations and circumstances as did public health units. According to school board representatives, board-level operational plans were kept flexible for three reasons: (1) to be able to easily fit other worthwhile strategies being proposed by their community partners and expand the scope of partnership possibilities; (2) to allow discretionary decision-making by school administrators to address school-specific needs according to their local contexts; and (3) to make necessary adjustments to accommodate existing capacity limits. As the mental health lead pointed out, flexibility in planning ensured continued partnership productivity at whatever capacity level that currently existed:

[We plan together], all within whatever constraints we may have. For [our public health partner], it may be staffing, programming, finances, resources. For us, it's much the same. (...) They may not have enough staff to deliver a great program this year, or (...) we may not have sufficient staff, or be able to pull people out for some training to implement that program this year. That's part of that flexible dialogue, looking at, 'What do we need? What do we have? What's possible?' and then working within that.

Additionally, board-level operational plans may be designed in such a way as to allow discretionary decision-making by school administrators, so that their own plans could be more responsive to their specific school needs. As the mental health lead stated, their non-rigid board-level work plan would be guiding school-level planning so that schools could take advantage of a wide array of possible initiatives as they best see fit:

[My work plan] doesn't spell out specifically what I would do versus what [our public health partner] would do. It's much more general than that. It's not that detailed in terms of the actual activities. It's not that formalized, (...) mostly because it just leaves room for some flexibility and some responsiveness to what schools might raise in the fall.

9.5.2 Ongoing communication

A steady stream of communication is vital for a fully functioning school health partnership. Communication between school health partners may take place formally through structured meetings, and then informally, through ad hoc get-togethers, telephone calls, and emails, along with informative reports, to further the discussions. Ongoing communication was only brought up once as a vital element for upholding cross-sector engagement. One director of education felt that it was important to make themselves accessible to their public health counterpart in-between formal meetings, and vice versa, to help ensure that partnership activities ran smoothly and to encourage further collaboration:

We're always both accessible to each other if any needs occur beyond our formal meeting days. We meet as required. (...) There are so many positive collaborations [that can come up].

9.5.3 Turnover management

Turnover management practices are especially important within school health partnerships, which tended to experience high rates of turnover. As did public health professionals, participating school board representatives reported on ways that had been used to maintain the connection with their public health partners during times of personnel change. Measures to preserve inter-organizational ties included the following: (1) cultivation of a pro-partnership culture; (2) in-person introductory meetings at the school board level; and (3) routine exploratory partnership meeting invitations at the school level around the

beginning of each new school year. the practice of re-establishing the connection between the principal and their public health representative at the beginning of each school year.

Participating school board executives were well aware of the importance of relationship building between partnering organizations. Accordingly, adopting turnover management practices to restore the relationship following a personnel turnover was facilitated by a pro-partnership culture. As a director of education stated, all the coterminous school boards within their extended school health partnership had embedded in their organizational cultures an implicit expectation that any break to an interorganizational connection due to a personnel change would be re-established without delay to maintain partnership momentum:

We have a culture in our board—and I would say in the other boards—that sees the potential of the partnerships with the health unit, and we stick with that, and in spite of the change in personnel, continue to try to enhance that partnership [right away]. (...) [For example,] there was a change [in the public health leadership], but the new one came in and we picked up the ball. (...) [We] keep the ball rolling.

Commenting on their turnover management practice, one of the participating superintendents referred to the time immediately following their promotion when they actively sought to meet with all community partners connected to their portfolio so that introductions could be made in person and partnership activities could continue with minimal interruption:

[When] I became the superintendent, (...) I spent a lot of [my first] year going to meet people to develop those relationships because, as we know, to make things happen, it's often all about the relationship. (...) I have done it for all of the portfolios that I am responsible for, whether it's safety, public health, mental health—so getting to know the people. It's very important, if you really want to get things done, to have these contacts.

Another turnover management practice that was mentioned consisted of annual exploratory partnership meetings between principals and public health frontline staff as a means to address personnel change from either organization early into the new school year. When permitted by the partnering school boards, meeting invitations were being routinely sent out to school principals not only to explore partnership opportunities for the new school year, but also to address personnel changes from either organization that had recently occurred. In one school health partnership, public health frontline staff were allowed to directly contact principals toward the end of each summer to interest them in discussing possible

partnership activities for the upcoming year. As the director of education stated, regarding this turnover management practice:

Where a nurse is supporting a school, it really is successful based on the relationship with that principal. (...) What public health has put in place is a strategy to try and deal with turnover: the public health nurses contact the school principals, early in September or late August, to introduce themselves. (...) So they take the initiative of calling the school principal, they don't wait for the principal to call them. They then arrange for a meeting to let them know the different areas (...) [where] they can support the principals and their schools. They're encouraged to connect directly with the schools.

Personnel turnover is not just about a person leaving their position in an organization, but it is also about the loss of the relationship that was connecting the two organizations together. With the ability of public health frontline staff to routinely arrange for an in-person meeting with school administrators, especially when a turnover has occurred, as illustrated in the example above, steps could be taken to begin cultivating a relationship on a personal one-on-one basis so that the partners could start off the new school year on a sure footing.

Relationships may not be the only loss encountered during personnel turnover. A school board representative brought up another possible loss at the school level: the time and effort invested in a school health initiative that was discontinued because the work of the new leader, or new frontline staff, took on another direction. This occurrence may have dire consequences for the partnership. This school board representative went on to say that schools may be somewhat reluctant in engaging in other cross-sector initiatives, when a change of public health nurse, or health promotor, has led to the substitution of a school health project already underway. From their perspective, a school's willingness to partner with their local public health unit may be greater if initiatives could be planned at a more central level and then localized in a way that would ensure continuation of a project despite any turnover. In this way, the new staff would simply be picking up where their predecessor left off, so that initiatives could be continued as initially intended:

When you're talking about the big plans and those relationships that you're looking to build with health promotion and the principals, when that health promoter leaves for something better, that's all gone. (...) If it's developed at a local level, (...) the result [of that turnover] is usually the project's cancelled (...) [because the health promoters,] they come up with their own projects. (...) [So, schools may think] 'maybe you can do that [project], and maybe you'll get the funding, maybe you won't; maybe you'll leave your job next week, maybe you won't. (...) If it was something that was created at the top [provincial] level and sent down to public

health to implement, that's fine. Regardless of who that [public health frontline staff] is, they can still implement that master plan [and] even localize it. (...) [So] if they came to us and said [for example], 'Here's the provincial strategy and framework on childhood obesity. Here's five projects that have been approved for working across the province of Ontario. Do you have this issue, and are you interested in partnering on any of these projects?' That would make sense, because if that person leaves, then the next [public health staff] is doing the same thing.

It appeared that measures would need to be taken to assure school staff that whatever the initiative was, it would still be continued even if there were to be a change in public health personnel. This may increase schools' confidence that the efforts they would be putting into a school health initiative would be worthwhile.

9.5.4 Commitment to the cross-sector engagement process

Commitment is another continuity element that was identified as an important factor to maintain cross-sector engagement. A school board's strong partnership commitment was attributed to an acknowledgement of interdependence between school health partners caring for the well-being of the same population: school-age children. According to a director of education, the commitment to engage with their local public health unit came from an assertion that a greater impact could most certainly be created by supporting each other's efforts that were geared toward the target population they both shared:

[A strong partnership is about] people who are committed to working together and serving the population which we've got—all the kids in our schools are part of that [shared] population. (...) It's just realizing that we can leverage so much by working together. (...) We would be hard pressed without their help, and I think, they would be hard pressed without our support.

9.6 Supporting conditions

The school board perspective covered the same three levels of buy-in for moving along the collaboration continuum as did the perspective from the public health sector. Each buy-in level corresponded to the willingness of school health partners to come together and share a distinct organizational asset: information, resources, or the decision-making process. Going from one level of buy-in to the next

increased the extensiveness of engagement across the education and public health sectors. Participating school board representatives brought up similar sets of supporting conditions to increase buy-in, as those expressed by public health professionals, and interestingly, provided further insights.

9.6.1 Sharing information to explore partnership opportunities for health promotion

From a school board perspective, two conditions favored school boards' willingness to network with their local public health unit for the purpose of sharing information and exploring partnership opportunities. The first condition was the official assignment of health promotion responsibilities to educators by the Ontario Ministry of Education. The second condition was inter-ministerial encouragement for partnerships between school boards and public health units to promote the well-being of the student population. These conditions have also been reported by the participating public health professionals.

a. Official assignment of health promotion responsibilities

Health promotion may have been carried out through certain school boards long before the Ministry of Education made student well-being one of its mandated goals. However, school board participants commented that the newly amended legislation, along with the release of the Foundations for a Healthy School framework, clearly indicated that action on student well-being had officially become a formal expectation within the education sector. As a director of education stated:

The renewed vision which introduced promoting well-being, that's a vision that the government has where they're (...) articulating that well-being should be one of our goals, whereas in the past, it was really about eliminating the academic gaps in public confidence. (...) What the [Foundations for a Healthy School framework] document has done is put [the various components] all together in one place as a nice reference point. (...) [But] it's always a challenge when you're adding different initiatives to a system that their primary focus is education and academics, and now we have responsibilities for other areas that tended to be covered by different groups or agencies in the past.

According to this school board executive, students' well-being was always an underlying concern throughout the provincial school system, but it had now become an additional responsibility that educators were striving to meet. This executive further commented that educators who were not actively

engaging with their local public health unit on health promotion could benefit from school health partnership opportunities, as a valuable means through which to fulfill their new health promotion responsibilities.

b. Ministerial encouragement for local school health partnerships

After the Foundations for a Healthy School framework, with its partnership component, was first co-launched by the Ministry of Education and the Ministry of Health and Long-term Care in 2006,^{*} another inter-ministerial strategic initiative provided a source of encouragement for working in partnership at the local level. This initiative, called the Open Minds, Healthy Minds Strategy, has been supported by the ministries of health, education and children and youth services.[†] According to the participating mental health lead, this inter-ministerial initiative indicated a concerted effort among the three ministries to reduce siloed functioning within the province. The mental health lead added that this effort resulted in the creation of mental health lead positions across school boards with the responsibility of connecting with key local public agencies and community-based organizations:

Now that we have the Open Minds, Healthy Minds Strategy, it's at least a message, from our provincial government that we want these three ministries to talk more, plan together, work together. So, it focuses the Ministry of Education to play in the sandbox with their community partners in a way that they haven't had to before, because there wasn't really the same level of expectation to do so. (...) [That] Strategy has facilitated [the hiring of] mental health leads as that connector to all of those community organizations.

Subsequently, the Ministry of Education expanded on this overarching strategy by launching another strategic initiative that rather had a broader well-being focus relative to the education sector. School board representatives commented that their Ministry's Well-being Strategy was guiding them to pull together all of their efforts to improve student well-being under the same umbrella strategy, which was to include the healthy school approach. The mental health lead stated that this ministerial strategic

^{*} People for Education. (2013). *Ready, Set, Go: Building Healthy Schools in Ontario*. Retrieved from <<http://peopleforeducation.ca/wp-content/uploads/2017/05/Ready-Set-Go-Building-Healthy-Schools-in-Ontario.pdf>>

[†] Government of Ontario. (2011). *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*. Toronto, Ontario: Queen's Printer for Ontario. Retrieved from <http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf>

initiative was instrumental not only in drawing attention to the upstream component of the mental health care continuum, placing as much emphasis on health promotion as on health care services, but also in legitimizing the health promotion role of public health professionals in schools as the other provincial initiative had done:

I see that [Well-being Strategy] as being a huge support. (...) Mental health leads are encouraged to really play a key role in supporting (...) upstream initiatives across their board, and very much, in collaboration with community partners. (...) Also, this past year, (...) I did a lot of it in partnership with public health. (...) [These provincial initiatives] have helped me really highlight the role of public health and formalize their place at the table. (...) [And] I think education is shifting and making room for that.

Over recent times, this mental health lead observed a growing acceptance among educators to engage more actively in health promotion, as these provincial initiatives were being carried out. However, since these initiatives did not mandate partnerships, but rather endorsed them, other conditions would have to be met to move beyond networking and enter into cooperative, and possibly collaborative, arrangements, as presented below.

9.6.2 Accepting public health units' school health resources

School boards had been encouraged at the inter-ministerial level to take on the added responsibility of student well-being in a more proactive manner through school health partnerships. For more extensive engagement to take hold at the local level, public health professionals identified three conditions to support the move from networking to cooperation. During the series of interviews with school board representatives, insights were given in relation to two of these conditions, concerning the adoption of a shared language and the preparation of a partnership proposal that focused on what mattered to school system actors.

a. Adopting a shared language

Participating school board representatives referred to their Ministry's Well-being Strategy as a key document for shaping all health promotion efforts under one umbrella strategy. This ministerial strategic initiative was viewed as fundamental for undertaking a coherent approach to promoting student well-

being. It was guiding the creation of healthy, equitable, inclusive, safe and accepting schools to uphold students' physical, emotional, mental, social, and spiritual well-being, as a whole. According to a superintendent, their school board would consider partnering more extensively with their local public health unit were they to adopt the same overall strategic approach and agree on how "a healthy school" is to be defined so that all well-being efforts could be linked together more readily:

At our board, and at almost every school board, we have developed an [approach] related to our Ministry's [high-level strategic] initiative. (...) We've combined all that was health and well-being services so that each group that had them no longer worked in silos. So, within the scope of 'well-being', we put in equity and inclusive education, we put in mental health. (...) We also integrated everything that has to do with working with external agencies (...) that are addressing health and safety in schools, so that they're considered as being under the same umbrella of well-being. (...) There would also be the healthy school approach, but (...) [to work together] we would have to agree on the definition of a healthy school. Of course, it would have to do with (...) an accepting school, an inclusive school, a safe school—all of those pieces.

Although public health professionals were making use of the Ministry of Education's Well-being Strategy mainly to gain educators' cooperation with the healthy school approach, one public health manager explicitly stated that their collaborative school health partnership had been based on the much broader definition of healthy schools, as stated above.

In addition to presenting educators' language, documents from the Ministry of Education served to introduce key public health concepts within the education sector. Just as public health professionals were using the language within ministerial documents to increase educators' interest in cooperating with them on school health initiatives, so too educators were being exposed to concepts that were at the core of the public health profession's philosophy. For example, the participating mental health lead viewed their Ministry's strategic well-being initiative as a practical instrument for promoting the public health philosophy that it is far better to address well-being issues through an upstream approach before more serious problems arise:

The shift in the last year has been to focus more on (...) promotion, not interventions necessarily, but really more of a proactive, upstream thinking. (...) Now, with the Ministry of Education coming out with a very specific Well-being Strategy, (...) that supports it even more, (...) because it really says, 'We need to focus on well-being and everyday mental health, we really need to think upstream,' which is completely singing the public health song. That's what public health units live and breathe. It's not what education lives and breathes, so it's new language and a new culture for them. But I think we're moving in the right direction and I just find myself in the middle of it all.

The education sector was seen as having to change to accommodate the current vision of student achievement that was now encompassing student well-being, in the broadest sense. Greater attention was being paid to positive mental health, where mental health issues were to be tackled through upstream, preventative measures as well, and not solely through early diagnosis and treatment.

b. Focusing on what mattered to school system actors

School boards were now expected to speak the public health sector's language of upstream health promotion, but public health units in turn had to ensure that what they were proposing to their local school boards was relevant to them. According to school board representatives, cooperation with local public health units would only be possible if their partnership proposals could actually contribute to their school boards' identified priorities and emerging needs related to student well-being. As a school board communications manager stated, school boards could not be expected to engage in major school health initiatives that went beyond the priorities that they had set, despite being worthwhile, due to a lack of capacity to take on additional work:

We do so many different things that (...) [the superintendents] are incredibly busy. (...) Although it would be nice to provide total support for public health, it is really important to get across (...) [that] the school boards have their own priorities: EQAO results, mental health initiatives, continued student success, partnering with universities and colleges for credit courses, etc. This is the world we live in and we have our responsibilities. (...) Again, our public health partners are amazing people, but with the pressure of increasing our EQAO results, our teachers are so stretched, and the requirements are so heavy on them.

For local public health units to have the opportunity to enter into a resource-sharing arrangement with their school boards, it was considered crucial that they first become aware of what school board executives had planned for the coming years.

9.6.3 Agreeing to fully share the decision-making process for student well-being

Entering into a collaborative partnership arrangement means holding cross-sector planning discussions throughout the main decision-making process, rather than at the end of this process or during side meetings. Even though resources were being shared for the delivery of school health initiatives, public health units and

school boards could still be preparing their multi-year and annual (operational) strategic plans, for the most part, through separate processes. For collaboration to take place, especially in terms of joint planning at the strategic level, further conditions would have to be met in addition to those mentioned above.

Validating the public health perspective and providing additional insights, school board representatives revealed that willingness to engage in joint strategic planning could arise under the following conditions: (1) the partnership is well founded on trusting relationships; (2) an agreement has been reached on a shared specific goal, based on the school board's top priorities, and enlivened by a deep sense of shared purpose; (3) the public health partner's participation at the planning table is perceived as an added value; and (4) the school board has cultivated an organizational culture of learning for continuous improvement that includes openness to diverse perspectives. Interestingly, these school board representatives shed additional light on the type of organizational culture that would be conducive to joint strategic planning, by elaborating on this fourth collaboration condition that public health professionals also brought up.

a. Trusting relationship across the public health and education sectors

From a school board perspective, a strong, trusting relationship was also considered a key condition for joint strategic planning. One school board's willingness to collaborate across sectors was facilitated by a history of building relationships through supportive partnership experiences. At this school board, public health representatives were allowed, by virtue of well-established relationships, to participate at their district-level school improvement planning session. As the director of education indicated:

[So, it's about] being open to (...) someone that can ask questions that an educator might not be aware of or might not see. (...) [Also,] those conditions were in place: the successful relationships, the communication. (...) [If the school health manager would have said,] 'We want to come to your school improvement planning session because we think we can do it better,' the answer would have been 'No.' But because we had a working relationship over the years of supporting each other's organization, (...) we knew [the public health] people coming out (...) were there to offer suggestions to schools that they could take or choose not to take. (...) They were there as support and to help us improve.

While full consideration was being given to the public health partner's views, it was nevertheless understood that final planning decisions rested with each school as they best saw fit. Strategizing together did not mean reaching consensus but rather deliberating together as to what would best serve the

interests of schools in achieving desired improvements. It was about schools being able to make well-informed decisions.

Strong, trusting relationships were seen as being particularly crucial for high-level collaboration, because strategic planning called for taking a close look at organizational weaknesses and even challenging the status quo to produce substantial improvements. With sufficient trust, the director of education quoted above felt comfortable having an external partner be present at their district-level planning sessions while their schools' shortcomings were being exposed and fully examined. As this school board executive further expressed, the presence of trust provided the assurance that their school board would not be judged in a poor light but rather supported and encouraged to improve:

We would not have been able to do [joint strategic planning] if we hadn't already had established good working relationships with public health. (...) [Otherwise,] there would have been a concern, a mistrust, such that principals would not want to admit to areas that needed improvement. If they feel someone is going to go out and paint a negative picture of their school or say negative things about them, you don't have that trusting environment. The fact that the nurses had met with the principals [one-on-one] early in the year, that they were there to support them, not to tell them what to do, those conditions were in place prior to us bringing them out to a meeting to talk strategically about school improvement. (...) We were comfortable that what was shared would be in confidence.

b. Shared goals, based on the school board's top priorities and a deep sense of shared purpose:

School board executives mentioned that they would set strategic directions and broad, strategic goals that were further refined into specific goals based on prioritized needs during their annual strategic (operational) planning process in order to guide action planning. One superintendent indicated that they always kept in mind their school board's broad goals as well as their data-driven annual priorities and specific goals when considering which strategies and initiatives to undertake. For this reason, they felt that their public health partners would have to orient their partnership interests accordingly for a collaborative partnership arrangement to be possible:

I think that sitting down at the table with various partners, [and] different school boards, is very good. (...) But to be very specific and then be able to say, 'This is how it meets the needs of my board,' at that moment, (...) we could look at planning [together]. (...) [What we must] always keep in mind is that all the things that would come out of this [operational planning] discussion must be directly tied to the goals in the board's strategic plan. (...) We have to plan for

initiatives that will allow us to reach our goals, and that's why I say, when we work from the school board's strategic plan, we know where we're heading, we know what we have to achieve.

According to this school board executive, cross-sector engagement could take on a collaborative arrangement rather than a cooperative one, in instances where the partnership focus would relate to a school board's specific well-being goal that had been prioritized in their strategic plan.

When participating school board representatives made reference to the cross-sector pursuit of a shared goal, they brought up the principle of shared responsibility. However, this was viewed in terms that went beyond responsibilities meant for specific professional positions. While commenting on professional responsibilities, these school board representatives spoke about the key actors within their school systems who made their own decisions based on the specific duties that they were expected to fulfill. For instance, principals decided by themselves how best to address their school boards' priorities, as well as their schools' emerging needs, and they were responsible for the creation of school health committees, or health action teams; teachers were the ones determining how they would be delivering their assigned curriculum; mental health leads were among those within their school boards who had the direct responsibility of developing an overall mental health strategy; and school board executives were in charge of making budgetary decisions, among other leadership decisions.

As a director of education explained, decision-makers within school boards had the final say in all matters related to their local school system since they were held accountable for their decisions, whereas final decisions for any issues that fell under the medical officer of health's authority would be left to that public health executive to make:

We would partner with [our local health unit] for input but when it comes to a Ministry of Education requirement, the final decisions are resting with the school board (...) since we are ultimately responsible. (...). When it's something that's a requirement from the Ministry of Health, that's where they're dictating to us and we're providing input and they're making the final decision. It comes down to which Ministry is requiring it. In this case, the Ministry of Education is setting a goal of healthy schools, [and] we are responsible for implementing it.

From a school board perspective, school boards and schools that collaborate with their local public health units are still the ones making the final decisions in those areas where their specific responsibilities rest—including health promotion, which has recently been officially recognized as one of educators'

responsibilities. This perspective was echoed by public health professionals, with one public health manager explicitly stating that “ultimately, it's their house and we have to play by their rules.”

While each school health partner would remain accountable for upholding the directives of their respective ministries, school boards may nevertheless choose to share the high-level responsibility of producing positive change in student well-being outcomes. Another director of education commented that they had chosen to share the responsibility of improving student well-being with their community partners, in order to pool their resources and join forces to make a greater impact in the lives of school-age children:

We're an education system with teachers, and we have support staff, but we need help with the various aspects of the work that we do with our kids. (...) We recognize we'll be stronger with our community partners helping us at the table. (...) We've recognized that we can't do it alone and we know what they can do, and they know what we can do. (...) I would say that it takes a village. (...) [Students' well-being] is our responsibility, but we choose to work collaboratively to share that responsibility.

At another school board, their overall mental health strategy was developed by involving all key community partners who felt equally responsible for student well-being outcomes. During this process, the participating mental health lead, along with the superintendent in charge, made all the final decisions, but not until this mental health lead engaged in lengthy cross-sector deliberations to take into account the perspectives of their community partners:

I have the primary responsibility for [our mental health] strategy along with my superintendent. (...) The board creates its own strategy, but I work pretty closely with the community partners. (...) [Public health,] they inform me, which then informs the direction of the strategy or the priority for the upcoming school year related to the strategy. They're quite instrumental in supporting it but also helping to develop it because they're really close to the action. (...) I think probably across the province, there's a recognition that school boards can't go it alone. We need our community partners, and our community partners need to work with us because the kids that they see, and support are in our schools, so we need to find a way to share that responsibility and do some of that planning together.

In the example above, community partners, including the local public health units, shared the high-level responsibility of improving student well-being, while the school board decision-makers were fulfilling their specific board-related responsibilities of preparing their mental health strategy.

Although schools did their own school improvement planning, school board representatives mentioned that school personnel, themselves, had historically relied on community partners to cooperatively look after students' well-being needs. School personnel were seen as having preferred to allow their community partners to do most of the planning for student well-being on their own due to mounting education pressures that left them unwilling or unable, to take on additional responsibilities. With the promotion of student well-being having officially become educators' responsibility, the mental health lead began to observe a shifting in mindset. School personnel's dependence on these external stakeholders had been changing toward a greater acceptance of overall shared responsibility, and a seemingly deepening sense of shared purpose:

Because (...) there's a lot of expectation in education, there's a lot of stress, there's a lot of pressure, I get how this system could look to its community partners and say, 'Please do this for me,' as opposed to, 'How are we going to do this together?' (...) There's lots of good folks in the system who think very much like 'We're working this together' but I think historically there's been a little bit more of arrows pointing one way as opposed to both ways. (...) There's a shift [happening]. I've seen it just this past year. My hope is that, going forward with [the Ministry's] Well-being Strategy, (...) we'll shift it [even more] and it'll feel even more like we're all in it together.

Although educators would still have to fulfill their teaching responsibilities that now included student well-being, this mental health lead was noticing an openness to sharing this responsibility, and the emergence of a collaborative spirit.

c. Partners' input at the planning table perceived as an added value

Even though a school board and their local public health unit may have had a trusting relationship built on a prioritized shared goal, they would not necessarily have been sharing the full decision-making process. There needed to be a perception of added value in inviting the other partner to join the planning deliberations. From a school board perspective, the perception that an external viewpoint had value during internal strategic planning discussions was a major point of consideration when determining the suitability of having a local public health unit be present at the planning table. Specifically, a director of education stated that they were willing to have their trusted public health partner attend their district-level planning sessions with a group of principals since they had come to realize the added value that this arrangement could bring for them:

Last year was the first time that we had [health unit representatives] attend our planning sessions. (...) Certainly from [our] side, we think there's value in having someone with a health background act as a critical partner to our school teams when they talk about well-being. (...) So, they attended our meetings, they sat in and offered suggestions (...) in terms of the well-being component of the [school improvement plans]. I think it's a great idea and it's not something we had done in the past. (...) It's something we will probably discuss next week in terms of (...) if there was value [for our health partner as well]. (...) For many of our schools, (...) they were looking at activities that would help improve the resiliency and (...) well-being of our students. Public health had lots to contribute in that area.

At this planning session, the value of accessing a public health perspective was further confirmed. This brought about an interest in considering the possibility of making joint strategic planning a recurring practice.

d. Organizational culture of learning for continuous improvement and openness to external perspectives:

Besides the conditions identified above, there was yet another, more fundamental, condition that would support high-level collaboration. Additional insights from the education sector pointed to a particular characteristic of an organizational culture that would welcome an external partner's perspective during internal strategic planning. School board executives who expressed a willingness to collaborate on a shared goal also spoke about an eagerness to learn for the sake of continuous improvement. Expanding on the related public health perspective, the participating directors of education linked their organizations' willingness to consider external views during their strategic planning to an organizational culture that prized learning in efforts to continuously improve. As one director of education stated regarding their organization's pursuit of continuous improvement:

Being open to improvement and open to iterative [planning] cycles is so important for the organizational culture (...)—always looking to improve and not staying with the status quo. (...) We've always had an openness to improve, but we never thought of inviting public health [until now]. (...) For our board, to have our health partner at the table when we did our strategic planning at the school level, that was a big change because those had always been closed meetings; that was a cultural change. (...) [This was possible because of our] learning organizational culture that (...) is more interested in a learning stance than a performance stance. (...) A performance stance would be a principal or a board saying how great they are and giving all kinds of great examples. A learning stance would be, 'We're doing great things. How can we do better even more, or improve areas where we still see some weaknesses?' The learning stance is really important, [it's about] innovation to find unique solutions that haven't been tried before.

According to this director of education, it was their improvement-driven learning culture that contributed to their organization's openness to inviting a trusted public health partner to join their internal strategic planning process.

9.7 Main partnership challenges and mitigating factors

Participating school board representatives mentioned several challenges that were hindering their engagement with public health units. These challenges included lack of capacity; competing priorities; the unfamiliar field of health promotion; personnel turnover; multiple overlapping jurisdictions; and French language requirements. The following presents these challenges in light of mitigating considerations.

The corollary of capacity limitations is competing priorities. The need to direct resources to improve students' well-being and the imperative of enhancing their academic performance were seen as competing priorities, given the lack of capacity. However, this challenge may be dealt with by reframing them as inter-related priorities. One of the participating directors of education clearly expressed the view that students cannot fully succeed in their academic studies and be proficient in literacy and numeracy without attending to their well-being, which underlies their academic performance. Despite a major focus on academics, participating school boards were addressing well-being issues to one extent or another.

However, the field of health promotion was not an area where educators had a long history of direct engagement. A school board representative's stated that a shift in mindset would be required for educators to overcome their struggles of having to take on new health promotion responsibilities, but this transition may be slow to take hold. However, this transitional requirement could also lead educators to seek support from their local public health units to fill their knowledge gap. As a school board executive commented, educators cannot possibly be expected to excel within the field of health promotion, given that this field is not their primary area of expertise. For this reason, greater consideration was being given to engaging with public health professionals so that they could provide insights for their school board's planning purposes.

In addition to competing priorities, high rates of turnover interfered with school health partners' ability to maintain their working relationships. Based on the partnership experiences of participating school

board representatives, the effects of turnover were being mitigated by (1) a school board culture, conveying the expectation that all incoming personnel were to re-establish existing partnership ties; (2) networking practices by the incoming executives to renew relationships with their predecessor's partnering organizations; and (3) routine partnership meetings between a principal and their local public health representative, at least at the beginning of each school year.

In situations where public health turnover rates were high and/or school board personnel were stretched for time, one school board representative suggested having greater access to pre-developed school health programs that would only require minor adjustments to be tailored to the local context. They went on to state that this practice would minimize the amount of time necessary for putting an initiative into practice and it would more likely continue to be implemented if a change in the public health frontline staff occurred right before or during the implementation period.

With multiple overlapping jurisdictions, one or more school boards must engage with multiple public health units. Indeed, there were reported instances where the geographical jurisdiction of the school board overlapped with that of more than one public health unit, hampering communication across the two sectors. To increase partnership-related efficiencies, partners from extended partnerships have worked together to establish common communication protocols, including administrative and information-sharing procedures. This had reduced confusion among school administrators moving to other schools in another public health unit's catchment area, and had made cross-sector engagement much easier.

In addition to other possible communication difficulties, extended partnerships complicated the ability for joint planning. Although school board executives found it advantageous to come together, along with their common public health partner, and create a shared vision for the promotion of student well-being, each partnering school board may have their own set of priorities that would be driving partnership activities. This would require separate partnership meetings for more detailed planning of possible cross-sector engagement.

Large geographical distances separating school health partner's headquarters hindered cross-sector engagement as well. When the school board was located far away from their public health partner, there were situations where only a few of their schools fell within that public health unit's catchment area. In

these cases, the principals would represent the school board at public health meetings, with occasional engagement of a superintendent or director of education, whenever decisions were to be made.

With their large geographical jurisdictions, French-speaking school boards had to take into account a multitude of different local contexts in their improvement plans. Furthermore, they usually had to engage with many public health units. However, this challenge was being addressed through the creation of community liaison positions, where individuals from the local community were employed in part to represent the voice of the school board at public health units' meetings, being held in their local areas. Superintendents would become directly involved when decisions needed to be made, otherwise these decisions were made at their central office through the community liaison, serving as an intermediary.

Chapter 10: Discussion and Concluding Remarks

Over time, the purpose of school health partnerships has evolved from the delivery of health protection services in schools to the implementation of additional initiatives that promote the well-being of the student population. It used to be that these health promotion initiatives were planned by public health professionals, and then offered to schools. However, schools have since been taking part in school health initiatives of their own, and certain schools have been doing so in partnership with their local public health units. The trend has begun for public health units to engage with school boards, as well as schools, in the planning process, while seeking greater integration between their respective sectors. Student well-being has always been a deep concern for educators, but now a transformation is happening whereby professionals within the education sector are playing a more active role in the promotion of student well-being, in all of its facets, rather than only attending to the needs of students who are already experiencing difficulties in their lives. Working more closely with the public health sector, school boards are being made aware of the importance of addressing students' well-being needs from an upstream perspective, before these needs manifest as entrenched health-related issues and learning problems.

My doctoral research journey led me to discover as much as I could about how local public health units and school boards engage with one another, as my main line of inquiry, and along this journey, I found out how schools were engaged as well. Specifically, I gained knowledge about who were the main actors within school health partnerships; in what ways they were pursuing cross-sector engagement; and what enriched, enabled, hindered, and supported this engagement process across the various types of partnership arrangements. There is wide variability across the province as to the key actors who engage in school health partnerships and how this engagement is taking place, owing in part to differences in capacity that are closely related to the geographical context. Partnerships operating in southern regions and urban settings tend to have a greater personnel force than those in northern regions and largely rural settings. My doctoral thesis project uncovered a variety of other factors that could be contributing to the variation found across the 142 unique school health partnership dyads in Ontario.

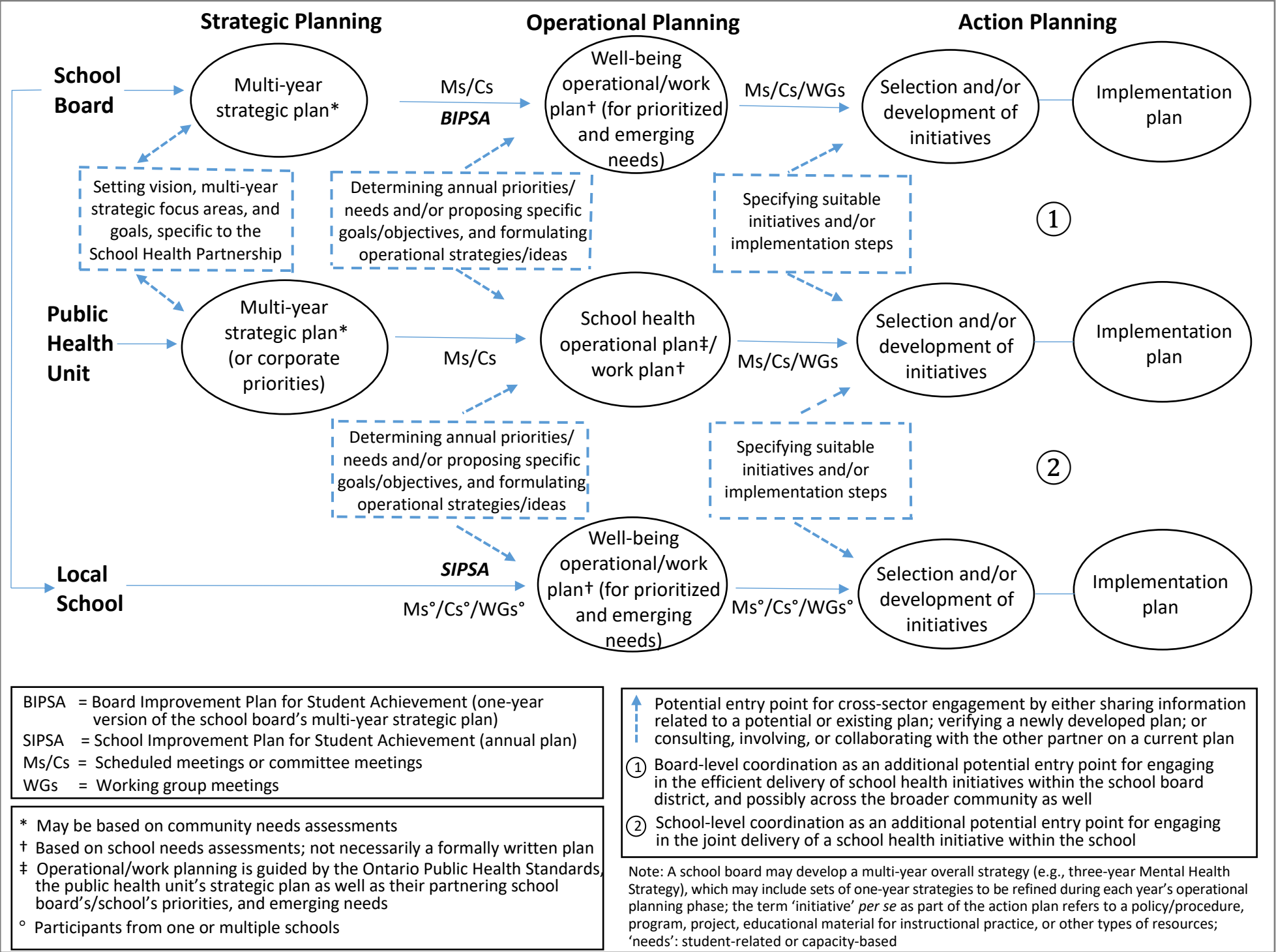
Interorganizational engagement from the top executive level to the ground level within each school health partnership dyad is crucial for communicating the partnership's specific health promotion vision, strategic direction and goals, and for encouraging cross-sector engagement at all levels. However, this is not always the case. Public health professionals in some partnership dyads engage, for the most part, with the school

personnel, while in other partnerships, they mainly work with school boards, with limited direct access to schools for health promotion. With capacity limitations and difficulties gaining the attention of principals, who represent the most influential actors within school health partnerships, public health units are increasingly more dependent on school boards to put in place systems for efficient communication with school administrators, and for the integration of planning processes to produce the maximum possible impact in the lives of their student population.

The research steering committee members expressed a strong interest in understanding the various ways public health units and school boards engage with each other along the collaboration continuum. They wanted to know how they could tell whether they were networking, cooperating or collaborating with their school board partners as an indication of how their partnerships were progressing. To them, making this determination proved to be difficult since the level of cross-sector engagement within the same partnership dyad was in constant flux from one year to the next. Eager to take on this challenge, I set out to map the various ways engagement could be pursued between local public health units and their partnering school boards and schools, irrespective of the health topic. It eventually became apparent after sorting through the research data that cross-sector engagement, in essence, is about undertaking one of two main engagement processes: sharing information only; or preparing plans with the other school health partner's input to a lesser or greater extent. Whereas the implementation process is for taking action on current school health plans, cross-sector engagement is rather for sharing the decision-making process, either partially or fully, when preparing these plans, or alternatively, for information sharing purposes only. School health partners may contribute their advice, or guidance, (i.e., professional planning resources) to each other's plans (including policy development) and/or make arrangements to provide implementation resources. Figure 5 illustrates the different types of planning that school boards, public health units and schools routinely undertake within their own organizations, along with the potential entry points for cross-sector engagement and corresponding elements.

Planning typically starts with the preparation of a multi-year strategic plan for the entire organization, whether it be the school board, or the public health unit (or municipal government with an integrated public health department). This strategic planning process is meant to articulate the organization's strategic directions and broad goals (or in certain cases, corporate priorities) for the coming three to five years. It relies on the input of internal personnel, and perhaps that of external stakeholders through community-needs assessments, in order to identify the pressing issues faced by their target populations and

Figure 5: Planning Phases for Possible Cross-sector Engagement



discuss how these issues could be tackled. As school community members, parents may have a say in school boards' strategic plans. Their voice would carry a great deal of weight during school boards' strategic planning, but the views and advice of community-based organizations and local public agencies may be considered, as well.

Since thousands of community residents, and many organizations representing a variety of stakeholder groups, may be offering their input on various topics, not solely on school health matters, the resulting multi-year strategic plans of public health units and school boards may be too broad to provide clear direction to school health partnership activities. Participating public health professionals in less advance partnerships have emphasized the need for partnership-specific strategic discussions to give a more substantial focus to their school health partnerships. Public health professionals and school board representatives can best fulfill their respective mandates and engage in a truly collaborative arrangement by maximizing the potential of their school health partnership through the co-development of a strategic guidance document. Advanced partnerships' plans have taken on the form of a partnership-specific multi-year strategic plan or strategic framework, or overall joint multi-year strategy, for the promotion of student well-being. Such a collaborative partnership arrangement may be made possible by first creating a partnership declaration, or a memorandum of understanding, to explicitly set the intention and commitment and specify the structures and processes for high-level joint planning.

The purpose of the multi-year strategic plan is to ensure that annual operational plans for each successive year lead the organization progressively closer to a substantial long-term goal. Within the education sector, each school board's improvement plan for student achievement (BIPSA) is the one-year version of their multi-year strategic plan, and this annual plan sets the stage for the preparation of school improvement plans for student achievement (SIPSA) as well as the school board's various operational plans. Both types of improvement plans may include a student well-being component. By contrast, public health professionals rely on their organizations' multi-year strategic plans and/or the Ontario Public Health Standards when determining the scope of possible partnership activity areas to include in their operational plans, while being creative in the way these standards are being interpreted. Certain public health units may choose to set their own specific goals and priorities in order to concentrate their resources on only a few public health standards related to school health.

Multi-year strategic plans undergo further refinements during the annual operational planning process, where the strategic directions and broad goals are expressed more concretely in terms of annual priorities and more specific goals and objectives that can be measured. Then, operational strategies, or ideas, are formulated to operationalize these goals and objectives, which may be formally written down. Additional needs that have not been covered in the initial version of operational plans can still be addressed as they emerge during the course of the school year.

Even though operational planning stems from an organization's multi-year strategic planning process, it is still carried out at the strategic thinking level. To be actualized, it calls for the preparation of an action plan. This plan entails selecting suitable initiatives (i.e., action strategies), or developing initiatives if not already available, according to the specified annual priorities and operational strategies. School health partners can contribute their views regarding each other's action plan to a lesser or greater extent. However, that input is not as influential as input that could be provided during strategic planning, where the field of possibilities is much wider. In addition to specifying the nature of school health initiatives, the action planning process would include the identification of the implementation steps required to deliver these initiatives.

When much guidance and expertise is required, having sufficient time available for cross-sector engagement at the strategic thinking level becomes that much more critical. Conversely, extensive engagement at the initiative development stage of action planning may not always be necessary or productive. At that level, initiative planning mainly by one partner, with some consultations to ensure suitability, can be a time-saver for the other partner. When the focus of action planning turns to the identification of specific implementation steps regarding the chosen initiative, any cross-sector engagement would be the least influential type of engagement since the major decisions have already been made. Now, all that is left are coordination decisions to determine logistical requirements (i.e., who does what) and timelines. Therefore, a good indicator of partnership progression would rather be about how extensive cross-sector engagement is during multi-year and operational planning, where opportunities to create synergy together can be most fully explored.

The planning phases within public health units, and local school systems, consist of similar tasks: the setting of strategic directions and broad goals (in the multi-year strategic planning phase); determination of annual priorities/emerging needs, and formulation of specific goals, objectives, and operational

strategies/ideas (in the operational planning phase); and selection or development of school health initiatives, and identification of implementation steps (in the action planning phase). Each of the task in these planning phases serves as a potential entry point to cross-sector engagement, which may proceed at various levels of extensiveness. Based on the engagement patterns emerging from interviews with participating public health professionals and school board representatives, each possible level of cross-sector engagement has been described in terms of their general characteristics and distinguishing features (as shown in Table 12).

Of the myriad of engagement possibilities, the level of cross-sector engagement that is actually pursued would vary according to the intention, whether it is to inform only (networking); to verify or consult (cooperation); or to involve or collaborate (collaboration). The intention for cross-sector engagement is set by the engager who would be representing the partnering organization that is to lead the corresponding planning phase. When co-leading a given planning phase, the partnering organizations from both the public health and education sectors would be acting as engagers.

Although the least extensive engagement level, information-sharing per se occurs outside any planning process. Information on existing plans from each of the three main phases, including already prepared initiatives, could be shared as a means to explore partnership opportunities at the networking stage. All other engagement levels, with the exception of coordination, would apply to the three main planning phases as well. Coordination only applies to the planning of implementation steps within the action planning phase since this particular task requires joint decision-making about how a public health initiative is to be implemented in a school setting.

The intention underlying the engagement across the two sectors would dictate the timing of the cross-sector engagement, whether it be prior to, or at the end, middle, or beginning of the planning process, or throughout this process. From this intention thus comes the decision as to which distinguishing organizational asset is to be shared: information, resources (i.e., professional planning input, and possibly implementation resources), or the full decision-making process. Public health professionals stated that each engagement level may be appropriate in relation to how much guidance, or expertise, is required to suitably enrich the partners' understanding or their decision-making (planning) process. It is a determination that would need to be made by the school health partners on a case-by-case basis.

Table 12: Spectrum of engagement across the public health and education sectors along the collaboration continuum

Distinct Features	Networking	Cooperation		Collaboration			
<i>Intention</i>	To inform	To verify	To consult*	To involve	To coordinate		To collaborate
<i>Description of Engagement Level (based on the intention)</i>	Sharing information about health-related issues, ways of thinking and working, role, strategies/ideas, and available resources, existing plans and priorities, as well as lessons learned and success stories	Verifying decisions made concerning the plan, to look for compatibility (i.e., common priorities), ensure completeness, feasibility, soundness, to get approval to provide resources, and/or access resources for implementation	Consulting the other partner for input on decisions to be made on the plan, at one or more time points during the process (possibly at the end as well)—this may include reaching agreement on what resources can be shared	Involving the other partner for input on the plan, all along the main decision-making process, possibly through an internal committee, or working group, or through a parallel process set up by a joint advisory group or external, cross-sector advisory committee	<i>School board level:</i> Coordinating the promotion and delivery of planned initiatives in schools across the district to avoid duplicating efforts and enhance efficiencies	<i>School level:</i> Coordinating the promotion and delivery of a planned initiative in a school for smoother and more effective implementation	Collaborating by having each other contribute input into a joint plan, as part of a shared decision-making process through executive meetings, a steering committee, an advisory group, or a working group, which may be internal to one of the partnering organizations, or jointly established
<i>Engager (i.e., lead planner)</i>	N/A	• Whichever partner who is leading the planning process (public health unit, school board, or school)			Both partners, jointly arranging the promotion, and delivery of planned initiatives (may engage with additional public health units and community partners)	Both partners, jointly arranging the promotion and delivery of a planned initiative in the school	Both partners, having the responsibility for setting up a joint strategic plan (e.g., co-creating a well-being strategy) or planning a joint initiative (e.g., co-developing a workshop; co-organizing a healthy school network event)
<i>Relevant Planning Phases (potential entry point)</i>	None, but the plan resulting from any of the 3 types of planning phases may be shown for information purposes only	• Multi-year strategic planning phase: strategic directions; broad goals • Operational planning phase: annual priorities/emerging needs; specific goals, objectives and operational strategies/ideas related to school health programming • Action planning phase: identification of initiatives/action strategies (excluding implementation steps)			Action planning, as to the implementation steps: ‘who does what’ within the school board’s district, and possibly across the broader community	Action planning, as to the implementation steps: ‘who does what’ in the school	Same as before: multi-year strategic planning; operational planning; and action planning, as to the identification of initiatives
<i>Timing of Engagement</i>	Pre-planning phase	Final phase of planning	Early and/or mid-planning phase	Throughout the planning process			
<i>Distinguishing Organizational Assets being Shared</i>	Information being shared solely for gaining familiarity—may potentially be used for future decision-making	Resources being shared (i.e., input, in terms of guidance, advice, content expertise, or data for planning purposes; and/or implementation resources); the decision-making (planning) process is only partially shared		The main decision-making process being completely shared to consider all partners’ extensive input into plans; implementation resources may also be shared			

* In certain instances, the other partner may be present throughout the engager’s decision-making/planning process, but as a source of reference for consultation purposes only (i.e., input provided upon request)

This doctoral thesis project was guided initially by my conceptual framework of cross-sector collaboration for social change. This framework was meant to shed light on the fundamental elements that made up highly-functioning partnerships regardless of which stakeholder sectors, or policy sectors, were engaged. It served as a useful analytical tool to review the published scientific literature on health promoting schools. The findings of this literature review are consistent with the findings of my doctoral thesis project on school health partnerships in Ontario.

Most of the partnership elements found in the reviewed articles were identified by the study participants as characterizing their own partnership experiences. However, certain elements pertaining to sustainability were not brought up by any of the participants, and the theme of leadership was not fully covered as it was in my conceptual framework, in terms of a distributive style of leadership and the various roles that effective leaders can assume. The large majority of participating public health professionals mentioning the importance of leadership did so in terms of the critical role that the medical officers of health, directors of education, superintendents, and principals played in encouraging engagement across the public health and education sectors. Nevertheless, key actors in mid-level leadership roles could be found throughout school health partnerships, and these actors were taken into account under other major themes, such as engagement at all interorganizational levels. School board participants did not expand a great deal on the theme of leadership, either. It is however possible that the leadership theme could have been further brought out had a more directed line of questioning on this topic been pursued during the interviews.

Although my doctoral thesis project did not reveal any contradictory findings relative to my review of the published studies in the area of health promoting schools, it did broaden my understanding of cross-sector engagement pertaining to local school systems. It uncovered a wider set of elements that went into the development of strong school health partnerships. I encapsulated this expanded knowledge in a model that refers specifically to school health partnerships. The resulting School Health Partnership Model for Student Well-being is made up of two dimensions: the Partnership Generator, with relationship building at its core; and the Collaboration Continuum, consisting of the three possible types of partnership arrangements, according to which distinctive organizational assets are being shared, as well as the three sets of supporting conditions that foster the partners' movement along this continuum. This model joins together the elements that public health and school board participants said contributed to their satisfying

partnership experiences. Even though findings are primarily based on the public health perspective, school board responses added more insights.

There are no two school health partnership dyads in Ontario that are operating in the same manner. Even each school health partnership dyad may be in constant flux, with personnel, situations and circumstances changing from one year to the next. However, taken as a whole, my research has uncovered elements that may be considered fundamental to the generation of satisfying school health partnerships. The more of these fundamental elements that can be found within the partnership at any given point in time, the stronger that partnership would be at that time.

As depicted in Figure 6, the Partnership Generator is an expanded version of the three interlocking components featured in my initial conceptual framework of cross-sector collaboration for social change to promote population health. The components of Cross-sector Engagement and Capacity in my school health partnership model include additional elements, while one of the engagement elements in my conceptual framework, namely the practice of conflict management, was excluded from this model since it did not come out as a critical engagement element. Conflict management was briefly mentioned, by two study participants, as an item in a partnership agreement. From the research findings, open conflict did not appear to be a major point of concern. Indeed, study participants repeatedly emphasized the cultivation of close, harmonious relationships as being pivotal for accomplishing their work. This is not to say that conflict does not occur, but that it seems to be managed well, with partners placing much of their attention on strengthening the relationship as a means of working out disagreements.

The third component of my initial conceptual framework, originally called Motivation, was further refined by splitting it into two distinct components: Connection and Continuity. Both components contain elements that are not inherent within the cross-sector engagement process, itself, nor are they part of a partnership's capacity to engage, but they are nevertheless important in enabling the pursuit of engagement across the public health and education sectors. Whereas Connection elements relate to creating, and enhancing, a rapport between school health partners to increase the likelihood of engaging across the two sectors, Continuity elements contribute to maintaining the momentum begun through the establishment of such a rapport. The image of a wheel signifies the interplay between all four components, as they reinforce one another throughout the course of the partnership.

Figure 6. Components of the Partnership Generator and their constituting elements: The 4 C's of School Health Partnership for Student Well-being



Along with relationship building at its core, the model's Partnership Generator shows six main elements, or success factors, in each of its components. Among these elements can be found, more or less, the essential conditions that Kania and Kramer (2011) assert are present in all successful cross-sector collaborations. As part of their collective impact model, these authors identified the following five conditions as essential for partnership effectiveness across sectors for large-scale community-driven initiatives: a common agenda; a shared measurement system; mutually reinforcing activities; continuous communication; and a backbone structure. These conditions are specifically featured in my conceptual framework on cross-sector collaboration for social change. Basically, for any cross-sector collaboration to be successful, partners need to establish a common agenda, where they all agree on a shared goal to improve a given problematic situation, which they have jointly defined. By defining the problem in the same manner, partners' efforts can then be funneled into the same area for maximum impact.

Next, all key partners must utilize a shared measurement system that allows them to assess and prioritize needs, and to track progress toward achieving their shared goal in order to make any required course corrections along the way. A shared measurement system, with its core set of indicators, is crucial to inform partners' strategic decisions regarding which activity areas to undertake. With the same outcome in mind, each partner's strategic activity area is chosen so as to mutually reinforce each other and produce a synergistic effect. Additionally, partners' activities must be well managed and coordinated through a backbone structure that can ensure continuous communication for maintaining partnership momentum. These essential conditions may apply to a certain extent to school health partnerships.

Within the context of school health partnerships, a common agenda has been explicitly established where key actors from the public health and education sectors were able to come together to document their common understanding as part of a high-level partnership strategic plan, a partnership strategic framework, or a joint strategy for health promotion, delineating a clear direction for partnership action. However, not all school health partnerships are as advanced. In some instances, partnership agreements have been limited to what types of programs and services that the public health unit is authorized to deliver in schools. Such an arrangement restricts the ability of school health partners to strategize together in order to make a greater impact in students' lives. Within advanced school health partnerships, the establishment of a common understanding of what could be accomplished together has come about through joint strategic planning. Public health professionals in collaborative partnership arrangements viewed a strong, trusting relationship as the most fundamental element for planning strategically

together. A formally written partnership agreement was considered useful, but only as a means to ensure that each partner does indeed have the same understanding, and as a source of reference to consult at any future time, in order to be reminded of that understanding. They did not intend for their partnership agreements to have any binding influence. This is consistent with other successful cross-sector partnerships, as described by Surman and Surman (2008), where light-weight agreements reflecting partners' common understanding would be prepared by the stewardship group while their commitment to the partnership would be what actually bound them to the cross-sector engagement process. Commitment emerges through ongoing relationship building.

Ideally, the preparation of a common agenda would be initiated at the executive level within the school health partnership, from where the ensuing shared vision and shared goal could be promulgated throughout their respective organizations to encourage cross-sector engagement at the other levels. Communicating the partnership vision and direction to all other levels would help alleviate the problem that many public health professionals are experiencing as to their local school boards' and schools' lack of familiarity with what they could be accomplishing together. Public health professionals felt that their school health partnerships would thrive better with increased visibility and endorsement by the top leadership from both sectors. Once the partnership-specific vision and shared goals have been set by the top leadership for that high-level strategic plan, work on establishing a common agenda could continue, with agreements on priorities and strategic approaches being made during operational planning.

In community collaboratives, the common agenda is usually established through steering committee-type structures for meaningful conversations (Hanleybrown et al., 2012). In advanced school health partnerships, meeting structures such as a joint steering committee, a partnership advisory group, and an executive-level meeting structure have been organized to formally produce a common agenda, or common understanding, reflecting the partners' agreements about shared goals and how to reach these goals. In other school health partnerships, conversations toward reaching a common understanding have proceeded in a less straightforward manner, through various combinations of informal and formal meeting structures. As part of a cooperative partnership arrangement, the common understanding would only be partially embraced in that the public health unit's proposed goal would be accepted but would not figure high on their school board's priority list. In this situation, the public health partner would be acting as a resource for a common purpose rather than as an equal partner in the pursuit of a shared goal.

The highest level of partnership advancement was attained when the public health unit and school board collaborated, for the long and short term, on joint strategic planning in a primary partnership-specific focus area. With a school health partnership's potential having been maximized in this way to pursue a shared goal, cross-sector engagement could still proceed cooperatively when strategizing in secondary focus areas. During the action planning phases, when developing or selecting initiatives regarding either primary or secondary goals, school health partners would then be choosing that cross-sector engagement level from the full engagement spectrum that best suits the partnership task at hand.

Within Ontario's education sector, there is a major expectation to engage in strategic planning for continuous improvement. The Ministry of Education expects school boards and schools to produce improvement plans each year. However, improvement efforts cannot yield favorable outcomes without an adequate performance measurement system to guide proper strategic decision-making (Chapman & Hyland, 2000; Oliver, 2009; Riley, Wong, & Manske., 2014). When shared, the measurement system allows partnering organizations to access the same data for needs assessments and the evaluation of school health initiatives so that strategic decisions can be made in a concerted manner for a greater impact. A well-established measurement system among school health partners would ensure that current efforts are meeting their intended targets, and would indicate whether their course of action must be changed in order to achieve better results. It would also justify the use of implementation resources where progress is being detected (Oliver, 2009).

A shared measurement system is another essential condition for maximizing partnership success (Kania & Kramer, 2011). In a community collaborative, representatives from community-based organizations, public agencies, and perhaps businesses, come together to identify a common set of core indicators that each would be using to measure the progress of their respective activities toward the same targeted outcome at the population level. When a shared measurement system exists to inform partnership-relevant decisions, it has been housed within the school board for the co-management of student surveys being administered across its district. It entails the common use of indicators to monitor and evaluate the joint delivery of school health initiatives, and it may include additional data-sharing practices, whereby public health professionals are allowed to gather additional data on some of the school health initiatives that they are leading.

The sharing of school-based data is only possible when privacy requirements have been satisfactorily met, and related concerns have been alleviated through the cultivation of trust. However, not all pertinent data may be available. Public health professionals in smaller communities do not have access to population health surveillance data for a more thorough assessment of school-age children's needs due to the absence of a province-wide surveillance system that could house local data, especially for public health units with limited data-gathering capacity. In a study about Youth Excel, a pan-Canadian initiative to build knowledge development and exchange capacity, key informants brought to light the importance of sustained commitment and trust building for setting up a province-wide health surveillance system that collects local data on the same core indicators (Riley et al., 2014). Riley et al. (2014) reasoned that such a surveillance system would enable meaningful comparison across various student populations, and reduce respondent burden. To make use of shared measurement systems, the cultivation of trust as well as the integration of data-collection procedures among various community partners would be imperative.

The establishment of a shared measurement system goes hand in hand with the planning of mutually reinforcing activities. As the third essential condition, mutually reinforcing activities can more easily be identified when the work of partnering organizations is based on the same set of indicators to measure progress toward a shared goal (Hanleybrown et al., 2012). According to Kania and Kramer (2011), planning mutually reinforcing activities means identifying each partnering organization's unique set of strengths and competencies, from which to select those partnership-relevant activities that could build off of each other. In this regard, joint planning is not necessarily about undertaking the same strategies, or initiatives, but rather it is about devising together a plan to carry out differentiated activities in such a way as to create synergy, and thereby, produce a much greater impact than if partners were to plan in isolation from one another. By creating synergy, the combined effect of partners' efforts is far greater than the sum of the effects that would have been produced by each partner's effort had they acted alone.

Regarding school health partnerships, the concept of mutually reinforcing activities is somewhat different in that it is inherent within the healthy school approach. The comprehensive approach to creating healthy schools is directed by the Ministry of Education's Foundations for a Healthy School framework, with its five inter-related components. The specific sets of activities, chosen for each of these components, would be working synergistically to produce a more substantial change in the desired direction. The same school health partner can be planning activities in most or all of this framework's components, rather than each component being handled by a different partner. Furthermore, planning within a school health

partnership arrangement may be more integrative, in those instances where the public health unit and school board are jointly strategizing and implementing school health initiatives. At the school level, partnership-related planning can be as integrative. At one public health unit, frontline staff would spend considerable time with each school community to gain intimate knowledge of their culture, strengths and aspirations to co-create a healthy environment for the student population, where the school's operational and action planning would be closely supported by the public health partner as well. However, not all public health units may have the workforce to engage at this level of extensiveness. Nevertheless, joint operational planning to identify common strategic approaches, as well as compatible strategies that build off of each other, at the school board level would be advantageous and may even help offset staffing shortages from both sectors.

The last two essential conditions, namely backbone structure and continuous communication, are inter-related. It is through the backbone structure that a steady flow of communication can be established. This structure is considered of utmost importance for partnership success (Kania & Kramer, 2011). Surman and Surman (2008) are proponents of employing third-party coordination as backbone structure, based on their longstanding experiences with cross-sector collaboration initiatives. By contrast, Hanleybrown et al. (2012) distinguished several different types of interorganizational backbone structures that successful community collaboratives have used to manage and coordinate their productive cross-sector engagement process.

Even though backbone structures may be set up differently across different interorganizational arrangements, they tend to take on the same set of functions. Hanleybrown et al. (2012) identified six backbone functions, as follows: (1) providing relevant information to the steering committee, or leadership table, as they are articulating their vision and strategic direction, and prioritizing and adapting their strategic areas of activity; (2) organizing meetings for the steering committee and working groups, while coordinating partnership activities to support strategic alignment; (3) managing shared measurement practices, and providing progress reports for informed decision-making; (4) cultivating community engagement through outreach efforts in conjunction with the steering committee and working group members; (5) supporting a policy agenda that impacts key systems and institutions; and (6) initiating or supporting fundraising efforts to gather more resources.

Within the context of school health partnerships, assignment of point people in public health units and school boards helps ensure fluid channels of communication, especially when these individuals assume the role of liaison. The liaison structure serves a vital backbone purpose; it is an excellent bridge for communication to proceed uninterrupted across the public health and education sectors. Similar to the functions described by Hanleybrown et al. (2012), liaisons not only act as internal connectors and primary contacts, but also as conveners in order to maintain steady communication; transmit messages efficiently; and bring the right people together to explore partnership opportunities. As such, the liaisons would be arranging partnership-specific strategic planning meetings at the top leadership level, while at the mid-partnership level, they would be orchestrating the myriad of ways that representatives within each partnering organization are to engage together. Some backbone functions, such as the preparation of updates and progress reports, may be distributed to other actors within either partnering organizations.

What sets the role of liaison apart from the other types of point person assignments (i.e., internal connector, and primary contact) is the added role of convener to promote meaningful conversations among key partnership actors. By assuming the pivotal function of convener, the liaison goes beyond merely providing internal contact information or serving as a go-between; they provide more extensive assistance with organizing the means whereby the right people from each sector can come together to explore partnership opportunities in a productive way. An additional backbone function found in school health partnerships, but not covered in the collective impact model, is the preliminary work conducted jointly by the liaisons from the public health unit and the school board to formulate partnership proposals in terms that would most likely resonate with influential actors within the local school system. This expanded role of a point person, serving as liaison, is critical for ensuring that partnership opportunities do not get missed, especially given a complex and dynamic work environment, possibly characterized by a multitude of different community partners, multiple overlapping jurisdictions, high rates of personnel turnover, and large, hierarchically structured organizations.

Collaboration represents the most extensive arrangement that can be pursued among partners. However, as previously discussed, its significance increases going from action planning to high-level strategic planning, in terms of the impact that the joint decision-making would have on partnership activities. During action planning, joint decision-making must occur when reaching the implementation planning stage, since the delivery of any school health initiative in which public health professionals are engaged must by necessity be coordinated with key actors within the local school system to one extent or

another—even if it is as simple as determining the right means to send a basic resource to the right person. This is the least influential type of cross-sector engagement, as all the major decisions about possible courses of action have already been made at higher planning stages. Not many public health units have been able to progress to the level of joint strategic planning with their partnering school boards and schools, and those who have not, aspire to do so. This aspiration rests on the recognition that joint strategic planning signifies collaboration at its highest potential. Joint strategic planning between public health units and school boards, and schools, lies at the heart of school health partnerships, since it is about fully embracing a common understanding of what can truly be accomplished by working closely together and being intent on maximizing the full potential of their school health partnership for the promotion of student well-being.

Planning strategically began within the public sector only a few decades ago. Around the mid-1980's when it was first introduced to government agencies, strategic planning used to be an uninspired undertaking (Bunning, 1992). According to Bunning (1992), government agencies viewed strategic planning, early on, in one of three limiting ways: (1) a process aimed at producing a plan on paper simply to meet the expectations of a higher-level government body or funding agency, without much follow through; (2) a means to determine simple goals that were considered easily achievable; or (3) a requirement to carve out a strategic course of action that none of the power players would find objectionable. This author went on to state that early efforts at strategic planning were met with implementation inadequacies, or failure, because of a lack of emphasis on continuous improvement efforts.

Increased public scrutiny of government operations, including the school system, has rendered the practice of continuous improvement imperative (Page, 2003). In Ontario, the Ministry of Education requires all school boards and schools to prepare annual board improvement plans and school improvement plans, guided by multi-year strategic directions, with the expectation that these plans would include goals related to student well-being. Continuous improvement is equally considered one of several key functions of public health governance. From a public health perspective, it is understood as an approach to “routinely evaluate, monitor, and set measurable outcomes for improving community health status and the public health agency’s or governing body’s own ability to meet its responsibilities” (Carlson, Chilton, Corso, & Beitsch, 2015, p. S163).

From the management literature, the ability to plan strategically for continuous improvement requires ongoing attention to organizational learning. According to Roche (2002), the practice of continuous improvement is dependent on organizational learning because without it, attempts at making improvements are likely to fail. Not only does learning increase the organization's performance by avoiding past mistakes and guiding corrective action when desired outcomes are not being realized, it may also enhance adaptability and lead to more suitable strategies for improvement plans (Oliver, 2009). Continuous improvement proceeds either through incremental positive changes, or through far-reaching innovation in a short period of time (Papadopoulos, 2011). Regardless of how it unfolds, there cannot be any substantial improvement without organizational learning.

Although widely researched in the corporate world, the link between continuous improvement and organizational learning is equally relevant within both the private and public sectors (Maden, 2012). Generally speaking, organizational learning can be defined as a necessary "process within an organization to maintain or improve performance based on experience" (Nevis, DiBella, & Gould, 1995, p. 73). Tied to improvement efforts, the process of organizational learning is therefore a critical part of strategic planning, where stakeholders' experiences, or perspectives, are transformed "into knowledge as a basis for future action." (Bunning, 1992, p. 57). Bunning (1992) asserts that a learning approach to strategic planning is especially important to solve complex problems whose solutions cannot be readily known. This is so because the nature of pressing issues and how to address them can be more fully grasp through the sharing of experiences, insights and expertise, which can in turn inform planning processes.

Organizational learning has technical and social aspects. Its technical aspect manifests as the learning that can enhance strategic planning processes—whether performed internally or across organizational boundaries—when improvement goals and objectives are set, and strategies need to be identified to create the desired improvements (Argyris & Schön, 1996; Finnigan & Daly, 2012). An organization's members may embark on two technical paths of learning to suit particular purposes. These learning paths have been termed differently by different scholars, but they bear similar meanings: adaptive and generative learning (Senge, 2006); lower and higher levels of learning (Fiol & Lyles, 1985); and single-loop and double-loop learning (Argyris & Schön, 1978). These concepts refer to the depth of learning that is occurring within the organization, whether customary or innovative.

The management literature describes both technical learning paths as offering their own set of advantages, and therefore together, they form a rigorous approach to learning and planning (Appelbaum & Reichart, 1997; Oliver 2009). Single-loop (lower) learning is about detecting performance gaps in organizational systems and finding ways of making incremental, routine changes to everyday practices in order to close these gaps, while remaining within existing structures and norms (Argyris & Schön, 1978; Easterby-Smith et al., 2000; Oliver, 2009). By contrast, double-loop (higher) learning is more profound in that it leads to truly innovative changes (Easterby-Smith et al., 2000). Transformation occurs when learning involves the questioning of engrained assumptions and norms that may have been preventing the organization from reaching greater performance levels. Such questioning may lead to the abandonment of assumptions that no longer serve the organization, in favor of new mental models, or theories of change, as well as new ways of behaving (Argyris & Schön, 1978; Beeby & Booth, 2000; Oliver, 2009). The pursuit of major improvement calls for fresh, new perspectives.

By offering their complementary perspectives, public health professionals have contributed to school boards' and schools' technical learning for promoting student well-being, in both respects. Working with curriculum consultants and mental health leads, they have developed educational material and undertook other partnership activities to assist teachers in finding new or improved ways of delivering required health messaging, as part of what I have termed first-order learning for the planning of school health initiatives. It is however the contributions that public health professionals could be making as to second-order learning, or what other scholars have called double-loop (higher) learning, that would justify joint strategic planning, beyond simply engaging in the development of one-off school health initiatives during action planning.

Double-loop learning is critical for thinking about problems and their solutions in whole, new ways that shatter engrained mental concepts and assumptions (Fillion, Koffi, & Ekionea; 2015; Huber, 1991). In their study about low-performing schools, Finnigan & Daly (2012) found that struggling principals did not have a great deal of access to school board guidance, nor to mentorship from high-performing schools, to be able to engage in double-loop learning as much as would have been necessary to achieve the improvements they were seeking. Although school staff meetings promoted the exchange of new ideas to improve their routine practices, these discussions remained most often within well-established paradigms. Challenging underlying assumptions for more profound learning was infrequently done, and the meetings were restricted to internal school personnel. The authors argued that the lack of access to

outside expertise hindered the schools' ability of exploring innovative ideas and practices in order to substantially increase their performance levels. When it comes to school health, the all-important double-loop learning would not only call for engagement across schools, but as importantly, across sector boundaries.

Of all the public health units interviewed, one stands out the most for the great strides they have made in partnering with their local school boards to help shift school personnel's paradigm about possibilities for enhancing their students' resilience. This public health unit attributes this success to the strong, trusting relationships they have built over many years. Indeed, barriers to engaging in organizational learning, and consequently to joint strategic planning for continuous improvement, whether within or across sector boundaries, are largely related to the social aspects of learning.

Whatever the organization, members are much less able to learn from each other, or from external stakeholders for that matter, in a social climate mired in distrust (Collinson, Cook, & Conley, 2006). Schneider, Brief, and Guzzo (1996) describe an organization's social climate as the way its members 'feel' about their workplace. These authors state that a multitude of factors can contribute to the social climate that affects organizational learning, although one main dimension is the quality of interpersonal relationships. This conforms with what is observed within the school system. In Finnigan and Daly's (2012) study, principals of low-performing schools lacked structured opportunities to network with principals of high-performing schools for their expertise, and they did not often have meetings with representatives from their school board's central office for joint problem-solving and support. These principals described the social climate in their district as being dysfunctional and unsupportive. The poorly developed relationships with school board personnel limited the low-performing schools' ability to learn and improve.

An organization's climate is the outward behavioral manifestation of its members' cultural values that affect the extent to which relationships are nurtured within their organization. The prevailing culture may also reflect an affinity, or resistance, to change and learning. Within the public sector, Bunning (1992) maintains that "organizational culture and established policies often act as strong obstacles to any major change and development, (...) [and so] where there is deeply entrenched opposition to responding in new ways, (...) it is hard to sell a collaborative learning approach to strategic planning" (p. 57). Specifically, within the school system, studies have shown that schools whose culture places much value on the

cultivation of trusting relationships are more likely to achieve improvements and innovation through internal collaboration (Bryk & Schneider, 2002; Mintrop, 2004; Mintrop & Trujillo, 2005).

Roche (2002) maintains that improvement efforts often are unsuccessful because of people's adherence to the status quo, perpetuated by unfavorable cultural norms and disconnected structures. According to this author, an organization's deficient social climate and its underlying non-cohesive culture, as characterized by distrust among the organization's members and reflected in its organizational structures, or lack thereof, are impediments to the learning that is required to fuel strategic thinking.

Joint strategic planning that spans across the public health and education sectors is not yet the norm across school health partnerships in Ontario. Public health professionals have recognized the need for a culture shift in both school health partners, where there would be greater engagement among the top leadership for more advanced cross-sector collaboration. However, a greater change in the school board's culture may be required since school health initiatives are to be planned and delivered within their workplace, and educators are not mandated to work in partnerships as professionals in the public health field are, let alone engage in joint strategic planning. Cross-sector collaborative work is already embedded in the public health standards, while collaboration across sectors is optional for school board personnel, although encouraged by their Ministry of Education. Nevertheless, high-level strategic planning for school health partnerships is not being routinely carried out within the province.

The progression to joint strategic planning, as the definitive indicator of a collaborative partnership arrangement, may be supported by an organization's culture of cohesiveness, openness, and learning for continuous improvement. My research findings suggest that the willingness of a school board to engage in joint strategic planning with their public health partners could be attributed to personnel that exhibits internal cohesiveness, demonstrates an openness to consider different points of view, and expresses an eagerness to learn in the pursuit of continuous improvement. Such findings have been confirmed by other scholars (e.g., Bunning, 1992; Freed, 2005; Roche, 2002; van Winkelen, 2010). Based on the existing scholarly work on organizational culture for continuous improvement, an organization's cohesiveness, openness, and eagerness to learn appear to be inter-related.

To be authentic, an organizational culture that welcomes learning opportunities for the sake of continuous improvement must also value cohesiveness in the work place, which fosters openness to diverse

perspectives. What makes people inclined to consider the views of others is a desire to learn from one another, through open dialogue based on trusting relationships, so that they can be more successful in improving areas of mutual concern. As Bunning states (1992, p. 57), the ability to explore the full realm of possibilities during the improvement planning process “requires a willingness to leave behind vested interests for the sake of finding answers which are in accord with the real needs of the actual situation.” Rather than plan on the basis of previously conceived assumptions and outdated interests, being open minded is critical when effective solutions to persistent issues are not readily detectable. Open-mindedness is a pre-requisite for double-loop learning. Roche (2002) asserts that “in a learning culture there must be an openness to challenge existing assumptions, a willingness to uncover the patterns of behavior which undermine [organizational] learning, (...) and finally, a commitment to lifelong learning” (p. 145). The basic unit of organizational learning is the individual. Learning is most effective when the individuals are “knowledgeable, committed, and open-minded” and they are skilled at building relationships with those who have different perspectives to share (van Winkelen, 2010, p. 15).

Organizational learning flourishes through the sharing of diverse views, supported by the cultivation of trusting relationships through mutual support (Maden, 2012). An organization that thrives on trusting relationships cultivates cohesiveness, and a cohesive culture creates a safe space for freely expressing one’s views in order to enhance learning. Freed (2005) brought home the importance of cultivating cohesiveness through trusting relationships between members of the same organization to promote organizational learning. She noted that “as people share their fears, concerns, and assumptions, they develop a higher level of confidence in one another [and] [a]s trust grows, an environment more conducive to learning is created, because learning depends on openly sharing ideas” (p. 67). As the foundation of collaborative interactions, trust creates a cohesive culture that can nurture learning by providing a feeling of safety for exploring uncharted territories of new practices and innovative ways of thinking, as well as a sense of tolerance for risk taking (Bryk & Shneider, 2002; Costa, Robert, & Tharsi, 2001; Garvin, Edmondson, & Gino, 2008; Stoll, 2009; Tschannen-Moran, 2004).

Each partnering organization’s own culture may well be the most important supporting condition for making joint strategic planning a possibility, since culture represents what behaviors, or practices, are deemed acceptable. In other words, it establishes norms of behavior, including those that would be influencing the type of planning practices that are routinely undertaken. For joint strategic planning to be part of partnership activities, the host organization would need to ensure that they first have a culture

that is driven by continuous improvement and supports internal collaboration through the fostering of cohesiveness, openness, and learning. Developing such a culture may then provide fertile ground for school boards to sow the seeds of joint strategic planning with their public health partners for even greater opportunities to pursue continuous improvement.

If the organization's culture is so vital to instill a mindset of collaboration, what could possibly shape it to favor an internal collaborative planning approach, and to then go beyond organizational boundaries and include external partners at the planning table? Shaping the culture of any organization is a top leadership role (Bunning, 1992; Garvin et al., 2008; Maden, 2012). Leaders who are skilled at creating a learning culture can inspire a vision around collective learning for continuous improvement; show their commitment to organizational learning by questioning their organizations' mental concepts and beliefs to uncover any incomplete and limiting assumptions; and invite the personnel to share different points of view about solving recurrent problems with innovative ideas (Garvin et al. 2008; Popper & Lipshitz, 2000; Senge, 2006). Senior management can contribute to a learning culture in other critical ways. Through their leadership, they can allocate resources, and establish structures to support the learning process, and reinforce norms of learning behavior (van Winkelen, 2010).

Within a school setting, organizational learning is usually an integral part of professional development (Rowling & Samdal, 2011). Learning among the teaching profession is facilitated through such structures as professional learning communities (also called communities of practice) and inquiry networks, which are collective learning opportunities within individual schools, and perhaps across schools, when orchestrated by school boards' central office to identify and solve school-based issues (Archbald, 2016). Finnigan and Daly (2012) emphasize the critical role of school board leaders in strengthening social norms and establishing supportive structures to develop strong, trusting ties that can allow for ideas to be shared freely; risks to be taken in trying out new practices; and knowledge and resources to be made available for invigorating the school system. In the absence of a command-and-control style of management seen in corporations and government bureaucracies, the school board leadership can more readily create momentum for change by "initiating and leading structural and cultural changes in schools to develop well-functioning PLCs [professional learning communities]" (Archbald, 2016, p. 122).

A professional learning community is one type of structure that can facilitate school-level strategic planning with external partners, particularly across a school board's district. In the present study, a public

health manager reported that their local school board organized a one-day community of practice event for teachers from a group of schools, where joint strategic planning was undertaken as part of their annual school improvement planning process. Other structures have been used for this same purpose. An invitation to join board-led planning sessions with principals was an avenue that another public health unit highly welcomed as it allowed them to start engaging with school leaders earlier into their school improvement planning. Yet another suitable structure has been collective inquiry groups at individual schools. Public health participation in such a group was deemed very advantageous for contributing external input into a school's improvement plan. Despite the planning advancements achieved by schools in the presence of their public health partners, these types of joint planning events did not frequently occur across school health partnerships in Ontario. However, it may be that opportunities for planning collaboratively within the school system itself may be lacking. As Archbald (2016) asserts, collective learning has been a great success in some schools to enhance strategic planning abilities, but it is still not the norm within the education sector and therefore major shifts in organizational structure and culture would be required where collaboration obstacles persist.

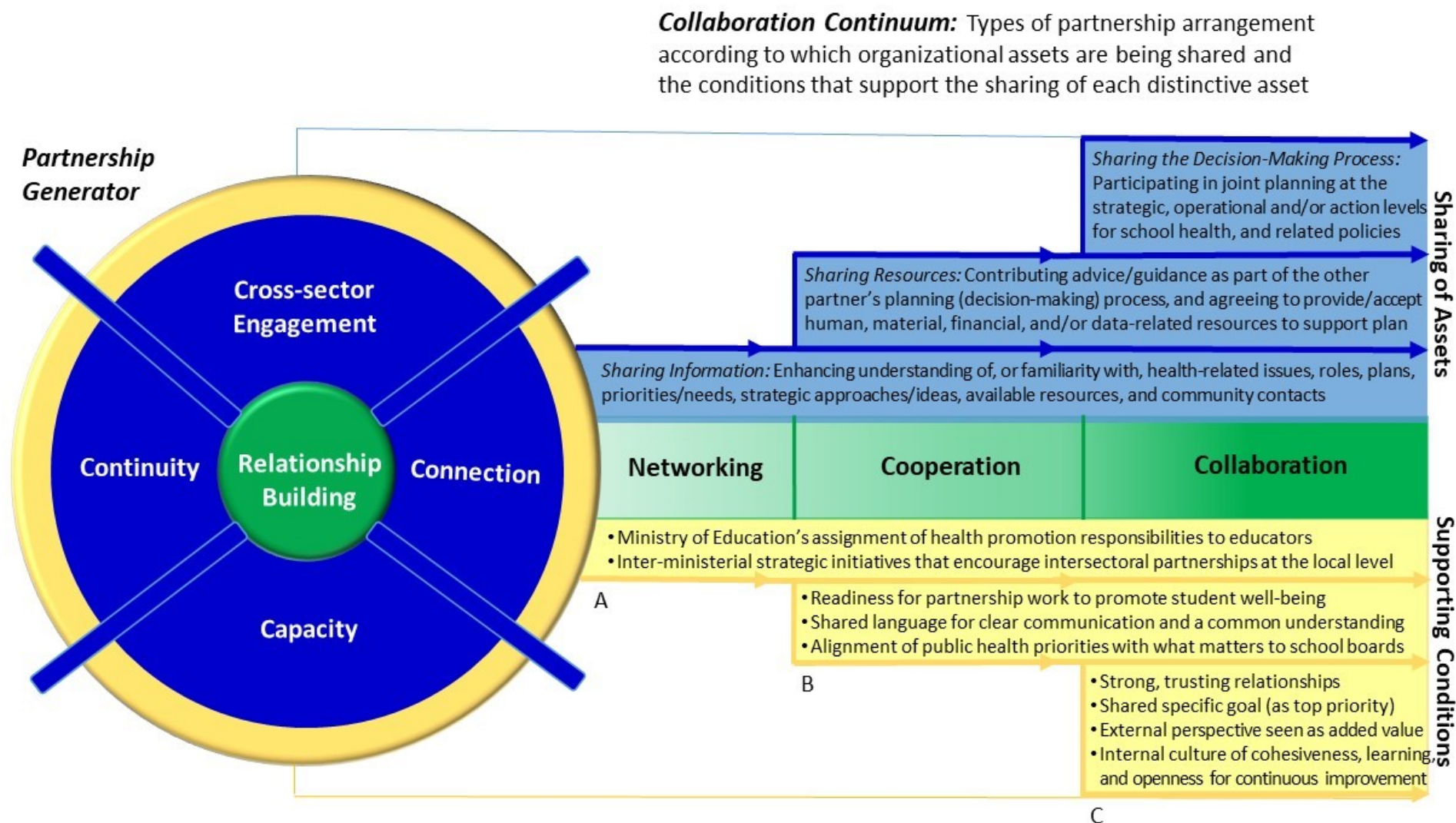
Notably, collective learning has been identified as residing at the core of cross-sector collaboration in my initial conceptual framework. However, a significant proportion of school health partnerships are not yet considered to be of a collaborative nature as it pertains to strategic planning. If collective learning at the basis of school improvement planning is challenging as an internal engagement process within the education sector, it would certainly be challenging for organizations working across different sectors. Nevertheless, breakthroughs in this regard have begun to surface within school health partnerships, as mentioned above, with collective learning structures being established at both the school board and school levels. Although such planning integration is yet to be widespread across the province, it may well be a sign of great transformational change to come. School health partnership's potential would be maximized by the preparation of a partnership-related multi-year strategic plan that would provide a clear, long-term direction to achieve specific shared goals for the promotion of student well-being. Whether these types of joint strategic planning will become the way of the future would likely depend on the extent to which the top leadership from both sectors can come together to promote a culture of cohesiveness, learning, and openness within their own organization, and then create the required cultural shift for collective learning across their respective sectors for achieving desired improvements for student well-being.

My research findings show congruence in perspectives between the public health and education sectors as to what are the enriching, enabling, and hindering elements characterizing school health partnerships. Although different viewpoints have been expressed, this was largely observed within the public health sector, itself. Even when perspectives differed, they were complementary rather than contradictory. Combining the input of all study participants has yielded the School Health Partnership Model for Student Well-being, as illustrated in Figure 7, with a consolidated list of the conditions supporting the movement of school health partners along the collaboration continuum. As relationships are built, school health partners move from networking to cooperation to collaboration, where increasingly more organizational assets—namely information, resources, and the decision-making process—are being shared for the promotion of student well-being. However, moving along the collaboration continuum is not linear.

Partnership arrangements move back and forth along this continuum, depending on the task at hand, as well as a number of other factors influencing the extensiveness of that engagement. These factors have been identified as the enriching, enabling and hindering elements of school health partnerships. The actual enriching and enabling elements constituting each component of the Partnership Generator, shown on the left-hand side of the model, has been graphically depicted earlier in this chapter.

My doctoral thesis project has notable strengths and limitations. One major strength is the guidance that was received through the research steering committee, which not only ensured the relevance of the research findings, but also a very high rate of public health participation. Another strength is the comprehensiveness of the ensuing partnership model, with a total of 24 elements contributing to well-functioning school health partnerships and the building of relationships, as well as nine supporting conditions for progressing along the collaboration continuum. With its comprehensiveness comes limitations. My research questions were quite ambitious and thus covered a very broad scope. As a consequence, synthesizing the data was very challenging. Furthermore, the thesis is written in an overly detailed manner. However, the highly detailed analysis was necessary to be able to finally make sense of such a complex and complicated subject matter as that of cross-sector engagement within a school setting. Another limitation is the small sample size of school board representatives. The School Health Partnership Model for Student Well-Being has been constructed mainly on the basis of public health professionals' perspectives. It is uncertain whether there are additional elements for strengthening school health partnerships that a school board perspective would have uncovered. Likewise, other insights on partnership challenges could have been missed.

Figure 7. School Health Partnership Model for Student Well-being: Public health units and school boards (schools included) engaging with one another toward the creation of healthy schools



Note 1:

A = These conditions support networking across the public health and education sectors

B = These conditions support moving from networking to cooperation

C = These conditions support moving from cooperation to collaboration

Note 2:

Networking = sharing information

Cooperation = sharing information and resources

Collaboration = sharing information, resources, and the full decision-making process

Despite these limitations, the research findings in this dissertation may serve as a valuable source of reference for school boards and schools to peer through a public health lens and gain a better understanding as to how their local public health units see their school health partnerships. This equally applies to public health professionals, since they have varied partnership experiences and may gain greater understanding as well. Furthermore, much knowledge can still be gained from the views expressed by the few school board representatives who participated in this thesis project. Since no two school health partnerships are alike, not all the elements in the school health partnership model would be equally applicable across the province. However, the model presents a list of success factors on which school health partners could ponder as they look for ways to strengthen their own partnerships. All in all, my doctoral thesis provides a valuable source of knowledge from which to distill key findings that could then be distributed in the form of short reports for knowledge translation purposes.

In conclusion, the resulting model provides the knowledge base for assessing the strengths of a given school health partnership and for shedding light on which partnership areas would need to be further developed. Overall, this model offers any professional, from the field of public health, education, or mental health, a closer look at what would be required for a school health partnership to become truly collaborative and reach its maximum potential. It promises to inspire and guide school health partners in their pursuit of more meaningful engagement with one another so that they can be of greater service to the children and youth, whose well-being rests under their shared responsibility.

School health partnerships in Ontario are at various stages of development, and partnership development through relationship building is an ongoing requirement given the dynamic work environments within which professionals from both the public health and education sectors operate. A school health partnership has reached its maximum potential, in terms of a collaborative arrangement, when joint strategic planning has become part of partnership activities. To this end, efforts would need to be directed toward establishing a joint planning system where the relevant parts of each partner's strategic and operational planning processes for student well-being can be integrated. However, such efforts may be in vain without each partner cultivating a suitable organizational culture of cohesiveness, openness, and learning that is shaped by an enduring quest for continuous improvement at the basis of strategic planning. Such a culture would provide the foundation on which to take planning beyond sector

boundaries in order to increase the likelihood of discovering together a more expanded field of possibilities for producing greater partnership successes.

My research has uncovered a leadership gap that needs to be further explored. Leaders within school health partnerships are critical for nurturing a collaboration-oriented culture within their own organization and for expanding this culture to include outsiders at their strategic planning table. Through this leadership, appropriate interorganizational structures would also need to be established in order to reinforce such a culture. One promising area in promoting the exchange of perspectives is collaborative inquiry. It is a learning process that has been imbedded in school's improvement planning for instructional practices. Its potential in the area of student well-being has yet to be fully tapped. Inquiry communities that bring together educators, mental health practitioners, and public health professionals, could well flourish by cultivating in all partnering organizations a cohesive, open, and learning culture for greater progress toward the creation of healthy schools.

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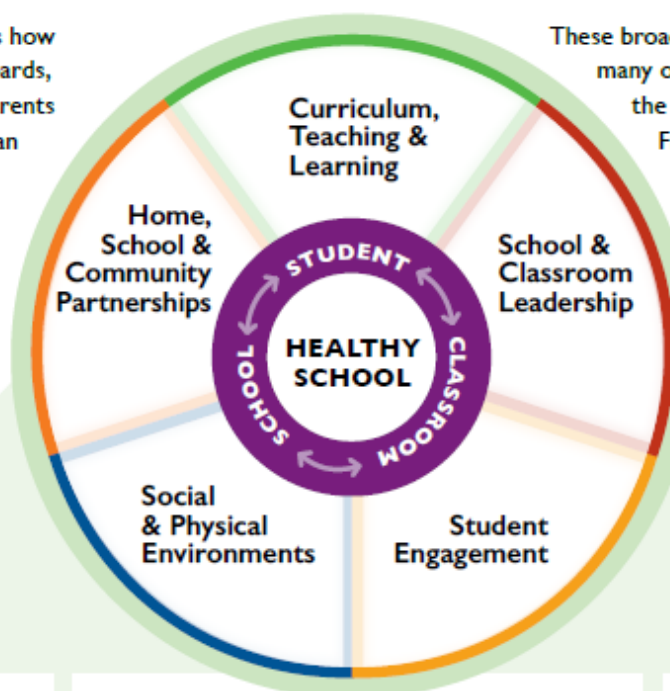
APPENDIX SECTION 1:

Background Material

Foundations for a Healthy School

Promoting well-being
is part of Ontario's
Achieving Excellence vision

This resource outlines how schools and school boards, in partnership with parents and the community, can develop a healthier school. The foundations for a healthy school are built within five broad areas that have strategies and activities for the school, classroom and student.



These broad areas align with many of the components of the School Effectiveness Framework to help schools and school boards use *Foundations for a Healthy School* as part of their planning process and as a resource for implementation.

INTEGRATED APPROACH

Key to building a strong foundation is the use of an integrated approach to address a range of health-related topics.

HEALTH-RELATED TOPICS

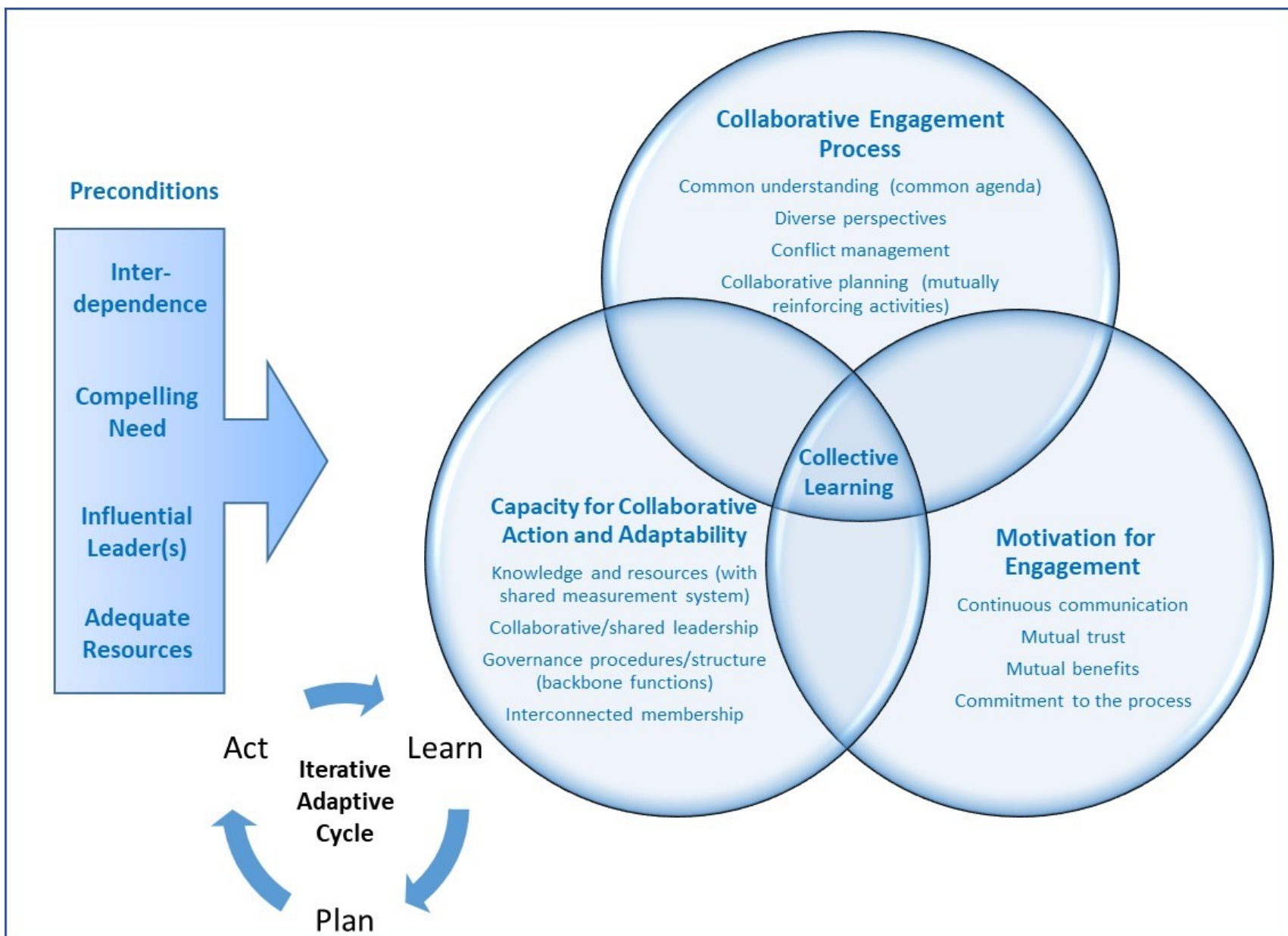
This resource provides many sample strategies and activities related to six curriculum-linked, health-related topics. A school may choose to address these topics and related living skills in its efforts to become healthier.

- Physical Activity
- Healthy Eating
- Personal Safety and Injury Prevention
- Growth and Development
- Mental Health
- Substance Use, Addictions and Related Behaviours

POSITIVE SCHOOL CLIMATE

Collectively, strategies and activities undertaken within these areas also contribute to a positive school climate, which is also key to a healthy school.

Appendix 1B. Conceptual Framework of Cross-Sector Collaboration for Social Change to Promote Population Health



Appendix 1C. Search Strategy for Scoping Review of the Scholarly Literature on Health Promoting Schools and Results

I. Searches conducted in OvidSP on August 31, 2015:

#	Searches	Results
1	(health?promoting school? or coordinated school health or comprehensive school health or healthy school? or whole?school).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, nm, kf, px, rx, ui, pt, an]	3362
2	(implement* or partner* or network* or collaborat* or cooperat* or communit* or process* or capacity).mp. [mp=ti, ab, hw, tn, ot, dm, mf, dv, kw, nm, kf, px, rx, ui, pt, an]	9493112
3	1 and 2 <u>Embase <1974 to 2015 August 31> (794)</u> <u>Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) <1946 to Present> (618)</u> <u>Social Policy and Practice <201507> (413)</u>	1825
4	limit 3 to (english) [Limit not valid in Social Policy and Practice; records were retained] <u>Embase <1974 to 2015 August 31> (735)</u> <u>Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) <1946 to Present> (566)</u> <u>Social Policy and Practice <201507> (413)</u>	1714
5	limit 4 to yr="2005 -Current" <u>Embase <1974 to 2015 August 31> (499)</u> <u>Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) <1946 to Present> (364)</u> <u>Social Policy and Practice <201507> (203)</u>	1066
6	remove duplicates from 5 <u>Embase <1974 to 2015 August 31> (209)</u> <u>Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) <1946 to Present> (352)</u> <u>Social Policy and Practice <201507> (195)</u>	756
7	Transferring to Refworks and then Excel to remove additional duplicates Embase MEDLINE Social Policy and Practice	349 181 165
	Removing citations other than journal articles and remaining duplicates in Excel Embase MEDLINE Social Policy and Practice	345 67 67

II. Searches conducted in ERIC on August 31, 2015:

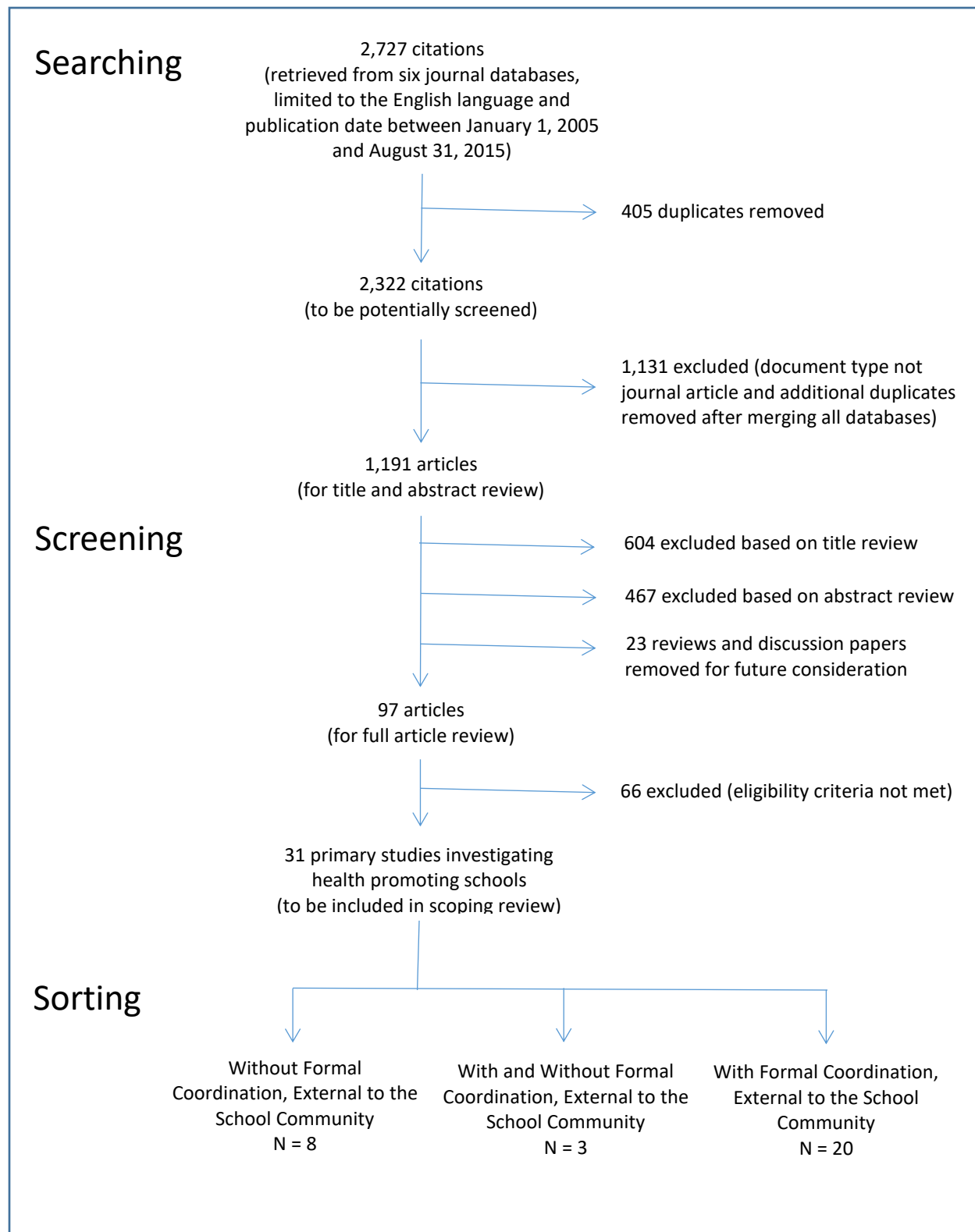
#	Searches	Results
1	(SU.EXACT("Comprehensive School Health Education") OR ti,ab("health?promoting school?") OR ti,ab("coordinated school health") OR ti,ab ("comprehensive school health") OR ti,ab ("healthy school?") OR ti,ab("whole?school")) AND (SU.EXACT("Cooperation") OR SU.EXACT("Agency Cooperation") OR SU.EXACT("School Community Relationship") OR ti,ab(implement* OR partner* OR network* OR collaborat* OR cooperat* OR communit* OR process* OR capacity))	1,476
2	Applying limits: English and since 2005	734
3	Transferring to Refworks and then Excel to remove additional duplicates	721
4	Removing citations other than journal articles and remaining duplicates in Excel (any overlap with Ovid citations have been removed)	523

III. Searches conducted in SCOPUS on August 31, 2015:

#	Searches	Results
1	(TITLE-ABS-KEY ("health?promoting school?" OR "coordinated school health" OR "comprehensive school health" OR "healthy school?" OR "whole?school") AND TITLE-ABS-KEY (implement* OR partner* OR network* OR collaborat* OR cooperat* OR communit* OR process* OR capacity))	1,368
2	AND (LIMIT-TO (LANGUAGE , "English")) AND (LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005)) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re"))	922
3	Transferring to Refworks and then Excel to remove additional duplicates	901
4	Removing citations other than journal articles and remaining duplicates in Excel (any overlap with Ovid citations have been removed)	184

II. Searches conducted in The Campbell Library on August 31, 2015:

#	Searches	Results
1	"promoting school" OR "comprehensive school" OR "coordinated school" in all text	5



Appendix 1E: Background Information on Included Studies for the Scoping Review

Without Formal Coordination				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Ahmed, 2005 (United States)	To evaluate the process of council formation, needs assessment, and implementation, of coordinated school health councils in schools within an American state.	Training initiative on how to implement the CSHP model in schools, in the form of a leadership conference, with a small initial grant in the first year [including guidance to conduct needs assessment] and a 5-year process evaluation	The state departments of education and health selected schools from a pool of school applications for initial funding and leadership training in the CSHP model	Table 5: A2; B4; C1 Table 6: A5; B1,2,4; C1,4
Aldinger , Zhang, Liu, Guo et al., 2008 (China)	To describe the key processes and activities through which schools in a Chinese province became Health promoting Schools and the challenges that they needed to overcome.	The scaling-up of the HPS program across a Chinese province by a government institution, beginning with a training workshop by national and international health promotion experts for headmasters and teachers (from 51 schools), along with health and education officers of the prefectures	With WHO support and the joint endorsement of the provincial departments of education and health, the province's Health Education Institute launched the scaling-up of the HPS program across its jurisdiction. The Health Education Institute selected the schools that were to participate in this study with guidance from the researchers.	Table 5: A1; B3; C1 Table 6: n/a; B1,2,4; C4
Aldinger, Zhang, Liu, Pan et al. 2008b (China)	To describe the implementation of the HPS program by schools in a Chinese province at different stages and the changes that have been experienced.	The scaling-up of the HPS program across a Chinese province by a government institution, beginning with a training workshop by national and international health promotion experts for headmasters and teachers (from 51 schools), along with health and education officers of the prefectures	With WHO support and the joint endorsement of the provincial departments of education and health, the province's Health Education Institute launched the scaling-up of the HPS program across its jurisdiction. The Health Education Institute selected the schools that were to participate in this study with guidance from the researchers.	Table 5: A1; B4; C1 Table 6: n/a; B1,2; C4
Christian et al., 2015 (Wales)	To explore head teachers' views and experiences regarding school-based health interventions, and identify factors that could facilitate implementation of complex school-based interventions.	Implementation of multi-component school-based health interventions	One of the following groups: government, local authority, public health, universities and charities	Table 5: A2; B1; C1 Table 6: n/a; B2,3; C4
Clarke et al., 2010 (Ireland)	To describe whole-school contextual factors that influence the implementation of a mental health promotion program	Zippy's Friends, an international emotional wellbeing program for primary schoolchildren, mandated by the national government	The national department of education and science, ensuring implementation of this universal program through trained classroom teachers	Table 5: A2; B4; C1 Table 6: A3; B3; C4
Flaschberger et al., 2012 (Austria)	To explore how a pilot training course could support school heads and teachers (representing project coordinators or project team members) during the implementation phase of health promoting schools	Pilot training course on implementation of the health promoting school approach in order to embed health promotion into a quality management and school development process; participating schools received small initial grant (3,000 euros) from federal government	The federal ministries of education and health, along with a national association for social security, initiated a Healthy School project that provided teacher training and helped establish health management in schools	Table 5: A2; B3; C1 Table 6: n/a; B1,4,5; C1,4

Without Formal Coordination (continued)				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Flaschberger et al., 2013 (Austria)	To assess how the various network stakeholders perceived learning in an Austrian regional health promoting schools network and identify barriers to organizational learning for health promoting schools.	An Austrian regional health promoting schools network for organizational learning and knowledge exchanges about ways to implement the HPS approach; with funding available via an application process for schools at levels 2 (committed to the whole school approach) and 3 (integrating health promotion into school improvement plans)	As part of WHO's Healthy City movement, a municipality initiated a regional network of schools through a steering group consisting of members from local government, a <i>municipality-related organization focused on HP</i> ; a statutory health insurance provider; and regional educational institutions.	Table 5: A2; B2; C4 Table 6: A1; B1,2; C1
Gugglberger & Dur, 2011 (Austria)	To identify capacity building factors that schools can either acquire themselves or need from their environment to facilitate the implementation of the health promoting school concept.	Implementation of the HPS approach in select schools.	Schools that have already adopted a health promoting approach, and thus were successful to some extent in building capacity.	Table 5: A2; B2; C1 Table 6: A1; B2,5; n/a

With and Without Formal Coordination				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Khan et al., 2011 (Australia)	To assess the uptake of MindMatters by secondary schools and identify predictors of successful implementation of a whole school approach and to compare implementation factors and outcomes between schools with and without buddy support	A two-year full implementation of a buddy scheme project to complement MindMatters, a mental health promotion program for secondary schools based on a coordinated whole-school approach that provides resources related to mental health; schools that participated or did not participate in this intervention were invited to take part in this evaluation study for comparison purposes	School-Link, which includes the MindMatters program, is an initiative of the New South Wales Government in collaboration with the Department of Education and Training at the national level	Table 5: A2; B3; C1 Table 6: A1,2,3; B3; C3,5
Stolp et al., 2014 (Canada)	To describe the essential strategies and elements utilized within school communities to facilitate a Comprehensive School Health approach in creating healthy school communities.	Comprehensive School Health (CSH) approaches, which aim to develop a healthy school community, with a focus on school health champions, through funding from a provincial granting agency	Provincial health ministry's Healthy School Community Wellness Fund supported the development of healthy school communities through the CSH framework via project facilitation and funding.	Table 5: A2; B5; C2 Table 6: A12; B2,3,4; C2,4
Valois et al., 2015 (United States and Canada)	To describe the levers of change in a school community that allow for the initiation and implementation of best practice and policy for improving school health.	Two-year Healthy School Communities pilot project, which engaged school communities to develop a Healthy School Communities (HSC) team of diverse stakeholders, assess the school health environment, develop an HSC action plan, and implement the plan over the duration of the project, with initial funding of \$10,000 for the first year, with one possible renewal in the second year	The Association for Supervision and Curriculum Development (ASCD) Healthy School Communities, an American professional association of educators of various levels providing grant funding and technical support. This association provided funding to successful school applicants to support them in creating healthy school environments	Table 5: A2; B3; C1 Table 6: A1,2,4; B1,5; C4

With Formal Coordination				
<i>A. From public or nonprofit health-related agency:</i>				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Firth et al., 2008 (Australia)	To identify barriers and enablers in the implementation of the beyondblue initiative.	Three year beyondblue: The National Depression initiative to prevent development of depression in young people by increasing individual and environmental protective factors and to improve the ability of schools and young people to deal with mental health issues.	Beyondblue, a national, independent, not-for-profit organization, receiving national and state funding; beyondblue project management team working collaborating with a research team from universities in three states on a three-year process evaluation	Table 5: A2; B4; C1 Table 6: A3; B2,3; C5
Khan et al., 2012 (Australia)	To evaluate the strategies, achievements and challenges of implementing MindMatters and the views of the partner schools toward the buddy support scheme.	Following a two-year pilot project with 10 secondary schools, a 2-year buddy scheme project was undertaken with 14 secondary schools to complement MindMatters, a mental health promotion program for secondary schools based on a coordinated whole-school approach that provides resources related to mental health, with provision of a small grant (AUD\$2,000) per school	In collaboration with a mental health program developed by the Australian state government, a local health agency developed and piloted a 'buddy support scheme' to help schools integrate the MindMatters program, as part of an initiative between the state government and the national department of education and training,	Table 5: A2; B4; C1 Table 6: A1,2,3; B3; C5
Rowe et al., 2010 (Australia)	To describe the Kids Café school nutrition initiative according to its "structural" and "process" aspects and identify the key supporting factors of the HPS approach that facilitated its adoption, implementation and sustainability.	Kids Café' school nutrition initiative based on the HPS approach, as a result of receiving an initial grant (AU\$28 000 over three years)	A state public health agency supported 10 school communities through the Western Gateway Health Promoting Schools Grant Scheme; Kids Café is among the HPS initiatives supported in this way.	Table 5: A1; B4; C1 Table 6: A1; B2,5; C4
Senior, 2012 (Australia)	To examine the practicalities of implementing the health promoting school (HPS) framework, including conducting a whole school audit, to enable a primary school to successfully adopt the HPS principles.	Implementation of the Health Promoting School approach, including a whole school audit and evaluation of related programs	The local community health service, EACH Social and Community Health (EACH), established a formal partnership agreement with a school and provided support by appointing a Health Promotion Officer (HPO) to work at the school one day per week	Table 5: A1; B4; C1 Table 6: n/a; n/a; C5
Pucher et al., 2015 (Netherlands)	To explore a systematic approach to the development of intersectoral collaborations based on an analysis of facilitating and impeding factors in implementing the Healthy School Approach and the use of appropriate change strategies, using the Diagnosis of Sustainable Collaboration (DISC) model.	Two-year development phase of intersectoral collaboration based on the Dutch Healthy School Approach (HSA), which provided coaching support from a central facilitator with specialized expertise in HSA implementation) to five regional coordinators in order to strengthen collaboration among stakeholders providing services to schools within their respective regions	Public health service agency developed the Dutch Healthy School Approach and the DISC model	Table 5: A1; B1; C3 Table 6: A2; n/a; C3

With Formal Coordination (continued)				
<i>B. From health and education partnerships:</i>				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Soulatou & Duncan, 2009 (Greece)	To explore the barriers and facilitators of building partnerships in terms of the national school health education (SHE) curriculum in Greek secondary education.	The national school health education (SHE) curriculum in Greek secondary education, guided by WHO's comprehensive school health concept and involving external partners	The Ministry of Education, driving a top-down approach to establishing partnerships for school health education through local health education officers as their intermediaries	Table 5: A1; B2; C1 Table 6: n/a; n/a; n/a
Inchley et al., 2006 (Scotland)	To demonstrate that the processes involved in developing and implementing health promoting schools at local level is critical to understanding how schools are progressively able to exert an influence on health-related behaviors and environments.	Implementation of the HPS approach in a flexible way, responsive to schools' identified needs, with funding of £4,000 to support HPS development over a 2-year period	The European Network of HPS (ENHPS) in Scotland initiated a 4-year project, with start-up funding, to focus on the promotion of healthy eating as entry point for the creation of health promoting schools	Table 5: A2; B3; C4 Table 6: n/a; B5; C1,4
Liao et al., 2015 (Taiwan)	To examine the opinions of school staff members in charge of health promoting school (HPS) projects within the HPS Supporting Network about school partnerships and HPS policies, as well as the factors influencing HPS implementation.	HPS implementation as supported by the Health promoting School Supporting Network, which supports schools through local governments, and directly provides consulting services, teaching material, trainings, and information on their websites	Through the National Health promoting School Supporting Network (linking the national government to local governments and schools via its Administrative Support group and consultant team), the national departments of education and health established a HPS partnership through which to provide funding, awards and oversight and make available health resources, services, and medical facilities, respectively, to health promoting schools, as well as grant access to central coordinators.	Table 5: A1; B5; C4 Table 6: A4; n/a; C1,7
Rothwell et al., 2010 (Wales)	To determine how closely a network of healthy school schemes conforms to the Ottawa Charter framework of advocacy, mediation and enablement in promoting environments conducive to health, and network-related factors that facilitate these actions.	The Welsh Network of Healthy School Schemes (WNHSS), which gave rise to healthy schools coordinators to blur professional boundaries and provides guidance and resources for HS implementation, is a multi-level cross-sector arrangement spanning national, local and school levels, with Assembly Government grant available to fund support for certain schools (where HSCs' salaries covered by another source)	National government created local health and education partnerships through a network of Healthy School schemes headed by a national coordinator, responsible for training healthy schools coordinators (HSC) and encouraging collaboration through these HSCs and some initial funding. National government provided funding to local health and education partnerships to appoint HSCs, whose role was to establish and maintain local schemes	Table 5: A2; B4; C4 Table 6: A1,2,4; B5; C1,3,5

With Formal Coordination (continued)				
<i>C. From multi-agency group:</i>				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Thomas et al., 2010 (Australia)	To examine the enabling factors of effective school-community partnerships and the ways in which sustainability was supported as part of a HPS project.	Implementation of the Logan Healthy Schools Project across five schools; this project aimed to improve eating and physical activity behaviors through before, during, and after-school activities based on the Health Promoting School approach, with a focus on building partnerships between the school and community partners, with initial funding of AUD \$230,000 to help cover the cost of a project officer	Partnership of five secondary schools and their community partners through a steering committee for strategic planning	Table 5: A1; B1; C3 Table 6: n/a; n/a; C3
Gollub et al., 2014 (United States)	To assess the process of developing a comprehensive school wellness policy and engaging the school community to generate environments conducive to healthy eating, physical activity and the prevention of tobacco use.	The Schools Putting Prevention to Work (SPPW) pilot program, which assists selected public school districts in developing a comprehensive school wellness program and engaging the school community and community partners to support, implement, and sustain healthy behaviors.	The Louisiana Tobacco Control Program ran the SPPW pilot in collaboration with the school wellness project state team, a stakeholder advisory group with representation from the state departments of education and health, and other state-level organizations in the area of health promotion and disease prevention.	Table 5: A1; B1; C3 Table 6: A1; n/a; C1,2,3
Staten et al., 2005 (United States)	To describe the implementation process of the School Health Index through Border Health ¡SI! And the barriers to promoting healthy eating and physical activity encountered in the school environment.	A three-year Border Health Strategic Initiative supported the hiring and training of an external coordinator from a community-based organization to work with schools and implement the Coordinated School Health Program, including the School Health Index (SHI), with a specific focus on nutrition and physical activity, with schools being offered a financial incentive of US \$1,500 upon completion of the SHI.	Border Health ¡SI! involves policy coalitions and interventions funded by the state government; one of these coalitions of community-based agencies, which included a state public health research institution for technical assistance, had targeted school health	Table 5: A2; B4; C3 Table 6: A4; B5; C3,5

With Formal Coordination (continued)				
<i>D. From school districts</i>				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Gleddie & Hobin, 2011 (Canada)	To examine how the school environment and health behaviors (healthy eating, physical activity and mental wellness) of children and youth can be improved when a health promoting schools model, the Ever Active Schools program, is implemented with school division support.	Battle River Project, a three-year, multilevel partnership designed to improve the efficacy of implementing the Health Promoting School approach at a school division level, with funding from two granting agencies, totaling \$105,000 per year	Ever Active Schools, a provincial, nongovernment organization assisting schools in fostering social and physical environments that support healthy active school communities, entered into a partnership with the school division and the local health authority to engage in this project.	Table 5: A2; B5; C2 Table 6: A1; n/a; C2
Gleddie, 2011 (Canada)	To explore how a particular Health Promoting Schools model actually worked in terms of its effect on the school/district culture and its success factors at the district level to bring about change related to healthy eating, physical activity and mental health.	The Battle River Project, which involved the implementation of the Ever Active Schools Program based on the Health promoting Schools model, at the school division level, where participating schools had access to a variety of resources and supports	Project was initiated by the Ever Active Schools Program (EAS) who also offer equivalent guidelines and frameworks for school communities that wish to utilize the HPS approach, in partnership with the BRSD and assisted by Alberta Health Services ([AHS] the provincial and regional health services provider).	Table 5: A2; B3; C2 Table 6: A1; n/a; C2,4
Gleddie, 2010 (Canada)	To examine the process leading to the development and implementation of comprehensive healthy school policy as part of a particular division-level Health Promoting School implementation model in relation to healthy eating, physical activity and mental health.	Battle River Project, a multilevel partnership designed to improve the efficacy of implementing the Health Promoting School approach at a school division level	A partnership initiated by a provincial non-government organization (Ever Active Schools, EAS) that sought to engage directly with a school division when working with school communities and the local health authority, in Alberta, Canada.	Table 5: A1; B1; C2 Table 6: n/a; n/a; C2
Barnes et al., 2013 (United States)	To assess the extent to which school systems met expectations for building Coordinated School Health partnership capacity in terms of the structural outputs from resource inputs (i.e., financial and material resources, training and technical assistance) as well as district-level activities	A 5-year training initiative through the MICHIANA Coordinated School Health Leadership Institute, which provided leadership training to personnel from school districts so that they could go on to complete a needs assessment in their respective district, employ a full-time Coordinated School Health coordinator, create and implement a healthy school improvement plan, and document progress being made.	Partnership between the education and health departments of two states and a health-based national nongovernment organization providing funding and training opportunities to recruited teams from selected school districts. Partnership between the American Cancer Society and the state departments of education and health in both Indiana and Michigan recruited school district teams to receive a grant award and participate in their leadership training initiative.	Table 5: A1; B1; C2 Table 6: A4; B1,4; C1,2

With Formal Coordination (continued)				
<i>D. From school districts (continued)</i>				
Authors, year (Country)	Research Aim	What was initiated as the study focus?	By whom?	Scoping Results
Cornwell et al., 2007 (United States)	To explore the process by which a school district modified and implemented the Coordinated School Health Program (CSHP)'s methods.	Multi-year Coordinated School Health Program development process by a school district in a rural, high-need area, initiated as a result of a successful grant application that included funds for the creation of a school health coordination position	Following a competitive process, the state department of education provided federal funding to the rural school district to implement the CSHP model, including funds for a school health coordinator position. With funding secured, the school district implemented the coordinated school health model through the hiring of a school health coordinator.	Table 5: A1; B1; C2 Table 6: A4; B3,4; C2
Hoyle et al., 2008 (United States)	To describe the pre-existing conditions and ongoing processes in a school district that built capacity for the development and continuous improvement of health promoting schools.	Implementation of the Coordinated School Health Program by a school district that demonstrated a good level of readiness to further develop its health promotion initiatives	The American School Health Association, through its cooperative agreement with the US Centers for Disease Control and Prevention, provided funding to the school district to further pursue its coordinated school health program.	Table 5: A1; B5; C2 Table 6: A1,4; B2,5; C3
Miller & Bice, 2014 (United States)	To describe the process and application of the Coordinated School Health Program in a large elementary school district.	Three-year project to implement the Coordinated School Health Program in a rural school district's four school sites, with grant funding from the U.S. Department of Education	A District Wellness Committee, conducting a needs assessment and then successfully applying for funding from the US Department of Education to make further progress in creating environments conducive to health and wellness. [Funding: source of empowerment to take action through this multi-agency committee, no coordinator mentioned though]	Table 5: A1; B2; C2 Table 6: n/a; n/a; C2
Westrich et al., 2015 (United States)	To explore the role of wellness coordinators and the ways in which they contribute to the coordination of health and wellness programs and activities in their school districts.	A San Francisco Bay Area school health initiative to improve wellness programs in local school districts using the Coordinated School Health (CSH) model, including funding for each school district to hire a wellness coordinator to oversee implementation of this model.	Local community health organization whose catchment area encompasses four school districts provided initial funding for partnering school district to hire a wellness coordinator and coordinate the 8 CSH components across their most deprived schools. The publicly elected board of the San Francisco Bay Area healthcare district, established this 3-year community initiative.	Table 5: A2; B5; C2 Table 6: A1,2,3; B2,4; C2

APPENDIX SECTION 2:

Recruitment and Data Collection Material for Phase 1

Appendix 2A: List of Public Health Units in Ontario

I. Local Public Health Agencies—36 Health Units

Algoma Public Health Unit
Brant County Health Unit
Chatham-Kent Health Unit
City of Hamilton - Public Health & Social Services
Durham Region Health Department
Eastern Ontario Health Unit
Elgin-St. Thomas Health Unit
Grey Bruce Health Unit
Haldimand-Norfolk Health Unit
Haliburton, Kawartha, Pine Ridge District Health Unit
Halton Region Health Department
Hastings and Prince Edward Counties Health Unit
Huron County Health Unit
Kingston, Frontenac and Lennox & Addington Health Unit
Lambton Health Unit
Leeds, Grenville and Lanark District Health Unit
Middlesex-London Health Unit
Niagara Region Public Health Department
North Bay Parry Sound District Health Unit
Northwestern Health Unit
Ottawa Public Health
Oxford County Public Health
Peel Public Health
Perth District Health Unit
Peterborough County-City Health Unit
Porcupine Health Unit
Region of Waterloo, Public Health
Renfrew County and District Health Unit
Simcoe Muskoka District Health Unit
Sudbury and District Health Unit
Thunder Bay District Health Unit
Timiskaming Health Unit
Toronto Public Health
Wellington-Dufferin-Guelph Health Unit
Windsor-Essex County Health Unit
York Region Public Health Services



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April 20, 2015

Dear Dr. Jaeger and Director Crocco:

My Thesis Director and I are pleased to share with you recent developments about the participatory research project, *Exploring Partnerships across the Health and Education Sectors in Ontario*, which is a major component of my doctoral thesis at the University of Ottawa's Institute of Population Health. Much interest in taking part in this thesis project was expressed by the Ontario School Health Management in Public Health Network during their November 24, 2014 teleconference. The impetus to be involved in the research came from network members' recognition that partnerships between education and public health are very important in carrying out their health units' mandate.

In response to this interest, a Research Steering Committee composed of 10 network members was established to guide the research. This committee has directly contributed to a survey questionnaire that has been produced for all 36 health units, with the intent of informing and complementing the CODE-COMOH Committee's initiative to help foster strong partnerships between school boards and boards of health. A similar participatory research process will be offered to school board representatives to take into account the education sector's perspective in the second phase of the thesis project.

Exploring partnership experiences may shed light on possibilities for moving forward. Given that this research is meant to assist the work of the CODE-COMOH Committee, we are forwarding to you the draft survey package that may be circulated for your committee's review in order to ensure that this undertaking is beneficial to all concerned; please see attachments. Furthermore, we feel that your committee's endorsement of the proposed health unit survey would help increase its level of success. If your committee agrees to endorse this survey, a letter of support to this effect would certainly add relevance to the survey package for all health units. We hope to prepare a final research report based on a broad coverage to better support your efforts.

Please let us know if it would be possible to receive your committee's feedback on the draft survey package and on our endorsement request by May 4. The Phase 1 Research Steering Committee will be notified of your committee's reply to determine next steps.

We look forward to hearing from you.

Sincerely,

BRIEFING NOTE TO THE CODE/COMOH COMMITTEE

Support and Feedback Requested to Explore Partnerships across the Health and Education Sectors through a Participatory Research Project

SUMMARY

- This briefing note is to provide information on an opportunity that has come up to explore partnerships across the health and education sectors in Ontario through a participatory research project by a doctoral candidate at the University of Ottawa
- A Research Steering Committee was established in December 2014, with 10 School Health Managers, to direct this project in such areas as the development of a School Health Partnership survey questionnaire for health units in Ontario
- CODE/COMOH Committee members are being invited to:
 - (1) review the draft survey questionnaire so that they may be prepared to provide comments at the next committee meeting in order to ensure its practical value;
 - (2) express support, possibly in the form of a cover letter, to confirm the relevance of the research and encourage health units' participation in the survey; and
 - (3) give feedback on the proposed approach to launch the survey in a timely manner

BACKGROUND:

Last fall, Joanne de Montigny, a doctoral candidate in Population Health at the University of Ottawa, sought to explore partnerships between the health and education sectors in Ontario through a participatory research project.

On November 24, 2014, Joanne presented her research proposal at the Ontario School Health Management in Public Health Network's teleconference and invited network members to participate in a Research Steering Committee. Valuing an inclusive engagement process, she accepted all 10 School Health Managers who were interested in joining this committee.

Through a series of teleconferences and email exchanges from December 2014 to April 2015, the Research Steering Committee refined their knowledge interests and contributed to the development of a draft survey questionnaire to gather the input of all 36 health units on school health partnerships in Ontario. This survey questionnaire was prepared with the intent of informing and complementing the CODE/COMOH Committee's initiative to help foster strong partnerships between school boards and boards of health

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This project's present focus is on health units. However, the Research Steering Committee has expressed an interest in learning from the perspective of the education sector through a second phase of the research project (see attachment 2A). This possibility may be discussed at a later date (all research-related documents for school boards would be provided in both official languages).

CONSIDERATION:

At the previous teleconference of the Ontario School Health Management in Public Health Network, strong interest was expressed to involve both the health and education sectors, represented on the CODE/COMOH Committee, in the research project. Network members felt that the Committee's review of the survey questionnaire and its support would help ensure that this research would be of practical use to all concerned and be deemed relevant.

OPPORTUNITY FOR THE CODE/COMOH COMMITTEE:

In response to this interest, Joanne and her Thesis Director, Louise Bouchard, are inviting CODE/COMOH Committee members to review the School Health Partnership survey questionnaire at this time so that members may be prepared to provide comments at the next committee meeting (see attachments 3 and 4). Since they find it important to ensure that the committee's knowledge interests are also covered in the research project, adjustments to the survey questionnaire is still possible.

In addition, the Committee is being invited to express its support, possibly in the form of a cover letter, to confirm the relevance of this research and encourage participation in the survey. It is felt that such a letter of support would help capture a broad variety of input to enrich the understanding of partnerships between school boards and health units across the province. Furthermore, the anticipated research findings may serve to inform future committee deliberations for added value.

If the CODE/COMOH Committee wishes to proceed with this research invitation, the following approach to launch the survey in a timely manner is being proposed for feedback:

- (1) Step 1: Communicate the outcome of the Committee's deliberation to Joanne, who will then notify the Phase 1 Research Steering Committee and finalize the survey questionnaire accordingly;
- (2) Step 2: Provide a CODE/COMOH cover letter, to Joanne, expressing support and encouragement for participation, and introducing the survey package that would include:
 - the University of Ottawa's letter to the Medical Officers of Health (MOHs), inviting their health units to participate in the online survey (see attachment 1C, in addition to attachments 2A, 3 and 4); and

- the necessary documents for the MOHs to seek ethics approval from their respective Research Ethics Review Boards (see attachments 5 and 6);
- (3) Step 3: Have Joanne email the survey package, on behalf of the CODE/COMOH Committee and the University of Ottawa, directly to each MOH and their School Health Manager for increased efficiency at the survey's ethics approval and launch stage; and
- (4) Step 4: Once health units have notified Joanne that they are interested and have received their ethics approval, she will send a second email containing the electronic survey link and survey instructions to the School Health Managers, as the primary survey respondents, with a c.c. to the MOHs.

NEXT STEPS:

Approval is currently being requested by the CODE/COMOH Committee Co-Chairs through their respective Research Ethics Review Boards for an initial verification of the research process.

Joanne is hoping to begin analysis of survey data during the summer months, and then engage the Phase 1 Research Steering Committee in data interpretation, and possibly conduct focus group sessions, in the fall of 2015. With this timeline, a preliminary research report for the first phase is anticipated to be ready for internal distribution by winter 2016.

The survey package for the CODE/COMOH Committee's information contains the following:

Attachment No. 1C: Invitation Letter to Health Units

Attachment No. 2A: Information Sheet

Attachment No. 2B: Fiche d'information

Attachment No. 3: Survey Questionnaire for Health Units

Attachment No. 4: Survey Questionnaire Appendix

Attachment No. 5: UoO Ethics Approval BOUCHARD_DE MONTIGNY

Attachment No. 6: Ethics Review Application Form_J deMontigny_JAN 2015

(Please note: When accessing attachment No. 6, the message "Please enter a valid email address" may appear. If so, click "OK" twice and wait a few seconds for it to open.

Please also note that full approval from the University of Ottawa's Research Ethics Review Board was granted twice, the second time took into account changes made following deliberations of the Phase 1 Research Steering Committee, as per the attachments provided here.)

NOTE DE BREFFAGE POUR LE COMITÉ DU CODE/COMÉH

Demande de soutien et de commentaires concernant un projet de recherche participative visant à explorer les partenariats entre les secteurs de la santé et de l'éducation

RÉSUMÉ

- Cette note de breffage vise à informer les membres d'une opportunité d'explorer les partenariats entre les secteurs de la santé et de l'éducation en Ontario par l'entremise d'un projet de recherche participative, initié par une candidate au doctorat à l'Université d'Ottawa.
- En décembre 2014, un Comité directeur de la recherche, réunissant 10 gestionnaires de santé en milieu scolaire, a été créé dans le but de mener cette recherche, en autres dans l'élaboration d'un questionnaire d'enquête pour mieux comprendre les partenariats sur la santé en milieu scolaire
- Les membres du Comité du CODE/COMÉH sont invités à :
 - (1) examiner l'ébauche du questionnaire d'enquête, pour être en mesure d'apporter des commentaires lors de la prochaine réunion et ainsi s'assurer de sa valeur pratique ;
 - (2) exprimer leur soutien, possiblement sous la forme d'une lettre de présentation, pour souligner la pertinence de la recherche et encourager la participation à l'enquête des bureaux de santé ; et
 - (3) apporter des commentaires sur l'approche proposée pour lancer l'enquête de façon efficace.

CONTEXTE :

L'automne dernier, Joanne de Montigny, candidate au doctorat en santé des populations à l'Université d'Ottawa, a voulu faire une recherche participative sur les partenariats entre les secteurs de la santé et de l'éducation en Ontario.

Le 24 novembre 2014, Joanne a présenté sa proposition de recherche à la téléconférence du « Ontario School Health Management in Public Health Network » et a invité les membres du réseau à participer à un comité directeur de la recherche. Valorisant un processus d'engagement inclusif, elle a accepté l'ensemble des 10 gestionnaires de santé en milieu scolaire qui ont manifesté leurs intérêts à se joindre à ce comité.

Au cours d'une série de téléconférences et d'échanges de courriels, de décembre 2014 à avril 2015, les membres du Comité directeur de la recherche ont pu préciser leur besoin de connaissances et contribuer à une ébauche d'un questionnaire d'enquête afin de recueillir la perspective de tous les 36 bureaux de santé au sujet de leurs partenariats sur la santé en milieu scolaire en Ontario. Ce questionnaire a été préparé avec l'intention d'informer et d'être complémentaire à l'initiative du Comité du Conseil ontarien des directrices et directeurs de l'éducation et le Conseil ontarien des médecins hygiénistes (CODE/COMÉH) qui vise à favoriser des partenariats solides entre les conseils scolaires et les conseils de santé.

L'emphasis actuelle de ce projet porte sur les bureaux de santé. Toutefois, le Comité directeur de la recherche a exprimé un intérêt pour connaître le point de vue du secteur de l'éducation à travers une deuxième phase (voir la pièce jointe 2B). Cette possibilité pourrait faire l'objet, à une date ultérieure, d'une autre discussion (tous les documents liés à la recherche pour les conseils scolaires seraient fournis dans les deux langues officielles).

CONSIDÉRATION :

Lors d'une récente téléconférence du « Ontario School Health Management in Public Health Network », un grand intérêt a été exprimé pour impliquer à la fois les représentants des secteurs de la santé et de l'éducation qui siègent sur le Comité du CODE/COMÉH. Les membres du réseau ont estimé que l'examen du questionnaire de l'enquête par le Comité et son soutien permettraient de mieux garantir que cette recherche serait utile et pertinente.

OPPORTUNITÉ POUR LE COMITÉ CODE-COMÉH :

En réponse à cet intérêt, Joanne et sa directrice de thèse, Louise Bouchard, invitent les membres du Comité du CODE/COMÉH à examiner le questionnaire de l'enquête *School Health Partnership* pour être en mesure d'apporter des commentaires lors de la prochaine réunion du comité (voir les pièces jointes 3 et 4). Un élément important de cette recherche est de s'assurer que le projet permet également au Comité d'en retirer les connaissances nécessaires et pertinentes, par conséquent, elles ajusteront le questionnaire en fonction des besoins exprimés.

En plus, le Comité est invité à exprimer son soutien, possiblement sous la forme d'une lettre de présentation, pour confirmer la pertinence de cette recherche et encourager la participation à l'enquête. Il est estimé que cette lettre de soutien pourrait aider à recueillir une grande variété de perspectives pour enrichir la compréhension des partenariats entre les conseils scolaires et les bureaux de santé à travers la province. Ce qui permettra également de faire en sorte que les résultats de recherche attendus pourront servir à éclairer les futures interventions du Comité.

Si le Comité du CODE/COMÉH souhaite aller de l'avant dans son engagement avec cette recherche, une approche pour lancer l'enquête de façon efficace est proposée ci-dessous afin d'y apporter des commentaires :

- (1) Étape 1: Le Comité informe Joanne des décisions prises pour lui permettre d'informer le Comité directeur de la recherche de la Phase 1 et de finaliser le questionnaire de l'enquête (si applicable);
- (2) Étape 2: Le Comité du CODE/COMÉH transmet une lettre à Joanne, exprimant son soutien pour encourager la participation et pour introduire la trousse de l'enquête qui inclura :
 - une lettre de l'Université d'Ottawa adressée aux médecins hygiénistes, invitant leurs bureaux de santé à participer à l'enquête en ligne (voir la pièce jointe 1C, en plus des pièces jointes 2A, 3 et 4); et

- les documents nécessaires pour les médecins hygiénistes pour obtenir l'approbation de leur comité d'éthique de recherche respectif (voir pièces jointes 5 et 6).
- (3) Étape 3: Joanne envoie un courriel au nom du Comité du CODE/COMÉH et de l'Université d'Ottawa pour faire parvenir la trousse directement à chaque médecins hygiénistes et leur gestionnaire de santé en milieu scolaire pour une efficacité accrue lors de la phase de l'approbation de l'éthique et le lancement de l'enquête; et
- (4) Étape 4: Une fois que les bureaux de santé expriment leur intérêt avec l'approbation de leur conseil d'éthique, Joanne enverra un second courriel contenant le lien de l'enquête électronique, ainsi que des instructions, aux gestionnaires de la santé en milieux scolaire, en tant que répondants principaux à l'enquête, avec une copie conforme aux médecins hygiénistes.

PROCHAINES ÉTAPES :

L'approbation est demandée actuellement par les co-présidents du Comité du CODE/COMÉH à travers leurs comités d'éthique de recherche pour une vérification initiale du processus de recherche.

Joanne espère commencer l'analyse des données de l'enquête au cours de cet été, puis engager le Comité directeur de la recherche de la phase dans l'interprétation des données, et possiblement mener des séances de discussion de groupes, à l'automne de 2015. Avec ce calendrier, un rapport de recherche préliminaire pour la première phase sera prêt à être distribué à interne à l'hiver 2016.

À titre d'information, la trousse de l'enquête contiendra les éléments suivants:

Pièce jointe n ° 1C: Invitation Letter to Health Units

Pièce jointe n ° 2A: Information Sheet

Pièce jointe n ° 2B: Fiche d'information

Pièce jointe n ° 3: Survey Questionnaire for Health Units

Pièce jointe n ° 4: Survey Questionnaire Appendix

Pièce jointe n ° 5: UoO Ethics Approval BOUCHARD_DE MONTIGNY

Pièce jointe n ° 6: Ethics Review Application Form_J deMontigny_JAN 2015

(Veuillez prendre note que lors de l'ouverture de la pièce jointe n ° 6, le message "Please enter a valid email address" pourrait apparaître. Si ceci est le cas, cliquez sur "OK" deux fois et attendez quelques secondes pour qu'il s'ouvre.

Veuillez noter également que l'approbation complète du Comité d'éthique de l'Université d'Ottawa a été accordée deux fois; la seconde pour reconnaître les changements apportés par le Comité de direction de la recherche.)



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en santé des
populations

University of Ottawa

Faculty of Graduate and
Postdoctoral Studies

PhD in Population
Health Program

Title of Thesis Project: Exploring Partnerships across the Health and Education Sectors in Ontario

Principal Researcher:

Joanne de Montigny, B.Sc.(Hon.), MHA, PhD(c)

Institute of Population Health, University of Ottawa

Thesis Director:

Louise Bouchard, PhD, Professor

Institute of Population Health, University of Ottawa

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Introduction

Ontario's renewed vision for student achievement encompasses health and well-being so that every school-age child has a better chance of reaching his or her full potential.¹ This vision reflects the undeniable interdependence between the education and health sectors. Promoting health improves academic performance.²⁻¹¹ Succeeding in school, in turn, contributes to enhanced life management skills and a favorable socioeconomic status in adulthood, both of which may lead to better health outcomes.¹²⁻¹⁴

Joanne de Montigny, PhD candidate at the University of Ottawa and fellow at the Public Health Agency of Canada, has initiated a doctoral thesis project that seeks to understand how and to what extent the health and education sectors are working together toward Ontario's broader vision for student achievement. Her research is being funded by the Canadian Institutes of Health Research through the Transdisciplinary Research Program on Public Health Interventions, administered by the Quebec Population Health Research Network.

Research Plan

The goal of the proposed doctoral thesis project is to generate knowledge on partnership development across the health and education sectors and to shed light on the potential for collaborating toward the creation of healthy schools in Ontario. Its purpose is to inform and complement the Council of Ontario Directors of Education and the Council of Ontario Medical Officers of Health (CODE-COMOH) Committee's initiative to help foster strong partnerships between school boards and boards of health. Research objectives are as follows:

- (1) to determine the different types of partnerships between health units and school boards across Ontario, specifically in relation to health promotion and prevention initiatives beyond legislated health services;

- (2) to identify the enabling and hindering factors and improvements experienced in these cross-sector partnerships;
- (3) to examine the extent to which these cross-sector partnerships are utilizing the *Foundations for a Healthy School* document for guidance;
- (4) to gain a better understanding of the ways in which the *Foundations for a Healthy School* document has been produced and disseminated; and
- (5) to articulate recommendations to help guide and inspire efforts to strengthen cross-sector partnerships for boards of health's and school boards' consideration.

The research design follows a participatory research methodology that is predominantly qualitative in nature, so that research findings could be of practical value to knowledge users. The participatory research process is being guided by Dr. Jonathan Salsberg, Associate Director at the centre for Participatory Research at McGill University (PRAM), who is a member of the doctoral thesis committee. This thesis project has three phases. Phase 1 relates to the health sector in Ontario. Given this thesis project's participatory orientation, a Research Steering Committee of 10 School Health Managers has been established for this initial phase to engage in (1) the co-development of data-collection tools at the health-unit level, (2) data interpretation, and (3) the formulation of recommendations. The study population consists of personnel in all 36 health units, who interact directly with school board representatives. Data collection will consist of a survey to all health units, and possibly focus group sessions with survey respondents to further explore emerging themes, as deemed beneficial by the Research Steering Committee.

Phase 2 involves Ontario's education sector. A participatory research process is planned with school board representatives, to be invited to join a Research Steering Committee to gather information about the education sector's partnership perspective. The study population is public school board representatives who are responsible for health-related matters within schools under their jurisdiction. Due to the larger number of school boards, quota sampling will be undertaken with respect to school-board type and regional location.

Phase 3 concerns the Ontario ministries of education and health. Key informants within these ministries will be interviewed to gather background information on cross-sector partnerships at their level, particularly in regards to the *Foundations for a Healthy School* document and its significance in providing strategic direction.

Cross-cutting all research phases is a review of pertinent documents from the health and education sectors, at various levels, to provide contextual data, historical facts, and other background information, and to inform data collection tools.

Expected Results

A final report of main research findings from all phases, including recommendations via research steering committees, will be disseminated to all study participants, the CODE-COMOH committee, boards of health and school boards to use as they best see fit. These findings are expected to illustrate in what ways cross-sector partnerships are taking place, highlight areas of partnership development that require further attention, and uncover approaches for enriching the partnership engagement process. Recommendations arising from this knowledge will help to strengthen cross-sector partnerships for greater success with the implementation of the Healthy School/Comprehensive School Health approach.

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Projet de thèse : Exploration des partenariats entre les secteurs de la santé et de l'éducation en Ontario

Chercheure principale:
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Institut de recherche sur la santé des populations
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Directrice de thèse:
Louise Bouchard, PhD, Professeure
Institut de recherche sur la santé des populations
Université d'Ottawa

Introduction

La vision renouvelée de l'Ontario pour la réussite des élèves englobe la santé et le bien-être afin que chaque enfant d'âge scolaire ait une meilleure chance d'atteindre son plein potentiel.¹ Cette vision reflète l'interdépendance indéniable entre les secteurs de l'éducation et de la santé. La promotion de la santé améliore le rendement scolaire des élèves.²⁻¹¹ Réussir à l'école, à son tour, contribue à l'amélioration des compétences de gestion de vie et à un statut socio-économique favorable à l'âge adulte, ce qui peut conduire à des meilleurs résultats de santé.¹²⁻¹⁴

Joanne de Montigny, candidate au doctorat en santé des populations de l'Université d'Ottawa et stagiaire à l'Agence de la santé publique du Canada, a entrepris un projet de thèse de doctorat qui cherche à comprendre comment et dans quelle mesure les secteurs de la santé et de l'éducation travaillent ensemble vers une vision élargie de la réussite des élèves en Ontario. Ce projet de thèse est financé par les Instituts de recherche en santé du Canada par le biais du Réseau de recherche en santé des populations du Québec, et son programme en recherche transdisciplinaire sur les interventions de santé publique.

Plan de recherche

Le but du projet de recherche doctorale proposée est de générer des connaissances sur le développement des partenariats entre les secteurs de la santé et de l'éducation et de mettre en valeur le potentiel de la collaboration pour la création d'écoles saines en Ontario. Ce projet vise à informer et à compléter l'initiative du Comité du Conseil ontarien des directrices et directeurs de l'éducation/Conseil des médecins-hygiénistes de l'Ontario (CODDE/CoMHO) pour favoriser des partenariats solides entre les conseils scolaires et les conseils de santé. Les objectifs de recherche sont les suivants:

- (1) déterminer les différentes modalités de partenariats entre les bureaux de santé et les conseils scolaires de l'Ontario, spécifiquement en ce qui concerne la promotion de la santé et les initiatives de prévention au-delà des services de santé prévus par la loi;
- (2) identifier les facteurs favorables et défavorables au développement de ces partenariats intersectoriels pour la promotion de la santé ainsi que les améliorations possibles;
- (3) examiner la façon dont ces partenariats intersectoriels s'appuient sur le document d'orientation *Fondements d'une école saine*;
- (4) acquérir une meilleure compréhension de la façon dont le document *Fondements d'une école saine* a été produit et diffusé ; et
- (5) articuler des recommandations qui contribuent à orienter et inspirer les efforts visant à renforcer les partenariats intersectoriels des conseils de santé et des conseils scolaires.

La conception de la recherche suit une méthodologie de recherche participative qui est principalement de nature qualitative, de sorte que les résultats de la recherche aient une valeur pratique pour les utilisateurs des connaissances. Le processus de recherche participative est guidé par Professeur Jonathan Salsberg, directeur associé du Centre pour la recherche participative à l'Université McGill, qui est membre du comité de thèse de doctorat. Ce projet de thèse a trois phases. La phase 1 concerne le secteur de la santé en Ontario. Compte tenu de l'approche participative de ce projet de thèse, un comité directeur de la recherche de 10 gestionnaires de la santé en milieu scolaire a été établi pour cette phase initiale afin (1) de co-développer les outils de collecte de données auprès des bureaux de santé, (2) d'interpréter les données et (3) de formuler des recommandations. L'étude vise la participation du personnel des 36 bureaux de santé, qui interagissent directement avec les représentants des conseils scolaires. La collecte de données consiste à distribuer un questionnaire d'enquête auprès des bureaux de santé. La cueillette d'information pourra être complétée par la réalisation de groupes de discussion auprès de ces mêmes répondants, si cette étape est jugée pertinente par le Comité directeur de la recherche.

La phase 2 portera sur le secteur de l'éducation de l'Ontario. Un processus de recherche participative est prévu avec les représentants des conseils scolaires, qui seront invités à joindre un deuxième comité directeur de la recherche pour la perspective du secteur de l'éducation. La population à l'étude comprend des représentants/représentantes des conseils scolaires publics qui sont chargés des questions liées à la santé dans les écoles. En raison du nombre plus élevé de conseils scolaires, l'échantillonnage par quotas sera entrepris à l'égard du type de conseil scolaire et la localisation régionale.

La phase 3 concerne les ministères de l'éducation et de la santé de l'Ontario. Les informateurs clés au sein de ces ministères seront interviewés pour recueillir des renseignements généraux sur les partenariats intersectoriels au niveau gouvernemental, en particulier en ce qui concerne le document *Fondements d'une école saine* et son importance dans l'orientation stratégique.

De manière transversale, toutes les phases de recherche comprennent un examen des documents pertinents des secteurs de la santé et de l'éducation, à différents niveaux, afin de fournir des données contextuelles, des faits historiques, et autres renseignements généraux, et d'informer les outils de collecte de données.

Résultats attendus

Un rapport final des principales conclusions de toutes les phases, y compris des recommandations des comités directeurs de la recherche, sera diffusé à tous les participants à l'étude et au Comité du CODDE/CoMHO. Ces résultats attendus permettront d'illustrer de quelle manière les partenariats intersectoriels se déroulent, de souligner les besoins de développement des partenariats, et de découvrir des approches pour enrichir le processus d'engagement des partenariats. Les recommandations découlant de cette connaissance pourront aider à renforcer les partenariats intersectoriels dans le but d'une meilleure réussite avec la mise en œuvre de l'approche Écoles saines/approche globale de la santé en milieu scolaire.

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Appendix 2C: Recruitment for Participation in the School Health Partnership Survey—Email Message to All 36 Medical Officers of Health, including Personalized Invitation Letter and Endorsement Letter from the CODE-COMOH Committee

First Email Message:

Recipients: Medical Officer of Health, with c.c. to the member(s) of the Ontario School Health Management in Public Health Network employed in their health unit

Subject: Research Invitation to All Public Health Units

Dear [Name of Medical Officer of Health]:

We cordially invite your public health unit to take part in the online School Health Partnership Survey. Please find attached our invitation letter, along with the CODE/COMOH letter of support, an information sheet about the overall research project, and our University of Ottawa's certificate of ethics approval. It is our hope that the research results will provide useful knowledge to support all of your aspirations for strong partnerships with school boards for the health and well-being of Ontario's schoolchildren.

Kind regards,

Joanne

Joanne de Montigny
PhD Candidate in Population Health
University of Ottawa

June 11, 2015

Dear [Name of Medical Officer of Health]:

My Thesis Director and I would like to invite your [Name of Health Unit] to participate in the participatory research project entitled *Exploring Partnerships across the Health and Education Sectors in Ontario*, via the online *School Health Partnership Survey*. This research project is a major component of my doctoral thesis in Population Health, at the University of Ottawa. Please find additional details in the attached information sheet.

Much interest in taking part in this thesis project was expressed by the Ontario School Health Management in Public Health Network during their November 24, 2014 teleconference. The impetus to be involved in the research came from network members' recognition that partnerships between education and public health are very important in carrying out their health units' mandate.

The Research Steering Committee, composed of 10 network members, has been involved in the development of the *School Health Partnership* survey to assist the CODE/COMOH Committee with their current partnership initiative. As you know, this initiative aspires to help foster strong partnerships between school boards and boards of health. We would appreciate your health unit's participation in this research project, however your health unit is free to decline this invitation if you so wish.

If your health unit would like to accept our survey invitation, we have attached our University's certificate of ethics approval for your information. Our research project also received ethics approval from Dr. Jaeger's Niagara Region Public Health Unit before requesting the endorsement from the CODE/COMOH Committee. Please let us know if you will be seeking ethics approval from your side as well, by contacting me at jdemo096@uottawa.ca. Should this be the case, I could send you the Word document of our survey questionnaire, in addition to any other required documents, to assist you in this process. Please do not hesitate to contact me about any questions that you may have.

We would greatly appreciate receiving your reply to this invitation by July 6, or sooner if at all possible. Once we have been notified by you that we can proceed with the survey, we would like to send the electronic survey link to your School Health Manager, as the primary survey respondent, right away with a copy to you.

Although brief survey answers would suffice, much could be gained from the amount of time your health unit can take in reflecting on what has been learned and realized while working with school boards. This being said, we would be giving your health unit four weeks to complete this survey, so that school health personnel may provide responses as time permits, and benefit from taking time to engage in personal and team-based reflection.

.../2

Survey completion time will vary across health units depending on how much input would be available for answering each survey question. However, your health unit's level of input is equally important, whether high or low.

Please note that it will be possible for multiple members of your health unit to add, one at a time, responses to the same survey questionnaire so that collating responses would not be necessary. Further instructions will be sent with the survey link.

To help ensure we receive your health unit's valuable input in time, we would be sending friendly reminders to your School Health Manager.

We look forward to hearing from you, and having your health unit join us in exploring school health partnerships to further support the health and well-being of Ontario's schoolchildren.

Sincerely,

Joanne de Montigny, B.Sc. (Hon.), MHA
PhD Candidate

Louise Bouchard, PhD, Professor
Director, Thesis Committee

c.c. [Name of Member(s) of the Ontario School Health Management in Public Health Network]

CODE

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Toronto, Ontario M5B 1J3
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June 4th, 2015

Dear Medical Officers of Health

Re: Participatory Research Project Survey – Exploring Partnerships across health and education sectors in Ontario

Last fall, Joanne de Montigny, a doctoral candidate in Population Health at the University of Ottawa, sought to explore partnerships across the health and education sectors in Ontario through a participatory research project.

In November, Joanne presented her research proposal at the Ontario School Health Management in Public Health Network's teleconference and invited network members to participate in a Research Steering Committee. Valuing an inclusive engagement process, she accepted all 10 School Health Managers who were interested in joining this committee.

Through a series of teleconferences and email exchanges from December 2014 to April 2015, the Research Steering Committee refined their knowledge interests and contributed to the development of a draft survey questionnaire to gather the input of all 36 health units on school health partnerships in Ontario. This survey questionnaire was prepared with the intent of informing and complementing the CODE/COMOH Committee's initiative to help foster strong partnerships between school boards and boards of health. The CODE/COMOH Committee has also read the survey questionnaire and has been given the opportunity to comment.

This project's current focus is on health units. However, the Research Steering Committee has expressed an interest in learning from the perspective of the education sector through a second research phase so this may follow sometime in the future.

At the recent COMOH/CODE meeting held May 27th, the research proposal was endorsed and the Co-Chairs were directed to reach out to COMOH members to communicate the support of CODE/COMOH for this endeavor. We request that all health units please encourage your staff to complete this survey. Many other details are found in the accompanying materials from Joanne who will be more than happy to answer any questions.

Best regards,

Dr. Valerie Jaeger
Medical Officer of Health, Niagara Region
Co-Chair CODE/COMOH

John Crocco
Director of Education
Niagara Catholic District School Board
Co-Chair CODE/COMOH

Second Email Message to Non-responders:

Recipients: Medical Officer of Health, with c.c. to corresponding member(s) of the Ontario School Health Management in Public Health Network

Subject: Inter-unit learning opportunity for the Ontario School Health Management in Public Health Network

Dear [Name of Medical Officer of Health]:

We would like to follow up on our research invitation to your health unit, sent on June 12 (please see attachments from the previous email, re-sent for your convenience).

We are hoping that your health unit may join this present opportunity for inter-unit learning about existing partnerships with school boards to cover as many contexts and perspectives as possible. Fortunately, representatives from the Ontario School Health Management in Public Health Network have been directly involved in the development of the School Health Partnership Survey to ensure relevance and practical value.

We were wondering if you were in the process of considering accepting this invitation. Your health unit's input in this survey will be very valuable to shed light on the partnership landscape across the province, and on what further knowledge is required for moving forward with health promotion in Ontario's schools.

We are looking forward to the collective generation of knowledge that will help ensure further progress in the crucial work that health units are doing in improving the health of the next generation. We would greatly appreciate hearing from your health unit in the days to come.

Kind regards,

Joanne

Joanne de Montigny, BSc, MHA
PhD Candidate in Population Health
University of Ottawa

Appendix 2D: Email Message to All 36 Health Units Who Accepted Invitation to Participate in the School Health Partnership Survey, with Online Survey Link and Survey Instructions

Recipients: Members of the School Health Management in Public Health Network

Subject: School Health Partnership Survey Link and Instructions

Hi [Name of Study Participant],

We thank you and your health unit for agreeing to participate in the School Health Partnership Survey. Having received approval through your Medical Officer of Health, we are sending you the link to access the online survey questionnaire:

[http://uottawa.fluidsurveys.com/surveys/joanne/school-health-partnership-survey/?code\[...\]](http://uottawa.fluidsurveys.com/surveys/joanne/school-health-partnership-survey/?code[...])

As you well know, this survey is intended to support the work being carried out by your Ontario School Health Management in Public Health Network as well as the CODE/COMOH Committee's initiative to help foster strong partnerships between school boards and boards of health.

We would like to invite responses from all members of your health unit who directly interact with school boards. It is possible for multiple members of your health unit to add, one at a time, responses to the same survey questionnaire so that collating responses will not be necessary.

As the primary survey contact person, could you please provide consent on behalf of yourself and your health unit by responding to the Consent Form on the first page of the survey questionnaire. Please find attached the PDF version of the Consent Form to keep for your records.

We are also sending you the Survey Appendix, which contains additional information that your health unit will need in order to complete the survey.

Please note the following:

1. You may save your responses by clicking on the "Save" button at the bottom of the page.
2. If you want to close the survey and continue at another time, click on "Save and continue later" button. A text box will appear where you can enter your email address to receive a new, updated URL survey link so that you can retrieve the survey with the latest responses next time [PS. If you run into any technical difficulty (which is highly unlikely), please contact me to have it resolved.]
3. You may also pass on the new, updated URL survey link to another member of your health unit who would like to enter his or her responses at their own computer (using the same type of browser) by entering their email address instead of yours after clicking the "Save and continue later" button.
4. For certain questions, you may wish to prepare a team response to help capture more fully your health unit's experiences with school boards.

PLEASE NOTE: it is important to have the survey link be used by only one person at a time, otherwise responses may be lost.

Please do not hesitate to contact me at jdemo096@uottawa.ca if you would like clarification on any part of the survey. If you prefer, we could set a time, via email, to communicate by telephone.

Although this survey has many parts, your health unit's contribution to all the closed-ended questions would be very much appreciated so that we may generate meaningful descriptive statistics.

The survey period is from July 6 to July 31, 2015. Given that your health unit has accepted our invitation, we are providing you with the survey link in advance to help ensure your health unit has sufficient time to fully participate as vacation season is almost upon us.

We are looking forward to gaining a better understanding of all of your partnership experiences with school boards and facilitating the learning process in order to assist health units in fulfilling your mandate concerning the health and well-being of Ontario's schoolchildren.

Kind regards,

Joanne
Joanne de Montigny, BSc, MHA
PhD Candidate in Population Health
University of Ottawa

Appendix 2E: Email Invitations to Participate in Follow-Up Interview

I. Initial Invitation Message

Recipients: Study Participants

Subject: School Health Partnership Study: Interview Invitation

Dear [Name of Study Participant],

As you may already know, the School Health Partnership Survey in which you participated has been a great success, with all 36 health units in Ontario sharing their valuable experiences and insights.

We are now embarking on the interview phase to delve deeper into survey responses. I am contacting you today since you expressed interest in participating in a follow-up interview when submitting the completed survey questionnaire.

This interview will consist of three parts with the following aims:

Part 1: clarifying partnership-based outcomes, and their corresponding level of engagement, to more accurately describe the collaboration continuum;

Part 2: verifying key features that characterize each of the five clusters of health units, grouped according to similar levels of satisfaction with school health partnerships, to gain a better understanding of what accounts for movement along the collaboration continuum; and

Part 3: further exploring specific survey responses from your health unit to fill in gaps regarding the preliminary School Health Partnership Model for Student Well-being.

The consent that you provided concerning participation in the School Health Partnership Survey, on behalf of your health unit as a whole, still applies since this interview process is an extension of the survey questionnaire. Confidentiality and anonymity of survey and interview responses is guaranteed.

The survey has succeeded in covering such a breadth of knowledge that an interview of up to 90 minutes, if at all possible, would help ensure the co-creation of a complete and practical cross-sector partnership model. This model will serve to guide and inspire the work that you and your peers across the province are carrying out with school boards. As stated in the consent form, the research results will be shared with the CODE-COMOH Committee as well.

If you wish, and if interest is there within your health unit, you may have other members of your team join you in this interview, to be conducted via teleconference.

Could you please provide a number of possible days and times of the day that would be suitable for you during the upcoming 3-week window—from _____—ideally to accommodate an interview of up to 90 minutes, if possible? I will be notifying you of the time and day that will be selected for our interview shortly afterwards.

Alternatively, in the event that only one hour can be booked at a time, it would be appreciated if a second session could be arranged later on in case more time is needed.

Please do not hesitate to contact me at _____ if you have any questions. I can also send you an additional copy of the consent form, if you are unable to retrieve the pdf version that was forwarded to you, along with the survey questionnaire.

I am looking much forward to setting a convenient time for the interview with you.

Joanne

Joanne de Montigny, BSc, MHA
PhD Candidate in Population Health
University of Ottawa

II. Second Invitation Message

Recipients: Study Participants
Subject: Our School Health Partnership Model

Hi [Name of Study Participant],

I would like to follow-up on the interview invitation sent to you in May concerning our School Health Partnership Study.

Since the research results are meant to be used by all health units in Ontario, I would like to ensure that your valued input is fully represented in the final partnership model. For this reason, I have extended the data collection period to make every effort from my side to accommodate your work schedule. For greater ease of participation in the interview phase, I have prepared structured questions to simply check off as applicable, and questions that relate back to participants' survey responses.

Please let me know if you and members of your team would like to participate by teleconference, and if so, when would be a good time for you. It could even be in July if this would accommodate you better.

Looking forward to connecting with you

Joanne

Joanne de Montigny, BSc, MHA
PhD Candidate in Population Health
University of Ottawa

Appendix 2F: Online School Health Partnership Survey Questionnaire

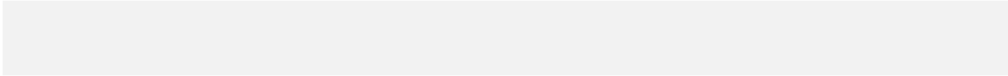
School Health Partnership Survey

Consent Form

Title of the Thesis Project: Exploring Partnerships across the Health and Education Sectors in Ontario

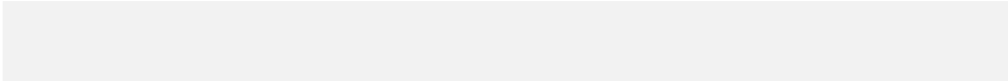
Principal Researcher:

Joanne de Montigny, B.Sc.(Hon.), MHA
PhD Candidate in Population Health
University of Ottawa



Thesis Director:

Louise Bouchard, PhD, Professor
University of Ottawa
1 Steward Street, Room 225, Ottawa, Ontario K1N 6N5



Invitation to Participate: School health personnel from your health unit are invited to participate in the abovementioned thesis project conducted by Joanne de Montigny, who is being supervised by Professor Louise Bouchard, at the University of Ottawa.

This project is funded by the Canadian Institutes of Health Research through the Transdisciplinary Research Program on Public Health Interventions, administered by the Quebec Population Health Research Network.

Voluntary Participation: If you, as primary survey contact person, and school health personnel at your health unit wish to participate in this study, please complete this online survey. Each one of you is under no obligation to participate, and if each one of you chooses to participate, you can withdraw from this project any time you wish, or you can decline to answer any questions that you do not want to answer, without any negative consequences.

Purpose of the Survey: This online survey has been created to capture health units' partnership experiences and the possibilities that lie ahead for partnership development. Its purpose is to inform and complement the CODE/COMOH Committee's initiative to help foster strong partnerships between school boards and boards of health. The specific objectives of this survey are to: (1) determine the types of partnership that health units are experiencing with school boards; (2) identify health units' level of satisfaction with opportunities to partner with school boards; (3) collect feedback on the sharing of information, resources/activities, and decision-making influence; and (4) collect feedback on the use of the *Foundations for a Healthy School* document.

Although brief answers would suffice, much could be gained from the amount of time your health unit can take in reflecting on what you have learned and have come to realize while working with school boards. We are giving your health unit four weeks to complete this survey so that you may provide responses as time permits, and benefit from taking time to engage in personal and team-based reflection. Survey completion time will vary across health units depending on how much input you and other school

health personnel will have available for answering each survey question. However, your level of input is equally important, whether high or low. Please note that it is possible for multiple members of your health unit to add, one at a time, responses to the same survey questionnaire so that collating responses is not necessary. Survey findings may serve to orient focus group sessions for deeper exploration of partnership experiences in Phase 2 of this thesis project. To help ensure we receive your valuable input in time, we will be sending you friendly reminders.

Benefits: Through the final research report, all study participants may learn from each other's partnership experiences and gain inspiration and guidance for further partnership development. This research report may also provide assistance with refinements to partnership agreements between health units and school boards.

Confidentiality and Anonymity: The information that your health unit will share will remain strictly confidential and will be used solely for the purposes of this research. The only person who will have access to the raw research data is myself, Joanne de Montigny, and my Thesis Director, Louise Bouchard. Your answers to the survey questions may be used verbatim in presentations and publications but neither you nor your organization will be identified. Your anonymity is guaranteed, however for follow-up purposes we would like to ask for the key contact person to identify herself or himself at the end of the survey questionnaire when ready to submit your health unit's responses. This would permit the tracking of survey submissions as well.

Conservation of data: The hard copies of the surveys will be securely kept in a locked filing cabinet in the office of my Thesis Director, Professor Louise Bouchard, at the University of Ottawa for a period of 5 years at which time they will be destroyed.

Information about the Study Results: A preliminary report of survey findings will be shared with health units through the Ontario School Health Management in Public Health Network, and will be made available to the CODE/COMOH Committee and Ontario school boards for their information. This report will then be integrated into the final research report, which will be including recommendations to help guide and inspire efforts to strengthen cross-sector partnerships for boards of health's and school boards' consideration.

To receive clarification about any survey question, you may communicate with me, Joanne de Montigny, via email for a written reply or to set up a telephone call. If you have any questions or require more information about the thesis project itself, you may contact myself or my Thesis Director as indicated at the top of this screen.

If you have any questions with regards to the ethical conduct of this thesis project, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, at (613) 562-5387 or ethics@uottawa.ca.

By selecting "Yes" below you are indicating that you, as primary survey contact person, have read and understood this consent form and that you are giving consent, on behalf of yourself and your health unit, to participate in this thesis project.

- ☐ Yes
- ☐ No

School Health Partnership Survey

Input is being requested from every health unit in Ontario. Once analyzed, the anonymous data will be interpreted through the Research Steering Committee and will contribute toward a final research report with recommendations to help guide and inspire efforts to strengthen partnerships between health units and school boards. Thank you for taking the time to participate in this survey.

Part 1: Entering your Health Unit's Profile

Question 1. What is the setting of your health unit's jurisdiction?

- ☐ Mostly rural
- ☐ Mostly urban
- ☐ Mostly suburban (for larger cities)
- ☐ Mostly inner city (for larger cities)
- ☐ Mix of urban and inner city (for larger cities)
- ☐ Mix of rural and urban

Question 2. Which region does your health unit serve?

- ☐ Central East
- ☐ Central West
- ☐ Eastern
- ☐ North East
- ☐ North West
- ☐ South West
- ☐ Toronto Central

Question 3. Please specify your health unit's organizational arrangements for context purposes (please refer to Section 1 in the Appendix regarding health-related topics):

- a. Do you have health unit staff who are assigned to specific schools as part of a formal school health team and deliver a variety of programs, which include health promotion and prevention initiatives? ☐ Yes ☐ No
- b. If you answered 'No', could you briefly describe any other type of arrangement your health unit has in place to engage with schools for health promotion and prevention initiatives (which may or may not also involve immunization and dental health)?
- c. Please briefly describe any team approach your health unit has in place to engage with school boards.

Question 4. What is the name of your health unit?

- This information is being requested for tracking and mapping purposes.

Question 5. What are the names of the school boards in your area?

- This information will be used to visually represent on maps the complexity of linkages between health units and school boards across Ontario

Part 2: Determining the Types of Partnership between your Health Unit and School Boards

Your responses below will help us to better understand the current partnership landscape in regards to health promotion and prevention, beyond legislated health services. Please familiarize yourself, first, with the different types of partnership between health units and school boards along the collaboration continuum as presented in the following table (Please see Sections I and II in the Appendix for further explanation and references).

Table 1. Partnership Types along the Collaboration Continuum

Type	Brief Description
Awareness	Minimal information exchange, limited to school board awareness of the health unit's health promotion and prevention initiatives beyond legislated health services (i.e., sharing of information only)
Networking	Mutually beneficial information exchange regarding the health unit's activities, in particular health promotion and prevention initiatives, and the school board's policies, programs and initiatives [but does not involve any requirements related to shared resources and activities yet] (i.e., sharing of information only)
Cooperative	Mutually beneficial information exchange with a greater focus on a common goal, through explicit recognition of mutual interests, where the health unit and the school board assist one another by providing to each other resource material and expertise, aligning activities, and/or coordinating initiatives for health promotion and prevention [but does not involve policy development or formal planning] (i.e., sharing of information and resources/activities)
Collaborative	It is the same as for cooperating, and includes the following: joint influence on policy development and/or formal planning (e.g., strategic and multi-year plans) by the health unit and the school board through a shared goal, toward the Healthy School/Comprehensive School Health approach, and may also involve shared staff, pooled funding as well as joint school needs assessments and progress monitoring with shared indicators of success (i.e., sharing of information, resources/activities, and decision making influence)

Question 1. How many of your school boards correspond to each partnership type described above, with respect to health promotion and prevention, other than legislated health services?

- If more than one type is experienced with the same school board for different administrative levels, or for different health-related topics (excluding legislated health services such as immunization and dental health), please assign the type that is furthest along the collaboration continuum to that school board so that it is only counted once.

Type:	No. of School Boards per Type:
Awareness:	_____
Networking:	_____
Cooperative:	_____
Collaborative:	_____

Please note: Even though your health unit may not have experienced all these types of partnership yet, you may still have feedback to contribute about challenges and possibilities for moving forward that could be worthwhile to further explore. Therefore, your feedback would be equally valuable in each part of the survey.

Part 3: Providing Feedback about Sharing Information with School Boards to Discover Mutual Interests

Question 1. In general, what is your health unit's level of satisfaction with the extent to which *information-sharing* opportunities with school boards were mutually beneficial, especially in terms of recognizing *mutual interests* beyond legislated health services (Please see Section I in the Appendix)?

- Please respond according to your position listed below. You may check mark more than one box, if your health unit has had different kinds of experiences with different school boards, generally speaking.

	Not Satisfied	Slightly Satisfied	Moderately Satisfied	Mostly Satisfied	Completely Satisfied	Not Applicable
Director	☐	☐	☐	☐	☐	☐
Manager(s)	☐	☐	☐	☐	☐	☐
Liaison Staff (Coordinator for School Board(s))	☐	☐	☐	☐	☐	☐
Program Staff	☐	☐	☐	☐	☐	☐

Question 2. In reflecting further on your responses above, please answer the following questions:

a. What were the contributing factors that helped information sharing opportunities be mutually beneficial and uncover mutual interests to the extent that was experienced? Please provide brief examples that truly represent your own experiences.

- (Ideas to help you reflect: links to priorities; health promotion as basis for improved academic outcomes; shared vision; frameworks for common language and stronger connection; champion; Parent Involvement Committee; community partners; evidence of effectiveness; use of needs and strengths assessments; sense of mutual support; and/or other)

Box for Director (if applicable)

Box for Manager(s) (if applicable)

Box for Liaison Staff (if applicable)

Box for Program Staff (if applicable)

b. What challenges did your health unit have in sharing information in order to discover mutual interests? Please provide brief examples that truly represent your own experiences.

- (Ideas to help you reflect: feasibility concerns; capacity issues; lack of data; limited time; lack of familiarity or receptivity in the Healthy School/Comprehensive School Health approach; geographical distances; high personnel turnover; more professional development required; jurisdictional tensions/turf sensitivities; and/or other)

Box for Director (if applicable)

Box for Manager(s) (if applicable)

Box for Liaison Staff (if applicable)

Box for Program Staff (if applicable)

c. Was your health unit able to address these challenges?

- ☐ Yes
☐ No

i. If yes, how?

ii. If no, what may help to address them?

- (Ideas to help you reflect: leadership at all levels; facilitated workshops; joint conferences; and/or other)

Part 4: Providing Feedback about Sharing Resources and Activities with School Boards

Please refer to the following table when responding to Question 1.

Table 2. Opportunities for Sharing Resources and Activities

Opportunity	Description
A	Holding meetings, or teleconferences, with superintendents and/or other school board contacts to discuss a common goal and be given access to their schools in order to implement your health unit's health promotion and prevention initiatives
B	Your health unit and school board providing resource material and expertise to each other to assist with the implementation of health promotion and prevention initiatives
C	Engaging with school board personnel to align your health unit's health promotion and prevention activities with school board's activities in order to build from them
D	Holding meetings or teleconferences, or establishing a committee, to coordinate your health unit's initiatives in keeping with the Healthy School/Comprehensive School Health approach, especially when more than one health unit, or school board, is involved (may also include other partners)
E	Participating in ongoing verbal or written communication (e.g., telephone calls, emails) about resources and/or activities

Question 1. In general, what is your health unit's level of satisfaction with the following opportunities *to share resources and activities* with school boards regarding health promotion and prevention initiatives, other than legislated health services?

- Instead of check marks, please enter the number of school boards corresponding to a particular level of satisfaction for each opportunity listed below (please scroll to the right of your screen to view all the options). For example, let's say a given health unit has had experiences, generally speaking, with opportunity A where they felt "slightly satisfied" in relation to 2 school boards, and felt "mostly satisfied" in relation to 3 school boards, while this opportunity never presented itself for their remaining 2 school boards. In this situation, this health unit would enter, in row A, the number "2" under "slightly satisfied", "3" under "mostly satisfied" and "2" under "not applicable".

<i>Opportunities to share resources and activities:</i>	Not Satisfied	Slightly Satisfied	Moderately Satisfied	Mostly Satisfied	Completely Satisfied	Not Applicable
A: Common goal and school access						
B: Mutual provision of resources/expertise						
C: Alignment of activities						
D: Coordination of initiatives						
E: Ongoing communication						

Question 2. If you answered “not applicable” to any of these opportunities, what may help further encourage the sharing of resources and activities with respect to health promotion and prevention?

Question 3. In reflecting further on your responses regarding applicable opportunities, please answer the following questions:

a. What were the contributing factors that helped make these opportunities satisfying to the extent that was experienced? Please provide brief examples that truly represent your own experiences.

- (Ideas to help you reflect: familiarity with the comprehensive approach; resource availability; mutually reinforcing activities; recognition of mutual benefits; process facilitator or mediator; conflict management practices; communication processes and protocols in place; school-board coordinator to help access community resources; and/or other)

b. What challenges did your health unit come across that made these opportunities not completely satisfying? Please provide brief examples that truly represent your own experiences.

- (Ideas to help you reflect: competing priorities; lack of resources; conflicting opinions; communication barriers; community partners with isolated missions or action plans; and/or other)

c. Was your health unit able to address these challenges?

- ☐ Yes i. If yes, how?
- ☐ No ii. If no, what may help to address them?

Question 4. Does your health unit know of any instances where your school board(s) helped build capacity for the Healthy School/Comprehensive School Health approach at the school level, in terms of:

	Yes	No
Professional development, or training, for school administrators	☐	☐
Professional development, or training, for teachers or support staff	☐	☐
Release time for teachers or staff to engage in partnership activities	☐	☐
Inter-school events for collective learning of success stories/lessons learned	☐	☐
District-wide workshops for healthy school committees	☐	☐
Other, please specify		

Part 5: Providing Feedback about Sharing Decision-Making Influence with School Boards

Please refer to the following table when responding to Question 1.

Table 3. Opportunities for Sharing Decision-Making Influence

Opportunity	Description
A	Holding meetings, or teleconferences, to jointly plan and implement school-based needs and strengths assessments to help identify the school board's priority health-related issues or topics
B	Holding meetings, or teleconferences, to jointly develop healthy school policies or topic-specific policies
C	Holding meetings, or teleconferences, to jointly develop formal plans (e.g., strategic, multi-year, other) in keeping with the Healthy School/Comprehensive School Health approach
D	Holding meetings, or teleconferences, to jointly develop resources, programs, and/or projects with the school board in keeping with the Healthy School/ Comprehensive School Health approach
E	Engaging with the school board to co-manage and co-deliver programs and services
F	Holding meetings, or teleconferences, to reach agreement on indicators of success and data sharing, and to jointly monitor and evaluate health promotion and prevention initiatives, in keeping with the Healthy School/ Comprehensive School Health approach

Question 1. In general, what is your health unit's level of satisfaction with the following opportunities *to share decision-making influence* with school boards regarding health promotion and prevention initiatives (other than legislated health services)?

- Instead of check marks, please enter the number of school boards corresponding to a particular level of satisfaction for each opportunity listed below (please scroll to the right of your screen to view all the options). For example, let's say a given health unit has had experiences, generally speaking, with opportunity A where they felt "slightly satisfied" in relation to 1 school board, and felt "moderately satisfied", in relation to 2 school boards, while this opportunity never presented itself for their remaining 2 school boards. In this situation, this health unit would enter, in row A, the number "1" under "slightly satisfied", "2" under "moderately satisfied" and "2" under "not applicable".

<i>Opportunities to share decision-making influence:</i>	Not Satisfied	Slightly Satisfied	Moderately Satisfied	Mostly Satisfied	Completely Satisfied	Not Applicable
A: Joint school-based assessments						
B: Joint policy development						
C: Joint planning						
D: Joint development of resources/ activities						
E: Co-management and co-delivery of programs/services						
F: Data sharing, and joint monitoring and evaluation						

Question 2. If you answered “not applicable” to any of these opportunities, what may help encourage the sharing of decision-making influence with respect to health promotion and prevention?

Question 3. In reflecting further on your responses regarding applicable opportunities, please answer the following questions:

a. What were the contributing factors that helped make these opportunities satisfying to the extent that was experienced? Please provide brief examples that truly represent your own experiences.

- (Ideas to help you reflect: shared goal; clearly defined issues; common ground/mutual understanding; flexible and adaptable strategic planning; trust building; a sense of shared responsibility; celebrations of small wins; acceptance of technical expertise for school board policy development; shared measurement system; regular and open communication; content and process experts for technical assistance; blending of organizational cultures; infrastructure support; culture of learning; and/or other)

b. What challenges did your health unit come across that made these opportunities not completely satisfying? Please provide brief examples that truly represent your own experiences.

- (Ideas to help you reflect: low buy-in for the Healthy School/Comprehensive School Health approach; joint policy-making and planning not part of organizational culture; irregular communication; concerns over anticipated loss of autonomy; ongoing need to re-establish trust; training/professional development required; and/or other)

c. Was your health unit able to address these challenges?

- ☐ Yes
- ☐ No

i. If yes, how?

ii. If no, what may help to address them?

Question 4. Does your health unit and any of your school boards share staff to conduct duties related to health promotion and prevention initiatives?

- ☐ Yes
- ☐ No

If yes, please briefly describe the arrangement and specify whether there are any findings indicating that this arrangement has enhanced the collaboration:

Question 5. Does your health unit participate, along with representatives from any of your school boards, in collaborative committees or cross-sector steering committees (or coalitions) whose work involves health promotion and prevention initiatives?

- ☐ Yes
- ☐ No

If yes, please list the name of the committee(s) that have been created, along with their purpose, and the sectors represented:

Part 6: Providing Feedback on the Foundations for a Healthy School

The *Foundations for a Healthy School* document is consistent with the Comprehensive School Health Model by encouraging a comprehensive health promotion approach, which includes prevention.

Question 1. To guide your partnership activities and work with school boards, does your health unit:

	Yes	No
a. Currently use the original version of the Foundations document?	☐	☐
b. Currently use, or intend to use, the new, expanded version of the Foundations document?	☐	☐
c. Currently use the Comprehensive School Health Model (CSH)?	☐	☐
d. Currently use, or intend to use, another model instead of the CSH model please specify:	☐	☐

Question 2. Has there been any interactions between your health unit and school boards to discuss moving forward with partnership activities using, specifically, the new *Foundations for a Healthy School* document?

Yes	No
☐	☐

If yes, please briefly describe how these interactions were initiated and what was agreed.

Question 3. Please indicate your health unit's likelihood of supporting your school boards by offering to work on the following components of the new *Foundations for a Healthy School* with them and their schools (Please see Section III in the Appendix for further explanation)

	Not Likely	Likely	Very Likely	Too soon to tell
Curriculum, teaching and learning	☐	☐	☐	☐
School and classroom leadership	☐	☐	☐	☐
Student engagement	☐	☐	☐	☐
Social and physical environments	☐	☐	☐	☐
Home, school and community partnerships (helping to engage other partners)	☐	☐	☐	☐

Question 4. Please respond to the following questions below, if applicable.

a. How does your health unit use, or intend to use, the new version of the *Foundations for a Healthy School* document? Please provide brief examples, along with the general positions of personnel involved from both sectors.

- (Ideas to help you reflect: to use only for health unit's work plans; to use only with schools but not school boards; to use with school boards only if first demonstrate receptivity/readiness; to create awareness; to justify data sharing and joint assessments and progress monitoring; to engage other partners; to develop policies with school boards; and/or other)

b. In reflecting on your prior experiences, what potential challenges does your health unit foresee might come up in using the new version?

- (Ideas to help you reflect: unclear how to put in place all components; school board's sense of overwhelm; additional frameworks required; uncertainty as to health unit's role in the new version; leadership/capacity requirements; and/or other)

c. What does your health unit think may help mitigate potential challenges?

Part 7. Overall

Question 1. Does your health unit have any written agreements, or Memoranda of Understanding, with any of your school boards?

- ☐ Yes
☐ No

If yes, please identify the type (agreement or MoU), and the purpose (e.g., partnership, program/service-delivery in schools, data-sharing, etc.), including whether it involves legislated health services, health promotion and prevention initiatives, or both, by referring to each relevant school board numerically (e.g., School Board #1; School Board #2; etc.).

Question 2. Would you have any further comments to offer?

Part 8: Permission Request for Potential Follow-up

We appreciate the time that your health unit has taken in providing your valuable feedback.

It would also be of great value if you, as primary survey contact person, could grant permission to be contacted, in the following months, by telephone should there be a need for clarifying certain survey responses in order to help make emerging patterns more evident. This telephone call is not expected to exceed 30 minutes.

	Yes	No
Would it be possible to contact you, or an alternate, for some follow-up questions?	☐	☐

If yes, please provide your contact information or that of an alternative person.

Name:

Telephone:

Email:

Appendix 2G: Survey Questionnaire Appendix

Survey Questionnaire Appendix: Definitions of Concepts and Terms

Section I: Common Health-Related Topics – For All Parts of the Survey

When considering health-related topics of concern to the health and education sectors, there is a broad overlap between the new, expanded version of the *Foundations for a Healthy School* and health units' school health programming (see Table below). For the purpose of this survey, relevant health-related topics are those falling under the category of health promotion and prevention.

Table: Comparing Health-Related Topics of Concern

Category	<i>Foundations for a Healthy School</i> ¹	Health Units' School Health Programming ²
Health promotion and prevention	<i>Healthy Eating</i> <i>Physical Activity</i> <i>Substance Use, Addictions and Related Behaviors:</i> - Tobacco control - Substance misuse <i>Personal safety and injury prevention</i>	- Healthy eating - Physical activity - Smoking/Chew Tobacco - Substance misuse: - Alcohol use - Marijuana use - Drug use (e.g., oxy/painkillers) - School ground safety and injury prevention
	<i>Mental Health:</i> - Mental health promotion - Mental health problems	- Positive Mental Health Promotion - Bullying - Stress/anxiety - Discrimination - Loneliness/sadness - Peer Pressure
	<i>Growth & Development:</i> - Body image - Sexual health (not clearly defined) and human development - Health services (other than legislated services, but not specified)	- Healthy weights (body image) - Sexual health (non-legislated services but some related to reportable conditions): - Birth control - Teen pregnancy - Reproductive health - STI/HIV/AIDS screening - May correspond to human development: - Poverty - Environmental health protection - Other: - Rabies prevention and control
Legislated health services	<i>Growth & Development (continued):</i> - Oral health care - Immunization	- Dental health (Dental Health Act) - Vaccine-preventable diseases (Immunization of School Pupils Act)

References:

1. Government of Ontario. (2014). *Foundations for a Healthy School: Promoting Well-Being is Part of Ontario's Achieving Excellence Vision*. Retrieved from <<http://www.edu.gov.on.ca/eng/healthyschools/resourceF4HS.pdf>>.
2. Thomson, C., & Montagnese, M. (2012). *Survey of Ontario Health Units regarding School Health Programming*. Simcoe-Muskoka District Health Unit

Section II: Adapted Collaboration Continuum Model—For Part Two of the Survey

Partnerships exist along a continuum of increasing levels of engagement, commitment and asset sharing. Various continuum models are presented in the scholarly and grey literature but they cover essentially the same components. From an education-sector perspective, the collaboration continuum model involves four equally important types of partnership arrangements: networking, cooperating, collaborating and integrating (Government of Alberta, 2013; Linkages Committee, 2011). It is analogous to the integration continuum model developed by Ryan & Robinson (2005) in 2002, and adopted by Browne et al. (2004) for service delivery.

As one of the early contributors to the collaboration continuum model, Himmelman (1994, 1996, 2001) described the components of networking, coordination/cooperation, and collaboration as strategies for working together under particular circumstances. The appropriate strategy would depend on the extent to which there is agreement on a common vision and plan of action, and the extent to which time, trust, and turf are enabling conditions—in that, increased trust is related to reduced turf protection. Building on this earlier work, Crosby & Bryson (2005) introduced a continuum of similar components, characterized by a cumulative sharing of organizational assets: information, resources/activities, decision-making influence, and authority (within integrated organizations).

Taking into account the models mentioned above, an adapted collaboration continuum model has been developed to categorize and explain the various types of partnership between health units and school boards found in practice across Ontario (see Table below). These explanations provide reference points for responding to Part 2 of the survey questionnaire.

Table: Collaboration Continuum Model: Adapted to Partnerships between Health Units and School Boards in Ontario

<i>Partnership Type</i>	<i>Description*</i>	<i>Application to Partnerships between School Boards and Health Units</i>
Awareness-raising	Initial exchange of information (i.e., sharing of information only)	School board executives/staff are aware of their health unit's health promotion and prevention initiatives beyond legislated health services. Information exchange is minimal.
Networking	Mutually beneficial exchange of information No fiscal or human resources needed Does not require a high level of trust between partners (i.e., sharing of information only)	Through networking opportunities, school board executives/staff learn of their health unit's activities, including health promotion and prevention initiatives. In turn, the health unit learns of their school board's policies, programs and initiatives.
Cooperating	Mutually beneficial exchange of information and sharing of strategies to achieve common goal May require some resources Requires a higher level of trust than networking, and ability to make decisions (i.e., sharing of information and resources/activities)	School board executives/staff exchange information with their health unit, with a greater focus on a common goal through explicit recognition of mutual interests. School board executives allow their health unit to implement school-level initiatives. This permission may be in the form of a written agreement to confirm their approval and grant access to their schools. School board executives/staff and their health unit provide resource material and expertise to each other, and may start making joint decisions, when aligning activities and coordinating initiatives in support of the Healthy School/Comprehensive School Health approach.
Collaborating	Incorporates previous category and adds shared risks, responsibilities, rewards, and commitment from participating organizations Requires fiscal resources that may be pooled to achieve agreed-upon outcomes Requires high level of trust [and shared decision-making] (i.e., sharing of information, resources/activities, and decision making influence)	While cooperating with one another, school board executives/staff and their health unit also engage in a shared goal by jointly developing policies and/or formal plans in support of the Healthy School/ Comprehensive School Health approach. The school board and their health unit may also share staff (e.g., secondment arrangement) to conduct duties related to the creation of Healthy Schools for <u>enhanced collaboration</u> . Or, some other form of resource pooling may be undertaken in regards to program funding and data sharing for joint school needs assessment and progress monitoring (including shared indicators of success).

* Adapted from Himmelman, 2001

References

- Browne, G., Roberts, J., Gafni, A., Byrne, C., Kertyzia, & J., Loney, P. (2004). Conceptualizing and validating the human services integration measure. *International Journal of Integrated Care* [serial online], 4. Retrieved December 23, 2014 from <<http://www.ijic.org/>>.
- Crosby, B., C., & Bryson, J., M. (2005). *Leadership for the Common Good: Tackling Public Problems in a Shared-Power World*, second edition. San Francisco, CA: John Wiley & Sons, Inc.
- Government of Alberta. (2003). Working Together: Collaborative Practices and Partnership Toolkit. Edmonton, Alta: Alberta Education. Retrieved January 22, 2015 from <<http://education.alberta.ca/media/6877700/working-together-toolkit.pdf>>.
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- Ryan, B., & Robinson, R. (2005). *Service Integration in Ontario: Critical Insights from the Service Community*. NG337:i-E-7. Retrieved January 2, 2015 from <<http://www.rrdssab.ca/files/serviceintegrationreport.pdf>>.

Section III: Opportunities for Sharing Resources and Activities – For Part 4 of the Survey

Opportunities	Description
A	Holding meetings, or teleconferences, with superintendents and/or other school board contacts to discuss a common goal and receive approval to have access to their schools in order to implement your health unit's health promotion and prevention initiatives
B	Your health unit and school board providing resource material and expertise to each other to assist with the implementation of health promotion and prevention initiatives
C	Engaging with school board personnel to align your health unit's health promotion and prevention activities with school board's activities in order to build from them
D	Holding meetings or teleconferences, or establishing a committee, to coordinate your health unit's initiatives in support of the Healthy School/Comprehensive School Health approach, especially when more than one health unit, or school board, is involved (may also include other partners)
E	Participating in ongoing verbal or written communication (e.g., telephone calls, emails) about resources and/or activities

Section IV: Opportunities for Sharing Decision-Making Influence – For Part 5 of the Survey

Opportunities	Description
A	Holding meetings, or teleconferences, to jointly plan and implement school-based needs and strengths assessments to help identify the school board's priority health-related issues or topics
B	Holding meetings, or teleconferences, to jointly develop healthy school policy or topic-specific policies
C	Holding meetings, or teleconferences, to jointly develop formal plans (e.g., board improvement, strategic, multi-year, other) in support of the Healthy School/Comprehensive School Health approach
D	Holding meetings, or teleconferences, to jointly develop resources, programs, and projects with the school board in support of the Healthy School/ Comprehensive School Health approach
E	Engaging with the school board to co-manage and co-deliver programs and services
F	Holding meetings, or teleconferences, to reach agreement on indicators of success and data sharing, and to jointly monitor and evaluate health promotion and prevention initiatives, in support of the Healthy School/ Comprehensive School Health approach

Section V: The *Foundations for a Healthy School Framework* – For Part 6 of the Survey

Well-functioning cross-sector partnerships usually take their guidance from a comprehensive yet simple and flexible strategic framework that is based on a shared goal and conceived at the top leadership level.¹ Having been jointly introduced by Ontario's ministries of education and health,² the original *Foundations for a Healthy School framework* provided such a high-level strategic framework, with its four strategic areas guiding operational (practice-level) activities across both sectors.

The expanded version of the *Foundations for a Healthy School* is intended as a companion resource to the *K-12 School Effectiveness Framework*.³ This companion resource still appears to be a high-level strategic tool, since four of its five strategic areas form the components of the *School Effectiveness Framework*.⁴ The Framework is operationalizing the *Foundations of a Healthy School* at the practice level by serving as a school needs assessment

resource to “inform instructional practice, programming and professional learning (p. 5)” for both school boards and schools.⁴

From a strategic perspective, the newly revised *Foundations for a Healthy School* has been designed “to help contribute to a learning environment that promotes and supports child and student well-being—one of the four core goals in Ontario’s renewed vision for education (p. 2).”³ Since this goal is equally shared by public health, the new Foundations document may be instrumental in forging partnerships between school boards and health units, in terms of promoting healthy schools and developing a coordinated approach, as stated below.

“The *Foundations for a Healthy School* resource has been updated to support the integration of healthy schools policies, programs and initiatives into school and school board planning and implementation processes.” (p. 3)

It “supports the development of a coordinated approach (...) [for] identifying, planning, implementing, evaluating and celebrating healthy schools policies, programs, and initiatives.” (p. 7).

The new *Foundations for a Healthy School* is guiding the development of policies, programs, and initiatives at both school board and school levels. It consists of a multi-pronged, interconnected approach to addressing health within the local school context, with its strategic areas fully described at <http://www.edu.gov.on.ca/eng/healthyschools/resourceF4HS.pdf> and summarized as follows:

- *Curriculum, Teaching and Learning*: Formal curriculum programs and informal learning opportunities for students to lead healthy, active lives, supported by teaching/learning strategies, resources, and assessment/evaluation practices, and by professional learning opportunities for teachers and staff.
- *School and Classroom Leadership*: Creation of a positive classroom and school environment by integrating healthy school policies and programs into school improvement planning processes, including policy monitoring and data collection to identify priority areas and related programming that is responsive to student needs.
- *Student Engagement*: Opportunities for students to be empowered as active contributors not only to their own learning and well-being, but also to the development and implementation of policies, programs and initiatives at school and in the broader community.
- *Social and Physical Environments*: Support for the development and maintenance of positive relationships and for appropriate material and equipment on school premises in order to promote the positive cognitive, emotional, social and physical development of students.
- *Home, School and Community Partnerships*: Coordination of available services, expertise and resources through the engagement of parents, school staff, school/student councils, school boards, family support programs, public health units, and other community groups.

References:

1. Hanleybrown, F., Kania, J., & Kramer, M. (2012). Channeling change: making collective impact work. *Stanford Social Innovation Review*, January: 1-8.
2. Ministry of Health Promotion. (2010). *School Health: Guidance Document*, p. 11. Retrieved from <http://www.mhp.gov.on.ca/en/healthy-communities/public-health/guidance-docs/SchoolHealth.pdf>
3. Government of Ontario. (2014). *Foundations for a Healthy School: Promoting Well-Being is Part of Ontario’s Achieving Excellence Vision*. Retrieved from <http://www.edu.gov.on.ca/eng/healthyschools/resourceF4HS.pdf>.
4. Ontario Ministry of Education. (2013). *K-12 School Effectiveness Framework: A support for school improvement and student success*. Retrieved from <http://www.edu.gov.on.ca/eng/literacynumeracy/SEF2013.pdf>.

Appendix 2H: Interview Guide Template for Survey Follow-Up Questions

Interview Guide

Part 1: Partnership Opportunities and Corresponding Levels of Engagement

To put together a more accurate description of the collaboration continuum, your health unit is being asked to consider the following statements for further reflection. For each set of statements mentioned below, please identify which level(s) of engagement relate(s) to your partnership experiences with one or more of your school boards. Given that your health unit may experience different engagement levels with different school boards, or even within the same school board at different time periods and for different areas of work, more than one statement would likely apply for each task.

In the interest of time, please take a moment prior to the interview, if possible, and circle the number appearing next to the statements that apply to your health unit. Also, place a check mark next to the statements that do not apply to at least one school board and that you wish could one day become part of your partnership experiences with school boards. At the interview, you will be asked to provide the numbers only, as well as any comments you would like to make for greater clarity. Your responses will indicate possible engagement levels: how health units and school boards are currently engaging with each other, and what are health units' aspirations for further engagement.

Task 1. Policy Development

1.1	Your school board and your health unit make decisions together on health-related policies throughout the development process
1.2	Your school board invites your health unit to provide policy input and takes into account your information/recommendations when examining policy choices and deciding on a course of action
1.3	Your school board asks your health unit for feedback on a draft of their health-related policy to check for completeness and alignment with best practices and current evidence
1.4	Your health unit reaches out to your school board to provide input on their health-related policies
1.5	Your health unit provides health-related information to your school board in order to assist them in understanding health-related issues and possible ways of addressing these issues through policy work
1.6	Your school board develops their health-related policies on their own
1.7	Other

Task 2. Strategic Planning for Health Promotion in Schools

2.1	Your health unit and school board come together for <i>joint</i> strategic planning, or make use of a <i>common</i> strategy, or model (dual ownership), for health promotion in schools
2.2	Your health unit formally invites* your school board's input on setting strategic direction and takes into account their interests/strategic priorities when developing <i>your</i> multi-year plan, or strategic priorities, related to health promotion to help create synergies or meet a need (with possibility of annual feedback to reassess priorities)
2.3	Your school board formally invites your health unit's input on setting strategic direction and takes into account your identified priorities and/or knowledge of emerging health-related issues when developing <i>their</i> multi-year plan, or strategic priorities, related to health promotion to help create synergies or meet a need (with possibility of annual feedback to reassess priorities)
2.4	Your health unit asks your school board for feedback on your newly developed multi-year plan, or strategic priorities, so that their interests or concerns may be acknowledged
2.5	Your school board asks your health unit for feedback on their newly developed multi-year plan, or strategic priorities, so that your interests or concerns may be acknowledged
2.6	Your health unit informally finds out about your school board's priorities or needs, and adjusts your multi-year plan, or strategic priorities, in response
2.7	Your health unit provides health-related information to assist your school board in developing their multi-year plan or strategic priorities
2.8	Your school board provides health-related student data to assist your health unit in developing your multi-year plan or strategic priorities
2.9	Your health unit develops your multi-year plan or sets your strategic priorities on your own, not knowing about your school board's plans/priorities
2.10	Your school board develops their multi-year plan or sets their strategic priorities in areas related to student well-being/health promotion on their own, not knowing about your health unit's plans/priorities
2.11	Other

* "formally invites": i.e., structured process for gathering stakeholders' input (e.g., online survey, facilitated workshop, scheduled meeting for that very purpose)

Task 3. Operational Planning: Development of Health Promotion Initiatives* (generic term referring to resources, projects, programs and/or services)

— please indicate if these initiatives include the Healthy School approach: Yes No

3.1	Your health unit and school board develop a <i>joint</i> initiative (dual ownership) which may require, from each other, different but mutually reinforcing activities
3.2	Your health unit formally invites your school board to express their views on what is important to them and takes into account their needs/interests when developing <i>your</i> initiative, to ensure that all aligns well
3.3	Your school board formally invites your health unit to express your views on what is important to you and takes into account your needs/interests when developing <i>their</i> initiative, to ensure that all aligns well
3.4	Your health unit asks your school board for feedback/approval on initiatives that your health unit has developed so that their interests or concerns may be acknowledged
3.5	Your school board asks your health unit for feedback on initiatives that your school board has developed so that your interests or concerns may be acknowledged
3.6	Your health unit informally finds out about your school board's priorities or needs and develops activities/initiatives, or provides already developed resources/programs/services in response
3.7	Your health unit provides health-related information to your school board to assist them with understanding health-related issues and possible ways of addressing these issues through health promotion initiatives
3.8	Your health unit develops your initiatives on your own, without going through your school board, and offers them directly to schools, not knowing of available resources that could be shared
3.9	Your school board develops their initiatives on their own, not knowing about available resources that could be shared (e.g., evidence of best practices, connections with potential partners)
3.10	Other

* Please note that priorities may also relate to ongoing curriculum requirements

Task 4. Implementation Consideration Specific to the Healthy School/Comprehensive School Health Approach

4.1.	Your school board is empowered to lead their schools in using the Healthy Schools process,* with your health unit's resource support and coordination assistance
4.2.	Your health unit and your school board coordinate together the Healthy Schools process, with your school board providing leadership to encourage its use by schools
4.3	Your health unit and your school board make decisions together about how to facilitate the use of the Healthy Schools process by schools
4.4	Your health unit formally invites your school board's input on the Healthy School approach and takes into account their interests and concerns when deciding on how to facilitate the use of the Healthy Schools process by schools
4.5	Your school board formally invites your health unit's input on the Healthy School approach and takes into account your interests and concerns when deciding on how to facilitate the use of the Healthy Schools process by schools
4.6	Your health unit asks your school board for feedback/approval on your newly developed plans to facilitate the use of the Healthy Schools process in receptive schools to acknowledge their interests or concerns
4.7	Your school board asks your health unit for advice on how they can facilitate the use of the Healthy Schools process in receptive schools to benefit from your school-based experiences
4.8	Your health unit provides information to your school board about the Healthy Schools process to encourage their buy-in
4.9	Other

* "Healthy Schools process steps": i.e., Healthy School team, assessments, prioritizing, action planning, monitoring and celebration, along with the Foundations for a Healthy School components

Appendix 2I: Information Sheet for Attending Meetings of the Ontario School Health Management in Public Health Network



uOttawa

L'Université canadienne
Canada's university

Université d'Ottawa

Faculté des sciences de
la santé

Programme de doctorat
en santé des
populations

University of Ottawa

Faculty of Health
Sciences

PhD in Population
Health Program

Information Sheet for Meeting Observation

Title of Thesis Project: Collaborative Governance for Healthy Public Policies: Exploring Partnerships across the Health and Education Sectors in Ontario

Principal Researcher:

Joanne de Montigny, B.Sc. (Hon.), MHA, PhD(c)

University of Ottawa

Thesis Director:

Louise Bouchard, PhD, Professor

University of Ottawa

Purpose: This letter is to advise you of my presence during your meetings to collect observation notes for the abovementioned study as part of my PhD thesis project at the University of Ottawa. These meetings will be audio-recorded (but not transcribed) for the purpose of reflecting further on the proceedings after the meeting has taken place. My note taking will enable me to gain a deeper understanding of your field of practice, which will facilitate the data interpretation stage.

This project is funded by the Canadian Institutes of Health Research and administered through the Quebec Population Health Research Network's Training Program in Transdisciplinary Research on Public Health Interventions.

Research Goal and Objectives: The goal of the proposed doctoral research project is to generate knowledge on partnership development across the health and education sectors and to discover the potential for collaborating on the creation of healthy schools in Ontario. Research objectives are as follows:

- (1) to gain a better understanding of the different stages of partnerships between health units and school boards across Ontario, particularly in relation to health promotion initiatives (including prevention beyond legislated health services);
- (2) to identify the enabling and hindering factors and improvements experienced in these cross-sector partnerships for health promotion;
- (3) to shed light on the extent to which cross-sector partnerships are being guided by the *Foundations for a Healthy School Framework*;
- (4) to document the way in which the *Foundations for a Healthy School Framework* has been produced and disseminated; and
- (5) to articulate recommended features of a formal partnership agreement between health units and school boards for consideration by the joint committee of Directors of Education and Medical Officers of Health.

Confidentiality and Anonymity: Any information on your identity, such as your name or position, will be kept confidential. Furthermore, no direct quotes arising from meeting discussions and no paraphrased comments that may or may not be attributed to you will be used in the thesis report.

Conservation of data: The data collected from tape recordings and observation notes will be kept in a locked filing cabinet in the office of my Thesis Director, Professor Louise Bouchard, at the University of Ottawa, for a period of 5 years at which time they will be destroyed.

Requests:

If you have any questions about the research project or any concerns about the observation of meetings, please contact Joanne de Montigny directly so that you may discuss how to accommodate your preferences.

If you have any concerns or questions regarding the ethical conduct of this research project, you may contact the Protocol Officer for Ethics in Research at the following address:

Office of Research Ethics and Integrity
Tabaret Hall, University of Ottawa
550 Cumberland Street, Room 154, Ottawa, ON K1N 6N8
Tel.: 613-562-5800 Email: ethics@uottawa.ca

Please keep this information sheet for your records.

Joanne de Montigny, PhD(c)
February 18, 2015

APPENDIX SECTION 3:

Recruitment and Data Collection Material for Phase 2

Appendix 3A: List of School Boards in Ontario

I. English-speaking Public School System—33 School Boards

Algoma District School Board – Sault Ste Marie, ON
Avon Maitland District School Board – Seaforth, ON
Bluewater District School Board – Chesley, ON
District School Board of Niagara – St Catharines, ON
District School Board Ontario North East – Timmins, ON
Durham District School Board – Whitby, ON
Grand Erie District School Board – Brantford, ON
Greater Essex County District School Board – Windsor, ON
Halton District School Board – Burlington, ON
Hamilton-Wentworth District School Board – Hamilton, ON
Hastings & Prince Edward District School Board – Belleville, ON
James Bay Lowlands Secondary School Board – Moosonee, ON
Kawartha Pine Ridge District School Board – Peterborough, ON
Keewatin-Patricia District School Board – Kenora, ON
Lakehead District School Board – Thunder Bay, ON
Lambton Kent District School Board – Sarnia, ON
Limestone District School Board – Kingston, ON
Moosonee District School Area Board – Moosonee, ON
Near North District School Board – North Bay, ON
Ottawa-Carleton District School Board – Nepean, ON
Peel District School Board – Mississauga, ON
Rainbow District School Board – Sudbury, ON
Rainy River District School Board – Fort Frances, ON
Renfrew County District School Board – Pembroke, ON
Simcoe County District School Board – Midhurst, ON
Superior-Greenstone District School Board – Marathon, ON
Thames Valley District School Board – London, ON
Toronto District School Board – Toronto, ON
Trillium Lakelands District School Board – Lindsay, ON
Upper Canada District School Board – Brockville, ON
Upper Grand District School Board – Guelph, ON
Waterloo Region District School Board – Kitchener, ON
York Region District School Board – Aurora, ON

II. English-speaking Catholic School System—29 School Boards

Algonquin and Lakeshore Catholic District School Board – Napanee, ON
Brant Haldimand Norfolk Catholic District School Board – Brantford, ON
Bruce-Grey Catholic District School Board – Hanover, ON
Catholic District School Board of Eastern Ontario – Kemptville, ON
Dufferin-Peel Catholic District School Board – Mississauga, ON
Durham Catholic District School Board – Oshawa, ON
Halton Catholic District School Board – Burlington, ON
Hamilton-Wentworth Catholic District School Board – Hamilton, ON
Huron-Superior Catholic District School Board – Sault Ste Marie, ON
Huron Perth Catholic District School Board – Dublin, ON

Kenora Catholic District School Board – Kenora, ON
London District Catholic School Board – London, ON
Niagara Catholic District School Board – Welland, ON
Nipissing-Parry Sound Catholic District School Board – North Bay, ON
Northeastern Catholic District School Board – Timmins, ON
Northwest Catholic District School Board – Fort Frances, ON
Ottawa Catholic District School Board – Nepean, ON
Peterborough Victoria Northumberland and Clarington Catholic District School Board – Peterborough, ON
Renfrew County Catholic District School Board – Pembroke, ON
Simcoe Muskoka Catholic District School Board – Barrie, ON
St Clair Catholic District School Board – Wallaceburg, ON
Sudbury Catholic District School Board – Sudbury, ON
Superior North Catholic District School Board – Terrace Bay, ON
Thunder Bay Catholic District School Board – Thunder Bay, ON
Toronto Catholic District School Board – Toronto, ON
Waterloo Catholic District School Board – Kitchener, ON
Wellington Catholic District School Board – Guelph, ON
Windsor-Essex Catholic District School Board – Windsor, ON
York Catholic District School Board – Aurora, ON

III. French-speaking Public School System—4 School Boards

Conseil des écoles publiques de l'Est de l'Ontario – Ottawa, ON
Conseil scolaire Viamonde – North York, ON
Conseil scolaire de district du Grand Nord de l'Ontario – Sudbury, ON
Conseil scolaire de district du Nord-Est de l'Ontario – North Bay, ON

VI. French-speaking Catholic School System—8 School Boards

Conseil scolaire de district catholique Centre-Sud– Toronto, ON
Conseil scolaire de district catholique de l'Est Ontarien – L'Orignal, ON
Conseil des écoles catholiques de langue française du Centre-Est – Gloucester, ON
Conseil scolaire catholique Providence – Windsor, ON
Conseil scolaire catholique du Nouvel-Ontario – Sudbury, ON
Conseil scolaire catholique Franco-Nord – North Bay, ON
Conseil scolaire catholique de district des Grandes Rivières –Timmins, ON
Conseil scolaire de district catholique des Aurores boréales – Thunder Bay, ON

VII. Separate School System

The Protestant Separate School Board of the Town of Penetanguishene

Appendix 3B: Invitation letter, along with Information Sheet, to School Boards in Both Official Languages



Université d'Ottawa
Faculté des sciences de la
santé

Programme de doctorat en
santé des populations

University of Ottawa
Faculty of Health
Sciences

PhD in Population Health
Program

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1 Stewart Street, Room 231
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Tel.: 613.562.5660
Fax: 613.562.5423
Email : pop@uOttawa.ca

June 28, 2016

Dear Directors of Education:

My thesis director and I would like to extend an invitation to you, or your designate, to participate in my doctoral thesis project this summer.

With the endorsement of the CODE-COMOH Committee last year, I embarked on a participatory research project with all 36 public health units in Ontario. The purpose of this research is to support the Committee's initiative to help foster strong partnerships between school boards and boards of health.

A number of insights have been drawn from public health units' partnership experiences with their school boards regarding health promotion in schools. However, this research would remain incomplete without the input of Directors of Education, or their designate.

Your participation would contribute valuable knowledge about the current situation with cross-sector partnerships for student well-being. Given resource constraints, we would need to limit the number of participants. I am therefore in search of a representative set of Directors of Education (or their designate) to provide their perspectives: 7 from the English public system, 7 from the English Catholic system, 2 from the French Catholic system and 1 from the French public system.

Participation in this research would consist of a 45 to 60-minute telephone interview, to be held at a convenient time during the month of August 2016. This research phase aims to gain a deeper understanding of school boards' challenges, expectations, breakthroughs and/or successes related to their engagement with public health units for the promotion of student well-being. Participants will have the opportunity to review their confidential interview transcripts and make revisions as they best see fit.

Please let me know if you would like to accept this research invitation by contacting me at jdemo096@uottawa.ca and I will notify you of the recruitment results.

The research report will be describing a partnership model for student well-being that is meant to guide and inspire the development of partnerships across the health and education sectors in Ontario. I hope that all of you will be interested in examining this research report when completed, and that you will find it of practical use.

Yours sincerely,

Title of Thesis Project: Exploring Partnerships across the Health and Education Sectors in Ontario

Principal Researcher:

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Institute of Population Health, University of Ottawa

Thesis Director:

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Introduction

Ontario's renewed vision for student achievement encompasses health and well-being so that every school-age child has a better chance of reaching his or her full potential.¹ This vision reflects the undeniable interdependence between the education and health sectors. Promoting health improves academic performance.²⁻¹¹ Succeeding in school, in turn, contributes to enhanced life management skills and a favorable socioeconomic status in adulthood, both of which may lead to better health outcomes.¹²⁻¹⁴

Joanne de Montigny, PhD candidate in Population Health at the University of Ottawa, has initiated a doctoral thesis project that seeks to understand how and to what extent the health and education sectors are working together toward Ontario's broader vision for student achievement. Her research is being funded by the Canadian Institutes of Health Research through the Transdisciplinary Research Program on Public Health Interventions, administered by the Quebec Population Health Research Network.

Research Plan

The goal of the doctoral thesis project is to generate knowledge on partnership development across the health and education sectors and to shed light on the potential for collaborating toward the creation of healthy schools in Ontario. Its purpose is to inform and complement the Council of Ontario Directors of Education and the Council of Ontario Medical Officers of Health (CODE-COMOH) Committee's initiative to help foster strong partnerships between school boards and boards of health. Research objectives are as follows:

- (1) to determine the different types of partnership engagement between health units and school boards across Ontario, specifically in relation to health promotion and prevention initiatives beyond legislated health services;
- (2) to identify the enabling and hindering factors experienced in these cross-sector partnerships as well as possibilities for improvement;

- (3) to examine the extent to which these cross-sector partnerships are utilizing the *Foundations for a Healthy School* document for guidance; and
- (4) to articulate recommendations to help guide and inspire efforts to strengthen cross-sector partnerships for boards of health's and school boards' consideration.

The research design follows a participatory research methodology that is predominantly qualitative in nature, so that research findings could be of practical value to knowledge users. The participatory research process is being guided by Dr. Jonathan Salsberg, Associate Director at the centre for Participatory Research at McGill University (PRAM), who is a member of the doctoral thesis committee. This thesis project has two main phases. Phase 1 relates to the health sector in Ontario. Given this thesis project's participatory approach, a Research Steering Committee of 10 School Health Managers has been established for this initial phase to engage in (1) the co-development of data-collection tools at the health-unit level, (2) data interpretation, and (3) the formulation of recommendations. Personnel from all 36 health units in Ontario, who interact directly with school board representatives, are among the study participants. The data that have been collected through an online survey questionnaire are currently being supplemented by follow-up interviews for a richer understanding of partnership experiences. Each participant is being given the opportunity to review their confidential interview transcripts to ensure accuracy and completeness.

Phase 2 involves Ontario's education sector. Including the perspective of school board personnel is critical for a thorough understanding of the challenges, expectations, breakthroughs and/or successes that inform partnership considerations between the two sectors. The study population consists of school board personnel who have views to share about their partnerships with their local public health unit for the promotion of student well-being. Due to the larger number of school boards, quota sampling will be undertaken with respect to school-board type and regional location. The sampling frame of Directors of Education (or their designate) would be as follows: 7 from the English public system, 7 from the English Catholic system, 2 from the French Catholic system and 1 from the French public system. After consultation with representatives from the education sector, participation in this research via telephone interviews was deemed to be the most appropriate direction to take. Interviews will be held during the month of August, 2016, at a convenient time for each participant. These participants will also have the opportunity to review their confidential interview transcripts and make revisions as they wish.

Expected Results

A final report of main research findings, including recommendations, will be disseminated to all study participants and the CODE-COMOH committee to use as they best see fit. These findings are expected to illustrate in what ways cross-sector partnerships are taking place, highlight areas of partnership development that require further attention, and uncover approaches for enriching the partnership engagement process. Recommendations arising from this knowledge may help to strengthen cross-sector partnerships for greater success with the implementation of health promotion initiatives within schools.

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Le 28 juin, 2016

Chers directeurs et directrices de l'éducation:

Ma directrice de thèse et moi aimerions lancer une invitation à vous, ou votre délégué, à participer à mon projet de thèse de doctorat cet été.

L'an dernier, mon projet a reçu l'approbation du Comité du Conseil ontarien des directrices et directeurs de l'éducation/Conseil des médecins-hygiénistes de l'Ontario (Comité). La première phase de ce projet s'agit d'une recherche participative avec tous les 36 unités de santé publique en Ontario. Le but de cette recherche est de soutenir l'initiative du Comité pour aider à favoriser les partenariats forts entre les conseils scolaires et les conseils de santé.

De grands aperçus ont été retirés à partir des expériences de partenariat des bureaux de santé publique auprès de leurs conseils scolaires concernant la promotion de la santé dans les écoles. Cependant, cette recherche serait incomplète sans l'apport des directeurs et directrice de l'éducation, ou leur délégué.

Votre participation contribuera de précieuses connaissances sur la situation actuelle des partenariats intersectoriels pour le bien-être des étudiants. Compte tenu des contraintes de ressources, nous aurons besoin de limiter le nombre de participants. Je suis donc à la recherche d'un ensemble représentatif de directeurs et directrices de l'éducation (ou leur délégué) pour fournir leurs points de vue: 7 du système public anglais, 7 du système catholique anglais, 2 du système catholique français et 1 du système public français.

La participation à cette recherche consistera en une entrevue téléphonique de 45 à 60 minutes, qui se tiendra à un moment opportun durant le mois d'Août 2016. Cette deuxième phase de recherche vise à acquérir une meilleure compréhension des défis des conseils scolaires, leurs attentes, leurs percées et / ou leurs succès liés à leur engagement avec les bureaux de santé publique pour la promotion du bien-être auprès des étudiants. Les participants auront l'occasion d'examiner leurs transcriptions d'entretiens confidentiels et faire des révisions comme ils le jugeront à propos.

S'il vous plaît laissez-moi savoir si vous voulez accepter cette invitation de recherche en me contactant au jdemo096@uottawa.ca et je vous informerai des résultats de recrutement.

Le rapport de recherche servira à décrire un modèle de partenariat pour le bien-être des étudiants, qui sera destiné à guider et inspirer le développement de partenariats entre les secteurs de la santé et de l'éducation en Ontario. J'espère que vous serez tous intéressés à examiner ce rapport de recherche une fois terminé, et que vous allez trouver une utilité pratique.

Cordialement,

Projet de thèse : Exploration des partenariats entre les secteurs de la santé et de l'éducation en Ontario

Chercheuse principale:

Joanne de Montigny, Étudiante au doctorat
Institut de recherche sur la santé des populations
Université d'Ottawa

Directrice de thèse:

Louise Bouchard, PhD, Professeure
Institut de recherche sur la santé des populations
Université d'Ottawa

Introduction

La vision renouvelée de l'Ontario pour la réussite des élèves englobe la santé et le bien-être afin que chaque enfant d'âge scolaire ait une meilleure chance d'atteindre son plein potentiel.¹ Cette vision reflète l'interdépendance indéniable entre les secteurs de l'éducation et de la santé. La promotion de la santé améliore le rendement scolaire des élèves.²⁻¹¹ Réussir à l'école, à son tour, contribue à l'amélioration des compétences de gestion de vie et à un statut socio-économique favorable à l'âge adulte, ce qui peut conduire à des meilleurs résultats de santé.¹²⁻¹⁴

Joanne de Montigny, candidate au doctorat en santé des populations de l'Université d'Ottawa et stagiaire à l'Agence de la santé publique du Canada, a entrepris un projet de thèse de doctorat qui cherche à comprendre comment et dans quelle mesure les secteurs de la santé et de l'éducation travaillent ensemble vers une vision élargie de la réussite des élèves en Ontario. Ce projet de thèse est financé par les Instituts de recherche en santé du Canada par le biais du Réseau de recherche en santé des populations du Québec, et son programme en recherche transdisciplinaire sur les interventions de santé publique.

Plan de recherche

Le but du projet de recherche doctorale proposée est de générer des connaissances sur le développement des partenariats entre les secteurs de la santé et de l'éducation et de mettre en valeur le potentiel de la collaboration pour la création d'écoles saines en Ontario. Ce projet vise à informer et à compléter l'initiative du Comité du Conseil ontarien des directrices et directeurs de l'éducation/Conseil des médecins-hygiénistes de l'Ontario (CODDE/CoMHO) pour favoriser des partenariats solides entre les conseils scolaires et les conseils de santé. Les objectifs de recherche sont les suivants:

- (1) déterminer les différentes modalités de partenariats entre les bureaux de santé et les conseils scolaires de l'Ontario, spécifiquement en ce qui concerne la promotion de la santé et les initiatives de prévention au-delà des services de santé prévus par la loi;
- (2) identifier les facteurs favorables et défavorables au développement de ces partenariats intersectoriels pour la promotion de la santé ainsi que les améliorations possibles;
- (3) examiner la façon dont ces partenariats intersectoriels s'appuient sur le document d'orientation *Fondements d'une école saine*;
- (4) articuler des recommandations qui contribuent à orienter et inspirer les efforts visant à renforcer les partenariats intersectoriels des conseils de santé et des conseils scolaires.

La conception de la recherche suit une méthodologie de recherche participative qui est principalement de nature qualitative, de sorte que les résultats de la recherche aient une valeur pratique pour les utilisateurs des connaissances. Le processus de recherche participative est guidé par Professeur Jonathan Salsberg, directeur associé du Centre pour la recherche participative à l'Université McGill, qui est membre du comité de thèse de doctorat. Ce projet de thèse a deux phases principales. La phase 1 concerne le secteur de la santé en Ontario. Compte tenu de l'approche participative de ce projet de thèse, un comité directeur de la recherche de 10 gestionnaires de la santé en milieu scolaire a été établi pour cette phase initiale afin (1) de co-développer les outils de collecte de données auprès des bureaux de santé, (2) d'interpréter les données et (3) de formuler des recommandations. Les participants à cette étude incluent le personnel des 36 bureaux de santé, qui interagissent directement avec des représentants des conseils scolaires. La collecte de données a consisté d'un questionnaire d'enquête en ligne auprès des bureaux de santé. Des entretiens de suivi sont maintenant menés pour une meilleure compréhension des expériences de partenariat. Tous les participants sont offerts la possibilité de revoir leurs transcriptions d'entretiens confidentiels afin d'assurer l'exactitude et l'exhaustivité.

La phase 2 portera sur le secteur de l'éducation de l'Ontario. Tenir compte du point de vue du personnel des conseils scolaires est essentielle pour une compréhension approfondie des défis, des attentes, des percées et / ou des réussites qui renseignent les considérations de partenariat entre les deux secteurs. La population étudiée se compose du personnel des conseils scolaires qui ont des perspectives à partager sur leurs partenariats avec des représentants de leurs bureaux locaux de santé publique pour la promotion du bien-être des écoliers. En raison du nombre plus élevé de conseils scolaires, l'échantillonnage par quotas sera entrepris à l'égard du type de conseil scolaire et la localisation régionale. Le cadre d'échantillonnage des directeurs de l'éducation (ou leur représentant) serait la suivante : 7 du système public anglais, 7 du système catholique anglais, 2 du système catholique français et 1 du système public français. Après une série de consultation auprès des représentants du secteur de l'éducation, la participation à cette recherche par le biais d'entrevues téléphoniques a été considérée comme la direction la plus appropriée à prendre. Ces entrevues téléphoniques se tiendront durant le mois d'Août 2016 à un moment opportun pour chacun des participants. Les participants auront aussi l'occasion de revoir leurs transcriptions d'entrevues confidentielles et apporter des modifications à leur guise.

Résultats attendus

Un rapport final des principales conclusions, y compris des recommandations, sera diffusé à tous les participants à l'étude et au Comité du CODDE/CoMHO. Ces résultats attendus permettront d'illustrer de quelle manière les partenariats intersectoriels se déroulent, de souligner les besoins de développement des partenariats, et de découvrir des approches pour enrichir le processus d'engagement des partenariats. Les recommandations découlant de cette connaissance pourront aider à renforcer les partenariats intersectoriels dans le but d'une meilleure réussite avec la mise en oeuvre de l'approche École en santé/Santé globale en milieu scolaire.

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Interview Guide—Directors of Education or their Designate

I. Opening

- A. [Establishing a Rapport] I appreciate your taking the time to be interviewed. This interview is part of my doctoral thesis project, at the University of Ottawa. I'm doing this research project to gain a deeper understanding of how school boards and public health units may be partnering with each other to promote student well-being. I'd also like to capture key learnings from your partnership experiences. In addition, I'd like to find out about your role regarding student well-being to provide context for your responses.
- B. [Purpose] Are you familiar with the Council of Ontario Directors of Education and the Council of Ontario Medical Officers of Health Committee, known as the CODE-COMOH Committee? [...] It so happens that the purpose of my thesis project is to support them in their initiative to help strengthen partnerships between school boards and boards of health.
- C. [Motivation] With the knowledge that I'm gathering, I intend to develop a school health partnership model to be of benefit to all school boards as well as public health units across Ontario. I'm hoping that this model will help guide and inspire cross-sector partnerships for promoting student well-being.
- D. [Timeline]: The interview should take about one hour. Is this alright with you?

[Transition: To begin, I would like to first ask you some questions about your professional aspiration]

II. Body

- A. (Topic) Aspiration:
 - 1. In a few words, what would you say is your vision for the children and youth in your schools?

[Transition: I would now like to find out more about your role as _____ in relation to health promotion]

- B. (Topic) Role:
 - 1. What is your role regarding the Ministry of Education's renewed vision of Achieving Excellence that now includes promoting student well-being as one of its goals?
 - 2. Are you familiar with the Ministry of Education's document entitled, *Foundations for a Healthy School: Promoting well-being is part of Ontario's Achieving Excellence vision*? It's a companion resource to the K-12 School Effectiveness Framework.
 - a. [If yes] Have you played a role in its implementation? What has been your school board's experience with implementing the components of that document?
 - b. [If no, state that you will then focus the rest of the interview on the overall goal of promoting student well-being; move on to Question C.1, and omit the last questions that deal with the Healthy School approach]

[Transition: Now I would like to explore your partnership experiences]

C. (Topic) Partnership Experiences:

1. How many public health units does your school board partner with?
2. Do you receive help from your public health unit(s) toward achieving the goal of promoting student well-being, beyond immunization and dental care?
 - a. [If yes] Do you consider your public health unit(s) to be your primary community partner for promoting student well-being, or one among many other community partners for this purpose? Why is that so?
 - b. [If no, move on to Question C.7]
3. Do you think your public health unit(s) has/have a role to play in helping your school board with mental health promotion, in addition to other health topics, as part of student well-being? Why is that so?
4. How does your school board engage with your public health partners for the purpose of promoting student well-being, beyond immunization and dental care, in terms of inter-organizational structure? (e.g., Executive Committee; Liaison Committee; work groups; Parent Involvement Committee; scheduled meetings).
 - a. What advantage would you say inter-organizational structure provides/could provide (if no formal way of engaging currently exists) for working together?
5. What may have kept your school board from fully engaging in a partnership with your public health unit(s) to promote student well-being, beyond immunization and dental care? (e.g., differences in organizational cultures; competing priorities/capacity issues; high personnel turnover; multiple public health units and school boards' overlapping jurisdictions; hierarchical system; geographical distances; data sharing concerns; absence of superintendent with healthy schools as part of their portfolio; labour disputes; not clear about public health unit's role)
 - a. Why is that so?
 - b. How do you think these barriers could be overcome?
6. What may have contributed to a beneficial engagement between your school board and your public health partners in the promotion of student well-being, beyond immunization and dental care? (e.g., strong relationship; common understanding/shared goals; recognizing public health's contributions; trust/respect; mutual support; clear communication processes; senior leadership as driver; recognition of interdependency/pressing need)
 - a. What benefits has your school board gained from this engagement?
 - b. Do you see possibilities for further improvement? [If yes] In what way?

[Transition: This last series of questions is to explore the potential for collaboration with your public health unit(s):

D. (Topic) Potential for Collaboration:

1. What are your views about the prospect of your school board's senior management—that is the director of education, associate directors, and superintendents—undertaking joint strategic planning with your public health unit(s) to work together on a shared vision and shared goals for student well-being, beyond immunization and dental care? [i.e., if deemed of practical value, what supporting conditions would be necessary to make this a reality?]

2. What are your views about the prospect of your school board's superintendents and central board staff undertaking joint operational planning with your public health unit(s) to develop initiatives together, at the school board level, for promoting student well-being beyond immunization and dental care? [i.e., if deemed of practical value, what supporting conditions would be necessary to make this a reality?]
3. What are your views about the prospect of your school board developing policies together with your public health unit(s) in areas related to the promotion of student well-being beyond medical conditions (such as concussions, asthma, allergies, and diabetes)? [i.e., if deemed of practical value, what supporting conditions would be necessary to make this a reality?]
4. Health units have been working with receptive schools to support them in implementing their healthy schools process, which includes a health action team at the school level for action planning and monitoring. What are your views about the prospect of your school board partnering with your public health unit to coordinate together the implementation of the healthy schools process? [i.e., if deemed of practical value, what collaborative arrangement would need to be put in place to make this a reality?]
5. Alternatively, what are your views about the prospect of your school board being empowered to lead your schools in taking up the healthy schools process, with the support of your public health partner(s) as secondary actor?

[Transition: It has been very interesting and helpful learning about your engagement with your public health partners as well as your partnership experiences and views]

III Closing

- A. [Maintain Rapport] I appreciate the time you have taken for this interview. Is there anything else you think would be valuable for me to know as I develop further our partnership model?
- B. [Action to be Taken] I will have the recording of this interview transcribed shortly. Would it be alright if I were to send you the transcript for your review and perhaps ask some clarifying questions if needed? I think the transcript will be ready in a couple of weeks.

Thank you again for your time and I hope you will enjoy reading all about our partnership model that I will be sharing with all of you, once my research report is completed. Bye for now.

I. Ouverture

- A. [L'établissement d'un Rapport] Je vous suis reconnaissante de prendre le temps de m'accorder cet entretien. Cette entrevue fait partie de mon projet de thèse de doctorat, à l'Université d'Ottawa. En travaillant sur ce projet de recherche, je vise à acquérir une meilleure compréhension de la façon dont les conseils scolaires et les bureaux de la santé publique peuvent créer des partenariats l'un avec l'autre pour promouvoir le bien-être des élèves. Je tiens également à saisir les principales leçons de vos expériences de partenariat. Aussi, je voudrais en savoir plus sur votre rôle en ce qui concerne le bien-être des élèves afin de fournir un contexte pour vos réponses.
- B. [But] Êtes-vous familier avec le Comité du Conseil ontarien des directrices et directeurs de l'éducation/Conseil des médecins-hygiénistes de l'Ontario, connu sous le nom du Comité CODDE-CoMHO? [...] Le but de mon projet de thèse est de les soutenir dans leur initiative de renforcement des partenariats entre les conseils scolaires et les bureaux de santé publique.
- C. [Motivation] Avec les informations que je suis en train de recueillir, je compte développer un modèle de partenariat pour les écoles en santé qui pourrait être utile à tous les conseils scolaires et les bureaux de la santé publique à travers l'Ontario. J'espère que ce modèle aidera à guider et à inspirer des partenariats intersectoriels pour promouvoir le bien-être des élèves.
- D. [Chronologie]: L'entrevue devrait durer environ une heure. Est-ce bien pour vous?

[Transition: Pour commencer, je voudrais d'abord vous poser quelques questions au sujet de vos aspirations professionnelles]

II. Corps

A. (Sujet) Aspiration:

- 1. En quelques mots, quelle est votre vision pour les enfants et les jeunes dans vos écoles?

[Transition : Je voudrais maintenant en savoir plus sur votre rôle en tant que _____ en ce qui concerne la promotion de la santé]

B. (Sujet) Rôle :

- 1. Quel est votre rôle au sujet de la vision renouvelée du ministère de l'éducation se rapportant au document Atteindre l'excellence qui inclut maintenant la promotion du bien-être des élèves comme un de ses objectifs ?
- 2. Êtes-vous familier avec le document du ministère de l'éducation intitulé *Les Fondements d'une école saine : Promouvoir le bien-être dans le cadre de la vision renouvelée Atteindre l'excellence*. Il s'agit d'un guide pour le Cadre d'efficacité pour la réussite de chaque élève à l'école de langue française (M-12).
 - a. [Si oui] Avez-vous joué un rôle dans sa mise en œuvre ? Quelle a été l'expérience de votre conseil scolaire lors de la mise en œuvre des cinq volets de ce document?
 - b. [Si non, précisez que le reste de l'entrevue portera sur l'objectif global de promouvoir le bien-être des élèves ; passer à la question C.1, et omettre les dernières questions qui traitent de l'approche École en santé]

[Transition : Maintenant, je voudrais explorer vos expériences de partenariat]

C. (Sujet) Expériences de partenariat :

1. Combien de bureaux de santé publique comptez-vous parmi vos partenaires ?
2. Avez-vous reçu de l'aide de votre (vos) bureau(x) de santé publique en vue d'atteindre l'objectif de promouvoir le bien-être des élèves?
 - a. [Si oui] Est-ce que vous considérez votre (vos) bureau(x) de la santé publique comme étant votre partenaire communautaire primaire pour promouvoir le bien-être des élèves, ou l'un de nombreux autres partenaires communautaires à cette fin? Pourquoi est-ce ainsi?
 - b. [Si non, passer à la question C.7]
3. Pensez-vous que votre (vos) bureau(x) de la santé publique a / ont un rôle à jouer pour aider votre conseil scolaire dans la promotion de la santé mentale en particulier, en plus des autres thèmes de santé reliés au bien-être des élèves? Pourquoi est-ce ainsi ?
4. Comment est-ce que votre conseil scolaire s'engage avec vos partenaires de santé publique dans le but de promouvoir le bien-être des élèves en termes de structure inter-organisationnelle ? (Par ex., Comité exécutif, Comité de liaison, groupes de travail, le Comité de participation des parents, des réunions prévues).
 - a. Quel avantage selon vous fournit / pourrait fournir (s'il y a pas encore de moyen formel d'engagement) la structure inter- organisationnelle pour travailler ensemble?
5. Qu'est ce qui aurait pu empêcher votre conseil scolaire à s'engager pleinement dans un partenariat avec votre (vos) bureau(x) de la santé publique pour promouvoir le bien-être des étudiants ? (Par ex., les différences de cultures organisationnelles ; priorités / problèmes de capacité concurrents ; roulement de personnel élevé ; multiples bureaux de la santé publique et conseils scolaires avec leur juridiction qui se chevauchent; système hiérarchique ; distances géographiques, préoccupations concernant le partage des données ; absence d'un surintendant des écoles en santé dans le cadre de leur portefeuille ; les conflits de travail ; manque de clarté concernant le rôle de votre bureau de santé publique
 - a. Pourquoi est-ce ainsi?
 - b . Comment pensez-vous que ces obstacles pourraient être surmontés ?
6. Qu'est ce qui aurait pu contribué à un engagement bénéfique entre votre conseil scolaire et vos partenaires de santé publique dans la promotion du bien-être des élèves ? (Par ex., une forte relation, compréhension commune / objectifs communs ; reconnaissance des contributions de la santé publique ; la confiance / respect, le soutien mutuel, les processus de communication clairs, la haute direction en tant que déclencheur ; reconnaissance de l'interdépendance / besoins urgents)
 - a. Quels bénéfices votre conseil scolaire aurait-il pu gagner de cet engagement ?
 - b . Voyez-vous des possibilités d'amélioration ? [Si oui] De quelle manière?

[Transition : Cette dernière séries de questions a pour but d'explorer les possibilités de collaboration avec votre (vos) bureaux de la santé publique]

D. (Sujet) Possibilités de collaboration :

1. Que pensez-vous d'un engagement de la part de la haute direction de votre conseil scolaire— c'est-à-dire, le directeur/directrice de l'éducation, les directeurs/directrices associé(e)s, et surintendants/surintendantes— avec vos partenaires en santé publique pour entreprendre une planification stratégique conjointe afin de travailler ensemble sur une vision commune et des objectifs communs pour le bien-être des élèves? [c'est-à-dire, si cela est jugé d'une valeur pratique, quelles conditions de soutien seraient nécessaires pour en faire une réalité ?]
2. Que pensez-vous d'un engagement des surintendants/surintendantes et le personnel central de votre conseil scolaire avec vos partenaires en santé publique pour entreprendre une planification opérationnelle conjointe afin de développer des initiatives ensemble, pour promouvoir le bien-être des élèves ? [c'est-à-dire, si cela est jugé d'une valeur pratique, quelles conditions de soutien seraient nécessaires pour en faire une réalité ?]
3. Que pensez-vous d'un engagement de votre conseil scolaire avec vos partenaires en santé publique pour élaborer des politiques dans les domaines liés à la promotion du bien-être des élèves, au-delà des conditions médicales (telles que les commotions cérébrales, l'asthme, les allergies et le diabète) ? [c'est-à-dire, si cela est jugé d'une valeur pratique, quelles conditions de soutien seraient nécessaires pour en faire une réalité ?]
4. Les bureaux de santé publique ont travaillé avec les écoles réceptives pour les soutenir dans la mise en œuvre de leur processus d'écoles en santé, qui comprend une équipe d'action en santé au milieu scolaire pour la planification et le suivi. Que pensez-vous d'un partenariat entre votre conseil scolaire et votre (vos) bureaux de la santé publique pour coordonner ensemble la mise en œuvre du processus d'écoles en santé ? [c'est-à-dire, si cela est jugé d'une valeur pratique, quel(s) mécanisme(s) de collaboration devraient être mis en place pour en faire une réalité ?]
5. Alternativement, que pensez-vous de voir votre conseil scolaire habilité à diriger lui-même la mise en œuvre du processus d'écoles en santé, avec le soutien de votre (vos) partenaire(s) de santé publique en tant qu'acteurs secondaires?

[Transition: Il m'a semblé très intéressant et utile de mieux comprendre votre engagement dans la promotion de la santé, ainsi que vos expériences et points de vues concernant les partenariats]

III Clôture

- A. [Maintenir Rapport] Je vous remercie du temps que vous avez pris pour cette entretien . Y at-il autre chose qui me serait utile de savoir lorsque je développerai davantage notre modèle de partenariat ?
- B. [Mesure à prendre] J'aurai une transcription de cet entretien sous peu. Accepteriez-vous de recevoir cette transcription et de valider son contenu ? Je pense que le manuscrit sera prêt dans quelques semaines.

Merci encore pour votre temps et je souhaite que le modèle de partenariat issu de cette recherche vous soit utile à vous tous. Au revoir.

Consent Form for Key-Informant Interviews—School Boards

Title of the Study: Exploring Partnerships across the Health and Education Sectors in Ontario

Principal Researcher:

Joanne de Montigny, B.Sc.(Hon.), MHA, PhD(c)

Population Health Program, University of Ottawa

Thesis Director:

Louise Bouchard, PhD, Professor

Population Health Program, University of Ottawa

Invitation to Participate: You are invited to participate in the abovementioned research study, conducted by Joanne de Montigny, who is being supervised by Professor Louise Bouchard at the University of Ottawa. This project is funded by the Canadian Institutes of Health Research and administered by the Quebec Population Health Research Network through their Training Program in Transdisciplinary Research on Public Health Interventions.

Participation: Your participation will consist of a telephone interview of approximately one hour in length. This interview has been scheduled for _____.

Purpose of the Study: From this research project we wish to generate knowledge on partnership development across the health and education sectors and discover the potential for collaborating on the creation of healthy schools in Ontario. The purpose of this research project is to inform the initiative launched by the Council of Ontario Directors of Education and the Council of Ontario Medical Officers of Health (CODE-COMOH) Committee, which aims to help foster strong partnerships between school boards and boards of health. The specific objective of the interview is to gain a better understanding of the challenges and opportunities that school boards encounter in working in partnership with their local public health units for the promotion of student well-being.

Benefits: Research findings will be disseminated to all public health units and school board associations in Ontario as reference material to help guide and inspire efforts in developing partnerships for health promotion. These findings are expected to illustrate in what ways cross-sector partnerships are taking place, and what are the factors to consider for further progress across the province. From this knowledge, a set of recommendations will be formulated to inform the way forward for decision makers, thereby assisting public health units and school boards in fulfilling their aspirations of creating supportive school environments for promoting the health and academic performance of the student population.

Confidentiality and Anonymity: The information that you will share will remain strictly confidential and anonymous, and will be used solely for the purposes of this research. The only people who will have access to the raw research data is myself, Joanne de Montigny, and my thesis director. Your answers to the interview questions may be used verbatim in presentations and publications but neither you nor your organization will be identified.

Conservation of Data: The data saved on a USB key as audio-recording files and converted into interview transcripts will be securely kept in a locked filing cabinet in the office of my Thesis Director, Professor Louise Bouchard, at the University of Ottawa for a period of 5 years at which time they will be destroyed.

Voluntary Participation: You are under no obligation to participate and if you choose to participate, you may refuse to answer questions that you do not want to answer.

Information about the Study Results: The research findings will be made available to participants in a research report format and shared with the Ontario School Health Management in Public Health Network and the four public school board associations for dissemination among its members.

If you have any questions or require more information about the study itself, you may contact myself or my Thesis Director at the numbers mentioned above.

If you have any questions with regards to the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, tel.: (613) 562-5387 or ethics@uottawa.ca.

By signing this consent form below, you are indicating that you have read and understood the nature of your involvement in this research project. Please keep this signed consent form for your records and return to me a scanned copy at jdemo096@uottawa.ca prior to our scheduled interview.

Thank you for your time and consideration.

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

Texte de consentement pour informateurs clés — Conseils Scolaires

Projet de thèse : Exploration des partenariats entre les secteurs de la santé et de l'éducation en Ontario

Chercheure principale:
Joanne de Montigny, Étudiante au doctorat
Institut de recherche sur la santé des populations
Université d'Ottawa

Directrice de thèse:
Louise Bouchard, PhD, Professeure
Institut de recherche sur la santé des populations
Université d'Ottawa

Invitation: Vous êtes invité à participer au projet nommé ci-haut, mené par Joanne de Montigny, qui est supervisée par Professeure Louise Bouchard de l'Université d'Ottawa. Ce projet est financé par les Instituts de recherche en santé du Canada et administré par le biais du Réseau de recherche en santé des populations du Québec, et leur programme en recherche transdisciplinaire sur les interventions de santé publique.

Participation: Votre participation consistera d'un entretien téléphonique d'environ une durée d'une heure. Cette interview a été prévue pour le _____.

Objectif de l'étude: Ce projet de recherche vise à générer des connaissances sur le développement des partenariats entre les secteurs de la santé et de l'éducation. Il vise aussi à découvrir le potentiel pour de la collaboration sur la création d'écoles saines en Ontario. Le but de ce projet de recherche est d'informer l'initiative lancée par le Conseil d'administration du Comité du Conseil ontarien des directrices et directeurs de l'éducation/Conseil des médecins-hygiénistes de l'Ontario, qui vise à contribuer à favoriser des partenariats solides entre les conseils scolaires et les conseils de santé. L'objectif spécifique de l'interview est d'acquérir une meilleure compréhension des défis et des opportunités rencontrés par les conseils scolaires pour travailler en partenariat avec leurs bureaux de santé publique locaux sur la promotion du bien-être des élèves.

Avantages: Les résultats de la recherche seront diffusés auprès de tous les bureaux de santé publique ainsi qu'auprès de toutes les associations de conseils scolaires de l'Ontario. Ils pourront servir en tant que matériel de référence pour guider et inspirer les efforts dans le développement de partenariats pour la promotion de la santé. On souhaiterait que ces résultats puissent illustrer de quelle manière les partenariats intersectoriels en cours sont

développés, et quels sont les facteurs à considérer pour de éventuelles améliorations dans la province.

Un ensemble de recommandations sera élaboré sur la base des connaissances acquises. Elles informeront les décideurs sur des voies possibles à suivre pour aider les bureaux de santé publique et les conseils scolaires à créer des milieux scolaires de soutien pour promouvoir la santé et le rendement scolaire de la population étudiante.

Confidentialité et anonymat: L'information que vous partagerez restera strictement confidentielle et anonyme, et le contenu ne sera utilisé que pour les fins de cette recherche. Les seules personnes qui auront accès aux données sont moi-même, Joanne de Montigny, et ma directrice de thèse. Vos réponses aux questions de l'enquête pourraient être utilisées textuellement dans des présentations et des publications, mais ni vous ni votre organisation seront identifiés.

Conservation des données: Les données enregistrées sur une clé USB sous forme de fichiers audio - enregistrement et convertis en transcriptions d'entrevues seront conservées en toute sécurité dans un classeur verrouillé dans le bureau de ma directrice de thèse, Professeure Louise Bouchard, à l'Université d'Ottawa pour une période de cinq ans, et par la suite, elles seront détruites.

Participation volontaire: Vous êtes sous aucune obligation de participer et si vous décidez de participer, vous pouvez refuser de répondre aux questions que vous ne souhaitez pas répondre.

Pour tout renseignement additionnel concernant cette étude, vous pouvez communiquer avec moi ou ma directrice de thèse aux numéros indiqués ci haut.

Pour tout renseignement sur les aspects éthiques de cette recherche, vous pouvez vous adresser au Responsable de l'éthique en recherche à l'Université d'Ottawa, 550, rue Cumberland, pièce 154, (613) 562-5387 ou ethique@uottawa.ca.

En signant ce formulaire de consentement ci-dessous, vous indiquez que vous avez lu et compris la nature de votre participation à ce projet de recherche. S'il vous plaît garder ce formulaire de consentement signé pour vos dossiers et me retourner une copie numérisée à jdemo096@uottawa.ca avant notre entrevue prévue .

Merci pour votre temps et votre considération.

Signature du participant: _____ Date: _____

Signature du chercheur: _____ Date: _____

APPENDIX SECTION 4:

Additional Information about School Health Partnerships

Appendix 4A: Additional Details on the Engagement Spectrum from the Public Health Perspective

In this Appendix, knowledge about how school health partners engage with one another is covered in-depth from the public health perspective. Within the context of school health, public health units and school boards may engage with one another, to varying extent, either to share information or to gain additional input as they pursue one of four specific planning tasks: high-level, multi-year strategic planning; program-level, annual operational planning; action planning; and policy development—a distinct form of operational and action planning. Cross-sector engagement can also happen at the school level in terms of information sharing and school planning (i.e., a combination of operational and action planning for program and policy initiatives). It is through school-level planning that the six-step healthy school process is carried out. Each of the different planning tasks that have been identified essentially belong to one of two main types of planning, as it pertains to programs or policies at the school board level or the school level. These planning types are strategic planning (long-term or short-term) and action planning. Operational planning is still a form of strategic thinking.

For each of the five distinct partnership-relevant tasks mentioned above, public health units have experienced a broad spectrum of engagement levels across different school boards, and schools, within their catchment areas, and even with the same school board, or school, at different times and for different areas of work, depending on the health topic, current circumstances, the personnel employed at the time, and the strength of the relationship. Engagement levels differ according to the extensiveness of the cross-sector interaction. Each possible level of cross-sector engagement reflects the intention behind the interaction along the collaboration continuum, whether it be to inform (related to a networking partnership arrangement); or to verify or consult (related to a cooperative partnership arrangement); or to involve, coordinate, or collaborate (related to a collaborative partnership arrangement).

The interview guide template (as shown in Appendix 2H) contained lists of statements that corresponded to possible levels of engagement for each specific task, as initially conceived following an analysis of the School Health Partnership Survey responses. These statements were pilot tested for appropriateness prior to the interview period, and they have been restated in the sections below with further refinements based on interview responses. This appendix describes realistic scenarios of ways public health units and school boards/schools engage with one another, without accounting for the exact number of public health units that have reported experiencing any one of the possible cross-sector engagement tasks. The purpose of this research project is not to evaluate school health partnerships but rather to gain a better

understanding of engagement experiences, and identify the elements that strengthen these partnerships. It is to be noted that upon further analysis, Task 3 actually represented engagement between public health units and school boards related to both operational and action planning. Each of these planning tasks is examined separately, below.

A. Overview of partnership-relevant tasks

As previously explained in Chapter 6, the engagement spectrum refers to the different levels of extensiveness characterizing cross-sector engagement along the collaboration continuum related to various partnership-relevant tasks. Cross-sector engagement pertains to either information sharing or planning. Outside of any intention to make planning decisions, information is given for the purpose of gaining understanding of partnership-related matters and exploring possibilities for working in partnership. This constitutes a networking partnership arrangement. As for planning, there exist three planning tasks that may be carried out in part, or in whole, within the context of a school health partnership: multi-year strategic planning, annual operational planning, and action planning. The first task is applicable to public health units and school boards, while the last two tasks are applicable to these organizations, as well as schools. Policy development may be considered as having both operational and action planning aspects.

For each of these planning processes, school health partners may engage cooperatively, either for verification or consultation purposes. During a verification, each partner informs the other partner about the content of their respective final plans either to confirm their compatibility and identify common priorities for partnership activities, or to check the soundness of their plans, which may lead to adjustments. During a consultation, input is being sought on their respective plans that are still under development, separate from their main decision-making processes. Alternatively, these partners may choose to make a collaborative arrangement that would pertain to either an involvement on a partner's plan or a collaboration on a joint plan. A collaborative arrangement would set in when one partner involves the other partner throughout their main decision-making process. It would also set in when both partners collaborate on a joint plan that they are co-leading. Whereas operational and action planning is undertaken by public health units, school boards, and schools, multi-year strategic planning is a task that is performed at the organizational level only, and never at the school level; this phase is also referred to as multi-year organizational planning.

Public health units and school boards may engage with each other, possibly along with other key community partners, in the preparation of their respective multi-year strategic plans. From the public health unit side, strategic planning can be initiated by a variety of personnel. Among those who have led the planning process are the medical officer of health, the director responsible for health promotion, or the public health manager for those public health units that are horizontally structured and do not have director positions. Some public health units have all of their community partners present at the planning table, while others undertake separate processes for engaging with key external stakeholders, such as directors of education, in the development of their multi-year strategic plan.

Public health units' internal planning table can be inclusive, where participants include the medical officer of health, directors, managers, coordinators, and other frontline staff, or it can be restricted to senior management. Personnel from all levels may have insights to contribute to strategic planning. One public health unit even held an off-site strategic planning session that was facilitated by an external consultant to engage its top leadership, managers, staff, and municipal counsellors. When internal planning committee membership is limited to senior management, they may nevertheless bring to their group discussions the input received from public health managers, based on their interactions with school boards and information provided by their frontline staff regarding their experiences at the school level.

Some public health units have not yet embarked on the journey toward engaging their school board partners in strategic planning, due either to time constraints on the part of public health executives or to the impression that such a request would further tax an already overburden school board leadership. For other public health units, conversations are just beginning with school boards' decision-makers to explore what joint planning at the strategic level could look like for their school health partnerships. They are focusing mainly on strengthening relationships, and are gradually bringing up for discussion such topics as what would be the most suitable system (e.g., structures and processes) through which to pursue higher-level joint planning and who should participate. Although public health units may be engaging with their school board and school partners as opportunities arise for action planning, many public health professionals in less advanced school health partnerships seek to undertake a more proactive approach to health promotion within the local school system. Having conversations about the potential of engaging with one another in multi-year strategic planning, where both of their mandates intersect, is that all-important first step, as one public health unit described:

That one particular school board shares their strategic plan with us. We talk often about our shared mandates, and we are always having conversations about how we can better [engage, but] right now, we're at the infancy stage, where we recognize we have these shared mandates and priorities, and that we collaborate when the opportunities present themselves. But wouldn't it be great if we took a step back and did joint strategic planning on the areas that we overlap. (...) So getting a structure in place to do that strategic planning, that's where we're [at right now], in that infancy [stage].

The next planning task concerns the preparation of an operational plan, at times referred to as work plan. Public health units may prepare an operational plan for each of their program areas (e.g., chronic disease prevention; school health; health protection; environmental health), while school boards produce board improvement plans and schools prepare school improvement plans, as an extension of those portions of their multi-year strategic plans that correspond to the government-mandated goals of student achievement and well-being.

Within both public health units and school boards, multi-year strategic plans set the directions and broad goals for creating desired change, which are then operationalized in the form of an operational plan. In addition to their organization's strategic directions, which are often times stated in broad terms, public health units focus their partnership activities according to their mandate as laid out in the *Ontario Public Health Standards*. These standards officially indicate in which health topic areas public health professionals are expected to work, although some flexibility in their interpretation is permitted:

The development of initiatives is really based on the ministry's direction. It can be related to our strategic plan, but it doesn't have to be. The core pieces of our health promotion activities in the schools come from the Ontario Public Health Standards, and that's from the Ministry of Health and Long-term Care. (...) Sometimes we're quite liberal in how we interpret, but that's [due to] the local context and the need that's identified.

Within the public health sector, multi-year strategic plans may be kept broadly stated, and therefore, public health professionals would be relying more on their Ontario Public Health Standards to determine the scope of possible partnership activities. Alternatively, public health units may choose to set specific goals and priorities, thereby concentrating their resources on only certain areas within their public health standards:

Sometimes the strategic plan may have an impact on your mandate because your board of health may decide that 'We don't want to do anything around injury prevention because we want to spend more time on substance misuse, or something like that.

Strong reliance on the Ontario Public Health Standards may be especially the case where public health units are integrated in their local government, with their multi-year strategic plans having a much larger scope, and therefore, it would not be as practical for determining in which areas to direct their school health efforts. However, public health units would still seek to align their priorities with those of their local school boards:

We have our own priorities as well from our Ontario Public Health Standards. There are certain things we should be doing, but we've learned from years of working with the school boards that it's very difficult to do our priorities if they're not shared priorities by school boards.

Certain public health units do not prepare multi-year strategic plans, but rather set long-term corporate priorities.

Operational planning still relies on strategic thinking, but compared to multi-year strategic planning, the ensuing plan is written out in more concrete terms, with a narrower timeframe. An operational plan consists of setting annual priorities to focus efforts on the most important activities related to areas requiring improvement. It also entails specifying measurable goals, objectives and operational strategies/ideas aimed at making these desired improvements. Operational planning can also mean the articulation of an overall strategy in a formally written document. An overall strategy is a broad approach that is chosen to produce a desired change. When elaborated in a formal document, it can be especially useful for steering committees, or similar groups, to provide guidance to working groups. Based on public health units' partnership experiences, operational plans does not necessarily have to be written down; decisions to engage in a particular partnership activity are informally made, through verbal agreements, in response to a school board's or school's need that has emerged at some point during the school year.

As part of their school health partnership, public health units engage in a third type of planning, namely action planning, through which to actualize operational plans. This is another possible entry point for engagement with school boards or individual schools. Action planning is about the selection and/or development of school health initiatives, according to annual priorities and strategies, and the identification of implementation steps for the delivery of these initiatives within the local school system. The implementation stage of action planning may also engage other community partners to establish links with initiatives available within the broader community.

Cross-sector engagement is about information sharing as well as participating in each other's planning process to a greater or lesser extent. Within a networking partnership arrangement, information sharing lies outside the planning process, where the sole purpose is to enhance understanding and explore partnership opportunities. Besides engaging solely to inform, school health partners may get together during each other's planning process at the strategic, operational, and/or action phases, with a specific intention in mind: to verify, consult, involve, coordinate, or collaborate. It is this intention that would determine the extent of input being sought. Such wide variability in the possible levels of engagement makes partnership experiences multi-faceted and complex.

Each possible level of engagement is described below, along with the supporting research data, according to the tasks undertaken by the school health partners. The descriptions are stated below in terms that are applicable to both public health units and school boards, reciprocally. However, this is done for the sake of simplicity. In reality, one organization may not necessarily choose to engage in the same manner as their partner for any given partnership-related task.

B. Information sharing outside the planning process

Description: *Information sharing* for networking purposes refers to the cross-sector engagement process where the information is being shared solely to generate understanding of current issues and potential ways of addressing them together, outside any immediate planning process. However, it may possibly be used for future decision-making. Networking-related information include information about health-related issues, roles, ways of thinking and working, strategies/ideas, and available resources. As part of networking activities, the public health unit and school board may directly (in-person), or indirectly (website posting, email) be informed of each other's multi-year strategic plan, and/or annual priorities. Public health professionals may also share information about other community partners' resources and student referral possibilities.

A public health unit and a school board *shared information* with each other for various reasons: to raise awareness about school health issues and available partnership supports; to present current plans; and to exchange success stories and lessons learned about the promotion of student well-being. In addition, public health units informed their school boards about potential engagement with other community

partners for accessing additional resources to be delivered within schools, and potential community-based programs and services for student referrals.

B.1 Raising awareness about school health issues and available partnership supports

Public health units engage in awareness-raising activities with school boards directly, or through community-based committees. Through such networking activities, public health units and school boards can become aware of relevant health-related issues and the potential of working together to address them. Together, they can also familiarize each other with their respective fields of work in order to enhance their understanding of each other's sector and what kinds of support would be most useful.

Networking to raise awareness of what health-related issues are affecting the student population and how to improve the school environment is one of the first major steps in any school health partnership. As a result of productive networking activities, public health professionals were able to help their local school board counterparts become aware of pressing issues of mutual concern, and potential opportunities to work in partnership regarding these issues. Together, they have shared information about their roles, strategies/ideas, and available resources. In certain instances, they have even gained a better understanding of each other's distinct ways of thinking and working, which then allowed them to bridge any cultural differences that could have been hindering their engagement process. Being well informed through networking practices about how the other partner conducts their business and how they express themselves is essential to garner their interest in considering working in partnership:

I think if you want to influence something, you need to understand what it is. How their organization works, what is important to them, what is their language? You need to deepen your understanding of those pieces. It's not about, 'I'm going to come and do this, or I can offer you this.' It's about actually understanding how they work, so you can actually engage them, or gain their buy-in in a meaningful way, because you speak their language, you speak their priorities.

Equally important is spending time to become better informed about the culture in each partnering school prior to proposing any planning work.

In other instances, public health units and school boards inform one another about their current work simply to stay in touch and be made aware of issues when they arise so that partnership work could be

arranged through other engagement avenues on a needs basis. For example, one school board recently put in place a cross-sector committee simply to remain updated about their public health partner's activities and seize partnership opportunities as they arise:

My impression of that [school board] committee is it's more of a networking, sharing, keeping everyone in the loop, discussing issues as they arise. For example, at the last one, [a particular issue] was brought forward. (...) So, we discussed perhaps doing some workshops and doing some capacity building. That conversation continued offline with just public health and the [school board representative] about putting a plan together for that, but I would say that that committee does not function on an operational level. It doesn't inform operational planning at a board or, if it does, it's more informal.

Such committees function for networking purposes only, and any partnership-related planning happens by making other partnership arrangements.

At times, public health professionals sit on committees organized either by their local school boards or a community coalition for information sharing. They would attend committee meetings as observers, or as reference support, to provide information to their partners on request. They are not active participants in the planning process, but they remain available in the event that opportunities to directly engage with one of their partners open up in the near future. This has been the case at one community coalition that has been currently focused on the mental illness aspects of the Government of Ontario's Mental Health and Addictions Strategy. The public health unit within that community has been invited to follow this coalition's initiative and become familiar with their work:

There are coalitions that come together to talk about [for example] mental health on the other end of the spectrum for [early] diagnosis and treatment and intervention. [School board representatives] are at those tables. So, it's an opportunity to connect and have a face-to-face, or through video conference or (...) teleconference and just get to learn what they're busy with and how their strategic planning is going for the mental health strategy side of things specifically. (...) It's a very new development for that coalition, so it's evolving very slowly. (...) It's to identify opportunities to collaborate and plan together. Otherwise there's information exchange across the different partners in terms of who's doing what.

At this point, the conversations are geared toward students who need mental-health interventions. As an observer, the public health representative is not engaged in decision-making, but their presence would help ensure a greater likelihood of engagement when the attention turns toward mental health promotion and prevention, areas in which they can directly participate in the planning process and lend

their support. One public health manager commented that this type of cross-sector engagement is a slow process that requires time for all partners to get to know each other's work, understand the role that each one can take on, and discover opportunities to engage in a complementary way.

Besides staying in touch should their support be needed, public health units seek to familiarize their school board partners with evidence-based strategic approaches to current health-related issues for advocacy purposes. This is done either indirectly through reports on public health units' websites, or directly, during meeting presentations that public health professionals make by themselves, or jointly, with school board representatives. Where the school health partnership is still in its beginning stage at the school board level, they have been advocating for the healthy school approach, cognizant that leadership in this area needs to come from school board executives, as well as school administrators. As one public health manager pointed out:

We help guide them, we encourage, we advocate for [the healthy school] approach, but they do what they want. (...) We're not leading it. It really has to come from the school board and schools, and we support.

B.2 Presenting information about current plans

In certain school health partnerships, information about multi-year strategic plans and/or annual operational plans is shared without the intention of engaging the other partner in any planning decision at that time. School boards and public health units may prefer to make their plans available for information only for one of four reasons: (1) the partnership is not advanced enough to provide input into each other's plans; (2) planning with external stakeholders is not part of the organizational culture of either the public health unit or the school boards; (3) the existence of multiple public health units and multiple school boards with overlapping jurisdiction, within an extended school health partnership, overly complicates the task of planning together; or (4) planning together, especially at a high strategic level, is not deemed necessary due to the large extent of flexibility built into public health units' multi-year, organizational plans.

When cross-sector engagement is a new development at the school board level, time is rather spent on sharing information about current plans and priorities, so that the school health partners can first become

better acquainted with each other's work. As stated earlier, gaining familiarity with each other's main concerns and areas of responsibility is a necessary step prior to engaging in the planning process together:

Right now, it's increasing awareness and knowledge about priorities and mandates and learning about public health—opportunities for public health and the education sector to come together and talk about mutual interests, mandates. [We] often meet in the community at larger forums, so this [meeting] is an opportunity for [just] public health and education to come together, once a year. It's information sharing, it's not planning, yet.

This public health unit views information sharing about what each partnering organization is focusing on as an ideal way to begin building relationships and as a preliminary step toward possibility providing input into each other's plan. Much conversation would need to take place to set the stage for public health units and school boards to be in a position to engage in planning together at the strategic level. It is through lengthy conversations that a common understanding gets established for strategic planning.

B.3 Exchanging success stories and lessons learned

Networking meetings facilitate the exchange of success stories and lessons learned. Based on the School Health Partnership Survey, 15 out of 34 public health responses (44%)—less than half of public health units in the province—indicated that at least one of their school board partners has supported inter-school networking activities related to the promotion of student well-being. Public health units may have directly participated by helping to organize the networking event. Some public health professionals indicated that their school board partners have adopted the family-of-school model, where schools are grouped according to similar characteristics. Through this model, personnel from school boards, schools, and public health units are able to meet face-to-face more often since the number of participants are fewer for each meeting occasion. Through such opportunities to network with one another, they are able to come together to learn about what works and what doesn't and help each other persevere.

Additionally, public health professionals have been invited to share lessons learned and success stories of their own, as part of a professional development day hosted by their partnering school boards, or as part of a principals' group meeting.

B.4 Linking the school system to other community partners for additional resources

Public health units are not the only community partners that can assist school boards in developing and implementing health promotion initiatives in schools. On the other hand, public health units can play a key role in facilitating linkages between school boards/schools and other community partners that are offering the kinds of support and resources they are seeking. With this view in mind, one public health unit is positioning their frontline staff within the broader community to become more effective connectors so that they may better assist their school board partners in gaining access to community resources:

A key role for public health is to be a connector. And that role for the nurses to play in their schools is very difficult, if they don't know what's going on in their neighborhood. So, we've started to open up more doors and connect our nurses more and more with what's going on around their schools and their neighborhoods. We've got various tables that we sit at where the right partners are sitting around the table, but our school health nurses haven't had that access. And we're creating that access now. (...) So we're trying to open that door for our nurses to know more so that they can feel competent in going and sitting with the principals and be able to say [things like] 'Oh, you want to focus in that area? Actually, I can bring you some of the resources that are available in your neighbourhood.' (...) Things like that, we can start to bring to the table that I think the schools will appreciate because it could meet some of their needs.

In certain school health partnerships, public health units are assisting schools by providing them with networking support to access additional resources from the broader community. As a public health manager pointed out:

We definitely serve the role of a connector if a school needs something, or they have a question about something that's not something that we do, we will put them in touch with the appropriate community partner or organization. But it doesn't happen formally.

Public health professionals can inform local school boards and their schools about potential partners to help them meet their needs and priorities. However, their assistance may not always be required. As noted by one public health manager, school boards are themselves expected to build linkages with community partners, since they own the Foundations for a Healthy School and one of its major component is the cultivation of community partnerships:

[School boards] are supposed to reach out to a variety of agencies and partners, not just us. They own [the Foundations for a Healthy School], they have to own it. (...) We're 'a' champion,

we're not 'the' champion. (...) So, you can work with a school and champion a healthy school approach with that school and they can partner with any agency to help fulfill some of the plans that fall under that Foundations [document] because community partnership is one of the pillars.

This public health manager went on to say that school boards and schools may already know which other community partners they could be engaging with, or they may be guided to them by other partnering agencies. Nevertheless, the role of connector is one possible networking role that public health units have taken on across the province for added support.

B.5 Identifying potential community-based programs and services for student referrals

When public health units engage with their school board partners through networking arrangements, it is not necessarily to explore the potential of working together, or learn from each other, or even help bring more community resources into the school system. Instead, it could be to provide information about the programs and services of other public service agencies and community-based organizations that can serve the student population outside of the school environment. For example, one public health manager brought the availability of subsidized community programs to the attention of school board personnel so that they could refer their eligible students to these programs.

C. Multi-year strategic planning

Multi-year strategic planning is usually undertaken every three to five years by both public health units and their local school boards for their entire organizations, although it is unlikely that their planning cycles would be synchronized with one another. Some public health units have corporate priorities instead of an actual multi-year strategic plan, while those public health units that have been integrated within the local government do not have plans of their own at that level, but rather one that is meant for the entire municipality. However, these situations do not seem to pose any hurdles, given that their public health units' plans and priorities are typically kept flexible and broad in nature. For example, at one public health unit, one of the strategic pillars revolves around strengthening their partnership ties. So, any work that they would do within the education sector would fall under that pillar. As a public health manager stated:

I work on a school health team, so our health unit's priorities are developed at our board level and I would not say that our board connects with their board. So, our strategic priorities, they're at a macro level. They're higher. (...) We will strengthen relationships. That's one of our strategic priorities. (...) They will not talk specifically about school health. They would talk about our mandate and within the mandate there is school health. To me strategic priorities at a [health] board level versus at a program level is very different. When I meet with the school board, I as the school health lead, manager, I talk about their priorities in terms of programming within their schools and direction around health and well-being.

When public health units' multi-year strategic plans, or corporate priorities, are quite broad, they have the flexibility to support their school boards in a substantial manner despite not knowing about their partners' priorities at the time their strategic plan is being developed. For more focused cross-sector engagement, other school health partners have made collaborative agreements on a strategic direction that is specific to their school health partnerships.

Engagement between public health units and school boards, and possibly other community partners, during multi-year strategic planning may take place according to one of four possible levels of extensiveness: verification; consultation; involvement; or collaboration. Going from one engagement level to the next indicates increases in the influence one partner could have on the decisions being made regarding the other partner's strategic directions and broad goals, with implication for the extent to which cross-sector engagement can be undertaken during operational planning.

C.1 Verification at the final stage of multi-year strategic planning

Description: The public health unit and school board ask for each other's input on their respective multi-year strategic plans, or corporate priorities, that have been newly developed, so that their advice can be taken into consideration at the end of the planning process. The purpose is to verify decisions that have already been made on strategic directions and broad goals to see if any adjustments could be made to improve strategic alignments, or where plans are not to be changed, to see if there already exist common areas of focus toward which to direct their partnership efforts.

In certain cases, public health units and school boards have verified their respective multi-year strategic plans by asking feedback from one another, and from other key stakeholders within the broader

community, to see if adjustments could be made for better alignment. Various methods have been used to collect feedback: electronic communication, online surveys, interviews, and focus groups.

Direct electronic communication may take place between the top leadership at the public health unit and school board:

We're doing the strategic planning and then we're sharing our strategic plan with [our school boards] for [feedback] to review and communicate if they have anything they would like to clarify or add to the strategic plan (...) by email. (...) It was sent to the Directors through the MOH.

At this public health unit, the medical officer of health requested feedback from the directors of education at the school boards within their catchment area to find out what, if any, adjustments could be made to their multi-year strategic plan. However, it is not certain if all of them were able to find the time to respond. Another public health unit felt that they might conduct focus group sessions rather than launch an online survey, since they are aware that the indirect method is “not always the best way to engage” partners. The focus group approach would certainly produce a higher level of engagement, provided that time is not an issue.

However, a request for feedback may not always be the preferred approach. Other public health units have found the request for feedback on decisions already taken to be rather constraining. For example, one public health partner felt reluctant to share their point of view that would present an alternative course of action after decisions had already been made:

When our [school] board did their new strategic plan, they sent out surveys to all of their community partners, getting feedback from their partners. (...) The [school] board, even though they sought community [engagement], they basically knew what their priorities were. (...) The consultation didn't come in the planning stage, it came after. (...) It's harder to make changes when you pretty much have a final draft.

Although feedback is being given, the tendency may be to limit comments within the parameters already established within the strategic plan. Opportunities to find strategic alignments may therefore be missed.

For other public health professionals, being asked to verify their school boards' strategic plans is less of a concern. These public health professionals have found flexibility embedded in their school boards'

strategic plans as well, such that they can still uncover partnership opportunities even though they may be asked for input only at the end of their school board partners' strategic planning process:

There's been times where the boards have developed their strategic plans and then provided a survey that we could provide some [feedback] into and so we have participated in that. (...) Those are the high level [strategic] plans that aren't necessarily the work, it's more the areas of focus.

Much latitude for working in partnership may already be embedded in multi-year strategic plans such that adjustments would barely be necessary. When compared to the planning potential that could be reaped through earlier engagement in the planning process, however, asking for feedback after the strategic plan has already been prepared may limit partnership potential in certain instances.

Another major point of consideration is the complexity of planning in relation to extended school health partnerships. For some public health units, verification may be a suitable level of engagement, especially when multiple school boards and multiple health units are concerned. As one public health unit pointed out, they much prefer simply sharing information about their long-term strategic priorities with their multiple school board partners, who are partnering with other public health units. They would be sharing the contents of their respective plans to verify their compatibility, by looking for any common areas in which to focus their health promotion efforts within the local school system. As one public health manager commented:

It's more of an 'FYI, this is what we're doing. Here are our priorities, what do you think of our priorities and where could we work with you on those priorities?' That's the kind of feedback we're eliciting. Not so much we're going to change it. (...) The strategic planning process at each organization is very difficult to pull together. Because we're mandated for certain priorities, we have to figure out what it is that our priorities are and typically then we go out and try to ask for feedback and information from other partners, but the buy-in to sit at these tables, isn't there. We don't necessarily have the time (...) to help [our school board partners] identify priorities, and it goes for all organizations, both ways. It's a time and capacity factor as well. Ideally, it would make sense, but logistically and realistically, it's very challenging. (...) Just trying to get your own health unit, [that is your] management and board of health teams together to be able to do the strategic planning is challenging enough, never mind dealing with different health units and different school boards [whose jurisdictions overlap].

It can become a daunting task for a public health unit to make adjustments to their multi-year strategic plan in order to respond to the priorities of more than one school board, who are also working in partnership with other public health units. Time and capacity limitations are exacerbated when having to engage with multiple school boards and public health units, with overlapping jurisdictions.

C.2 Consultation in the early or mid-stages of multi-year strategic planning

Description: The public health unit and school board request each other's input early, or midway into, the preparation of their respective multi-year strategic plans to take into account their partner's identified issues, interests and/or professional knowledge. The purpose is to consult the other partner on their views about relevant strategic directions and broad goals. A process, referred to as community needs assessment, is usually conducted either through meetings, key-informant interviews, telephone calls, electronic communication (i.e., email or online survey), or focus group sessions at the beginning of a new strategic planning cycle. Separate, internal meetings are then held to finalize their respective multi-year strategic plans.

Partners are said to be *consulted* when input is sought early on and/or midway into the process of preparing multi-year strategic plans. Some public health units and school boards send a broad call out to all of their community partners for their input at the beginning of their high-level planning process. In this way, they take into consideration their partners' views and/or data when deciding on their strategic direction, or priority areas of focus, and broad goals for the next three to five years.

Partner consultation during this high-level planning phase is usually referred to as a community needs assessment. Input from external stakeholders can be acquired through either electronic communication, telephone exchanges, online surveys, or scheduled meetings throughout the year. Hearing external views may also proceed in a more formal way, through a facilitator-led focus group discussion with a variety of community partners in a workshop-type setting (i.e., focus-group sessions), and/or key-informant interviews by external consultants. School boards have adopted similar approaches for their stakeholder engagement.

Whereas public health units would seek to identify school boards' areas of interest when doing their strategic planning, school boards are more likely to ask their public health partners for their knowledge of community health issues and suitable approaches to address these issues when preparing their strategic plans. School boards may be interested in hearing from their public health partner about community needs and the evidence that they have that could help shape their strategic direction concerning student well-being. One public health manager commented that local public health units often function as a messenger for many other community partnerships that they work through.

Public health professionals have experienced instances where school boards would informally find out about their priority areas of focus, through casual conversations or by accessing a report they would have produced. A consultation by school boards would then ensue to gain greater familiarity with the related health issue affecting their student population in order to inform their strategic planning about improving student well-being. As a public health manager commented:

It may be an emergent priority, so the area of childhood obesity or area of mental health. We may have identified some data and written a report. (...) We didn't really bring them together to have that conversation, but the school board hears about that report and then the conversation starts.

Informal accounts of public health nurses' experiences on the ground with school personnel have also been sources of input to guide multi-year strategic planning.

Additionally, prearranged consultation sessions with community partners may be facilitated by external consultants, who would be hired to assist with the formal gathering of input on high-level strategic planning. For example, one public health unit is considering sending out some preliminary information and then elicit their partner's input through an engagement process organized by consultants in order to prepare a first draft of their strategic plan. They would then show their completed plan to these partners, offering them one more opportunity to provide their comments:

It would just involve sending an email with some information and then arranging for a face-to-face meeting if they have time. (...) The larger strategic planning group might actually invite [the directors of education and the superintendents, for example] for a consultation but I'm not sure what that will look like yet. (...) The school boards are on the list of people to consult. It's all of the school boards in our district. (...) But we have external consultants that are leading that process, so I'm not exactly sure when throughout the process our partners will get consulted. [One possible scenario is that] it will be both. They'll get consulted before the plan is put together and then they will be asked for feedback on the final plan.

The public health unit mentioned above is contemplating engaging their partners early on into their multi-year strategic planning process via an external consultant. Consultations for multi-year strategic planning can be a time-consuming process. Public health units' multi-year strategic plans concern the full range of public health programs and services. For a public health unit that is incorporated within the local government, their strategic plan is even more extensive, since it belongs to the entire municipality and includes elected officials' priorities related to a wide array of municipal affairs. According to public health

professionals, school boards may not have the time, or find it worthwhile, to participate in a focus group session that involves a wide variety of community partners and that lasts more than one day.

However, strategic planning consultation with school boards need not be a one-time occurrence covering the full scope of a public health unit's mandated activities. Certain public health professionals have consulted with their school board partners throughout the course of the school year during partnership meetings. As they gained a better understanding of their local school boards' interests and concerns during meetings, they would make sure to keep their partners' views in mind when holding their internal high-level strategic discussions. By engaging in frequent conversations, both formal and informal, with school boards to discuss health-related issues throughout the year, the public health unit is in a much better position to prepare their multi-year strategic plan in a way that is most reflective of their partners' areas of focus and needs. Although public health units' multi-year strategic plans tend to be broadly stated, the trend has been to focus much attention on long-term efforts to promote mental health within local school systems.

As is the case with public health units, school boards' multi-year strategic plans cover several different topic areas. Public health units may be directly consulted early on for their surveillance data and knowledge that could then be used to guide their school board partners' separate decision-making process related to strategic directions and goals. As a public health manager indicated:

At a high level, we've actually fed into [our school boards' multi-year strategic plans]. (...) We feed into it by providing them surveillance data. We feed into it by meeting with them and explaining what we're seeing on the ground, because even at the board level, they're hearing things from principals but we're able to validate that through the nurses.

In certain instances, consultations may be carried out indirectly through an online survey as part of school boards' efforts to consider the many voices within their broader community. However, this approach may be somewhat limited. In other instances, online surveys have been supplemented with a focus group discussion for a more meaningful engagement. Focus group discussions have not only shed light on student-related needs but also enabled the discovery of partnership opportunities among a variety of community partners, in their pursuit of a common goal. This more formal cross-sector engagement is then completed through school board executives' internal decision-making process. A public health professional stated that one of their school board partners' focus group session was about discovering what was important to the community partners and discussing synergies in terms of what could be done together. In this session, mental health was widely considered a major concern, where all partners shared

a role in mental health promotion. They further stated that another school board may follow an engagement approach that is very different, since the strategic planning process is very particular to each school board.

Public health professionals have found that participation in school boards' community needs assessments can be advantageous for uncovering the potential of building from each other's efforts on inter-related goals. However, given the wide variety of community partners, the broad scope of possible partnership opportunities may not lead to productive discussions. Based on public health professionals' partnership experiences, some school boards have taken up the practice of inviting their multiple community partners to attend separate consultation meetings to discuss specific topic areas to be addressed in different parts of their strategic plans. This approach is much less time-consuming for participants.

Likewise, planning consultations relative to extended partnerships can proceed in a stepwise fashion. For example, one public health unit is able to provide input into their school board partners' strategic plans whenever their respective planning cycles restart at different time points. In turn, this public health unit is inviting the input from their partnering school boards during their strategic planning cycle, despite the fact that there are four partners to accommodate:

We've got four boards with four different [planning cycles.] (...) Our strategic planning is going on right now. One of our boards is in the middle of their strategic plan. They have a five-year [cycle], we have a four-year. We will provide input when we have the opportunity to influence their strategic plan and vice versa, we'll ask for [their input]. This is talking just about the multi-year plan.

Providing input into each other's strategic plan within the context of extended school health partnerships may be easier to undertake when all the partnering school boards are not also partnering with other public health units as is the case with the example above.

C.3 Involvement during the multi-year strategic planning process

Description: The public health unit and school board request each other's extensive input into their respective multi-year strategic plans to take into account their partner's identified issues, interests and/or professional knowledge. The purpose is to fully capture the other partner's views on strategic directions and broad goals by involving them in the main decision-making process. Involvement takes place through an interorganizational structure, such as a steering committee of community partners,

to gather input from each member organization and jointly prepare the strategic plan for the lead partnering organization. In this way, the views of community partners are directly integrated into the lead partnering organization's multi-year strategic plan.

Involvement in multi-year strategic planning occurs when one partner is invited to participate in the other partner's main decision-making process. An interorganizational structure is usually established to enable this level of engagement. For example, in one school health partnership, a public health unit engaged their community partners extensively in their multi-year strategic planning through a steering committee structure:

Recently, we did put out a new strategic plan, and we had a steering committee put together. On that steering committee, we did have representation from our school boards. (...) Our strategic plan wasn't just around schools, it was for our entire health unit's programs and services. (...) The community partners were involved at every stage, in terms of the brainstorming stage, of the key things, right to the final review of the plan (...) A team at the health unit wrote it with the input from the steering committee.

This steering committee was engaged for several months to put together the public health unit's multi-year strategic plan in a collaborative manner. Although the public health team was responsible for writing the plan, all community partners on the committee played their part in shaping its content; even their coterminous school boards took the time to be committee members. Partner involvement in multi-year strategic planning is meant to gain thorough input from all key external stakeholders.

C.4 Collaboration during the multi-year strategic planning process

Description: The public health unit and school board contribute each other's extensive input into a joint multi-year strategic plan that is specific to their school health partnership, and that includes shared vision, strategic direction, and goals. It either flows from each partnering organization's multi-year strategic plan or it is fed into these plans. The purpose is to collaborate fully on a shared strategic direction for maximum impact.

Multi-year strategic plans are prepared at the level of the entire organization, and school health partners' high-level planning cycles are usually out of sync. However, certain school health partners have

collaborated on the preparation of multi-year strategic plans that are specific to their partnerships, thereby circumventing the lack of synchronicity between their respective organizational planning cycles.

Collaborative school health partnerships are fueled by the joint preparation of a multi-year strategic plan, framework, or a multi-year overall strategy, which may be supported by a partnership-specific vision of how they see themselves working together for the well-being of the student population. Regarding the multi-year strategy, it may not only include a vision statement, broad focus areas and broad goals, but also, for each year that is covered, it may specify sets of strategies to be further refined during the operational planning phase. In certain school health partnerships, the public health unit and school board would collaborate by coming together, through a joint steering committee or cross-sector advisory group.

D. Operational planning

Operational planning consists of operationalizing the multi-year strategic plan by setting annual priorities based on further assessments of need, or resource requirement, and by formulating specific goals, objectives and corresponding operational strategies (or ideas) to guide the identification of initiatives in response to these priorities. Similar to cross-sector engagement at the higher strategic planning process, one school health partner's strategic influence on the other partner's activities increases when engagement goes moves from verification to consultation to involvement, to collaboration.

D.1 Verification at the final stage of operational planning

Description: The public health unit and school board ask for each other's input on their respective operational plans, which have been newly developed, so that their advice can be taken into consideration at the end of their planning process. The purpose is to verify decisions that have already been made on annual priorities, or emerging needs, as well as specific need-related goals and objectives, and corresponding operational strategies, to see if any adjustments could be made to ensure better feasibility, and appropriateness, or if there are no changes to be made, to confirm compatibility between plans and look for common priorities to guide partnership activities.

When one partner verifies their operational plans with the other partner, they are essentially asking for feedback and/or approval, whichever the case may be, on decisions already made about annual priorities, as well as specific goals, objectives, and corresponding operational strategies (or ideas), in order to check for feasibility and interest to pursue partnership activities. Based on public health professionals' partnership experiences, school boards that present their finalized operational plans to them are doing so to verify whether their school board priorities and operational strategies are a good fit with their public health partner's mandate. If there is compatibility, these school boards would then inquire whether public health resources could be made available to put their strategies into action. At other times, school boards may simply put out a request for resources to meet an emerging need, which may then become part of their partnering public health unit's operational plan to guide their decision at the action planning phase as to what resource would be the most appropriated to provide.

By contrast, public health units would verify that their operational strategies, or ideas for an initiative, are well suited for the work being carried out within their partnering school boards:

[We're] looking at doing initiatives (...), more in general [first, and] then we would look at the specifics. We don't bother [our school boards] with the specifics (...) We're not going to [discuss with them] the actual activities that we're going to be doing in the schools. We would (...) [ask for their feedback,] 'Does that meet with your mandate?' We would confirm with them that those are their priorities as well, and that [school staff] are working on those types of action plans at the school level. (...) [And then], the school and the principal and the PHN work together to plan the [specific] activities (...) [for their] action plan.

In addition to ensuring compatibility with the school boards' own priorities, public health units would seek feedback on how best to approach school personnel about their public health operational plans, once deemed feasible by their school board partners. As one public health manager expressed:

We always go through them [with our strategies] and sometimes they could suggest how that may or may not work with principals, or with schools, or (...) [they may say] how that's not going to fly or that's a really good idea, that kind of thing. They can provide advice on how best to approach principles or staff, or whether that [strategy] fits with their strategic direction and can we use that to help get principals' buy-in.

At the very least, most public health units invite feedback and/or request approval on their chosen general course of action to ensure that it fits with their school boards' plans and priorities and that their approach for recruiting schools is appropriate. However, some public health units go directly to school principals to obtain permission. Even though school boards may only be slightly engaged in providing feedback on the

actual nature of public health strategies, this cross-sector engagement could still have a great deal of merit in other respects. Indeed, school boards may provide guidance to public health professionals about the feasibility of their strategies and the best way to pitch their proposed plan for greater school receptivity. In certain instances, public health units and school boards have been shown the final versions of each other's operational/improvement plans, without the intention of possibly making adjustments to their plans. This is especially the case in extended school health partnerships with multiple school boards and multiple public health units. They would verify the compatibility of their operational plans and identify any priorities they may already have in common. Awareness of common priorities would then guide decision-making about health promotion actions that their partnerships could carry out:

The school board is very good to share with us their strategic plans as a partner. They're not asking for input. They're simply sharing, 'Here is our plan already written.' We usually use that to look at where we can try and match and piggyback on things that are already happening in the school board with some of our health promotion work.

For school boards, the verification process is usually about securing resources from their partner. With this intention, they would check to see whether their local public health unit would be interested in assisting them in actualizing their operational plan by delivering relevant initiatives in their schools, should the public health unit's capacity be sufficient.

Partnership arrangements where priorities are preset, and strategies are predetermined from either sector would not be conducive to maximizing the potential impact of the partnership, by themselves. For maximizing partnership impact, additional levels of engagement would likely be required.

D.2 Consulting in the early or mid-stages of operational planning

Description: The public health unit and school board ask for each other's input at some point during the development of their respective operational plans so that their interests and advice can be taken into consideration as part of a separate decision-making process. The purpose is to consult the other partner so that decisions are made while keeping in mind their concerns, needs and professional knowledge to ensure that the operational plan is feasible and appropriate. Early partner consultation consists of receiving input on annual priorities (i.e., prioritized needs), or emerging needs, and possibly specific need-related goals and objectives, and corresponding operational strategies, whereas midway

partner consultation would focus attention on the formulation of strategies after needs have already been prioritized. Consultations on operational plans may also be an intermittent process to be more responsive to emerging needs.

During a consultation initiated by either partner, operational plans are not yet finalized. One partner may choose to engage in an early consultation and inquire about the other partner's concerns, needs, or professional knowledge, before deciding on their own annual priorities and strategies. When public health units consult their partnering school boards early on to find out about their focus, or priorities, for the coming year, they are in a better position to direct their efforts in areas of actual interest to their partners. In this way, they are more likely to create opportunities to work in partnership. As one public health manager pointed out:

For us to engage with [local school boards], we need to understand what their priorities are, then for us to frame what we do in meeting those, as opposed to adding on a different set of activities. They have some areas that they're responsible for, and then we have some areas we're responsible for. But there's this middle ground, and we want to find out what this middle ground is, so that we can make it such that it's not an add-on--we can actually be a support, as opposed to extra work.

Public health units feel it is important to be knowledgeable about their school boards' priorities, since they rely heavily on this information to prepare their operational plans that underlie the selection and development of school health initiatives.

Early consultation would be advantageous for public health units to ensure that the resources they are developing are relevant and of practical use. For example, public health professionals' consultations may directly target teachers early on to receive guidance with their efforts to enhance these teachers' ability to effectively impart health-related messaging to their students. Some consulting approaches being considered at one public health unit include surveys and focus group sessions through which to conduct needs assessments and find out what operational strategies most resonate with the teaching faculty across a school board's district:

We'd like to engage with the teachers to find out a couple of things: what are the topic areas that they feel they need the most support with, that fall under our mandate, and what types of support that they feel they need or would use the most--is it related to full lesson plans, is it related to in-person support? Ultimately, we want to be able to empower teachers to take resources that we have developed, or provided to them, and competently and comfortably

teach those health-related topics or weave them into their other lessons in a way that is successful with the students. Given that the health curriculum is so large and that there's lots of grade levels and ages to potentially target, we want to make sure that (...) we're creating or revising resources that are the types of resources they actually want to use. And what does that look like? Do we need to start to incorporate new technologies a little more, to use social media a little more, to use multi-media types of things? And that would depend on the age, I guess, and grade level. But we thought that if we did that, we could do surveys, or we could maybe also engage them in focus groups, and maybe that could happen, like in a PD day-type of situation, within the school board. (...) [But] one homogenous PD day, I don't think so because there'd be a lot of teachers. I think they'd do families of schools, but I'm not certain about that.

As indicated by this public health manager, early consultations about their operational plans would be more efficient in smaller, more uniformly arranged groups of teachers, organized by their partnering school boards.

When school boards are not available to meet with their public health partner specifically for the purpose of a consultation on their priorities to know what needs to be addressed, their input can still be captured in other ways. In such situations, public health professionals would find alternative means through which to find out the interests and priorities of their local school boards to ensure greater receptivity to their partnership offers. They would do so, indirectly, by viewing their school boards' plans online when posted on their websites, and informally, either through side conversations at meetings with school board representatives; through casual conversations that public health frontline staff would be having with school administrators; or by being shown a hard copy of their partner's plan. As one school health manager explained:

When we're doing [operational] planning, we informally search for information on school board priorities to inform our plans [through] their websites—they have strategic plans on their websites—and just conversations throughout the year with the school principals who would be aware of strategic directions at the school board level. (...) There's not [a lot of interaction because] when we partner with [our other health unit] to try and meet with them, they're just very busy. It's difficult for them to come to the table.

Once their local school boards' prioritized needs have been uncovered, public health professionals would then prepare their operational plans, or adjust an existing one, as a living document, should it be possible based on their strategic plan, or mandate, and capacity level.

Midway consultation would be taking place when advice is being sought on operational strategies once needs assessments have already been conducted to set priorities. Such consultation may occur between the main contact person from each sector to ensure that partnership work is relevant and fits within the work being carried out in their local school boards; it may not necessarily require that all key actors be engaged. Through a one-on-one type of liaison meeting, the school board contact would be providing advice on how to bring the public health strategy, still under development, to a level where it could garner much interest from their partnering school board:

[It's] about making sure that [our operational strategy] is framed in a way that is relevant to the education sector, (...) and [it fits] the school effectiveness framework. (...) [And so,] we frame it internally (...) and then there's work done at the level of the liaison with their particular partner [at the school board]. (...) So, that allows for that discussion to occur, before we might even pitch it further within the board.

Cross-sector engagement in operational planning could also be an intermittent process. Operational plans may undergo adjustments as unanticipated school system needs emerge throughout the school year. For example, one public health unit regularly meets with school board representatives not only to update them on what public health frontline staff have been working on in their schools, but also to further assess school boards' needs. When other needs emerge during the school year, they make any necessary adjustments to their own operational plans so that the strategies they develop internally remain relevant to their school board partner.

Based on public health professionals' partnership experiences, they may also be consulted by their local school boards, when having to decide about which need to prioritize and which corresponding strategies to take on. During such consultative engagement process, advice is being provided to complement the school board's main decision-making process, as a separate process.

D.3 Involvement on an annual operational/work plan

Description: The public health unit and school board ask for each other's input on their respective annual operational plans as they are being developed so that their interests and advice can be taken into consideration throughout the decision-making process. The purpose is to involve the other partner so that decisions reflect their concerns, needs and professional knowledge and can ensure that the

operational plans are feasible and appropriate. Partner involvement means that one partner is providing extensive input on the other partner's prioritized or emerging needs, as well as goals/objectives and corresponding operational strategies to address these needs, as part of their main decision-making process for operational planning.

Public health units involve their school board partners in their operational planning when seeking to familiarize themselves with their perspective so that decisions on priorities and strategies could fully reflect their concerns, needs and professional knowledge. Public health professionals' involvement of school board partners in their operational planning process is about having meaningful conversations regarding what can be realistically accomplished through partnership work, and collectively, setting annual priorities and agreeing on relevant strategic approaches that would then guide the preparation of the public health unit's action plan.

Some public health professionals are just starting to involve their school board counterparts in their operational planning process, whereas in the past, they used to consult them. A turning point for one public health unit occurred when the leadership sought to enhance their school health partnership by engaging in the joint exploration of possible strategic options that would be most relevant to their school boards' current areas of focus:

We're moving toward a more need-based and priority-based approach, where we talk more about this with the school boards up front, about their needs and priorities, and then work [together] on [public health] programming options that are more related to their priorities. I think (...) [this new way of engaging] was stemming from the conversations with the directors of education (...) and the opportunities for enhanced partnership.

In their efforts to improve their school health programming and strengthen their partnership, this public health unit has been given the opportunity to attend high-level school board meetings, which has provided them with the opportunity to gain a clearer understanding of their school board partners' needs and priorities as well as how they work. Through this arrangement, the public health unit is able to involve their school board in the preparation of their operating plan for much greater relevance and receptivity.

Conversely, school boards' operational planning process can involve their local public health unit as a source of external expertise and population health surveillance data in order to fill a capacity gap. Engaging extensively with local public health units allows school boards to become aware of health-

related issues that need to be addressed if student well-being is to be fully promoted. It also grants wide access to additional professional knowledge for strategizing suitable health promotion approaches. Efforts to counteract childhood obesity is one area where local public health units are actively being involved in the preparation of school boards' operational plans related to proper student nutrition. As experienced at one public health unit:

The best example we've had, in the past, is around nutrition. (...) So, in nutrition we really have jointly planned. And [our school boards] defer to our nutritionist who's on our school team as the expert and she works diligently with them to help them plan or review [what's] to occur within their schools. (...) [She] is sought out at all levels to provide input into [school boards'] strategies and [their action] plans related to nutrition.

In the above example, the nutritionist was equally involved in the development of school boards' nutrition procedures and supported their school board partners with the planning of healthy eating programs and other related resources.

At the school level, much involvement between school health partners may also take place. This may call on public health professionals to have extensive conversations with school representatives to gain a firm understanding of their culture and what is important to them, and then, tailor their approach and propose public health supports accordingly. For example, at one public health unit, the staff ensures that they have a good grasp of the school culture, and the areas in which they are excelling, so that whatever partnership opportunity they have to propose, it will build on schools' existing values and strengths, and thus, be met with greater receptivity:

We meet on a regular basis, we don't come in with programs to offer. (...) We recognize that each school has a unique culture, so we really spend time hearing their story, what is important to them, what are their strengths and start from what is working well. (...) We strive to really be part of their school community. (...) Each school is its own little culture, so every [school] plan is very different depending on their [broad] goals, the resources they have, their location, the needs etc. (...) Staff also develop a strong partnership with the principal and school staff they work with. They also get to work with parents, community partners and with the students. They take the time required to really understand the culture of the school and what is important to them. (...) [And then,] we'll co-create it. (...) Together as a school community, they have been able to advance projects, outcomes and health, in a meaningful way.

D.4 Collaboration on a joint annual operational/work plans

Description: The public health unit and school board prepare a joint annual operational plan that responds to prioritized or emerging needs that is specific to their partnership. The purpose is to jointly plan a course of action that reflects each partner's concerns, needs, and professional knowledge, while being feasible and appropriate. Together, they determine the partnership's shared priorities as well as specify shared goals and objectives, and operational strategies. This common platform serves to guide each other's own action planning phase and/or the development/selection of joint initiatives.

Each year, when the time comes to operationalize strategic directions, or mandates, public health directors and/or public health managers may engage with school board executives and their central staff to prepare a joint operational plan.

Operational plans need not be formally written down and only be prepared at the beginning of each school year. In certain school health partnerships, joint operational planning is even undertaken as the needs arise. Enabled by an interorganizational structure to engage in ongoing communication, school health partners can jointly identify emerging student-related needs, as well as school-based capacity needs, and then formulate operational strategies, or ideas, on how to respond to them throughout the school year. With one school health partnership, their joint operational planning process through regularly scheduled group meetings provided the mechanism through which to guide the action plan of public health frontline staff in a collective manner:

We've developed a collaborative working group that gets together (...) key members get together or from time to time the full group gets together to plan the in-servicing or to talk about what the needs are and how we can support and that sort of thing. It really depends what the area of focus is, but we're in very close communication and communicate with each other to identify needs that have arisen and how we can support both at the board level and at the school level. We don't have a set meeting [schedule]. It is as we need to. (...) Our staff are still mostly developing [the resources themselves], but there'd be consultations. Likely they'll get it to a certain point, and then they'll flip it to the school board for feedback and suggestions.

E. Action planning: Selection and Development of Initiative

According to public health professionals, the action planning phase consists of two stages: the development and selection of suitable school health initiatives according to priorities and strategies/ideas previously determined, and the identification of implementation steps for their delivery in schools. In this doctoral thesis, 'initiative' is a collective term that refers to a policy, program, project, curriculum material, or any other type of resources.

E.1 Verification at the final stage of action planning

Description: The public health unit and school board ask for each other's input on their respective action plans, which have been newly prepared, so that their advice can be taken into consideration. The purpose is to verify decisions that have already been made on the development, or selection, of school health initiatives to see if any adjustments would be necessary to ensure better feasibility, and appropriateness. Verification is also undertaken when public health units are seeking school board approval to offer a school health initiative to schools, and when school boards have a school health initiative that they want their public health partners to deliver in schools.

School health partners may wish to verify their action plans with one another. Verification would be for initiatives that school health partners developed or acquired through a third party. Newly developed, or selected, initiatives would be checked with the other partner to see if they are feasible and/or appropriate. As part of verification, public health units and school boards may review each other's initiatives to ensure that either partner has the opportunity to voice any concerns that would require some adjustments:

We try to always make sure that when it comes to things like, say, mental health or certain [other] topics, that we're always in alignment. And we're often are. So, we'll review each other's materials, or they'll review our programs, and unless there's some glaring concerns, they don't usually push back.

Public health professionals may verify the soundness of their public health resources with their school board partners before proceeding to offer it to their schools. Their school board partners are far more familiar with the local school context and would have a better sense as to what initiatives would fare well

in their schools. Rather than propose ideas for a school health initiative to seek input during operational planning, public health professionals may take up this partnership activity during action planning, with initiatives already developed or selected. As one public health manager pointed out:

Sometimes, something might have been made (...) and then we take it to that group and say, 'What do you think of this?' (...) Sometimes you have an initiative that you know is evidence based, you know that it works, but you want to take it to that group and see what they think about it. (...) [Either] there are different activities we might do because we have been doing them for a long time, or maybe we're taking [an initiative developed elsewhere] to them to ask, 'Do you think this will work in the schools?', or "Does this approach work?" rather than sitting there and saying 'OK, we have to come up with something' (...) It's a time thing.

Public health units' school health initiatives may be newly developed or pulled from their well-established menu of programs and services. However, as indicated above, not all school health initiatives are designed by the local public health unit. Some initiatives come from other organizations already made, and this cuts down substantially on the amount of time required to do action planning.

School boards do not seek their local public health units' approval when selecting or developing a school health initiative for their schools. However, they may approach their public health partners to verify that an initiative they have planned for their schools can be implemented through public health staff:

Within [one of our school boards], there was a [third-party well-being] program that the school board wanted to implement, and (...) they're taking the lead. And they [engaged] with us at public health. We looked at this program, we determined that it would meet all of our needs and mandate and that we'd worked with them through this program.

A school board may also engage in conversation with their local public health unit to check their choice of a third-party school health initiative, from a public health perspective. However, this may not be a regular practice across school boards. One public health manager suggested that school boards would be more inclined to check such decisions in situations where a close working relationship already exists with their local public health unit, and this cross-sector engagement is clearly seen as necessary.

In one school health partnership, the necessity to verify the selection of a school health initiative became evident, in retrospect. The school board undertook what was initially considered a routine information-sharing session about health promotion activities being undertaken in their district. A concern was raised by their partnering public health unit regarding one of the components of a health promotion program

whose purchase had already been made. Fortunately, the matter was rectified, and the cross-sector engagement was enhanced as a result:

A meeting [was organized] (...) where we learned more about the [school board's health promotion] program. We had some concerns (...), but we found out that it was pretty much a go within their school board, and they'd already purchased the program. So, we assisted in [suggesting adjustments]. (...) In the end, it was a good opportunity. I think if we didn't have this opportunity, it wouldn't have opened the door to talk about [our approach to mitigate the identified issue]. (...) So it opened the door to that approach, and that information. (...) Every year, [our school board] invites [our health unit] to come to talk about [our] approach. So initially we thought, 'Oh, that wasn't a great outcome. They already purchased the program,' but if you look at some of the secondary outcomes that have come about, I think it opened the door for conversation on other things. You don't know what you don't know. (...) I think it was really eye-opening.

Although the school board had already purchased all of the resources, they unexpectedly saw their decision in a whole new light once they sought their public health partner's perspective, which then led to a very positive outcome regarding their implementation efforts.

When public health units seek to have their initiatives reviewed and approved by their partnering school boards, separate engagement paths may have to be undertaken, since different school board representatives may need to provide their input. For instance, certain public health professionals must go through a school board's communications agent, acting as a gatekeeper, who would be reviewing their school health initiatives, and then, this gatekeeper would either make approval decisions themselves, or send off the approval request to a school board executive. Requests for school board approval may be necessary to send information to students and/or parents, incorporate public health messaging into lesson plans, or deliver programs or other health promotion activities in the schools.

Verification at the action planning phase is not only about checking the appropriateness of a school health initiative, but it can also be about confirming with the other partner whether they would be able to provide resources to support its implementation. For example, a school board may inform their local public health unit about a school health initiative that they already have in mind in order to verify if they could provide implementation resources for its delivery in schools. As one public health professional indicated:

The school health manager from our health unit is part of the discussion. When we are invited to the table with school boards the idea is already defined, and public health supports the promotion and implementation of the initiative.

E.2 Consultation in the early or mid-stages of action planning

Description: The public health unit and school board ask for each other's input on their respective action plans that are being developed so that their interests and advice can be taken into consideration at some point during a separate, internal decision-making process. The purpose is to consult the other partner so that decisions are made while keeping in mind their needs, concerns, and professional knowledge to ensure that the initiative to be developed or selected is feasible and appropriate. Consultations on the suitability of an initiative can take place early on and/or mid-way into its development or selection deliberation.

Public health professionals may consult their school board counterparts at key time points during the process of developing or selecting their school health initiatives. Consultations may take place early to gain insights as to how best to design an initiative, before getting started. Alternatively, consultations may be conducted from time to time during the planning process, to make sure that the initiative being worked on, or considered, is indeed capturing their partner's needs and preferences.

At one public health unit, they used to consult their school boards' lead curriculum consultants on occasion but now they intend to increase the number of consultations so that their public health resources can meet curriculum requirements in the best possible way:

We've done it a little bit in the past, (...) to have regular consultations, especially during this phase of revising resources. But to have a good working relationship with the curriculum specialists within the boards, [is important] (...) because they can be very helpful to us when we're looking at the curriculum. (...) [They can] make sure that our lesson plans reflect not only the structure and even the lay-out of what the curriculum typically looks like for teachers, but that we make sure that we're doing a good job of embedding the health messages in a way that is 'teachable,'—something that the teachers are used to looking at, and that is familiar to them when they look at it to plan their lessons or activities for their kids. (...) The way that we've engaged with the curriculum specialists in this past year, (...) we had [them] come to our team meeting to talk about the changes specifically in the human development curriculum, (...) just to help us understand what the changes were, where they were occurring, just to have

an informative discussion about it so that we could look at our resources and decide where we needed to make changes so that they were applicable to the new curriculum.

During action planning, public health consultations with school boards may center around the development of curriculum resources. For increased teacher receptivity, public health staff are encouraged to first verify their ideas for health-related classroom material with curriculum specialists during operational planning, and then undertake one or more consultations during the development of their resources. For example, at one public health unit, arrangements have been made for their public health teams to engage with their partnering school boards' curriculum committees, before starting to produce teaching resources. If their ideas are found to meet a school board's need, they would then meet with curriculum consultants early on for input on how their proposed resources can be made to fit with the existing curriculums. The health and physical education curriculum consultants know the full gamut of curricular offerings, and if the initiative could fit in areas other than health and physical education specifically, they may then refer public health team members to other curriculum consultants working in those other areas (e.g., linking concept of preconception with a high school science class to convey the understanding that individuals' state of health affects the children they will be having in the future). These team members would return with a draft for further input to ensure that their lesson plans fully reflect curriculum requirements. A school board's curriculum committee would also be able to guide public health professionals on suitable ways to get their resources in the hands of the right teachers. This process gives the public health teams the opportunity to get on the inside track of what might work well in schools.

The reverse can also happen where public health units are consulted in the planning of their partnering school boards' school health initiatives. In one school health partnership, the public health unit and their school board partner have made arrangements to consult each other on health-related curriculum resources they are each developing:

As I mentioned, we're revamping our school health program, (...) [and] depending on what we're working on, having different meetings. Like when we're having a review of our curriculum supports, we'll include their curriculum specialist to provide input, (...) and that would include input to maybe some of their curriculum as well. It will be a back and forth approach.

However, school boards are not taking full advantage of opportunities to consult their local public health units. Public health professionals feel that it would be in school boards' best interest to consult them when

developing their initiatives. They see themselves as a readily available source of professional knowledge to cut down on the amount of work that would otherwise be required by school board staff:

I do sometimes think that it would be valuable if they did that. I think it would save them some effort, in some cases, if they came first and ask for [our input]. (...) Because sometimes when we've come across some things they have developed, and then provided some input, they're like, 'Oh, we didn't think of that.' (...) Sometimes, it takes a lot of their capacity to go and find information, because they're not necessarily familiar with it. If they'd ask an external partner like the health unit, we might have that at our finger tips and that would save them time and effort in doing it, and we could sort through some more valid information [for them].

E.3 Involvement during the action planning phase

Description: The public health unit and school board ask for each other's input on their respective action plans as they are being developed so that their interests and advice can be taken into consideration by sharing the decision-making process. The purpose is to involve the other partner so that decisions reflect their needs, concerns, and professional knowledge to ensure that the initiative being developed or considered for selection is feasible and appropriate. Partner involvement at this level means that one partner provides extensive input during the development, or selection, of a school health initiative for which the other partner takes the lead, or is responsible.

When in the process of developing, or selecting, a school health initiative as part of their offer of support to schools, public health professionals may involve school board representatives who have content expertise and/or guidance to contribute. For example, one public health unit sought the expertise of their local school board's mental health leads as they were developing a student workshop that addressed the topic of mental health. Although this was a public health unit's initiative, its content was shaped with extensive input from their school board counterparts:

We have a menu of [public health] workshops and programming that we offer on different health topics. (...) If we're developing something new, for example, and it has a mental health component, then we work with the board's mental health lead on the program, or the workshop, and fine tune it [together]. (...) And then we would bring it to the superintendent level for approval and then it would get rolled out to schools, to principals and teachers, through our public health nurses. (...) [We developed] a workshop for students (...) [and] one of our school board mental health leads was involved in the development of that workshop. [Another mental health lead] provided input (...) [on] existing programs or research to consider, feedback and suggestions for material to include or remove in the beginning of the

program planning process, and off and on during the whole development process, including a review at the end. There were [a number of] working group meetings and communication via email.

Public health units and school boards engage with each other at various levels, even within the same partnership activity. Although the second mental health lead was not always present during the workshop development process, their contribution was still extensive throughout this process. Involvement is not so much about being a standing member of the other partner's committee, or working group, as it is about providing input early on and at key time during the planning process, including at the very end when all decisions are finalized.

Likewise, school boards may involve their local public health units in the development of their initiatives—possibly through participation on one of their working groups as well. For example, as part of their school health partnership, one school board was looking to actualize their mental health strategy through a cross-sector steering committee, along with working groups, established to create nurturing school environments. Public health representatives were invited to contribute to the development of that school board's initiatives by participating in those working groups whose activity areas overlapped with their public health mandate.

E.4 Collaboration during the action planning phase

Description: The public health unit and school board are jointly responsible for developing or selecting a school health initiative to address a shared priority. The purpose is to collaborate on a joint initiative that is being co-led by both school health partners. Collaboration at this level means pooling expertise and possibly resources to take concerted action.

Collaboration between public health units and school boards during action planning means sharing the responsibility of making decisions about initiatives for a group of schools, or all schools across the local school system. Public health units and school boards collaborate on initiatives when they seek to act in concert. As one public health manager pointed out:

[Our health promotion and prevention] group is still very active. (...) When we plan for the mental health awareness week, we bring those partners back on because we want to make a collaborative effort and we want to have one voice. (...) [In addition, that group] tried to find ways to assist youth, teachers, and parents to mind stress. That's where (...) [this] project was initiated. (...) It was a tool to show kids how to relax and how to meditate and reflect. The toolkit was developed [together] with the expertise of mental health supports and it was adapted in the schools.

Other public health professionals gave examples of joint initiatives prepared at the school board level. Additional examples of joint initiatives include the development of youth engagement projects, the preparation of teachers' workshops, the organization of healthy schools network events, and the building of a parent lending library to access health-related resources.

E.5 Coordination at the implementation planning stage of action planning

Coordination means collaboration at the implementation stage of action planning. At the school board level, school health partners engage in simple coordination when deciding what each partner will do in terms of promoting and delivering school health initiatives across all schools, or a group of selected schools, within the school board's jurisdiction. In certain school health partnerships, more elaborate coordination of programs and services has taken place through the engagement of multiple community partners, including one or more public health units, and their partnering school boards. This form of engagement consists of mapping out the various activities that are being undertaken locally to serve the needs of schoolchildren, and then planning for the greatest level of efficiency possible.

F. Policy development and implementation planning

During school boards' operational planning, the idea for a school health policy may originate from either the Ministry of Education, local public health units, or the school boards, themselves. Ministry-derived policy requirements are communicated through official Policy and Program Memorandums (PPMs), some of which may also be legislated. The topic areas range from life-threatening medical conditions typically found within the student population, such as anaphylaxis, asthma, and concussions, to health promotion matters, such as healthy eating, physical activity, prevention of tobacco use, and active transportation.

School health policies, also referred to as procedures, are locally produced by each individual school board. They may be based on information being shared by the local public health unit, and on the administrative directives of school board executives.

The Ministry of Education has been encouraging school boards to engage with their local public health units on student well-being initiatives, including the development of school health policies, especially those driven by PPMs. As a result of cross-sector communication, public health units became aware of current ministerial calls to prepare PPM-based policies through various methods: emails, teleconferences, and media releases. Public health units have been directly notified by the Ministry of Health and Long-term Care, acting on behalf of the Ministry of Education, that the release of a policy directive to school boards was imminent. As one public health manager commented:

[The ministries] are working better together and we are seeing the signs of that. (...) We are often included now in communications. We are considered a key stakeholder, which is really nice. For instance, we would get an email through our Ministry that would be from the Ministry of Education. So, our Minister of Health, and the people who work at the provincial level, might send us a memo or a news release that comes from the Ministry of Education saying 'FYI, this new policy is coming out.'

When public health units would find out about policy expectations through interministerial channels, they would reach out to their school boards and offer their technical assistance. The increased cross-sector engagement at the very top level of the provincial government is to be lauded. Nevertheless, another public health manager stated that there is still room for improvement regarding interministerial support for greater consistency in policy-making at all levels across the province and for the joint development of local school board policies on student well-being.

Although more can be done in encouraging greater cross-sector engagement in local policy-making, this is nevertheless a delicate situation to address. When reaching out to their local school boards with policy-related information, public health professionals have learned from experience that great care must be taken to carry out such an activity in a tactful and non-imposing manner, less they run the risk of upsetting their school board contacts and damaging the relationship:

We certainly found at different times--and you have to be cognizant of relationships--if we came back with feedback on a particular policy that they've created--it's their policy and their organization--so if somebody came along and said, 'I don't really like how you did [this], it should have been this,' you could actually wreck your relationship, and you may never look at

that person the same way because of the way they handled that--if they weren't asking for our feedback and we've provided it. We have run into situations where that has been negative to the relationship, and so we're just cognizant of that. I think just gentle encouragement to consider where we might have expertise and input on particular policies, and as those relationships develop, then the opportunities expand. (...) We are reluctant to provide specific feedback without being requested to; we might suggest that there might be other avenues to consider and that we could support that.

Public health professionals would initiate the sharing of relevant school health information with their local school boards when deemed appropriate, but this would not necessarily lead to cross-sector engagement in policy work. They would provide this type of information for school boards' consideration upon hearing of their policy intentions through informal or formal means of communication. Informal approaches include side conversations with school board representatives, information-sharing networks, and postings on school boards' websites. Public health units would formally find out about school boards' policy intentions through meetings that are specifically held to discuss issues/hot topics and potential policies, with the top leadership from both partnering organizations present at the table, and through participation on school boards' parent involvement committees. The types of policy-related information being offered by public health professionals include literature reviews, needs assessments, surveillance reports, and copies of other school boards' school health policies that could be adapted.

From time to time, public health units are invited by their school boards to contribute to school health policies that the Ministry of Education expects them to prepare, or that they have chosen, on their own, to develop. By requesting public health professionals' content expertise, school boards may also stand to gain their policy endorsement in order to garner more public support. The level of a public health unit's contribution can vary depending on the extent to which their subject matter expertise is being sought or is available; the number of other external stakeholders who are also able to provide input; and the school board's preferred engagement process, among other possible factors.

Policy work across the public health and education sectors ranges from revising or refining the language of policy documents to writing entire school board policies, or procedures, together. Based on school health partnership experiences regarding policy work, public health professionals have engaged with their local school boards in various ways: providing feedback on a completed school health policy draft, or on the revisions made to an existing policy that has recently come up for renewal (verification); discussing the possible content of a policy before its development (early consultation); commenting on a rough policy

draft, or on an existing policy up for renewal (midway consultation); and providing input on a school board's policy while being present all along the policy development process (involvement).

In some instances, the timing of cross-sector engagement for policy development may not matter, whereas in other instances, extensive engagement would be preferred. It would depend on the type of policy that is being considered. As a public health manager pointed out:

It depends on what they want from us. Sometimes they'll say, 'Just send us the information, and we'll incorporate.' Sometimes they'll say, 'Can you review what we have, is it aligned, or are we missing something?' Or sometimes we'll sit at the table with them. But either way, we're providing input. (...) So, if I'm just transferring information, then it's ok to have information sharing, to be at that level of the continuum. But if I want a huge policy shift, then you definitely need collaboration.

In the example above, the sharing of information is mentioned. However, in keeping with the description of the engagement spectrum in this thesis, the information being provided is being directly applied to a partnership activity, which is the provision of consultative support in the form of policy advice, or professional input *per se*. Therefore, in this instance, the information being provided is rather a planning resource for policy development.

In terms of a cross-sector engagement at the verification level, school boards may choose to have their school health policies be checked for completeness and for alignment with current evidence and best practices. Public health professionals highly welcome being asked to verify a school board's school health policy:

It was good, and it was the first time that that had happened. (...) There was a rep from all health units that were invited to review [the policy] ahead of time and then sit down and discuss it, so it was excellent.

Regarding extended school health partnerships, a school board may favor engagement with their main public health partner over other public health partners, whose catchment areas would be covering much fewer schools. Nevertheless, public health professionals with fewer schools to service feel that they have equally valuable insights to provide based on their perspective of unique local realities. As indicated in the above example, providing feedback on a final policy draft can still be a rewarding experience even though late in the development process, especially when opportunities are created for direct, in-person engagement.

School boards may engage with their public health partners to receive their input at various times during the development of a new school health policy: at the final stage, pertaining to verification; at the beginning and/or mid-point stage, pertaining to consultation; and throughout the process, pertaining to involvement. Public health input may also be requested on existing policies that are coming up for review. As existing school board policies near the time for their renewal, public health units may submit their suggestions for improvement directly in person, or indirectly, by email or by visiting their school boards' websites and providing feedback online—although the indirect method of communication may restrict the extent to which comments can be shared and understood.

According to public health professionals, work on school health policies may proceed with minimal to substantial cross-sector engagement. Much back-and-forth discussion would certainly be required when seeking to clarify perspectives on health-related issues and exploring policy options:

Sitting at the same table and working that through, and what does that mean and how does that look, and these are the challenges that they're seeing in schools, what would we recommend [for] the policy to help incorporate that.

Public health professionals appreciate the opportunity to be consulted on policy work early on into the development process. A public health manager commented that one major advantage of early public health participation in policy work is the possibility of lessening school boards' workload and avoiding the situation where major changes would have to be made to their newly crafted policies. When it comes to health promotion, public health units have a considerable amount of knowledge that tend not to be fully utilized by their local school boards.

Working on a rough policy draft can be just as productive in certain instances. There have been times when school boards have consulted their partnering public health units mid-way into their policy development process by presenting to them a preliminary policy draft. Such policy draft can stimulate the discussion and provide a clear direction for moving forward. This approach is particularly suited for PPMs, since the draft would be bringing to public health professionals' attention those policy components that the Ministry of Education require school boards to include in their locally tailored school health policy, and it would provide the foundations on which to build the technical aspects of the policy together:

[When showing us policy drafts, school boards will] say 'This is what the Ministry's asked, and this is what we've come up with.' They'll pull all of us together and say, 'What are your

concerns? What are things that are missing?' So, they have something as a starting point; it's not like this is final. They've done whatever they need to do internally to make sure that it aligns with what the requirements are of the PPMs, because they have to do that.

Public health professionals provide technical assistance, or content expertise, in support of school boards' policy work. This level of engagement may take place in parallel to school boards' internal decision-making process on the non-technical aspects of their policies that center around administrative considerations and logistical requirements. As such, this decision-making process would then lie outside partnership activities. However, it is possible for public health partners to be given the chance to also provide final comments after policy decisions have been made through school boards' internal processes:

We sat down together and worked through a lot of different things and then together came up with a [school health] policy. And, [school board personnel] would work further on it and then we'd bring it back to that table—at our MOH/Directors [of Education] meeting—for more feedback.

Not all public health units have had ample opportunities to discuss school health policies during consultations by school boards. A public health manager pointed out that the policy development and review process would benefit from broader discussions about the rationale behind public health suggestions for school health policies. At one public health unit, headway was made when a local school board invited a public health representative to be an official member on their school board's Parent Involvement Committee, where decisions on school health policies are usually discussed and finalized. Other internal school board committee structures have enabled the involvement of public health professionals in school boards' policy-making process. Policy involvement provides additional advantages, especially when it enhances public health professionals' ability to support the policy during the implementation stage, as a result of feeling better prepared and more knowledgeable about the full scope of the work that needs to get done.

Public health units may be involved in school boards' policy work, but they would never actually collaborate with them, according to how collaboration is defined in this thesis. When school health partners are collaborating on joint programmatic initiatives, responsibility is explicitly shared. However, all policy-related initiatives are the sole domain of school boards. At the policy development stage, decisions are not made jointly:

There were some [policy] areas where [the school board] absolutely took our advice and, yet, we still can't say that we made that decision together with them in those areas.

Even if invited to co-write a school health policy, public health professionals consistently commented that school boards, ultimately, have the final say in policy decision-making. Public health professionals do not seek consensus when participating in school boards' policy work, but rather prefer the chance to discuss their views sufficiently with their partnering school boards to feel heard and understood. Once having fully expressed themselves, they are cognizant that *"it would be up to the [school board] to decide what they want to accept and not accept."*

On the other hand, school health partners may make joint decisions as to what resources would need to be shared to implement the policy once developed. Public health units' policy resource support includes the delivery of training sessions in schools, which would require the preparation of educational material on the policy itself (e.g., rationale, background, and directives) and how to apply it.

G. School planning

In the least advanced school health partnerships relative to schools, engagement centers heavily around a networking partnership arrangement. Public health professionals seek to share information at school meetings about available public health support. They make presentations to the principals and teaching faculty about the healthy school approach and how they can provide assistance with planning and implementation. In some instances, opportunities to make such presentations have yet to come, because school boards and their schools are, for the time being, focusing their limited resources on students who are experiencing difficulties in their lives. When these school boards and schools accept public health support and enter into a cooperative partnership arrangement, it is usually for a one-off health promotion initiative, rather than a healthy school initiative with an intention to include additional components over time for a comprehensive approach.

School health partners whose partnerships are somewhat advanced at the school level may be contributing input at some point during each other's operational and action planning phases, but it would not be in any extensive way. They may check each other's plans for suitability or provide input at one time or another during their respective planning processes (i.e., verification or consultation, within a

cooperative partnership arrangement) in addition to sharing implementation resources. Although schools may be requesting input on school plans mainly to secure resources, public health professionals would take this opportunity to ensure that these plans reflect evidence-based practices and are as comprehensive as possible. Likewise, public health professionals would seek input to ensure that their public health plans are feasible and can garner principals' approval.

At the most advanced end of the school health partnership scale, local public health units are extensively involved, planning collaboratively with schools that are receptive and ready to take on specific strategies and initiatives for promoting the well-being of specific groups of students or for enhancing the resilience of the entire student population. In those school health partnerships with highly active school-level planning engagement, networking can still take place from time to time, along with the other types of partnership arrangements, be it cooperative or collaborative. Networking would consist of exploring additional school health partnership opportunities and identifying other potential community partners with whom to engage for more resources.

As part of networking activities, public health professionals would link schools to other community partners that could potentially provide more specialized resources to actualize certain parts of their school plans. Furthermore, public health frontline staff may come across resources from other credible organizations during the course of the school year and proactively recommend them to teachers in anticipation of any unmet school need. Indeed, various levels of engagement may be experienced along different planning processes.

Operational plans, whether prepared through the school planning process or the public health planning process, ideally begin with a needs assessment at the school level. Assessment results may uncover trends in health-related issues and capacity issues in schools across the same school board district. They not only help determine the strategic directions of school boards' multi-year strategic plans, but also serve to fine-tune priority areas that are documented in annual board improvement plans for student achievement (BIPSA). It is from the BIPSA that schools take their direction for preparing school improvement plans for student achievement (SIPSA) in each school year. Although the priorities in a school board's BIPSA are meant to be reflected in the SIPSA of every school under their jurisdiction, certain schools may prioritize other needs that require equal or greater attention due to their local context:

The school boards will develop and identify what their priority areas of focus are, and the schools obviously need to support those priorities. But the principals have the authority that if there are school-based issues going on that need a priority focus, those can be embedded too. So, it's a bit of both.

In addition to supporting schools' planning process for their own school health initiatives, public health units prepare internal operational and action plans of their own in order to offer school health initiatives that they would have a hand in implementing in schools. Public health professionals would at the very least be asking principals to verify these plans for their approval. However, they could also consult or involve principals and/or school staff during their planning process to ensure relevance, feasibility, and schools' resource support. As a public health manager stated:

[In late spring, the school nurses] basically determine from [the school needs assessment results]—it's a qualitative and quantitative [process]—what are the priorities within each school, together with the principal. (...) [Then] based on this conversation, the nurses would create an action plan, over the summer. (...) In the fall, they go back to the school, they'll have another meeting with the school principal and go over the plan, [and ask,] 'Is this a good reflection of what our conversation was in the spring?' 'Are you willing and able to assist and potentially assign staff to parts of the plan?' and then the implementation of that.

According to this public health manager, the extent of cross-sector engagement, whether it is a consultation or an involvement, would depend on how high of a priority the principal considers the health topic to be.

As another planning approach to involving school personnel, a working group could be established by a public health frontline staff when leading the development of school health initiatives for a particular school. For example, public health professionals have engaged with a teacher representative, or a group of teachers from the same school, throughout the development of classroom material so that their capacity needs could be addressed appropriately.

School planning does not proceed in any set way, nor is it necessarily a linear process; operational and action planning may undergo cyclical iterations, going back and forth from strategic to action-oriented thinking. Moreover, some parts of school planning may be done with school administrators, other parts with school committees, and still other parts can be further elaborated through participation in networks of schools. Public health units may contribute to these school planning processes, and their input would necessarily find their way into their own public health plans when offering additional resources. Amid the

myriad of ways that planning for the improvement of student well-being could be undertaken, the critical point is that formal processes can be put in place to ensure that schools have access to the required evidence and knowledge from their partnering public health units for effective school health plans.

Public health units' operational planning for school health does not only occur formally, but is an ongoing process, with informal requests to respond to unanticipated school needs emerging from time to time during the course of the school year. Usually, teachers would communicate with their public health partner to verify whether or not they have resources to help them meet a particular curriculum-related requirement. As public health professionals propose suitable resources to meet emerging needs, they may then take this occasion to provide additional ideas about how to engage in the other components of the healthy school approach in order to address these needs as comprehensively as possible within their classrooms.

During their school improvement planning process, a school may mention to their local public health unit what health-related areas they intend to focus on for the upcoming year, so that they may discuss what supports could be made available to them from the broader community. For example, if physical literacy would be their chosen priority, a public health frontline staff could offer to put them in contact with all the community partners related to physical literacy. Then, the school would seek opportunities to meet with these other partners to further develop their plan around that topic.

In addition to providing input into school plans, offering information and available resources as required, public health partners may link schools to other community partners so that they could have access to all the necessary resources that can be made available to them to further develop their plans. Public health frontline staff provide networking support to schools in two ways. They can build linkages between schools and other community partners outside their formal planning process. Alternatively, they can do so while serving as an active member of their school committee (e.g., healthy school committee, well-being committee, or wellness council).

The implementation planning stages at the school level and at the school board level do not exactly resemble one another. In terms of similarities, the purpose of coordination is the alignment of promotional and initiative-based activities across partnership actors, regardless of the organizational level. Not only do school health partners plan activities to be undertaken as part of school health initiatives,

but they also organize how these activities are to be promoted to increase participation by the targeted populations. Where coordination differs between levels is related to the extent of details that are going into the implementation plans. More detailed coordination is required when the time comes to implement the initiatives on the ground, especially for those initiatives that have many implementation steps.

According to public health professionals, their more elaborate school health initiatives would be standardized for uniform delivery across the school board's district. The core messaging and action strategies would remain the same from school to school to maintain the integrity of those initiative components that have been scientifically demonstrated to be effective. However, these components may not be put in place in the same way across schools, owing to variations in local contexts and capacity. Therefore, public health professionals stated that school health partners at the school level must come together to coordinate who does what and how, in order to tailor multi-step initiatives according to what structures and processes can be used for a smoother and more effective implementation. Furthermore, when public health professionals request input from school administrators, this input is not usually about the actual content of the school health initiative, but rather about determining the school-specific implementation steps and assigning school staff to undertake certain initiative-related activities, as required.

Appendix 4B: Background Information about Cross-sector Engagement related to School Health Partnerships

In this appendix, background information is provided on the different types of school health partners' engagement processes. This appendix first presents additional details on the similarities of multi-year strategic planning processes undertaken by the public health and education sectors. Then it covers the distinct process within local school systems of preparing board and school improvement plans. Next, high-level overall strategies driven by the provincial government, with direct influences on school health partnerships, are explained. More details on policy development within the education sector are also given. Lastly, school health partners' participation in community-based partnerships is elucidated in reference to community coalitions and collective-impact initiatives.

A. Background information on multi-year strategic planning

Public health units are mandated to partner with local school boards and their schools on health promotion initiatives (i.e., policies, programs, services, projects and other resources).¹ Although school boards are now mandated to promote student well-being as well, they are not mandated to do so in partnership with their local public health units.² However, this is not to say that educators view partnerships with their local public health units as unimportant for accomplishing their mandate.

The Ontario Education Services Corporation (OESC) highly recommends that school boards engage with their community partners, including public health units, in their strategic planning process. OESC is an umbrella organization for the Council of Ontario Directors of Education (CODE) and the school trustee associations within all four school systems in the province. In one of OESC's instructional modules, Boards of Trustees are advised to begin their strategic planning process by conducting an environmental scan, as they engage with their stakeholders. The purpose of the environmental scan is to gather internal and

¹ Ontario Ministry of Health and Long-Term Care. (2016). *Ontario Public Health Standard, 2008* (Revised May 2016). Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf

² Government of Ontario. (2016). *Education Act, R.S.O. 1990, c. E.2*. Retrieved from <https://www.ontario.ca/laws/statute/90e02/v65>

external data and identify organizational strengths and weaknesses, emerging issues, trends, and suitable approaches for producing desired change or improvements within the school system.³

Stakeholder engagement, via community needs assessments, is encouraged to better understand needs and expectations. OESC recognizes partnerships with internal and external stakeholders as critical to achieving school boards' goals. They state that a school board could benefit from seizing opportunities to "obtain multiple perspectives from parents, partners, students and board staff in order to identify common critical issues, needs, expectations and possibilities (...) [and] engage its stakeholders and the broader community as valid, essential and interdependent members of a larger network (p. 6)."³ Their good governance practices recognize that even though the Board of Trustees makes the final decisions, a partnership approach is worthwhile when developing their multi-year strategic plan.⁴ This practice has started to be taken up by school boards across the province. A recent operational review of Ontario district school boards conducted by the Ministry of Education revealed key developments in the area of governance. As part of governance modernization efforts, school boards have "improved their strategic and annual planning processes by engaging a broader base of stakeholders (p. 4)."⁵ A trend is emerging where school boards are gaining interest in having their community partners be part of their planning processes.

Both public health units and school boards are required to produce multi-year strategic plans. According to the *2011 Ontario Public Health Organizational Standards*, each board of health is expected to prepare a strategic plan that (1) covers a 3-to-5-year timeframe; (2) encompasses the advice and input of community partners, as well as staff; and (3) is reviewed at least every other year.⁶ Similarly, Ontario's

³ Ontario Education Services Corporation. (n.s.). *Professional Development Program for School Board Trustees Module 6: The Strategic Role and Multi-Year Strategic Planning*. Retrieved from <http://modules.ontarioschooltrustees.org/files/en_m6.pdf>

⁴ Ontario Education Services Corporation. (2014). *Good Governance: A Guide for Trustees, School Boards, Directors of Education and Communities*. Retrieved from http://cge.ontarioschooltrustees.org/files/en_good-governance.pdf

⁵ Ontario Ministry of Education. (2013). *The Road Ahead: A Report on the Continuous Improvement in School Board Operations* (Operational Review Final Report). Retrieved from <https://sbsb.edu.gov.on.ca/VDIR1/Operational%20Reviews/SummaryReports.aspx?Link=OP>

⁶ Ontario Ministry of Health and Long-Term Care and Ministry of Health Promotion and Sport. (2011). *Ontario Public Health Organizational Standards*. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/orgstandards/docs/org_stds.pdf

Education Act stipulates that the boards of education must develop a plan that applies to three or more school years and that is reviewed on an annual basis.⁷ To be compliant with this act, school boards' multi-year strategic plans must be directed toward the high-level, government-mandated goals of student achievement and well-being; a positive school climate; effective stewardship of the board's resources; and the delivery of effective and appropriate education programs. The OESC emphasizes that strategic planning "involves understanding the bigger context, determining the board's goals and strategies, setting relevant policy, allocating resources and monitoring progress toward realization of the board's mission and vision (p. 2)".⁸

In line with this perspective, the multi-year strategic plans for boards of health and boards of education are expected to include their organizations' mission, vision, and values; strategic directions; and broad goals in terms of their priority areas of focus that reflect the needs and expectations of their local communities, in addition to a performance measurement framework.^{8,9,10} Furthermore, school boards' broad goals are meant to be refined into SMART (i.e., specific, measurable, achievable, realistic, and time-based) goals. For each specific goal that has been refined and set, school boards are then required to identify suitable strategies that they have the capacity to carry out. OESC defines a strategy as "a set of planned, appropriate and optimal approaches and solutions that enable an organization to reach a goal or to have an impact (p.7)".⁸ Strategies are part of the operational plan (i.e., the one-year version of the multi-year strategic plan).

An examination of a sample of web-posted public health units' multi-year strategic plans revealed similar components, with high variability in their presentation. The 18 multi-year strategic plans, accessed online, included public health units' statements on their mission, vision and/or values, with some incorporating

⁷ Government of Ontario. (2016). *Education Act, R.S.O. 1990, c. E.2*. Retrieved from <<https://www.ontario.ca/laws/statute/90e02/v65>>

⁸ Ontario Education Services Corporation. (n.s.). *Professional Development Program for School Board Trustees Module 6: The Strategic Role and Multi-Year Strategic Planning*. Retrieved from <http://modules.ontarioschooltrustees.org/files/en_m6.pdf>

⁹ Ontario Education Services Corporation. (2014). *Good Governance: A Guide for Trustees, School Boards, Directors of Education and Communities*. Retrieved from http://cge.ontarioschooltrustees.org/files/en_good-governance.pdf

¹⁰ Ontario Ministry of Health and Long-Term Care and Ministry of Health Promotion and Sport. (2011). *Ontario Public Health Organizational Standards*. Retrieved from http://www.health.gov.on.ca/en/pro/programs/publichealth/orgstandards/docs/org_stds.pdf

guiding principles. These statements provide the foundation on which to carry out strategic planning. According to the information that some public health units added to their strategic plans, the strategic planning process may consist of a data gathering stage, including an environmental scan or situational assessment with internal and external stakeholders, as well as a trend analysis for the purpose of setting strategic directions and high-level priorities. For example, one multi-year strategic plan listed a situational assessment and environmental scan as key activities for guiding the development of an overall multi-year strategy. Examples of high-level public health strategies include a health equity strategy, an anti-obesity strategy, and a strategy for tobacco-use prevention.

Different terminology is being used to name the components of multi-year strategic plans. For instance, high-level priorities may be expressed in terms of 'strategic focus areas,' 'priority areas of focus,' 'strategic priorities,' or 'priority directions.' In order to operationalize high-level strategic plans, specific priorities, goals and objectives are spelled out to further describe the direction that is being planned through the setting of focus areas. In this way, high-level priority focus areas can be more readily reflected in operational plans. Specific strategies may also be found at the end of each priority section within the operational component of multi-year strategic plans. Following the setting of the strategic directions and broad goals, many plans included an operational component that identified a broad course of action, at times referred to as operational 'strategies', for each specifically stated priority. Each broad course of action, or set of operational strategies, was expressed as an intention to do something in response to that priority area. Some strategy statements also conveyed their purpose or anticipated impact.

In regard to the performance measurement framework that ought to be an integral part of strategic planning, only two of the examined multi-year strategic plans linked indicators, or outcome targets, to objectives under each of their strategic priorities. For the other plans, it seems that the information on indicators of success would be presented in separate documents. No high-level, multi-year strategic plans that were found online mentioned budget allocation. This information may be more relevant at the operational planning stage, either as an integral part of the operational plan or as a separate document pertaining to the organization's accountability framework encompassing both budget decisions and performance indicators.

B. Background information on board and school improvement planning

The Board Improvement Plan for Student Achievement (BIPSA), as well as the School Improvement Plan for Student Achievement (SIPSA), are key planning documents under the responsibility of the director of education and the school principal, respectively (Ontario Ministry of Education, 2011a; Education Improvement Commission, 2000). BIPSA lays out a course of action at the board level to achieve annual goals targeting students' academic and well-being needs. SIPSA would in turn specify the school team's priorities that are specific to their local context, as well as the specific goals, operational strategies and corresponding initiatives (including action strategies) to respond to these priorities.

The strategic components of the BIPSA (as with the SIPSA) are similar to those found in the multi-year strategic plan, except that they cover only those areas that are to be prioritized for the coming school year in the area of student achievement and well-being. As a school health coordinator explained:

[Their board improvement plan] is at a next level down, and then from there, it goes down to the school improvement plans. The elements from the board strategic plan, the headings, the columns, those are moved down to the board [improvement plan] level, which are moved down to the school improvement plan.

Both kinds of improvement plans are strategic in nature. In addition to the articulation of school boards' mission, vision, and values, the strategic components that make up the annual BIPSA (as with the SIPSA) include the needs assessment (i.e., analysis of student data) and the one-year goals derived from identified needs that fall under the initially set high-level, broad goals. These one-year goals are meant to be specific, measurable, attainable, relevant, and time-bound (i.e., SMART) (Ontario Ministry of Education, 2011a). Although this operational planning phase consists of strategic thinking, it covers a shorter timespan than multi-year strategic planning. The next phase is action planning, which is concerned about putting the strategies/ideas conceived during operational planning into practice. It entails selecting or developing targeted and evidence-based initiatives, as guided by operational strategies/ideas to achieve the SMART goals (Ontario Ministry of Education, 2011a; Ontario Education Services Corporation, 2014).

Not all public health units are familiar with their school boards' improvement plans, and these plans are not generally a topic of discussion at partnership meetings. Although some public health units may know about these plans directly from their school board partners, other public health units tend to find out

about them from visiting their partners' websites, or they would hear about the BIPSA priorities either during formal board meetings, informal conversations, or school visits.

Board improvement planning is carried out to guide internal board functions, and as such, would unlikely be a subject for discussion with the local public health unit:

I think having input in their strategic plan makes sense because that reflects their community. Their board improvement plan does it too because they would reference their strategic plan and priorities in their improvement plan. But their improvement plan is what they are going to do with their board.

However, knowledge of school boards' priorities is critical to public health units since public health professionals aim as much as possible to focus their operational plans around what their school boards view as important to them. As one public health professional commented:

[It is] difficult to plan when you don't have access to school improvement plans or board improvement plans, or data collected within schools.

Without a full understanding of school boards' plans and priorities, it is difficult for public health units to meet their partners' needs. By having full knowledge of board improvement plans, public health units are in a better position to prepare their school health operational plans in a manner that could best fit with their school boards' own plans. This may also pave the way for greater cross-sector engagement. Indeed, some public health professionals are working closely with their school board partners to create alignment with their board improvement plans, and thereby use existing opportunities within their local school system to contribute their school health support rather than add extra work to the promotion of student well-being.

C. Background information on operational planning related to school health partnerships

There currently exist at least three main areas where public health units' and school boards' operational planning can intersect for concerted action: the inter-ministerial Mental Health and Addictions Strategy; the Ministry of Education's newly revised Health and Physical Education Curriculum; and the Ministry of

Education's Foundations for a Healthy School framework, which aligns with the Ministry of Health and Long-Term Care's Comprehensive School Health model.

C.1 Mental Health and Addictions Strategy

Several years ago, a major provincial initiative was launched regarding mental health and well-being across Ontario. The Government of Ontario's *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* has major implications for school health partnerships, particularly in relation to its first two overarching goals: (1) to improve mental health and well-being; and (2) to create healthy, resilient, inclusive communities (Government of Ontario, 2011). The first three years following the Strategy's launch focused government attention on children and youth, through the joint efforts of the three provincial ministries with responsibility for health, education, and children and youth services, respectively.⁵ Under this inter-ministerial strategic initiative, the Ministry of Education provided funding to all school boards to hire a mental health leader to develop and implement a Board Mental Health Strategy (Ontario Ministry of Education, 2011b, 2012, 2014b). Some school boards have posted their own versions of a multi-year mental health strategy on their websites. Such overall strategies are expected to align with multi-year board strategic plans, and be an integral part of board improvement plans.⁶

The Ministry of Education is providing resources to school boards to promote healthy development and to make use of specific classroom-based strategies, or action strategies, for student well-being. One major resource is the School Mental Health ASSIST coaching support. Although many government resources are being made available, the Ministry of Education's memorandums to directors of education have been encouraging school boards to partner with community agencies when creating and operationalizing their own mental health strategy (Ontario Ministry of Education, 2011b, 2012).

⁵ Information taken from the Registered Nurses' Association of Ontario's website at <http://ymhac.rnao.ca/en/section-eight/8.2.2>

⁶ Information taken from the Waterloo Region District School Board's website at <http://www.wrdsb.ca/bipsa/wp-content/uploads/sites/31/Mental-Health-Strategy.pdf>

Each school board's mental health strategy may be developed differently, but it is essentially a three-tier approach at its core. The first tier is centered on universal mental health promotion; the second tier targets at-risk students for early identification and preventive interventions; and the third tier aims at ensuring that students with mental health problems receive the care they need through appropriate treatment referrals.⁷ A variety of health professionals have been mobilized to engage in this type of strategy. Among these professionals are mental health workers (e.g., social workers, child and youth workers, psychologists, family therapists) and mental health and addiction nurses from community-based agencies (Ontario Ministry of Education, 2011). Their expertise is especially geared toward the early identification and treatment end of the mental health spectrum of care. However, Tier 1 and part of Tier 2 of a school board's mental health strategy are of particular relevance to public health professionals since they emphasize the promotion of positive mental health and the prevention of mental illnesses. These areas of mental health promotion and prevention lend themselves well to the development of comprehensive approaches that align with the Foundations for a Healthy School.

C.2 Health and Physical Education Curriculum

Recently, the Ministry of Education released its revised Health and Physical Education Curriculum for Grades 1-8 and for Grades 9-12. According to these curriculum documents, one of the priorities for educators across the province is:

promoting the healthy development of all students, as well as enabling all students to reach their full potential, (...) [since] [s]tudents' health and well-being contribute to their ability to learn in all disciplines, including health and physical education, and that learning in turn contributes to their overall well-being (Ontario Ministry of Education, 2015a, 2015b, p. 3 in each document).

The revised health and physical education curriculum emphasizes a holistic approach to educating students about how to promote their health. It does so by addressing a variety of inter-related health topics, namely healthy eating, physical activity, mental health, substance use, safety and injury prevention, human development, and sexual health, with the aim of empowering children and youth to

⁷ Information taken from the School Mental Health-ASSIST's website at <https://drive.google.com/file/d/0Bx9WOcdOIVzNTFctam5UeDY3XzQ/view>

take better care of themselves in every aspect of their lives. Through this approach, it is expected that students will gain the knowledge and skills necessary for leading a healthy, productive and socially responsible way of life.

The health and physical education curriculum is a tool to support school boards and school personnel in implementing government policies and high-level strategies related to schoolchildren.⁸ The abovementioned curriculum documents for elementary and secondary schools highlight the contributions of community partners as being vital to the success of a school's health and physical education curriculum, drawing particular attention to the Ontario Public Health Standards mandating public health units to work in partnership with school boards and schools on comprehensive health promotion. In partnership with school boards and schools, public health messaging can be integrated not only in health-related courses but across the curriculum of other disciplines, where appropriate, for greater relevance to the students' learning experiences (Ontario Ministry of Education, 2015a, 2015b). Furthermore, the health and physical education curriculum is meant to be delivered using the Foundations for a Healthy School framework. In this way, what students are learning in the classroom can be reinforced through initiatives that promote healthy, active living within other areas of the school environment, the home, and the broader community.

D. Background information on school health policy development

The promotion of student well-being is carried out through the development and implementation of both programs and policies. A policy is understood by public health units as a formal or informal statement that broadly indicates what an organization is expected to do, or what course of action they are required to undertake. Health-related policies within a school setting are defined in this thesis as any policy for student well-being that aligns with the mandates of health-oriented agencies and organizations, not limited to public health units. Not all health-related policies fall within the mandate of the field of public health, and for certain health topics, there are other actors within the health system who could give better policy advice. School boards' school health policies, considered a sub-set of health-related policies, would then be those policies of relevance to public health units within the context of their school health partnerships.

⁸ Information taken from the Ontario Physical and Health Education Association (OPHEA)'s website at https://www.ophea.net/sites/default/files/file_attach/RESP_FactSheet_02OC12.pdf

Formal school board policies related to school health originate from ministerial directives. The Ministry of Education, possibly in collaboration with other provincial ministries, formulates policy directives through two different policy instruments: (1) Policy/Program Memorandums (PPMs) that may or may not be legislated (e.g., PPM 150—School Food and Beverage Policy, derived from the Healthy Food for Healthy Schools Act in 2008, versus PPM 138—Daily Physical Activity, with no corresponding legislation); and (2) laws and their regulations to ensure the proper prevention, identification and management of medical conditions and injuries (e.g., Ryan’s Law, Sabrina’s Law and Rowan’s Law—these laws were named in memory of those students who lost their lives due to a preventable event, namely an asthma attack, a severe allergic (anaphylactic) reaction, and a fatal concussion, respectively).⁹ Rowan’s Law is also accompanied by a ministerial memorandum on concussions (PPM 158). School boards’ tobacco policies stem from the Ministry of Health and Long-term Care’s Smoke-Free Ontario Act, which prohibits smoking in all public places across the province including all public and private school premises.¹⁰

Since PPMs and legislation represent broadly articulated policy directives, they are insufficient for school boards and schools to know how they can be applied to their local setting. School boards are then required to create their own policy documents, which may be referred to as ‘procedures’, or as a ‘policy’ that includes a broad statement followed by a set of procedures. Formal school board policies/procedures give specific instructions as to how PPMs and legislation are to be implemented locally. However, school health policies/procedures may also be informally developed by school boards without there being any overarching ministerial directive to dictate their content (e.g., pediculosis [head lice] procedure).

Within the education sector, policies and procedures have been described as “belief statements and operating guidelines for parents and staff regarding the administration of programs, property, student, staff and Board matters.”¹¹ Moreover, a policy is understood as “a statement or position of a principle, intent or belief adopted by the Board of Trustees that provides the framework for the development of a

⁹ Additional information taken from the Ontario Ministry of Education at <http://www.edu.gov.on.ca/eng/parents/healthyschools.html>

¹⁰ Additional information taken from the Ontario Ministry of Health and Long-Term Care at <http://www.mhp.gov.on.ca/en/smoke-free/>

¹¹ From York Region District School Board’s website, <http://www.yrdsb.ca/AboutUs/Policy/Pages/default.aspx>

course of action.”¹² By contrast, procedures either state “the operational steps to implement Board policies,”¹³ or provide “direction to specific situations where an accompanying Board policy is not required.”¹⁴ Procedures are particularly useful to “establish an expectation of how an issue is to be addressed in order to ensure common understanding and practice.”²¹ According to public health professionals, school boards tend to use the term ‘policy’ for health matters that are strictly in regards to PPMs from the Ministry of Education, and refer to their own policy documents as ‘procedures,’ although the terms “guidelines,” “protocols” and “operating policies” have also been used.

According to public health professionals, school board policies/procedures that are mandated by the Ministry of Education are unlikely to deviate from the minimal requirements found in the provincial policy documents. However, they commented that school boards can expand their policies/procedures beyond these requirements. In addition to their policies derived from PPMs and legislation mentioned above, school boards have developed policies of their own in many other areas. As one public health manager explained, school board policies may cover a broad range of topics related to school health:

[Other] areas are around bicycle safety, child abuse, alcohol, tobacco and drug education in schools, safe arrival at school, bullying prevention and intervention, (...), student mental health, playground equipment. This is how broad it is.

School health programming is generally directed toward the promotion of health and the prevention of disease/injury at the student population level, and it includes related policy work with school boards and schools. Work on policies about medical conditions lies within a grey area, in that expertise in medical conditions varies widely across public health units. Public health managers and nurses may contribute either directly or indirectly to the policy development process. Some public health units view policy advice on certain medical conditions as a secondary role. Nevertheless, public health units have been supporting their school boards and schools in areas such as asthma, anaphylaxis and tuberculosis, by providing their technical assistance to the best of their ability and/or by networking with the broader community in efforts to secure additional expertise and resources to provide to their school board partners.

¹² From Dufferin-Peel Catholic District School Board’s website, <http://www3.dpcdsb.org/about-us/policies>

¹³ From Halton District School Board’s website, <https://www.hdsb.ca/our-board/Pages/Policies-and-Administrative-Procedures.aspx>

¹⁴ From York Catholic District School Board’s website, <http://www.ycdsb.ca/trustees/policies.htm>

Public health units have been engaging in the development of school board procedures, or guidelines, mainly in regard to the implementation of provincially mandated policies or legislation within the context of school health. The creation of school boards' own policies/procedures related to school health is another area in which some public health units have been active. However, there are certain policy-related areas in which public health units wish to engage, but they may not all be given the opportunity to do so because the link with public health is not clearly understood by most school boards. A key example pertains to the social dimension of the school environment, which public health professionals consider to be integral to health promotion:

Another one is around school culture, or school climate, that social environment piece in schools that we're really concerned about. [School boards] largely don't see the connection to why public health would be interested or concerned about that.

At times, school board policy-makers may not think that their public health partners would have input to provide on certain of their policies, whose health implications on health would not self-evident to them.

Whether or not they are actively engaged in policy work at the school board level, public health professionals could still be contributing input on school policies. School health policy making is not exclusively carried out at the school board level. In fact, public health units have been working directly with school administrators to develop or expand school health procedures that are specific to their schools. In certain cases, the hope is that the health messages in these policies would be taken up by the school boards. One public health manager pointed out that the development of school health policies cannot be isolated to only one level of the school system:

This is a complex system where sometimes public health units are working at the board level, but they're also working at a local school level and that school nurse is hammering away at procedures and guidelines, at educational supports and programs for the kids, at parent engagement and the school councils to get buy in. So comprehensive school health, that is the complexity. It's not like we only work at the board level around policy. It's multi-layered, that's really critical [to understand.] (...) If we limit policy or guideline conversations solely to be at that board-wide level, we won't capture the complexity of it. Oftentimes where many of these provincial policies have initiated is from the school level.

Sometimes policies/procedures have started at the school level, and then the Ministry of Education formalized them across the whole province. The initial school projects that looked into healthy eating guidelines are clear examples of this practice. These projects attracted the Ministry's attention. By

learning about the possibilities for improved nutrition within schools, Ministry officials scaled up nutrition-based policies provincially.

School health-related policies may be initiated with the help of public health partners. According to public health professionals, a school health program that is launched within one or more pilot schools with partnership support may become a school board policy if the school board leadership decides to have all or a greater number of schools adopt this new program. Similarly, a school health-related policy prepared by a public health nurse, or health promoter, could be reviewed by a school's administration, and potentially brought to the attention of their school board executives for possible application throughout their district. Therefore, policy from a public health perspective can also be a school board's directive to mandate the implementation of a school program or policy across its district.

As an additional consideration, policies need not be written statements in and of themselves. A broader view of policy-making encompasses the idea of 'policy' as any decision that a school board has made concerning a certain course of action. As a public health manager explained:

It could be done through actual changes to current [planning], without saying it is a policy. They can say, '[This organization] should provide [such and such] (...).' It might be changing it from that angle, where they are changing philosophically their existing protocols. [So] it may not be a policy [for them]; it may be a shift in their planning. (...) They only make formal policies from PPM—any health-related ones from the Ministry—but they may change a lot of [their own] procedures and processes to influence or create supportive environments, which are part of policy work from a public health perspective.

From a public health perspective, changes made to a school board's planning direction or their organizational requirements could be considered policy-type decisions since these changes can still have an influence on the school environment and student behavior, just as a formally written policy document would have. This may not be recognized as such in planning documents nor be identified as 'policy' by school board personnel, but it is an area of decision-making of great interest to public health professionals for its policy relevance.

Viewed from a broader perspective, a school health-related policy (or procedure) is understood as any decision made on a course of action by school boards or schools that may have implications for the creation of a healthier school environment—whether it be explicitly written in policy documents or implied in planning documents and routine school-system operations. As mentioned earlier, a policy is a

broad statement, or a general course of action, that must be accompanied by procedures, possibly in terms of guidelines/protocols, to be put into practice. Although procedures are created to implement school board policies that are mandated through ministerial directives (i.e., PPMs or legislation), they may also be stand-alone documents that indicate policy-related requirements. Policy development is therefore understood as the preparation of a broad statement on a general course of action, and/or, the formulation of specific procedures that may then require resources for their implementation.

Procedures stipulate those expectations that schools have to meet in order to conform to the school board's policy direction. They may include communication plans (e.g., messaging for parents; connecting with physicians) along with other administrative and operational requirements to assist with the interpretation and operationalization of the policy at the school level. Where there exist only stand-alone procedures, 'policy' is implicitly embedded in these documents. Procedures provide the basis on which to prepare the specific action plan for policy implementation—that is, a plan that identifies the steps that must be taken and the resources that must be made available to support schools in adopting a particular policy direction.

E. Community coalitions

At the broader community level, public health units and school boards engage in joint strategic planning, along with other community partners, through their participation in community coalitions for which this planning process is an essential task. Actually, the Ontario Ministry of Children and Youth Services require all regions across the province to establish coalitions of public agencies and community-based organizations, called children's planning table. A number of school boards have joined their public health partners to collaborate in their region's community-based initiatives.

In addition, 46 local governments received funding through the Ontario Ministry of Health and Long-term Care to plan, develop and implement initiatives under the Healthy Kids Community Challenge, in collaboration with community partners. Strategic planning is undertaken through a community leadership table, which then steers action planning through implementation committees with influence across the broader community, including the school system:

There are representatives [from our] engaged school boards at the implementation committee level as well as at the leadership table. Through the planning and implementation of the first round of activities--there's only been one round so far, they'll be several rounds over the course of the next three years--we worked very closely with the school boards as well as other partners in the city to plan and implement the activities and the projects (...) It was an opportunity for us to see some of [our school boards'] challenges and be able to be more aware of how things need to occur in order to work with the school boards at that level. But then, for them, I think they were impressed by what we could do if we were engaged from the beginning.

School board and public health representatives take the lead on the majority of the activities to be carried out within schools. Such partnership opportunities have deepened cross-sector engagement by allowing public health units to have a clearer understanding of their school boards' capacity challenges, and by allowing school boards to experience first-hand the contributions their public health partners could make when engaged in a collaborative planning process from the beginning.

F. Collective-impact initiatives

Some community coalitions have adopted the collective impact approach. Collective impact initiatives follow a best-practice model that holds the promise of maximizing synergy among community partners for greater impact on shared goals. One participating public health professional reported that their community coalition would like to use this approach for all of their joint initiatives, starting with the one that is currently being funded:

[Our] children's planning table, (...) I think they really want to take this [collective impact] model and apply it to everything that we do. I think we're seeing this [grant] as an opportunity to work with a coach and to really learn the process through a practical project. Hopefully, as we move forward, we can use it in other ways. (...) What we're trying to do, in our collective impact [approach], is get us all on the same page using the same [resiliency] framework, using the same measurement [system], and working on one or two [mental health assets] all together to have a greater impact.

This collective-impact collaboration has targeted the goal of improved resilience among the younger generation, as part of an overall strategy to addressing mental health concerns. This community collaborative is strategically determining which children and youth's mental health assets all community partners are to prioritize as their desired outcomes for the creation of a *common agenda*, the first essential collective-impact condition. According to this public health professional, the coalition will be

looking at how the various operational strategies from all the community partners at the table can be better aligned with each other for a stronger impact. These different but *mutually reinforcing activities* or strategies (i.e., the second essential collective-impact condition) are to be undertaken in schools and in various other places within the broader community. Although different courses of action are to be carried out by different partners, the operational planning of these actions will be done jointly as part of one larger plan, with each partner taking on the role that best fit with their mandate.

This resilience-building coalition is fulfilling all five conditions for collective impact. In addition to a common agenda and the identification of mutually reinforcing activities, the third essential condition that is referred to as *continuous communication* is being met through monthly meetings and the facilitating services of a coordinator. As the public health professional explained, the coalition's coordinator position is not affiliated with any of the partnering organizations, but is rather supported by the Ontario Ministry of Children and Youth. This coordinator engages with partners during regularly scheduled meetings and between meetings to keep them informed and motivated. Furthermore, this individual also assumes the functions of a *backbone infrastructure* that represent the fourth and perhaps the most critical condition of the collective impact approach. This position is instrumental in performing the necessary logistical duties of arranging meetings and preparing progress reports to keep the coalition moving forward. Lastly, the public health professional pointed out that all coalition partners have adopted the same resilience indicators from which to consistently collect survey data that will measure the extent to which children and youth's resilience has improved. This *shared measurement system* is the fifth and final essential condition for collective impact.

The collective impact approach highlights the importance of working synergistically on shared priorities. The backbone infrastructure may be external to the coalition—as in the case of an externally funded coordinator position mentioned above—or it may be taken up by one of the coalition partners. Across the province of Ontario, there is at least one public health unit that is serving as the backbone infrastructure for a community coalition. Public health unit staff provide administrative support and other services for research activities, position papers, and progress reporting, while maintaining a community focus. One public health manager who is an advocate of this systems-based approach commented as follows:

For me, collective impact is moving collaborative work to a more strategic direction to support outcome-driven results. With the five pillars, you're setting that common agenda, and looking at (...) [mutually reinforcing] activities. What sometimes happens is that you have the common

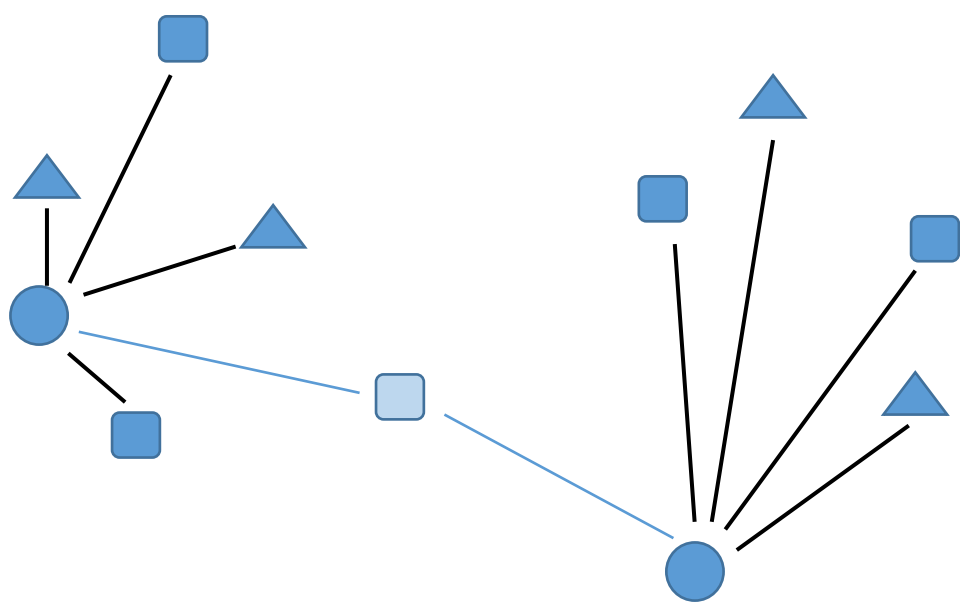
agenda but each sector does activities in silos. So I think with collective impact, really what you're looking at is [not only] what each partner's role will be, but how together that [alignment of activities] can be strengthened. And then that continuous communication, I think that's so key (...); it's [looking] at how do we develop those communication strategies to keep everyone moving forward. And then looking at how can we use the data that we're already collecting more effectively together. But I do think you need to have that backbone infrastructure. So you need to have someone who can provide some coordination and leadership.

This public health professional recognizes that a school-centered initiative would have a much greater impact if it were to be aligned with other activities being carried out in the broader community. For this reason, they are building a strong relationship with their school boards to encourage greater community engagement from them. They are endeavoring to build the capacity that would enable their school boards, one day, to fully undertake a whole-of-community approach based on the collective impact model.

APPENDIX SECTION 5:

Maps of Partnership Dyads between Public Health Units and School Boards by Region across Ontario

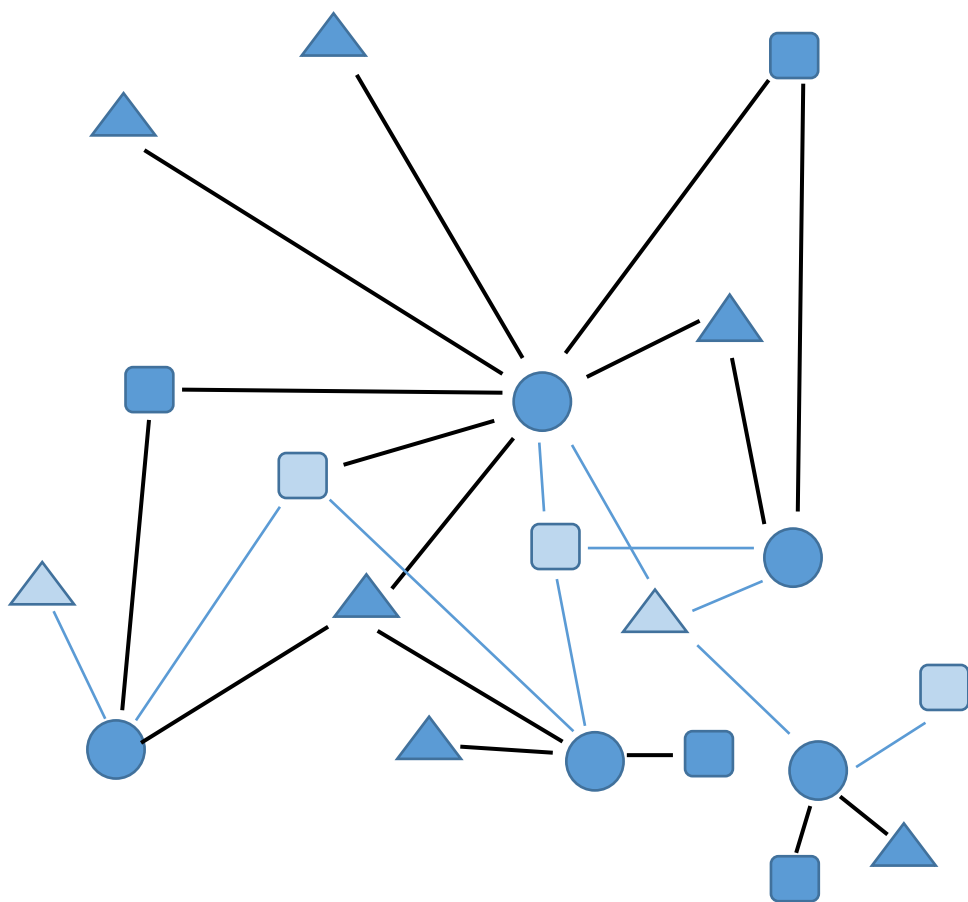
North-West Region



Legend:

-  Local public health unit
-  English-speaking public school board
-  English-speaking Catholic school board
-  French-speaking public school board
-  French-speaking Catholic school board

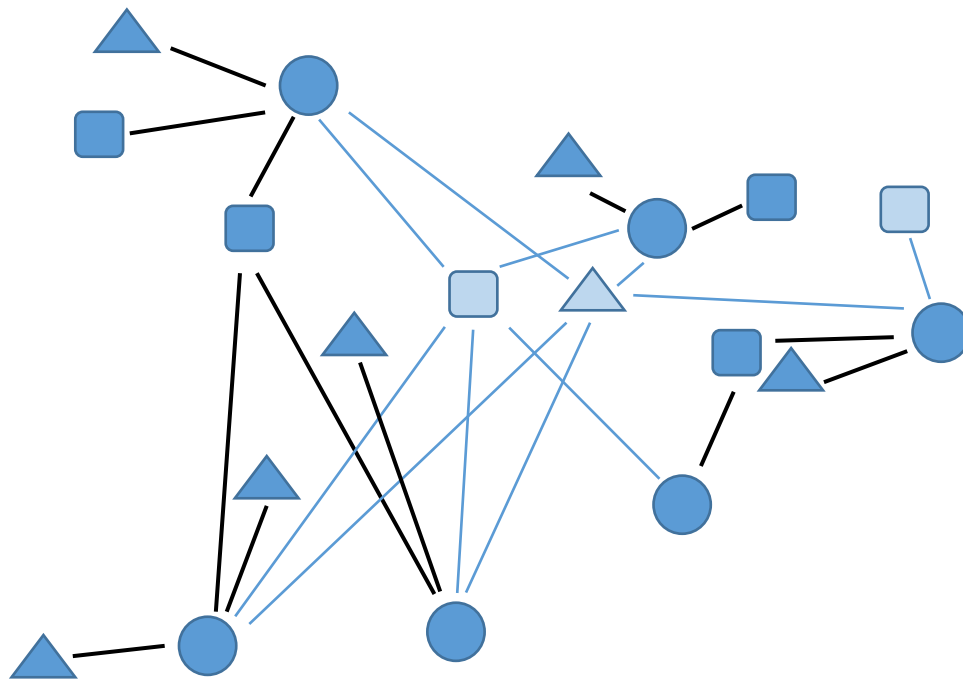
North-East Region



Legend:

- Local public health unit
- English-speaking public school board
- English-speaking Catholic school board
- French-speaking public school board
- French-speaking Catholic school board

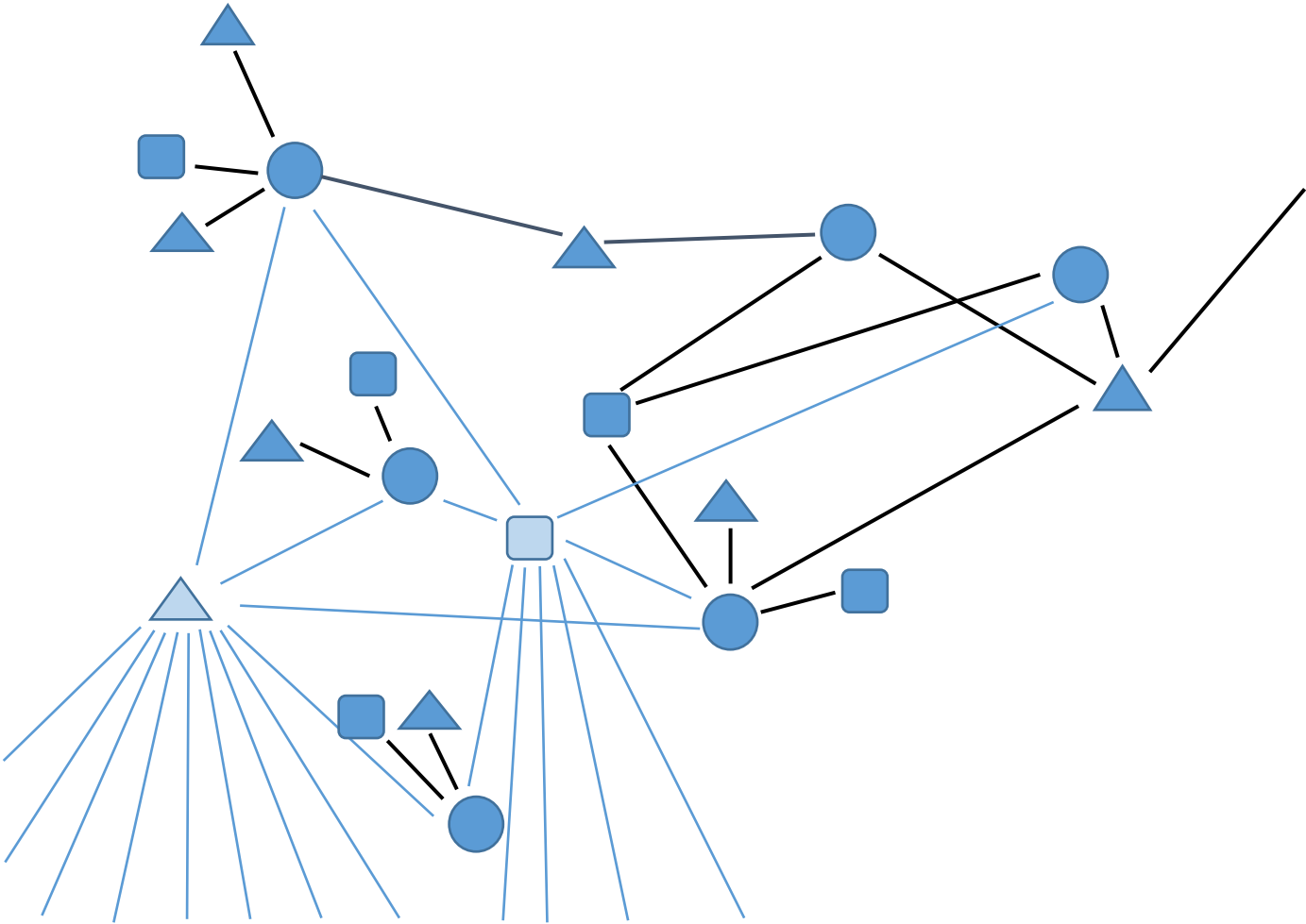
Eastern Region



Legend:

-  Local public health unit
-  English-speaking public school board
-  English-speaking Catholic school board
-  French-speaking public school board
-  French-speaking Catholic school board

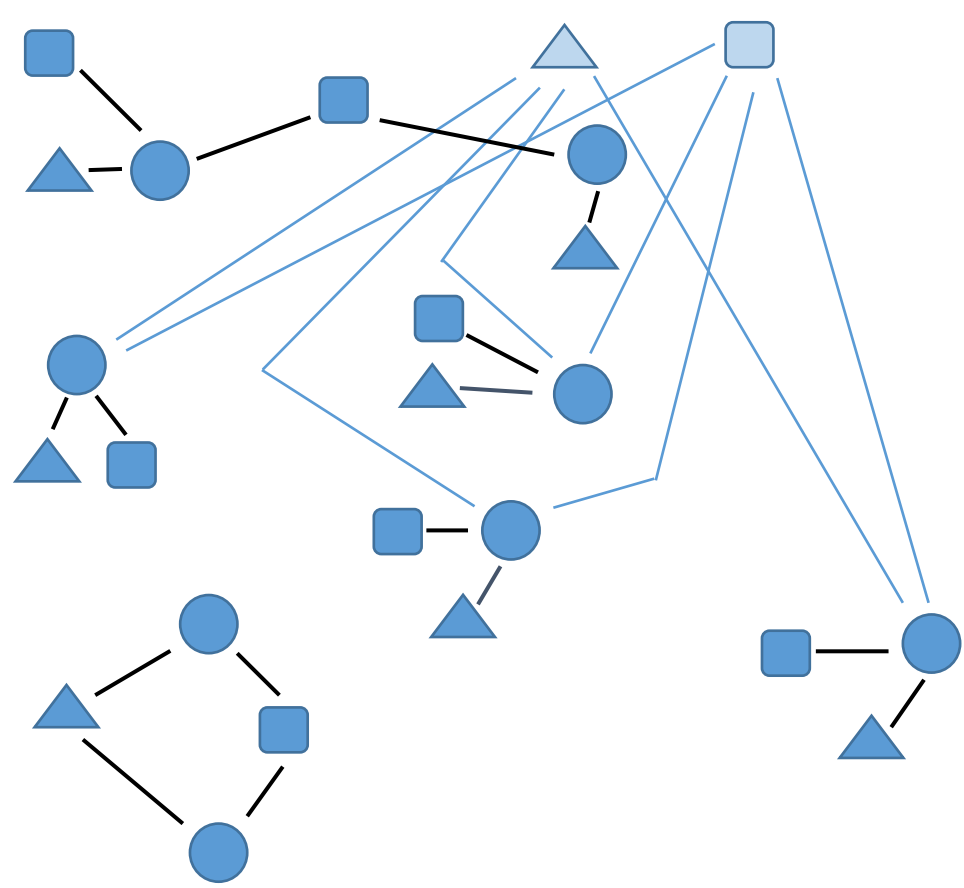
Central-East and Toronto Region



Legend:

- Local public health unit
- English-speaking public school board
- English-speaking Catholic school board
- French-speaking public school board
- French-speaking Catholic school board

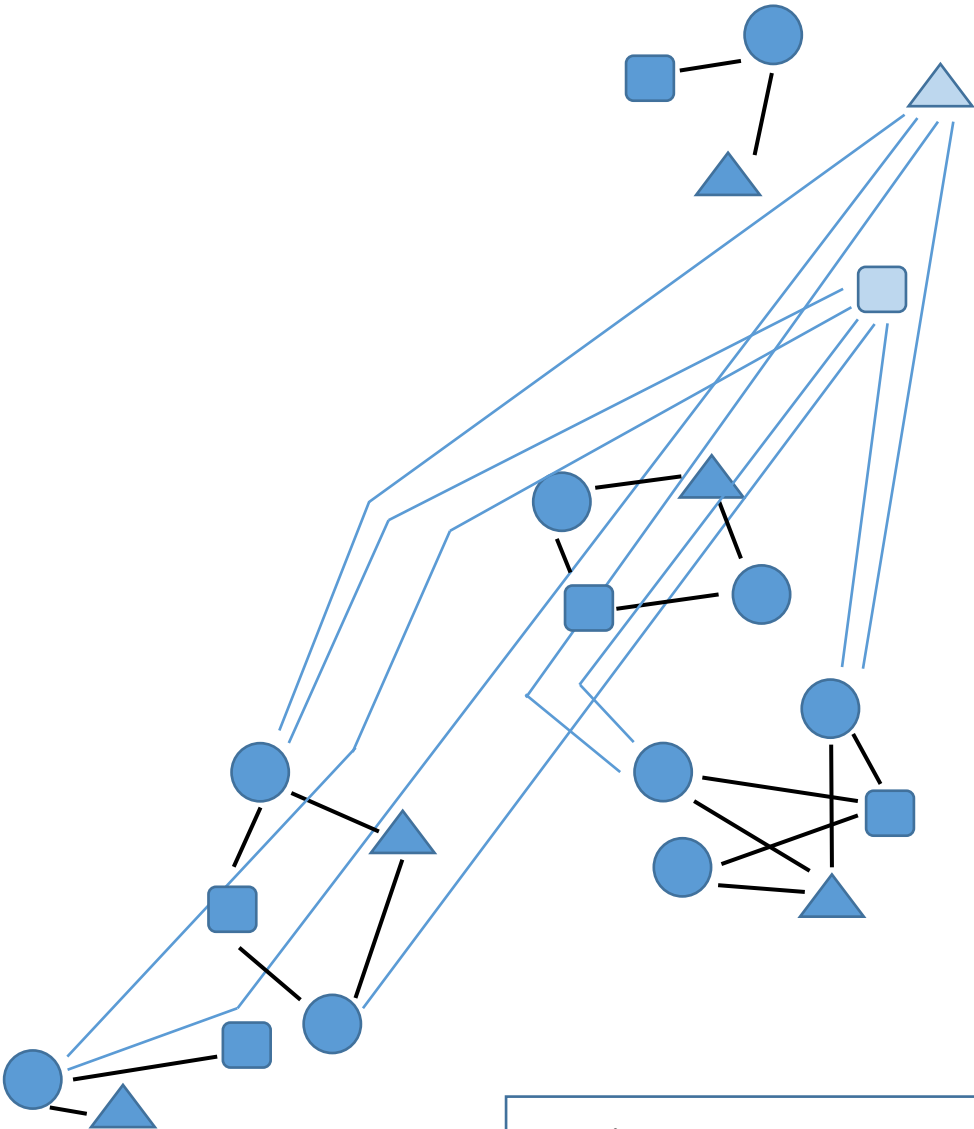
Central-West Region



Legend:

- Local public health unit
- English-speaking public school board
- English-speaking Catholic school board
- French-speaking public school board
- French-speaking Catholic school board

South-West Region



Legend:

- Local public health unit
- English-speaking public school board
- English-speaking Catholic school board
- French-speaking public school board
- French-speaking Catholic school board